



Migrant maternity in an era of superdiversity: New migrants' access to, and experience of, antenatal care in the West Midlands, UK



Jenny Phillimore

Director Institute of Research into Superdiversity, School of Social Policy and Social Work, University of Birmingham, Edgbaston, Birmingham, B15 2TT, United Kingdom

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ABSTRACT

Rapid increase in the scale, speed and spread of immigration over the past two decades has led to an increase in complexity of populations termed superdiversity. Concerns have been expressed about impacts of the pressure that superdiversity is said to place upon maternity services. High migrant fertility and infant and maternal mortality rates have long been observed in diverse areas with inadequate antenatal monitoring seen as a major causal factor in migrants' maternity outcomes. Using qualitative data from a study of new migrants' access to maternity services in the UK's West Midlands region, with some of the highest infant and maternal mortality rates in Europe, this paper looks at the reasons migrants' access to antenatal care is poor. The paper finds that contrary to earlier studies which pointed to a lack of priority placed on such care by migrants, a combination of structural, legal and institutional barriers prevent migrant women accessing effective antenatal care.

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1. Introduction

Enormous demographic changes have been witnessed in Europe over the past two decades as EU countries have transformed from being countries of emigration to countries of immigration receiving over twenty-six million migrants in just two decades (Boeri, 2011). Driven by these changes populations have become more diverse as the complexity, spread and scale of migrant arrivals increases. Whilst many new migrants move to existing areas of diversity, others move to towns and rural areas with little experience of immigration. Earlier migrations involved large numbers of people migrating for employment from a few former colonies to a small number of places. These so-called "old" migration flows continue alongside the arrival of new migrants from almost every country in the world to many more places. Internal differentiation within country of origin groups has further diversified populations and is observable by immigration status, religion, class, age, gender, ethnicity, language and education resulting in what Vertovec (2007) refers to as superdiversity.

A combination of the increased scale, spread and complexity of migration flows has led to concerns about the impact of migration at local level (Dustmann and Frattini, 2013) associated with

negative political and media rhetoric. In response to concerns about the ability of service providers to meet the social and welfare needs of superdiverse new migrants (Law, 2009; Vertovec, 2007), politicians have developed policy that restricts migrants' access to welfare, with a particular emphasis on health – withdrawing free access to secondary healthcare for irregular migrants and failed asylum seekers. A crackdown on "health tourism" based on notions that some migrants come for health gain (Williams, 2005) is part of the Home Office's strategy to increase the discomforts associated with living illegally in the UK, encourage irregular migrants to leave and prospective migrants to go elsewhere. The crackdown includes charging migrants with no recourse to public funds and failed asylum seekers for maternity care.

Migrants' access to maternity services has received considerable attention with allegations of "overload" of services in areas unaccustomed to migrant mothers (Hayes et al., 2011). Attention has also been paid to claims that migration is fuelling a rise in fertility rates in Europe and concerns about high levels of migrant maternal and infant mortality (Hayes et al., 2011). Research points to women from minority and migrant backgrounds booking later than recommended for antenatal monitoring, and attending fewer appointments and antenatal classes (Chot et al., 2011; Cross-Sudworth et al., 2011; Redshaw and Heikkila, 2010). While there is a well-established relationship between intensity of antenatal monitoring and health outcomes of mother and baby, little is

E-mail address: j.a.phillimore@bham.ac.uk.

known about the reasons migrant mothers book late or miss follow-up appointments with speculation that culture influences propensity to access antenatal care (see [Jayaweera et al., 2005](#)). Using research undertaken in the West Midlands, UK, this paper explores the reasons new migrant women book late and do not attend antenatal follow-up appointments and identifies a combination of legal, structural and institutional barriers.

1.1. Migrant birth outcomes

While there is little evidence that migrant women overload the maternity system, data demonstrate that migrants have higher fertility rates than white-British women with births to women with migrant backgrounds constituting 31% of all births in the Eurozone ([Hayes et al., 2011](#)). This pattern is echoed in the UK where between 2001 and 2006 women from 200 countries of origin gave birth and the proportion of births to foreign-born mothers increased by 65% constituting 24.7% of all live births ([Hayes et al., 2011:321](#)). At the same time general fertility rates (GFR) have been increasing in the UK largely, it is suggested, because of migration ([ONS, 2013](#)). The UK born GFR is 60 (per 1000), and overseas born 88, but there is huge variation between groups for example with women born in Pakistan having a GFR of 147, Nigeria 138, and Poland 90 ([Zumpe et al., 2012](#)).

Evidence suggests that maternal mortality and morbidity are increased for migrants, particularly those from Africa and asylum seekers. The Confidential Enquiry into Maternal and Child Deaths (CEMACH) “*identified disproportionately high rates in the migrant population.*” ([Hayes et al., 2011: 321](#)). Immigration status is barely acknowledged in UK data meaning no precise information about clinical outcomes is available and problems faced by migrant mothers are under-reported.

