

**African Migrant Women's Perception of Health Disparities in  
Pregnancy and Childbirth- An integrative review**

by

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## TABLE OF CONTENTS

### Part 1 Master Thesis

ABSTRACT

LIST OF ABBREVIATIONS

1.0 INTRODUCTION.....	1
1.1 Background to the study.....	1
1.2 Aims and research questions .....	3
1.3 Structure of thesis.....	3
2.0 THEORETICAL BACKGROUND.....	4
2.1 Health.....	4
2.2 Determinants of health.....	5
2.3 Migration in the EU-27.....	6
2.4 Health Promotion.....	9
2.5 Promoting health of African migrant women.....	10
2.6 The Relevance of user involvement and nursing .....	11
3.0 METHODOLOGY APPROACH – INTEGRATIVE REVIEW.....	12
3.1 Significance and Limitations of Integrative review.....	12
3.2 Quality appraisal.....	13
3.3 Data analysis .....	14
3.4 Author’s pre understanding of African beliefs and health practices.....	15
3.5 Ethical consideration.....	16
4.0 SUMMARY OF FINDINGS.....	17
4.1 Barriers at Maternal level.....	17
4.2 Barriers at Provider’s level.....	18
4.3 Barriers at Health system level.....	19
5.0 DISCUSSION.....	21
5.1 Methodological Considerations.....	24
6.0 CONCLUSION.....	25
7.0 IMPLICATION FOR NURSING PRACTICE AND FURTHER STUDIES.....	25
REFERENCES.....	26

<b>PART II: ARTICLE</b> .....	30
African migrant women perception of health disparities in pregnancy and childbirth.....	31
Abstract.....	32
Introduction.....	33
Methods.....	34
Summary of findings.....	37
Discussion.....	42
Conclusions.....	45
References.....	46
Appendix 1a: Figure 1.....	i
Appendix 1b: Table 1.....	ii
Appendix 2a: Figure 2.....	v
Appendix 2b: Table 2.....	vi
Appendix 3: Table 3.....	vii
Appendix 4: Summary of critique criteria for evaluating integrative research.....	viii
Appendix 5: Table of research reviewed for this integrative literature review.....	ix
Attachment 1: Author guidelines.....	xiii
Attachment 2: Covering letter to the Editor -in-Chief.....	xvi

To care for another person,  
I must be able to understand him  
And his world as I were inside it.  
I must be able to see, as it were, with  
his eyes what his world is like to him  
and how he sees himself...

I must be able to be with him in his world, going into his world in order to sense  
From inside what life is like for him.

Robert Bolton, 1979

## **ABSTRACT**

**Background:** As the “world becomes smaller” and individuals and societies become more mobile, there is an increasing interaction with individuals from other cultures and demands for health service that fit different cultures continue to fuel. Pregnancy and childbirth care are no exception. Europe enjoys one of the lowest perinatal mortality rates in the world through improved antenatal care, living conditions and health education, yet, evidence points to the fact that African migrant women (AMW) having most health problems during pregnancy and childbirth, resulting in the highest perinatal mortality rates in the region. AMW have their own experiences, different cultural values and belief patterns, behaviors, decision making tendencies and language proficiencies from those of the main stream which pose major obstacles for nurses and health care systems in their host countries. This integrative review was conducted to present a synthesis of past research on AMW perception of health disparities in pregnancy and childbirth as well as to recommend health promotion intervention strategies for nursing practice. The thesis is in two parts, part one is the thesis and part two is the article for publication.

**Aim:** The aim of the thesis is to present a synthesis of previous research on African migrant women perception of health disparities in pregnancy and childbirth as well as to recommend health promotion intervention strategies for nursing practice.

**Methods:** An integrative review based on a systematic literature search was developed, covering the period from January 2000 to December 2011. Based on the inclusion criteria, 11 empirical articles were found. The analysis process involved 1) Data reduction, 2) Data display, 3) data comparison and 4) Syntheses and verification.

**Findings:** One important theme emerged: Barriers to pregnancy and childbirth care. Barriers to care was manifested at three subthemes which are: i) Barriers at maternal level, ii) Barriers at health provider's or nurse's level and iii) Barrier at health system level.

**Conclusion:** There is no doubt that there exist health disparities in pregnancy and childbirth of AMW. Communication is adjudged the most important element which plays a central role in promoting the health of AMW during pregnancy and childbirth effectively. How nurses get key messages out in a clear, consistent and concise ways to those whom they wish to inform, influence and motivate can make a difference. However, the style of communication and timing is imperative. An authoritative, sometimes confrontational communication style can be construed as intrusive and repulsive.

Further studies should be targeted at health promotion interventions such as education, patient centered care and communication skills. In addition, research is needed to develop training modules that will breed excellent people skills in nurses to enable them respond to the real time needs of AMW thereby maximizing their professional impact.

**Keywords:** African migrant, health perception, health disparities, pregnancy and childbirth, health promotion, nursing.



## **LIST OF ABBREVIATIONS**

AMW	Africa migrant women
AMW's	Africa migrant women's
CMACE	Centre for Maternal and Child Enquiries
CSDH	Commission on Social Determinants of Health
EHFG	European Health Forum Gastein
EU	European Union
EUKN	European Urban Knowledge Network
IOM	International Organization for Migration
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
WHO	World Health Organization

## **1.0 INTRODUCTION**

The number of female migrants from Africa coming to the European Union (EU) has increased significantly over the past decades. Their scales and complexities are prompting governments and the civil society to address the challenges and to consider appropriate solutions. According to the 2009 Census of total migrant population (Eurostat, 2009), there were 14.9 million female migrants in the 27 countries of the EU, constituting 47.3 per cent of the foreign-born population. With regards to the distribution by continent of origin, 25.2 per cent came from Africa (European Urban Knowledge Network (EUKN) 2009, Eurostat, 2010). These groups of migrant women have their own experiences, different cultural values and belief patterns, behaviors, decision making tendencies and language proficiencies from those of the main stream (Katbamna, 2000), which pose major obstacles for nurses and health care systems in their host countries (European Health Forum Gastein (EHFG), 2011). According to EHFG (2011) report, one of the major obstacles is problem associated with pregnancy and childbirth. Pregnancy and childbirth are the most significant events in the life cycle of most women irrespective of social class, culture and ethnic background (Katbamna 2000).

### **1.1 Background to the study**

Europe enjoys one of the lowest perinatal mortality rates in the world. In spite of dramatic reduction in maternal and perinatal morbidity and mortality within the EU through improved antenatal care, high living standards and good health education, yet, migrant mothers tend to miss out in all three respects (EHFG 2011). Women of African origin have the most health problems during pregnancy and childbirth. A good proportion of their health issues go unreported as a result of cultural gaps in their expression of symptoms, acculturating, language barrier, expectations, discrimination and conflicting beliefs in systems (Choudhry, 2001; Lasser et al, 2006; Oxman-Martinez & Hanley, 2006; Reitmanova & Gustafson, 2008). The recent report from the Centre for Maternal and Child Enquiries (2011) "Saving Mothers Lives" suggested that increased mortality rate in black African mothers may not only be attributed to social

circumstance and recent migration but also cultural factors. Evidence has shown that health care disparities are not entirely explained by differences in access, clinical appropriateness, or patient preference (Smedley et al, 2003), but rather, providers behavior, practice patterns, organizational process and compromise quality in care (van Ryn, 2003). These inequalities in perinatal health carry long-term consequences as studies increasingly show that a healthy pregnancy reduces the risk of adult illnesses. The European strategic approach (2008) report calls for action to be taken to improve the health system, strengthen health worker's intercultural, interpersonal capacities and skills for interacting and working with women, families and communities. Health inequalities have enjoyed varying degrees of prominence within global health policy over recent decades (Gwatkin 2002; Braveman & Tarimo, 2002). Emphasis on primary health care strategy intended to reduce inequalities in health arising from the Alma Ata Declaration of Health for All in 1978 (World Health Organization (WHO), 1978) was overtaken by a focus on health sector reform and promotion of long- term sustainability in healthcare systems. At the World Summit on Sustainable Development in Johannesburg in 2002 (Sarch, 2002), health was seen as an integral part of the economic development process (United Nations Development Programme (UNDP), 2003). In 2003 World Health report, the Director General of WHO Dr. Lee Jong-Wook called global health gaps unacceptable and referred back to the principles set at Alma Ata. He recommended systems that integrate both health promotion and disease prevention strategies as the way forward. Migrant mothers from Africa have emigrated from locations where complications and death related to maternal and perinatal care are still high, whereas maternal and perinatal care remained low due to several reasons such as cultural practices and traditions, language differences and heterogeneity of the Africa continent, poor health seeking behaviors, poverty and many more ( Hussain & Mpembeni 2005, p. 119). Promoting healthy pregnancy and safe childbirth is a goal of all European health care systems. Before attainment of this goal, all sources and forms of disparities in the healthcare system especially that of vulnerable groups such as African migrant women ought to be identified. This, in turn will precipitate the development

and implementation of the appropriate interventions. One of such means to ascertain the health disparities among African migrants is to review past research studies conducted on them.

## **1.2 Aims and research questions**

The aim of the thesis is to present a synthesis of previous research on AMW's perception of health disparities in pregnancy and childbirth as well as to recommend health promotion intervention strategies for nursing practice.

The specific objectives is to find out

1. AMW's contribution to health disparities in pregnancy and childbirth,
2. Health care provider's contribution to health disparities in pregnancy and childbirth of AMW.
3. The health systems' contribution to health disparities in pregnancy and childbirth of African migrants

The following two research questions were formulated:

- a) What characterizes non-western migrant women's perceptions of disparities during pregnancy and childbirth?
- b) What health promotion intervention strategies can be used in practice?

## **1.3 Structure of thesis**

Chapter one describes the background of the thesis, aims and research questions, while chapter two presents the theoretical background of health, determinants of health, migration in the EU-27, health promotion and AMW, relevance of user involvement and nursing. In chapter three, the integrative literature review with systematic approach, quality appraisal, data analysis and Author's pre understanding of African beliefs and health practices and its implication for development of knowledge is presented. Chapter four covers the synthesis of findings while chapter five discusses the findings. The conclusions are captured in chapter six.

## **2.0 THEORETICAL BACKGROUND**

This chapter presents the theoretical background of health and its determinants, health system and migration in the EU-27. Health promotion and interventions and strategies related to Africa migrant disparities are also described. At the end of chapter two, relevance of the user involvement and nursing are captured.

### **2.1 Health**

Health is fundamental to human development, social and economic advancement and active participation in one's community and society. The state of one's health is reflective of an individual's ability to meet life's challenges and maintain his or her capacity for optimal functioning (Healthy People 2010). This requires the various aspects of one's makeup that is mental, physical and biochemical to maintain the level of functioning that has a positive influence and support for one another. The word "health" is derived from the old English word for heal which means "whole", signaling the health concerns of the whole person and his or her soundness, integrity and well-being. The concept of health is open to different interpretations. The biological perspective of health focuses on presence or absence of diagnosed diseases (Healthy People 2010). Florence Nightingale in 1860 described health as "being well and using one's powers to the fullest extent". In 1946, WHO proposed a definition of health that emphasized "wholeness" and the positive qualities of health: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1946: 100). WHO's definition: (i) reflect concern for the individual as a total person; (ii) place health in the context of the social environment; and (iii) equate health with production and creative living.

Health can also be viewed as a socially constructed phenomenon having different meanings for different people (Scambler, 1997). Many actors have discussed results from studies in fields such as anthropology and sociology which have demonstrated that individuals vary in their perception of what counts as healthy or unhealthy and in their definitions of illness (Butler &

Parr, 1999). People use different conceptual frameworks to understand health. Frameworks for understanding and explaining health includes;

- The idea of health as balance, or illness as imbalance.
- The notion of the body as a machine and of illness as malfunction of the machine.
- The idea of locus of control (perception of the degree of control an individual has over his or her own health).
- Health or illness seen as the outcome of fate or divine will.
- Idea about health providing freedom to do as one pleases or functional ability to carry out key roles such as work as an employee or a homemaker.
- The concept of health as resilience against threats of infection or hazards.
- Ideas about access to the means for good health, such as health care and a reasonable standard of living.

These health beliefs are held by different individuals, in varying degree, however, some elements of health perception are shared and reinforced collectively among people in the same society or ethnic groups (Sarah, 2004). Perception of factors or determinants which produce health and illness also depends on social or geographical context (The Commission on Social Determinants of Health (CSDH 2005).

## **2.2 Determinants of health**

The manner in which an individual lives is of great importance to his/her health status and quality of life. It is increasingly recognized that health is maintained and improved not only through the advancement and application of health science, but also through the efforts and intelligent lifestyle choices of the individual and society. According to the WHO (1946, 2000a), the main determinants of health include the social and economic environment, the physical environment, culture and the person's individual characteristics and behaviors (CSDH 2005).

**Social and economic environment:** Social and community networks, support from families, friends and communities are linked with better health. The care and respect which occur in such

social relationships help people to cope with challenges and also act as a buffer against health problems. Education is closely tied to socio-economic status. It increases opportunities for job and income security, improves people's ability to access and understand information to help them keep healthy. Higher income status generally results in more control and discretion. Income determines living conditions such as safe housing and ability to buy sufficient good food.

**Physical environment:** Physical environment entails elements such as safe water, clean air, healthy workplaces and safe houses, design of communities and transportation systems which all contribute to good health.

**Culture:** customs, traditions and beliefs of the family and community all affect health.

A Person's behaviors and characteristics such as age, sex and genetic factors play a part in determining lifespan and likelihood of developing certain illnesses. Healthy lifestyle factors including diet, physical exercise, smoking, drinking and sexual behavior, etc. enhances health. Finally, all the aforementioned determinants of health can singularly or in combination impair access to and use of health services that prevent and treat diseases.

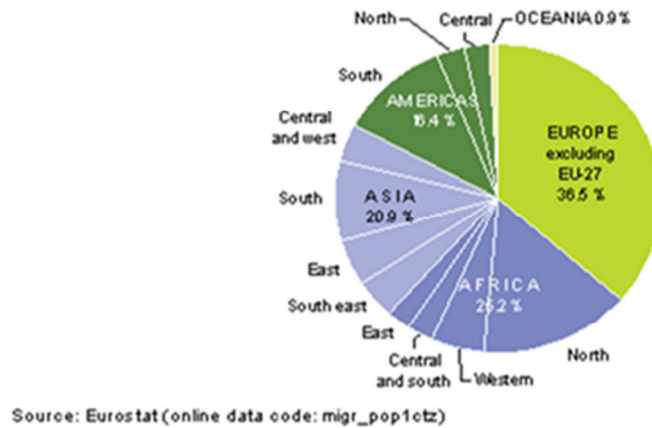
### **2.3 Migration in the EU-27**

Movements of people searching for a better life, livelihood or refuge, or rushing to flee natural disasters are as old as humankind. People migrate within their own countries, mainly from rural to urban areas, as well as across borders. Today, women constitute almost half of all international migrants worldwide (UNFPA, 2006). Men and women show differences in their migratory behaviors, cope with different risks and challenges such as human rights abuses- both as migrants and as females, exploitation, discrimination and specific health risks. Specific health risks facing the European today is the migration of women from non-western countries and health related to pregnancy and childbirth (UNFPA 2006; EHTG, 2011).

As of 1st January 2010, there were 32.5 million foreigners in the EU-27, corresponding to 6.5% of the total population. The majority of them, 20.2 million, were third-country nationals

(i.e. citizens of non-EU countries). The proportion of migrant into EU-27 by origin is shown in Figure A.

**Figure A** Showing distribution of migrants by origin into EU-27



African migrant constituted 26.2 % of the population (Eurostat, 2011). Many of these migrants from Africa possess little information regarding health matters. Their health status may be further compromised by the stress of adjusting to a new country and culture. Moreover, studies in the EU have found that AMW can be exposed to discrimination while receiving pregnancy-related services, receive inadequate or no antenatal care and exhibit higher rates of stillbirth and infant mortality (Passage to Hope, p. 36; EHFG, 2011).

The social and economic circumstances of many African migrants are not conducive to good health. According to Lewis (2007), the maternal mortality rate for Black African women is six times that of White women. Many African women are not aware of their entitlement to maternity care and even where they do, they are not well-placed to enforce them (Lewis, 2007). There is recognition of social policy heterogeneity in the European Union and the territory is not yet seamless health-care entitlement domain (Warnes, 2002). Report that maps the European Commission's policies related to migration indicates that migration does not feature highly in strategic policy documents on health (Kate & Niessen, 2008). According to Carballo et al. (1998), pregnancy and childbirth is still one of the most important and unmet public health challenges



within the European Territory. Evidence gathered on pregnancy and childbirth demonstrates that there are health inequalities between migrant women and the national population (Carballo et al, 1998; Fernandes, 2009; Mladovsky, 2009).

Migration represents a great opportunity for the European Union by enhancing its economic potential and meeting the needs of an increasingly demanding labor market and at the same time contributing to socio - cultural enrichment. However, migration is also a challenge in the European Union. New needs emerge as the population becomes heterogeneous. As of 1st January 2011, the population of the EU was about 502.52 million people. Approximately 7.6% of the total EU population is foreign born (Eurostat, 2011). Even though migration is accepted as a phenomenon necessary for demographic and economic growth and therefore unavoidable, increasing and feminization trends of migration in Europe means that, greater efforts are needed to integrate migrant groups in the health care system. Access to good quality health care is thus an important aspect of social inclusion or exclusion of migrants (Ingleby, 2008), and a matter of human rights and their socio economic promise. However, there is growing awareness that women who migrate are particularly vulnerable and that their reproductive health and especially pregnancy and childbirth care remains unnoticed and unaddressed (Gwyneth et al, 2006; Ny et al, 2007; Jasseron et al, 2008). The WHO (1996) highlights the importance of giving greater priority to pregnancy and childbirth monitoring of women in all migration related situations as an integral aspect for decrease of family and community poverty (Carballo et al, 1996; WHO, 2005, Healthcare Commission 2008). According to the World Bank (2001), effort on pregnancy and childbirth for migrant women creates immediate, long term and intergenerational effect and an important foundation for the sustainable development of the society where they belong (United Nations Population Fund (UNFPA), 2006).

## 2.4 Health promotion

The best known definition of health promotion was promulgated by the American Journal of Health Promotion (1986) as the science and art of helping people change their lifestyle to move toward a state of optimal health. This definition was derived from the 1974 Lalonde report from the Government of Canada, which contained a health promotion strategy "aimed at informing, influencing and assisting both individuals and organizations so that they will accept more responsibility and be more active in matters affecting mental and physical health" (Lalonde, 1974). Healthy People report of the Surgeon General of the United States, which noted that health promotion "seeks the development of community and individual measures which can help people to develop lifestyles that can maintain and enhance the state of well-being" (Minkler, 1989). In 1986, WHO Ottawa Charter contended that health promotion unifies changes in the ways and conditions of living, mediates between people and their environments and combined personal choice with social responsibility. The Ottawa Charter widened the debate by emphasizing a population approach, a focus on social context, the cause of disease and the need to employ a range of methods such as communication, education, legislation and community development. Health promotion is therefore defined as the process of enabling people improve and increase control over and to improve their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with environment. Health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyle to well-being (WHO, 1986:1). Health promotion moves beyond a focus on individual behavior towards a wide range of social and environmental interventions. In outlining the prerequisites for health, the Ottawa Charter calls for equity in health, health alliance and partnership between relevant organizations. Health promotion extends to building healthy public policies, creating supportive environments, strengthening community action and social networks, developing personal links and reorienting health services (European Commission, 2000, WHO, 2005).

## **2.5 Promoting health in African migrant women**

The socioeconomic conditions of the African region have to a large extent influenced the level of health knowledge of the African migrant. Low levels of literacy, poverty and inadequate understanding of the role of health promotion and how health promotion interventions are directed and received (Govender, 2005). Reproductive health promotion is not primarily targeted and therefore the habit to promote health during pregnancy and childbirth among African women is missing. After migration, migrants are also exposed to poverty, inequality and marginalization in their host countries (Maffle, 2008). Even when in principle migrant women living and working legally in another country have access to health care, it is not always "migrant friendly". Cultural differences, language barriers and xenophobic attitudes can and do impact on a migrant's ability to get the necessary care she needs (Lyberg et al, 2011).

This vulnerability is being exacerbated to unacceptable levels by the lack of access to appropriate maternal and child health services, which can have a long-term public and social cost. Maternal and child health, often thought of as preventative care, can and does lead to life-threatening situations with tragic results because problems have not been spotted in good time or because the right skills and treatment are unavailable (International Organization for migration (IOM), 2009). Babies and children of women who have not had ante-natal care can be more susceptible to problems such as pre-mature births and growth and development issues. To avert the forgoing problem, one of the solutions championed by IOM is the establishment and development of existing midwifery and community health skills among migrant communities. This would help to spot problems and potential problems in advance and build knowledge on when a patient needs to be referred (IOM, 2009). The Ottawa Charter (1986) sees health promotion as involving three components being health education, service improvement and advocacy.

## **2.6 The relevance of user involvement and nursing**

In this study, emphasis is placed on African migrant's perception of the care they receive during pregnancy and childbirth. This alters the power balance such that African migrants with increased capacity to act on their own behalf are encouraged to engage in partnerships with healthcare providers/nurses (Jonsdottir et al, 2004). Partnership implies equal positioning between client and nurse. According to Cahill (1998), Clients want to participate in their care when they are informed, when options exist, and, when they are permitted and encouraged to do so. In 1970, Henderson defined nursing as helping people to engage in activities that improves health or aid recovery and to move to a position where they are free from need for nursing interventions. Benner and Wrubel in 1989 talked about the importance of caring to the role of a nurse while Benner in 1983 identified seven domain of practice on which particular relevance was placed about helping patients understand and develop control of their illness and adapt their lifestyle accordingly. In 2004, the International Council of Nurses defined the scope of nursing practice by five criteria:

1. The implementation and evaluation of nursing care
2. Advocacy
3. Supervision and delegation
4. Leading, managing, teaching, researching
5. Health policy development.

To support the latter, the Nursing and Midwifery Council (2004) stressed that all patients and clients have a right to accurate, truthful and easy understandable information about their health. Therapeutic relationships between nurses and those entrusted to their care are characterized by respect for dignity of each person and recognition that, at a human level, both are equal.

### **3.0 METHODOLOGICAL APPROACH - INTERGRATIVE REVIEW**

Research method employed is an integrative review. The creation and use of systematic, organized and diligently researched literature reviews can provide a connection between research and evidence based practice. (Polit & Tatano, 2008). Systematic literature reviews are viewed as important methodologies in the advancement of a discipline. This is because they accumulate past endeavours, summarized major issues and are important ways to disseminate the information generated by a large number of individual studies” (Evans & Kowanka, 2000, p. 33). An integrative literature review allows a researcher to survey and summarize a vast body of research in order to inform practice or policy development (Whittemore & Knafl, 2005). The aims of an integrative literature review are very broad and include objectives such as “to define concepts, to review theories, to review evidence, and to analyze methodological issues” (Whittemore & Knafl, 2005, pp. 547-548). There are important steps involved in an integrative review process including: identification of a problem, literature search, data evaluation, analysis, presentation and conclusion (Whittemore & Knafl, 2005). In addition, the author’s pre understanding of the subject matter of this thesis is anchored on my background as an immigrant from Africa and a mother who has experienced the health care system in Europe. These privileged positions fine-tuned the author’s abstraction and interpretation of information from past research articles thereby bringing unique insights and clarity to the subject.

#### **3.1 Significance and limitations of integrative review**

Integrative literature review is a specific approach that summarizes past empirical or literature to provide a more comprehensive understanding of a particular phenomenon or healthcare problem (Whittemore & Knafl, 2005). Integrative literature review presents the state of science, contributes to theory development and has direct applicability to practice, policy and promotion of wellness (Whittemore & Knafl, 2005). According to Oxman (1994), the risk of error undertaking integrative study increases exponentially without explicit and systematic approach.

Systematic approach aims as much as possible to find the research relevant to the particular research questions, and uses explicit methods to identify what can reliably be said on the basis of these studies. The integrative literature review is one example of a systematic literature review and is considered a research methodology in its own right (Polit & Tatano, 2008). Integrative reviews have the power to enhance nursing practice by providing overviews of experimental and theoretical knowledge in addition to identifying areas where further research is needed. With these capabilities in mind, the research methodology of an integrative review selected is the most appropriate methodology for probing the research questions posed.

### **3.2 Quality appraisal**

There are two important steps in data evaluation in an integrative review. Step one is a critique of each article to evaluate its merit and the second is the summary or synthesis of all the articles that flows into recommendations for best practice based on legitimate studies. First and foremost, while the researcher will include many different forms of research and theoretical works, the research quality of each article is evaluated by examining validity, bias and appropriate methodology (Whittemore, 2005). In an ideal situation, two independent people will code the studies for quality using a scoring mechanism and the amount of agreement (Whittemore & Knafl, 2005). Because this was an individual student project, requiring demonstration of independent work, it was therefore not feasible to have two researchers score the articles. Thus, the articles were scored independently, to determine variations between studies and evaluate validity and reliability. Each selected article was described with critique (Appendix 5) and the quality issues well notated (Table 1 in Appendix 1b). More emphasis was given to studies that meet criteria of a “good” study and the weaknesses of other papers noted. While these criteria are presented as guidelines, use of methodological consistency is recommended since there are no established “gold standard” assessment tools yet available to evaluate research for an integrative review (Kirkevold 1997; Polit and Beck, 2008).

The challenge in the integrative review in the data analysis stage is noting variability between studies and accounting for this variability as well as evaluating the studies for validity and reliability and if there are problems in these areas, making sure that data summaries reflect this. For the purpose of these studies, Polit and Beck 2004, Chapter 26 was utilized to evaluate each article. The criteria utilized in this project are summarized in Appendix 4.

### **3.3 Data Analysis**

After critiquing and evaluating each article, the second phase referred to as the synthesis phase begins. According to Whitemore & Knafl, with defined criteria, “an innovative synthesis of the evidence, are the goals of the data analysis stage” (Whitemore & Knafl, 2005, p. 550). While there are varieties of data analysis methods that can be employed, one methodology is constant comparison which is a methodology employed in qualitative research. In a constant comparison methodology, the “extracted data are compared item by item so that similar data are categorized and grouped together. Subsequently, these coded categories are compared which further the analysis and synthesis methodologies” (Whitemore, 2005, p. 550). The methodologies utilized in qualitative research have been applied into the methodologies in the integrative literature review with the benefit of reducing error and potential bias (Whitemore & Knafl, 2005). The methodologies include data reduction, data display and data comparison and synthesis (Whitemore & Knafl, 2005). Data reduction refers to classifying topics in articles to various pre-determined subject groups; data display refers to the process of putting the data extracted into some form of visual aid such as a chart or table; and data comparison refers to comparing and contrasting the data extracted from the articles (Figure 2 in Appendix 2a).

Synthesizing AMW perception of disparities in pregnancy and childbirth, one looks for recurring theme which in this instance is Barriers to pregnancy and childbirth care. The identified theme is manifest in three sub-themes such as barriers at maternal level, barrier at health provider’s or nurse’s level, barriers at health care system level and so on.

### **3.4 Author's pre understanding of African beliefs and health practices**

The interest to undertake my master thesis within the subject area of maternal and perinatal health is anchored on my background as migrant from Africa and a mother who has experienced the health care system in Europe. To a large extent I grew up in a community where beliefs and practices related to pregnancy and childbirth are quite different from that of the host nation. Many African women believe natural illness occurs out of God's will and unnatural illness is the handiwork of evil forces or witchcraft. A cure for natural illness includes an antidote or other logical protective actions whiles unnatural illness is treated by resorting to religious prayers, consulting fetish shrines and/or use of herbal medicines. These behavioral tendencies often times lead to delays in seeking professional health care.

In African settings, new mothers are not permitted to stay outdoors. They are supposed to stay indoors, eat more to gain weight seen as grandiose lifestyle. The maternal or paternal grandmother is on hand to assist the mother in attending to the newborn. This arrangement gives the new mother more time to sleep. Putting up weight under such circumstances is deemed as beautiful and mark of upscale health status.

Traditionally, an African man is not present during the delivery of a child. Female members such as the mother, mother-in-law, grandmothers and elder sisters in the extended family assist during labor. This norm alienates fathers from participating in activities during pregnancy, labor and postnatal care. Because of the forgoing practices, AMW living abroad endure enhanced challenges during pregnancy and childbirth insofar as there are no extended family members on hand to help or offer advice. Lastly, the African culture tends to assign domineering role to the male figure in the family, giving him the last word on most issues such as finance and decision making. This arrangement sometimes frustrates the woman in her desire to seek care during pregnancy and childbirth. These unique insights and knowledge fine-tuned my abstraction and interpretation of information from past research articles thereby injecting clarity to the subject. In my clinical practice as a nurse, I have also come to believe that nurses are in a good position to



influence positively on AMW through patient centered care, education and empowerment to manage their pregnancies and promote well-being.

### **3.5 Ethical consideration**

The author has ensured that all manuscripts included in this integrative review states the proper title and authors. Therefore, there are no conflicting evidence attached to this master thesis

## 4.0 SUMMARY OF FINDINGS

The articles that focused on AMW perception of health disparities in pregnancy and childbirth summarized in Appendix 5 were carefully reviewed. Collectively the articles provide one main theme: Barriers to pregnancy and childbirth care and three sub-themes relating to AMW. These sub-themes include barriers at maternal level, barriers at health provider's or nurse's level and barriers at the health system level (Table 2 and Table 3 in appendix 2b and 3 respectively).

### 4.1 Barriers at maternal Level

The research findings showed that low education of African migrants acts as a barrier to the access of health care and the measures it incorporates (Alderliesten, et al, 2007). In addition to less education, African migrants with no regular income and unplanned pregnancy were likely to receive inadequate care or face some specific barriers such as personal, socioeconomic, organizational and cultural when receiving care (Delvaux et al, 2001). Furthermore, AMW's lack of knowledge of the health care system in their host countries and health literacy played important role in how they received care (Zwart et al, 2008).

According to Essén et al., AMW's unawareness of service availability or a lack of knowledge about the services at one's disposal also acts as a barrier to the use of health services (Essén, et al, 2000a; 2000b). AMW's short stay in their host country, their lack of social support network (Zwart et al, 2008) and their feeling of loneliness and isolation during pregnancy and childbirth brought on by the absence of supporting relatives create barriers in seeking care (Essén, *et al.* 2000a). Delay in seeking antenatal care, missed appointment jeopardizes the pregnancy outcomes of African migrants (Zanconato et al, 2001).

Most women from Africa construed safe delivery to be a normal vaginal delivery and thus, expressed fear of caesarean section which they perceived as a life threatening event (Essén et al, 2000a, Essén et al, 2002). Their apprehensiveness primarily are grounded on memories of the

situation prevailing in their countries of origin (Africa) where there is high risk of maternal mortality and their knowledge of someone who had died through caesarean section.

In the quest of African women to avoid Caesarean section, they have had to adopt a strategy to voluntarily reduce their food intake thereby having small fetus: a situation that works best for them in Africa (Essén et al, 2000a). Furthermore, they do not understand why routine antenatal care was necessary as pregnancy to them is a normal health state and only go for check-up if they think something is wrong (Essén *et al.* 2000a). African migrants actively sought health information when they deemed such information would lead to increased certainty and not cause distress whereas they avoided information when they believed they could not influence the outcome of the situation (Davis & Birth, 2001).

#### **4.2 Barriers at provider's level**

Cultural differences creates barrier to care of African migrants (Delvaux et al, 2001). Lack of cultural knowledge about, e.g. traditional family patterns and values, is regarded as essential to the provision of health promotion and preventive care. The health personnel's lack of knowledge of cultures and traditions of African migrants can lead to neglect of potential risk factors, and also contribute to adverse perinatal outcomes (Essén et al, 2000a).

Discourteous care and stereotypical attitudes towards minority patients such as migrant women during pregnancy and childbirth have a detrimental effect. African women reported they were denied information in prenatal care due to punitive attitudes and prejudiced views among health professionals towards them (Malin & Gissler, 2009). Factors such as communication problems due to language barrier jeopardize the pregnancy outcomes of African migrants (Zanconato et al, 2011). African migrants from Somali were unhappy about clinical practice and the quality of maternal care received. They wanted more information in the delivery room, pain medications, prenatal visits and roles of hospital staff (Malin & Gissler, 2009).

According to Essén et al., it appears perinatal care services do not presently meet the communication needs required by a multiethnic population (Essén et al, 2002). Reducing language barrier in an attempt to meet the needs of culturally diverse minority groups might also encourage women to obtain prenatal care (Delvaux et al, 2001). Care of migrants and especially those of African origin could be improved by improving the communication between caregivers and the women concerned (Alderliesten et al, 2008). Malin and Gissler study recommended for nurses and midwives, supplementary training that is culturally sensitive and respond better to the health needs of women and their new-born (Malin & Gissler, 2009).

Booking time and waiting period of appointment and interpreters could lead to acquaintances and family members being used. However, concern about confidentiality with the use of family members as interpreters prevented African migrants from disclosing important issues that could be detrimental to their health leading to denial of appropriate medical care. The use of different interpreters, and other untrained staff as interpreters with low level of medical knowledge causes anxiety perceived to be a barrier to care given to AMW (Davis & Bath, 2001). Furthermore, certain cases might also have had a positive outcome if there were routine use of interpreters (Essén et al, 2002; Malin & Gissler, 2009).

#### **4.3 Barriers at health system level**

Health service organization remains significant impediments to care of African migrants (Delvaux et al, 2001). Essén et al. suggested the initial antenatal visit for screening African migrants may not be sufficient or appropriate to determine those at risk. This may lead to fewer referrals to specialist care than would otherwise be needed (Essén et al, 2000b). Comprehensive prenatal care program, including appropriate location, consultation schedules and walk-in care facilities might favor adequate utilization of prenatal care services (Delvaux et al, 2001).

Antenatal care programme has until now, lacked appropriate measures to meet the pregnancy strategies of African migrant groups leading to substandard of care (Essén et al, 2002). Substandard care is present if perinatal care did not meet the defined minimally accepted

standards (Alderliesten et al, 2008). Furthermore, insufficient monitoring of this group compared to the general population during pregnancy and childbirth, late arrival of pediatricians, delayed transfer to neonatal intensive care units were all identified as suboptimal factors (Zwart et al, 2008). Health care personnel may also be less experienced in the surveillance of mothers of African origin and their infants, resulting in a less active and belated management (Essén et a, 2002). Malin and Gissler emphasized that, AMW had more visits to the hospital outpatient clinics during their pregnancies than any other ethnic groups. They had the highest caesarean section rates and six-fold mortality rate compared to any other groups (Malin & Gissler, 2009). After delivery, the newborns were given more antibiotics and diagnosed to have more asphyxia and intubation (Malin & Gissler, 2009).

## 5.0 DISCUSSION

It has been identified that nurse's ability to notice cues, place them within the context of the patient situation, integrate them with an understanding of the patient experience, and providing reassurance through their action and verbal response were imperative. In addition, the nurse's ability to develop communication and people skills to find the right moment to impact their African clients and the ability to get their messages out in a clear, consistent and concise way can make a huge difference. However, the style of communication and timing is very paramount. African migrant will express uncertainty in a variety of ways for example, openly stating fears, being quiet and withdrawn, numerous requests, lack of confidence and other demands. An authoritative, sometimes confrontational communication style of the nurse at this point can be construed as intrusive and thereby repulsive. The literature study revealed that an AMW as passionate as she is about her belief patterns and practices requires counseling, knowledge and skills to make lifestyle modification and cultural adjustments. The knowledge the nurse seeks to apply in the process of educating or informing their African migrant patients is vital.

Nurses use different knowledge in the process of caring for their patients. These knowledge types also help the nurse in understanding the uniqueness of their patients and the importance of relating to them. Liaschenko & Fisher (1999) categorized the knowledge into three types: case knowledge, patient knowledge and person knowledge. Case knowledge is based on the clinical situation and includes knowledge of anatomy, physiology, physical disease process and pharmacology. Nurses need not interact with patients in order to use this knowledge. Patient knowledge is the knowledge of how individual patients are responding to their clinical situations. This knowledge enables the nurse to negotiate the care of the patient in the healthcare system. Patient knowledge is also based on understanding how the patient is experiencing and therefore requires interaction between the nurse and the patient. Person knowledge identified by Liaschenko & Fisher involves an understanding of the unique individuality of the patient,

knowing the patient personnel and private biography and understanding how the person's actions make sense for them (Liaschenko & Fisher 1999).

African cultures permeates through a vast range of traditions and religious practices which is why most women rely on traditional medicine and healing practices during pregnancy. These beliefs continue despite acculturation and thereby prevent individuals from seeking health advice. One major obstacle for nurses in giving advice relating to childbearing is the clashes with cultural practices which African women relied to protect themselves and the unborn child during pregnancy and childbirth. The study further revealed that, cultural conflict could be the basis for these women to reject any health advice given them. In this light, Adeigbe (2011), recommended information given to African migrants during pregnancy and childbirth be culturally appropriate and minimally conflicting with their cultural beliefs. Moreover, understanding and explaining health and illness are often culturally determined. Therefore the need for individual empowerment in the process of increasing their capacity to make choices and to transform those choices into desired actions and outcomes is crucial. Healthcare is disease oriented, based on notions of objectivity which is generalized to all people whiles, illness is what a patient experiences and thus subjective. These subjective experiences of illness are imbued with cultural meaning. African migrant's explanation and other practices during pregnancy and childbirth can be very different from the scientific explanatory model and the consequences for these differences unfortunately accrue directly to the African mother.

The review identified education as an important component and mechanism to provide information and knowledge in the hope that African migrants will subsequently modify their behavior as a result of their own choices. Choices they are allowed to make during pregnancy and childbirth have a greater impact on their outcomes than those made by nurses. The aims of educating African migrants during pregnancy and childbirth are to improve their knowledge and skills to enable them take control of their own condition, understand their behaviors, seek medical help and early intervention when needed. The nurse at this stage should no longer feel responsible

to solve all the woman's problems. Instead, it allows the nurse to enter into a dialogue during which, solutions to problems emerge naturally from exploring issues in a relationship based on trust and respect. Nursing Care administered with the presumed intent of changing the recipient's life style, behavior or needs is construed as intrusive and repulsive, because it assumes the nurse is superior, more competent, or more powerful.

Timing is crucial when sharing information and this is best expressed as capturing the patient's readiness to learn (Benner, 1984, p. 79). If information is shared before AWM is ready, it may fall on deaf ears or creates anxiety. When it occurs too late, sharing information fails to achieve its desired outcome. In addition, the cultural awareness of the nurse and level of cultural competency is important. Without cultural competency nurses' background can create barriers to understanding their African migrant patients. On the other hand, culturally competent nurses see the entire picture while avoiding stereotyping and misapplication of scientific knowledge to improve the quality of care and health outcomes. A nurse who lacks knowledge about cross-cultural, psycho sociological and linguistic differences evident in diverse multicultural populations is likely to make inaccurate assessments (Adeigbe, 2011) resulting into substandard of care thereby resulting in health disparity.

According to Davis & Bath (2001), information exchange between the nurse and the African migrant recipient is very important. Communication is adjudged focal point when providing culturally appropriate care. Weak communication skills resulting into incorrect professional practices act as a barrier for African migrants receiving care. Women are most vulnerable during pregnancy and childbirth. At this point their ability to verbally communicate or express their feeling diminishes. With a strong communication skill attribute, a nurse can gauge the right feeling of the woman just by observing say, body language, facial expressions, emotional expressions and mood swings etc. In some instances, such observation might be the best means to decide giving the patient in need of pain medication. Communication styles are distinct among diverse groups thus; knowledge of cultural differences in communication is



paramount in the delivery of healthcare and health promotion programs. Insofar as word interpretation, verbal communication and non-verbal communication such as through body language vary across cultures, health promotion programs are successful and cost effective when delivered in the language the recipient understands and feels comfortable with. Nonetheless, Essén et al. (2000a) have indicated that, in spite of every woman's right to obstetrical information during pregnancy and labor yet, sub optimal verbal communication made it impossible. Essén et al. (2002) study concluded present perinatal care services do not presently meet the communication needs required by a multiethnic population.

### **5.1 Methodological Considerations**

The author of this thesis is a migrant, belongs to the African ethnic group, experienced pregnancy and childbirth health care in a host country in Europe and working as a Registered Nurse thus, my background affected the interpretation of result. On the other hand, it can be regarded as strength in terms of bringing useful first hand knowledge and experience to compliment the existing knowledge.

## **6.0 CONCLUSION**

The studies reviewed characterized and adjudged communication as the most important element which plays a central role in promoting the health of AMW during pregnancy and childbirth effectively. How nurses get key messages out in a clear, consistent and concise way to those, whom they wish to inform, influence and motivate can make a difference.

## **7.0 Implication for Nursing practice and further studies**

The findings points to the fact that the style of communication with AMW is very paramount. An authoritative, sometimes confrontational communication style of the nurse can result in shame and discomfort. Weak communication skills resulting in misunderstanding the health promotion program run the risk of incorrectly homogenizing and universalizing women and their needs and thereby weakening its effectiveness.

Further studies should be targeted at health promotion interventions such as education, patient centered care and communication skills. In addition, research is needed to develop training modules that will breed excellent people skills in nurses to enable them respond to the real time needs of AMW thereby maximizing their professional impact.

## REFERENCES

Aday Lu Ann and Andersen R, (1975). "A framework for the study of access to medical care". *Health Service Research*; 9(3): 208–220.

Alderliesten M.E., Stronks K., Jan M.M. van Lith, Smit, B.J., Marcel F. van der Wal, Bonsel G.J., Bleker, O. P. (2008). Ethnic differences in perinatal mortality. A perinatal audit on the role of substandard care. *European Journal of Obstetrics & Gynecology and Reproductive Biology* 138: 164-170.

Benner, P. (1984). *From novice to expert: excellence and power in clinical nursing practice*. Addison-Wesley, Menlo Park CA.

Andersen Ronald (1995). "Revisiting the behavioral model and access to medical care: does it matter?" *Journal of Health Social Behavior* 36 (1): 1–10.

Andersen R., Newman, J.F., (1973). "Societal and individual determinants of medical care utilization in the United States". *Milbank Memorial Fund Q Health Society* 51 (1): 95–124.

Bandura, A. (1986). *Social foundations of thought and action; A social cognitive theory*. Prentice Hall: Englewood Cliffs, N.J.

Burns, N., & Grove, S. (2009). *The practice of Nursing Research. Appraisal, Synthesis, and Generation of Evidence*. St Louis, MO: Saunders Elsevier.

Cahill, J. (1998). Patient participation: a review of the literature. *Journal of clinical nursing*, 7(2), 119-128.

Choudhry, U. K., (2001). Uprooting and resettlement experience of South Asian immigrant women. *Western Journal of Nursing Research*, 23, 376-393.

Commission on Social Determinants of Health. "Closing the gap in a generation: Health equity through action on the social determinants of health" (2005). (Accessed March 2012) Available at: [http://www.who.int/social\\_determinants/thecommission/finalreport/en/](http://www.who.int/social_determinants/thecommission/finalreport/en/)

Cooper L.A, Hill M.N, Powe N. R., (2002). Designing and evaluating interventions to eliminate racial and ethnic disparities in health care. *Journal General International Medicine*, 17:477-486.

Davis M., Bath P.A. (2001). The maternity information concerns of Somali women in the United Kingdom. *Journal of Advanced Nursing*, 36:237-245.

Delvaux, T., Buekens P., Godin I., Boutsen M., et.al. (2001). Barriers to prenatal care in Europe. *American Journal of Preventive Medicine*, 21(1):52-59.

Donatelle, R. (2009). *Promoting Healthy Behavior Change. Health: The basics*. (pp. 4). 8th edition. San Francisco, CA: Pearson Education, Inc.

Elliot D. (2005). Reading review papers. In: Schnider Z., Elliot D., Lo Biondo-Wood G., Haber, J. (eds). *Nursing Research. Methods, Critical Appraisal and Utilisation*. Sydney: Mosby Elsevier, 73-90.

Esegbone-Adeigbe, Sarah (2011). Acquiring cultural competency in caring for black African women. *British Journal of Midwifery*; 19(8): 489-496.

Essén, B., Hanson, S., östegren, B., Lindqvist, P., Gudmundsson, S.(2000a). Increases mortality among sub- Saharan immigrants in a city population in Sweden. *Acta Obstetricia Gynecologica Scandinavia*, 79:737-743.

Essén, B., Johnsdotter, S., Hoveliuss, B., Gudmundsson, S., Sjöberg N.O., Friedman J., Ostergren P.O. (2000b). Qualitative study of pregnancy and childbirth experiences in Somalian women resident in Sweden: *An International Journal of Obstetrics and Gynaecology (BJOG)*; Vol.107 (12), pp. 1507-1512.

Essén, B., Bödker B, S., Sjöberg, Langhoff-Roos, J., Greisen, G., Gudmundsson, S., Ostergren P.O. (2002). Are some perinatal deaths in immigrant groups linked to suboptimal perinatal care services? *An International Journal of Obstetrics and Gynaecology (BJOG)*; Vol.107 (12), pp. 1507-1512.

European Commission (2000). European Commission (2000) *The Evidence of Health Promotion Effectiveness, Shaping Public Health in a New Europe*. 2nd edn. Part One & Two. London, ML Design

European Health Forum Gastein (EHFG) (2011). Press Conference "Health without borders?"(Assessed 30 Dec 2011) EHFG Workshop 9 "Migration". 6 and 7 October 2011.

Elliot, D. (2005). Reading review papers. In: Schneider, Z., Elliot, D., Lo Biondo-Wood, G., Haber, J., (eds). *Nursing Research. Methods Critical Appraisal and Utilisation*. Sydney: Mosby Elsevier, 73-90.

European Urban Knowledge Network (EUKN) 2009 *Social Inclusion/ Integration of Social Groups, Ethnic Minorities*. (Accessed March 2012). Available at: <http://www.eukn.org>.

EURO-PERISTAT Project, with SCPE, EUROCAT, EURONEOSTAT. *European Perinatal Health Report. 2008, (European Strategic Approach 2008)*. (Accessed March 2012) Available at: [www.europeristat.com](http://www.europeristat.com).

Evans, D. & Kowanka, I. (2000). Literature reviews: Evolution of a research methodology. *Australian Journal of Advanced Nursing*, 18 (2), 33-38.

Healthcare Commission (2008) Towards better births: a review of maternity services in England. London: Healthcare Commission. (Accessed: 2 November 2011). Available at: [http://www.cqc.org.uk/\\_db/\\_documents/Towards\\_better\\_births\\_200807221338.pdf](http://www.cqc.org.uk/_db/_documents/Towards_better_births_200807221338.pdf).

Healthy People (2010). Centers for Disease Control and Prevention.

[http://www.cdc.gov/nchs/healthy\\_people/hp2010](http://www.cdc.gov/nchs/healthy_people/hp2010). (Accessed in March 2012).

Jonsdottir, H., Litchfield, M. & Dexheimer, M. (2004). The rational course of nursing practice as partnership. *Journal of advanced nursing*, 47, 241-250.

Kate, Mary-Ann & Jan Niessen.(2008). Guide to Location Migration Policies in the European Commission. 2nd ed. Brussels: Migration Policy Group 2008.

Lasser K. E., Himmelstein D. U., & Woolhandler S., (2006). Access to care, health issues, and health disparities in the United States and Canada: Results o a cross-national population-based survey. *American Journal of Public Health*, 96, 1300-1307.

Liaschenko, J & Fisher, A. (1999). Theorizing the knowledge that nurses use in conduct of their work. Scholarly inquiry for nursing practice: *An International Journal*, 13(1), 29-41.

Lyberg et al (2011). Lyberg A., Viken B., Haruna M. & Severinsson E. (2011) Diversity and challenges in the management of maternity care for migrant women. (Accessed: 25 November 2011). *Journal of Nursing Management*.

Malin M., and Gissler M., (2009). Maternal care and birth outcomes among ethnic minority women. *BMC Public Health*, 9:84.

McKenzie, J., Neiger, B., Thackeray, R. (2009). Health Education and Health Promotion. Planning, Implementing, & Evaluating Health Promotion Programs. (pp. 3-4). 5th edition. San Francisco, CA: Pearson Education, Inc.

Minkler, M. (1989). Health education, health promotion and the open society: An historical perspective. *Health Education Quarterly*, 16, 17-30.

Newhouse, J (1993). Free for All? Lessons from the RAND Health Insurance Experiment. Harvard University Press ISBN 0-674-31846-3.

Oxman-Martinez, J. & Hanley, J. (2006). Health and Social Services for Canada's Multicultural Population: Changes for Equity. Participants at the 6th Global Conference on Health Promotion. The Bangkok Charter for health promotion in a globalized world. Geneva, Switzerland: (Feb 4. Accessed 2011). *World Health Organization*, 2005 Aug 11.

Polit, D.F. & Beck, C.T. (2004). Evaluating research reports. In *Nursing research: Principles and methods* (7th ed., pp. 655 – 672). Philadelphia: Lippincott Williams and Wilkins.

Population and population change statistics (Eurostat 2010). (Accessed March 2012)  
<http://epp.eurostat.ec.europa.eu>

Reitmanova, S & Diana L. G., (2008). "They can't understand it": Maternity health and care needs of immigrant Muslim women in St. John's, Newfoundland. *Maternity and Child Health Journal*. Vol. 12: 101-111.

Whittemore, R. & Knafl, K. (2005). The integrative review: Updated methodology. *Journal of Advanced Nursing*, 52(5), 546-553.

Zanconato G., Lacovella C., Parazzini F., Bergamini V., Franchi M., (2011). Pregnancy outcome of migrant women delivering in a public institution in northern Italy. *Gynecologic and Obstetric Investigation*, ISSN: 1423-002X; Vol. 72 (3), pp. 157-62.

Zwart, J.J., Richters J.M, öry F., de Vries J.I.P., Bloemenkamp K.W.M., van Roosmalen J. (2008). Severe maternal morbidity during pregnancy, delivery and puerperium in the Netherlands -a nationwide population study of 371000 pregnancies. *An International Journal of Obstetrics and Gynaecology*. BJOG; 115:842-850.

**PART II: ARTICLE**

African migrant women´s perception of health disparities in pregnancy and  
childbirth: an integrative review

by

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## **African migrant women's perception of health disparities in pregnancy and childbirth: an integrative review.**

### **ABSTRACT**

This integrative review describes and establishes a synthesis of previous research on African migrant women's perception of health disparities in pregnancy and childbirth. 11 empirical articles were selected. The analysis process involved data reduction, data display, data comparison, syntheses and verification. One important theme emerged: Barriers to pregnancy and childbirth care. Barriers to care were manifested under three subthemes which are: i) Barriers at maternal level, ii) Barriers at health provider's iii) Barrier at health system level. Communication is adjudged the most important element in promoting the health of African Migrant Women during pregnancy and childbirth effectively. How nurses get key messages out in a clear, consistent and concise ways to those under their care can make a difference. However, the style of communication and timing is imperative. An authoritative, sometimes confrontational communication style can be construed as intrusive and repulsive.

Further studies should be targeted at health promotion interventions such as education, patient centered care and communication skills. In addition, research is needed to develop training modules that will breed excellent people skills in nurses to enable them respond to the real time needs of AMW thereby maximizing their professional impact.

**Keywords:** African migrant, health perception, health disparities, pregnancy and childbirth, health promotion.

## INTRODUCTION

This systematic review deals with African migrant women's (AMW) perception of disparities in health related to pregnancy and childbirth. Migrations in the European Union nowadays are the heart of policy debates at the national, regional and international level (Maffle, 2008). Their scales and complexities are prompting governments and the civil society to address the challenges and to consider appropriate solutions (European Health Forum Gastein (EHFG), 2011). In 2009, there were 14.9 million female migrants in the 27 countries of the European Union (EU), constituting 47.3 per cent of the foreign-born population. With regards to the distribution by continent of origin, 25.2 per cent came from Africa (Eurostat, 2010; European Urban Knowledge Network (EUKN), 2009). These groups of migrant women have different cultural values and belief patterns, behaviors, decision making tendencies and language proficiencies which pose major obstacles for nurses and health care systems in their host countries (EHFG, 2011; Maffle 2008).

According to EHFG (2011) report, one of the major obstacles is problem associated with pregnancy and childbirth. The European strategic approach (2008) indicated maternal mortality ratio in the EU Region was between 15 and 200 per 100,000 live births in 2002. In spite of dramatic reduction in maternal and perinatal morbidity and mortality within the EU through improved antenatal care, living conditions and health education yet, migrant mothers tend to miss out in all three respects (EHFG, 2011). The European strategic approach (2008) emphasized that maternal deaths in Europe are sentinel events that raise questions about the administration of effective treatment and the provision of substandard care. In this regard, women of African origin appear to have the most health problems during pregnancy and childbirth (minority women's health, 2010). A good proportion of their health issues go unreported as a result of cultural gaps in their expression of symptoms, acculturating, language barrier, expectations, discrimination and conflicting beliefs in systems (Choudhry, 2001; Lasser *et al.*, 2006; Oxman-Martinez & Hanley, 2006; Reitmanova & Gustafson, 2008). Promoting

healthy pregnancy and safe childbirth is therefore of utmost importance to counteract substandard care in European healthcare systems (WHO, 2007).

Globally, health promotion is defined as the process of enabling people increase control over their health and its determinants to improve their well-being and quality of life (WHO, 2005). The Ottawa Charter widened the debate by emphasizing a population approach, a focus on social context, the cause of disease and the need to employ a range of methods such as communication, education, legislation and community development (WHO, 1986). Before attainment of this goal, all sources and forms of disparities in the healthcare system especially that of vulnerable groups such as AMW ought to be identified. This, in turn will precipitate the development and implementation of appropriate interventions. One of such means to ascertaining the health disparities among African migrant's women (AMW) is to review previous research studies conducted on them. A systematic review may identify gaps in present knowledge, and provide suggestions for further research.

## **AIM**

The aim of the study was to describe and establish a synthesis of previous research on AMW's perception of disparities in health related to pregnancy and childbirth. The review questions addressed were: i) what is the current knowledge of African migrant women's perceptions of disparities during pregnancy and childbirth?

## **METHOD**

### **Design**

An integrative review was performed in order to determine current knowledge and establish a synthesis of understanding (Burns & Grove, 2011). It involved identifying, selecting and synthesizing previous research containing diverse methodologies. This approach included setting clear goals for the review, determining appropriate inclusion and exclusion criteria, and using a coherent search strategy that is replicable by others (Greenhalgh, 1997).

## **Search methods**

A systematic search of CINAHL, MEDLINE, Psych Info, ISI Web of Science and Academic Search Elite electronic databases was performed covering the period from January 2000 to December 2011. The following keywords were used in various combinations: “African migrant”, “health perception”, “health disparities”, “pregnancy and childbirth”, “health promotion” and “nursing”. The search was limited due to the inclusion criteria. In addition, references in relevant articles were manually scanned for studies that might have been missed by the database searches.

## **Inclusion and exclusion criteria**

The inclusion criteria employed were:

- Peer reviewed articles published in the period January 2000 – December 2011.
- Studies in English.
- Studies with quantitative and qualitative design.
- Studies focused on AMW living in Europe.
- Studies that included data related to AMW’s perception of disparities in health related to pregnancy and childbirth.

The exclusion criteria were:

- Studies focused on AMW but not related to pregnancy and childbirth.
- Studies focused on non-western migrant women with origin from countries other than Africa.
- Research conducted outside the European Union (EU).

## **Search outcomes**

Overall, the systematic searches produced 134 articles. The titles and abstracts where necessary were reviewed according to the inclusion and exclusion criteria after which 27 articles were considered relevant. These were then reviewed in their entirety, and 18 were excluded as it did not comply with the inclusion criteria and the research question. A manual search of the reference lists of the included studies and other relevant articles added 2 articles. The final sample consisted of 11 studies for further analysis (Table 1 in Appendix 1b). To render the research transparent, the retrieval and selection process is presented in Figure 1 in Appendix 1a.

## **Analytical process**

Inspiration was drawn from data analysis proposed by Whitemore & Knafl (2005). It involves the following steps: data reduction, data display, data comparison, synthesis and verification.

- 1) Data reduction phase entails devising an overall classification system that allows the reviewer to sort the data set into meaningful categories and promote comparison across diverse methodologies (Whitemore & Knafl, 2005). In this review, I began by using initial subgroup classifications such as a) AMW's contribution to health disparities, b) the health care provider's contribution to health disparities and c) the health system contribution to health disparities. Data were then extracted and coded in the group classification system.
- 2) Data Display is one in which the reviewer "assembles the data from multiple primary sources around particular variables or subgroups" (Whitemore & Knafl, 2005, p. 551). During this stage, various data displays were constructed that assisted in organizing the data in accordance with the group classification system.
- 3) Data comparison stage entails the identification of themes, patterns or relationships through an iterative process of examining the data displays (Whitemore & Knafl, 2005). For each data display, I looked for general patterns and themes, not only within the display itself, but

collectively among the displays. I used the review research questions at this stage to maintain focus on the intent of the review and prevent myself from being engulfed in the study details. The following questions were asked: 1) How do AMW contribute to barriers to care that lead to disparities of care? 2) How do health care providers contribute to barrier to care that lead to health disparities? 3) How do the health systems contribute to barriers to care that lead to disparities? 4) In what ways must health disparities during pregnancy and childbirth be viewed from health promotion perspective?

4) Synthesis and verification is understood as a concluding step of the data analysis in an integrative review, it involves “the synthesis of important elements or conclusions of each subgroup into an integrative summation of the topic or phenomenon” (Whittemore & Knafl, 2005 p. 551). This final stage of the analysis was commenced by critiquing the various elements of the study dimensions before attending to the task of summarizing the findings. Important elements were synthesized into an integrative summary of the topic, after which the main theme and the three sub themes were developed. I concluded by offering a preliminary synthesis of the studies’ findings, drawing conclusions on how these particular study dimensions could be conceptualized through the perspective of AMW’s perception of health disparities in pregnancy and childbirth.

## **SUMMARY OF FINDINGS**

Out of the eleven selected articles, five (5) had qualitative design (Essén et al, 2000a; Delvaux et al, 2001; Davis & Bath, 2001; Essén et al, 2002; Alderliesten et al, 2008) and six ( 6 ) were quantitative studies (Essén et al, 2000b; Alderliesten et al, 2007; Bollini et al, 2008; Zwart et al, 2008; Malin & Gissler, 2009; Zanconato et al, 2011). With regards to the origin, one each came from Italy (Zanconato et al, 2011), Finland (Malin & Gissler, 2009), Switzerland (Bollini et al, 2008) and UK (Davis & Bath, 2001), three each from Netherlands (Alderliesten et al, 2007; Alderliesten et al, 2008; Zwart et al, 2008) and Sweden (Essén et al, 2000a; Essén et

al, 2000b; Essén et al, 2002) and one was a case study (Delvaux et al, 2001 ) performed in a region comprising of ten Europe countries (Austria, Denmark, Germany, Greece, Hungary, Ireland, Italy, Portugal, Spain, and Sweden). None of the selected articles included illegal migrants however; three sub-themes emerged under the broad theme of “Barriers to pregnancy and childbirth care”. the three subthemes are: i) barriers at maternal level, ii) barriers at health care provider’s or nurses level and, iii) barrier at health care system level. Each of the themes is descriptively presented below in order to provide a comprehensive picture of the research field.

### **Barriers at maternal Level**

The findings revealed that low education of AMW acts as a barrier to the access of health care (Alderliesten et al, 2007; Delvaux et al, 2001). In addition to less education, AMW with no regular income and unplanned pregnancy were likely to receive inadequate care or face some specific barriers such as personal, socioeconomic, organizational and cultural when receiving care (Alderliesten et al, 2007; Delvaux et al, 2001). Moreover, it was evident that AMW’s lack of knowledge of the health care system in their host countries and health literacy played important role in how they received care (Delvaux et al, 2001; Alderliesten et al, 2007, Zwart et al, 2008). Essén et al. studies emphasized that AMW’s unawareness of service availability or lack of knowledge about the services at their disposal also act as a barrier to the use of health services (Delvaux et al, 2001, Essén et al, 2000a; Essén et al, 2000b).

Evidently, AMW’s short stay in their host country, their lack of social support network (Zwart et al, 2008; Bollini et al, 2008) and their feeling of loneliness and isolation during pregnancy and childbirth brought on by the absence of supporting relatives create barriers in seeking care (Essén *et al.*, 2000a). A number of studies underlined the fact that delay in seeking antenatal care, missed appointment jeopardizes the pregnancy outcomes of AMW (Bollini et al, 2008; Alderliesten et al, 2008; Alderliesten et al, 2007; Zanconato et al, 2001).

Most women from Africa construed safe delivery to be a normal vaginal delivery and thus, expressed fear of caesarean section which they perceived as a life threatening event (Essén et al, 2000a, Essén et al, 2002). The studies by Essén et al. revealed that AMW's apprehensiveness primarily are grounded on memories of the situation prevailing in their countries of origin (Africa) where there is high risk of maternal mortality and their knowledge of someone who had died through caesarean section. In the quest of AMW to avoid Caesarean section, they have had to adopt a strategy to voluntarily reduce their food intake thereby having small fetus: a situation that works best for them in Africa (Essén et al, 2000a). Furthermore, Essén et al. indicated that, AMW do not understand why routine antenatal care was necessary as pregnancy to them is a normal health state and only go for check-up if they think something is wrong (Essén et al, 2000a). In this regard, AMW actively sought health information when they deemed such information would lead to increased certainty and not cause distress whereas they avoided information when they believed they could not influence the outcome of the situation (Davis & Birth, 2001).

### **Barriers at provider's or nurse's level**

The findings revealed that cultural differences create barrier to care of African migrants (Alderliesten et al, 2007; Delvaux et al, 2001). Lack of cultural knowledge about, e.g. traditional family patterns and values are regarded as essential to the provision of health promotion and preventive care. Health personnel less knowledge of culture and tradition of African migrants can lead to neglect of potential risk factors, and contributes to adverse perinatal outcomes (Essén et al, 2000a). Malin and Gissler study revealed that nurses and midwives need supplementary training that is culturally sensitive and respond better to the health needs of women and their new-born (Malin & Gissler, 2009). Discourteous care and stereotypical attitudes towards minority patients such as AMW during pregnancy and childbirth have a detrimental effect (Bollini et al, 2008). African women reported they were denied information on prenatal care due



to punitive attitudes and prejudiced views among health professionals towards them (Malin & Gissler, 2009). Bollini et al. (2008), studies made mention of the need for deep societal change to integrate and respect migrant communities in receiving care. They emphasized that migrant women need targeted attention to improve the health of their newborn.

Communication problems due to language barrier jeopardize the pregnancy outcomes of AMW (Essén et al, 2002; Alderliesten et al, 2007; Malin & Gissler, 2009; Zanconato et al, 2011). AMW from Somali were unhappy about clinical practice and the quality of maternal care received. They wanted more information in the delivery room, pain medications, prenatal visits and roles of hospital staff (Malin & Gissler, 2009). According to Essén et al. (2002), it appears perinatal care services do not presently meet the communication needs required by a multiethnic population. The findings revealed that care of migrants and especially those of African origin could be improved by improving the communication between caregivers and the women concerned (Alderliesten et al. 2008). Reducing language barrier in an attempt to meet the needs of culturally diverse minority groups might also encourage women to obtain prenatal care (Delvaux et al, 2001). Booking time and waiting period of appointment and interpreters could lead to acquaintances and family members being used (Davis & Bath, 2001). However, concern about confidentiality with the use of family members as interpreters prevented African migrants from disclosing important issues that could be detrimental to their health leading to denial of appropriate medical care (Essén et al, 2002; Alderliesten et al, 2007). The use of different interpreters, and other untrained staff as interpreters with low level of medical knowledge, causes anxiety perceived to be a barrier to care given to Africa migrant women (Davis & Bath, 2001). Certain cases might also have had a positive outcome if there were routine use of interpreters (Essén et al, 2002; Malin & Gissler, 2009).

### **Barriers at health system level**

Health service organization remains significant impediments to care of AMW (Delvaux et al, 2001). Essén et al. (2000b) suggested the initial antenatal visit for screening AMW may not be sufficient or appropriate to determine those at risk. This may lead to fewer referrals to specialist care than would otherwise be needed (Essén et al, 2000b). Comprehensive prenatal care program, including appropriate location, consultation schedules and walk-in care facilities might favor adequate utilization of prenatal care services (Delvaux et al, 2001; Bollini et al, 2008).

Antenatal care programme has until now, lacked appropriate measures to meet the pregnancy strategies of AMW groups leading to substandard of care (Essén et al, 2002). Substandard care is present if perinatal care did not meet the defined minimally accepted standards (Alderliesten et al, 2008). Furthermore, insufficient monitoring of this group compared to the general population during pregnancy and childbirth, late arrival of pediatricians, delayed transfer to neonatal intensive care units were all identified as suboptimal factors (Essén et al, 2002; Alderliesten et al, 2007; Alderliesten et al, 2008; Zwart et al, 2008). Health care personnel's lack of experience in the surveillance of mothers of African origin and their infants, results in a less active and belated management (Essén et al, 2002). Malin and Gissler emphasized that, AMW had more visits to the hospital outpatient clinics during their pregnancies than any other ethnic groups. They had the highest caesarean section rates and six-fold mortality rate compared to any other groups (Essén et al, 2000a; Essén et al, 2002; Malin & Gissler, 2009). After delivery, the newborns were given more antibiotics and diagnosed to have more asphyxia and intubation (Malin & Gissler, 2009).

## DISCUSSION

The study created a synthesis of the research on AMW's perception of disparities in pregnancy and childbirth. It is important to acknowledge that the synthesized process and understanding were influenced by the authors perception and pre-understanding (Burns & Grove, 2011). The author of this article is a migrant, belongs to the African ethnic group, experienced pregnancy and childbirth health care and a nurse thus, my background affected the interpretation of results. On the other hand, it can be regarded as strength in terms of injecting useful and insightful knowledge and experience as an African migrant into this study. Nonetheless, for the complexity of knowledge due to substantively different types of knowledge that cannot be easily translated into each other, other authors with divergent interests may read the studies differently (Reid et al, 2009).

Though the 11 selected studies illuminate AMW's perception of disparities in pregnancy and childbirth, the generalization of the findings is limited due to the small number of studies. Barriers to health care are obstacles within health care system that prevent vulnerable patient populations from getting needed health care, or that cause them to get inferior health care compared to advantaged patient populations. Barriers to care lead to racial, ethnic and geographic disparities in health status and clinical outcomes. Important aspects to consider when caring for AMW during pregnancy and childbirth is the nurse's ability to notice cues such as emotions, place them within the context of the patient situation, integrate them with an understanding of the patient experience. In addition, the need for nurses to develop requisite people skills to find the right moment to impact on AMW and the communication prowess to get their messages out in clear, consistent and concise way is paramount in making a huge difference.

The review revealed that African cultures permeates through a vast range of traditions and religious practices which is why most women rely on traditional medicine and healing practices during pregnancy (Adeigbe, 2011). These beliefs continue despite acculturation and thereby

prevent individuals from seeking health advice. One major obstacle for caregivers in giving advice relating to childbearing is the clashes with cultural practices of AMW which they regarded to protect themselves and the unborn child during pregnancy and childbirth (Callister et al, 2001). The study revealed that, cultural conflict could be the basis by AMW to reject any health advice given them (Callister, 1993).

AMW as passionate as she is about her belief patterns and practices requires counseling, knowledge and skills to make lifestyle modification and cultural adjustments. The review identified education as an important component and mechanism to provide information and knowledge in the hope that, the recipient will subsequently modify their behavior as a result of their own choice (Adeigbe, 2011). The aims of educating AMW during pregnancy and childbirth are to improve their knowledge and skills to enable them take control of their own condition, understand their behaviors, seek medical help and early intervention when needed. The nurse should no longer feel responsible to solve all the woman's problems but instead, enter into a dialogue during which, solutions to problems emerge naturally from exploring issues in a relationship based on trust and respect. Care administered with the presumed intent of changing the recipient's life style, behavior or needs is construed as intrusive and repulsive. Because it assumes the nurse is superior, more competent, or more powerful (Walker et al, 1995).

Without cultural competence, nurse's background can create barriers to understanding their AMW. Cultural competence is obtaining cultural information and then applying that knowledge. This allows the nurse to see the entire picture while avoiding stereotyping and misapplication of scientific knowledge to improve the quality of care and health outcomes. A caregiver who lacks knowledge about cross-cultural, psycho-sociological and linguistic differences evident in diverse multicultural populations is likely to make inaccurate assessments (Adeigbe, 2011).

The findings indicated that nurse's communicative competency (Akerjordet, 2009) is central when providing culturally appropriate care. Weak communication skills and incorrect practices also act as a barrier. Women are most vulnerable during pregnancy and childbirth. At

that period their ability to verbally communicate or express their feeling diminishes. With a strong communication skill attribute, a caregiver can gauge the right feeling of the woman just by observing say, body language, facial expressions, emotional expressions and mood swings etc. (Corbett & Callister, 2000). In some instances, such observation might be the best means to decide giving the patient pain medication. However, the style of communication and timing is very paramount. AMW will express uncertainty in a variety of ways for example, openly stating fears, being quiet and withdrawn, numerous requests, lack of confidence and other demands. An authoritative, sometimes confrontational communication style can be construed as intrusive and repulsive.

In spite of every woman's right to obstetrical information during pregnancy and labor yet, sub optimal verbal communication made it impossible. Essén et al. (2002) study concluded present perinatal care services do not presently meet the communication needs required by a multiethnic population. This is supported by the research of International Organization of Migration (IOM), (2009).

Communication styles are distinct among diverse groups thus; knowledge of cultural differences in communication is paramount in the delivery of healthcare during pregnancy and childbirth (Lyberg et al, 2011). Callister (1993) studies indicated that women perceived nurses as knowledgeable when they communicated information, instruction, and advice. Information exchange between the nurse and the AMW recipient is very important (VandeVusse, 1999). The study of Bollini et al. (2008) recommended health promotion programme that is patient-centered and based on respect, compassion and the belief that human beings have an inherent drive to achieve their own physical, psychological, intellectual, and spiritual well-being.

## **CONCLUSION**

This review has provided important insights and adds important dimension into AMW perception of disparities in pregnancy and childbirth. There is no doubt that AMW form a group at risk of adverse pregnancy outcomes. This findings support the idea that nurse's ability to notice cues, place them within the context of the patient's situation, integrate them with an understanding of AMW's experience, and providing reassurance through their action and verbal response is crucial during pregnancy. In addition, the nurse's ability to develop good communication skills to get their messages out in a clear, consistent and concise way can make a huge difference.

In conclusion, health promotion that promotes culturally sensitive perinatal health care system which is not only accessible, but respects the beliefs, attitudes, and cultural lifestyle of AMW are is cardinal to safeguarding the reproductive aspirations of AMW. To this end, bringing perinatal health care parity to non-western migrant women should not be premised only on the provision of physical health care service and facilities but a need for a paradigm shift, one that imbibes the cultural background and expand the frontiers of inclusion of the individual.

Further studies should be targeted at health promotion interventions such as education, patient centered care and communication skills. In addition, research is needed to develop training modules that will breed excellent people skills in nurses to enable them respond to the real time needs of AMW thereby maximizing their professional impact.

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## **Authors Contribution**

Vivian Kruh was responsible for the study conception, design, data analysis and drafting of the manuscript. Kristin Akerjordet critically revised the manuscript.

## REFERENCES

Aday Lu Ann and Andersen R, (1975). A framework for the study of access to medical care. *Health Service Research*; 9(3): 208–220.

Akerjordet K. (2009). An Inquiry Concerning Emotional Intelligence and Its Empirical Significance. Doctoral Thesis. Department of Health Studies, Faculty of Social Sciences, University of Stavanger, Norway.

Alderliesten M. E., Stronks K., Jan M.M. van Lith, Smit, B.J., Marcel F. van der Wal, Bonsel G.J., & Bleker, O. P., (2008). Ethnic differences in perinatal mortality. A perinatal audit on the role of substandard care. *European Journal of Obstetrics & Gynecology and Reproductive Biology* 138: 164-170.

Alderliesten M. E., Vrijkotte, T. G. M., Marcel F. van der Wal & Bonsel G.J. (2007). Late start of antenatal care among ethnic minorities in a large cohort of pregnant women. *International Journal of Obstetrics and Gynaecology* (BJOG); 114: 1232-1239.

Burns, N., & Grove, S. K., (2011). Understanding nursing research. Building an evidence-based practice. 5<sup>th</sup> edition. Maryland Heights: Saunders Elsevier.

Bollini, P., Pampallona, S., Wanner, P., & Kupelnick, B. (2008). Pregnancy outcome of women and integration policy: A systematic review of the international literature. *Social Science & Medicine* 68(2009): 452-461

Callister, L. C. (1993). The role of the nurse in childbirth: Perception of the childbearing women. *Clinical Nurse Specialist*, 7(6), 288-293, 317

Callister, L. C., Vehvilainen-Julkunen, K., & Lauri, S. (2001). Giving birth: Perceptions of Finnish childbearing women. *MCN: American Journal of Maternal-Child Nursing*, 26, 28-32.

Choudhry, U. K., (2001). Uprooting and resettlement experience of South Asian immigrant women. *Western Journal of Nursing Research*, 23, 376-393.

Cooper L. A, Hill M. N, Powe N. R., (2002). Designing and evaluating interventions to eliminate racial and ethnic disparities in health care. *Journal of General International Medicine*, 17:477-486.

Corbett, C., & Callister, L. C. (2000). Nursing support during labor. *Clinical Nursing Research*, 9, 70-83.

Davis M., Bath P., A. (2001). The maternity information concerns of Somali women in the United Kingdom. *Journal of Advanced Nursing*, 36:237-245.

Delvaux, T., Buekens P., Go din I., Boutsen M., et.al. (2001). Barriers to prenatal care in Europe. *American Journal of Preventive Medicine*, 21(1): 52-59.

Dejin-Karlsson E, Ostergren P.,O. (2003). Psychosocial factors, lifestyle, and fetal growth: the added value of both pre- and post-natal assessments. *Europe Journal of Public Health* 13:210-217.

Elliot D. (2005). Reading review papers. In: Schnider Z, Elliot D, Lo Biondo-Wood G. Haber J (eds). *Nursing Research. Methods, Critical Appraisal and Utilization*. Sydney: Mosby Elsevier, 73-90.

Essén, B., Bödker B, S., Sjöberg, Langhoff-Roos, J., Greisen, G., Gudmundsson, S., Ostergren P.O. (2002). Are some perinatal deaths in immigrant groups linked to suboptimal perinatal care services? *An International Journal of Obstetrics and Gynaecology (BJOG)*; Vol.107 (12), pp. 1507-1512.

Essén, B., Hanson, S., östegren, B., Lindqvist, P., Gudmundsson, S.(2000a). Increases mortality among sub- Saharan immigrants in a city population in Sweden. *Acta Obstetricia Gynecologica Scandinavia*, 79:737-743.

Essén, B., Johnsdotter, S., Hoveliuss, B., Gudmundsson, S., Sjöberg N.O., Friedman J., Ostergren P.O. (2000b). Qualitative study of pregnancy and childbirth experiences in Somalian women resident in Sweden: *An International Journal of Obstetrics and Gynaecology (BJOG)*; Vol.107 (12), pp. 1507-1512.

Esegbone-Adeigbe, Sarah (2011). Acquiring cultural competency in caring for black African women. *British Journal of Midwifery*; 19(8): 489-496.

European Health Forum Gastein (EHFG) (2011). Press Conference “Health without borders?” EHFG Workshop 9 “Migration”. 6 and 7 October 2011. (Accessed 30 Dec 2011).

European Urban Knowledge Network (EUKN) (2009). Social Inclusion/ Integration of Social Groups, Ethnic Minorities. (Accessed March 2012). Available at: <http://www.eukn.org>.

EURO-PERISTAT Project, with SCPE, EUROCAT, EURONEOSTAT. European Perinatal Health Report. 2008, (European Strategic Approach 2008). (Accessed March 2012). Available: [www.europeristat.com](http://www.europeristat.com).



Greenhalgh, T. (1997). How to read a paper: getting your bearings (deciding what the paper is about. *BMJ* 1997; 315: 243)

Gagnon, A., Mazan, R., Desjardins, B., Smith, K., R. (2008). Post-reproductive longevity in a natural fertility population. In: Bengtsson T, Mineau G, editors. *Kinship and Demographic Behavior in the Past: Springer / IUSSP*. p 225-241.

Govender, R.D (2005). The barriers and challenges to Health Promotion in Africa. Department of Family Medicine, University of Kwa-Zulu Natal SA Fam Pract;47(10): 39-42

International Organization of immigration (2009). Maternal and Child healthcare for Immigrant Population. (Assessed June 2012). Available at: <http://www.migrant-health-europe.org>

Lasser K. E., Himmelstein D. U., & Woolhandler S., (2006). Access to care, health issues, and health disparities in the United States and Canada: Results o a cross-national population-based survey. *American Journal of Public Health* 96:1300-1307.

Mackey, M., & Stepan, M. (1994). Women's evaluation of their labor and delivery nurses. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 23, 413-420.

Malin M., and Gissler M., (2009). Maternal care and birth outcomes among ethnic minority women. *BMC Public Health*, 9:84.

Minority women's health (2010). Pregnancy related deaths. (Assessed June 2011). Available at: <http://www.womenshealth.gov>.

Oxman-Martinez, J., & J., Hanley. 2006. Health and Social Services for Canada's Multicultural Population: Changes for Equity.

Population and population change statistics (Eurostat 2010). (Accessed March 2012). Available at: <http://epp.eurostat.ec.europa.eu>

Participants at the 6th Global Conference on Health Promotion (2005). The Bangkok Charter for health promotion in a globalized world. Geneva, Switzerland: (Accessed 4 Feb 2009). *World Health Organization*.

Reid, B., Sinclair, M., Barr, O., Dobbs, F. & Crealey G. (2009). A meta-synthesis of pregnant women's decision-making processes with regard to antenatal screening for Down syndrome. *Social Science & Medicine* 69, 1561-1573.

Reitmanova, S., & Diana L. G. (2008). "They can't understand it": Maternity health and care needs of immigrant Muslim women in St. John's, Newfoundland. *Maternity and Child Health Journal*. Vol. 12: 101-11.

Urquia, M. L., Glazier, R. H., Blondel, B., Zeitlin, J., Gissler M., Macfarlane, A., Ng, E., Heaman, M., I Stray-Pedersen, B., & Gagnon, A., J. (2010). International migration and adverse birth outcomes: role of ethnicity, region of origin and destination. *Journal of Epidemiol Community Health*; 64:243-251.

VandeVusse, L. (1999). The essential forces of labor revisited: 13Ps reported in women's birth stories. *MCN: American Journal of Maternal-Child Nursing*, 24, 176-184.

Walker, J., Hall, S., & Thomas, M. (1995). The experience of labour: A perspective from those receiving care in mid-wife-led unit. *Midwifery*, 11, 120-129.

Whittemore, R. & Knafl K. (2005). The integrative review: updated methodology. *Journal of Advanced Nursing* 52 (5), 546-553.

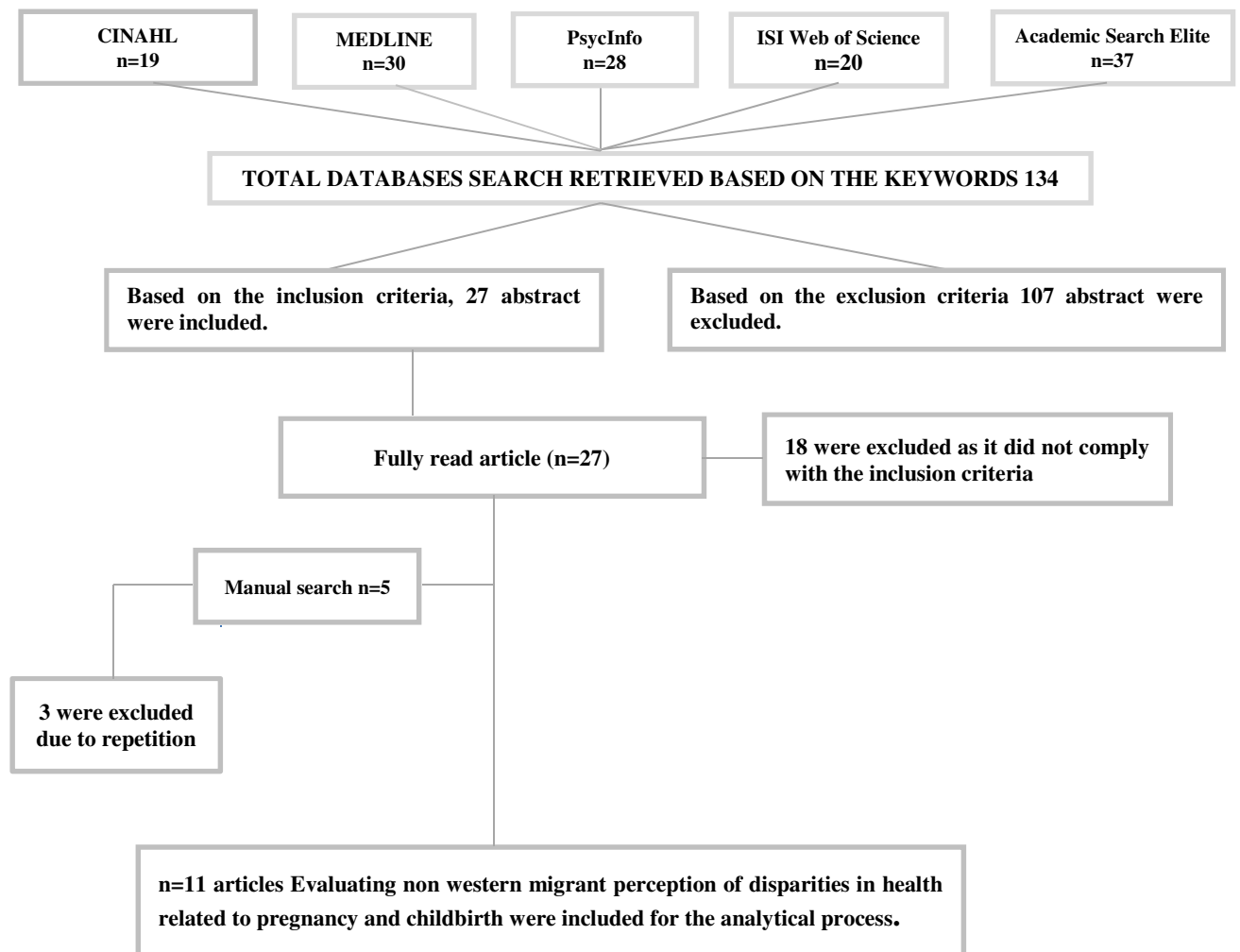
World Health Organization (1986). The Ottawa Charter for Health Promotion: First International Conference on Health Promotion, Ottawa, (Assessed 21 November 1986). Available at: <http://www.who.int>

World Health Organization (2005). New Bangkok charter for health promotion adopted to address rapidly changing global health issues Concludes 6th Global Conference on Health Promotion, Thailand, 7-11 August. (Assessed March 2011). Available at: <http://www.who.int>.

World Health Organization (2005). Pregnancy and Safe Childbirth: Maternal and perinatal health.

Zanconato, G., Lacovella C., Parazzini F., Bergamini V., Franchi M. (2011). Pregnancy outcome of migrant women delivering in a public institution in northern Italy. *Gynecologic and Obstetric Investigation*, ISSN: 1423-002X; Vol. 72 (3), pp. 157-162.

Zwart, J.J., Richters J.M, Öry F., de Vries J.I.P., Bloemenkamp K.W.M., van Roosmalen J. (2008). Severe maternal morbidity during pregnancy, delivery and puerperium in the Netherlands -a nationwide population study of 371000 pregnancies. *An International Journal of Obstetrics and Gynaecology (BJOG)*; 115:842-850.

**Appendix 1a: Figure 1.** Flow chart of the search outcomes and selection process

**Appendix 1b: Table 1.** Final articles pertaining to AMW's perception of disparities in health - integrative review

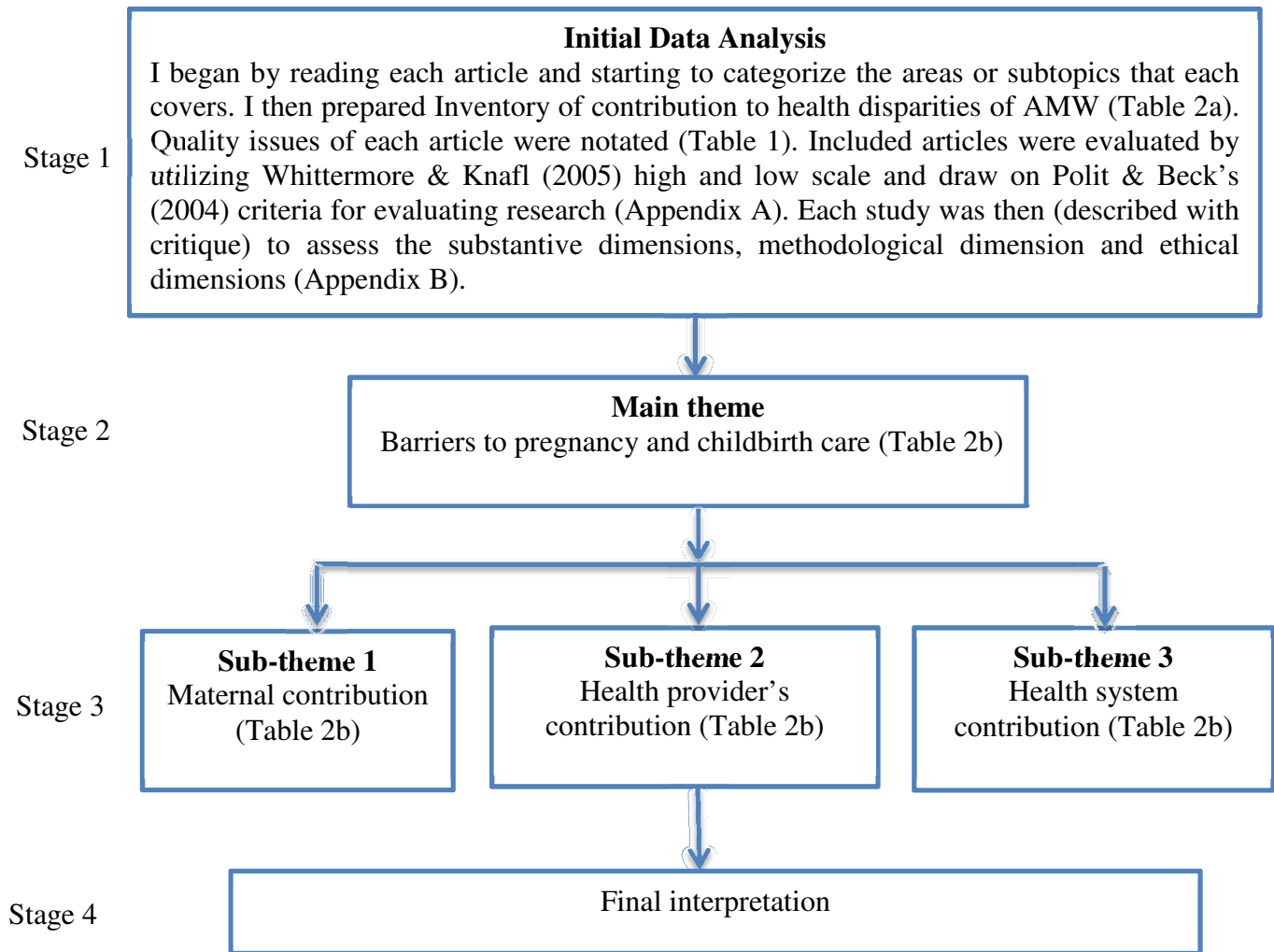
Author(s) and reference	Aim(s)	Sample size	Data collection and procedure	Analysis	Findings	Quality issues
<b>Essén, et. al. (2000a).</b>	To explore the culturally determined attitudes, strategies and habits of Somali immigrant women towards pregnancy and childbirth in Somalia as well as in Sweden, in order to gain an understanding of how such factors affect perinatal outcome.	15 women from Somali community in a city in Sweden between the ages of 20 and 55	Interpretive assisted qualitative in depth interview.	Systematic text analysis of the interview material was conducted.	The interview describes how the women themselves perceived their experiences of childbirth in the migrant situation. Many voluntarily decreased food intake in order to have a smaller fetus, an easier delivery and avoid caesarean section. The participants considered a safe delivery to be the same as a normal vaginal delivery. They reduced food intake in order to diminish the growth of the fetus, thereby avoiding caesarean section and mortality. The practice of food intake reduction, while rational for the participants when in Somalia was found less rational in Sweden and may lead to suboptimal obstetric surveillance.	The qualities of the studies were increased by the close relationship between the interviewer and the participants and women with language incompatibility were not excluded.
<b>Essén, et. al. (2000b).</b>	To investigate how the maternal country of origin affected the risk for perinatal mortality and to determine which are the perinatal risk factors that seem to be of importance in this context.	A study of 16,088 deliveries in University Hospital MAS, Malmö, Sweden.	Community based cohort study obtained from the Swedish Medical Birth Register from 1990 to 1995	Statistical analysis using SPSS, odds ratio with 95% confidence interval and multivariate analysis with logistic regression	Perinatal mortality was increased among infants to women of Foreign origin as compared to those delivered by women of Swedish origin. Even after adjustments for maternal background and risk factors (diabetes, anemia, pre-eclampsia, placental abruption and small- for- gestational age), the increased risk of perinatal mortality among women of Foreign origin remained statistically significant. Women from sub-Saharan Africa, comprising 7.3% of all immigrants, differed from all other subgroups of women of foreign origin by having a higher risk of adverse outcome.	All the participants were selected from one hospital
<b>Delvaux, et.al. (2001)</b>	To assess characteristics associated with inadequate prenatal care, and to identify the perceptions of childbearing women of possible barriers to care and the reasons for not obtaining it in Europe.	A total of 1283 women in ten European countries.	A case-control study. Postpartum interviews conducted from May 1995 to September 1996.	Crude odd ratios and 95% confidence intervals were calculated for all categorical variables.	Based on combined data of the ten countries, lack of health insurance was found to be an important risk factor for inadequate prenatal care. Women with inadequate prenatal care were more likely to be aged < 20 years and higher parity (number of children previously borne) than control. They were more likely to be foreign nationals, unmarried, and with an unplanned pregnancy. Women with inadequate care were also more likely to have less education and no regular income. They had more difficulties dealing with health services organization and child care. Cultural and financial barriers were present, but after adjusting for cofounders by logistic regression, perceived financial difficulty was not a significant factor for inadequate prenatal care.	The issues was known by the case respondents as well as the interviewers and might have influenced the way the questions were asked

Appendix 1b: Table 1. Continued

Author(s) And reference	Aim(s)	Sample size	Data collection and procedure	Analysis	Findings	Quality issues
<b>Davis, &amp; Bath, (2001)</b>	To explore the maternity information concerns of a group of Somali women in a Northern English city and to investigate the relationships of these women with maternity health professionals.	Unspecified number of English-speaking and non-English speaking Somali in a large English city.	A user-centered study utilizing a focus group and semi-structured interviews.	Qualitative analysis identifying themes passages of the transcript from 13 participants draws on naturalistic inquiry	Poor communication between the non-English speaking Somali women and health workers was perceived as an underlying problem in seeking information. Fears about misinterpretation and confidentiality, limit the usefulness of interpreters. The Somali women perceived that they were denied information due to punitive attitudes and prejudiced views among health personals.	Participants were selected using both purposive and convenience sampling techniques.
<b>Essén, et. al. (2002)</b>	To test the hypothesis that suboptimal factors in perinatal care services are more likely to result potentially avoidable perinatal deaths among immigrant mothers from the Horn of Africa, when compared with Swedish mothers.	183 perinatal deaths pregnant women from Horn of Africa and stratified sample of native-born Swedish women	Full cohort of pregnant women from the Horn of Africa and stratified sample of native-born Swedish women was made from 1990-1996	Statistical analysis using SPSS, odds ratio with 95% confidence interval and multivariate analysis with logistic regression	The rate of suboptimal factors likely to result in potentially avoidable perinatal death was significantly higher among African immigrants. In the group of antenatal death, the odds ratio (OR) was 6.3, the OR for intraparturial deaths was 13 and the OR for neonatal deaths was 18, when compared with Swedish mothers. The most common factors were delay in seeking health care, mothers refusing caesarean sections, insufficient surveillance of intrauterine growth restriction, inadequate medication, misinterpretation of cardiotocography and interpersonal miscommunication.	The cases was from a wide range of hospital across Sweden
<b>Alderliesten.et. al. (2007)</b>	To investigate the difference in timing of the first antenatal visit between ethnic groups and to explore the contribution of several noneconomic risk factors	Consecutive cohort of 12381 pregnant women ethnic groups were distinguished by country of birth	Data from a large prospective cohort of pregnant women in the city of Amsterdam between January 2003 and March 2004	Univariate and multivariate analysis using SPSS 12.0	All non-Dutch ethnic groups were significantly later in starting antenatal care during the whole duration of pregnancy compared with Dutch group. The range at which 90% were in care varied between 16 weeks and 3 days for Dutch and 24 weeks and 4 days for Ghanaians.	The mode of data collection combined with the large unselected cohort provided detailed information on ethnicity, timing difference and specific determinants.
<b>Alderliesten.et. al. (2008)</b>	To investigate the contribution of standard care to ethnic inequalities in perinatal mortality.	137 consecutive perinatal death cases	Perinatal audit from February until October 1999	The completeness of the cohort was established by comparing the data with the National Dutch perinatal Database.	In Surinamese and other non-Western mothers (mainly from Ghana) perinatal mortality, beyond 16 weeks' gestation, was statistically significantly higher than among native Dutch mothers.	The audit members were blinded to the ethnic background of the cases and judgment of substandard of care could not be influenced by the ethnic origin of mother

