Migrants, Midwives, and the Transition to Parenthood

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1 Introduction

Human migration has existed since the prehistoric times, and it will certainly remain a feature of human society throughout the coming decades (International Federation of Red Cross and Red Crescent Societies 2012). After births and deaths, migration is the third important demographic factor that controls the structure and size of a population. It is a complex phenomenon because it encompasses the movement of individuals over time, oftentimes across international borders (United Nations 2012). This chapter targets migration from a different perspective other than demography. It addresses the psycho-social challenges that migrant women and their families face in host countries during pregnancy, childbirth, and post-partum period. An overall picture of the perinatal outcomes of migrant women will be provided and discussed from a medical and sociocultural standpoint. Subsequently, this chapter further explores the significant role of midwives, in providing culturally competent maternity care to migrant women and their families. It also highlights how midwives support and facilitate the transition to parenthood in migrant women and enables them to successfully adapt to this life-changing experience.

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2 Migration: A Global Phenomenon

Over the course of human history, migration has played a crucial role in shaping societies, cultures, and the world we live in today (International Federation of Red Cross and Red Crescent Societies 2012). Migration refers to the movement of people away from their habitual residence, either within a country (internal migration) or across an international border (International Organization for Migration 2019). Recent estimates indicate that currently there are 1 billion migrants in the world, suggesting that about one in every seven individuals is a migrant (World Health Organization 2021). Highlights on migration in the 2020 United Nations publication imply that, in 2020, the world region hosting the largest number of international migrants was Europe with the number of migrants reaching 87 million, followed by Northern America (almost 59 million). Northern Africa and Western Asia account for nearly 50 million migrants. The disruptions brought about by the COVID-19 pandemic situation appear to have had a major impact on migration trends because of travel and mobility restrictions together with many migrants returning to their home countries (Chamie 2020). Indeed, so far, evidence suggests that globally, by June 2020, the number of international migrants may have decreased by two million. This translates to a reduction of 27% in the migration growth expected between July 2019 and mid-June 2020. Moreover, while the decline in migration flows has been observed in all world regions, the effect of the COVID-19 pandemic on migration was more evident in the European region (United Nations 2020).

The factors driving migration are diverse, ever-changing, and highly dependent on a complex interaction of personal, societal, environmental, political, and economic factors. People are forcibly displaced or flee their home to seek refuge in host countries out of choice due to wars, political instability (Kühlmeyer et al. 2019), persecution (United Nations 2020), and human rights abuse in their homeland (Roman et al. 2010). Other individuals migrate for educational purposes, family reunification, economic improvement, poverty, healthcare needs, social and cultural discrimination (Roman et al. 2010), and environmental causes, such as rising sea levels (Hauer et al. 2020).

2.1 Migrant: Refugee Definitions

Considering that international migration is one of the leading items on the global development agenda, the United Nations (2012) emphasizes on the need to collect and analyse reliable, comparable, and timely migration data to enable a more thorough understanding of the consequences of human migration and to address these issues on a national, regional, and international level. Although it is recommended to gather data on who the migrants are, when and why they migrated, and the countries from which they come from United Nations (2012), this is problematic in the absence of a universally acceptable definition of the word ‘migrant’ (International Organization for Migration 2019). Consequently, different entities have developed different definitions for the same term. In view of this heterogeneity, it may be

challenging for researchers to study particular aspects of migration, especially sensitive issues from the health and the social perspective. A consensus on a single definition of the term 'migrant' is therefore of utmost importance as it enables consistency in data collection and representation (Anderson and Blinder 2019).

