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REVIEW PAPER

A qualitative review of migrant women's perceptions of their needs and experiences related to pregnancy and childbirth

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Abstract

Aim. A synthesis of the evidence of migrant women's perceptions of their needs and experiences in relation to pregnancy and childbirth.

Background. Despite the fact that all European Union member states have ratified human rights-based resolutions aimed at non-discrimination, there is a relationship between social inequality and access to pre-, intra-, and postpartum care.

Design. A qualitative systematic review of studies from European countries.

Data sources. A search was made for relevant articles published between January 1996–June 2010.

Review methods. Data were analysed by means of thematic synthesis.

Results. Sixteen articles were selected, analysed, and synthesized. One overall theme; 'Preserving one's integrity in the new country' revealed two key aspects; 'Struggling to find meaning' and 'Caring relationships'. 'Struggling to find meaning' comprised four sub-themes; 'Communication and connection', 'Striving to cope and manage', 'Struggling to achieve a safe pregnancy and childbirth', and 'Maintaining bodily integrity'. 'Caring relationships' was based on the following three sub-themes: 'Sources of strength', 'Organizational barriers to maternity care', and 'The nature and quality of caring relationships'.

Conclusion. The results of this review demonstrate that migrant women are in a vulnerable situation when pregnant and giving birth and that their access to health services must be improved to better meet their needs. Research is required to develop continuity of care and improve integrated maternal care.

Keywords: barriers to healthcare services, caring relationship, communication, maternity care, migrant women, nursing, preserving integrity, qualitative studies, systematic review

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Introduction

All members of the European Union have ratified human rights treaties (United Nations 1948) aimed at non-discrimination, such as the Covenant on the Elimination of all forms of Discrimination Against Women (United Nations 1979), the International Convention on Economic, Social, and Cultural Rights (United Nations 1966), and the Convention on the Rights of the Child (United Nations 1989). In the light of these treaties, pregnancy, childbirth, and puerperium are acknowledged to be processes in women's lives that need to be protected by healthcare professionals and systems.

Despite the theoretical, human rights-based, governmental obligations to fulfil the demands of the above-mentioned treaties, there is a relationship between social inequality and access to pre-, intra-, and postpartum care in the EU (Healthcare Commission 2008, Raleigh *et al.* 2010). Many official reports as well as quantitative and qualitative studies have demonstrated that migrants belong to one of the disadvantaged population groups that experience barriers in accessing obstetric and/or midwifery-led care (Wolff *et al.* 2008). Prematurity and low birthweight are proven indicators of social inequality (Kelly *et al.* 2009, Chiavarini *et al.* 2012) and significantly associated with high morbidity and mortality rates (Smith *et al.* 2010, Tomé *et al.* 2009).

In several European countries, migrant women are currently responsible for over one-fifth of all live births (Sobotka 2008). Migration is motivated by several factors, such as economic improvement, family reunion, and the seeking of refugee status, and takes a range of forms including 'illegal', undocumented, forced, free and controlled. However, all these forms of migration are important factors in the erosion of traditional boundaries between languages, cultures, ethnic groups, and nation states (Castles 2000). The resulting increase in cultural and ethnic diversity in society adds specific challenges to the requirement of delivering public services such as health care to consumers, particularly maternity care, where migrant women seem to have the same wishes as native women, but are less likely to have them fulfilled (Small *et al.* 2002).

This review is part of an ongoing project, *Childbirth Cultures, Concerns and Consequences: Creating a Dynamic EU Framework for Optimal Maternity Care* funded by the European Union (2010, COST Action No. IS0907). The review was designed by the 'Impact on Migrant Women' workgroup to determine gaps in the body of research and for the purpose of generating a relevant conceptual framework for research. The 9 authors, who come from five European countries, are members of the workgroup and possess interdisciplinary competence (nursing, midwifery, anthropology, psychology, and history).

The review

Aim

The aim of the review was to explore migrant women's perceptions of their needs and experiences related to pregnancy and childbirth. The review questions addressed were: (1) What are migrant women's experiences of pregnancy and childbirth? and (2) What are migrant women's health needs and how can their access to maternity services be described?

Design

A qualitative systematic review methodology was used (Noyes & Popay 2007, Sandelowsky & Barusso 2007). The systematic review was carried out by means of a thematic synthesis (Ring *et al.* 2011). It identifies the recurring themes, analyses these themes and draws conclusions with the purpose of developing analytical themes through a descriptive synthesis and finding explanations relevant to particular review questions (Ring *et al.* 2011, pp. 19–20). In the review reported here, we were concerned with

answering questions related to migrant women's experiences of pregnancy, childbirth, health needs, and access to maternity services.

