

Barrier-free communication in maternity care of allophone migrants: BRIDGE study protocol

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Abstract

Aim: To describe communication and access barriers encountered by allophone women of different migration backgrounds in the Swiss maternity care services, from the perspective of users, healthcare professionals and intercultural interpreters.

Background: In addition to the challenges of maternal adjustment, pregnant migrant women must also deal with an unfamiliar health service system. Some must overcome language barriers and the stress of uncertain residence status. Limited access to maternity care increases perinatal morbidity and mortality. Almost 10% of foreigners speak none of Switzerland's official languages. Factors that facilitate or hinder communication between migrant women and perinatal healthcare professionals are under-studied and must be understood if we are to overcome those barriers in clinical practice.

Design: Qualitative exploratory study with quantitative sub-study.

Methods: Participants will be drawn from German to speaking regions of Switzerland. We will conduct focus group discussions and semi-structured interviews with users in their own language (Albanian and Tigrinya) and with healthcare professionals and intercultural interpreters (March–June 2016), then perform Thematic Analysis on the data. In the sub-study, midwives will report their experience of using a telephone interpreting service during postnatal home visits in a questionnaire (October 2013–March 2016). Data will be analysed with descriptive statistics.

Discussion: Our study will reveal patterns in communications between allophone migrant women and healthcare providers and communication barriers. By incorporating multiple perspectives, we will describe the challenges all parties face. Our results will inform those who draft recommendations to improve provision of maternity care to allophone women and their families.

Trial Registration: ClinicalTrials.gov ID: BernUAS NCT02695316.

KEYWORDS

access to health care, communication barriers, health services needs and demand, intercultural interpreter, maternal health services, midwifery, migrants, nursing, professional–patient relations

1 | INTRODUCTION

Pregnant migrant women and their families are under stress from multiple sources. They must cope with unfamiliar living conditions in their host country, make an effort to integrate and meet the physical, psychological and social demands of pregnancy and motherhood (David & Borde, 2011). This stress can be exacerbated by maternal health problems more common in migrant women than native-born women in Switzerland. Immigrant women have higher maternal and child morbidity and mortality, including higher rates of depression and mental disorders during pregnancy and after birth, higher rates of caesarean sections, much higher maternal death rates and their infants more often need neonatal intensive care (Merten & Gari, 2013). Comparisons between migrant and resident women in Germany have produced similar results, reporting that refugees and first-generation migrants face more health problems than native-born women (Gissler et al. 2009, David et al. 2015).

The poorer perinatal outcome seems to be correlated with a limited access to obstetric and maternity care services for migrants (Merten & Gari, 2013). In Switzerland, health insurance is mandatory and covers all costs for maternal-child health care. But even when health care is affordable, women still need to seek and understand appropriate information, engage in and adhere to caregiver support (Levesque, Harris, & Russell, 2013). Patterns of use of healthcare services are very complex and as many different factors, such as nationality or residence status, interact (Moreau-Gruet, 2013). However, access barriers might not only exist on the part of the women but also the healthcare system might not sufficiently meet the needs of this vulnerable patient population either.

In migrant women, lack of local language skills, high unemployment and little social support is associated with poorer health (Bundesamt für Gesundheit & Bundesamt für Migration, 2011). Insecurity about residence status increases their vulnerability and hinders their ability to integrate in the host country (Achermann, Chimienti, & Stants, 2006). Adverse birth outcomes are linked to language proficiency; for example, rates of high-risk deliveries doubled for migrant groups that lacked official language skills (Sentell et al. 2016). Language barriers can prevent migrant women from accessing the healthcare system and result in poorer outcomes for migrant women and their infants.

1.1 | Background

Documented foreigners make up 24.6% of Switzerland's population. Almost half of them are women (Bundesamt für Statistik, 2016). These women are very heterogeneous, ranging from professionally qualified women with high incomes to destitute refugees. We will include two groups of migrant women in this study: those who were asylum seekers when they arrived in Switzerland and those who immigrated directly as permanent residents (e.g. for family reunions). We seek to capture their different experiences with the Swiss healthcare system.

Why is this research or review needed?

- Despite improvements in the last few years, there still remain communication barriers between allophone migrant women and maternity care health service providers in Switzerland.
- Communication barriers prevent women accessing and absorbing accurate information about perinatal and maternal health, and hinder their access to women-centered health care.
- To meet the needs of migrant women and improve their experience in the Swiss healthcare system, assessments from all involved perspectives and changes on the professional institutional and systemic level are needed.

1.1.1 | Migrant women with permanent resident status

Those with legal foreigner status (resident and settled foreign nationals) must usually navigate the Swiss health system on their own, as no systems exist to orient them. This is especially difficult for migrant women who cannot speak the local language (allophone migrant women). Of those with a migration background who have lived in Switzerland for more than a year, 9.8% do not speak German, French, or Italian. Men are less likely to not speak any of the official languages (8.4%) than women (11.1%). First-generation non-EU27 and non-EFTA nationals are the largest group of people (23%) who do not use an official language (Bundesamt für Statistik, 2015). In 2014, Tigrinya was the first and Albanian the second most frequently translated languages (not counting Swiss national languages and English) (Interpret, 2016). We thus chose these two language groups for this study.

