Midwifery

‘I know my place’ ; a meta-ethnographic synthesis of disadvantaged and vulnerable women’s negative experiences of maternity care in high-income countries.

--Manuscript Draft--

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Abstract:	Objective During pregnancy and childbirth, vulnerable and disadvantaged women have poorer outcomes, have less opportunities and face barriers in accessing care, and are at a greater risk of experiencing a traumatic birth. A recent synthesis of women’s negative experiences of maternity care gathered data from predominantly low-income countries. However, these studies did not focus on vulnerable groups, and are not easily transferable into high-income settings due to differences in maternity care provision. The aim of this study was to synthesise existing qualitative literature focused on disadvantaged and vulnerable women’s experience of maternity care in high-income countries. Methods A systematic literature search and meta-ethnographic methods were used. Search methods included searches on four databases, author run, and backward and forward chaining. Searches were conducted in March 2016 and updated in May 2020. Findings A total of 13,330 articles were identified and following checks against inclusion / exclusion criteria and quality appraisal 20 studies were included. Meta-ethnographic translation analytical methods were used to identify reciprocal and refutational findings, and to undertake a line of argument synthesis. Three third order reciprocal constructs were identified, ‘ Prejudiced and deindividualized care’ , ‘ Interpersonal relationships and interactions’ and ‘ Embodied responses.’ A line of argument synthesis entitled ‘ I know my place’ encapsulates the experiences of disadvantaged and vulnerable women across the studies, acknowledging differential care practices, stigma and judgmental attitudes. A refutational translation was conceptualised as ‘ Being seen, being heard ’ acknowledging positive aspects of maternity reported by women. Conclusion Insights highlight how women’s vulnerability was compounded by complex life factors, judgmental and stigmatizing attitudes by health professionals, and differential care provision. Further research is needed to identify suitable care pathways for disadvantaged and vulnerable women and the development of suitable training to highlight negative attuites towards these women in maternity care settings.

Revisions

Reviewer #1:

1. The third highlight could include the suggestion that continuity of midwifery care could enhance relationship based individualised care as was suggested in the Discussion.

   Thank you – we have added a new highlight to address this issue.

2. Highlight 3 states:

   "Measuring levels of cultural competence offers an approach to enhance maternity care experiences for disadvantaged and vulnerable women by identifying competency and educational gaps within maternity care organisations"
   These highlight points made in highlight 3 also need to be made in the conclusion but are currently absent.

   This aspect has now been added to the conclusion as suggested.

3. On page 10 and page 11 the same quote is used to represent different sub-themes. This needs to include different quotes as this draws into question the integrity of the analysis and the themes and subthemes.

   Thank you for highlighting this inconsistency. This was an oversight and an additional quote has been used.

4. On page 11 the reference to the third order construct "Embodied responses" does not seem to capture the synthesis of the subthemes conforming or resisting and exacerbating insecurities.

   Thank you, we have now revised the title to *'Creating and enhancing insecurities'*.

5. Page 12 has the word woman used twice in a sentence one after the other

   Corrected.

6. Page 13 should say a Lesbian woman not lesbian women

   Corrected.

7. Page 14 the point being made from the Ebert 2014 paper is very confusing for the reader. I am not sure what point you are making here.

   This sentence has been amended. I acknowledge the confusion here. The midwife was also referred to as the caregiver misleading the reader. The sentence now makes it clear that

the women was aware of pressures the midwife was facing that she felt directly impacted upon her ability to be an advocate for her.

8. Similarly, the quote at the top of page 15 needs some context around the point being made as it is not clear. Page 15 articulation of the Third order construct "Embodies Responses" is not clear or compelling. I wonder if a different term could be used rather than embodied

Thank you. As above, we have revised the title to *'Creating and enhancing insecurities'* – with one of the subthemes in this theme being revised from *'Exacerbating insecurities'* to *'Feeling disempowered'.*

9. The refutational translation was excellent and great to highlight the key factors that made experiences of care positive. The final presentation of the line of argument synthesis comes after the refutational translation in the manuscript. It would be better for the reader if this had come first before the presentation of the themes and subthemes

Thank you for this comment. We would ideally like to keep this in its current location – it is more usual to present this way and we feel including at the end enables us to identify and highlight all the issues, which then culminates in a clear and evidence based translation. If this remains a sticking point for acceptance, we would be happy to discuss further.

10. The reference to Mead 1934 should be updated to take into consideration the more recent literature on social constructionism.

This has been amended to reflect the work of Hogg & Williams who discuss the construction of social identities and provides a more contemporary reference.

11. The last sentence in the first paragraph on page 18 was very confusing. It is unclear what the authors mean by "normal childbearing state".

This has been changed to pregnancy.

12. I think the authors are making a point about awareness raising when stating "promote conscious awareness". The first sentence of the conclusion could be amended for clarity to state: The meta-ethnographic synthesis identified how disadvantaged and vulnerable women experience ….

Sentence added as a lead in for the discussion regarding conscious awareness to provide clarity.

13. The conclusion makes the following statement: Questions remain on how maternity care could better facilitate an environment of empowerment… Yet this paper articulates the system level issues that could be addressed including offering continuity of midwifery care to vulnerable women as a priority. The conclusion should clearly state the recommendations that are concluded from this work.

Great point – I have added a sentence in the conclusion noting that within the studies continuity of midwifery care support positive experiences. This lead into the point

highlighting the need for further exploration relating to potential deep seated biases and disrespectful practices to facilitate positive experiences for all women – not just those receiving continuity of care.

Reviewer #2:

1. Introduction: it would be useful to consider inclusion of more REFS from non-UK studies re issues faced by disadvantaged and vulnerable women

   Thankyou for your suggestion. Additional references have been added and highlighted to provide a more international perspective of the issues faced by disadvantaged and vulnerable women.

2. Similarly, evidence re those groups of women most at risk of poorer pregnancy outcomes again reflect more UK evidence. Are mortality rates/poorer pregnancy outcomes also higher among women in different ethnic groups in other high income countries? Important to present more of a global perspective.

   Yes they are. I have included references to reflect a more global picture within the introduction, with particular reference to America and the shocking statistics relating to maternal morbidities associated with race, status and income.

3. In Methods, the authors refer to 'recent' evidence but the supporting REFS are quite old – are there more recent REFs to cite here, if this criticism still stands?

   As above, this has been addressed and highlighted within the methods section to include the 2019 best practice guidance published by France et al 2019.

4. Useful to clarify why a meta-ethnography was the approach of choice

   Further text has now been included: ***'A meta-ethnography was chosen as it has clear methodological guidelines, its ability to synthesise a variety of qualitative studies focused on a specific phenomenon, and our aim was to create a new conceptual understanding, and not to just describe what was reported (Noblit & Hare 1988)'***

5. Discussion. Ensure that when 'global' issues are referred to, supporting REFs are not just from the UK/high income countries

   Following on from comments made above encouraging a global perspective on disrespect and abuse, additional literature has been added throughout and highlighted for reference.

