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The value of grounded theory for disentangling inequalities in maternal-child healthcare in contexts of diversity: A psycho-sociopolitical approach

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ABSTRACT

Adopting a psycho-sociopolitical approach, the present paper describes the results of a community-based participatory needs assessment focusing on the perceived needs of women of reproductive age as users of primary healthcare in contexts of migration-driven diversity and socioeconomic vulnerability in the Metropolitan Area of Lisbon. The investigation comprised 64 in-depth interviews with women, including natives and immigrants to Portugal from the main origin countries in the context under study (Brazil, Cape Verde, and other Portuguese- speaking African countries) and a survey of 125 women, again natives and immigrants from these countries. The central role of qualitative methodology and grounded theory, in the framework of a multi-method research, allowed understanding the needs of women as embedded in contexts characterized by asymmetrical power relations, in terms of unequal opportunities and resources, at multiple interrelated ecological levels (personal, relational, organizational, community, socioeconomic, health system/policy, cultural/migration). The priority perceived needs of women were primarily related to socioeconomic disadvantage, severely aggravated in the current contexts of crisis; and factors at the health system level, mainly unequal access to family doctors, excessive waiting lists, and increases in the direct costs of healthcare. Results allow questioning the adequacy of cultural competence approaches for the reduction of inequalities in maternal-child healthcare in the context under study, showing the critical and innovative value of qualitative methodology and grounded theory in research on social justice and health in contexts of diversity characterized by unequal power dynamics.

La importancia de la Teoría Fundamentada para la investigación sobre la desigualdad en salud materno-Infantil en contextos de diversidad: una aproximación psicosociopolítica

Palabras clave
Desigualdades
Salud materno-infantil
Inmigración
Justicia social
Teoría Fundamentada

RESUMEN

Adoptando una aproximación psico-sociopolítica, en el presente trabajo se describen los resultados de una evaluación de necesidades percibidas por las mujeres en edad reproductiva como usuarias de cuidados de salud primarios en contextos de diversidad asociada a la inmigración y vulnerabilidad socio-económica, en el área metropolitana de Lisboa. Se llevaron a cabo 64 entrevistas en profundidad a mujeres, tanto autóctonas como inmigrantes, de los principales países de origen en el contexto analizado (Brasil, Cabo Verde y otros países africanos de lengua oficial portuguesa) y una encuesta en la que participaron 125 mujeres, tanto autóctonas como inmigrantes, procedentes de los mencionados países. El papel central de la metodología cualitativa y la Teoría Fundamentada, en el marco de una investigación multimétodo, permitió comprender cómo las necesidades de las mujeres se insertan en contextos caracterizados por relaciones de poder asimétricas, basadas en el acceso desigual a los recursos y oportunidades, a múltiples niveles ecológicos, interrelacionados entre sí (personal, relacional, organizacional, comunitario, socioeconómico, sistema/políticas de salud, cultura/migración). Las necesidades prioritarias identificadas se relacionan principalmente con la situación de desventaja socio-económica en la que se encuentran las mujeres, agravada en el actual contexto de crisis, y con factores a nivel de sistema de salud, tales como el acceso desigual al médico de familia, las elevadas listas de espera, o los costes cada vez mayores de la atención sanitaria. En este sentido, los resultados obtenidos permiten cuestionar la adecuación de la competencia cultural como estrategia para reducir las desigualdades en salud materno-infantil en el contexto objeto de estudio, mostrando el valor de la metodología cualitativa y la teoría fundamentada en la investigación sobre justicia social y salud en contextos de diversidad y dinámicas de poder asimétricas.

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In the current context of crisis, uncertainty, and progressive impoverishment of an increasing part of the population in Portugal and other Southern European countries, some of the greatest risks are the deterioration of health, increased health inequalities, the decrease of life expectancy, and the rise of mortality rates, particularly in populations living under conditions of socioeconomic vulnerability (Karanikolos et al., 2013; Kentikelenis, Karanikolos, Reeves, McKee, & Stuckler, 2014; Kentikelenis et al., 2011; Legido-Quigley, Otero et al., 2013; Legido-Quigley, Urdoneta et al., 2013). In this turbulent context of crisis, people cope with changes and uncertainty from asymmetrical positions of power and the ability to mobilize different kinds of resources. Some of the most vulnerable populations are pregnant women, newborns, and mothers, particularly those suffering with more strength the consequences of the financial crisis as a result of unemployment, economic instability, and the general precariousness of working and living conditions.

Although there is still very scarce research on the health consequences of the financial crisis, the limited empirical evidence available shows a devastating image. Most empirical evidence comes from Greece, where an overwhelming report recently published by the *Lancet* (Kentikelenis et al., 2014) describes a 43% rise in infant mortality rates between 2008 and 2010, with increases in both neonatal and post-neonatal deaths. It is suggested that this increase is associated with barriers in access to timely and effective care in pregnancy and early life together with worsening socioeconomic circumstances. In addition, this report describes a 19% increase in the number of low-birth-weight babies between 2008 and 2010 and a 21% rise in stillbirths between 2008 and 2011, all attributed to reduced access to prenatal health services for pregnant women.

