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Training healthcare professionals on perinatal care necessities of migrant women

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Abstract

Introduction: Migrant women are a vulnerable group with limited access to health services and face ineffective system response to their needs, especially during the perinatal period. Effectiveness of the training of healthcare professionals (HCPs) is vital in order to enhance the quality of migrant perinatal care offered in line with the ORAMMA (Operational Refugee and Migrant Maternal Approach) project's guidelines and approach.

Methods: 47 HCPs involved with migrant perinatal care in Greece were recruited in the ORAMMA project's training. An evaluation questionnaire, especially developed, was completed pre- and post- training. Cultural competence, knowledge, skills and self-perceived cultural competence were evaluated to accelerate accurate application of the ORAMMA interventions.

Results: Validated translation of relevant tools was used to identify critical divergence between pre- training and post-training scores. The questionnaires were completed pre- and post-training to assess the effectiveness of the intervention. The results indicated an increase in knowledge and self-perceived cultural competence whereas the attitude and skills scores improved slightly. Female healthcare professionals (e.g. midwives) could contribute to perinatal migrant's needs-based assessment to establish capacity-building mechanisms with emphasis on women centered and compassionate-based primary healthcare (PHC) services.

Conclusions: Despite the restricted number of participants, this pilot analysis indicates that the ORAMMA project could bridge over HCPs' training with effective planning and implementation strategies to address and improve the quality of migrant perinatal health.

Keywords: Migrants; Training; Literacy; Healthcare professionals; Perinatal care

1. Introduction

In recent times, the number of migrants is continuing to increase worldwide [1] (Figure 1) [2], a large percentage of which are pregnant women or women in reproductive age [3], leading to a considerable raise in the number of migrants who need to access health care services [4]. In response to large movements of migrants, the General Assembly adopted the New York Declaration for Refugees and Migrants on 19 September 2016. The Declaration called for the development of two global compacts, both to be adopted in 2018. Whereas a proposed refugee compact was being developed under the auspices of the United Nations refugee agency (UNHCR) and was presented in 2018 for consideration by Member States, the development of the migration compact was led by the General Assembly [5]. Only 10% of the global migratory

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population is corresponding to people fleeing from their home due to conflict and political instability [5]. Environmental conditions have exacerbated water and food shortages, thus leading to migratory waves towards Europe, with a high percentage of migrants reaching Europe's borders [5]. Migrant health has been recognized as a priority by the international community and the health of migrants has been classified as a human right [6, 7]. The UNHCR (United Nations High Commissioner for Refugees) convention defines refugees as persons who have a 'well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it' [8]. The Global Compact should ensure specific protection for migrants in vulnerable situations who are not refugees but who, nonetheless, are entitled to protection under the international human rights framework. States should operationalize their commitment to combat the abuses and exploitation suffered by countless migrants in vulnerable situations. Migrants in vulnerable situations are unable to effectively enjoy their human rights and are accordingly entitled to call on a duty-bearer's heightened duty of care. Factors that generate vulnerability are not limited to the country of origin, but can also occur during transit or at borders, such as torture, gender-based violence, arbitrary detention, or serious health issues. Moreover, some migrants find themselves in vulnerable situations due to individual factors, such as disabilities, gender and sexual orientation, or by virtue of being older, a child or a pregnant or nursing woman. OHCHR (Office of the United Nations High Commissioner for Human Rights), along with partners in the Global Migration Group, has developed a set of Principles and Guidelines, supported by practical guidance, on the human rights protection of migrants in vulnerable situations, which provide normative and practical guidance to States in this regard [9].