Cover Letter

Dr Stephanie Heys
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School of Community Health and Midwifery,
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PR1 2HE.

08.12.2020

Dear Professor Bick

We wish to submit an original research article entitled '*I know my place'; a meta-ethnographic synthesis of disadvantaged and vulnerable women's negative experiences of maternity care in high-income countries.'* for consideration by Midwifery.

We confirm that this work is original and has not been published elsewhere, nor is it currently under consideration for publication elsewhere.

In this paper, we report on disadvantaged and vulnerable women's experiences of maternity care in high income countries. The review highlights that women's vulnerability is often compounded by complex life factors, judgmental and stigmatizing attitudes by health professionals, and differential care provision.

This is significant because by acknowledging these experiences and realities, whilst illuminating the process of '*Othering*' within maternity care services, maternity care providers could be encouraged to support a better understanding of attitudes and the treatment of disadvantage and vulnerable women in high income countries.

Additionally, measuring levels of cultural competence, as recommended within the review, may enhance maternity care experiences for disadvantaged and vulnerable women by identifying competency and educational gaps within maternity care organisations.

We have no conflicts of interest to disclose. Please address all correspondence concerning this manuscript to me at SHeys1@uclan.ac.uk

Thank you for your consideration of this manuscript.

Sincerely,

Title Page (including author details and affiliations)

'I know my place'; a meta-ethnographic synthesis of disadvantaged and vulnerable women's negative experiences of maternity care in high-income countries.

Authors

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1. Conflict of Interest

   None Declared.

2. Ethical Approval

   Not Applicable.

3. Funding

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Highlights

- Women's vulnerability was compounded by complex life factors, judgmental and stigmatizing attitudes by health professionals, and differential care provision
- Acknowledging the process of '*Othering*' within maternity care services could provide a platform from which to build a better understanding of attitudes and the treatment of disadvantage and vulnerable women
- Measuring levels of cultural competence offers an approach to enhance maternity care experiences for disadvantaged and vulnerable women by identifying competency and educational gaps within maternity care organisations
- Continuity of midwifery care could enhance relationship based individualised care for disadvantaged and vulnerable women

Abstract

Objective: During pregnancy and childbirth, vulnerable and disadvantaged women have poorer outcomes, have less opportunities and face barriers in accessing care, and are at a greater risk of experiencing a traumatic birth. A recent synthesis of women's negative experiences of maternity care gathered data from predominantly low-income countries. However, these studies did not focus on vulnerable groups, and are not easily transferable into high-income settings due to differences in maternity care provision. The aim of this study was to synthesise existing qualitative literature focused on disadvantaged and vulnerable women's experience of maternity care in high-income countries.

Methods: A systematic literature search and meta-ethnographic methods were used. Search methods included searches on four databases, author run, and backward and forward chaining. Searches were conducted in March 2016 and updated in May 2020.

Findings: A total of 13,330 articles were identified and following checks against inclusion / exclusion criteria and quality appraisal 20 studies were included. Meta-ethnographic translation analytical methods were used to identify reciprocal and refutational findings, and to undertake a line of argument synthesis. Three third order reciprocal constructs were identified, '*Prejudiced and deindividualized care'*, '*Interpersonal relationships and interactions'* and '*Creating and enhancing insecurities.'* A line of argument synthesis entitled '*I know my place'* encapsulates the experiences of disadvantaged and vulnerable women across the studies, acknowledging differential care practices, stigma and judgmental attitudes. A refutational translation was conceptualised as '*Being seen, being heard*' acknowledging positive aspects of maternity reported by women.

Conclusion: Insights highlight how women's vulnerability was compounded by complex life factors, judgmental and stigmatizing attitudes by health professionals, and differential care provision. Further research is needed to identify suitable care pathways for disadvantaged and vulnerable women and the development of suitable training to highlight negative attuites towards these women in maternity care settings.

Key words

*Childbirth***,** *Vulnerable***,** *Disadvantaged, Experiences, Meta-ethnography***,** *Qualitative,*

Introduction

The Sustainable Development Goals and the Global Strategy for Women's, Children's and Adolescents' Health agenda aims to reduce maternal mortality and to address inequalities in access to, and the quality of, reproductive, maternal, and newborn health care services (United Nations 2015). Despite these calls, disadvantaged and vulnerable women continue to face poor maternal and infant health outcomes and increased risk of mortality (NICE 2012; Hollowell et al., 2012, MBRRACE, 2018). While terms such as disadvantaged, vulnerable and/or marginalized are often used interchangeably, they relate to people who are excluded from social, economic and/or educational opportunities due to numerous factors beyond their control. These include factors at the social level (such as economic inequality, violence, stigma, racism, migration), family level (including neglect and abuse) and individual level (e.g. disability, ethnicity, mental health) (The World Health Organization WHO 2016). Disadvantaged and vulnerable groups include women who are immigrants or refugees; sexual minorities; those living in poverty and the socioeconomically deprived; those who suffer from neglect and/or abuse; and those who belong to a stigmatized indigenous, ethnic, tribal or religious group (Zuccala & Horton 2018).

Disadvantaged and vulnerable women have been found to be more likely to have poor access to healthcare due to issues such as mistrust of professionals (Dixon–Woods et al, 2005, Marryat & Martin, 2011, Finlayson & Downe 2013, De Schepper et al, 2016, Hajizadeh et al., 2020, Kassa et al., 2020, Mayra et al., 2021), social stressors such as lack of support and complex life factors (Kramer et al., 2000, Mackenbach et al., 2008, Knight et al., 2009, Kramer et al., 2011, Finlayson & Downe 2013), communication barriers (Raine et al., 2010), health literacy (Brodie et al., 2000, Blencowe et al., 2013) and fear of stigma and judgments (Sorbye et al., 2016, Jakobsen & Overgaard 2018, Yang & Hall 2019). Black, Asian and minority ethnic (BAME) women and those from disadvantaged and vulnerable backgrounds have a higher risk of preterm, low birth weight babies (NICE 2012, Ncube et al., 2017), are at a greater risk of poor mental health such as depression, anxiety and stress and are more likely to die during childbirth (Say et al., 2014, MBRRACE 2018; Knight 2019, Vilda et al., 2019). Disadvantaged and vulnerable women can also feel that they have less agency and choices when making decisions about their maternity care (Ebert et al., 2014) and may experience higher levels of obstetric intervention (Raymet-Jones et al., 2015). Globally, the WHO recently highlighted that although maternal mortality rates are falling, high maternal mortality rates persist amongst poorer communities and women with multiple vulnerabilities (WHO, 2019). These issues illuminate the need for a greater understanding of the lived experience of these women when accessing maternity care.