In contexts of migration-driven diversity, the impact of the financial crisis may be even more pernicious, taking into consideration wide empirical evidence showing that immigrants and ethnic minorities tend to have worse health and more limited access to quality healthcare when compared to the broader general population (Ingleby, Chiarenza, Devillé, & Kotsioni, 2012; Ingleby, Krasnik, Lorant, & Razum, 2012; World Health Organization [WHO] Regional Office for Europe, 2010). In the particular case of maternal-child health, research conducted in a variety of European countries has shown that immigrant women tend to suffer higher infant and maternal morbidity and mortality rates, increased premature births, higher rates of postpartum depression, and more frequent complications during pregnancy and childbirth (Almeida, Caldas, Ayres-de-Campos, Salcedo-Barrientos, & Dias, 2013; Luque, Bueno, & de Mateo, 2010; Luque, Gutiérrez, & Bueno, 2010; Minsart, Englert, & Buekens, 2012; Zwart et al., 2010). The same pattern has been observed in the specific case of Portugal, where immigrant women tend to have increased premature childbirths, more health problems during pregnancy, and higher rates of fetal and neonatal mortality (Machado, 2008; Machado et al., 2007).

Maternal-child health inequalities in contexts of migration-driven diversity may be explained by two interrelated sets of factors: (1) disadvantaged socioeconomic conditions based on the less favourable social position that immigrants tend to occupy in the host societies (Ingleby, 2012), often with conditions of social exclusion as a major cause of health inequities among migrants and ethnic minorities (CSDH, 2008); and (2) inequities in terms of less accessible and inferior quality healthcare for migrant populations, including pregnant women and mothers (Ingleby et al., 2012; Machado et al., 2009; Padilla et al., 2013; WHO Regional Office for Europe, 2010). In Portugal, both sets of factors may be contributing to increased maternal-child health inequities in the current context of crisis, due to growing unemployment, precarious living conditions, and the retrenchment of the welfare state in terms of increasing cuts in public expenditure on healthcare and rising direct costs for users when public resources are most needed.

One of the most well-known strategies for reducing disparities in health and healthcare in contexts of migration-driven diversity is the promotion of cultural competence among professionals and healthcare organizations. Cultural competence has been defined as "a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations" (Cross, Bazron, Dennis, & Isaac, 1989, p. 13). However, lessons learned from research and experiences of implementing "cultural competence" programmes have led to profound debates and criticism about this concept (Balcazar, Suarez-Balcazar, Willis, & Alvarado, 2010; Chiarenza, 2012; Ingleby, 2011), and the need to look for innovative and more comprehensive approaches.

In line with this, the main aim of this paper is to critically examine the adequacy of cultural competence as a strategy to reduce healthcare inequalities in contexts of migration-driven diversity and socioeconomic vulnerability with a special focus on the health of women in reproductive age. This critical examination is based on the perceived needs, views, and experiences of women as primary healthcare users, paying particular attention to those suffering conditions of socioeconomic disadvantage in a specific local context, the Metropolitan Area of Lisbon, severely struck by the financial crisis and the subsequent austerity measures.

The Value of Qualitative Methodology and Grounded Theory

The central role of qualitative methodology and grounded theory (Glaser & Strauss, 1967; Strauss & Corbin, 1998) in the framework of a multi-method research allowed us to:

(1) Emphasize the role of the context, adopting a psycho-sociopolitical (Albar et al., 2010; García-Ramírez, de la Mata, Paloma, & Hernández-Plaza, 2011; Hernández-Plaza, 2013; Hernández-Plaza, García-Ramírez, Camacho, & Paloma, 2010; Martín Baró, 1986, 1996; Prilleltensky, 2011, 2008a, 2008b), and ecological (Trickett, 2009) view of the human being, embedded in multiple contexts characterized by unequal power dynamics at diverse ecological levels (personal, relational, cultural, organizational, community, socioeconomic, and health system/policy).

(2) Apprehend the dynamic nature of psychosocial phenomena in rapidly changing times of crisis in order to identify emergent conditions, themes, concepts, and relations as a basis for enforcing, redefining, or questioning the adequacy of cultural competence as a strategy for the reduction of health inequalities in each specific context: socioeconomic, political, historic, cultural, and local.

(3) Inductively examine the needs and experiences of women, giving voice and prominence to the most disadvantaged groups in the analysis of the barriers, inequities, and injustices they face in using healthcare services as central for the critical examination of cultural competence in contexts of severe socioeconomic vulnerability.

(4) Merge the perspectives of community psychology, sociology, public policy, and anthropology through an interdisciplinary dialogue that emphasizes multiple interconnected levels of analysis, grounded on the needs, experiences, and views of women.

The emphasis on qualitative methodology was also central in the community-based participatory approach adopted, emphasizing collaborative work through a community coalition composed of an interdisciplinary group of researchers with a background in community psychology, sociology, public policy, and anthropology and diverse stakeholders in the field of migration and health (e.g., health professionals, social workers, intercultural mediators in health centres and municipalities, governmental agencies, non-governmental organizations in the field of immigration, and health community organizations).

The Portuguese National Health Service: Entitlements in Maternal-child Healthcare for Immigrant Women

The examination of perceived needs of women as users of primary healthcare requires the contextualization of these needs in the framework of the National Health Service (NHS) and public health policies in Portugal. In this country, the right to the protection of health is granted by the National Constitution of 1976 (art. 64), establishing that it should be accomplished by a National Health System that should be universal, general, and free of charge, and by the creation of the social, economic, and cultural conditions that guarantee the protection of children, youth, and the elderly. The National Health Service was created in 1979 (Law 56) involving all integrated healthcare services, including health promotion, disease prevention, diagnosis, and treatment, and medical and social rehabilitation. In 1986, at the time Portugal entered the European Community, it became concerned with the conditions to exercising the right to access the NHS, opening the window to charge services. In 1989, an amendment to the Constitution dropped the attribute "free of charge" from the NHS, and in 1992 fees (moderator taxes) were finally imposed for emergency care and other services, such as medical appointments, diagnosis tests, ambulatory care, and many others.