The International Organization for Migration (IOM) has provided a broad definition of the term 'migrant'; it refers to a person who moves away from his/her habitual residence for various intentions, either for a limited time or permanently, within a state or across different countries (International Organization for Migration 2019). This definition does not differentiate between the different types of migrants and includes also certain categories of individuals such as smuggled migrants, migrant workers, and international students. Anderson and Blinder (2019) argue that the word 'migrant' can be defined in terms of country of birth, nationality, and length of stay in foreign country; yet each of these aspects poses several challenges. In case of the latter factor, for instance, although it may be instinctive to define migrants as 'foreign-born', some 'foreign-born' individuals may still be citizens of the host country. Further difficulties may arise when the definition of migrant is based on persons' nationality, simply because nationality can change over time. Moreover, when nationality is self-reported, it may be influenced by individuals' personal feelings, as well as their social and cultural affinity, rather than the legal status (Anderson and Blinder 2019). Additional complications may surface in cases where individuals have multiple citizenships, since many a time, data sources represent only one citizenship. It is also difficult to know how long a person intends to stay in the host country, making it problematic to base the term 'migrant' on people's length of stay (Anderson and Blinder 2019).

There is a common misconception that the terms 'migrant' and 'refugee' can be used interchangeably. Yet, the incorrect usage neglects the distinctiveness of each term (see Fig. 1) and presents further challenges to researchers and policy makers who are trying to understand and act upon issues brought about by migration. In fact, as previously mentioned, while a formal definition of 'international migrant' does not exist, the term 'refugees' refers specifically to persons who are outside of

MIGRANT: *An umbrella term, referring to an individual who moves away from his/her habitual residence for various intentions, either for a limited time or permanently, within a state or across different countries. This term includes well-defined legal categories of persons, for example migrant workers. It also refers to persons whose specific means of movement is legally defined (smuggled migrants), and those whose status is not particularly defined under international law (international students) (developed by the IOM but not defined under international law) (International Organization for Migration 2019).*

REFUGEE: *A person who is outside the country of his/her nationality because of a justifiable fear of persecution based on his/her race, religion, affiliation with a particular social group, political opinion,or nationality, and as a resultof these aspect is reluctant to, or unable to benefit from the protection of that country. The term also refers to a stateless individual who is outside the country of his/her previous place of habitual residence and due to fear of such events, he/she is unable or does not wish to return to his/her country (Adapted from 1951 Convention relating to the Status of Refugees) (UNHCR 2019).*

Fig. 1 Commonly used definitions of the terms 'migrant' and 'refugee'

their country of origin and are seeking international protection as a consequence of a justifiable fear of persecution in their home country based on their race, religion, political opinion, violence, conflict, or situations that have disturbed public order (United Nations 2021).

These definitions continue to bring to light the diversity that exists within migrant populations and, consequently, the importance of using the correct terminology when addressing issues pertaining to migration, especially in the context of healthcare. This is because the needs, particularly health needs, and the social determinants of health of individuals moving for economic or educational purposes may be considerably different than the needs of people who are forced to leave their home country or flee their habitual residence to seek protection.

2.2 Women and Migration

From a gender perspective, data on migration suggests that since the 1960s, the trend of female migration has remained stable (Migration Data Portal 2021). In the year 2020, almost half of all forcibly displaced individuals across national borders were women and girls (United Nations 2020). Being a migrant, irrespective of the gender, places individuals vulnerable to physical and/or economic abuse and ill-treatment (United Nations Population Fund 2018). However, women and girls have an increased risk of sexual abuse, violence, and trafficking; in fact, almost three-quarters (71%) of all human trafficking victims are women and girls (United Nations Population Fund 2018). This alarming figure requires immediate action on an international scale. The displacement of female migrants because of natural disasters or conflict places the health of women and girls in jeopardy as the collapse of protection systems gives perpetrators the impunity for violence (United Nations Population Fund 2018). Poverty, overcrowding of migrants in camps, poorly lit toilets, as well as lack of suitable shelter further predispose females to physical and sexual abuse, in some instances driving them to forced child marriage as a means of coping with extreme poverty (United Nations Population Fund 2018). In addition, seeking help in such situations is challenging for females due to their lack of knowledge related to support systems and/or the unavailability of adequate support resources and systems.

