Immigrant women's experience of maternity services in Canada: A meta-ethnography

ARTICLE *in* MIDWIFERY · AUGUST 2013

Impact Factor: 1.71 · DOI: 10.1016/j.midw.2013.06.004 · Source: PubMed

Midwifery ■ (■■■■) ■■■–■■■

Contents lists available at ScienceDirect

Midwifery

journal homepage: www.elsevier.com/midw

Immigrant women's experience of maternity services in Canada: A meta-ethnography

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ARTICLE INFO

Article history:
Received 15 April 2013
Received in revised form
6 June 2013
Accepted 11 June 2013

Keywords:
Meta-ethnography
Emigrants and immigrants
Maternal-child nursing
Canada

ABSTRACT

Objective: to synthesise data on immigrant women's experiences of maternity services in Canada.
Design: a qualitative systematic literature review using a meta-ethnographic approach
Methods: a comprehensive search strategy of multiple databases was employed in consultation with an information librarian, to identify qualitative research studies published in English or French between 1990 and December 2011 on maternity care experiences of immigrant women in Canada. A modified version of Noblit and Hare's meta-ethnographic theoretical approach was undertaken to develop an inductive and interpretive form of knowledge synthesis. The seven-phase process involved comparative textual analysis of published qualitative studies, including the translation of key concepts and meanings from one study to another to derive second and third-order concepts encompassing more than that offered by any individual study. ATLAS.ti qualitative data analysis software was used to store and manage the studies and synthesise their findings.
Findings: the literature search identified 393 papers, of which 22 met the inclusion criteria and were synthesised. The literature contained seven key concepts related to maternity service experiences including social (professional and informal) support, communication, socio-economic barriers, organisational environment, knowledge about maternity services and health care, cultural beliefs and practices, and different expectations between health care staff and immigrant women. Three second-order interpretations served as the foundation for two third-order interpretations. Societal positioning of immigrant women resulted in difficulties receiving high quality maternity health care. Maternity services were an experience in which cultural knowledge and beliefs, and religious and traditional preferences were highly relevant as well but often overlooked in Canadian maternity settings.
Key conclusions and implications for practice: in order to implement woman-centered care, to enhance access to maternity services, and to promote immigrant women's health, it is important to consider these women's social position, cultural knowledge and beliefs, and traditional customs in the health care.

Introduction

International migration has increased in recent years and this phenomenon will become more evident in the 21st century (International Organization for Migration, 2013). In Canada about 20% of the population are immigrants, 16.2% of the population belong to visible minority groups (Statistics Canada, 2008), and the percentage of females who are immigrants is expected to increase upwards of 27% over the next two decades (Urquijo and Milan, 2011). Moreover, the female immigrant population is becoming more diverse, with the largest groups having origins in Asian and Middle Eastern countries (41%), Europe (36%), Central and South America, the Caribbean and Bermuda (12%), China (7.9%), and Africa (5.6%) (Urquijo and Milan, 2011). Female immigrants constitute an increasing proportion of women giving birth in industrialised countries, partly due to their tendency to have larger families than women born in the receiving countries (Sobotka, 2008).

Receiving poor health care may have a significant impact on an immigrant woman's health and well-being, particularly during a vulnerable life stage such as maternity where immediacy of care is critical (Grewal et al., 2008). Immigrant women having recently arrived in their host country and with poor social networks, limited language proficiency and lack of knowledge about accessing or inability to legitimately access medical or obstetric care are at the greatest risk for receiving poor maternity care (Sanmartin and Ross, 2006; Sword et al., 2006a; Hayes et al., 2011). A previous report has indicated that potential barriers for receiving effective

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http://dx.doi.org/10.1016/j.midw.2013.06.004

health care in the United Kingdom (UK), Canada and Germany may include cultural misunderstandings, communication problems and racism (Salway et al., 2011). Other international studies include those in the United Kingdom (UK) looking at variables related to maternal morbidity and mortality (Ameh and Van den Broek, 2008; Knight et al., 2009) which found that black and ethnic minority women who do not access or receive optimal care can have higher risk of morbidity and death, partly due to factors related to care during pregnancy, labour, and birth. Maternity care in the UK, from the perspectives of immigrant Muslim women, was insensitive to women's needs because of the lack of knowledge by some health care professionals (Ali and Burchett, 2004). Immigrant women from Somalia, Eritrea and Sudan residing in Sweden experienced maternity care differently than when in their country of origin and those who had undergone female genital cutting (FGC) felt stigmatised (Berggren et al., 2006). The women felt vulnerable in their encounters with health care staff, not only because memories of the FGC experiences were reawakened with childbirth, but because they perceived midwives to view them as powerless victims and to hold negative attitudes towards them and their husbands. Consequentially, many of the women reported avoiding antenatal care to avoid alleged insults from the midwives (Berggren et al., 2006). Similarly, Somali women in Canada reported dissatisfaction with both clinical practice and quality of care and that their needs were frequently unmet during pregnancy and birth (Chalmers and Hashi, 2000; Chalmers and Omer-Hashi, 2002). On the other hand, African migrants receiving antenatal care in Australia valued the care they received as important and desirable and they described a process of adjustment to the notion of continuous antenatal care (Carolan and Cassar, 2010). The consequences of not receiving high quality antenatal care are that women may be less prepared for childbirth and may also present at childbirth with untreated diseases and conditions, resulting in complications for both the mother and her newborn child.

Our preliminary review of quantitative studies conducted in Canada identified evidence that immigrant women are receiving less than optimal maternity care which may negatively impact their maternity outcomes. Immigrant women may be at greater risk for low birth weight and caesarean section childbirths (Shah et al., 2011) and were significantly more likely to have low family incomes, low social support, poorer health, possible post partum depression, learning needs that were unmet in hospital, and a need for financial assistance (Sword et al., 2006b). Gagnon et al. (2007) demonstrated that having additional support in health and social supports was higher for immigrant women living in Toronto or Montreal, than for those living in Vancouver, suggesting some geographical variation. Being born outside Canada predicted women who were at an increased risk of sub-clinical and major post partum depression in one study (Davey et al., 2011). Additionally, lack of informal supports (family/friends), barriers to formal supports (community groups) and limited financial resources are factors that may contribute to post partum depression in immigrants (Zelkowitz et al., 2004; O'Mahony and Donnelly, 2010). Culture, communication and literacy impeded immigrant women to receive appropriate maternity care (Katz and Gagnon, 2002; Redwood-Campbell et al., 2008; Hayes et al., 2011). To further enhance understandings of factors contributing to these disparities, synthesising findings from a number of qualitative studies, which often give primacy to the voices of immigrant women, will be beneficial in order to provide health care professionals and other stakeholders with an understanding to facilitate immigrant women's access and navigation of high quality and meaningful maternity care. This contribution will also offer the opportunity for new insights related to conceptual and theoretical knowledge relevant to the experience of immigrant women within the maternity health care arena.

Aim

The aim of this study was to synthesise qualitative literature to describe how immigrant women experience maternity services in Canada.

Methodology

Design

A meta-ethnographic approach was used to develop an inductive and interpretive form of knowledge synthesis based on the methods by Noblit and Hare (1988) as recently modified by Campbell et al. (2011) (Table 1). Meta-ethnography encompasses a comparative textual analysis of published qualitative studies. This involves selecting relevant empirical studies to be synthesised, reading them repeatedly and noting down concepts (interpretive metaphors) that can then lead to a synthesis whereby there is translation of findings from small groups of closely related studies into one another. This approach encourages understanding and transferring of ideas, concepts and metaphors across different studies (Noblit and Hare, 1988; Campbell et al., 2011).

Search strategy

The search was conducted on March 8, 2012, as designed by a health sciences librarian. The following databases were searched: Ovid MEDLINE 1948- and MEDLINE In-Process & Other

Table 1
Stages of the meta-ethnography synthesis.

