

Immigrant women's experience of and access to maternity care in the United Kingdom (UK): a narrative synthesis systematic review

Gina Marie Awoko Higginbottom,^{1*} Catrin Evans,¹ Myfanwy Morgan,² Kuldip Kaur Bharj,³ Jeanette Eldridge,¹ Basharat Hussain,¹ Karen Salt¹

¹ Faculty of Medicine and Health Sciences, Queen's Medical Centre, University of Nottingham, Lenton Boulevard, Nottingham, NG7 2HA, UK

² Institute of Pharmaceutical Science, Faculty of Life Sciences and Medicine, King's College London, UK

³ Division of Midwifery, University of Leeds, Leeds, UK

⁴ Centre for Research into Race and Rights, University of Nottingham, Lenton Boulevard, Nottingham, NG7 2HA

Corresponding author:

Professor Gina Higginbottom,
The Mary Seacole Professor of Ethnicity and Community Health
Faculty of Medicine and Health Sciences, Queen's Medical Centre, Nottingham, NG7 2UH,
UK
Tel: 0115 82 30991
Email: gawoko@hotmail.com or ntagh2@nottingham.ac.uk

Declared competing interests of authors: none

Keywords: maternity, immigration, interventions, access to services, systematic review, narrative

Date: 21st January 2019

Important

A 'first look' scientific summary is created from the original author-supplied summary once the normal NIHR Journals Library peer and editorial review processes are complete. The summary has undergone full peer and editorial review as documented at NIHR Journals Library website and may undergo rewrite during the publication process. The order of authors was correct at editorial sign-off stage.

A final version (which has undergone a rigorous copy-edit and proofreading) will publish as part of a fuller account of the research in a forthcoming issue of the Health Services and Delivery Research journal.

Any queries about this 'first look' version of the scientific summary should be addressed to the NIHR Journals Library Editorial Office – journals.library@nihr.ac.uk

The research reported in this 'first look' scientific summary was funded by the HS&DR programme as project number 15/55/03. For more information visit <https://www.journalslibrary.nihr.ac.uk/programmes/hsdr/155503/#/>

The authors have been wholly responsible for all data collection, analysis and interpretation, and for writing up their work. The HS&DR editors have tried to ensure the accuracy of the authors' work and would like to thank the reviewers for their constructive comments however; they do not accept liability for damages or losses arising from material published in this scientific summary.

This 'first look' scientific summary presents independent research funded by the National Institute for Health Research (NIHR). The views and opinions expressed by authors in this publication are those of the authors and do not necessarily reflect those of the NHS, the NIHR, NETSCC, the HS&DR programme or the Department of Health and Social Care. If there are verbatim quotations included in this publication the views and opinions expressed by the interviewees are those of the interviewees and do not necessarily reflect those of the authors, those of the NHS, the NIHR, NETSCC, the HS&DR programme or the Department of Health and Social Care.

Scientific summary

Background

Increasing global migration means that knowledge related to immigrant experiences of maternity care is urgently needed. One in four births in the UK is to foreign-born women and immigrant (both first and second-generation) women suffer disproportionately in respect of

maternal and perinatal mortality. Consequently addressing health inequities in care pathways in addition to the organisation and delivery of services is a major goal of the NHS.

Objectives

Our objective was to conduct a systematic review employing a validated narrative synthesis (NS) approach to identify, appraise, and synthesise reports on empirical research focused on access to maternity care and interventions that improve such care for immigrant women. Qualitative, quantitative, and mixed-methods research evidence is included to assist understanding of the broader influences of ethnicity, socioeconomic status, and geographical location, explaining the differences between differing study designs and the topic of investigation in this case immigrant women; and facilitate the development and implementation of better maternity services and health interventions.