Nowadays, more women are migrating independently for educational purposes and to seek job opportunities. Even these female migrants, when compared to males, can experience discrimination in host countries: discrimination arising from the fact that these women are migrants and simply because they are females (Migration Data Portal 2021). This, consequently, leaves them susceptible to maltreatment and sexual exploitation in various aspects of their lives, even during their most vulnerable state, such as when using healthcare services (United Nations Population Fund 2018). Along with the psychological trauma that this chaos brings with it, one must not disregard the possibility of pregnancy (United Nations Population Fund 2018) and sexually transmitted infections (WHO Regional Office for Europe 2018a) as a consequence of sexual assault. In addition, during the migration process, women

often lose access to healthcare, particularly safe antenatal and intrapartum care, which puts them at significant risk of morbidity and mortality (United Nations Population Fund 2018). Indeed, the absence of safe maternity care is one of the leading causes of death among migrant females of childbearing age (United Nations Population Fund 2018).

3 The Social Determinants of Migrant Women's Health

Resettlement in a new country brings with it hope for a promising future; yet, the difficulties that migrant women experience in transit do not end upon reaching the host countries (United Nations Population Fund 2018). Migrant women are faced with an endless list of adjustment challenges in the host country that inhibits their integration into the community and makes them susceptible to several adverse reproductive health outcomes.

Evidence suggests that in host countries, migrant women experience poor living conditions particularly in asylum centres (Vervliet et al. 2014) and difficulties finding employment (Robertson 2015) or at times are forbidden to work (Briscoe and Lavender 2009). The financial burden brought about by these challenges along with the remittance expected by migrants' families back home (Rapa 2015) often results in difficulties covering living costs (Phillimore 2015) and transport to access healthcare services (United Nations Population Fund 2018). It also restricts migrants from communicating with their families (Ny et al. 2007). Furthermore, settling in a new country is often accompanied by feelings of isolation, cultural shock, different policies and social norms (Connor 2012), racial discrimination, social oppression (Murray et al. 2010), and stigma when lacking understanding of the host country's language (Phung et al. 2020), all of which may potentially impact their health negatively (Menke et al. 2003). These are some of the social determinants of health responsible for the health inequalities and inequities in migrant women (International Organization for Migration 2021) that impact not only their health and well-being, but also their functioning capabilities and quality of life (Social Determinants of Health 2021).

Along with these challenges, a major social determinant of health faced by migrant women in host countries is communication problems (Rapa 2015). This not only inhibits women's interaction with the community, but also puts them in a more vulnerable position in terms of their health when this challenge is experienced during clinical encounters. This is further exacerbated by migrants' lack of knowledge on the structure and functionality of the healthcare system in host countries (Almeida et al. 2014). In such instances, migrants often resort to relatives or friends to translate communications with health providers and assist them in navigating the healthcare system (Phung et al. 2020). Despite its practicality, the use of relatives as interpreters is strongly discouraged (The Royal College of Obstetricians and Gynaecologists 2008) because the latter may not be able to accurately translate the conversation due to their lack of medical knowledge and the emotional connection they share with women (Cantwell et al. 2011). Moreover, women may fear sharing

personal concerns due to confidentiality issues (Rapa 2015), particularly in cases of domestic violence, where reliance on the husband or family members will undoubtedly inhibit disclosure of abuse (Phillimore 2015).

