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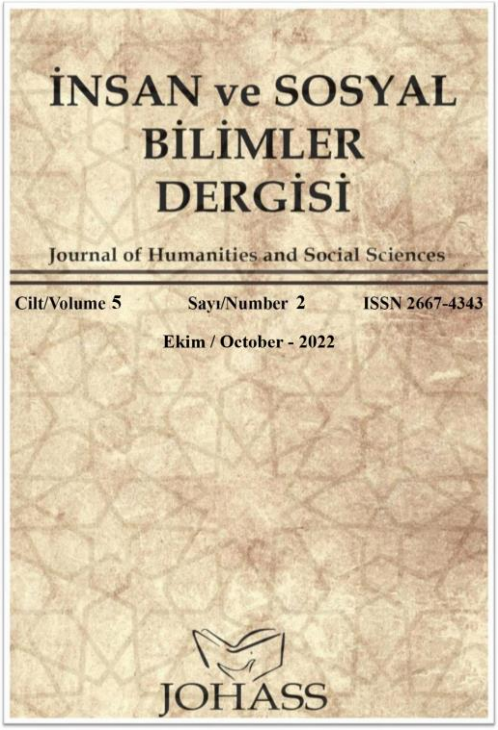

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Examples of Childbirth Education Courses for Migrant Women in The World and Turkey: Literature Review

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Examples of Childbirth Education Courses for Migrant Women in The World and Turkey: Literature Review

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Abstract

The healthcare guidelines were prepared in different languages for migrants in hospitals of European Countries. These guidelines briefly describe referrals in-hospital and important informations and direct migrants to the addresses where they need to go. It has been determined that in America and European countries such as Germany, Switzerland and Austria, cultural identities and mother tongues of immigrant women are less barriers, equality of opportunity is provided to a certain extent, and they contribute to their use of reproductive and preventive health services. Also, they have special childbirth education courses that they conduct, counseling units and information brochures for immigrants. In counseling services, information are related pre-pregnancy care to postpartum depression were given to them. While they are giving these services in the counseling centers, they use intercultural interpreters and telephone lines, which are usually opened by midwives and supported by the municipality, to prevent translation errors. In Turkey, some state hospitals have been started childbirth education for immigrant women with the midwives accompanied by consecutive translation in Arabic since 2017. But unfortunately, these educations interrupted due to the pandemic restrictions. It is thought that the deficiency in immigrant friendly services can be overcome by increasing the available social assistance and allowances for immigrants, providing awareness trainings to increase the health literacy of immigrants, and ensuring that immigrant women have appropriate access to maternity care services. In this review, it was aimed to investigate the childbirth education for immigrant women in the World and Turkey.

Keywords: Antenatal education, childbirth, migrant, pregnants, women, care.

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Introduction

The bond that people develop with their environment is extremely important and meaningful for that person. Therefore, migration can be one of the important factor that damage the bond between people and their environment. Migration has become an important problem since nation states and borders have existed. Migration is defined in the literature as a phenomenon with economic, social, political and cultural causes and consequences (Dedeoğlu ve Gökmen, 2020; Ekici ve Tuncel, 2015). According to the dictionary of international migration terms, migration is the movement of a person or group of people across an international border or within a state. It is a population movement in which people are displaced regardless of their duration, structure and reason. This includes the migration of refugees, displaced persons, people who migrate for economic reasons, and people who move for different purposes such as family reunification (International Organization for Migration [IOM], Migration Terms Dictionary. No: 31, 2013).

If the immigrant; whether migration is voluntary or involuntary for various reasons, temporarily or permanently, within a country or across an international border; It is the name given to the person who moves away from the place of residence regardless of the reasons for migration or how long the stay is. The term includes many defined categories of immigrants, such as migrant workers. These include legally defined persons such as illegal immigrants; international students can be given as an example (Ekici ve Tuncel, 2015). According to the World Migration Report published by the United Nations (UN), it was revealed that there were approximately 272 million international migrants in the world in 2019, which is equal to 3.5 percent of the global population. According to the same report, 48% of these immigrants are women and most of them are in their fertile age. Their 2.8% are children between the ages of 0-4 (IOM, 2020).

