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Barriers and Challenges of Immigrant Women's Access to and Experience of Optimal Maternity Care

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ABSTRACT With an increase in immigrant populations, healthcare systems are experiencing a new wave of ethnic-cultural diversity among patients. For the 48.1% of women among global migrants, maternal healthcare services are often the first level of contact with new healthcare systems in countries of resettlement. However, immigrants face many barriers, including socioeconomic and language considerations. As maternal care requires frequent contact with health care services through all stages of pregnancy, ensuring the quality of care is important to protect maternal and infant health. Using a systematic review method analyzing 17 articles from PubMed and Google Scholar in the past 20 years, three overarching themes were identified: lack of access to prenatal care, cultural insensitivity during in-hospital settings and challenge in identifying and experiencing postpartum depression. This literature review reveals the broader influences and contextual variables in maternity care and highlights problems relating to the acceptability and accessibility of maternity services for immigrant women. Overall, this paper reveals the importance of considering immigrants' socio-cultural context of childbirth practices, creating more accessible prenatal classes and addressing disparities in postpartum depression. This knowledge can better inform health services delivery and formulate health promotion strategies to address discrepancies in maternal health outcomes.

KEY WORDS Immigrant women, maternal healthcare, prenatal care, postpartum depression, in-hospital care, barriers

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INTRODUCTION

In an increasingly globalized world, women constitute 48.1% of the global international migrant stock [1]. However, language barriers, lack of access to services and socioeconomic and political marginalization make relocating and navigating an unfamiliar environment difficult for many immigrants [2]. The vulnerability of immigrant women can be further exacerbated by pregnancy and childbirth, making maternity an important area of attention for enhancing immigrant health. In the U.S. alone, immigrants have accounted for almost one-fourth (23%) of newborn babies [3]. In turn, maternity care is often among the first forms of contact with new healthcare systems. Consequently, healthcare workers are providing care to an increasingly diverse patient group. However, immigrant women are more likely to risk poor pregnancy outcomes compared to native women: 43% higher risk of low birth weight, 24% of pre-term delivery, 50% of perinatal mortality and 61% of congenital malformations [4].

The significant hurdles can explain the disproportionate health outcomes in accessing services and receiving optimal care relating to transportation issues, limited financial capacity, language and health literacy [5]. However, one of the biggest challenges is the availability of culturally sensitive maternity care that accommodates the needs of immigrant women, who may bring embedded cultural values to their receiving country. Medical scholars and researchers increasingly recognize that culture plays a large role in determining health perceptions and practices [6]. This is notably manifested in childbirth, a significant period often marked by celebratory rituals and varying traditional practices. [7]. However, healthcare systems often ignore or devalue cultural needs, resulting in mistrust and misunderstandings between patients and health providers [2]. With a larger portion of foreign-born mothers utilizing maternal healthcare services, it is critical to evaluate and identify potential contributors to disparities in access, utilization and delivery of maternal care.

This literature review will bring together the myriad childbirth experiences of immigrant women and their access to maternity services in their corresponding geographical area, as they have been discussed in the literature so far. This paper will then answer the questions: 1) How can immigrants' access to and experience in maternity services be described?; and 2) What role does culture play in childbirth practices, and how do practitioners and healthcare infrastructures receive their needs? The review used the World Health Organization's (WHO) definition of maternal health as "the health of women during pregnancy, childbirth and the postpartum period" in addition to the definition of "immigrant" as proposed by the United Nations: "a person who has settled permanently in another country." Specifically, this paper examines those who have re-established a new residence in a Western industrialized country. The primary countries of investigation include Norway, Canada, Sweden, the United Kingdom and the U.S, as they are popular countries for migration. While previous quantitative studies have explored case studies of certain immigrant populations, to date, there are few systematic reviews investigating the lived experiences of pregnant migrant mothers for stronger evidence-based knowledge. However, synthesizing the broad commonalities across different immigrant groups is essential to identify key challenges and gaps in strategic health interventions. By reviewing sociological literature published in the past 20 years across 5 countries, this paper highlights the common challenges immigrant women face in accessing prenatal healthcare, cultural insensitivity in in-hospital delivery and postpartum depression.

MATERIALS AND METHODS

A systematic literature review methodology was used. An initial scoping search was made of PubMed, Google Scholar, NIH, and ScienceDirect for studies from the past 20 years. The following keywords were used in various combinations: 'immigrant women,' 'birth,' 'cultural practices in childbirth,' 'cultural diversity,' 'prenatal care' and 'disparities,' which produced (n= 762) relevant papers to be screened. Through a PRISMA flowchart (see Figure n=1), the papers were first scanned for relevance using the title and then assessed through the abstract to examine the paper's research objectives. Finally, through the process of exclusion criteria, full-text scans were performed to determine the quality and validity of the studies. Evidence compiled from quantitative, qualitative and mixed-review studies, consisting of interviews, questionnaires and surveys of immigrant women and healthcare providers, were considered to answer the research questions.

