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Original research article

Trust in maternity care: challenges for healthcare professionals and migrant women

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Abstract
Migrant women have a greater potential to experience limits when using maternity care than non-migrant women; therefore, they have a greater risk of vulnerability. Vulnerability and barriers to maternity care have the potential to erode trust, which is an important aspect of maternity care in general. In this exploratory qualitative study, we analyzed factors influencing trust in interactions between migrant women and healthcare professionals in maternity care. In total, 71 in-depth interviews were conducted with migrant women and healthcare professionals in the Czech Republic. Migrant women generally trust medical care, and healthcare professionals trust the capacity of women's bodies and their expertise. Unfortunately, in relation to women giving birth, healthcare professionals do not see the importance of building or strengthening trust but appreciate obedience, no matter what it is based on. In this context, healthcare professionals are limited by the routinization of care and a lack of time. Consequently, migrant women have a higher probability of being excluded from maternal care as active agents, which increases their vulnerable position.

Keywords: Czech Republic; Health insurance; Maternity care; Migration; Organizational culture; Trust

Introduction

Contradictions shape the experiences of many women around the world. On one hand, it is well-known and supported with evidence that well-timed and quality maternity care significantly influences birth outcomes for women, their children, and their health (Bollini et al., 2009). On the other hand, access to quality maternal health care is not provided to all women; it depends on their position in the structure of unequal societies around the world (Srivastava and McGuire, 2015). In particular, for migrant women, various political, economic, social and cultural barriers limit the possibilities for women (and their children) to exercise their human rights to health care (WHO, 2008).

Health service utilization in the Czech Republic is formed via health policy. This policy distinguishes between insiders and outsiders, and research in this context has documented the existence of barriers limiting access to the healthcare system, particularly the healthcare insurance system, for non-citizens (Dzúrová et al., 2014). Existing barriers sustain the vulnerability of the non-citizen population in the healthcare system, and therefore increase risks for non-citizen women when accessing and receiving maternity care. We see this as an important factor highlighting the need for (mutual) trust (Campos-Castillo et al., 2016). In this article, we analyze the factors influencing trust in interactions between migrant women and healthcare professionals.

Background

Migrant women and their needs

When considering the possibilities and limitations of an individual in the context of access and use of the health care system, it is necessary to include a gender perspective to see the specific position of migrant women and the risk of vulnerability when their gender, legal position, and social status intersect (Gkiouleka and Huijts, 2020). In general, migrant women have more difficulties accessing maternity care and experience poorer pregnancy outcomes than non-migrant women. Limited access to and inadequate care provision leads to higher morbidity and mortality rates and specific health conditions (Gieles et al., 2019; Fair et al., 2020). Moreover, when pregnancy and motherhood are interwoven with poor health, poverty and stress, the situation of women and their children is exacerbated (Jones et al., 2022).

There is some evidence of the vulnerability of migrant women and the existence of barriers generally, but also at an interpersonal level; confirming communication difficulties when in contact with institutional health care (Robertson, 2015). In the Czech Republic, giving birth in a hospital is highly preferred, and according to general statistics, it has long been the most common reason why foreigners, and therefore migrant women, are hospitalized (Šmídová, 2015). Some studies have addressed the limits of access to health care, the healthy migrant effect (Drbohlav and Dzúrová, 2017), and migrants' awareness of the Czech insurance and healthcare systems (Schebelle et al., 2020). Only a few studies have focused on mi-

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grant women and their specific needs in the Czech Republic, pointing out the economic burdens of migrant women when receiving gynaecological care (Pěničková, 2014), the vulnerability of migrant women as a consequence of communication barriers (Hrešanová and Glajchová, 2018), and the welcomed obedience of migrant women (Glajchová, 2019).