It was in 2001 that a first piece of legislation was approved about the right of immigrants to access health protection. The main issue was who constituted a subject of right, or who the "citizen" is for the NHS. Dispatch 25.360/2001 granted legal immigrants access to healthcare under the same conditions as nationals while undocumented immigrants could gain access by requesting a card that proved residency (more than 90 days). Yet, this latter group has to pay higher fees or apply for an exemption card. As vulnerable populations, all pregnant women and minors have universal access, free of charge, regardless of their country of origin and immigrant status.

In 2011, the public debt crisis led the country to seek financial assistance from the European Financial Stabilization Mechanism, which has required cutting down spending in all public sectors, including health and social protection (Figueiredo-Augusto, 2012). This has had negative consequences in both access and quality of healthcare (Björngren-Cuadra & Cattacin, 2010; Padilla, 2013; Padilla et al., 2013). Accessibility has been hindered as some services, diagnosis tests, and treatment have been discontinued, and fees have more than doubled (e.g., from 2011 to 2013 the fee/moderator tax rose from 2.25€ to 5€ for a primary care consultation and from 9.6€ to 20.6€ for hospital emergency visits).

New restrictions to healthcare are similar for nationals and legal immigrants. Nevertheless, for undocumented immigrants, access has been restrained mainly through increased unaffordable costs, and previous exemptions have been terminated, with the exception of pregnant women and minors. However, they have not been immune as recent changes in the NHS computer system led to restrictions that do not allow health professionals to prescribe diagnostic tests, free of charge, to undocumented pregnant women, which poses serious risks for the health of the women and the newborns.

Method

The studies presented in this article are part of two larger, parallel mixed-methods research projects on healthcare inequalities in contexts of migration-driven diversity, specifically focused on maternal-child and primary healthcare. In both investigations, the context under study was the Metropolitan Area of Lisbon, characterized by the highest levels of diversity linked to migration in Portugal, concentrating 53.4 % of the total foreign-born population in the country (SEF, 2012).

Study 1: Qualitative Research

Participants. The qualitative phase of the project comprised a total of 185 in-depth interviews with 65 women, 55 health professionals (25 doctors, 30 nurses), 25 other professionals of the NHS (22 social workers, 3 intercultural mediators), and 40 stakeholders in the field of migration and health (21 members of civil society organizations, 1 representative of a governmental agency, 3 professionals in local municipalities, 2 members of health professional organizations, 10 educators, 2 other professionals, 1 community leader).

The results described in this article are specifically focused on women of reproductive age (up to 49 years old, according to WHO). Taking this criterion into account, one woman was excluded from the sample, which was finally composed of 64 women, aged 18 to 49 years old, from the main origin countries in the local contexts under study: Cape Verde (9), Guinea Bissau (11), Angola (6), São Tomé e Príncipe (6), Brazil (6), and others (5), as well as native Portuguese (10) and African-origin Portuguese (11). The interviewees resided in the following municipalities within the Metropolitan Area of Lisbon: Amadora (10), Sintra (15), Loures (20), Lisbon (13), and Seixal (6), all characterized by high levels of migration-driven diversity and socioeconomic vulnerability.

Instruments. Data gathering was based on a semi-structured, in-depth interview guide, including the following thematic areas: reproductive and women's health, pregnancy, birth and puerperium, healthcare access and utilization, needs and barriers, health system in the country of origin, information received and knowledge about the Portuguese NHS, relationship with health professionals, discrimination in healthcare, neighborhood and living conditions, employment and economic conditions, family and social networks, migratory trajectory, and socio-demographic information.

Procedure and data analysis. A great diversification of modes of access to participants through collaborative work with the community coalition and snowball sampling ensured a high level of variability in the interviewees' profiles. Most interviews were conducted in the private offices of community organizations, non-governmental organizations, and members of the community coalition. A smaller number were conducted in private offices of health centres or at the respondents' workplaces. Data gathering took place in 2012 and 2013, during the so-called troika intervention in Portugal.

All the interviews were audio recorded and transcribed, with previous informed consent. The analytical procedures of grounded theory (Glaser & Strauss, 1967; Strauss & Corbin, 1998) – open coding, axial coding, and selective coding; constant comparison and theoretical sensitivity – were utilized, assisted by the software package MaxQDA Plus version 10.

Study 2: Quantitative Research

Participants. The quantitative phase of the project consisted of a survey to a sample of 125 women, aged 18 to 49 years old (reproductive age, according to the WHO); 70 were in Amadora, 43 in Sintra, and 12 in other municipalities (Lisbon, Cascais) of the Metropolitan Area of Lisbon with a homogeneous representation of the main origin countries in these contexts: 24 Cape Verdeans, 32 women from other Portuguese-speaking African countries (PALOP countries: Angola, Guinea Bissau, São Tomé e Príncipe), 24 Brazilians, 23 native Portuguese, and 22 women of African-origin born in Portugal (see Table 1 for a detailed description of the sample). Participants were selected through stratified sampling by quotas with constant affixation, using country of origin and municipality of residence as stratification variables. Although strict constant quotas were not attained, a homogeneous representation of these variables in the sample was sought.