Albanians are a representative group of the permanent resident foreign population with a potential language barrier. By 2015, between 200,000-250,000 Albanians lived in Switzerland. Herein, we define Albanians as an ethnic group, rather than a nationality. Albanians mainly come from Kosovo (about 70%) and from Macedonia, South Serbia and Albania itself (Burri Sharani et al., 2010). There is a higher ratio of young people in the Kosovar-Albanian population in Switzerland is characterized by a high ratio of young people and by higher birth rates and bigger households than other population groups. It can be characterized as a relatively healthy population, although the immigrants of the 1990s were burdened by their war experience. Hard work and poor living conditions in the host country caused some immigrants health problems and mental disorders. As well, Kosovar-Albanians more frequently engage in some risky health behaviours; for example, Albanian women tend more towards obesity of women and Albanian men are more likely to smoke than the Swiss general population (Burri Sharani et al., 2010).

The perinatal outcome of Kosovar-Albanians migrants was shown not to differ considerably from native to born women in some European countries (Bakken, Skjeldal, & Stray-Pedersen, 2015; Yoong,

Wagley, Fong, Chukwuma, & Nauta, 2004). The few studies that investigated this, however, had rather small sample sizes, such that potential differences might not have been manifested (Origlia Ikhilor, Hasenberg, & Mühlheim, 2016). Another study on healthcare experience of Kosovar-Albanian patients in Switzerland revealed some of the needs and values they had. The participants very much estimated the Swiss health system. To them, medical authority and expertise was important. In fact, they even placed more value on being treated and given drugs than on conversations (Karrer, 2006). Similarly, pregnant women and young mothers were more responsive for obstetric medical care than antenatal classes, maternity counselling or midwifery-led care (Künzler, 2003). Cultural and also language barriers might have hindered the persons to demand for services characterized by counselling, and also by preventative approaches and health education.

1.1.2 | Women asylum seekers

Those with legal asylum status (asylum seekers, provisionally admitted foreigners and persons in need protection) are in a different situation. They access healthcare services in another way than permanent foreign residents. Cantonal authorities provide general practitioner insurance to asylum seekers (Bundesamt für Gesundheit & Schweizerisches Rotes Kreuz, 2011). Expectant and new mothers have basic insurance, and supervising authorities assign them to healthcare professionals through supervising authorities. Contact persons of the refugee centres help newcomers choose their provider, set up appointments and organize an interpreter.

For the last few years Switzerland, the highest number of asylum seekers have come from Eritrea. In 2015, 9,966 requests (25% of all asylum seekers) were made by Eritrean nationals. A year later, the number had dropped to 5,178 (19%). Because the situation for deserters was critical in Eritrea, many refugees received asylum or a provisional admission (protection rate was 70.3% in 2015) (Staatssekretariat für Migration, 2016, 2017a, 2017b).

Eritrea does not provide sufficient basic health care. It has much higher mother and child mortality rates than other countries in Africa (GBD 2013 Mortality and Causes of Death Collaborators, 2015; Kassebaum et al., 2014). Eritrean immigrants are unfamiliar with the highly developed Swiss health system and unused to provision of services like basic medical health care, maternity care or the general practitioner model. In addition to linguistic barriers, different cultural reference systems complicate communication (Eyer & Schweizer, 2010). About 40% of Eritrean women are illiterate (Central Intelligence Agency, 2013).

Both, the Albanian and the Eritrean population may have health conditions caused or exacerbated by poor healthcare systems in their home countries. Communication barriers may pose special problems for these immigrants when they try to seek care in Switzerland.

1.1.3 | Gaps in maternity care

Though the standard of maternity care in Switzerland can be considered as high, it is characterized by a high fragmentation which might

affect allophone women when using it. There is a large range of professionals in outpatient and stationary services that cover the whole spectrum, from pregnancy, to birth, to the postpartum and breastfeeding period. König and Pehlke-Milde (2010) investigated existing care, counselling and support services for postpartum mothers. Even though women were very satisfied with existing offers, it seemed impossible to ensure continuous patient care, so relevant patient information was not consistently shared with other professionals (König & Pehlke-Milde, 2010). In such a fragmented system, information sharing between the individual providers and the professions becomes especially important, as allophone migrant women have a hard time communicating this information themselves.

In the past years, in Switzerland efforts on different levels have been undertaken to improve healthcare services for migrant women. The Migrant Friendly Hospital Initiative (since 2015 named "Hospitals for Equity") has trained healthcare professionals in migration and transcultural competence in hospitals (Pluess & Zellweger, 2014; Saladin, 2009). Training has also been offered by professional associations (Schweizerischer Hebammenverband Sektion Bern, 2009) and in midwifery training (Brendel-Hofmann & Schwager, 2014; Origlia Ikhilor, 2005), and in other healthcare professional trainings. A comprehensive information portal made health information available in different languages (Schweizerisches Rotes Kreuz, 2015). Thereby, healthcare professionals and also immigrants themselves have access to publications, brochures, contact addresses and advice on different topics like general health information or pregnancy. More local projects have been established (e.g. antenatal classes). However, from a public health perspective, these initiatives and projects are heterogeneous, not enough well-coordinated and do not cover all areas of need (Hermann, 2013; Merten & Gari, 2013). We do not know conclusively how healthcare professionals implement their acquired transcultural competences in practice and how they use the available resources.

