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Quality of maternal and newborn care around the time of childbirth for migrant versus nonmigrant women during the COVID-19 pandemic: Results of the IMAGINE EURO study in 11 countries of the WHO European region

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Abstract

Objective: To describe the perception of quality of maternal and newborn care (QMNC) around the time of childbirth among migrant and nonmigrant women in Europe.

Methods: Women who gave birth at a health facility in 11 countries of the WHO European Region from March 2020 to July 2021 were invited to answer an online questionnaire including demographics and childbirth experience. Data were analyzed and compared for 1781 migrant and 20 653 nonmigrant women.

Results: Migrant women who experienced labor perceived slightly more difficulties in attending routine antenatal visits (41.2% vs 39.4%; $P = 0.001$), more barriers in accessing facilities (32.9% vs 29.9%; $P = 0.001$), lack of timely care (14.7% vs 13.0%; $P = 0.025$), inadequate room comfort and equipment (9.2% vs 8.5%; $P = 0.004$), inadequate number of women per room (9.4% vs 8.6%; $P = 0.039$), being prevented from staying with their baby as they wished (7.8% vs 6.9%; $P = 0.011$), or suffering abuse (14.5% vs 12.7%; $P = 0.022$) compared with nonmigrant women. For women who had a prelabor cesarean, migrant women were more likely not to receive pain relief after birth (16.8% vs 13.5%; $P = 0.039$) and less likely to provide informal payment (1.8% vs 4.4%; $P = 0.005$) compared with nonmigrant women. Overall, the QMNC index was not significantly different for migrant compared with nonmigrant women.

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Conclusion: Gaps in overall QMNC were reported by both migrant and nonmigrant women, with improvements to healthcare necessary for all.

KEYWORDS

childbirth, COVID-19, IMAGiNE EURO study, maternal health care, migrant women, migrant-friendly health systems, neonatal health care, pregnancy

1 | INTRODUCTION

Over the last two decades, the number of international migrants has increased by more than 100 million worldwide.¹ About 90.7 million international migrants live in the World Health Organization (WHO) European Region, accounting for almost 10% of the population in the region and 35% of the global international migrant population.² Additionally, the International Organization for Migration (IOM)³ has alerted that a crisis in migration is expected in the WHO European Region; by March 19, 2022, 3.39 million Ukrainians, mostly women and children, have already crossed borders to neighboring countries and a total 4 million are estimated to migrate from Ukraine to escape the war.⁴

Overall, the health of migrants has been reported to be significantly poorer compared with that of nonmigrants, with variations depending on country, residence status, or length of stay.^{5,6} Pregnant women and newborns are particularly vulnerable groups of migrants⁷ and complications during pregnancy and birth are among the most frequent health problems for migrant women.⁸ Although there is variation (depending on the host country and country of origin), compared with nonmigrant women, migrant women tend to experience higher rates of health problems during pregnancy and childbirth,^{2,9–11} higher risk for postpartum depression and relatively poor neonatal outcomes,^{9,12–14} and higher maternal and infant mortality.^{15–19}

In addition, important inequities in access to care among migrants,²⁰ in particular to maternal and child healthcare services,^{21,22} have been

documented in Europe. Lower utilization of antenatal health care may be a consequence of barriers migrants face in accessing care,²² including lack of social support, lack of health literacy, language barriers, lack of information, poor experience of care, and discrimination.^{21,23} Furthermore, within the process of provision of healthcare services to migrant women, multiple factors associated with poor healthcare experiences have been previously documented, including difficulties related to communication, unfamiliarity with the healthcare system, lack of kind and respectful care,^{24–27} lack of language support, cultural insensitivity, poor interactions with healthcare providers, lack of knowledge of legal entitlements and guidelines on the provision of welfare support and maternity care,^{5,28} and outright discrimination.^{27–30}

The COVID-19 pandemic has, in addition to the increased burden on health systems, reshaped migration flows, the composition of migrant populations in Europe, and the economic panorama, with important consequences for migrants who are overrepresented in low-skilled professions.³¹ Although there is a lack of studies on the effect of the COVID-19 pandemic on migrant health, literature suggests that women of racial and ethnic minority groups experienced less social support during pregnancy, childbirth, and the postpartum period.³²

The WHO has highlighted the urgency of integrating health data from migrant populations in the monitoring framework of the COVID-19 pandemic to assist in the development of adequate response plans and healthcare preparedness.³³ However, even in the European Region, there is an overall lack of routine standardized monitoring systems for assessing and comparing the quality of care in general and disaggregated data for migrant women across countries and regions. How health systems provided maternal care services for migrant women during the COVID-19 pandemic and how migrant women perceived the quality of this care have not been documented.

Assessing the quality of maternal and newborn care (QMNC) among migrant women is important to understand the factors that can potentially affect their health and that of their infants and to promote policies that respond to their specific needs. This information can be used to develop programs with the objective of achieving respectful, migrant-friendly, economically sustainable, and equitable health systems.³⁴ Migrant-friendly health systems consciously and systematically incorporate the needs of migrants into health financing, policy, planning, implementation and evaluation, including such considerations as the epidemiological profiles of migrant populations, relevant cultural, language, and socioeconomic factors and the impact of the migration process on the health of migrants.³⁵ Maternal and newborn health outcomes could be improved by increasing the quality of care³⁶ and reducing healthcare delays among migrant populations.³⁷

Using data from the IMAGiNE EURO study, a multicountry effort to document QMNC during the COVID-19 pandemic using standardized data collection instruments, including a set of 40 WHO standards-based quality measures³⁸ and demographic questions, we aimed to describe the maternal perception of QMNC around the time of childbirth among migrant versus nonmigrant women during the COVID-19 pandemic, in 11 countries of the WHO European Region. Additionally, we aimed to understand how the QMNC index varied by migrant status, when adjusted for country and for sociodemographic characteristics.

2 | MATERIALS AND METHODS

2.1 | Study design and participants

This cross-sectional study used the Strengthening the Reporting of Observational Studies (STROBE)³⁹ in Epidemiology guidelines. The STROBE Checklist is included as supporting information [Table 1](#). The study protocol was registered in [ClinicalTrials.gov](#) (NCT04847336).

Details of the IMAGiNE EURO study methods have been reported elsewhere.⁴⁰ Briefly, the study was conducted using an anonymous online survey, between September 2, 2020, and October 28, 2021. Women aged 18 years and older who gave birth in the WHO European Region during the study period (March 1 to October 28, 2021) were eligible. Exclusion criteria were home births. The survey was available in 23 languages and disseminated by study partners in 16 countries of the WHO European Region (Bosnia and Herzegovina, Croatia, Italy, Israel, France, Germany, Latvia, Luxembourg, Norway, Portugal, Romania, Serbia, Slovenia, Spain, Sweden, and Switzerland).

As described elsewhere,⁴⁰ suspected duplicates and cases missing 20% or more answers on 45 key variables, including the 40 key quality measures and five key sociodemographic variables (date of birth, age, education, parity, and migrant status) were excluded. There is no universal consensus on the definition of migrant. According to the IOM, migrant is “an umbrella term, not defined under international law, reflecting the common lay understanding of a person who moves away from his or her place of usual residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons”.³⁵ The present study defined a migrant as a woman who gave birth in a different country than the one in which she was born.

From the 27712 participants in the IMAGiNE EURO study, women with missing information on migrant status were excluded. Furthermore, power analysis was performed overall and for each country. Only countries with sufficient power ($\geq 80\%$) to assess at least a 10% difference in the quality measures between migrant and nonmigrant groups were included in the analysis, given an expected frequency of each quality measure of 10% in the nonmigrant group, a two-tailed z test, and a significance level of 0.05. Based on these predefined criteria, 22434 participants, from 11 countries, were included in the analysis ([Figure 1](#)) of which 16472 participants contributing to the QMNC index (i.e. participants without missing data in any of the questions that contribute to the QMNC index calculation as reported previously).⁴⁰ This sample had a 99% power to detect a 5% difference in the QMNC index between the migrant and nonmigrant group, given a QMNC index of 340 in the nonmigrant group, a two-tailed z test, and a significance level of 0.05.

2.2 | Data collection

Data were collected using a structured questionnaire, based on the WHO standards for improving maternal and newborn care in health

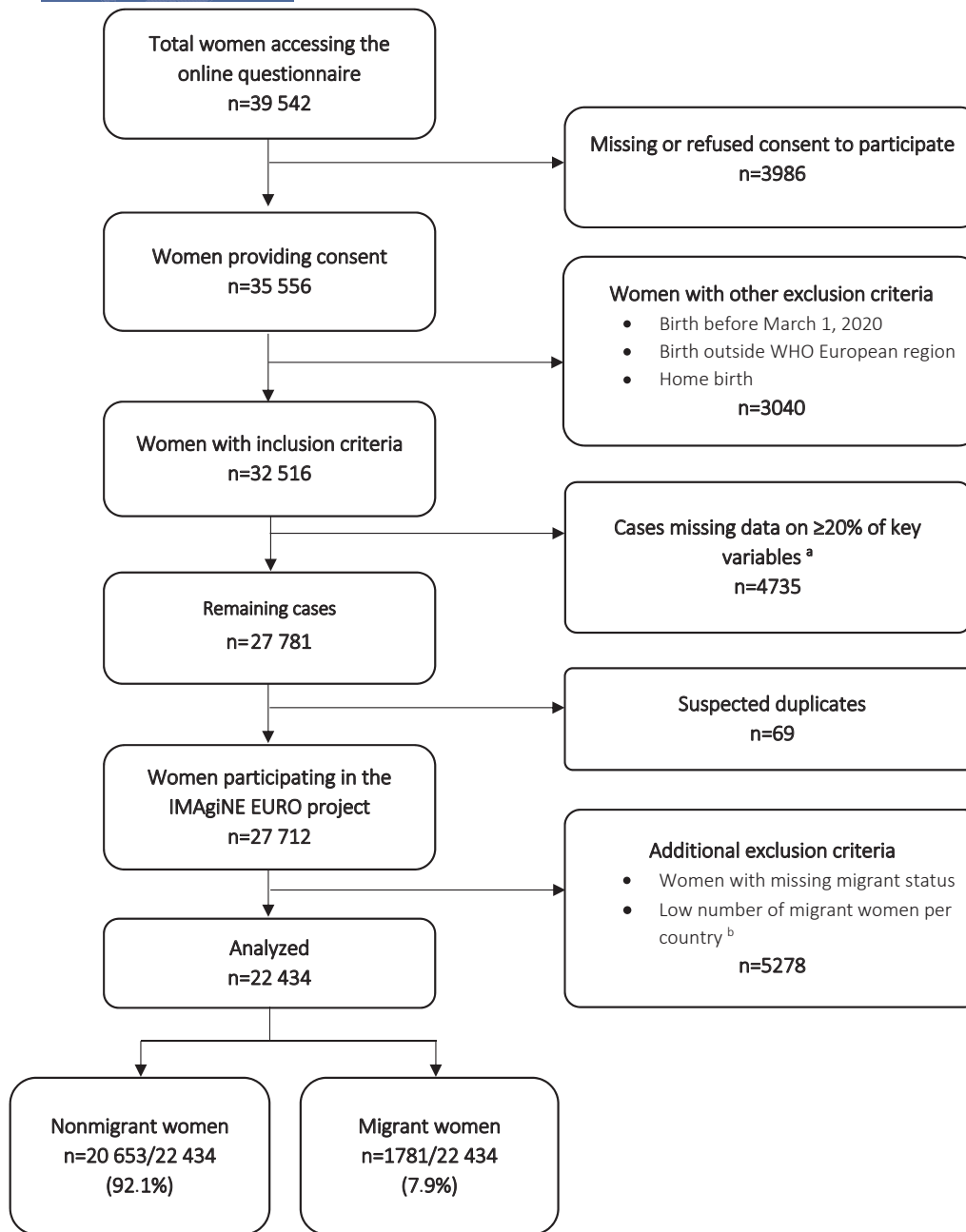


FIGURE 1 Flowchart of participants. ^aPercentage of missing data for each woman was calculated over mandatory questions ($n = 45$). ^bNumber of migrant women not sufficient to guarantee a sufficient power ($\geq 80\%$) to assess a 10% difference in the quality measures between migrant and nonmigrant groups, given an expected frequency of each quality measure of 10% in the nonmigrant group, a two-tailed z test, and a significance level of 0.05.

facilities.³⁸ The survey was disseminated on social media, on institutional websites, or via local networks, according to the local settings and resources.⁴⁰ Data were entered using REDCap 8.5.21 (Vanderbilt University, Nashville, TN, USA), via a centralized platform. The process of questionnaire development, validation, and previous use as well as the process of translation and back-translation of the questionnaire is described elsewhere.^{41,42,43}

The questionnaire assessed QMNC in health facilities and included 40 questions on one key indicator each. The 40 key indicators were equally distributed in four domains: (1) provision of care;

(2) experience of care; (3) availability of human resources and essential physical resources; and (4) reorganization due to the COVID-19 pandemic. These 40 indicators contributed to a total quality index, calculated according to predefined criteria,³⁸ with higher scores indicating higher adherence to WHO standards. The questionnaire had two versions, one for women who experienced labor and one for those who had a prelabor cesarean, differing only by a few questions, as appropriate (e.g. women who did not experience labor were not asked about pain relief during labor). A definition of labor according to guidelines of the National Institute of Health and Care

Excellence was provided in the questionnaire: "the phase of labor in which you felt strong, regular and painful contractions and the dilatation was around 4 cm or greater".⁴⁴ Additionally, indicators were tailored to take into account different modes of birth (spontaneous vaginal, instrumental vaginal, and elective or emergency cesarean), with each woman reporting on 40 WHO quality measures.

