GUELPH WELLINGTON NEWCOMER MATERNITY EXPERIENCES STUDY

April 2023

Chitegetse Rutihinda, MSc., BBA

Table of Content

Introduction

The term "Newcomer" refers to someone who has been in Canada for a period of fewer than 5 years. A Newcomer can be an immigrant or a refugee who moved from their country of origin to another country (Ottawa Public Health, 2020). For the purposes of our report, the definition is slightly broader and may also include women who have been in the country longer. In Canada, 1 in 5 people (22%) were born outside of the country (Ottawa Public Health, 2020). In 2021, Canada welcomed 401,000 new permanent residents, the most Newcomers in any year in Canadian history, which in turn increased the number of births in 2021 (Statistics Canada, 2022a). According to Statistics Canada, 31% to 33% of children born in 2017 - 2021 had a mother who was born outside of Canada (Statistics Canada, 2022b). Newcomers continue to make large contributions to Canada's birth rate, economic growth and bring a wealth of experience, knowledge, and cultural diversity. As a result, it is imperative that our healthcare system put Newcomer women's health at the forefront of Canadian healthcare discussions, especially regarding the improvement of policies, services, and consequently, their maternity experiences.

A positive maternity experience results from adopting respectful maternity care, which yields good maternity outcomes. Respectful maternity care (RMC) is important because of its ethical, psychological, social, and cultural implications in childbirth. Although there is no specific definition of the term, it is thought to be compassionate and woman-centred care that is considered a fundamental human right that surrounds the respect of women's beliefs, autonomy, dignity, feelings, choices, and preferences, and the right to companionship during maternity care (Hajizadeh et al., 2020; Bangal et al., 2020).

In order to ensure a positive maternity experience, it is important to adopt the concept of "Culturally Appropriate Care" in maternity healthcare (some older literature uses the term Culturally Competent Care, but we will use the more modern phrasing in this report). Culturally Competent [Appropriate] Care is care that is aware of the differences individuals have due to their heritage, sexual orientation, socioeconomic situation, ethnicity, and cultural background (Meleis, 1999). These differences inform healthcare practitioners about people's responses to care and the processes of caring for them. Culturally Competent [Appropriate] Healthcare provides an explanatory system focused on cultural diversity, access and critical use of medical information and is influenced by language and communication that is patient-specific (Meleis, 1999).

This report will highlight and discuss commonly prevailing themes that affect a positive maternity experience for Newcomer women, present a summary of findings from Focus Group discussions held with both Maternity service professionals and Service Users in Guelph-Wellington County and provide recommendations that will help improve the provision of Culturally Appropriate Care for Newcomer maternity patients in Guelph-Wellington County. This report also includes a comprehensive list of maternity services available to Newcomer women and features current best practices and currently existing barriers that limit the provision of Culturally Appropriate Care.

Demographics

According to the 2021 Census, 23.8% of the population, 33,780 out of 141,840 people, were foreign-born immigrants living in Guelph. 5,855 of these immigrants (17% of the population) came between 2016 and 2021 (Statistics Canada, 2022d). The top three places of birth among immigrants living in Guelph were India, the United Kingdom, and the Philippines and the top recent immigrants were from India, Eritrea, and the Philippines.

Table 1:

Top places of birth of recent immigrants, Guelph (City), 2016 and 2021

Place of Birth	2016 - Number	2016 - %	2016 - Rank	2021 - Number	2021 - %	2021 - Rank
Recent immigrants	**3,580**	**100**		**5,855**	**100**	
India	460	12.8	2	1140	19.5	1
Eritrea	185	5.2	4	1030	17.6	2
Philippines	790	22.1	1	545	9.3	3
Syria	70	2	10	410	7	4
China	365	10.2	3	195	3.3	5
Viet Nam	155	4.3	5	195	3.3	5
Pakistan	130	3.6	6	180	3.1	7
Nigeria	40	1.1	14	135	2.3	8
Iraq	30	0.8	23	130	2.2	9
United States of America	80	2.2	9	125	2.1	10

Source : Statistics Canada, 2021 Census of Population.

In Wellington County, 11.4% of the population which is 10,980 out of 96,245 people were foreign-born immigrants according to the 2021 Census. 6100 immigrants came between 2016 and 2021 representing 5.6% of the immigrant population (Statistics Canada, 2022c). The top three places of birth among immigrants in 2021 were the United Kingdom, India, and the Philippines.

Table 2:

Top places of birth of recent immigrants, Wellington County, 2016 and 2021

Place of Birth	2016 - Number	2016 - %	2016 - Rank	2021 - Number	2021 - %	2021 - Rank
Recent immigrants	**445**	**100**		**610**	**100**	
United Kington	145	32.6%	1	150	24.6%	1
India	35	7.9%	4	130	21.3%	2
Philippines	55	12.4%	2	80	13.1%	3
United States of America	25	5.6%	5	65	10.7%	4
Syria	50	11.2%	3	60	9.8%	5

Source: Statistics Canada, 2021 Census of Population.

Immigration is important in Canada to sustain population growth and contribute to increasing the fertility rate. 184,500 immigrants were admitted into Canada in 2020, roughly 45% fewer immigrants than in 2019 resulting in a decrease in births in 2020. In contrast, the country welcomed 401,000 new permanent residents in 2021, the most Newcomers in any year in Canadian history, which in turn increased the number of births in 2021 (Statistics Canada, 2022a). Births to immigrant mothers surpassed 30% of all births for the first time in 2016. The share of births to immigrants reached more than 20% in most provinces (J. B. Lee et al., 2020). According to Statistics Canada, 31% to 33% of children born in 2017 - 2021 had a mother who was born outside of Canada (Statistics Canada, 2022b).

Table 3:

Live births, birth weight indicators, by characteristics of the mother and child

Characteristics of mother and child	2017	2018	2019	2020	2021
Total, birthplace of mother	377,627	374,617	372,978	360,552	367,684
Birthplace of mother, Canada	254,564	248,958	244,788	235,108	242,982
Birthplace of mother, outside Canada	116,869	119,770	122,804	119,810	118,508
Birthplace of mother, not stated	6,194	5,889	5,386	5,634	6,194
Percentage	31%	32%	33%	33%	32%

Source: Statistics Canada, Canadian Vital Statistics - Birth database (CVSB).

Taking into consideration the increase in new immigrants to Guelph and Wellington County and the percentage of children born to immigrant mothers in Canada, the concept of respectful maternity care is crucial to ensuring a positive maternity experience. Given the contribution to the overall birthrate, immigrants (and their needs) should not be ignored, and it is our healthcare system's obligation to respond and evolve to meet the needs of our locality's changing population.

Research Objectives

The purpose of the Newcomer Maternity Experiences Study is to understand the range of experiences and intersectional influences that shape the Newcomer women's maternity experience in Guelph and Wellington County.

Commonly prevailing themes that affect a positive maternity experience for Newcomer women are:

- Access to health care services
- Navigation of the health care system
- Pregnancy and birth outcomes
- Understanding healthcare information

- Access to antenatal classes
- Barriers such as language, transport, childcare, and financial constraints
- Social support
- Postpartum health, care, and mental health
- Breastfeeding support and experiences

An understanding of these topics will help to positively influence future directions for maternity services delivery to Newcomer women and help to inform the current evidence base for addressing inequities in care.

Methodology

A literature review of prevailing themes, an environmental scan of existing maternity services, and qualitative interviews at the organizational and individual levels were conducted as part of this research.

Peer-reviewed articles and journals for the literature review were obtained through the PubMed Database and supplemented by additional articles from the Web of Science Database. A search for 'immigrant maternity experience' was conducted and papers with recurring or relevant themes based on the research objectives were reviewed and included.

An environmental scan was performed through a web search of maternity services in Guelph and Wellington County, followed by services in Ontario and Canada, and was expanded to worldwide and available online resources. A list of relevant information was compiled to be used as a reference guide for service providers and related institutions that provide information to Newcomer mothers and mothers-to-be (See Appendix A).

Interview participants were invited through a poster sent to service provider networks for professionals (see Appendix B) and a doodle poll was created to set two interview meetings for a majority availability. Service User interview participants were invited through a poster with event dates and detail to sign-up through Eventbrite (see Appendix C). These posters were translated into French, Spanish, Arabic, Nepali, Tigrinya and Ukrainian (see Appendix C). These posters were also distributed through local networks to seek participation. Two focus group interviews were conducted for professionals and three questionnaire response interviews, while three focus group interviews were conducted for Service Users. The services of an interpreter through the "TIPS" Translation & Interpretation Service at Immigrant Services Guelph Wellington was used during the Service User interview as requested. All interviews were conducted on Zoom and were approximately 90 minutes long. See Appendix D for interview questions. Information collected was coded on NVivo using the predetermined codes determined by the research objectives and the literature review, and findings were reported below.

Limitations

This research was limited to a small group of participants that do not necessarily represent the thoughts and experiences of the entire Newcomer population and maternity service professionals in Guelph and Wellington County. Although the majority of the Service User participants represent a population experiencing the highest need for appropriate maternity care, there is room for an expansion of this study or follow-up study to other specific demographic groups as noted in the place of birth lists in Tables 1&2.

