Access to and interventions to improve maternity care services for immigrant women: a narrative synthesis systematic review

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Scientific summary

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Background

Increasing global migration means that knowledge related to immigrant experiences of maternity care is urgently needed. Over one in four births in the UK is to a foreign-born woman, 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 to 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
- has lived in the UK for > 12 months or had the intention to live in the UK for ≥ 12 months when she first entered the UK.

Inclusion criteria

- Population: immigrant women from any country other than England, Scotland, Northern Ireland or Wales.
- Phenomenon of interest: maternity care.
- Context setting: UK.
- Study designs: qualitative, quantitative and mixed-methods studies.
- Language: English.
- Date limitations: January 1990 to January 2018.

Exclusion criteria

- Context: studies located in any country other than England, Scotland, Northern Ireland or Wales.
- Participants: black and minority ethnic women born in the UK.
- Study design: non-empirical research, opinion pieces or editorials.

Methods

Narrative synthesis (NA) 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'.87 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. Narrative synthesis allowed us to encompass cross-disciplinary and methodologically pluralistic research in our review. The general framework for a NS comprises four elements: (1) development of a theory of how, why and for whom the findings apply; (2) development of a preliminary synthesis of the findings; (3) exploration of the relationships in the data; and (4) 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 to January 2018 and employed a three-stage process:

1. screening
2. preliminary categorisation
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. In addition, we facilitated a national stakeholder event to further verify our preliminary findings. Attendees included academics, clinicians, representatives of community groups and associations, and two immigrant women.

Results

We identified 40 research studies that met our inclusion criteria catergorised 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). The quality of the included studies was generally appraised as medium to high, with high relevance congruence. We did not identify any studies that rigorously evaluated an intervention, although we know that new services and interventions exist from our consultations with key stakeholders; these have not been scientifically evaluated.

Strength of evidence

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

Results

Our systematic review analysed and synthesised 40 studies that met our inclusion criteria and these were carefully analysed. These studies were grouped into the following five themes.

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 time frame (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 (FGM), 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 antenatal care as a facet of the medicalisation of childbirth.

Theme 2: maternity care relationships between immigrant women and health-care professionals

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

Study participants expressed a need for the HCPs to be empathetic, respectful, culturally congruent and professional when providing maternity care services. Some women also suggested employing HCPs 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 HCPs use medical or professional language that is difficult to understand. Non-verbal 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 HCPs. 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 about caring for their baby. Studies identified that participants were often not understood by HCPs and sometimes felt frightened and ignored.

Theme 4: organisation of maternity care, legal entitlements and their impact on the maternity care experiences of immigrant women

The service users in our included studies had mixed experiences of maternity care services in the UK. Positive experiences included feeling safe in giving birth at a hospital rather than at home, being able to register a complaint if poor health care 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 the 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 of the support that they received from HCPs 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 12 studies.

Study participants of Muslim faith in our included studies criticised assumptions held by HCPs, including about Muslim food practices and that women's partners or husbands should help them during labour. In addition, evidence suggested that they also felt that they were viewed as different and dangerous people.

Moreover, some studies reported that HCPs lacked 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 relationship of Muslim culture to maternity. Moreover, studies reported participant dissatisfaction with antenatal classes that had a gender mix. Some studies reported that women of Muslim faith felt that their cultural and religious needs for breastfeeding were not met and they felt that the staff lacked any understanding of FGM.

However, in some cases, midwives were happy to meet the cultural and religious needs of the study participants 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 in cultural practices and medical systems between the home countries of the immigrants and the UK.

Conclusions

The evidence in this review suggests that 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 HCPs, 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 was 1990–2016; however, the majority of the included studies are from 2010 to 2016, meaning that the evidence in this review is contemporaneous. We would suggest that the small number of studies arising from the 1990s are still relevant to current services, as the focus on 'link workers' addresses the issue of 'cultural brokerage', with the focus on linguistic and cultural issues. There is a paucity of evidence in respect of the 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 in education for maternity care professionals.
- Continuity in maternity caregivers and the compulsory provision of interpreters would also help to improve the experiences of immigrant women, as language issues appeared a 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 into a wide range of languages may be a solution. Additionally, the identification of best language practices should be identified with regard to improving 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 that the attitude of some, but not all, maternity care providers is crucial. Ethnoculturally based stereotypes, racism, judgemental 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 the macro and micro levels, 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 the 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 the 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 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 HCPs focused on the provision of cultural safety for the UK's diverse population.
- Significantly, the NHS in the UK has a hugely diverse workforce, with a vast untapped linguistic resource and employees who hold tacit cultural knowledge. Strategies might be developed to harness this resource in a non-exploitative fashion, ensuring that NHS employees are correctly remunerated for using their linguistic and cultural knowledge.
- More research is required for 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 and immigration status, impact on the experience of maternity care.

Gaps in the evidence

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

Study registration

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