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Subproject B

Migrant-friendly information and training in mother and child care

Pathway for implementation and evaluation

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Executive summary

The problem

The literature consistently shows that postpartal period is usually a joyful event but also a critical time for the health of the mother and her baby. Especially for first-time mothers, insufficient knowledge about mother and baby needs and warning signals, as well as the physical, emotional and social stress of a new and unknown situation represents a high pressure situation for the young family. Nonetheless, the postpartal period is often not sufficiently covered by maternity care, which concentrates on the prenatal care phase.

For migrant populations, this problem is altered for several reasons:

- Follow-up care is not uniformly implemented in care processes and women are discharged from hospital to an environment of inadequate postpartal care. At the same time, psychosocial studies show that the needs of immigrant new mothers in the postpartal period are high, since they are separated from traditional postpartal practices and support networks.
- Members of migrant groups and ethnic minorities are more likely not to attend existing patient education programmes during pregnancy¹. Partly this behaviour can be attributed to cultural unawareness and misunderstandings in patient education programs.

A lack of literacy and culturally sensitive approaches is mainly a problem for the patients, but also a challenge for the quality of health care professionals' work and satisfaction as well as hospitals' interest in efficient service provision and consumer satisfaction.

Solutions

In addition to professional improvements regarding postpartum care, the expert discussion mentions systematic and culturally sensitive patient education and empowerment as entry points for quality development in the field of mother and child care.

Subproject B focuses on culturally sensitive information and training on central postpartal topics in a hospital maternity department setting.

Characteristics of the proposed intervention

The intervention in SP B is built up in modules, following 4 dimensions of the intervention:

1. Appropriate access (organisation)
2. Appropriate information (content)
3. Appropriate formats of information (sensitive to literacy levels and culture)
4. Appropriate facilitators and educational model (empowerment)

The modular structure offers the possibility to plan and implement measures in accordance with the resources available in the participating hospitals.

¹ Interview with Mag. Hilde Wolf, Clinical Psychologist, Director of "fem sued", Health Center for Women, parents and girls, Vienna, 10.9.2003

The Measure

A wide range of ongoing initiatives as well as several evaluated models can be identified in maternity care. (Theron 1999 and e.g. <http://www.stjoe.on.ca/>; <http://www.fem.at/femsued/suedhome.htm>; <http://www.pepcourse.co.za>) Nevertheless, in the literature search undertaken, no comprehensive model was found that integrated the issues of:

- Cultural sensitivity considering language, attitudes and behaviour,
- Health literacy, and the
- Postpartum period.

The proposed measure in SP B is therefore a combination of measures from several models of good practice that cover parts of the field.

The measure in SP B is built up in modules, following 4 quality dimensions:

M1: Appropriate access / provision

M2: Appropriate information (content)

M3: Appropriate formats of information (sensitive to literacy levels and culture)

M4: Appropriate relationship between clients and facilitators (culturally sensitive, enabling)

The modular structure offers the possibility to plan and implement measures in accordance with the resources available within the participating hospitals. Depending on the resources and needs of maternity wards participating in SP B, the intervention can range from implementing an existing tool (e.g., translating breastfeeding video) to the development and implementation of a training course using new developed information material presented by trained facilitators.

Decisions on what measures to implement are made within participating hospitals on the basis of both feasibility criteria (what can be done) and the needs and expectations of the clients (what should be done)

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Table: Modules of SPB

	Module / Component	Examples for content
Culturally sensitive patient information and education in model maternity departments	1) Access to / provision of information appropriate to clientele concerning access, linkage to community	<ul style="list-style-type: none"> ▪ No costs for women ▪ Cooperation with community in providing information material ▪ Held at appropriate time and with appropriate duration if organised in courses (e.g. evening hours, number and duration of sessions according to women's needs) ▪ Dissemination of information material (outreach)
	2) Information given adequate to needs and interests of clientele	<ul style="list-style-type: none"> ▪ Postpartal depression ▪ Breastfeeding ▪ Contraception ▪ Early parenting
	3) Formats and tools used adequate to needs of clientele	<ul style="list-style-type: none"> ▪ Video ▪ Storytelling ▪ Photo stories ▪ Games, e.g. Bingo ▪ Verbal communication if organised in courses
	4) Relationship between clients and facilitators; Empowering clients	<ul style="list-style-type: none"> ▪ Training for facilitators ▪ Bilingual (co)-facilitator

Module 1: Access and provision

A culturally sensitive patient information and education has to meet clienteles preferences, possibilities and resources. Therefore planning of a measure starts with a needs assessment of clientele.