Women's experiences of poor maternity care have been identified globally, including care in the UK (Hodnett, 2002, Feder et al, 2006, Furber & McGowan, 2011, Bohren et al, 2015, MBRRACE 2018). Bohren and colleagues undertook a landscape report (including secondary and empirical insights) to highlight women experiences of disrespect and abuse in faculty based maternity care across high, middle- and low-income countries; with the majority of included studies undertaken in low income settings. Issues identified in the report included physical abuse, non-consented clinical care, non-confidential care, non-dignified care, discrimination and abandonment (Bohren et al., 2015). Negative interactions with care providers have also been identified as a key risk factor for birth trauma and post-traumatic stress disorder (PTSD) onset following childbirth (Yildiz et al, 2018). A qualitative synthesis of women's experiences of a traumatic birth highlighted a lack of consent, poor information giving, and poor and degrading care as recurrent issues (Elmir et al 2010). Disadvantaged and vulnerable women are also more likely to face negative experiences of intrapartum care when compared to more privileged women (Bohren et al., 2015, WHO 2018). While this raises important

issues into how maternity care is provided and experienced by women who face more complex life situations, to date there has been no review to provide comprehensive insights and understanding in this area. We aimed to address this knowledge gap to identify and synthesise existing qualitative research into vulnerable and disadvantaged women's experiences of antenatal and intrapartum maternity care in high income countires; with a focus on women's interactions with healthcare providers.

Methods

Research design

A systematic literature search and Noblit and Hare's (1988) meta-ethnography analytical methods were used for this study. A meta-ethnography was chosen as it has clear methodological guidelines, its ability to synthesise a variety of qualitative studies focused on a specific phenomenon, and our aim was to create a new conceptual understanding, and not to just describe what was reported (Noblit & Hare 1988). The quality and conduct of meta-ethnographies have been subject to recent criticism (France et al., 2014). More recently, best practice guidance has been published (France et al, 2019), with principles relating to meta-ethnographic reporting adhered to within this study (France et al., 2019).

Review question and search strategy

The 'Population and their Problems, Exposure and Outcomes or Themes' (PEO) framework was used to develop a review question (Aslam & Emmanuel 2010) - '*What are vulnerable/marginalised women's experiences of antenatal and intrapartum maternity care in high-income settings'* - to inform the search strategy, i.e. the search terms, and inclusion/exclusion criteria (Higgins & Green 2011). An overview of the search string developed according to the PEO structure, the inclusion and exclusion criteria and additional selection criteria (time period study type, language and high-income status) is reported in Table 1.

Table 1. Population, Exposure, Outcome Table

PEO	Search terms	Inclusion criteria	Exclusion criteria
Population and their problems.	Wom?n* OR maternal OR mother*OR patient OR consumer OR service user OR service-user	Women who have experienced childbirth Women who meet criteria for disadvantaged and vulnerable	Women who do not meet criteria for disadvantaged and vulnerable
Exposure	prenatal OR prepartum OR antenatal OR ante-natal OR pueperium OR puerperal OR intrapartum OR intranatal, OR birth OR parturition OR childbearing OR child-bearing OR childbirth OR labour not work OR labor not work	Papers that focus on women's experience of childbirth during the antenatal or intrapartum period	Accounts of childbirth given by other members of the women's family/friends or healthcare professionals.
Outcomes or themes	Experience* OR perspective* OR view* OR perception* OR encounter* OR account*OR description* OR opinion* OR observation* OR satisfaction	Women's views and experiences of antenatal or intrapartum care.	Research that does not address views or experiences

Study type	qualitative OR ethnograph* OR phenomenol* OR "grounded theor* OR hermeneutic* OR "lived experience*" OR "symbolic interaction*" OR narrative* OR "life experience*" OR "action research" OR observation* OR "focus group*" OR interview* OR "mixed method*" OR mixed-method* or "multimethod"	Qualitative and/or adopting a mixed-methods approach with a qualitative component.	Quantitative based studies Discussion/opinion papers Grey literature
High-income country		Research undertaken in high-income context	Research undertaken in a low- or middle-income context
Language		Papers written in English	Papers in languages other than English
Time period		Research published 1993 onwards	Research published prior to 1993

Search terms were identified to help identify papers that focused on women's experiences of antenatal or intrapartum care. These papers were then screened against a second level of inclusion to assess whether the women within the studies met the definition of disadvantaged or vulnerable (see Table 2). The criteria for vulnerable and disadvantaged were developed through drawing on definitions provided by key organisations including the World Health Organization, The National Institute for Health Research (NIHR) and midwifery-based research that focused on disadvantaged and vulnerable women (Ronsmans et al., 2006, Rayment-Jones et al., 2015, Grote et al., 2016, WHO 2019).

Table 2. Disadvantaged and vulnerable criteria – second level of inclusion criteria.

Teenage mothers
Asylum seeking women
Victims/survivors of domestic abuse/sexual abuse
Substance (drugs & alcohol) abusers
Living in poverty/extreme financial hardship
Excluded from education
Specific ethnic minority groups
Travellers
Poor mental health
Homeless / Living in temporary accommodation
Learning disabilities / physical disabilities
Known to child protection services

LBGTQ women
Women living in deprived areas
Women in prison
Recently arrived migrants
Refugee women
Women that self-define as vulnerable

The country where the research was undertaken was assessed against World Bank classifications to only include studies undertaken in high-income countries. The decision to include papers from 1993 onwards was due to the publication of the UK Department of Health (DOH) governmental policy '*Changing Childbirth'* (DOH, 1993). This marked a change in the discourse surrounding childbirth and prioritised women's rights to choice, control, and continuity of carer. Finally, for pragmatic reasons, only papers written in English were included. Search terms, adapted for different architecture, were used to identify relevant studies within four databases – MEDLINE, Embase, CINAHL and PSYCHinfo. Additional search methods included forward, back chaining, and author searches (Bates 1989). The initial search was undertaken in March 2016 and then updated in May 2020.

Quality appraisal

Title and abstract screening were undertaken by the lead author, and full text review was undertaken by two authors (blinded for review). While there are debates surrounding the significance of quality assessments when undertaking a qualitative synthesis (Atkins et al., 2008, France et al., 2019), the need to ensure that robust measures of quality are in place are highlighted (Walsh & Downe, 2006, Thomas & Harden, 2008, Campbell et al., 2012). All eligible papers were quality appraised using an instrument developed by Walsh and Downe (2006) and modified by Downe, Walsh, Simpson and Steen (2009). This framework assesses key criteria such as scope and purpose, sampling strategy, analysis and interpretation and methodological design, and then grades the papers on a scale of A to D (figure 1). This process was undertaken by two of the authors independently, with agreement for inclusion made by consensus. Papers graded D were not included in the synthesis.

