# Prenatal Care of Newcomers to Canada: Helping two cultures meet

Family Medicine Forum
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Dr. Hannah Shenker MD CCFP
McGill University

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## Session Objectives:

- At the end of the session the participants will be able to:
  - Identify common complications of pregnancy experienced by recent immigrants and refugees.
  - Describe the evidence based clinical practice guidelines for immigrants and refugees to Canada as they pertain to maternity care.
  - Apply the principles of cultural competency to the perinatal care of newcomers to Canada.

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## Speaker disclosure

- No financial or in-kind support was received from a commercial organization to develop this presentation
- I have no affiliations (financial or otherwise) with pharmaceutical, medical device or communications organization to disclose.
- I do not intend to make therapeutic recommendations for medications that have not received regulatory approval (i.e. "off-label" use of medication).

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## International Migration

- Defined by the United Nations as

"persons, and family members, moving to another country or region to better their material or social conditions and improve the prospect for themselves or their family"

- Currently 214 million international migrants worldwide
- 49% of international migrants are women
- 14% of international migrants are children

International Organization for Migration 2019;

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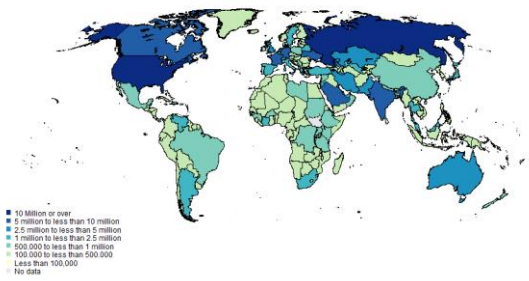
## Numbers of International Migrants worldwide.




Geospacial information section, United Nations. 2019

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## Migration to Canada:

- Currently *8 million international migrants* living in Canada
- 21.3% of the general population
- Includes *156 000 refugees*

- 52.4% of international migrants in Canada are women
- *22% of births* in Canada are to foreign born women

WHO Global Consultation on the Health of Migrants, 2018

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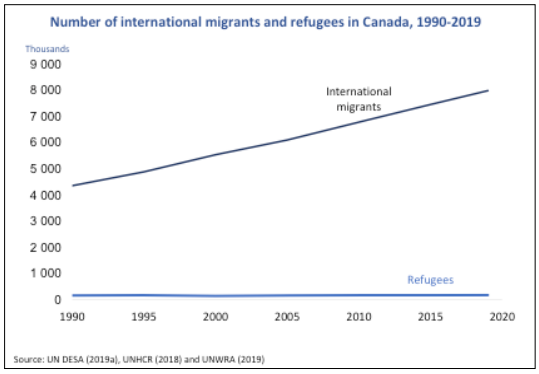


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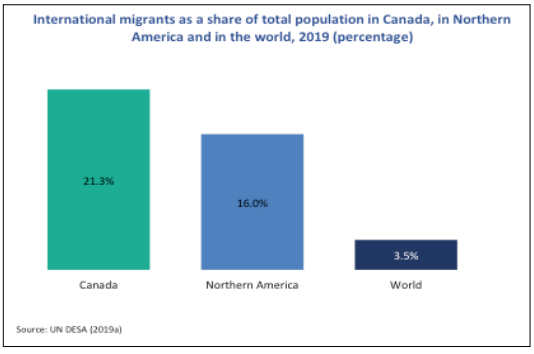


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**Table 1A:** Classification of international migration to Canada (2007)*

| Immigration category | Annual migration (no.)†‡ |
|---|---|
| **Permanent residents**[¶] | |
| Economic class (business and economic migrants) | 131 000 |
| Family class (family reunification) | 66 000 |
| Humanitarian class (refugees resettled from abroad or selected in Canada from refugee claimants) | 28 000 |
| Others | 11 000 |
| Total | 237 000 |
| **Temporary residents**[¶] | |
| Migrant workers | 165 000 |
| International students | 74 000 |
| Refugee claimants (those arriving in Canada and claiming to be refugees)[¶] | 28 000 |
| Other temporary residents[¶] | 89 000 |
| Total[¶] | 357 000 |
| **Other migrants** | |
| Total irregular migrants,§ not annual migration[1] | ~ 200 000 |
| Visitors[¶] | ~ 30 100 000 |

*Reproduced, with permission, from Gushulak et al.[1]
†Numbers rounded to nearest 1000. Total in each category may not match sum of values reported because of rounding.
‡Unless otherwise indicated.
§No official migration status; this population includes those who have entered Canada as visitors or temporary residents and remained to live or work without official status. It also includes those who may have entered the country illegally and not registered with authorities or applied for residence.

