

## 8.L. Workshop: Understanding and meeting the sexual and reproductive health services among migrant women in Europe

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More than 500 000 migrant women give birth every year in the EU and the rate is increasing. Migrant women originating from other than industrialised countries have higher rates of maternal death and severe morbidity as well as stillbirth and infant death. Sub-optimal care is one reason for these poor outcomes and reflects the failure of European health systems to provide care adapted to the needs of migrant populations. Little is known about migrant women's sexual and reproductive health, especially contraception and induced abortion.

Adverse perinatal health outcomes have a high social impact because of their long-lasting health, psychological and financial costs and their contribution to social inequalities in health and wellbeing across the life cycle and generations. Furthermore, as pregnancy provides a window for repeated contact with the health system, there is a strong potential for improving health literacy and preventive care more widely, also after pregnancy and for the health of other family members.

Providing high quality prenatal and childbirth care for migrant women poses challenges because of sociocultural differences, linguistic barriers, a higher prevalence of underlying and unrecognized medical conditions, and low levels of cultural competence at provider and organisational levels. Low health literacy, the difficult economic and social circumstances and the psychological trauma associated with migration, especially for refugees, also need to be considered. These difficulties are widely recognised by health professionals and some interventional approaches have been created to address or mitigate them. However, most interventions have been introduced without evidence-informed design, adequate engagement of migrant women themselves or rigorous evaluation, and little is known about their effectiveness in improving birth outcomes or satisfaction with care. Similarly, scarce attention has been paid to analyse the extent to which health surveillance indicators are reliable to capture the specific needs of the migrant population.

More accurate information to patients and caregivers is central for meeting the needs of migrant women and is an important aspect of the tailoring of existing interventions to them. Likewise, guidelines for prevention and treatment of diseases and management of co-morbidities with attention to the barriers migrant women face in achieving good quality health care are essential in improving migrant women's health. More effective and safer interventions at individual and population level will lead to higher utilisation of sexual and reproductive health services and prenatal care, and a

better fit between healthcare and patient needs and expectations. The health care providers managing the challenges related to social and ethnic health disparities today also identify the need for novel approaches and to improve the cultural competence, the knowledge, awareness and skills of the health workforce.

### Key messages:

- Migrant women have special needs for sexual and reproductive health services, which the current health systems cannot always satisfy.
- Participatory (co-production) research methods can help to develop acceptable and effective approaches to meeting migrant women's sexual and reproductive health needs.

### Induced abortions among migrant women in Finland 2001–2014

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People of migrant origin may have barriers in obtaining accessible and good quality sexual and reproductive health care services. We investigated induced abortions among migrant women in Finland. The Register on Induced Abortions was linked with the Population Register data of Statistics Finland on women's background characteristics with personal identity numbers (PIN). Among the 148 044 induced abortions in 2001–2014, 1211 (0.8%) had incomplete PIN and 693 (0.5%) missing data on their origin. These include recent migrants, asylum seekers and non-resident women. Women with Finnish background and born in Finland had the lowest abortion rate (8.4/1000 women aged 15–49 years). Women with migrant background had a higher rate, both those born in Finland (10.3/1000) and those born elsewhere (14.9/1000). The largest migrant groups were from the former Soviet Union, Sweden, Estonia, Somalia and Iran. Migrant women had less late induced abortions after 12 weeks (5.9%) than women with Finnish background (7.7%), but more repeated abortions (21.5% vs. 11.6%). No use of contraceptives before pregnancy was reported by 40% of women with Finnish background and 58% of migrant women. After the abortion, oral contraceptives and IUDs were the most common choices both for women with Finnish background (54% and 24%) and migrant women (48% and 33%). To improve migrants' sexual and reproductive health, family planning services should focus in prevention of unwanted pregnancies among women with different cultural backgrounds. Migrant women may need special support when seeking abortion and when they are in need of abortion.

## Could co-production contribute to equitable contraceptive counselling among immigrants? Towards a more equitable contraceptive counselling among immigrants from Middle East in Sweden

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Several European studies have shown that immigrants are more likely to have an induced abortion as compared to non-immigrants. Preventing unwanted pregnancies from a population perspective would help reduce abortion rates, and knowledge as to what risk factors are associated with abortion is the key in reducing contraceptive failure or non-use. Based on our previous studies, we hypothesize that the sexual and reproductive health services are potential contentious spaces but also a source of solutions on how to deal with the sensitive but fundamental values related to reproductive rights. By building on quantitative and qualitative data we coproduced contraceptive counselling relevant to the target group. Quantitative data was a cross sectional study was conducted in eight abortion clinics in Stockholm County in 2015. Qualitative interviews were held with immigrant women and health care providers (HCPs) working with in abortion and contraceptive care. Immigrant women seeking abortion care were older as compared to non-immigrant women. Immigrant women from certain countries were overrepresented among women seeking abortion care and did not represent to the proportion in the general population. In addition, contraceptive use ever in life and at time of conception was lower among immigrant women as compared to non-immigrant women. HCPs identified specific challenging situations in contraceptive counselling, for example a mismatch where HCPs believe that immigrant women's culture/religion does not allow the use of contraception, but that the immigrants themselves does not agree, the organization and structure of the contraceptive counselling that contribute to low-quality counselling. By using these data tools that could assist HCP to provide sexual and reproductive health services will be developed and evaluated.

