



Timing of the initiation of antenatal care: An exploratory qualitative study of women and service providers in East London

Bethan Hatherall, PhD (Research Fellow)^{a,*}, Joanne Morris, PhD (Research Manager)^b,
Farah Jamal, PhD (Research Officer)^{c,1}, Lorna Sweeney, PhD (Research Fellow)^a,
Meg Wiggins, MA (Senior Research Officer)^c,
Inderjeet Kaur, MSc (Consultant Midwife, Public Health)^d,
Adrian Renton, FFPHM (Professor, Public Health)^a,
Angela Harden, PhD (Professor, Community and Family Health)^{a,b}

^a Institute for Health and Human Development (IHHD), University of East London, Water Lane, London E15 4LZ, UK

^b Barts Health NHS Trust, Newham University Hospital, Glen Rd, London E13 8SL, UK

^c Department of Social Science, UCL Institute of Education, 20 Bedford Way, London WC1H 0AL, UK

^d Barts Health NHS Trust, Royal London Hospital, Women's Services, Whitechapel Road, E1 1BB London, UK

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ABSTRACT

Objective: to explore the factors which influence the timing of the initiation of a package of publicly-funded antenatal care for pregnant women living in a diverse urban setting

Design: a qualitative study involving thematic analysis of 21 individual interviews and six focus group discussions.

Setting: Newham, a culturally diverse borough in East London, UK

Participants: individual interviews were conducted with 21 pregnant and postnatal women and focus group discussions were conducted with a total of 26 health service staff members (midwives and bilingual health advocates) and 32 women from four community groups (Bangladeshi, Somali, Lithuanian and Polish).

Findings: initial care-seeking by pregnant women is influenced by the perception that the package of antenatal care offered by the National Health Service is for viable and continuing pregnancies, as well as little perceived urgency in initiating antenatal care. This is particularly true when set against competing responsibilities and commitments in women's lives and for pregnancies with no apparent complications or disconcerting symptoms. Barriers to access to this package of antenatal care include difficulties in navigating the health service and referral system, which are compounded for women unable to speak English, and service provider delays in the processing of referrals. Accessing antenatal care was sometimes equated with relinquishing control, particularly for young women and women for whom language barriers prohibit active engagement with care.

Conclusions and implications for practice: if women are to be encouraged to seek antenatal care from maternity services early in pregnancy, the purpose and value to all women of doing so need to be made clear across the communities in which they live. As a woman may need time to accept her pregnancy and address other priorities in her life before seeking antenatal care, it is crucial that once she does decide to seek such care, access is quick and easy. Difficulties found in navigating the system of referral for antenatal care point to a need for improved access to primary care and a simple and efficient process of direct referral to antenatal care, alongside the delivery of antenatal care which is woman-centred and experienced as empowering.

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Introduction

Outcomes for pregnant women and their babies are widely considered to be improved through effective antenatal care (Hollowell et al., 2012). However, qualitative research in high-income countries – predominantly the USA and Canada – indicates that a

* Corresponding author.

E-mail addresses: b.hatherall@uel.ac.uk (B. Hatherall),

joanne.morris@bartshealth.nhs.uk (J. Morris), lsweeney@uel.ac.uk (L. Sweeney),

m.wiggins@ioe.ac.uk (M. Wiggins), inderjeet.kaur@bartshealth.nhs.uk (I. Kaur),

a.renton@uel.ac.uk (A. Renton), a.harden@uel.ac.uk (A. Harden).

¹ Deceased 8th January 2016.

number of personal, structural and service-related factors delay or prevent access to antenatal care (Downe et al. 2009). To identify how such factors can be effectively addressed, an understanding of local contexts and of both factors that promote and delay the early initiation of antenatal care is needed.

In the UK, the publically funded National Health Service (NHS) offers consultant-led care for high-risk pregnancies and a minimum standard of midwife-led care for low-risk pregnancies. Both models of care typically begin with a 'booking appointment' which, depending on where in the UK a woman lives, is usually with a midwife or a General Practitioner (GP) (Dhange et al., 2013). The 'booking appointment' involves a health and social care assessment of needs and risks to ascertain whether a woman needs additional care and support during her pregnancy, and the provision of information regarding pregnancy and the pregnancy care pathway, including information on screening tests. The UK's National Institute for Health and Clinical Excellence (NICE) recommends that women attend this first appointment before the end of their first trimester, and ideally by 10 weeks of pregnancy (National Institute for Health and Clinical Excellence, 2008). The percentage of pregnant women attending the booking appointment by 12 completed weeks of pregnancy has been set as an indicator of access for benchmarking and improving local services by the UK's Department of Health (HSCIC, 2009).