- *International migrants to Canada are a heterogeneous group*
- Disease prevalence differs with
  - Exposure to infectious disease
  - Migration trajectories
  - Living conditions
  - Genetic predispositions

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## Clinical Vignette #1: Edna

- 40 year old G6P4L3A1 at 34 weeks GA
- Originally from Nigeria, left in 2016, transit via the USA and claimed asylum in Canada in February 2019 with her husband and 3 living children.
- LMP in March 2019. Unplanned pregnancy
- Working as an orderly in a geriatrics facility
- Social background:
  - Victim of religious persecution in home country
  - Refused female genital mutilation
  - First son murdered at age 17 months
  - Second son targeted at 11 months but survived

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## Clinical Vignette #1: Edna

- POBHx:
  - CS x 4 in Nigeria
  - SAB x 1 (first trimester) with D+C
  - Gestational Hypertension in G5
  - Postpartum depression in 2015
- PMHx:
  - Morbid obesity
  - Appendectomy
  - Suicidal ideation in 2011 after the death of her son
  - Post traumatic stress disorder diagnosed at Refugee Clinic in Montreal 2019
- Refugee Health Assessment in April 2019
  - 6 weeks pregnant by dates
  - Weight 137 kg, BP 110 70
  - CBC normal, Hb electrophoresis normal
  - Iron deficiency (mild)
  - Glucose and lipid profile normal
  - HIV, Hep B,C, VDRL, Strongyloides, Schistosoma serologies negative
  - Gono, Chlam negative
  - Subclinical hyperthyroidism (anti TPO negative)
  - PAP test normal
  - VZV immune, Rubella non immune

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## Clinical Vignette #1: Edna

- Current Pregnancy:
  - Low risk serum screen for T21
  - Put off work in first trimester via Quebec's occupational health and safety program for pregnant workers (CNESST)
  - Gestational diabetes diagnosed in 2nd trimester
    - co-followed at the GDM clinic of affiliate hospital by interdisciplinary team
    - well controlled on Insulin
    - serial US shows normal growth
    - Normal BP monitoring
  - Routine third trimester fetal surveillance as per GDM and AMA protocols
  - Planed repeat CS at 38-39 weeks GA
  - Ongoing depressed mood, insomnia, flashbacks
    - Declines medication
    - Declines referral to psychological services, feels she will improve once immigration status hearing takes place (no date confirmed yet)
    - Followed by a community social worker for basic support and by the Regional Program for the settlement of asylum seekers in Montreal
    - Continues to function well, looking forward to the birth of her 5th child, well supported by her spouse

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## Pregnancy in Immigrants and Refugees in Canada

- Increased risk of adverse obstetrical and perinatal outcomes including:
  - Low birth weight infants
  - Preterm birth
  - Postpartum hemorrhage
  - Infection
  - Fetal mortality
  - Higher rates of cesarean section
- High prevalence of mental health disorders
- Asylum seekers and refugees have worse perinatal outcomes than other migrants.

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## Multiple Barriers to Accessing Maternity Care

- Linguistic
- Cultural
  - Treatment differences and expectations (compared to home country)
  - Acceptability of certain procedures (ie – prenatal diagnosis)
  - Misunderstanding and mistrust of the healthcare system
- Logistic and Financial
  - Lack of awareness of available services
  - Differential eligibility for healthcare services
  - Up to 3 month waiting period for provincial health coverage
  - Clinician misunderstanding of the Interim Federal Health Program Plan

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## Health Screening of refugees and asylum seekers performed by the Canada Border Services Agency

