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# Cross-Cultural Childbirth: Prioritizing the Healthcare Experiences of Migrant Women in Competent Models of Care

Emma Hall
*SIT Graduate Institute - Study Abroad*, ehall7@luc.edu

# CROSS-CULTURAL CHILDBIRTH: PRIORITIZING THE HEALTHCARE EXPERIENCES OF MIGRANT WOMEN IN COMPETENT MODELS OF CARE

Emma Hall
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SIT Switzerland: Global Health and Developmental Policy
Dana Garbarski, PhD
Dr. Alexandre Lambert

Loyola University Chicago
Anthropology

**ABSTRACT**

In the context of the feminization of increasing global migration, it is impossible to understand maternal and child health in a given country without considering the experience of female migrants. As the total migrant population increases in the European Union, migration and its effects on health care provision in receiving countries and the experiences of immigrant populations must be recognized. Past research exposes an increased risk of complications and maternal mortality in migrant populations, but little information exists on the tangible programs that could respond to disparity. According to the World Health Organization, maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. What this definition does not address are the motivations and cultural perceptions of maternal health practices and pregnancy, which may influence the choices a woman makes in her perinatal care and the ultimate outcomes of her pregnancy. This study uses personal interviews with experts and available literature to evaluate the current trends in maternal health experiences and the sociocultural barriers to care. Migrant women face language barriers, rupture of social networks, and cultural insensitivity during a very vulnerable and chaotic experience of pregnancy. Culturally competent physicians can employ practical tools to assess the health perceptions of migrant women without referring to preconceived cultural expectations. Pan-Milar, an existing education program that provides interpretation and social support for migrant women is an effective model for future programs. In addition, woman-centered models such as the Midwives Model of Care inherently include the needs of migrant women in their method of practice and could be prioritized in the immediate response to disparities.

**TABLE OF CONTENTS**

**PREFACE**

Since the beginning of my undergraduate career, I have been interested in Global Health and, more specifically, maternal and women's health. However, through courses in Anthropology, Biology, and Sociology, I began to recognize the incredibly interdisciplinary and interdependent aspects of maternal health. Because of this, I decided to pursue a two-year research scholarship at Loyola University Chicago, for which I would focus on global maternal health. The initial idea for this project originated from a discussion with my research mentor, Dana Garbarski, PhD, at Loyola University Chicago. In an effort to narrow my research topic, she offered her knowledge on social and cultural barriers to healthcare and how these adversely affect vulnerable populations. In addition, we discussed the current global migration trends and how this would affect access to quality healthcare, especially for female migrants. After further literature review, the disparities in migrant maternal health were evident, and I decided to study this topic as my undergraduate research project.

When I arrived in Switzerland for the SIT Global Health and Developmental Policy Program, I had already determined my general topic, but through lectures at the IOM and by psychiatrists (Dr. Ariel Eytan and Dr. Argyro Daliani) who specialize in migrant mental healthcare, the focus of my project developed. Migrant women arrive from their countries of origin with a more cultural and health profile that the host country's health system may not have the resources to adequately address. In addition, I became aware of the scope of migration in both Switzerland and other European nation. Because of the large population of established and new migrants and the existing knowledge on barriers to healthcare, I decided to combine my passion for maternal health and interest in migrant health.

At the beginning of the SIT program, I had planned to pursue global health research as a future career. However, this project has helped me to realize that I would not be satisfied with a career solely focused in research. Through my discussions with midwives, doulas, and

physicians, I have decided that I will study to become a Certified Nurse Midwife (CNM). In this profession, I can work to provide women with culturally competent and supportive maternal health care. I am so thankful for this project for helping me to realize this goal. For that reason, I chose to look specifically at opportunities for the Midwife Model of Care to be applied to migrant maternal health, which led to an interesting and promising connection.

**ACKNOWLEDGEMENTS**

Without the help of multiple professionals, experts, and advisors, this project could not have been completed. I would like to thank my research mentor, Dana Garbarski, PhD, at Loyola University Chicago for advising me throughout the formulation of this project. In addition, the SIT program staff (Dr. Alexandre Lambert, Dr. Heikki Mattila, and Francoise Flourens) have provided me with support and guidance throughout this project. I would also like to thank those professionals that were willing to speak with me on this subject. Dr. Saira-Christine Renteria, Sophie Paroz, Stephanie Pfister, Karin Gasser, and Dr. Alejandra Cassillas graciously took their time to offer their knowledge and experience. I also appreciate the expertise of lecturers such as Dr. Argyro Daliani that offered their recommendations and references even though this project is not in their specific fields of study. Finally, I would like to thank the other SIT students for their offering their support and willingness to have purposeful discussions.

