Cultural awareness and maternity care

Women who have recently migrated to the UK face many challenges when it comes to using maternity services, but training for healthcare workers to develop better intercultural awareness and communication can help alleviate the problems and improve women’s experiences, says Rachel Heathcock.

This article introduces two projects in the East of England which provided an insight into the health and social care needs of recently migrated women from outside of the European Union (often termed as third-country nationals*), and supported by the European Integration Fund. The projects revealed not only the challenges for these women and families in accessing maternity care, but also the challenges for healthcare workers dealing with different cultures and traditional practices.

As NCT practitioners, it is important to ensure that we provide services that reach and engage with the needs of all of the diverse and dynamic

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communities in the UK. Third-country women and their families have a wealth of knowledge that is invaluable and could influence approaches to maternity care in the UK. The opportunity to share experiences and knowledge should be promoted and explored as an example of best practice for all to follow.

When reading this article it is important to remember that every individual is different and will not uniformly share the beliefs or practices of their faith or cultural community. Many customs, rituals, beliefs or practices possibly may not apply or be as important to an individual if they are younger or a second or third generation UK citizen.

**The EACH and ACCESS Projects**

Embedding Ambassadors in Community Health (EACH) focussed on female migrants who came from beyond the EU’s borders (India, Pakistan, Bangladesh, China and Africa) to the East of England, in order to promote their use of healthcare services.¹

The aims of the project were to develop intercultural awareness for healthcare professionals and to provide culturally-appropriate healthcare for non-EU migrant women. This was achieved by the project team working with local Black, Asian and Minority Ethnic (BAME) community groups who delivered highly interactive workshops to frontline staff on intercultural awareness and also on working effectively with interpreters in healthcare settings.

The Acquiring Cultural Competence, Equalities, Successful Safeguarding (ACCESS) project followed the EACH project. Using the knowledge and findings from the EACH project, ACCESS was similar in delivering cultural awareness training to frontline local government workers and other public sector staff working with new migrant communities from outside Europe.²

**What about the migrant women?**

Our aim with both projects was to contribute to the health and social care improvement of recently-arrived migrant women. We conducted ‘Open Dialogue Workshops’ (ODWs) — informal facilitated sessions for an invited cross-section of professionals and local migrant women — so as to offer recently-arrived women a unique opportunity to meet health and social care providers in community venues. Through interpreters we helped the women share their positive and negative experiences of accessing health and social care services.

Both the recently-arrived women and health and social care providers commended this face-to-face contact as an invaluable opportunity to share experiences and improve/adapt services. One healthcare professional commented, ‘I never knew how many different cultures we had living in our town, thank you for this opportunity.’

**What was learnt from the projects?**

The women had difficulties in understanding and/or accessing services and mentioned, for example, the complexity of booking appointments and poor communication systems. Many women had arrived from countries with completely different healthcare systems. Those who became pregnant, for example, did not know that they were entitled to antenatal care and support and often did not meet a midwife until the third trimester of pregnancy.
Interpreting and translation continually caused concerns. Many women spoke little English and depended on their husbands for interpretation. This meant that they struggled to access health services until their husbands returned home from work, often late in the evening or at the weekends, when many of the services had closed. One woman explained that she was unable to access health visitor appointments in the local town as she could not drive and the bus service was very irregular. She had not heard that health visitors would visit her at home.

Without encouragement and support, migrant populations who do not have a good command of English will avoid integrating into local communities, which in turn makes it harder for them to learn English. Some women come to the UK and never leave the house alone. As a result they become isolated and lonely, especially if they become pregnant and have no-one to ask for advice or support apart from their husbands.

The women described how posters, letters and service information leaflets were all provided in English, and even women who could read English found that the language used was too complicated to understand. Aubrey Mason from Translation and Interpreting Provider Ltd (TIP) in Ipswich explained that translators are requested by health professionals to call clients to let them know about their appointment times and venues that use interpreters. ‘It proves very effective as the clients understand what is written in a letter and they are also made aware that an interpreter will be available to translate at their appointment, making them more willing to attend.’

There was a feeling amongst some BAME clients that staff do not understand (or do not necessarily want to understand) other cultures and/or the associated beliefs and practices which may impact on how they use public services. However, I spoke to many health and social professionals who were very interested in developing their knowledge and understanding of different cultural practices and religious beliefs, but lack of time and resources affected their ability to do so effectively.

The workshops highlighted that some third-country national women were arriving in the UK after arranged marriages in their home countries. In some cases, once in the UK, the women realised that they were not happy in their new homes and really struggled to adapt to their new lives.

Often these women are young and speak little English and do not know how to access support outside their new family. The workshops highlighted the importance of making sure that third-country national women knew their rights, and had opportunities to access services and support.

### Recognising and understanding different cultures and traditions

Information gathered by facilitators who took part in the EACH and ACCESS workshops enabled us to identify many cultural practices and traditions relevant to pregnancy, birth and the postnatal period, which are important to the migrant communities involved. We were then able to refer to these in the training provided to health and social care professionals. The following examples are from the Indian, Chinese and Kenyan communities based in the East of England.
The Indian community

In Ipswich, when a recently-migrated Indian woman’s pregnancy is confirmed, she will often first inform her mother and then her mother-in-law, one of whom then plans to be with her as soon as possible. They constantly advise (instruct) her by phone on how to manage her pregnancy until they arrive from India.

