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DOI:

[10.1016/j.socscimed.2015.11.030](https://doi.org/10.1016/j.socscimed.2015.11.030)

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Document Version

Peer reviewed version

Citation for published version (Harvard):

Phillimore, J 2016, 'Migrant maternity in an era of superdiversity: new migrants' access to, and experience of, antenatal care in the West Midlands, UK', *Social Science and Medicine*, vol. 148, pp. 152-159. <https://doi.org/10.1016/j.socscimed.2015.11.030>

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Accepted Manuscript

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PII: S0277-9536(15)30238-0

DOI: [10.1016/j.socscimed.2015.11.030](https://doi.org/10.1016/j.socscimed.2015.11.030)

Reference: SSM 10375

To appear in: *Social Science & Medicine*

Received Date: 19 December 2014

Revised Date: 7 October 2015

Accepted Date: 20 November 2015

Please cite this article as: Phillimore, J., Migrant maternity in an era of superdiversity: new migrants' access to, and experience of, antenatal care in the West Midlands, UK, *Social Science & Medicine* (2015), doi: 10.1016/j.socscimed.2015.11.030.

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Social Science and Medicine Manuscript Number SSM-D-14-03455

Migrant maternity in an era of superdiversity : new migrants' access to, and experience of, antenatal care in the West Midlands, UK

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Acknowledgements

The author wishes to acknowledge colleagues Jayne Thornhill, Zahira Latif and Marcianne Uwimana for the interviews they undertook for their project and the Department of Health West Midlands for funding the research. Thanks also go to the anonymous refugees for their useful comments.

Abstract

Rapid increase in the scale, speed and spread of immigration over the past two decades has led to an increase in complexity of populations termed superdiversity. Concerns have been expressed about impacts of the pressure that superdiversity is said to place upon maternity services. High migrant fertility and infant and maternal mortality rates have long been observed in diverse areas with inadequate antenatal monitoring seen as a major causal factor in migrants' maternity outcomes. Using qualitative data from a study of new migrants' access to maternity services in the UK's West Midlands region, with some of the highest infant and maternal mortality rates in Europe, this paper looks at the reasons migrants' access to antenatal care is poor. The paper finds that contrary to earlier studies which pointed to a lack of priority placed on such care by migrants, a combination of structural, legal and institutional barriers prevent migrant women accessing effective antenatal care.

Key words: migrant, maternity, antenatal care, superdiversity, UK

Introduction

Enormous demographic changes have been witnessed in Europe over the past two decades as EU countries have transformed from being countries of emigration to countries of immigration receiving over twenty-six million migrants in just two decades (Boeri 2011). Driven by these changes populations have become more diverse as the complexity, spread and scale of migrant arrivals increases. Whilst many new migrants move to existing areas of diversity, others move to towns and rural areas with little experience of immigration. Earlier migrations involved large numbers of people migrating for employment from a few former colonies to a small number of places. These so-called "old" migration flows continue alongside the arrival of new migrants from almost every country in the world to many more

places. Internal differentiation within country of origin groups has further diversified populations and is observable by immigration status, religion, class, age, gender, ethnicity, language and education resulting in what Vertovec (2007) refers to as superdiversity.

A combination of the increased scale, spread and complexity of migration flows has led to concerns about the impact of migration at local level (Dustmann and Frattini 2013) associated with negative political and media rhetoric. In response to concerns about the ability of service providers to meet the social and welfare needs of superdiverse new migrants (Law 2009; Vertovec 2007), politicians have developed policy that restricts migrants' access to welfare, with a particular emphasis on health - withdrawing free access to secondary healthcare for irregular migrants and failed asylum seekers. A crackdown on "health tourism" based on notions that some migrants come for health gain (Williams 2005) is part of the Home Office's strategy to increase the discomforts associated with living illegally in the UK, encourage irregular migrants to leave and prospective migrants to go elsewhere. The crackdown includes charging migrants with no recourse to public funds and failed asylum seekers for maternity care.

Migrants' access to maternity services has received considerable attention with allegations of "overload" of services in areas unaccustomed to migrant mothers (Hayes et al 2011). Attention has also been paid to claims that migration is fuelling a rise in fertility rates in Europe and concerns about high levels of migrant maternal and infant mortality (Hayes et al 2011). Research points to women from minority and migrant backgrounds booking later than recommended for antenatal monitoring, and attending fewer appointments and antenatal classes (Chot 2011; Cross-Sudworth et al 2010; Redshaw and Heikkila 2010). While there is a well-established relationship between intensity of antenatal monitoring and health outcomes

of mother and baby, little is known about the reasons migrant mothers book late or miss follow-up appointments with speculation that culture influences propensity to access antenatal care (see Jayaweera *et al.* 2005). Using research undertaken in the West Midlands, UK, this paper explores the reasons new migrant women book late and do not attend antenatal follow-up appointments and identifies a combination of legal, structural and institutional barriers.