Table 1
Socio-demographic profile of the sample (N = 125)

Socio-demographic variables	%	*n*
Country of birth		
Portugal, native	18.4	23
Portugal, descendant	17.6	22
Cape Verde	19.2	24
Other Portuguese-speaking African country	25.6	32
Brazil	19.2	24
Municipality (Metropolitan Area of Lisbon)		
Amadora	56	70
Sintra	34.4	43
Other	9.6	12
Age		
18-30 years	63	50.4
31-40 years	38	30.4
41-49 years	24	19.2
Educational level		
Illiterate	5	4.1
Primary education	59	48.7
Secondary education	32	26.4
Professional qualification	2	1.7
Higher education (not finished)	4	3.3
Higher education (finished)	8	6.6
Postgraduate studies	11	9.1
Employment status		
Employed	51	41.5
Unemployed	58	47.2
Student	11	8.9
Labour incapacity	1	0.8
Domestic work (unpaid)	2	1.6
	N = 125	
Migration variables		
Years in Portugal		
< 5 years	22	30.1
5-10 years	26	35.6
> 10 years	25	34.2
Legal situation		
Residence permit	54	62.8
Portuguese nationality	18	20.9
Student visa	7	8.1
In process	4	4.7
Undocumented	3	3.5
	n = 80	

Instruments. The questionnaire was composed of 117 items. Results presented in this paper correspond to three specific sections: (1) socio-demographic profile and migration trajectory, using 14 items from the Portuguese version of the European Social Survey (ESS); (2) employment and socioeconomic conditions, using 10 items from the Portuguese version of the ESS and the National Health Survey; and (3) needs assessment, focused on the prioritization of perceived needs through two items that required respondents to indicate the three most important difficulties they face in primary healthcare access based on experience with their health centers and health professionals. Response alternatives included needs and difficulties at multiple ecological levels (personal, relational, organizational, community, socioeconomic, health system/policy, cultural/migration), based on grounded theory qualitative data analysis (see Figure 1), together with an open-ended option that allowed respondents to indicate any unlisted difficulty. Three additional closed items were also utilized as indicators of the priority needs identified.

Therefore, grounded theory informed and guided the quantitative data gathering as the core methodological approach to the whole project.

Procedure and data analysis. Interviews were conducted by five trained female interviewers whose profiles reflected the diversity of the target populations, including two native Portuguese, one Brazilian, and two Portuguese-born descendants of African immigrants. Most of the interviews were conducted in private offices of community organizations and non-governmental organizations or other members of the community coalition. A smaller number were conducted at the respondents' workplaces. All the interviews were voluntary, anonymous, and strictly based on previous informed consent. Data gathering took place in 2013, from April to June.

The software package IBM SPSS Statistics version 20 was used for quantitative data analysis. In this article, descriptive analyses are presented. Data coding and introduction in SPSS files was conducted by two research assistants, also involved in the survey implementation.

Results

Study 1: Qualitative Research

Grounded theory analysis allowed the identification of healthcare needs at multiple interconnected ecological levels: personal, relational, organizational, community, socioeconomic, health system/policy, and cultural/migration (see Figure 1). The examination of women's narratives about their difficulties, barriers, and experiences with primary healthcare revealed that the core dimensions involved in their perceived needs are those related to power asymmetries in terms of unequal access to opportunities and resources, at the socio-economic level and the health system/policy level, which are seriously aggravated in current context of financial crisis.