Figure 1: Grading framework; Walsh & Downe (2006)

A: No, or few flaws. The study credibility, transferability, dependability and confirmability are 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.

Synthesis

A fundamental tenet of the meta-ethnographic approach is the translation of study findings (France et al, 2019). Data analysis involved a series of stages. First, second order concepts (author interpretations) - metaphors, phrases, and key issues - were extracted from the identified studies from within the findings and discussion sections, together with any supporting quotes (first order concepts). The next stage involved translating the concepts, so comparing and contrasting the second order concepts against each other for reciprocal (identifying what is similar) and refutational

(identifying contradictions) purposes. The second order concepts were then synthesised to create third order constructs (review author interpretations) which comprises themes together with associated sub-themes. The final form of translation is a 'line of argument' synthesis. This is a focused synthesis of the whole data set that provides a new conceptualisation of the data set (Noblit & Hare, 1988).

Results

Overall 13,330 hits were identified, 75 papers were screened in full and 20 papers were included in the final synthesis (see Figure 2 for Prisma diagram). These papers represent the views of a total of 593 disadvantaged and vulnerable women. All studies were undertaken from 2000 to 2019 in seven high-income countries. Data collection methods predominantly involved semi-structured interviews and focus groups, with different analytical approaches used. Characteristics of all included papers are detailed in Table 3.

Figure 2 Prisma diagram

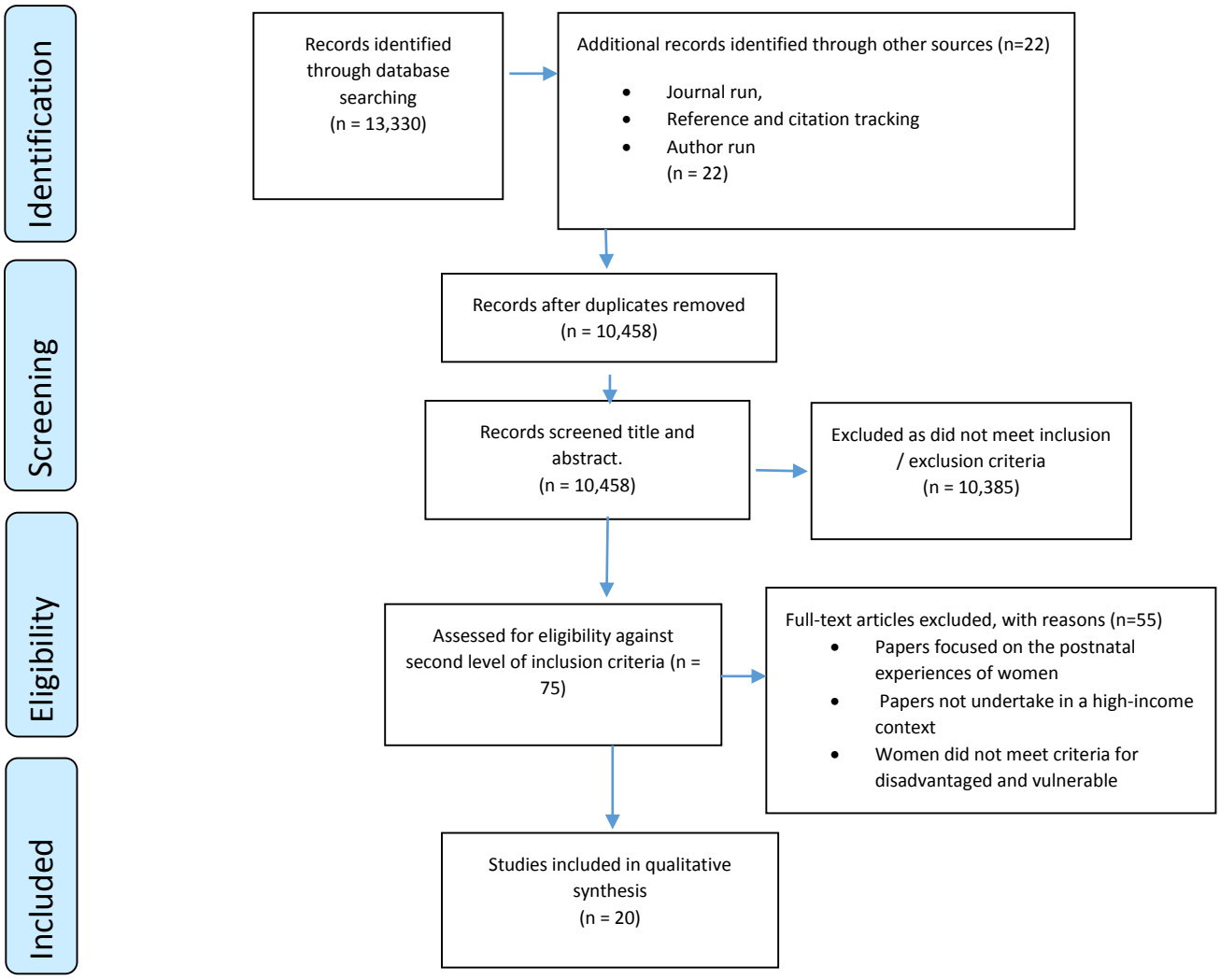

Table 3. Summary of included studies

Paper number	Authors (Reference)	Year of publication	Country	Methods used	Aim of study	Number of participants	Quality grading
1	Briscoe & Lavender (2009)	2009	UK	Longitudinal exploratory study using multiple case studies	To explore and synthesise the experience of maternity care by female asylum seekers and refugees. No theoretical perspective stated.	4	B
2	Ny et al (2007)	2007	Sweden	Focus groups and individual interviews	To describe middle eastern mothers' experiences of maternal health care services in Sweden. No theoretical perspective stated.	13	B
3	Reitmanova & Gustafson (2008)	2008	Canada	Qualitative narrative enquiry using semi-structured interviews	To document and explore the maternity health care needs and the barriers to accessing maternity health services from the perspective of immigrant Muslim women. Theoretical perspective not stated	6	C
4	Davies & Bath (2001)	2001	UK	Focus group and semi-structured interviews	The aims of the study were 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. Grounded theory design.	13	B
5	Cross-Sudworth et al (2011).	2011	UK	Semi – structured interviews and focus groups	To explore first and second-generation Pakistani women's experiences of maternity service in the UK and the inter-generational differences/comparisons. Theoretical perspective not stated.	15	B
6	Bailey et al (2004)	2004	UK	Focus groups and semi-structured interviews	The aim of the project was to consider health and wellbeing in pregnancy, birth and postnatally for women who become pregnant under the age of twenty years by exploring experience of antenatal	38	C