- Designed to assess a limited number of public health risks, not to provide preventative screening
- Done within 12 months prior to arrival in Canada, or within 60 days of saylum claim in Canada
  - Physical exam by a designate physician
  - CXR (>11y)
  - VDRL (>15y)
  - UA (> 5y)
  - HIV (>15y or HIV +ve mother or recipient blood products)
- Results are not necessarily linked with any f/u
- Patient may not be aware of need for f/u
- Results difficult to access as they are property of the government

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## Refugee Health Assessment

- Voluntary
- Covered by the Interim federal health program
- Offered in 14 cities across Québec
- Well being assessment by a social worker
- Health assessment by a nurse
  - History and physical exam
  - CBC, Hb electrophoresis, Vit D level
  - Screening for HIV, VDRL, Shisto, varicella IgG, HBV, HCV, TB
  - Referral for specialized care as necessary
  - Referral to primary care for ongoing medical needs

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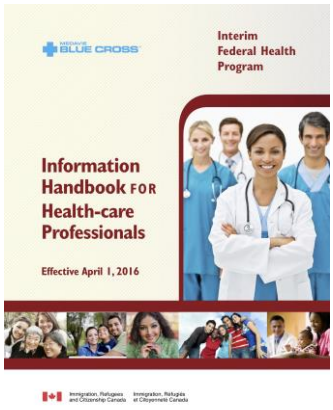
https://www.canada.ca/en/immigration-refugees-citizenship/services/refugees/help-within-canada/health-care/professionals.html

*health care providers who see asylum seekers may register with medavie blue cross for billing purposes.

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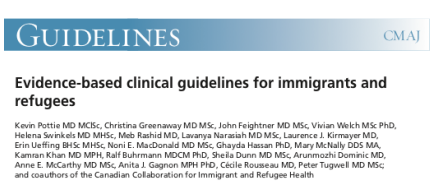


CMAJ, September 6, 2011, 183 (12)

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## Key points from the Canadian clinical practice guideline for immigrant and refugee health, 2011

- Clinical preventive care should be informed by the person's region or country of origin and migration history.
- Forced migration, low income and limited proficiency in English or French increase the risk of a decline in health and should be considered in the assessment and delivery of preventive care.
- Routinely offer:
  - Vaccination
    - measles, mumps, rubella, diphtheria, tetanus, pertussis, polio, VZV, hepatitis B, HPV
  - Screening for
    - hepatitis B and C, TB, HIV, intestinal parasites (strongyloides, schisto)
    - iron deficiency, dental pain, loss of vision, cervical cancer
- Detecting and addressing the following conditions should be individualized to improve detection, adherence and treatment outcomes.
  - malaria, depression, PTSD, child maltreatment, intimate partner violence, diabetes mellitus, contraceptive needs, ***pregnancy***

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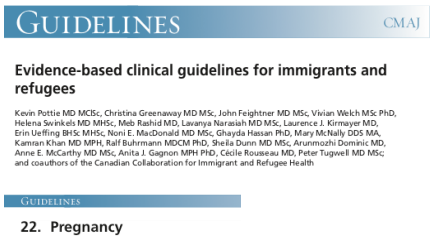


CMAJ, September 6, 2011, 183 (12)

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## Pregnancy in the migrant Population from the CMAJ 2011

- Social Isolation, Depression, PTSD
  - associated with SGA infants and
  - increased maternal morbidity
- Poor Nutritional Status
- Workplace hazards
  - Increased exposure to unregulated and unprotected work environments
  - Lack of knowledge of employee rights
- Incomplete or incorrect obstetrical histories
  - Previous records unavailable
  - Fear of jeopardizing claimant application

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## Pregnancy in the migrant Population from the CMAJ 2011

- Sexual Abuse
  - unwanted pregnancies
  - psychological distress
  - STIs and PID
  - reproductive tract trauma
  - social rejection
  - infant abandonment or mistreatment
- Infectious Diseases
  - Hep B,C, HIV, Syphilis, Zika exposure
- Hemoglobinopathies
- Female genital mutilation

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## Clinical Vignette #2: Amena

