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Migrant Polish women overcoming communication challenges in Scottish maternity services: a qualitative descriptive study.

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Migrant Polish women overcoming communication challenges in Scottish maternity services: A qualitative descriptive study.

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ABSTRACT:

Background: Migrant women are more likely to experience sub-optimal maternity outcomes and are often described in a problematised way. Communication is crucial in maternity and can be compromised if the language of that service is delivered in a language incomprehensible to migrant women.

Methods: Qualitative descriptive study using 9 in-depth individual interviews with Polish women who recently had experience of local maternity services. Recorded interviews were transcribed and thematically analysed. A salutogenic conceptual framework was adopted for data analysis.

Findings: Three descriptive themes: 'Communication and understanding', 'Relationships matter' and Values and expectations'. Seven related subthemes where identified.

Discussion: Vulnerability in this study is understood as uncertainty, risk and emotional exposure to situations that are not understandable. Applying a salutogenic lens to analysis reveals the significance of quality communication, relationship and culturally sensitive practices as ways of mitigating feelings of vulnerability in the host country. Antonovski's Sense of Coherence' (SoC) highlights migrant women's ability to comprehend and capacity to understand their unique experiences of communication challenges. Participant's psychosocial, cultural, and individual beliefs reveal an ability to trust maternity systems that are different from their own cultural

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values and help them move towards a Sense of Coherence (SOC) and face their vulnerability.

Conclusion: Working with migrant women requires a salutary focus. Maternity care professionals involved in the care of this population need to consider individual internal and external resources and avoid treating migrant women as a problematic group. Maternity care provision needs to acknowledge migrant women's strengths, values and expectations and adapt local services. This is done by addressing individual woman's needs through a salutary focus, person-centredness and a system of care that values relationships and social connectedness.

KEYWORDS: Communication, Language, Maternity, Migrants, Polish, Salutogenesis

1. *CONTRIBUTION OF THE PAPER*

'What is already known about the topic?'

- There is a growing migrant population of women using maternity services in host countries
- Migrant women have sub-optimal maternity outcomes and are often viewed as problematic
- Migrant women can face challenges in using maternity services due to cultural, language and value differences and can feel alienated and vulnerable

'What this paper adds'

- This study highlights how maternity services need to avoid problematising migrant women both as individuals and as a group.
- This study shows how a salutogenic focus to maternity care provision for migrant women promotes strength based and person-centred care.

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- This study questions current maternity systems, not an individual woman's migrant status, revealing how migrant women require a salutary focus.

1. Introduction and background

Being able to communicate effectively and understand maternity systems is essential when seeking maternity care, yet this can be compromised if the language of that service is delivered in a language that is different to your own. This is often an added stressor to women who are already vulnerable (Balaam et al., 2013). There has been a significant rise in migration globally in recent years (DeSa, 2013) and a total of 4.7 million people immigrated to one of the EU- 28 Member States during 2015 (Eurostat 2017). In the UK, the numbers of migrants has continued to rise; 270,000 more people came to the UK than left in the year ending March 2018 with approximately 90,000 being EU citizens (Office for National Statistics, 2018). Polish migrants are a leading migrant group to Scotland. In 2015, one in five migrants to Scotland were Polish, with a recorded Polish migrant population of 86,000 (Scottish Government, 2018). Nearly half of the migrant population are women in the childbearing age (United Nations, 2013), posing potential challenges to migrant women seeking maternity care and the local host maternity services.

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In Scotland the number of births to non-UK born mothers rose from 14% in 2004 to 38% in 2015 (Scottish Government, 2018) with Polish migrants now forming the largest group of foreign nationals in Scotland. Consistently the rate of maternal mortality is higher among women living in social deprived areas and Non-English speaking ethnic minority groups, compared with the general UK population (MBRACE-UK, 2018). Part of this has been shown to be linked to poor uptake of

antenatal care in migrant populations due to language issues (Puthussery, 2016), inadequate cultural sensitivity, stereotyping and inappropriate provider attitudes (Phillimore, 2016). The increasing diversity in culture and languages among migrants pose challenges to health care professions (Lyberg et al., 2012, Suphanchaimat et al., 2015, Viken, 2016).

Language proficiency is not the only concern in this population and cultural differences reflect varying approaches to childbirth which add to the challenges of providing maternity care. Evidence suggests that economic migrants experience cultural differences in relation to health care and continue to access health services from their country of origin due to lack of trust and/or when they do not understand the services available in host maternity systems (Sime, 2014). Phillimore (2016) identified structural barriers such as insufficient funding and restricted unsocial working hours deterring migrants attending appointments which can be exacerbated by limited understanding of how services in the adopted country operate. Phillimore also highlighted that it is often migrant status rather than ethnicity that increases the vulnerability of migrants accessing UK maternity services. Concomitantly, the current understaffing and underfunding in the UK's health system can lead to unresponsive care in an environment with superdiverse needs (Edwards, 2018). With these structural barriers in mind it is evident that effective communication is crucial in providing safe effect care (NMC, 2015).

In response to the evidence, Scottish maternity policy has called for a focus on the needs of non-English speaking women accessing translation services in Scotland (Grant, 2017). However, little is known about the current experiences of Polish women who access Scottish maternity care in relation to communication and language concerns. A qualitative study in an urban city of Scotland was therefore

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initiated to address this paucity of evidence and inform local maternity care policy and practice improvements. The aim of the study was to explore Polish migrant women's experiences of language and communication concerns when accessing UK maternity services.

