PERINATAL AND MATERNAL OUTCOMES OF MIGRANT WOMEN IN ICELAND AND THEIR EXPERIENCE OF CARE

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. ABSTRACT

Background: The population composition in Iceland has changed considerably during the last decades, which calls for a health system that supports the needs of a more diverse group ofchildbearing women.

Method: Two population-based cohort studies and a longitudinal qualitative study were conducted. Migrant women were defined as women with citizenship other than an Icelandic one and categorised into three groups, based on the human development index (HDI) score of their country of citizenship. Study I included women who gave birth to a singleton in Iceland between 1997 and 2018, i.e. a total of 92,403 births and study II between year 2007 and 2018, i.e. a total of 48,173 births. The outcome measures included onset of labour, mode of birth, and pain management methods. In both studies adjusted odds ratios and 95% confidence intervals were calculated using logistic regression models. Study III involved individual semi-structured interviews with eight Polish women who participated in two interviews during pregnancy and after birth. The interviews were analysed using reflexive thematic analysis. Results: Overall, migrant women had higher odds for episiotomy and instrumental births and lower odds for induction of labour compared to Icelandic women. Migrant women also had higher odds for no use of pain management, and lower odds for the use of acupuncture, transcutaneous electrical nerve stimulation, shower/bath, aromatherapy, and nitrous oxide

inhalation, when compared to Icelandic women. From the interviews the themes reflected the feeling of being alone and not understood, the importance of having a voice and respectful individualized care.

Conclusion: Women's citizenship and country of citizenship HDI scores are associated with a range of maternal and perinatal complications and interventions, and less use of labour non-pharmacological pain relief methods. By acknowledging migrant women´s diversity in experiences of security, knowledge and personal values, we can implement policies that will help us take better care of migrant women in maternity care.

Keywords:

Migrants, outcome, childbirth, midwifery, care, experience.

Obstetric interventions in migrant women studied

using the Robson´s Ten Group Classification System

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Research has shown increased likelihood of complications and interventions during labour in some groups of migrants compared to natives. The proportion of births of migrant women was 17% the year 2020 and it is therefore important to study the difference in interventions during labour between migrant women and Icelandic women in Iceland.

Methods:

The research is a populations-based cohort study based on data from The Icelandic Birth Registry the years 1997-2020 (N=104.697). Migrant women were defined as women that did not have Icelandic citizenship when any of their birth took place (N=10.409). Migrant women were divided into three group based of the Human Development Index of the country of origin. The division into Robson groups was studied by origin and within the groups proportion of inductions and mode of birth. Chi squared test was used and significance $p<0.05$.

Results:

Migrant women were more often primiparas and the rate of induction was lower with both nulliparas and multiparas (Robson groups 1 / 2 and 3 / 4). For both primiparas and multiparas (Robson groups 1 and 3) with lower Human Development Index of country of origin (<0,900) the rate of instrumental birth was increased and for women with the lowest Human Development Index of country of origin (<0,850) the rate of emergency caesareans was increased. For women with a scar on the uterus (Robson group 5) the rate of instrumental births and emergency caesareans was increased for migrant women, higher as the Human Development Index of country of origin was lower. Corresponding the rate of normal vaginal births and elective caesareans was lower.

Conclusion:

Migrant women are more likely to be primiparas, their births are less often induced and more often end with instruments or emergency caesareans. The difference increases with decreasing Human Development Index of country of origin.

Respect, autonomy and childbirth experience of migrant women in Icelandic maternity care

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Objective

To explore differences between migrant and native-born women in respectful maternity care, autonomy in decision-making, childbirth experience and mistreatment.

Methods

An online survey was developed in Icelandic, English and Polish which included standardized international instruments such as The Mothers on Respect Index, Mother's Autonomy in Decision Making Scale, the Childbirth Experience Questionnaire version 2 and the Mistreatment by Care Providers in Childbirth Indicators to assess women's experiences of respectful care, autonomy and childbirth experience and mistreatment. Requirements to participate were: Age ≥ 18 years; received antenatal care and childbirth in Iceland 2015-2021; and fluency in Icelandic, English or Polish.

Descriptive analysis and regression models were conducted.

Results

Over 1,300 women participated. Migrant women reported lower scores for respectful care [aOR 2.16 (1.55-3.00)], autonomy [aOR 1.42 (1.02-1.97)] and birth experience [$F(12, 1352) = 23.97$, $p < .001$] compared to native-born women. There was no statistical difference between groups regarding mistreatment in childbirth. One in four of all women reported at least one form of mistreatment.

Conclusion

This study sheds light on inequity in maternity care among migrant women and a pressing need to address mistreatment in childbirth for all women. Our results suggest further research in this area as well as evaluation of maternity systems, training in cultural competency and effective communication.

"We at least say we are equal": Gender equality and class in healthcare professionals' discursive framing of migrant mothers

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In the last few decades, the demography of Iceland has become increasingly diverse with an immigrant population similar to that of the other Nordic countries. Women comprise almost half of all international migrants and many of those female migrants require maternity care in their host countries. While some literature describes how migrant women experience the healthcare provisions of their host countries, less is known about the experience of providing the service, from the perspective of the healthcare practitioners. In this study we adopt a social constructionist perspective to explore the discourses of knowledge healthcare professionals in Iceland draw on in their discussion of prenatal and postpartum healthcare in Iceland. Interviews were conducted with 16 healthcare professionals with extensive experience of providing maternity care to migrant women to understand how they construct and make sense of the needs and behaviour of migrant women seeking maternity care. Our findings suggest that some healthcare professionals subject migrant women to normative professional discourses of parenting, without considering how those ideals are tailored to white, middle class women. Migrant mothers and pregnant women are thus excluded from the middle-class mothering norms that are ascribed to Icelandic women. Our findings also highlight how national identity, such as being part of a gender equal society and the image of Iceland as a classless society, influences how healthcare professionals view migrant women. This underscores the importance of cultural reflexivity, and policies and scholarship where an intersectional understanding of

Implementing research into clinical practice: An example from the Reykjavik Birth Center

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Abstract

With emerging evidence about challenges faced and difference in birth outcomes among immigrant women compared to Icelandic women, there is increased pressure on healthcare systems and healthcare providers to respond and provide solutions. The Reykjavik Birth Center opened in 2022 and has from the beginning put an emphasis on equal acccess to information and equal access to midwifery services. The first step was to provide their website in Icelandic, English and Polish and offereing all birth preparation and breastfeeding classes in the three languages. Polish was chosen as Polish immigrants are the largest immigrant group in Iceland. This first step created not only equal access but also a clear welcome to non-Icelandic speaking families.

The next step was to connect with the immigrant community, engage them and build trust. With this in mind the midwives actively invited healthcare providers that were immigrants and providing

services for childbearing women to collaborate. Since the beginning a midwife originally from the US has been on the midwifery team, providing midwifery services and teaching classes in English. A Polish doula has taught classes in Polish at the center from the beginning as well, and later a Polish midwife joined the team and provides lactation consultation at the Birth Center. This has resulted in a large number of immigrant families coming to the center, participating in classes and events and building community with each other and Icelandic families. The Polish midwife and doula have hosted open houses for the Polish speaking community, with short presentations about the healthcare system and health related topics. These open houses have been vital in building trust among the midwives and the Polish speaking community.

In 2023, 65 babies were born at the birthcenter. Twenty three (35%) had parents that were immigrants in Iceland, representing at least eighteen nationalites. No significant difference was seen in outcomes or birth experience among the 65 families. Hundreds of families have participated in classes and events at the Reykjavik Birth Center and thereby taken an active part in building a community that emphasises inclusion, trust and respect.