Questions on 24 sociodemographic indicators related to individual characteristics of the participants, including age, education (elementary school, junior high school, high school, university degree, postgraduate degree/master/doctorate or higher), parity (nulliparous, multiparous), multiple birth (yes, no), country of birth, and country where the women gave birth, were collected.

2.3 | Ethical aspects

The study was approved by the Institutional Review Board of the coordinating center: the IRCCS "Burlo Garofolo" Trieste, Italy (IRB-BURLO 05/2020 15.07.2020). The study protocol was also reviewed and approved by the ethical committees of four other countries to comply with local regulations: Portugal (Instituto de Saúde Pública da Universidade do Porto, CE20159); Norway (Norwegian Regional Committee for Medical Research Ethics, 2020/213047), Germany (Bielefeld University Ethics Committee, 2020-176); and Latvia (Rīgas Stradiņa universitātes, 22-2/140/2021-16/03/2021). A formal approval was waived by the ethical committee of the other countries, since the questionnaire was online, voluntary, and anonymous (i.e. no personal data were collected). The study was conducted according to General Data Protection Regulation (GDPR) regulations. Women were informed prior to the survey on the objectives and methods of the study, including their rights in declining participation, and each provided informed consent before responding to the questionnaires. Anonymity in data collection during the survey phase was ensured by not collecting any information that could disclose participants' identity. Data transmission and storage were secured by encryption.

2.4 | Data analysis

We performed descriptive analyses, calculating absolute frequencies and percentages for sociodemographic variables and for each of the 40 key quality measures for nonmigrant and migrant women by country and separately for women who experienced labor or who had a prelabor cesarean. Differences between nonmigrant and migrant groups for each quality measure were tested with a χ^2 test. Since there were differences in the proportion of migrants by country, and country is a confounder in the association between quality measures and migrant status, we also performed a logistic regression adjusting for country.

We calculated medians and interquartile ranges (IQRs) for the QMNC index in each dimension of care (provision of care, experience of care, availability of human resources and essential resources, reorganizational changes due to COVID-19) for nonmigrant versus

migrant women, by country. Nonparametric Mann-Whitney test was conducted to compare differences between two independent samples (nonmigrant vs migrant women) in each dimension of care and the QMNC index overall and for each country.

Quantile regression analyses were conducted due to the non-normal distribution of the QMNC index,⁴⁵ adjusted for country, on the whole sample, with QMNC index as the dependent variable and migrant status (nonmigrant vs migrant women) as the independent variable, including sociodemographic and perinatal characteristics (i.e. maternal age, maternal education, type of hospital, country, type of birth, presence of an obstetrics and gynecology doctor in the team who assisted birth), to account for potential confounding of crude associations by other variables. The same model was performed for each subdomain of the QMNC index.

Additionally, quantile regressions were also conducted by country for each QMNC subdomain and total index as dependent variables, and migrant status as the independent variable adjusted for the sociodemographic and perinatal potential confounders listed above.

Two-tailed $P < 0.05$ was considered statistically significant. Statistical analyses were performed using Stata/SE version 14.0 (Stata Corporation, College Station, TX, USA) and R.⁴⁶

3 | RESULTS

Characteristics of the participants are given in Table 1. Most participants were aged between 25 and 35 years, had a university degree or higher, were nulliparous, and had a vaginal delivery. Migrants were more likely to be older (≥ 36 years, 24.9% [$n = 444$] vs 19.3% [$n = 3985$]; $P < 0.001$) and to have a postgraduate degree or higher (36.6% [$n = 651$] vs 25.7% [$n = 5314$]; $P < 0.001$) compared with nonmigrant women. When adjusting for country, migrants were more likely to be assisted during birth by a nurse (41.0% [$n = 730$] vs 38.8% [$n = 8004$]; $P = 0.004$) or an obstetrics/gynecology doctor (55.8% [$n = 993$] vs 53.2% [$n = 10980$]; $P = 0.012$) or an obstetrics registrar/medical resident (under postgraduate training) (20.4% [$n = 363$] vs 18.4% [$n = 3796$]; $P = 0.023$), and were less likely to be assisted by a midwife (88.4% [$n = 1574$] vs 89.3% [$n = 18433$]; $P = 0.025$).

Migrant women who experienced labor perceived slightly more difficulties in attending routine antenatal visits (41.2% [$n = 621$] vs 39.4% [$n = 7063$]; $P = 0.001$), barriers in accessing the facility (32.9% [$n = 496$] vs 29.9% [$n = 5358$]; $P = 0.001$), not receiving timely care at facility arrival (14.7% [$n = 221$] vs 13.0% [$n = 2331$]; $P = 0.025$), inadequate room comfort and equipment (9.2% [$n = 138$] vs 8.5% [$n = 1524$]; $P = 0.004$), inadequate number of women per rooms (9.4% [$n = 142$] vs 8.6% [$n = 1537$]; $P = 0.039$), not being allowed to stay with their baby as they wished (7.8% [$n = 117$] vs 6.9% [$n = 1235$]; $P = 0.011$), less likely to report no early breastfeeding (10.1% [$n = 152$] vs 13.7% [$n = 2460$]; $P = 0.002$), and more likely to suffer physical/verbal/emotional abuse (14.5% [$n = 218$] vs 12.7% [$n = 2280$]; $P = 0.022$) than nonmigrant women who experienced labor. Migrant women who

TABLE 1 Social and demographic characteristics of participants, type of health care, and perinatal outcomes by migration status (nonmigrant versus migrant women)

	Participants		P value	P value ^a
	Nonmigrant (n = 20 653) No. (%)	Migrant (n = 1781) No. (%)		
Country				
Sweden	4418 (21.4)	339 (19.0)	0.020	-
Italy	4462 (21.6)	222 (12.5)	<0.001	-
Norway	3032 (14.7)	233 (13.1)	0.066	-
Slovenia	2179 (10.6)	104 (5.8)	<0.001	-
Portugal	1668 (8.1)	136 (7.6)	0.512	-
France	1272 (6.2)	80 (4.5)	<0.001	-
Germany	986 (4.8)	119 (6.7)	<0.001	-
Croatia	975 (4.7)	97 (5.4)	0.168	-
Serbia	913 (4.4)	83 (4.7)	0.638	-
Switzerland	427 (2.1)	190 (10.7)	<0.001	-
Luxembourg	321 (1.6)	178 (10.0)	<0.001	-
Maternal age, year				
≤24	1017 (4.9)	62 (3.5)	0.006	0.063
25–35	15 648 (75.8)	1275 (71.6)	<0.001	<0.001
≥36	3985 (19.3)	444 (24.9)	<0.001	<0.001
Missing	3 (0.0)	0 (0.0)	>0.999	>0.999
Maternal education				
None	7 (0.0)	1 (0.1)	0.484	0.589
Elementary school	53 (0.3)	6 (0.3)	0.526	0.762
Junior high school	1191 (5.8)	80 (4.5)	0.026	0.126
High school	5312 (25.7)	371 (20.8)	<0.001	<0.001
University degree	8772 (42.5)	672 (37.7)	<0.001	0.002
Postgraduate degree/Master/ Doctorate or higher	5314 (25.7)	651 (36.6)	<0.001	<0.001
Missing	4 (0.0)	0 (0.0)	>0.999	>0.999
Parity at childbirth				
Nulliparous	12 322 (59.7)	1071 (60.1)	0.696	0.056
Multiparous	8328 (40.3)	708 (39.8)	0.638	0.047
Missing	3 (0.0)	2 (0.1)	0.054	-
Multiple birth				
Yes	262 (1.3)	27 (1.5)	0.374	0.515
Type of birth				
Vaginal	14 068 (68.1)	1168 (65.6)	0.028	0.458
Instrumental vaginal	1909 (9.2)	185 (10.4)	0.111	0.554
Cesarean	4676 (22.6)	428 (24.0)	0.179	0.689
Newborn admitted to NICU				
Yes	1719 (8.3)	132 (7.4)	0.180	0.376
Mother admitted to ICU				
Yes	328 (1.6)	25 (1.4)	0.548	0.546
Type of hospital				
Public	19 068 (92.3)	1617 (90.8)	0.021	0.438
Private	1581 (7.7)	164 (9.2)	0.019	0.450
Missing	4 (0.0)	0 (0.0)	>0.999	>0.999

TABLE 1 (Continued)

	Participants		P value	P value ^a
	Nonmigrant (n = 20 653) No. (%)	Migrant (n = 17 811) No. (%)		
Type of healthcare provider who directly assisted childbirth				
Midwife	18 433 (89.3)	1574 (88.4)	0.255	0.025
Nurse	8004 (38.8)	730 (41.0)	0.064	0.004
Student (before graduation)	3463 (16.8)	324 (18.2)	0.124	0.424
Obstetrics registrar/medical resident (under postgraduate training)	3796 (18.4)	363 (20.4)	0.037	0.023
Obstetrics/gynecology doctor	10 980 (53.2)	993 (55.8)	0.035	0.012
I do not know (healthcare providers did not introduce themselves)	1960 (9.5)	144 (8.1)	0.051	0.244
Other	3022 (14.6)	202 (11.3)	<0.001	0.001

Abbreviations: ICU, Intensive Care Unit; NICU, Neonatal Intensive Care Unit.

^aP value adjusted for country.

had a prelabor cesarean were more likely not to receive pain relief after cesarean (16.8% [$n = 46$] vs 13.5% [$n = 371$]; $P = 0.039$) and less likely to provide informal payment (1.8% [$n = 5$] vs 4.4% [$n = 122$]; $P = 0.005$) compared with nonmigrant women who had a prelabor cesarean (supporting information Tables 2–5).

Migrant women reported similar overall QMNC indexes to nonmigrant women (Figure 2). The adjusted models confirmed that the QMNC index did not differ by migration status in any of the four key domains (Table 2). When results were disaggregated by country, migrant women who gave birth in Portugal reported significantly lower overall QMNC index ($P = 0.039$), whereas those who gave birth in Luxembourg ($P = 0.002$) reported significantly higher QMNC median index compared with nonmigrant women who gave birth in the same country. In the remaining countries, there were no differences between migrant women's and nonmigrant women's perspectives on overall QMNC (Figure 2A; supporting information Table 6).