Search methods

An initial scoping search was made of the MEDLINE, EMBASE, CINAHL, and ISI Web of Knowledge electronic databases for articles published between January 1996–June 2010. The decision to commence the search in this period coincided with a systematic review and meta-regression analysis by the Reproductive Outcomes and Migration (ROAM) collaboration action (Urquia *et al.* 2010, Ring *et al.* 2011). The following key words were used in various combinations: 'migrant women', 'refugees', 'asylum seekers', 'birth', 'premature birth', 'birth weight', 'mother child relations/or maternity care', 'immigrant', 'female, childbirth', 'transients and migrants/women', 'infant', 'low birth weight' and 'cultural diversity culture', which produced 88 abstracts. The initial search was followed by reflection and a refocusing of the review questions and application of the inclusion and exclusion criteria. A new free-text search of the same databases was undertaken. This produced a total of 140 results. The total was reduced to 96 by excluding duplicates and applying the inclusion and exclusion criteria reducing to 44. The focus was narrowed to include only articles with European focus and a qualitative approach which left nine articles. The nine articles were compared with the initial scoping search and two were added. References and citations for these 11 were checked adding three more articles. Finally, several journals were manually searched. This produced another five ending in 19 that were evaluated for quality and 16 were selected for analysis. A second search was conducted applying the terms used in the previous search to the MESH headings in the same databases and extending the search to Psychinfo, Embase, and IBSS. No new articles were identified in this search.

Inclusion criteria were studies focusing on: (1) migrant women including refugees, asylum-seekers, illegal, and economic migrants; (2) the maternity care needs of migrant women; (3) migrant women's experiences of maternity care; (4) maternity care that promotes the health and well-being of migrant women; (5) migrant women's experiences of conception, pregnancy, delivery, prematurity, and low birthweight; (6) peer-reviewed articles published in English. The exclusion criteria were: official reports; review articles; book reviews; theoretical articles; conference proceedings; editorials; and dissertations as well as studies with limited scope and inadequate information that made it impossible to establish the quality of the research.

Search outcome

Of 19 articles evaluated for quality, 16 were selected for further analysis (Table 1). The team work procedure included arranging regular meetings for the development and evaluation of the review. The workgroup met in Greece in 2011 to select, perform a quality appraisal of, and discuss the articles selected for inclusion. This involved excluding duplicates and articles with quantitative methods, reading the articles in full and discussing which articles met the inclusion criteria. The authors communicated on an ongoing basis about the review by means of e-mail. Three of the authors met in Norway to validate the content of the review at descriptive level and conduct a quality assessment of the main elements corresponding to the systematic review criteria guided by the review questions (Popay *et al.* 2006).

Quality appraisal

The quality of most of the articles was good, although some weaknesses were found in sampling strategy as well as in the ethical and reflexive accounting. The reasons for exclusion were: (1) inadequate information to establish the quality of the research; (2) limited scope; and (3) official reports. Finally, the second and third authors performed manual searches in the following journals: *Birth*, *Journal of Advanced Nursing*, *Midwifery*, and *Social Science and Medicine*.

Walsh and Downe's (2006, p. 115) eight essential criteria and specific prompts were used for the analysis, including scope and purpose, methodology, relevance/transferability, and researchers' reflexivity. The sixteen studies selected for inclusion in the qualitative analysis were from a small number of European countries; five from Sweden, six from UK, two from Switzerland, and one each from Norway, Ireland, and Greece. Several of the studies were related to non-western migrant women (ethnic Africans), from countries where female genital mutilation at a young age is considered an important transition ritual. Furthermore, asylum-seeking and refugee women were represented in seven of the included studies. No study included illegal migrant women or women′s experiences of prematurity and low birthweight. Various qualitative approaches representing different philosophical schools and disciplines were applied. One study had a mixed approach, two included interviews with men and women from the host country as well as relatives and friends. Four studies included the perspective of healthcare professionals using qualitative data and focusing on migrant women. Moreover, the selected studies present

Table 1 Included studies.