1.1.4 | Intercultural interpreters in maternity care

In addition to interpreting, intercultural interpreters are responsible for transcultural mediation, which is crucial to mutual comprehension (Bischoff, Kurth, & Henley, 2012). Gehrig, Caldéron, Guggisberg, and Gardiol (2012) evaluated use and impact of intercultural translation in hospitals and found that assigning intercultural interpreters had positive effects on patients' health. About one-fifth of the work intercultural interpreters do in Swiss hospitals is in the gynaecology and obstetrics. Interpreters were consulted more often if patients were in poor health or seemed to have less health competence. Even though the number of assignments for interpreters almost doubled between 2006 and 2010, family members or non-medical hospital staff often must serve as translators (Gehrig et al., 2012). A patient's relatives are unsuited to be translators and may lower the quality of consultation (Bischoff & Steinauer, 2007). In 2011, Swiss authorities have implemented a national telephone interpreting service. By 2015, telephone interpreting accounted for almost 2% of all intercultural interpreting and mediation in

Switzerland (Interpret, 2016), but the usefulness of this service still needs to be evaluated.

In 2014, midwives cared for approximately 70% of postpartum women at home (Bundesamt für Statistik, 2017, Erdin, Iljuschin, van Gogh, Schmid, & Pehlke-Milde, 2015). There is no money assigned to cover professional intercultural interpreters during midwife outpatient activities. Where language barriers persisted during visits, the midwife was assisted by ad hoc translators (usually spouses). But intimate topics like breastfeeding, involution, sexuality and contraception have to be translated in gender- and culture-specific terms by a trusted trained professional to avoid misunderstandings (Flores, 2005; Flores, Abreu, Barone, Bachur, & Lin, 2012). Midwives point out that communication barrier can sometimes cause women to skip appointments, missing out on postpartum visits and services.

Healthcare professionals are faced with increased numbers of migrant clients. The numbers of women asylum seekers who need care from a midwife have increased significantly (Bennett & Scammell, 2014) and will probably grow. In maternity care, effective communication is needed to address complex and pathological situations and to explain physiological processes, health counselling and education. A multi-perspective approach is needed to overcome the barriers faced by allophone migrant women in accessing maternal health care.

2 | THE STUDY

2.1 | Aims

This study aims to describe the communication and access barriers faced by permanent resident or asylum seekers allophone women when they need access to maternity care services. We explore the perspectives of maternity service users, healthcare professionals and intercultural interpreters. Our findings will serve as a basis for recommendations to improve quality and access to maternity care services, transcultural understanding between professionals and users and coordination and inter-professional cooperation between the maternity care services in Switzerland.

We ask these specific questions of the three study groups:

2.1.1 | Users

What experiences do allophone women have with healthcare services in pregnancy, childbirth and postpartum? How do they communicate with health professionals and obtain oral and written information? Do information and care providers meet their and their family's needs?

2.1.2 | Healthcare professionals

How do midwives, maternity counsellors, nurses and physicians describe the barriers they face when they communicate with allophone women in pregnancy, childbirth and postpartum care and treatment? What different forms of communication do they use and how do they use them? (For example, what materials do they provide and what tools do they use? Do they rely on on-site professional intercultural

interpreters, telephone interpreters, or ad hoc interpreters?) What inter-professional cooperation is required to care for allophone women?

2.1.3 | Intercultural interpreters

What experiences have intercultural interpreters in maternity care? What are the advantages and disadvantages of on-site and telephone interpreting? Where do you see opportunities for improving communication?

2.2 | Design/methodology

This exploratory study is mainly qualitative, but includes a quantitative descriptive element (Figure 1). Data for the study will be gathered with a qualitative approach, based on focus group discussions (FGD) and individual interviews so we can analyse three perspectives on provision of maternity care. We will complement the healthcare providers' perspective with quantitative analysis of questionnaires filled in by midwives in the home care setting after they have used a telephone interpreting service.

We chose this qualitative approach to identify and better understand the experiences of all actors up and down the maternity care communication chain. By analysing these different perspectives, we can see how the views of participants both differ and align. Examining communication barriers from multiple perspectives will reveal processes, interpretive frames and patterns (Flick, von Kardorff, & Steinke, 2010).

Focus group discussions are often used in transcultural research, especially among minorities. It might be easier for a participant to speak out or talk about sensitive topics in a group of one's peers (Thierfelder, Tanner, & Bodiang, 2005). Spontaneous comments from participants introduce new ideas and group interactions lead to new discussions about the subject. The goal is not to reach consensus, but to hear different opinions. Possible socially desirable opinions will easily be questioned by other participants. Focus group discussions allow individuals to express themselves and also reveal collective knowledge (Krueger & Casey, 2009; Schulz, 2012).

The study is complemented by quantitative analysis of questionnaires on the use of a telephone interpreting service. Since 2013, a midwife network in Northwestern Switzerland has collaborated with the National Telephone Interpreter Service to overcome communication barriers with foreign-language families (Kurth, 2013). The midwives use the service during postpartum home visits. Every use of the telephone interpreting service has been documented via questionnaire by attending midwives (October 2013–March 2016). The questionnaire asks about the purpose and content of the interpreting service, and midwives' opinion on its usefulness and difficulties that arose during calls.