					and parentcraft classes, birth experience and experience on the maternity wards.		
7	Ebert et al (2014).	2014	UK	Focus groups recorded using three separate groups	To provide an understanding of the issues that affect socioeconomically disadvantaged women's ability to actively engage in decision making processes relevant to their care	17	B
8	Herrel et al (2004).	2004	USA	Focus groups	The research study aimed to understand how Somalian women had experiences pregnancy and childbirth in the USA.	14	C
9	Price & Mitchel (2004).	2004	UK	In-depth interviews	To document young pregnant women's experiences of the maternity services and to identify strategies for improving services, in order to make them more sensitive and responsive.	10	B
10	Arthur et al (2007).	2007	UK	Semi – structured interviews	To explore teenage mothers' experiences of maternity services in the county, focusing on the accessibility and acceptability of services and to identify whether maternity services in the county meet the standards set by the Children's and Maternity National Service Framework.	8	B
11	Robb et al (2013)	2013	Scotland	Unstructured interviews	The objective was to explore young mothers' experiences of seeking and accessing health services, specifically maternity care	7	B
12	Jomeen & Redshaw (2013).	2013	UK	Survey data and questionnaire with open ended responses	The aim of this study was to explore Black and minority ethnic (BME) women's experiences of maternity care in England.	219	A

13	Shafiei & McLachlan (2012)	2012	Australia	Over the phone interviews using closed questions. Face-face Interviews in participants homes.	To explore immigrant afghan woman's views and experiences of maternity care in Melbourne Australia.	50	B
14	Spidsberg (2007)	2007	Norway	Semi structured interviews	This paper is a report of a study to describe the maternity care experiences narrated by a sample of lesbian couples	6	B
15	Ward et al (2013)	2013	USA	Focus groups	To explore perceptions of Prenatal Care Experiences among African American Women with Limited Incomes.	29	B
16	Wilton & Kaufman (2000)	2000	UK	Self-completed questionnaires with free text questions responses	Mixed method design using survey methods to elicit Lesbian mothers accounts of care in the UK, both survey data and interviews undertaken	50	C
17	Howard (2015)	2015	USA	Group interviews	A qualitative study to examine the experiences of opioid-dependent women during their prenatal and early postpartum care	20	C
18	McLeish & Redshaw (2019)	2019	UK	Semi structured interviews	The aim of this study was to explore women with multiple disadvantages experiences of maternity care in the UK	40	B
19	Barkensjö et al (2018)	2018	Sweden	Content analysis	The study aimed to provide a composite description of undocumented migrant women women's experiences of clinical encounters throughout pregnancy and childbirth, when living as in Sweden.	13	B
20	Hassan et al (2019)	2019	UK	Longitudinal semi-structured interviews	The aim of the study was to investigate Muslim women's perceived needs and the factors that influence their health	21	B

					seeking decisions when engaging with maternity services located in North-West of England.		

Overall, 35 second order constructs were synthesised to create three third order constructs (each with supporting sub-themes). In Table 4, all second and third order constructs are outlined, mapped against the code number of the included studies (see Table 3) together with an exemplar quote.

In the following sections, we describe the themes using illustrative quotes from the studies. While, as reflected in the theme titles, the vast majority of women's experiences were negative, a separate refutational theme 'Being seen, being heard' that considers positive aspects of care and contradicts these adverse accounts has also been included.

Table 4. Summary of themes

Second order constructs	***Third order constructs***	
Key codes, issues, metaphors from included studies	***Sub-themes***	***Themes***
Judged (4,6,7,8,10,18,12,13,16,18) Inappropriate comments (4,8,10,16,18.20) Preconceptions (1,3,6,7,18.19) Presumptions (2,4,5,9,10.11,1219.20)	**Judgmental attitudes** *'I told [my midwife] I didn't like going to my appointments, and one day she just asked me, 'do you do crack?'… Just because I don't want to come to my appointments, I got to be a drug addict?'* (Ward 2013 p 1756)	Prejudiced and deindividualized care
A lonely experience (4,6,7,11,12,13) Cultural incompetence (1,3,4,8,13,14,17, 20) Need for culturally contextual understandings (3,17,14,13,8, 18, 19, 20) Language barrier (4,5,8,13,14,18, 19) Poorly communicated information (2,3,4,6,8,10,11,13,18) Communication failure (1,4,5,6,8,11,13.14,18)	**Lack of cultural contextual care** *'They have no idea what is halal food……They offered me bacon and asked me if I can eat it. So I said 'I can't.' They told me that someone will come and ask me what food I need. And nobody came until I left the hospital.'* (Reitmanova & Gustafason 2008 pg 106)	

Craving empathy (4,5,18,13) Need for interactions (3,5,13) Need for compassionate care (3,7,10,13, 19) Rude staff (5,18,11,13,14,15,16,17) Mistrust of professionals (2,4,7,18,11,12,15,17, 18,19) Lack of continuity (4,6,7,10, 13,17,18)	**Poor emotional connections** *'I understand there is a staff shortage and staff are under a lot of pressure but attitudes should remain sympathetic towards mothers.... as giving birth can be very traumatic and care received has a lasting effect on their lives and views about hospital care'* (Jomeen & Redshaw 2013 pg 286)	
Abandoned (12,13,16) Feeling vulnerable (3,11,12,18) Left to suffer (3,6,7,11,12,13,14) Feeling abused (4,6,7,11,12,13,18) Scared (1,3,4,10,11,13,7) Felt punished (18,6) Feeling victimized (13,17,12,10,3,1,6,8,15,18)	**Abusive and neglectful care** *'An internal examination at nine months was so rough it made me bleed, and worse, was so painful and frightening I felt I had been assaulted'* (Wilton & Kauffman 2001 pg 209)	Interpersonal relationships and interactions
Subservient interactions (3,4,13,15) Demoralized (6,8,12,18,13,17) Being ignored (3,4,5,6,7,10,11,13,14) Paternalistic care (3,4,6,10,11,13)	**Demoralizing interactions** *''Get your life together'. I thought to myself, She's very unprofessional. My life is together.'* (Howard, 2015 p 430)	
Comparing their care to others (4,6,8,12,7,18,17) Lack of self-efficacy (6,10,11,13, 18) Made to feel guilty (18,7,12,17) Shamed (7,18,13,17,18) Lack of choice (3,4,6,13,14,18, 19)	**Conforming or resisting** *'She (midwife) treated me like a child more than older women, she treated them like a friend, because when she used to call them in they would get up and start chatting and stuff. But when it was my turn she would more or less direct me which room to go into and that was it and then make me sit down for my blood pressure'* (Price & Mitchel 2004 pg 3)	Creating and enhancing insecurities
Accepting poor care (3, 5, 8, 9, 10,12,13,17,18) Feeling the need to escape / leave (3,6, 8, 9, 11,18,20) Feeling the need to conform (1,4,6,7,10,13,16)	**Feeling disempowered** *'I've had a lot of issues in the past with people telling me I'm not good enough….but that's exactly what they were doing, making you feel like you was not good enough' (McLeish & Redshaw 2018 p 181).*	