For the specific subdomains of the QMNC, migrant women who gave birth in Slovenia ($P = 0.025$) or Sweden ($P = 0.004$) reported significantly lower medians on the provision of care index compared with nonmigrant women who gave birth in the same countries (Figure 2B; supporting information Table 6). Migrant women who gave birth in Croatia ($P = 0.025$) and Portugal ($P = 0.024$) reported a significantly lower median on the availability of human resources and essential physical resources index compared with nonmigrant women who gave birth in the same countries (Figure 2D; supporting information Table 6). Migrant women who gave birth in Luxembourg reported a significantly higher median on the availability of human resources and essential physical resources index ($P = 0.021$), and on reorganizational changes due to the COVID-19 pandemic index ($P = 0.003$) compared with nonmigrant women (Figure 2D, Figure 2E; supporting information Table 6). There was no association between migration status and QMNC when statistical analyses were

conducted per country, adjusting for sociodemographic and perinatal characteristics (supporting information Figure 1 and supporting information Tables 7–16).

4 | DISCUSSION

To the best of our knowledge, this is the first multicountry study comparing a large sample of migrant and nonmigrant women's perceptions of the QMNC around childbirth at facility level in 11 countries of the WHO European Region during the COVID-19 pandemic, using a comprehensive set of WHO standards-based quality measures. Results of the study show that, overall, migrant women are more likely to report poor QMNC on specific quality measures; for example, more likely to be separated from their newborn, more likely to suffer from physical, verbal, or emotional abuse, less likely to have timely care at facility arrival, and to experience more barriers to access health facilities. However, when all the indicators are taken into consideration, and adjusted for potential confounders, gaps on the overall QMNC were reported by both nonmigrant and migrant women, without significant differences between them. Similar findings were observed when data were analyzed by country.

Previous literature has reported lower QMNC for migrant women. A recent systematic review on migrant women's experiences of pregnancy, childbirth, and maternity care in European countries found, with high confidence of evidence, that migrant women have difficulties and face barriers in accessing maternity care.²⁶ Our study shows a substantial proportion of migrant and nonmigrant women had difficulties in attending routine antenatal visits (41.2% vs 39.4%, respectively), and had barriers in accessing the facility (32.9% vs 29.9%, respectively). Previous qualitative studies have emphasized that migrant women feel ignored or rejected

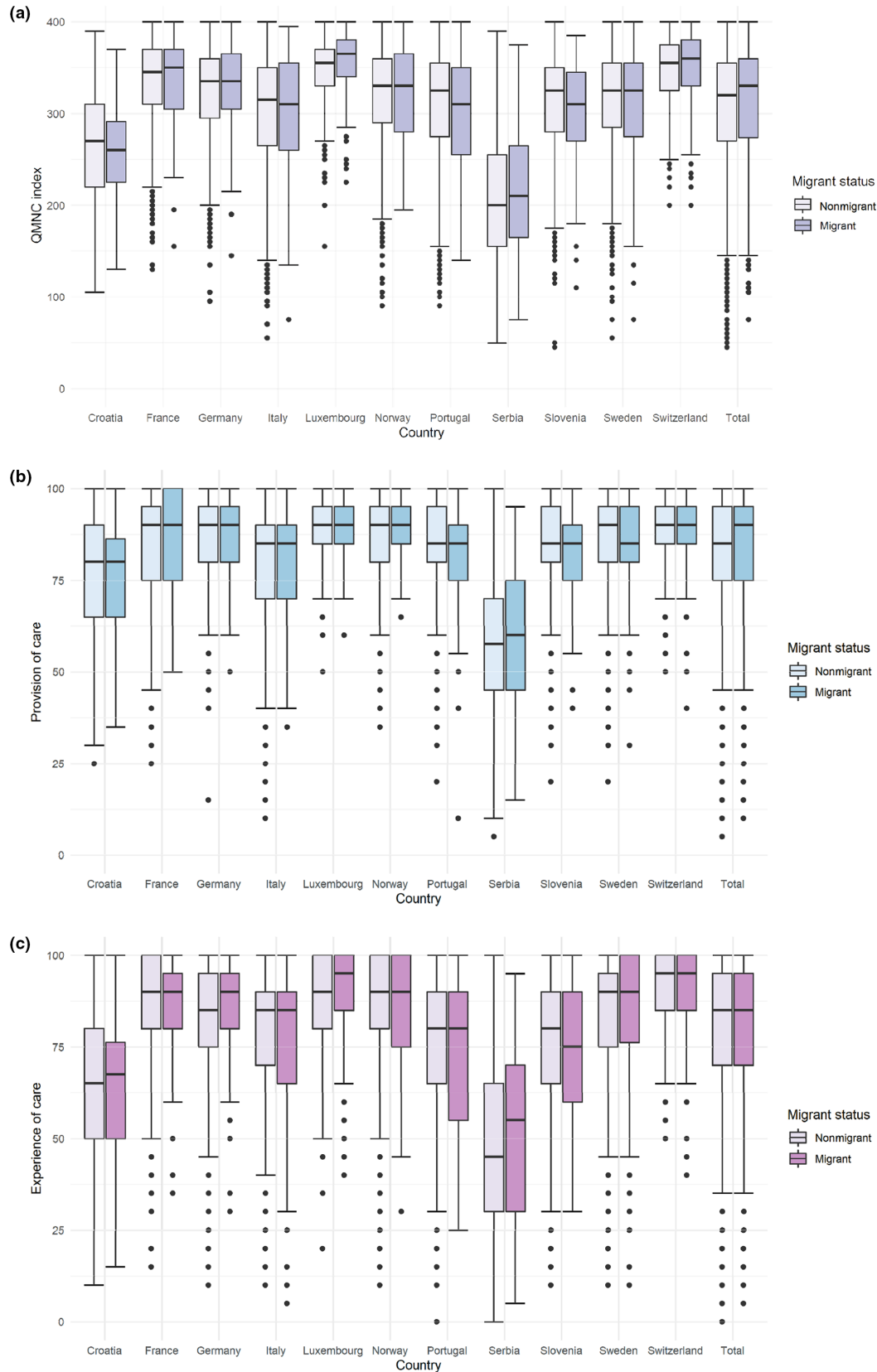


FIGURE 2 (a) Median, interquartile range, and ranges for the QMNC index total by country and migrant status ($n = 16472$). (b) Median, interquartile range, and ranges of the QMNC index on provision of care by country and migrant status ($n = 16472$). (c) Median, interquartile range, and ranges of the QMNC index on experience of care by country and migrant status ($n = 16472$). (d) Median, interquartile range, and ranges of the QMNC index on the availability of motivated human resources and essential physical resources by country and migrant status ($n = 16472$). (E) Median, interquartile ranges, and ranges of the QMNC index on reorganizational changes due to COVID-19 pandemic by country and migrant status ($n = 16472$)

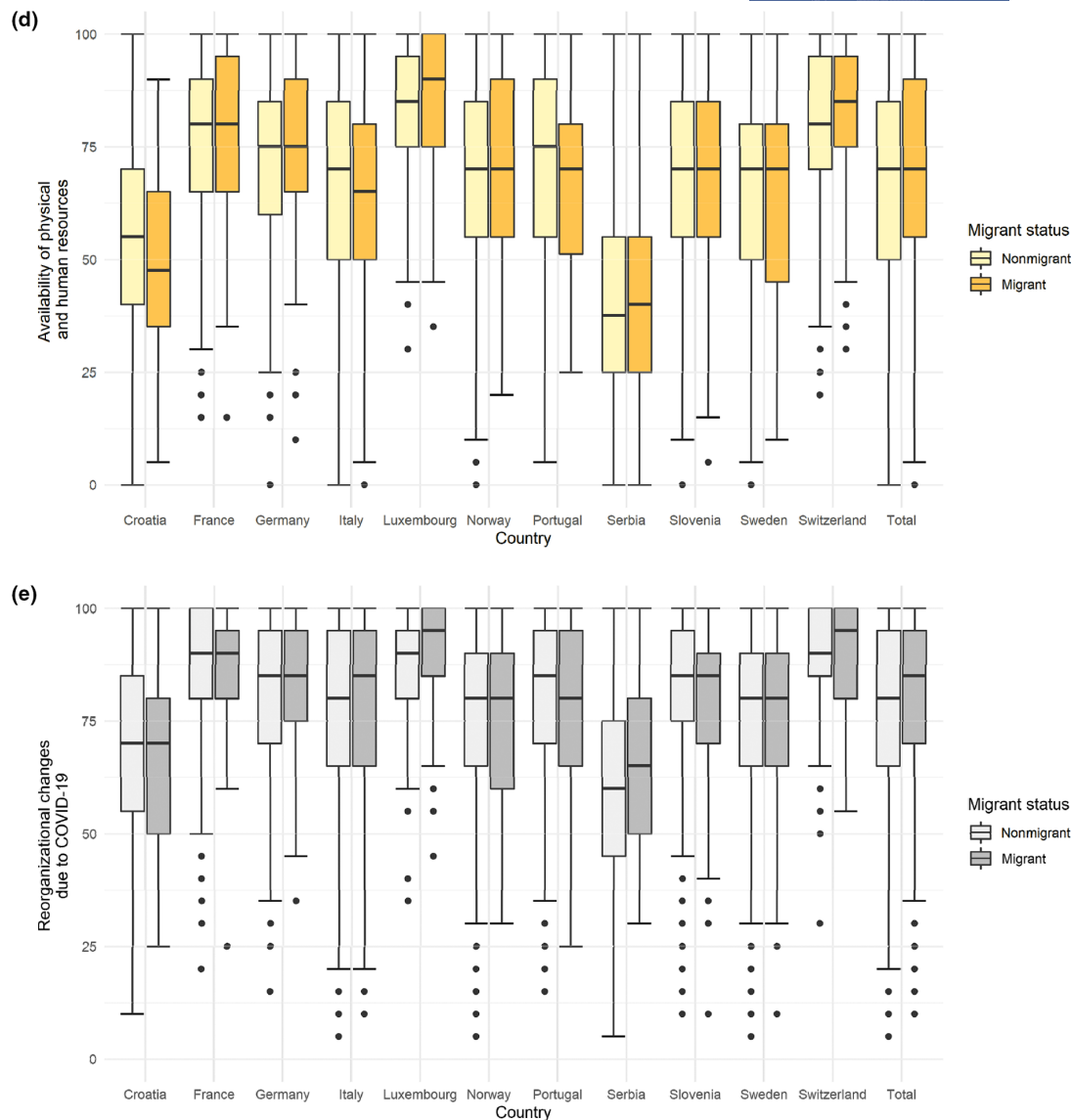


FIGURE 2 (Continued)

in healthcare encounters⁴⁷ and report serious neglect of perceived care needs.⁴⁸ In a systematic review that included 10 studies and 198 migrant women, Leppälä et al.²⁹ reported that late provision of health information and diminishment or nonrecognition of care needs by healthcare professionals is an important theme among migrant women seeking maternity care in European Nordic countries. This is still a major issue in healthcare provision,²⁷⁻³⁰ which is concerning in itself, but also because suboptimal care may lead to negative health outcomes.

Almost 15% of migrant (and 12.7% of nonmigrant) women reported suffering from physical, verbal, or emotional abuse in health facilities, even in high-income countries.^{49,50} Experiences of care-related discrimination,²⁹ such as prejudice and stereotyping²⁶, negative attitudes and behaviors^{29,51,52}, lack of respect, indifference and distant and absent behavior⁵³ have been reported in previous studies related to migrant women's health care and undocumented migrant pregnant women.⁵⁴ In our study, forms of physical abuse included,

but were not restricted to, being touched improperly and/or without asking permission and being pushed, beaten, slapped, pinched, physically restrained, or gagged. Verbal abuse included, but was not restricted to, being shouted at, insulted, or spoken to rudely. Emotional abuse included, but was not restricted to, being neglected, mocked, or forgotten by healthcare providers. Disrespectful and hostile attitudes from healthcare providers may lead to avoidance of healthcare services,^{55,56} which may jeopardize women's and newborns' health outcomes. Our results show that not only migrant women, but also nonmigrant women have experienced this type of mistreatment, which is a call for generalized action to improve respectful care in healthcare facilities.