1.1. Conceptual framework

This inquiry embraced a salutary focus that sought not to further problematise this group. A salutogenic conceptual framework was adopted for data analysis, informed by (Antonovsky, 1987) (see box 1). The rationale for this framework was to foreground the experiences of migrant women and how they overcome the structural and experiential barriers identified in the literature to highlight practice recommendations. Focusing on a woman's internal and external resources, or 'generalised resistance resources' (GRR see box 1) of this group of women is empowering, inclusive and person-centred because it honours individual strengths and assets. Without this appreciative and affirming focus the risk of preconceived ideas and assumptions about this group of women could have been reinforced resulting in recommendations that are concerned with risk avoidance eliding any reference to health and wellbeing. Although there is a paucity of evidence situating maternity care within a salutogenic framework (Perez-Botella et al., 2015), it is becoming acknowledged as a framework that avoids further problematising migrant women by bringing focus to their strengths and resources (Viken, 2016). The conceptual framework thus strengthens the study by foregrounding the dynamic and varied nature of migrant childbearing women's experiences within a health promoting paradigm.

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Box 1: Antonovski's salutogenic conceptual framework (1987)
Generalised Resistance Resources (GRR) a person's internal and external resources, e.g. • Personal characteristics • Psychosocial influences • Cultural, religious beliefs • Social relationships. ***Sense of Coherence*** (SoC) three constituent parts: • Comprehensibility (the capacity to understand challenges in life), • Manageability (accessibility to sufficient personal, or internal and external resources) • Meaningfulness (finding meaning in life experiences).

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2. Methods

A naturalistic approach was adopted (Lincoln and Guba, 1985) using qualitative descriptive methodology (Sandelowski, 2000) to describe the lived experiences of Polish women within the context of their everyday lived experiences. All interviews were undertaken by one investigator (2nd author) experienced in qualitative interviewing. Interviews were recorded and transcribed for analysis.

Rigour of a study is primarily achieved by the researchers in data collection and analysis (Morse, 2015). As instruments of this qualitative inquiry the authors sought to be as reflexive as possible. Both investigators are academic midwives, both are

migrants to Scotland, one speaks English as a second language. Neither investigator speaks Polish. During data collection and analysis, we constantly asked each other self-reflexive questions to ensure transparency and trustworthiness of the findings: e.g. 'what do I know and what shapes my perceptions of this domain? What perspectives are we bringing to the study?' This helped us appreciate the silent voices we were wanting to foreground and not privilege our own professional and personal preconceptions throughout the study.

The study was undertaken in an urban city of Scotland in 2017/18. A Polish parish community, run by a Roman Catholic Diocese, was approached and agreed to help advertise the study. Adopting a purposive sampling approach, a small sample size of nine participants was recruited and provided the data for analysis. The number of participants in this study was small yet investigators were continually close to the study and discussed the need for more interviews throughout data collection. Although theoretical saturation is contested (O'reilly and Parker, 2013), we use the notion to justify the small sample size. Once no new insights emerged and repetition occurred in the interview data, we ceased recruitment. The interviews explored participant's experiences of maternity services specifically related to language and communication aspects. The sample provided sufficient variation of the population of Polish women accessing this maternity service within the previous twelve months at start of study (Table 1: Demographic characteristics). Box 2 refers to the inclusion and exclusion criteria adopted.

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Box 2: Inclusion and exclusion criteria

Inclusion criteria:

- Polish migrants who have given birth at the chosen NHS maternity hospital within 12 months at the start of the study (no distinction was made between high and low complex care)
- Polish migrants who have limited or no ability to speak and understand English (English proficiency was varied, but all had some challenges concerning English comprehension)

Exclusion criteria:

- Polish migrant women who do not consent to be interviewed

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Following signed informed consent semi-structured interviews at a time and venue suitable to the women were organised. Interviews were conducted in Polish or in English according to the woman's preference. Proficiency of English was varied across the sample and all participants reported some degree of concern about English language proficiency that affected their maternity care. Three participants who spoke little or no English and requested Polish interpreting during the interviews. Translations occurred during interviews when needed, either by a relative, friend or independent interpreter employed specifically for the study. The choice of using the professional interpreter or known person was left to the woman and arranged prior to her interview. Seven participants opted to be interviewed in English as they had adequate proficiency to describe their care. All interviews were audio recorded.

Participants	Age	Parity	Most recent Birth in Scotland	Time stayed in Scotland (months/years)	Interviews conducted
1	38	3	CS	3.5 years	Non English speaking (use interpreter)
2	36	4	SVD	11 months	Converse in English
3	25	1	SVD	3 years	Converse in English
4	39	2	CS	10 years	Converse in English
5	34	3	SVD	8 months	Converse in English
6	39	3	CS	5 months	Non English speaking (use of interpreter)
7	28	1	SVD	4 years	Converse in English
8	36	4	SVD	7 years	Converse in English
9	30	2	CS	5 years	Non English speaking (use of interpretor)

Table 1 : Demographic characteristics

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Data collection was through the semi structured interviews using an interview guide with prompts (see Box 3) to maintain focus and allow for the unfolding of women's individual narratives. Data collection occurred between July 2017 and November 2017. Ethical approval was obtained from University ethics panel (SERP No: 17-13 Dated: 13/07/2017). Interviewing women about their childbirth experiences could be sensitive and could cause psycho-emotional trauma/disturbances. The participants were free to withdraw at any time during the interview and the interviewer recommended they could meet with their Polish Chaplain who would refer them to relevant pastoral support or/and their GP if necessary. (N.B. All women interviewed at time of interviews had been discharged from NHS midwifery care)

Box 3: Semi-structured indicative interview guide with probes

Views about their recent birth experiences of accessing maternity services

Tell me about your experiences of the maternity services.