The vast majority of people do not migrate across borders, rather they migrate internally within the country. However, the increase in the number of international migrants has become evident over time, both numerically and proportionally, at a faster rate than anticipated (IOM, 2020; 2022). According to the 2019 report of the UN Department of Economic and Social Affairs (UNDESA), 141 million of international migrants live in Europe and North America. The United States of America (USA), which has more than 50 million international immigrants, is the country that hosts the most immigrants in the world. The USA is followed by Germany, Saudi Arabia, Russia and the United Kingdom. India, on the other hand, is placed first in the ranking of the countries that send the most immigrants with 17.5 million international immigrants. Mexico comes after India. The number of people immigrating from Syria has also exceeded eight million due to the civil war. A large number of European countries are also among the sending countries, including Ukraine, Poland, the United Kingdom and Germany.

Since 2019, there are 5 million 876 thousand 829 international immigrants in Turkey. The war, that started in Syria in 2011, has created the world's largest contemporary refugee crisis. The majority of Syrian refugees have fled to neighboring countries such as Turkey, where currently hosts the largest number of Syrian refugees in the world, and settled as refugees/asylum seekers (Acarturk et al.,2021). According to the migration statistics announced in Turkey on March 24, 2022; the number of registered Syrians under temporary protection increased by 7 thousand 917 compared to the previous month and reached a total of 3 million 754 thousand 591 persons. One million 785 thousand 690 of these people are children between the ages of 0-18. The total number of children and women aged 0-18 is two million 661 thousand 90 (Number of Syrians in Turkey, 2022).

1. Types and Causes of Migration

There are multiple reasons for migration, including economic, natural, political and social.

Economic reasons; It is the migration of people from regions where economic opportunities are not good enough to go to regions where conditions are better. For example, in the 1960s, labor shortages emerged in many Europe and many people migrated to European countries to work (Günay et al., 2017).

Natural reasons; These are the migrations in which people leave their place due to natural disasters such as earthquake, landslide, drought, desertification, flood, volcanic eruptions. For example, the 1999 Gölcük earthquake caused people to migrate to other regions (Varol ve Gültekin, 2016).

Political reasons; These are the migrations made as a result of reasons such as war, change of country borders with political agreements. For example, after the War of Independence, the exchange between the Greeks living in our country and the Turks living there as a result of the treaty is an example of political migration. In addition, the displacement of the majority of the population as a result of civil wars in countries such as Bosnia, Kosovo, Bulgaria and Iraq after the great dissolution in the early 1990s can be given as an example of political migration (Danış, 2004).

Social reasons; It is a type of migration that occurs as a result of reasons such as education, population growth, health and safety concerns. Example of this is a person's relocation to another country or city for educational purposes (Yılmaz, 2014).

2. Consequences of Migration Affecting Women's Health

Increasing global migration in recent years has also affected our country. However, the consequences are more severe, especially for women. Immigrants face more health problems due to problems such as access to health services, treatment and care, difficulties in housing, sanitation, economic situation, lack of health insurance, malnutrition and hygiene during and after the migration process. In addition, these individuals experience significant problems in national and international counseling, basic and preventive health services, diagnosis, treatment opportunities and access to drugs. Transportation and language barriers, social and psychological stress are also among the factors that negatively affect migrant/refugee health. Nutritional disorders, dehydration, food poisoning, reproductive health problems, hepatitis A, typhoid fever, fecal-oral diseases, airborne diseases, parasitic diseases and depression can be seen in immigrants/refugees (İldam Çalım et al., 2012; Turkish Medical Association [TMA], 2016; Tuzcu ve Bademli, 2014; İlhan et al., 2016; Söğüt ve Bilge, 2021).

Differences in mother tongue and ethnic origin cause an increase in chronic diseases, previous health problems, age, gender and duration of stressors can increase negative health outcomes. The effects of migration on women and women's response to migration stress are different from men's. Immigrant women are forced to cope with social obstacles, difficulties and poverty that adversely affect their health physically and psychologically, they are exposed to harassment, rape and violence, and sometimes they can be forced into prostitution. This situation increases the risk of depression, especially by affecting the mental health of women who have been forced to migrate, and puts these women in the risk group in terms of anxiety and post-traumatic stress disorders, unwanted pregnancies, unhealthy abortions, inadequate prenatal care and sexually transmitted diseases. (Çelik ve Sevil, 2016; Hacıhasanoğlu Aşılar ve Yıldırım, 2018; İldam Çalım et al., 2012; Mardinet al., 2020; Sudhinaraset, et al., 2019; Miller et al., 2007; Tuzcu et al., 2014).

