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Research Article

Social Support of Pregnant Immigrants with Psychosocial Risk

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Introduction

Background: Social support structure helps women facing migration processes to integrate and adapt to society, especially in unforeseen circumstances. To know the social support of pregnant immigrants with social risk. Descriptive cross-sectional study. A social survey was conducted prior to the signing of the informed consent.

Methods: Through the self-report, women identified primary and secondary relationships.

Results: Of the 37 immigrant women and their partners, the majority come from Latin American countries, especially Peru (62.2%), with ages between 20 and 34 years (64.9%), unmarried civil status (32.4%), head of household (27%) and the type of single-parent family (29.7%) are determinants of social risk for pregnant women, especially if they do not have social support. 75% of women had an unplanned pregnancy and one in two had depression.

Conclusions: The available social support network was reduced to the family network and the health center. The interactions that occur with the social network contribute to the well-being and self-esteem of the person, aspects that should be considered in prenatal care, because of the implications it has for the health of the woman and child.

Pregnancy is an incomparable event in a woman's life, involving deep physical, physiological, and emotional changes, constituting, in adverse contexts, a state of stress during pregnancy and postpartum [1]. For this reason, the role of the social network such as couples, family, friends and health professionals, which can be the most significant source of social support for pregnant women, is fundamental [1]. It has been reported that having social support during the postpartum stage can reduce the risk of depression; also, good relationships with the couple have a protective "buffer" effect against those determinants that cause stress during pregnancy and postnatal stage thus decreasing the risk of depression [2-4]. According to a study in which emotional, instrumental and informational social support was provided during the third trimester of pregnancy and during the postpartum period, the results showed an average life satisfaction value of 24.52% in the third trimester of pregnancy, with 25,71% in the postpartum period [2]. In the case of women carrying out migratory processes, the existence of a social support structure favors the ability to adapt and integrate into society, such as being in contact with neighbors, having friends, acquaintances in the neighborhood and belonging to social groups [5] According to a study conducted in Spain, on the social support network of family members, friends and associations of Latin American, African and Eastern European immigrants, 2.2% reported having none of these networks, 23.3% reported having only the family and 37,3% reported having family and friends. A 37.2% reported having relatives, friends and members of the above-mentioned associations [5]. Another study reported a 32.0% estimated prevalence of prenatal depression and a 26% of probable postpartum depression using the Edinburgh Postnatal Depression Scale (EPDS) of ≥13. They investigated complex life circumstances, 26% were prone to develop depressive symptoms after birth, high levels of stress in life, general ill health, low social support and difficulty caring for their babies were observed [6].

In Portugal it has been observed that immigrant mothers have a higher risk of postpartum depression and less satisfaction with the social support received, the results revealed a higher risk of postpartum depression (OR = 6.118; IC del 95%: 1.991-18.798), p< 0,05 [7].n (OR = 6.444; IC of 95%: 1.858-22.344) and low

satisfaction with social support (OR = 6.118; IC of 95%: 1.991-18.798), p< 0,05 [7]. In addition, migrant women in situations of social vulnerability during pregnancy and childbirth face barriers to access to health services due to the lack of health insurance and the lack of financial resources to pay for services, or, failing to understand the administrative formalities to be carried out [8, 9]. Unfavorable socio-economic status appears to influence the quality of health care, associated with a lack of cultural sensitivity of health professionals, leading to non-use of health services [10]. In Chile, immigrant women have the right to receive health care during pregnancy and child-rearing periods, through the Comprehensive Child Protection System "*Chile Crece Contigo* (SChCC)," which aims to provide social support to populations of families in a situation of social vulnerability [11,12]. Given the background described the need to generate background on support networks in pregnant immigrant women was raised with the following research question, what are the support networks that immigrant pregnant women with psychosocial risk, who are served in centers of the public primary health network of an urban community in Santiago of Chile, have? allowing us to learn about psychosocial risk and support networks available to study participants.

Materials and Methods

A descriptive cross-sectional study was conducted in a universe of 37 immigrant pregnant women with psychosocial risk who entered the prenatal check-up from October 2015 to February 2016 in two primary health centers in the Santiago of Chile. Since we worked with the total universe, no samples were used. The technique used was the social survey. The primary information was obtained through the application of a structured interview that allowed obtaining the following antecedens of the woman, her family and her partner: psychosocial, mental health and obstetric, and institutional support. The interview was conducted by two female researchers in the health centers, after the voluntary signing of the informed consent certificate. Secondary information was obtained from the consultation of the conventional electronic clinical records of the health centers, this information was collected by a female investigator on the screening tests applied during the prenatal control, the history of childbirth and newbor, and the benefits received. The evaluation of the interviewed women, regarding to the perception of the size, structure, type and quality of the primary and secondary social network, was evaluated with an instrument that represents an ecomap. This instrument contained a set of symbolic figures that represented the relationships with networks of primary and secondary type and quality, which were identified with a traffic light-like drawing, which contained the four categories of the interviewee's perception in relation to each of the social networks: bad, regular, good and no relation In this way each interviewee reported autonomously the type of relationship she had with each recognized social support network. The critical analysis and processing of the data was supported by the computational program S.P.S.S. Descriptive, position and dispersion statisticians according to the type of variable were calculated. Rates and ratios were calculated the comparison of proportions was made through the chi-square test.