These limitations affect the delivery of effective maternity care (Cantwell et al. 2011) and may unintentionally threaten migrant women's health (Jonkers et al. 2011). Consequently, evidence suggests that women encountering language barriers during medical encounters should be provided with the service of professional interpreters to ensure effective two-way communication between women and health providers. Yet, despite their obvious need, migrant women are not always offered appropriate interpretation services. Several logistic factors may make the availability of interpreter facilities inconsistent. Some apparent barriers include the shortage of and inaccessible interpreters (WHO Regional Office for Europe 2018b), difficulties organizing a session (Bell et al. 2019) and contacting interpreters, non-attendance to appointments, and professionals failing to book for such services (Phillimore 2015). The provision of unreliable services is one of the reasons why migrant women report negative experiences when using the assistance of an interpreter (Crowther and Lau 2019). This may potentially explain why at times, when given the option, women object to using this service. Furthermore, research indicates that women distrust interpreters due to fear of breach in confidentiality (Mohale et al. 2017) and are sceptic about their ability or willingness to accurately translate the communication (Missal et al. 2016). These barriers limit migrant women from expressing their needs and concerns, which may be indicative of a potential obstetric complication (Phillimore 2015) and hinder understanding of the medical procedures being proposed and the risks involved (Hunter-Adams and Rother 2017). This often leads to non-attendance to medical services (Phung et al. 2020). The use of interpretive facilities is also adversely viewed by healthcare professionals since the involvement of interpreters interferes with the person-to-person communication process so essential to building trust and understanding. There may also be the feeling that what is said during the consultation is paraphrased.

3.1 Psychological Issues Faced by Migrant Women

The life-changing experience of becoming a mother is an emotionally and physically taxing experience for all childbearing women. Yet, amidst all the social adaptations and difficulties that migrant women experience in host countries, the absence of a family and social support system (Ny et al. 2007) makes the adjustment process of the transition to parenthood a hurdle. Migrant women report experiencing deep distress due to hopelessness (Fair et al. 2020) and isolation and, consequently, long for instrumental and emotional support (Rapa 2015), particularly from their own mother during critical moments of the childbearing period (Ny et al. 2007). Along with this, the literature recognizes that migrant women, particularly those seeking asylum, may also experience insecurity of personal identity (Straus et al. 2009), worries concerning the outcome of their asylum application, and fear of the possible impact that rejection may have on their children (Vervliet et al. 2014).

These social support challenges are not the only psychological and emotional issues faced by migrant mothers in the host countries. A multiple case study research reported that past traumatic experiences of both physical and psychological violence witnessed in their country of origin created emotional difficulties that continued to exacerbate the difficulties that migrant women faced during the perinatal period in host countries (Vervliet et al. 2014).

4 The Perinatal Outcomes of Migrant Women

Research indicates that the perinatal outcomes of migrant women are oftentimes worse than those observed for host country nationals (WHO Regional Office for Europe 2018a) despite their interaction with highly complex healthcare systems in most host countries (Bollini et al. 2009). In fact, there is ample evidence suggesting that during pregnancy, migrant women originating from underdeveloped countries are more likely to commence antenatal care later, have less visits during pregnancy (Råssjö et al. 2013), and experience more infections, hyperemesis gravidarum (Råssjö et al. 2013), pre-eclampsia (Urquia et al. 2017), oligohydramnios (Salim et al. 2012), diabetes (Bakken et al. 2015), anaemia (Råssjö et al. 2013), severe life-threatening complications (Urquia et al. 2017), and hospital admissions (Råssjö et al. 2013). Yet, despite these complications, they have fewer medical interventions during pregnancy (Malin and Gissler 2009). This negative trend extends to the intrapartum and post-partum period, wherein the risk of giving birth by caesarean section is higher (Savona-Ventura et al. 2009). Experiencing early post-partum haemorrhage (Salim et al. 2012) is likewise significantly higher for migrant populations. Moreover, when compared to host country nationals, migrant women who give birth by vaginal delivery are also more at risk of suffering from perineal tears (Michaan et al. 2014).

In addition to these adverse maternal outcomes, studies identified that infants born to migrant women have a significantly higher risk of being born premature (Savona-Ventura et al. 2009) or post-term (Bakken et al. 2015), with a low birth weight (Savona-Ventura et al. 2009), small for gestational age, and a low Apgar score (Bakken et al. 2015), and may require more admission to intensive care (Michaan et al. 2014). Besides these complications, the perinatal mortality rate is evidently higher in infants born to migrant women in various countries all over the globe (Råssjö et al. 2013).