Respectful care (4, 6, 7, 13, 20) Positive language (1, 3, 7, 10, 19) Cultural competence (5, 6, 8, 12, 14, 17, 18) Equitable care delivery (8. 10, 11, 15, 18, 19, 20) Specialist midwifery care (5, 7, 8, 12, 20)	**Personalised care delivery** *The midwife that took care of me during my labour was so supportive she was amazing, she did not let me feel scared at anytime, everyone was just so good I did not feel I didn't belong there, I felt like I was in good hands'.* (Jomeen & Redshaw 2013 p 290).	Being seen, being heard

Prejudiced and deindividualized care

This theme describes how women could feel prejudiced and receive deindividualized care due to *'judgemental attitudes'* of healthcare providers, and how a lack of consideration of their cultural, social and economic backgrounds led to a '*Lack of culturally contextual care'*.

Judgemental attitudes

In 13 studies women reported how healthcare professionals made judgmental comments related to their treatment preferences, level of family support, complex life situations, social status, past history and/or sexual orientation. There were experiences of women experiencing shame when healthcare professionals did not acknowledge their sexuality: *'The midwife said she had never heard of people like us. She wouldn't book me in; espoused her Christian beliefs'* (Wilton & Kaufmann 2001 p 205). Whereas in the study by Ward (2013) that explored the maternity care experiences of African American women with limited incomes, one woman disclosed how her midwife made disparaging and inappropriate comments based on their biases, rather than the woman's reality:

> *'I told [my midwife] I didn't like going to my appointments, and one day she just asked me, 'do you do crack?'… Just because I don't want to come to my appointments, I got to be a drug addict?'* (Ward 2013 p 1756)

The women who faced multiple disadvantages within the McLeish and Redshaw's (2019) study also experienced unpleasant and disrespectful attitudes from their care providers reflected in comments such as: *"racist abuse", "patronising", 'really rude and arrogant", "horrible . . . stigmatising" 'a power trip . . . awful*".

Two of the studies (Reitmanova & Gustafason 2008, Wilton & Kaufman 2001) also highlighted issues where women felt offended by the prejudicial attitudes of staff in relation to their choice and/or preferences. This could be in relation to women's religious choices, or as one Muslim woman in Reitmanova and Gustafason (2008) reported, this concerned the midwife making inappropriate comments about her choice to wear a hijab in labour:

> ''*Oh, why you are crying, you are beautiful. You don't need to cover yourself.*' (Reitmanova & Gustafason 2008 p 106).

Whereas a lesbian woman in Wilton & Kaufmann's (2001) study was reported to social services due to judgmental beliefs held by her health care providers: *'[They] placed [my] child on [the] concern list! Because of the nature of our relationship, i.e. lesbians.' (*Reitmanova & Gustafason 2008 p 6*).*

Lack of culturally contextual care

A lack of culturally contextual care was evident in 12 of the included studies whereby women reported feeling that they would, or had been mistreated due to either their social, cultural or ethnic backgrounds:

> *'If the nursing staff see you are foreign or of a different colour, they treat you badly'* (Herrel et al, 2004 p 4).

For some women, as reported in the study by Reitmanova & Gustafson (2008), this related to how their requests for female doctors due to their specific cultural and religious needs was not met:

> '*There was a male who entered my room, I also put a sign on the door, but they didn't respect it. This man came and saw me. I was very upset and crying.'* (Reitmanova & Gustafason 2008 p 106).

In some cases, BAME women had to rely on non-verbal cues when unable to communicate, which could result in women feeling scared during interactions with their health care professionals*:*

> '*Some of the midwives spoke to me very arrogantly, sometimes I got scared as I don't know the English language…… It would be very nice if they gave you a smile now and then…..it would be nice if they didn't give orders'* (Jomeen & Redshaw 2013, p 290).

Even on occasions when the midwife was from the same cultural background as the woman, this did not guarantee that the support would be positive:

> *'I had a midwife originating from my home country, but she was not nice or helpful*' (Ny et al 2007, p 8).

Interpersonal relationships and interactions

Interpersonal relationships and interactions relate to how '*demoralising interactions'* and '*poor emotional connections'* led to women experiencing what they perceived as *'abusive & neglectful care*'.

Demoralising interactions

Demoralising interactions were noted in 13 studies and concerned paternalistic and undermining professional-woman exchanges. For instance, an opioid dependent woman in Howard's study (2015) recalled her obstetrician saying: *''Get your life together'. I thought to myself, She's very unprofessional. My life is together.'* (Howard p 430).

A lesbian mother in Spidsberg's study (2007) reported how her General Practitioner (family doctor) disregarded and minimised her opinions following disclosure of her sexual orientation:

> *'He was a little, you know, 'my opinion is irrelevant'. I expected more than this. I believed him to be more liberal and tolerant'* (Spidsberg, 2007 p 483).

Whereas a teenage mother in the paper by Price and Mitchell (2004) expressed how she felt treated like a child during antenatal education classes and during midwife appointments:

> *'She [midwife] treated me like a child more than older women, she treated them like a friend, because when she used to call them in, they would get up and start chatting and stuff. But when it was my turn, she would direct me which room to go into and that was it and then make me sit down for my blood pressure'* (Price & Mitchell 2004 p.5).

Poor emotional connections

Poor emotional connections were noted in 13 of the included studies, creating barriers in developing women-provider relationships, and women feeling disengaged from the birth process. In the study by Howard (2015) opioid dependent women reported feeling *'punished'* rather than supported by their healthcare providers. One mother stated:

> *'The providers in the unit where the babies are treated tend to punish the mothers; The mothers are making the best decisions they can, and they have a tremendous amount of guilt and sadness. I wish there were more of an emphasis on helping them parent, rather than punishing them'* (Howard 2015 p 2).

Ethnic minority women in a study by Jomeen & Redshaw (2013) described staff as *'insensitive'*, with one woman reporting:

> *'Every time I saw the midwife during pregnancy and labour, I felt that I was just being processed, there was no opportunity to develop a working relationship'.* (Jomeen & Redshaw, 2013 p 287).