In relation to rates of cesarean, we found no differences between nonmigrant and migrant women, whereas previous evidence showed that differences in rates of cesarean in migrant women living in high-income countries compared with nonmigrant women depend on a combination of factors, including country of origin and hosting

TABLE 2 Perceived quality of care by migration status ($n = 16\,472$)^a

	0.25th centile		0.50th centile (median)		0.75th centile	
	Coefficient (95% CI)	P value	Coefficient (95% CI)	P value	Coefficient (95% CI)	P value
Provision of care						
Nonmigrant	Ref.		Ref.		Ref.	
Migrant	0.00 (-5.62; 5.62)	>0.999	0.00 (-4.49; 4.49)	>0.999	0.00 (-4.70; 4.70)	>0.999
Experience of care						
Nonmigrant	Ref.		Ref.		Ref.	
Migrant	0.00 (-2.16; 2.16)	>0.999	0.00 (-4.88; 4.88)	>0.999	0.00 (-4.68; 4.68)	>0.999
Availability of human and physical resources						
Nonmigrant	Ref.		Ref.		Ref.	
Migrant	0.00 (-3.11; 3.11)	>0.999	0.00 (-1.35; 1.35)	>0.999	0.00 (-1.70; 1.70)	>0.999
Reorganizational changes due to COVID-19 pandemic						
Nonmigrant	Ref.		Ref.		Ref.	
Migrant	0.00 (-1.55; 1.55)	>0.999	0.00 (-1.12; 1.12)	>0.999	0.63 (-5.42; 6.67)	0.840
QMNC index						
Nonmigrant	Ref.		Ref.		Ref.	
Migrant	-4.00 (-8.70; 0.70)	0.095	0.00 (-3.18; 3.18)	>0.999	0.00 (-2.47; 2.47)	>0.999

Abbreviation: QMNC, quality of maternal and newborn care.

^a95% CIs and *P* values were calculated using robust estimation of standard errors, adjusted for country and for sociodemographic and perinatal confounders (i.e. maternal age, maternal education, type of hospital, type of birth, presence of an obstetrics/gynecology doctor in the team who assisted birth).

country.^{9,57} Study data were not analyzed by country of origin or hosting country, and therefore our findings do not include potential specific differences that might have occurred for the prevalence of cesarean between nonmigrants and migrants from different origin countries or hosting countries (e.g. women from Syria living in Germany vs women from France living in Portugal). Additionally, we found no differences between migrant and nonmigrant women for pain relief during labor, whereas previous studies documented that migrant women, especially those from low-income countries, had significantly lower use of epidural analgesia. This could be due to communication problems, since migrant women with a partner from the hosting country were more likely to receive pain relief during childbirth, compared with those with a migrant partner.⁵⁸ When there are language barriers and lack of interpretation, patient-provider communication may be reduced to a minimum, with a negative impact on providing adequate information on treatment and meeting women's expectations and needs.⁵⁹ However, Byrskog et al.⁶⁰ found that migrant women with a community-based bilingual doula present during childbirth used less pain relief compared with nonmigrant women, which could be interpreted as improved management of pain or missing out on available pain relief. Razum et al.⁶¹ found that, among second generation migrants, receiving appropriate neuraxial anesthesia for vaginal births and for cesarean (instead of general anesthesia) was independent of migration status, whereas first generation migrants with low local language skills or low educational level had lower chances of receiving neuraxial anesthesia for vaginal births.

After cesarean, migrant women in our study were more likely not to receive adequate pain relief compared with nonmigrant women. Future studies analyzing in depth women's perspectives and beliefs on pain relief could identify determinants of pain relief during labor, birth, and postpartum if and when it is wanted.

Migrant women were slightly more likely to report that they were not allowed to stay with their baby as they wished and were more likely to report early breastfeeding compared with nonmigrant women who experienced labor. Rooming-in promotes mother-infant bonding⁶² and moderates individual risk factors for postpartum depression.⁶³ Thus, denying a woman's right to stay with her baby can have a negative effect not only on the mother, but also on the baby and the mother-infant relationship.⁶² Regardless, migrant women were more likely to initiate early breastfeeding compared with nonmigrant women, which is reassuring for mother-infant interactions. In some European countries, exclusive breastfeeding rates for the first day in hospital are high for both migrant and nonmigrant women, with migrant women more likely to breastfeed exclusively.⁶⁴ Additionally, qualitative studies have reported that migrant women perceived guidance on breastfeeding practices to be good and helpful after birth.⁵²

Migrant women were more likely to perceive inadequate room comfort and equipment, an inadequate number of women per room, and were less likely to have provided informal payments. Possible explanations for migrant women's dissatisfaction with healthcare facilities in our study may be because, in general, the sample was comprised of highly educated women who may have

had high expectations of facilities providing maternal and newborn health care in middle/high-income countries.

Finally, our data show that migrant women who gave birth in Croatia, Portugal, Slovenia, and Sweden reported significantly lower QMNC compared with nonmigrant women for specific subdomains of the QMNC, whereas the opposite occurred in Luxembourg. This shows that differences in health care between migrant and nonmigrant women are highly dependent on the hosting country, which has been identified previously for specific aspects of maternal health care.^{9,57} To understand these differences, qualitative studies with mothers and healthcare providers could inform factors that determine uptake and quality of care for migrant women in specific countries. However, these differences were not significant after adjustments for relevant factors, indicating gaps in the QMNC for all women, regardless of migration status, and need for overall improvements in the provision of care.

A limitation of the present study is that about one-third of the participants (both migrants and nonmigrant) were from northern European countries and had a relatively high level of education compared with that expected in the overall general population, and especially among migrants. Higher educational levels could be associated with better access to high QMNC for both migrants and nonmigrant women, but could also be associated with higher expectations compared to migrant and nonmigrant women with lower education levels. We acknowledge the complexity of the nonmigrant and migrant population in Europe, and that women with lower educational level, lower socioeconomic background, and/or at greater distress may have been less likely to answer the questionnaire. Additionally, despite the large sample size in the current study, we did not compare the total number of births in the various countries and the numbers of participants in this study by migrant status, therefore we cannot report on bias nor assume that the sample is representative of the population. Studies with more representative samples of the most vulnerable migrants from recent conflict areas, or from southern European countries where there are recent emerging migration flows and social and demographic conditions are less favorable, may have yielded different results.

According to the International Organization for Migration³⁵ there is no universal consensus on the definition of "migrant" and, in this study, we defined migrant as a woman giving birth in a foreign country, i.e. not in the country in which she was born. As we did not have information on how long ago these women moved from their country of origin and how long they were living in the country where they gave birth, we are unable to elucidate the potential effects of acculturation. We did not collect information on the legal resident status of the women, their partner, or family members (e.g. refugee or asylum seekers, or those with temporary vs permanent residency status) and therefore we are unable to discern the impact of documented status on perception of QMNC. We also did not examine the association between QMNC and individual factors, such as migrant women's acculturation or understanding of the local language, and specific indicators such as communication with healthcare providers. Further analysis on the association between sociodemographic characteristics and specific indicators of QMNC will be provided in

future publications. Finally, we do not know whether women were COVID-19 positive specifically at the time of childbirth, which could explain differences in several quality measures since there were specific restrictions and denials of women's rights in those cases. Nonetheless, in our sample a similar proportion of migrant and nonmigrant women (3.8% vs 3.6%) had COVID-19 at some point during pregnancy, childbirth, or postpartum so this does not fully explain the differential in QMNC scores. Future studies analyzing QMNC from the perspectives of women with COVID-19 during the perinatal period, regardless of their migrant status, would be of great interest.

In conclusion, gaps in overall QMNC were reported by both migrant and nonmigrant women, showing that improvements to health care are necessary for all. Continuous monitoring of QMNC for both migrant and nonmigrant women in Europe is important to improve healthcare for all and improve women's experiences. Migrant issues are especially relevant in a transforming Europe with reshaped migration flows due to the COVID-19 pandemic and to a migration crisis related to violent armed conflicts in Eastern Europe. Urgent actions are needed to understand how health care operates for migrants within the WHO European Region, to improve QMNC for all women, and to develop migrant-friendly health systems that incorporate the needs of migrants into health care by attending to cultural and socioeconomic specificities to achieve equity and healthier societies.

AUTHOR CONTRIBUTIONS

RC wrote the first draft, with major inputs from all authors. ML conceived the study, with major inputs from EPV, BC, and additional input from all other authors. IM analyzed the data, with major inputs from RC, CR, HD, CB, ML, EV, BC, IC, RA, KL, HE, MZ, MA, ES, LW, VR, and CM. All authors developed and promoted the surveys, contributed to data collection, and approved the final version of the manuscript.

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CONFLICT OF INTEREST

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DATA AVAILABILITY STATEMENT

Data can be made available on reasonable request to the corresponding author.

DISCLAIMER

The authors alone are responsible for the views expressed in this article and they do not necessarily represent the views, decisions, or policies of the institutions with which they are affiliated.

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REFERENCES

- United Nations Department of Economic and Social Affairs. International Migration 2020 Highlights. UN; 2020. https://www.un.org/development/desa/pd/sites/www.un.org.development.desa.pd/files/undesd_pd_2020_international_migration_highlights.pdf. Accessed January 27, 2022.
- World Health Organization. Report on the health of refugees and immigrants in the WHO European region: no public health without refugee and migrant health. WHO; 2018.
- International Organization for Migration. Regional Ukraine Response. Situation Report #9, 21 March 2022. https://www.iom.int/sites/g/files/tmzbd1486/files/situation_reports/file/iom-regional-ukraine-response-external-sitrep-21032022.pdf. Accessed March 22, 2022.
- International Organization for Migration. Regional Ukraine Response. Situation Report #3, 9 March 2022. https://www.iom.int/sites/g/files/tmzbd1486/files/situation_reports/file/iom-regional-ukraine-response-external-sitrep-07032022-final.pdf. Accessed March 10, 2022.
- Abubakar I, Aldridge RW, Devakumar D, et al. The UCL–Lancet Commission on migration and health: the health of a world on the move. *Lancet*. 2018;392:2606–2654.
- Moullan Y, Jusot F. Why is the 'healthy immigrant effect' different between European countries? *Eur J Public Health*. 2014;24(Suppl 1):80–86.
- ISSOP Migration Working Group. ISSOP position statement on migrant child health. *Child Care Health Dev*. 2018;44:161–170.
- World Health Organization. Situation update 3: refugee crisis World Health Organization regional Office for Europe. WHO; 2016.
- Bastola K, Koponen P, Gissler M, Kinnunen TI. Differences in caesarean delivery and neonatal outcomes among women of migrant origin in Finland: a population-based study. *Paediatr Perinat Epidemiol*. 2020;34:12–20.
- Keygnaert I, Ivanova O, Guieu A, Van Parys A-S, Leye E, Roelens K. What is the evidence on the reduction of inequalities in accessibility and quality of maternal health care delivery for migrants? A review of the existing evidence in the WHO European Region. WHO Regional Office for Europe; 2016.
- Malin M, Gissler M. Maternal care and birth outcomes among ethnic minority women in Finland. *BMC Public Health*. 2009;9:84.
- Collins CH, Zimmerman C, Howard LM. Refugee, asylum seeker, immigrant women and postnatal depression: rates and risk factors. *Arch Womens Ment Health*. 2011;14:3–11.
- Juárez SP, Revuelta-Eugercios BA. Too heavy, too late: investigating perinatal health outcomes in immigrants residing in Spain. A cross-sectional study (2009–2011). *J Epidemiol Community Health*. 2014;68:863–868.
- Reeske A, Kutschmann M, Razum O, Spallek J. Stillbirth differences according to regions of origin: an analysis of the German perinatal database, 2004–2007. *BMC Pregnancy Childbirth*. 2011;11:63.
- Damsted Rasmussen T, Villadsen SF, Kragh Andersen P, Smith Jervelund S, Nybo Andersen AM. Social and ethnic disparities in stillbirth and infant death in Denmark, 2005–2016. *Sci Rep*. 2021;11:8001.
- Pedersen GS, Grøntved A, Mortensen LH, Andersen AM, Rich-Edwards J. Maternal mortality among migrants in Western Europe: a meta-analysis. *Matern Child Health J*. 2014;18:1628–1638.
- Vik ES, Aasheim V, Schytt E, Small R, Moster D, Nilsen RM. Stillbirth in relation to maternal country of birth and other migration related factors: a population-based study in Norway. *BMC Pregnancy Childbirth*. 2019;19:5.
- Sauvegrain P, Stewart Z, Gonthier C, Saurel-Cubizolles M-J, Saucedo M, Deneux-Tharoux C. Accès aux soins prénatals et santé maternelle des femmes immigrées [access to prenatal care and maternal health of immigrant women in France]. *Bulletin Epidémiologique Hebdomadaire*. 2017;19–20:389–395.
- Urquia ML, Glazier RH, Mortensen L, et al. Severe maternal morbidity associated with maternal birthplace in three high-immigration settings. *Eur J Public Health*. 2015;25:620–625.
- Klein J, von dem Knesebeck O. Inequalities in health care utilization among migrants and non-migrants in Germany: a systematic review. *Int J Equity Health*. 2018;17:160.
- Sami J, Quack Lötscher KC, Eperon I, et al. Giving birth in Switzerland: a qualitative study exploring migrant women's experiences during pregnancy and childbirth in Geneva and Zurich using focus groups. *Reprod Health*. 2019;16:112.
- Spallek J, Lehnhardt J, Reeske A, Razum O, David M. Perinatal outcomes of immigrant women of Turkish, middle eastern and north African origin in Berlin, Germany: a comparison of two time periods. *Arch Gynecol Obstet*. 2014;289:505–512.
- Sacks E, Peca E. Confronting the culture of care: a call to end disrespect, discrimination, and detainment of women and newborns in health facilities everywhere. *BMC Pregnancy Childbirth*. 2020;20:249.