Survey data has found that in England the proportion of pregnant women having their booking appointment by 12 completed weeks of pregnancy is 86% and by 10 weeks of pregnancy, as recommended by NICE guidelines, is 63% (Redshaw and Heikkilä, 2010). These proportions vary across regions, with the proportion of pregnant women having their booking appointment by 10 weeks of pregnancy being lowest in London (49%). A number of studies have identified socio-demographic predictors of late initiation of antenatal care for pregnant women living in the UK—including young age, high parity, lower socio-economic status, non-White British ethnicity, being born outside of the UK and not being able to speak English—indicating that late initiation of antenatal care is more likely amongst groups of women already known to be at higher risk of adverse pregnancy outcomes (Kupek et al., 2002; Rowe and Garcia, 2003; Rowe et al., 2008; Baker and Rajasingam, 2012; Cresswell et al., 2013). Although these studies serve to describe the characteristics of women who begin their antenatal care late in pregnancy, qualitative studies can provide insights into women's views and experiences of seeking care and of accessing and engaging with antenatal care services.

A systematic review and synthesis of qualitative research exploring disadvantaged and vulnerable women's views and experiences of antenatal care in the UK identified multiple barriers to early initiation of antenatal care (Hollowell et al., 2012). However, the reviewers noted that within the studies included in the review, few women explicitly talked about what personally enabled them or prevented them from seeking antenatal care, and so, barriers to care seeking and obtaining and receiving care had to be inferred. A recent study conducted in South Yorkshire in the UK has aimed to fill this gap by exploring delayed access to antenatal care from the experiences and perspectives of women who had their antenatal booking appointment after 20 weeks gestation (Haddrill et al., 2014). However, the vast majority of women who begin their antenatal care later than the Department of Health's target of 12 completed weeks do so between 13 and 19 weeks of pregnancy (Redshaw and Heikkilä, 2010).

The qualitative research presented in this paper explores the factors influencing the timing of the antenatal booking appointment from the perspectives of women with recent experience of pregnancy as well as health service staff. We included women who had had their booking appointment before 12 completed weeks of pregnancy, as well as those who had had their booking

appointment between 13 and 19 weeks and later, to understand not only what delays but also what enables women to begin their antenatal care early in pregnancy. Funded by a UK National Institute for Health Research (NIHR) Programme Development Grant, the purpose was to undertake exploratory research that would inform the development of a new intervention to improve early initiation of antenatal care.

The study received ethical approval from the NHS East London 3 Research Ethics Committee (ref 10/H0701/88) and the University of East London research ethics committee, and written informed consent was obtained from all participants prior to the start of each interview and focus group discussion.

Methods

Using a qualitative study design, we set out to further understand what prevents or enables women living in an urban setting with high levels of diversity and social deprivation to begin a package of publically-funded antenatal care early in pregnancy.

Study setting

The study was set in the London borough of Newham in the UK, where in 2010/11 over a quarter of pregnant women (27%) had their antenatal booking appointment later than 12 completed weeks of pregnancy (Department of Health, 2012). Newham is characterised by high levels of ethnic diversity and social deprivation, with the majority of babies born to mothers from ethnic minority groups (80.7%) and in households within the most deprived quintile of areas in England (84.1%) (Cresswell et al., 2013; Office for National Statistics, 2010). In Newham, all women have their antenatal booking appointment with a midwife at an antenatal booking centre based in the hospital, regardless of whether they plan to have a home birth, or give birth at the hospital or freestanding midwifery unit. Although some women contact the booking centre directly to receive an appointment, most visit their GP first to request a referral. Subsequent routine antenatal appointments occur with a midwife either at the hospital or in a community setting, such as a GP practice, with additional care provided by consultants at the hospital if necessary.