Study	Sample	Methodology and data collection
1. McCourt and Pearce (2000), UK	20 Ethnic minority women including some refugees	Qualitative anthropological: tape-recorded semi-structured interviews
2. Wiklund *et al.* (2000), Sweden	9 Somali women aged 21–55 years and 7 men aged 27–57 years	Grounded theory: in most cases, tape-recorded interviews
3. Essén *et al.* (2000), Sweden	15 Somali women aged 20–55 years	Medical anthropological: tape-recorded interviews
4. Cheung (2002), Scotland	10 Chinese women, 10 Scottish women, and 45 health workers, relatives, or friends	Comparative qualitative method: in most cases, tape-recorded interviews
5. Kennedy and Murphy -Lawless (2003), Ireland	61 Women from 12 different countries	Fieldwork approach: extended interviews
6. Vangen *et al.* (2004), Norway	23 Somali women and 36 (18–55) healthcare professionals	Qualitative interpretative: tape-recorded repeated interviews or notes
7. McLeish (2005), UK	33 Women aged 16-40 years from 19 different countries	Qualitative: tape-recorded semi-structured interviews
8. Berggren *et al.* (2006), Sweden	22 Women; 6 Eritrean, 11 Somali, and 5 from Sudan, mean age 35	Qualitative: tape-recorded interviews
9. Bollini *et al.* (2007), Switzerland	40 Women; 14 Turkish, 17 Portuguese, 9 Swiss	Qualitative: tape-recorded interviews and field notes
10. Ny *et al.* (2007), Sweden	13 Migrant women from Middle Eastern countries	Triangulation: tape-recorded focus group discussions and individual interviews
11. Lundberg and Gerezgiher (2008), Sweden	19 Eritrean migrant women	Ethnographic approach: semi-structured tape-recorded interviews
12. Iliadi (2008), Greece	26 Refugee women from 11 different Asian, African, and East European countries	Focused ethnography: semi-structured tape-recorded interviews
13. Straus *et al.* (2009), UK	8 Somali women aged 23–57 years	Ethnographic approach: semi-structured interviews
14. Briscoe and Lavender (2009), UK	4 Asylum-seekers/refugees (Afghanistan, Congo, Rwanda, Somalia)	Longitudinal exploratory multiple case research: semi-structured tape-recorded interviews, field notes, and photographs
15. Kurth *et al.* (2010), Switzerland	80 Asylum-seekers (former Yugoslavia, Africa, Asia, Eastern Europe, others) and 10 care providers	Descriptive and grounded theory: textual information from files. Semi-structured taped interviews
16. Becky and White (2010), UK	11 Professionals (midwives, nurses, interpreters, health visitors, volunteers, and managers)	Not stated: semi-structured tape-recorded consultations

qualitative findings at different points of time of pregnancy and childbirth. Various ethnic groups with differing migration status were also included. The reader therefore needs to place the findings of this qualitative synthesis in the context of other studies with similar diverse perspectives (Reid *et al.* 2009).

Data abstraction

Extracted data from 16 articles were evaluated by the authors in terms of aim and design, type of data collected and by whom, methods used, rigour of data analysis, how the results were presented, and the inclusion of an extract outlining the findings. Furthermore, ethical considerations, study limitations, implications for practice, research, and education as well as researcher reflexivity were analysed to gain a sense of the research articles.

Thematic synthesis

The process of thematic synthesis involves three steps (Thomas *et al.* 2004, Ring *et al.* 2011). In the first step, the authors read the studies using free line-by-line coding. The second step was to organize the codes into descriptive themes. The authors agreed on a five-box classification system for sorting and analysing the content of the articles at descriptive level. The boxes represent types of emotional reaction, health problem and risk, challenge, need of and access to health services, and health resource. The result of this synthesis provided the descriptive level. The authors spent time discussing and comparing the different types of evidence, which resulted in a preliminary synthesis of the women's experiences and needs in relation to maternity services. The latent level was finally reached when the authors reflected on the content, abstracted it, and, after

discussion, agreed on the theoretical concepts arrived (Graneheim & Lundman 2004). Finally, the authors abstracted the findings to produce a new interpretation, which goes beyond the original studies. An example of data extraction at descriptive level is provided in Table 2 (Appendix S1).

Results

The following overall theme was identified based on the data extracted at descriptive level related to perceptions of childbirth (Table 3): 'Preserving one's integrity in the new country'. The findings also revealed two key aspects: 'Struggling to find meaning' and 'Caring relationships'. There were four sub-themes related to the overall theme: 'Communication and connection', 'Striving to cope and manage', 'Struggling to achieve a safe pregnancy and birth', and 'Maintaining bodily integrity'. 'Caring relationships' was based on the following three sub-themes: 'Sources of strength', 'Organizational barriers to maternity care' and 'The nature and quality of caring relationships'.