24. Balaam MC, Akerjordet K, Lyberg A, et al. A qualitative review of migrant women's perceptions of their needs and experiences related to pregnancy and childbirth. *J Adv Nurs*. 2013;69:1919-1930.
25. De Freitas C, Massag J, Amorim M, Fraga S. Involvement in maternal care by migrants and ethnic minorities: a narrative review. *Public Health Rev*. 2020;41:5.
26. Fair F, Raben L, Watson H, et al. Migrant women's experiences of pregnancy, childbirth and maternity care in European countries: a systematic review. *PLoS ONE*. 2020;15:e0228378.
27. Small R, Roth C, Raval M, et al. Immigrant and non-immigrant women's experiences of maternity care: a systematic and comparative review of studies in five countries. *BMC Pregnancy Childbirth*. 2014;14:152.
28. Higginbottom GMA, Evans C, Morgan M, et al. Access to and interventions to improve maternity care services for immigrant women: a narrative synthesis systematic review. *NIHR journals. Library*. 2020;8:1-122.
29. Leppälä S, Lamminpää R, Gissler M, Vehviläinen-Julkunen K. Humanitarian migrant women's experiences of maternity care in Nordic countries: a systematic integrative review of qualitative research. *Midwifery*. 2020;80:102572.
30. Rivenbark JG, Ichou M. Discrimination in healthcare as a barrier to care: experiences of socially disadvantaged populations in France from a nationally representative survey. *BMC Public Health*. 2020;20:31.
31. European Commission, Joint Research Centre, Atlas of migration 2020, Publications Office, 2020. <https://op.europa.eu/en/publication-detail/-/publication/078d8a2f-433b-11eb-b27b-01aa75ed71a1>. Accessed January 23, 2022
32. Barbosa-Leiker C, Smith CL, Crespi EJ, et al. Stressors, coping, and resources needed during the COVID-19 pandemic in a sample of perinatal women. *BMC Pregnancy Childbirth*. 2021;21:171.
33. World Health Organization. Collection and integration of data on refugee and migrant health in the WHO European region. WHO; 2020.
34. Trummer U, Krasnik A. Migrant health: the economic argument. *Eur J Public Health*. 2017;27:590-591.
35. International Organization for Migration. International Migration Law: Glossary on Migration. IOM; 2019. https://publications.iom.int/system/files/pdf/iml_34_glossary.pdf. Accessed January 23, 2022.
36. van Roosmalen J, Schuitmaker NW, Brand R, van Dongen PW, Bennebroek GJ. Substandard care in immigrant versus indigenous maternal deaths in The Netherlands. *BJOG*. 2002;109:212-213.
37. Essén B, Bödker B, Sjöberg NO, et al. Are some perinatal deaths in immigrant groups linked to suboptimal perinatal care services? *BJOG*. 2002;109:677-682.
38. World Health Organization. Standards for improving quality of maternal and newborn care in health facilities. WHO; 2016.
39. von Elm E, Altman DG, Egger M, Pocock SJ, Gøtzsche PC, Vandenbroucke JP. The strengthening the reporting of observational studies in epidemiology (STROBE) statement: guidelines for reporting observational studies. *Lancet*. 2007;370:1453-1457.
40. Lazzarini M, Covi B, Mariani I, et al. Quality of facility-based maternal and newborn care around the time of childbirth during the COVID-19 pandemic: online survey investigating maternal perspectives in 12 countries of the WHO European region. *Lancet Reg Health Eur*. 2022;13:100268.
41. Lazzarini M, Argentini G, Mariani I, et al. WHO standards-based tool to measure women's views on the quality of care around the time of childbirth at facility level in the WHO European region: development and validation in Italy. *BMJ Open*. 2022;12:e048195.
42. Lazzarini M, Covi B, Mariani I, Giusti A, Pessa Valente E; for the IMAGiNE EURO Study Group. Quality of care at childbirth: Findings of IMAGiNE EURO in Italy during the first year of the COVID-19 pandemic. *Int J Gynecol Obstet*. 2022;157:405-417.
43. Zaigham M, Linden K, Sengpiel V, et al. IMAGiNE EURO Study Group. Large gaps in the quality of healthcare experienced by Swedish mothers during the COVID-19 pandemic: a cross-sectional study based on WHO standards. *Women Birth*. 2022;35:619-627.
44. National Institute of Health and Care Excellence (NICE). Intrapartum care for healthy women and babies. Clinical guideline 190. December 2014. <https://www.nice.org.uk/guidance/cg190/resources/intrapartum-care-for-healthy-womenand-babies-pdf-35109866447557>. Accessed January 27, 2022.
45. Koenker R. *Quantile Regression*. Cambridge University Press; 2015.
46. R Core Team. *R: A Language and Environment for Statistical Computing*. R Foundation for Statistical Computing. 2021. <https://www.R-project.org/>.
47. Robertson EK. "To be taken seriously": women's reflections on how migration and resettlement experiences influence their healthcare needs during childbearing in Sweden. *Sex Reprod Health*. 2015;6:59-65.
48. Lillrank A. Trust, vacillation and neglect - refugee women's experiences regarding pregnancy and birth giving in Finland. *Nordic J Migr Res*. 2015;5:83-90.
49. Bohren MA, Vogel JP, Hunter EC, et al. The mistreatment of women during childbirth in health facilities globally: a mixed-methods systematic review. *PLoS Med*. 2015;12:e1001847.
50. Vidmar Šimić M, Lučovnik M, Leskošek V, et al. Abuse of pregnant women in the healthcare system. *J Matern Fetal Neonatal Med*. 2020;33:790-793.
51. Degni F, Suominen SB, El Ansari W, Vehviläinen-Julkunen K, Essen B. Reproductive and maternity health care services in Finland: perceptions and experiences of Somali-born immigrant women. *Ethn Health*. 2014;19:348-366.
52. Glavin K, Saeteren B. Cultural diversity in perinatal care: Somali new mothers' experiences with health care in Norway. *Health Sci J*. 2016;10:17.
53. Viken B, Lyberg A, Severinsson E. Maternal health coping strategies of migrant women in Norway. *Nurs Res Pract*. 2015;2015:878040.
54. Barkensjö M, Greenbrook JTV, Rosenlundh J, Ascher H, Elden H. The need for trust and safety inducing encounters: a qualitative exploration of women's experiences of seeking perinatal care when living as undocumented migrants in Sweden. *BMC Pregnancy Childbirth*. 2018;18:217.
55. McLeish J. Maternity experiences of asylum seekers in England. *Br J Midwifery*. 2005;13:782-789.
56. Berggren V, Bergstrom S, Edberg AK. Being different and vulnerable: experiences of immigrant African women who have been circumcised and sought maternity care in Sweden. *J Transcontinental Nurs*. 2006;17:50-57.
57. Merry L, Vangen S, Small R. Caesarean births among migrant women in high-income countries. *Best Pract Res Clin Obstet Gynaecol*. 2016;32:88-99.
58. Ekéus C, Cnattingius S, Hjern A. Epidural analgesia during labor among immigrant women in Sweden. *Acta Obstet Gynecol Scand*. 2010;89:243-249.
59. Origlia Ikhilor P, Hasenberg G, Kurth E, Asefaw F, Pehlke-Milde J, Cignacco E. Communication barriers in maternity care of allophone migrants: experiences of women, healthcare professionals, and intercultural interpreters. *J Adv Nurs*. 2019;75:2200-2210.
60. Byrskog U, Small R, Schytt E. Community-based bilingual doulas for migrant women in labour and birth - findings from a Swedish register-based cohort study. *BMC Pregnancy Childbirth*. 2020;20:721.
61. Razum O, Reiss K, Breckenkamp J, et al. Comparing provision and appropriateness of health care between immigrants and non-immigrants in Germany using the example of neuraxial anaesthesia during labour: cross-sectional study. *BMJ Open*. 2017;7:e015913.
62. Handelzalts JE, Levy S, Molmen-Lichter M, et al. Associations of rooming-in with maternal postpartum bonding: the impact of mothers' pre-delivery intentions. *Midwifery*. 2021;95:102942.
63. Molmen Lichter M, Peled Y, Levy S, Wiznitzer A, Krissi H, Handelzalts JE. The associations between insecure attachment,

- rooming-in, and postpartum depression: a 2 months' longitudinal study. *Infant Ment Health J.* 2021;42:74-86.
64. Lisi C, De Freitas C, Barros H. Maternal country of birth and exclusive breastfeeding during the first in-hospital day in Portugal: the influence of the baby-friendly hospital initiative. *J Hum Lact.* 2021;37:147-157.

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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Supporting information Table 1. Checklist of items that should be included in reports of cross-sectional studies

	Item No	Recommendation	Pages
Title and abstract	1	(a) Indicate the study's design with a commonly used term in the title or the abstract	1
		(b) Provide in the abstract an informative and balanced summary of what was done and what was found	1
Introduction			
Background/rationale	2	Explain the scientific background and rationale for the investigation being reported	2
Objectives	3	State specific objectives, including any prespecified hypotheses	2
Methods			
Study design	4	Present key elements of study design early in the paper	2-3
Setting	5	Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection	3
Participants	6	(a) Give the eligibility criteria, and the sources and methods of selection of participants	3
Variables	7	Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable	3
Data sources/measurement	8*	For each variable of interest, give sources of data and details of methods of assessment (measurement). Describe comparability of assessment methods if there is more than one group	3
Bias	9	Describe any efforts to address potential sources of bias	4
Study size	10	Explain how the study size was arrived at	3
Quantitative variables	11	Explain how quantitative variables were handled in the analyses. If applicable, describe which groupings were chosen and why	4
Statistical methods	12	(a) Describe all statistical methods, including those used to control for confounding	4
		(b) Describe any methods used to examine subgroups and interactions	4
		(c) Explain how missing data were addressed	4
		(d) If applicable, describe analytical methods taking account of sampling strategy	n/a
		(e) Describe any sensitivity analyses	n/a
Results			
Participants	13*	(a) Report numbers of individuals at each stage of study—eg numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analyzed	4
		(b) Give reasons for non-participation at each stage	n/a
		(c) Consider use of a flow diagram	7
Descriptive data	14*	(a) Give characteristics of study participants (eg demographic, clinical, social) and information on exposures and potential confounders	4
		(b) Indicate number of participants with missing data for each variable of interest	3
Outcome data	15*	Report numbers of outcome events or summary measures	4
Main results	16	(a) Give unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (eg, 95% confidence interval). Make clear which confounders were adjusted for and why they were included	4
		(b) Report category boundaries when continuous variables were categorized	4
		(c) If relevant, consider translating estimates of relative risk into absolute risk for a meaningful time period	n/a
Other analyses	17	Report other analyses done—eg analyses of subgroups and interactions, and sensitivity analyses	Supp. Files
Discussion			
Key results	18	Summarize key results with reference to study objectives	5
Limitations	19	Discuss limitations of the study, taking into account sources of potential bias or imprecision. Discuss both direction and magnitude of any potential bias	6
Interpretation	20	Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies, and other relevant evidence	5-6
Generalizability	21	Discuss the generalizability (external validity) of the study results	6
Other information			
Funding	22	Give the source of funding and the role of the funders for the present study and, if applicable, for the original study on which the present article is based	16

Notes: * Give information separately for exposed and unexposed groups.