Study procedures

Qualitative data was collected between October 2010 and March 2011 through 21 individual interviews and six focus group discussions. The interviews were conducted with five women who were pregnant at the time of the interview and 16 who had recently given birth. Women were recruited through a hospital-based maternity service, a hospital-based bilingual health advocacy service and community-based organisations, to ensure a varied sample of women possessing a range of different socio-demographic characteristics identified in previous research as being associated with late initiation of antenatal care. The sample intentionally comprised at least 10 women who had had their antenatal booking appointment before 12 completed weeks of pregnancy ($n=11$) and at least 10 women who had had their antenatal booking appointment later than 12 completed weeks of pregnancy ($n=10$), including eight who had had their booking appointment between 13 and 19 weeks, to help us understand both what delays and what enables care-seeking, referral and attendance at the booking appointment within the first trimester of pregnancy.

In the interviews the women were asked to recount their personal experiences of pregnancy and antenatal care services, beginning with their first suspicion of pregnancy through to either

the present, if still pregnant, or to childbirth. An interview guide provided a broad structure to the interviews which were conducted in places convenient to and chosen by the research participants. Of the 21 interviews, two members of the research team (BH and JM) conducted 16 interviews in English and two in other languages using interpreters. Three interviews were conducted entirely in languages other than English by a postgraduate student and a bilingual health advocate who received training and support from the research team. All interviews were audio-recorded, where necessary translated, and transcribed for analysis.

To further explore the contexts which influence the timing of the antenatal booking appointment, as well as perspectives on pregnancy and care, six focus group discussions were conducted. Four of these were conducted with the assistance of interpreters in community settings with groups of 12 Bangladeshi, 13 Somali, four Lithuanian and three Polish women. Recruitment targeted these groups of women as our analysis of routinely collected hospital data, presented in another paper, showed that large numbers of Bangladeshi women and high proportions of Somali, Lithuanian and Polish women have their antenatal booking appointment after 12 weeks of pregnancy (Cresswell et al., 2013). Participants were recruited by a third sector community development organisation called Social Action for Health, using a variety of routes and means, including local services, community events and gatherings, leafletting and word-of-mouth.

Two focus group discussions were with service providers employed by the National Health Service, with one comprising 11 midwives and the other comprising 15 bilingual health advocates who provided interpreting and support to health service users in their mother tongue. For practicality, these focus groups were scheduled to follow a team meeting and a training session at which the bilingual health advocates and midwives, respectively, were already gathered. At the end of the meeting and training session, those present were invited to stay on to participate in the discussions. As with the interviews, all focus group discussions were audio-recorded and transcribed.

Participants

Reflecting the enormously diverse population of women using maternity services in Newham, three quarters of the women we interviewed ($n=16$) were born outside the UK in 13 different countries. Eleven of the women in the sample were married, six had a partner and four had no partner. Sixteen of the women interviewed did not have other children, whereas five had one other child. While the majority of the women in the sample were aged 20–34 years ($n=14$), the sample also included four women aged under 20 years.

Women in the focus groups originated from Bangladesh, Somalia, Lithuania and Poland, and all were resident in Newham at the time of the study. Unlike the interview participants, the women in the focus groups did not necessarily have recent personal experience of pregnancy.

Although the 11 midwives participating in a focus group worked across the maternity service, all had experience of delivering antenatal care and of providing antenatal booking appointments. Likewise, the 15 bilingual health advocates participating in the focus group all had experience of providing interpreting and support to users of antenatal services and together catered for speakers of 10 different Asian, European and African languages.

Analysis

We conducted a thematic analysis of the interview and focus group datasets. Thematic analysis is a method of qualitative data

analysis that is used to identify, interpret and report patterns (or themes) that exist across a dataset, and which represent beliefs, observations and experiences that participants may share in relation to the research question (Braun and Clarke, 2006). This form of analysis is well suited to producing findings that may be used to inform policy development (Pope et al., 2006).

