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Recency of migration, region of origin and women's experience of maternity care in England: Evidence from a large cross-sectional survey

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ABSTRACT

Background: In the UK, changes to legislation in 2003 regarding the free movement of people in the European Union resulted in an increase in immigration from countries that joined the EU since 2004, the Accession countries.
Objective: To describe and compare the maternity experiences of recent migrant mothers to those who had been resident in the UK for longer, and to UK-born women, while taking into account their region of origin.
Design: Cross-sectional national survey.
Setting: England, 2009.
Participants: Random sample of postpartum women.
Measurements: Questionnaires asked about demographic characteristics, care during pregnancy, labour, birth and postnatally, about country of origin and, if not born in the UK, when they came to the UK. Country of origin was grouped into UK, Accession countries, and rest of the world. Recency of migration was grouped into recent arrivals (0–3 years), and earlier arrivals (4 or more years since arrival). Descriptive statistics and binary logistic regression were used to explore women's experiences of care. Stratified analyses were used to account for the strong correlation between recency of migration and region of origin.
Findings: Overall, 5332 women responded to the survey (a usable response rate of 54%). Seventy-nine percent of women were UK-born. Of the 21% born outside the UK, a third were born in Accession countries. All migrants reported a poorer experience of care than UK-born women. In particular, recent migrants from the Accession countries were significantly less likely to feel that they were spoken to so they could understand and treated with kindness and respect.
Conclusions: Given the rising population of non-UK-born women of childbearing age resident in the UK and the relatively high proportion from Accession countries, it is important that staff are able to communicate effectively, through interpreters if necessary.
Implications for practice: The differences in clinical practice between women's home countries and the UK should be discussed so that women's expectations of care are informed about the options available to them.

Introduction

In the UK, changes to legislation in 2003 regarding the free movement of people in the European Union resulted in an increase in immigration from the A8 countries (Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia), and

Abbreviations: UK, United Kingdom; EU, European Union; EEA, European Economic Area; MW, midwife; AN, antenatal; PN, postnatal; BME, Black and ethnic minority.

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the A2 countries (Romania and Bulgaria), which joined the European Union in 2004 and 2007 respectively (Tromans, Natamba, & Jefferie, 2009). We refer to these countries collectively as the Accession countries. In 2015, 27.5% of live births in England and Wales were to women born outside the UK (Office for National Statistics, 2016) and about a quarter (6.1% overall) of these women were born in the Accession countries. The greatest number came from Poland (Office for National Statistics, 2014), and in large cities such as London and Birmingham these proportions are far higher (Cross-Sudworth, Williams, & Herron-Marx, 2011). Two thirds of the increase in fertility in the UK between 2001 and 2007 can be attributed to births to women born outside the UK (Tromans et al., 2009) although this was principally driven by women from South Asia (Waller, Berrington, & Raymer, 2012).

While the maternity care experiences of Black and Minority Ethic (BME) women and migrants from non-European countries have been well-documented (Cross-Sudworth et al., 2011; Hayes, 1995; Henderson, Gao, & Redshaw, 2013; Jomeen and Redshaw, 2013; Raleigh, Hussey, Seccombe, & Hallt, 2010), the experience of European women born outside the UK has been relatively unexplored in this context. Local evidence suggests that women from Central and Eastern Europe may experience prejudice and poorer care than women born in the UK or North and Western Europe. Studies in Kent, Norfolk and Warrington indicate that midwives and health visitors are under-utilised by these women, that they have difficulty understanding the process and organisation of maternity care, that they don't feel listened to and they feel that their care is not sufficiently comprehensive (Eida, Not stated; Madden, Harris, Harrison, & Timpson, 2014; Revill, 2016).

There is relatively little research on the effects of recency of migration on women's experience of maternity care. A systematic review of migration to western industrialised countries and perinatal health conducted in 2008 (Gagnon et al., 2009) found that migrants' outcomes in terms of preterm birth, birthweight and health-promoting behaviour were as good as those for non-migrant women, but the authors noted that duration of residence was rarely studied. A Canadian study examined the maternity experiences of recent (five years or fewer) and less recent migrants, compared to Canadian-born women (Kingston et al., 2011). They found no statistically significant differences in perceived compassion, competence, respect or privacy shown by healthcare professionals, but more migrant women (both recent and non-recent) reported finding it difficult to see a provider for their own and their infant's care and expressed slightly less satisfaction with postpartum care. More recently, a review of factors leading to high rates of potentially preventable emergency caesarean section among migrant women in high income countries included length of time in the receiving country as one of several predictive factors (Merry et al., 2016). The review indicated that for some migrants the risk of emergency caesarean section increased with duration of residence as women adopted a less healthy lifestyle, but for others there was no effect. However, factors important for one health outcome may not apply to another (Jayaweera & Quigley, 2010).