## INTRODUCTION

According to the UN Resolution on International Migration and Development (2014), there were 232 million international migrants in 2013, with 72 million of these migrants living in Europe. While migration is not a new phenomenon, it has become more complex and diverse. During the recent waves of global migration, developed nations have experienced a feminization of their migrant population. Currently, women constitute nearly half of the global migrant population, and they display a similar, and often higher, rate of migration to developed nations (Llacer, 2007), and women often initiate the process of migration at childbearing age (Caldas et. al, 2013). In several European countries, foreign-born women are responsible for over 1/5 of all life births (Balaam et al., 2013). In the context of improving maternal health on a global scale, receiving health systems, particularly those Westernized systems of Europe, are faced with new challenges in ensuring access to care for an increasing number of pregnant migrant women. However, challenges and disparities do not halt the health needs of a population, and pregnancy and childbirth will continue despite barriers to accessible care.

The World Health Organizations defines maternal health as the health of women during pregnancy, childbirth and the postpartum period. What this definition does not address are the motivations and cultural perceptions of maternal health practices and pregnancy, which may influence the choices a woman makes in her perinatal care and the ultimate outcomes of her pregnancy. Before immigration, an individual's health behavior is determined by the social norms and values of his/her country of origin. Migrant women bring with them "health beliefs, traditions, and cultural practices of their home countries" (Perreira, 2008); however, the norms and values of the receiving or host country may not be the same. These norms and values have shaped the existing health systems, perceptions of health, and

health education in migrant host countries, and, therefore, are not often equipped to adequately address the psychosocial health needs of migrants.

Large-scale, multi-faceted reports such as the European Health Systems Observatory's *Migration and health in the European Union* and the WHO's *Health of Migrants—The Way Forward* have identified migrant health as a global priority by illustrating how the migration process can increase vulnerability to ill health and increase risk for negative health outcomes. However, many of these reports lack a gender perspective, which is necessary in addressing the specific needs of female migrants. The Mother and Child Health postulate within the Migration and Health project of the Swiss Federal Office of Public Health was described by the research project manager, Karin Gasser, as one of the first specific research endeavors dedicated to maternal migrant health on a federal level (personal communication, November 12, 2015). Although the statistical findings of the postulate solidified the disparities in the health experiences of pregnant migrant women and are not heavily referenced in this study, Gasser's experience in creating a collaborative, large-scale dialogue and facing qualitative research challenges on the specific subject illustrates the increasing importance and prioritization of migrant maternal health.

The gender specific literature that is available recognizes that the health effect of migration on women "is determined by the conditions under which the migration occurred, the extent of integration into host society, the social status of the woman in the host country, and the prevailing health conditions in the host country" (Adanu et. al, 2009). For the purpose of this study, articles that integrate a gender and migrant perspective on maternal health are heavily relied upon, yet more general statistics and reports on maternal or migrant health are also used to illustrate the current gaps in the literature. One of the major gaps that emerged through review of existing research was the lack of integration of all relevant topics and goals. For example, a large body of literature and established guidelines exist on the

provision of culturally competent care for diverse patient populations, yet little knowledge exists on how to specifically adapt these guidelines and principles to migrant women. In this study, I will utilize the general global standards to illustrate the strategy of culturally competent care, but rely on the few specific articles and the personal experience of Sophie Paroz, a researcher with experience in migrant health and cultural competency training.

Maternal health, migrant health, and cultural competency have existed as independent priorities for a long time on the global health agenda. Yet, few studies offer a holistic assessment of all three. Many statistical, country-based assessments of migrant maternal health outcomes call for the development of cross-cultural and innovative ways to identify the indirect causes of health disparities (Almeida, Caldas, Ayres-De-Campos, Salcedo-Barrientos, & Dias, 2013). The literature on cultural competency in migrant care recommends specific training programs for clinician and projects that can offer specialized care to migrant patients. Studies on perceptions of both migrant patients and clinicians call for improved access to population indicators and supportive programs. However, there is little review of successful programs or potential models of care that consider maternal health, migration, and cultural competency as interrelated and interdependent topics. This study will attempt to address this gap by highlighting the physician training programs in cultural competency. I will also profile an existing program for pregnant migrant women as a model for future target programs and assess how the model of midwife care could play into the future improvement of migrant care.

### *Objective and Research Questions*

The objective of this study is to provide a holistic review of the maternal health experiences of migrant women in Switzerland and other similar European countries. I aim to not only assess the disparities in access and experience of care, but also work to identify the

systemic, cultural, and social origins of these disparities. In addition, this project will hopefully begin to assess the current availability of culturally competent care for migrant women and identify possible solutions and recommendations for the future. The following are the research questions I used to achieve this objective:

- What are the principal differences in the maternal health experience and access to care for migrant women?
- What social and cultural barriers to maternal health exist for migrant women?
- What are the current practices in place to better service migrant women? What models of care can be applied to the specific maternal health needs of migrant women?