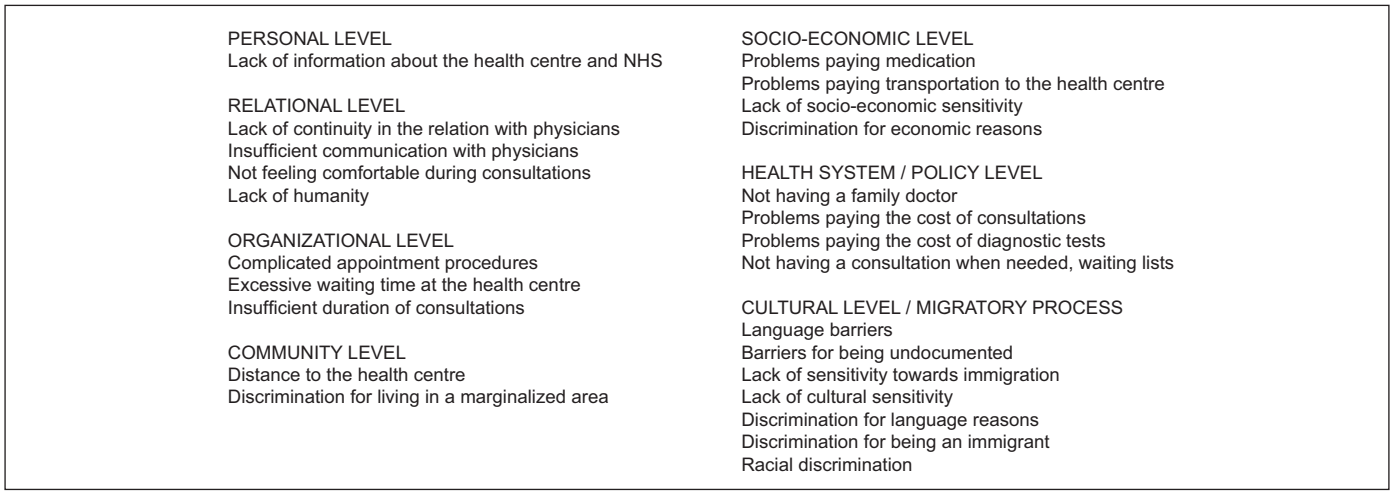

Figure 1. Perceived needs assessment: A psycho-sociopolitical approach

On the one hand, at the socioeconomic level, severe conditions of disadvantage and oppression are observed, usually linked to unemployment, leading to serious problems of access to a sufficient and healthy diet. These may impose grave health risks to the most vulnerable groups such as pregnant women, newborn mothers, and children:

> The nurse said: "In one month you have to make one kind of soup for lunch and another one for dinner. And I thought why do I have to do two types of soup per day: one with meat and another one with fish? Since I came to Portugal, I think I never ate fish because it is much more expensive and the situation, as I said, is not good. I make a quantity of soup, for example, with meat, for three days. I eat it for lunch and dinner. When it's over, I make chicken soup for three days" (*Brazilian mother, residence permit, unemployed, Amadora*).

> "I'm getting the €239 allowance [from Social Security] which is good for nothing [...]. It does not provide for a family of six people, including two babies. They need diapers, need milk, and baby food, don't they? Not to mention the clothes, because the clothes I can ask for them, there are people who have given me clothes and so I have not bought clothes for the babies. Otherwise, we would walk around naked! […] I really needed help from the food bank, and they told me I have to stay on the waiting list […] I even got depressed because I never saw myself in this situation. […] I'm just going to the church every month, where they give me 2 kg of rice, 2 liters of milk; of course, they cannot give me everything! And that's how I live" (*Cape Verdean mother, Portuguese nationality, unemployed, Cova da Moura, Amadora*).

Narratives make it possible to identify a clear pattern of unequal access to primary healthcare, depending on the socioeconomic situation of women, in terms of severe problems of access to medicines, medical consultations, and diagnostic tests. Difficulties in buying prescriptions, due to the lack of economic resources, is again imposing serious health risks to vulnerable populations, such as mothers and other women with chronic diseases, often unable to buy prescribed medications due to other basic household priorities (e.g., food, housing):

> "It's been four years since I started having diabetes. The high blood pressure started now, and high cholesterol also started a year or two ago […] To buy the medication I'm left with difficulties, so I was asking for an allowance [from Social Security] […] The medication for cholesterol, the one I cannot be without, sometimes I stay for two or three months without buying this medication […] When I don't have money, I don't buy the medication; I only buy when I have enough money" (*Mother from São Tomé e Príncipe, permanent residence permit, unemployed, 6th May neighbourhood, Amadora*).

> "In the beginning the doctor would prescribe me other medications, and sometimes I left the prescription hanging there for a long time, I would buy them only later" (*Pregnant woman from Guinea-Bissau, permanent residence permit, unemployed, Catujal, Loures*).

Considerable difficulties in paying the costs of consultations and diagnostic tests (moderator taxes) are also observed, particularly since the year 2012, due to increased direct costs of healthcare for users, leading to augmented barriers in healthcare access for users in poor socioeconomic conditions:

> "Now I'm always going to the doctor, and I have to pay for the consultation. I didn`t go once or twice to the doctor, although I needed, because I had no money to pay" (*Mother from São Tomé e Príncipe, permanent residence permit, labour incapacity, Cova da Moura, Amadora*).

Problems paying consultation costs are particularly critical for undocumented women, who are entitled to healthcare but at much higher costs. This leads to most undocumented women, including mothers, finding it impossible to afford the costs of healthcare:

> "I was not registered [at the health centre]. And as I was not registered, I had to pay 32€ to get a medical consultation. And I gave up because I had no money to pay […] And to pay less, I need to have the Social Security number and there it was. I need to have the documents and need to work, and I was unemployed. That's why I never went for any consultation" (*Pregnant woman from Angola, undocumented but in process of regularization, Lumiar, Lisbon*).

On the other hand, at the health system level, women's narratives reveal major deficiencies of the Portuguese NHS, such as excessive waiting lists, leading to the impossibility of having a primary care consultation when needed, complicated appointment procedures, and excessive waiting time at the health centre:

> "Because here you're sick, but you have to make an appointment a month, two months from now. And I'm always asking, but will the disease wait? I always ask this question. Because in the two months we'll wait for the doctor's appointment, I will not get better. For example, now I need to make an appointment because I have a small infection and they gave me the next appointment for September. So, I wonder, during this time, how is the problem? Will it stay? Of course not, it will evolve. Honestly, for me, things aren't good" (*Mother from Angola, residence card, student, Lumiar, Lisbon*).

> "We have to get up at 5 a.m. to go there and schedule an appointment, and then it takes a long time and sometimes we have to wait our turn. Yes, there are so many people! There is really a lot of people. It is very tiring. Sometimes a person is sick and has to go there at 5 a.m. There is no place indoors to wait; we have to stay on the staircase. It's horrible. It's really awful" (*Woman born in Portugal, African origin, one daughter, Portuguese nationality, employed full time, Cacém, Mira-Sintra*).