- 22 year old G3P2 presenting for prenatal care.
- Born in Syria, had been living in a refugee camp in Jordan x 5 years where she met her husband and gave birth to 2 daughters.
- Unilingual arabic
- All 4 family members are government sponsored refugees who arrived in Canada 3 months earlier
- Living in an apartment in Montreal with support from the Centre Sociale d'Aide aux Immigrants (CSAI)
- Referred to PRAIDA (Regional Program for the settlement of asylum seekers) for a voluntary refugee health assessment

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## Clinical Vignette #2: Amena

- A ***Refugee health assessment*** was performed by a nurse clinician:
  - 12 weeks pregnant
  - Iron deficiency
  - Vitamin D deficiency
  - Hyperemesis gravidarum - mild
  - CBC and Hb electrophoresis normal
  - Screening for HIV, Hepatitis B,C, Syphilis, Strongyloides all negative
  - Vaccines up to date
  - CXR Normal
  - Mental Health Disorders
    - Symptoms of OCD and PTSD
    - Flat affect, poor eye contact, agitated
  - Contact dermatitis both hands due to repetitive hand washing
- Referred to "La Maison Bleue" clinic for interdisciplinary prenatal care and towards psychological services for victims of organized violence.

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## Perinatal Mental Health Disorders in the migrant population

- Higher prevalence of mental health disorders as compared to women born in the host countries
- Postpartum depression up to 60%
- Antenatal depression up to 45%
- Any depressive disorder up to 31%
- Post traumatic stress disorder up to 15%

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## Risk Factors for the development of perinatal mental health disorders in immigrants and refugees

- Lack of social or family supports
- Difficulty adjusting to host country
- Language barrier
- Personal history of violence or abuse
- Experience of organized violence in home country
- Primiparity
- Operative delivery
- Difficulty with breastfeeding
- Socio-demographics
  - Low income
  - Unemployment
  - Poor education
- Personal or family history of mental health disorder

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- Lack of psychosocial resources for pregnant women has been associated with SGA infants
- Perceived lack of social support has been reported by15.4% of immigrant women vs 7.2% of non migrant women in Canada
- Protective factors against perinatal mental health disorders include
  - having a good social support system
  - adherence to traditional postpartum practices

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## Social support is related to better health outcomes

- Upon landing in Canada, immigrants are typically healthier than the average Canadian-born person.
- The "healthy immigrant effect" has been shown to decrease with time spent in Canada, particularly in seniors and women.
- This health decline has been attributed in part to stresses associated with migration including:
  - Unemployment
  - Language difficulties
  - Rebuilding social networks in a new country
- The health risks associated with the stresses of migration can be mitigated by social support and services provided within the community.
- Social support from family and community sources buffers the stresses of migration and resettlement, promotes mental and physical health, and enables help-seeking.

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## Clinical vignette #3: Souadou

- 26 year old G3P0A2 at 15 weeks GA
- Born in Ghana, living in Canada x 10 years
- Recent travel to visit family in Ghana followed by a trip to Mexico on her way back to Canada
- PMHx, POBHx
  - Tuberculosis as as child
  - Chlamydia in 2009, 2010
  - TAB x 2 remote
- Presents with fever, diarrhea and malaise
- Physical exam:
  - Temp 38.5 po, Pulse 135, BP 109 66, RR 20, FHR +
  - Diaphoretic, looks unwell

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## Clinical vignette #3: Souadou

- Basic Laboratory work up:
  - Hb 75, Plt 69, WBC 26.
  - Electrolytes, Creat, LFTs normal
  - CXR shows patchy bibasilar consolidation and small pleural effusion
- Urine, Blood, Stool cultures, O+P, C diff all negative
- Malaria smear is positive (falciparum)
- Zika PCR negative
- Admitted to hospital and treated with quinine + clindamycin, switched to malarone + artesunate due to quinine side effects (hypoglycemia and thrombocytopenia)
- Normal serial obstetrical ultrasound
- Discharged after 10 days to FMOB care with follow up in ID and High Risk Obstetrics.