2.2.1 | Samples

Sample 1: Users

We will recruit a convenience sample of 10–16 migrant women from two different language groups. Those included will have received

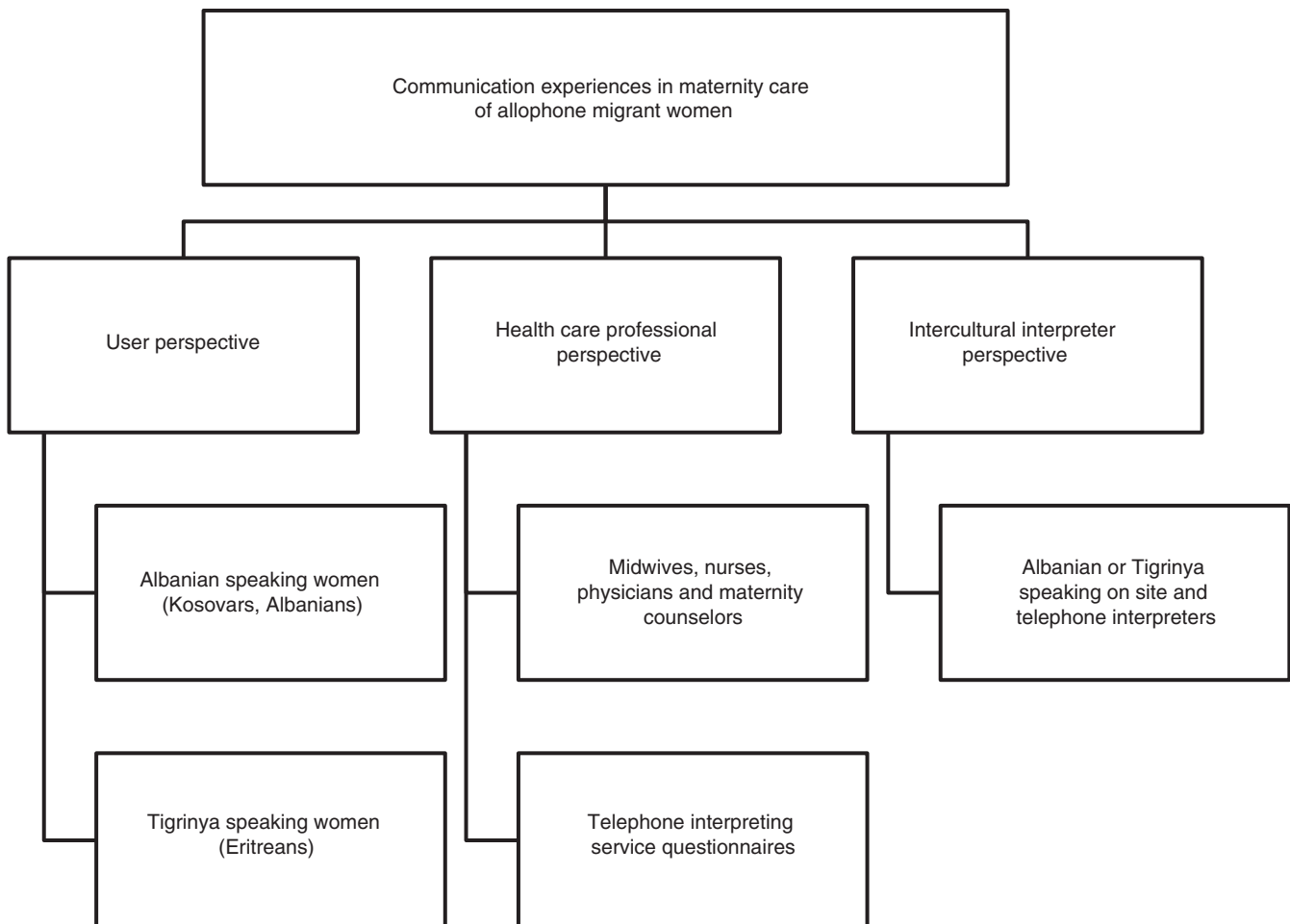


FIGURE 1 Design of the BRIDGE study

treatment from healthcare professionals in the German-speaking part of Switzerland during pregnancy, birth or postpartum. Some women may have had professional interpreters during maternity care. Other participation criteria will include:

1. Native Albanian or Tigrinya speakers.
2. No, or very little knowledge of German.
3. Mother of a healthy infant up to a year old.

We will exclude mothers if they or their children had a serious disease during their last pregnancy, childbirth or postpartum.

Sample 2: Healthcare professionals

This sample will be drawn heterogeneously to assess the different aspects of maternity care, and inter-professional collaboration in health care for allophone women. We will seek healthcare professionals with various roles and expertise in pregnancy, birth, postpartum or neonatology/paediatrics. We will also look for professionals who have operated in different settings, including outpatient, hospital or home environments and rural or urban areas. We will solicit the participation of healthcare professionals experienced in using telephone interpreting services.

The convenience sample will consist of 16–20 midwives, obstetricians, neonatologists, paediatricians, nurses and maternity counselors. Participation criteria will be:

1. At least a year of working experience.
2. Treating women during pregnancy, birth, postpartum, or mothers and/or children in their first year of life.
3. Experienced in caring for allophone women.

Sample 3: Intercultural interpreters

We will choose a convenience sample of four Tigrinya or Albanian-speaking interpreters, with experience translating on site or on phone and specific expertise in the maternity setting. Participation criteria will be:

1. Female.
2. At least a year of working experience as an intercultural interpreter in Albanian or Tigrinya.
3. Experience interpreting on site or over the phone.
4. Experience interpreting for consultations during pregnancy, birth, postpartum, or for mothers and/or children in their first year of life.

Intercultural interpreters will contribute to this study by describing own views and experiences on obstacles and resources from the mother's and the health professional's side.