Supporting information Table 2. Provision of care^a

Women who experienced labor (n=19 861)					Women with a prelabor cesarean (n=3120)				
	Nonmigrant No. (%)	Migrant No. (%)	<i>P</i> value	<i>P</i> value ^b		Nonmigrant No. (%)	Migrant No. (%)	<i>P</i> value	<i>P</i> value ^b
No.	17 906	1507			No.	2747	274		
1. No pain relief during labor	3703 (20.7)	293 (19.4)	0.285	0.329	1. Mode of birth				
2. Mode of birth					1a. Elective cesarean	1829 (66.6)	190 (69.3)	0.391	0.767
2a. IVB	1909 (10.7)	185 (12.3)	0.052	0.485	1b. EC before labor	918 (33.4)	84 (30.7)	0.391	0.767
2b. EC during labor	1929 (10.8)	154 (10.2)	0.505	0.247	2. No pain relief after cesarean	371 (13.5)	46 (16.8)	0.281	0.039
3a. Episiotomy (in SVB)	2857/14068 (20.3)	228/1168 (19.5)	0.520	0.921	3. No skin to skin	881 (32.1)	64 (23.4)	0.001	0.281
3b. Fundal pressure (in IVB)	768/1909 (40.2)	65/185 (35.1)	0.177	0.655	4. No early breastfeeding	924 (33.6)	84 (30.7)	0.328	0.901
3c. No pain relief after cesarean	292/1929 (15.1)	17/154 (11.0)	0.171	0.179	5. Inadequate breastfeeding support	1005 (36.6)	95 (34.7)	0.574	0.529
4. No skin to skin	1545 (8.6)	93 (6.2)	0.003	0.086	6. No rooming-in	986 (35.9)	94 (34.3)	0.648	0.403
5. No early breastfeeding	2460 (13.7)	152 (10.1)	<0.001	0.002	7. Not allowed to stay with the baby as wished	370 (13.5)	36 (13.1)	0.952	0.284
6. Inadequate breastfeeding support	5499 (30.7)	463 (30.7)	1.000	0.078	8. No exclusive breastfeeding at discharge	1268 (46.2)	124 (45.3)	0.824	0.676
7. No rooming-in	3566 (19.9)	275 (18.2)	0.127	0.950	9. No immediate attention when needed	970 (35.3)	92 (33.6)	0.612	0.966
8. Not allowed to stay with the baby as wished	1235 (6.9)	117 (7.8)	0.224	0.011	10. No timely care by HCP at facility arrival	416 (15.1)	39 (14.2)	0.754	0.966
9. No exclusive breastfeeding at discharge	5133 (28.7)	436 (28.9)	0.850	0.193					
10. No immediate attention when needed	5642 (31.5)	448 (29.7)	0.161	0.984					

Abbreviations: IVB, instrumental vaginal delivery; SVB, spontaneous vaginal delivery; EC, emergency cesarean; HCP, healthcare provider.

^a All the indicators in the domain of provision of care are directly based on WHO standards. Statistically significant results in boldface print. Indicators identified with letters (e.g. 3a, 3b) were tailored to take into account different mode of birth (i.e. spontaneous vaginal, instrumental vaginal, and cesarean). These were calculated on subsamples (e.g. 3a was calculated on spontaneous vaginal births; 3b was calculated on instrumental vaginal births).

^b *P* value adjusted for country.

Supporting information Table 3. Experience of care^a

Women who experienced labor (n=19 861)					Women with a prelabor cesarean (n=3120)				
	Nonmigrant No. (%)	Migrant No. (%)	<i>P</i> value	<i>P</i> value ^b		Nonmigrant No. (%)	Migrant No. (%)	<i>P</i> value	<i>P</i> value ^b
No.	17 906	1507			No.	2747	274		
1. No freedom of movements during labor	4802 (26.8)	374 (24.8)	0.108	0.958	1. No consent requested for vaginal examination	828 (30.1)	71 (25.9)	0.341	0.650
2a. No choice of birth position (in SVB)	6189/14 068 (44.0)	518/1168 (44.3)	0.814	0.790	2. No information on newborn	778 (28.3)	76 (27.7)	0.885	0.911
2b. No consent requested (for IVB)	1004/1909 (52.6)	96/185 (51.9)	0.916	0.594	3. No clear/effective communication from HCP	963 (35.1)	86 (31.4)	0.250	0.885
2c. No information on newborn (in EC)	755/1929 (39.1)	51/154 (33.1)	0.278	0.251	4. No involvement in choices	1182 (43.0)	102 (37.2)	0.074	0.832
3. No clear/effective communication from HCP	5463 (30.5)	445 (29.5)	0.444	0.391	5. Companionship not allowed	1898 (69.1)	168 (61.3)	0.010	0.346
4. No involvement in choices	6222 (34.7)	529 (35.1)	0.803	0.104	6. Not treated with dignity	841 (30.6)	71 (25.9)	0.122	0.527
5. Companionship not allowed	11053 (61.7)	813 (53.9)	<0.001	0.141	7. No emotional support	873 (31.8)	88 (32.1)	0.963	0.451
6. Not treated with dignity	4325 (24.2)	357 (23.7)	0.709	0.457	8. No privacy	604 (22.0)	61 (22.3)	0.977	0.674
7. No emotional support	4976 (27.8)	435 (28.9)	0.387	0.089	9. Abuse (physical/verbal/emotional)	397 (14.5)	37 (13.5)	0.736	0.901
8. No privacy	3387 (18.9)	287 (19.0)	0.929	0.387	10. Informal payment	122 (4.4)	5 (1.8)	0.057	0.005
9. Abuse (physical/verbal/emotional)	2280 (12.7)	218 (14.5)	0.059	0.022					
10. Informal payment	442 (2.5)	47 (3.1)	0.144	0.877					

Abbreviations: EC, emergency cesarean; HCP, healthcare provider; IVB, instrumental vaginal birth; SVB, spontaneous vaginal birth

^a All the indicators in the domain of experience of care are directly based on WHO standards. Statistically significant results in boldface print. Indicators identified with letters (e.g. 2a, 2b) were tailored to take into account different mode of birth (i.e. spontaneous vaginal, instrumental vaginal, and cesarean). These were calculated on subsamples (e.g. 2a was calculated on spontaneous vaginal births; 2b was calculated on instrumental vaginal births).

^b *P* value adjusted for country.

Supporting information Table 4. Availability of motivated human resources and essential physical resources^a

Women who experienced labor (n=19 861)					Women with a prelabor cesarean (n=3120)				
	Nonmigrant No. (%)	Migrant No. (%)	<i>P</i> value	<i>P</i> value ^b		Nonmigrant No. (%)	Migrant No. (%)	<i>P</i> value	<i>P</i> value ^b
No.	17 906	1507			No.	2747	274		
1. No timely care by HCPs at facility arrival	2331 (13.0)	221 (14.7)	0.075	0.025	1. No information on maternal danger signs	1264 (46.0)	128 (46.7)	0.874	0.268
2. No information on maternal danger signs	8183 (45.7)	682 (45.3)	0.760	0.285	2. No information on newborn danger signs	1450 (52.8)	148 (54.0)	0.745	0.275
3. No information on newborn danger signs	9725 (54.3)	802 (53.2)	0.429	0.870	3. Inadequate room comfort and equipment	321 (11.7)	23 (8.4)	0.125	0.572
4. Inadequate room comfort and equipment	1524 (8.5)	138 (9.2)	0.416	0.004	4. Inadequate number of women per rooms	185 (6.7)	15 (5.5)	0.501	0.531
5. Inadequate number of women per rooms	1537 (8.6)	142 (9.4)	0.287	0.039	5. Inadequate room cleaning	227 (8.3)	25 (9.1)	0.706	0.237
6. Inadequate room cleaning	1235 (6.9)	110 (7.3)	0.591	0.090	6. Inadequate bathroom	399 (14.5)	36 (13.1)	0.594	0.465
7. Inadequate bathroom	2474 (13.8)	192 (12.7)	0.486	0.524	7. Inadequate partner visiting hours	1778 (64.7)	152 (55.5)	0.003	0.641
8. Inadequate partner visiting hours	11122 (62.1)	827 (54.9)	<0.001	0.495	8. Inadequate HCP number	624 (22.7)	50 (18.2)	0.106	0.191
9. Inadequate HCP number	3901 (21.8)	295 (19.6)	0.049	0.404	9. Inadequate HCP professionalism	185 (6.7)	16 (5.8)	0.660	0.656
10. Inadequate HCP professionalism	1009 (5.6)	94 (6.2)	0.361	0.056	10. Inadequate wards reorganization	1130 (41.1)	106 (38.7)	0.432	0.542

Abbreviation: HCP, healthcare provider.

^a All the indicators in the domain of resources are directly based on WHO standards. Statistically significant results in boldface print.

^b *P* value adjusted for country.

Supporting information Table 5. Reorganizational changes due to COVID-19^a

Women who experienced labor (n=19 861)					Women with a prelabor cesarean (n=3120)				
	Nonmigrant n(%)	Migrant n(%)	<i>P</i> value	<i>P</i> value ^b		Nonmigrant No. (%)	Migrant No. (%)	<i>P</i> value	<i>P</i> value ^b
No.	17 906	1507			No.	2747	274		
1. Difficulties in attending routine antenatal visits	7063 (39.4)	621 (41.2)	0.179	0.001	1. Difficulties in attending routine antenatal visits	1149 (41.8)	115 (42.0)	1.000	0.274
2. Any barriers in accessing the facility	5358 (29.9)	496 (32.9)	0.016	0.001	2. Any barriers in accessing the facility	940 (34.2)	92 (33.6)	0.831	0.842
3. Inadequate info graphics	1009 (5.6)	94 (6.2)	0.361	0.056	3. Inadequate info graphics	185 (6.7)	16 (5.8)	0.660	0.656
4. Inadequate wards reorganization	6669 (37.2)	526 (34.9)	0.075	0.978	4. Inadequate wards reorganization	1130 (41.1)	106 (38.7)	0.432	0.542
5. Inadequate room reorganization	6822 (38.1)	540 (35.8)	0.082	0.957	5. Inadequate room reorganization	1097 (39.9)	106 (38.7)	0.687	0.297
6. Lacking one functioning accessible hand-washing station	2423 (13.5)	170 (11.3)	0.015	0.855	6. Lacking one functioning accessible hand-washing station	530 (19.3)	31 (11.3)	0.002	0.166
7. HCP not always using PPE	5964 (33.3)	459 (30.5)	0.026	0.608	7. HCP not always using PPE	771 (28.1)	79 (28.8)	0.843	0.239
8. Insufficient HCP number	5819 (32.5)	456 (30.3)	0.079	0.347	8. Insufficient HCP number	959 (34.9)	91 (33.2)	0.573	0.846
9. Communication inadequate to contain COVID-19-related stress	6790 (37.9)	573 (38.0)	0.937	0.060	9. Communication inadequate to contain COVID-19-related stress	1177 (42.8)	122 (44.5)	0.592	0.125
10. Reduction in QMNC due to COVID-19	8734 (48.8)	692 (45.9)	0.033	0.541	10. Reduction in QMNC due to COVID-19	1359 (49.5)	112 (40.9)	0.007	0.103

Abbreviations: HCP, healthcare provider; PPE, personal protective equipment; QMNC, quality of maternal and newborn care.