We identified empirical studies in scientific journals and on the grey literature, to provide perspectives on access and maternity care interventions directed at immigrant women in the UK. We adopted the following definition of an immigrant woman for the purposes of our review, and to inform our inclusion and exclusion criteria. A woman is an immigrant if she is:

- Born outside the UK, and;
- Is living in the UK for more than 12 months or had the intention to live in the UK for 12 (or more) months when first entered. .

Inclusion Criteria

<i>Population</i>	Immigrant women from any country other than England, Scotland, Northern Ireland or Wales
<i>Phenomena of Interest</i>	Maternity care
<i>Context Setting</i>	United Kingdom
<i>Study designs</i>	Qualitative, quantitative and mixed methods studies
<i>Language</i>	English
<i>Date limitations</i>	Jan 1990 - Jan 2018

Exclusion Criteria

<i>Context</i>	Studies located in any country other than England, Scotland, Northern Ireland or Wales
<i>Participants</i>	Black and minority ethnic women born in the United Kingdom
<i>Study Design</i>	Non-empirical research, opinion pieces or editorial

Methods

NS is ‘an approach to the systematic review and synthesis of findings from multiple studies that relies primarily on the use of words and text to summarise and explain the findings of the synthesis. The emphasis is on an interpretive synthesis of the narrative findings rather than on a meta-analysis of data. All review steps involved two or more reviewers. NS allowed us to encompass cross-disciplinary and methodologically pluralistic research in our review. The general framework for an NS comprises four elements: (a) development of a theory of how, why, and for whom the findings apply; (b) development of a preliminary synthesis of the findings; (c) exploration of the relationships in the data; and (d) assessment of the robustness of the synthesis. These elements are not independent, and the synthesis takes an iterative approach. An experienced information scientist designed the database search strategies, which were reviewed by the entire research team. We included all empirically based studies from January 1990 – January 2018 and employed a three-stage process:

1. Screening;
2. Preliminary categorisation; and
3. Retrieval, final selection, and final categorisation (independent double screening).

To ensure the robustness of the NS, the methodological quality of key literature was appraised using tools from the Center for Evidence-Based Management (CEBMA) tools. In addition, we facilitated a national stakeholder event to further verify our preliminary findings. Attendees included academics, clinicians, representatives of community groups and association and two immigrant women.

Results

We identified 40 research studies that met our inclusion criteria categorised into five themes. The evidence for each theme was almost equal in division with a smaller number of studies in themes 4 and 5 (11 and 12 studies respectively). Please see *Appendix 6* for the theme distribution table. The quality of the included studies was generally appraised as medium to high, with high relevance congruence *see Table 4*. We did not identify any studies which rigorously evaluated an intervention, although we know new services and interventions exist from our consultations with key-stakeholders, these have not been scientifically evaluated, *see Supplementary file 2*

Strength of evidence

The included studies demonstrated a high level of relevance to the review question and the scientific quality was largely medium to high, however many studies lacked methodological detail such as a clear description of the study sample.

Results

Our systematic review synthesized 40 studies that met our inclusion criteria, and these were carefully analysed. These studies were grouped into five themes as follows: -

Theme 1: Access and utilisation of maternity care services by immigrant women

Included studies identified that immigrant women study participants tended to book and access antenatal care later than the recommended timeframe (during the first 10 weeks of pregnancy). Reported factors included limited English language proficiency, immigration status, lack of awareness of the services, lack of understanding of the purpose of the services, income barriers, the presence of female genital mutilation, differences between the maternity care systems of their countries of origin and the UK, arrival in the UK late in the pregnancy, frequent relocations after arrival, the poor reputations of antenatal services in specific communities and perceptions of regarding antenatal care as a facet of medicalisation of childbirth.

Theme 2: Maternity care relationships between immigrant women and healthcare professionals.

