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Pregnancy in women born abroad

EDITORIAL

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Immigrant women are at higher risk of pre-, intra- and post-natal complications.

Caesarean section is a standard surgical procedure throughout the world, but the frequency varies considerably between countries and regions. Caesarean section performed without a clear medical indication can be more harmful than beneficial for the mother and child. The World Health Organization has concluded that the caesarean section rate is unnecessarily high in many middle- and high-income countries, while many low-income countries have insufficient access to the procedure (1). A caesarean section should be offered to pregnant women who need it, rather than striving to achieve a set rate (2).

A study on caesarean sections among foreign-born women in Norway by Ottesen et al. has now been published in the Journal of the Norwegian Medical Association (3). The current caesarean rate in Norway is low compared with other high-income countries, and the health outcomes for mother and child are among the best in the world. As summarised by Ottesen et al., previous studies have shown that pregnant women in Norway who were born in Sub-Saharan Africa are at a particularly high risk of caesarean section, premature birth or stillbirth. The reasons for this are still largely unknown, as neither maternal, obstetric nor socio-economic factors can fully explain the differences.

> ***«Pregnant immigrant women represent a heterogeneous group for whom pregnancy outcomes also vary»***

The study in question covered births in Norway in the period 2008–17, which were linked to public data on the mothers' education (3). The mother's place of birth was registered in four categories, where women born in Norway, around 73 %, constituted the reference group. Women born outside Norway were divided into the groups Sub-Saharan Africa, other low- and middle-income countries, and other high-income countries. The analyses showed that the impact of level of education differed between foreign-born women and Norwegian-born women. Women born in low-income countries, especially countries in Sub-Saharan Africa, were more likely to have an emergency caesarean section regardless of their level of education, even when known risk factors were taken into account (3).

An increasingly large proportion of children in Norway are being born to immigrant women (4). In 2021, there were 56,060 live births in Norway, and around a quarter of these were by women registered as immigrants (5, 6). The majority of these mothers were born in Europe (36 %) or Asia (32 %), while women born in Africa made up the third largest group (17 %). In terms of countries, women from Poland and Somalia had the most births among immigrants (4). Fifteen years ago, only 15 % of women who gave birth were registered as immigrants in Norway (4). However, the fertility rate in this group has not increased; on the contrary, it has decreased in most immigrant groups. Women who immigrated from Africa still have a significantly higher fertility rate than the rest of the population (4).

Pregnant immigrant women represent a heterogeneous group for whom pregnancy outcomes also vary. The incidence of gestational diabetes in Norway is higher for women born in Asia and Africa than for those born in Norway, which is reflected in the guidelines for screening for gestational diabetes (7). Certain groups of immigrant women have an increased risk of premature birth, but this is not currently factored into systematic risk assessments. Gestational hypertension is more frequent among women born in Norway than those born abroad (8).

Immigrant women are at higher risk of pre-, intra- and post-natal complications, as pinpointed in a report by the Norwegian Directorate of Health from 2020 (9). The Directorate points to several factors that can increase the risk of such complications during pregnancy and childbirth, such as language barriers, different understandings and cultural practices related to pregnancy and childbirth, poor health literacy and lack of familiarity with the Norwegian health service, trauma and psychological problems, poor self-care and insufficient networks and social support. The report emphasises that a qualified interpreter should be used where necessary. However, researchers behind a recently published literature review on prenatal health among immigrant women in Norway found little research on the connection between language skills, use of interpreting services and adverse pregnancy outcomes (10). They quite rightly call for intervention studies and qualitative studies to shed more light on the experiences of families with an immigrant background.

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