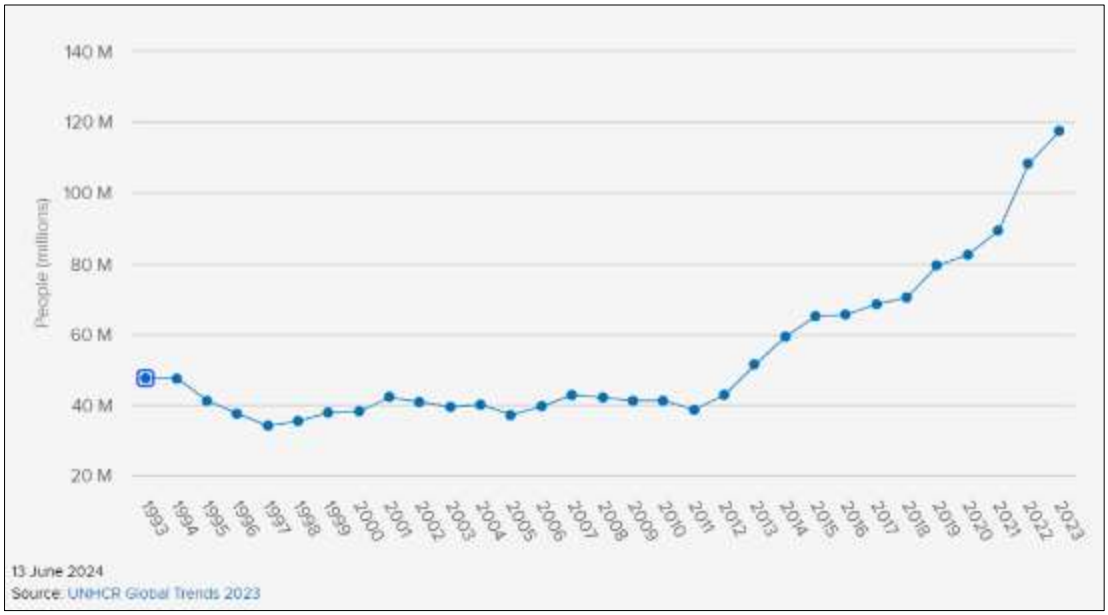

Figure 1 Number of migrants worldwide. UNHCR Global Trends 2023

During humanitarian crises, the female population (women and girls) is more likely to endure the difficult responsibility of both supporting their relatives and communities in general, usually having experienced pre-migratory loss of family members as well as family separations [4]. Oftentimes pregnant women or young mothers travel alone or with unaccompanied minors, and this combination of conditions places them in a precarious situation of increased vulnerability independently of the arrival reasons [5]. The sexual and reproductive health needs of female migrants have equally been emphasized in studies [10, 11] having a higher risk of experiencing gender-based violence (SGBV), sexual abuse, exploitation in combination with limited access to contraception [10,12] in addition to feeling isolated due to failure of social networks which can have a negative impact on their perinatal health [4], whereas the vulnerability of migrant women is remarkably increased during the perinatal period. As defined by WHO, the perinatal period commences at 22 completed weeks of pregnancy and ends seven completed days after birth [13]. Inevitably, maternal health care is a crucial aspect of care to consider when delivering health care to migrants [14]. Maternal health, as defined by WHO (World Health Organisation), covers the health of women during pregnancy, childbirth and the postpartum period, linking this straightforwardly to wider health conditions that precede and/or contextualize maternal health like family planning and other risk factors [15, 14].

Research on health outcomes of resettled migrant women in countries like Australia, Canada and Sweden indicates notable differences in maternal and perinatal outcomes in comparison to non-displaced women, including high-risk pregnancies, prematurity and low birth-weight infants, and stillbirths as well as increased maternal morbidity and mortality rates [16, 17, 18]. Prematurity and low birthweight are proven indicators of social inequality [19, 20]. A considerable amount of the aforementioned negative outcomes is associated with avoidable risk factors including suboptimal pre-pregnancy health and difficulty in obtaining prenatal care on time, which reduces the possibility of diagnosing and treating maternal health [21] and has been related to adverse outcomes [22, 23]. Migrant women are likely to have delayed antenatal care, as well as less antenatal visits, due to various factors, including language barriers, cultural differences and difficulty in familiarizing with complicated health care and social services in host countries [24].