Stage	Description
1	Topic selection
2	Description of what was relevant to initial interest for the study; the sample for meta-ethnography synthesis was purposely selected in relation to the topic of interested in order of achieving interpretative explanation. This step included finding relevant studies; making decisions for inclusion; and assessing the quality of included studies.
3	The findings and concepts were summarised for each study, using raw data for the initial extraction of main concepts. The process involved a degree of organising and summarising; thus, to some extent an initial process of interpretation was underway, especially when organising descriptive findings that had not been interpreted in the articles. To make this process more transparent, we completed a grid (Table 4) comparing the identified concepts between studies.
4	We determined how the studies were related to each other and began by organising the studies thematically and then within *first-order* interpretations (key concepts).
5	The papers that were brought together thematically within first-order interpretations (key concepts) were translated into each other to achieve *second-order* interpretation (main themes). The synthesis proceeded as a reciprocal translation that involved comparing the findings and concepts from each included paper with those of the others from which a line of argument could be developed (Noblit and Hare, 1988).
6	We determined how findings related to each other within and across second-order interpretations (main themes). This initially involved re-reading the textual syntheses for each of the thematically groups (referring back to the original papers where clarification was necessary) to produce an overall textual synthesis of immigrant women's experiences of maternity care (Table 5). This overall textual synthesis was a 'lines-of-argument' synthesis (Noblit and Hare, 1988) or 'third order' interpretation (Campbell et al., 2011). The 'lines-of-argument' synthesis involved first translating studies into each other and then constructing an interpretation that may serve to discover what was hidden in individual studies to illuminate overarching synthesis (Campbell et al., 2011; Noblit and Hare, 1988).
7	We expressed the overall textual synthesis for the health care practitioners and policy makers who can use it to develop new interventions to optimise care and outcomes.

Please cite this article as: Higginbottom, G.M.A., et al., Immigrant women's experience of maternity services in Canada: A meta-ethnography. Midwifery (2013), http://dx.doi.org/10.1016/j.midw.2013.06.004

Non-Indexed Citations, Ovid EMBASE 1980-, Ovid PsycINFO 1972-, EBSCOhost CINAHL, Scopus, ISI Web of Science: Science Citation Index 1899-, Social Sciences Citation Index 1898-, Conference Proceedings Citation Index- Science 1900-, Conference Proceedings Citation Index- Social Science & Humanities 1900-, and CSA Sociological Abstracts. Subject headings and key words were used in the search and subject headings and search operators were modified for each specific database. The search contained four concepts: pregnancy and maternal health care; immigrants and refugees; Canada; and a qualitative study design filter; appropriate subject headings and keywords were used to retrieve literature about each of these concept areas. In databases, where large sets of results were not retrieved the qualitative filter was not used. Apart from the database searches, additional articles were sought by reviewing the reference lists of identified systematic reviews and key articles. When unsure about the methodological approach of publications, contact with the authors was made to provide clarification.

Inclusion criteria

The study applied the following inclusion criteria: qualitative original, or primary, research studies; published between 1990 and December 2011; English or French language; describing immigrant women's experiences of maternity care; and Canadian residency of the participants. Papers describing immigrant women's experiences through the perspectives of people other than immigrant women (e.g. health care professionals) were eligible. Those papers describing 'ethnic' populations which were not explicitly reported as being immigrants were excluded due to ambiguity between ethnicity and immigration. Systematic and other forms of reviews as well as commentaries and brief reports (including letters to editor) were also excluded although their reference lists were reviewed for further identification of primary research papers.

Selection and management of articles for synthesis

The results from all searches were stored in RefWorks, an online research management program, and duplicates were removed. The abstract of each article was read either using RefWorks or by obtaining the article through the authors' institution, and those appearing to meet the inclusion criteria were obtained and read in full to determine final selection. One investigator (EH) applied the selection criteria and also identified those abstracts which were ambiguous and for which the opinion of the second reviewer (GH) was sought. The final selection was based on both of these reviewers' agreement of the relevance of the study to this synthesis.

Quality appraisal

An assessment of the methodological quality of included articles was performed to document descriptive information on aspects of their quality rather to serve as a basis for rejecting studies (Noblit and Hare, 1988; Campbell et al., 2011). This aligns with a concern that relatively minor methodological flaws may result in insightful studies being excluded from syntheses (Sandelowski et al., 1997). Essentially, we used the critical appraisals to assess the value of each source for informing our synthesis; in general, key concepts which were described in one study of poor or questionable quality would not be relied upon to inform the synthesis. To choose a suitable appraisal tool, two authors (EH and GH) performed a pilot whereby four papers were appraised using four different tools for assessing methodology and reporting of qualitative research articles:

- Critical Appraisal Skills Program (CASP, 2010);
- Consolidated Criteria for Reporting Qualitative Research (COREQ) (Tong et al., 2007);
- National Institute for Health and Clinical Excellence (NICE) Quality Checklist – Qualitative Studies (National Institute For Health and Clinical Excellence, 2009) and
- Joanna Briggs Institute Checklist Critical Appraisal Checklist for Interpretative & Critical Research (JBI QARI) (Joanna Briggs Institute, 2011).

It was concluded that the JBI QARI tool was most congruent with our narrative approach and we thus assessed all included studies using this ten-question tool (Table 2). Moreover, one of the authors (GH) created a three-level (high, medium and low) grading system (Table 2) to allow for discussion of the relative contributions of the studies towards the synthesis. Five articles were appraised independently by two authors (EH and GH) using the JBI QARI checklist. After confirming good agreement on the quality scoring, one author (EH) completed the remaining quality appraisals.

Data extraction and synthesis

Data abstraction and synthesis followed the meta-ethnographic approach (Noblit and Hare; 1988; Campbell et al., 2011). Information on each study's aim, sample and sampling, methodology, and main findings were extracted into a standardised table and the portable document formats (pdfs) were uploaded into ATLAS.ti qualitative software (Scientific Software Development GmbH, Berlin, Germany) for coding and theming. After identifying key concepts (first-order interpretations) within each study, a grid was created to compare studies. First-order interpretations were then translated into each other to achieve second-order interpretations (main themes), using reciprocal translation that involved comparing the findings and concepts from each included paper with those of the others from which a line of argument could be developed (Noblit and Hare, 1988). Finally, we determined how findings related to each other within and across second-order interpretations (main themes) to produce a tabular display and an overall

Table 2
Joanna Briggs Institute (JBI) QARI questions and appraisal scoring criteria developed by the first author. The QARI questions were reproduced with kind permission from The Joanna Briggs Institute.

JBI QARI questions (each having possible scores of Yes, No, or Unclear)	
1. Is there congruity between the stated philosophical perspective and the research methodology?	
2. Is there congruity between the research methodology and the research question or objectives?	
3. Is there congruity between the research methodology and the methods used to collect data?	
4. Is there congruity between the research methodology and the representation and analysis of data?	
5. Is there congruity between the research methodology and the interpretation of results?	
6. Is there a statement locating the researcher culturally or theoretically?	
7. Is the influence of the researcher on the research, and vice-versa, addressed?	
8. Are participants, and their voices, adequately represented?	
9. Is the research ethical according to current criteria (noted approval from ethical board)?	
10. Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?	
Evaluation criterion	**Criterion statement**
High	A study with a rigorous and robust scientific approach which largely meets all JBI benchmarks, perhaps 7 or more Yes
Medium	A study with some flaws but not seriously undermining the quality and scientific value of the research conducted – perhaps 5–7 Yes
Low	A study with serious or fatal flaws and poor scientific value – perhaps below 5 of the benchmarks met

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textual synthesis of immigrant women's experiences of maternity care to serve as a 'lines-of-argument' synthesis (Noblit and Hare, 1988) or 'third-order' interpretation (Campbell et al., 2011). The final stage involved first translating studies into each other and then constructing an interpretation that helped discover what was hidden in individual studies to illuminate the overarching synthesis (Noblit and Hare, 1988; Campbell et al., 2011).

To enhance the trustworthiness in this study, we followed the steps described by Patton (2002). Credibility was ensured with both authors reviewing all stages of the meta-ethnography. The first author (GH) assisted with selection and quality appraisal (as described above) of the synthesised articles and reviewed the second author's work during stages three through six of the synthesis to confirm the appropriateness and relevance of the interpretations. Furthermore, the second- and third-order interpretations were also reviewed and assessed for relevance by the interdisciplinary research team (co-authors) having research and practical experience in maternity care. Dependability was enhanced by describing the methodological process as clearly as possible (Patton, 2002).