Concerns about maternal and infant mortality in migrant populations are not new. [Clarke and Clayton \(1983\)](#) found Asian mothers had 1.5 times the risk of perinatal mortality than the general population while [Cross-Sudworth et al. \(2011\)](#) found Pakistani women in Birmingham had three times the maternal mortality rate of white-British women. Early thinking suggested that infant and maternal mortality would be reduced in second generation migrants yet for South Asian women this has not been the case ([Cross-Sudworth et al., 2011](#)). Furthermore the picture is not uniform. In a review of reproductive outcomes in industrialised Western countries [Gagnon et al. \(2009\)](#) found that migrants' results for pre-term birth were good or better than receiving country women in 50% of studies. This review indicated that Asian, North African and sub-Saharan migrants have a greater risk of foeto-infant mortality while Asian and sub-Saharan African migrants are at most risk of pre-term birth.

In the UK differences were also identified in mortality/morbidity by ethnic group with Black African and Black Caribbean groups frequently found to be at greatest risk ([CEMACH, 2011](#)). Few studies have looked at immigration status although asylum seekers in the Netherlands have been found to be high risk while in Canada uninsured immigrant, refugee and migrant mothers have poor access to prenatal care impacting upon neonatal resuscitation rates ([Wilson-Mitchell and Rummens, 2013](#)). In the UK the CEMACH was unable to quantify the risks faced by different categories of migrant women, but highlighted that 12% of all maternal deaths were refugees and asylum seekers, despite only making up 0.3% of the UK population ([UNHCR, 2014](#)). Overall, compared to UK-born women, immigrants have a clear disadvantage for all outcomes including 43% higher risk of low birth weight, 24% of pre-term delivery, 50% of perinatal mortality, and 61% of congenital malformations ([Bollini et al., 2009](#)). This is supported by a systematic review of obstetric outcomes across EU which found greater frequency of low weight

babies, preterm delivery, perinatal mortality and congenital malformations in migrant populations ([Hayes et al., 2011: 322](#)).

Research indicates that a range of risk factors impact upon infant mortality. These include late access to services, lack of advice about available support and healthy lifestyles, and poverty impacting upon maternal diet and resulting in poor intrauterine growth ([Kanneh, 2009; Redshaw et al., 2006](#)). Infant mortality is more common where women were lone parents or underweight. Cultural practices such as female genital mutilation (FGM) and consanguinity have also been argued to impact on the health of mother or infant although such problems are said to be exaggerated because of the tendency to essentialise minority cultures and pathologise ethnicity and traditional practices. In Toronto clinically significant numbers of uninsured immigrant and refugee women were found to have hypertension or diabetes ([Wilson-Mitchell, 2014](#)). While it is clear that there are tangible inequalities in outcomes for some migrant mothers and babies far less is known about the reasons for these inequalities. Furthermore at the current time data collected about fertility and infant and maternal mortality rates in the UK is largely collated by ethnicity with key dimensions of superdiversity overlooked: in particular migration route and immigration status (and associated rights and entitlements), and language ability.

1.2. Migrants' access to maternity care

There is evidence from across the EU that minority and migrant women tend to book later and use antenatal services less than non-migrant women ([Chot et al., 2011; Redshaw and Heikkila, 2010](#)). Data collected on asylum seekers in one East London clinic identified that 68% of pregnant women were unable to access antenatal care via the NHS, 90% couldn't register with a GP and 25% had no antenatal care by 18 weeks ([Hargreaves and Burnett, 2008; Bryant, 2011](#)). Late bookers are more likely to deliver pre-term, have lower weight babies and need neonatal intensive care ([Clarke and Clayton, 1983](#)). Deficiencies in antenatal care have been found to contribute to poor outcomes such as chronic disease and pregnancy-related conditions which need to be identified and managed early ([Hayes et al., 2011:326](#)). There is a dearth of research focussing upon *why* migrant women might be less engaged with antenatal care in the UK where, at the time of writing, access was free except for undocumented migrants and failed asylum seekers. The current body of knowledge focuses upon small samples of women with specific ethnic origins, primarily South Asian, or particular migration statuses, usually asylum seekers. There is heavy reliance upon the perspectives of health professionals.

Increased attention has been given to the role of social determinants of health in shaping the health outcomes of the general population. While [Whitehead and Dahlgren \(1991\)](#) place individual lifestyle factors at the centre of their social determinants model they are clear that these factors operate within the context of social and community networks and most importantly general socio-economic, cultural and environmental conditions. [Jayaweera et al. \(2005\)](#) argue that there is an over-emphasis on individual factors such as culture and religion in research around Southeast Asian women's use of maternity services. She contends that insufficient attention is paid to structural inequalities, language competency, migration histories or discrimination and that constrained material circumstances limit access to services and good health. There is some empirical support for her argument with [Davies and Bath \(2001\)](#) finding poor communication between the non-English speaking Somali women and health providers served as a barrier to seeking information. Non-English speaking women believed they were perceived as ‘difficult patients’ and given inferior treatment. The use of family members as interpreters was problematic because women were too embarrassed to discuss sensitive issues.

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