Literature Review

Access to Care

Newcomer women's maternity service experiences are closely related to social (both professional and informal) support, communication, socio-economic barriers, healthcare organizational environment, knowledge about maternity services and healthcare, cultural beliefs and practices, and different expectations between healthcare staff and immigrant women (Higginbottom et al., 2014).

The societal positioning of Newcomer women is a major factor hindering the obtaining of high-quality maternity health care (Higginbottom et al., 2014). Navigating a new healthcare system in a new country makes it difficult for Newcomer women to be aware of all maternity services available to them (Marie et al., 2019). It is the role of healthcare providers to ensure their maternity patients understand their care options, the purpose of antenatal appointments and their importance to the mother's health and the health of their baby.

Existing Barriers to Care

Access to maternity healthcare is influenced by contextual and personal factors such as communication, socio-economic barriers, and the healthcare system (Higginbottom et al., 2014). Healthcare providers expected immigrant women to express themselves in and be able to understand English but, immigrant women described struggles with conveying health concerns and understanding technical medical information provided to them or making appropriate choices for the care they need (Higginbottom et al., 2014). The following are examples of different barriers that limit access to culturally appropriate care:

Culture

Newcomer women come from diverse backgrounds, there are different sets of cultural knowledge, religious belief and traditions which vary from country to country and at times differ from the maternity healthcare practises in Canada (Higginbottom et al., 2014). Some women feel vulnerable in their encounters with healthcare staff, because of how negatively some cultural issues like Female Genital Cutting (FGC) are perceived outside of their home countries (Higginbottom et al., 2014) or find it more difficult to

discuss female health concerns with male practitioners (Seo et al., 2018). Consequentially, some women reported avoiding antenatal care to avoid discussing such issues outside their homes and often felt dissatisfied with both clinical practice and quality of care because their needs were frequently unmet during pregnancy and birth (Higginbottom et al., 2014; Seo et al., 2018).

Adversely, culture can influence Newcomer women's access to healthcare by influencing their interpretations and perceptions of symptoms, decision-making, and help-seeking behaviour (Seo et al., 2018). Many Newcomer women fear the stigma attached to mental illness and its perception within both the family and ethnic community. Culture also prescribes acceptable norms for behaviours associated with gender roles this includes women's engagement in employment outside the home, caregiving, and the reaction to domestic violence (Urindwanayo, 2018).

Language Barriers

Communication difficulties extended beyond matters of language competency and extend to non-verbal communication and its relation to shared meaning as well as cultural factors which affect open communication. People from diverse sociocultural backgrounds might understand words, concepts and their consequences differently based on their perceptions of health, well-being, and service provision (Higginbottom et al., 2015). Labour and birth are vulnerable and stressful times so deep communication between women and their healthcare providers is needed (Higginbottom et al., 2015). Maternity care in one's own language is the difference between asking simple questions in English and asking deeper detailed questions in one's own language (T.-Y. Lee et al., 2014).

Culturally Appropriate Care

Newcomer women think it is important to share a common language with healthcare staff and an understanding of the cultural context (Higginbottom et al., 2014; T.-Y. Lee et al., 2014). Several women complain about the cultural insensitivity of intrapartum and postpartum hospital maternity care. For example, in Chinese tradition, a woman should not touch anything cold after childbirth, but the nurses applied ice packs and provided cold beverages to the new mothers after childbirth (T.-Y. Lee et al., 2014).

Misinformation among Ethnic Communities

Misinformation in ethnic communities and cultural customs can also lead to barriers to providing proper maternity care. For example, Vietnamese immigrant women in Canada demonstrated a low rate of breastfeeding. Their decision to bottle-feed was because of conflicts between Vietnamese cultural practices and their new life in Canada. The women understood that breast milk was of better quality than baby formula, but they felt that they could not produce fresh milk in their current Canadian environment. This is because living in Canada did not allow specific family members to conduct postnatal traditional rituals hence jeopardizing mothers' perceived health and the quality of their milk (Higginbottom et al., 2014).

Transportation, Childcare and Financial constraints

Other barriers such as transport, childcare, and financial constraints also affect the quality of maternity care for Newcomer women. Pregnant Newcomer women reported difficulties receiving support from their husbands because of already-existing financial pressures that make their husbands work multiple jobs or long hours (Higginbottom et al., 2014). They also described difficulties when wanting to seek help at maternity healthcare facilities because of a lack of available childcare (Higginbottom et al., 2014).

Postpartum Health, Care, and Mental Health

The literature shows a high number of depression cases among immigrant women, and mental health problems are higher among visible minorities than their Caucasian counterparts. The highest antenatal and postpartum depression recorded is 42% and 13%, respectively (Urindwanayo, 2018). Lack of informal supports such as family and friends, barriers to formal supports such as community services and supports, and limited financial resources are factors that may contribute to post-partum depression among Newcomer women. There are also oftentimes conflicts within the women's cultural practices that prevent their willingness to seek help outside of their family for fear of being alienated or breaking family harmony (Higginbottom et al., 2014; Stirling Cameron et al., 2022).

There are new studies depicting the occurrence of depression during pregnancy among Newcomer women. The prevalence of antenatal depressive symptoms was highest for recent immigrants of 5 years or less at (25.3–30.8%) compared to long-term immigrants (16.9–19.2%) and Canadian-born women (11.7–13.8%) (Vaillancourt et al., 2022). Poor social support among immigrant women, particularly among women who have recently immigrated and have not had the time to rebuild an extensive social network is one of the highest risk factors (Vaillancourt et al., 2022). Knowledge of these risk factors may help improve antenatal screening and inform the development of tailored solutions to meet the mental health needs of immigrant women during the perinatal period (Vaillancourt et al., 2022).

Pregnancy and Birth Outcomes

Immigrant women may be at greater risk for negative birth outcomes resulting in caesarean childbirth and low birth weight due to less-than-optimal maternity care (Higginbottom et al., 2014). Similar trends are seen in Europe, where some groups of non-Western immigrant women specifically, have an increased risk of stillbirth and infant mortality (Johnsen et al., 2021). The healthcare structures and power relationships between midwives and non-Western immigrant women affected mutual interactions. This is seen as a contributing factor for deterring immigrant women's use of antenatal services that reduce the risk of these negative birth outcomes. Additional resources are needed to help support service providers such as midwives' task loads and time

resources if they are to have the necessary capacity to adapt their care structure to immigrant women's individual needs (Johnsen et al., 2021).

Findings

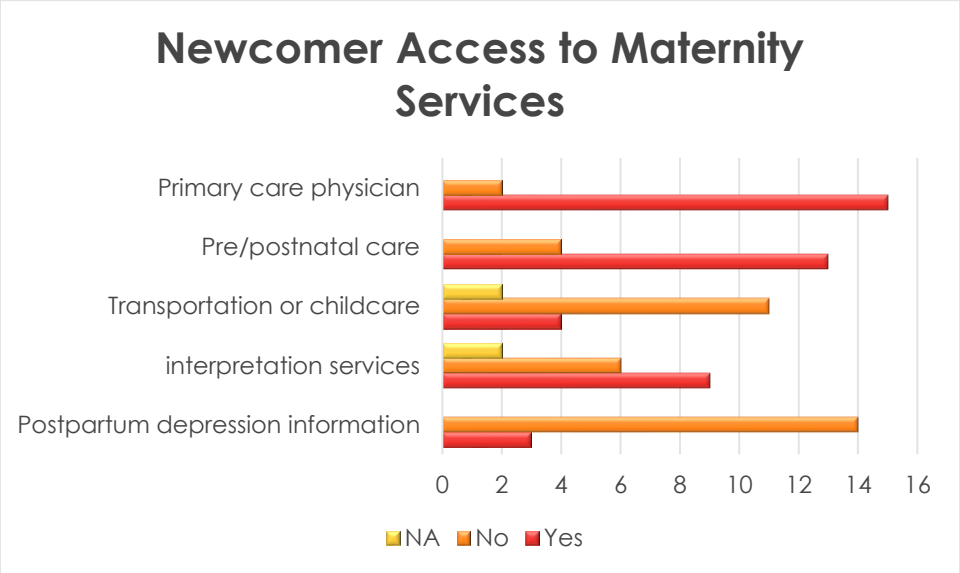
Newcomer Women's Maternity Experience

Most of the women who participated in the Focus Groups had a similar maternity experience where they first consulted their family doctor, who then directed them to a specialist or midwife through a local clinic and delivered their baby at the Guelph General Hospital. The women had regular monthly check-ups with increasing frequency as they got closer to their due dates. The ones who had midwives were very pleased with how helpful the midwives were and how supported they felt throughout their pregnancy and even after delivery as one mentioned, "*…yes, they are really helpful especially when it comes to guidance on how to use car seats, how to hold the baby, how to care for the baby, I found it really helpful, with clear answers to questions*".

One woman who immigrated to Canada when she was 8 months pregnant and managed to get connected to a midwife said, "*…good thing I went to Immigrant Service's office, Newcomers start registration through Immigrant Service's office… so they referred me to the [Community Centre] and gave me all the information like when to go to general hospital and the [midwife] was there with me during the delivery. Even when the labour started at home, she told me to call her first to see how I was progressing. She visited me often and used to come with toys for my other kids… yes, I felt well supported, especially by the midwife, she was very supportive*".