2.2.2 | Recruitment

Participants will be recruited in public hospitals and outpatient maternity care services, e.g. by midwives, maternity counsellors and professional associations. The language barrier may be an obstacle to user recruitment. We will involve key stakeholders to help us understand how best to reach participants (Krueger & Casey, 2009). A short flyer, translated in to the mother tongue of participants, will serve as the basis for an explanation of the study. The flyer will be presented to potential participants during a maternity consultation, either by a healthcare professional, or an intercultural interpreter who speaks their language. If a woman wants to know more about the study, the contact person will ask her permission to transmit her contact details of the research team. Then, an interpreter from the research team will make contact, determine if she meets the participation criteria and inform in detail about the study and her rights. Women will get written information in her mother tongue.

Eligible healthcare professionals and intercultural interpreters will be identified by contact persons at the study hospitals, national and regional central offices. They will receive written information about the study and a notice that they will be approached by researchers. If, after the researchers provide oral information, the candidates are interested and qualified to participate, they will receive a written declaration of consent together with a detailed study description.

Before they collect data, the research team will ensure again that all participants know their rights that they have answered all open questions and that participants have all signed consent forms. Sociodemographic data will be collected via brief, anonymized questionnaire.

2.2.3 | Setting

Focus group discussions with user groups will be held in rented rooms outside the hospital. Focus groups with healthcare professionals will be held in recruiting hospitals. Individual interviews with interpreters will be held at a place of their choosing. Participants will be reimbursed for their travel expenses and receive a small gift in recognition of their participation. Mothers will be allowed to bring their child along. Qualified child care will be available but participants may also come with a companion of their choice.

2.2.4 | Data collection

Data of users and healthcare professionals will be collected in the FGD and data of the sample of intercultural interpreters will be collected in individual interviews (March–June 2016). As participating women do not speak German, discussions will be held in Albanian or

Tigrinya and will be facilitated by interpreters from the research team (thus other interpreters than those interviewed as participants in this study). A researcher will join the discussion with a second interpreter who will translate simultaneously. This oral translation will ensure that communication flows in both directions. The researcher can ask questions, join the discussion and support the facilitator if necessary.

Some of the information shared between the facilitator and participants will not be immediately and fully accessible to the research team. However, experts agree that despite the content losses caused by translation a relevant knowledge gain about the study object is possible (Kruse, 2012; Lauterbach, 2014). The researchers therefore will instruct the Albanian and Eritrean facilitators in depth to get them a comprehensive understanding about the study subject and the FGD method.

A semi-structured interview guide provides the framework for the FGD and single interviews. It suggests topics for the different groups:

2.2.5 | Users

1. Experiences with maternity and the health system in their country of origin.
2. Experiences with the maternity care system in Switzerland.
3. Communication with healthcare professionals and intercultural interpreters.
4. Evaluation of different information and communication paths.
5. Care provision by different healthcare professionals.
6. Role of family and compatriots.

2.2.6 | Healthcare professionals

1. Communication across language barriers.
2. Assignment of professional interpreters.
3. Experiences with allophone women's families.
4. Using specific information materials and tools.
5. Interdisciplinary care and cooperation.
6. Own transcultural competence.

2.2.7 | Intercultural interpreters

1. Interpreting services in maternity care.
2. On site and telephone interpreting.
3. Language barriers in communication.
4. Perceived role of allophone women's families.
5. Perceived importance of residence status of women.

Immediately after the FGD, the researcher will conclude the discussion with a first Member Check. She will ask if all points that were made are accurately summed up and reproduced. The participants will have the opportunity to amend and confirm contents. This procedure is thought as a content validation with the aim to

increase the credibility of data (Goldblatt, Karnieli-Miller, & Neumann, 2011). We will audio record FGD and interviews and complement them with researchers' notes. Interviews in Albanian and Tigrinya will be directly transcribed into German.

2.2.8 | Qualitative data analysis

The qualitative analysis follows procedures described by Braun and Clarke (2006). These are particularly useful for identifying patterns and topics in transcribed data texts. The method is not bound to a particular philosophical approach, but is pragmatic and suited to gaining a comprehensive understanding of human experiences, including individual and social realities.

Two researchers, supported by a peer group of about five researchers will conduct most of the analysis. The reflections and discussions in the peer group allow us to scrutinize additionally the analysis. In the case of deviant interpretations, the researchers must find conclusive explanations and a consensus. We plan to meet five times during the analysis. Transcripts will be analysed in four full-day meetings; two transcripts will be analysed in each meeting. All data will be synthesized during the last meeting. We will implement these six steps for data analysis (Braun & Clarke, 2006):

1. Familiarize ourselves with the data
Researchers individually familiarize themselves with the material, repeatedly reading the data. They note first ideas about the content.
2. Generate initial codes
In ongoing individual work, researchers systematically search all data for answers to the study questions. They generate initial codes and assign them to relevant data, documenting their work in ATLAS.TI® Software 7.0.
3. Search for themes
Together, researchers group similar codes to create possible themes and merge associated data. The collaborate create a code list.
4. Review themes
During the final analysis meeting, researcher review topics related to the study question from all three perspectives (users, healthcare professionals and intercultural interpreters). They will determine how much these themes match the coded data entries and data in general. Relations between themes and patterns will become apparent and be visualized in a thematic map.
5. Define and name topics
Themes from the analysis will be continuously refined until a rich and differentiated overview is created. Every topic will be named and clearly defined.
6. Report
Finally, we will compile all results. Themes will be highlighted with a selection of meaningful extracts and concluded with an

interpretation. When we write the scientific report, we will relate the analysis to initial research questions and existing literature.

