Mig-HealthCare Roadmap & Toolbox

Maternal and Child Health

Co-funded by the European Union's Health Programme (2014-2020)

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Maternal and Child Health

1. Magnitude of the problem

Maternal health covers the health of women during pregnancy, childbirth and the six weeks thereafter (WHO, 2018). It is connected to broader health aspects that precede and contextualize it, such as family planning and other risk factors (Keygnaert et al., 2016).

Maternal mortality, defined as the death of a woman during pregnancy or within 42 days thereafter from any cause related to the pregnancy, is a principal indicator of maternal health and of access to quality maternal health care. WHO (2018) claims that maternal mortality is unacceptably high; every day approximately 830 women die from preventable and treatable pregnancy - and childbirth - related complications, with the poor and the vulnerable suffering the most. Approximately 75% of all maternal deaths are the result of the following major complications (WHO, 2018):

- severe bleeding (mostly bleeding after childbirth)
- infections (usually after childbirth)
- high blood pressure during pregnancy (pre-eclampsia and eclampsia)
- complications from delivery
- unsafe abortion

The health-care solutions to prevent or handle complications are well-known. All women need access to antenatal care in pregnancy, skilled care during childbirth, and care and support in the weeks that follow. Improved accessibility to such health care services allowed maternal mortality to drop worldwide by about 44%, between 1990 and 2015. Given the fact that it is possible to accelerate this decline, countries have united behind a new target under Sustainable Development Goal 3: to reduce the global maternal mortality ratio to less than 70 per 100.000 births (WHO, 2015), specifically addressing the vulnerability of migrants.

It must be noted, that maternal health and new-born health are closely linked. In 2015, approximately 2.7 million babies died and 2.6 million were stillborn (WHO, 2018). Skilled care by health professionals before, during and after childbirth could have saved the lives of these women and new-born babies (WHO, 2018).

With regards to child health, prematurity, birth asphyxia, trauma and congenital abnormalities are among the 5 most common causes of death among children under 5 years worldwide for the year 2016 indicating the importance of action to promote maternal health especially in vulnerable populations. Moreover, neonatal deaths accounted for 46% of all deaths in children aged up to 5 years. As such, through promotion of maternal health we could avoid these premature deaths and also focus on aspects like early child development, breastfeeding, child growth, prevention of NCDs and prevention of infection of communicable childhood diseases (WHO, 2018.Global Health Estimates Technical Paper, https://www.who.int/maternal_child_adolescent/data/causes-death-children/en/).

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2. Reference to the problem concerning migrants/refugees

The marked increase in refugees, asylum seekers and migrants in Europe in recent years has focused attention to the need for a concerted response to ensure good health status to vulnerable newcomers. Women make up approximately 52% of the migrant population (IOM, 2017). As of 2006, 10% of the births across Europe were from migrant mothers (Sobotka, 2008, p. 229). As a result, maternal health care is a significant issue in the provision of health care to migrants.

Most research shows poorer maternal and new-born health outcomes for migrants and refugees compared to their respective host populations. According to a meta-analysis in 2014, migrant women in Western European countries are twice as likely to die during or shortly after pregnancy (Pedersen et al., 2014, p. 1634). Results also find that migrant women face a higher risk of death as a result from direct as opposed to indirect causes, which may suggest that substandard obstetric care is responsible for the excess mortality among migrants (Pedersen et al., 2014).

A similar pattern of increased risk is found for maternal morbidity (Van den Akker, 2016). Migrant women generally face poorer pregnancy outcomes compared to native women, as reflected in the higher incidence of induced abortions, caesarean sections, instrumental deliveries and other complications among migrants (Keygneart et al., 2016). In addition, migrant women face higher incidence of postpartum depression. Although these outcomes vary among different migrant groups and between and within host countries (WHO, 2018), it has been found that newly arrived migrant women, especially if they are in their final stages of pregnancy or have uncertain legal status, are particularly at risk of negative outcomes (Gissler et al., 2010; Hayes, Enohumah & McCaul, 2011).

Besides increased maternal mortality and morbidity among migrant women, WHO (2018) has identified a marked trend for the worse pregnancy-related indicators in migrants. Although these factors vary depending on host country, country of origin and outcome, they include:

- mental ill health, such as postpartum depression
- perinatal and neonatal morbidity and mortality (e.g. stillbirth, preterm birth and congenital anomalies)
- suboptimal quality of care

This higher risk profile of maternal health complications can be a result of different contributing factors, which can be cultural, biological, socioeconomic or related to the migrant journey. However, studies have noted that a substantial part of the increased morbidity and mortality among migrant women must be sought in suboptimal healthcare factors in the respective host countries (see for example Van den Akker, 2016; Keynaert et al., 2016):

- access to and uptake of antenatal care
- the quality of services offered, including the ability of health services to cater to diverse clientele

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- access to and comprehensibility of the health systems

In general, the highest risk to experiencing suboptimal healthcare factors has been observed among the most recent migrant groups, most often of non-European nationality (Almeida, 2013; Pedersen et al., 2014; Grech, Tratnik, & Pisani, 2016).