The results of the Service User focus groups findings about whether participating Newcomer women were able to access essential maternity services in Guelph were quantified in Exhibit 1 and discussed below:

Exhibit 1:



Primary Care Physician

15 out of 17 participants had a family doctor, some with a combination of a family doctor and a midwife while others were referred to a specialist depending on their circumstances. The two who didn't have family doctors were either seen regularly at Guelph General Hospital or by their midwife. According to the maternity service providers we interviewed there is no fast track to gaining access to a family doctor for new mothers except through community centres and walk-in clinics as access to a family doctor is a problem in and of itself for everyone in Southwestern Ontario (Reid et al., 2009). Sometimes service providers are aware of doctors accepting new clients but there are language barriers to accessing the clinics and registering as a new patient. Midwives however can support new families to navigate the healthcare system, providing referrals and accessing an OBGYN for health concerns for up to 6-8 weeks. The issue is that very few new families get involved with the midwifery network in the first place.

Pre/Post-natal Care

13 of the 17 participants had access to prenatal and postnatal classes as they were connected to these programs through their community centre and clinic, and some accessed the services one-on-one through their midwives. Some of the programs the participants attended were the EarlyON program, the Pregnancy to Parenting (P2P) program, the Beginnings Family Services, and the Guelph General Hospital for postnatal information. Although there were some barriers as the resources and literature were only available in English. As one woman noted, "*The program gave us enough information about women's health, breastfeeding, nutrition, and even post-natal information about how to take care of babies and what to feed them. I went to the programs both in person and online services, in addition to that, there were vitamins for the woman and the baby, also each visit they provided a support of $30 to encourage women to come to the services*". However, these programs had a limited number of spots available and limited business hours making them inaccessible to working women.

The remaining 4 participants were not aware of such programs and thought the programs would have been very helpful had they known about them. One participant shared that they "*didn't get any information, but it is good to get information about nutrition and how to look after yourself during pregnancy. It would be good if they could let mums know where they can get help before they leave the hospital*".

The midwifery group of professionals directly provides any pre-and post-natal care for expecting mothers "*Breastfeeding is something that often needs support, with tongue-tie for example, may be covered by OHIP and babies get OHIP quickly… our clients are in a privileged place in some ways regarding this…*". Whereas other professional groups have indirect or informal ways of providing or connecting expecting mothers to these services if they are not part of their core programming as one mentioned, "*Connections to [Community Centres programs] on Mondays and answer infant care questions and provide breastfeeding support. We regularly go to the [Community Centre], to answer*

questions and give support. These are not formalized programs, we are able to adapt depending on need, but not a core part of our role", another said they, *"…can also find and provide information for primary caregivers, lactation consultants, other supports for breastfeeding, post-partum difficulties and connect with groups and other healthcare practitioners…".*

Transportation and Childcare

When it came to transportation most of the participants were taken to appointments by their husbands and even brought their other kids with them to appointments. Some participants called 911 when they were in labour and left their children with family members or friends. Many had never heard of the possibility of support for transportation or childcare and felt *"on their own with everything",* as one mentioned, *"…not only are you in pain but also thinking about the kids at home and a new baby coming creates a lot of stress and pain".*

4 out of the 17 participants noticed that there was childcare when they attended prenatal classes at their local Community Centre. One participant was able to find childcare through a conversation with the in-take receptionist at their local clinic saying, *"…I asked them if I could fill out a form because I need childcare support. I was able to fill out a form and was able to get childcare support for my other children, this was a great experience. However, many mums don't know that there are even forms to fill out, this should be open for everyone, it is good for all mums to have rest…* and know they are *able to get support for their children for 3 or 4 days".*

According to the service professionals, some programs are able to provide bus tickets to help Newcomer women who require them to get to appointments, and some organizations provide information about how to access childcare but don't necessarily provide childcare for other kids when mothers need to attend appointments or go into the hospital for delivery.

Interpretation and Translation

9 out of 17 women accessed interpretation services during their maternity as one participant mentioned, *"…for translation yes they ask you, especially in the hospital they ask if you need a translator, didn't see documents that are in Tigrinya, the development stages of a baby, I didn't see a translation of that, but [they] asked if I need an interpreter"* and another, *"in my opinion, it is very important to have the interpreter, especially with doctors to understand what they are saying, so its good to keep up with [the service]".*

2 out of 17 were English speakers and did not need interpretation but the remaining 6 didn't know about these services and used friends instead or were afraid to ask for language support, like two participants said, *"…if you ask for one, you have a right and they do provide language support, but if you don't ask you don't get it [interpreter]", "it was a very stressful experience, because there was no language interpreter available there... if I don't know how to say what pain I was feeling, then it is hard to get the support."*

Midwifery services are provided in English and French, and they use translation & interpretation services often, either one-on-one or over the phone with ISGW interpreters, depending on the client's preference. They also use translation & interpretation services at Guelph General Hospital and during covid, they used the services over the phone or online. When there are no interpreters available, Google Translate is sometimes used or family members act as interpreters. One professional stated, "*Unfortunately- translations cannot be done in our Pregnancy Postpartum Mood Disorder (PPMD) groups- which is a problem for Newcomer moms who do not speak English*".

At the Guelph Community Health Centre, "*…we support clients with Arabic and Tigrinya primarily, if asked we can get others, but classes are 100% Tigrinya, so we have a translator on staff. Presentations are in English, but the translator is present in class… we don't [have one] outside of the class setting, on occasion we use interpreters with medical appointments set up but that's an exception. Our breastfeeding program is a peer support program, so we do have a number of peers who speak different languages depending on peers and requests, previously we had Arabic, French and Spanish*". For Public Health Nurses translation & interpretation services are used "*when it is indicated that a family needs an interpreter, and we have access interpreters for in-home visits*".

For La Leche League Canada "*part of our work is doing the translation, another thing we have recently done is our leaders across Canada have to renew their status each year, we started asking what languages our leaders speak so that we can reach out to another leader somewhere in Canada that can help in their own language so we can have that in our database to make it easy to do a search and find those resources…we currently have material translated into simplified Chinese, Punjabi, Farsi, Urdu, Somali, Vietnamese, Arabic, are the top 10 languages*".

A representative from the Eritrean Community in Guelph mentioned that "*yes, it is the number 1 problem and still unsolved, being a Newcomer in new culture all these affect the mum's health. For many young women the number 1 issue is also language when going to the family doctor they cannot say exactly what they feel even with an interpreter, sometimes they feel like they do not want to expose everything about their health which causes more stress. Most women don't have a family doctor in their language, and some Newcomers came through Sudan and speak a little Arabic, if a family doctor from another culture speaks Arabic, a lot of people come to one family doctor, and the family doctor can't support everyone.*"

Postpartum Depression

13 out of the 17 women were never made aware of any postpartum depression support nor knew how to access these services. Most women said they did not see depression as a problem to them as they have many friends and family from their country who are their neighbours and help relieve their stresses. One or two mentioned that they did experience this or knew someone who experienced it but didn't know whom to reach out to about it, "*but she said she was experiencing this kind of stress during pregnancy*

since the doctor mentioned to her that the baby was unhealthy, so she was stressed but was unable to get support, I didn't know where to send her for mental health support, it is a huge issue for women to get such support". One participant with a midwife mentioned, "*she asked if I was getting enough sleep or if I get tired or feel emotional, around 10 minutes once a week, every 2-3 weeks I got help from the midwife. I didn't know that we could get depressed after giving birth, but they kept asking and gave me a lot of advice so appreciate them!*" another said, "*the public health nurse was here yesterday, talking about post-partum depression, if anything needs to be discussed, they can lend an ear*". One woman had this information after her caesarean birth, "*the midwife told me that if this does not stop, have to go to a family doctor and get a check-up. I didn't accept this mental health issue, we have our own beliefs, we say if we have mental problems, we don't accept it, and we don't want that problem to be ours but this information has to be everywhere for the mums, that this is normal, that mums could experience these kinds of problems, for example at the family doctor and the [Community Centre] they can give this information*".

Midwives can refer clients to mental health professionals and connect them with support groups, practitioners and mental health supports if they notice signs and symptoms, they will help get them in touch with community supports, but there is a need for deeper observations and understanding of the Newcomer needs. The Pregnancy Postpartum Mood Disorder [PPMD] group at the Guelph Community Health Centre is free, online and in-person, but is always full. They try to triage through those who need support right away, but the need is greater than the services that are available.

As for public nurses, "*before covid anyone screened by the hospital post-partum… anyone who had that 2 or more score, with high risk, triage would call the patient, and made two attempts to reach out over the phone and if they failed to reach them a letter is sent out, [there is an] opportunity to self-refer if outside of that period. Pre covid anyone that was at risk was offered a home visit. Since covid we haven't returned to those families… hoping to get back to providing a post-partum mood disorder group*".