- Did your midwife/doctor help you to understand the service?
- Tell me about your experience in communicating with the midwives/doctors.
- Did you understand what they said at appointments?
- Did you understand the information provided (e.g. could be oral or written) related to your care?
- Was there any difficulty in understanding what the midwives/doctors said/explained?
- Were you able to ask questions to clarify information or seek answers to issues concerning you?
- How did the maternity care team staff talk to you?

Views about the interpreting services

- If you used interpreting services, tell me about your experience:

  (probes – e.g. who initiated, quality of translation, whether it met your needs)
- Was it a face to face interpreter or via telephone? How was your experience about the service?
- Can you suggest how the service could have been improved or provided differently?

Views about maternity services

- Tell me about your needs when accessing maternity services.
- Can you give suggestions on how to improve communication between you and the maternity care team? If yes, please explain.
- Can you give suggestions on how to improve language, communication and interpreting services? If yes, please explain.

Prompts :

Can you tell me more about your experience of…..?

Can you explain further what you mean by…..?

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The data were analysed using thematic content analysis by the research team who were experienced in qualitative data analysis. All interviews were transcribed verbatim. All transcripts were checked with original audio recording and read through by both investigators. Descriptions of the topic were coded and clustered across transcripts looking for commonality and differences. Major clusters of descriptions themes and subthemes were discussed and analysed among the research team. Codes were discussed and analysed among the research team. Themes were identified, and cross checked with the quotes from the participants transcripts by the research team. Each theme emerged through data analysis of individual interviews line by line and then contrasted and compared across all interviews together until common descriptive patterns emerged. Provisional findings were then presented to a faculty research symposium to help ensure plausibility and credibility of the conclusions.

3. FINDINGS

Data analysis identified three descriptive themes and seven related subthemes (Table 2). The themes provide a descriptive picture of an experience that reflects the literature on the importance of language, communication, understanding and relationships in maternity care; all contributing to positive experiences for women.

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Themes	Sub-themes
Communicating and understanding	Language differences
	Experiencing inconsistency of interpretation services
	Quality and type of information
Relationships matter	Importance of relational continuity and social connections
	Empowering and responsive caring communication
Values and expectations	Living with differences
	Valuing the differences

Table 2: Themes and sub-themes from analysis of interview data

3.1 Communicating and understanding

Participants highlighted how the ability to communicate and understand care in a language they were not confident in posed challenges. Feelings of vulnerability around language proficiency were described.

3.2.1. Language differences

Milena describes her feelings of vulnerability when faced with language differences but also how staff tried to mitigate this.

> *I've told them that I do understand some parts of English, but not all and that's why they were alert and they were speaking slowly and simply so I can manage to understand a bit more. (Milena)*

This can be particularly difficult if participants felt they could not ask for language help as this would make them feel even more like an outsider.

> *It never occurred to me that I could ask for the translator. I always thought that it would create more problems and their perception*

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towards me would be worse. I believe that in this country, not knowing and not being able to speak the language will create a problem and is not welcomed (Milena)

These vulnerable feelings due to differences caused embarrassment when needing to communicate. Dorota describes how she dreaded hospital staff talking to her:

*I was quite embarrassed of not speaking, I was literally praying that no one was approaching me. Frankly it wasn't comfortable, I would rather nod my head showing that I do understand, but I couldn't [understand]. (*Dorota*)*

Feelings of embarrassment and discomfort also meant that some participants did not get individual needs met.

*It definitely affects my ability of giving an answer. I don't know how to answer or I'm running out of words, sometimes when I'm trying to say something [I need] I get stressed, nervous and forget some words, mix it up, then I get locked and can't say anything after. (*Iwona*)*

3.2.2. Experiencing inconsistency of interpretation services

To address communication challenges among non-English speaking migrant participants accessed interpretation services. The accessibility was inconsistent, and quality of interpreting services varied. Renata describes her experiences and how she had to manage this.

I use an interpreter over the phone during all my antenatal clinics appointment with the midwife at the GP practice. Every single word and question the midwife was saying, the lady over the phone was

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> *translating back to me. Each time it was a different person, the voice is different. I didn't mind whoever she is as long as it is a Polish translator and understand what's going on. I didn't have the [interpreting] service when I attended my [hospital] appointments as no one told me that I could ask for the interpretation service; so, I brought my son as my interpreter. (Renata)*

The choice available to participants concerning interpreting and translation services was at times a positive experience when maternity staff took the time to provide choices sensitively, Dominika describes:

> *There was an option, the midwife asked me at the beginning if I need any translator. I said 'no' as I'm quite happy with my understanding and my situation. She also asked me if I need Polish leaflets. I didn't, yet still I have an option to choose Polish leaflets..….everything was explained and I liked the way they showed me with examples (Dominika)*

However, there were times when women used Polish speaking staff and relatives to help them navigate the maternity services, Renata describes how she found a way to manage her care when in labour that best suited her personal needs,

> *Because I did not know that I could have a translator service over the phone when I was in labour, I arranged my friend as the interpreter when I was in labour because it was more comfortable for me having a person as my friend and my husband instead of using the telephone service. (Renata)*

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Having a professional interpreter, often a stranger, in an intimate situation in labour and birth highlights the additional challenges in maternity services and provision of interpreting services. Discussing and organising an interpreter at the time of labour onset is personally and organisationally too late. Exploration of these needs antenatally by care providers would be preferable. Yet despite this lack of planning Renata, like other participants, found ways to manage their maternity care experience. It is evident that flexibility is needed whilst balancing personal and cultural preferences as well as legal and ethical concerns.