One socioeconomically deprived woman in the study by Ebert (2014) felt the lack of emotional connection with her midwife was directly due to external pressures impacting upon the midwife's ability to advocate for her. This woman observed tensions between lines of authority (medical vs. midwife) which in turn influenced the care she received:

> *'I could still feel it, and I'm looking at the midwife, I was crying and she's going, 'I know', and I'm thinking why you can't say anything. She [the midwife] didn't say anything she was just, I don't know. Cause he'd [the doctor] jumped in [and said], 'I will do it', and she was supposed to do it''* (Ebert et al 2014 p135).

Some of the women also reflected on how a poor relationship with healthcare providers could have a lasting and negative impact on women's views of maternity care:

> *'I understand there is a staff shortage and staff are under a lot of pressure but attitudes should remain sympathetic towards mothers.... as giving birth can be very traumatic and care received has a lasting effect on their lives and views about hospital care'* (Jomeen & Redshaw, 2013 p 286)**.**

Abusive and neglectful care

A lack of respectful care was reported in 12 papers, with these insights bordering and sometimes crossing the threshold into abusive and neglectful care. In the paper by Arthur (2007), one woman described how a healthcare professional refused to stop a painful procedure that resulted in her experiencing her birth as traumatic:

> *'I had an internal and she had a piece of skin ...I was in absolute agony. The midwife was determined she did not have a piece of skin and didn't stop, it was like it was all in my head.'* (Arthur et al, 2007 p 675)**.**

A lesbian woman in a paper by Wilton & Kaufman (2001) shared a similar experience stating:

> *'An internal examination at nine months was so rough it made me bleed, and worse, was so painful and frightening I felt I had been assaulted'* (Wilton & Kaufman 2001 p 209)**.**

Neglectful care was also reported by survivors of human trafficking in Mcleigh & Redshaw's study (2018) in which a woman relives her experience of an internal examination:

> *'She (the midwife) did not explain that to me. She just started to put – and when I shouted, she – she didn't explain nothing to me. Oh my God'* (McLeish & Redshaw 2019 p 5)

Creating and enhancing insecurities

This theme concerns how women's insecurities were created or enhanced through interactions with maternity care providers. Women spoke of feeling that they had no choice but to conform to their surroundings or demonstrated resistance by escaping from negative care interactions ('*Conforming or resisting'*). Women experiences of judgemental and negative care were reported to have led to them 'feeling disempowered' with negative impacts on women's confidence and self-esteem

Confirming or resisting

In 11 studies, women described their negative experience of decision making when accessing care, making them feel conflicted and pressurised into making decisions. A socially disadvantaged woman who was not born in the UK in McLeish & Redshaw's study (2019) expressed how she felt pressured and threatened into accepting surgery:

> *'[The midwife] didn't have much patience because after like six, seven hours she was like, 'they'll have to do you surgery, they'll have to do surgery' Like she is forcing me to accept that they'll have to do surgery. I no was happy but she is the doctor so…At the end she say, no, no, but you have to do it now, I was just say 'Ok give me the form and I sign'* (Mcleish & Redshaw, 2019 p 182)

Whereas a socially disadvantaged woman in a study by Ebert et al (2014) reported feeling like a *'guinea pig'* when reliving experiences of examinations - she felt she had no choice but to conform:

> *'[I would like to] not be the guinea pig where they go, 'do you mind, once I feel how far dilated you are, if someone else has a go up there?' They need to respect if you don't [want students to do additional vaginal examinations], and you feel like you can't [say no], and you go all right, [because] if I say no then they're going to leave me alone all the time. So you sort of go, yeah, okay, even if you don't want them to [so] you're [not] going to be treated differently'* (Ebert et al, 2014 p 136)

A woman in the study by Ebert et al, (2014) noted how healthcare professionals used the threat of danger and authoritative knowledge to assure her conformity:

> *'You do what they say because like, you're going to be a mother and you want to do everything the special people who are the professionals tell you to do because you don't want anything*

to happen to your baby and if that's what they need you to do, you jump through the hoops' (Ebert et al 2014, p 135)**.**

However, from a counter perspective, there were a few occasions of women resisting poor care. An opioid dependent woman in Howard's (2015) study referred to how upsetting and judgemental interactions would deter her from accessing care:

> *'The way they looked at me and treated me, all of it at once was just too much for me. You know, I couldn't take it for more than like an hour at the hospital and then I'd leave. And I'd get to the point where I just wouldn't show up.'* (Howard, 2015 p 431).

Feeling disempowered

Socioeconomically disadvantaged women in the study by McLeish & Redshaw (2019) reported being made to feel '*low category', 'stupid*' and '*weird'* when professionals were perceived to have made thoughtless and inappropriate comments. Another woman in the study by McLeish & Redshaw (2019) expressed how poor care exacerbated her already fragile confidence due to previous negative life experiences:

> *'I've had a lot of issues in the past with people telling me I'm not good enough….but that's exactly what they were doing, making you feel like you was not good enough'* (McLeish & Redshaw 2019 p 181).

Such interactions were also reported in a study by Davies and Bath (2001), in which women would compare their care to others:

> *'When I saw her with the other women in the hospital and she was so respectful: `What do you want to do', and `It's your baby?' Not like with me'* (Davies & Bath, 2001, p 243).

Refutational translation

A refutational translation relates to concepts that may contradict others (Noblit & Hare 1988). A largely undocumented aspect of undertaking a meta-ethnography, France et al (2014) acknowledges the benefit of including any refutational translations which disconfirm or contradict emerging understandings of the data as a whole. In the case of this review, refutational findings are presented as a standalone theme to help identify aspects of care that women expressed as positive.

'Being seen, being heard'

Woman within six of the studies experienced positive aspects of care, noting effective communication, informed choice and continuity of carer as key (Wilton & Kaufman 2001; Spidsberg 2007; Jomeen & Redshaw 2013; Howard 2015; Barkensjö et al., 2018; McLeish & Redshaw 2019). Four of the studies also highlighted aspect of maternity care in which providers acknowledged women's individual needs and preferences (Reitmanova & Gustafason 2008; Cross-Sudworth et al., 2011, Jomeen & Redshaw 2013; Hassan et al., 2019). Women reported how welcoming and supportive behaviours of staff impacted upon their sense of belonging in an unfamiliar cultural context, as expressed by one Black non-UK born women in Jomeen & Redshaw's study (2013):

> *'I was well cared for at (***) hospital, no one there was rude, all the staff have been great, they did not choose for me, they gave the choice. The team of midwives have been so good I*

> *did not feel worried at anytime. The midwife that took care of me during my labour was so supportive she was amazing, she did not let me feel scared at anytime, everyone was just so good I did not feel I didn't belong there, I felt like I was in good hands'.* (Jomeen & Redshaw 2013 p 290).