Positive Experiences

Women with positive experiences describe healthcare professionals as caring, confidential, and openly communicative in meeting their medical, emotional, psychological, and social needs (Marie et al., 2019). The Focus group participants who had a midwife felt they had a very good experience because they felt support every step of the way with everything especially because they went to their homes even after delivery, helped with breastfeeding, nutrition and information about how to take care of the baby and helped with referral and sometimes even childcare if the women had to go into the hospital for appointments, "*all of the midwives look like they're mothers in the hospital, 3 different midwives but they are like [having] family in the hospital!*", and "*I was just Newcomer just one month, used to visit me every week, don't know for how long, she used to come with toys for the other kids… yes well supported, especially from the midwife, she was very supportive*".

The women also said the services at the Guelph General Hospital were good as the hospital had specific services for Newcomers in Guelph on how to handle the baby, breastfeed and arranged follow-up appointments, "*you don't need to walk, just press the bell button to call the nurse… I really appreciate that... they came fast whenever you called, I didn't have a hard time, they were always with me, so thanks to the hospital and everybody working there*".

The participants who attended the Pregnancy to Parenting (P2P) program and EarlyON program had only good things to say about it, "*when my due date [came] closer, I got information and support from them with all pregnancy-related information, I also [received] diapers, baby clothes and other things to prepare for arrival of the baby, when my due date came I went to Guelph General Hospital with the items I received*".

Maternity service professionals believe that positive maternity experiences are when pregnant people report being heard, involved in, or take the lead in the decision-making process, feel supported and understand what is happening. A service that meets physical, emotional, and religious needs and ideas of one's expectations, and can be different for different people and cultures. What determines a good experience is good information and education surrounding maternity care, having supportive, caring, and understanding staff in and outside the hospital in addition to having culturally appropriate and accessible language. As a service provider said, "…*this is one that is close to my heart, women-centred approach to health care is probably the biggest thing, also having supports within your own family unit, friends, and community supports, and access to information, that's the biggest thing for a positive birth, parenting, and pregnancy outcomes*".

Negative Experiences

Newcomer women with negative views perceive health professionals as rude, discriminatory, and insensitive to their cultural and social needs. These women, therefore, avoided continuously utilizing maternity care (Marie et al., 2019). According to the Service User Focus group participants, their negative maternity experiences were due to medical complications that they did not properly understand coupled with culture shock when they were told they had to leave the hospital right after delivery, and lack of transportation during winter. Some felt they or their husbands were judged for not participating in household duties as they come from a patriarchal culture where men are not involved in the changing of diapers and felt an invasion of privacy when a nurse or midwife inspected their homes and their lifestyles.

The issue of Female Genital Cutting [FGC] was brought up and a participant mentioned that she felt that the doctors seemed confused and could not make a decision that benefited the baby during the critical moment of delivery, this was entirely due to both a cultural and language barrier. Another felt that she was not involved in the making of a decision to use assisted delivery tools by health practitioners like metal forceps which she thought might affect the baby.

Service providers believe a negative experience is when there is poor communication, the client not does not feel heard or understood, and the client is not informed of what is happening resulting in a poor debrief as one said, *"lack of translation is a major issue for sure, also when somebody doesn't understand the question, you don't understand the symptoms they have, another is [lack of] social connection within the community, what makes them feel comfortable, isolated, it is important to link people to their own culture… this can be very powerful…".*

Barriers to Providing Better Maternity Care

Maternity service professionals agree that the biggest barrier to providing better care is language followed by isolation and not being able to navigate the Canadian healthcare system. Not having access to childcare, or transportation to services and not knowing what they have access to are also some major barriers to care. Financial barriers can limit the number of services some Newcomers could access and gives them an overall feeling of not being able to do more because of their income or economic status. The following are the barriers to providing better maternity care that were noted during the Focus Group discussions:

Lack of Awareness of Maternity Services

Some service providers who attended the Focus Groups see few racialized Newcomer maternity patients due to a lack of awareness of the availability of these services. It was noted that a lack of knowledge of these maternity programs or options was another barrier to providing care, *"I would say, not knowing about us or what midwives do, sometimes people come from a place where midwifery is for poor people and is seen as not safe enough, they have no way of knowing the Ontario context, that in fact, midwifery care is a better form of care… or that there are even midwives available to them"*. For midwives they noted, *"it is hard to tell the percentage of Newcomers, probably about 10%, this doesn't seem super high, [some are] very recent Newcomers without a health card this would perhaps bring it to more than 10%".* And some health units facilitated by public health nurses were put on hold for a period during the COVID-19 pandemic.

Lack of Funding

One Community Health Centre has a majority of Newcomer participation in their programs due to their outreach efforts but also face barriers related to funding, *"Funding is another barrier to care, most of these programs haven't received additional funding to support the change of care structure and demographic that come with Newcomer women, there is a limit to the business hours for the services and lack of staff to provide appropriate care and lack of capacity in the program to provide care to more women i.e. larger number of people in classes or group setting care".*

Lack of Accessibility of Services in Rural Communities

One professional mentioned that *"We talked a lot about Guelph, but for North Wellington [and] Centre Wellington there is only one [midwife] in each area, as housing*

prices go through the roof, we do have Newcomers moving to those smaller communities. Accessing supports in those areas is a barrier, so an increase in transportation to get to Guelph is essential". Another professional stated that "*It's very hard to have good prenatal care when you have food insecurity or unstable housing. I also think the needs and services have changed since the pandemic and I think there's a lack of clarity in the community over who is offering what services meanwhile the needs seem to be greater*".

Lack of Language Support

When it comes to Service Users, the number one issue is also language, when they go to a family doctor, they feel like they cannot say exactly what they feel even with an interpreter, because of a fear of exposing everything about their healthcare and stress. This is because they don't have family doctors in their language, "*some Newcomers came through Sudan and speak a little Arabic, if a family doctor from another culture speaks Arabic, a lot of people come to one family doctor, and the doctor can't support everyone.*"

Limited Hours of Operation

Another barrier is access to already available maternity programs, one woman mentioned that "*attending community programs wasn't easy, if I wanted to go see them, I can't go to work, I would have to take the day off. For the [Community Centre] it's the same, it is not easy even if there are afternoon classes, it didn't work for me. Even for evening classes because I also have other kids and have to take care of them*". The women also commonly highlighted that their expectations of care are not met due to a difference in the healthcare system, where in Canada very little support is given to mothers after delivery and the quick discharge after delivery, has been a culture shock to them as they are not prepared to take care of themselves, their newborn and their family a day after delivery.

Culture and Culturally Appropriate Care

Practitioners' cultural awareness:

A lack of understanding of their cultural values limits the ability of Newcomer women to receive care for issues relating to FGC and patriarchal family beliefs. However, some cultural beliefs of Newcomer women against mental healthcare are limiting access to these services to them or increasing the stigma when one needs to get these services, "*Another challenge is we're not even ready to open up to go these services, even though I used to go to [Community Centre] events, I maybe see one other woman or no one*".

Service users' preconception of care:

T.-Y. Lee et al. (2014) noted in their research that there is a preference for an obstetrician over a midwife among Newcomer women because they were afraid a midwife would not be able to provide good care especially if there were

complications. One of these women shared: "We don't choose a midwife back home. I am afraid if I need a caesarean section, a midwife can't do the operation. If I had a choice, I wouldn't use a midwife". The other participant stated: "Midwives have never been one of my choices to deliver my baby." However after being rejected by several obstetricians, they thought that a Mandarin-speaking midwife might be a good option because at least the communication with the midwife would be easier than that of an English-speaking doctor(T.-Y. Lee et al., 2014).

Misinformation within Ethnic societies:

Women from diverse backgrounds with perinatal depression encounter individual-level, social, and clinician-related barriers to treatment engagement (Iturralde et al., 2021). Treatment barriers included social stigma, difficulties recognizing one's own depression, low understanding of treatment options, and lack of time for treatment. Distinct factors emerged for Newcomer women including culturally specific messages discouraging treatment, low social support, trauma history, and difficulty taking time off from work for treatment. Clinician factors included knowledge and skill in handling perinatal depression, cultural competencies, and language barriers (Iturralde et al., 2021).

Examples of Best Practices

Best practices within maternity healthcare are care services rooted in cultural awareness that have been shown through research and practice to result in positive maternity experiences for Newcomer women. These procedures should be established as a standard practice suitable for adoption within the Canadian healthcare system. This is important because children born of Newcomer women and their parents are future Canadian citizens who not only contribute to the cultural and economic growth but also to a renewed perspective of work and life through a multicultural lens. Prioritizing maternity health for Newcomer women is a step towards ensuring better healthcare for all.

Positive maternity experiences are good maternity outcomes resulting from adopting respectful maternity care. Respectful maternity care (RMC) emphasizes the importance of ethical, psychological, social, and cultural implications in childbirth. Respect for women's beliefs, autonomy, dignity, feelings, choices, and preferences, and the right to companionship during maternity care, are essential to compassionate and woman-centred care (Hajizadeh et al., 2020; Bangal et al., 2020).

Best Practices in the Guelph Wellington County

The Guelph Community Health Centre is an example of a place with best practices for maternity care for Newcomer women, "*yes, we run a postpartum group for parents who identify as racialized and/or Newcomer. We have not done a formal evaluation, but it helps build community. There are no other spaces specifically for this population prenatally or postpartum. Several informal connections have been made and connections to various community programs have been made… We assist with subsidized bus passes application, and on exception payments for cabs, we have done*

that too. There are also social prescribing programs, for example, the lending of a laptop so [one] can attend classes virtually, we have done that with a phone as well."