Struggling to find meaning

Unsuccessful 'communication with' and 'lack of connection' to healthcare professionals and society were described in most of the studies (Essén *et al.* 2000, McCourt & Pearce 2000, Wiklund *et al.* 2000, Kennedy & Murphy-Lawless 2003, Vangen *et al.* 2004, McLeish 2005, Berggren *et al.* 2006, Bollini *et al.* 2007, Iliadi 2008, Lundberg & Gerezgiher 2008, Straus *et al.* 2009, Becky & White 2010, Kurth *et al.* 2010). Some studies highlighted poor communication, as it was evident that migrant women did not receive the information they needed, leading to nutritional problems and inadequate access to maternity services for regular check-ups during pregnancy (Wiklund *et al.* 2000, Berggren *et al.* 2006, Lundberg & Gerezgiher 2008). The risk of misunderstanding and feelings of being stigmatized increased when communication problems occurred (McCourt & Pearce 2000, Wiklund *et al.* 2000, Vangen *et al.* 2004, McLeish 2005, Berggren *et al.* 2006, Bollini *et al.* 2007, Iliadi 2008, Lundberg & Gerezgiher 2008). Feeling ashamed about being different made adaptation to the new cultural context both confusing and difficult (Wiklund *et al.* 2000, Kennedy & Murphy-Lawless 2003, Berggren *et al.* 2006). The women's beliefs were shattered and they often missed their female network (McCourt & Pearce 2000, Cheung 2002, Kennedy & Murphy-Lawless 2003, Berggren *et al.* 2006, Iliadi 2008, Lundberg & Gerezgiher 2008). The need for good communication and being able to connect to the maternity professionals was evident. It is, therefore, serious when studies report that migrant women lack confidence to discuss their concerns and are afraid to ask midwives questions (McLeish 2005, Berggren *et al.* 2006). In addition, they experience dissatisfaction and lack of care (McCourt & Pearce 2000). 'Striving to cope and manage' their new situation as migrant pregnant women was clearly evident in the articles. The women viewed childbirth as a transition and a critical milestone towards a better social status. This was the case when they lived under poor socioeconomic conditions and had worries and concerns about the future as well as experiences of discrimination, racism, and hostility (McCourt & Pearce 2000, Wiklund *et al.* 2000, Cheung 2002, Kennedy & Murphy-Lawless 2003, McLeish 2005, Berggren *et al.* 2006, Bollini *et al.* 2007, Briscoe & Lavender 2009, Kurth *et al.* 2010). Social and psychological problems such as stress, low self-esteem, and insecurity about their personal identities were common (Straus *et al.* 2009, Becky & White 2010, Kurth *et al.* 2010). It was also evident that the women had physical and mental health problems such as depression, feelings of loneliness, isolation, and longing for family members (Essén *et al.* 2000, McCourt & Pearce 2000, Wiklund *et al.* 2000, Cheung 2002, Kennedy & Murphy-Lawless 2003, McLeish 2005, Berggren *et al.* 2006, Bollini *et al.* 2007, Ny *et al.* 2007, Iliadi 2008, Lundberg & Gerezgiher 2008, Briscoe & Lavender 2009, Straus *et al.* 2009, Kurth *et al.* 2010). Other feelings reported were great sadness, vulnerability, and anxiety together with severe nausea (Essén *et al.* 2000, Kennedy & Murphy-Lawless 2003, Vangen *et al.* 2004, McLeish 2005, Berggren *et al.* 2006, Iliadi 2008, Briscoe & Lavender 2009, Straus *et al.* 2009). The migrant women 'struggled to achieve a safe pregnancy and birth'. The dominant western medical philosophy and terminology were often alien, making it difficult for them to understand certain aspects of care (Wiklund *et al.* 2000, Bollini *et al.* 2007, Ny *et al.* 2007, Straus *et al.* 2009, Kurth *et al.* 2010). Some were more accustomed to trusting their religion rather than technology when it came to giving birth (Wiklund *et al.* 2000, Bollini *et al.* 2007, Ny *et al.* 2007, Lundberg & Gerezgiher 2008, Briscoe & Lavender 2009, Becky & White 2010). Others employed nutritional strategies to reduce food intake, thereby reducing the risk of ruptures and caesarean section (Essén *et al.* 2000, Lundberg & Gerezgiher 2008). Studies reported that fear of childbirth and distress caused pathological foetal heart rate (Vangen *et al.* 2004, Berggren *et al.* 2006). In addition, other studies described the impact of female genital mutilation/circumcision as extreme pain and long-term complications (Essén *et al.* 2000, McCourt & Pearce 2000,

Table 2 Example of data extraction.