Women also highlighted informed choices as a positive experience of care as it allowed them to advocate for themselves:

> *'I'm very happy that I was given option at 30 weeks; my baby was breech; I had my baby turning instead of caesarean section. I'm very happy to be given option to choose'* (Shafiei & McLachlan, 2012 p 201).

Continuity of carer was also an impactful intervention that supported vulnerable women to feel respected and listened to:

> "*[The specialist midwife] actually thought about me as a person, rather than just being a pregnant mum*" (McLeish & Redshaw 2019, Pg 183).

Non-verbal interactions were also noted in several studies as integral to women feeling safe and listened to, particularly for women whose English was not their first language:

> *"The best thing the midwife did for me was to sit by the bed, at eye-level, hold my hand, and acknowledge me. That was the best in order for me to feel secure as a woman–that I was heard'* (Barkensjö et al., 2018 Pg 7)

Line of argument synthesis

In consideration of the overwhelming data concerned with negative interactions and experiences, the line of argument from this synthesis is *'I know my place'*. Women were, at times, aware of institutional inequality and judgments made against them when accessing maternity services and during interpersonal interactions with staff. Women across the data set often felt they had no other option than to accept poor, inconsistent and deindividualized care, raising important ethical questions. Women were conscious of their differences, reinforced through differential treatment, prejudiced attitudes, and a lack of culturally contextual care when accessing maternity care in high-income countries.

Discussion

This meta-synthesis provides rich insights into the experiences of disadvantaged and vulnerable women when interacting with healthcare professionals during antenatal and intrapartum care in high-income countries. While some insights into positive experiences of maternity care are reported, findings within the included studies were overwhelmingly negative. Third order constructs and sub-themes highlight how women experienced a lack of individualized care, an absence of emotional support and varying levels of inequalities, often directly associated with their complex or *'different'* life factors. Judgmental attitudes from healthcare providers were seen to cause barriers to women's engagement and the opportunity to build trustful relationships. The underlying beliefs and attitudes of staff were translated through negative interpersonal interactions, and which in turn exacerbated negative self-perceptions amongst women. These findings reflect those of disadvantaged and vulnerable women globally (Houweling et al., 2007; Bohren et al., 2015; Shaw et al., 2016; Black et al., 2016), reflecting systemic and institutional failures to meet the needs of women who arguably need the most support.

Globally, a lack of culturally contextual care practices, alongside disrespectful and stigmatising practices have been seen to defer women from engaging with services (Downe et al., 2009; Ebert et al., 2014; MBRRACE 2018). Similar to the findings of this review, wider reports also highlight systemic level failures in meeting the needs of disadvantaged and vulnerable communities (Matthews et al., 2010; Almeida et al., 2013; Graham et al., 2016). While the findings of this review provide similar findings to the global literature, a key and more unique finding is reflected in the line of argument synthesis '*I know my place'*. Inequalities in healthcare were reflected in constructed levels of *'deservedness'* whereby women appeared to expect and conform to poor care. This overarching theme reflects a process referred to as '*othering'.* Othering is whereby an individual or a group are deemed and castigated as different, and how this opposition and criticism founds their self-identity – a self that is set apart and unworthy (Canales, 2000). Hogg and Williams acknowledge that social identities are created through social interaction with other people and our consequent self-reflection about who we think we are, becomes formed according to these social exchanges (Hogg & Williams 2000). As reflected in this review, certain groups/people were viewed as different, or, not fitting into predefined boxes of what constitutes normal within a society (Syed & Fish 2018) and outside the boundaries and the realms of a *'normal'* pregnancy (Thomson & Schmied, 2017).

Acknowledging the process of '*Othering*' within maternity care services could provide a platform from which to build a better understanding of attitudes and the treatment of disadvantaged and vulnerable women accessing maternity services in high-income countries (Johnson et al., 2004; Roberts & Schiavenato, 2017). This may include examining the interplay between maternity professionals' duty of care and their individual worldviews to deconstruct disadvantaged and vulnerable women's experiences of care. Measuring levels of cultural competence also offers an approach to enhance maternity care experiences for disadvantaged and vulnerable women by identifying competency and educational gaps within maternity care organisations (NHS England 2016).

While there is specific guidelines for the care of women with complex needs (NICE 2012), gaps in provision have been widely documented (Koblinsky et al., 2016, Knight et al., 2020), with inequalities and issues surrounding the adverse outcomes for minority groups persistent (MBRACE 2018, Anekwe 2020). This includes an acknowledgment amongst healthcare professionals surrounding the oppression of minorities, stigmatising practices and institutional racism within maternity services (Katbamna 2000, Lyons et al., 2008, Sumankuuro et al., 2018). Refutational findings within this study strengthen the Better Birth agenda in terms of the value and need for more personalized, continuity of care where women feel respected, informed and engaged (NHS England 2016). The meta-ethnographic synthesis identified how positive impacts were a minority amongst disadvantaged and vulnerable women, highlighting the need for strategies to promote conscious awareness of potentially divisive and oppressive interactions to help reconnect staff with the human experience of childbearing (Fannin, 2013: Tyler, 2013, Kaiser, 2018).

Strengths and limitations

The main strength relates to a comprehensive search strategy, and within a defined context (e.g. high income) to aid generalisability. The team members were from a midwifery or psychology background, and two of which have a wide range of expertise in undertaking systematic reviews and/or qualitative syntheses thereby enhancing the rigour of this work. While the review adopted a broad approach to

understand vulnerable and disadvantaged women's experiences, further work to assess for differences and similarities between these cohorts would be beneficial. However, as most of the key findings were reflected across the data set, it has highlighted system level issues that require addressing. This work calls for further research to understand key contributory factors to poor interpersonal care, both on an institutional and personal level, and for interventions to enhance cultural competency within maternity care organisations.

Conclusion

This systematic review and meta-ethnographic methods identified how disadvantaged and vulnerable women experience disrespectful and negative interactions with their health care providers whilst receiving maternity care in high-income countries. The key themes identify how judgemental and insensitive interactions can result in a lack of agency and stigmatization, directly impacting upon women's psychosocial wellbeing. Negative interactions with healthcare providers are reminiscent of *'othering'* and found to distil women's sense of self, value and worth. Whilst identified that continuity of carer supports positive experiences amongst women within the studies, questions remain on how maternity care could better facilitate an environment of empowerment and respect as part of such models. The exploration of potential deep-seated prejudices and socio-political influences that directly affect healthcare professionals' interactions with women is also recommended. Additionally, work is needed to enable maternity care providers to question instances of mistreatment, acknowledge levels of cultural competence amongst staff and encouraging the multidisciplinary teams within maternity care to critically evaluate their own, and others practices to promote and nurture a more humanistic framework of care provision.

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Conflict of interest checklist

Declaration of interests

☒ The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

☐The authors declare the following financial interests/personal relationships which may be considered as potential competing interests: