Lost in translation-

Reproductive health among immigrants and ethnic minorities

Ingvil Krarup Sørbye
Consultant OBGYN, PhD
Dep. Of Obstetrics
Oslo University Hospital Rikshospitalet
Norway

Norwegian Advisory Unit for Women’s Health

NFOG Stockholm April 26th 2019
No conflict of interests

• Travel grants from Ferring, Azanta
• Recipient (PI) of grant from Norwegian Research Council 2018-2022 for the MIPREG study
- Why immigrant reproductive health is important

- What we already know

- So, what?
  Some steps towards better care
- Why immigrant reproductive health is important

- What we already know

- So, what?
  Some steps towards better care
More women in reproductive age are migrants

Norwegian Medical Birth Registry
Health services equity or equality in Nordic countries?

Most RH health services free/low-cost

Universal free public maternity care

However:
Varying integration policies

Integrated or «migrant-specific» health services?

Norway: Migrant characteristics does not warrant particular care
Case 1

- «Fatima» 50 years, married, husband living abroad
- Born Ethiopia, in Norway from 1999
- G7, P6
- 5 normal births, last birth emergency CS w 32+6, PE

- Week 10
  «Referred for OB assessment. Does not opt for early fetal ultrasound/fetal diagnostics»
  Aspirin not given
• OGGT week 8:
  Fasting glucose 6.2, 2-hours: 12.0 = DM
• Metformin

• Week 18: fetal ultrasound: elevated risk trisomi
• Does not opt for invasive diagnostics

• Week 28: travel abroad for 1 month
• Week 33: Admitted OB ward with susp. PE
  Fetal US: susp. chromosome abnormality
• Discharges herself, seeks second hospital

• Week 34: readmitted OB ward
  Headache, nausea, vomiting, reduced fetal
  movements
  BP 150/100, +4 proteinuria
• CTG: pathological
• Emergency CS due to imminent fetal asphyxia
  Did not opt for peripartum sterilization

• Girl, 2732g, Apgar 4-5-7.
• Art umb. pH 7.33, BE 1.4, pCO2 6.88
• Transfer NICU
• Trisomy 21 – Transient Abnormal Myelopoiese

• Uneventful maternal recovery
• No postpartum check-up
• «speaks minimal Norwegian»
• «consultation without interpreter, partly in Norwegian, partly in English»
• «consultation together with her son, who interprets»
• «her daughter/son interpreted during the consultation»

• «one cannot be sure that there is no misunderstanding»
• «she does not know why she has been referred»

• «she did not opt for contraceptive counselling»
Challenges?

- communication
- language barriers
- collaboration
- trust
- continuity
For a fair selection everybody has to take the same exam: please climb that tree.
Health literacy

• Ability to obtain, read, understand and use health care information to make appropriate health decisions and follow instructions for treatment
Migrant origin

• Country of origin
  – Socioeconomic conditions childhood
  – Exposure to conflict, violence, abuse

• Migration process
  – Loss of resources: health, financial, social
  – Mental health: depression/anxiety

• Destination country
  – Integration: language, work
  – Racism/discrimination
  – Trust health system/personnel
  – Culturally-related practices
- Why immigrant reproductive health is important

- **What we already know**

- **So, what?**
  Some steps towards better care
More migrant women have unmet needs for reproductive health services

- Fewer use hormonal contraceptives
- More likely to use hormonal contraceptives with longer residency
- More apply for TOP
- Less contraceptive use when applying for TOP

Emtell-Iwarsson K et al. BMJ Sex Reprod Health 2019.
Omland G et al. BJOG 2014.
More migrant women have unmet needs for reproductive health services

• Lower participation in cancer screening programs
  - Cervical cancer
  
  Delayed diagnosis of breast cancer

• Inadequate access to treatment for women exposed to FGM

But also beneficial sociocultural practices in some migrant groups

• Higher breastfeeding initiation
• Prolonged breastfeeding

• Low substance abuse (tobacco, alcohol)
Ethnic minorities are overrepresented among maternal deaths
Maternal death Norway 2005-09

Maternal death UK 2014-16

Distribution of MMR by ethnicity

<table>
<thead>
<tr>
<th>MMR</th>
<th>Africa/Asia</th>
<th>Norway</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>Red</td>
<td>Blue</td>
</tr>
</tbody>
</table>

Black and Asian women have a higher risk of dying in pregnancy

- White women: 8/100,000
- Asian women: 2x 15/100,000
- Black women: 5x 40/100,000

7/27 mothers had an African/Asian name.

Vangen S et al. Tidsskr Nor Legeforen 2014

MMBRACE 2018 Saving Mothers Lives

Esscher A. BMC Pregnancy Childbirth 2014

Women with multiple vulnerabilities most at risk
Maternal near-miss due to miliary TBC

En høygravid kvinne med hodepine og feber

Figur 1 Røntgen thorax (dag 1) viser små nodulære infiltrater bilateral.