These three main questions shaped the major content and goals of this project. However, because further information and new questions arose through the research process, they are expanded on and supplemented in the analysis and results.

***Research Methodology***

Both primary and secondary sources were utilized in this project to obtain a holistic understanding of maternal health and migration. Research began with a review of the existing literature and publications. Online databases such as PubMed, the Loyola University Chicago Library, and the UN Library were searched using relevant key terms. The resulting articles offered specific, existing knowledge on trends in female migration, culturally competent care, and the maternal health of migrant women. In addition, I reviewed the publications on migration, migrant health, and maternal health from organizations such as the UN, WHO, IOM, and the Swiss Federal Office of Public Health. These publications provided me with a more general framework in which to study my specific topic. Population, migration, and birth statistics were collected sources such as OECD, UN, IOM, Eurostat, and country-specific databases.

Though a large portion of my research was done through literature and statistical review, interviews were also an important component of this study. Literature and online statistics were necessary due to the time constraint of this project and provided me with enough knowledge and familiarity with current trends to comfortably speak with experts. Interviews allowed me to gain the personal perspectives and first-hand experiences of professionals who work in the field of migrant health. Experts and professionals were identified through web searches, referrals by SIT program advisors and lecturers, and references in existing peer-reviewed articles. Potential interviewees were then recruiting via e-mail. Follow-up coordination was then done over additional e-mail correspondence or phone conversations. In the initial recruitment e-mail, I communicated the subject of my project, purpose of the interview, and how the expert would be included in the paper and presentation. I obtained interviews with Dr. Saira-Christine Renteria, CHUV; Sophie Paroz, CHUV; Stephanie Pfister, Pan-Milar; and Karin Gasser, Swiss FOPH. The physician, midwife, and research perspectives provided me with an interdisciplinary understanding of maternal and migration in both a theoretical and practical context.

The formal interviews were semi-structured: experts were asked a pre-determined set of questions, but spontaneous follow-up questions guided the direction of the interview. The interviews were conducted in English, but French was used in the case of term clarification or unknown translation. The interviews were not recorded, but detailed notes were transcribed during each interview. Three of the four formal interviews were conducted at the expert's place of work. The only exception was my interview with Karin Gasser at the, who was in Geneva for a colloquium at HUG on the day of the interview. Because it lessened travel costs to her place of work in Bern, Switzerland, her interview was conducted in the café at HUG.

The limitations of this study are primarily related to time and population constraints.

This project was developed and completed over a three-month period; however, I was only able to devote one full month to it due to other classes and assignments. This time frame was extremely limited to reach out to and obtain interviews with experts and professionals. Therefore, the interviews obtained with the four experts may not be a diverse representation of all professionals who work in maternal health and migration, cultural competency, and research. In addition, I believe that including the pregnancy and childbirth experiences of migrant women would have enhanced the study and provided a more authentic assessment of migrant experiences and needs. Due to time constraints and ethical restrictions on working with a vulnerable population, such interviews were not possible.

## SUMMARY: DISPARITIES IN HEALTH OUTCOMES OF MIGRANT WOMEN

When assessing the relationship between migrant status and pregnancy outcomes, it is important to note that the association is not uniform, and it is highly dependent on migrant subgroup, race/ethnicity, economic status, education level, country of origin, and receiving country (Urquia et al., 2010). Though the situations of diverse migrant populations cannot be overgeneralized because needs are varied in different regions and health facilities (Paroz, personal communication, November 2, 2015), this cannot stop the creation of a dialogue around the issue and an assessment of the current disparities (Gasser, personal communication, November 12, 2015). As displayed in the previous statistics, it is evident that in comparison to non-foreign-born women, migrant women experience higher rates of negative medical outcomes during pregnancy and childbirth and while foreign-born status is not always a "consistent indicator of poor perinatal health … [it is a] large enough disparity to need attention" (Balaam et al., 2013). Because there is little knowledge available on how individual indicators influence specific health outcomes and the purpose of this paper is to illustrate overarching trends, the following disparities are assessed in a more generalized way.

The most extreme physical consequence of pregnancy and childbirth is maternal mortality, which is defined as the death of a woman during pregnancy or within 42 days of delivery. A country's maternal mortality rate is one indicator of the maternal health of its population and the most general representation of the quality of and access to maternal health care (Pedersen, Grontved, Mortensen, Andersen, & Rich-Edwards, 2013). Western European countries have some of the lowest maternal mortality rates in the world, migrant populations within these countries show higher rates of maternal mortality than those of the native female population. In two meta-analyses of past studies done on the maternal mortality in Western European countries, migrant women in Western Europe were found to have a, on average, doubled risk of dying during or after pregnancy in comparison to native-born women (Pedersen et al., 2013; Almeida, Caldas, Ayres-De-Campos, Salcedo-Barrientos, & Dias, 2013).