Although in Portugal all healthcare users are entitled to have a family doctor, this right is not generalized. There is still a significant proportion of users without a regular family doctor, obliged to see different physicians each time they go to the health centre, depending on availability. According to women's experiences, unequal access to family doctors leads to strong disparities in healthcare quality. Women without regular family doctors usually express extreme dissatisfaction with healthcare, more complicated appointment procedures, excessive waiting lists, difficult access, lack of continuity of care, and interaction based on a lack of sensitivity towards the socioeconomic conditions of women and their families.

> "Here we don't have a family doctor. Here, we go to the consultation, one day there's a doctor, another day there's another, another day there's another. It is a very annoying thing!" (*Cape Verdean mother, Portuguese nationality, unemployed, Cova da Moura, Amadora*).

> "I do not have a family doctor, so I have to wait, where they can fit me in […] I told her that I cannot be making two types of soup […] But they just say, 'You have to make soup with meat, fish.' But they do not know that people do not have conditions for buying food […] I think the issue of financial constraints, they should write it there on the medical files, because it's embarrassing for us to be always saying, Oh doctor, I am not able to buy this medicine because it is very expensive" (*Brazilian mother, residence permit, unemployed, Amadora*).

> Interviewer: "Since you schedule an appointment until you're seen by the doctor, how long does it take? A week? Two weeks? A month?"
>
> Woman: "Sometimes a week, a month, or even more than a month. Sometimes up to three months waiting."
>
> Interviewer: "For a consultation for your child?"
>
> Woman: "Yes […] The schedule for the appointments, I have trouble because I don't have documents, I have no family doctor, it's a bit difficult for me. For example, I don't like the health centre because I can stay for a long time in the queue to schedule an

appointment, because I don't a family doctor. It's hard, we have to stay in the queue, six or five hours to schedule an appointment" (*Cape Verdean mother, undocumented, employed part time, Cova da Moura, Amadora*).

On the other hand, women with a regular family doctor often describe easier appointment procedures and access, sufficient duration of consultations, continuity of care based on a long-term, personalized doctor-patient relationship and adequate communication, care, respect, and satisfaction. Therefore, having a family doctor may be considered a facilitator of healthcare access and quality:

"If I need a faster appointment, even in the same week, I always talk to the doctor first and she gives me a piece of paper and I schedule the appointment right away, downstairs, for that same week […] It's easy […] She's very thorough, and so it takes a long time, over half an hour. For each patient she takes, at least, half an hour […] When she prescribes a medicine that I don't know or if I have doubts, she explains (*Native mother, unemployed, Santa Filomena, Amadora*).

"I continue to be in Odivelas health centre. I have a family doctor there and I still go there. She treats me well and carefully. I never had problems. When I was pregnant, I was also well assisted. Claudio was born in MAC [Maternity Alfredo da Costa]. Everything went well" (*Mother from Guinea Bissau, permanent residence permit, employed, Quinta da Fonte, Loures*).

"She happens to be very kind to me, she makes check-ups well, and she asks me what I need, what I have, she is very good with me" (*Mother from São Tomé e Príncipe, permanent residence permit, unemployed, 6th May neighbourhood, Amadora*)

Study 2: Quantitative Research

In line with qualitative results, descriptive analysis of the needs-assessment survey revealed that the three most important difficulties in primary healthcare access for immigrant women in reproductive age, based on their experience with their health centre and health professionals are: (1) not having a consultation when needed due to excessive waiting lists (33.1%); (2) not having a family doctor (32.5%); and (3) not able to afford medicines (32.3%).

Other relevant problems, mentioned by more than 20% of the participants were: (4) complicated appointment procedures (31.5%); (5) lack of continuity in the relationship with their physicians (29.2%); (6) excessive waiting time at the health centre (26.6%); (7) difficulties affording the cost of diagnostic tests (21%); and (8) problems affording the cost of consultations (20.2%).

The least important problems for the interviewees were: (1) the lack of cultural sensitivity of health professionals (0.8%) and (2) discrimination due to their economic situation (0.8%). No women indicated as a relevant problem the lack of sensitivity of health professionals towards immigration, language discrimination, or general discrimination.

Results of the perceived-needs assessment are detailed in Table 2, together with some indicators of the three priority needs identified. Women reported an average waiting time for a primary care consultation of more than 26 days (Mean = 26.3, *SD* = 23.8), 35.2% do not have a family doctor, and 44.7% indicate that they cannot buy prescribed medicines (sometimes, frequently, or never buy) due to lack of economic resources.

Perceived-needs assessment by country of origin. The analysis of perceived needs by country of origin revealed a slightly differentiated pattern of priorities, depending on the women's origin. For native women, the three most important difficulties are (1) complicated appointment procedures (34.8%); (2) not having a primary care consultation when needed due to waiting lists (26.1%), excessive waiting time at the health centre (26.1%); and (3) problems affording the cost of medicines (21.7%). Access to family doctors was not a relevant problem for native women, only highlighted by a 4.5% of this group of women.

For descendants, women born in Portugal with immigrant (African) origin, priority needs are related to (1) lack of continuity in the relationships with health professionals (55%); (2) not having a primary care consultation when needed due to waiting lists (33.3%); (3) not having a family doctor (30%) and not feeling comfortable enough during consultations (30%). Descendants are, therefore, the most concerned about their relationships with health professionals.