Types of emotional reaction	Types of health problem and risk	Types of challenge	Types of need and access to health services	Types of health resource
Strong feelings of loneliness, isolation and longing for female network, family, and relatives (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15) Dissatisfaction due to dependency on social benefits (10) Feelings of lack of emotional support and fear/insecurity due to insufficient knowledge of Female Genital Mutilation on the part of healthcare professionals (1, 3, 6, 8, 11) A sense of not being taken seriously (6) A feeling of insecurity during delivery (8) A feeling of powerlessness, hopelessness and lack of control (1, 7, 8, 12, 14)	Risk of being stigmatized because of circumcision, including poor communication with healthcare professionals (1, 2, 6, 7, 8, 9, 11, 12) Poor awareness of the need for regular check-ups during pregnancy (2, 3, 9, 12) Severe nausea (3) Nutritional strategy of routinely reducing food intake to make the labour easier, decreasing the risk of ruptures and caesarean section (3, 11)	Immense loss of status, independence and self-respect both socially and economically (2, 5, 7, 16) Adaptation confusing and difficult (2) Trying to adapt to a new cultural context, missing the female network and (5, 8) Striving to protect their daughters (5, 8, 11) Breaking traditional norms – an inherent vulnerability factor (2, 4, 10) Patriarchal/paternalistic ideology (2, 4, 8, 14)	Experiences of disrespectful and hostile attitudes from professionals when accessing maternity services thus did not attend (7, 8) Tardy, inadequate, and time constrained antenatal care (9, 14) Unhelpful, frightening or threatening advice that did not take the women's reality into account (7) Difficulties in accessing and travelling to maternity services, including cost and childcare (5, 7) Arriving late for antenatal care, missing appointments (5, 7, 8, 12, 16)	Viewed the receiving country as safe and peaceful (2, 8, 11) Positive attitudes towards antenatal care (2, 3, 5, 6, 7, 8, 9, 10, 11) Familiar with the healthcare system (2, 12) Strong trust in God and prayer (2, 3, 10) Men become primary support as a coping strategy (2, 3, 7, 10, 11, 12) Support from family network, relatives, and friends (4, 9, 11, 12)

1. McCourt and Pearce (2000); 2. Wiklund *et al.* (2000); 3. Essén *et al.* (2000); 4. Cheung (2002); 5. Kennedy and Murphy-Lawless (2003); 6. Vangen *et al.* (2004); 7. McLeish (2005); 8. Berggren *et al.* (2006); 9. Bollini *et al.* (2007); 10. Ny *et al.* (2007); 11. Lundberg and Gerezgiher (2008); 12. Iliadi (2008); 13. Straus *et al.* (2009); 14. Briscoe and Lavender (2009); 15. Kurth *et al.* (2010); 16. Becky and White (2010).

Table 3 Overview of abstracted themes and sub-themes of migrant women's experiences of health needs and access to maternity services.

Overall theme: *Preserving one's integrity in the new country*		
Key aspects	Struggling to find meaning	Caring relationships
Sub-themes	Communicate and connection	Sources of strength
	Striving to cope and manage	Organizational barriers to maternity care
	Struggling to achieve a safe pregnancy and birth	The nature and quality of caring relationships
	Maintaining bodily integrity	

Vangen *et al.* 2004, McLeish 2005, Berggren *et al.* 2006, Lundberg & Gerezgiher 2008, Briscoe & Lavender 2009, Straus *et al.* 2009). Poor health including infected wounds, HIV, and hepatitis, which caused complications for the women and the new born babies was also reported (Kennedy & Murphy-Lawless 2003, McLeish 2005, Berggren *et al.* 2006, Lundberg & Gerezgiher 2008). Struggling 'to maintain bodily integrity' meant that several women experienced feelings of insecurity and not being taken seriously during childbirth (Vangen *et al.* 2004, Berggren *et al.* 2006). Other feelings reported were powerlessness, hopelessness, and loss of bodily integrity when pregnant and giving birth in the new country, which sometimes involved breaking their traditional norms (Essén *et al.* 2000, Wiklund *et al.* 2000, Cheung 2002, McLeish 2005, Berggren *et al.* 2006, Ny *et al.* 2007, Iliadi 2008, Briscoe & Lavender 2009). For example, being exposed by healthcare professionals, feeling shy, embarrassed, or ashamed during the birth when the husband was present ((Wiklund *et al.* 2000, Cheung 2002, McLeish 2005, Berggren *et al.* 2006) made it difficult for them to preserve their bodily integrity.

Caring relationships

The need for caring relationships was linked to the women's 'sources of strength' and had a positive influence on their psychological well-being and physical health, which also influenced their relationship with the foetus and the baby