Best practices within the midwifery practice in Guelph include the Community Access Midwifery Program. "*Our CAMP program has a satellite office at Shelldale Family Gateway, and we receive lots of referrals from the EarlyON centre*". The increase in racialized nurses and midwives and cultural sensitivity awareness has helped them provide better and longer regular sessions to Newcomer women. They also have the ability to offer home visits which help break the accessibility barriers that sometimes exist. One staff member reported that the program is "*going well, we are supporting pregnant people and are very conscious about our locations. We have prenatal class at Shelldale, where lots of Newcomers and racialized people attend classes, once we relocated, we found that we were reaching the right people… also the ability to connect with other service providers, increase food security, get people the baby items that they need such as car seats and strollers, I believe [it's] going well."*

For public health nurses, some best practices were seen before the COVID-19 pandemic… "*before COVID we were able to give pregnant and new moms prenatal vitamins for mom and baby… we can support families if food is a barrier and refer them to community supports, provide some grocery vouchers, and suggest healthy options for meals along with help to make a specific meal. Some new mothers are learning how to use the food they get from the food bank and make those recipes. We provide access to doctors, [we] do try to connect families to those accepting new patients, and regularly do immunizations for children who don't have a family doctor, clinical services and voluntary program with no fees associated. We make sure to support families if there's a need by helping families navigate the healthcare system, making those calls to get children on waitlists and often [providing] referrals to prenatal services. We also help find translated materials and resources…*".

Best Practices from Other Countries

In Australia, women who received Refugee Midwifery Group Practice care were more likely to have spontaneous onset of labour, normal birth, and less likely to use epidural analgesia and have a preterm baby (Dube et al., 2022). This attests to the fact that a Refugee Midwifery Group Practice that incorporates 24/7 phone availability and group antenatal care is feasible and clinically effective. Women who use the Refugee Midwifery Group Practice service share their positive experiences within their social networks, which increases the number of women who make early direct contact to book into the service and encouraged active involvement in healthcare (Dube et al., 2022).

Trust between a woman and her midwife is fundamental to the disclosure of sensitive information, and cohesion in the development and delivery of care plans and translates to better outcomes (Dube et al., 2022). There was a willingness to disclose sensitive information, such as disclosing female genital cutting which was higher in the Refugee Midwifery Group Practice group, as the midwife learns and understands the women's values, aspirations, strengths, and fears. Similar services that promote woman-

centred care and cultural safety improve accessibility to care, address communication and social needs, improve understanding of education, and strengthen woman-midwife relationships, which are fundamental to improving maternity care service use and could potentially improve outcomes for women from a refugee background who resettle in high-income countries (Dube et al., 2022).

The Hooyo (mother in Somali) group antenatal care (gANC) intervention in Sweden was received positively by both the Somali women and the midwives. The main mechanisms of impact were more comprehensive antenatal care and enhanced mutual cultural understanding. The position of women was strengthened in the groups, and the way in which the midwives expanded their understanding of the participants, and their narratives was promising. To be feasible at a large scale, gANC might require further adaptations while eliminating the "othering" of women in risk groups (Ahrne et al., 2022).

NFÖR (Individuell förlossningsförberedelse) is an interpretation program adopted in Swedish hospitals and is a two-hour individual language-supported visit at the labour ward, for non-Swedish speaking pregnant women and their partners. This was a structured system with an agenda that was tailored to each expectant mother complete with a tour of the maternity and postpartum ward. The guides described it as being a bridge and creating safety, achieved by meeting with women and providing practical information about the Swedish healthcare system. The guides felt that they fulfilled an important purpose, they were dedicated and adapted to the women's individual needs. Providing extra language-assisted support to migrant pregnant women was developing and enriching as it encouraged genuine engagement. The guides wished that INFOR could become a standard part of antenatal care and reach more parents in need of the program, but the model needs to be further developed, and a better system for recruitment must be introduced (Akselsson et al., 2022).

A doula is a person who provides guidance and support to a pregnant woman during labour. A doula typically does not have formal obstetric training and works alongside licenced medical practitioners to provide maternity care. Min-Lee Khaw et al. (2022) and Schytt et al. (2022) describe community-based doulas as ones who share the same cultural, linguistic, and ethnic backgrounds or social experiences as the women they support. Community-based doulas may be able to bridge gaps for migrant and refugee women in maternity settings in high-income countries (HICs) particularly when they are effectively trained, knowledgeable and experienced in providing support in labour and birth. Doulas complemented the maternity care team best when roles are clearly defined, and boundaries were understood by both doulas and other maternity care providers. Community-based doula support bridged barriers to equitable access to continuity of care models. Community-based doula programmes can provide culturally responsive care to migrant and refugee women in HICs (Min-Lee Khaw et al., 2022; Schytt et al., 2022).

Role of Racialization in Maternity Care

Racialization in maternity care plays a major role due to the increase in Newcomer women in need of maternity services. In our Service User Focus Groups, all participants were racialized Newcomer women. Although Ontario has a universal healthcare system, this does not mean that all pregnant people experience the same level of trust and respect during care, nor does it mean that all pregnant people have equal access to care(Miao et al., 2022). We can help mitigate long-standing inequities by implementing healthcare policies that promote Anti-racism, Equity, Diversity, and Inclusion and through re-education of healthcare staff on these principles and their impact on a positive maternity experience (Logan et al., 2022).

According to the Service Professionals we interviewed, their organizations have Anti-racism policies and Equity, Diversity, and Inclusion policies in place. This is a major step towards ensuring Culturally Appropriate Care. Three Service Professionals identified as racialized while others mentioned they had racialized people working in their practice. This helps bridge some of the cultural gaps and increase cultural awareness in maternity care as one professional mentioned, "…*yes we do… [provide care] based off an understanding of what is acceptable or not when issue arise*…".

Recommendations

Culturally Appropriate Care

Providing culturally appropriate care was recommended by both Service Users and professionals with an emphasis on Group Maternity services offered in different languages. "*Active recruiting of multilingual care providers is needed along with more social services that meet the needs of this specific demographic.*" Those providing healthcare services to immigrants might benefit from becoming astute to these differences, and from learning ways to communicate medical concepts and procedures without relying on technical and medical terminology and while being cognisant of possible differences in interpretations and attributions (Higginbottom et al., 2015). Providing cultural awareness programs for healthcare providers can reduce the risks of misunderstanding, and providing maternity care for people with different ethnocultural backgrounds need both 'language support', 'culturally appropriate care' and 'cultural and gender-diverse physicians' (Wooding et al., 2020) (Higginbottom et al., 2015).

Consideration also needs to be given to the pre-migration history and issues faced by many refugees who came to Canada to escape conflict, war and different social, political, and economic difficulties or circumstances in their home countries (Higginbottom et al., 2015). For example, many women experienced female genital cutting, which creates several risks that could affect birth. Physicians, midwives, and nurses should be urged to consider the need for cultural competency in their discussions with women in this situation. These women may not openly recall their negative or positive experiences or discuss their personal views on the procedure yet, special care and sensitivity are necessary when having these discussions (Higginbottom et al., 2015).

Language Interpretation and Document Translation

Reducing the language barriers by sustaining language support as one professional mentioned, "*interpretation services are highly valued, funding always another thing, but it is better than it used to be. I am afraid that it's going to go away, we need to improve, provide more accessible services, and train more people in that service.*" Interpretation of material distributed at the hospital will also help reduce the language gaps as Newcomers are having issues finding that information accessible. Interpretation is especially important at a specialist doctor or when requesting a referral as a focus group participant stated, "*…however the biggest challenge is getting an interpreter when visiting a family doctor or specialist, my baby had skin rash eczema, the baby was suffering for a while, I used to visit my family doctor, but because my English is limited I could not explain the baby's suffering…*". This goes hand-in-hand with interpretation during critical moments such as labour and delivery as another participant mentioned, "*what I have seen from a close family member was when her water broke, they return them back home, saying she was not ready, at home [her country] when your water breaks you stay at the hospital. So here my family member was in pain for 2-3 days while staying at home, this is very dangerous… At the hospital, if they don't speak*

English, they can't ask what they need, for those families, they need to pay attention and focus on them".

Mental Health Support

Another recommendation is the expansion of mental health supports, particularly in other languages and at low or no cost to increase accessibility. Knowledge of pregnancy-specific anxiety and stress factors may help improve antenatal screening and inform the development of tailored interventions to meet the mental health needs of immigrant women during the perinatal period (Vaillancourt et al., 2022). Some research in the US has demonstrated the efficacy of using culturally and linguistically tailored psychotherapy (e.g., IPT and CBT), or a healthy lifestyle intervention (that is community-planned, and culturally and linguistically tailored) to treat symptoms of ante-natal depression in immigrant women. One focus group participant suggested an awareness campaign for post-natal depression among cultural groups that will aim at increasing awareness, normalizing, and destigmatizing mental health and where to receive support. Collaborating with community services to provide psychoeducation on mental health that is acceptable to community members and tapping into religious organizations as a resource for social support could be valuable sectors of intervention among immigrants (Vaillancourt et al., 2022).