The particular mental, physical, reproductive health and cultural needs of the increasing number of migrant women need to urgently be addressed by the host countries [25, 26]. The implementation and establishment of evidence-based healthcare involvement could help prevent negative maternal and neonatal outcomes for migrant women [25, 27]. Diversity in language, health literacy, culture and religion have to be taken into account by HCPs in order to be able to provide effective person-centered care.

Cultural competence, described as “the attitudes, knowledge and skills necessary to deliver high quality care to ethnically and culturally diverse patient populations” is essential for person-centered, culturally appropriate and integrated care to be provided [28]. Application of cultural competence is vital in healthcare as a plan of action to focus on ethnic and racial health inequalities [29]. By ensuring migrant women have access to culturally sensitive reproductive care from conception to the postpartum period, modifiable risk factors can be reduced and an effort to eliminate disparities in maternal and newborn outcomes can be aimed [25]. Moreover, evidence is emerging on interventions improving maternal and newborn outcomes being cost–effective [30], thus, ensuring healthcare system sustainability and optimal resource allocation. The direct and indirect costs incurred across the lifespan associated with high-risk pregnancies, preterm deliveries and low birth-weight infants are considerably higher than those related with healthy term infants [31] and will lead to further resource utilization beyond the healthcare sector.

To meet the needs of the diverse group of pregnant women in Europe, culturally competent healthcare systems are needed in which care is given by compassionate, culturally sensitive HCPs [21, 32, 33]. There are a great number of definitions to describe compassionate care. Compassionate care is an essential characteristic of health care provision, especially when these vulnerable populations are involved. Compassion involves demonstrating characteristics such as empathy, acceptance, sensitivity, kindness, warmth and attention to basic needs. Lack of compassion may aggravate any agony or suffering already being experienced (34, 35, 36, 37). Needs-based assessment to establish capacity-building mechanisms indicates this is the kind of care these populations not only require, but are actually aware they need, with emphasis on person-centered and compassionate-based primary healthcare (PHC) services [1, 37]. Nevertheless, efforts assessing prior capacity-building actions and systematic efforts, leading to evidence-based interventions, are scarce in Europe [1], whereas the majority of HCP training in Europe is concentrated on the individual and not on a comprehension of broader social structures that could potentially influence health and wellbeing [38, 14]. Still, there is evidence to demonstrate cultural awareness and competence of HCPs can be improved through various interventions; cultural competence training has been shown to advance cultural competences of HCPs [39, 40].

The present article reports on work conducted in the context of a European capacity-building project, conducted under the auspices of the European Commission and funded under the 3rd Health Program by the Consumers, Health, Agriculture and Food Executive Agency (CHAFEA), entitled "Operational Refugee and Migrant Maternal Approach" (ORAMMA). Specifically, the ORAMMA pilot study was carried out in three countries (Greece, the Netherlands and the United Kingdom), and its overall aim was to bridge over HCPs’ training with effective planning and implementation strategies to address and improve the quality of migrant perinatal health. This initiative focuses on the delivery of culturally sensitive perinatal care by training HCPs to offer support to pregnant migrants from women with a similar background, a role conceptualized to meet such needs and referred to as “Maternity Peer Supporter (MPS)”.

2. Methods

2.1. Study design

To meet all the aforementioned project goals, a pre-training and a post-training assessment questionnaire were utilized. Both questionnaires obtained the same questions, apart from the demographics, that were only present at the pre-training Greek questionnaire. The questionnaire duration was approximately 10 minutes. Each participant had a participation code documented on both pre- and post- training questionnaires. Questionnaires were anonymous and all

data were treated confidentially. This design has been regularly used in studies as a tool to assess the outcome of HCPs' training [39]. The training sessions were carried out with the duration of the training being two days.