3. Reference to issues of particular interest

Apart from higher rates of maternal mortality and morbidity, which have been discussed more elaborately in the previous sections, migrant women face additional risks for perinatal issues, mental health issues, and sexual violence.

Perinatal issues

In general, migrant and refugee women have been found to have worse perinatal health outcomes compared to their respective host populations (Gissler, 2009; Keygnaert et al., 2016), with increased vulnerability in women from several Asian and Sub-Saharan African countries (WHO, 2018). Compared to European host societies, migrant women generally have higher rates of both planned and emergency caesarean sections. WHO (2018) points out that too few, but too late, or too many caesarean sections may be indicative of suboptimal care. However, it remains unclear what the effects of caesarean sections are on other outcomes, such as maternal and perinatal morbidity, paediatric outcomes and psychosocial well-being (WHO, 2018).

What is certain is that antenatal care is crucial to preventing pregnancy and delivery complications, including unnecessary or emergency caesarean sections. Antenatal care is key to determine the due date of the pregnancy, to detect adverse intrauterine growth, to detect and manage pre-eclampsia, and to detect congenital malformations and chromosomal abnormalities (WHO, 2018). It has been suggested, that the increased risk of negative perinatal health outcomes among migrant women may be linked to migrants' lack of knowledge and utilisation of antenatal care services (e.g. Reeske & Rasum, 2011; Pedersen et al., 2014). Migrant women tend to start antenatal visits later than non-migrant women and also make fewer visits (Reeske & Rasum, 2011). This is potentially attributed to language barriers and cultural differences that make access to quality health care difficult.

Female genital mutilation

Several studies have found that women who had undergone female genital mutilation (FGM) were more likely to face complications during childbirth (Banks, Merik & Farley, 2006), such as induction of labour, foetal distress, slow to absent cervical dilatation, prolonged labour, operative delivery and increased risk of perinatal death and stillbirths (Keynaert et al., 2016). These FGM-related complications also increase the likelihood of post-labour problems, such as infection, maternal morbidity, and physical and psychological trauma, especially when host country societies are not well informed about the consequences of FGM (Grech, Tratnik & Pisani, 2016).

As a result of FGM labour complications, western obstetricians commonly intervene by performing caesarean sections (Brown, Caroll & Fogarty, 2010; Grech, Tratnik & Pisani, 2016). For many refugee women this is

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unacceptable; they associate the resort to caesarean sections with a lack of skills to care for women who have been stitched (Brown, Caroll & Fogarty, 2010). Although WHO (2018) reports that substantial knowledge on how to take care of circumcised women and girls already exists within Europe, several studies reiterate the need for health practitioners to become more familiar with the ways to treat pregnant women living with FGM and receive training on techniques such as de-infibulation in order to facilitate childbirth (Grech, Tratnik & Pisani, 2016).

Maternal mental health

Research also indicates that migrants generally are at higher risk for mental health disorders. During pregnancy and after childbirth, migrant women are particularly vulnerable to mental health risk, which can have an impact on both fetal development and pregnancy outcomes. A systematic review found that mental health, including postnatal depression, antenatal depression, anxiety and post-traumatic stress disorder, was a more frequently reported outcome among refugee and asylum seeking women than among host populations (Heslehurst et al., 2018). At the same time, several studies found that migrant mothers were less likely to be asked about their emotional well-being or social or familial support (Almeida, 2013). Research indicates that migrants are at higher risk of mental health issues due to factors associated with the migration process, as well as a range of other risk factors, such as socioeconomic disadvantage, marginalisation, insecurity, isolation and difficulty in integration (WHO, 2018).

4. Important steps for the Health care sector

Access to health care

Migrants' and refugees' knowledge, motivation and competences to access, understand, appraise and apply health information in their respective host societies can be restricted due to a combination of cultural, socioeconomic and bureaucratic factors. A low level of "health literacy" affects their ability to make informative decisions and judgements concerning health care, in order to maintain and improve their health status, and may explain the health-seeking behaviours of migrant and refugee women (WHO, 2018). WHO refers to certain issues that are particularly problematic for refugee and migrant women. These include but are not limited to:

- feeling understood and supported by health care providers and being able to actively engage with them
- knowing how to find good health information, as well as being able to read and understand it well enough for active management of personal health
- having social support for health; and
- understanding the health care system in order to navigate it

Recommendations

- Use plain-language health information initiatives, such as workshops, brochures and advertising campaigns with socio-culturally appropriate maternal health care content (both antenatal and postnatal) and the corresponding health risks;
- Develop information content in the target group's native language about warning signs of pregnancy and navigation of the health care system, as well as provide social support during antenatal care;

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- Share responsibility to increase health literacy of migrant and refugee women between stakeholders, including government agencies, health care facilities and practitioners, educators and community- and faith-based organisations;
- Implement or support initiatives that pair pregnant migrant women with women from a similar background who have already experienced giving birth in the respective host society.