4.1 Why Do Migrant Women Have Worse Perinatal Outcomes?

The consequences of these adverse perinatal outcomes are multifaceted and influenced by various personal, social, cultural, and institutional factors and social-health disparities that migrant women experience in host countries. Evidence clearly indicates that poor antenatal care attendance is one of the reasons contributing to the above-mentioned complications among migrant populations (Flenady et al. 2016).

Moreover, language difficulties (Kopin and Integra Foundation 2016), migrants' lack of knowledge regarding their entitlement for prenatal care (Schoevers et al. 2010), and differences that exist in maternity healthcare systems between originating and host countries may be additional factors inhibiting migrant women from accessing antenatal care. One must not overlook the possibility that women's cultural norms, their perception to maternity care, as well as the attitudes of healthcare staff may be other subtle but deeply ingrained factors limiting migrant women from seeking and availing themselves of the available prenatal services. Indeed, migrant women coming from countries where multiparity is perceived to be a cultural norm and therefore where pregnancy is considered to be a natural event in a woman's life may not perceive the need to seek antenatal care (Feldman 2013). Additionally, migrant women may be reluctant to access maternity care fearing that they may lose their job, have their children taken away, or be deported (Schoevers et al. 2010). Furthermore, migrant women originating from countries with a strikingly high maternal mortality rate and where healthcare is provided by low-skilled health providers lacking proper medical equipment and supplies (UNICEF 2019) may be unwilling to seek healthcare in a foreign land, having unfamiliar customs, language, and people.

In addition to poor antenatal care, Flenady et al. (2016) argued that being a migrant, in itself, doubles women's risk of experiencing a stillbirth. Moreover, certain socio-demographic characteristics observed predominantly in migrant populations, such as young age (Savona-Ventura et al. 2009), low educational level (Bakken et al. 2015), unemployment (Råssjö et al. 2013), low socio-economic status (Calderon-Margalit et al. 2015), and low BMI (Salim et al. 2012), have been linked to premature birth (Taylor and Rundle 2016) and its aftermath, particularly, neonatal mortality (Lassi et al. 2014). Likewise, migrant women's medical and obstetrics history plays another fundamental role in determining the outcomes of their pregnancy. In particular, this is evident in the high rate of sexually transmitted infections reported for migrant women, mainly genital herpes, syphilis (Salim et al. 2012), HIV, hepatitis B, and hepatitis C (Savona-Ventura et al. 2009). One must also acknowledge the impact that female genital mutilation or cutting has on women's intrapartum outcomes and post-partum recovery, especially considering that many migrant women are fleeing from countries with a high prevalence rate of this human right violation (World Health Organization 2018).

4.2 Satisfactory Perinatal Outcomes in Migrant Women

Migration flow is a rather dynamic process, typically influenced by the amendments in migration policies, and political systems, and the changes in legislation that occur through the years in host countries. Roman et al. (2010) argued that in addition to economic factors and educational opportunities, other political and social precarious factors such as poor governance, poverty, lack of basic health, human

trafficking, and human rights abuse have influenced migration from the Central and Eastern European region. Considering this diversity in the consequences leading to migration, it is intriguing to note that migrant women originating from this region, who are typically referred to as 'economic migrants', had better obstetric outcomes than host-country women despite having less antenatal check-ups (Martínez-García et al. 2012) and less prenatal ultrasound scans (Malin and Gissler 2009). In fact, research identified that this migrant population experienced fewer complications during pregnancy (Urquia et al. 2017) and had more spontaneous vaginal births (Walsh et al. 2011) and fewer caesarean sections when compared to host countries' nationals (Malin and Gissler 2009).