Peer-support Groups

According to our findings, peer-support groups are essential to ensuring a positive maternity experience for Newcomer women. Peer-support groups help eliminate isolation by connecting Newcomer women to other women going through the same experiences. These groups also help reduce the rate of mental health issues associated with isolation and promote information sharing among small groups of women. These small group settings are a conducive environment for learning where women feel more comfortable sharing their experiences and learning from others. Language support is provided at some of the peer-support group settings at the Community Centre antenatal classes in Guelph and some local cultural organizations provide opportunities for Newcomer women to create these networks. Promoting the importance of connecting with others and ensuring existing groups are widely known will help attract more Newcomer women to these services.

Community Outreach

Increasing accessibility in rural areas outside of Guelph through transportation subsidies or home visits can increase accessibility to much-needed maternity care. Outreach campaigns need to be better developed as the services are there, but targeted demographic groups don't access these services. Only after problems arise is when they get connected to those services and receive the appropriate care if referred on time. More health awareness is required to ensure better maternity outcomes among Newcomer women. As one professional pointed out these barriers can be overcome through, "… [creating] great websites, should be fairly easy to have all languages in website, know it has to be possible. Usually have access to a phone, at least someone they know [has one]".

Community-available pre- and post-natal programs are so powerful in ensuring a positive maternity experience for Newcomer women. They are access points for women in the community to receive important information about the health of their baby, and themselves and provide an opportunity for women to develop relationships and form peer groups. Practitioners in these settings can also provide key onward referrals to maternity services and supports based on individual needs. Expansion of operating hours for pre-and post-natal services will increase attendance in these programs and lead to better maternity outcomes for Newcomer women as one woman mentioned, *"I got pregnancy information mostly from my Community Centre, but I didn't attend pre-natal classes, as I did not have time and the hours of operation is not good for us, like Thursday class offered only one time, which was working hours only."*

Another community outreach aspect is connecting to existing informal networks that Newcomers engage in to form informal support systems within their new community. Although these networks are helpful in building community and ensuring support when Newcomer women are far away from their families, they also have the potential to disseminate incorrect information about the host country's healthcare system and instill stigma to seeking and accepting appropriate care. The need for maternity service professionals to connect to these networks is to directly raise awareness of the importance of antenatal/postnatal care and the available maternity health services.

Aggregation of Information at Multiple Access Points

Accessibility can be increased by ensuring information is available at public places like libraries where Newcomers go first for information about the host city or country and link with faith-based organizations in their community. One service provider mentioned that *"even a list or something that shows all available supports that could be given to care providers or other community organizations"*. Another professional said they were, *"focused on having community partners aware of our services"* which results in a better referral system in the community.

Participants suggested, *"[getting] information from doctors, everybody follows up with their doctors, may be easier to get that information from them also midwives, and community centres too, attended the prenatal program at the community centre, where I go"*. Another woman emphasized that, *"pre-natal classes should be encouraged, they should let people know about these services, they are really helpful for everybody, any person who is going to have a baby, or who has babies. They can make one friend circle, as it can be hard in countries like these to make friends, so everybody can discuss their questions about their babies, and learn from each other"*.

Cultural Awareness Training for Practitioners

The knowledge, understanding and attitudes of maternity care providers are critical determinants of culturally appropriate care. Ethno-culturally based stereotypes, racism, judgemental views, and direct and indirect discrimination should be challenged and eradicated at all levels: individual, institutional, clinical, and societal (Marie et al., 2019). Maternity care staff require a greater level of mandated education to have better

cultural awareness of the needs of diverse client groups including Newcomers. Demonstrating compassion, empathy, and warmth in health professional relationships with these women is important to reinforce positive attitudes among immigrant women. It is essential for maternity care providers to value diversity among Service Users and to offer individualized and culturally congruent care. Maternity care staff should seek to empower immigrant women by providing comprehensible information and better education concerning the configuration of the maternity system and conveying accurate information about care delivery. Further education and training of health professionals in meeting the challenges of a super-diverse population may enhance the quality of care, and the perceptions and experiences of maternity care by immigrant women (Marie et al., 2019)

In addition, better integration of mental health treatment with obstetric care will result in greater treatment convenience (e.g., telemedicine), and programmatic attention to cultural factors and social determinants of health. The importance of intervention and policy approaches affecting change at multiple levels to increase perinatal depression treatment engagement (Iturralde et al., 2021).

Program Funding

Most community-available maternity programs are run based on government or community-based funding. Community organizations are in constant need of increasing capacity in terms of staff and their training as well as resources to help properly support program attendees. Maternity service providers suggest an increase in funding to meet increased demand and increase accessibility for existing programs, "*[Some] programs we run have not had a funding increase in 25 years. We provide grocery gift cards weekly and the amount we are able to give is just not going very far these days*". Funding is also needed for new programs that will match the needs of the changing Newcomer demographic, to support language programs and new ethnic peer-support groups. In order to attract more Newcomers to work in maternity care funding and promotion of bridging programs and healthcare education and certification are necessary. This is help increase the number of culturally competent healthcare providers who can best support Newcomer women in need of practitioners from a similar background as them.

Conclusion

Due to the increase in intake and settlement of recent immigrants in Guelph and Wellington County, there is consequently an increase in the need for culturally appropriate maternity care for Newcomer women who might be facing a variety of barriers including, language, transportation, social and financial in nature. In order to implement woman-centred care, that is respectful of women's beliefs, autonomy, dignity, feelings, choices, and preferences and result in positive maternity experiences in Newcomer women in turn producing positive maternity outcomes, it is important to consider these women's social position, cultural knowledge and beliefs, and traditional customs in the healthcare (Higginbottom et al., 2014). Our findings suggest active recruiting of multilingual care providers and increasing social services are crucial in meeting the needs of this specific demographic. Providing cultural awareness programs for healthcare providers can reduce the risks of misunderstanding and providing maternity care for people with different ethnocultural backgrounds. Language barriers be minimized by increasing the interpretation of printed materials and materials available online and by ensuring interpretation is available during moments of critical care such as when visiting specialist doctors, labour, and delivery. It is important to increase awareness of existing services and reduce misinformation about health issues by increasing outreach activities in Newcomer communities and tapping into information networks that already exist in the community. Guelph and Wellington County should make sure information about maternity services in the community is available and provided to Newcomer women at the beginning of their pregnancy journey through libraries, family doctors and community centers. And lastly, cultural awareness training should be required of practitioners to know how to appropriately address the maternity care needs of Newcomer women who might have different cultures and values from their own. All of these suggestions can be better implemented with the increase in funding to meet the needs of this new demographic and their changing priorities.

References

Ahrne, M., Byrskog, U., Essén, B., Andersson, E., Small, R., & Schytt, E. (2022). Group antenatal care (gANC) for Somali-speaking women in Sweden - a process evaluation. *BMC Pregnancy and Childbirth*, *22*, 721. https://doi.org/10.1186/s12884-022-05044-9

Bangal, V. B., Vikhe, S., Borhade, S., & Thorat, U. (2020). Respectful maternity care for positive birthing experience at Pravara Rural Hospital. *International Journal of Reproduction, Contraception, Obstetrics and Gynecology*, 9(8), 3297. https://doi.org/10.18203/2320-1770.ijrcog20203312

Dube, M., Gao, Y., Steel, M., Bromley, A., Ireland, S., & Kildea, S. (2022). Effect of an Australian community-based caseload midwifery group practice service on maternal and neonatal outcomes for women from a refugee background. *Women and Birth*. https://doi.org/10.1016/j.wombi.2022.10.004

Hajizadeh, K., Vaezi, M., Meedya, S., Mohammad, S., Charandabi, A., & Mirghafourvand, M. (2020). Respectful maternity care and its relationship with childbirth experience in Iranian women: a prospective cohort study. *BMC Pregnancy and Childbirth*, *20*(468). https://doi.org/10.1186/s12884-020-03118-0

Higginbottom, G. M. A., Hadziabdic, E., Yohani, S., & Paton, P. (2014). Immigrant women's experience of maternity services in Canada: A meta-ethnography. *Midwifery*, *30*(5), 544–559. https://doi.org/10.1016/J.MIDW.2013.06.004

Higginbottom, G. M. A., Safipour, J., Yohani, S., O'Brien, B., Mumtaz, Z., & Paton, P. (2015). An ethnographic study of communication challenges in maternity care for immigrant women in rural Alberta. *Midwifery*, *31*, 297–304. https://doi.org/10.1016/j.midw.2014.09.009

Iturralde, E., Hsiao, C. A., Nkemere, L., Kubo, A., Sterling, S. A., Flanagan, T., & Avalos, L. A. (2021). Engagement in perinatal depression treatment: a qualitative study of barriers across and within racial/ethnic groups. *BMC Pregnancy Childbirth*, *21*, 512. https://doi.org/10.1186/s12884-021-03969-1