2.2.9 | Quantitative data analysis

We will analyse approximately 50 questionnaires about using telephone interpreting. Our evaluation of protocols will comprise a descriptive analysis of sampling characteristics and four multiple choice questions, analysis of a question with a visual analogue scale and thematic analysis of an open question. We will summarize data on individual variables with appropriate descriptive statistics and consider each variable's level of measurement and the observed distribution of its data. Data will be analysed with Microsoft-Excel 2010 (Version 14.0.7177.5000).

2.3 | Ethical considerations

Recruiting migrant women is a challenge because they are hard to reach. Social status, uncertainty about residence status and linguistic barriers make migrant women particularly vulnerable. Pregnancy and other maternal adjustment processes make them more vulnerable. Vulnerability may degrade health, but we will include only healthy women in this study. Key persons (midwives, maternity counsellors, interpreters) will contact migrant women. This may lead to loyalty and role conflicts, if the key person was trusted before. Even if it is challenging to include migrant women, it would be unethical not to do so (Merry, Low, Carnevale, & Gagnon, 2016).

In addition to providing the first details on the study in the mother tongues of allophone women, potential participants will receive information letters and written declarations of consent. Participation in this study is voluntary: participants have the right to withdraw at any time.

All data collected will be anonymized and secured. Individuals will not be identifiable and we will draw no conclusions about them. The complete data sets will be stored at a secure facility for 10 years, in accordance with the international and ethical guidelines known as Good Clinical Practice and the national legal provisions. Pursuant to a memorandum from the competent ethics committee, no ethical approval was needed for this study (Ethics Committee Bern, November 10, 2015 and Ethics Committee Northwest/Central Switzerland, December 16, 2015).

2.4 | Validity and reliability/rigour

By investigating this topic from three different perspectives, we can reveal, confirm or relativize differences in the perception of the parties. This method is more likely to reveal relevant aspects than if we collected only a single perspective.

We do not underestimate the risk of a cultural bias in this study. The researchers may interpret and judge the statements of the user group by standards inherent to their own culture. People born into a

particular culture that grow up absorbing the values and behaviours of the culture will develop a worldview that considers their culture to be the norm. This phenomenon can only be antagonized by an extended self-reflectivity (Dornheim, 2007). Therefore, we foresee the Albanian and Eritrean interpreters of the research team or a social anthropologist to attend the analysis meeting. This shall help the research group to better understand cultural interpretative patterns and to avoid an ethnizing attitude. A research team member is also qualified in transcultural competence. External experts with the same migration backgrounds as the users will review our results in an additional Member Check. This independent examination will assess and confirm the plausibility of our results (Goldblatt et al., 2011).

The quantitative analysis of the use of telephone interpreting services is a census and therefore has no sampling bias. Yet, the result may be limited because of the nature of closed questions used in the questionnaire. Only a small open field for general comments allows the respondents to add relevant information on the perceived difficulties and benefits of using the service. A more differentiated insight might be gained in the FGD of healthcare professionals.

3 | DISCUSSION

This study will provide comprehensive basic information about communication patterns and barriers between allophone migrant women and healthcare professionals in the German-speaking part of Switzerland, with special focus on maternity care, birth and postpartum. It will reveal communication challenges, expectations and needs from different perspectives. We need to fully understand these challenges to develop recommendations to improve quality. On one side, service provisions should be helpful and comprehensible for the users; on the other side, we will detect gaps in maternity care and collect suggestions for improving collaboration and coordination between different healthcare providers.

3.1 | Limitations

The convenience samples for all of the three study groups are small. The multi-perspective design of the study and the addition of telephone interpreting service questionnaires should still provide broad insights and a path for improving the maternity care system for allophone women.

4 | CONCLUSION

This study investigates the views of users, healthcare professionals and intercultural interpreters and should help in developing strategies to lower barriers to communication and improve health care for allophone women on a personal, institutional and systemic level.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

AUTHOR CONTRIBUTIONS

All authors have agreed on the final version and meet at least one of the following criteria (recommended by the ICMJE [<http://www.icmje.org/recommendations/>]):

- substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data;
- drafting the article or revising it critically for important intellectual content.

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REFERENCES

- Achermann, C., Chimienti, M., & Stants, F. (2006). *Migration, Prekarität und Gesundheit, Ressourcen und Risiken von vorläufig Aufgenommenen und Sans-papiers in Genf und Zürich*. Neuchâtel: SFM, 135.
- Bakken, K. S., Skjeldal, O. H., & Stray-Pedersen, B. (2015). Immigrants from conflict-zone countries: An observational comparison study of obstetric outcomes in a low-risk maternity ward in Norway. *Pregnancy and Childbirth*, 15, 162–175.
- Bennett, S., & Scammell, J. (2014). Midwives caring for asylum-seeking women: Research findings. *The Practising Midwife*, 17, 9–12.
- Bischoff, A., Kurth, E., & Henley, A. (2012). Staying in the middle: A qualitative study of health care interpreters' perceptions of their work. *Interpreting*, 14, 1–22.
- Bischoff, A., & Steinauer, R. (2007). Nursing interpreters? Interpreting nurses? *Pflege*, 20, 343–51.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77–101.
- Brendel-Hofmann, K., & Schwager, M. (2014). *Cultural competence development within the bachelor of midwifery programme: Poster*. In International Conference of Midwives, International Conference of Midwives Triennial Congress, Prague.
- Bundesamt für Gesundheit & Bundesamt für Migration. (2011). *Gesundheitsmonitoring der Migrationsbevölkerung (GMM) in der Schweiz, Schlussbericht*. Arbeitsgemeinschaft BASS, ZHAW, ISPM, M.I.S TREND.
- Bundesamt für Gesundheit & Schweizerisches Rotes Kreuz. (2011). *Gesundheitswegweiser Schweiz*. Liebfeld & Wabern: BAG & SRK.