Barriers for migrants in the Czech healthcare system

Health insurance is regarded as one of the largest barriers within the health system for migrants. The Czech healthcare system works based on mandatory (public) health insurance. This means that three main actors organize the healthcare system: (1) the care provider, (2) the care recipient and (3), and the care mediator, a health insurance company. Health insurance is available to all individuals participating in the labor market or the welfare system, including migrants (Office of Health Insurance, 2021). However, migrants who do not have permanent residence (typically received after five years in the country) and who are not regular employees are mostly excluded from public health insurance and depend on commercial health insurance. Commercial health insurance is limited by its duration, high cost, and the foreigner's health status. Some insurance companies state in their conditions that insured individuals must be in good health and explicitly define "non-insurable foreigners", *e.g.*, with nervous disorders, mental illnesses, *etc.* The most vulnerable group among "non-insurable foreigners" are premature babies and children with congenital defects. Thus, commercial health insurance provides very limited access to health care and influences the willingness of healthcare professionals to accept the person as a patient (Zassiedko and Tušková, 2011). The unattractive insurance conditions lead to an insufficient network of contracted healthcare facilities, further limiting the availability of health care for migrants. As commercial insurance limits the amount of accessible care, the economic aspect influences migrants' choices of health care because they have to pay for it (Čižinský, 2010; Pěničková, 2014).

Another significant limitation experienced by migrants is language, documented by some international studies, as well as in the context of the Czech Republic (Rasi, 2020; Rolantová and Vacková, 2015). This type of barrier affects communication skills, orientation within the system, and understanding of information related to health. Migrants experience situations in which they do not understand medical professionals or understand only to a limited extent, or they do not know the details of how the system works (Holeček, 2009). The existing language barriers could be reduced by interpretation services; for them, there is no entitlement in the Czech health policy. However, the lack of professional interpreters and the associated administrative and financial costs complicate this option for many migrant women. As a result, many migrants ask relatives or community members to communicate with health professionals (Glajchová, 2019).

Another barrier is discrimination and intolerance within the healthcare system (Hrešanová and Glajchová, 2018). Migrant women experience racist comments and feelings of helplessness as they encounter the health system in a new country. The findings of some studies are alarming because unjustified medical advice or interventions may occur due to culturally insensitive approaches (Sopuchová and Bužgová, 2013).

Importance of trust in maternity care

Østergaard (2015) argued that trust within a healthcare relationship is widely seen as fundamental, with the potential to improve the working relationship between healthcare providers and patients. Therapeutic collaboration between the two is a precondition for good health outcomes. She stated, "it is easier for the patient to disclose symptoms and to comply with treatment instructions if she or he has faith in the provider's sense of confidentiality, competences and respect" (Østergaard, 2015, p. 1048).

The need for trust is inherited in the power asymmetry in interpersonal relationships; patients have to believe in the professionals' benevolence and good character (Pellegrini, 2017), although their interpersonal abilities and communication skills strongly influence the patient's trust (Gabay, 2015). Trusting relationships between women and professionals improve women's confidence or reduce the negative effects of trauma during childbirth (Aannestad et al., 2020; Kuzma et al., 2020). Without a trusting relationship between a woman and a midwife, the midwife's ability to provide care is limited; trust influences not only the course of birth but also women's experiences with birth (Aannestad et al., 2020; Karlström et al., 2015). Women who experience a lack of trust may not be able to give birth effectively and may have higher incidences of interventions and unplanned cesarean births (Flores, 2018).

When focusing on migrant women, the significant potential for their vulnerability erodes trust, and at the same time, trust is reduced due to many barriers. Higginbottom and colleagues' literature review showed that different cultural ideas, customs, and religious practices are key to migrant women's experiences within the medical environment, specifically with birth and postnatal care (Higginbottom et al., 2015, pp. 12–13). Migrant women may lack trust or deny that their health problems exist due to cultural insensitivity and a lack of cultural recognition (Heaman et al., 2015).