2.2. Recruitment - Participants

A total of 47 health care professionals took part in the training (36 midwives, 4 doctors, 5 social workers, 1 nurse who did not define their specialty). All healthcare professionals recruited for the ORAMMA project's training were familiar with providing care to migrants and all of them were working in primary care settings (governmental health services and NGOs for the support and provision of healthcare to migrants). The participants were approached nationally via email lists and public health professional associations such as associations of midwives in Greece and to CDC (Center for Disease Control and Prevention), through the physician in charge. Participation was voluntary. In order for a wide sample to be attained and reliability and richness of the data to be increased, participants were intentionally selected across professional groups, and experience with health care provision (e.g., years as an HCP, number of migrant women cared for daily).

2.3. Cultural competence training

The training offered to the HCPs covered three aspects of cultural competence: awareness - needs assessment of migrant mothers - approach and skills, including sufficient, culturally tailored empathetic communication. The structure of the training was developed by the ORAMMA project team based on systematic review of international literature regarding training [39] emphasizing on The Theoretical Domains Framework and Cultural Competence Conception Framework, followed by identification of successful behavior change methodology to forward the barriers and enablers described by participants [41, 42], as well as the particular needs of female migrants during the perinatal period and of HCPs caring for them. The objective of the educational interventions in the long term was to provide healthcare professionals with the tools to identify specific needs, develop, and provide quality, satisfactory and culturally sensitive maternal care in accordance with the ORAMMA project's guidelines and approach. The educational sessions included various didactic approaches to cover all three aspects of training: knowledge, attitude and skills. The official language of the educational sessions was Greek; the same training took place in the UK – in English, and the Netherlands – in Dutch, where the ORAMMA pilot project was also being implemented. The initiation of the training involved a presentation of the objectives of the ORAMMA-project, discussion among trainees about previous involvement in the perinatal care of migrants, role play, further group discussions, case scenarios, and short presentations.

2.4. Cultural competence evaluation questionnaire

Cultural competence can be evaluated via various tools, but very few are certified since they are mostly based on self-assessment, thus they are considered biased [43, 44, 45]. Both ORAMMA questionnaires (pre-training and post-training) were structured in line with a questionnaire developed in a study of Seeleman et al. [46] and modified to perinatal health needs. Thus, cultural competence was evaluated in a more objective way. Following meticulous meetings to decide the correct answers regarding attitude, answers to the questions were characterized either as culturally competent or culturally incompetent to generate domain scores. Eventually, the ORAMMA questionnaires were translated to Greek, during the cognitive debriefing process with 3 subjects, no changes were necessary to the original tool, but 10 items were added to enhance understanding on additional aspects such as knowledge. Apart from the three areas of cultural competence (knowledge, attitude and skills) [28], self-perceived cultural competence was also evaluated. Further variables in the questionnaire contained healthcare professionals' characteristics, including the adjusted Cultural Competence Groningen Reflection Ability Scale-score (CC GRAS-score) consisting of 10 items. The Groningen Reflection Ability Scale (GRAS) is a validated scale that measures participants' general ability of personal reflection [47].

2.5. Data analysis

The statistics applied to outline the participants' characteristics, the points of the cultural competence domains and the answers to each of the questions individually were descriptive. Statistically significant changes in median pre- and post-training scores were analyzed using the Wilcoxon signed-rank test. Additionally, to analyze statistically significant changes in answers to all questions, the McNemar's test was utilized. 27 participants completed both pre- and post-training questionnaires. Completed questionnaires were only used if not more than 2 items were missing. 4 questionnaires had more than 2 items missing thus they were canceled. All analyses were performed using SPSS statistic data editor version 22.

2.6. Ethical approval

Approval from the bioethical committee has been requested and received according to the existing legislative framework in Greece (Reference number: 5154/12-03-2018, G.H. "Elena Venizelou-Alexandra").

3. Results

3.1. Characteristics of volunteers participating in the ORAMMA-training

Not all participants completed both tests (27 completed both) and all 47 HCPs, who participated in the educational sessions, completed only the pre-training questionnaire (4 questionnaires were canceled, as there were more than 2 unanswered questions). All participants were female with at least one year of experience as healthcare providers in female migrants. The mean age was 37,9 years old (33-43). The participants' average CC (Cultural Competence) GRAS-scores and other detailed characteristics are demonstrated in Table 1.