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**Table 2. Key vector-borne infections in pregnancy**[4,11,18]

| Infection | Vector | Geographic distribution | Clinical manifestations | Consequences in pregnancy | Vaccine | Preventive strategies |
|---|---|---|---|---|---|---|
| Malaria | *Anopheles* mosquito (dusk and dawn) | Sub-Saharan Africa, Asia, South America | Febrile illness<br>Multiorgan dysfunction, including cerebral malaria | Non-immune host:<br>• Severe maternal infection<br>Immune host:<br>• Anemia<br>• Low birth weight | None | Behavioral<br>• Travel avoidance to risk areas during transmission seasons<br>• Avoidance of known active times or place of vector (e.g., dusk, outdoors for *Anopheles*)<br>Personal protective measures against arthropod bites:<br>Physical barriers<br>• Protected housing (screen doors, windows, air conditioning)<br>• Insecticide-treated bed nets<br>• Full-length, loose-fitting, light coloured clothing<br>Chemical barriers<br>• N,N-diethyl-m-toluamide (20% or more)<br>• Icaridin (20%)<br>• Insecticide-treated clothing<br>Vaccine where available |
| ZIKV | *Aedes* mosquito (day-biting) | Americas | Fever, rash, conjunctivitis, arthralgia | Congenital Zika syndrome | None | |
| Dengue virus | *Aedes* mosquito (day-biting) | Endemic in tropics and subtropics<br>High burden:<br>• Southeast Asia<br>• Pacific | Primary infection<br>• Subclinical<br>• Febrile illness<br>• Headache<br>• Myalgia<br>• Rash<br>Secondary infection<br>• Dengue hemorrhagic fever<br>• Bleeding<br>• Shock | Reports of[41–45]:<br>• Preterm birth<br>• Low birth weight<br>• Intrapartum hemorrhage<br>• Fetal death<br>• Miscarriage<br>• Neonatal death<br>• Neonatal dengue (fever, hepatomegaly, thrombocytopenia) | None | |
| Chikungunya virus | *Aedes* mosquito (day-biting) | Endemic in Africa and Asia<br>Outbreaks:<br>• Africa<br>• Asia<br>• Pacific<br>• Americas | Acute infection<br>• Febrile illness<br>• Rash<br>• Arthralgia (chronic arthropathy) | Reports of[46]:<br>• Neonatal chikungunya infection | None | |
| Yellow fever virus | *Aedes* mosquito (day-biting) | Sub-Saharan Africa<br>Tropical South America | Uncommon in travellers<br>• Multiorgan dysfunction<br>• Jaundice<br>• Hemorrhage<br>• High case-fatality rate | | Yes (see Table 1) | |
| Japanese encephalitis virus | *Culex* mosquito | Asia<br>Western Pacific | Uncommon in travellers<br>• Acute encephalitis<br>• High fatality rates<br>• Neurological consequences (children in endemic areas) | | Yes (see Table 1) | |

NOTE. CDC Malaria map available at: https://www.cdc.gov/malaria/travelers/about_maps.html.

Travel-Related Infections Among Pregnant Travellers to the Tropics: An Overview
J Obstet Gynaecol Can 2018;40(4):460–472

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## Screening for infectious diseases in Pregnant Immigrants and Refugees

- Standard screening
  - HIV, VDRL, Hepatitis B, Chlamydia, Gonorrhea
  - Varicella serology
  - Hepatitis C
- Consider:
  - Strongyloides screening
  - Schistosoma screening
  - Zika virus (travel history)
  - Tuberculosis

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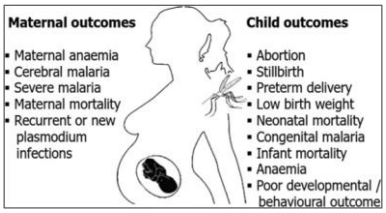
## Malaria in Pregnancy

- Pregnant women are the most vulnerable group of malaria-associated morbidity and mortality.
- Up to 4x increased risk of acquisition and 2x risk of death vs non-pregnant
- Infection acquired prior to pregnancy does not confer immunity during pregnancy




Epidemiology and burden of malaria in pregnancy. The Lancet Infectious Diseases. 2007;7(2):93–104.