The lack of a common language creates significant barriers and challenges for both sides – migrant women and health professionals. The conflict between expected and experienced communication difficulties with healthcare professionals affecting trust has also been documented (Kynø and Hanssen, 2022). Empirical evidence shows that many migrant women receive inadequate information, and health professionals automatically assume that migrant women are passive and unable to participate in the decision-making process – which is why professionals neglect women's involvement (Glajchová, 2019). Women's negative experiences may reinforce their feelings of insecurity and distrust of the healthcare system.

As the findings above suggest, trust is not static. Migrant women's expectations and their unfulfilled expectations of the care system (in Norway) can lead to distrust at the meso-level, which means distrust in the care system (Mehrara et al., 2022). Distrust can be reversed by the gradual building of individual trust between a woman and a particular health professional. It is also necessary to state that the level of distrust is strongly influenced by the structure of the system and its basic principles.

Materials and methods

The study is based on exploratory qualitative research focusing on the experiences of migrant women accessing maternity care in the Czech Republic. We conducted in-depth interviews with migrant women and healthcare professionals (Chart 1). Three researchers (two authors of this text and another colleague participating in a research project) conducted the interviews from May 2016 to August 2018. All informants were selected by the "snowball" method and in a purposive manner to create the sample.

Data collection

Migrant women were asked to participate in the research if they were not born in the Czech Republic and had their last birthing experience in the Czech Republic, not more than three years before. There were no other criteria for participation in the research. As the study was exploratory, the researchers tried to contact a diverse spectrum of women according to the type of migration experience, family status, and legal and socio-economic status. The women were from five continents; half were from Europe. They mostly had long-term residence permits or were citizens of a European Union (EU) country. Most were married or cohabited with the father of their last child and had one or two children. They were between 19 and 43 years old. Most lived in urban areas in the five regions of the Czech Republic. In-depth interviews were conducted (in Czech or English or with an interpreter), recorded and transcribed with 36 women and followed the trajectory of pregnancy, birth, and the postpartum period. Migration experience, life in the Czech Republic, and family settings were also part of the interview, as these create an important context in which women experience the trajectory.

In-depth interviews were conducted with 35 healthcare professionals from several maternity care facilities, especially maternity and labor wards. Some interviews were recorded, but many professionals refused to record the interview. Six ward nurses, 21 midwives, and 8 obstetricians participated in the research. Experience with caring for migrant women during pregnancy, the birth period or the postpartum period was the only selection criterion. The interviews focused specifically on the interactional and organizational aspects of their work. Taped interviews were transcribed. During non-taped interviews, the researchers made detailed notes and reconstructed the interview as soon as possible after it ended.

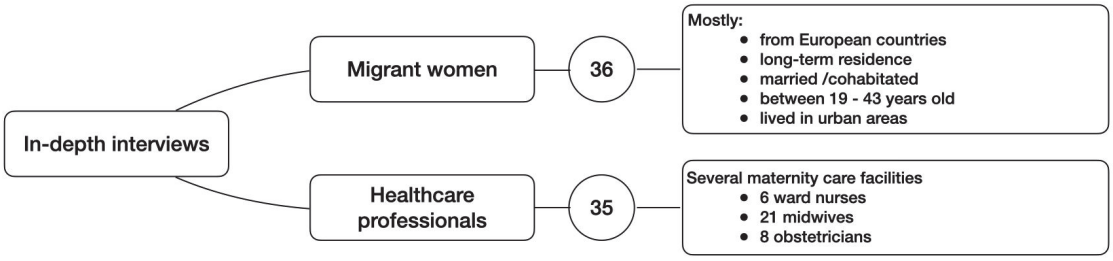

Chart 1. Participants of the study – overview

Data analysis

The authors of this study used thematic analysis as a tool to guide the analysis (Neuendorf, 2018). At the beginning of the analytical process, we read and coded the data collected from the migrant women and healthcare professionals separately. As the first step, we applied an open coding strategy. Trust emerged from the data as an important issue. We discussed the emergent themes and then went back to the data for a second coding stage. Another discussion about the themes and sub-themes followed, which led to collective work with the data.

