Acta Clin Croat 2023; 62:323-329
doi: 10.20471/acc.2023.62.02.10

Original Scientific Paper

UNDERSTANDING DEMOGRAPHIC AND EPIDEMIOLOGIC CHARACTERISTICS OF HOSPITALIZED IMMIGRANT FEMALE PATIENTS: A RETROSPECTIVE OBSERVATIONAL STUDY

Igor Karnjuš, Sabina Ličen and Mirko Prosen

University of Primorska, Faculty of Health Sciences, Izola, Slovenia

SUMMARY – Precise epidemiologic and demographic characteristics of immigrant women admitted to gynecology or obstetrics departments are rarely explored. The aim of this retrospective observational study was to analyze the epidemiologic and demographic characteristics of immigrant female patients hospitalized between 2012 and 2017 in one maternity hospital in south-west Slovenia. Clinical data retrieved from hospital electronic information system were used to analyze these characteristics. In the mentioned period, 605 immigrant women were hospitalized, most of them originating from countries of the former Yugoslavia (60.50%) or former Eastern Bloc (14.05%). The results show that in recent years there has been a constantly growing trend of immigrant women being admitted compared to the total number of hospitalizations. No statistical differences were established in the incidence of abortion, preterm delivery or vacuum extraction between Slovenian and immigrant women, although the analysis revealed a higher rate of cesarean section among immigrant women ($\chi 2=26.960$, $p<0.01$). Education level seems to be a significant predictor of the likelihood of an abortion in the group of immigrant women ($B=-0.492$, $p=0.015$), where less educated women are at a greater risk. To improve what is known about the sexual and reproductive health-related problems of immigrant women, a large-scale epidemiologic study is needed in the near future.

Key words: *Immigrant women; Sexual and reproductive health; Slovenia; Health disparities*

Introduction

Every day, healthcare organizations provide services for patients who are culturally diverse, yet the migration flows seen in recent years add tremendously to the challenges being faced in clinical settings. Moreover, race, ethnicity, religion, and other cultural characteristics are ever more important in terms of delivering culturally appropriate care to patients with various cultural backgrounds[1]. In response, health systems and health agencies, especially in Western countries, have endeavored to adapt service delivery practices and policies[2], since it has been established that certain cultural groups (migrants, minorities) are more likely to be underserved, perceive negative treatment, and receive differential treatment outcomes[2-6]. The primary reasons identified for inequalities are language barrier and general communication problems between healthcare professionals and patients, lower health literacy, cultural differences and professional uncertainty, negative attitudes and low-level trust between healthcare professionals and patients, higher socioeconomic stressors in migrants/minority groups, difficulties of arranging care for undocumented patients, and issues arising during hospital stay[6,7].

Correspondence to: *Assist. Prof. Igor Karnjuš, PhD, MSN, RN*, University of Primorska, Faculty of Health Sciences, Polje 42, 6310 Izola, Slovenia
E-mail: igor.karnjus@fvz.upr.si

Received June 10, 2020, accepted June 25, 2021

From this perspective, immigrant women are often regarded as one of the most vulnerable population groups. Abundant evidence indicates that immigrant women face greater health inequalities than male immigrants, specifically bigger health inequalities with respect to sexual and reproductive health[3,8]. Several studies concluded that immigrant or minority women, as well as their children suffered from maternal health disadvantages[9,10]. The pregnancy outcomes of immigrant women in European countries are associated with a greater risk of low birth weight, perinatal mortality, congenital malformations, and preterm delivery[10,11]. Walker *et al.*[4] pointed to maternal and perinatal mortality as a clear example of cultural inequality in health outcomes in obstetrics and gynecology in the United Kingdom. The risk of maternal death (2012-2014) was significantly higher amongst women from black and minority ethnic groups than women from white groups (RR 4.19; 95% CI 2.69-6.35). Black (9.2; 95% CI 8.3-10.3) and Asian (7.0; 95% CI 6.4-7.7) women experienced higher rates of stillbirth in comparison to white women (4.5; 95% CI 4.3-4.7).