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## ZIKA virus update

- Major outbreak in 2016-2017
- As of August 2018 (Canada)
  - 569 travel-related cases
  - 4 sexually transmitted
  - 45 cases amongst pregnant women
  - 5 congenital Zika syndrome cases
- Public Health Agency of Canada recommends:
  - Pregnant women should avoid travelling to Zika-affected areas
  - Avoid unprotected sexual contact with anyone who has travelled to Zika-affected country for the duration of pregnancy
  - If travel cannot be avoided: insect bite prevention measures
  - Male travellers should wait 3 months before conceiving
  - Female travellers should wait 2 months before conceiving

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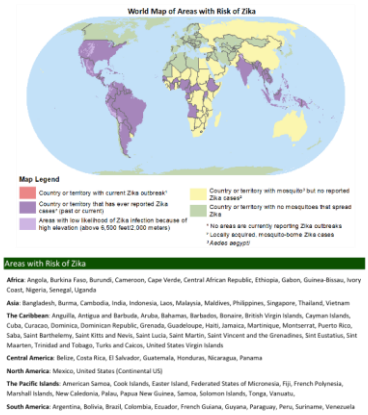


**Areas with Risk of Zika**

**Africa**: Angola, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Ethiopia, Gabon, Guinea-Bissau, Ivory Coast, Nigeria, Senegal, Uganda

**Asia**: Bangladesh, Burma, Cambodia, India, Indonesia, Laos, Malaysia, Maldives, Philippines, Singapore, Thailand, Vietnam

**The Caribbean**: Anguilla, Antigua and Barbuda, Aruba, Bahamas, Barbados, Bonaire, British Virgin Islands, Cayman Islands, Cuba, Curacao, Dominica, Dominican Republic, Grenada, Guadeloupe, Haiti, Jamaica, Martinique, Montserrat, Puerto Rico, Saba, Saint Barthelemy, Saint Kitts and Nevis, Saint Lucia, Saint Martin, Saint Vincent and the Grenadines, Sint Eustatius, Sint Maarten, Trinidad and Tobago, Turks and Caicos, United States Virgin Islands

**Central America**: Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, Panama

**North America**: Mexico, United States (Continental US)

**The Pacific Islands**: American Samoa, Cook Islands, Easter Island, Federated States of Micronesia, Fiji, French Polynesia, Marshall Islands, New Caledonia, Palau, Papua New Guinea, Samoa, Solomon Islands, Tonga, Vanuatu,

**South America**: Argentina, Bolivia, Brazil, Colombia, Ecuador, French Guiana, Guyana, Paraguay, Peru, Suriname, Venezuela

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## Testing for Zika infection

- In consultation with High Risk OBS and ID
- Any pregnant woman who has been in an area with Zika:
  - If within 14 days and symptomatic, send PCR and serology
  - If > 14 days since symptoms (or asx), send serology
  - If > 12 wks since trip or sx, DO NOT test (false negatives) but recommend to follow OBS U/S
  - OBS U/S within 4 wks of exposure and q4 wks until lab results

https://www.canada.ca/en/public-health/services/diseases/zika-virus.html

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**Table 1. Key Features of Congenital Zika Syndrome.**

| Lesion Type | Manifestations |
|---|---|
| Structural lesions | |
| Fetal brain disruption sequence* | Severe microcephaly, premature closure of fontanels, collapsed skull, overlapping sutures, redundant scalp skin |
| Brain abnormalities | Cortical atrophy with decreased myelination, cerebellar hypoplasia<br>Neuronal migration disorder — lissencephaly, agyria, pachygyria, polymicrogyria, heterotopia, dysgenesis of corpus callosum<br>Calcifications, mainly subcortical*<br>Ventriculomegaly, increased posterior fossa and pericerebral spaces |
| Ocular abnormalities | Pigmented retinal mottling*, chorioretinal atrophy*, macular scarring, glaucoma, optic nerve atrophy and abnormalities, intraocular calcifications<br>Microphthalmia, anophthalmia<br>Iris coloboma, lens subluxation, cataract |
| Congenital contractures | Arthrogryposis, talipes equinovarus, hip dislocation |
| Intrauterine growth restriction | |
| Functional lesions | |
| Seizures | |
| Pyramidal or extrapyramidal abnormalities* | Body tone abnormalities (mainly hypertonia), swallowing disorder, movement abnormalities (dyskinesia, dystonia), hyperexcitability, impatient crying, sleep disorders |
| Neurodevelopmental abnormalities | Visual impairment (strabismus, nystagmus, vision loss)<br>Hearing loss or deafness<br>Developmental delay |

* Lesions are rarely observed in other congenital infections.