In a study conducted in California, it was revealed that one in three immigrant women experienced trauma, more than half of the women were persecuted, and the language barrier in receiving health care was a major problem (Sudhinaraset et al., 2019). In a study of Latino

immigrants in South Carolina, participants cited the high cost of services (especially emergency services), lack of health insurance, family and work responsibilities, and language barriers as primary barriers to accessing health care. They stated that translation services, social support and low-cost prescriptions are among the factors that facilitate access to health services. In the study, one participant drew attention to the size of the financial barriers by saying "but you can pay to learn about your problem, not for treatment" (Luque et al., 2018). In other studies in the literature, it has been determined that migrant women have low use of family planning and birth control, and have difficulty in accessing health services and obtaining information about which they have little knowledge about family planning. In addition, it has been determined that they lack of information about sexually transmitted diseases and are not willing to take screening tests and treatment (Islam ve Gagnon, 2016; Salisbury et al., 2016; Zielinski et al., 2015).

Migrant women are at higher risk during pregnancy and childbirth due to the difficulties created by migration and need more health care. Premature birth, pregnancy and delivery complications are seen in these women who cannot access health care services, and these women may face the risk of home birth (Yağmur ve Aytekin, 2018). It has been determined that the rate of migrant women receiving pre-pregnancy and antenatal care, giving birth in a health center is low, and they benefit less from postnatal care and reproductive health services (Islam et al., 2016). In prenatal care, the primary goal is to ensure the birth of a healthy baby, to reduce maternal risks, to identify pregnant women at risk for complications, to predict and prevent problems. It is stated that providing training to immigrant women with courses and pregnant schools raises health awareness in pregnant women, increases the mother's power to cope with pregnancy and labor problems, provides confidence during childbirth and reduces anxiety (Dinç et al., 2015).

In this article, it is aimed to examine the examples of pregnant schools conducted for immigrant women in the world and in Turkey in line with the literature.

3. Examples of Pregnant Migrant Schools in the World

As a migrant woman, it is not possible to understand the healthcare system in the country without knowing the local language, while it is quite difficult even for the local people. Especially in European countries, there are health guides prepared in different languages for immigrants. These guides briefly explain in-hospital referrals and important information and direct immigrants to the addresses they need. Thus, guides ensure that immigrant citizens, regardless of their origins and cultural characteristics, know how to take care of their health and where to go when they have health problems (Bässler, 2016; Higginbottom et al., 2015).

Compared to other countries in the world, it is seen that immigrant women are provided with health care in their mother tongue and culture respectfully more in European countries (Frauenklinik, 2022; Santépsy, 2022). As a result of the researches, it has been revealed that in countries such as Germany, Switzerland and Austria, especially from European countries, the cultural identities and mother tongues of immigrant women are less barriers, equality of opportunity is provided to a certain extent, and they contribute to their benefit from reproductive health and preventive health services. There are childbirth education classes, counseling units and information brochures in languages such as English, German, French, Spanish, Arabic, Kurdish, Albanian, Hindi, Russian, Ukrainian, Serbian, Croatian, Turkish, Tamil, Persian and Tigri (Sicilian). Counseling services are provided in all kinds of issues, from pre-pregnancy care to postpartum depression. In these consultancy centers, which are generally opened by midwives and supported by the municipality, there are intercultural translators and telephone lines where they can get consultancy services 24/7 in

their own language to prevent translation errors (Bässler, 2016; Frauenklinik, 2022; Santé Sexuelle Suisse, 2017; Pala, 2016; Mamamundo, 2022; Santepsy, 2022).