3.2.2. Quality and type of information

The quality and type of information is crucial to all women throughout maternity services, yet this would seem even more pertinent to women who do not speak the local language or fully understand the host culture in which they are having maternity care. Spoken word was important in communication and understanding and needed to be clearly understood to be useful. Dominika describes the challenges of comprehending and how helpful maternity care providers can be if they take the time to speak clearly in simple terms:

> *I was worried about my early labour and the midwife mentioned that I got the steroids and the labour could stop. I was worried about my waters because they'd gone. I asked her to explain to me because I never heard that word before. She explained that the waters would be there and there would be enough waters for my baby and my body would produce the waters to fill it up and my tummy won't be empty, and he won't be without waters. It was explained to me in really simple detail. She asked if I wanted to explain it in more details and I said no as I was able to understand. (Dominika)*

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Comprehending the explanations of what is happening in the experience of maternity was crucial to feeling safe for Renata. Other forms of communicating information to participants was important yet not always available.

> *At the very first initial appointment at the GP practice, I got the whole book, it was in Polish and all sorts of leaflets were translated in Polish but during the antenatal clinic I haven't got any leaflets translated into Polish apart from polio vaccination information. (Renata)*

The frustration with attempting to understand maternity care in a context different to one's own cannot be underestimated. In some cases, participants resorted to technology to get the answers they needed.

> *When I go to the doctor, I usually don't know how this problem is called in English, so I try to prepare it in advance, I google some words then either memorise them or make a note of them. (Marzena)*

Care needs to be comprehensible to women. Understanding what is communicated is crucial if migrant women are to better manage their maternity care. Marzena seeks out the information she needs across different fora. This may lead to inappropriate actions if incorrect information is found. The importance of being able to communicate concerns with health care providers is crucial for all childbearing women. From a salutogeneic perspective it is evident that comprehension of care received was central to managing maternity experiences and helped them achieve a sense of coherence.

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3.2. Relationships matter

For good communications to occur in maternity care effective relationships matter and need to be nurtured. An attribute of GRR (General Resistance Resources, Box 1) is the recognition that social relationships, both in personal and public life are important. The women in this study continually found ways to navigate their needs through myriad relationships. Within this theme 2 sub-themes were identified: 'importance of relational continuity and social connections' and 'empowering and responsive caring communication'.

3.2.1. Importance of relational continuity and social connections

Continuity of carers, especially in midwifery, is not a new concept to maternity services and has considerable supporting published literature on this model of care (Sandall et al., 2016). Yet this model of care is not yet implemented in many maternity services, including the site of this study which still provides fragmented and non-integrated care (e.g. women do not have a named midwife or health care provider across the childbirth year and care remains divided between community and hospital staff). The lack of continuity in this study also illustrated how relationships with care providers over time were significant for participants.

> *Each time when I was seeing the midwife, it was a different person. I said the same stuff and same history to each midwife. I was diagnosed with Tokophobia in my first pregnancy before in Poland. I said that I need to see someone in hospital for further explanation about the rearrangement as I had tokophobia. They seemed to understand me, but they didn't and nobody follow up my request up until my fourth AN appointment with another midwife who seemed to*

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> *believe that I had tokophobia. Finally, I was referred to the psychologist. I had been asking them all the time. (Milena)*

In addition to the continuity of care providers the significance of social connectedness with family and social support was highlighted revealing how relationships bring further meaning to their experiences. Dorota emphasized that she had to speak in Polish when she felt stressed during her labour and felt reassured that her husband would speak on behalf in English. It is plausible that women who can converse sufficiently in English would feel emotionally and perhaps even cognitively compromised when feeling under duress due to a perceived threatening environment they find themselves in with unknown others.

> *I wanted my husband to be with me because labour was very stressful situation with lots of pain. For me, it would be difficult to think about English words and how to create a sentence. It would be easier for me to speak in Polish and he [my husband] could translate it for me. Labour was very intimate, and I prefer to have someone I trust to be with me. (Dorota)*

Milena and Dorota reveal how relationships lie at the heart of maternity experiences and challenge current maternity services to think differently about how services are constructed to ensure that relationships built over time are central to the maternity experience. Participants drew upon their own resources and ensured someone that they trust and can speak Polish was available. Having access to continuity of care(r) and having family members involved helped make maternity care more manageable and meaningful. In this context meaningful means ability to experience the care they receive in an interconnected, relational and significant way that makes sense

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personally. Although all women receiving maternity care require individualised, relational care that actively involves intimate partners and families, this appears particularly pertinent for migrant women receiving care in services because they do not fully understand the services and care provided. Through relational continuity they have a better opportunity to understand how the maternity care services work and be able to negotiate their specific needs which can lead to a greater sense of empowerment and coherence.

3.2.2. Empowering and responsive caring communication

The data revealed how participants experienced responsive caring communication as empowering and helped them feel safe.

> *I've high blood pressure so when I was in labour, I was supported by lots of staff. They told me that unfortunately the level of oxygen in our baby's seemed low and it is possible that after few attempts, I might have a caesarean section. All the staff were very kind and encouraged me; I felt safe and listened to. Eventually, I was able to push my baby out. (Paulina)*

Responsive communication helped them feel respected.