(Bollini *et al.* 2007, Ny *et al.* 2007, Iliadi 2008). Feelings of well-being were influenced by their trust in God (Essén *et al.* 2000, Wiklund *et al.* 2000, Ny *et al.* 2007) and a sense of being safe by viewing the new country as peaceful (Wiklund *et al.* 2000, Berggren *et al.* 2006, Lundberg & Gerezgiher 2008). The changed situation affected them positively, the baby representing a new beginning and a health resource (McLeish 2005). Feelings of satisfaction, maturity, and completeness due to giving birth also strengthened their emotional ties to the baby (Cheung 2002). Migrant women who were familiar with the 'organizational barriers to maternity care' had positive attitudes towards antenatal care, believing that 'foetal education' and postnatal care were more likely to be satisfactory (Wiklund *et al.* 2000, Cheung 2002, McLeish 2005, Berggren *et al.* 2006, Bollini *et al.* 2007, Iliadi 2008, Lundberg & Gerezgiher 2008). This was even more obvious when pregnancy was seen as a normal and healthy state (Essén *et al.* 2000, Wiklund *et al.* 2000, Cheung 2002, Iliadi 2008). If the woman was able to exhibit resilience, adjust, and change her cultural beliefs, the outcome was even better (Wiklund *et al.* 2000, Cheung 2002, Kennedy & Murphy-Lawless 2003, Bollini *et al.* 2007). Several women reported that they missed their family during pregnancy and early motherhood. Support from the healthcare professionals and primary support network such as the husband was therefore important (Essén *et al.* 2000, Wiklund *et al.* 2000, Cheung 2002, McLeish 2005, Bollini *et al.* 2007, Ny *et al.* 2007, Iliadi 2008, Lundberg & Gerezgiher 2008). If the women were unfamiliar with the healthcare system, they tended to avoid using the services. This could also happen if they experienced disrespectful and hostile attitudes on the part of professionals (McLeish 2005, Berggren *et al.* 2006). Several studies contained evidence suggesting that maternity care services in Europe can be patriarchal (Wiklund *et al.* 2000, Cheung 2002, Berggren *et al.* 2006, Briscoe & Lavender 2009). The advice provided was experienced as unhelpful, frightening, and/or failing to take account of the reality of the women (McLeish 2005). In cases where the women had been subjected to genital mutilation, they expected the healthcare professionals to discuss the circumcision before delivery, but found a lack of knowledge on the subject (McLeish 2005). They experienced that healthcare professionals lacked care routines, awareness, and skills related to their worries, fear, and anxiety (Essén *et al.* 2000, Wiklund *et al.* 2000, Vangen *et al.* 2004, Berggren *et al.* 2006, Bollini *et al.* 2007, Lundberg & Gerezgiher 2008, Straus *et al.* 2009). Refugee and asylum-seeking women were less willing to state their needs and wishes (Kennedy & Murphy-Lawless 2003, Becky & White 2010) and some were also disappointed and unprepared for the lack of practical help and support in postnatal care (McCourt & Pearce 2000, Vangen *et al.* 2004). Maternity services are not adapted to migrant women (Bollini *et al.* 2007, Briscoe & Lavender 2009) who often register late for antenatal care and are unable to attend an appropriate number of appointments (Kennedy & Murphy-Lawless 2003, McLeish 2005, Berggren *et al.* 2006, Iliadi 2008, Becky & White 2010). Their economic and social conditions are the main reasons why they struggle to maintain continuity of care (Bollini *et al.* 2007, Iliadi 2008, Straus *et al.* 2009, Kurth *et al.* 2010). There are also practical reasons such as the need for childcare, travel difficulties and the fact that some forms of accommodation for refugees and asylum-seekers are restricted by fixed mealtimes (Kennedy & Murphy-Lawless 2003, McLeish 2005). Access to care is also impeded due to cultural and language barriers, and there is a need for a better interpretation service (McCourt & Pearce 2000, Wiklund *et al.* 2000, Kennedy & Murphy-Lawless 2003, McLeish 2005, Berggren *et al.* 2006, Bollini *et al.* 2007, Iliadi 2008, Briscoe & Lavender 2009, Straus *et al.* 2009, Kurth *et al.* 2010). Migrant women prefer physicians who speak their language (Iliadi 2008). Instead of interpreters, they prefer relatives, children, and friends to help them (Wiklund *et al.* 2000, Ny *et al.* 2007, Straus *et al.* 2009).

Migrant women need a 'caring relationship' and support from maternity care services. 'The nature and quality of a caring relationship' is important to them. For example, they want to see professionals without having to make an appointment (Becky & White 2010). They value counselling and want access to a trustworthy midwife and physician whose competence includes cultural knowledge and insights into immigration (Ny *et al.* 2007, Lundberg & Gerezgiher 2008, Becky & White 2010). Female healthcare providers make them feel confident (Iliadi 2008). Migrant women expressed their need for sensitive psychosocial and physical care and support. They wanted better socioeconomic follow-up and help with practical needs (McCourt & Pearce 2000, Cheung 2002, Kennedy & Murphy-Lawless 2003, McLeish 2005, Berggren *et al.* 2006, Bollini *et al.* 2007, Iliadi 2008, Straus *et al.* 2009, Becky & White 2010, Kurth *et al.* 2010). The quality of information (Wiklund *et al.* 2000, Kennedy & Murphy-Lawless 2003, Vangen *et al.* 2004, Berggren *et al.* 2006, Iliadi 2008, Lundberg & Gerezgiher 2008, Straus *et al.* 2009) as well as knowledge and communication skills made them feel confident and in control (McCourt & Pearce 2000, Vangen *et al.* 2004, Berggren *et al.* 2006, Lundberg & Gerezgiher 2008). They wished for continuity of care and individualized information provided by empathetic, respectful, inter-