By recognizing the factors that potentially contribute to the existence of inequalities in the health of immigrant women, healthcare professionals can strive to ensure that women are given culturally appropriate healthcare[3]. Culturally competent care is defined as a patient-centered approach that engages in reporting and shared decision-making in the patient-healthcare professional relationship in a manner which respects the patient's values, goals, health needs and beliefs, and cultural background[5].

As Denier and Gastmans[7] explain, existing studies on standards, guidelines and good practices in clinical settings focus on need assessments, recommendations to improve healthcare service responsiveness to the needs of immigrant or minority patients, effective interventions in clinical practice, organizational support for culturally competent care, and monitoring demographic and epidemiologic data on those patients. The latter is often overlooked, even though it is very important for healthcare professionals in clinical settings from the aspect of cultural knowledge and skills, as well for the health system to develop appropriate strategies to address the issue of more systematically providing culturally appropriate care. Therefore, the aim of this study was to analyze the epidemiologic and demographic characteristics of immigrant female patients hospitalized in a maternity hospital in south-west Slovenia.

Material and Methods

The research design was grounded on a retrospective observational study involving immigrant patient data retrieved upon admission to a gynecologic and maternity hospital in the south-west part of Slovenia. This kind of research design often relies on data that are primarily collected for non-research purposes and, for example, stored in clinical databases[12]. Data were retrieved for the 2012-2017 period from the hospital electronic information system. The maternity ward is a medium-sized ward with 54 beds at two departments (Gynecology and Obstetrics) and 28 beds in the neonatal ward. Approximately 1,600 women give birth and over 1,900 gynecologic surgical procedures are performed every year.

In our study, migrants were defined as "any person who is moving or has moved across an international border or within a state away from his/her habitual place of residence, regardless of the person's legal status, voluntary or involuntary, causes, and the length of the stay"[13]. The following demographic data were retrieved: age, nationality, and education level. The epidemiologic data used in the analysis were number of hospitalizations for the six-year period, department to which the immigrant women were admitted, number of hospital days, and interventions to which the women were subjected. The study was approved by the Medical Ethics Committee of the Republic of Slovenia (0120-544/2017/7 as of October 26, 2017). Informed consent was obtained from all individual participants included in the study.

Data were analyzed using Statistical Package for the Social Sciences version 20.0 (SPSS Inc.™, Chicago, IL, USA). In the first phase, descriptive univariate statistical analysis was performed (frequency, percentage, mean value, standard deviation) to obtain general distribution of the data. The normality assumption was evaluated using normal probability plots and the Kolmogorov-Smirnov criterion. The χ^2-test was applied to identify any statistically significant differences regarding the incidence of certain interventions between Slovenian and immigrant women in the six-year period. Binary logistic regression was conducted to explain the abortion-cesarean section relationship in conjunction with the education level and age of the hospitalized immigrant women. The level of statistical significance was set at $p<0.05$.

Results

During the 2012-2017 period, 605 immigrant women were hospitalized. In the same period, the total number of hospitalizations was 20,526, meaning that immigrant women accounted for a 2.95% share. The mean age of the hospitalized immigrant women was 30.56±7.02 years, with the youngest aged 15 and the oldest 74 years. Most women were in the 20-29 age group (n=270; 44.63%) or 30-39 age group (n=264; 43.64%). Concerning education level completed, the largest proportion of immigrant women had completed high school (n=295; 48.76%); 172 (28.43%) had completed the undergraduate level or higher, while 108 (17.9%) had completed elementary school. Thirty (4.96%) women included in the study had not completed any level of formal education. Overall, the immigrant women came from 40 different countries, mostly the countries of former Yugoslavia (n=366; 60.50%) or former Eastern Bloc (n=85; 14.05%), e.g., Russia, Ukraine, Slovakia, etc.