Migrant birth outcomes

While there is little evidence that migrant women overload the maternity system, data demonstrate that migrants have higher fertility rates than white-British women with births to women with migrant backgrounds constituting 31% of all births in the Eurozone (Hayes *et al.* 2011). This pattern is echoed in the UK where between 2001 and 2006 women from 200 countries of origin gave birth and the proportion of births to foreign-born mothers increased by 65% constituting 24.7% of all live births (Hayes *et al.* 2011:321). At the same time general fertility rates (GRF) have been increasing in the UK largely, it is suggested, because of migration (ONS 2013). The UK born GRF is 60 (per 1000), and overseas born 88, but there is huge variation between groups for example with women born in Pakistan having a GFR of 147, Nigeria 138, and Poland 90 (Zumpe *et al.* 2012).

Evidence suggests that maternal mortality and morbidity are increased for migrants, particularly those from Africa and asylum seekers. The Confidential Enquiry into Maternal and Child Deaths (CEMACH) “*identified disproportionately high rates in the migrant population.*” (Hayes *et al.* 2011: 321). Immigration status is barely acknowledged in UK data meaning no precise information about clinical outcomes is available and problems faced by migrant mothers are under-reported.

Concerns about maternal and infant mortality in migrant populations are not new. Clarke and Clayton (1983) found Asian mothers had 1.5 times the risk of perinatal mortality than the general population while Cross-Sudworth *et al.* (2010) found Pakistani women in Birmingham had three times the maternal mortality rate of white-British women. Early thinking suggested that infant and maternal mortality would be reduced in second generation migrants yet for South Asian women this has not been the case (Cross-Sudworth *et al.* 2010). Furthermore the picture is not uniform. In a review of reproductive outcomes in industrialised Western countries Gagnon *et al.* (2009) found that migrants' results for pre-term birth were good or better than receiving country women in 50% of studies. This review indicated that Asian, North African and sub-Saharan migrants have a greater risk of foeto-infant mortality while Asian and sub-Saharan African migrants are at most risk of pre-term birth.

In the UK differences were also identified in mortality/morbidity by ethnic group with Black African and Black Caribbean groups frequently found to be at greatest risk (CEMACH 2011). Few studies have looked at immigration status although asylum seekers in the Netherlands have been found to be high risk while in Canada uninsured immigrant, refugee and migrant mothers have poor access to prenatal care impacting upon neonatal resuscitation rates (Wilson-Mitchell and Rummens 2013). In the UK the CEMACH (2007) was unable to quantify the risks faced by different categories of migrant women, but highlighted that 12% of all maternal deaths were refugees and asylum seekers, despite only making up 0.3% of the UK population (UNHCR 2011). Overall, compared to UK-born women, immigrants have a clear disadvantage for all outcomes including 43% higher risk of low birth weight, 24% of pre-term delivery, 50% of perinatal mortality, and 61% of congenital malformations (Bollini

et al. 2009). This is supported by a systematic review of obstetric outcomes across EU which found greater frequency of low weight babies, preterm delivery, perinatal mortality and congenital malformations in migrant populations (Hayes *et al.* 2011: 322).

Research indicates that a range of risk factors impact upon infant mortality. These include late access to services, lack of advice about available support and healthy lifestyles, and poverty impacting upon maternal diet and resulting in poor intrauterine growth (Kanneh 2009; Redshaw *et al.* 2006). Infant mortality is more common where women were lone parents or underweight. Cultural practices such as female genital mutilation (FGM) and consanguinity have also been argued to impact on the health of mother or infant although such problems are said to be exaggerated because of the tendency to essentialise minority cultures and pathologise ethnicity and traditional practices (Jayaweera 2010). In Toronto clinically significant numbers of uninsured immigrant and refugee women were found to have hypertension or diabetes (Wilson-Mitchell 2014). While it is clear that there are tangible inequalities in outcomes for some migrant mothers and babies far less is known about the reasons for these inequalities. Furthermore at the current time data collected about fertility and infant and maternal mortality rates in the UK is largely collated by ethnicity with key dimensions of superdiversity overlooked: in particular migration route and immigration status (and associated rights and entitlements), and language ability.

Migrants' access to maternity care

There is evidence from across the EU that minority and migrant women tend to book later and use antenatal services less than non-migrant women (Chot *et al.* 2011; Redshaw and Heikkila 2010). Data collected on asylum seekers in one East London clinic identified that 68% of pregnant women were unable to access antenatal care via the NHS, 90% couldn't

register with a GP and 25% had no antenatal care by 18 weeks (Hargreaves and Burnett 2008; Bryant 2011). Late bookers are more likely to deliver pre-term, have lower weight babies and need neonatal intensive care (Clarke and Clayton 1983). Deficiencies in antenatal care have been found to contribute to poor outcomes such as chronic disease and pregnancy-related conditions which need to be identified and managed early (Hayes et al 2011:326). There is a dearth of research focusing upon *why* migrant women might be less engaged with antenatal care in the UK where, at the time of writing, access was free except for undocumented migrants and failed asylum seekers. The current body of knowledge focuses upon small samples of women with specific ethnic origins, primarily South Asian, or particular migration statuses, usually asylum seekers. There is heavy reliance upon the perspectives of health professionals.

Increased attention has been given to the role of social determinants of health in shaping the health outcomes of the general population. While Whitehead and Dahlgren (1991) place individual lifestyle factors at the centre of their social determinants model they are clear that these factors operate within the context of social and community networks and most importantly general socio-economic, cultural and environmental conditions. Jayaweera et al. (2005) argue that there is an over-emphasis on individual factors such as culture and religion in research around Southeast Asian women's use of maternity services. She contends that insufficient attention is paid to structural inequalities, language competency, migration histories or discrimination and that constrained material circumstances limit access to services and good health. There is some empirical support for her argument with Davies and Bath (2001) finding poor communication between the non-English speaking Somali women and health providers served as a barrier to seeking information. Non-English speaking women believed they were perceived as 'difficult patients' and given inferior treatment. The

use of family members as interpreters was problematic because women were too embarrassed to discuss sensitive issues. Participants believed they were denied information due to castigatory attitudes and prejudice among health professionals, particularly in relation to large families (Davies and Bath 2011). Elsewhere Bowler (1993) found that midwives did indeed stereotype migrant women and that these attitudes were underpinned by communication problems wherein midwives lacked sufficient time to know women as individuals.

At present social determinant models lack explanatory powers to aid thinking about the experiences of migrants. Factors such as lack of understanding of the health and maternity systems in countries of migration emerge as an important theme in the literature which endures both temporally and geographically (Clarke and Clayton 1983; Davies and Bath 2001). Carolan and Cassar (2010) point also to the need for African migrants in Australia to undergo a process of adjustment from not valuing antenatal care to understanding its importance. They argue sensitive service provision is needed to promote acceptance of services and attendance at appointments. While not yet applied to maternity services Shim's (2010) concept of health cultural capital may help us to understand the way that inadequate repertoires of cultural skills, communication competencies and interactional styles on the part of patients *and* professionals contribute to unequal treatment and outcomes. The importance of trust in securing attendance is also raised by Bryant (2011) supporting Carolan and Cassar's (2010) argument that caregivers needed to be sensitive to migrants' lack of local knowledge, and tolerant of mistakes. Understanding the reasons for poor attendance is clearly important in helping providers to develop mechanisms to improve attendance levels and support better monitoring of pre-term health and potentially reducing migrant infant and maternal mortality.

Methods

The findings reported herein are taken from research commissioned by the Department of Health led by the author in 2010. The project aimed to provide insights into possible causes of poor migrant maternity outcomes in the West Midlands region of the UK and to develop recommendations that could help improve maternity services for migrants. The project focused upon new migrants whom earlier work suggested experienced the greatest difficulties accessing services (Taylor and Newall 2008). The lack of reliable socio-demographic data about the region's migrant population (see Author 2010) meant that probability sampling was not possible. A non-probability, purposive sample was generated as we selected individuals based upon particular characteristics, namely women who had moved to the UK within the past five years and subsequently utilised maternity services. We sought to move away from the tendency to focus on ethnicity/or asylum seekers and explore the demographic complexity evident across the region. We used five datasets each containing incomplete data to identify the key migrant population clusters by main countries of origin and, in some datasets, immigration statuses (see Appendix 1 for definitions of immigration statuses). Adopting a maximum variation sampling approach, wherein a small number of units or cases are selected that maximize the diversity relevant to the research issue, we included individuals with all immigration statuses, and from urban and rural locations, from the main country of origin groups and smaller populations. Variation was also evident in terms of employment backgrounds and housing tenures. Ethical approval was given by the University of Birmingham Ethical Review Committee prior to commencement of the research.

Questionnaire completion: migrant women

A semi-structured questionnaire exploring migrants' experiences of maternity services was co-designed with maternity professionals and migrant women. Informed consent was

achieved through discussing the nature and purpose of the project, opportunities to ask questions and the researcher and respondent signing a contract agreeing participation, data handling and presentation criteria. Experienced female poly-lingual community researchers interviewed respondents in the language chosen by the respondent or with the assistance of an interpreter. Some 82 questionnaires were completed with respondents identified through discussions with community groups and Children's Centres (which provide information and access to services for children aged 0-5 and their families) and using a snow-balling approach wherein respondents were asked to identify other migrants who had used maternity services. Using organisations to help identify respondents risked recruiting individuals who were sufficiently connected to engage with organisations. Migrants who were isolated from, or did not need, support may report different maternity experiences. Our sampling strategy was necessary because it proved difficult to locate women without using gatekeeper organisations. Of 82 respondents 12 were in employment, most of whom were A8s who had come to the UK after the expansion of the EU in 2004. Respondents spanned six different migration statuses with the vast majority under the age of 30 (see Table 1). The respondents came from 28 different countries including China, Iran, Pakistan, Poland and Zimbabwe. Four women were pregnant while the others had given birth in the UK. Women lived in a range of different housing tenures and family arrangements (see Table 1).

Questionnaire analysis

The data were analysed in two parts. Qualitative responses (questions such as what provision was made to meet your cultural or religious needs?) were themed using a systematic thematic analysis approach (Guest 2012). This involved interpretive code-and-retrieve methods wherein the qualitative data was transcribed and read by the research team who together identified codes and then undertook an interpretative thematic analysis. Quantitative

responses (questions such as how many weeks pregnant were you when you first informed a health professional that you were pregnant?) were analysed in SPSS. We used the frequency function to identify the most common barriers and challenges faced by migrant women followed by cross-tabulation to identify the characteristics of the women experiencing problems. The nature of our sample meant it was not appropriate to look for statistical significance but we could begin to identify common characteristics of those, for example, who had not attended follow up appointments, the range of barriers to attendance, and the characteristics of women experiencing the different types of barriers. Characteristics considered included urban/rural, religion, language competency, country of origin, and immigration and employment statuses.

Table 1 about here

In-depth interviews

The questionnaire analysis allowed categorisation of problems into those which appeared to affect a wide range of women, and those specific to particular groups. Using this information we identified women with different characteristics to participate in 13 in-depth interviews. The interviews explored in detail common problems, such as language barriers and lack of information, and some of the more specific difficulties, for example spousal migrants who had experienced domestic violence, isolated migrants living in rural areas, destitute undocumented women hiding from the authorities and refugees who had been dispersed around the UK when pregnant. The interviews recorded detailed stories of pregnancy and birthing experiences providing information which complemented and clarified patterns identified through the questionnaire analysis.

Triangulating findings

We then triangulated our findings by interviewing maternity professionals enabling a different “person” perspective to the methodological triangulation achieved via combining interview and questionnaire data. In-depth interviews were undertaken with 18 individuals working regularly with migrant women including community health staff; GPs; pregnancy outreach workers; hospital staff; and third sector workers. Respondents were identified following suggestions and introductions from the project advisory board, from migrant respondents, from direct approaches to hospitals and through snow-balling. Professionals were invited to participate via e-mail or telephone depending on the availability of contact information and then sent a participant information form and a consent form to consider before confirming their involvement. The participation of maternity professionals enabled us to further explore our earlier findings, examine the extent to which preliminary patterns identified were recognised, the reasons women had particular service experiences and consider additional issues not raised by our migrant respondents. This paper focuses upon access to antenatal care. Findings around birth and postnatal care are covered elsewhere (Phillimore & Thornhill 2011; 2015). The systematic thematic approach to analysis utilised when analysing the questionnaires was also employed for the in-depth and provider interviews.

Findings

Migrant maternity and infant mortality in the West Midlands

The West Midlands region is located in the centre of Britain and includes the second largest urban area in the UK, Birmingham; areas of high deprivation and prosperity; and remote countryside. The region, and urban areas in particular, have seen the emergence of superdiversity as large numbers of new migrants, predominantly asylum seekers (from 2000)

and Accession country migrants (A8s) (from 2004) arrived decades after the establishment of “old migrant” minority populations. The 2011 census shows that in the previous decade Birmingham’s population had become increasingly diverse with the proportion of people born overseas increasing from 14.3 to 22%. The extraordinary nature of Birmingham’s superdiversity is visible in GP registration data which, while only recording those who choose to register with a doctor, show 41,318 migrants moved there from 187 different countries between 2007 and 2010 (Birmingham City Council 2013). Arrivals come from old migration countries such as India and Pakistan, and new migration countries including European Accession countries, China, Afghanistan and Eritrea and are differentiated by gender, age, class, immigration status and associated rights and entitlements.

The new migrant population is increasingly fragmented with a quarter of migrants arriving in small groups or as individuals. Fewer than ten people came from each of 92 different countries including Kyrgyzstan, Nicaragua, Montenegro, Israel, Georgia, and Barbados. While many cluster in deprived, densely populated, inner-city neighbourhoods (Phillimore 2013), newcomers have moved to every neighbourhood. Other urban centres in the region demonstrate similar characteristics while rural counties such as Herefordshire and Worcestershire house some of the highest concentrations of A8s migrants in the UK. The speed, scale and spread of superdiversity has brought a wide range of challenges to welfare providers and arguably made achieving equality of outcome more difficult. Such inequality is evident in the field of maternity provision.

The West Midlands region has the highest total fertility rate of all the English regions at 2.08 births per woman in 2008 and the highest infant mortality rate at 6.0 per 1,000 live births in 2009 compared with the 4.6 UK average (Medland 2011:2). Perinatal mortality rates in

wards with large concentrations of migrants exceed the regional average with the most deprived superdiverse wards housing large proportions of migrant women being amongst the highest in the UK (17 per 1000 compared to 7.6 for England and Wales) (Martin and Gardosi 2007). Yet little was known about the experiences and needs of migrants accessing maternity services across the West Midlands and the ways in which those experiences impact upon the health of migrant mothers and their children.

Initial Booking

Pregnant women in the UK are advised to register their pregnancy at their GP surgery, a process known as “booking”, before they are 12 weeks pregnant with the majority of antenatal screening tests undertaken at 12 weeks. Some 82% respondents (67) accessed some kind of service when less than 12 weeks pregnant. Nine (11%) attended between 12 and 16 weeks, two (2%) between 17 and 20 weeks, one between 21 and 30 weeks and three (4%) after 31 weeks. These figures are considerably lower than the 95% that Redshaw and Heikkali (2010) identified in their survey of the general population. Late bookers tended to be asylum seekers, refugees and spousal migrants. The first services accessed were the GP (56), referral to a midwife for nutrition advice (53) or being offered advice about antenatal tests (47). Some 53 women had antenatal tests before 12 weeks while 15 women did not.

Women booked late for a range of reasons including not having sufficient information about services (8), not understanding the services available (5), lack of translated materials (4) lack of an interpreter (4) or not being registered with a GP (2). For example a Chinese refugee in Birmingham wanted to register her pregnancy but did not know who to contact “*my friend told me who to first contact. It is different to China where all health related services take place in a hospital*”. Respondents who had received advice about how to access maternity

services gained information from a community midwife (46), GP (31), family and friends (8) or community organisations (7).

Professional interviewees noted that migrants who arrived in the country late in their pregnancy or had re-located or been re-dispersed from elsewhere in the UK, were unable to register with a GP in sufficient time to access maternity services before birth. They highlighted the lack of flexibility in the system and absence of a fast-track for women registering late into their pregnancy. Professionals pointed to differences in institutional cultures outside of the UK as presenting a barrier to timely antenatal care access highlighting that women from countries without dedicated maternity services or where community-led home births were common had no knowledge about antenatal care and sometimes saw it as invasive. Some maternity professionals felt that understanding of the maternity system was assumed and that the system was designed for the homogenous white, middle class, pregnancy experience. Basic information about procedures and routines was not readily available to migrant women and rarely translated into new migrant languages. One refugee did not understand why she was told to have a blood test and sought advice via transnational networks *“I spoke to my father in law who is a surgeon in China, and mother-in-law in China who is midwife. They told me not to worry and that it was straightforward tests”*. Several women respondents could not find information about maintaining a healthy pregnancy and sought such help from friends and family *“My mother-in-law advised about the do’s and do nots in pregnancy. She also advised me about cultural things for example eating a mixture of nuts and natural sweeteners during last months of pregnancy”* (South Asian spousal migrant, Birmingham).

Lack of knowledge about pregnancy monitoring processes left women fearful of scans and tests and unsure whether they should consent to procedures. Women with immigration problems told how they worried that they would be tracked by immigration authorities and their babies removed if they registered with maternity services believing their presence in the UK would be evident if their name was entered into an electronic database. Lack of time was frequently raised as a barrier to effective communication by professionals. Maternity appointments were normally scheduled for around fifteen minutes which allowed midwives insufficient time to develop rapport and explain procedures particularly for vulnerable women with complex problems or those requiring an interpreter – the process of interpretation at least doubled the amount of time needed. Professionals told of an institutional culture which measured performance on caseload size, rather than quality of service or outcomes. Indeed a small number of women respondents felt unable to share their anxieties with their midwife *“as seemed rushed, as not enough time to talk through concerns”* (A8 migrant, Herefordshire) *“they did not give me time to ask different questions that I had. For example, I was worried about my baby who had a heart problem but I did not get enough information”* (South African refugee, Birmingham).

In some areas non-English speaking women represented 30-55% of caseloads. Professionals struggled to get hold of interpreters to enable a proper assessment. Interpreters were not available for some languages, for example there was a shortage of Somali interpreters in Birmingham, not available at short-notice in the event of emergencies or the inevitably unscheduled onset of natural labour, or did not understand a woman’s dialect or clinical terminology. Sometimes the interpreter provided was inappropriate, for example some women stopped attending appointments because the interpreter was male or because they knew the interpreter and were concerned about confidentiality. Family members were

frequently used for interpretation but such practice often excluded women from conversations about their care, a situation repeatedly raised as a concern by women respondents. One NRPF South Asian respondent, raped by her husband, told us she had wanted an abortion. However, her husband attended every appointment speaking directly with maternity professionals while clearly excluding her from decisions about care and refusing, either in the appointment or afterwards, to tell her anything about the procedures she was subject to. She explained that she wanted an interpreter to report the abuse she was experiencing and to ask how to get an abortion. Elsewhere translated information sheets were so poorly translated women said they were unintelligible.

Follow-on

In the UK pregnant women are expected to attend around ten antenatal follow-up appointments after booking in order that their health and that of their baby can be closely monitored. Having made initial contact with maternity services some 65 women (80%) were able to attend all the appointments they were offered while 16 (20%) were not. Reasons women gave for non-attendance included no transport (11) or inability to afford transport (8), not being well (6), inability to communicate (3), dispersal (2) or domestic responsibilities (2). All but two respondents in the rural areas attended their appointments while attendance in urban areas was patchier with between a third and all respondents in the different cities not attending follow-ups. A8 migrants were most likely to attend (94%) while 50% of South Asian respondents and two thirds of African respondents attended. Failed asylum seekers, NRPF and spousal migrants were the least likely to attend all follow up appointments. These figures are considerably lower than the 98% found to be attending follow-ups by Redshaw and Heikkali (2010).

Some failed asylum seekers in the UK receive Section 4 support which is set at 60% of income support levels, which themselves are already acknowledged to be too low to keep recipients above poverty lines. Section 4 payments are made via the Azure card and previously by vouchers which can only be used in certain shops. Respondents have no flexibility and choice, are unable to use cheaper shops and market and cannot travel *“it is so hard to live on vouchers only. I can’t go for an appointment”* (Congolese asylum seeker, Birmingham). Some failed asylum seekers and irregular migrants with no recourse to public funds (described herein as NRPF) are not permitted to work so no income whatsoever and depended upon friends for food and or cash for travel. Women on low incomes could reclaim the costs of travelling to appointments, but claims could only be made retrospectively. Respondents were unaware of the possibility of reclaiming costs while professionals did not realise that some migrant women had no access to cash.

Women said they sometimes stopped attending appointments because they felt attendance was pointless for example if their husbands did not explain procedures or communicate their concerns *“if I could have an interpreter who can speak to me, not only my husband it could help”* (spousal migrant Coventry). Others were unable to access a telephone to make an appointment or could not find the hospital or identify which bus to catch. Economic migrants sometimes skipped one or more follow-ups because their employers were reluctant to release them and they feared losing their job. Asylum seekers and failed asylum seekers wanted to attend appointments but were detained or dispersed by immigration services to areas away from their midwife. One HIV positive asylum seeker told how when detained for two months she was denied access to maternity care and retroviral medication. Asylum seeking women were sometimes preoccupied with resolving immediate crises, or attending solicitors’ appointments to discuss their asylum case, and tended to prioritise these matters over

attending antenatal follow-ups. New migrant women often moved home frequently, sometimes at short notice. Sometimes they forgot, or lacked time, to notify maternity services about their change of address and could not be contacted to arrange follow-ups.

Some of our professional interviewees explained that their colleagues could be unsympathetic to the wider social, legal and economic problems faced by migrant mothers – sometimes because they lacked understanding of those problems or they did not have time to learn about them. They were under a great deal of workload pressure and simply did not have time for empathy. Women with complex problems were sometimes viewed as “*difficult to manage*”. Professionals told us that discrimination and stereotyping of new migrant women could be problematic even in practices with much experience working with minority women. Patients were apparently not always greeted in a friendly and welcoming manner, or made to feel safe. Lack of continuity of care influenced the quality of patient-midwife relationships and sometimes affected women’s confidence to attend follow-ups. Some 50% of women respondents reported not having the name of a midwife they could contact when needed, a far lower figure than the 92% found in Redshaw and Heikkilä’s (2010) national survey. Lack of continuity made appointments less effective than those where a prior relationship with women existed “*I would like to have the same midwife throughout my pregnancy, because she can continue to help me.....without, I am starting new every time I see a new midwife*” (Spousal migrant, Birmingham).

Only 21 women (26%) attended antenatal classes, with attendance poor across the West Midlands, a lower proportion than the 40.2% who attended classes in Redshaw and Heikkilä’s (2010) national survey. African respondents were least likely to attend (13%) and A8 migrants most likely to attend (50%). Lack of information about classes (44), being

unable to communicate with healthcare staff (25), and lack of transport (21) or affordable transport (12), presented the main barriers to attendance. Particular problems attending classes were experienced by asylum seekers and those who were undocumented and hiding to avoid deportation.

Discussion and conclusions

The aim of this paper was to explore the reasons new migrants do not access antenatal care. The findings indicate that new migrant women were more likely to book late or fail to attend follow-ups than the general population (Redshaw and Heikkilä 2010). Because we accessed respondents via community groups, our study may well have omitted those who were most isolated, least likely to book and perhaps having even greater needs than those whose experiences captured in our study. Contradicting earlier work by Chot *et al.* (2011) we found no evidence that migrant women undervalued antenatal care or that late attendance was a problem experienced within particular ethnic groups but instead was influenced by a range of legal, structural and institutional barriers. The belief of failed asylum seekers and undocumented migrants that their status meant they were not permitted to use maternity care or that professionals would report them to the immigration authorities, whilst at the time of this study was incorrect, impacted upon their willingness to attend. Furthermore some asylum seekers spent their limited time, energy and resources on pursuing their asylum claim as this procedure was not suspended in order to permit them to focus on increasing their chances of having a healthy pregnancy. Those who connected with maternity services were often separated from those services by onward dispersal to alternative accommodation: obligatory moves to destinations over which they had no control.

Structural barriers, such as might be conceived of as the socio-economic conditions highlighted in social determinant models, were problematic for asylum seekers, failed asylum seekers and undocumented migrants who had insufficient funds to attend appointments and were unable to seek assistance with costs. Some economic migrants, although not destitute, worked unsociable hours and were not permitted, or could not afford, to attend appointments. This was particularly the case for migrants without recourse to public funds who often worked lengthy hours at below minimum wage. They lacked the protection of employment laws which at least in theory meant that migrants who were “on the books” were entitled to attend appointments. Many of these structural issues indeed emerge from the restricted rights and entitlements of migrants – important state imposed socially constructed determinants of access to health which see scant consideration in the social determinant literature but very clearly shaped women’s ability to access care.

Perhaps the greatest range of problems faced emerged as a result of institutional barriers. While many of the women we interviewed lived in areas with much familiarity with diversity, the experiences of both migrant women and the maternity professionals suggested that the institutional culture of maternity services was designed for those who understood, and could negotiate, the system. Most new arrivals were not familiar with the UK health service or maternity system which can only be accessed via GP gatekeepers. Even when connected with services they faced a range of barriers that made meaningful engagement difficult. Following Shim (2010:1) we argue that our study points to a lack of cultural health capital in that the migrant-provider interactions operated in ways that “*may generate disparities in health care*”. Various routine antenatal monitoring procedures: HIV tests, antenatal screening and scanning for dating and identification of birth abnormalities were not explained with knowledge about them sometimes assumed. This situation was clarified by

professionals who told of caseloads and targets which left those professionals who wanted to engage more fully with migrant women feeling stressed with insufficient time to invest in trust-building or explaining procedures. Further, professionals were not provided with information to help them develop their own understanding of the constraints and barriers experienced by migrant women, such as the compulsion associated with onward dispersal or lack of cash to pay for transport. In the absence of time, knowledge and support professionals were unable to develop their own health cultural capital or help migrants to develop the competencies they needed. Some professionals imagined their own explanations for migrant women's behaviours. Thus migrants who failed to show for appointments might be considered unreliable when in reality they may have been moved or detained, and those who booked late might be considered to undervalue antenatal care rather than being recently arrived.

While the newness of migrants and their lack of understanding of systems combined with the inflexibility of systems were highly problematic this dis-connect was exacerbated by language barriers. Hayes et al (2011) stress that effective communication between providers and patients is crucial to facilitate safe and optimal care and to reduce risk factors. We found that information was produced in a small number of community languages with the range of languages on offer not expanded despite the radical change of demographics in recent years and the emergence of large Polish, Somali and French-speaking communities. Literacy was assumed. Use of interpreters was limited and experiences mixed with use of family members, friends or children commonplace. Such practice disempowered some women effectively excluding them from discussions and decisions about their pregnancy, as well as vital information about how to promote a healthy pregnancy and how to interact with health services which may have helped to develop cultural health capital. NHS guidance advises

health professionals to use trained interpreters. Dependence upon family members might be explained through considering information we collected in discussions with trainee midwives in 2012 when we heard that they were informed in lectures to use trained interpreters but while on their practice placements were told that interpreters were too costly. Clearly further research is needed to explore this matter in detail: by failing to use interpreters migrant women's voices are silenced leaving them passive recipients of maternity care rather than active agents and potentially open to abuse by family members. Disempowered in this way it is conceivable that women may elect not to attend antenatal care, be excluded by relatives or prioritise matters such as finding housing, earning an income or resolving their asylum claims.

For each, and sometimes a combination of several, of these legal, structural and institutional reasons women struggled to access antenatal care. Low attendance or lack of knowledge about which issues to discuss during appointments are, as outlined earlier, major concerns in relation to infant and maternal mortality. Our findings break new ground in suggesting that migrant status rather than, or in addition to, ethnicity may be a key factor in increasing the vulnerability of migrants and is associated with legal and structural barriers to attending antenatal care or receiving efficacious care. To facilitate attendance of asylum-seeking women we suggest an end to dispersal after 12 weeks of pregnancy and giving women the option of suspending their asylum claim until six weeks after childbirth. Further we suggest that firewalls are established between maternity and immigration services so that it is widely understood, as in Portugal, that maternity professionals will not report undocumented migrants or failed asylum seekers.

While we know that infant and maternal mortality rates are particularly high in diverse areas we are currently unable to utilise mortality data to explore whether there is statistical evidence of a relationship between immigration status and mortality because although status data is recorded on some types of maternity notes, it is not input into monitoring systems which prioritise age, socio-economic status and ethnicity. The reliance upon ethnic categories that have barely changed for decades can at best provide a partial picture but at worst, as Bhopal (2012) illustrates, can lead to the essentialisation of ethnicity as a causal factor in infant/maternal mortality. It may be possible, with additional resources and exploration of ethical concerns, to undertake a review of maternity notes to identify migration status where infant or maternal death has occurred. Should a relationship between migration status and mortality be identified, a case might be made for systematically monitoring maternity outcomes by status. Undoubtedly there is much scope for further research in this area.

Our data indicate that the maternity system was insufficiently flexible to meet the needs of an emergent superdiverse population and could in itself operate as a barrier that reduced access to antenatal care or the efficacy of antenatal care. The persistence of high infant mortality rates in long-established minority populations raises questions about how responsive the maternity system is to new and diverse communities. Given ongoing superdiversification, particularly in deprived areas with high infant/maternal mortality rates, the time is right for a full review of UK maternity systems which looks at the pressures faced by professionals and explores how communication could be improved so women know how to identify and report pregnancy problems, and make informed decisions about the care they receive. Adaptations to the maternity services system would support a better fit with the life worlds of patients might include ensuring that maternity professionals are provided with the training they need

to offer appropriate care to all (see van Bortel 2012). Rather than adopting an approach whereby professionals possess cultural knowledge about ethnic groups, an approach which is simply not feasible in an era of superdiversity and has been argued to result in essentialism (Jayaweera 2005; Bhopal 2012), we suggest that training focuses on development of intercultural competence, a method which enables professionals to communicate effectively, empathetically and appropriately with people as individuals rather than as groups (Warmington 2012). Such skills would provide an important foundation for professionals and migrant women to begin to build the health cultural capital necessary to ensure effective antenatal interactions.

In a time when welfare restrictionism is used as a tool of immigration control, austerity cuts are prioritised and social justice concerns decrease in importance perhaps it is also necessary to count the pecuniary costs of poor migrant maternity care. NHS London (2012:7) make a strident case for improved migrant maternity care:

The disproportionate difficulties that pregnant migrant women experience in using maternity services and the wide variance in maternity service organisational knowledge, staff skills and resource allocation to meet health needs contributes to the unequal burden of damage and death. Evidence suggests that the majority of this is preventable. The unintended consequences of poorer maternal health outcomes for migrant women includes higher costs for many areas of health and social service provision in both medium and long term.

Investment in the short-term is likely to net longer term gains and increase the prospect that after decades of inequality in migrant and minority pregnancy outcomes maternity services provide appropriate care for all.

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Table 1: Migrant women respondents

Birmingham				
n = 44	employed			
	n= 1	Spousal Migrant	1	
	not employed			
	n= 43	Refugee	14	
		Asylum Seeker	11	
Spousal Migrant		18		
Elsewhere in West Midlands				
n = 38	employed			
	n=11	Refugee	1	
		Spousal Migrant	3	
		Eastern European Migrant A8	6	
		Other	1	
		not employed		
	n=27	Refugee	6	
		Asylum Seeker	6	
		Spousal Migrant	6	
		Failed Asylum Seeker	3	
		Eastern European Migrant A8	3	
		Undocumented	3	
		Age		
		Under 18	1	
	19-30	56		
	31-35	19		
	36-40	4		
	40+	2		
Arrival year				
	2005	37		
	2006	24		
	2007	11		
	2008	7		
	2009	3		
Accommodation type				
	Social housing	32		
	Privately renting	21		
	UK Borders Agency asylum seeker housing	10		
	Family owned	8		
	Hostel	2		
Living arrangements				
	With partner	49		
	Alone	27		
	Family	4		
	Other asylum seekers	2		

Highlights

- Migrants in the West Midlands receive less antenatal care than the general population
- Immigration status rather than ethnicity is a key factor in determining access
- Structural barriers mean some migrants cannot afford to travel to appointments
- Lack of cultural health capital in migrants and professionals hamper communication
- Antenatal care is not flexible enough to deliver effective services to migrants