Findings

A total of 393 articles were retrieved with 88 duplicates (Fig. 1); of these five were obtained outside of the database searches. After screening using the inclusion criteria, 41 full papers were retrieved for possible selection and 22 were chosen for the synthesis. Elimination of 19 articles was mainly due to a lack of reporting primary qualitative research or to insufficient focus on our topic. The retrieved articles were heterogeneous with respect to stage of maternity (antenatal (4), postnatal (9), and antenatal and postnatal (10)) and qualitative methodology (grounded theory (4), ethnographic approach (2), thematic analysis (5), unidentified or descriptive qualitative approach (11)). The summary data and quality appraisal scores of each study are listed in Table 3, and the grid displaying relationships between studies based on first-order interpretations (key concepts) is contained in Table 4.

Many of the studies were of medium ($n=5$) or high ($n=13$) methodological quality and the items of the JBI QARI checklist which were the most often incomplete were questions six and seven (Table 3), referring to statements on both locating the researcher culturally or theoretically and addressing the influence of the researcher on the research. Although these are arguably useful pieces of information for qualitative research, the authors acknowledge that these may not be routinely included in papers in all journals. Moreover, many medium quality studies had rich descriptions of their findings and thus very likely contributed well to the synthesis. Unless otherwise stated, the narrative here uses evidence from either multiple or only medium and high quality studies to illustrate the concepts and interpretations developed.

Our meta-ethnography identified three second-order interpretations, derived from seven key concepts, on the foundation of which two third-order interpretations (synthesis) were developed (Table 5). The textual description of our synthesis follows.

Quality of maternity health care for immigrant women depends on both interpersonal relationships with professionals (health care staff) and informal (families/friends) social supports, and contextual factors such as language proficiency, socio-economic barriers and the organisational environment

Societal positioning of immigrant women resulted in difficulties receiving high quality maternity health care because of lack of proximity to informal social supports, barriers to formal supports, lack of communication proficiency or adequate information sources, socio-economic barriers, and the organisational

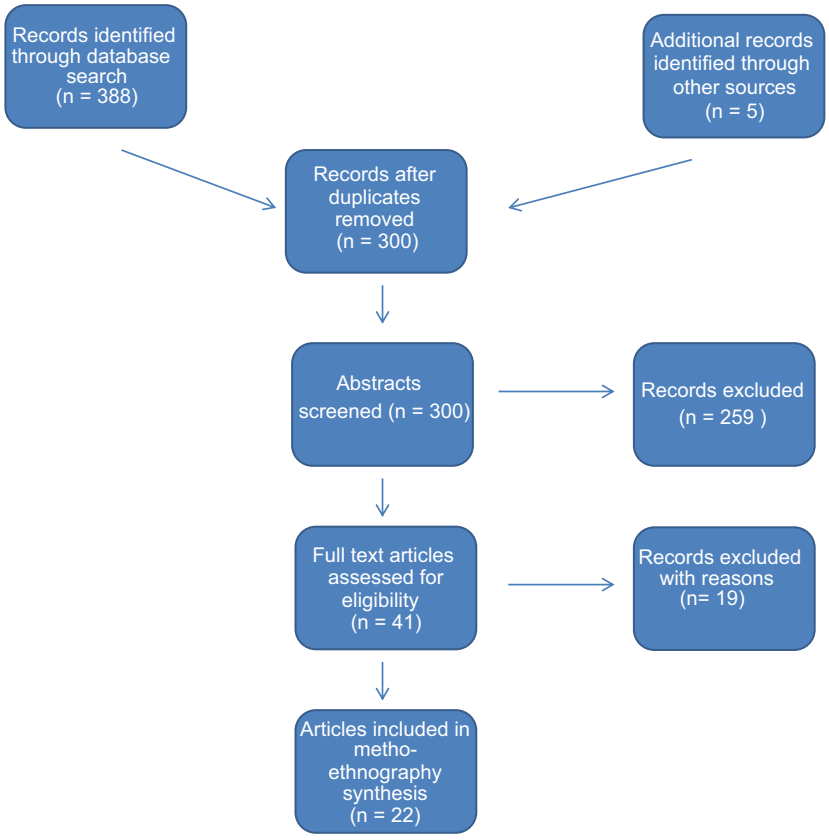

Fig. 1. Search and selection process.

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Table 3
Summary and quality appraisal of the synthesised qualitative studies.

Number	Author (s) and publication year	Study aim	Sample, recruitment and data collection	Methodology and quality appraisal grade with questions receiving No or Unclear for JBI QUARI	Summary of findings
1	Ardal et al. (2011)	To explore the experience of non-English speaking mothers with preterm, very low birth weight (VLBW) infants (1500 g); and (2) to examine mothers' assessment of a peer support program matching them with linguistically and culturally similar parent-buddies.	A convenience sample of eight immigrant, non-English speaking mothers identified by social workers or nursing staff on the unit or through their participation in the parent group programs during their infant's hospital stay. Interviews.	An exploratory, qualitative analysis based on grounded theory. Appraisal grade: High (1, 6, 7)	Mothers experienced intense role disequilibrium during the unanticipated crisis of preterm birth of a VLBW infant; situational crises owing to the high-tech NICU environment and their infant's condition; and developmental crises with feelings of loss, guilt, helplessness and anxiety. Language barriers compounded the difficulties. Parent-buddies helped non-English speaking mothers mobilise their strengths.
2	Merry et al. (2011)	To gain greater understanding of the barriers vulnerable migrant women face in accessing health and social services post partum.	112 maternal reports of services (51 Montreal, 61 Toronto).	Qualitative thematic analysis. Appraisal grade: Medium (1, 6, 7, 9)	There exists a problematic lack of assessment, support and referrals for psychosocial concerns for women.
3	Ng and Newbold (2011)	To gain a better understanding of the difficulties faced by health care professionals and how these difficulties affected the delivery of care to immigrant women.	10 female participants (three midwives, five nurse practitioners, two obstetrician gynaecologists, and a social worker) recruited through a standard email or phone call. Semi-structured, open question interviews	Grounded theory approach. Appraisal grade: Medium (1, 4–7)	Complexity of delivering care to immigrants, particularly with respect to expectations surrounding language, culture and type and professionalism of care.
4	Wiebe and Young (2011)	To explore parent (client/patient) perceptions of culturally congruent care within a tertiary neonatal intensive care unit with culturally diverse families (immigrants and Aboriginal) with hospitalised infants.	Potential families approached on a first-come basis by the neonatal research nurse. Of the 45 eligible families with infants in the NICU during the 8-month period of the study (2004), 21 consented. Thirteen of the families were immigrants, and eight of the parents interviewed were Aboriginal Canadian-born. Interviews conducted.	An exploratory qualitative approach Appraisal grade: High (6, 7, 9)	Four primary constructs: (a) a provider–client relationship of caring and trust, (b) respectful and appropriate communication, (c) culturally responsive and accessible social and spiritual supports, and (d) a welcoming and flexible organisational environment.
5	Gagnon et al. (2010)	To explore the inhibitors and facilitators of migrant women for following with referrals for care.	25 women born in 16 different countries were identified from an earlier chart review. Semi-structured group or individual interviews.	Qualitative analysis was driven with code, themes and sub-themes. Appraisal grade: High (1, 6, 7)	Study showed that inhibitors included language barriers, transportation problems, scheduling appointments, absence of husband, absence of childcare, cold weather, perceived inappropriate referrals, and cultural practice differences. Facilitators included choice of follow-up facilitator, appropriate services, empathetic professionals, and early receipt of information.
6	Janssen et al. (2009)	To define a role for obstetrical care providers in assisting among South Asian immigrants women who experience family violence.	Six South Asian women and 11 direct-service providers identified through phone calls to key informants, perusal of resource directories and web-based sources and word of mount to attend to workshop meetings.	Qualitative analysis was driven with developing of themes. Appraisal Grade: High (1, 2, 6)	Study found four themes focused on cultural issues, services and supports, education and prevention, and policy and advocacy. Participants highlighted challenges posed by the patriarchal nature of their culture and, for many families, by recent immigration. They emphasised the importance of routine assessment for family violence by obstetrical care providers and stressed the need to treat the entire family, not just the identified victim. They focused on the role of the caregiver as a conduit of information about social services and other