The news of the pregnancy would not be disclosed outside the family for at least three months. The pregnant woman is treated almost like a princess, advised to take a lot of rest, and has her diet supervised remotely. After the baby is born the mother is given a diet rich in proteins, fats and carbohydrates, while the baby’s feeding plan may also differ from what is considered customary in the UK.

When the new mother arrives home after the birth, she can rest as senior family members do all the work and care for the baby, keeping it wrapped up most of the time, and avoiding exposure to the outdoors if cold.

With thanks to interpreter Prachi Katdari from Ipswich Community Media

The Chinese community

In the Chinese community, ritual is important. During the first month after the birth (‘sitting month’) the mother will stay at home and do minimal tasks in order to look after herself, including not washing hair for a month, and not having a bath or shower straight after birth. She eats nutritious food, such as chicken and ginger, so as to improve health.

Family also plays an important role. The new mother’s mother will try to help out so that her daughter can rest. A new mother will not return to work until after at least one month. It is very common for women to give the baby a bottle when they return to work.

‘This is our postnatal care, doing minimal task, eating nutritious food and let the body to avoid water during that month.’

Thanks to Aubrey Mason and Annie Chow from Translating and Interpreting Provider Ltd

The Kenyan community

In the Kenyan community a child is considered to be raised by the whole community or village. During pregnancy a woman is given light tasks and is well supported by extended family.

‘When the mother returns home she is given special care by family. We have special food, soups that are given to the mother. ‘Njahe’ is from the beans family — it is boiled and mashed with ripe bananas or plantain — it is believed to help the mother produce milk for breastfeeding.’

‘Breastfeeding is a norm; it is equated to motherhood — when one of the midwives in the UK asked me if I will be using the bottle or breastfeeding I thought it was a strange question.’

Traditionally, breastfeeding is encouraged and helped by mothers carrying their babies in a sling. The baby can be rotated round to face the mother’s...
chest and feed — wherever they are. Grandmothers and mothers advise their daughters that breastfeeding is the key to all the problems of the baby; it provides contentment, close comfort and reassurance. Women are told to read their babies, as babies are open books.

*Thanks to Rachel Walton from African Families in the UK (AFiUK) CIC for the information provided.*

**The Bangladeshi Community**

Healthcare professionals can be the first people Bangladeshi women get to meet and know outside of their family in the UK. Many women are unaware of their rights in this country and don’t know that when they speak to a health professional the conversation is confidential.

Bangladeshi women regard health professionals as authority figures and it is important that professionals to use this trust and respect to educate and empower women. For example post-natal depression is still not recognised in many communities. Often women are called lazy or are accused of trying to avoid work if they share their feelings with family. Women may also be treated by witch doctors or given herbal remedies to treat post-natal depression.

Health professionals can support these women and their families by offering guidance and advice and explaining what post-natal depression is and how it can be treated. This education is essential to help remove the negative stigma associated with mental health.

*Thanks to Lila Begum from ATA CIC*

**What can cultural awareness teach professionals?**

The EACH and ACCESS projects have led to the following recommendations:

- Be aware that cultures are different and need to be respected. See the ACCESS project cultural diversity guide³
- Do not be afraid to ask questions, if you cannot pronounce someone’s name ask them how it is spoken. Ask whether you can shake a person’s hand — do not presume. Asking does not offend, making continuous mistakes will.
- Appreciate that women wear different clothing in different cultures.
- Consider that in many cultures it is not acceptable for women to be alone with men they do not know, so if possible offer a female professional to support the woman.
- Extended families have a very important role during pregnancy and postnatally in many BAME families. It is important to remember that family members travelling from abroad will be constrained by the time limits of travel visas and women may require extra support when their extended support network has to return home.
- Interpreters have an essential role. Ensure that the woman giving birth knows what is happening. Don’t focus on the husband or mother-in-law — use external interpreters if possible. It is important to know what the woman wants in labour, not just other family members.
- Be aware that it can be very lonely for a woman who does not speak English when her birth partner leaves after the birth.

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**Postnatal women express symptoms of low mood differently, therefore I am more aware that symptoms of physical pain may also be an indicator of postnatal emotional/psychological unhappiness.**

NHS staff, December 2013 (Ref.1)
• Consider the dietary needs of different cultures.
• Be aware of female genital mutilation (FGM). Women who have undergone FGM will probably not be familiar with this terminology, but they will require very special care. More information can be found on the Daughters of Eve website: http://www.dofeve.org/about-us.html and in the Home Office’s FGM multi-agency practice guidelines: http://bit.ly/1OUM78b
• Health professionals will need to consider that pregnant migrant women may have other issues that they need support with such as visas, housing, and specific reasons for leaving their home country. If professionals do not understand all the issues they may not develop a relationship with the mother. This is where they need to work in partnership with organisations that have skills and knowledge of BAME communities.
• Find out about the BAME groups in your area, what work they do and how you can become involved. Many groups welcome speakers — could you go and speak to the group about your work? Or would a representative from the group come and speak at your organisation?
• Be informed: the Race Equality Foundation has produced a wide range of briefings on minority ethnic health and wellbeing which are available to download from www.better-health.org.uk/ There are also many reports and studies available to review at the National Institute of Health and Care Excellence (NICE) at www.evidence.nhs.uk and through the NCT at http://bit.ly/1OUIYh2

*Third-country nationals, in migration terminology are those legally living within the EU who are not nationals of any of the current 28 EU member states.

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