- Bundesamt für Statistik. (2015). *Personen, die 3,2,1 oder keine Landessprache beherrschen*. Neuchâtel: BFS.
- Bundesamt für Statistik. (2016). *Die Bevölkerung der Schweiz 2015*. Neuchâtel: BFS.
- Bundesamt für Statistik. (2017). *Geburten, Geburtenhäufigkeit*. Neuchâtel: BFS.
- Burri Sharani, B., Efonyai-Mäder, D., Hammer, S., Pecoraro, M., Soland, B., Tsaka, A., & Wyssmüller, C. (2010). *Die kosovarische Bevölkerung in der Schweiz*. Bern-Wabern: Bundesamt für Migration.
- Central Intelligence Agency. (2013). *The world factbook 2013-14*. Washington, DC: Eritrea.
- David, M., & Borde, T. (2011). *Schwangerschaft, Geburt und frühe Kindheit in der Migration*. Frankfurt am Main: Mabuse.
- David, M., Borde, T., Brenne, S., Henrich, W., Breckenkamp, J., & Razum, O. (2015). Caesarean Section Frequency among Immigrants, Second- and Third-Generation Women, and Non-Immigrants: Prospective Study in Berlin/Germany. *PLoS One*, 10(5), e0127489.
- Dornheim, J. (2007). Kultur als Begriff und als Ideologie – historisch und aktuell. *Transkulturelle Kompetenz, Lehrbuch für Pflege-, Gesundheits- und Sozialberufe* (Domenig, D. ed. (pp. 29–48). Bern: Huber.
- Erdin, R., Iljuschin, I., van Gogh, S., Schmid, M., & Pehlke-Milde, J. (2015). *Tätigkeitserfassung der frei praktizierenden Hebammen der Schweiz*. Bericht zur Erhebung 2014. Im Auftrag des Schweizerischen Hebammenverbandes (SHV). ZHAW Departement Gesundheit, Winterthur, 83.
- Eyer, P., & Schweizer, R. (2010). *Die somalische und die eritreische Diaspora in der Schweiz*. Bern: Bundesamt für Migration.
- Flick, U., von Kardorff, E., & Steinke, I. (2010). *Qualitative Forschung*. Reinbek bei Hamburg: Rowohlt.
- Flores, G. (2005). The impact of medical interpreter services on the quality of health care: A systematic review. *Medical Care Research and Review: MCRR*, 62, 255–99.
- Flores, G., Abreu, M., Barone, C. P., Bachur, R., & Lin, H. (2012). Errors of medical interpretation and their potential clinical consequences: A comparison of professional versus ad hoc versus no interpreters. *Annals of Emergency Medicine*, 60, 545–53.
- GBD. (2013) Mortality and Causes of Death Collaborators. (2015). Global, regional and national age–sex specific all-cause and cause-specific mortality for 240 causes of death, 1990–2013: A systematic analysis for the Global Burden of Disease Study. *The Lancet*, 385, 117–171.
- Gehrig, M., Caldéron, R., Guggisberg, J., & Gardiol, L. (2012). *Einsatz und Wirkung von interkulturellem Übersetzen in Spitälern und Kliniken*. Bern: Bundesamt für Gesundheit, Nationales Programm Migration und Gesundheit (ed). Büro für arbeits- und sozialpolitische Studien BASS.
- Gissler, M., Alexander, S., MacFarlane, A., Small, R., Stray-Pedersen, B., Zeitlin, J., ... Gagnon, A. (2009). Stillbirths and infant deaths among migrants in industrialized countries. *Acta obstetrica et gynecologica Scandinavica*, 88(2), 134–148.
- Goldblatt, H., Karnieli-Miller, O., & Neumann, M. (2011). Sharing qualitative research findings with participants: Study experiences of methodological and ethical dilemmas. *Patient Education and Counseling*, 82, 389–95.
- Hermann, M. (2013). Migrationsgerechte Angebote im Bereich reproduktive Gesundheit und frühe Kindheit in der Schweiz. In E. D. D. I. Schweizerische Eidgenossenschaft (ed.), *Eine Bestandesaufnahme von Projekten, Massnahmen und Arbeitsmethoden*. Bern: Bundesamt für Gesundheit, Sektion Migration und Gesundheit.
- Interpret (2016). *Einsatzstatistiken zum interkulturellen Dolmetschen und vermitteln 2015*. Bern: Schweizerische Interessengemeinschaft für interkulturelles Dolmetschen und Vermitteln.
- Karrer, T. (2006). *Migrantinnen im Schweizerischen Geburtssystem. Wie Frauen mit Migrationshintergrund Schwangerschaft und Geburt in der Schweiz erleben: Fallstudien*. In Institut für Ethnologie, Lizenzarbeit Universität Bern, Bern.
- Kassebaum, N. J., Bertozzi-Villa, A., Coggeshall, M. S., Shackelford, K. A., Steiner, C., Heuton, K. R., ... Lozano, R. (2014). Global, regional, and national levels and causes of maternal mortality during 1990–2013: A systematic analysis for the Global Burden of Disease Study 2013. *The Lancet*, 384, 980–1004.