Female migrant populations also display a higher risk of pregnancy and childbirth-related complications and morbidities. A review of 65 European studies on maternal health and morbidity calculated the average risk migrant women have for morbidity and complications during pregnancy and childbirth. The study found that migrant women have a 43% higher risk of low birth rate, 24% of pre-term delivery, and 61% of congenital deformations (Urquia et al., 2013). It has also been observed that certain populations of migrant women, specifically those with a Sub-Saharan, Latin American, and Caribbean background, experience higher rates of pre-eclampsia and eclampsia (Urquia et al, 2014). As cited in Jentsch, Durham, Hundley, & Hussein (2007), there is also evidence that migrant women suffer from higher rates of complications such as gestational diabetes, post-natal depression, and higher rates of complications such as Cesarean Section, post-partum hemorrhage, perineal trauma and puerperal infection (Aroian, 1999). Although not applicable across all migrant subgroups and identities, these high-risk characteristics associated with

foreign-born women in Western Europe display a need for targeted maternal care efforts for migrant women and the identification of direct and indirect causes of disparity.

## PSYCHOSOCIAL AND SYSTEMIC CHALLENGES

While the available statistics illustrate and justify prioritizing the maternal health of migrant women to public health programs and hospitals (Gasser, personal communication, November 12, 2015), they are not always as distinguished in all regions and hospitals as studies present them to be. In her experience in the Maternity Department and Psychosocial Unit at Lausanne University Hospital in Switzerland, Dr. Saira-Christina Renteria has observed that there are few differences between migrant and native populations' medical consequences during pregnancy and birth. The disparities that do exist are more dependent on a woman's access to care and information, but once a migrant woman gains equal and sufficient access, the outcomes are essentially the same (personal communication, November 11, 2015). Although Dr. Renteria's experience may not be the same as those of other clinicians or facilities with different populations needs, it emphasizes the need to address the systemic and indirect barriers to care rather than solely focus on evaluating biological outcomes. Her experiences in the obstetric care prioritize the social and communication challenges.

### *Social and Cultural Identities*

The process of giving birth and the environment surrounding it varies between

cultures. For migrant women, the perceptions of the importance of health care and the expectations of this care that are formed by the available health services and culture in their countries of origin (Jentsch, Durham, Hundley, & Hussein, 2007). In some cultures, a woman only goes to the doctor when she is seriously ill, which often prevents her from seeking out prenatal or postnatal care in the receiving country. For some women, natural birth may be very important in their native culture, so they resist cesarean sections, even if it is medically necessary, and may experience medical complication due to delayed intervention or even depression after the procedure (Renteria, personal communication, November 11, 2015). Clinicians must explain the role of preventative care and the availability of relatively safe medical interventions while remaining aware of certain aspects of fear or mistrust the woman may have with health systems.

A clash in these perceptions with the reality in their Western European receiving countries can lead to migrant women feeling as if their integrity within the health system has not been preserved (Balaam et al,. 2013). By avoiding cultural differences and impose Western medical ideologies onto diverse and vulnerable migrant women, health systems create a culture of shame within their migrant patients. Instead, physicians should encourage women to keep their own special culture and work to integrate and normalize different cultural preference into the existing maternal health systems. For example, although the goal maternal care should empower the mother to make informed, independent decisions, Western clinicians often put a lot of pressure on women to make the health decisions that are considered normal for Western women. However, women from certain backgrounds may not be prepared to make such decisions due to gender and status relations in their native culture. Forcing these women to make such decision without the input of their husband or other male advisors may lead to increased stress on an already vulnerable pregnancy situation (Renteria, personal communication, November 11, 2015).

For many cultures, a rupture in the social network has been identified as one of the largest barriers to health care in receiving countries (Bollini, Pampallona, Wanner, & Kupelnick, 2009). Lack of familial ties and a network of other women can prevent migrant women from learning important information about pregnancy and childbirth and also lead to feelings of depression, isolation, and insecurity. These feelings are risk factors for poor perinatal health choices. Peer-education and intervention is important in accessing maternal care. Because obstetric care is more than just caring for the physical needs of the patient, maternal health services in receiving countries must find a way to substitute the family and social unit. An effective system integrates peer-education and community support into the clinical health environment.