^a Statistically significant results in boldface print. Indicator 6 was defined as at least one functioning and accessible hand-washing station (near or inside the room where the mother was hospitalized) supplied with water and soap or with disinfectant alcohol solution.

^b *P* value adjusted for country.

Supporting information Table 6. Perceived quality of maternal and newborn care by migration status^{a,b}

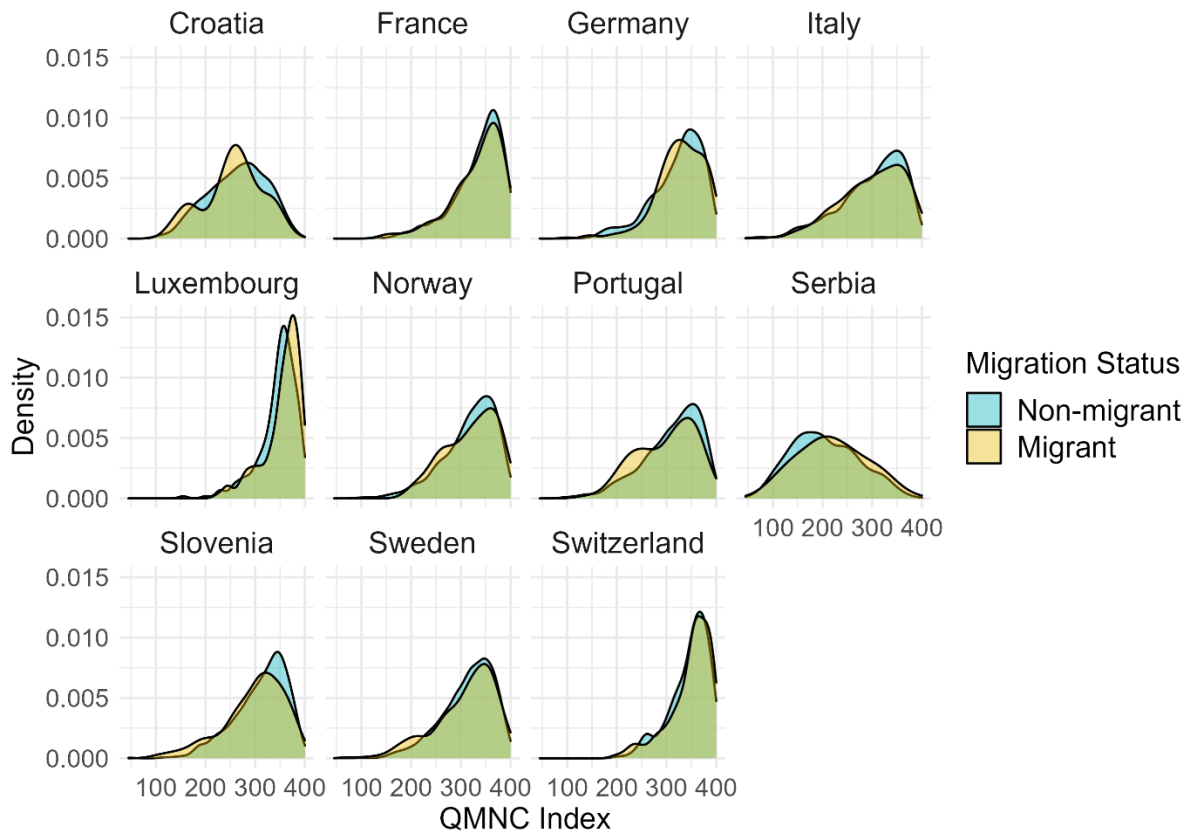
			Provision of care			Experience of care			Availability of human and physical resources			Reorganizational changes due to COVID-19			Total QMNC index		
	Nonmigrant No.	Migrant No.	Nonmigrant	Migrant	<i>P</i> value	Nonmigrant	Migrant	<i>P</i> value	Nonmigrant	Migrant	<i>P</i> value	Nonmigrant	Migrant	<i>P</i> value	Nonmigrant	Migrant	<i>P</i> value
Croatia	718	76	80.0 [65.0–90.0]	80.0 [65.0–86.2]	0.822	65.0 [50.0–80.0]	67.5 [50.0–76.2]	0.908	55.0 [40.0–70.0]	47.5 [35.0–65.0]	0.025	70.0 [55.0–85.0]	70.0 [50.0–80.0]	0.281	270.0 [220.0, 310.0]	260.0 [225.0–291.2]	0.222
France	986	61	90.0 [75.0–95.0]	90.0 [75.0–100.0]	0.897	90.0 [80.0–100.0]	90.0 [80.0–95.0]	0.961	80.0 [65.0–90.0]	80.0 [65.0–95.0]	0.732	90.0 [80.0–100.0]	90.0 [80.0–95.0]	0.130	345.0 [310.0–370.0]	350.0 [305.0–370.0]	0.921
Germany	725	98	90.0 [80.0–95.0]	90.0 [80.0–95.0]	0.690	85.0 [75.0–95.0]	90.0 [80.0–95.0]	0.296	75.0 [60.0–85.0]	75.0 [65.0–90.0]	0.313	85.0 [70.0–95.0]	85.0 [75.0–95.0]	0.570	335.0 [295.0–360.0]	335.0 [305.0–365.0]	0.413
Italy	3471	170	85.0 [70.0–90.0]	85.0 [70.0–90.0]	0.327	85.0 [70.0–90.0]	85.0 [65.0–90.0]	0.430	70.0 [50.0–85.0]	65.0 [50.0–80.0]	0.650	80.0 [65.0–95.0]	85.0 [65.0–95.0]	0.554	315.0 [265.0–350.0]	310.0 [260.0–355.0]	0.809
Luxembourg	246	153	90.0 [85.0–95.0]	90.0 [85.0–95.0]	0.465	90.0 [80.0–100.0]	95.0 [85.0–100.0]	0.337	85.0 [75.0–95.0]	90.0 [75.0–100.0]	0.021	90.0 [80.0–95.0]	95.0 [85.0–100.0]	0.003	355.0 [330.0–370.0]	365.0 [340.0–380.0]	0.002
Norway	1510	109	90.0 [80.0–95.0]	90.0 [85.0–95.0]	0.826	90.0 [80.0–100.0]	90.0 [75.0–100.0]	0.887	70.0 [55.0–85.0]	70.0 [55.0–90.0]	0.168	80.0 [65.0–90.0]	80.0 [60.0–90.0]	0.347	330.0 [290.0–360.0]	330.0 [280.0–365.0]	0.771
Portugal	1259	102	85.0 [80.0–95.0]	85.0 [75.0–90.0]	0.132	80.0 [65.0–90.0]	80.0 [55.0–90.0]	0.369	75.0 [55.0–90.0]	70.0 [51.2–80.0]	0.024	85.0 [70.0–95.0]	80.0 [65.0–95.0]	0.155	325.0 [275.0–355.0]	310.0 [255.0–350.0]	0.039
Serbia	682	61	57.5 [45.0–70.0]	60.0 [45.0–75.0]	0.737	45.0 [30.0–65.0]	55.0 [30.0–70.0]	0.087	37.5 [25.0–55.0]	40.0 [25.0–55.0]	0.279	60.0 [45.0–75.0]	65.0 [50.0–80.0]	0.059	200.0 [155.0–255.0]	210.0 [165.0–265.0]	0.123

Slovenia	1785	77	85.0 [80.0–95.0]	85.0 [75.0–90.0]	0.025	80.0 [65.0–90.0]	75.0 [60.0–90.0]	0.058	70.0 [55.0–85.0]	70.0 [55.0–85.0]	0.612	85.0 [75.0–95.0]	85.0 [70.0–90.0]	0.337	325.0 [280.0–350.0]	310.0 [270.0–345.0]	0.085
Sweden	3465	270	90.0 [80.0–95.0]	85.0 [80.0–95.0]	0.004	90.0 [75.0–95.0]	90.0 [76.2–100.0]	0.243	70.0 [50.0–80.0]	70.0 [45.0–80.0]	0.400	80.0 [65.0–90.0]	80.0 [65.0–90.0]	0.776	325.0 [285.0–355.0]	325.0 [275.0–355.0]	0.696
Switzerland	309	139	90.0 [85.0–95.0]	90.0 [85.0–95.0]	0.674	95.0 [85.0–100.0]	95.0 [85.0–100.0]	0.422	80.0 [70.0–95.0]	85.0 [75.0–95.0]	0.262	90.0 [85.0–100.0]	95.0 [80.0–100.0]	0.312	355.0 [325.0–375.0]	360.0 [330.0–380.0]	0.267
Total sample	15156	1316	85.0 [75.0–95.0]	90.0 [75.0–95.0]	0.187	85.0 [70.0–95.0]	85.0 [70.0–95.0]	<0.001	70.0 [50.0–85.0]	70.0 [55.0–90.0]	<0.001	80.0 [65.0–95.0]	85.0 [70.0–95.0]	<0.001	320.0 [270.0–355.0]	330.0 [273.8–360.0]	<0.001

^a Values are given as median [interquartile range IQR] unless otherwise indicated.

^b Provision of care, experience of care, availability of human and physical resources, reorganizational changes due to COVID-19 are the four domains of the QMNC index. Statistically significant results in boldface print.

Supporting information Figure 1. Perceived quality of maternal and newborn care (QMNC) in different countries by migration status (n=16 472)



Supporting information Table 7. Perceived quality of care in Croatia by migration status. Results from quantile regression for the 25th, 50th (median), and 75th quantiles (n=794)^a

Quantile	QMNC index	Coefficients	95%CI		P value
			Lower bound	Upper bound	
25th	Provision of care	0.00	-0.74	4.66	1.000
	Experience of care	0.00	-7.35	7.47	1.000
	Availability of human and physical resources	-5.00	-17.02	5.09	1.000
	COVID-19	0.00	-16.35	4.66	0.158
	QMNC index	-10.00	-34.37	30.49	0.854
50th	Provision of care	0.00	0.00	2.57	0.278
	Experience of care	0.00	-4.43	8.49	1.000
	Availability of human and physical resources	-5.00	-17.95	5.68	1.000
	COVID-19	0.00	-17.28	4.74	1.000
	QMNC index	0.00	-26.35	32.03	1.000
75th	Provision of care	0.00	-5.46	0.00	1.000
	Experience of care	0.00	-6.61	11.04	1.000
	Availability of human and physical resources	-5.00	-170.17	11.14	1.000
	COVID-19	-5.00	-70.88	53.24	1.000
	QMNC index	-15.00	-346.00	123.50	1.000

^a Nonmigrant women are the reference category in this analysis. Models adjusted for sociodemographic and perinatal characteristics (i.e. maternal age, maternal education, type of hospital, country, type of birth, presence of an obstetrics/gynecology doctor in the team who assisted the birth).

Supporting information Table 8. Perceived quality of care in France by migration status. Results from quantile regression for the 25th, 50th (median), and 75th quantiles (n=1047)^a

Quantile	QMNC index	Coefficients	95%CI		P value
			Lower bound	Upper bound	
25th	Provision of care	0.00	-10.24	5.36	1.000
	Experience of care	0.00	-5.23	7.55	1.000
	Availability of human and physical resources	0.00	-6.36	7.33	1.000
	COVID-19	-5.00	-5.33	4.05	0.124
	QMNC index	-2.50	-21.41	18.37	0.850
50th	Provision of care	-2.50	-3.04	3.18	0.299
	Experience of care	0.00	-6.05	6.86	1.000
	Availability of human and physical resources	0.00	-7.67	6.93	1.000
	COVID-19	0.00	-8.61	0.00	1.000
	QMNC index	0.00	-14.29	20.36	1.000
75th	Provision of care	0.00	-3.63	0.00	1.000
	Experience of care	0.00	0.00	0.81	1.000
	Availability of human and physical resources	0.00	-2.57	3.57	1.000
	COVID-19	0.00	-5.88	0.00	1.000
	QMNC index	0.00	-6.51	7.65	1.000

^a Nonmigrant women are the reference category in this analysis. Models adjusted for sociodemographic and perinatal characteristics (i.e. maternal age, maternal education, type of hospital, country, type of birth, presence of an obstetrics/gynecology doctor in the team who assisted the birth).