Appendix 1b: Table 1. Continued

Author(s) and reference	Aim(s)	Sample size	Data collection and procedure	Analysis	Findings	Quality issues
<b>Bollini et al., (2008)</b>	To make a qualitative synthesis of available evidence on association between pregnancy outcome and integration policy.	Pregnancy outcome of native versus immigrant women in Europe countries from 1966 to 2004	Epidemiological studies(cross-sectional studies, case control studies, or follow-up studies)	Statistical analysis was performed using statistical software package Stata.	The result highlights a serious problem of equity in perinatal health across European countries. Immigrant women clearly need targeted attention to improve the health of their newborn, but a deep societal change is also necessary to integrate and respect immigrant communities in receiving societies.	Papers were assessed and scored using the first three items of checklist adapted from Lognecker, et al.(1988)
<b>Zwart, et al., (2008)</b>	To assess incidence, case fatality, risk factors, and substandard care in severe maternal morbidity in the Netherlands	All pregnant women in the Netherlands (n= 371021) in a period of 2years in 98 hospital with a maternity unit in the Netherlands.	Prospective population-based cohort study	Statistical analysis was performed using SPSS statistical package 14.0	Non-Western immigrant women had a 1.3-fold increased risk of severe maternal morbidity when compared with Western women. Overall case fatality rate was 1 in 53, substandard care was found in 39 of a subset of 63 women (62%) through clinical audit.	Women were recruited from all the hospitals in the Netherlands. Study didn't record the individual characteristics of all maternities without severe maternal morbidity therefore RRs could not be adjusted for confounding variables.
<b>Malin, &amp; Gissler (2009)</b>	To compare the access to and use of maternity services, and their outcomes among ethnic minority women having a singleton birth in Finland	Study data included 6,532 women during 1999-2001 compared to 158,469 Finnish origin singletons.	Data based on the Finnish Medical Birth Register	Statistical analysis using frequency tables and adjusted mean values of each ethnic minority group, and the differences between migrant and the Finnish were tested using Student's t-test and the test of relative proportion.	Women of African and Somali origin had most health problems resulted in the highest perinatal mortality rate. Women from East Europe, the Middle East, North Africa and Somalia had a significant risk of low birth weight and small gestational age newborns. Most premature newborns were found among women from middle East, North Africa and South Asia. Primiparous women from Africa, Somalia and Latin America and Caribbean had most caesarean sections while newborns of Latin American origin had more interventions after birth,	The study included all recorded birth that took place during 1999-2001. Data collected are checked in the Medical Birth Register and seemingly incorrect information is sent back to the hospitals for correction.
<b>Zanonato et al.(2011)</b>	The study compares the obstetric outcomes of a native population and an immigrant population, focusing on relevant indicators of perinatal health; it also analyses pregnancy outcomes of distinct migrant sub-groups to ascertain disparities among patients of different geographical origin.	6,627 Italian and 2,768 immigrant women	Observational retrospective study during 5-year period from January 1, 2005, to December 31, 2009.	Statistical method where data were collected using Microsoft Office Access 2003 and were analyzed with Microsoft Office Excel 2003. 95% Confidence interval were calculated according to Confield and Fisher exact tests. Student t test and Mann-Whitney test utilized for comparison of means.	Immigrant women experienced very low birth weight ( $p < 0.005$ ) and preterm deliveries ( $p < 0.05$ ), more often than natives did. Among ethnic groups, data singled out Sub-Saharan African women to be at a higher risk for very small premature babies and caesarean section during labor.	All the participants were selected from one hospital

**Appendix 2a:** Figure 2: Description of Data Analysis

**Appendix 2b: Table 2.** Inventory of contribution to health disparities of AMW

<b>African migrant contribution</b>	<b>Health care provider's contribution</b>	<b>Health care system contribution</b>
Age (3,9,10)	Cultural knowledge (9)	Multilayered structure (4)
Maternal origin/ethnicity (2,7,8,9,10)	Communication (1,4,5,6,7,8,) Interpreters (1,4,5)	Service organization (3)
Health beliefs and practices (1,3,4,5,8,9)	Delay in recognition of symptoms (8,3)	
Fertility patterns (9)	Inadequate antenatal care (8,5)	
Social network (1)	Delay referral (8)	
Education level (3,6)		
Income (3)		
Marital status (3)		
Communication (1,4,5,6,7,8)		
Level of integration (10)		

(1) Essén,et.al.(2000a); (2) Essén,et.al.(2000a); (3) Delvaux,et.al.(2001); (4) Davis,&Bath,(2001); (5) Essén,et.al.(2002); (6) Alderliesten.et.al. (2007); (7) Alderliesten.et.al. (2008); (8) Zwart, et.al. (2008); (9) Malin, & Gissler (2009); (10) Zanconato et.al. (2011).



**Appendix 3: Table 3.** Overview of abstracted themes and sub-themes of AMW's perception of health disparities in pregnancy and childbirth.

Overall theme	Sub-theme	Categories
Barriers to care	Barriers at maternal level	Family and social support (1,2,3,7,8,9,10)
		Education (3,6,10)
		Health beliefs and practices (1,3,4,5,8,9,10)
	Barriers at providers level	Behavior (1,4,5,9,10)
		Cultural conflicts and social prejudice (9,10)
		Cultural competency in nursing practice and skills (8)
		Communication(1,4,5,6,7,8)
	Barriers at health system level	Organizational factors (1,4)
		Substandard of care (3,7)

(1) Bollini et al. 2008; (2)Essén et al.(2000a); (3) Essén et al.(2000a); (4) Delvaux et al.(2001); (5) Davis & Bath, (2001); (6) Essén et al. (2002); (7) Alderliesten et al. (2007); (8) Alderliesten et al. (2008); (9) Zwart et al. (2008); (10) Malin & Gissler (2009); (11) Zanconato et al. (2011).

**Appendix 4:** Summary of critique criteria for evaluating integrative research

An integrative review provides a succinct, current, thorough synthesis of research problem. I will utilize definition provided by Whittermore & Knafl (2005) high and low scale and draw on Polit & Beck's (2004) criteria for evaluating research. The following summarizes the key areas used in this literature review.

<b>Decision</b>	<b>Explanation of critique</b>	<b>Score</b>
Design problem	<ol style="list-style-type: none"> <li>1. Identification of the study question. Is it clear? Does it make sense?</li> <li>2. Where does it fit within the body of knowledge of African migrants perception of health disparities in pregnancy and childbirth?(My thesis question)</li> <li>3. What is the congruence between the study question and the methods used to address it?</li> </ol>	<b>3</b>
Setting and participant	<ol style="list-style-type: none"> <li>1. How was sample determined?</li> <li>2. How were they recruited, were the participants invited to join the study by force or choice?</li> <li>3. Are the sample size described?</li> </ol>	<b>3</b>
Data collection	<ol style="list-style-type: none"> <li>1. Does the literature review appear to be thorough?</li> <li>2. Are the ideas that are put forward logical and succinct?</li> <li>3. Is there a strong foundation communicated that explains the rationale for this study?</li> </ol>	<b>3</b>
Data analysis	<ol style="list-style-type: none"> <li>1. Is there congruence between the research variables as discussed in the introduction and described in the method section?</li> <li>2. Was statistical result (test value, p-value) detailed?</li> <li>3. Do the findings support or rebuke the theory if one is proposed.</li> </ol>	<b>3</b>
Ethical consideration	<ol style="list-style-type: none"> <li>1. Did the study discuss ethics approval?</li> </ol>	<b>1</b>
Relevance to nursing	<ol style="list-style-type: none"> <li>1. Are specific recommendations made concerning how the study could be improved or further research investigated?</li> </ol>	<b>1</b>
<b>Total score</b>		<b>14</b>

Polit & Beck (2004) Total scoring will be High= 12-16 Medium= 6-11 Low= 1-5. Adapted from Polit, D.F. & Beck, C.T. (2004). Evaluating research reports. In Nursing research: Principles and methods (7th ed., pp. 655 – 672). Philadelphia: Lippincott Williams and Wilkins

### Appendix 5: Table of literature reviewed for the integrative studies with critique

Citation	Primary type of research	Study Description with (Critique)
<p>Alderlisten, M. E., Stronks, K., van Lith, M.M.J., Smit, B.J., van der Wal F.M., Bonsel J. G., Blekker P.O. (2008). Ethnic differences in perinatal mortality. A perinatal audit on the role of substandard care. <i>European Journal of Obstetrics &amp; Gynecology and Reproductive Biology</i> 138:164-170.</p>	<p>Qualitative research (Perinatal audit) This study compared the perinatal death rates among ethnic groups living in the city of Amsterdam, the Netherlands, as indicator for perinatal care</p>	<p><b>Substantive dimension:</b> Perinatal mortality is reported as being higher among non-Western mothers (mainly from Ghana) than among native Dutch mothers. However, the result indicates that substandard care with maternal involvement plays a role in explaining their higher perinatal mortality rate. The study proposed that the care of pregnant migrants groups might improved by improving the communication between caregivers and the women concerned.</p> <p><b>Methodological dimensions:</b> This research was conducted in six hospitals in the city of Amsterdam, the Netherlands. It's included 137 consecutive cases of extended perinatal death from 16 weeks gestation onwards until 28 days after delivery. A total of 6922 deliveries occurred during the study period. Perinatal deaths are registered in the Dutch birth register from 16 weeks gestation onwards. The pattern of first antenatal visit consists of a booking visit around the 12<sup>th</sup> week of gestation, with independent midwife (low-risk pregnancy) or obstetrician (prior high-risk pregnancy). Forty-two percent of the women were nulliparous. The median maternal age was 31, (29 years in nulliparous and 33 years in multiparous) with no difference among ethnic groups. Only one mother was under 18 years of age. All but three deliveries occurred at the hospital under supervision of the obstetrician. Out of the 137 cases, 10 children represented five twin pairs and three children were each one of a pair twins. A higher percentage of mothers among ethnic minorities had a low socio-economic status compared with native Dutch mothers.</p> <p><b>Results:</b> perinatal mortality among non –Western mothers (mainly from Ghana) was statistically significantly higher than among native Dutch mothers (2.50 and 1.07%, respectively).</p> <p><b>Ethical Dimensions:</b> Ethical approval for this study was obtained from all participating hospitals.</p> <p>(This is study provides a new outlook of inequalities of perinatal mortality among non western migrants as compared to the native population. On the other hand, it fails to provide the cause of death).</p>
<p>Alderlisten, M. E., Vrijkotte, T.G.M., van der Wal F.M., Bonsel J. G. (2007). Late start of antenatal care among ethnic minorities in a large cohort of pregnant women. <i>BJOG, An International Journal of Obstetrics &amp; Gynecology</i> 114:1232-1239.</p>	<p>Quantitative Research (Prospective cohort study)</p>	<p><b>Substantive dimension:</b> All Dutch ethnic groups were significantly later in starting antenatal care during the whole duration of pregnancy compared with the ethnic Dutch groups. This article describes existing differential timing of the first antenatal visit according to ethnicity. They explore the contribution of several noneconomic determinants, both related and unrelated to ethnicity. Additionally, they propose ways of preventing such late starts and inadequate care in general if timing of the first antenatal visit is taken as a proxy</p> <p><b>Methodological dimensions:</b> This study describes existing differential timing of the first antenatal visit according to ethnicity. Data collection: Between January 2003 and March 2004, pregnant women were invited to participate in the study by their obstetric caregiver. In total, 12381 women were approached. A standard screening form, containing information on gestational age, was completed. All the women who were approached subsequently received a pregnancy questionnaire at their home address 2 weeks after the first antenatal visit. This questionnaire contained, among others, questions about maternal lifestyle and obstetric information. Questionnaires and standard screening forms were then linked with unique serial number. All approached women were asked to return the pregnancy questionnaires by prepaid mail. A written reminder was sent 2 weeks after the initial mailing. The questionnaire was available in Dutch, English, Turkish and Arabic language. Women who could read neither Dutch nor their mother language were offered the choice of responding to the questionnaire by telephone in their mother language.. The following factors were considered to be potential determinants for the date of the first antenatal visit: maternal age (&lt;20, 20–36, or &gt;36 years), language proficiency in Dutch (poor, fair, or good proficiency in Dutch), parity (primiparae versus multiparae), whether the pregnancy was wanted (yes or no), whether the pregnancy was planned (yes or no), risk awareness (stillbirth, miscarriage or severe congenital anomaly in the past) and maternal education level (years of education after primary school, defined according to three categories: &lt;5, 5–10 and &gt;10 years). (Excellent description of sample size and criteria). Data analysis: Survival analysis was performed because the variable gestational age at first antenatal visit (time till event) was of primary interest Descriptive life tables were used to calculate the percentage of women not in care at 18 and 24 weeks of gestational age. The full data set was used for these descriptive analyses. We restricted our data to all women who entered antenatal care after 9 completed weeks since we were not interested in the difference between 'early' and 'very early' antenatal care. Given the research objective, data were censored for those whose first visit was after 27 completed weeks of gestation. Ethnic-specific, first-visit curves were computed by the Kaplan–Meier method.</p> <p>A univariate survival analysis was used to analyses all determinants. A multivariate survival analysis was performed with the Cox-proportional hazards model, with inclusion of ethnic groups and all determinants that showed a univariate significant effect. Risk factors for late start were considered to be those with the highest prevalence of poor language proficiency .among Ghanaian (46.3%) and Turkish (43.1%) women. The study recommended that migrants should learn the language of their new host country and provides structures for health education. Additionally, the provision of information concerning early attendance of antenatal care should have an important role.</p> <p><b>Ethical Dimensions:</b> ethical approval for this study was obtained from the medical ethical committees of all Amsterdam hospitals and the registration committee of Amsterdam. All participating women gave written consent.</p>

## Appendix 5 Continued

Citation	Primary type of research	Study Description with (Critique)
<p>Bollini, P., Pampallona, S., Wanner, P., Kupelnick, B.(2008). Pregnancy outcome of migrant women and integration policy: A systematic review of the international literature. <i>Social Science &amp; Medicine</i> 68(2009) 452-461.</p>	<p>Quantitative Systematic synthesis of available evidence on the association between pregnancy outcomes and integration policies.</p>	<p><b>Substantive dimension:</b> the main hypothesis to be tested by this study is weather the differences in pregnancy outcome that we observe across receiving countries may be associated with varying degree of implementation of integration policies.</p> <p><b>Methodological dimensions:</b> Epidemiological studies conducted in European countries comparing pregnancy outcomes of immigrant and native women were the main source of evidence. 65 studies were included in this review out of which 47% were published between 1990-2004, 34% in the 1980s, and 19% in the 70s. Study quality was scored for all papers using first three items of a checklist adopted from Longnecker, Belin, Orza, and Chalmers (1988). The total number of pregnancy reviewed was over 18 million. Of which more than 1.5 million were immigrants and 6.5 million native. Statistical analysis was done relative risk (RR) or odd ratio (OR). Low birth weight was reported in 30 studies corresponding to 30bn series of native women and 73 series of immigrant women. 39 studies reported any risk factor and 18 studies reported low socio-economic status. Overall estimates point to a significant disadvantages for immigrants and more so in countries with weak integration policy. No recommendation was suggested.</p>
<p>Essén, B., Bödker B, Sjöberg, Langhoff-Roos, J., Greisen, G., Gudmundsson, S., Ostergren P.O. (2002a). Are some perinatal deaths in immigrant groups linked to suboptimal perinatal care services? <i>An International Journal of Obstetrics and Gynaecology (BJOG)</i>; Vol.107 (12), pp. 1507-1512.</p>	<p>Qualitative Research A perinatal audit, comparing cases of perinatal deaths among children of African immigrants residing in Sweden, with a stratified sample of cases among native Swedish women.</p>	<p><b>Substantive dimension:</b> The main hypothesis of this study is to test that suboptimal factors in perinatal care services resulting in perinatal deaths were more common among immigrant mothers from the Horn of Africa, when compared with Swedish mothers.</p> <p><b>Methodological dimensions:</b> Sixty-three cases of perinatal deaths among immigrant east African women delivered in Sweden hospital in 1990-1996, and 126 cases of perinatal deaths among native Swedish women. Perinatal death was defined as stillbirth after 28weeks of gestation, or death within the first week of life. Using the Swedish Medical Birth Register, all 63 perinatal deaths of children born in Sweden to women originating from Ethiopia, Somalia or Eritrea were identified (hereafter referred to as ESE). Statistical analyses were performed using SPSS. The study investigation shows that, to a significant degree, suboptimal factors in perinatal care which can be linked to perinatal death were observed among ESE mother than Swedish Mothers.</p> <p><b>Ethical consideration:</b> An expert panel of three obstetricians and one neonatologist was convened to review all the cases. Panelist worked with the narrative to identified suboptimal cares which were likely to have contributed to perinatal death. They were blind to the country of origin of each women studied. Primary criteria for identifying suboptimal factors were adopted from the EuroNatal study of perinatal mortality in Europe.</p> <p>(A very well done study; good summary: only problem was the lack of risk factors for perinatal death of migrant mothers).</p>
<p>Essén, B., Hanson, S., östegren, B., Lindqvist, P., Gudmundsson, S.(2000a). Increases mortality among sub- Saharan immigrants in a city population in Sweden. <i>Acta Obstetrica Gynecologica Scandinavia</i>, 79:737-743.</p>	<p>Quantitative Research A community based cohort studies.</p>	<p><b>Substantive dimension:</b> This study was to investigate how the maternal country of origin affected the risk for perinatal mortality and to determine which are the perinatal risk factors that seem to be of importance in this context Perinatal</p> <p><b>Methodological dimensions:</b> A total of 16,088 pregnancies giving birth at University Hospital MAS, Malmö, from 1990 to 1995. Information about pregnancy, delivery and the neonatal period was available in the perinatal database at the Department of Obstetrics and Gynecology, Malmö, which is the only delivery unit in the city</p> <p><b>Ethical consideration:</b> The study was approved by Ethics Committee of Lund University and by the Swedish Data Inspection Board. (Authors stated that information about participation in antenatal care, duration of residence in Sweden, the legal status of immigrant, refugee status or paternal country of birth were not available. The absence of these factors can make it difficult to determine migrant's right status and therefore the outcomes).</p>