We coded the content of the interview transcripts to identify factors which facilitated or delayed women having their antenatal booking appointment early in pregnancy. Although sometimes one factor appeared to play a key role in determining the timing of the booking appointment, most often multiple cumulative factors were involved. Three researchers (BH, JM and AH) coded a selection of transcripts in the first instance and compared them for consistency. The remaining transcripts were divided among the three researchers and coding was completed independently. However, as a further check on consistency and interpretation, the transcripts of interviews conducted by one researcher were coded by another researcher and the codes and analysis notes were shared and discussed. When all interview transcripts had been coded, codes were grouped together into meaningful categories to identify and develop common themes across the interview dataset. Thematic analysis of the focus group dataset followed the same steps as outlined above. Themes from the interview and focus group datasets were then compared and contrasted, and emerging findings were discussed to facilitate further interpretation and refinement of themes and concepts. Overarching themes were collectively agreed upon by the research team and are presented below.

Findings

In the UK, the timing of the antenatal booking appointment is used as an indicator of access to care in pregnancy. For the majority of the women we interviewed, the antenatal booking appointment was indeed preceded only by a single visit to a General Practitioner to request a referral to the maternity service for antenatal care. However, for some women, more substantial use of health services preceded the antenatal booking appointment. Of the 10 women interviewed who reported having had their antenatal booking appointment with the maternity service in Newham later than 12 completed weeks of pregnancy, two had previously received antenatal care from another NHS Trust, one had received medical care early in pregnancy from the emergency services and the gynaecology department, and one had had a pregnancy test at a community midwifery centre. Furthermore, the bilingual health advocates and some of the women participating in the focus group discussions reported that some women, particularly those from Eastern European and Baltic countries, if they can afford to, opt to initially either return to their countries of origin or access private clinics in London run by medical doctors from their home countries, in order to receive a model of care with which they are familiar in their mother tongue.

In the interviews, the women explicitly talked about what enabled or delayed their care-seeking, referral for and attendance at an antenatal booking appointment, with multiple factors often playing a cumulative role. These factors were found to relate to three broad themes: the perceived purpose and nature of the antenatal care provided by the NHS; the perceived purpose of health care provision more generally; and referral to and navigation of the service. Findings from the interview data are therefore presented under these three headings and are expanded upon with the data generated by the focus group discussions.

Perceived purpose and nature of antenatal care

The antenatal care provided by the NHS maternity service was found to be viewed as a package of care for viable and continuing pregnancies. Some women therefore saw little value in beginning this package of care earlier than 12 weeks of pregnancy because of the increased risk of miscarriage in the first trimester or because they needed time to accept the pregnancy.

"I just sort of sat on it for a while, and then when I hit the three-month mark, I then went to the doctor. I wanted to get my head round it, and I wanted to make sure that everything was going to be all right, sort of, before I went there and made it sort of official, if you like". (Interviewee 7)

It is likely that some service providers similarly deem the package of antenatal care to be specifically for viable and continuing pregnancies. One of the women interviewed had received medical care early in her pregnancy from the hospital's gynaecology service and explained how the service staff had advised her to wait until after the end of the first trimester of her pregnancy before seeking referral for an antenatal booking appointment in order to first ensure that the pregnancy was viable.

"They said to me, until we are sure that it's safe you see, to carry on with the pregnancy, then you can have a booking" (Interviewee 12)

Some of the women interviewed, especially those with unintended pregnancies, said they needed time to reflect on the pregnancy and to decide for themselves whether or not to continue with the pregnancy.

"I needed that time in order to decide whether I was going to have it, and what I was going to do, how my family would react". (Interviewee 4)

This time to decide whether to continue with the pregnancy and to accept the pregnancy was deemed necessary before seeking antenatal care, and sometimes even before disclosing the pregnancy to others. Some, especially the younger women interviewed, felt they might lose control over decisions surrounding their pregnancy once they disclose it to a parent, guardian or authority figure. These women indicated that once referral for an antenatal booking appointment had been sought their decision to continue with the pregnancy had already been made. As a result, one young woman was frustrated that during her antenatal appointments the midwives raised the option of terminating the pregnancy and another woman said that to do so is outside the midwife's remit as the midwife's role is specifically to prepare a woman to have her infant.