ested, and kind professionals (McCourt & Pearce 2000, Wiklund *et al.* 2000, Kennedy & Murphy-Lawless 2003, McLeish 2005, Bollini *et al.* 2007, Ny *et al.* 2007, Iliadi 2008, Straus *et al.* 2009).

Discussion

This review reported a synthesis of the research on migrant women's needs, experiences, and access to maternity care services in relation to pregnancy and childbirth. One overall theme 'Preserving integrity in the new country' emerged. The findings are in accordance with a study by Widäng *et al.* (2007) of how female patients perceived integrity in health care. The authors explored how the women perceived that integrity was preserved, threatened, or violated by care. The results indicated that it was necessary to have control over the private sphere to maintain the self. They also wanted to protect their identities by being seen as the people they really were. Furthermore, being respected and not exposed preserved their dignity. The evidence of this review accords with a study by Irurita and William (2001) focusing on the reciprocal process used by nurses and patients to preserve their own and each other's integrity, which involved contributing to co-operation, prioritizing, and sacrificing that is rational, while justifying comprised care and lower expectations; and protecting the self by attracting or repelling.

According to the evidence in the articles, it is acknowledged that the migrant women's situation in a new country is related to lack of 'communication and connection' to others (Lyberg *et al.* 2012). Their situation can be explained by the diversity in experiences of security, knowledge, and personal values. This finding refers to Australian studies, where providing interpretation services, social support for migrant women, and improving the cross-cultural training of healthcare providers were suggested to enhance maternity care services, particularly for Asian migrant women (Chu 2005). Thus, lack of flexibility and inability to meet the needs of a culturally diverse group (Reitmanova & Gustafson 2008, Hoang *et al.* 2009) may result in conflict between migrants and healthcare providers. There was evidence of the 'need for information and social support to achieve a safe pregnancy and birth'. Liamputtong and Watson (2006) specifically examined the experience of caesarean birth among 67 Cambodian, Lao, and Vietnamese women in Australia, and demonstrated that the women's social construction of their feelings stemmed from trust in medical knowledge, expectations, and 'communication' as well as an understanding of their caregivers' preferences. The provision of culturally appropriate social support is critical in the care of migrant childbearing women. There is evidence of sub-standard postpartum care for migrant women (Katz & Gagnon 2002). As they frequently do not follow-up referrals, they could be at increased health risk. Inhibitors that prevent migrant women from following up care referrals included language 'barriers', absence of husband, lack of childcare, perceived inappropriate referrals, and cultural differences (Gagnon *et al.* 2010). Facilitators comprised appropriate services, empathetic professionals, and early receipt of information, a need highlighted in this study in addition to continuity of care (Gagnon *et al.* 2010). The theme of 'Caring relationships' is related to the need to experience emotional comfort and linked to the women's sources of strength (Akerjordet & Severinsson 2010). However, individual, sensitive care appears to be insufficient. Maternity care services must be adapted to migrant women's expectations of support and cultural differences (Jentsch *et al.* 2007). The evidence clearly demonstrates that migrant women are exposed to a high degree of stress and vulnerability caused by their expectations, circumstances, and need for adaptability (Earvolino-Ramirez 2007, Norris *et al.* 2009). In view of the knowledge that prematurity and low birthweight are proven indicators of social inequality and stress (Harding *et al.* 2006, Kelly *et al.* 2009, Chiavarini *et al.* 2012) and significantly associated with high morbidity and mortality rates (Bollini *et al.* 2009), this evidence should be of major concern to midwives and healthcare professionals.