Inclusion criteria were studies focusing on 1) the maternity care needs of immigrant women, studies examining 2) immigrant women's experiences of pregnancy in the pre-, intra- and postnatal period and experiences with maternal health services provided by new home country, 3) peer-reviewed articles published in English and 4) studies focusing on women's experiences through the perspective of health care providers. Exclusion criteria were 1) grey literature, publications in a non-English language, 2) studies of the experience of ethnic minority patients who are not explicitly reported as immigrants or refugees, 3) studies not performed in included countries primarily to narrow the focus of the paper and 4) research solely focusing on cultural birth practices without investigating how these beliefs are received and the experiences of immigrant women in a clinical setting. 17 articles were included in the study.

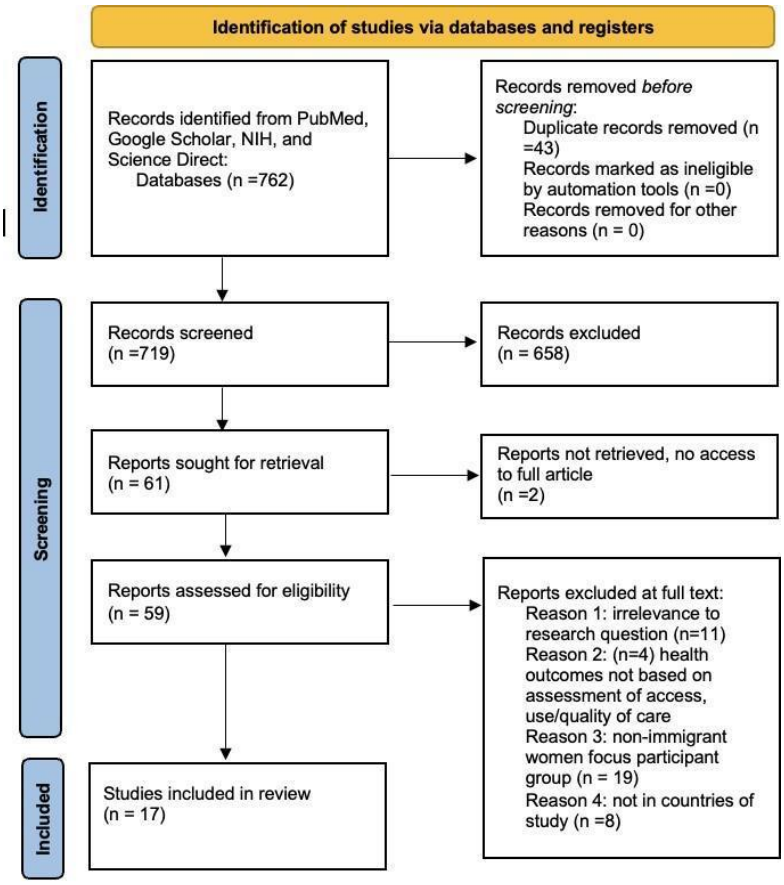

FIGURE 1. PRISMA flow diagram detailing the search and selection process of 762 records evaluated in this systematic review

RESULTS

Lack of Access and Utilization of Prenatal Care

Prenatal or antenatal care is defined as preventative healthcare comprising a regular series of clinical visits and checkups before delivery. Health information is particularly critical during this time due to significant physical and psychological changes women may experience and concerns surrounding the fetus' health. However, immigrant women receive inadequate or postponed prenatal care and attend fewer appointments and antenatal classes. For instance, a study conducted in London found that out of 29 immigrant women, only 5 (17%) had

their first antenatal appointment before the recommended 10 weeks gestation as opposed to 28.2% of the general non-immigrant women population. The deficiency of antenatal care is particularly disconcerting, as immigrant mothers who do not receive prenatal care are four times more likely to give birth to low birth-weight infants and seven times more likely to experience preterm births [8] A predominant factor contributing to this issue is the lack of awareness of available antenatal classes. A study of immigrant Muslim women living in St.John's, Canada reported that some immigrant women were not told about the classes or did not understand their purpose [9]. Yet, even when utilizing prenatal care, language barriers still pose a primary challenge in comprehending medical information and communicating pregnancy complications. Immigrant women often lack proficiency in the main language of the resettled countries. Many antenatal classes are offered in English, leaving women without an adequate understanding of procedures or the promotion of healthy pregnancy [10]. In a study of 401 immigrant women in Norway, one-third (33.4%) reported a poor understanding of the information, and two-thirds (63.3%) of women would have understood information during maternity care better if offered in another language [11]. Similarly, a questionnaire with 83 participants in the UK confirmed the scarcity of language resources despite the emergence of Polish, Somali, and French-speaking communities as well as an inadequacy of interpreters [10].