"I think midwives are into keeping babies. [] So I don't think any of them would have been suggesting anything like referral from your GP to have an abortion. [] I think they're more into preserving, making sure everything comes out alright". (Interviewee 14)

The notion that accessing antenatal care equates, to some degree, with relinquishing control was particularly notable among the Somali women participating in a focus group discussion. Though some aspects of antenatal care were valued, these women were particularly suspicious over the necessity of artificial induction of labour. The group was unanimous in agreeing that when presenting to a health professional for the first time in a pregnancy, they would give an incorrect date of the first day of their last menstrual period (LMP), so that their expected due date would be put backward by two or three weeks in order to avoid later induction of labour.

"We normally tell them [that the first day of our last period was] 2 or 3 weeks later, so that we cannot be told to come and be locked in. If they've given you a date and you haven't given birth on that day, they'll ask you to come in and of course you're going to have an intervention. We prefer to have a natural birth, instead of going to the hospital". (Somali woman, focus group)

As scheduling of the antenatal booking appointments is based on the expected date of childbirth calculated from the first day of a woman's LMP—which is only later corrected, if necessary, following her first ultrasound dating scan—such incorrect LMP dates may result in the late scheduling of antenatal booking appointments.

Besides the perception that there is little value or purpose in beginning antenatal care early in pregnancy, seeking antenatal care is also sometimes of lower priority to a woman in the first trimester of her pregnancy than other more immediate responsibilities and commitments in her life, such as housing, employment, education and care of other children and family members. One woman who chose not to begin antenatal care until after 12 weeks of pregnancy described how there were lots of other pressing priorities in her life at the time which she needed to address first.

Perceived purpose of health care

The interviews with women suggest that seeking care from a health professional becomes a priority when a woman feels unwell and is therefore seeking treatment, or when she is concerned and is therefore seeking reassurance. As health professionals and services are associated with the treatment of illness, women experiencing uncomfortable or disconcerting symptoms in early pregnancy reported seeking care from a GP and, consequently, being referred for an antenatal booking appointment. Some of the women interviewed who were feeling well in their early pregnancy said they saw no urgency in accessing health services.

"I wouldn't [go to the GP] if I'm ok, I don't want to take my time and their time because maybe people are sicker than me. So I don't go to the doctor straightaway". (Interviewee 21)

The bilingual health advocates and the Somali and Bangladeshi focus group participants suggested that a woman who previously had a normal pregnancy and uncomplicated childbirth may perceive less urgency or value in beginning antenatal care early for subsequent pregnancies, particularly if she had no or little antenatal care in her home country for her previous pregnancy.

"... you are already experienced in giving birth. [] you'll know what to do and how to look after yourself" (Focus group participant, Bangladeshi)

Referral to and navigation of the service

Difficulties with navigating the health service and the referral system featured prominently as a barrier to the initiation of antenatal care in the interviews with women and in the focus group discussions with both women and health service staff. Historically, in the UK, women have been required to access antenatal care through their General Practitioners (GPs) and so referral to the antenatal booking appointment is still most commonly sought via a GP, even though in recent years it has become increasingly possible for women to self-refer to a midwife (Smith et al. 2010). The interview and focus group data suggests awareness of the self-referral option is low, and so the start of the minimum standard of antenatal care was delayed for several women who did not have immediate access to a GP when they

first became pregnant. They were mostly new to the borough and unaware of local GP practices and/or did not have a permanent address and so were unable to provide the proof of address needed to register with a GP practice.

"It does take a long time because they don't take women without a GP at the hospital, so to get to the hospital she needed to get a GP, register with a GP, get an appointment and for her to be referred to the hospital it takes time. GP requires proof of address, some bill or something. And she did not have that address because they moved just recently so she was waiting for proof to come". (Interviewee 18, via an interpreter)

Those already registered with a GP practice spoke of difficulties getting an appointment with their GP and, once they had seen their GP, delays in being referred or receiving a response to their referral.

"My referral came late and that's why I had a late [booking] appointment. [] I did try phoning them but all they would say is that your referral form is not here yet. So I said that a lot of time has passed and my referral is still not here. This happened a few times. Then they said they would have another look". (Interviewee 11)

From the interview data there appeared to be some lost opportunities for other services within the NHS to refer women for an antenatal booking appointment. Eight of the women interviewed reported being asked to return to their GPs for a referral for the antenatal booking appointment after having directly accessed other health services (such as emergency services, an early pregnancy unit and a community midwifery centre) either to confirm their pregnancy or for problems early in their pregnancy. Four of these women subsequently had their antenatal booking appointments after the first trimester of pregnancy. Conversely, in some cases staff in other parts of the health service played a key role in connecting women with the maternity service, thereby enabling them to have their first antenatal appointment with a midwife within their first trimester. For example, one woman, without a GP, had her antenatal booking appointment by 11 weeks due to the proactive involvement of emergency service staff who referred her directly.