These pregnancy outcomes can be looked at from the perspective of the healthy migrant effect hypothesis. This hypothesis implies a health selection on migration. It suggests that since only healthy individuals succeed to migrate, these populations have better health status than host-country nationals (Moullan and Jusot 2014). In addition to this, migrants facing language difficulties and lacking familiarity with how the healthcare system operates in the host country often return home to seek medical treatment (Phung et al. 2020). Consequently, this migrant group may receive the recommended prenatal visits back home as reflected in their satisfactory perinatal outcomes.

5 Addressing the Problem

The movement of people impacts all aspects of society and all countries around the globe (United Nations 2020). It presents both challenges and opportunities to host countries (World Health Organization 2021). The healthcare system, particularly maternity healthcare, is one of the sectors that have been greatly affected by migration. Due to the inherently different perceptions towards life, health, and maternity care, the delivery of perinatal care becomes problematic when society becomes increasingly ethnic and culturally diverse (Small et al. 2002), especially when midwives and other healthcare providers practise within highly developed and organized maternity services (Savona-Ventura et al. 2009). Furthermore, the social determinants of health described earlier often lead to misunderstandings and missed antenatal appointments, which frustrate both pregnant women and practitioners (Kopin and Integra Foundation 2016). Additionally, the management of complicated obstetric cases poses challenges to health professionals whose sole purpose is to prevent morbidity and mortality and ensure safe high-quality care (Savona-Ventura et al. 2009).

In view of these burdens, the WHO (2018a) argued that the implementation of strong integration policies in host countries can safeguard migrant women against adverse perinatal outcomes. In fact, a systematic review by Bollini et al. (2009) found that after controlling for maternal age and parity, in countries having a strong integration policy, migrant women had an evidently reduced risk of preterm birth, low birth weight, perinatal mortality, and congenital malformations.

5.1 Supporting Migrants During the Transition to Parenthood: The Role of the Midwife

Midwives play a pivotal role in ensuring that migrant women are provided by the necessary support during the transition to parenthood. The International Confederation of Midwives (ICM) (Migrant and Refugee Women and Their Families 2017) emphasizes the importance of protecting and respecting the rights of migrant women. It advocates for the provision of culturally sensitive care and equity in accessing midwifery services to all childbearing women, in all countries, regardless of their situations, status, and the country from which they originated. The role of midwives goes beyond the physical aspect of the perinatal period. The social determinants of migrant women's health outlined throughout this chapter may potentially compete with antenatal care (WHO Regional Office for Europe 2018b), since the struggles brought about by resettlement in a new country, such as financial issues, may put pregnancy at the bottom list of priorities. Hence, the WHO (2018b) proposes the provision of a complete maternity care package for migrant women. This model of care, however, needs to be addressed from a multidisciplinary perspective in collaboration with governmental health and social care agencies and communities.

A Cochrane review in 2016, involving more than 17,000 women, found that women had better perinatal outcomes when provided by continuity of midwifery care in contrast to those being provided by fragmented models of maternity care (Sandall et al. 2016). Research also indicates that not only migrant women are dissatisfied by the involvement of multiple health providers during pregnancy (Crowther and Lau 2019), but also the fragmented care models affected their prenatal care attendance (Phillimore 2015), as it hindered the establishment of a trustful relationship (Straus et al. 2009) and women's ability to express their needs (Crowther and Lau 2019). This is further exacerbated in the presence of communication difficulties, which continues to delay the acquisition of care migrant women may require. In view of the advantages associated with continuity of maternity care, the implementation of the continuity of midwifery models of care for migrant populations should be on the agenda of midwifery organizations and global associations for maternal and child health and well-being.