Table 3 (*continued*)

Number	Author (s) and publication year	Study aim	Sample, recruitment and data collection	Methodology and quality appraisal grade with questions receiving No or Unclear for JBI QUARI	Summary of findings
					resources. Community-level interventions to address abuse were endorsed, including the use of lay media to deliver key messages about health and safety.
7	Ahmed et al. (2008)	To better understand the experience of depressed mood in immigrant new mothers.	10 women who had scored ≥10 on the Edinburgh Post partum Depression Scale (EPDS) at 7 to 10 days post partum during the NORMAPERS study, who lived in Toronto, Canada, and had been given referrals to maternal support centres. Semi-structured interviews.	Constant comparative method. Appraisal Grade: Medium (1, 4, 6, 7)	Study indicated that many women attributed their depressive symptoms to social isolation, physical changes, feeling overwhelmed and financial worries. They had poor knowledge of community services. Barriers to care included stigma, embarrassment, language, fear of being labelled an unfit mother, or the attitude of some staff. Facilitators to recovery included social support from friends, partners and family, community support groups, "getting out of the house", or personal psychological adjustment. Personal and systematic barriers exist in new immigrant mothers obtaining care for symptoms of depression
8	Reitmanova and Gustafson (2008)	To document and explore the maternity health care needs and the barriers to accessing maternity health services from the perspective of immigrant Muslim women living in St. John's, Canada.	6 through purposive approach. In-depth interviews.	Thematic analysis. Appraisal grade: Medium (1, 4, 6, 7)	Findings indicated that women experienced discrimination, insensitivity and lack of knowledge about their religious and cultural practices. Health information was limited or lacked the cultural and religious specificity to meet their needs during pregnancy, labour and childbirth, and post partum phases. There were also significant gaps between existing maternity health services and women's needs for emotional support, and culturally and linguistically appropriate information.
9	Grewal et al. (2008)	To describe the knowledge and cultural traditions that surround the new immigrant Punjabi women perinatal experiences and the ways that traditional beliefs and practices are legitimised and incorporated into the Canadian health care context. The role of the family and community in women' s perinatal experiences was also explored. In addition, women ' s interactions with the Canadian health care system during the perinatal period were examined.	15 immigrant Punjabi, first-time mothers who had immigrated to Canada from Punjab, India, within the past 5 years and had given birth to a full-term, healthy infant in the past 3 months participated. Individual interviews. Five health professionals and community leaders also took part in a focus group to confirm the study findings and to offer recommendations.	Naturalistic qualitative descriptive. Appraisal grade: High (7, 9)	Three major categories emerged from the analysis: (1) the pervasiveness of traditional health beliefs and practices related to the perinatal period (e.g., diet, lifestyle, and rituals), (2) the important role of family members in supporting women during the perinatal experiences, and (3) the positive and negative interactions women had with health professionals in the Canadian health care system.
10	Kulig et al. (2008)	To discuss LGS Mennonite women's childbearing knowledge and beliefs to develop and implement care that considers and includes their conservative religious beliefs.	38 LGS Mennonite women, using purposeful and snowball methods throughout Southern Alberta, Canada. Twenty-three had initially arrived in Alberta from Mexico with 14 of the 38 arriving in the 1990 s. Open-ended interviews.	An exploratory, descriptive study. Appraisal grade: High (1, 6)	Study claimed that the participants engaged in proscribed practices ('turning the baby') and adhered to specific dietary measures (increasing dairy products) during pregnancy to ensure a healthy birth outcome. During the post-partum period, extensive support is provided by other Mennonite women to assist the mother and newborn during this important transition.

11	Morrow et al. (2008)	To explore in the Canadian context the experiences of three groups of first-generation Punjabi-speaking, Cantonese-speaking, and Mandarin-speaking immigrant women with depression after childbirth.	18 (seven Mandarin-speaking women, eight Cantonese-speaking women, and three Punjabi-speaking women). Initial recruitment strategy using offices of general and family practitioners only used for 2 women; others through community agencies, community health nurses and community based organisations. Interviews.	Ethnographic narrative approach Appraisal grade: High (6, 7, 9)	Study found three themes with related sub themes: (1) Women's experiences and expressions of post partum depression, (2) Psychosocial stresses (a) the migration experience, (b) adherence to gendered roles, the roles of mothers in society, and (c) conflicts with family members, (d) desire for boy babies (3) The role of family, community, and social support, and help seeking (a) role of family, community, and social support.
12	Sutton et al. (2007)	To explore Vietnamese women's breast feeding experience and challenges, as were their families' needs for antenatal and post partum health professional programs and services.	Heterogeneous sample of 11 Vietnamese new (<2 years) mothers, mostly first-generation, identified from the database of registered service users in a family practice. In-depth, semi-structured interviews.	Qualitative study Appraisal grade: High (1)	Findings indicated lack of knowledge and misinformation were major barriers to breast feeding. Inability to communicate in English and a lack of effective transportation were key obstacles to the women's ability to access mainstream antenatal and post partum health programs and services. Standard nursing antenatal and post partum services appear not to have reached this group of mothers effectively.
13	Teng et al. (2007)	(1) to identify potential barriers to care that recent immigrant women may encounter as perceived by health care workers; and (2) to identify challenges health care workers felt that they faced as providers of care to this population.	16 key informants from various health care professions, identified from agencies providing post partum care to immigrant women in Metropolitan Toronto. Purposive sampling for diversity. Semi-structured interviews.	Constant comparative analysis (Grounded theory). Appraisal grade: High (1, 6, 7)	Analysis emerged two main categories of barriers to care for recent immigrant women: 'practical barriers' and 'culturally determined barriers'. Practical barriers included knowing where and how to access services, and language difficulties. Cultural barriers included fear of stigma and lack of validation of depressive symptoms by family and society. The challenges experienced by health care providers working with this population were organised into two other categories: 'professional limitations', and 'social-cultural barriers'. 'Professional limitations' included fear of incompetence, language barriers, and inadequate assessment tools. 'Social-cultural barriers' included the experience of cultural uncertainty.
14	Groleau et al. (2006)	The study examined possible influences on breast feeding practices amongst Vietnamese immigrants to Québec.	19 Vietnamese immigrant mothers recruited with purposive and snowball sampling using referrals from professionals. Community workers and leaders assisted with recruitment. Interviews.	Narratives were analysed along two main dimensions: (i) thematic content, mainly informed by interpretive and critical approaches of medical anthropology and, (ii) mode of reasoning. Appraisal Grade: High (6, 7)	The results suggest that the decision to bottle-feed was not related to acculturation to local practices as has been claimed in previous studies but to conflicts between Vietnamese cultural practices and the configuration of the new social space in Canada. Living in Canada did not allow specific family members to conduct postnatal traditional rituals thus jeopardising mothers' perceived health and the quality of their milk.

Table 3 (*continued*)