However, despite the recommended standards in providing interpretation services, only 19% of the women who needed interpretation were offered it in the Norwegian study [11]. Moreover, many women reported insufficient coverage and a lack of readily available information on maintaining a healthy pregnancy and, thus, had to seek help from family and friends instead [11]. Previous research has linked low language proficiency to low attendance in pregnancy preparation courses [12].

Other factors, including lack of transportation, health insurance and low socioeconomic status, contribute to the absence of prenatal care and continuity in care [13]. Prenatal care often requires women to visit physicians regularly, which poses a challenge for women working in extensive jobs and without reliable transportation [14]. Additionally, concerns about legal status, particularly among asylum seekers and refugees, can perturb their willingness to register with maternity services in fear of deportation [15]. Notably, all these factors play a role throughout the whole trajectory of maternal care but are more prominently manifested during the prenatal period. The studies point to the need for accessible prenatal classes offered in convenient locations in the languages of the immigrants. Further investigations are needed on existing migrant-specific prenatal care programs and their effects on prenatal care utilization.

TABLE 1. STUDY CHARACTERISTICS

Cultural Incongruence and Different Expectations of Childbirth Delivery and In-Hospital Care

Aside from language and access barriers, issues often arise when immigrant women bring in diverse beliefs during in-hospital settings that differ from standard medical practices. A consistent theme found throughout the studies is instances of misunderstandings between immigrant women and HCP, with immigrant women often reporting their cultural practices are ignored and devalued. For instance, multiple studies highlighted a broad theme especially pertinent among Somali immigrants over fear of cesarean section: A study with 34 Somalian women who have migrated to the U.S found that 75% of participants expressed aversion to cesarean section, with 22 describing worry or fear of cesarean section [16].

Considering labor as best left to run its natural course, many Somali women may consider cesarean section as not waiting for God's help. However, many participants in the study felt that U.S. clinicians were more likely to introduce medical interventions to hasten delivery, which clashed with the women's reliance on God's will regarding the delivery time [16]. In another study with 432 Somali women, cesarean section was wanted by less than 1% of women but was experienced by over 50% [17]. This desire to avoid a cesarean birth may explain why many Somali women delay going to the hospital when in labor, resulting in chaotic and frustrating experiences for both laboring women and HCP [18]. Another area of misunderstanding is female genital mutilation (FGM). In many countries, predominantly in Africa, genital mutilation, or the total or partial removal of the female

external genitalia or other injuries to the female genital organs, is a common practice [19]. Although this practice can contribute to complications during pregnancy, female genital mutilation is an important culturally-ingrained ceremonial rite of passage for many women [19]. Its prevalence should not be dismissed. The WHO reports that up to 97% of Somali refugee women who immigrate to Western countries have experienced type III infibulation, considered the most severe form of FGM [19]. However, women with FGM felt disrespected and negatively judged: in a study with 432 Somali women, 87.5% reported hurtful comments being made by their caregivers, including verbal expressions or surprise when the perineum was exposed to doctors or regarded with disgust [17]. 40.5% expressed that their nurses were highly insensitive to the particularly acute postpartum pain they experienced. Only 33.1% reported that their doctor had not avoided exposing their perineal area unnecessarily during labor [17]. Based on these results, changes in practice and clear guidelines are needed to treat women who have experienced female genital mutilation.

Additionally, women's religious and cultural beliefs shape their choices and preferences for HCP. For instance, in some religions, it is taboo to be treated by the opposite gender. A study found that among 6 Muslim immigrants interviewed in St. John's, Newfoundland, all participants expressed a strong preference for having female attendants care for them during their labor and delivery [9]. However, even with a female birth attendant, immigrant women are not always protected from negative attitudes from female care staff. A study with Somali immigrants corroborates this: many immigrants felt that midwives held stereotyped and negative attitudes toward them [20]. Many women also found their requests denied when it came to certain rituals and practices after delivery. In a Norwegian study with 401 immigrants, one woman who asked to pierce her infant's ears was denied by health personnel for concerns of causing pain to the child. Another woman who wanted to perform a traditional Islamic 'adhan' birth custom was rejected for fear of impairing the infants' hearing [21]. Dietary accommodations were also limited: Some cultural norms practice consuming certain temperature-level food and beverages to ease the healing process. However, in a study with Punjabi women in Canada, several reported challenges in their hospital stay, because they were not served hot food and instead provisioned cold foods like Jell-O, sandwiches and salads by hospital staff [22]. This experience is similarly shared amongst Chinese migrants, who may consider ingesting cold foods and applying ice packs after birth a traditional taboo. However, many were given cold beverages after birth [23].