Results

Table 1: Background of 37 immigrant pregnant women with psychosocial risk under the Chile Crece Contigo program, Santiago of Chile, 2015-2016.

Background	Categories	N	%
Nationality	Peruvian	23	62,2
	Colombian	5	13,5
	Dominican	3	8,1
	Other	6	16,2
Age	< 20 years old	4	10,8
	20 - 34 years old	24	64,9
	35 - 42 years old	9	24,3
Marital status	Single	12	32,4
	Partner	21	56,8
	Other	4	10,8
Schooling	< 12 years	21	56,8
Gainful occupation	Yes	21	56,8
Work contract	Yes	14	66,7
Social security of the work	Yes	12	57,1
Health insurance°	Yes	19	71,4
Woman head of household	Yes	10	27
Presence of progenitor at home	Yes	27	73,00%

Partner's nationality	Chilean	4	11,1
	Peruvian	22	61,1
	Colombian	4	11,1
	Haitian	2	5,6
	Other	4	11,1
Type of family	Single-parent nuclear	11	29,7
	Two-parent nuclear	26	70,3

Of the 37 immigrant women and their partners, the majority come from Latin American countries, especially Peru (62.2%), with ages between 20 and 34 years (64.9%). However, the group of women who became pregnant between the ages of 35 and 42 (24,3%) should be highlighted because it defines a risk condition for reproductive and neonatal health. Also, unmarried civil status (32.4%), head of household (27%) and the type of single-parent family (29.7%) are determinants of social risk for pregnant women, especially if they do not have social support. One in two women had incomplete schooling and paid employment and, of those who worked, only two out of three had a contract of employment and social security. In 1 out of 4 households, the father was not present [Table 1]. With regard to reproductive health records, 75% of women reported unplanned pregnancies, most of them were multiparous with admission after 12 weeks of pregnancy to the prenatal check-up, and had a prevalence of depression in 54,3%, which was detected by the application of the Edinburgh Scale [Table 2]. These events marked a condition of high risk for women in their mental and reproductive heath, and child health. With regard to the most significant psychosocial risks identified, in psychosocial tests carried out at the first prenatal check-up of 37 immigrant women, it was revealed that 36% had depressive symptoms, regarding the time of admission to prenatal care 26% did it after 20 weeks of gestation and is striking that 12% reported rejection to pregnancy. In women with depression, it was observed that depressive symptoms and rejection to pregnancy were the most important (64.7%) Regarding the quality of the primary social support network, women reported a low average of interaction with neighborhood councils and schools, however, with the maternal and paternal family reported good quality interaction. In the secondary networks, it is noteworthy that the health center was mostly recognized as good quality social support, followed by the relationship with the work network and the family of their partner [Table 3]. A similar behavior was found in the social support network in women with depression [Table 4].

Table 2: Obstetric and psychosocial history of 37 immigrant pregnant women with psychosocial risk under the Chile Crece Contigo program, Santiago of Chile, 2015-2016.

Background	Categories	N	%
First pregnancy	Yes	9	24,3
Gestational age at first prenatal check-up	≤ 12 weeks	12	32,4
	> 12 weeks	25	67,6
Planned pregnancy	No	27	75
Accepted pregnancy	Yes	26	96,3
Depression pregnancy	Yes	19	54,3
	No	16	47,2

Table 3: Quality of the primary and secondary social support network of 37 immigrant women at psycosocial risk.

Primary Networks			**Secondary Networks**							
			Healthcare Neighborhood					**Progenitor's Other**		
	Maternal Family	Paternal Family	Neighbors	School	Work	Center	council	Church	family	networks
Good	81,1	51,4	43,2	13,5	54,1	83,8	16,2	32,4	48,6	10,8
Regular	5,4	24,3	27,0	5,0	10,8	16,2	5,4	13,5	13,5	2,7
Bad		13,5	2,7		5,4		2,7		13,5	
Non-existent	13,5	10,8	27,0	81,1	29,7		75,7	54,1	24,3	86,5
	100,0	100,0	99,9	99,6	100,0	100,0	100,0	100,0	99,9	100,0

Table 4: Quality of the primary and secondary social support network of 37 immigrant women at psycosocial risk and depresion.