For Brazilian women, major perceived needs identified by more than 50% of the interviewees are (1) not having a primary care consultation when needed due to excessive waiting lists (70.8%); (2) not having a family doctor (62.5%); and (3) complicated appointment procedures (54.2%). More than 30% of Brazilian women also indicate difficulties related to the lack of continuity in the relationships with health professionals (41.7%) and excessive waiting time at the health centre (37.5%). Problems affording medicines, consultations, and diagnostic tests are less relevant for this group of women.

For Cape Verdean women, priority perceived needs are (1) problems affording the cost of medicines (45.8%) and (2) diagnostic tests (41.7%), and (3) excessive waiting time at the health centre (37.5%). More than 30% of the respondents also emphasized problems affording the cost of consultations (33.3%). Cape Verdean women are, therefore, the group with more problems of access to primary healthcare due to socio-economic disadvantage.

Finally, women from other Portuguese-speaking African countries refer as priority needs (1) difficulties affording prescribed medicines (50%); (2) not having a family doctor (41.9%); and (3) the associated lack of continuity in the relationship with health professionals (25.8%).

Concerning the least relevant perceived needs, there is common agreement in all groups. They are less concerned with the lack of sensitivity of health professionals towards immigration, discrimination for language reasons, the lack of cultural sensitivity, and discrimination for economic reasons.

Results of perceived needs assessment by country of origin are detailed in Table 2, together with indicators of the three priority needs identified. Significant differences are observed in problems of access to family doctors and medicines, depending on women's country of origin. As depicted in Table 2, foreign-born women have less access to family doctors, particularly Brazilian and Cape Verdean women. The most severe problems of access to medicines are observed among Cape Verdean and other African women, together with descendants of immigrants from these countries.

Discussion

In our studies, the perceived healthcare needs of women in contexts of migration-driven diversity and socioeconomic vulnerability in the Metropolitan Area of Lisbon were primarily related to (1) socioeconomic factors – observing severe problems of access to medicines, medical consultations, and diagnostic tests due to the impossibility of affording their increasing cost in the current context of cuts and reforms in the Portuguese NHS, also identifying serious difficulties in maintaining a sufficient and complete diet – and (2) factors at the health system level, such as the lack of family doctors and excessive waiting lists for primary care consultations due to insufficient health professionals to meet the health needs of the population in Portugal.

Inequalities, depending on the country of origin, were identified in access to family doctors, which was inferior for foreign-born women, and difficulties affording prescribed medicines, superior for Cape Verdean and other African women. This pattern is clearly reflected in women's perceived needs. On the one hand, for native women, not having a family doctor is not a main concern, as the majority of them have a regular family doctor and the subsequent benefit of continuity

Table 2
Needs assessment of women in reproductive age

	Total Sample N = 125		Natives n = 23		Descendant n = 22		Brazilians n = 24		Cape Verdeans n = 24		Other PALOP n = 32	
Perceived needs	Rank	%	*R*	%	*R*	%	*R*	%	*R*	%	*R*	%
Not having a consultation when needed / waiting lists	1	33.1	2	26.1	2	33,3	1	70,8	5	29.2	8	12.5
Not having a family doctor	2	32.5	7	4.5	3	30	2	62.5	7	17.4	2	41.9
Problems paying for medication	3	32.3	3	21.7	4	23.8	8	12.5	1	45.8	1	50
Complicated appointment procedures	4	31.5	1	34.8	4	23.8	3	54.2	6	20.8	4	25
Lack of continuity in the relationships with their physicians	5	29.2	6	9.1	1	55	4	41.7	7	17.4	3	25.8
Excessive waiting time at the health centre	6	26.6	2	26.1	4	23.8	5	37.5	3	37.5	8	12.5
Problems paying the cost of diagnostic tests	7	21	5	13	4	23.8	10	4.2	2	41.7	5	21.9
Problems paying the cost of consultations (moderator fee)	8	20.2	5	13	4	23.8	10	4.2	4	33.3	4	25
Not feeling comfortable enough during consultations	9	15.8	4	18.2	3	30	8	12.5	8	8.7	7	12.9
Insufficient duration of consultations	10	14.2	6	9.1	5	20	6	25	7	17.4	11	3.2
Lack of information about the health centre and system	11	12.1	8	4.3	6	19	6	25	10	4.2	9	9.4
Insufficient communication during consultations	12	10.8	4	18.2	7	15	9	8,3	8	8.7	10	6.5
Lack of humanity during consultations	13	9.2	6	9.1	8	10	7	16.7	8	8.7	12	3.2
Language barriers	14	5	-	-	9	5	-	-	-	-	6	16.1
Distance to the health centre	15	4.8	8	4.3	-	-	-	-	10	4.2	8	12.5
Lack of socioeconomic sensibility	16	3.3	7	4.5	9	5	10	4.2	9	4.3	12	3.2
Racial discrimination	17	2.5	-	-	8	10	-	-	-	-	12	3.2
Discrimination for living in marginalized neighbourhoods	18	1.7	-	-	9	5	-	-	9	4.3	-	-
Discrimination for being an immigrant	18	1.7	-	-	-	-	10	4.2	9	4.3	-	-
Problems paying transportation to the health centre	19	1.6	-	-	-	-	-	-	10	4.2	13	3.1
Barriers for being undocumented	19	1.6	-	-	-	-	-	-	10	4.2	13	3.1
Discrimination for economic reasons	20	0.8	-	-	-	-	-	-	-	-	12	3.2
Lack of cultural sensitivity	20	0.8	-	-	-	-	10	4.2	-	-	-	-
Discrimination (general)	21	0	-	-	-	-	-	-	-	-	-	-
Discrimination for language reasons	21	0	-	-	-	-	-	-	-	-	-	-
Lack of sensitivity towards immigration	21	0	-	-	-	-	-	-	-	-	-	-
Indicators of priority needs	Mean (*SD*)	%	Mean (*SD*)	%	Mean (*SD*)	%	Mean (*SD*)	%	Mean (*SD*)	%	Mean (*SD*)	%
Waiting time (in days) for a primary care consultation	26.37 (23.8)		35.95 (28.1)		27.33 (27.2)		21.37 (18.6)		30.88 (27.1)		16.6 (11.3)	
1–7 days		22.3		9.5		38.9		15.8		12.5		35
8–15 days		17		14.3		5.6		31.6		12.5		20
16–30 days		46.8		52.4		38.9		36.8		62.5		45
> 30 days		13.8		23.8		16.7		15.8		12.5		-
χ^2	16.48											
Women without a family doctor		35.2		4.3		22.7		66.7		41.7		37.5
χ^2	22.03***											
Women who cannot afford medicines (do not buy sometimes, frequently, or never buy)		44.7		34.8		42.6		17.4		62.6		59.4
χ^2	29.49*											