### *Language and Communication*

Unsuccessful communication and lack of connection to healthcare professionals often leads to feelings of dissatisfaction with maternal health care (Jentsch, Durham, Hundley, & Hussein, 2007). Inconsistency in the use and quality of interpretation services can also present a higher risk of miscommunication, and ultimately, misdiagnosis (Lyberg, Viken, Haruna, & Severinsson, 2012). The ideal way to combat language and communication barriers is to have consistent use of trained cultural mediators, but due to the large and diverse demand, translators are more often used in consultations with migrant women. However, clinicians cannot force a patient to accept a translator. Often, in cultures with more patriarchal relationships or when the husband speaks the language of the receiving nation, the couple will refuse translation service, and the husband will facilitate the communication with the clinician. But, it is difficult for physicians to know if the information is being understood and communicated to the woman (Renteria, personal communication, November 11, 2015). Lack of translated medical documents can also act as a barrier to adequate care. Because nurses and midwives must obtain informed consent and signatures from the woman, they are

often unable to proceed with care because they are unsure if the women completely comprehended the documents.

## STRATEGIES FOR ADDRESSING HEALTH DISPARITIES

### *Cultural Competence and Clinician Training Programs*

Cultural competency and sensitivity has been identified as a tangible way for to adjust to a diversifying population interactions, especially for professionals or service providers in cross-cultural situations. It can be defined as "appropriate and effective communication which requires the willingness to listen to and learn from members of diverse cultures, and the provision of services and information in appropriate languages, at appropriate comprehension and literacy levels, and in the context of an individual's cultural health beliefs and practices" (as cited in Chin, 2000). Because sociocultural factors influence health perceptions, lifestyle choices, and health behaviors of individuals, cultural competence is a critical tool in the treatments of a diverse patient population. In the United States, the Office of Minority Health National Standards on Culturally and Linguistically Appropriate Services has developed list (*Table 1*) of cultural competency standards for health care facilities and professionals. This list has been referenced and depended upon in studies on cultural competency in European health systems and serves as a relevant framework for understanding the current goals for cross cultural care.

*Table 1: CLAS standards for health providers. Extracted from "Educating Clinicians About Cultural Competence and Disparities in Health and Health Care" (Like, 2011).*

| Standard | Description |
|---|---|
| 1 | Ensure that patients/consumers receive from all staff member's effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language. |
| 2 | Implement strategies to recruit, retain, and promote a diverse staff and leadership that are representative of the demographic characteristics of the service area. |
| 3 | Ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery. |
| 4 | Offer and provide language assistance services, including bilingual staff and interpreter |

| | |
|---|---|
| | 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. |
| 5 | Provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services. |
| 6 | Assure 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 on request by the patient/consumer). |
| 7 | Make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area. |
| 8 | Develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services. |
| 9 | 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 outcomes-based evaluations. |
| 10 | 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. |
| 11 | Maintain current demographic, cultural, and epidemiological 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. |
| 12 | 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. |
| 13 | Ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers. |
| 14 | Regularly make available to the public information about their progress and successful innovations provide public notice in their communities about the availability of this information. |

In the context of migrant health, cultural competence is critical to the communication between migrant patient and health care provider because of increased psychosocial vulnerabilities such as immigration stress, lack of social networks, language barriers, limited access to services, and discrimination (Almeida, Caldas, Ayres-De-Camps, Salcedo-Barrientos, & Dias, 2013). Although hospital statistics display health disparities and the knowledge surrounding the health impact of a patient's sociocultural identity is growing, it is sometimes difficult to convince physicians to prioritize migrant health and cultural competence due to lack of personal interest and time (Gasser, personal communication, November 12, 2015). Because psychosocial education is not yet universally integrated into

medical training, cultural competency experts and researchers in the field of health develop specific training programs at hospitals and clinics. These programs aim to sufficiently prepare clinicians to practice culture competence when interacting with, diagnosing, and treating migrant patients.

In an interview with Sophie Paroz, a researcher and project chief at Lausanne University Hospital in Switzerland, she describes the facets and goals of cultural competency training programs for physicians, nurses, and other health care providers. She describes the current psychosocial education offered in medical schools is primarily theoretical. In contrast, the in-hospital training programs should provide clinicians with not only a theoretical understanding of how to understand social and cultural motivations, but also the tools to autonomously access resources such as mental health counsellors, language interpreters, and cultural mediators. Training physicians is about both encouraging sensitivity and tolerance and also emphasizing the importance of practical skills (Paroz, Personal Communication, November 2, 2015).

To ensure that providers are both capable of and comfortable with communicating with migrant patients who may have limited language skills and health literacy, simulations and role playing scenarios are often used for practice during training programs. In addition, experts and researchers develop psychosocial questionnaires for clinicians to utilize during consultations with migrant patients. These questions help physicians and other providers with limited experience working with migrant patients and cultural mediation services a practical way to evaluate perceptions of health and integrate culturally competent techniques into their daily practice. At the end of a consultation with a migrant patient, it is also useful for clinicians to employ a “teach-back” tool in which they request that the patient review and repeat all of the information that was discussed (Paroz, personal communication, November 2, 2015). Even if a cultural mediator or interpreter was present, this tactic helps ensure that a

patient with limited language ability and/or health literacy understood the diagnosis and instructions of the clinician. It is assists in the self-evaluation of physicians as the patient can immediately reveal what was difficult for him/her to comprehend.