In contrast to women born in Africa and the Indian subcontinent who tend to have higher rates of maternal and infant morbidity and mortality (Hollowell, Kurinczuk, Brocklehurst, & Gray, 2011; Knight, Kurinczuk, Spark, & Brocklehurst, 2009), women coming to the UK from European countries, including Accession countries, tend to have lower rates of poor outcome than UK-born women, and are more likely to have a normal birth (Gorman et al., 2014; Walsh et al., 2011). This has been partly ascribed to the 'healthy migrant effect' in which healthy women are more able and willing to migrate (Pendleton, 2015; Walsh et al., 2011). This may apply more to women from Europe and other high income countries for a variety of reasons including health care in the country of origin and socioeconomic differences. However, all migrant women may face difficulties in terms of unfamiliarity with the language and/or the British health service (Osipovič, 2013). In Poland, women with a normal pregnancy tend to have more screening and ultrasound scans (Morrison, 2009), and care is more commonly provided by an obstetrician rather than a midwife (Pendleton, 2015). Thus Polish women experiencing a normal pregnancy in the UK have been reported to feel that they had received sub-standard care, to have had difficulty with medical terminology, and some returned to Poland for additional scans and checks. Women with a complicated pregnancy may be even more inclined to return to their home country for further tests and reassurance (Goodwin, Polek, & Goodwin, 2012; Morrison, 2009; Osipovič, 2013; Pendleton, 2015; Sime, 2014).

Two national surveys of experience of maternity care in England of women of different ethnicities found that BME women had significantly more worries about the prospect of labour and poorer experience of care throughout pregnancy, childbirth, and in the postnatal period (Henderson et al., 2013; Jomeen and Redshaw, 2013; Redshaw & Heikkila, 2011). However, in both surveys White women were considered as a single homogenous group irrespective of their country of origin. Furthermore, to our knowledge, the effect of recency of migration on perception of maternity care has not been investigated in the UK. The aim of this study was therefore to examine women's experience of maternity care by both recency of migration and region of origin.

Methods

This study used data collected in a national maternity survey in England in 2010. The Office for National Statistics (ONS) randomly selected 10,000 women aged 16 years or over from birth registrations who had delivered a live birth in October or November 2009. They were sent a letter, information leaflet, and questionnaire 12 weeks after the birth. In addition a single sentence in 18 different languages encouraged them to call a Freephone number to enable them to complete the questionnaire by interview or through an interpreter if preferred. Women were excluded if their baby had died prior to the survey. Up to three reminders were sent to non-respondents using a tailored reminder system (Redshaw & Heikkila, 2010).

The questionnaire asked about clinical events and care during pregnancy, labour and birth, and in the postnatal period, about their country of origin and, if not born in the UK, what year they came to the UK. Information about maternal age, marital status, residence in an area of deprivation, ethnicity, and country of origin were provided by ONS for the whole sample to enable comparison between women who responded to the survey and those that did not.

As there have been changes to immigration rules since 2003, particularly regarding the Accession countries, it was decided to group ONS data on country of origin into UK, Accession countries, Old (pre-enlargement) European Economic Area (EEA), and 'rest of the world'. Women from the 'rest of the world' are a highly heterogeneous group included for the sake of completeness. Recency of migration was grouped into three years or fewer, four to six years, and seven years or more since coming to the UK. These cut-offs were a pragmatic choice informed by the distribution of time since arrival while allowing sufficient sample size in each group for analysis. For the purposes of this study women with multiple births were excluded as they would have a different care pathway. Analyses were weighted by age to take account of differences in response rate (Redshaw & Heikkila, 2010). Descriptive analyses were carried out comparing sociodemographic and clinical characteristics and reported experiences of care across the 'recency of migration groups'. Chi-square tests were used to assess associations between recency of migration and each of the variables. Although