## Healthy migrant effect or artefact? The impact of the gestational age estimate method on birth outcome disparities between migrants and Swedes

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Prior studies have shown that the offspring of migrant women have equal or lower risks of preterm births compared to those of natives (healthy migrant paradox). We evaluate whether this advantage is consistent across methods of estimation of the gestational age. This population-based register study includes all singleton live births occurred in Sweden (1992-2012) with information on gestational age estimated through the last menstruation period (LMP), ultrasound ( $n = 1,317,265$ ). Using multinomial regression, we compare gestational age outcomes (preterm, moderate and late preterm, post-term) between migrants and natives comparing different gestational age methods. We performed sensitivity analyses using a subsample of 718,191 uncomplicated pregnancies. Foreign-born mothers showed lower odd ratios of delivering preterm (OR: 0.98 [95% CI: 0.98, 1.01]) and late preterm (OR: 0.95 [95% CI: 0.92, 0.98]) using ultrasound while higher risk when LMP was used instead (respectively, OR: 1.10 [95% CI: 1.07, 1.14] and OR: 1.09 [95% CI: 1.06, 1.13]). These differences do not equally affect all migrant groups. The largest differences are found among women coming from Africa and, to a lesser extent, those from Eastern Europe & Russia, and the Middle East. Disparities in gestational age outcomes by mother's origin strongly depend on the method used to estimate gestational age. While the health advantage is partially confirmed in

almost all categories of gestational age using ultrasound (except for early preterm), foreign-born mothers show worse outcomes when LMP is used instead. This finding points out that the information used might have a sensitive impact on the comparison between migrants and natives across countries and time. Further studies should disentangle which method of estimation captures health differences among migrants better in order to improve maternal and child health surveillance.

## What initiatives might improve perinatal health of migrant women and their children?

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Many migrant women in Europe have increased risk of poor reproductive outcomes and suboptimal care is one of the underlying causes. First priority for European welfare states must be to ensure equity in quality of care for pregnant migrant women, however there is lack of evidence of best practice. Good quality interpretation services seem to be the most alarming equity issue across countries. Internationally, current promising efforts are focusing on language supported group antenatal care, bilingual/bicultural healthcare workers, and bilingual labour companions, increased health literacy for women and health systems, and programs to reduce discrimination. One experience is the Danish MAMA ACT study aiming at improved communication between immigrant women and midwives regarding symptoms of pregnancy complications in order to ensure appropriate care and thereby improve the perinatal health and survival. Activities were post-graduate training of midwives in cultural competence, health education materials on warning signs of pregnancy distributed to women, and a little more consultation time. A feasibility study was conducted in the antenatal care at one maternity ward and included pre ( $n = 268$ ) and post ( $n = 233$ ) intervention surveys among pregnant women and 22 focus groups with midwives. Substantive development in the cultural competence of midwives was seen and they expressed increased sensitivity and response to the women's individual needs. The health education material was well received by women and the midwives found it a good tool for overcoming both psychosocially and culturally barriers. Thus, the project is promising and a national trial is funded and in planning. Shared lessons learned are that health system efforts need to be based on co-creation with the target group and providers and address providers' interactional skills as well as organizational barriers. Large scale process and effectiveness evaluations and cross country comparisons should be the next step.

## Co-production and testing of a community genetic literacy intervention among a minority ethnic community

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Infant mortality shows significant ethnic inequalities. Elevated risk in some migrant groups is in part due to rare autosomal recessive genetic disorders linked to customary consanguineous marriage. WHO recommends community level action to raise genetic literacy combined with enhanced access to genetics services, but UK interventions are in their infancy with no national response. A combination of a valued social practice affecting marginalised ethnic minority communities, complicated risk patterns, and low professional awareness makes this a complex issue. We developed a community-level genetic literacy intervention responsive to local needs. Our participatory approach drew on user-centred design and engaged 6 local 'co-researchers' in Sheffield, UK. Two phases of insight gathering used group discussions, interviews and participatory exercises to describe current understanding,

knowledge gaps and trusted communication networks. A series of testing-and-refinement cycles followed. A set of communication materials was co-produced and tested for acceptability, appeal and comprehension. Open-ended tools and a before-and-after structured design were used. Over 200 people participated in the insight and testing work. Information needs and preferred communication channels varied widely. Despite some resistance, there was strong engagement and high demand for information. A narrative, real life video was indicated and developed, supported by factual information in

leaflets and a website. Conveying accurate information and meeting differing demands for detail within generic materials was challenging. Knowledge gain through one-off exposure was mixed, with older participants showing less improvement. Materials were, however, well-received, being considered credible, relevant and inoffensive. Participatory action research can result in culturally appropriate genetic literacy materials. Repeated exposure and opportunities for discussion are needed to address misconceptions.