Number	Author (s) and publication year	Study aim	Sample, recruitment and data collection	Methodology and quality appraisal grade with questions receiving No or Unclear for JBI QUARI	Summary of findings
15	Groleau (2005)	To contribute to the understanding of the complexity of the meaning Vietnamese immigrants, suffering from HG (Hypermeis Gravidarium) attribute to their symptoms.	19 Vietnamese immigrant mothers living in a urban area of south-eastern Quebec. Ethnographic interviews and questionnaires.	Ethnographic interviews were analysed using an interpretive approach and medical anthropology concepts in order to understand the maternal meanings, and were supplemented by questionnaire data. Appraisal grade: High (6, 7)	The produced narratives suggested that 42% of mothers suffered from severe nausea and vomiting during their pregnancy in Québec. Mothers' attributions coincided with Sino-Vietnamese popular theory of health. They also indirectly point to a disequilibrium in their social environment due to the absence of key members of their extended family that stayed in their country of origin. Vietnamese have a collective identity and are particularly attached to their extended family.
16	Spitzer (2004)	To examine the hospital childbirth experiences of visible minority women, including their interactions with nursing staff, in light of increased dissatisfaction noted by minority women, particularly in routine patient exit surveys.	(1) A convenience sample of 19 new mothers (five First Nations, six South Asian Canadian, five Vietnamese Canadian, and three Euro Canadian women who ranged in age from 15 to 40) who had given birth in one of three participating community health centres or hospitals. Interviewed individually or as part of a focus group using a semi structured interview guide. (2) 11 obstetrical nurses (four foreign born) from hospitals interviewed.	Qualitative content analysis Appraisal grade: Low (1, 2, 4, 6, 7)	Service users were members of culturally marginalised populations whose bodies were read by nurses as potentially problematic and time consuming. As their calls for assistance go unanswered, visible minority women complained of feeling invisible. Taken in context of historical and contemporary interethnic relations, these women regarded such avoidance patterns as evidence of racism. Obstetrical nurses, too, understood that the new economy of care wrought by health care restructuring has altered nursing practice and patient care to the detriment of minority women.
17	Brathwaite and Williams (2004)	To explore the connections between culture and expectations surrounding the childbirth experience for professional Chinese Canadian women.	Six highly educated (three health care professionals, one journalist, one computer programmer and one office clerk) women through snowball sampling from a community health care centre in metropolitan Toronto. Ethnographic interviewing technique.	Descriptive and qualitative study. Appraisal grade: High (4, 5, 6)	The respondents described adherence to many traditional values, beliefs, and practices throughout the pregnancy and childbirth experience. However, some practices were modified to address functioning in a context that could not support full expression of cultural traditions. Recent immigration to Canada was associated with less adherence to traditional Chinese rituals and beliefs.
18	Hyman and Dussault (2000)	To explore health behaviours (e.g. smoking, alcohol, diet) social support and stress in a group of pregnant Southeast Asian immigrant women displaying different levels of acculturation.	17 pregnant Southeast Asian women (Vietnamese, Cambodian, Laotian) identified from agencies, community health departments, obstetricians, Southeast Asian health staff and word of month. Semi-structured interviews.	Qualitative approach. Appraisal grade: Low (1, 2, 4, 5, 9)	Study described that acculturation had negative consequences for immigrant women. Higher level of acculturation was associated with dieting during pregnancy, inadequate social support and stressful life.
19	Dhari et al. (2000)	To capture the perspective of Indo-Canadian women on issues of perinatal health and to explore ways of enabling these women to establish partnerships with health care providers in the community.	133 people participated in 15 focus groups. Most participants described themselves as Indo-Canadian or South Asian women. Most of the professional participants were nurses working in community health or maternal-child settings in hospitals. Clinicians, nutritionists and social workers also participated.	This qualitative study was based on principles of participatory research and models of community development. Appraisal grade: Low (1, 2, 4, 5, 8–10)	Analysing emerged four themes: (1) Defining community (2) Traditions and nurturing activities (3) Women at the risk (4) Learning resources

20	Bodo and Gibson (1999)	To examine and understand how differences in the cultural backgrounds of Canadian clinicians and their Vietnamese patients can affect the quality and efficacy of antenatal and postnatal treatment.	Members of the Vietnamese community in Edmonton were recruited for the interviews through Changing Together. The semi-structured interviews were focused on testing the accuracy of information from the literature and integrating and correlating the personal experiences of Vietnamese community members.	On the basis of interviews and literature review. Appraisal grade: Low (1–7, 9)	Traditional Vietnamese beliefs and practices surrounding birth are very different from the biomedical view of the Canadian medical system. Such cultural differences could contribute to misunderstandings between clinicians and patients and could affect the quality and efficacy of health care provided.
21	Dhari et al. (1997)	The purpose was to raise awareness of the health and social issues facing Indo-Canadian women within the Canadian mosaic.	15 women of Punjabi origin with ages from 18 to 27 years were interviewed before childbirth and after the births of their babies. Participants were sought through referrals from local clinicians.	Qualitative approach Appraisal grade: Medium (1, 4–6)	Study indicated that the amount of knowledge women had about each of the topic areas increased significantly over the course of the program. Overall, the women's knowledge almost doubled.
22	Kulig (1990)	(a) What is the Cambodian refugee women's cultural knowledge of conception and fetal development? (b) How does this cultural knowledge relate to birth control usage and antenatal care among Cambodian refugee women?	12 Cambodian refugee women who had begun childbearing in Southeast Asia and had the potential to continue childbearing in Canada. Participants were selected through author's contacts as a PHN Ethnographic interviews and participant observation.	Ethnographic approach. Appraisal grade: High (9)	The study showed that there are links between conception and birth control use, and fetal development and antenatal care. The women interviewed believed that conception occurs when the body is cool and named herbal medicine to heat the body, thereby preventing conception. The women also believed that conception is an uncontrollable and infrequent event, and that birth control taken on a regular basis would not be useful. Instead, they probably connected to a tubal ligation because of its effectiveness in controlling this event.

environment. This first third-order interpretation, as produced using ATLAS.ti, is depicted in Fig. 2 and described here in relation to the second-order interpretations as formed from the key concepts.

Cultural adaptation and social support were significant for the receipt of high quality maternity health care

Weak or inadequate professional and informal support was clearly noted by several studies. Women reported being separated from family and friends, having no access to child care or few links within their community, and facing considerable challenges in obtaining maternity services (Sutton et al., 2007; Teng et al., 2007; Ahmed et al., 2008; Reitmanova and Gustafson, 2008; Gagnon et al., 2010; Merry et al., 2011). Pregnant women or mothers reported difficulties receiving support from their husbands resulting from financial pressures making their husbands work multiple jobs or long hours. Women also expressed a need for more support from the health care system and professionals with respect to their emotional (mental) well-being and practical necessities (Brathwaite and Williams, 2004; Teng et al., 2007; Ahmed et al., 2008; Morrow et al., 2008; Reitmanova and Gustafson, 2008). Women described difficulties when wanting to seek help at maternity health care institutions because of a lack of available childcare (Dyck, 1993; Ahmed et al., 2008; Kulig et al., 2008; Morrow et al., 2008; Reitmanova and Gustafson, 2008; Janssen et al., 2009; Gagnon et al., 2010; Wiebe and Young, 2011). Support from nurses was thought most important for some women (Ahmed et al., 2008; Grewal et al., 2008; Morrow et al., 2008; Wiebe and Young, 2011), whereas others described physicians as most important during the antenatal period (Grewal et al., 2008). It was found that culturally accessible social support both from health care services and women's social networks, such as families and communities, is important to immigrant women in order for them to cope with the experiences encountered during the maternity period (Kulig, 1990; Dyck, 1993; Dhari et al., 1997; Hyman and Dussault, 2000; Groleau, 2005; Ahmed et al., 2008; Grewal et al., 2008; Kulig et al., 2008; Reitmanova and Gustafson, 2008; Ardal et al., 2011; Wiebe and Young, 2011).

With respect to breast feeding, Vietnamese immigrant women in Canada demonstrated low prevalence of breast feeding and their decision to bottle-feed was related to conflicts between Vietnamese cultural practices and the configuration of the new social space in Canada (Groleau et al., 2006). In the maternity period there were both challenges and facilitators in accessing timely health care and also an importance of the family and community in informing and supporting women (Groleau et al., 2006; Sutton et al., 2007). Lack of informal supports from family and/or friends, and barriers to formal supports, from for instance community groups, were factors that contributed to post partum depression in immigrant women because their own lack of knowledge about access and navigation to community services and limited language proficiency (Hyman and Dussault, 2000; Teng et al., 2007; Ahmed et al., 2008; Morrow et al., 2008; Reitmanova and Gustafson, 2008; Janssen et al., 2009).

Access to maternity health care is influenced by contextual and personal factors such as communication, socio-economic barriers and the organisational environment

Differences in expectations of verbal communication ability were identified between the studies. Health care providers expected that immigrant women articulate themselves in and be able to understand English (Ng and Newbold, 2011); however, immigrant women described difficulties with articulating health concerns and an inability to understand or make appointments for

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Table 4
Grid displaying key concepts within each study to help determine relationships between studies.

