

'Weighing up and balancing out': a meta-synthesis of barriers to antenatal care for marginalised women in high-income countries

S Downe,^a K Finlayson,^a D Walsh,^a T Lavender^b

^aResearch in Childbirth and Health (ReaCH) Group, School of Public Health and Clinical Sciences, University of Central Lancashire, Preston, Lancashire, UK ^bSchool of Nursing, Midwifery and Social Work, The University of Manchester, Manchester, UK

Correspondence: Prof. S Downe, Research in Childbirth and Health (ReaCH) Group, School of Public Health and Clinical Sciences, University of Central Lancashire, Preston, Lancashire PR1 2HE, UK. Email sdowne@uclan.ac.uk

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Background In high-resource settings around 20% of maternal deaths are attributed to women who fail to receive adequate antenatal care. Epidemiological evidence suggests many of these women belong to marginalised groups often living in areas of relative deprivation. Reasons for inadequate antenatal attendance have yet to be fully evaluated.

Objectives To identify the factors affecting access to antenatal care for marginalised pregnant women living in developed countries.

Search strategy We included qualitative studies from developed countries published in English language journals (1980–2007).

Selection criteria Qualitative studies exploring the views of marginalised women living in developed countries who either failed to attend for any antenatal care or did so late or irregularly.

Data collection and analysis Eight studies fulfilled the selection criteria and were synthesised in accord with the techniques derived from meta-ethnography.

Main results Initial access is influenced by late pregnancy recognition and subsequent denial or acceptance. Continuing access appears to depend on a strategy of weighing up and balancing out of the perceived gains and losses. Personal resources in terms of time, money and social support are considered alongside service provision issues including the perceived quality of care, the trustworthiness and cultural sensitivity of staff and feelings of mutual respect.

Conclusions A nonthreatening, nonjudgemental antenatal service run by culturally sensitive staff may increase access to antenatal care for marginalised women. Multiagency initiatives aimed at raising awareness of, and providing access to, antenatal care may also increase uptake.

Keywords Antenatal care, marginalised groups, meta-synthesis, systematic review.

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Introduction

Systemised screening programmes for antenatal care were introduced in Western Europe at the beginning of the 20th century.¹ By combining scientific innovations with an organised, preventative approach to health care, it was hoped that routine antenatal care would contribute to a reduction in perinatal and maternal mortality. During the following decades, a steady decline in maternal and infant mortality rates in countries offering standardised antenatal care seemed to validate this approach.^{2,3}

While early and regular attendance at antenatal clinics is still advocated in developing countries,^{4,5} the debate in high-

resource settings is now focused on evaluation. A Cochrane review of ten RCTs involving more than 57 000 pregnant women showed no difference in maternal mortality/morbidity rates between women attending fewer antenatal appointments (4–9 visits) compared with those adhering to the traditional model of antenatal care (12–14 visits).⁶ However, most of the participants in these studies involved 'low risk', women who might be expected to maintain a normal pregnancy regardless of the number of antenatal visits.

Evidence equating late, infrequent or nonattendance at antenatal services with adverse maternal outcomes is limited, but the recent UK Confidential Enquiry into Maternal and Child Health (CEMACH)⁷ highlights late booking or poor

attendance as an important associated factor in cases of maternal death. The same enquiry also suggests women from specific socio-demographic groups may be particularly vulnerable. Black African women from relatively deprived areas of the UK are not only less likely to attend antenatal care but also up to six times more likely to die during pregnancy or shortly after birth compared with their white counterparts.⁷

Reasons for late, infrequent or nonattendance at antenatal services in the UK have yet to be fully evaluated, but data from elsewhere (North America, Australia and Europe) indicate that epidemiological disparities are likely to be relevant. A number of interrelated factors have been identified including, high parity,^{8,9} low income,^{10–12} belonging to a minority ethnic group,¹³ low socio-economic status,¹⁴ low level of education^{9,15} and young maternal age.^{11,15} However, knowing that certain factors appear to influence outcomes does not tell us about the mechanisms and contexts in which these factors flourish. Interventions to address these factors cannot be devised unless the underlying mechanisms and contexts are understood and addressed.

From a UK perspective, the Black Report¹⁶ precipitated a flurry of antenatal-based research in the 1980s, but a recent quantitative systematic review of some of these studies found, 'little good quality evidence to support social and ethnic inequalities in attendance for antenatal care in the UK'.¹⁷ Notably, the authors of the review emphasise the need for further research in this area due to the poor quality and age of many of the studies they identified. They highlight barriers to access, particularly among marginalised minorities, as being of research interest and suggest this topic should be explored from a personal (woman's) viewpoint as well as a professional/service perspective.¹⁷

With this in mind, we set out to locate and synthesise qualitative accounts of barriers to antenatal care as reported by high risk, marginalised, pregnant women in the UK.

Methods

Design

Antenatal care is a complex intervention that is 'built up from a number of components, which may act both independently and interdependently'.¹⁸ There is a growing consensus that studies of complex interventions require a phased approach, beginning with an understanding of the theories underlying the intervention (i.e. why should it work?); moving through a planning phase to understand how it may work in practice; then moving on to methods of evaluating the effectiveness of the intervention that has been developed. This study is concerned with the relationship between the theory of antenatal care as a risk-reduction tool (it should work because it identifies and manages potential risk) and the apparent lack of uptake for a specific group of women who may be at risk of

serious morbidity and mortality (the limitations of the theory when it is applied to practice).

To model the nature of the limitations of the model to practice, we adapted the realist review approach, which is usually framed by the question, *what works, for who, and in what circumstances?* and the equation context + mechanism = outcomes.¹⁹ In this case, we were looking for 'what doesn't work, for who, in what circumstances', and we predefined the 'who' as marginalised, pregnant women receiving inadequate antenatal care.

We formulated a working theoretical model of current antenatal care provision in high-income countries as one of utilitarian surveillance²⁰ based on a healthism/lifestyleism approach to public health.²¹ Healthism/lifestyleism approaches presuppose that service users understand and accept the need to maintain good health (that they are 'health literate'), that they have personal autonomy, and possess the capacity and resources to access healthcare provision. In addition, there is an implicit assumption that pregnant women will trust caregivers and care systems and believe that professionals are competent and caring.

Search strategy

Preliminary searches confirmed our suspicions that there was a lack of UK-based research in this area. We therefore chose to broaden our inclusion criteria to include studies from countries with similar socio-economic demographics to the UK and general access to antenatal care provision (e.g. Europe, USA, Canada, Australia). Therefore, studies exploring antenatal care experiences, attitudes and/or beliefs from marginalised pregnant women living in resource-rich countries who were identified as having accessed antenatal care late, irregularly or not at all were all included in our initial searches.

We used the databases Medline, AMED, Embase, Cinahl, BNI, PsychInfo and the National Research Register to conduct our searches and used keywords covering the main search domains ('antenatal', 'prenatal', 'care', 'service', 'delay', 'late', 'access' and 'qualitative'). Some specific papers were recommended by colleagues and we hand searched relevant journals in the departmental and university libraries. Other articles were obtained from reference lists published in identified studies. All searches were restricted to papers published in peer-reviewed journals between 1 January 1980 and 15 November 2007. The year 1980 was chosen as a starting point since it coincided with the publication of The Black Report and would therefore catch the subsequent peak of interest in the health care of disadvantaged and marginalised UK populations.

Quality appraisal

Papers were assessed for quality using a tool developed from the amalgamation of several published quality checklists.²² This tool incorporates a pragmatic grading system based on

the work of Lincoln and Guba²³ and uses an A–D scoring system (Table 2). Studies scoring B/C or higher on the quality score were included in the final review.

Synthesis

For the synthesis, we used the meta-ethnographic approach developed by Noblit and Hare.²⁴ This has been used successfully in several different healthcare settings^{25–27} and is familiar to the authors.^{28,29} Recent applications of the technique have incorporated a range of research designs, and this approach is now more commonly referred to as ‘meta-synthesis’. Unlike a standard qualitative literature review, which is open to study selection bias and to simple summarising of alternative positions, the emphasis in meta-synthesis is on rigorous study selection and on theoretical interpretation of data across studies, contexts and populations.³⁰ This approach makes it easier to identify the full range of issues that emerge in relation to a specific topic and the application of these issues in a range of settings and for a range of service user groups. The technique is based on a careful analysis of both reciprocal findings (what is similar across the included studies) and refutational investigation (what is different or what challenges the emerging theory). The final synthesis must take account of both these similarities and differences and is ultimately expressed in a summary statement or ‘line of argument’ synthesis.²⁴

We began by identifying the findings from one paper and comparing them with the findings from another. This strategy of analysis, identification of findings and comparison was repeated across all eight papers with the objective of finding common themes. Once identified, these themes were subject to refutational examination to make sure that they explained all the original findings, and to check if we had missed anything that might contradict our emerging synthesis. Finally, the themes and concepts were mapped together into a ‘line of argument synthesis’.²⁴ This is a statement that integrates all the findings into a logical theoretical argument.

Results

Included studies

Of 5940 studies identified using the initial search criteria, 5561 were excluded by title because they failed to meet the preliminary selection criteria. Three hundred and seventy-nine studies were subsequently taken forward for detailed abstract review by two of the authors (S.D. and K.F.) independently. After evaluation and comparison, a further 278 studies were excluded because they were duplicates, only reported quantitative data, or were not research studies. The remaining 101 studies were subject to full text review by two of the authors (S.D. and K.F.) acting independently. Following evaluation and discussion, a further 89 studies were excluded because they either failed to reflect the views of marginalised women ($n = 44$), relied on the views of health

professionals ($n = 6$) were conducted in resource poor countries ($n = 14$), or contained no explicit information about delayed or inadequate attendance at antenatal services ($n = 25$) (see Figure 1, for flow diagram of search). Of the 25 papers in the last group, two were intervention based and sought the views of specific groups of marginalised pregnant women after particular interventions (to encourage antenatal access) had been put in place. We did not include either of these studies in the final synthesis as they failed to identify when or how often women attended either before or after the intervention. However, both are summarised in the discussion section of this paper as they offer further insights into scope of this review.

This left 12 papers that were taken forward for quality assessment. Two members of the research team (S.D. and K.F.) assessed the 12 studies independently and during a subsequent group discussion, a grade for each paper was reached by consensus. Four studies failed to meet the quality requirements; two because of insufficient data to support the findings,^{31,32} one because of an over reliance on quantitative data³³ and one, a 26-year-old occasional paper, which failed to meet contemporary quality standards.³⁴ The characteristics of the remaining eight studies taken forward for analysis and synthesis are summarised in Table 1.

Findings

The eight papers included in the final synthesis represent findings from three countries – six American, one Canadian and one from the UK. Participants included women from low-income backgrounds, from minority ethnic groups, the homeless, refugees, asylum seekers, substance abusers, women from travelling communities and women who had experienced domestic violence. Results indicate that a number of interrelated personal, structural and health provider barriers delay, curtail or prevent access to antenatal care.

The emerging themes, second-order constructs and final line of argument synthesis are summarised in Table 2. We identified three second-order constructs (summarised below) that relate specifically to factors impinging upon initial access to antenatal care and, just as importantly, sustaining access.

Initial access: personal factors

Awareness and acceptance of pregnancy. The ability of marginalised women to first identify and then to accept their pregnancy is highlighted in several studies.^{35–37} Younger women (adolescents and teenagers) were particularly likely to delay accessing antenatal care until late in the second trimester simply because they were unaware of typical pregnancy indicators.³⁵ In these circumstances, where youth and physiological naivety lead to deferred antenatal attendance, recognition of the signs and symptoms of pregnancy was often made by relatives, partners and other members of social networks.^{35–37}

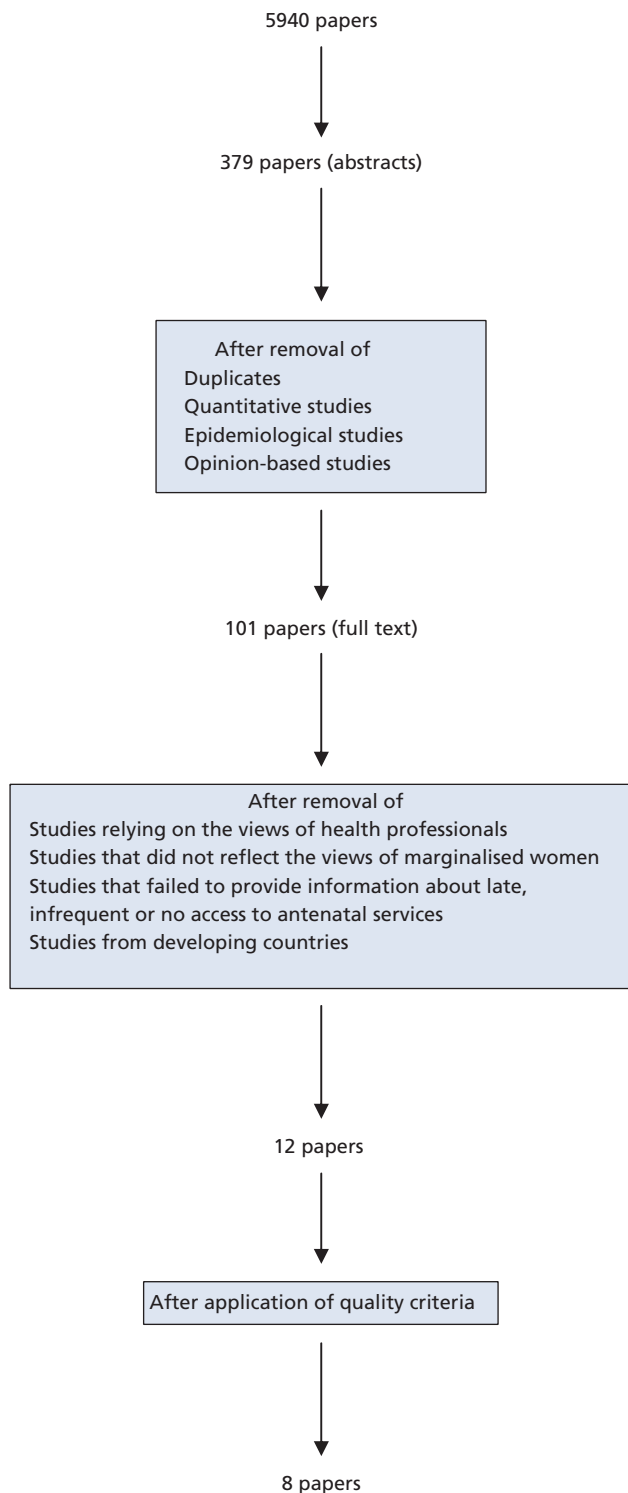


Figure 1. Flow chart summarising search strategy.

My baby's father was telling me 'you pregnant, you pregnant, I could tell by the way you act'. And I was like, 'No, I'm not'. So he's like, 'Okay, we're going to get up and go to the doctor'. So we went to the doctor and I was pregnant.³⁶

The indicators of pregnancy were more likely to be missed in unplanned and unexpected pregnancies.^{35–38} Even in circumstances where the evidence seemed overwhelming a sense of denial persisted in instances where the conception was unplanned. This view is typified by a Puerto Rican mother living in a low-income community in Chicago,

I knew I could take care of a baby but we weren't really ready financially. So I was kinda thinking to myself, if I don't go to the doctor maybe it will go away.³⁷

In contrast to the delight experienced by many women when a pregnancy is planned, the recognition of an unplanned pregnancy can be devastating. Many women recalled struggling to accept their situation as they were unprepared to make changes in their lives and they spent much time considering termination of pregnancy.^{35,37,38} In addition, the reaction and support from family, partners and friends appeared to have a significant effect on women's willingness to accept their pregnancy. Fears relating to parental or partner disapproval and concerns about being stigmatised by peer group members caused some study participants to delay accessing antenatal services until the second or even third trimester.^{35–37,39}

Influence of chaotic lifestyles. For women leading chaotic lifestyles, the motivation to attend antenatal clinics was frequently overwhelmed by the basic requirement to take care of simple survival needs. Indeed, homeless women and drug/alcohol misusers in the UK study tended to overlook virtually all healthcare needs in favour of more immediate survival concerns.³⁹ An alcohol-dependent woman from this study explained,

You can't plan ahead, you don't think, 'oh my baby'; you're going to go out and get some money for drugs or alcohol.³⁹

Trying to make enough money to survive or to maintain a drug habit led some women into periodic phases of homelessness and, in some cases, prostitution.³⁸ This kind of self-destructive behaviour is associated with a transient existence where regular engagement with health services is difficult to maintain and, from a provider perspective, difficult to monitor.

Perception that antenatal care offers no clear benefits. Even in instances where a pregnancy is recognised, accepted and wanted, there may still be a reluctance to engage with antenatal services if there is no belief that it might be beneficial. For some women who were late seekers of antenatal care in the USA findings suggest prenatal care was regarded with a certain amount of indifference.³⁶

If you go through all this prenatal care and something still come out wrong with the baby, where does that kick in? Versus if a person don't get prenatal care and their baby just as healthy as yours...³⁶

Table 1. Characteristics of studies included after quality review

Author/date/country	Mackey and Tiller (1998) (USA) ³⁵	Napravnik et al. (2000) (USA) ³⁸	Peacock et al. (2001) (USA) ³⁷	Sword (2003) (Canada) ¹²
Code	37	69	67	7
Topic area and aims	To study the descriptions and management of pregnancy/preterm labour among adolescents	To understand issues affecting prenatal care access and utilisation from the perspectives of HIV-infected women who receive inadequate prenatal care	To explore the process of pregnancy discovery and acceptance among a multicultural group of low-income primiparous women	To explore the use of prenatal services by women from low-income backgrounds
Theoretical perspective	No clear theoretical perspective	Not given	Not given	No clear theoretical perspective
Design	Naturalistic approach based on grounded theory	Interview study	Focus groups using participatory action research methodology	Grounded theory
Setting and context	Two medical centres in South Eastern USA	Two paediatric clinics in 'Central North Carolina'	Low-income communities in Chicago	Two 'deprived' areas of Ontario
Sampling strategy and sample size	Purposive sampling of adolescents younger than 20 years; 24–35 weeks of gestation, singleton pregnancy; strategy unclear (N = 13)	Convenience sampling of women who had experienced a live birth while HIV infected and who initiated prenatal care in or after the fifth month of pregnancy or who had <50% of the recommended number of antenatal care visits (N = 3)	Purposive sampling of five charitable community-based healthcare organisations; eight focus groups: 8–12 participants in each (N = 87)	Initial contact via staff at local antenatal care programmes, then snowball sampling to recruit nonattenders: theoretical sampling (N = 26)
Other participant characteristics	Age range 14–19 (mean=16.9); ten single, two married and one separated; five at school and five employed; 11 unplanned pregnancies; five began prenatal care between 5 and 7 months	Full case histories given. Two with multiple drug and socio-economic problems, one with family history of AIDS but no other obvious socio-economic problems	28% African American; 24% white women; 26% Mexican; 22% Puerto Rican; age range: 16–42. Median: 21.5; 63% – 'unintended' pregnancy; 9% had low birth weight infant (<2500 g); 7% had premature babies	27 years old (median); 73% – unemployed; 42% – some secondary education; 42% – family income between \$10 000 and 14 999; all had more than one child at home
Data collection methods	'Intensive' interviewing in hospital, after birth and at home, each had one to seven interviews (total 61)	Semistructured interviews	Focus groups – semistructured questions – some conducted in Spanish	Three focus groups + two individual interviews
Analytic approach	Coding and categorising using a grounded theory approach	Inductive thematic analysis. Two independent coders and consensus on themes	Transcripts analysed using Atlas.ti 4.1. – identification of themes cross-referenced into topic areas	Grounded theory – constant comparison and theoretical saturation. Feedback to participants for verification
Quality rating	B/C	B/C	B	B

(continued)

Table 1. (Continued)

Author/date/country	Dartnall et al. (2005) (UK) ³⁹	Lutz (2005) (USA) ⁴⁰	Tandon et al. (2005) (USA) ⁴¹	Daniels et al. (2006) (USA) ³⁶
Code	83	40	17	64
Topic area and aims	To identify how the Department of Health could encourage marginalised groups to access maternity services	To explore how intimate partner abuse during pregnancy influences women's decisions about seeking care and disclosing abuse	To better understand Hispanic women's perceptions of prenatal care providers patient centeredness	To identify attitudinal and psychosocial determinants of early prenatal care among black women of low socioeconomic status
Theoretical perspective	Not given	No clear theoretical perspective	Not given	Not given: although a qualitative method is used
Design	Two-stage interview study	Symbolic interactionism using grounded theory	Interview study	Focus group study
Setting and context	London based? (not clarified). Details of each group given	Two prenatal clinics in Pacific North West	Palm Beach county, Florida: high Hispanic population	Community health centres in Atlanta, Georgia
Sampling strategy and sample size	Two phases: phase 1 – approached SH from 'intermediary organisations' for target audiences. Phase 2: purposive sample of women from target audience; both 'users' and 'minimal users' of antenatal care were included; sample size: phase 1 – n = 14; phase 2 – 'minimal users', n = 12, +4 fathers; users n = 26, +3 fathers	Convenience-based sampling via clinic for women who had suffered abuse – then snowball technique for theoretical sampling based on emerging themes and concepts. Uptake slow so resorted to retrospective accounts; 21 interviews with 12 diverse participants	Intended: proportionate random sample of both early and late initiators, stratified by ethnicity; N = 358: 68 'late' (third trimester); total number of Hispanic participants = 125 (numbers of early/late initiators among the Hispanic population not given)	Appears to be initially convenience sampling (black women seeking prenatal care or who had received it in the last 2 years) and then purposive to create groups of early and late (after first trimester) initiators of prenatal care; 114 approached: 61 consented; 32 took part
Other participant characteristics	Pakistani/Bangladeshi women: three + one SH; Somali women (Muslim): three + two SH; Asylum seekers: five + one SH; learning disabilities: ten + one SH; travelling women: four + two SH; homeless women: four + one SH; dependent on alcohol: one + two SH; dependent on drugs: three + three SH; teenagers: five + one SH; fathers: seven + one SH	Six white women, four black women and two Arab American; two did not complete high school; six employed and six unemployed; five currently being abused; two delayed seeking prenatal care: + 'irregular' attenders	Hispanic group; 49% high school graduates; 49% married; 33% private insurance; 24.6 years median; 30% late initiators; 42% primiparous	Age range 16–36, mean 22; 72% high school graduates; 88% below poverty line; 89% single; 92% Medicaid recipients; final number of early and late initiators not given, although at least 12 were identified as early and 7 late
Data collection methods	Phase 1: in-depth interviews and 'mingroup' discussions Phase 2: Not stated	First interview: establish rapport, collect demographic info, obtain consent then in-depth follow-up interview; field notes, analytic memos Grounded theory approach, including coding and analysis during data collection, theoretical saturation and theory development	Semistructured interviews	Semistructured focus groups
Analytic approach	Not stated		Atlas ti 4.1. analysis concurrent with data collection, using open and then pattern coding	Inductive thematic coding using NUDIST 6. Review of intercoder consistency and further external review
Quality rating	B	A–B	B/C	B

SH, stakeholders.

Key to quality rating system: A, no or few flaws. The study credibility, transferability, dependability and confirmability is high; B, some flaws, unlikely to affect the credibility, transferability, dependability and/or confirmability of the study; C, some flaws that may affect the credibility, transferability, dependability and/or confirmability of the study; D, significant flaws that are very likely to affect the credibility, transferability, dependability and/or confirmability of the study.

In the UK studies, similar feelings of ambivalence were highlighted by some women in marginalised communities who tended to view any form of state organised health provision with a degree of suspicion. Romany travellers, for example often chose traditional approaches (using natural remedies) to antenatal care in preference to conventional care because of a historical mistrust of state-regulated health care.³⁹ A reliance on traditional, cultural approaches was also identified in participants from the UK Asian Muslim community who sought advice and support from community elders rather than health professionals.³⁹

Pregnancy as an opportunity for change. Despite the fact that the papers were selected on the basis of barriers to access, there was evidence that being pregnant offered strong incentives to some women to re-evaluate and, in many cases, alter their current lifestyle.^{12,38,40} One HIV-infected participant, who had hitherto financed her existence via prostitution, described her transformative moment in the following manner,

I think what happened is that I made, I don't know if I should say a spiritual awakening, love for another human being, my baby ... because before I was pregnant I just did crazy things, I didn't care about myself. I always wanted to die ... It was like the whole earth changed but it was me changing, and I said, well, I got to do this right.³⁸

Prompted by such moments of enlightenment some women sought the best possible care for their unborn child and willingly attended antenatal clinics relatively early in their pregnancies even though this was not the norm for their peer group.

Initial and sustaining access: social factors

Influence of resources. The perception that UK antenatal provision is free and therefore universally available is countered by findings, which suggest that personal and provider resources maybe stretched in certain circumstances.³⁹ Personal costs incurred by travelling to and from antenatal clinics may put a strain on the limited financial resources of women from relatively deprived communities or those leading chaotic, transient lifestyles. For healthcare managers, the indirect costs of providing interpreters, translators or advocates may place an untenable burden on limited resources. These factors may diminish the potential for women to access antenatal care early and regularly.³⁹

The UK study³⁹ also identified a number of marginalised groups who were either unaware of antenatal provision or found antenatal services difficult to access. Asylum seekers reported that they did not know how to access care or were under the impression they would have to pay for it. Finding information in a relevant and understandable format also presented problems for some. Although many non-English-

speaking participants understandably struggled with language and communication difficulties even native speaking residents from some marginalised groups (teenagers and the homeless) remained unaware of the full range of services available.³⁹ A London-based homeless woman explained,

I didn't know about antenatal care or classes, no one told me about it, I just got on with it and tried to do it myself, no one explained anything³⁹

Need to value women's time. Having accepted their pregnancy and found the motivation to attend an antenatal appointment, some women in the North American studies found themselves increasingly frustrated at the amount of time they had to wait for a consultation.^{36,37} In many cases, this had a detrimental effect on future visits:

My first visit, it took 5 hours to see me and I was mad. I was fixing to leave. That's why I don't like going to the doctor. That's why I just stayed home next time.³⁶

From a slightly different perspective, findings in the UK suggest that the 'onerous family and domestic responsibilities' assumed by many Asian Muslim women restrict antenatal visits, even when there is a willingness to attend. Providers offering rigid and inflexible appointment systems did little to foster a more user friendly service.³⁹

Sustaining access: provision of care

Need for care in the caregiving. The standardised, routine nature of antenatal appointments left many women feeling unrespected and objectified.^{12,38,41} When health professionals became more focused on the task at hand rather than interacting with the women in their care, the inclination to return for future appointments was diminished.^{12,39,41} The thoughts of a US-based Hispanic mother encapsulate these feelings of alienation.

They would rush me and not talk to me during appointments. They wouldn't answer my questions which was so rude. It just seemed like they had too many appointments and didn't want to be bothered with me.⁴¹

This industrialist, time critical approach to antenatal care where speed and efficiency are favoured over interaction and care was also noted in a UK setting.

Many (pregnant women) felt unable to ask health professionals questions, and some left (antenatal) appointments feeling worse than when they first came in, which deterred them from making and attending future appointments.³⁹

Even when health professionals took the time to address nonfetal concerns, the crude methods employed to elicit information were sometimes regarded with suspicion and alarm. One US study exploring the prenatal experiences of domestically abused women found the methodical and insensitive

Table 2. Emerging themes and concepts

Themes, first iteration	Relevant papers	Second-order construct final iteration	Core concept
Awareness and acceptance of pregnancy	37, 64, 67, 69	Initial access: personal factors	Weighing up and balancing out
Influence of chaotic lifestyles	69, 83		
Perception that clinic offers no clear benefits	64, 83		
Pregnancy (care) as opportunity for change	7, 40, 69	Initial and sustaining access: social factors	
Influence of economic/resource issues	69, 83		
Need to value women's time	64, 83	Sustaining access: provision of care	
Need for caring in the caregiving	7, 17, 40, 64, 69, 83		
Need for respect for women and for their lifestyle and self-knowledge	7, 17, 40, 69, 83		
Need for cultural, emotional and physical safety	40, 69, 83		
Need for staff credibility and excellent communication/interpersonal skills	7, 17, 69, 83		

screening techniques adopted by health professionals did little to encourage a caring relationship and discouraged women from attending future appointments.⁴⁰

I didn't feel like the questions that were asked really covered what was going on. It was more emotional at that point, but it (screening for domestic abuse) doesn't really address that.⁴⁰

In contrast, when health professionals were perceived to be kind, attentive and courteous, the antenatal experience was greatly enhanced. When asked to make recommendations to foster a more disclosure friendly environment, the abused participants in the above study described empathy, concern and a willingness to focus on the woman (as well as the fetus) as being of particular importance.⁴⁰

Need for respect for women and for their life and self-knowledge. Encounters with nurses, midwives and doctors were perceived as disrespectful when genuine concerns and queries were minimised or dismissed by health professionals.¹² Women became increasingly frustrated when this dismissive attitude conflicted with their personal views.

I remember telling them, you know, like I know my iron is low and they're trying to tell me no, it's not, it's because you work and maybe you need to give up your job, and it's like pardon me, like this is my body, I should know They finally checked after telling me many times, and you know, I was right, you know like they should listen to you in the first place.¹²

Women also felt a lack of respect when they sensed their lifestyles were being judged unfavourably. For many marginalised groups in the UK, previous negative encounters with health providers had undermined their self-esteem. A drug user explained,

I didn't feel like going there (to an antenatal scan), it's like they see you differently, they don't see you as a normal person, they see you as a drug addict.³⁹

This perception of being labelled and judged was shared by Romany travellers, alcoholics, drug addicts and some minority ethnic populations.³⁹

Need for cultural, emotional and physical safety. For HIV-infected women in one of the US studies, the general support of health professionals was occasionally compromised by lapses in confidentiality.³⁸ Being talked about in front of other people or referred to as 'the woman with HIV' made participants feel uncomfortable and being identified as 'HIV' in front of other (known) members of the community made participants feel emotionally and even physically unsafe.³⁸

From a different perspective, participants in the UK highlighted 'mistrust of healthcare providers' as being closely linked with physical and emotional safety.³⁹ Women from several marginalised groups (drug and alcohol abusers and women with learning difficulties) expressed concerns about what might happen to their baby after birth. A suspicion that social services would be informed and their baby taken from them discouraged further engagement. This perceived threat to emotional and physical safety was also experienced by asylum seekers who failed to engage with antenatal services.

In addition, participants from several minority ethnic groups, particularly Asian Muslims, were less likely to maintain antenatal appointments if their traditional values were ignored. Being seen by a male doctor, for example transgressed cultural, emotional and even physical safety conventions.³⁹

Need for staff credibility and excellent communication/interpersonal skills. Women found it difficult to accept antenatal advice from midwives who had never experienced a pregnancy.¹² Credibility was further undermined if interventions were recommended, which were perceived to be inappropriate

or unnecessary. Even in situations where appropriate advice was given, women found it difficult to accept if there was a suspicion that the advisor would not behave in such a way themselves. One US participant described an encounter with a nurse,

She'd tell you all about cleanliness and how to take care of your baby and everything and she's, you know, preaching at us about all this, when she's not a very clean person.¹²

Such inconsistencies can deter women from attending future antenatal appointments and may be exacerbated by the poor communication skills of some staff members. For example participants encountered rudeness,⁴¹ harshness,³⁹ discrimination^{38,39} and insensitivity.^{36–38} For marginalised women who are already feeling insecure and vulnerable, the level of impoliteness expressed by some staff members may discourage antenatal attendance during a current pregnancy and, more importantly, curtail any further involvement with antenatal services during subsequent pregnancies.⁴¹

Line of argument synthesis

Having discussed the data, we reached an agreement that the following synthesis expressed the essential elements of our findings:

in order to maintain or become socially acceptable (or valued), and to protect themselves (and their baby where the pregnancy is accepted), marginalised women decide whether or not to access antenatal care through a process of 'weighing

up and balancing out' personal issues and circumstances within their social context, and in the context of the care provision they anticipate and encounter.

Discussion

These results indicate that for marginalised women, the normative assumptions in documents such as the National Institute for Clinical Excellence antenatal guidelines⁴² do not apply. Women in this group did not appear to have or to be able to have a 'healthism' approach to their lives. Some of them were not health literate in the currently accepted sense. Many of them were not able to mobilise personal autonomy, social and cultural support for themselves and their pregnancies. They did not have the capacity and/or resources to be mobile and/or available to attend clinical sessions. For a number of the participants, there was a lack of trust in caregivers and care systems and a lack of caring, respect and kindness in the care they received.

For the women in this study, the factors that come into play when deciding to access prenatal care (or not) can be explained by the Health Belief Model (HBM).⁴³ The HBM has seven inputs to the likelihood of seeking care: psychosocial and socio-demographic modifiers, perceived benefits minus perceived barriers, perceived susceptibility, perceived severity, perceived need and cues to action. It is flexible enough to account for the 'what works, in what circumstances' elements of a realist review question (Table 3).

Table 3. Influencing factors

(A) Initial access to antenatal care is influenced by

Pregnancy rejection or acceptance (psychosocial and socio-demographic modifiers)

Personal capacity or incapacity (perceived susceptibility, perceived severity and perceived need)

(B) Continued access is influenced more strongly by a balance between

	Factors	Mediated by
Gains (perceived benefits)	<p>Clinical Self, baby</p> <p>Psychosocial Chance to change, creating a socially valued pregnancy, consequent (gain in) confidence, pride, knowledge</p>	<p>Provision of Cultural, emotional, physical safety Caring in the care Credible staff with excellent communication and interpersonal skills</p>
Versus		
Losses	<p>Psychosocial loss Stigma, powerlessness, broken confidence</p> <p>Resource loss (money, time)</p>	<p>Lack of Cultural, emotional, physical safety Caring in the care Credible staff with excellent Communication and interpersonal skills Respect for women's self- and lifestyle knowledge Difficult/expensive access to care Perception that antenatal care provides no benefit Failure to value women's time</p>

It seems unlikely that the views of marginalised women embodied in this review fully represent the diverse perceptions of women from disparate groups in different countries with different healthcare systems. Eight studies from only three developed countries were included and six of the eight come from one country – the USA. Because of the financial implications of medical provision in the USA, one might have expected individual financial resources to have had important effects on decision making. However, all American authors mention that the vast majority of their participants were receiving state funding via recognised health programmes like Medicaid. Ironically, the only article to highlight personal finance was the one British study where the perceived cost of antenatal care (by asylum seekers or refugees) or the direct costs incurred by travelling to and from antenatal appointments were viewed as potential barriers.³⁹

In high-income countries with regular influxes of immigrants, refugees or asylum seekers, studies exploring barriers to antenatal access in relevant countries of origin may yield additional insights. Research conducted in Mozambique,⁴⁴ Nigeria,⁴⁵ Jamaica⁴⁶ and Zimbabwe⁴⁷ reveal several significant factors including a lack of knowledge, the disapproval of a partner and a reliance on cultural traditions. These findings equate very well with some of the themes and concepts identified in our synthesis. There may also be reluctance on the part of some new arrivals (illegal immigrants and asylum seekers) to engage with state organised health services as they may perceive this form of centralised provision as a threat to their residential status. Several quantitative studies exploring the reasons for poor uptake of antenatal services among immigrant Latina populations in the USA found this to be a significant factor.^{48–50}

As this synthesis is primarily focused on marginalised women who did not engage with antenatal care providers or sought care late or infrequently, we omitted studies that either did not identify the timing of initial antenatal access or solely represented the views of marginalised women who attended early and regularly. This is a limitation of the study.

The studies in the review included some examples of women who went against the trend for their peer groups and accessed care. For these women, the opportunity provided by the pregnancy to re-evaluate their lives led to a weighing up and balancing out process in which being a valued pregnant woman was associated with attendance at antenatal clinic, as an overt and public expression of their intention to change. Our search strategy located only one paper that was explicitly focused on marginalised women who all attended all their standard antenatal appointments.⁵¹ The study was of Thai women who had emigrated to Australia. The data suggested a strong belief among the participants that antenatal care was a protective mechanism and that it offered generally positive experiences.

Two recent studies of early/regular attendees have also identified facilitators.^{52,53} Findings from Australia highlight the availability of well-informed interpreters and the support and empathy of clinic staff as key determinants in antenatal attendance among a group of African refugees in Melbourne.⁵² While the need for culturally sensitive staff working within a framework conducive to the establishment of safe, mutually respectful relationships is reinforced by findings from a participatory research study with an aboriginal community in Canada.⁵³ All these factors are enablers in the process of weighing up and balancing out, once a pregnancy is accepted and valued by the relevant peer group and they can be incorporated into the model that emerges from our analysis

Conclusions

There is sufficient data from repeated epidemiological studies that socio-economic deprivation is linked to both decreased access to antenatal care and increased maternal morbidity and mortality. This paper offers a model for interpreting the contextual factors that impact on choice making for individual women and for identification of the mechanisms of service design and delivery that might obstruct or maximise service uptake. As is the case with any individual, marginalised women make rational choices based on their circumstances. Multiagency initiatives to raise awareness of the signs and symptoms of early pregnancy and of the availability and benefits of early antenatal care in marginalised communities may increase initial uptake. A nonjudgemental, contextually tailored antenatal service that pays attention to the specific circumstances of disadvantaged women may increase sustained access to antenatal care by tipping the balance in favour of attendance. This review provides some insights for future exploratory intervention research and service development in this area of maternity care.

Disclosure of interests

No interests to declare.

Contribution to authorship

All authors contributed to conception and design. K.F. undertook data collection; S.D. and K.F. undertook the analysis. All authors contributed to the drafting and final approval of the paper.

Details of ethics approval

None needed, as this is a systematic review.

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