Ethics

We followed the ethical principles embedded in the social sciences, particularly the American Sociological Association (ASA) code of ethics (ASA, 2018). All informants gave verbal informed consent to participate in the research. The researchers are not disclosing any information that could lead to the identification of informants. Pseudonyms are used in this article.

Results

Generalized trust

Trust was part of the narratives of migrant women and healthcare professionals. Migrant women mostly declared that they trusted the healthcare system in the Czech Republic. This trust is framed by their trust in Western medicine and the expertise of health professionals. Thus, migrant women did not address trust in a specific healthcare professional or rarely in a particular hospital, such as Rose.

"I was afraid a little, but at the hospital, they gave me the information and did all the examinations, so I had more confidence; maybe it was running the way it was supposed to, but I had no idea if that was how it was supposed to be, but I trusted the system to do everything well, and I remember the first pregnancy quite positively" (Rose, migrant woman).

Healthcare professionals also declared trust on a general level. They declared they trusted the birthing competence of women's bodies. They trusted physiology in the naturalness of the human body, not the birthing "skills" of particular women. For example, a midwife, Žaneta, who works in the delivery room, said that "women know" how to give birth. They trusted women in their ability to give birth and become mothers, and they saw it as universal: *"It's all exactly the same [...] mothers behave the same everywhere in the world"* (Jana, antenatal department).

Thus, the migrant women talked about trust in healthcare professionals and medicine, and the healthcare professionals trusted in the physiology of the female body. The trust of women and professionals recorded at the general level was not fulfilled at the interpersonal level.

Routine and communication

Still, during the interviews, healthcare professionals stressed complications more than the process of building trusting relationships and pointed out the importance of their work routine. Their work is structured by standardized tasks and the appropriate time given for each task, which the professionals are forced to follow. Thus, an interaction with a migrant woman is determined by the required documents, correctly filled out, and the sequence of specific steps. Professionals expect that women are familiar with this routine and follow it. However, this routine is not easy for someone from outside the organization (care recipient) to follow, especially if they are encountering this system for the first time: *"Always problems. They don't understand. They answer something else and don't know*

what we want them to do. […] to arrange an appointment with a foreign woman is so difficult. […] And also an encounter with a foreign woman who doesn't speak Czech prolongs the examination too much, and others [women in the waiting room] *have to wait longer, and all the appointments shift"* (midwife Dana, prenatal department).

Midwife Dana showed her frustration and negative emotions toward complications connected with migrant women, seeing them as non-standard patients. In addition, the need for different documentation (connected, for example, with commercial insurance as a less conventional type of insurance) compared to native women has the potential to strengthen the negative label of non-standard patients with two consequences: (1) It negatively influences the interactions between healthcare professionals and women, and (2) it can lead to their non-acceptance as patients, especially by private facilities. Non-acceptance as a patient can occur at any stage of maternity care except birth, which is seen as a condition necessitating emergency medical treatment; birthing women must be accepted by a maternity and labor ward. The situation of "standard unacceptable but urgent" is illustrated by the doctor's excerpt about an emergency and unplanned birth: *"(…) she* [migrant woman from Romania] *was on the way from England to give birth at home. But she gave birth here, on the way. Incredible drama around the birth. (…) But the problem: she is not covered, they have no money, they're not insured. (…) Everything was completely out of order, out of normal action"* (gynaecologist).

Both consequences are related to interpersonal and institutional levels of trust, with the potential for disruption. In extreme cases, it builds distrust in the Czech healthcare system and professionals, motivating women to postpone care or seek it abroad. One of the participants in this study described how, after her first and last visit to a gynaecological ambulance, she relied on telemedicine and video consultations with practitioners from her home country, thousands of kilometres from the Czech Republic. The reason for this decision was her experience with professionals interested only in her type of insurance and limited language skills. Thus, she received medical advice and medication during her pregnancy. According to her narrative, during childbirth, she was labelled an "irresponsible mother" by the healthcare professionals and treated harshly and unhelpfully.