Table 1 Characteristics of the HCPs who received the training on culturally sensitive maternity care (N=23)

Age (95% Cl)	37,9% (33-43)
Gender, % female	100% (23/23)
Ethnicity, % non- Western migrants	4,5 % (1/23)
CC GRAS - score[a] (95% Cl) scale 0-50	35,0% (33,1-36,8)
Experience with pregnant migrants *	
None	0,0% (0/23)
1-10 patients	0,0% (0/23)
>10 patients	100% (23/23)
Experience with language barriers **	
None	13% (3/23)
1-5 patients	30,4% (7/23)
5-10 patients	8,7% (2/23)
>10 patients	47,8% (11/23)
Experience as HCP	
<1 year	Unknown[b]
1-5 years	-
5-10 years	-
>10 years	-

* Number of pregnant migrants supported in the last 5 years; ** Number of women supported in the last 6 months with whom there was a language barrier; [a] The Groningen Reflection Ability Scale (GRAS) is a validated scale that measures participants' general ability of personal reflection. ; [b] Missing data due to no answer

3.2. Domains of cultural competence and self-perceived cultural competence (SPCC)

The scores for the three domains of cultural competence before and after the training on culturally sensitive maternity care are demonstrated in Table 2.

Table 2 Median scores [IQR] for knowledge, attitude, skills and self-perceived cultural competence (N=23)

	Pre	**Post**	**P***
Knowledge (score 0-28)			
Median	16	19	0,002
IQR	14-18	17-20	
Attitude (score 0-11)			

Median	7	7	0.912
IQR	6-7	6-7	
Skills (score 0-9)			
Median	6	5	0,156
IQR	4-7	4-8	
SPCC (score 1-10)			
Median	7	8	0,007
IQR	6-8	7,1-9	

IQR, Interquartile range. SPCC, Self-Perceived Cultural Competence.; P* Differences between median pre- and post-score (Wilcoxon signed-rank test).

- Knowledge. Enhancement of the knowledge score was noticed (p<0,05, Table 2) after participation in the training. The knowledge pre-training score was 16 and post-training score was 19 (Table 2).
- Attitude. The results did not identify any improvement in the attitude score of the participants. The attitude post score was 7, out of a total score of 11 (p=0,001, Table 2). However, the number of healthcare professionals reporting respect and understanding in the choices of female refugees during this vulnerable period of their life increased after the training sessions.
- Skills. No statistically significant improvement was noticed as far as skills are concerned.
- Self-perceived cultural competence. An improvement of self-perceived cultural competence was noticed.

Thorough and detailed examination of the sub domains of SPCC revealed a development in terms of communication, handling social deviation and referring to social services. However, no statistically significant differences were noticed (p=0,007, Table 2).

Meticulous examination of the participants' answers unveiled a few thought-provoking data. Following the end of the training sessions, many participants reported not feeling the need to be consulted by somebody with more experience when providing care to pregnant migrants. This was stated by 30,4% (7 of 23 HCPs) before the training and 56,5% (13/23) after the training (McNemar's test, p=0,031). Besides, most participants (93,3% 14/15) were not happy to use an adult informal interpreter after the training. A slight increase in awareness on national regulations and legal and procedural features associated with asylum applications or migration status might imply some deficiency in the training content.

4. Discussion

The current study suggests that the ORAMMA project could bridge over HCPs' training with effective planning and implementation strategies to address and improve the quality of migrant perinatal health. Rigorous examination of the participants' answers on attitude revealed slight enhancement in terms of respect, empathy and awareness of the conditions pregnant migrants face, even though no remarkable statistical difference on the attitude score was noticed. Moreover, the ORAMMA training included areas for provision of cultural competence, application of asylum policies and procedures and evidence-based procedures in specific health conditions often described to be faced by migrant women. The establishment of the ORAMMA clinical evidence-based protocols for the provision of migrant perinatal care was recommended.

