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

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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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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.