Number	Author(s) and publication year of study	Communication	Social (professional and informal) support	Organisational environment	Socio-economic barriers	Cultural (religious and traditional) beliefs and practices	Knowledge about maternity services and health care	Expectation of care between health care staff and women
1	Ardal et al. (2011)	X	X	X				
2	Merry et al. (2011)	X	X	X	X		X	X
3	Ng and Newbold (2011)	X	X		X	X		X
4	Wiebe and Young (2011)	X	X	X	X	X		
5	Gagnon et al. (2010)	X	X	X	X	X	X	
6	Janssen et al. (2009)	X	X	X	X	X	X	
7	Ahmed et al. (2008)	X	X		X	X	X	
8	Reitmanova and Gustafson (2008)	X	X	X	X	X	X	X
9	Grewal et al. (2008)	X	X	X	X	X	X	X
10	Kulig et al. (2008)		X			X	X	
11	Morrow et al. (2008)	X	X		X	X		X
12	Sutton et al. (2007)	X	X		x	X	x	
13	Teng et al. (2007)	X	X	X	X	X	X	X
14	Groleau et al. (2006)	X	X		X	X		
15	Groleau (2005) (FRENCH)		X			X	X	X
16	Spitzer (2004)	X	X	X				
17	Brathwaite and Williams (2004)		X			X	X	
18	Hyman and Dussault (2000)	X	X		X			
19	Dhari et al. (2000)	X	X		X	X		
20	Bodo and Gibson (1999)	X				X		
21	Dhari et al. (1997)	X	X	X		X		
22	Kulig (1990)	X				X	X	

Table 5
Synthesis including key concepts and second- and third-order interpretations.

Key concepts	Second-order interpretations	Third-order interpretations
(1) Social support: Lack of informal and professional networks for immigrant women; women were dependent on their husbands and health care staff	Cultural adaption and social support were significant in respect of receipt of high quality maternity health care	Quality of maternity health care for immigrant women depends on both interpersonal relationships (with professional health care staff) and informal (family/friends/community) social support, and contextual factors such as language proficiency, socio-economic barriers, and the organisational environment
(2) Communication: Language barriers are huge barriers to convey health concerns and to access needed care	Access to maternity health care is influenced by contextual and personal factors such as communication, socio-economic barriers and the organisational environment	
(3) Organisational environment: Highly technical, spatial and procedural environment restricts patients and their families involvement in care; the economy does not allow for time-consuming interactions		
(4) Socio-economic barriers: Transportation difficulties included that many women could not afford to access automobiles and/or find and pay for a baby sitter; financial pressures to take free time during maternity period		
(5) Cultural (religious and traditional) beliefs and practices: Choices made by women often related to cultural beliefs and meanings of health	Procedures and policies in conflict with cultural beliefs and wishes of the immigrant women	Immigrant women's cultural beliefs, religious and traditional customs and practices are in conflict with biomedical views in western maternity health care
(6) Knowledge about maternity services and health care: Women's experiences with services, illness and health were based on the health care system in their home country; received inadequate information about maternity service opportunities as needed to navigate through unfamiliar system		
(7) Expectations of the care between health care staff and women: Differences between how cultural practices are approached, type of health care provider and level of professionalism		

the care they needed (Groleau, 2005; Sutton et al., 2007; Teng et al., 2007; Ahmed et al., 2008; Grewal et al., 2008; Reitmanova and Gustafson, 2008; Gagnon et al., 2010; Merry et al., 2011; Ng and Newbold, 2011; Wiebe and Young, 2011). To overcome language barriers, interpreters are often used which was reported to cause its own problems such as different expectations between service user and health care staff about, for example, who is an appropriate interpreter in the consultation (Bodo and Gibson, 1999; Teng et al., 2007; Janssen et al., 2009; Ng and Newbold, 2011; Wiebe and Young, 2011) or who should be burdened with the task and costs (Ng and Newbold, 2011). Depending on the training and experience of the interpreter other questions are often raised around knowledge, professionalism and confidentiality. Thus, instead of improving the communication, communication could be inadvertently reduced and lead to frustration on both sides (Teng et al., 2007; Janssen et al., 2009; Ng and Newbold, 2011). Immigrant women also reported that even when they called for assistance and requested medication, nurses passed by without attending to their requests (Spitzer, 2004; Reitmanova and Gustafson, 2008). Some women expressed that it was not only important to share a common language with health care staff, but also to share a culture fostered on understanding of the cultural context (Bodo and Gibson, 1999; Sutton et al., 2007; Ardal et al., 2011).

Practical issues reflecting socio-economic barriers to accessing maternity health care included transportation difficulties due to financial problems, lack of employment, living in temporary accommodation without a phone or mailing address and distance between homes and appointment locations (Dyck, 1993; Hyman and Dussault, 2000; Groleau et al., 2006; Sutton et al., 2007; Teng et al., 2007; Ahmed et al., 2008; Grewal et al., 2008; Reitmanova and Gustafson, 2008; Janssen et al., 2009; Gagnon et al., 2010; Merry et al., 2011). Compounding access issues, socio-economic factors related to migration such as reduced ability to find good employment (for instance due to lack of recognition of credentials), the necessity in many cases for the husband to hold multiple jobs, and lack of stable housing have also been demonstrated to contribute to stress and inadequate spousal support, and in turn to mental illness (Morrow et al., 2008).

Related to the organisational environment, women described awareness of many advantages within the Canadian health care services, such as high maternity care standards, good access to technology (Dyck, 1993; Hyman and Dussault, 2000; Grewal et al., 2008) and the wide-range of health care services and staff (Ahmed et al., 2008; Gagnon et al., 2010). Conversely, several studies reported that the highly complex, technological spatial and procedural restriction within the health care system seemed to lead to alienation of participants with respect to their involvement in maternity health care (Teng et al., 2007; Grewal et al., 2008; Ardal et al., 2011; Wiebe and Young, 2011). Participants reported perceiving that referrals from health care staff were inadequate (Janssen et al., 2009; Gagnon et al., 2010) and as a result some of women preferred to make the referral themselves (Gagnon et al., 2010). Maternity health care providers highlighted the importance of routine assessment for family violence and the need to treat the entire family. Health care staff should be a conduit of information about social services and other opportunities (Janssen et al., 2009) and systems should be flexible enough to meet diverse needs of all women (Reitmanova and Gustafson, 2008).

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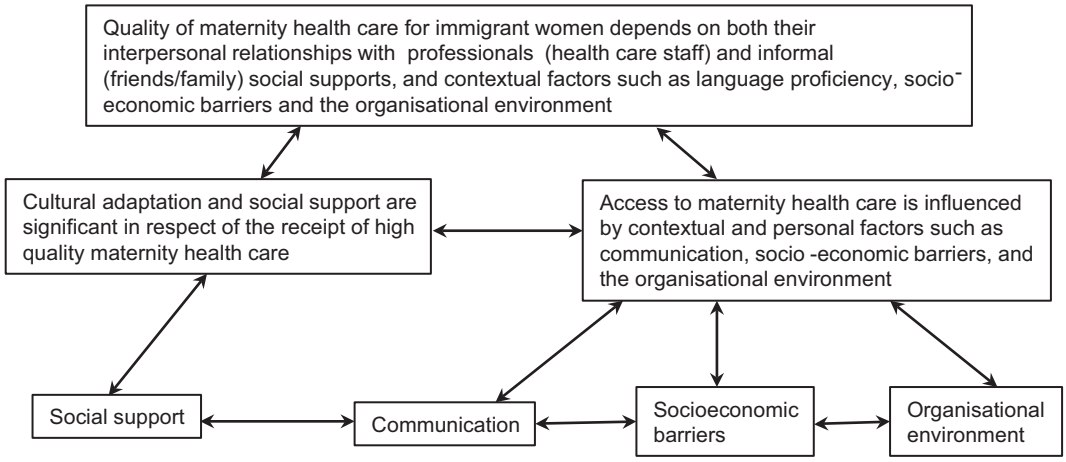

Fig. 2. First third-order interpretation.

Immigrant women's cultural beliefs, religious and traditional customs and practices are in conflict with biomedical views in western maternity health care

The findings of the papers consistently indicated that many immigrant women and health care staff had different views on how maternity health care should be provided. Although immigrant women expected that maternity health care should take into account their cultural needs, health care professionals put most emphasis on the biomedical needs. Our second third-order interpretation is depicted in Fig. 3 and described here in relation to the second-order interpretations as formed from key concepts.