Zika Virus Infection - After the Pandemic. N Engl J Med 2019; 381:1444-1457

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## Clinical vignette #4: Fozia

- 33 year old G1P0 presents for first prenatal visit at 11 weeks GA
- Asylum seeker from Djibouti x 2017 with her husband
- Working in a factory, manual labor
- Female genital mutilation as a child (type II)
- Conjugal abuse in previous marriage
- Describes anxiety, fearfulness, insomnia
- Multiple visits to urgent care clinic with palpitations, headache, dizziness.

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## Female Genital Mutilation

- Refers to all procedures involving partial or total removal of the external female genitalia
  - Classified as types I, II, III, IV.
- Communities that practice female genital mutilation report a variety of social and religious reasons
- No known health benefits
- Between 100 and 140 million girls and women in the world are estimated to have undergone such procedures
- 3 million girls are estimated to be at risk of undergoing the procedures every year
- Practice is most prevalent in the western, eastern, and north-eastern regions of Africa, some countries in Asia and the Middle East and among certain immigrant communities in North America and Europe
- Performing or assisting in female genital cutting is a criminal offense in Canada

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**Table 4. Recognized complications and risks of female genital cutting[1]**

| Immediate risks of Types I, II, and III | Long-term risks of Types I, II, and III | Additional risks associated with Type III |
|---|---|---|
| Pain due to the cutting of the nerves and sensitive genital tissues | Chronic pain due to trapped or unprotected nerves | Surgery to enable penetration during sexual intercourse and for childbirth, and sometimes re-infibulation |
| Shock caused by pain and/or hemorrhage | Epithelial inclusion cysts | Inability to have intercourse |
| Excessive bleeding | Infections (i.e. abscesses and genital ulcers; chronic pelvic infections; urinary tract infections) | Infertility |
| Difficulty in passing urine/ passing feces | Keloid formation | Dysmenorrhea due to outflow obstruction |
| Infections | Sexually transmitted infections, especially genital herpes | Endometriosis |
| Increased risk of blood borne viral infections including hepatitis and HIV due to the use of unsterilized and shared instruments | Increased risk of blood-borne viral infections including hepatitis and HIV due to genital trauma during intercourse (especially for Type III) | Difficulty voiding |
| Death | Sexual dysfunction (i.e. decreased sexual pleasure, pain during sex) | Difficulty using tampons, diaphragms, pessaries, etc. |
| Psychological consequences | Vulvar or vaginal lacerations with intercourse or childbirth | Difficulty with speculum examinations |
| Unintended labial fusion | Increased Caesarean section rates, obstructed labour | Difficulty accessing Pap smear screening and other gynaecological procedures requiring vaginal access (cervical cultures, endometrial biopsy, IUD placement, etc.) |
| Re-infibulation due to unsuccessful healing | Psychological consequences (i.e. fear of sexual intercourse, post traumatic stress disorder, anxiety, depression and memory loss) | |

SOGC Clinical Practice Guideline #299. November 2013.

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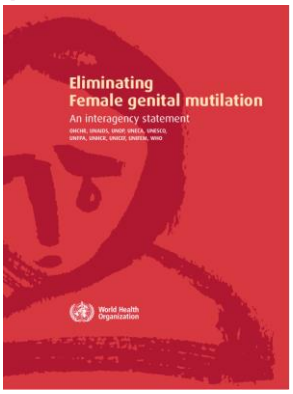


- Joint policy Statement calling on all States to uphold the rights of girls and women.
- "On behalf of our respective agencies, we reaffirm our commitment to the elimination of female genital mutilation within a generation."