Many maternity professionals similarly recognize that the maternity system caters predominantly to the homogenous white, middle-class pregnancy experience [10]. Another study from a healthcare provider perspective offers insight into how legal restrictions and regulations can make it difficult to adhere to immigrant's requests: For instance, some women request burning or eating the placenta, but in Quebec, placentas are stored in the hospital for safety reasons [24]. Consequently, frequent misunderstandings between competing beliefs can fuel prejudice that handling these patients is too "difficult," funneling the cycle where immigrant women feel discriminated against and have their needs ignored. For instance, midwives in the Norwegian study explained how recommendations for physical activity level after birth differed from some women's expectations from their birth country, potentially contributing to the perception of immigrant women as lazy and less cooperative [21]. These findings all point to the importance of cultural humility among HCPs when treating immigrant women who often come with their own cultural understanding of childbirth practices. This is an important area to discuss, as mistrust and cultural insensitivity in healthcare services can affect the utilization and quality outcomes of health services.

Challenges in Identifying and Treating PostPartum Depression

Postpartum depression, defined as the experience of depressive symptoms such as feelings of sadness and helplessness and loss of energy typically within the first three months after birth, can occur among many women [25]. Past research has linked the stress of migration with the experience of PPD. For instance, a Canadian study reported postpartum depression was five times more likely among immigrant women [26]. Recent immigrant women had significantly higher rates (6%) of depressive symptoms at 16 weeks postpartum than Canadian-born women (2.9%). Asylum-seekers had the highest rate (14.3%), followed by refugees (11.5%) and non-refugee immigrant women (5.1%) [26]. One possible explanation as raised by literature so far for these differences is that

asylum seekers may experience more uncertainty and stress related to their immigration status, which can contribute to feelings of isolation and lack of social support [27]. Additionally, asylum seekers may have limited access to healthcare and other resources, which can exacerbate mental health problems such as PPD [27]. However, several barriers stand in the way of accessing treatment. In many cultures, terminologies like postpartum "depression" and symptoms of "depression" are not explicitly recognized, creating a challenge to diagnose and address the issue. A qualitative study of South Asian immigrants revealed struggles to find explanations and express the types of PPD thoughts and mood changes [28]. Instead, many women may attribute symptoms as products of situational stresses. Indeed, the migration process triggers enormous stress and emotional upheaval. Financial and work burden can make immigrant women and their partners less available to provide care to their child [29].

Additionally, a lack of connection to a family support system compounded with challenges while moving to a new country can contribute to worsened postpartum depression and feelings of isolation [26]. While in home countries, women can turn to parents and siblings for assistance, but being alone in a country without a sense of security can feel particularly disconcerting in handling the challenges of providing care for a newborn [30]. Specifically, many immigrant women in Canada noted the difficulties of successfully obtaining visitor visas for family members from abroad to provide support during this critical period [23] Not only do women express a lack of understanding of PPD, but a culture of guilt and fear attached to PPD can also prevent women from seeking help. Gender expectations, like the ability of mothers to handle all childcare responsibilities individually, can make some women reluctant to talk about emotional health [30]. For instance, one participant in a study with Hispanic immigrant women stated, "In the Hispanic culture, the mothers always do everything, like taking care of the children, cleaning the house. They are expected to do everything. And people really think less of them when they have an expression of anger. Some women [may] think they cannot take it anymore, and that she is going to explode her emotions" [31]. As stigma and insufficient information about postpartum depression can negatively impact help-seeking behavior, provisioning education about symptoms and seeking help is critical for treatment [32]. Lack of language proficiency, transportation and similar barriers to access mirror cases with discrepancies in prenatal care. Future studies should consider PPD screening rates among immigrant women as a preventative measure seeing the relative invisibility of the illness and the gap in diagnosis and recognition of the issue. Additionally, investigations into immigrant women's experience of postpartum services can provide insight into the adequacy of such services and whether immigrant women feel safe disclosing information to healthcare providers.