A basic needs assessment must check:

- What information do women want to get concerning postpartal phase?
- What are appropriate formats of non-verbal information material (written/non-written, video/audio)?
- What is an appropriate time frame for training sessions?
- What is an appropriate way of disseminating information material if no training sessions are conducted?

One main resource that the women need to have is time. Planning services according to women's preferences and possibilities means choosing appropriate time and duration if the information given is organised in courses. Concerning the needs of your target group (e.g., evening hours, number and duration of sessions) consult the NAC. For example, during Ramadhan the Muslim women's attendance at prenatal programmes decreases.

For a model of good practice see the appendix:

Detailed model description 2: CULTURAL AND RELIGIOUS – RAMADHAN ANTE NATAL CLINIC, Bradford

Assure that all your efforts are free of charge for the participants.

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Module 2: Information

The information given aims to increase women's maternal health literacy in order to raise their motivation and self confidence as well as their ability to act in a healthy and health promoting way. It should enable them to handle the postpartal phase in a foreign and unfamiliar health care system yet remain in accordance with their own cultural frame of reference.

The selection of information to be given undertaken from the perspectives of both the experts (what do clients need to know) and the clients (what do clients want to know).

The main postpartal topics as named in literature are²:

Care of the baby

- Appropriate feeding, esp. breast feeding (UNICEF UK Baby Friendly Initiative 2001)
- Adequate environmental temperature
- A safe environment
- Parental care
- Management of common newborn problems
- Cleanliness
- Observation of body signs
- Access to health care
- Nurturing, cuddling, stimulation
- Protection from disease, harmful practices and violence
- Acceptance of the baby's gender, appearance and size
- Recognition by the state (vital registration system)

Care of the mother

- What happens to her body
- Postpartal blues and postpartal depression
- Nutrition
- Self care
- Hygiene and healing
- Sexual life
- Contraception
- Prevention and early detection and treatment of complications and disease

Support systems

- Partner and family
- Health care providers

Social reintegration

- Into partnership
- Into family
- Into community
- Protection from violence

² See World Health Organization 1998, Wimmer-Puchinger, Baldaszi 1997; Carlough 1999

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Module 3: Formats and tools

Information must be given in an appropriate way to have an impact. It must be easily understood and be reasonable in order for it to increase women's motivation and improve their ability to act.

To meet clients' needs, materials must be chosen or created in accordance with prevailing literacy levels³ and cultural and social backgrounds.

One can use existing material if it is appropriate or one can adapt existing material or develop new material.

According to the Center for Health Strategies (2000, 2001, 2002 a & b)⁴, developing culturally appropriate presentations and materials includes the following steps:

- Identify the population segments
- Involve minority patients in developing materials to assure tailoring messages to incorporate the audiences' beliefs and values
- Choose words that show respect for the patients' culture
- Field test materials for comprehension and cultural acceptance

Written material

Target group: Literate clientele. It should be:

- Easy to read and easy to understand (commonly understood words, short sentences, clear headings)
- Translated into the language(s) of the population(s) served

It is recommended to use non-written material as components of brochures, e.g. graphics, pictures and examples that reflect the audience.

Non-written material

Target group: Literate and illiterate clientele.

Examples for non-written materials include video tapes, audio tapes, photo stories, games. Available models collected in SPB are:

Video: BRIDGING THE GAP – A VIDEO APPROACH, Bradford

Audio: Bradford

Photonovels: “MOTHERS GIVE ADVICE ON BREASTFEEDING”, “THE FIRST WEEK WITH BABY”, Auger Communications

Games: Bradford

Module 4: Relationship

³ for assessing your clients needs and their literacy level contact SPB-Needs assessment – clientele

⁴ (Center for Health Strategies 2000; Center for Health Care Strategies 2001; Center for Health Care Strategies 2002a; Center for Health Care Strategies 2002b

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A crucial element in information and training is the quality of the relationship between professionals and their clientele. Trainers should have the appropriate professional backgrounds and communication skills, as these are essential to making co-operation with and the empowerment of clientele possible.