*p < .05, ***p < .001

of care. As suggested by the qualitative data, unequal access to family doctors may be a core factor, at the health system level, leading to important inequities in healthcare access and quality in the contexts under study based on the asymmetrical distribution of scarce, valued resources (family doctors). In our studies, Brazilian women were the most disadvantaged in terms of access to family doctors and the consequent lack of continuity of care.

On the other hand, the lack of economic resources seems to be particularly severe for Cape Verdean and other African women, as reflected in their reported difficulties in paying the cost of medicines, consultations, and diagnostic tests. Problems affording the cost of primary care consultations and diagnostic tests may impose serious health risks to these groups of women, given the importance of regular check-ups for the prevention of breast cancer, cervical cancer, and other diseases related to women's health.

As stated above, the studies described here are part of two broader projects on healthcare inequalities in contexts of migration-driven diversity, specifically focused on maternal-child and primary

healthcare in the Metropolitan Area of Lisbon. Therefore, the results presented in this paper, focused on women's experiences and perceived needs, should be complemented with the views and perspectives of health professionals and other stakeholders in the field of health and migration in the contexts under study. Furthermore, an important limitation of the survey conducted concerns the generalization of results, as sample size is limited and random sampling cannot be used with immigrant populations. This was the main reason for choosing stratified sampling by quotas, which is the nonrandom design that allows getting results similar to random procedures. A great diversification of modes of access to participants through collaborative work with the community coalition and snowball sampling ensured a high level of variability in the interviewees' profiles, allowing for the reduction of possible biases associated with non-probability sampling procedures.

Conclusions

Adopting a psycho-sociopolitical approach, we utilized grounded theory principles and analytical procedures to identify and prioritize the healthcare needs of women of reproductive age in a context characterized by migration-driven diversity and socioeconomic vulnerability. Grounded theory allowed us to understand the needs of the women, based on their own views and experiences as embedded in contexts characterized by asymmetrical power relations, in terms of unequal opportunities and resources, and at multiple interrelated ecological levels (personal, relational, organizational, community, socioeconomic, health system/policy, cultural/migration).

Identified needs were the basis for a critical examination of cultural competence as a strategy for the reduction of healthcare inequities in the specific context under study, severely struck by the financial crisis and the subsequent austerity measures in terms of cuts in the NHS and rising direct costs for healthcare users. In opposition to cultural competence approaches, which have usually emphasized the role of cultural and relational factors as determinants of healthcare inequalities in contexts of migration-driven diversity, the results described in this paper suggest the need to conceptualize the relationship between health professionals and users (women) as embedded in macro-level systems (health system, socio-economic system, welfare state, political system) which determine the relational context where healthcare encounters take place.

In our studies, the priority perceived needs of women were primarily related to socio-economic vulnerability, severely aggravated as a result of increasing unemployment in the current context of financial crisis, and factors at the health system level (e.g., waiting lists and unequal access to family doctors due to an insufficiency of medical doctors, increasing direct costs of consultations and diagnostic tests), also worsened as a result of austerity measures in Portugal in terms of cuts in the NHS and the general retrenchment of the welfare state. The Portuguese NHS already had serious inefficiencies and lack of resources (insufficient family doctors, favouring capitalization of the private sector through perverse private-public partnerships) before the crisis. Nevertheless, the magnitude of imposed change has constrained the capacity of the NHS to respond to the needs of the population at a time of increasing demand, as the results of our studies suggest.

As social scientists dealing with problems beyond the individual, we need to think ecologically and de-psychologize community psychology (Smail, 2001), particularly in the current context of financial crisis, in which the needs of individuals and communities are embedded in macro-level systems more than ever (e.g., financial system, political system, public policies characterized by austerity measures, retrenchment of the welfare state, and restricted definitions of who is a citizen), characterized by asymmetrical power relations and lack of social justice, with great impact on our health and well-being.

Conflict of Interest

The authors of this article declare no conflict of interest.

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