DISCUSSION

Strengths and Limitations

This systematic review of 17 studies from 5 countries represents the experiences and perceptions of various immigrant women and paints a collective overview of the complex needs of childbearing women at a critical time when they are most dependent on health support systems. However, some methodological limitations must be acknowledged when considering the research findings. Experiences of foreign-born women are not uniform and may vary by migrant subgroups as categorized by place of origin and race/ethnicity. Specifically, not all cultural practices surrounding birth could be accounted for and examined in depth for how they are received. Since some of the studies drawn are small and qualitative, the representativeness of immigrant participants cannot be ascertained. Additionally, as it was impossible to summarize the findings from all higher-income countries, this study was largely focused on five countries, though migration is widely distributed among many more. However, the systematic review provided an overarching cumulation of multiple different perspectives from patients and healthcare providers, allowing a comprehensive understanding of the challenges that immigrant women face throughout the total trajectory of maternal health. Synthesizing evidence from qualitative studies with testimonies from immigrant participants directly allowed for personal insights, useful for assessing contributors to postpartum depression that can be beneficial in accessing contributors and personal challenges like cultural discrepancies.

Recommendations for Future Research

Regarding directions for future research, it should be noted that in many studies, the length of time in the receiving country and immigration status were often not considered potential confounding variables. Further research is needed to determine how specific institutional policies and healthcare systems may influence women's ability to obtain maternity care. For prenatal health, further investigations could be helpful in identifying existing migrant-specific prenatal care programs and their effects on prenatal care utilization. In addition, future studies should consider PPD screening rates among immigrant women as a preventative measure seeing the relative invisibility of the illness and the gap in diagnosis and recognition of the issue.

Investigations into immigrant women's experience of postpartum services can provide insight into the adequacy of such services and whether immigrant women feel safe disclosing information to healthcare providers. More studies on subsequent generations of immigrants can also provide insight into the degree to which traditional practices are maintained and the effect of acculturation on maternal health outcomes, as the length of stay can affect the level of familiarity with the healthcare system while at the same time may hold onto traditional family practices.

Recommendations for Health Professionals

Throughout the trajectory of maternal care, it is evident that multiple obstacles stand in the way of immigrant women. However, there are multiple suggested measures that healthcare providers and services can take to resolve the disparities. For prenatal care, increased availability of trained interpreters or offering pregnancy preparation courses in other languages is crucial to overcoming language barriers. Different models of antenatal care catered toward immigrant women have been proposed in past studies: Group antenatal care offered in-language information, and group advising was received as supportive and positively evaluated [33]. Additionally, there should be measures to increase awareness of the availability of such services. Due to the often limited knowledge immigrants have about the structure of the healthcare system in the new country, additional guidance on how the healthcare system is built, informing pregnant patients of their rights and education on all the available options and support systems are suggested. Moreover, the studies highlighted the importance of culturally sensitive care. While it is not possible to learn every ethnic group's beliefs, providers should be trained in cultural humility, defined as an ongoing process of self-reflection wherein individuals reflect on their background and situation, which can encourage an atmosphere that is receptive of and acknowledges differing patient interests and beliefs that conflict with the healthcare provider's form of care [34]. There should be a focus on promoting equity and non-discriminatory attitudes among HCPs. As a possible solution, HCPs can consider the use of multicultural doulas. A doula is a woman experienced in childbirth and can provide continuous support throughout the duration before, during and after birth. Doulas who share a language and culture with the women can help facilitate discussions for midwives while also providing emotional support and bridging divides in understanding women's cultural customs and practices [35]. As another recommendation, it's important to ask women their preferences to provide any specific needs they may have to make them feel attuned to their specific circumstances: i/e, a) whether women who have undergone female genital mutilation want to undergo deinfibulation, a practice performed before pregnancy to minimize the risk of extensive perineal tearing, b) whether they want a cesarean section, and c) whether they would like to be seen by only female midwives, among many other adjustive practices like providing hot drinks and alternative comfort measures instead of ice packs [36]. Finally, disparities in rates of postpartum depression reveal the need to raise awareness of depression early on in the healthcare setting with accessible community-based support. For instance, a study showed Latina women attending group-based cognitive behavioral therapy resulted in lower perinatal depressive symptoms during pregnancy and postpartum [37].

CONCLUSION

Using a systematic methodology examining 17 articles, this literature review attempts to identify barriers and challenges immigrant women face while attempting to access and utilize maternal healthcare services during significant periods of pregnancy, from prenatal care and in-hospital delivery to postpartum depression. Overall, the studies highlight the need for maternal care service providers to be open to considering differing cultural expectations of care and adopt flexible models that support immigrant women's needs. Measures should be taken

to address systemic barriers to care relating to access and language services, quality of care experience that is receptive to cultural needs, and wider screening and awareness for unaddressed and unknown health concerns.

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