Table 1 presents the constantly increasing trend of immigrant women admissions compared to the total number of hospitalizations in recent years. During the observation period, the mean hospital stay of immigrant women was 3.79±2.45 days; 1-day hospitalization was most common (n=175; 28.93%). The latter relates to the 'day hospital' (or outpatient clinic). The maximum hospital stay was 23 days (1 case).

Of 605 immigrant women, 233 (38.5%) were hospitalized at the Gynecology Department and 372 (61.5%) at the Maternity Department. The mean age of immigrant women hospitalized at the Gynecology Department was higher than of those hospitalized at the Maternity Department (32.94±8.33 *vs.* 29.07±5.56 years). The reasons for hospitalization at the Gynecol-

Table 1. Immigrant women admitted to hospital by years in the 2012-2017 period versus all hospitalizations

Year	All hospitalized women, N	Hospitalized immigrant women, N	%
2012	4,565	87	1.91
2013	4,077	87	2.13
2014	4,020	88	2.19
2015	4,012	97	2.41
2016	3,852	125	3.24
2017	3,655	121	3.31

Table 2. Distribution of reasons for hospitalization of immigrant women in the 2012-2017 period

Department (N=605 all)	Classification of reasons	2012	2013	2014	2015	2016	2017	Total
Gynecology Department	*In vitro* fertilization	9	9	15	12	21	21	87
	Abortion	12	6	13	8	5	6	50
	Operative procedure	3	2	4	7	6	8	30
	Diagnostic procedure	7	4	3	5	2	4	25
	Minor operative procedure	7	10	3	3	6	7	36
	Therapy administration	0	2	0	2	1	0	5
Maternity Department	Spontaneous delivery	29	30	27	33	47	29	195
	Preterm delivery	1	2	3	0	0	2	8
	Cesarean section	16	7	11	17	20	22	93
	Vacuum extraction	3	5	1	1	4	4	18
Missing data	No data	0	10	8	9	13	18	58
	Total	87	87	88	97	125	121	605

ogy Department were classified in six subgroups, as follows: *in vitro* fertilization (IVF), abortion, operative procedure, minor operative procedure, diagnostic procedure, and therapy administration (intramuscular, intravenous). The reasons for hospitalization at the Maternity Department were classified as follows: spontaneous delivery, preterm delivery, cesarean section, and vacuum extraction. Table 2 shows distribution of reasons for hospitalization of immigrant women in the 6-year period. At the Gynecology Department, a larger share of immigrant women were hospitalized for IVF or abortion. Most of the immigrant women hospitalized at the Maternity Department had spontaneous delivery.

Table 3 presents comparison of reasons for hospitalization between Slovenian (n=19921) and immigrant women (n=605). The analysis revealed no statistical differences in the incidence of abortion, preterm delivery or vacuum extraction between the two groups (p>0.05). However, there was a statistically significant difference in the number of cesarean sections with a greater incidence recorded among immigrant women (p<0.01).

Logistic regression was performed to ascertain the effects of age and education level on the likelihood of the participants to have an abortion. The Wald test demonstrated that the level of education added significantly to the prediction (p=0.015), although age did not (p=0.262). Further, the logistic regression model was statistically significant ($\chi^2(8)=16.532$, p=0.035) and explained 3.5% (Nagelkerke R2) of variance in abortion and correctly classified 90.8% of cases. A lower level of education was associated with an increased likelihood of having an abortion (B=-0.492). Most immigrant women who had an abortion had completed less than high secondary education (n=28), followed by women with a high school diploma (n=14) and undergraduate educational level or higher (n=8). Their mean age was 29.16±6.84, age range 15-45 years. In the group of cesarean section, neither education level (p=0.066) nor age (p=0.080) added significantly to the prediction. The mean age in this group was 29.67±5.74, age range 18-45 years.

Discussion

Hospital admissions increased among immigrant women during the study period. Although there were no statistical differences in the incidence of abortion, preterm delivery or vacuum extraction between the Slovenian and immigrant women, the analysis revealed a higher incidence of cesarean section among immigrant women. Further, education level seems to be a good predictor of the probability of abortion in the group of immigrant women. Those with a lower educational level are more likely to have an abortion.