Johnsen, H., Christensen, U., Juhl, M., & Villadsen, S. F. (2021). Implementing the MAMAACT intervention in Danish antenatal care: a qualitative study of non-Western immigrant women's and midwives' attitudes and experiences. *Midwifery*, *95*. https://doi.org/10.1016/j.midw.2021.102935

Lee, J. B., Hinds, A., & Urquia, M. L. (2020). Provincial variations in birth outcomes according to maternal country of birth. *Statistics Canada Health Reports*, *31*(4), 13–21. https://doi.org/10.25318/82-003-x202000400002-eng

Lee, T.-Y., Landy, C. K., Wahoush, O., Khanlou, N., Liu, Y.-C., & Li, C.-C. (2014). A descriptive phenomenology study of newcomers' experience of maternity care services: Chinese women's perspectives. *BMC Health Services Research*, *14*, 114. https://doi.org/10.1186/1472-6963-14-114

Logan, R. G., Mclemore, M. R., Julian, Z., Stoll, K., Malhotra, N., Saraswathi, |, & Rm, V. (2022). Coercion and non-consent during birth and newborn care in the United States. *Birth Issues In Perinatal Care*, *49*, 749–762. https://doi.org/10.1111/birt.12641

Marie, G., Higginbottom, A., Evans, C., Morgan, M., Bharj, K. K., Eldridge, J., & Hussain, B. (2019). Experience of and access to maternity care in the UK by immigrant women: a narrative synthesis systematic review. *BMJ Open*, *9*, 29478. https://doi.org/10.1136/bmjopen-2019-029478

Meleis, A. I. (1999). Culturally Competent Care. *Journal of Transcultural Nursing*, *10*(1). https://doi.org/10.1177/104365969901000108

Miao, Q., Guo, Y., Erwin, E., Sharif, F., Berhe, M., Wen, S. W., & Walker, M. (2022). Racial variations of adverse perinatal outcomes: A population-based retrospective cohort study in Ontario, Canada. *PLoS ONE*, *17*(6 June). https://doi.org/10.1371/journal.pone.0269158

Min-Lee Khaw, S., Islamiah Zahroh, R., Elizabeth Dearnley, R., Homer, C., & Bohren, M. A. (2022). Community-based doulas for migrant and refugee women: a mixed-method systematic review and narrative synthesis Community-based doulas for migrant and refugee women: a mixed-method systematic review and narrative synthesis. *BMJ Global Health*, *7*, 9098. https://doi.org/10.1136/bmjgh-2022-009098

Ottawa Public Health. (2020). *Are You New to Canada? Welcome!* HaveTHATtalk.Ca. https://www.ottawapublichealth.ca/en/public-health-topics/resources/Documents/are_you_new_to_canada_activity_guide_en.pdf

Reid, G. J., Freeman, T. R., Thind, A., Stewart, M., Brown, J. B., & Vingilis, E. R. (2009). Access to Family Physicians in Southwestern Ontario Accès aux médecins de famille dans le sud-ouest ontarien. *Healthcare Policy*, *5*(2), 187–206.

Schytt, E., Wahlberg, A., Eltayb, A., Tsekhmestruk, N., Small, R., & Lindgren, H. (2022). Community-based bilingual doula support during labour and birth to improve migrant women's intrapartum care experiences and emotional well-being–Findings from a randomised controlled trial in Stockholm, Sweden [NCT03461640]. *PLoS ONE*, *17*(11 November). https://doi.org/10.1371/journal.pone.0277533

Seo, J. Y., Li, J., & Li, K. (2018). Cervical Cancer Screening Experiences Among Chinese American Immigrant Women in the United States. *JOGNN - Journal of Obstetric, Gynecologic, and Neonatal Nursing*, *47*(1), 52–63. https://doi.org/10.1016/J.JOGN.2017.10.003

Statistics Canada. (2022a, September 28). *Births, 2021*. The Daily. https://www150.statcan.gc.ca/n1/daily-quotidien/220928/dq220928d-eng.htm

Statistics Canada. (2022b, September 28). *Live births, birth weight indicators, by characteristics of the mother and child*. Table: 13-10-0424-01. https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310042401

Statistics Canada. (2022c, December 16). *Focus on Geography Series, 2021 Census - Centre Wellington (Census subdivision)*. 2021 Census of Population. https://www12.statcan.gc.ca/census-recensement/2021/as-sa/fogs-spg/page.cfm?topic=9&lang=E&dguid=2021A00053523025

Statistics Canada. (2022d, December 16). *Focus on Geography Series, 2021 Census - Guelph (Census subdivision)*. 2021 Census of Population. https://www12.statcan.gc.ca/census-recensement/2021/as-sa/fogs-spg/page.cfm?topic=9&lang=E&dguid=2021A00053523008

Stirling Cameron, E., Aston, M., Ramos, H., Kuri, M., & Jackson, L. (2022). The postnatal experiences of resettled Syrian refugee women: Access to healthcare and social support in Nova Scotia, Canada. *Midwifery*, *104*. https://doi.org/10.1016/j.midw.2021.103171

Urindwanayo, D. (2018). Immigrant Women's Mental Health in Canada in the Antenatal and Postpartum Period. *The Canadian Journal of Nursing Research*, *50*(3), 155–162. https://doi.org/10.1177/0844562118784811/FORMAT/EPUB

Vaillancourt, M., Lane, V., Ditto, ·Blaine, & Da Costa, D. (2022). Parity and Psychosocial Risk Factors Increase the Risk of Depression During Pregnancy Among Recent Immigrant Women in Canada. *Journal of Immigrant and Minority Health*, *24*, 570–579. https://doi.org/10.1007/s10903-021-01284-7

Appendix A: Environmental Scan

Guelph-Wellington Local Immigration Partnership

Newcomer Maternity Experiences

ENVIRONMENTAL SCAN

Guelph-Wellington County Maternity Services

Newcomer services[1] can be accessed through the government of Canada website which has a category for **services for newcomer women**[2] that are displayed by postal code[3]. **Immigrant Services of Guelph-Wellington Incorporated** is the only listed service organization in the county[4]. The organization is a catch-all for all immigrant settlement services as they can help with everyday life and even new baby registration as listed in the **"I want to..."** section.

Strengths

- Service listed on the government of Canada website

Limitations

- Only one service general for all, which may cause pregnant immigrant women to miss an opportunity to receive this service

Michael House[5] provides shelter and support to pregnant and parenting women and their children in need. This includes food, medical attention, life skills training and access to community support and resources.

Strengths

- Provides a well-rounded support system for vulnerable pregnant women.

Limitations

- No specific mention of services to immigrant women who are not necessarily removed from their homes
-

[1] Newcomer services - Canada.ca
[2] Welcoming women in Canada - Canada.ca
[3] Find free newcomer services near you (canada.ca)
[4] Home - ISGW (is-gw.ca)
[5] Home - Michael House

Family and Children's Services of Guelph and Wellington County[6] looks out for the well-being of the children, youth and families who live in the community.

Strengths

- Services are available to all members of the community regardless of race, ancestry, colour, citizenship, gender, sexual orientation, age, marital status, disability or financial means.

Limitations

- Organization's target is youth and children

Guelph Pregnancy to Parenting Program at the Guelph Community Health Centre[7] walks through multiple approaches to provide services that support all families belonging to their prioritized population.

Strengths

- Specify target group including Newcomer Mothers
- Offers supports to families at all stages, including postnatal breastfeeding and postpartum support
- Facilitators provide support, education and resources through individual consultation and group programming.

SHORE Centre[8] offers a variety of emotional support and medical appointments including Pregnancy Options Support, Abortion Options Support, Support After an Abortion, Adoption Options Support, Support After Placing a Child for Adoption, Support During Pregnancy and Support After Giving Birth. They also offer **language-specific group programs** for newcomers in the community through the **Newcomer Health Program**[9]**.**

Strengths

- interpretation is available upon request
- Programs, services and policies are inclusive of all genders, orientations, abilities, ages and cultures
- Specific programming from Newcomers that includes childcare, bus tickets and trained peer facilitators in their own language

Guelph Midwives[10] offers personalized, professional and evidence-informed care to families in Guelph, Fergus and the surrounding area. Midwives provide comprehensive primary care during pregnancy, labour, birth and up to six weeks postpartum for low-risk mothers and infants.

Strengths

---

[6] Family and Children's Services | About Us (fcsgw.org)
[7] Families and Children - Guelph CHC
[8] Our Services - SHORE Centre
[9] Newcomer Health Programs - SHORE Centre
[10] Home - Guelph Midwives

- Registered midwives with varied backgrounds and international experience, offering care in four languages
- Located at the Guelph's Community Health Centre, sharing a location with a weekly breastfeeding cafe, postpartum resources, infant programs and community acupuncture
- Provide extensive useful links to other resources in the community

Canadian Arab Women's Association provides barrier-free and culturally sensitive tools and resources. Most programs are facilitated in **Arabic** based on the needs of the participants. Their **Mother-to-Mother program** intends to connect **Arabic-speaking mothers** either pregnant or who recently gave birth with volunteers in similar positions and provide **social and emotional support**[11]**.**

Shelldale Family Gateway[12] is a non-profit, community benefit, charitable organization that aims to enrich the quality of life for everyone it serves. Their **C.A.M.P. – Community Access Midwifery Program**[13] provides accessible reproductive care by dropping in on Mondays from 10 a.m. - 4 p.m. and Wednesdays from 1 p.m. - 4 p.m.

