

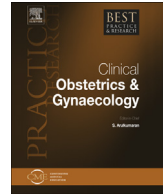


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# Reproductive health research of women migrants to Western countries: A systematic review for refining the clinical lens



Anita J. Gagnon, RN, MPH, PhD, Professor & Interim Director <sup>a,\*</sup>,  
Kara L. Redden, RN, MSc (A) Cand., Research Assistant <sup>b</sup>

<sup>a</sup> *Ingram School of Nursing, McGill University, Research Institute of the McGill University Health Centre, Montreal, Canada*

<sup>b</sup> *Ingram School of Nursing, McGill University, Montreal, Canada*

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Influxes of migrant women of childbearing age to Western receiving countries have made their reproductive health a priority in those countries. Yet, providing optimal care to these women may be hampered by an inadequate volume or quality of research to inform practice. We reviewed reports of studies recently published to assess the extent to which current research is able to inform reproductive health care practices for migrant women (i.e., those born in countries other than the receiving country) - in so doing, we sought to offer a view of the landscape from which clinicians may interpret relevant publications. Additionally, we sought to identify topics for which clinicians may choose to advocate for additional research to be performed.

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## Background

By the end of 2013, Western nations received over 130 million international migrants with women constituting more than half (56.1%) of this group [1] and care for migrants has recently been declared to be a priority for research and action [2]. Studies in the industrialized West have recorded health inequalities between migrants (including immigrants, refugees, asylum-seekers and undocumented persons) and receiving-country nationals [3–8]. These inequalities encompass disparities in perinatal health outcomes and care [9–15] and to a lesser extent, other reproductive health and care outcomes

\* Corresponding author. Tel.: +1 (514) 398 4145.  
E-mail address: [anita.gagnon@mcgill.ca](mailto:anita.gagnon@mcgill.ca) (A.J. Gagnon).

[16]. In light of the increasing proportion of births to migrant women [17], these disparities and the reproductive health status of migrant women at large take on added importance.

Although the health of migrants has arrived on the policy agenda across a number of settings, the research available to support effective clinical decision-making is by no means conclusive [9]. One of the key reasons for this has to do with methodological differences in choices made by investigators when developing their research studies [9]. Each design decision can affect the results obtained, making it difficult for both the direction and estimates of effects to be similar across studies. The consequent variation in results may lead to confusion or often a perception that results are too complicated to be understood and put into practice.

Some of the broad design issues which could affect results are those included in assessments of study quality [18] such as: group comparability, adequacy of follow-up, appropriate variable measurement, 'exposure' definition, and control for potential confounders.

There exist key methodological issues specific to the examination of the reproductive health of migrant women and these are driven by the study question. The basis of all scientific inquiry is conceptual - the scientific issue in question. All study design issues are driven by this question and require selection of the most rigorous approaches to answering it. Once the basic study design is chosen, the underlying hypothesis being tested will direct how the sample should be created. For example, is it a difference in genetic make-up that is suspected as the mechanism through which the outcomes occur, in which case 'ethnicity' as defined by lineage might be the appropriate way to select the sample, or are cultural practices thought to be the mechanism, in which case degree of "connection" to the culture of origin may be the most appropriate way to select the sample? Is eligibility for governmental subsidy of needed services thought to be the mechanism? If so, defining study groups based on legal immigration class (e.g., undocumented/documentated) may be most useful. Variations in hypotheses such as these can be extended to other migration-related variables such as length of time in receiving country, documentation of health history, and language fluency. Prior to changing clinical practice, repeatedly similar results testing the same hypothesis in a range of settings obtained through high quality inquiry is reassuring, if not essential.

In some studies, migrant populations are characterized by cross-border movement, while in others, migrants are characterized by their reported ethnicity. It is also possible that studies that control for social factors attain different outcomes from those that do not. Lower socio-economic status, for example, is more common among migrant families [19] and is correlated with a higher prevalence of maternal and child health complications [20].

Differences in study outcomes may also signify heterogeneity within migrant groups. For instance, many individual risk profiles can be merged into the single groupings, 'migrant' or 'receiving country-born' [21]. For example, refugee and asylum-seekers often face greater risk of poor outcome because of a history of gender-based violence [22–24], post-traumatic stress disorder [22,25] and official language difficulties [26]. Increased risk of infectious diseases and poor maternal nutritional status [27] are also commonly observed in women who have resided in refugee camps and war-torn areas [28]. In contrast, economic migrants may be richer and in better health than other migrants, and their data may well outshine those of higher-risk and less numerically visible migrants, such as refugees and asylum-seekers [21,29]. The 'healthy immigrant effect', in which newcomers exhibit better health outcomes than their receiving-country counterparts and subsequently worsen over time [29,30], is cited to account for cases where migrants have better or similar health outcomes.

An accurate overview of the discrepancies that exist between study methodologies is important to know to help understand conclusions to be drawn from the combined body of literature on the reproductive health of migrant women. We therefore conducted a systematic review of recent literature (2010–2014) making particular note of methodological issues that might impact conclusions drawn in individual studies and consequently, lead to an inability to draw conclusions upon which to base clinical practice.

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