The training should be conducted by one expert trainer (usually a midwife), and other experts may join as co-trainers depending on the topic that is presented (these other experts might include an interprofessional team of doctors, nurses, midwives, and other staff of the maternity ward).

Requirements for trainers

As a rule of thumb, the minimum requirements for trainers are that they possess solid communication skills and have a good knowledge of and background in cultural diversity issues. Trainers should be familiar with the routines and procedures in the maternity ward and supporting systems for the postpartal phase.

Trainers need cultural and linguistic competence and therefore must be aware of:

- Different personal communication styles
- Diversity in perceptions of maternity
- Relevant belief systems relating to health, healing and wellness, help-seeking behaviours, and attitudes toward health care providers,
- Specific types of social support provided by family and community members who are relevant in the situation
- Specific everyday routines (nutrition, hygiene) relevant in the situation
- Specific spiritual and religious needs

Requirements for verbal communication

Verbal communication must be tailored to clientele:

- Deliver information in the language of your audience by involving native speakers or interpreting services.
- Slow down and listen to the minority patient's concerns
- Create an atmosphere of respect and comfort; build trust with the patient.
- Always start with a kind of needs assessment: listen to your target group!

Assist verbal information with written, audio, video and picture material

Requirements for organisation

- The course should promote cognitive and emotional learning, which suggests the use of diverse and interactive educational methods such as case studies, role plays (up to drama elements), discussions, panel discussions to demonstrate different perspectives, use of guest speakers on certain topics etc.
- Diversity of educational methods also recognizes participants' different learning styles
- Size and makeup of groups that work together in group activities should vary in the course
- The purpose of each activity, exercise, and lecture should be made clear to every participant
- It is recommended to start and to end with activities which have a low potential to create powerful emotions

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Example: tailoring your training course – steps and phases

Step	people
Planning of training: <ul style="list-style-type: none"> ▪ Definition of target group and specific needs of target group ▪ Timing / Scheduling of courses ▪ Definition of rooms ▪ Definition of needed skills of trainers ▪ Selection and training of trainers regarding cultural sensitivity (if necessary): training to strengthen cross-cultural competence (theoretical and methodical issues; pregnant ethnic minority women as experts) ▪ Selection of tools and methods to improve health literacy (written material, videos, audio material, photo stories, ...) ▪ Possibly, the production of new information material 	Preparation group + External experts + Client representative
Advertising for the program, recruitment of participants (participation of all migrant and ethnic minority patients of the maternity ward should be voluntary but heavily championed by caregivers): <ul style="list-style-type: none"> ▪ Integrate appointment-making into routine medical checks or other routine appointments in prenatal care process 	Preparation group + Staff on maternal ward and/or the midwife who has first contact with women
Conducting a pilot culturally sensitive course for parents-to-be on postpartal topics in addition to existing programmes	Interdisciplinary team of trainers (doctors, nurses, midwives, psychologist, social worker, ...)
First step in the course: <ul style="list-style-type: none"> ▪ Getting to know each other, assessment of relevant background of clientele: <ul style="list-style-type: none"> ○ Literacy level ○ Social background (partnership, relatives..) ○ Land of origin ○ Tradition of postpartum care in home-cultures (e.g. 40 days rest-phase) ▪ Group interview/ discussion as basis for fine-tuning and conducting course and baseline for training evaluation concentrating on: <ul style="list-style-type: none"> ○ Expectations of clients concerning content of information ○ Preferences of clients concerning format of training and information material ○ Initiation of social networking 	
Last step in the course: <ul style="list-style-type: none"> ▪ structured feedback by clients ▪ conduct of structured interview to evaluate training 	<div style="border: 1px solid black; width: 60px; height: 40px; margin: 0 auto;"></div>

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Discussion of pilot course concerning: <ul style="list-style-type: none">▪ Feasibility▪ Acceptance of clientele (based on structured feedback)▪ Acceptance of staff▪ Quality and appropriateness of tools and methods	Interdisciplinary team of trainers Preparation group
Public presentation of results to all ward staff at the end of the pilot phase	Hospital management, Decision makers, Preparation group
Adaptation and integration of the course into the regular training programme for all clients of the maternity ward	Preparation group





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Choosing your measure

Choose your measure according to both the needs of your clientele and the nature of your resources. A decision tree can help you to develop your selection in a step by step fashion:

Decision tree: Choosing a measure

1a. Needs assessment – Clientele	1b. Resource and motivation assessment – maternity ward (team meeting)
2. Select target group and learn about its needs and preferences	
3. Select content	
4. Select (trainers,) tools, and materials	
4a. Use existing material	4b. Adapt existing material
4c. Develop new tools and/or material	
<p>If you want to use or adapt (i.e., translate) models of good practice in SP B please contact Susan Auger for information on photo stories or Bradford Hospital for Breastfeeding video- and audio-tapes or Bingo-Game</p>	
<p>If you want to develop a course, please see the hints below</p>	
5. Tailoring of evaluation strategy (in co-operation with LBI)	
6. Final decision to implement program and start (Hospital management)	



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Planning and implementing your measure

For planning and implementing your measure please use the two supporting tools:

- 1) "SPB: Checklist for steps in planning and implementing measures" gives an outline of how to successfully plan and implement your measure in your hospital.
- 2) "SPB: Documentation of the planning and implementation of a measure" gives an outline of the necessary steps in the practical realisation of the measure.

Describing and monitoring your measure

To describe and monitor your measure please use "SPB: Documentation of the planning and implementation of a measure" again. In the planning phase, you already used this tool to plan your practical implementation steps. Please now check whether these planned steps were done, adapt where necessary, and insert the information on dates, people involved, material used, and material developed.

Evaluating your measure

Evaluation strategies and instruments are currently being developed. Below is a first collection of dimensions covered by the evaluation and measurement instruments:

- Existence of an adapted concept for the culturally sensitive training course
- The actual holding of the culturally sensitive training course
- Women's attendance at the culturally sensitive training course
- Development of women's knowledge and skills (maternal health literacy)
- Women's satisfaction with the service and all the materials that were used (adequacy and attractiveness of service and material in relation to women's needs and expectations)
- Staff's satisfaction with the service
- Management's satisfaction with the service and its costs
- Continuation of the service

Data is collected along with the intervention itself as it takes place. Examples for measurement instruments include:

- Concept for culturally sensitive training course
- Written documentation: time, trainers, participants and content of each module.
- Recorded and transcribed verbal feed back about the programme by the participants
- Short questionnaire for the maternity ward staff members



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Bradford Teaching Hospitals (BTH) Detailed model description 1

BRIDGING THE GAP – A VIDEO APPROACH

Description of problems and aims

In 2003, 48% of the 5,300 clients using the Maternity Services in Bradford were from minority ethnic groups, mainly Pakistani. There was an identified need for more relevant and culturally appropriate breastfeeding education for this group of women. There were particular problems associated with language and literacy (Tuffnell et al 1994). The video approach using various South Asian languages had already proved successful locally.

This project was the production of a multicultural breastfeeding video in relevant community languages, improving and extending an existing service. Information and advice was updated in line with the Baby Friendly Initiative Ten Steps to successful breastfeeding (UNICEF 1998). The initiative states that information should be provided to **all** women about the benefits of breastfeeding.

Problems to be solved

- ❑ Difficulty with providing all women with breastfeeding information in order to meet UNICEF recommendations
- ❑ Cultural and linguistic barriers
- ❑ Literacy issues

Target group

All women who would be delivering in Bradford but particularly those clients for whom culture, language or literacy may be a barrier to receiving appropriate information.

Aims

- ❑ To provide education about the importance and management of breastfeeding.
- ❑ To bridge cultural and linguistic gaps.
- ❑ To improve communication
- ❑ To provide information for women who cannot read.
- ❑ To use as a teaching resource.
- ❑ For every woman to have a video via a lone scheme.

Activities

- ❑ Members of the project were drawn from a multi disciplinary team, including:

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- ❑ women from the local community who participated in the film and also made recommendations regarding the filming
- ❑ the film crew, A local video production company was used by the maternity staff and women to produce the film. This company is a community video resource grant aided by the council that works with local groups that do not normally have access to this resource
- ❑ bilingual health support workers who recruited local women, advised on filming and provided linguistic and cultural support
- ❑ midwives who participated in the film and advised.
- ❑ infant feeding co-ordinator who coordinated the project
- ❑ managers who facilitated and helped to coordinate the project

Description of routine in model

Prerequisites

Premises

Locations for filming were explored, including GP clinics, hospitals, women's homes, and clinics in the community.

Technical Facilities Involved

Negotiation with the film companies including deadlines and timings, production, voiceovers, translations and costs, reviewing rough edits and finalising the production.