It is important to base health promotion on core values such as equity, empowerment, and engagement to lead to a view of the migrant women as active partners (Lindström & Eriksson 2006). Health promotion is a process that enables individuals and communities to achieve control, thereby improving health and allowing people to live an active and productive life (WHO 1986). How migrant women perceive social structures has a central impact on health (Eriksson & Lindström 2008). This means that women with a strong sense of coherence regard their environment and the events in their lives as comprehensible, manageable, and meaningful (Antonovsky 1996). Thus, migrant women's psychosocial resources, such as hope, emotional intelligence, and resilience are of major importance for understanding the longitudinal trajectories of responses to stress and mental ill health (Snyder & Lopez 2007, Akerjordet & Severinsson 2009). Evidence reveals that if migrant women are able to exhibit resilience, adjust, and change their cultural beliefs, the outcomes may be better. This implies that being a migrant is not a consistent indicator of poor perinatal health (Gagnon *et al.* 2010). Individuals often adapt far better than suggested by objec-

What is already known about this topic

- Migrant women belong to a vulnerable social group where health risks such as low birthweight and preterm birth are high.
- Migrant women experienced deficiencies in healthcare provision due to inequalities in relation to their health problems, language barriers, and difficulties accessing health services.

What this paper adds

- Migrant women need to preserve their integrity in the new country.
- Migrant women need caring relationships to help them access maternity care.
- Migrant women struggle to find meaning in their new country to be able to cope, communicate, connect, and achieve a safe pregnancy and childbirth.

Implications for practice and/or policy

- Healthcare professionals must develop routines that ensure continuity of care for migrant pregnant women to reduce the barriers they experience in maternity care.
- Monitoring and improving the health of migrant women are essential for the provision of appropriate healthcare services.
- Implementation of strategies to preserve the integrity of migrant women is of the utmost importance.

tive circumstances, 'bouncing back', despite substantial adversity (Earvolino-Ramirez 2007, Norris *et al.* 2009).

The resulting growing cultural and ethnic diversity in societies adds specific challenges to the requirement of delivering maternity services (Martin & Martin 2006). The challenges of achieving equity in maternity care for migrant women appear to be related to managing and supporting educational, relational, and cultural diversity to ensure the provision of appropriate care (Lyberg *et al.* 2012). Health professionals such as nurses and midwives are responsible for this, as they are in a position to strengthen the migrant women's resources, address health inequality, work in partnership, and develop wider alliances and support networks (Kaufmann 2002). Participation and partnership, which empower migrant women and communities, are therefore valuable processes and outcomes of health promotion (Akerjordet 2009). However, they cannot be achieved in the presence of organizational barriers and inadequate integration policy (Bollini *et al.* 2009). The cost of health care could be a major barrier, particularly in countries like Switzerland where each individual has to arrange and pay for her/his own health insurance (Wolff *et al.* 2008). Therefore, improved access to health care for migrants requires creative financial solutions, i.e. it should be free or only a minimal charge levied and the language competencies of healthcare providers and administrative staff also need attention (Wolff *et al.* 2008). Care-related problems could be partly prevented by improving the efficacy of care during pregnancy and childbirth (Malin & Gissler 2009). Because there are significant differences in the clinical outcomes of birth and in the care provided to and used by ethnic minority migrant women during pregnancy and childbirth, maternity care practices should be carefully re-examined to establish whether they systematically vary according to the mother's ethnicity and other non-clinical factors.

Limitations

There are some methodological limitations that need to be acknowledged when considering the research findings. The first is the selection of qualitative studies conducted in European countries. The second is how the systematic review was carried out. The authors demonstrated transparency by describing the background of some of their judgements on which some of their decisions were based. The different disciplines and professional competencies in the multi-cultural research group were a strength but also a limitation due to range of interpretations. To strengthen the quality, the research group discussed and agreed on the final composite analysis and synthesis as well as achieving consensus on the main theoretical concepts developed in Table 3. Nevertheless, it is important to acknowledge that this review represents the researchers' reading of the studies in question; other authors with divergent interests may arrive at a different conclusion (Reid *et al.* 2009). The third limitation is the focus on the individual level in terms of the migrant women's experiences of, need for, and access to health care. Longitudinal studies on the impact of maternity care and its long-term consequences for health outcomes and healthcare delivery are needed.

Conclusion

In conclusion, migrant women's vulnerable situation when pregnant and giving birth must be improved. This can be achieved by strengthening continuity of care and providing a caring relationship to help them find meaning in the new

country. More research about migrant women's needs and experiences is clearly necessary. Such research will strengthen collaboration, making it possible to accumulate knowledge of reproductive health as well as problems related to pre- and postnatal care in addition to migration in a European and an international context. This would deepen understanding of the migrant family, especially the women's health and family situation.

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Conflict of interest

No conflict of interest has been declared by the authors.

Author contributions

All authors have agreed on the final version and meet at least one of the following criteria [recommended by the ICMJE (http://www.icmje.org/ethical_1author.html)]:

- substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data;
- draughting the article or revising it critically for important intellectual content.

Supporting Information Online

Additional Supporting Information may be found in the online version of this article:

Appendix S1. Data extraction at the descriptive level.

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