Quality care

In addition to the previous findings, WHO (2018) identifies issues and recommendations with regards to the quality of maternal health services for migrant women. Providing quality care to migrant and refugee women has often been compromised due to language barriers, cultural differences (e.g. type of gender of health practitioner), and differences in conceptions of motherhood, health, expectations from health care and so on (Almeida, 2013; WHO, 2018). This can lead to difficulties in communication between patients and health professionals.

Recommendations:

- Make screening processes during pregnancy available for all;
- Adopt a person-centred model of care that involves the same quality of care to all pregnant women (e.g. timeliness, information, respect, sufficient diagnostics, adequate management and transport), regardless of migration status, and that is sensitive to diversity;
- Refer refugee and migrant women to a higher level of care, if a risk assessment suggests that they should be screened for tuberculosis, pre-eclampsia and a small for gestational-age fetus;
- Use professional interpreters and cultural mediators when needed, rather than family members, to facilitate communication between medical staff and refugee and migrant women. Consider telephone sessions as a cost-effective alternative when face-to-face interpreting services are not an option.

5. Prevention

Preventing negative maternal health outcomes

Previous research findings highlight communication barriers as an underlying concern for the ability of migrant and refugee women to access quality maternal health care. Indeed, language barriers and cultural differences have been associated with a lack of understanding and poor compliance with antenatal care programs (Almeida, 2013; Grech, Tratnik & Pisani, 2016). Indeed, migrant women have been found to feel misunderstood by health care workers or estranged within the health care systems of host societies. Migrant and refugee women might give up attending their antenatal visits and simply turn up in hospital when it is time to give birth (Grech, Tratnik & Pisani, 2016).

Undocumented migrant women and those with an uncertain legal status have been found to be particularly vulnerable. A recent report found, that among pregnant women seeking or having been refused asylum in Europe, 65% had no access to antenatal care, 42% accessed care after 12 weeks of pregnancy, and two-thirds were classified as ‘at risk’ requiring urgent or semi-urgent care (Chauvin et al., 2015). This is problematic, as the lack of knowledge and utilization of antenatal care is connected to misjudgements, unnecessary caesarean sections, and even loss of life in labour situations (Pedersen et al., 2014), causing frustration among

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practitioners, who may potentially misinterpret migrant women's behaviour as negligence (Grech, Tratnik & Pisani, 2016).

In order to help prevent medical complications, it is important that communication is a dialogical process and is not limited to the transmission of information without full comprehension from the migrant's perspective (Grech, Tratnik & Pisani, 2016). Positively engaging migrant and refugee women in the learning process will encourage their active participation in their own health care (Grech, Tratnik & Pisani, 2016).

Therefore, it is important that health systems invest in interpreting services and cultural mediation that allow migrant women to communicate with the attending health practitioner and obtain relevant information (Van den Akker, 2015). At the community level, it is important that health practitioners fulfil their educative responsibility by informing both migrant women and their communities on the healthcare system in general and the country's maternal health provisions in particular by means of a dialogue geared towards mutual trust and understanding (Grech, Tratnik & Pisani, 2016).

6. Examples of best practices

The Mig-HealthCare project has reviewed and evaluated relevant interventions that address special maternal health problems among migrants and refugees. This roadmap includes some examples that can be used in different settings also based on a systematic review that was conducted by the Mig-HealthCare partners in 2018. More information about these and other promising practices can be found on the project's website http://www.mighealthcare.eu/ by accessing the report titled 'D5.1: Report on models of community health and social care and best practices'.

I. Meeting minority health needs through special MCH projects (Hutchins & Walch, 1989)

This maternal and child health program was developed for immigrant and minority populations in the United States. It found that committed community and agency partnerships through multiple mobilization strategies were considered successful in breaking down language, culture and access barriers to health services for pregnant women. The projects that resulted from these partnerships range from breastfeeding initiatives to an area-wide genetic service program in different regional areas, and helped improve the health status of pregnant women with a migration background.

II. Women's health centers and minority women: addressing barriers to care. The National Centers of Excellence in Women's Health (Jackson et al., 2001)

Early results of this review on the National Centers of Excellence in Women's Health, (COeoEs) show that these centers serve more diverse female populations that traditional models of care. It was found that capacity building to maintain the interest of service providers and community members was essential for program sustainability. In general, partnerships between the target community and

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the different local healthcare providers is recommended in order to identify the barriers faced by women and potential solutions for improving access to care.

III. A new clinic model for refugee health care: adaptation of cultural safety (Reavy et al., 2012)

For vulnerable populations such as prenatal and paediatric refugee patients, this program found that a Culturally Appropriate Resources and Education (C.A.R.E.) Clinic Health Advisor is recommended for specialty clinics. This type of health advisor facilitates communication, establishes the sense of community and helps patients navigate the healthcare system. The intervention was successful in reducing non-adherence to appointments from 25% to 2,5% and is strongly recommended for use with other vulnerable populations.

7. Toolbox

Please access our toolbox for additional tools related to Maternal and Child Health among migrants and refugees.

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