## Appendix 5 Continued

Citation	Primary type of research	Study Description with (Critique)
<p>Essén, B., Johnsdotter, S., Hovellius, B., Gudmundsson, S., Sjöberg N.O., Friedman J., Ostergren P.O. (2000b). Qualitative study of pregnancy and childbirth experiences in Somali women resident in Sweden: An International Journal of Obstetrics and Gynaecology (BJOG); Vol.107 (12), pp. 1507-12.</p>	<p>Qualitative (Interpreted assisted)</p>	<p><b>Substantive dimension:</b> The main objective of the study is to explore the attitude, strategies and habits of Somali immigrant women related to pregnancy and childbirth, in order to gain understanding as to how cultural factors might affect perinatal outcome.</p> <p><b>Methodological dimensions:</b> Qualitative interview was performed, from October 1998 to January 1999, on fifteen women born in Somalia and now living in Sweden. The range of age was 20-55 years. The child experience varied from 2 to 9 children. The time elapsed since last delivery was between 6 months and 7 years. However their social and demographic backgrounds were heterogeneous. Interview topics were perception, attitude, practice and strategy regarding pregnancy and childbirth both in Somalia and Sweden. The women were asked questions about background and demographics condition. Data analysis: The interview was tape recorded and the Swedish version was then transcribed verbatim.</p> <p><b>Ethical consideration:</b> The study was approved by Ethics Committee of Lund University.</p> <p>(The female interpreter was informed beforehand about aim of the study and its topic and this can affect the action and interpretation of the interpreter).</p>
<p>Davis M., Bath P.A. (2001). The maternity information concerns of Somali women in the United Kingdom. Journal of Advanced Nursing, 36:237-45.</p>	<p>Qualitative study</p>	<p><b>Substantive dimension:</b> The study explores the maternity information concerns of a group of Somali women in the Northern English city and to investigate the relationship of these women with maternity health professionals.</p> <p><b>Methodological dimensions:</b> A user-centred study utilizing a focus group and semi-structured interviews with English-speaking and non-English speaking Somali women was conducted in a large English city. Discussions were audiotaped, translated, transcribed and then analysed using a variation of the constant comparative Method: Themes and categories were identified across transcripts during data collection and analysis and appropriate quotations are used to illustrate all themes.</p> <p><b>Ethical consideration:</b> informed written consent to permit a researcher (MD) to store and use data from the discussion was obtained by asking the participants to sign a consent and anonymity form, which was explained to them by interpreter. Focus group participants were also required to sign</p>
<p>Delvaux, T., Buekens P., Godin I., Boutsens M., et.al. (2001). Barriers to prenatal care in Europe. American Journal of Preventive Medicine, 21(1):52-9.</p>	<p>Qualitative Research</p>	<p><b>Substantive dimension:</b> In Europe, it is sometimes assumed that few barriers to prenatal care exist because extensive program of health insurance and initiatives to promote participation in prenatal care have been established for many decades. This study is to assess characteristics associated with inadequate prenatal care, and to identify the perception of childbearing women of possible barriers to care and the reason for not obtaining it in Europe.</p> <p><b>Methodological dimensions:</b> Postpartum interview was conducted from May 1995 to September 1996 in ten European countries (Austria, Denmark, Germany, Greece, Hungary, Ireland, Italy, Portugal, Spain and Sweden). The cases consisted of all women with inadequate prenatal care who gave birth during the study period in each participating hospital. A total of 1283 cases included in the study. 1239 women (96.6%) were interviewed at the maternity ward; 11 % were interviewed by telephone and for 44 women, data was taken from the medical files. Data were analyzed using SPSS for Windows, version 6.1.3(Chicago, SPSS Institute)</p> <p><b>Ethical consideration:</b> Participating countries had agreed on standard definitions before the start of the study. Inadequate perinatal care was defined as either no prenatal care, less than three visits, or late perinatal care.</p>
<p>Malin M., and Gissler M., (2009). Maternal care and birth outcomes among ethnic minority women. BMC Public Health, 9:84.</p>	<p>Quantitative research</p>	<p><b>Substantive dimension:</b> Study shows that people of migrant origin have barrier to obtaining accessible and good quality care compared to people in the host society. The aim of this study is to compare assess to and use of maternity services, and their outcomes among ethnic minority women having singleton birth in Finland.</p> <p><b>Methodological dimensions:</b> The study included 6,532 women of foreign origin (3.9%) with a singleton birth in Finland during 1999-2001. The data were linked to information in the general population register. woman's ethnicity was define by three items: her country of birth, (her nationality) and her mother tongue and consequently, we formed 15 ethnic minority groups which were:1) Finnish, 2) Nordic, 3) Western, 4) former Eastern Europe, 5) former Soviet Union, Russia, 6) Baltic, 7) Middle Eastern, North African, 8) South Asian (for example India, Pakistan, Bangladesh), 9) Chinese, 10) Iranian, Iraqi, Afghan,11) Southeast Asian (for example Philippines, Thailand, Malaysia excluded Vietnam), 12) Vietnamese, 13) African, 14) Somali and 15) Latin American, Caribbean. The statistical analysis was conducted using frequency tables and adjusted mean values of each minority group, and the differences between migrant origin groups and the Finnish origin group were tested using student's t-test and the test of relative proportion.</p> <p><b>Ethical consideration:</b> The ethical committee at STAKES (past National Research and Development Centre for Welfare and Health) approved the study protocol and the data protection ombudsman was informed about the study, as required by law.</p>

## Appendix 5 Continued

Citation	Primary type of research	Study Description with (Critique)
<p>Zanconato G., Lacovella C., Parazzini F., Bergamini V., Franchi M., (2011). Pregnancy outcome of migrant women delivering in a public institution in northern Italy. <i>Gynecologic and Obstetric Investigation</i>, ISSN: 1423-002X; Vol. 72 (3), pp. 157-62.</p>	<p>Quantitative study</p>	<p><b>Substantive dimension:</b> European societies are facing a wave of incoming immigrants and needs of a new multiethnic obstetrical population. It remains controversial whether native and immigrant women have equivalent pregnancy outcomes. This study compares pregnancy outcome of migrant women with those of native-born delivering in a public institution in northern Italy.</p> <p><b>Methodological dimensions:</b> This study is an observational retrospective study which includes 6,627 Italian and 2,768 immigrant women who delivered during the 5-year period from January 1, 2005, to December 31, 2009 at the Obstetrical Department of the University Hospital of Verona. Data were collected using Microsoft Office Access 2003 software and analyzed with Microsoft Office Excel 2003 program. Odd ratios with 95% confidence interval were calculated according to Cornfield and Fisher exact tests. Statistical significance was set at <math>p &lt; 0.05</math>. For comparison of means, the Student t test and the Mann-Whitney test were utilized. The data indicated that during the 5-years period, immigrant women from sub-Saharan African faced an increased risk of premature delivery, stillbirth and also delivered significantly more often C-section performed either before or during labor.</p> <p><b>Ethical consideration:</b> undertook the study on assumption that more information is needed to established if a difference exist in terms of the perinatal outcome between Italian and migrant women, which would imply a disparity in the quality of care offered.</p>
<p>Zwart, J.J., Richters J.M, öry F., de Vries J.I.P., Bloemenkamp K.W.M., van Roosmalen J. (2008). Severe maternal morbidity during pregnancy, delivery and puerperium in the Netherlands -a nationwide population study of 371000 pregnancies. <i>An International Journal of Obstetrics and Gynaecology</i>. BJOG; 115:842-850.</p>	<p>Qualitative study</p>	<p><b>Substantive dimension:</b> the aim of the study was to assess incidence, case fatality rate, risk factors and substandard care in severe maternal morbidity in the Netherlands.</p> <p><b>Methodological dimensions:</b> Women were included from 1 August 2004 until 1 August 2006. All 98 hospitals (100%) with a maternity unit in the Netherlands participated in the survey: 10 tertiary care centers, 33 non-university teaching hospitals and 55 other general hospitals. Study reported that immigrant women (mostly from sub-Saharan Africa) experienced and increased risk of severe maternal morbidity as compared with Western women.</p> <p><b>Ethical consideration:</b> Inclusion criteria were defined after searching the literature and after agreement with the National Maternal Mortality Committee of the Dutch Society of Obstetrics and Gynaecology. An expert panel of obstetricians advised about the design of the study.</p>

## Attachment 1: Author guidelines

### Authors Guidelines

Nursing & Health Sciences provides readers with a deeper understanding of health care around the world, and the opportunity to enrich their own practices to improve global health. The types of articles published in NHS are papers on:

- Original research of all designs and methods, related to clinical practice, education, health policy, health management, health service delivery and evaluation, or public health.
- Research methodology and protocols.
- Systematic reviews of research evidence (qualitative, quantitative, mixed methods); meta-analyses, meta-syntheses. (Please note that narrative or traditional literature reviews are no longer published).
- Scholarly papers presenting in-depth analysis and discussion of philosophical, theoretical, conceptual, professional practice or health policy issues or innovations. Authors should note that concept analysis papers are not a priority for publication in NHS.
- Commentary on previous articles published in NHS (include all details of the article being published) or Letters to the Editor.

**Acceptance Criteria:** Criteria for acceptance of manuscripts by NHS include: the originality and timeliness of the scholarly endeavor; the quality, clarity, and readability of the manuscript; and relevance of information.

**Ethical Guidelines:** The Editor-in-Chief takes final responsibility for this journal to ensure the highest standards of publication and reserves the right to reject any manuscript where it suspected there is unethical conduct during a research project, or in the manuscript authoring or content.

**Manuscript restrictions:** Due to space restrictions, the length of a manuscript must not exceed the totals stated below. Over length manuscripts will be returned to authors for revision prior to being considered for peer review.

Original research, practice or education articles: 4,000 words

Review article: 6,000 words

Special reports: 2,000 words

Commentary on previous papers published in NHS: 1,500 words.

- Submissions should be double-spaced.
- All margins should be at least 30 mm.
- All pages should be numbered consecutively in the top right-hand corner, beginning with the title page.

A covering letter must be submitted as a part of the online submission process, stating on behalf of all the authors that the work has not been published and is not being considered for publication elsewhere.

**Parts of the Manuscript:** Manuscripts should be presented in the following order: (i) title page, (ii) abstract and key words, (iii) text, (iv) acknowledgements, (v) references, (vi) appendices, (vii) figure legends, (viii) tables (each table complete with title and footnotes) and (ix) figures.

b) Footnotes to the text must not be used. Material should be incorporated into the text as parenthetical matter.

**Reference:** The list of references should be in alphabetical order. Cite the names of all authors when there are six or fewer; when more than seven list the first three followed by et al. Names of journals should be abbreviated in the style used in Index Medicus. Reference to unpublished data and personal communications should not appear in the list but should be cited in the text only (e.g. Smith A, 2000, unpubl. data). Examples of correct reference formats follow:

### **Journals**

Xiaolian J, Chaiwan S, Panuthai S, Yijuan C, Lei Y, Jiping L. Family support and self-care behavior of Chinese chronic obstructive pulmonary disease patients. *Nurs. Health Sci.* 2002; 4: 41-49.

### **Online article not yet published in an issue**

An online article that has not yet been published in an issue (therefore has no volume, issue or page numbers) can be cited by its Digital Object Identifier (DOI). The DOI will remain valid and allow an article to be tracked even after its allocation to an issue.

Aga F, Kylmä J, Nikkonen M. Sociocultural factors influencing HIV/AIDS caregiving in Addis Ababa, Ethiopia. *Nursing and Health Services* 2009 doi: 10.1111/j.1442-2018.2009.00448.x

### **Books**

Marriner-Tomey A, Alligood M. *Nursing Theorists and Their Work*. St Louis: Mosby, 2002.

### **Chapter in a book**

Redeker N. A description of the nature and dynamics of coping following coronary bypass surgery. In: Hyman R, Corbin J (eds). *Chronic Illness: Research and Theory for Nursing Practise*. New York: Springer, 2001; 25-35.

### **Report**

Osgood D, Wilson J. Co-variation of adolescent health problems. Report. Lincoln, NB: University of Nebraska, 2000. NTIS no. PB 91-154 377/AS.

### **Appendices**

These should be placed at the end of the paper, numbered in Roman numerals and referred to in the text. If written by a person other than the author of the main text, the writer's name should be included below the title.

**Figures:** should be supplied as a separate file, with the figure or table number incorporated in the file name. For submission, low-resolution figures saved as .jpg or .bmp files should be uploaded, for ease of transmission during the review process. Upon acceptance of the article, high-resolution figures (at least 300 d.p.i.) saved as .eps or .tif files should be uploaded. Digital images supplied only as low-resolution files cannot be used. Further instructions are available at the submission site. All illustrations (line drawings and photographs) are classified as figures. Figures should be cited in consecutive order in the text. Figures should be sized to fit within the column (83 mm), intermediate (117 mm) or the full text width (174 mm). Magnifications should be indicated using a scale bar on the illustration. Line figures should be sharp, black and white graphs or diagrams, drawn professionally or with a



computer graphics package. Lettering must be included and should be sized to be no larger than the journal text. Color figures Authors wishing to use color illustrations should contact the Editors. The cost of publishing figures, tables, illustrations or photographs in color will be met by authors, not NHS.

**Figure legends** should be self-explanatory and typed on a separate page. The legend should incorporate definitions of any symbols used and all abbreviations and units of measurement should be explained so that the figure and its legend is understandable without reference to the text. (Provide a letter stating copyright authorization if figures have been reproduced from another source.)

Tables should be supplied as a separate file, and should complement, but not duplicate, information contained in the text. Tables should be numbered consecutively in Arabic numerals. Each table should be presented on a separate sheet of A4 paper with a comprehensive but concise legend above the table. Tables should be double-spaced and vertical lines should not be used to separate columns. Column headings should be brief, with units of measurement in parentheses; all abbreviations should be defined in footnotes.

Proofs will be sent via e-mail to the corresponding author. The purpose of the PDF proof is a final check of the layout and of tables and figures. The proof should be checked, and approval to publish the article should be emailed to the Publisher by the date indicated; otherwise, it may be signed off by the Editor-in-Chief, or held over to the next issue.

Attachment 2: Covering letter to the Editor-in-Chief

28.07.2012

Stareveien 15H

4042 Stavanger

Norway

Sue Turale, the Editor-in-Chief.

Dear Sir

The enclosed integrative report describes and establishes previous research on African Migrant perception of health disparities in pregnancy and childbirth. A systematic literature search covering the period of January 2000 – December 2011 was conducted.

Eleven (11) studies that met the inclusion criteria were selected, analyzed and synthesized. One broad theme emerged: Barriers to pregnancy and childbirth care under which, there were three sub-themes which are: i) Barriers at maternal level, ii) Barrier at health provider's level and iii) Barriers at health system level. Communication is adjudged the most important element when promoting the health of African Migrant Women during pregnancy and childbirth. How nurses get key messages out in a clear, consistent and concise way to this group can make a difference.

I hope the manuscript will be of interest to readers of the Nursing & Health Sciences (NHS) journals. Please channel all future correspondences through my address as indicated above.

Yours Sincerely

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