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International migration to Canada: The post-birth health of mothers and infants by immigration class

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ABSTRACT

There are over 214 million international migrants worldwide, half of whom are women, and all of them assigned by the receiving country to an immigration class. Immigration classes are associated with certain health risks and regulatory restrictions related to eligibility for health care. Prior to this study, reports of international migrant post-birth health had not been compared between immigration classes, with the exception of our earlier, smaller study in which we found asylum-seekers to be at greatest risk for health concerns. In order to determine whether refugee or asylum-seeking women or their infants experience a greater number or a different distribution of professionally-identified health concerns after birth than immigrant or Canadian-born women, we recruited 1127 migrant (and in Canada <5 years) women–infant pairs, defined by immigration class (refugee, asylum-seeker, immigrant, or Canadian-born). Between February 2006 and May 2009, we followed them from childbirth (in one of eleven birthing centres in Montreal or Toronto) to four months and found that at one week postpartum, asylum-seeking and immigrant women had greater rates of professionally-identified health concerns than Canadian-born women; and at four months, all three migrant groups had greater rates of professionally-identified concerns. Further, international migrants were at greater risk of not having these concerns addressed by the Canadian health care system. The current study supports our earlier findings and highlights the need for case-finding and services for international migrant women, particularly for psychosocial difficulties. Policy and program mechanisms to address migrants' needs would best be developed within the various immigration classes.

Introduction

Immigration classes: eligibility and access to health care

Migrants are "persons, and family members, moving to another country or region to better their material or social conditions and improve the prospect for themselves or their family" (International Organization for Migration, 2004). In 2008, there were 214 million international migrants worldwide, 49% of them women (International Organization for Migration, 2008). From 1999 to 2008, Canada received 2 million migrants in the immigrant class, 1.2 million asylum-seekers, and 284,285 refugees; with the majority of the last two groups settling in Toronto and Montreal (Citizenship and Immigration Canada, 2009). Independent- or family-class *immigrants*, generally choose to migrate to re-establish themselves in a new country with the promise of a better life (Gravel, Battaglini, Riberdy, Guay, & UnitéÉcologie humaine et sociale – DSP de Montréal-Centre, 2000); *refugees* are forced to leave their countries to ensure their survival (UNHCR, 2004); and *asylum-seekers*, seek the protection of a receiving

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country after their arrival in that country. Each class is associated with regulatory restrictions related to eligibility for health care (Gagnon, 2004). In Canada, immigrants face a three-month wait for provincial health insurance eligibility and asylum-seekers are only eligible for the Interim Federal Health Program (IFHP). Migrants with limited health insurance delay seeking care until the situation is urgent (Romero, Chavkin, Wise, & Smith, 2003) and avoid seeking care for fear of harming their chances of successful settlement (Esses, Dovidio, Jackson, & Armstrong, 2001; Harney, 2001). Language (Anisef, Kilbride, Ochocka, & Janzen, 2001; Bowen, 2001), transportation, costs of transportation/child care and previous experience have been shown to influence access to health services by migrants (Kobayashi, Moore, & Rosenberg, 1998, pp. 1–51). Racism may also be implicated as a barrier to access (Saidullah, 2001).

Immigration classes: importance to health

In addition to determining eligibility for health care services, health differences between immigration classes have been noted. A large body of literature has documented a 'healthy immigrant effect' in migrants [mostly immigrants (Citizenship and Immigration Canada – Research and Evaluation Branch, 2007), who arrive healthy and experience health decline over time (Gushulak, 2007; Jasso, Massey, Rosenzweiger, & Smith, 2004; Marmot, Adelstein, & Bulusu, 1984; Palloni & Ewbank, 2004)]. Conversely, refugees arrive from strife-torn areas, often having lived in camps with associated health risks (e.g., exposure to infection, violence). Asylum-seekers live under extreme stress concerning whether they will be allowed to make the receiving country their home. This is particularly acute for postpartum women who fear that their applications may be rejected while their infants may be permitted to stay (as citizens, in Canada). In this case, they must decide whether to abandon the infant, return with the infant to the 'home' from which refuge is sought, or remain with the infant in the receiving country as an undocumented migrant.

There are several factors key to considering the health of female refugees and asylum-seekers. These include a history of torture (Hynes & Cardozo, 2000) and sex and gender-based violence (Hynes & Cardozo, 2000; Kira, Smith, Lewandowski, & Templin, 2010), female genital mutilation (FGM) (Thierfelder et al., 2005; Weir, 2000), somatisation (Perron & Hudelson, 2006), and post-traumatic stress disorder (PTSD) (Kira et al., 2010; Redwood-Campbell et al., 2008). Increased risk of infectious diseases and poor maternal nutritional status are seen in women who have spent time in refugee camps and in war-torn areas.