Incorporating a gender-specific perspective into cultural competency training is not yet a major priority of researchers and experts, but it is often gender-specific challenges are often used as examples in simulations (Paroz, personal communication, November 2, 2015). Yet, the standards for culturally competent health facilities and the practices in sensitivity training inherently account for the inclusion of migrant woman in competent care. Both increase the awareness of the health needs and identities of linguistically and culturally diverse patients. By integrating standards into maternity units and training OB/GYNs, nurses, midwives, and other health professionals in how to employ culturally competent practices, new modifications and priorities in gender-specific cultural competency for female migrants could arise.

### *Patient-Centered and Woman-Centered Care*

Because it is difficult to validate qualitative data to clinicians and hospitals, general trends and statistics help to prioritize the health of migrant women. Combining the quantitative and qualitative information illustrates that the need for assessment is clear (Gasser, personal communication, November 12, 2015). While the trends in qualitative health outcomes and quantitative experiences of pregnant migrants were generalized for the purpose and limited scope of this study, it is critical to avoid the same generalization when evaluating practical techniques that could improve the both the biological and psychosocial outcomes of an individual migrant woman. Qualitative research humanizes the quantitative trends, and when developing culturally competent models of care, it is vital to remember that each statistic represents a mother with her own specific personal, medical, and cultural history.

Even if the perinatal care provided to pregnant migrant women employs cultural sensitivity and competency, it is important recognize the individual woman's personal experience and embodiment of her own cultural identity. In the past, physicians have treated migrants based on generalized community standards and cultural guidelines that were considered to be recognizing the influence of culture on health, but this practice was criticized because it often lead to experiences of increased experiences of prejudice and misdiagnosis due to pre-determined expectations of cultural behavior. Physicians and institutions tend to desire the big picture representation of how to address language and culture barriers, but doing so can lead to misinformation. Cultural competency training can provide clues and tools, but providers must understand that they are not applicable to every individual. (Paroz, personal communication, November 2, 2015).

Applied in the framework of culturally competent facilities and clinicians, patient-centered or in this particular subject, woman-centered, models of care in maternity health have the ability to serve both the larger migrant population, but also remain focused on the individual health experience of each woman. In a patient-centered model, the provider should not enter consultations or interactions with presumed expectations regarding the health literacy, behaviors, and needs based on the patient's race, ethnicity, country of origin, age, or religion. Instead, the perceptions of health and cultural representations of pregnancy and birth will come from the individual patient (Paroz, personal communication, November 2, 2015). All the relevant information should emerge from the woman herself, but providers need to be given the right questions to ask in order to gain a better understanding of all cultural and physical risk factors. According to Dr. Renteria, a woman-based, culturally competent consultation begins with a holistic evaluation of a pregnant migrant woman's situation. Along with the medical history of the woman, it is important that the physician or nurse also collects a detailed personal and psycho-social history.

***Case Study in Effective Programs: Pan-Milar, Canton Vaud, Switzerland[1]***


*Figure 1: The logo of Pan-Milar. English translation: For 38 countries, in 28 languages.*

Pan-Milar is an example of a program designed to serve the specific social and educational needs of migrant women in Western European countries through cultural competence, women-centered care, and language interpretation. The non-profit association, which operates out of Lausanne, Switzerland, aims to provide migrant women in the Canton of Vaud access to culturally sensitive and needs-based perinatal care. The organization is subsidized by the Federal Office of Public Health and partners with the Lausanne University Hospital. It is organized by a group of midwives who work with experienced community interpreters and cultural mediators to offer birth preparation courses, which can be translated into over 20 languages. In order to better understand the services offered by Pan-Milar and gain a personal perspective on caring for pregnant migrant women, Stephanie Pfister, a midwife and cantonal and regional co-coordinator of the organization, was interview for this study.

