Optimizing hospital and community-based maternity care for immigrant and minority women in Alberta

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BACKGROUND

- Maternity care which lacks ethnocultural appropriateness may create negative short and long term consequences for immigrant women and their families.[1]
- Although evidence suggests that immigrant/newcomer women have difficulty when accessing, navigating, and utilizing maternity care services, little knowledge exists on how factors such as ethnic group, English-language skills, cultural norms, or pre-migration histories (e.g. violence, trauma) intersect and influence maternity care and maternal outcomes.
- Our aim is to use multidisciplinary perspectives to map out experiences of immigrant women in maternity services, by analyzing existing data and capturing the perspectives of the women and key stakeholders (clinicians, social service providers, policy & decision makers) with respect to the challenges faced in optimizing care for this population.
- Our overarching research question is:

  How can we reduce or eliminate the disparity experienced by immigrant women in accessing and navigating maternity care services in Alberta?

STUDY DESIGN & METHODOLOGY

Multidisciplinary Team → Academic and health services investigators from nursing & midwifery, public health, medicine, social sciences & humanities (gender studies, psychology), education, immigrant support, and knowledge management bringing a rich, coherent and meaningful explanation.

Mixed Methodological Research Design

Phase 1 - Secondary analysis of data from the Maternity Experiences Survey (MES)[2] & analysis of existing Alberta health surveillance and administrative databases.

Phase 2 - Qualitative investigation employing a focused ethnography using purposive sampling and semi-structured individual and focus group interviews.

Focused Ethnography to explore distinct groups of people within complex societies and uncover underlying power relationships within a culture which may influence health care practices, opportunities and care related decisions.[3] Key features include a) focus on discrete community or social phenomena, b) problem focused and context specific, c) limited number of participants, d) participants usually hold specific knowledge, and e) episodic or no participant observation.[4]

Phase 3 - Qualitative meta-ethnography of evidence on maternity care for immigrant women.

Qualitative meta-ethnography- an inductive and interpretive form of qualitative research synthesis, using Noblit and Hare's[5] theoretical approach as modified by Campbell et al.[6] The approach consists of a 7-phase process involving a comparative textual analysis of published qualitative studies. The translation of key concepts from one study to another is idiomatic, thus involving translating the meaning of the text (even if not explicitly identified) to derive second and third-order concepts that encompass more than offered by any individual study.

Phase 4 - A program of knowledge translation and transformative activities.

Study Locations

Edmonton and Brooks (with 17% of population being visible minorities) in Alberta, selected to provide insights into immigrant experiences in both urban and rural locations.

DATA COLLECTION

Non-probability purposive sampling for heterogeneity ("'maximum variation sampling" or "phenomenal variation")

- **Edmonton** – 45 participants, with 22 immigrant women*, 16 health care professionals, 5 social service providers, and 2 policy makers. This included 2 focus groups with 13 women. Ethnic origins of women include: Sudanese, Chinese, South Asian, Columbian, Tajikistan
- **Brooks** – 31 participants (in progress), with 12 immigrant women, 13 health care professionals, and 6 social service providers

* Immigrant women sample included any newcomer (<5 years) women to Canada who gave birth in Alberta within 2-3 years.

QUALITATIVE DATA ANALYSIS

Qualitative data will be managed and classified and ordered with the aid of Atlas.ti[7] and using Roper & Shapira's[8] ethnographic analysis framework.

→ Analytical steps include: a) coding for descriptive labels, b) sorting for patterns, c) identification of outliers or negative cases, d) generalizing with constructs and theories, e) memoing and reflective remarks, and f) constructing a narrative.

QUALITATIVE FINDINGS – PRELIMINARY THEMES

Lack of choice - Most newcomer women and many health professionals and community organizations do not know about alternative maternity services (e.g. midwives).

Navigation of the system - Information may not be available in the women's language & newcomer women often have little knowledge about how to navigate the system.

> ...Mainly they come here asking, "Okay, now what is what I have to do? What do I have to expect?" Because they go to the doctor and no one tells them. Just everyone assumes that they know because everyone in Canada knows what happens when you go to the hospital, right? (Participant 1, settlement support)

Transportation – The women may have difficulty getting to appointments or pre-natal classes – having small children with them, bus schedules, expense, etc.

Expensive medication - Affording certain medications that are prescribed is very challenging.

Engagement with care providers - Differing norms can result in tensions between health professionals and newcomer patients in relation to: punctuality, showing up for appointments, duration of appointment, concepts around "normal" birth.

- Many newcomers don't feel able to complain because health care is free
- Need for care providers to have cultural sensitivity

Interactions within the healthcare system - Communication problems were the most frequently mentioned issue.

- Immigrant women's concerns: 1) Medical terms are confusing, 2) Canadians speak very fast for new language learners, 3) Language differences increase time of visit, and 4) Even women who speak English may have trouble when they are stressed (such as when in labour)

> They treat you very well but you don't understand what they are doing and they don't – [I:Talk to you?]... Yeah. (Participant 11, newcomer woman)

- Health professionals' concerns: 1) Inadequate informed consent, and 2) Relaying complex information (genetic tests, family planning)

> It's one thing to understand the tests that you're providing somebody, but then to break it down to somebody who doesn't understand English and then who doesn't understand biology and chromosomes, you have to guess whether or not sometimes you think they've understood or comprehended. (Participant 44, obstetrician)

- Social services providers' concern: Inability to communicate is frustrating and traumatic for newcomer women

> ...Just recognizing that some of those women have experienced trauma and, you know, when you're unwell or when you're dealing with childbirth it's really important to have somebody who speaks your language. (Participant 2, policy maker, health promotion)

Issues with interpreters – 1) Lack of interpreters, especially after-hours, 2) Interpreters may not be familiar with health issues, 3) Concerns about confidentiality and modesty, 4) Dependence on family member, which may lead to a change in family dynamics.

> ...When you use your kids, your own kids as the interpreters for Social Services, for anything, and for health in particular because it's an intimate thing, it's a more private thing, it creates - instead of the parents being respected with authority, you reverse that pyramid and you have the kids taking control and saying, "You don't know anything. I have to do this for you." (Participant 4, settlement support)

Cultural norms - In patriarchal societies, men or older female relatives may make decisions about women's health. Women may feel discomfort and shame with male doctors.

Racial profiling and stereotyping.

> You see the person walk in, you get the racial blocking right away. "Oh, my gosh, there she is, she's got her head covered, she's black, she's going to be a problem. Because we're not going to be able to talk to her, she's going to refuse things, what are we going to do?" (Participant 21, physician)

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