In the last decade, the entire European Union (EU) has witnessed large flows of migration, leading to an ever more ethnically diverse population in many EU member countries. However, these populations have different habits, traditions, healthcare needs, languages, and previous levels of care. This diversity may exacerbate the current health inequality and thereby challenge healthcare systems in the host country if left unaddressed[14]. As a full member of the EU, Slovenia encounters the same problems. In our study, most of the immigrant women admitted to the hospital in re-

Table 3. Comparison of abortion, preterm delivery, cesarean section and vacuum extraction between Slovenian and immigrant women

Reason for hospitalization	Nationality	n	%	p (χ^2)
Abortion	Slovenian	2,017	10.12	2.244/0.152
	Immigrant	50	8.26	
Preterm delivery	Slovenian	413	2.07	1.648/0.243
	Immigrant	8	1.32	
Cesarean section	Slovenian	1,821	9.14	26.960/0.000*
	Immigrant	93	15.37	
Vacuum extraction	Slovenian	514	2.58	0.363/0.526
	Immigrant	18	2.97	

n = number; *p<0.01

cent years originated from former Yugoslav republics (mainly Bosnia and Herzegovina, Macedonia, Serbia and Kosovo). Yet, recent reports indicate that we are also increasingly encountering other nationalities such as Ukrainians, Russians, Iranians, Syrians, people from Afghanistan, etc.[15]. It is therefore essential to have culturally competent healthcare staff in place for this scenario because every woman, regardless of her background or origin, has the right to appropriate sexual and reproductive healthcare services[16]. Immigrant women's utilization of health services may differ from the typical user in the host country since their needs and access to healthcare are influenced by several factors related to the migration process, such as cultural differences, socioeconomic status, health beliefs, self-perceived needs, etc. This is even more noticeable among newly arrived women since they possess less knowledge about how to navigate the health system[17].

The World Health Organization reports that immigrant women incur a greater risk of experiencing unwanted pregnancy, induced abortion and obstetric complications than women in the host country[18]. Our study showed a higher rate of cesarean sections in immigrant women compared to Slovenian ones. A meta-analysis performed by Merry *et al.*[19] also revealed that, out of 75 studies that met the inclusion criteria, 53 reported higher cesarean section rates among immigrant women compared to women in the host country. An OECD report[20] indicates that cesarean section rates in several European countries, including Slovenia, have grown significantly over the last decade. Migration itself is a risk factor for cesarean delivery. The latter is associated with the risks such as severe maternal and neonatal morbidity and mortality[21]. However, the actual causes of the high cesarean section incidence among immigrant women remain unknown. In the literature, certain factors that may lead to cesarean delivery are grouped into six broad categories, as follows: poor maternal health, high body weight and gestational diabetes mellitus, women's cultural attitudes and expectations regarding labor and delivery management, cultural assimilation, genital mutilation, language and cultural barriers, and quality of care[22,23]. In fact, obstruction of the natural delivery process leading to cesarean section may also be a result of psychological hindrances faced by the woman, which may be a consequence of poor communication with the staff, stress, fear and anxiety. Sometimes surgical delivery can also be a result of the medical staff inability to deal with a woman who has different needs, values and desires. Understanding how migration directly and indirectly affects the incidence of cesarean section is vital, so that new strategies can be developed and applied to lower the rate of cesarean section among immigrant women[21].