Supporting information Table 9. Perceived quality of care in Germany by migration status. Results from quantile regression for the 25th, 50th (median), and 75th quantiles (n=823)^a

Quantile	QMNC Index	Coefficients	95%CI		P value
			Lower bound	Upper bound	
25th	Provision of Care	0.00	-7.86	5.42	1.000
	Experience of Care	2.50	-6.89	8.65	1.000
	Availability of human and physical resources	5.00	0.64	8.96	1.000
	COVID-19	0.00	-5.14	2.50	0.165
	QMNC Index	5.00	-18.86	26.49	0.848
50th	Provision of Care	0.00	0.00	0.00	0.340
	Experience of Care	0.00	0.00	3.24	1.000
	Availability of human and physical resources	2.50	-6.56	6.72	1.000
	COVID-19	0.00	0.00	8.24	1.000
	QMNC Index	0.00	-29.30	14.99	1.000
75th	Provision of Care	0.00	0.00	0.00	1.000
	Experience of Care	0.00	0.00	4.38	1.000
	Availability of human and physical resources	0.00	-5.37	2.12	1.000
	COVID-19	1.67	0.17	4.08	1.000
	QMNC Index	0.00	-8.36	17.26	1.000

^a Nonmigrant women are the reference category in this analysis. Models adjusted for sociodemographic and perinatal characteristics (i.e. maternal age, maternal education, type of hospital, country, type of birth, presence of an obstetrics/gynecology doctor in the team who assisted the birth).

Supporting information Table 10. Perceived quality of care in Italy by migration status. Results from quantile regression for the 25th, 50th (median), and 75th quantiles (n=3641)^a

Quantile	QMNC Index	Coefficients	95% CI		P value
			Lower bound	Upper bound	
25th	Provision of Care	0.00	-5.61	5.08	1.000
	Experience of Care	-7.50	-15.47	3.71	1.000
	Availability of human and physical resources	0.00	-5.23	1.22	1.000
	COVID-19	-3.33	-15.03	7.14	0.125
	QMNC Index	-10.00	-23.79	1.23	0.849
50th	Provision of Care	1.67	-2.81	5.19	0.334
	Experience of Care	0.00	-5.96	0.75	1.000
	Availability of human and physical resources	0.00	-10.79	0.00	1.000
	COVID-19	0.00	0.00	3.63	1.000
	QMNC Index	-10.00	-17.16	8.25	1.000
75th	Provision of Care	0.00	0.00	1.56	1.000
	Experience of Care	0.00	-2.74	0.00	1.000
	Availability of human and physical resources	-1.67	-6.17	3.68	1.000
	COVID-19	0.00	-1.28	2.73	1.000
	QMNC Index	0.00	-10.44	9.27	1.000

^a Nonmigrant women are the reference category in this analysis. Models adjusted for sociodemographic and perinatal characteristics (i.e. maternal age, maternal education, type of hospital, country, type of birth, presence of an obstetrics/gynecology doctor in the team who assisted the birth).

Supporting information Table 11. Perceived quality of care in Luxemburg by migration status. Results from quantile regression for the 25th, 50th (median), and 75th quantiles (n=399)^a

Quantile	QMNC Index	Coefficients	95%CI		P value
			Lower bound	Upper bound	
25th	Provision of Care	0.00	-0.05	4.58	1.000
	Experience of Care	0.00	-4.33	9.53	1.000
	Availability of human and physical resources	5.00	-0.93	5.00	1.000
	COVID-19	5.00	-0.06	5.00	0.133
	QMNC Index	10.00	-1.33	16.14	0.836
50th	Provision of Care	0.00	-2.38	0.49	0.294
	Experience of Care	0.00	-0.33	7.61	1.000
	Availability of human and physical resources	5.00	-3.22	5.00	1.000
	COVID-19	5.00	-0.72	5.00	1.000
	QMNC Index	10.00	-1.09	15.49	1.000
75th	Provision of Care	-1.25	-2.32	1.96	1.000
	Experience of Care	0.00	0.00	0.00	1.000
	Availability of human and physical resources	5.00	1.49	5.31	1.000
	COVID-19	5.00	-0.55	5.00	1.000
	QMNC Index	8.33	1.18	19.62	1.000

^a Nonmigrant women are the reference category in this analysis. Models adjusted for sociodemographic and perinatal characteristics (i.e. maternal age, maternal education, type of hospital, country, type of birth, presence of an obstetrics/gynecology doctor in the team who assisted the birth).

Supporting information Table 12. Perceived quality of care in Norway by migration status. Results from quantile regression for the 25th, 50th (median), and 75th quantiles (n=1619)^a

Quantile	Index	Coefficients	95%CI		P value
			Lower bound	Upper bound	
25th	Provision of Care	0.00	0.00	1.63	1.000
	Experience of Care	0.00	-29.51	0.89	1.000
	Availability of human and physical resources	0.00	-6.50	12.64	1.000
	COVID-19	-5.00	-24.09	3.18	0.146
	QMNC Index	-15.00	-35.40	7.01	0.853
50th	Provision of Care	0.00	0.00	0.35	0.327
	Experience of Care	0.00	-1.26	9.69	1.000
	Availability of human and physical resources	0.00	-4.46	7.53	1.000
	COVID-19	0.00	-11.05	3.52	1.000
	QMNC Index	0.00	-20.14	15.85	1.000
75th	Provision of Care	0.00	-2.73	0.00	1.000
	Experience of Care	0.00	0.00	0.00	1.000
	Availability of human and physical resources	5.00	-1.66	11.35	1.000
	COVID-19	0.00	0.00	3.26	1.000
	QMNC Index	5.00	-6.36	30.45	1.000

^a Nonmigrant women are the reference category in this analysis. Models adjusted for sociodemographic and perinatal characteristics (i.e. maternal age, maternal education, type of hospital, country, type of birth, presence of an obstetrics/gynecology doctor in the team who assisted the birth).

Supporting information Table 13. Perceived quality of care in Portugal by migration status. Results from quantile regression for the 25th, 50th (median), and 75th quantiles (n=1361)^a

Quantile	Index	Coefficients	95%CI		P value
			Lower bound	Upper bound	
25th	Provision of Care	-2.50	-8.53	2.72	1.000
	Experience of Care	-5.00	-9.81	5.16	1.000
	Availability of human and physical resources	-5.00	-10.28	0.45	1.000
	COVID-19	-5.00	-7.47	5.07	0.132
	QMNC Index	-21.25	-40.47	0.17	0.846
50th	Provision of Care	0.00	0.00	0.00	0.360
	Experience of Care	0.00	-12.70	3.44	1.000
	Availability of human and physical resources	0.00	-10.28	0.00	1.000
	COVID-19	0.00	-5.90	0.00	1.000
	QMNC Index	-10.00	-24.98	-4.59	1.000
75th	Provision of Care	0.00	-5.29	0.00	1.000
	Experience of Care	0.00	-2.60	0.00	1.000
	Availability of human and physical resources	-5.00	-9.56	-0.20	1.000
	COVID-19	0.00	-7.60	0.00	1.000
	QMNC Index	-5.00	-17.44	5.47	1.000

^a Nonmigrant women are the reference category in this analysis. Models adjusted for sociodemographic and perinatal characteristics (i.e. maternal age, maternal education, type of hospital, country, type of birth, presence of an obstetrics/gynecology doctor in the team who assisted the birth).

Supporting information Table 14. Perceived quality of care in Serbia by migration status. Results from quantile regression for the 25th, 50th (median), and 75th quantiles (n=743)^a

Quantile	Index	Coefficients	95%CI		P value
			Lower bound	Upper bound	
25th	Provision of Care	5.00	-6.01	11.78	1.000
	Experience of Care	0.00	-6.76	15.51	1.000
	Availability of human and physical resources	1.67	-2.81	9.34	1.000
	COVID-19	5.00	-2.97	10.95	0.105
	QMNC Index	10.00	-8.64	48.56	0.856
50th	Provision of Care	0.00	-4.11	5.67	0.279
	Experience of Care	7.50	-8.20	25.60	1.000
	Availability of human and physical resources	5.00	-3.82	13.52	1.000
	COVID-19	5.00	-1.27	16.25	1.000
	QMNC Index	25.00	-4.28	51.41	1.000
75th	Provision of Care	-2.50	-15.24	9.25	1.000
	Experience of Care	5.00	-9.41	15.99	1.000
	Availability of human and physical resources	3.33	-6.35	14.13	1.000
	COVID-19	5.00	-7.52	9.25	1.000
	QMNC Index	15.00	-4.17	31.55	1.000

^a Nonmigrant women are the reference category in this analysis. Models adjusted for sociodemographic and perinatal characteristics (i.e. maternal age, maternal education, type of hospital, country, type of birth, presence of an obstetrics/gynecology doctor in the team who assisted the birth).

Supporting information Table 15. Perceived quality of care in Slovenia by migration status. Results from quantile regression for the 25th, 50th (median), and 75th quantiles (n=1862)^a

Quantile	Index	Coefficients	95%CI		P value
			Lower bound	Upper bound	
25th	Provision of Care	-5.00	-9.10	1.18	1.00
	Experience of Care	-7.50	-15.08	7.38	1.00
	Availability of human and physical resources	-5.00	-11.88	1.83	1.00
	COVID-19	0.00	-10.87	5.54	0.14
	QMNC Index	-15.00	-36.59	9.78	0.85
50th	Provision of Care	0.00	-8.08	0.00	0.35
	Experience of Care	0.00	-18.39	0.00	1.00
	Availability of human and physical resources	0.00	-11.27	0.40	1.00
	COVID-19	0.00	-15.83	0.00	1.00
	QMNC Index	-10.00	-36.70	22.61	1.00
75th	Provision of Care	0.00	-15.82	1.80E+308	1.00
	Experience of Care	0.00	-2.48	0.00	1.00
	Availability of human and physical resources	5.00	-9.59	5.00	1.00
	COVID-19	-2.50	-6.43	5.57	1.00
	QMNC Index	-5.00	-14.27	6.82	1.00

^a Nonmigrant women are the reference category in this analysis. Models adjusted for sociodemographic and perinatal characteristics (i.e. maternal age, maternal education, type of hospital, country, type of birth, presence of an obstetrics/gynecology doctor in the team who assisted the birth).

Supporting information Table 16. Perceived quality of care in Switzerland by migration status. Results from quantile regression for the 25th, 50th (median), and 75th quantiles (n=448)^a

Quantile	Index	Coefficients	95%CI		P value
			Lower bound	Upper bound	
25th	Provision of Care	0.00	-0.24	1.79	1.00
	Experience of Care	2.50	-2.44	3.27	1.00
	Availability of human and physical resources	1.67	-2.02	6.16	1.00
	COVID-19	0.00	-4.37	2.17	0.14
	QMNC Index	10.00	-11.90	19.63	0.86
50th	Provision of Care	0.00	0.00	0.00	0.29
	Experience of Care	0.00	0.00	0.00	1.00
	Availability of human and physical resources	5.00	-3.16	5.00	1.00
	COVID-19	0.00	0.00	5.98	1.00
	QMNC Index	2.50	-4.24	15.28	1.00
75th	Provision of Care	0.00	0.00	0.00	1.00
	Experience of Care	0.00	0.00	0.00	1.00
	Availability of human and physical resources	0.00	0.00	6.98	1.00
	COVID-19	0.00	0.00	0.00	1.00
	QMNC Index	7.50	-3.12	16.80	1.00

^a Nonmigrant women are the reference category in this analysis. Models adjusted for sociodemographic and perinatal characteristics (i.e. maternal age, maternal education, type of hospital, country, type of birth, presence of an obstetrics/gynecology doctor in the team who assisted the birth).