For women who do not speak English fluently, language can be a key barrier to accessing care. The bilingual health advocates who participated in a focus group discussion stressed that language difficulties do not just restrict pregnant women in their communication with health professionals, but also make it difficult for women to arrange or reschedule appointments and to organise travel to appointments. Indeed, the interviewed women interviewed who were unable to speak English fluently described the particular challenges of registering and making an appointment with a GP to obtain a referral for an antenatal booking appointment. Once referred, these women spoke of the added difficulty of having to arrange for a trusted friend or family member to accompany them to their appointment in order to translate on their behalf. Although the maternity service in Newham makes use of a bilingual health advocacy service to support women in their communication with healthcare staff, not all women knew prior to their antenatal booking appointment that the service was available, and the midwives and bilingual health advocates who participated in the focus group discussions reported that referral forms do not always state whether an interpreter is needed and for which language. This can then necessitate the cancellation and rescheduling of appointments which results in delays in the provision of care.

Discussion

In this study we explored factors influencing the timing of the first appointment of a package of care for women who are pregnant, offered in a context where antenatal care is publically-funded and predominantly midwife-led. The proportion of women having this first appointment, known as the antenatal booking appointment, by 12 completed weeks of pregnancy is used as an indicator of access to care by the UK's Department of Health (HSCIC, 2009). As an indicator it measures access to a specific package of care in pregnancy, but may be imperfect as an indicator of access to or utilisation of pregnancy care services more broadly, as findings from this study suggest some women may receive care from overseas, private practitioners and other NHS services prior to their booking appointment.

The perception that antenatal care provided by maternity services is a process of care for viable and continuing pregnancies and the awareness among women of the increased risk of miscarriage in the first trimester of pregnancy may deter some women from seeking antenatal care 'too early'. Indeed in the event of a miscarriage or threatened miscarriage, in the UK, care is usually provided by an early pregnancy assessment service, rather than the maternity services providing antenatal care (NICE, 2012). Furthermore, the current study suggests that, even where a pregnancy is to continue and is deemed viable, the purpose of seeking antenatal care early is not apparent, particularly for women with no concerning symptoms and previous experience of uncomplicated pregnancies. Finlayson and Downe (2013) similarly report that pregnancy is viewed not as a medical condition, but as a normal life event, especially for multiparous women, in their meta-synthesis of antenatal service use in low and middle-income countries. In the UK, antenatal care, despite being largely focussed on monitoring, prevention and support, is provided by a medical service traditionally associated with the treatment of ill health. If women are to be encouraged to seek antenatal care from the maternity services early in pregnancy, the purpose and value to all women of doing so will need to be made clear across the communities in which they live. The authors of a systematic review of interventions to increase early access to antenatal care for socially disadvantaged groups of women noted that there is a lack of good quality evidence on their effectiveness, but that interventions meriting further development and evaluation include community-level programmes in which local women are recruited to promote the use of antenatal care services within their communities (Oakley et al., 2009). As a sequel to the exploratory research presented in this paper, a community-level intervention to increase early initiation of antenatal care in pregnancy is now being developed and evaluated.

Of course while for maternity services in the UK it is a priority that all women have their booking appointment by 12 completed weeks of pregnancy, it is not always of equal priority to women. Some of the women interviewed spoke of needing time to accept their pregnancy before making it 'official' by starting antenatal care and others spoke of competing demands and responsibilities in their lives, such as housing, education, employment and caring responsibilities. Indeed, as Downe et al. (2009) pointed out in their meta-synthesis of barriers to antenatal care for marginalised women in high-income countries, taking care of basic survival needs frequently overwhelms the motivation to seek antenatal care. As a woman may need time to accept her pregnancy and address other priorities in her life before seeking antenatal care, it is crucial that once she does decide to seek such care, access is quick and easy.

Difficulties with navigating the system of referral for antenatal care featured prominently both in the interviews and focus group discussions. Some of the barriers to early initiation of antenatal

care are therefore also barriers to accessing primary care as they include difficulties registering with and getting an appointment with a GP, as well as subsequent delays in being referred to maternity services or receiving a response to a referral. Such difficulties, also identified by Haddrill et al. (2014) as system failures, point to a need for a simple and efficient referral process, where women know how to and are able to easily register and arrange appointments with a GP or refer themselves for an antenatal booking appointment directly, where referrals are processed quickly and where specific requirements for interpreting services are clearly indicated. As this study found that direct referral to antenatal care from other NHS services, such as emergency services, facilitated the early initiation of antenatal care, proactive referral to maternity services by staff working across the health service should be encouraged.

While NICE guidelines (2008) recommend that care should be woman-centred and that decisions made by women with regards to their pregnancies should be both informed and respected, concerns raised by some of the research participants about having to relinquish control over the pregnancy to healthcare professionals suggests that for some women antenatal care is experienced as being disempowering. This may be particularly the case for women with limited English. Previous research in London has highlighted the language and communication barrier between immigrant pregnant women and healthcare providers as a major barrier to accessing the benefits of antenatal care (Harper Bulman and McCourt, 2002, Binder et al. 2012a, 2012b). In the UK, National Institute for Health and Clinical Excellence (2010) guidelines recommend that women who are recent migrants, or who have difficulty communicating in English, ought to be provided with an interpreter, who is not a family member, for their antenatal care appointments. However, our findings highlight that this is not always the case and the lack of an available or pre-booked interpreter can sometimes result in the cancellation and rescheduling of appointments and is likely to hinder the provision of meaningful and supportive antenatal care.

Strengths and limitations

Since we included women who had had their antenatal booking appointments within, as well as later than, the first trimester of pregnancy, we were able to explore factors which influence the timing of the initiation of antenatal care both positively and negatively. Through the addition of focus groups discussions, we were also able to explore the community and health service contexts within which the personal experiences and perspectives of the women interviewed are situated.

Although we used multiple methods of recruitment to ensure a varied sample, the majority of the women interviewed were first time mothers and those who were multiparous each had just one other child. As the quantitative analysis of routinely collected hospital data in the same study setting identified high parity as a predictor of late initiation of antenatal care (Cresswell et al. 2013), further research focussing specifically on the experiences and perspectives of pregnant women with multiple children is warranted.

Difficulties recruiting Lithuanian and Polish women meant that the numbers of participants in these focus groups were smaller than intended. However, this research is the first to present the views of women from Eastern European and Baltic countries (Poland, Lithuania, Romania and Bulgaria) regarding the provision of antenatal care in the UK; views which are especially important to understand given that Poland is the most common country of birth for overseas born mothers in the UK (GLA Intelligence Unit, 2015).

Conclusion

This paper has highlighted influences on the timing of the initiation of antenatal care which fall under three broad areas. The first relates to the perceived purpose of antenatal care which, in the context of Newham in East London, is provided by the maternity service and begins with an antenatal booking appointment with a midwife. The second relates to the situating of antenatal care within a health service traditionally focussed on the treatment of illness and accessed predominantly via referral from a General Practitioner. The third focusses on service-related barriers linked to difficulties with navigating the health service and the referral system. We highlight the need for the purpose and value for all women of beginning antenatal care early to be made clear across the communities in which they live and for women, including those with limited English, to be able to obtain their first antenatal appointment simply, quickly and efficiently, with proactive referral from staff working across the health services. We also raise concerns that some women, especially those faced with language barriers, equate starting antenatal care with relinquishing control over decisions about their pregnancy. Antenatal care ought to be promoted as woman-centred and as a means to empower women to feel in control of their own pregnancy.

Conflict of interests

The authors declare no known conflicts of interest with respect to this publication and its authorship.

Authors' contributions

BH and JM collected and analysed the data and BH drafted and finalised the manuscript. FJ and LS helped synthesise the research findings and helped to draft the manuscript. AH conceived of and managed the study, participated in the analysis and reviewed the manuscript. AR, IK and MW contributed to the design of the study and reviewed the manuscript. All authors read and approved the final manuscript.

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