Free translation services are provided in many public hospitals in Switzerland and Germany, and instant translation service is also available over the phone. In a childbirth education for immigrants, which is carried out in the company of a midwife and cultural translator at Basel University Hospital in Switzerland, consists of a total of 12 hours (6 x 2 hours), is held between 18.00 and 20.00, and provide counseling service by phone. In this training, information is given on pregnancy, birth, breastfeeding and the first time at home with the child, and they are prepared for birth with physical exercises and relaxation methods. Amount of the education fee is covered by the participating immigrant mothers, and rest of it is covered by health insurance. In another course conducted in Switzerland, birth preparation training is given to immigrants in 19 different languages, where prenatal childbirth education classes are conducted by a midwife in six groups with the help of a community interpreter. In these trainings, information is given on the development of the baby, the mother's health, birth, parenting role, baby care, breastfeeding, useful facilities for the baby and the family (Frauenklinik, 2022; Santépsy, 2022; Panmilar, 2022).

A midwife also conducts the pregnancy training class organized with the support of the municipality in the Frauenklinik hospital in Germany, and in the training information about the pregnancy process, birth, coping with labor pains, birth positions, postpartum period, post-hospital care is given and at the end of the training maternity service and the room where they will stay after birth are visited. The course is given on weekdays between 14.00- 16.30 in Arabic, Tigrinya, Turkish, Tamil and French languages and offered for a fee. It is stated that if the migrant woman wishes, she can apply to health insurance for the course fee and a discount can be provided. According to the "Maternal Health" guide prepared in 7 languages for immigrant women in Germany, women should start childbirth education classes from the 6th or 7th month of pregnancy, and obstetricians do not take care of women who do not attend these classes (Frauenklinik, 2022; MİMİ, 2019).

In the health guide prepared by the Red Cross in Switzerland in 18 languages, it is stated that immigrant women can get free information from their midwives and doctors in the counseling units when they realize that they are pregnants, medical examinations, childbirth education course, maternity-postpartum care services at hospital and home are covered by the immigrants' health insurance and these institutions work with a partially free intercultural translator. It was also stated that immigrants should learn what kind of health insurance they have from their employers, because mothers can receive eighty percent of their prenatal salary for 14 weeks after giving birth (Swiss Red Cross, 2017).

In Austria, there is a health brochure titled "Startklar" prepared in Turkish by the State of Vienna's Ministry of Health, which contains information about preparation for childbirth, pregnancy, birth and parenthood. In this brochure has been stated that, paid counseling can be obtained from midwives in the country, the City of Vienna has family midwives that provide free services, immigrant women should apply to the hospital where they want to give birth between the 6th and 12th weeks of pregnancy, should attend the birth preparation classes at the 17th-20th weeks of pregnancy, could visit the delivery units of the hospitals, their spouses or one of relatives can accompany their childbirth, to be discharged early after delivery in hospitals is not possible, and midwife continue home visits for five days after delivery (Frauen-Vienna Women's Health Program, 2022).

A childbirth education class was designed for Spanish-speaking Latino immigrant women living in rural areas within the scope of the master's thesis prepared by Calleson and Drostin (2010) at the University of North Carolina in the USA. In this program, it is foreseen that the educators will consist of nurses and health personnel and their training will last for four months, and the weekend travel time and expenses required for training materials and

childbirth preparation class training are also taken into consideration. It has been stated that the pregnant trainings will start in the eighth month in the presence of a translator and will consist of five two-hour sessions, and will be planned for evenings or weekends.

Pregnant women can participate in these trainings alone or accompanied. Immigrant women benefit from most of the childbirth education classes at a discount, they pay a small part themselves and the rest or the whole fee is covered by their health insurance. In these trainings, there is no general regulation about at which stage of pregnancy it is appropriate to attend birth preparation training, and it is recommended to attend these trainings starting from the 5th, 6th or 7th month of pregnancy. Participation in the birth preparation course is not compulsory. Pregnancy process, relaxation exercises, breathing techniques, birth and positions, advantages and disadvantages of gynecology centers, items to be brought to the hospital, breastfeeding, newborn care and health checks, postpartum period, gymnastics and depression are explained to expectant mothers in the course. Expectant mothers can attend these courses alone or with a relative. Courses offered by midwives are also covered by many health insurances (Frauenklinik, 2022; Pala, 2016; Mamamundo, 2022).