Despite the importance of immigration class to both eligibility for health care and health risk, reports of migrant reproductive health and care have generally not been compared by immigration classes. A systematic review of studies of international migrant women/infants related to pregnancy or birth identified 133 reports (>20,000,000 migrants) (Gagnon, Zimbeck, & Zeitlin, 2009). Migrants were described primarily by geographic origin; immigration status was not studied. Migrants' results for preterm birth, low birth weight and health-promoting behaviour were as good or better as those for receiving country women in ≥50% of all studies. Meta-analyses found that Asian, North African and sub-Saharan African migrants were at greater risk of feto-infant mortality than 'majority' receiving populations, and Asian and sub-Saharan African migrants at greater risk of preterm birth. Considerations of later post-birth health were absent from this body of literature.

The few comparative studies of refugee perinatal health have mixed results. In one, refugees were found to have higher rates of stillbirth, neonatal, and infant mortality than native-born mothers (Gissler et al., 2009). Another study found lower risks of pre-term birth and small-for gestational age infants to be born to former Yugoslavian Republic mothers (assumed to be refugees) than US-born non-Hispanic whites (Janevic, Savitz, & Janevic, 2011); while a study in Thailand found refugees living in camps and migrants living in the same province had similar rates of prematurity and low birth weight (Carrara, Hogan, De Pree, Nosten, & McGready, 2011).

Reports of international migrants' difficulties in accessing health care have been reported. These include: refusal to care for infants (born as Canadians) whose mothers were covered under Canada's IFHP (Merry, Gagnon, Kalim, & Bouris, 2011); refusals to care for others covered under IFHP (Kuile, Rousseau, Munoz, Nadeau, & Ouimet, 2007; Simich, Wu, & Nerad, 2007); difficulties of public health nurses to reach women (Merry, Gagnon, Kalim et al., 2011); a general lack of assessment, support, and referral for psychosocial concerns (Merry, Gagnon, Kalim et al., 2011); isolation (Merry, Gagnon, Kalim et al., 2011); language barriers (Kuile et al., 2007; Merry, Gagnon, Kalim et al., 2011; Simich et al., 2007); low health literacy (Merry, Gagnon, Kalim et al., 2011); and confusion and limitations of the IFHP (Kuile et al., 2007; Merry, Gagnon, Kalim et al., 2011; Simich et al., 2007). In the postpartum period, there is also often hesitance to seek care which might be related to mistrust or cultural mismatch of services for certain concerns (Gagnon et al., 2010). Related to this, perceptions of health care professionals with regards to health care access likely play an important role. In a recent on-line study of hospital and primary care centre staff ($n = 1048$), 61.1% of health care practitioners supported full or broad access in contrast with 42.1% of support staff, and 53.5% of managers and administrators; and hospital staff were less supportive (49.2%) than primary care staff (68.5%) (Ruiz-Casares et al., 2012).

Migrants and postpartum care in receiving countries

The proportion of people living in Canada who were born elsewhere is 19.8% (Statistics Canada, 2007), 52% of them women (Citizenship and Immigration Canada, 2009). In Canada, the majority of women giving birth will be discharged from hospital within 1–2 days after a vaginal birth, 3–4 after a cesarean. Although postpartum care varies by province and health unit, most women will be contacted by a public health nurse following discharge, assessed via telephone for any health concerns and possibly offered a home visit. During these contacts, teaching, support, and referrals for additional care may be made. However, responsibility for the uptake of these referrals, by contacting health or other professionals, often lies with the women or their families (regardless of their language ability) depending on the practice of the administrative unit.

In addition to the specifics of health care organization and delivery in migrant receiving countries such as Canada, there exists specific policies and programs that operate within and outside of the health sector with the potential to impact migrant health at a population level (Institute of Population Public Health, 2011). These encompass a range of social determinants of health (Hawe & Potvin, 2009). Considering migrant women, the immigration sector is key (Bollini, 1993). Intervention examples in the immigration sector include immigration assistance programs (including restrictions to social and health care access based on legal status, pending legal status, length of time in the receiving country) and policies regarding access to essential language skills. Despite migrants often having reduced entitlements in receiving-countries and greater exposure to a lack of employment and housing or poor working and living conditions, we know of only one recent study