- König, C., & Pehlke-Milde, J. (2010). *Bestandesaufnahme des Betreuungs-, Beratungs- und Unterstützungsangebots für Wöchnerinnen in der Schweiz, Schlussbericht*. Winterthur: Zürcher Hochschule für angewandte Wissenschaften.
- Krueger, R. A., & Casey, M. A. (2009). *Focus groups: A practical guide for applied research*. Thousand Oaks, California: Sage Publications.
- Kruse, J. (2012). *Qualitative Interviewforschung in und mit fremden Sprachen: Eine Einführung in Theorie und Praxis*. Weinheim: Beltz Juventa.
- Künzler, E. (2003). Gesundheit und Krankheit bei kosovarischen MigrantInnen; Hinweise zur medizinischen Betreuung. Health and illness by Kosovar immigrants; indications to medical consultation. *Praxis*, 92, 228–232.
- Kurth, E. (2013). *FamilyStart beider Basel – Ein koordinierter Betreuungsservice für Familien nach der Geburt*. Hebamme.ch, (7/8), 35–37.
- Lauterbach, G. (2014). Dolmetscher/inneneinsatz in der qualitativen Sozialforschung. Zu Anforderungen und Auswirkungen in gedolmetschten Interviews. *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research*, 15(2), Art. 5.
- Levesque, J. F., Harris, M. F., & Russell, G. (2013). Patient-centred access to health care: Conceptualising access at the interface of health systems and populations. *International Journal for Equity in Health*, 12, 18.
- Merry, L., Low, A., Carnevale, F., & Gagnon, A. J. (2016). Participation of childbearing international migrant women in research: The ethical balance. *Nursing Ethics*, 23, 61–78.
- Merten, S., & Gari, S. (2013). *Die reproduktive Gesundheit der Migrationsbevölkerung in der Schweiz und anderen ausgewählten Aufnahmeländern. Eine Zusammenfassung der Literatur 2006-2012*. Basel: Swiss Tropical and Public Health Institute.
- Moreau-Gruet, F. (2013). *Inanspruchnahme von Gesundheitsleistungen durch migrantinnen und migranten*. Neuchâtel: Zusammenfassung. Schweizerisches Gesundheitsobservatorium.
- Origlia Ikhilor, P. (2005). *Hebammen als Lebensweltenbummlerinnen: Förderung der transkulturellen Kompetenz an der Hebammenschule Bern*. Aarau: Weiterbildungszentrum für Gesundheitsberufe WE'G.
- Origlia Ikhilor, P., Hasenberg, G., & Mühlheim, R. (2016). Vertrauen als chance für die begleitend von kosovo-albanischen frauen. *Hebamme.ch*, (12), 18–21.
- Pluess, S., & Zellweger, E. (2014). *Diversitätsmanagement im Spital. Aktionsprogramme «Migrant-Friendly Hospitals»*. Bern: Evaluanda.
- Saladin, P. (2009). *Diversität und Chancengleichheit. Grundlagen für erfolgreiches Handeln im Mikrokosmos der Gesundheitsinstitutionen*. Bern: Bundesamtes für Gesundheit BAG in Zusammenarbeit mit H+ Die Spitäler der Schweiz.
- Schulz, M. (2012). *Fokusgruppen in der empirischen Sozialwissenschaft: von der Konzeption bis zur Auswertung*. Wiesbaden: Springer.
- Schweizerischer Hebammenverband Sektion Bern. (2009) Familienwerdung in der Migration - Reproduktive Gesundheit bei Frauen mit Migrantenhintergrund fördern. In Berner Hebammenfortbildung Schweizerischer Hebammenverband, Sektion Bern, Bern.
- Schweizerisches Rotes Kreuz. (2015). *Migesplus*. Vol. 2015. SRK.
- Sentell, T., Chang, A., Ahn, H. J., & Miyamura, J. (2016). Maternal language and adverse birth outcomes in a statewide analysis. *Women Health*, 56(3), 257–280.
- Staatssekretariat für Migration. (2016). *Eritrea: Häufig gestellte Fragen – Ist die Schweiz das wichtigste Zielland für eritreische Asylsuchende?* Bern-Wabern: SEM.
- Staatssekretariat für Migration. (2017a). *Asylgesuche nach Nationen (1986 bis 2017)*. Bern-Wabern: SEM.
- Staatssekretariat für Migration. (2017b). *Asylsuchende aus Eritrea*. Bern-Wabern: SEM.

- Thierfelder, C., Tanner, M., & Bodiang, C. M. (2005). Female genital mutilation in the context of migration: Experience of African women with the Swiss health care system. *The European Journal of Public Health*, 15, 86–90.
- Yoong, W., Wagley, A., Fong, C., Chukwuma, C., & Nauta, M. (2004). Obstetric performance of ethnic Kosovo Albanian asylum seekers in London: A case-control study. *Journal of Obstetrics and Gynaecology*, 24, 510–512.

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