Figur 2 CT caput med kontrast (dag 6) viser kontrastlødende lesjoner i venstre lilor, med omkringliggende ødem.
Caesarean section (CS)

Høyinntektsland
Sentral- og Øst-Europa, Sentral-Asia
Nord-Afrika og Midt-Østen
Afrika sør for Sahara
Sørøst- og Øst-Asia, Oseania
Sør-Asia
Latin-Amerika og Karibia

Norwegian Medical Birth Registry
2000-2014
% CS according to maternal country of birth

Nulliparous

- Somalia: Planned 0%, Emergency 26%
- Philippines: Planned 0%, Emergency 26%
- Thailand: Planned 0%, Emergency 13%
- Sri Lanka: Planned 0%, Emergency 16%
- Iraq: Planned 0%, Emergency 16%
- Poland: Planned 0%, Emergency 13%
- Pakistan: Planned 0%, Emergency 13%
- Turkey: Planned 0%, Emergency 13%
- Vietnam: Planned 0%, Emergency 13%
- Yugoslavia: Planned 0%, Emergency 13%
- Norway: Planned 0%, Emergency 16%

Legend:
- Blue: Planned
- Red: Emergency
Case 2

- «Idil» 27 years. Works as health secretary
- Born in Somalia, in Norway since 14 years of age
- Excellent Norwegian skills
- First pregnancy, antenatal check-ups with GP/midwife

- Week 40+4
- Less fetal movements, worried, contacts department
- «Wants a post-dates check-up, transfer of call to the OPD»
- Appointment scheduled after 5 days for post-dates consultation
• Admitted day after call at week 40+5 due to contractions
• IUFD

• FGM type III, not referred before pregnancy, not deinfibulated

• Stillborn boy 3200g
• Did not want investigations

• Uneventful maternal recovery
• Did not want postpartum follow-up
## Perinatal death

<table>
<thead>
<tr>
<th>Region</th>
<th>Odds ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Høyinntektsland</td>
<td></td>
</tr>
<tr>
<td>Sentral- og Øst-Europa, Sentral-Asia</td>
<td></td>
</tr>
<tr>
<td>Nord-Afrika og Midt-Østen</td>
<td></td>
</tr>
<tr>
<td>Afrika sør for Sahara</td>
<td></td>
</tr>
<tr>
<td>Sørøst- og Øst-Asia, Oseania</td>
<td></td>
</tr>
<tr>
<td>Sør-Asia</td>
<td></td>
</tr>
<tr>
<td>Latin-Amerika og Karibia</td>
<td></td>
</tr>
</tbody>
</table>

Norwegian Medical Birth Registry 2000-2014
## Stillbirth

<table>
<thead>
<tr>
<th>Maternal country of birth</th>
<th>Stillbirth rate/ 1000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan</td>
<td>13.5</td>
</tr>
<tr>
<td>Pakistan</td>
<td>9.7</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>9.1</td>
</tr>
<tr>
<td>Somalia</td>
<td>8.9</td>
</tr>
<tr>
<td>Norge</td>
<td>5.0</td>
</tr>
<tr>
<td>Iraq</td>
<td>4.7</td>
</tr>
<tr>
<td>Vietnam</td>
<td>4.7</td>
</tr>
</tbody>
</table>

Naimy et al. BMC Public Health 2013

Norwegian Medical Birth Registry 1986-2005
- Why immigrant reproductive health is important

- What we already know

- So, what?

  **Some steps towards better care**
- 44 fetal deaths could have been averted

«One third of stillborn infants could have been saved, shows new report. Clinicians want better follow-up of pregnancies among migrant women, older women and women that are obese. Of the preventable stillbirths, 50% occurred among migrant women»
How to address ”known” factors?

- Suboptimal interaction/use of health system services and resources
- Substandard care
- Differences in health behaviour
- Differences in maternal health, including migration-related factors
- Socio-economic conditions

- We do not know which interventions are effective
Patient  ↔  Health system
Obstacles to seeking timely care:

- Health literacy
- Information
- Knowledge
- Trust
- Language proficiency
- Partner support
- Social support

Obstacles to providing timely care:

- Cultural competence
  - Knowledge
  - Attitudes
  - Respect
  - Prejudice, racism
  - Communication skills
- Translation services
- Organization
- Ethnic minority staff
Getting the balance right

What interventions work?

• MAMAACT (Denmark)
• ORAMMA (Belgium)
• MIPREG (Norway)
Etnisk lighed i dødfødsler og spædbarnsdød

MAMAACT i hele landet vil gøre en forskel!

Sarah Fredsted Villadsen
Institut for Folkesundhedsvidenskab

UNIVERSITY OF COPENHAGEN
The MiPreg Project
Closing the gaps in migrant maternity care in Oslo

Partners:

The Research Council of Norway
Akershus universitetssykehus
Oslo kommune Helseetaten
Aims

Improve pregnancy outcomes among recent migrants
- Identify health-care related factors that limit quality
- Design a pilot intervention to address modifiable factors

Inclusion
- International migrants 15-49 years
- Greater Oslo region
- Born in low-/ middle-income country
- <5 years residence
Material and Methodology

Phase I: Finding the gaps

1. Baseline maternal/infant outcomes
   Linked registry studies 2008-2017

2. Women own care experience:
   • Information
   • Communication
   Structured Interview Questionnaire: Postpartum interview with interpreter (n=400)
   Qualitative interviews (n=40)

3. Perceptions among maternity staff
   Qualitative interviews and focus groups (n=40)

MiPreg
Take home

✓ Work towards equity rather than equality
✓ Make maternity care «migrant-friendly»
✓ Individualized care
✓ Assure adequate communication