In Kazik's (2016) study, it was stated that doulas who can speak the same language as immigrant women and have a command of their culture will increase the satisfaction of perinatal and postpartum period care of the women, and will ensure that immigrant women receive care that is sensitive and respectful to their culture by establishing a cultural bridge between them and clinical staff. As a result of the study conducted by Lutenbacher et al. (2018) by making home visits to pregnant Hispanic women in Tennessee with their peer mentors for six months within the scope of the Maternal Baby Health Outreach Worker (MIHOW) program, women's breastfeeding self-efficacy increased, they developed safe sleep practices and baby stimulation at home, their depressive symptom and parenting stress levels were decreased. Byrskog et al. (2019) conducted focus group interviews with the Hooyo Project in Sweden, in which they determined the expectations and cultural needs of Somali migrant mothers from antenatal care. and aims to provide the most appropriate care to migrant women and to improve maternal and infant health outcomes.

4. Childbirth Education for Migrant in Turkey

Refugee women in Turkey face many problems during birth and pregnancy, especially language barriers, and this reduces the quality of prenatal and postnatal care (Dağ, 2017; Aksu et al., 2021; Pregnant School, 2019).

It was determined that immigrant women experienced breastfeeding and milking problems, negative birth experience and trauma, could not communicate with health personnel at birth, and health personnel, patients and their relatives applied physical and verbal violence to each other. In addition, it is stated that these women suffer from malpractice as a result of erroneous translations due to the inability to reach interpreter support in hospitals and the use of other patients and their relatives for translation (Dağ, 2017; Aksu et al., 2021).

After determining the risks that this situation may pose, Esenler Maternity Hospital and the International Doctors Association (AID, 2019) started a Pregnant School project for refugee women in 2017 as a joint effort. Within the scope of the project, four training session, which includes question and answer sessions, were organized by midwives accompanied with Arabic consecutive translation, for pregnant women, about women's reproductive health, pregnancy, antenatal and postnatal care, mother-baby health, access to health services in Turkey and pregnancy during the Covid-19 period. By this way, it was tried to facilitate the physical and mental adaptation of the participants to the pregnancy and childbirth processes. In addition to educational services, referral and information sessions were also held for pregnant women who had medical, social support or more complicated problems during

pregnancy. The project started in 2017 and lasted until July 2019 and were reached 239 women within the scope of it. Due to the pandemic, these trainings continued to be held online as of June 2020 (Pregnant School, 2019).

There is no data in the literature about the content of the education that many immigrant women receive in units such as childbirth education class/ pregnant school, the way it is transmitted, the language and methods used, and their experiences in accessing and benefiting from health care services, positively or negatively. In order to improve the health services provided to immigrant women, it is important to receive feedback from these women and to develop modern strategies to overcome the negativities in these reports. Lack of language support, cultural insensitivity, discrimination, inadequate communication between health professionals, financial aid, and lack of legal authorization and guidelines for prenatal care services are among the most important factors that migrant women will be adversely affected by the health services they receive. Health professionals' knowledge, understanding and attitudes are a critical determinant of care, and they need to have greater cultural awareness of the needs of various refugee groups (Tortumluoğlu, 2004; Kaufmann et. al, 2020).

It is seen that prenatal care practices for migrant women are insufficient worldwide and in our country. This inadequacy can be explained by increasing the available social assistance and allowances for immigrants, providing awareness trainings to increase the health literacy of immigrants, assigning cultural doulas, making home visits, shooting informative videos-films, developing mobile applications, having tablets in the services where you can watch images about birth in their own language, It is thought that the establishment of health and parenting schools can be overcome by ensuring that immigrant women have appropriate access to maternity care services (Smith et al., 2016; Nyström et al., 2022).

Results and Discussion

As a result of the literature review, only one pregnant school opened for Syrian immigrants has been reached in our country, and it is seen that the education of immigrants generally does not go beyond what is described in the antenatal follow-up made by the physician. Although there are childbirth education classes for immigrants conducted by non-governmental organizations, municipalities and maternal and child health units in our country, it is not known because they are not included in social media and scientific articles. Besides, in many European countries, in addition to antenatal follow-up, immigrant women benefit from childbirth education classes in their mother tongue, and this education is given to women in accordance with cultural care (Pregnant School, 2022; Frauenklinik, 2022; Santépsy, 2022).

