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CLINICAL ARTICLE

Obstetric care in a migrant population with free access to health care

Lígia M. Almeida [a,b,c,*], Cristina C. Santos [d], José P. Caldas [b,c], Diogo Ayres-de-Campos [e], Sónia Dias [f]

[a] Institute of Public Health, University of Porto Medical School, Porto, Portugal
[b] Centre for Research and Intervention in Education, Faculty of Psychology and Educational Sciences, University of Porto, Porto, Portugal
[c] Iberoamerican Observatory of Health and Citizenship, Porto, Portugal
[d] Centre for Research in Health Technologies and Information Systems, Department of Information Sciences and Decision in Health, University of Porto Medical School, Porto, Portugal
[e] Department of Obstetrics and Gynecology, University of Porto Medical School and São João Hospital, Porto, Portugal
[f] Institute of Hygiene and Tropical Medicine, New University of Lisbon, Lisbon, Portugal

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ABSTRACT

Objective: To evaluate differences in obstetric care between immigrant and native women in a country with free access to health care. *Methods:* A cross-sectional study was carried out of immigrant mothers delivering in one of the four public hospitals in the Porto, Portugal, metropolitan area between February and December 2012. The comparison group included native Portuguese mothers who delivered in the same institutions. The participants (89 immigrant mothers and 188 Portuguese mothers) were recruited by telephone and completed a written questionnaire during a home visit. *Results:* Immigrant women were more likely to have their first pregnancy appointment after 12 weeks of pregnancy (27.0% vs 14.4%, $P = 0.011$) and to have fewer than three prenatal visits (2.2% vs 0.0%, $P < 0.001$). They were also more likely to have had a cesarean delivery (48.3% vs 31.4%, $P = 0.023$), perineal laceration (48.8% vs 11.6%, $P < 0.001$), or postpartum hemorrhage (33.5% vs 12.3%, $P < 0.001$). *Conclusion:* Migrants were more prone to late prenatal care and to intrapartum complications. Unsatisfactory interactions with healthcare staff may play an important role in these findings.
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1. Introduction

Immigrants and ethnic minorities often have increased health risks and may receive less health care, when compared with native populations [1,2]. Pregnant women are particularly vulnerable, because they face the stress of the migration process on top of the demanding experiences of pregnancy and maternity [3]. It is commonly accepted that migration is a risk factor in obstetric management [1,4,5] that is associated with increased rates of operative delivery and less adequate postpartum care. This may be attributable to barriers in access to and/or engagement with the health services [6,7]. Financial difficulties may also limit health contacts, be it because of the costs of travel or the need to pay for health care. Some governments have attempted to tackle the latter problem by eliminating healthcare payments during pregnancy for immigrants regardless of their legal status. This may, however, not be sufficient to assure equity in health care. The absence of qualified interpreters [2] and cultural differences in views about health, health literacy, and health expectations may lead to poorer prenatal care and lower adherence to recommendations [4,7–12].

Some studies [13–16] report improved perinatal outcomes in immigrant populations in spite of increased demographic and socioeconomic risk factors—a phenomenon known as the "healthy migrant effect." This could be explained by the protective influence of family networks or informal social support during pregnancy [3] and/or by healthier behaviors when compared with the native population [13]. This effect tends to fade with increasing time spent in the host country [6,17,18] and may mask the situation in more vulnerable subpopulations within the immigrant group, such as those with a lower educational level or socioeconomic status [19].

The main goal of the present study was to evaluate possible differences in obstetric care between immigrant and native women in an urban population where free health care was available to all during pregnancy, irrespective of the women's legal status.

2. Materials and methods

The administrative databases of the four public maternity hospitals in the Porto, Portugal, metropolitan area (Centro Hospitalar de São João, Centro Hospitalar de Vila Nova de Gaia e Espinho, Centro Hospitalar do Porto, and Hospital Pedro Hispano) were searched on a weekly basis between February 1 and December 31, 2012, in order to identify all births that occurred in immigrant mothers. Immigrant mothers were defined as women born outside Portugal whose parents

* Corresponding author at: Centre for Research and Intervention in Education, Faculty of Psychology and Educational Sciences, University of Porto, Rua Alfredo Allen, 4200-135 Porto, Portugal. Tel.: +351 226 079 700 308.
E-mail addresses: ligia_almeida@fpce.up.pt, ligia.m.almeida@gmail.com (L.M. Almeida).

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were also born outside Portugal, irrespective of their documentation status. For each of these births, the two subsequent births registered at the respective hospital to native Portuguese mothers were selected for the comparison group. The contact telephone numbers of all mothers were obtained from the hospital records. The study was approved by the Ethics Committees of all participating hospitals.

In the 3–4 weeks that followed delivery, one of the researchers (L.A.) attempted to telephone all selected women (n = 352). Participants were considered nonresponders if they failed to answer three telephone calls (immigrants, n = 18; Portuguese, n = 33). Responders were excluded from the study if they reported residing outside the Porto metropolitan area (immigrants, n = 7; Portuguese, n = 3), if they reported a multiple birth (immigrants, n = 3; Portuguese, n = 8), or if they indicated that they were giving the infant up for adoption (immigrants, n = 0; Portuguese, n = 3). All remaining women were given an explanation of the aim of the study and asked for informed consent to participate, and the researcher attempted to schedule a visit to their home or another location of convenience to complete a written questionnaire. A total of 117 immigrant mothers and 235 Portuguese mothers were contacted by telephone; of these, 89 (76.1%) immigrant mothers and 188 (80.0%) Portuguese mothers answered the phone, agreed to schedule a visit, and were visited. A total of 277 completed questionnaires were obtained.