Although various studies in the EU indicate a higher incidence of abortion among immigrant women in comparison to their native counterparts[24,25], our study did not confirm it. One reason for this might be related to the education level, given that more than 70% of the immigrant women included in our study had completed at least high school or more. The level of education is recognized as a factor that impacts family planning. In fact, several studies show that immigrant women with a lower level of educational attainment are less likely to use contraception[26,27]. Our study demonstrates that education level in the group of immigrant women appears to be a good predictor of the probability of abortion, where less educated women are at a greater risk. This indicates that it is necessary to improve health literacy among immigrant women. Since the entire EU must cope with an increasingly diverse population, there is a strong need of culturally competent healthcare professionals who are able to effectively address the health needs of immigrant women. Endler *et al.*[14] emphasized the absence of studies on the training of obstetricians and gynecologists with respect to providing healthcare to immigrant women. Moreover, a recent study in Switzerland shows that many women have negative experiences in clinical settings due to providers' deficient cultural competence[28]. Therefore, there is a need to unify and strengthen the curriculum on sexual and reproductive health training throughout medical education in order to ensure equitable and quality care for women[14]. It has been shown that increasing cultural awareness among healthcare professionals increases the acceptance of culturally appropriate care[29]. Awareness of the particular needs of a vulnerable group like immigrant women is essential if high-quality sexual and reproductive healthcare is to be offered to these populations.

Several limitations of this study should be considered. The sample size was relatively small (N=605). In addition, the study included immigrant women treated at just one regional maternity hospital in Slovenia. Therefore, caution needs to be taken while seeking to generalize the study findings. Another limitation stems from the study period, which included only a

six-year period. It should also be emphasized that immigrant women represent a non-homogeneous population group with equally non-homogeneous needs or health-related vulnerabilities. Therefore, the same concept of clinical treatment cannot be applied to all and it is necessary to adopt an individualized approach. Moreover, delivery outcomes are also strongly psychological. Medical history alone provides little information on the thoughts and feelings of the women in the situation at the time of delivery, which could not be extracted from our data because they are very physically oriented and thus the holistic view of an individual was limited by the available data. Despite these limitations, our findings are valuable for the health system to develop appropriate strategies to provide culturally appropriate care in a more systematic manner.

Conclusions

This study shows that hospital admissions among immigrant women are increasing and, compared to their native counterparts, they tend to have a higher cesarean section rate. Further, in the group of immigrant women, those with lower education have a greater risk of having an abortion. Faced with an increasingly diverse population, cultural competence is nowadays proving to be essential in the provision of quality healthcare. Efforts to raise cultural awareness among healthcare professionals are needed in order to improve the quality of care among immigrant women. To improve what is known about the sexual and reproductive health-related problems of immigrant women in Slovenia, it is necessary to conduct a large-scale epidemiologic study in the near future.

Acknowledgment

The authors would like to thank the clinicians, midwives and administrative staff at the Postojna Gynecologic and Maternity Hospital for their support and enthusiasm during this study.