Procedures and policies in conflict with cultural beliefs and wishes of the immigrant women

Immigrant women's lack of knowledge about maternity service opportunities, and their differing beliefs about health and illness, led to difficulties for them when trying to navigate unfamiliar systems to find and access services. Having inadequate English communication skills and/or practical (e.g. transportation) barriers may interfere with an immigrant woman's ability to take advantage of available information or programs (Groleau, 2005; Teng et al., 2007; Ahmed et al., 2008; Grewal et al., 2008; Morrow et al., 2008; Reitmanova and Gustafson, 2008; Gagnon et al., 2010; Merry et al., 2011; Ng and Newbold, 2011). It was also found that some women were not able to recognise their pregnancy (Kulig, 1990; Kulig et al., 2008) and, in one small study, routine maternity health care check-ups were viewed as a burden without benefit (Reitmanova and Gustafson, 2008). A woman's choice to feed her infant artificial milk instead of breast milk may also relate to her own cultural meanings of breast- and/or artificial milk feeding rather than biomedical evidence and western recommendations (Sutton et al., 2007).

Differences in expectations around care incorporating cultural beliefs and practices were evidenced (Ng and Newbold, 2011); although women expected health care staff to know and understand their cultural customs and practices, this expectation was not always satisfied (Reitmanova and Gustafson, 2008; Ng and Newbold, 2011). Immigrant women follow diverse ethnocultural traditional customs and practices during childbirth and these may not be congruent with western health care system philosophy. Traditionally, female family members are important providers of advice, information and support related to diet and lifestyle for pregnant women; many study participants reported that they were encouraged in this manner to be healthy and stress-free during their pregnancy and postpartum periods (Kulig, 1990; Dhari et al., 1997; Bodo and Gibson, 1999; Brathwaite and Williams, 2004; Spitzer, 2004; Groleau, 2005; Sutton et al., 2007; Grewal et al., 2008; Kulig et al., 2008; Morrow et al., 2008; Reitmanova and Gustafson, 2008). However, women reported that some of this advice was in conflict with that from health care staff and that they experienced challenges in their interface with the health care system (Kulig, 1990; Dhari et al., 1997; Bodo and Gibson, 1999; Brathwaite and Williams, 2004; Spitzer, 2004; Grewal et al., 2008; Kulig et al., 2008; Morrow et al., 2008; Reitmanova and Gustafson, 2008).

One good example of this conflict is that Vietnamese women struggled with their choice to breast or bottle feed, largely related to the constraints of their lives in Canada which hindered traditional postnatal rituals, dietary regimes and social support from older women. Multiparous women understood that breast milk was of better quality than commercial artificial milk but they felt that they could not produce fresh milk in their Canadian environment (Groleau et al., 2006). Primiparous women talked of considerable distress related to the absence of their mothers and childbirth support. None of the women breast fed exclusively and those who did breast feed (5 of 19; all multiparous) only did so for an average duration of 2.2 months. Furthermore, conflicts between women's cultural practices and the organisation of the maternity services were also shown in the case of post partum depression; in some cultures women were unwilling to seek help outside of their family for fear of being alienated or breaking family harmony (Teng et al., 2007; Ahmed et al., 2008; Morrow et al., 2008; Janssen et al., 2009).

Health care systems are based on a western model of health care that does not tend to accommodate the variability of cultural practices that are present in many immigrant populations. Some women participants were confused and dissatisfied with the care they received, particularly related to the role of technology in labour and childbirth and the role and attitude of nurses in the postpartum period (Kulig, 1990; Dhari et al., 1997; Bodo and Gibson, 1999; Brathwaite and Williams, 2004; Spitzer, 2004; Grewal et al., 2008; Kulig et al., 2008) as well as their difficulties with respect to cultural practices of having female providers (Bodo and Gibson, 1999; Reitmanova and Gustafson, 2008; Ng and Newbold, 2011). Thus, some participants modified some practices to enable functioning within a maternity health care context that they reported could not fully support their cultural traditions (Grewal et al., 2008). For example, Punjabi immigrant women in Grewal et al.'s (2008) study reported their use of a kiss or a drop of breast milk instead of using the traditional sugar water for their practice of gurtty, when a person respected by the family, usually an elder, touches the infant's lips with something sweet soon after birth so the infant would take after the person. It was noted that

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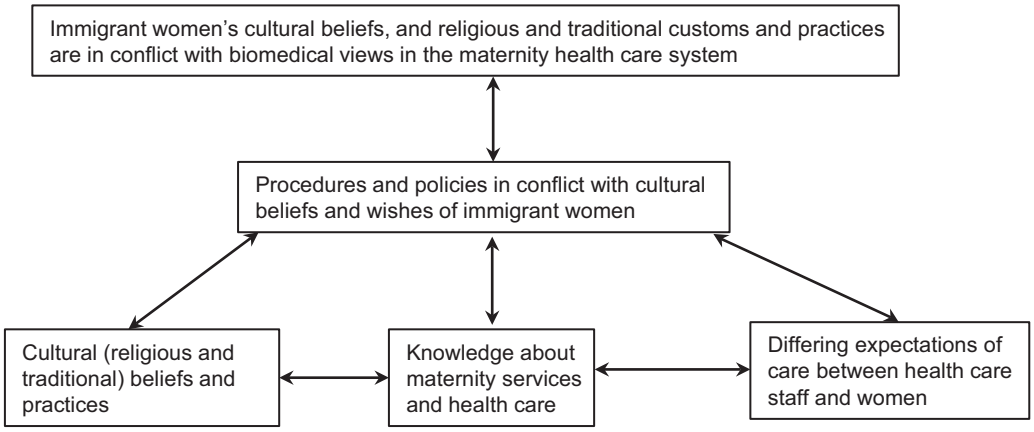

Fig. 3. Second third-order interpretation.

even when Canadian health care institutional practices were adapted to allow for rituals, some women expressed frustration when the health care staff reportedly denied them the opportunities (Spitzer, 2004; Reitmanova and Gustafson, 2008). The source of most conflict for immigrant women was that their health-related cultural and religious practices were mostly linked to non-biomedical sciences (Teng et al., 2007; Reitmanova and Gustafson, 2008; Gagnon et al., 2010; Merry et al., 2011).

Apart from the differences in expectations between immigrant women and providers around communication issues already discussed, expectations of care provision were also identified as barriers in maternity health care. It was found that some barriers in accessing maternity care were based on immigrant women's experiences with the health care system in their home country (Kulig, 1990; Bodo and Gibson, 1999; Groleau, 2005; Grewal et al., 2008; Ng and Newbold, 2011). Women immigrating from some countries perceive, through their past experience or knowledge, that midwives do not have formal training which prompts them to decline to have midwives oversee their maternity health care in Canada; many women insist on seeing medical doctors for which they know are highly educated (Teng et al., 2007; Reitmanova and Gustafson, 2008; Gagnon et al., 2010; Ng and Newbold, 2011). Through the perspective of some health care providers in one study (Ng and Newbold, 2011), immigrant women not only associate midwives with substandard care but also to having a lower socio-economic status. These participants also suggested that the level of care would not be compromised if standard care practices were changed to suit the cultural needs of their service users, although there were divergent views about whether the service user or provider should initiate the discussion of cultural practices (Ng and Newbold, 2011). Moreover, some of these health care staff had expectations that service users were able to navigate the system when several reports suggest otherwise (Ng and Newbold, 2011). Similarly, some Muslim immigrant women expected that health care staff were familiar with and respected their cultural and religious beliefs and practices (Reitmanova and Gustafson, 2008).

Discussion

This meta-ethnography indicates that quality of maternity care for immigrant women may be improved by increasing the availability of informal and formal social supports, provision of professional medical interpreters and information presented in appropriate languages and formats, reducing barriers related to socio-economic status (for example as relates to transportation), and an organisational environment which fosters culturally competent care. Furthermore, there seems to be a need to acknowledge differing expectations of immigrant families and health care providers in several areas of maternity care. Generally, cultural knowledge and beliefs, and religious and traditional customs highly influence experiences of immigrant women whereas health care staff place higher emphasis on their service users' biomedical needs.

Social support, verbal communication, socio-economic barriers and the health care organisational environment were interconnected, and if addressed together and appropriately would likely contribute to optimal quality and outcomes of maternity health care for immigrant women. This agrees with a study which surveyed mothers of premature infants in a neonatal intensive care unit who received trained support matched in language, ethnicity and culture (Preyde, 2007); these mothers felt more confident in their parenting, understood the medical condition of their infants, and experienced greater quality of their listening support than control mothers. From our study findings, the amount of social support within many migrant communities may depend on whether their members elect to maintain stronger or weaker ties with their birth culture, language and homeland. Many immigrants maintain transnational families which enable them to create and sustain relationships on numerous social levels between their home and host countries. Current technology is changing forms of communication and essentially minimises the impact of a large geographic distance between the home and host countries. This facilitates families to remain involved in many aspects of life including supports during the maternity period. Nevertheless, the community where these individuals reside is essential to maintaining links and ties to the home country and to the value of extended social networks both at home and in the host country; community in certain cultures plays the role in defining one's values, attitudes and behaviours which are not only defined by social networks in the home country but also by the collective shared and lived memories of those in the host countries (Dhar, 2011). Health care staff and institutions would benefit from becoming more attuned and accommodating to the supportive role of family and recognising that most families are dynamic and adaptable to their family member's needs and requirements (Leininger and McFarland, 2006).

The research synthesised in this meta-ethnography acknowledges the potential risks of communication barriers to the provision and reception of effective maternity health care. Furthermore, the use of untrained interpreters and of current services (i.e. telephone lines) to overcome language barriers is not optimal. A report to Health Canada concluded that the evidence on negative outcomes related to language barriers was sufficient to warrant the development and evaluation of standards of practice and models of delivery to improve language access to care (Bowen, 2001). This report highlights that interpretation practices in the primary health sector are hampered largely by limited resources.

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This increases reliance on family and friends to interpret, which can compromise the privacy and confidentiality of patients. Using professional interpreters was recommended, as they have good knowledge of medical terms and systems and can facilitate effective and productive communication. This phenomenon is not unique to Canada (Hadziabdic et al., 2009, 2010, 2011). Moreover, studies in the United Kingdom and Sweden have shown that effectiveness of interpretation services is influenced by ethnocultural factors (Hadziabdic et al., 2011). Legislation related to interpretation exists in some countries such as Sweden, but it is ambiguous or lacking in other countries including the UK and Canada. The demand for appropriate communication is illustrated by evidence that some hospital units located within a diverse neighbourhood in western Canada receive an average of 20 requests daily for language interpretation covering multiple languages (Higginbottom et al., 2010).

Existing research in Canada has also indicated that immigrants are particularly disadvantaged in health literacy such as ability to interpret use health information (Rootman and Gordon-El-Bihbety, 2008) due to lack of awareness of resources, language barriers, and limited social and institutional networks (Katz and Gagnon, 2002; Redwood-Campbell et al., 2008; Hayes et al., 2011; Higginbottom et al., 2011). In the postpartum period, immigrant women's information needs have been shown to be significantly higher than women born in Canada (Sword et al., 2006b). Of the papers in this review, Reitmanova and Gustafson (2008) found that for Muslim women health information was limited or lacked the cultural and religious specificity to meet their needs during the perinatal period. The participants in the study of Sutton et al. (2007) described being limited in their ability to understand media health education messages; these women preferred audio-visual to written materials. Merry et al. (2011) also discussed how recommended health literacy approaches for immigrants (e.g., plain language and pictograms) should be applied in teaching to enhance usability of health information and services by refugee claimant women. Finally, our results also indicate a need for health care providers to take a role in addressing issues specific to the access to information about Canadian patient's health care rights.

Migration can lead to benefits but also to harm, partly related to a lower socio-economic status which may hinder access of maternity services and contribute to development of post partum depression (Morrow et al., 2008). Our findings align with other research indicating that employment status, housing conditions, and the reactions of the host society are likely contributors to immigrant women's mental illness (Zelkowitz et al., 2004; Helman, 2007; O'Mahony and Donnelly, 2010). Immigrant women's sociocultural contexts, although not directly influenced by health care providers, should be acknowledged as a potential source of impact on maternity service access and outcomes.

This meta-ethnography indicated that maternity health care was an experience in which cultural beliefs, religious and traditional preferences were highly relevant for immigrant women but often overlooked in Canadian health care settings. Women's health care knowledge and beliefs were often placed within their social and the supernatural world, whereas those of health care systems in the western world are positioned within the natural and the individual world (Helman, 2007). Indeed, social and supernatural explanations are common in non-industrialised countries (Helman, 2007). For instance, within western health care systems relationships are generally viewed as dyads, characterised as clinician–client, clinician–nurse, or nurse–client, whereas the women participants in the reviewed papers described their relationships in terms of various social units including their parents, other relatives, and non-relatives within their community. Beliefs about pregnancy, as a normal life event rather than a treatable condition, have shown to be prominent for African-born as compared to Swedish-born women (Hjelm et al., 2005); this study's participants with gestational diabetes were dissimilar in their risk awareness which guided self-care and care seeking. Our findings also highlighted the importance of mothers' cultural health and diet beliefs and that traditional customs need to be considered to develop woman-centered care plans for immigrant parents.

Limitations and strengths

A potential limitation of this meta-ethnography synthesis could be our decision to not eliminate four papers which were rated as having poor quality. Although 19 papers were eliminated on the basis of lack of reporting primary qualitative research or to insufficient focus on our topic, the aforementioned papers met our criteria but were rated as poor due to inadequate reporting of methods. Alternatively, consideration can be given to the notion that poor reporting of methods does not always equate with poorly conducted research and thus papers that were intuitively good research may not have fared well in the quality assessment (Campbell et al., 2011). The reason to perform quality assessment was to ensure that findings were credible, that knowledge gained from the study could be transferable, the samples were appropriate and reflected inclusion criteria, data collection were suitable, findings were presented in a coherent and succinct way, and level of depth and understanding was portrayed through the interpretation of the findings (Hannes et al., 2010).

The strengths of this meta-ethnography synthesis were its use of interdisciplinary (including social science and clinical) team perspectives in developing the focus for the synthesis, interpreting the steps of the meta-ethnography, and translating and interpreting meaning in the results of the synthesis (Noblit and Hare, 1988). Further, the synthesis identified most relevant papers through comprehensive electronic searches of eight bibliographic databases, consultation with key authors, and manual searches. The congruence of concepts across individual papers were used to clarify second order interpretation of which two third-order interpretations (synthesis) were developed that can be used both by health care professionals and policy makers to reorganise treatment and care processes to improve health care access and outcomes for immigrant women (Noblit and Hare, 1988).

Conclusion

This meta-ethnography found that experiences in maternity health care for immigrant women are deeply embedded in the social position of the women. Social positioning influences the availability of social supports, communication possibilities with professional health care staff, and socio-economic status, all of which relate to the organisational environment. Furthermore, immigrants and health care staff have different beliefs and values which form their perceptions on how maternity health care should be provided. Cultural knowledge and beliefs, as well as religious and traditional customs, were most relevant for immigrants whereas health care staff emphasise biomedical needs. This study highlights the importance of considering social positioning, cultural health knowledge, and beliefs and customs when formulating woman-centered maternity care as well as policies to improve health care access for immigrant women in Canada.

Acknowledgements

This study was funded through an Emerging Team Grant provided by the Faculty of Medicine and Dentistry, University of Alberta, the Women and Children's Health Research Institute, and

Alberta Health Services, Edmonton, Canada. We are grateful to Thane Chambers, Librarian, Faculty of Nursing, University of Alberta, Canada, for her guidance with the search strategy. We also thank Jennifer Pillay, Research Project Coordinator, Faculty of Nursing, University of Alberta, Canada, who edited the manuscript. Dr. Gina Higginbottom is funded by a Canada Research Chair in Ethnicity and Health (http://www.chairs-chaires.gc.ca).

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Please cite this article as: Higginbottom, G.M.A., et al., Immigrant women's experience of maternity services in Canada: A meta-ethnography. Midwifery (2013), http://dx.doi.org/10.1016/j.midw.2013.06.004

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Please cite this article as: Higginbottom, G.M.A., et al., Immigrant women's experience of maternity services in Canada: A meta-ethnography. Midwifery (2013), http://dx.doi.org/10.1016/j.midw.2013.06.004