Struggles with communication are one of the major difficulties faced by migrant women, midwives, and other health providers during maternity care encounters. Literature suggests that the initial feelings of embarrassment and vulnerability felt by migrant women are counterbalanced by feelings of safety especially during childbirth when healthcare providers adapt to women's communication needs (Crowther and Lau 2019). Consequently, Hayes et al. (2011) suggest that women's requirements for interpretation services should be determined at an early stage during the pregnancy so that the use of these facilities would be organized for subsequent appointments up until childbirth. This is also in line with the ICM (Migrant and Refugee Women and Their Families 2017) position, which supports the use of translators when necessary. Healthcare providers caring for migrant mothers should endeavour to provide relevant literature in the women's vernacular language

outlining the services available together with an outline plan of routine antenatal care generally provided. This literature resource should include information on the range of antenatal, intrapartum, and post-partum services available. In addition, information should be provided in respect to other available social and support services.

Midwives' attitudes are significant in shaping migrant women's perinatal experiences. The ICM (Migrant and Refugee Women and Their Families 2017) strongly suggests midwives to provide humanized care for migrant women. A large body of literature suggests that migrant women value health providers' respect (Mohale et al. 2017) and culturally sensitive care (Carolan and Cassar 2010) as this leads to a more meaningful perinatal experience (Crowther and Lau 2019). Moreover, professionals' presence and emotional support (Missal et al. 2016), explanations (Siad et al. 2018), advice, and reassurance (Glavin and Sæteren 2016) enable the establishment of a trusting relationship (Missal et al. 2016), which makes women feel safe especially during childbirth (Crowther and Lau 2019). These positive experiences signify the importance of the midwife's role in providing culturally competent continuity of maternity care (Fair et al. 2020).

5.2 Future Directions

The disparity in perinatal outcomes observed in migrant populations raises several questions and concerns about the quality of maternity care being offered to migrant women in host countries. In view of this, it is necessary that further studies are undertaken from the clinical perspective to observe the quality and effectiveness of the current maternity services. Studies are also needed to identify whether the current maternity services are actually being reached by all migrant women and, if not, identify other more effective models of care particularly in the community. Moreover, it is significant to conduct research to determine how the delivery of perinatal care can be improved to address migrant women's needs and promote attendance. Future research also needs to address service providers by exploring the viewpoints, experiences, and challenges that midwives and maternity healthcare professionals encounter when caring for migrant women.

In addition to these recommendations, it would be of great value to gather disaggregated data such as migrants' year of arrival in the host country; their socioeconomic, behavioural, and environmental determinants of health; and inputting this data into pre-existing health databases (WHO Regional Office for Europe 2020). This will enable researchers to conduct in-depth retrospective analysis on migrant women's health, pregnancy outcomes, and risk factors predisposing women and infants to certain complications. Furthermore, this will ultimately inform policymakers to ensure that the maternity healthcare systems currently in place are inclusive to all migrant women.

Although this chapter provided a brief overview of the social determinants of health faced by migrant women in host countries, the diversity in migrant groups and integration policies in host countries merits investigation of the risk factors that

place certain migrants at increased risk of adverse complications during pregnancy. Moreover, in-depth qualitative studies need to be carried out to understand migrant women's views towards maternity care and their experiences of pregnancy and childbirth in host countries. Yet, it is imperative that conclusions drawn from these studies should bear in mind the socio-cultural diversity in migrant populations, especially if the study sample is significantly heterogenous in terms of nationality and socio-cultural background.

6 Conclusion

Migration is far from a recent phenomenon. The movement of people across international borders has been part and parcel of human history and will remain evident throughout the decades which follow. Although migration presents challenges to the health, social, and economic sectors, migration can provide a valuable contribution to the development of both originating and host countries when migrants are supported by the appropriate policies (United Nations 2020).

This chapter introduced some of the social aspects brought about by migration. It centred its focus on the vulnerabilities associated with being a woman and a migrant and outlined how the social determinants of migrant women's health brought about by migration can have a major impact on their perinatal outcomes. The significance of the midwife's role in supporting migrant women during the transition to parenthood has been emphasized, particularly in ensuring that all migrants have access to person-centred, culturally sensitive continuity of maternity care. In conclusion, future directions for the improvement of maternity care services have been outlined and recommendations for additional research were put forward.

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