Primary Networks			Secondary Networks							
			Healthcare Neighborhood					Progenitor's family		
	Maternal Family	Paternal Family	Neighbors	School	Work	Center	council	Church	Other	networks
Good	88,9	55,6	27,8	5,6	55,6	83,3	11,1	27,8	50,0	11,1
Regular	5,6	22,2	33,3		5,6	16,7	11,1	11,1	11,1	5,6
Bad		16,7	5,6		11,1				5,6	
Non-existent	5,5	5,5	33,3	94,4	27,7		77,8	61,1	33,3	83,3

Discussion

Findings demonstrate that immigrant women's reproductive health is exposed to a high rate of unplanned pregnancies, pregnancy rejection and late prenatal care admission, which is worse when the women are depressed. The ambivalence of identity development in some migrant populations may accommodate the social role of motherhood in women, coupled with difficulties of access and limited information on fertility regulation methods, increasing the likelihood of unplanned pregnancy [13-15]. On the other hand, late care is more frequent in unplanned pregnancies, this situation leads to an increase in the percentages of abortion, constituting a public health problem especially in countries where it is not legalized, resulting in an increase in morbidity and mortality related to clandestine abortions [16]. Appart from all the above mentioned, it has to be added the difficulties of care centers in meeting the needs of immigrant women in the area of family planning [17,18]. In terms of timely access to health care for early detection of pregnancy, this is crucial for women who did not plan a pregnancy because it has been observed that they recognize the pregnancy two weeks later than women with desired pregnancies. Early prenatal care can prevent the adoption of behaviors that promote reproductive health, especially among women with unwanted pregnancies. The negative effect of harmful behavior on health, such as drinking and smoking during the embryonic stage, results in most malformations [19]. This work revealed that immigrant women had an unplanned pregnancy coupled with depression, evidence indicates that such health conditions increase health care costs for them, identifying, sometimes, personal and family crises that may affect the results of the child's upbringing and development [20,21]. As a result, being an immigrant, may generate a greater predisposition to develop depression both prenatal and postnatal. In addition, children born from unplanned pregnancies have lower birth weight and lower cognitive performance [22]. In the United States, reported maternal mortality and morbidity is highest among women from migrant groups, despite advances in prenatal care. There has also been an increase in the age of pregnancy and high infant mortality rates, mainly associated with prematurity, it should be noted that in Japan infant and stillbirth mortality rates are higher in immigrant women than in native women [23, 24]. On the other hand, the rates of chronic diseases such as obesity, hypertension, diabetes, use of illicit substances and congenital malformations have increased in these populations [24]. The fact that one in two pregnant immigrant women has depression represents the consequences of facing an unforeseen situation and in a context of social vulnerability. It has been pointed out that the impact of migration on pregnant women generates in the psychological area feelings of insecurity, isolation, discomfort in the circle of more intimate relationships and nostalgia for their culture and family [25-27].

In addition, low incomes with poor security conditions, low schooling and barriers to access to health care predispose women to a profound deterioration in mental health [25,27]. Another of the findings of this study showed the quality of social support networks. The primary network is the family and is essentially focused on the maternal family that remains in the country of origin of the women. According to studies carried out on social support for immigrant women, they corroborate the findings obtained about the support networks that are mainly concentrated in the primary network such as the family of origin, in most cases [28]. In relation to the secondary network is focused on the health center, family of the partner. It is relevant to mention that the revised literature indicates that pregnant immigrant women face high levels of stress in life and have poor social support and are therefore more likely to develop postnatal depression, anxiety, somatization and post-traumatic stress disorder than pregnant women with adequate and relevant social support [6,29]. Regarding social support networks, they are essential to counteract the social isolation because they provide the help, care and emotional support that immigrant women need in this process [10], which must be increased during pregnancy and postpartum. Also, having support networks of family, friends or other types such as care networks provides tools that reduce social isolation and facilitate integration into the host country [30]. The information provided has given rise to concern about showing the vulnerability of immigrant women in primary public health care. It is necessary to consider and incorporate in public policies strategies for survival and adaptation to the new contexts developed by the immigrant population, which must be based on the strengthening of their social networks and their interaction dynamics because it provides them with adaptive and integrative coping strategies [5,31]. It is essential to consider that motherhood in immigrant women has various difficulties, which requires the support of a cultural, social and health structure that provides care with a holistic and interdisciplinary approach [32]. The interactions that occur with each component of the social network contribute to personal well-being and self-esteem, aspects

that have health implications, since social support is associated with life events, disease, mortality and health promotion [5]. The respect and dignity for the human, must be is the primary concern in the attention of health [33,34].

Conclusion

Confirming the conclusions of our research on the quality of social support in pregnant immigrant women with psychosocial risk, attended in public health centers in an urban community of Santiago de Chile, the support networks are essentially centered on the maternal and paternal nucleus and health-care centers. Based on studies carried out, we can affirm that one of the most relevant components in the above-mentioned topic is related to the health care provided by health professionals, mainly midwives and nurses who are responsible for the health care of this population during a long period of time, therefore the challenge is to provide care with a comprehensive approach and cultural sensitivity, in order to respond to the real needs of pregnant immigrant women, avoiding further harm to both the mother, child and family. Therefore, we can affirm that having a structure of social support networks contributes to well-being, quality of life and mental health especially in people facing migratory processes, these networks promote integration and adaptation to the host society, especially in unexpected circumstances. From a perspective of the contribution of these findings, they can be useful to promote comprehensive and cross-cultural strategies and interventions in the population of pregnant immigrant women at psychosocial risk.

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Disclosure statement

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