Strengths

- A multicultural approach to meet the needs of a diverse community offering programs and supports in over 30 languages
- Provides services in collaboration with other agencies such as Family and Children's Services, Guelph Community Health Centre, Lutherwood and Immigrant Services
- A provider of EarlyON programs (ages 0-6) through the County of Wellington

Nationwide Programs in Canada

The Canadian Prenatal Nutrition Program[14] is a community-based program designed to help pregnant women and is available to **newcomers** across different cities in each province.

Refugees are also eligible for temporary coverage of **healthcare benefits** through the **Interim Federal Health Program**[15].

International Breastfeeding Centre[16] provides reliable and well-researched information based on 34 years of evidence-based practice to offer real, practical breastfeeding help. IBC provides **multilanguage** information sheets in **14 languages** and videos in **21 languages**.

[11] Mother to Mother | CAWA (cawakw.ca)
[12] About Us — Shelldale Family Gateway
[13] Our Programs — Shelldale Family Gateway
[14] Canada Prenatal Nutrition Program - Projects Directory Online (phac-aspc.gc.ca)
[15] Health care – Refugees - Canada.ca
[16] International BreastFeeding Centre | Multilanguage information sheets (ibconline.ca)

BC Women's Hospital and Health centre provides **primary health care** to **newcomer women**[17] with the availability of **medical interpreters** during visits[18]. They also provide **information on miscarriages** and how to access help in **Cantonese, French, Mandarin and Punjabi**[19]**.**

IWHC Toronto formerly **Immigrant Women's Health Centre** is a sexual health and reproductive health clinic that provides testing, treatment, counselling and outreach to all genders for a wide range of issues with a **multilingual, all-female staff**. They also provide **pregnancy counselling** and **referrals**[20].

Toronto Pregnancy Centre provides an array of pregnancy services to individuals who are met with an unexpected pregnancy, free and confidential. They provide services to newcomers in E**nglish, Spanish and Chinese**[21] and connect newcomers with these **ethnic communities.**

Immigrant Women Services Ottawa provides settlement and integration services, crisis intervention and counselling, and interpretation and translation for **immigrant women**[22]**.**

Women's Health In Women's Hands Community Health Centre is committed to providing holistic health services to **racialized women** in the GTA including **Prenatal & Postnatal Care**[23]**.**

South Asian Women's Centre is a place where **South Asian Women** of all backgrounds and ages can access a variety of programs and services. Services are interpretation and translation, information and referral, family counselling, advocacy, support and crisis intervention delivered in **English, Bengali, Hindi, Kanada, Marathi, Malay, Nepalese, Oriya, Punjabi, Sinhalese, Tamil, Telegu, Tibetan, Sindhi, Asamese, Urdu** as well as other languages as needed by clients[24].

Alliance for Healthier Communities' Partnering to support pregnant women without status program is a collaboration between **Ontario's Community Health Centres (CHCs) and Midwives** to deliver powerful positive change[25].

Centre for Immigrant and Community Services[26] offers unique programming and services for **immigrant women and their families** from diverse backgrounds as they integrate into a new country. Settlement Workers provide one-on-one settlement service, orientation, information and referrals, interpretation and advocacy to all immigrant women in need including **Pre-natal Classes**.

---

17 Maternity Care for New Immigrants (bcwomens.ca)
18 Newcomer Women's Health Clinic (bcwomens.ca)
19 Miscarriage (bcwomens.ca)
20 Clinical Services - IWHC Toronto
21 What if I am New to Canada? | Pregnancy Care Centre Toronto (iamnotalone.ca)
22 Services (immigrantwomenservices.com)
23 Primary Health Care | Women's Health In Women's Hands (whiwh.com)
24 Programs and Services | South Asian Women's Centre (sawc.org)
25 Partnering to support pregnant women without status | Alliance for Healthier Communities (allianceon.org)
26 CICS (cicscanada.com)

International Programs and Resources

La Leche League International[27] is an international organization a primarily focuses on the personal one-to-one sharing of information and encouragement that provides new parents with the confidence they need to breastfeed their babies. They connect mothers with specialists and groups in their area. Web information is available in **12 languages and is Google translate enabled for other languages.** They also provide information in **18 languages** on infant feeding in crisis situations.

Postpartum Support International[28] works across all levels to meet goals of support, education, advocacy, and research for people living with **mental illness** through various activities including providing links to resources in **multiple languages** and providing services in **English and Spanish**.

Online Informational Resources

The Society of Obstetricians and Gynecologists of Canada[29] Pregnancy Planning for Newcomers to Canada

TMCA Next stop Canada[30] Pregnant Newcomers to Canada: Things you need to know

Employment and Social Development Canada[31] Having a baby

[27] Infant Feeding in Emergencies (Multilingual) - La Leche League International (llli.org)
[28] Resources in Other Languages | Postpartum Support International (PSI)
[29] Pregnancy planning for newcomers to Canada – Pregnancy Info
[30] Pregnant Newcomer to Canada: Things You Need to Know – Next Stop Canada
[31] Having a baby - Canada.ca

Appendix B: Maternity Experiences Study Call for Professionals Poster

Appendix C: Maternity Experiences Study Call for Services Users Poster

Appendix D: Interview Questions

Guelph Wellington Local Immigration Partnership
Newcomer Maternity Experience
Focus Group Questions - Professionals

1. Demographic Information:
   a. In what capacity have you serviced pregnant newcomer women?
   b. How many years of experience do you have in your profession?
   c. Do you work in a rural or urban setting?
   d. Do you identify as an immigrant or visible minority?

2. General Practice information:
   a. What type of maternity services do you provide?
   b. How many patients do you typically see?
   c. What percentage of your patients are newcomer women?
   d. What percentage of women are racialized?
   e. What languages are you able to provide care in?
   f. Do you use translator services for direct patient care? If yes, how often? Are translators used in person, or over the phone?
   g. Do you use translators in clinics or in hospitals?
   h. Does your organization have an EDI & Anti-Racism policy?
   i. Do you have co-workers or team members who are immigrants or are racialized?

3. Defining the quality of maternity experiences:
   a. What do you think defines a positive maternity experience?
   b. What do you think leads to a positive maternity experience?
   c. What do you think defines a negative maternity experience?
   d. What do you think leads to a negative maternity experience?

4. What is going well:
   a. Are there programs within your organization that support positive maternity experiences for newcomer women?
   b. Are these programs effective?
   i. Why or why not?
   c. Can you connect newcomer women to:
   i. A Primary Care Physician
   ii. Prenatal supports and services
   iii. Childcare
   iv. Interpretation and translation
   v. Transportation
   vi. Maternity service and supports in the community
   vii. Postnatal supports and services

5. What is not going well:
   a. What barriers do you think exists for newcomer women when accessing maternity services?
   b. How would you describe the newcomer woman's experience:
   i. Accessing health care services?

- Primary care doctor?

i. Navigating the health care system?
ii. Understanding healthcare information?

- Does this impact their ability to make informed decisions and choices in the care?

i. Accessing antenatal classes?
ii. Accessing breastfeeding support?
iii. With barriers such as language

- Does your organization offer interpretation or translated materials?

i. With barriers such as transport, childcare, financial constraints?
ii. With access to social support?
iii. With postpartum health, care, and mental health?

6. Community Outreach:
   a. Does your organization provide maternity information sessions that newcomer women can attend in the community?
   b. When sharing information about maternity services and support, does your organization tap into informal networks that already exist in the community?

7. Understanding the adequacy of services:
   a. Do you feel that the maternity services in Guelph and Wellington County adequately meeting the needs of newcomer women.
   i. Why or why not?

8. Suggestions for improvement:
   a. Do you have any suggestions to improve newcomer women's access to quality maternity services and support?

Guelph Wellington Local Immigration Partnership
Newcomer Maternity Experience
Focus Group Questions – Service Users

1. Ask service users to introduce themselves

- How long have they been in Guelph and Wellington County?
- When did they first access maternity services in Guelph and Wellington County?
- How many times did they access maternity services in Guelph and Wellington County?

2. Ask service users to speak about their general maternity experience.

- What services did they access?
- Did you have the below supports and services, if not mentioned above:
- Having a primary health provider?
- Pre and postnatal services or resources?
- Transportation to appointments and classes?
- Postpartum mental health support?
- Childcare for other children?
- Information in your first language... Interpretation or translation?
- Emotional support?

3. What went well with your maternity experience in Guelph and Wellington County?

4. Was the information provided to you easy to understand?
- Were you given the opportunity to ask questions?
- Did you feel like you understood the information well enough to make informed choices?

5. What didn't go well with your maternity experience in Guelph and Wellington County?

6. What would you do to improve maternity services for newcomers?

7. Where do you think immigrants can best access information about maternity care? Who should we give this information to in order to reach you?

GUELPH | WELLINGTON
Local Immigration Partnership

Funded by:
Immigration, Refugees and Citizenship Canada

Financé par :
Immigration, Réfugiés et Citoyenneté Canada