The legal and political context appears to be important in addressing the maternity care needs of migrant women. It seems imperative to universally embrace the goal of achieving optimal maternity care for all, as demonstrated by current policies. Although these opportunities are offered to migrant women in many countries, women face barriers to accessing health services such as lack of information, lack of awareness, insufficient support and failure to meet expectations. When the migrant childbirth education programs offered by the countries are examined, it has been seen that there are differences in the subjects of education, duration, trainer features, interpreter support, and pricing, and they are usually carried out in hospitals (Grauenklinik, 2022; Frauenklinik, 2022; Santépsy, 2022). In research projects, it is seen that immigrant childbirth education classes are planned in time periods focused on culture and needs, if possible with cultural doulas/migrant midwives-nurses, including rural areas, home visits, evening and weekends, as well as supporting spouse participation (Byrskog et. al, 2019; Calleson & Drostin, 2010; Kazik, 2016; Lutenbacher et

al., 2018). It is thought that the fact that the migrant childbirth education classes are held on weekdays and during working hours may cause the spouses of migrant women to not be able to attend, the partial interpreter support provided will reduce the comprehensibility of the information provided, and the paid courses may also reduce participation. As in our country, the absence of translators in obstetrics clinics will reduce the satisfaction of mothers in maternity care.

Studies show that the rate of migrant women receiving prenatal education is very low. In the study of Dadras et al. (2020), it was determined that only 36% of immigrant women received the necessary antenatal care. In addition, it was stated that among the immigrant women, those with a high level of education, good income, residing in the country for a longer period of time and having legal immigrant status received more antenatal care. In a study in which the effect of internal migration on women's health in our country was investigated, it was found that the rate of benefiting from health care services before, during and after birth increased when women migrated from disadvantaged regions to a developed region (Aksu et al., 2021). In another study, it was determined that the illegal accommodation of immigrant women prevented them from going to the necessary education classes and pregnancy controls, and that these women did not have information about antenatal care classes and courses (Phillimore, 2020).

Despite the current migrant-friendly pregnant schools and the maternity services provided, many migrant women experience negative childbirth. Communication problems experienced by immigrant women in the health care system, their unfamiliarity with the health system of the country they come from, and the discriminatory and disrespectful care behaviors of health workers negatively affect their birth experiences (Dağ, 2017). Postpartum depression is frequently seen in immigrant women due to negative birth experience, lack of social support, social isolation, language barrier, inability to express their feelings, negative experiences with health workers (forced discharge, etc.), pressure from economic problems and visa problems (Dağ, 2017; Higginbottom, et al., 2015; Small et all., 2014). Considering the current situation in our country, considering the fertility rate of migrant women, there are no adequate and adequate number of birth preparation classes for Syrians and immigrants from other countries.

According to the Turkish Medical Association (2016) report, the statements of a Syrian woman regarding the current situation in our country are as follows; "*We have a problem in healthcare. There are no female doctors. Seeing a male doctor is not in line with our belief. Sometimes we cannot explain our problem to the doctors. We have a translation problem. I realized later that someone from the previous doctor gave me a birth control pill due to a wrong translation, when he should have given me flu medicine".*

In order to improve the health status of migrant women; It is recommended to evaluate health behaviors, review their beliefs and lifestyles, and organize trainings by healthcare professionals, taking into account cultural differences in areas that are inadequate. Ensuring that immigrant women benefit from antenatal care services, accessibility and acceptability of these services is very important for maternal and infant health. Although these opportunities are offered to migrant women in many countries, women face barriers to accessing health services such as lack of information, lack of awareness, insufficient support and failure to meet expectations. Culture-based, respectful and adequate care should be provided and developed for migrant women in obstetrics clinics. Midwives and nurses should try to teach migrant women more about their rights to care, available maternity services and how to refer them. Women should be allowed to participate in care decisions. In addition, childbirth education courses given to immigrant women in their mother tongue or accompanied by an interpreter should be expanded, the expenses of these courses should be covered by the state, and migrant midwife, nurse or doula support should be provided before, during and after the

birth. It is recommended that women be guided within the hospital in their mother tongue, and brochures about the health system and necessary care should be distributed. In this way, it will be possible for immigrant women to regularly come to antenatal check-ups, have screening tests, decrease maternal and fetal mortality rates, avoid postpartum breastfeeding and depression problems, and access information and services regarding the methods required for family planning.

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