Our review evidence indicated that the perceptions of study participants regarding the ways that healthcare professionals delivered maternity care services were both positive and negative. Some studies found positive relationships between healthcare professionals and immigrant women, and the women felt that the healthcare professionals were caring, respected confidentiality, and communicated openly in meeting their medical as well as emotional, psychological, and social needs. Evidence also suggests negative relationships between participants in our included studies and healthcare professionals. In some cases, healthcare professionals were perceived as rude, discriminatory, or insensitive to the cultural and social needs of the women. Consequently, these women tended to avoid accessing utilising maternity care services consistently.

Study participants expressed a need for the healthcare professionals to be empathetic, respectful, culturally congruent, and professional when providing maternity care services. Some women also suggested employing healthcare professionals from the immigrant population.

Theme 3: Communication challenges experienced by immigrant women in maternity care.

Verbal communication challenges occur when immigrant women have limited English language fluency and when healthcare professionals use medical or professional language

that is difficult to understand. Nonverbal communication challenges can also occur through misunderstandings of facial expressions, gestures, or pictorial representations. Consequently, participants in our included studies were reported to have limited awareness of available services in addition to miscommunication with healthcare professionals. Participants often expressed challenges accessing services, were unable to understand procedures and their outcomes, were unable to articulate their health or maternity needs to service providers, were hindered in their involvement and decision making, often gave consent for clinical procedures without full understanding, and did not receive proper advice on baby care. Studies identified that participants were often not understood by healthcare professionals and sometimes felt frightened and ignored.

Theme 4: Organisation of maternity care, legal entitlements and their impacts on the maternity care experiences of immigrant women.

The service users in our included studies had mixed experiences with the maternity care services in the UK. Positive experiences included feeling safe in giving birth at hospital rather than at home, being able to register a complaint if poor healthcare was received, being close to a hospital facility, not being denied access to a maternity service, and having good experiences with postnatal care. The negative experiences included not being able to see same maternity care providers each time and being unaware of how maternity services work. Participants in included studies were also unhappy with the bureaucracy involved and with the UK maternity care model for obstetric interventions and caesarean section births.

The legal entitlements of immigrant women in the UK had an important bearing on their access to maternity care. The immigrant women without entitlement to free maternity care services in the UK were deterred from accessing timely antenatal care by the costs and by the confidentiality of their legal status. Moreover, some women arrived in the UK during the final phase of their pregnancies, which resulted in discontinuities in the care process, loss of their social networks, reduced control over their lives, increased mental stress, and increased vulnerability to domestic violence.

Study participants in our included studies were reported to have had mixed experiences in the support they received from healthcare professionals regarding breastfeeding.

Theme 5: Discrimination, racism, stereotyping, cultural sensitivity, inaction, and cultural clash in maternity care for immigrant women.

Discrimination and cultural insensitivity in maternity care services contribute to inequalities in access, utilisation, and outcomes for immigrant women. Discrimination was often subtle and difficult to identify, but direct and overt discrimination was reported in some studies (12).

Study participants in our included studies of Muslim faiths criticised assumptions held by healthcare professionals, including those held regarding Muslim food practices and that their partners or husbands should help the women during labour. In addition, evidence suggested that they also felt that they were viewed as different and dangerous people, although this evidence arises from is based on one small study from the grey literature.

Moreover, healthcare professionals were reported in some studies to lack cultural sensitivity and cultural understanding. For example, women did not optimally benefit from antenatal classes facilitated by a non-Muslim educator who had no knowledge of the relationships of Muslim culture to maternity. Moreover, studies reported participant dissatisfaction of antenatal class with a gender mix. Some studies reported that women of Muslim faith felt their cultural and religious needs for breastfeeding were not met, and they felt that the staff lacked any understanding of female genital mutilation (FGM).

In some cases, however, midwives were happy to meet the cultural and religious needs of the study participants in our included studies in both antenatal and postnatal settings.

Our findings also identified instances of cultural clash and conflicting advice during pregnancy and maternity care, mostly resulting from differences between the home countries of the immigrants and the UK in their cultural practices and medical systems.