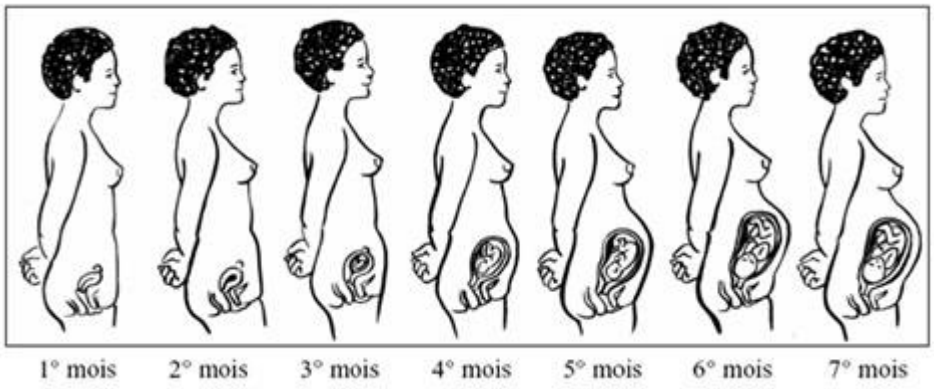
According to Pfister (personal communication, November 13, 2015), accessing and recruiting the women that may benefit from Pan-Milar services is one of the organization's largest challenges. Migrant women experience decreased access to facilities and social support systems that can reference them to supportive programs. They also may have preconceived cultural concepts of maternal health that would prevent them from seeking out care. Because of this, the mid-wives at Pan-Milar are more often responsible for identifying and recruiting pregnant migrant women. In partnership with the Policlinique at Lausanne

[1] Information not credited to Stephanie Pfister can be found online at pan-milar.ch.

University Hospital, Pan-Milar can access the files of pregnant patient and identify if the woman would benefit from the preparation course. After identification, the midwife will then contact an interpreter to reach out to the woman in her native language and explain the program and its importance.

The gaps in the health education of migrant women cannot be generalized; therefore, Pan-Milar midwives and interpreters aim to respond to the individual needs of migrant women and couples while also providing the essential information on birth and pregnancy. Birth preparation courses are a slow-progression that begin at the basics to account for all levels of health literacy. During the five pre-natal sessions and the one post-partum session, midwives and interpreters can provide a woman with the level of explanation she needs regarding her rights as a patient, what to expect during her pregnancy, how to recognize signs of labor, and other important details. Pfister explains that a lot of migrant women in the region feel as if they do not receive the same level of care and treatment as native Swiss women when they go to the hospital. This often leads to frustration and lack of trust, which can serve as barriers to health. Pan-Milar courses offer women the opportunity to ask questions about their pregnancy, receive advice from midwives, and learn how to recognize correct information about pregnancy and birth.

*Figure 2: A simple infographic from pan-milar.ch that illustrates the growth and ideal positioning of a baby at different months (French translation, "mois") throughout the pregnancy.*



Access to practical health information is not the only purpose of birth preparation courses, they also serve to substitute the social and cultural support systems of their countries of origin. For many migrant women in the programs, access to care providers and health information is not the largest problem due to large hospital facilities and online medical information. Instead, it is the lack of social support systems and continuity of care. Online pregnancy advice and periodic check-ups cannot substitute for the very personal experience of birth (Pfister, personal communication, November 13, 2015). Midwives and community interpreters aim to address the individual social and cultural needs of migrant women by helping them to understand their own health perceptions, cultural practices, and vulnerabilities in the context of the Swiss maternal health care system. In addition, because the preparations courses are group-based, the women have the opportunity to build a new social community with other pregnant women in similar situations and learn from the experiences from other migrant women. By creating a network of migrant women who can share knowledge and experiences, the group sessions exemplify a method of rebuilding social networks and encouraging peer-education.

While Pan-Milar offers the supportive, competent, and woman-centered care in a way that hospitals and other health facilities do not currently have the capacity to offer, the organization still struggles with barriers to accessing the migrant population, providing enough interpretation and mediation options, and limited focus in their mandated services. In regards to cultural mediators, Pfister explains that because the population is so linguistically and culturally diverse, but also is spread across a large canton, it is often difficult to encourage mediators to travel long distance in order to visit the women at their home or a familiar place, which is important is ensuring the comfort and trust of the vulnerable woman. Pfister also expresses the desire to keep the organization growing in response to evolving needs and priorities.

Currently, the timing and subject of the group sessions are primarily focused on birth preparation, and Pfister feels that there is a growing need to address the post-partum psychosocial and medical support needs of migrant women. She also has experienced the bond that develops when a woman is linked to a Pan-Milar midwife or interpreter. For vulnerable and chaotic situation of many pregnant migrant women, the continuity of care is crucial to the effectiveness (Pfister, personal communication, November 13, 2015). Both of the described challenges threaten the trust for continual relationship that develops.

Despite the challenges or potential gaps in care, Pan-Milar offers a model for future targeted programs. At its base, it integrates the recognition of the adverse health outcomes, barriers to care, complex cultural perceptions of pregnancy, and individual needs of migrant women.