There are currently no relevant studies regarding training of HCPs on perinatal care for migrants. The ORAMMA training intervention demonstrated effectiveness in developing cultural sensitivity, knowledge and skills for perinatal migrant care. [39, 48, 40, 49]. There are critical restraints to compare the current study's outcomes with other studies. As Truong et al [50] and Price et al [51] assumed, many studies assessing training of HCPs for migrant populations present with an absence of methodological rigor. The above results from the fact that no other studies have performed a quantitative evaluation of the outcomes of training HCPs on perinatal migrant care. The ORAMMA training for HCPs utilized a comprehensive structure of cultural competence [28] and implemented a clear, thorough description of both participants and educational sessions in order to accelerate accurate reproduction of interventions – data that was missing in most of the prior studies [51]. Overall, the training raised the knowledge, attitudes and skills of these professionals as aimed, while the paper brought to light new information on health care providers (HCPs) and their ability to confer culturally relevant services to meet the perinatal needs of migrants.

The design of a not-validated questionnaire decreased the effectiveness of the study's validity, but was unavoidable as there were no relevant, unbiased tools to assess cultural competence in maternity care existing. Nevertheless, as for the external validity, the extent to which the findings of the study could generalize to other situations, people, settings, and measures, a large sample is believed to be helpful in providing more reliable results. Whereas this is true for some specific cases, a large sample may not be helpful because of the higher possibility of errors and reduced validity. A large sample may be required only for the studies with highly variable outcomes, where an estimate of the effect size with high precision is required, or when the effect size to be detected is small. This communication underscores the importance of small samples in reaching a valid conclusion in certain situations and describes the situations where a large sample is not only unnecessary but may even compromise the validity by not being able to exercise full care in the assessments [53].

Forward-backward bilingual translation was performed at the questionnaire from English to Greek, aiming to prohibit alterations in the content and order of the questions. Last but not least, the limited sample size has reduced the likelihood to identify critical divergence between the pre-training and the post-training scores. Some results might have been of greater statistical importance had the sample size been larger or the duration of the training longer.

4.1. Recommendations for future training

Healthcare providers need to be adequately resourced to match the complicated needs of migrants [11]. HCPs dealing with patients who present with complicated psychological and social complications should be supplied with additional professional support, and there is evidence from other projects highlighting the need for quality mental healthcare, and efficient referral pathways [1].

4.2. Recommendations for future research

Subsequent research involving a wider sample or even training in individualized professional groups is necessitated for more validated proof of the ORAMMA project's training efficiency on culturally competent perinatal care to be provided. A longer duration, more practical and skills-based training could also be of benefit. Future studies should also include evaluation of the duration of the cultural competence gained via the training and possibly suggest the frequency in which it should be obtained. Also, performing other validation tests such as test-retest reliability is also highly relevant and might be considered important.

As noted by Chavennes [52], difficulties can be faced when transferring gained knowledge into practice and more research on this subject is required. Further research could take place in order to investigate experiences of HCPs working with migrants in other domains of the healthcare system as well. This could help in the creation of an overall healthcare service model for this vulnerable group of people

5. Conclusion

While the migratory waves towards Europe are increasing, female migrants remain at high risk of adverse pregnancy outcomes. It is vital for culturally competent care to be provided to this group of women for improved maternal and children outcomes. This can only be achieved through professional development for health care staff to enhance the confidence of the HCPs to provide quality care for these women, and, of course, to increase cultural awareness, improve competencies and responsiveness. The ORAMMA training of HCPs on culturally sensitive people centered and evidence-based perinatal care has been observed to increase knowledge and self-perceived cultural competence. Further study on a wider sample would be beneficial, not only in Greece, but across European settings.

Compliance with ethical standards

Disclosure of conflict of interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this article.

Statement of ethical approval

Full ethical approval was obtained for this study from Elena Venizelou – Alexandra General Hospital, under the reference number 8/E/14-03-2018. All information sheets and consent forms were approved by the ethical committee

Statement of informed consent

Informed consent was obtained from all individual participants included in the study.

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