According to the healthcare professionals' interviews, women who do not follow the system are not only irresponsible but also untrustworthy, as they do not care about their children's health. For this woman, the initial general trust in maternity care framed by the medical approach did not translate into trust at the interpersonal and institutional levels; on the contrary, through interpersonal experiences, her mistrust was built and reinforced. Moreover, she was stigmatized and, as a result, perceived as untrustworthy.

Another theme identified during the analysis and represented in the previous midwife's statement is language and its necessity for communication. In the statement, the participant pointed out how limitations in Czech language, or its absence altogether, create communication problems for healthcare professionals and, therefore, complicate their work routine. The healthcare professionals saw the problems with communication only on the side of migrant women, as they have a duty to understand the Czech language on such a level that they can communicate with healthcare professionals. The healthcare professionals did not see it as their responsibility to help migrant women understand, with, for example, the aid of professional interpreters. Thus, securing communication is the responsibility of migrant women, especially in a private gynaecological practice, which is more market-oriented compared to hospital maternity and gynaecological units. Only midwives on maternity wards, where women must be accepted regardless of their language skills, documentation, *etc.*, stated that during childbirth, basic communication is possible without language, with gestures, as birth is a physiological issue, and language is not as important.

Migrant women shared different perspectives; they want and need communication during maternity care to be able to express their needs and wishes and to be informed about their own and their babies' health and care. Its absence increased women's insecurity and their need to rely on general trust in medicine. Some women expressed very negative evaluations of the care they received and their experience: *"I don't know* [why they induced the water to break]. *They just did it; there was no reason. It was clean and everything. They just do it this way; they have their routine, and they just have it. They just wanted to do it. I don't know. I hate it"* (Petunia, migrant woman).

Migrant women appreciate kindness and helpfulness in healthcare professionals' communication. These two communication characteristics can be seen as the basis for transferring general trust to the institutional and interpersonal levels.

Women who do not speak the Czech language or feel insecure communicating in Czech usually found a family member with better language skills, or requested an interpreter from a local non-government organization (NGO) that offers such services. Some paid for a private professional interpreter. In some narratives, especially when family members or NGO workers served as interpreters, trusting relationships were built between the women and the interpreters, not between the women and the healthcare professionals.

Discussion

Organizational culture in the context of migrant women

Professionals stressed the importance of routine in almost every interview; migrant women mentioned it as the necessary context of their experience to which they had to orient themselves and follow. Based on the interviews, we see the routine and its importance as a part of the organizational culture of ambulances and hospital wards. This organizational culture, defined as shared ways of thinking, feelings and behaviors (Mannion and Davies, 2018), influences the interactions between migrant women and professionals. We argue that the importance of participative communication is also not part of the organizational culture, as seen in the limited amount of informational materials in foreign languages, the absence of interpreter services and the time limits for medical encounters based on communication with Czech native speakers (Shim, 2010).

The organizational culture limits the opportunities and willingness of particular professionals to communicate, although communication is important for building trust in the patient–professional relationship. Participative communication is a predictor of patients' trust (Sripad et al., 2018), and positive clinical encounters support trust and increase feelings of safety, especially for migrants in precarious positions (Barkensjö et al., 2018). We point to the importance of participative communication between maternity care providers and women in labor, and consider it "effective" if it includes many aspects, such as respect, positive attitudes, active listening and compassion, which are in accordance with trust-supportive communication (WHO, 2018).

