



Antenatal Care in Industrialized Countries: Low-income Women Experience Disadvantages

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Background

- In Switzerland, single mothers and immigrants, are the most affected by poverty. Approx. 14.2% of the population are at risk of poverty, 6% live in material deprivation (1).
- Poverty in industrialized countries is identified as being a key factor for a poor perinatal and maternal outcome:** higher rates of premature birth, lower birth weight, higher perinatal mortality, higher maternal morbidity and mortality, more drug abuse, non-nutritious or non-recommended infant feeding practices (2, 3).
- In Northern America and other European countries the health disparities of poor pregnant women have been extensively shown (2, 4). Comparable data are only available for migrant women in Switzerland (5).
- The reasons for a worse outcome are complex and multifactorial, e.g. socio-economic, ethnic, epigenetic, environmental factors and **worse access and utilization of adequate antenatal care** (6, 7).

Integrative Review (8)

- Systematic search in Medline, CINAHL, MIDIRS, Medpilot, Cochrane and hand search.
- Inclusion: publications from 2004-2014, from OECD-countries, examining women with socio-economic deprivation and analyzing overall experiences with pregnancy care.
- Exclusion: studies testing specific interventions; narrowly focused on health behavior; in connection with pathological conditions.
- Tree workshops with three researchers were conducted to determine quality criteria, to systematically appraise the studies and to identify relevant themes and dimensions.

Results



All selected studies (9-17) met the quality criteria, n=6 were qualitative, n=3 quantitative. They were conducted in USA (n=5), Australia (n=2), United Kingdom (n=1) and Germany (n=1).

What are the experiences of socio-economically deprived women in industrialized countries made with antenatal care?

Choice of service provision model	Experience of feeling valued	Manifold discrimination	Structural and interpersonal accessibility	Comprehensibility / trustworthiness	Engagement and sense of responsibility
Women complied mainly with the prevailing medical or public clinic care model although this was associated with lower satisfaction compared to midwifery care models. Lack of awareness that they have the right to choose their model of care and provider and therefore an inequity in terms of choice . Where choice was restricted, the lack was experienced in a negative way. (9-11)	Women felt valued when professionals cared about her health and wellbeing and showed empathy towards personal or challenging circumstances. Missing sympathy , not listening , not addressing their needs reduced the women's feeling of being valued and their trust towards professionals. Women with unwanted pregnancies perceived less appreciation and concern of provider than other women. (10, 12-15)	Discrimination based on race, income, insurance status, age, parity and having other views than the professionals . Women felt their treatment was generally worse than others or they were accustomed "to being last" . Fear led some women to avoid potential discrimination by not using a service or leaving it limited. (10, 11, 14, 16)	Accessibility to care provision and the professionals' attitude contributed to empowerment of women, e.g. low-threshold care ; home visits; women get service fast, easily and without any complicated preconditions and professionals are approachable and not intimidating . Women felt more confident with midwives , nurses or lay health workers and there they dare to ask trivial questions . The exchange of experiences with peers was of prime importance. Problems with structural accessibility included long waiting times, long travel time, transportation, problems with parking or difficulties with finding suitable child care during the prenatal appointment. (10, 12-14, 16)	Women wanted to understand , what to expect from pregnancy and to know if there is a problem with her child. The feeling that information was withheld and receiving little or inconsistent information led to loss of trust . Continuity of care , the monitoring of the unborn child, as well as technical investigations increased the feeling of trust. Basically, women were just happy to be treated . (10, 12-14, 17)	Women handed over responsibility for their pregnancy to their supervising clinician or midwife. They saw the professionals as the expert regarding health decisions and expected that they acted and informed proactively. There were many signs of low engagement . However, they didn't feel safe enough to request further information because they were made aware of their apparent lack of knowledge . By following the rules imposed, they take responsibility for the child. Professionals fail to guide women in their maternity care choices , leaving them unable to engage fully in decision making. (10, 14, 17)

Literature

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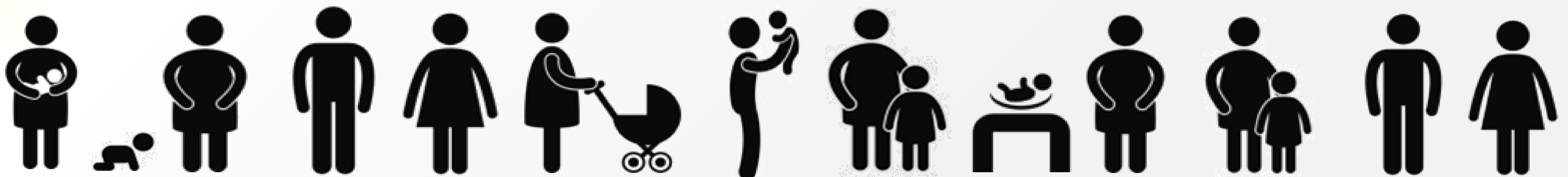
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Illustrations: <http://pictogram-free.com/material/>

Discussion

Socio-economic disadvantage has increased since the recent economic crisis (18). Poverty and health inequality of Swiss natives women is socially little perceived and in under-researched. There is also a lack of awareness about the connection of inequalities in maternity outcome and the client-provider relationship (19). Antenatal care must be better targeted at socially deprived women (20). A qualitative study on experiences of mothers with low socio-economic status with the maternity care in Switzerland is planned.



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