> *They always answered whatever questions I have. I never felt my question was stupid and they were really open to discuss everything with me. So I feel very comfortable and looked after. I never had to wait for an answer longer than necessary. Even if they were doing something and they always came back as soon as they could. I never felt I was not important. Care was good and brilliant. (Ola)*

Responsive caring communications also helped participants feel understood.

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> *When I asked for a hairband because my hair was disturbing me they tried to find something for me. I felt they understood me and cared about me (Dorota)*

Effective communications and establishing relationships within maternity care help nurture meaningfulness in their maternity experience and appears to help them achieve a sense of coherence. The exact mechanism on how this is achieved is unclear but is plausible that relationships (between healthcare providers and women) over time can facilitate trust and enable a personalised focused understanding of needs. The need to find meaning in life's experiences can be compromised when values and expectations are at odds with the dominant culture in which one finds oneself, especially when there is not opportunity to express these expectations and values with a known and trusted healthcare provider.

2. Values and expectations

Maternity care providers attempted to provide information in ways that increased comprehensibility of care and services yet at times this was difficult due to underlining philosophical differences between maternity services in Poland and Scotland. There are 2 sub-themes in this theme, Living with differences and valuing the differences.

3.2.3. Living with differences

The participants often spoke about the differences in the systems of care they experience, either first hand if they had previous births in Poland, or/and heard from other Polish women living in Scotland or who are still in Poland. One of the main differences was around cadre of care providers. Here, Dominika narrates her unease with UK midwives' approach to care:

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> *The thing I didn't like during the pregnancy is that… the meeting with the midwife is like… it's not helpful at all, because you go to the clinic, you go to the midwife and the only thing they doing is asking you question, how are you, how are you feeling? How is your baby… doing? Obviously, I can say I feel the baby is moving, stuff like that but you have only two scans which is not helpful. [Midwives] are helpful, but I don't think it is enough. It's like checking and chatting and then that's it, and then you can go! I found it quite strange to be honest (Dominika)*

Several participants described how they preferred medical care and medical monitoring over the focus on psychosocial care that UK midwives practice. Marzena describes how she expected to have more medical input into her maternity care:

> *I was quite surprised that I didn't have any examination by the gynaecologist that I was actually pregnant, I was just asked when my last period was. In Poland, all the visits are being led by a doctor. I asked directly at one visit if I would be seeing a doctor at all during my pregnancy. (Marzena)*

Participants often attempt to fully comprehend the UK NHS maternity system, especially the focus on psychosocial care by midwives when their cultural meaning of childbirth was informed by the prevalent Polish biomedical model of maternity. These cultural differences could be particularly challenging for some participants.

> *In my second pregnancy, I had bleeding earlier on. I am a Christian and I believe that every child is not just a pack of cells. When the*

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> *doctor said that if the baby dies then the baby dies and there is nothing to do about it. I was shocked and they weren't keen to do anything at this stage; a test or scan or anything. I was really angry, fortunately nothing happened and my pregnancy was fine at the end. In Poland they provide a better care at the beginning of the pregnancy and you really feel looked after and try to do everything to keep your child. But when the baby is born care is much better [in the UK] than in Poland. (Ola).*

Ola highlights the challenges of UK NHS maternity yet acknowledges the positive experiences she has had in the UK system and comes to value the differences

3.2.4. Valuing the differences

The previous sub-theme reveals how internal resources are used to re-orientate to the care provided by finding some solace in the reassuring parts of the system of care. Participants drawing on their personal strengths often found ways to cope and adapt. Despite some of the reservations about type of care in the UK maternity services participants valued many of differences, learnt how to manage their own expectations finding fresh meaning in the UK services, for example they appreciated the free access to maternity services in the UK.

> *It's very good that you have access to all the painkillers or anything you want … if you need a C S there is no problem in hospital they will do it. But in my country you if want to have a c section you have to prove that you really need it; if you want painkiller or epidural, you have to pay for it. (Ewa)*

Participants also welcomed the choices and autonomy afforded them in the NHS maternity service compared to Poland.

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> *The doctor asked me a lot of questions about my experiences with previous tear and how I felt. He told me that there was about 5% chance that I could have another tear this time and asked if I was happy to labour naturally or have a caesarean section. I was very pleased that I could have a choice to choose. (Dorota)*

The focus on autonomy reveals the empowering nature of the care provided. Participants found meaning, in perhaps unexpected ways, that empowered them to draw on resources that could manage the challenges encountered traversing a system of care that at times, conflicted with their own values and expectations.

The final section discusses these findings in relation to the literature and presents implications for policy, practice, education and further research.

4. DISCUSSION

The focus of this study was to explore the Polish migrant women's experiences of accessing Scottish maternity care services, and to provide insight about language and communication challenges among these women. The thematic analysis identified the significance of quality communication, relationship and culturally sensitive practices as ways of mitigating feelings of vulnerability and alienation in the host country with different culture and language. The ability to comprehend and find meaning in maternity experiences can be challenging when the context of those experiences is vastly different to preconceived ideas and values and when care is articulated through a non-native poorly understood language.

Antonovsky (1996) highlighted the impact of socio-demographic influences on ability to cope with life stresses. Migrant women bring additional stressors to the maternity care experience in their adopted home, yet this study has shown that they bring a vast

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array of adaptive and coping strategies, their generalised resistance resources (GRR), that need acknowledging by those who care for them. The GRR of participants reveals an emergent ability to trust health care systems and staff despite the differences encountered with their own cultural values.

Congruent with other literature, findings illustrated inconsistent access to interpreting and translation services (Cross-Sudworth et al., 2011, Suphanchaimat et al., 2015). This needs to be proactively addressed in all maternity services. Robust translating/interpretive services must be made accessible to migrant women. Provision of quality and accessible translated information in plain language and pictograms that take into consideration health literacy, such as ability to interpret health information would enhance usability of health information and services by migrant women (Merry et al., 2011). In addition, evidence suggests that inter-professional care needs to employ innovative ways such as using decision aids and birth plans and online resources (Molenaar et al., 2018). Molenaar also identified the usefulness of interactive and practical awareness intervention programmes for parents as well as for inter-professionals in facilitating shared decision-making. However, it cannot be assumed that bespoke, accessible and acceptable translation and interpreting services for this population will lead to automatic positive maternity experiences.

Childbirth and maternity care traverse a host of varied experiences including the intimacy of birth itself. It has been shown previously that the mood in the labour room is influenced (positively and otherwise) by who is in the room (Crowther et al., 2014). Likewise, the Polish women in this study report some reservations about using translator's particularly during the intimacy of labour, preferring to choose family members or bilingual relatives. This preference has been reflected in other studies

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(Binder et al., 2012, Lyberg et al., 2012). However, evidence also suggests the use of relatives and other staff members acting as interpreters can lead to medical terminology being lost in translation as well as deter women from sharing sensitive issues such as domestic abuse and intimate violence (Asif et al., 2015). How this can be addressed requires sensitive responsive communication strategies between healthcare providers and migrant women during pre-birth discussion of birth plans.

The role of a specialist midwife and multi-agency collaboration in areas with a high prevalence of pregnant migrant women could provide continuity of care and support for these women (Asif et al., 2015). A recent systematic review found that local family and cultural norms and how these are linked to provision of maternity services matters to women (Downe et al., 2018). At local level, service user organisations and a Maternity Service Liaison Committee (UK committees including professional and user groups) can often help reflect myriad ethical and cultural diversity in communities and address migrant needs in local maternity services (Puthussery, 2016).

A personalised relational care service would potentially be better placed to co-ordinate accessibility of translating services and improve communication so that women who need language support could identify and report pregnancy concerns enabling them to make informed choices. This current study illustrates how responsive communication and caring relationships of health care professionals are crucial to engage with these women in order to identify their specific cultural and emotional needs. Responsive communications involve a multitude of factors, such as, language and cultural competencies of healthcare providers that acknowledge and work with each migrant woman's unique GRR. In this form of communication, a migrant woman can utilise or develop their GRR to overcome, or at least mitigate, the additional

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stressors they face when entering maternity care far from their own home. Evidence and recent health policy supports models of care that facilitate personalised woman-centred relational continuity (e.g. Grant, 2017, Sandall et al., 2016).

Although participants appear to be accustomed to a more authoritarian style of health care in Poland they appreciated the increased sense of autonomy, choice and accessibility of free services in the UK. They reported a developing trust towards UK maternity care models despite the differences in maternity care models in UK and Poland. These differences have been highlighted previously and reveal how Polish women associate pregnancy with illness and therefore anticipate a medicalised approach to maternity care (Dempsey and Peeren, 2016). With this bio-medical frame of reference Polish women often expect more tests and appointments with the doctor and become disappointed if only seen by midwives during antenatal care (Main, 2016). This can affect Polish women's health-seeking behaviour to the degree that they return to Poland to seek additional scans and treatments. Improving communication and accessible information about host country services is necessary. Phillimore (2016) suggests that staff training on intercultural competence would enable health care professionals to explain and communicate empathetically and appropriately with migrant women as individuals rather than as a homogenous group. Phillimore asserts that this would help migrant women to build cultural awareness about the host country health systems, build confidence and help manage expectations.

It is evident that health care professionals involved in the care of migrant women need to consider the GRR of these women and not treat them as a minority problematic group within maternity services. For example, midwives and medical staff need to acknowledge the unique psychosocial and cultural needs of individual migrant women

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by tailoring care so that it encourages them to nurture their own internal and external resources (GRR). Through appreciation of their personal assets and resources migrant women can become empowered and find a sense of coherence (SOC) in situations that may feel alien, challenging and even threatening. In other words, maternity care providers working together with the Third Sector, such as local Polish associations and community support groups could help. This would enable them to draw upon their personal, social and community resources (Viken, 2016). In addition, multidisciplinary teams to support migrant woman who are navigating maternity systems different to their own could help demystify approaches to care and the roles and responsibility of the different cadre of maternity care providers.

Findings in this study have illustrated how migrant women use their internal and external resources to facilitate them moving towards a Sense of Coherence (SOC). The emergent sense of coherence (SOC), in this sample of migrant women, is threaded throughout the data and uncovers a growing level of integration and psychosocial acculturation into the host country's culture and philosophy (Riedel et al., 2011). A focus on salutary outcomes may be more challenging to define because its focus is on wellbeing and health (Downe and McCourt, 2008), yet a salutogenic framework provides a lens through which to examine the needs of this population without overly privileging the current discourse around risk factors and sub-optimal outcomes. Risk and pathology is only part of the experience of migrant women (Downe and McCourt, 2008) and this need not be the sole impetus of maternity care provision or research agendas. Assigning this 'group' with a risk label is unhelpful and does not address individual needs. On the contrary, allocating these women as at risk only serves to make them vulnerable to excessive medicalisation and not having their individual needs heard and addressed (Merry et al., 2016). The

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salutogenic theory as applied here, ‘sees’ a migrant woman as part of a population without identifying her as part of a shared high-risk group (Antonovsky, 1996). This situates the woman’s experience in the centre by highlighting her individual SOC during her journey in accessing maternity care without ascribing low and high-risk labels.

By employing Antonovski’s sense of coherence (SoC) we have highlighted how Polish migrant women utilise their internal and external resources such as family support and social support to find meaning in their individual maternity experiences helping them to be more resilient when confronted with language and cultural barriers assessing maternity services. We speculate that such a salutary focus privileges normality and wellbeing through emphasising positive affirming experiences and helps improve migrant women’s satisfaction which could potentially improve biomedical outcomes in this population. However, this needs further exploration and evidence. This study contributes to the growing literature on migrant women’s health and has value to other maternity services who wish to appreciate the unique needs of migrant women. Vulnerability need not be defined as weakness; indeed, vulnerability can be understood as uncertainty, risk and emotional exposure to situations that are not understandable. Vulnerability of migrant women need not be construed as negative. Perhaps migrating to a different culture and environment could be understood as an opportunity for personal growth, joy, courage, empathy and creativity (Brown, 2013).

Future research

This study needs to be taken in the context of global research priorities for maternity, namely a call to do research that emphasises equity of maternity care tailored to

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individuals, person-centred and enhances socio-cultural, emotional and physical wellbeing (Kennedy et al., 2018). These priorities are built on the evidence based framework for quality and newborn care (Renfrew et al., 2014) that foregrounds the significance of values, social and cultural aspects of maternity care for all women and privileges continuity of care. With the contemporary migratory nature of human population, it is essential that future research on migrant women experiences of language and communication within maternity services in host countries be undertaken across multiple sites to inform evidenced based solutions that can be translated into practice that may improve accessibility, acceptability and satisfaction with services. The use of Antonovski's SOC questionnaire could be used to identify specific factors that enable migrant women's own internal and external resources. Addressing barriers to effective communication through such a salutogenic lens could also improve bio-medical and psychosocial outcomes, although more work in this area needs to be done.

STRENGTHS AND LIMITATIONS

Although this study was undertaken in one city in the Scottish context, the high numbers of global migration of women within childbearing age suggest that the findings may be transferable to other regions in UK where maternity services emphasise woman's autonomy and where healthcare professionals are regulated, for example other Organisation for Economic Co-operation and Development (OECD) regions. The situation of childbearing women in regions where professional regulation and healthcare structures are lacking requires further context specific studies. This study had a small sample size; however, this is consistent with naturalistic methodologies which privilege context rich experiential data. Through theoretical saturation sufficient data was collected to provide new and insightful findings.

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Purposive sampling can be accused of biased recruitment to achieve a certain outcome, however, the nature of this study meant that such sampling was necessary given the topic area and the small population from which the sample could be recruited. Using or not using interpreters could affect the data collected due to differences in translation and could have altered the content of interviews. Despite these concerns the research team deemed it necessary to ensure women had the option to decide. The conceptual framework could be accused of overly simplifying a complex situation and framing women's experiences too positively. However, adoption of a salutogenic focus encouraged an affirming and non-stigmatising approach to research on a marginalised group.

5. CONCLUSION

Non-English-speaking Polish migrant women using NHS maternity services in Scotland face challenges navigating a very different maternity system. They find themselves traversing maternity services vastly different to those in their home country. Migrant women can adjust and mobilise their resources to find meaning in their maternity experience with support. Adopting a salutogenic lens avoids a problematising focus on migrant women's experience of maternity care. Whilst it is important to acknowledge migrant women's concerns a salutogenic focus can help service providers understand this population in a more strength-based, empowering and person-centred way. A salutogenic approach highlights the significance of meaning and context for how migrant women deploy internal and external resources (GRR) at a personal level to adapt and thrive. Relationships over time have been revealed as critical as is the need for improving accessible and culturally sensitive interpreting services when needed. Any changes to current maternity care provision

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for non-English migrant women (in English speaking regions) needs to acknowledge migrant women's strengths, values and expectations. Therefore, it is the values of the maternity system that is questioned and how the organisational culture and its employees' function when confronted with unique needs; not an individual woman's migrant status when she comes seeking maternity care.

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7. REFERENCES

Antonovsky, A., 1996. The salutogenic model as a theory to guide health promotion. Health promotion international 11 (1), 11-18.

Antonovsky, A., 1987. Unraveling the mystery of health: How people manage stress and stay well. Jossey-bass.

Asif, S., Baugh, A., Jones, N.W., 2015. The obstetric care of asylum seekers and refugee women in the UK. J The Obstetrician Gynaecologist 17 (4), 223-231.

Balaam, M.C., Akerjordet, K., Lyberg, A., Kaiser, B., Schoening, E., Fredriksen, A.M., Ensel, A., Gouni, O., Severinsson, E., 2013. A qualitative review of migrant women's perceptions of their needs and experiences related to pregnancy and childbirth. Journal of advanced nursing 69 (9), 1919-1930.

Binder, P., Borné, Y., Johnsdotter, S., Essén, B., 2012. Shared language is essential: communication in a multiethnic obstetric care setting. Journal of health communication 17 (10), 1171-1186.

Brown, B., 2013. The Power of Vulnerability: Teachings on Authenticity, Connection, and Courage. Louisville: Sounds True.