Maternity care in the Czech Republic: Between Eastern and Western Europe

We are aware that the east-west distinction is superficial, generalizing and stereotyping, as each region involves some variability of care. Nevertheless, some authors identify two perspectives on maternity care, each related to one area of geo-political distinction in Europe. For example, Miteniece et al. (2017) claimed that maternity care principles in Eastern European countries are characterized by the limited availability of care, outdated equipment, the lack of professionals and pharmaceuticals, and women's lack of information, autonomy, and trust in medical doctors. On the other side, principles of maternity care in countries of a Western cultural perspective are based on respect and patient autonomy, which means without paternalistic tendencies in the doctor-patient relationship (Thompson et al., 2022). Czech maternity care can be considered as between East and West. Although the interviewed women mainly trust professionals in/and the Czech maternity care system, we can recognize persistent paternalistic tendencies and professionals' approaches to care recipients, considering trust as a one-sided and automatic element that does not require an active and respectful approach and behaviour on the part of professionals. Also, Hrešanová (2014) described the Czech maternity care system as paternalistic, emphasizing medicalization, placed within the sphere of a technocratic model of care. Other findings of a recent survey with midwives and doulas revealed that many women experienced situations when procedures were not explained to them, along with other considerable levels of disrespectful, non-evidenced-based, non-consensual, and abusive practices that may leave women with life-long trauma and suffering (Begley et al., 2018).

Satisfaction with the care received and cultural expectations

Women from Eastern Europe most frequently expressed satisfaction with the maternity care received in the Czech Republic. In these cases, several supportive factors come together simultaneously. First, these women were mostly "paper standard", which means they were part of the public insurance system, and administration of their care did not require any non-standard and routine-breaking tasks. Second, they had very good knowledge of the Czech language and/or somebody to provide continuous support in communicating and orienting themselves in the system. Third, they met kind and willing professionals. Fourth, the migrant women, especially women from Ukraine, Bulgaria and Romania, compared their experience with the (Czech) maternal care they received to the care in their home countries, which they described as worse in terms of inadequate material conditions in hospitals and the existence of bribes, where women have to give healthcare professionals additional payments to receive care. Limitations in communication and thus limitations in the possibility of being informed about care and expressing their needs and wishes were seen as negative aspects of the women's experience. Still, they highly appreciated the material conditions and comfort in hospitals.

A note about the COVID-19 pandemic

We collected our data before the outbreak of COVID-19, and the impact of this period on maternity care is yet to be the subject of current research. However, when focusing on trust during maternity care in the Czech Republic, we assume there has been an amplification of the negative aspects associated with the routinization of care and a displacement of the challenge of trust building. The hygiene measures introduced, such as restrictions on interpersonal contact or mandatory wearing of respirators and shields, did not allow for building an intimate and trusting relationship between women and medical staff – as has happened in other countries (Bradfield et al., 2022; Fumagalli et al., 2023).

Conclusion

Concerted trust in Western medicine and expert knowledge may not always translate into interactions that reinforce this trust and a safe experience of maternity care. Failure to transfer trust in interactions between professionals and women can lead to women's insecurity, making their needs invisible and increasing their vulnerability. Although trust is central to interactions, and in maternity care, trust between professionals and patients is essential, the system of care and its organizational culture and institutional settings do not have anchored support for it. Thus, the fact that some migrant women describe very good experiences of maternity care is not a consequence of the standard functioning of the maternity care system and its professionals, but instead, a consequence of the interplay of several factors (for example, standard type of health insurance, language capabilities, professionals' individual characteristics), which are not automatically likely to intersect in a migrant woman's life experience and situation.

Our research findings imply the formulation of recommendations to support communication skills development and inclusive practices among healthcare professionals. Moreover, these inclusive practices should be embedded in the principles and routines of the healthcare system itself. Our findings also support the integration of intercultural workers into the routine practice of maternity care. Future research can develop a deeper understanding of these issues by exploring the setting of a routinized healthcare environment that reinforces the vulnerability of women or other care recipients within the healthcare organization and how the building of trustworthy relationships is affected by expectations of professionals, which can be standardized, not oriented to individual requirements and cultural differences.

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Ethical aspects and conflict of interest

The authors have no conflict of interest to declare.

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