During the home visits, which were carried out by a single researcher (L.A., a Psychology graduate who was not involved in the provision of health care), each participant received written and oral information on the study, and written informed consent to participate was obtained. Mothers were asked to fill in the questionnaire in the presence of the researcher, and whenever doubts about a question arose or a delay in response was noticed, the respective item was explained. Both the questionnaire and the written information were presented in Portuguese and described carefully to all women. Obstetric data were complemented and confirmed with information from the mother's pregnancy health book—a record of prenatal and intrapartum clinical care that is given to all pregnant women in Portugal.

The questionnaire enabled data collection on demographic characteristics, socioeconomic status, education level, income and employment status, household and family constellation, lifestyle and health behaviors, gynecologic and obstetric history, prenatal and intrapartum care, and complications of pregnancy and labor.

Free health care for all pregnant women, regardless of their legal documentation status, has been offered in Portugal since 2009. There are a large number of local primary healthcare centers run by family physicians, and the system mandates first contact at this level unless there are acute health problems. If this is the case, these individuals have access to prehospital care and transport, or direct admission to emergency hospital services. Specialized care takes place in public hospitals on referral of the family physician. Primary healthcare centers also run local campaigns for the promotion of health, prevention of disease, and vaccination and rehabilitation programs, usually organized by nursing teams. Prenatal care in low-risk pregnancies is provided at the primary healthcare centers, with guidelines [8] in place for the referral of pregnant women to specialized obstetric care. National guidelines also exist on the number of prenatal visits, laboratory evaluations, and ultrasound examinations to be performed in low-risk pregnancy [20].

The data analysis was carried out using SPSS version 19.0 (IBM, Amonk, NY, USA). Categorical variables were analyzed by the χ^2 or Fisher test, whereas continuous variables were evaluated using the *t* test. $P < 0.05$ was considered statistically significant.

3. Results

In the immigrant group, 48 (53.9%) women originated from Brazil, 23 (25.8%) from Eastern European countries, and 18 (20.2%) from Portuguese-speaking African countries. The mean length of stay in Portugal was 7.35 ± 3.63 years. A total of 47 (52.8%) women reported that it was legal for them to be in the country (some showed documentation), whereas 36 (40.4%) said they were in the process of achieving legal status, and 6 (6.7%) remained illegal.

Table 1
Sociodemographic data.[a]

Parameter	Migrants (n = 89)	Portuguese (n = 188)	Total (n = 277)	*P* value
Maternal age, y	30.5 ± 4.72	28.5 ± 4.66	29.0 ± 4.77	0.001[b]
Parity				0.005[c]
Primiparous	37 (41.6)	112 (59.6)	149 (53.8)	–
Multiparous	52 (58.4)	76 (40.4)	128 (46.2)	–
Marital status				0.720[c]
With partner	67 (76.1)	146 (78.1)	213 (77.5)	–
Without partner	21 (23.9)	41 (21.9)	63 (22.5)	–
Family income[d]				0.119[c]
<€500	26 (29.2)	34 (18.2)	60 (21.7)	–
€500–1000	39 (43.8)	75 (40.1)	114 (41.3)	–
€1001–1500	12 (13.5)	43 (23.0)	55 (19.9)	–
€1501–2000	9 (10.1)	25 (13.4)	34 (12.3)	–
>€2000	3 (3.4)	10 (5.3)	13 (4.7)	–
Family income [d]				0.018[c]
≤€1000	65 (73.0)	109 (58.3)	174 (63.0)	–
>€1000	24 (27.0)	78 (41.7)	102 (37.0)	–
Maternal education				0.024[c]
1–4 years	4 (4.5)	12 (6.4)	16 (5.8)	–
5–6 years	11 (12.4)	13 (6.9)	24 (8.7)	–
7–9 years	15 (16.9)	57 (30.3)	72 (26.0)	–
10–12 years	44 (49.4)	64 (34.0)	108 (39.0)	–
Higher education	15 (16.9)	42 (22.3)	57 (20.6)	–

[a] Values are given as mean ± SD or number (percentage).
[b] *t* test.
[c] χ^2 or Fisher exact test.
[d] To exclude the possibility that the lack of significance for family income might be attributable to the classification scheme, we explored two schemes: classification into five classes and classification into two classes.

The maternal age was significantly higher among immigrants, who were also more likely to be multiparous and have a family income of €1000 or less (Table 1). The proportions of Portuguese women who had received 7–9 years or 10–12 years of schooling or a higher education were distributed relatively evenly (30.3%, 34.0%, and 22.3%, respectively), whereas most migrants (49.4%) had completed 10–12 years of schooling.

In terms of prenatal care, migrant women were more likely than native Portuguese women to have their first pregnancy appointment after 12 weeks of pregnancy and to have fewer than three prenatal visits (Table 2). Urinary infections and placental abruption were more common among Portuguese women, but there were no differences in deleterious habits or the incidence of other pregnancy complications. There were also no significant differences in the incidence rates of diseases, such as depression, anemia, and dyslipidemia prior to pregnancy (data not presented). However, immigrant women were more likely to be nonsmokers before pregnancy (83.1% versus 75.9%), and they reported a higher incidence of previous adverse obstetric outcomes, such as spontaneous abortion, ectopic pregnancy, stillbirth, or neonatal death.

With regard to intrapartum care, migrant women were less likely to have a vaginal delivery and more likely to have a cesarean delivery, perineal laceration, or postpartum hemorrhage (Table 3). No significant differences were found in the incidences of preterm delivery, low birth weight, and fetal malformations.

Immigrant women were more often dissatisfied with the support given by administrative and medical staff during prenatal visits, compared with Portuguese women (Table 4). By contrast, Portuguese women were more frequently dissatisfied with the support received from the nursing team during labor.

4. Discussion

The present study shows that, even in settings where health care is free for all women during pregnancy irrespective of their legal status,

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