Final accepted manuscript

Cross-Sudworth, F., Williams, A., Herron-Marx, S., 2011. Maternity services in multi-cultural Britain: Using Q methodology to explore the views of first- and second-generation women of Pakistani origin. Midwifery 27 (4), 458-468.

Crowther, S., Smythe, L., Spence, D., 2014. Mood and birth experience. Women and birth : journal of the Australian College of Midwives 27 (1), 21-25.

Dempsey, M., Peeren, S., 2016. Keeping things under control: exploring migrant Eastern European womens' experiences of pregnancy in Ireland. Journal of Reproductive and Infant Psychology 34 (4), 370-382.

DeSa, U., 2013. Inequality matters. Report on the World Social Situation 2013. New York, United Nations.

Downe, S., Finlayson, K., Oladapo, O., Bonet, M., Gülmezoglu, A.M., 2018. What matters to women during childbirth: a systematic qualitative review. PloS one 13 (4), e0194906.

Downe, S., McCourt, C., 2008. From being to becoming: reconstructing childbirth. Normal Childbirth E-Book: Evidence and Debate 3.

Edwards, N., 2018. The trauma women experience as the result of our current maternity services. In, Untangling the Maternity Crisis. Routledge, pp. 79-85.

Grant, J., 2017. The Best Start: A Five-year Forward Plan for Maternity and Neonatal Care in Scotland. Scottish Government.

Kennedy, H.P., Cheyney, M., Dahlen, H.G., Downe, S., Foureur, M.J., Homer, C.S., Jefford, E., McFadden, A., Michel-Schuldt, M., Sandall, J., 2018. Asking different questions: A call to action for research to improve the quality of care for every woman, every child. Birth.

Lincoln, Y., Guba, E., 1985. Naturalistic inquiry. Sage, Beverly Hills, CA.

Lyberg, A., Viken, B., Haruna, M., Severinsson, E., 2012. Diversity and challenges in the management of maternity care for migrant women. Journal of nursing management 20 (2), 287-295.

Main, I., 2016. Biomedical practices from a patient perspective. Experiences of Polish female migrants in Barcelona, Berlin and London. Anthropology & medicine 23 (2), 188-204.

MBRACE-UK, 2018. Saving Lives, Improving Mothers' Care. Oxford university, Oxford.

Final accepted manuscript

Merry, L., Vangen, S., Small, R., 2016. Caesarean births among migrant women in high-income countries. J Best Practice Research Clinical Obstetrics Gynaecology 32, 88-99.

Merry, L.A., Gagnon, A.J., Kalim, N., Bouris, S., 2011. Refugee claimant women and barriers to health and social services post-birth. Canadian Journal of Public Health/Revue Canadienne de Sante'e Publique, 286-290.

Molenaar, J., Korstjens, I., Hendrix, M., Vries, R., Nieuwenhuijze, M., 2018. Needs of parents and professionals to improve shared decision-making in interprofessional maternity care practice: A qualitative study. Birth 45 (3), 245-254.

Morse, J.M., 2015. Critical Analysis of Strategies for Determining Rigor in Qualitative Inquiry. Qualitative Health Research 25 (9), 1212.

NMC, 2015. The Code: Professional standards of practice and behaviour for nurses and midwives. Nursing Midwifery Council.

O'reilly, M., Parker, N., 2013. 'Unsatisfactory Saturation': a critical exploration of the notion of saturated sample sizes in qualitative research. J Qualitative research 13 (2), 190-197.

Office for National Statistics, 2018. Migration Statistics Quarterly Report: August 2018. Office for National Statistics (ONS), UK.

Perez-Botella, M., Downe, S., Magistretti, C.M., Lindstrom, B., Berg, M.J.S., Healthcare, R., 2015. The use of salutogenesis theory in empirical studies of maternity care for healthy mothers and babies. 6 (1), 33-39.

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 & Medicine 148, 152-159.

Puthussery, S., 2016. Perinatal outcomes among migrant mothers in the United Kingdom: is it a matter of biology, behaviour, policy, social determinants or access to health care? J Best Practice Research Clinical Obstetrics Gynaecology 32, 39-49.

Renfrew, M., Homer, C., Downe, S., McFadden, A., Muir, N., Prentice, T., Hoope-Bender, P.t., 2014. Midwifery series: Executive summary. The Lancet.

Riedel, J., Wiesmann, U., Hannich, H.-J., 2011. An integrative theoretical framework of acculturation and salutogenesis. Taylor & Francis.

Final accepted manuscript

Sandall, J., Soltani, H., Gates, S., Shennan, A., Devane, D., 2016. Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database of Systematic Reviews (4).

Sandelowski, M., 2000. Whatever happened to qualitative description? Research in nursing & health 23 (4), 334-340.

Scottish Government, 2018. National Records of Scotland. Scottish Government, Migration between Scotland and Overseas.

Sime, D., 2014. 'I think that Polish doctors are better': newly arrived migrant children and their parents' experiences and views of health services in Scotland. Health and Place 30, 86-93.

Suphanchaimat, R., Kantamaturapoj, K., Putthasri, W., Prakongsai, P., 2015. Challenges in the provision of healthcare services for migrants: a systematic review through providers' lens. BMC health services research 15 (1), 390.

United Nations, 2013. International Migration Report 2013. Population Division. United Nations, New York.

Viken, B., Balaam, M.C., Lyberg, A., 2016. A salutogenic perspective on maternity care for migrant women. In, New Thinking on improving maternity care : International Perspectives. Pinter & Martin Limited, UK.

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