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## Antenatal care of women who have undergone female genital mutilation

- Pregnancy will often be the first opportunity for a woman post FGM to present to the healthcare system
- Health care professionals must be careful not to stigmatize women who have undergone FGM
- Health care professionals should advocate for the availability of and access to appropriate support and counselling services
- Use culturally competent interpreters when possible and ensure privacy
- Prenatal visits are an opportunity to provide a woman with information about her reproductive system and her sexual and reproductive health, as well as to prepare her for delivery
- Female genital cutting is not considered an indication for Caesarean section (Level III evidence)

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## Intrapartum care of women who have undergone female genital mutilation

- Most forms of FGC do not directly impact obstetrical care.
- Associated with increased incidence of
  - vaginal/vulvar lacerations
  - Cesarean section
  - Postpartum hemorrhage
  - Extended hospital stay
  - Infant resuscitation
  - Neonatal death
- If defibulation is performed intrapartum, an episiotomy performed at the same could be considered to facilitate delivery and minimize vaginal lacerations.

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## Intrapartum care of women who have undergone female genital mutilation

- Possible scenarios should be discussed in advance
- Give woman ample opportunity to
  - state her views
  - ask questions
  - understand the reasoning behind common interventions such as analgesia in labour, defibulation, episiotomy, and Caesarean section.
- *Postpartum Care*:
- Increased vulvar pain
- good analgesia
- assistance with care of the newborn
- Cultural sensitivity

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## "What Somali women say about giving birth in Canada"

J Reprod Infant Psychol 2002; 20: 267-82


- Most cases of FGM in Somalia, Sudan and Djibouti are type III (80-90%)
- Practitioners attending Somali births in Canada were found to lack knowledge of FGM and to manifest unprofessional attitudes towards these women.
- Less interventionist clinical care, and increased sensitivity to cross-cultural practices are needed.

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## Resources on the Perinatal management of FGM

- World Health Organization, Department of Reproductive Health and Research. Management of pregnancy, childbirth and the postpartum period in the presence of genital mutilation.
  - http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/RHR_01_13_/en/index.html.
- SOGC Clinical Practice Guideline #299. November 2013
- Chalmers B., Omer-Hashi K. What Somali women say about giving birth in Canada. Journal of Reproductive and Infant Psychology 2002;20:267–82

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## Cultural Safety in Maternity Care

- "The work of cultural safety is to challenge [health care providers] to identify that there are other ways in which people experience life and view the world."

  • -Maori Nurse Irihapeti Ramsden (New Zealand)

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## Culturally Safe Care

- The integration of knowledge about individuals and groups of people into specific standards of care, policies, and practices.
- Care must be adapted to the particular socio-cultural context of diverse populations
- Incorporates an awareness of unique needs, interests, health beliefs, and behaviors

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## Why is culturally safe healthcare important?

- Trust, compassion, and mutual respect between health care professionals and their patients are essential to improving patients' well-being.
- Discriminating behavior by health care professionals, even if unintentional, hinders patients' access to quality health care and can be detrimental to their health.
- Being understood as an individual helps to build the trust necessary for meaningful therapeutic relationships.

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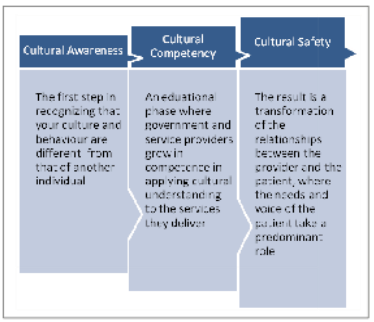
**Figure 8.1. Cultural awareness, competency, and safety**

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Changing outcomes through culturally competent care. JOGC June 2013

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## Supporting culturally appropriate care

- Involve:
  - Interpreters
  - Cultural Brokers
  - Family members
  - Community Supports
- Practice patience, humility and non judgment
- Reflect on your own cultural identity and it's impact on your clinical practice
- The implementation of recommendations may take multiple visits to achieve patient understanding and trust.

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## Take home messages….

- Immigrants and Refugees to Canada are at increased risk for adverse perinatal outcomes
- Screen for mental health disorders
- Screen for infectious diseases
- Aim to practice culturally safe care
- Involve allied healthcare professionals and consider innovative models of care such as grouped prenatal care

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## References


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