References

1. Jhutti-Johal J. Understanding and coping with diversity in healthcare. Health Care Anal. 2013 Sep 1;21(3):259-70.
2. Shepherd SM, Willis-Esqueda C, Newton D, Sivasubramaniam D, Paradies Y. The challenge of cultural competence in the workplace: perspectives of healthcare providers. BMC Health Serv Res. 2019 Dec;19(1):135.
3. Prosen M, Ličen S, Bogataj U, Rebec D, Karnjuš I. Migrant women's perspectives on reproductive health issues and their healthcare encounters. In: Ličen S, Karnjuš I, Prosen M, editors. Women, Migrations and Health [Internet]. University of Primorska Press; 2019 [cited 2020 Apr 17]. p. 117-37. Available from: http://www.hippocampus.si/ISBN/978-961-7055-43-6/117-137.pdf
4. Walker KF, Gribbin C, Siddiqui F. Cultural aspects of care in obstetrics and gynaecology. Obstet Gynaecol Reprod Med. 2018 Nov 1;28(11):366-7.
5. McKesey J, Berger TG, Lim HW, McMichael AJ, Torres A, Pandya AG. Cultural competence for the 21st century dermatologist practicing in the United States. J Am Acad Dermatol. 2017 Dec 1;77(6):1159-69.
6. Jayaweera H. Access to healthcare for vulnerable migrant women in England: a human security approach. Curr Sociol [Internet]. 2017 Nov 23;66(2). [cited 2020 Apr 17] Available from: https://journals.sagepub.com/doi/10.1177/0011392117736307?icid=int.sj-abstract.similar-articles.2
7. Denier Y, Gastmans C. Realizing good care within a context of cross-cultural diversity: an ethical guideline for healthcare organizations in Flanders, Belgium. Soc Sci Med. 2013 Sep 1;93:38-46.
8. Arousell J, Carlbom A. Culture and religious beliefs in relation to reproductive health. Best Pract Res Clin Obstet Gynaecol. 2016 Apr;32:77-87.
9. Robertson EK. "To be taken seriously": Women's reflections on how migration and resettlement experiences influence their healthcare needs during childbearing in Sweden. Sex Reprod Healthc. 2015 Jun;6(2):59-65.
10. Reeske A, Razum O, Rechel B, Mladovsky P, DevilléW, Rijks B, *et al*. Maternal and child health – from conception to first birthday. [Internet]. 2011 [cited 2020 Apr 17]. Available from: https://www.semanticscholar.org/paper/Maternal-and-child-health-from-conception-to-first-Reeske-Razum/13ea18a7c84b6a3e839e65280802b225992f023c
11. Hargreaves S, Friedland JS, Gothard P, Saxena S, Millington H, Eliahoo J, *et al*. Impact on and use of health services by international migrants: questionnaire survey of inner city London A&E attenders. BMC Health Serv Res. 2006 Nov 29;6:153.
12. Gray JR, Grove SK, Sutherland S. Burns and Grove's The Practice of Nursing Research: Appraisal, Synthesis, and Generation of Evidence. 8th edn. St. Louis, Missouri: Saunders, 2016; p. 736.
13. Luiking ML, Patel H. Migrants' experiences in the healthcare system. In: Ličen S, Karnjuš I, Prosen M, editors. Women, Migrations and Health [Internet]. University of Primorska Press; 2019 [cited 2021 Jun 20]. p. 95–105. Available from: https://www.hippocampus.si/ISBN/978-961-7055-44-3/files/downloads/pages/Page97.pdf
14. Endler M, Al Haidari T, Chowdhury S, Christilaw J, El Kak F, Galimberti D, *et al*. Sexual and reproductive health and rights of refugee and migrant women: gynecologists' and obstetricians' responsibilities. Int J Gynecol Obstet. 2020 Apr 1;149(1):113-9.
15. European Migration Network. Migration and Slovenia [Internet]. EMN European Migration Network. [cited 2018 Nov 27]. Available from: https://emm.si/en/migration-and-slovenia/