Conclusions

The evidence in this review suggests experiences of immigrant women in accessing and using maternity care services in the UK are both positive and negative; however, immigrant women largely had poor experiences. Factors contributing to poor experiences included lack of language support, cultural insensitivity, discrimination, poor relationships between immigrant women and healthcare professionals, and a lack of legal entitlements and guidelines on the provision of welfare support and maternity care to immigrants. The range of publication dates for the included studies 1990–2016, however the majority of the included studies are from 2010–2016 meaning the evidence in this review is contemporaneous. We would suggest that the small number of studies arising from 1990's still have relevance for current services as the focus on 'link-workers' addresses the issue of 'cultural brokerage' with focus on linguistic and cultural issues. There is a paucity of evidence in respect of evaluation of interventions, our included studies largely focused on women's experiences and perceptions of maternity care services. Therefore, the quality and strength of the evidence largely resides in the latter domain.

Implications of findings for maternity care policy, practice, and service delivery

- Maternity services should aim for optimal care for all and not just for immigrant women.
- An awareness of immigrant women's legal rights may be an essential consideration for education for maternity care professionals.
- Continuity in maternity caregivers and compulsory provision of interpreters would also help to improve the experiences of immigrant women as language issues appeared to be key determinant of optimal access and utilisation of maternity care services.
- Setting up a national-level website offering standard information on maternity care with the option of translation in a wide range of languages may be a solution. Additionally, the identification of best language practices should be identified with regard to improve the current language service model.
- Challenging discrimination and racism at all levels: individual, institutional, clinical, and societal is an urgent imperative. The evidence arising from 12 studies suggests the attitude of some but not all maternity care providers is crucial. Ethno-culturally based stereotypes, racism, judgmental views, and direct and indirect discrimination require eradication, however it is important to note that not all women experienced these issues.
- Interventions are required with implementation at macro and micro level including organisational, service, and staff initiatives.
- Increasing the social capital, health literacy, and advocacy resources for immigrant women would empower them to access and utilise maternity care services appropriately.
- Maternity care staff require education to achieve greater cultural awareness of needs of diverse client groups including newcomers to the UK. Our findings highlight the importance of demonstrating compassion, empathy, and warmth.
- Greater use of individualised birth plans would assist in achievement of the aforementioned goal.

- Central to these suggestions is the inclusion of volunteer and third-sector organisations to work as links between the statutory maternity services and immigrant women. A system of ‘cultural brokerage’ that resides outside the NHS may be a strategy for enhancement of maternity care services.
- We suggest that a focus on cultural safety and competence could provide vehicles and mechanisms for improving maternity care services for immigrant women in the UK

Implications for future research

- Interventions to improve maternity care for immigrant women are scant, and economic evaluations of these interventions were very absent
- Studies are needed that focus on the development of interventions and the rigorous scientific evaluation of these interventions.
- Development and evaluation of online antenatal education resources in multiple languages could be explored and obviate the need for written materials and expensive interpreter time.
- Development and appraisal of education packages for health care professionals focused on provision of cultural safe for the UK’s diverse population.
- Significantly, the NHS in the UK has hugely diverse workforce with a vast untapped linguistic resource, with employees who hold tacit cultural knowledge. Strategies might be developed to harness this resource in a non-exploitative fashion ensuring NHS employees are correctly remunerated for using this linguistic and cultural knowledge.
- More research is required into the term ‘immigrant’, how it is used, and the changes in its use over time that may affect immigrant women’s care. At present, the term is used very broadly and simplistically, which masks its inherent heterogeneity. Furthermore, more research is needed to understand how the intersections of particular characteristics – such as gender, education status, immigration status etc.

Gaps in the evidence

Few published and evaluated interventions had been implemented to address inequalities in access and quality in maternity care for immigrant women, and the effectiveness of these few had not been evaluated robustly.

PROSPERO 2015: CRD42015023605

Funding details

Health Services and Delivery Research programme (Grant No. HS&DR-15/55/03)

First look draft