### *Midwifery Model of Care*[2]

The Midwifery Model of Care is identified as a woman-centered approach to obstetric care that is "uniquely nurturing, hands-on car before during, and after birth." (Midwife Model). *Table* 2 illustrates the holistic nature of this model. It is fundamentally different than the current obstetric care in that it explicitly includes the psychosocial health of the pregnant woman. According to the Midwives Alliance North America, this model is utilized in countries with the best recorded infant and mother health outcomes, and the World Health Organization birth statistics have shown that "births attended by midwives have lower infection rates, lower Cesarean section rates, fewer complications and healthier outcomes—thus, lower overall medical costs—than physician-attended hospital births" (Midwife Model).

*Table 2: Definition and Tenants of Care in the Midwives Model of Care (extracted from Mana.org)*

| Definition: |
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[2] The Midwives Model of Care definition and term © is Copyrighted by the Midwifery Task Force

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| • Monitoring the physical, psychological and social well-being of the mother throughout the childbearing cycle<br>• Providing the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support<br>• Minimizing technological interventions<br>• Identifying and referring women who require obstetrical attention. |
| Tenants of Care: |
| • Familiar face at each of your appointments, and provide adequate time to ask questions and address your concerns.<br>• A midwife is a specialist in pregnancy, birth and postpartum care who has designed a complete program of care to nurture healthy pregnancy, joyful birth and confident parenting.<br>• Woman will receive individualized, culturally appropriate, family-centered full-scope prenatal services, and continuous care and support during labor and birth.<br>• Incorporation of shared decision-making into care so that the woman will feel informed and empowered to make good health decisions for the mother, infant and family.<br>• A midwife has the skills and knowledge to facilitate healthy normal childbirth, to assure comfort and safety for the mother and baby, and to accommodate the family's needs.<br>• A midwife has a plan for collaboration with obstetricians, pediatricians, and other specialists in the rare case where medical care for mother or baby is needed.<br>• Women will receive nurturing postpartum care and support in their home and the midwife's office in the weeks and months after birth as the mother adjusts to her new baby and the changes in her family. |

Based on the identified disparities in medical outcomes of pregnant migrant women and the current sociocultural challenges to providing competent care, the Midwife Model of Care seems to have the potential to fit the specific health needs of migrant women. Its inherent emphasis on specialized medical care, cultural appropriateness, individualized education and preparation, shared-decision making, and continuity of care directly correspond with some of the most important aspects of sufficient migrant maternal health care. Organizations such as Pan-Milar illustrate the effectiveness of midwife coordination in issues in this subject. In addition, midwifery is a globally established health profession and holistic cultural competency and woman-centered obstetric care is already built into the education process. Because of this, midwives can respond to the increasing feminization of migration and need for competent providers until cultural competency training in other fields has the capacity to address the needs of migrants.

Stephanie Pfister, a midwife and coordinator at Pan-Milar, provided a perspective based on personal experience with pregnant migrant women. Unlike some other medical providers, midwives have more time devoted to in their day-to-day practice continuity of care for vulnerable populations. They can also offer more than the standard checklists of medical and physical requirements that must take priority in more clinical setting, which is necessary in the provision of care to migrant women. Because their training emphasizes social and psychological support, they offer maternal care that can be centered on the woman throughout the entire perinatal and postnatal process (Pfister, personal communication, November 13, 2015).

Although migrant women may display higher risks for medical complications during pregnancy and childbirth, studies have shown that there is no difference in the health outcomes of low and moderate-risk pregnancies attended by midwives versus those attended by physicians (Cragin, 2006). As stated earlier in this project, the medical risks often originate in lack of access to sufficient and culturally appropriate care. Healthy migrant women with healthy pregnancies do not always get the time and relationship they desire when pursuing obstetric care with a doctor (Pfister, personal communication, November 13, 2015). Midwives are generally accessible to most population in Western Europe; therefore, the increased accessibility, decreased health risk, and integrated sociocultural competency associated with the Midwife Model of Care could potentially be prioritized to fill gaps in available care. To develop the role of midwives in migrant maternal health care, future research on the relationship between migrant status, midwifery care, birth outcomes, and perceived satisfaction of the patient are necessary. Specific and integrated guidelines for midwives in the continuity of care throughout the pregnancy and post-partum care of migrant women.

## CONCLUSION

Disparities in the health outcomes and experiences of migrant maternal health are not solely based in biological indicators and medical statistics. Because migrant women bring with them their own specific cultural expectations of pregnancy through the stressful process of migration, increased evaluation of the psychosocial backgrounds is necessary for the improvement of migrant maternal health. Cultural competence training and woman-centered care can be practically applied by clinicians to better accommodate for the sociocultural identities of migrant women. Migrant maternal health is a complex topic with many possible solutions. However, existing programs such as Pan-Milar offers a model for successful future programs, and established models of care like the Midwives Model of Care can be prioritized in the immediate response to health disparities. Future research should prioritize finding supportive and holistic solutions to provide equal access to migrant women and achieve healthy cross-cultural childbirth.

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