16. Raben LAD, van den Muijsenbergh METC. Inequity in contraceptive care between refugees and other migrant women? A retrospective study in Dutch general practice. Fam Pract. 2018 Aug 23;35(4):468-74.
17. Norredam ML, Nielsen AS, Krasnik A. Migrants' access to healthcare. Dan Med Bull. 2007 Feb;54(1):48-9.
18. WHO | World Health Organization. Pregnancy-related complications [Internet]. [cited 2018 Nov 30]. Available from: http://www.who.int
19. Merry L, Small R, Blondel B, Gagnon AJ. International migration and caesarean birth: a systematic review and meta-analysis. BMC Pregnancy Childbirth. 2013 Jan 30;13:27.
20. OECD Health Statistics 2014 - Frequently Requested Data - OECD [Internet]. [cited 2020 Apr 22]. Available from: http://www.oecd.org/els/health-systems/oecd-health-statistics-2014-frequently-requested-data.htm
21. Merry L, Semenic S, Gyorkos TW, Fraser W, Small R, Gagnon AJ. International migration as a determinant of emergency caesarean. Women Birth. 2016 Oct;29(5):e89-98.
22. Merry L, Vangen S, Small R. Caesarean births among migrant women in high-income countries. Best Pract Res Clin Obstet Gynaecol. 2016 Apr;32:88-99.
23. Sabolović Rudman S, Djaković I, Gall V, Željko Djaković Ž, Košec V. Pregnancy outcome in gestational diabetes compared to body mass index. Acta Clin Croat. 2019;58:37-41. doi: 10.20471/acc.2019.58.01.05
24. Jokela S, Lilja E, Kinnunen TI, Gissler M, Castaneda AE, Koponen P. Births and induced abortions among women of Russian, Somali and Kurdish origin, and the general population in Finland – comparison of self-reported and register data. BMC Pregnancy Childbirth. 2018 Dec;18(1):296.
25. Heino AE, Gissler M, Malin M, Väisänen H. Induced abortions by woman's country of origin in Finland 2001-2014: Scand J Public Health [Internet]. 2018 Nov 29;48(1). [cited 2020 Apr 22] [about 5p.]. Available from: https://cmk-proxy.mf.uni-lj.si:2507/doi/10.1177/1403494818812640
26. Poncet LC, Huang N, Rei W, Lin Y-C, Chen C-Y. Contraceptive use and method among immigrant women in France: relationship with socioeconomic status. Eur J Contracept Reprod Health Care. 2013 Dec;18(6):468-79.
27. Shah R, Kiriya J, Shibanuma A, Jimba M. Use of modern contraceptive methods and its association with QOL among Nepalese female migrants living in Japan. PLoS One. 2018 May 16;13(5):e0197243.
28. Sami J, Quack Lötscher KC, Eperon I, Gonik L, Martinez de Tejada B, Epiney M, *et al*. Giving birth in Switzerland: a qualitative study exploring migrant women's experiences during pregnancy and childbirth in Geneva and Zurich using focus groups. Reprod Health. 2019 Dec;16(1):112.
29. Beune EJ, Bindels PJ, Mohrs J, Stronks K, Haafkens JA. Pilot study evaluating the effects of an intervention to enhance culturally appropriate hypertension education among healthcare providers in a primary care setting. Implement Sci. 2010 May 14;5(1):35.

Sažetak

RAZUMIJEVANJE DEMOGRAFSKIH I EPIDEMIOLOŠKIH ZNAČAJKA HOSPITALIZIRANIH IMIGRANTICA: RETROSPEKTIVNO OPSERVACIJSKO ISTRAŽIVANJE

I. Karnjuš, S. Ličen i *M. Prosen*

Točni epidemiološki i demografski podatci imigrantica primljenih na ginekološkom ili porođajnom odjelu su rijetko dostupni. Cilj naše retrospektivne opservacijske studije bila je analiza epidemioloških i demografskih značajka bolesnica imigrantica koje su bile hospitalizirane u jednom rodilištu na jugozapadu Slovenije u razdoblju od 2012. do 2017. godine. Za analizu spomenutih značajka primijenjeni su podatci dobiveni putem bolničkog elektroničkog informacijskog sustava. U navedenom razdoblju hospitalizirano je 605 imigrantica. Većina njih potječe iz bivših republika Jugoslavije (60,50%) ili bivših zemalja Istočnog bloka (14,05%). Rezultati su pokazali da je trend prijma imigrantica u odnosu na ukupan broj hospitalizacija posljednjih godina u stalnom porastu. Analiza nije pokazala statistički značajne razlike u učestalosti pobačaja, prijevremenog porođaja ili vakuumske ekstrakcije između slovenskih žena i žena imigrantica, ali se je kod ovih posljednjih pokazala veća stopa carskog reza (χ^2=26,960, p<0,01). Čini se da je stupanj obrazovanja značajan prediktor vjerojatnosti pobačaja u skupini žena imigrantica (B=-0,492, p=0,015), gdje su manje obrazovane žene sklonije pobačaju. Radi boljeg razumijevanja problematike na području seksualnog i reproduktivnog zdravlja kod imigrantica potrebno se je u bliskoj budućnosti usmjeriti na izradu većih epidemioloških studija.

Ključne riječi: *Imigrantice; Seksualno i reproduktivno zdravlje; Slovenija; Zdravstvene nejednakosti*