Staff

The staff involved were those outlined in section 2.'Activities'. Their expertise was varied. All staff and the film crew were experienced in working with Muslim clients and clients whose first language may not be English. They were also accustomed to the differing needs of this client group.

Education and training.

All participants were thoroughly briefed and prepared for the filming prior to the actual shooting date to try to ensure a smooth process once filming week began.

Budget

The Department of Health grant was obtained under the promotional strategy for increasing breastfeeding rates, particularly amongst low socio-economic groups - £10,000.

Process description.

Filming the video took place under close supervision with three main co-ordinators.

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Contact was made with the ethics committees and consent of all women being filmed was obtained.

After initial filming, the rough edits reviewed by staff and women and changes made accordingly until everyone was happy with the final version.

A distribution scheme was set up, packaging and marketing was organised.

Leaflets and posters advertising the videos were distributed to the health and midwifery press.

A launch day was held with the local press in attendance.

A loan scheme has now been established whereby all pregnant women who book with Bradford Maternity Services will be loaned a video.

Midwives, health visitors and health promotion have access to copies.

The video is available in four languages – English, Urdu, Punjabi and Bengali.

Implementation Pathway

Steps / tasks

- Identify need
- Negotiate budget
- Plan video content
- Consult with all stake holders
- Recruit local women
- Filming
- Review rough edits and make changes
- Agree on final version
- Arrange high Profile launch
- Advertise, market and distribute the video.
- Establish loan scheme to enable every woman to have access to video.
- Audit, evaluate, change

Tasks

- Include women's views
- Use local women
- Translation by reliable source
- Female camera crew where possible
- Prepare Well for filming i.e. prepare the staff and women who are to be filmed. Also prepare props and locations well in advance and have back ups if needed
- Named co-ordinators essential
- Ensure launch is high profile and well publicised.

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Evaluation of model

Criteria for success

- ❑ Every woman receiving a video on loan
- ❑ Womens' knowledge re breastfeeding increasing
- ❑ Breastfeeding rates improving
- ❑ Value for money

Measurements

- ❑ Every woman's care plan contains records of whether a video was given.
- ❑ Ongoing breastfeeding audit which assesses information given to women, and breastfeeding rates.
- ❑ Baby Friendly Initiative assessment in May 2003 which assessed womens' knowledge about breastfeeding and fed back comments about the video.
- ❑ Financial position.

Available Evaluation

- ❑ An audit of care plans in May 03 showed that 80% of women had been loaned a video. To date 4000 videos are in circulation.
- ❑ Although not directly attributable to the video only, the breastfeeding initiation rate in Bradford has increased from 53% in 1999 to 63% in 2003.
- ❑ At the recent Baby Friendly Initiative Assessment for Baby Friendly Hospital Status (UNICEF May 03) one of the criteria was that women should be able to discuss 2 management issues around breastfeeding. This criteria was passed: 62% of women were able to discuss management. All women questioned mentioned skin to skin contact as an issue which they had seen on the video.
- ❑ Baby Friendly also fed back that ' a significant proportion of women interviewed referred to the information in the video and several commented on how much they had enjoyed viewing it. '
- ❑ Baby Friendly stated 'A culturally sensitive video has been produced in Bradford explaining the benefits of breastfeeding and the Baby Friendly Initiative best practice standards. The unit is highly commended for this imaginative innovation.'
- ❑ The video is income generating and will become self-funding and is therefore excellent value for money.

References

DOH (1998): *Delivering Our Future. Report from the Standing Nursing Advisory Committee.* DOH

Tuffnell et al (1994): *Use of translated written material to communicate with non English speaking patients.* British Medical Journal, p. 309, 302.

UNICEF (1998): *Baby Friendly Initiative. Ten Steps to Successful Breastfeeding.* UNICEF.

UNICEF Baby Friendly Initiative Assessment on Bradford Royal Infirmary Maternity Unit May 2003.

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Bradford Teaching Hospitals (BTH) Detailed model description 2

CULTURAL AND RELIGIOUS – RAMADHAN ANTE NATAL CLINIC

Summary

Attendance by Muslim women at Ante natal clinics falls during Ramadan. This is due to the changing daily routines in this holy period. With this in mind a team of community midwives set up a Ramadan Clinic to respond to the clinical, spiritual and cultural needs of this client group (Pearce 2003). The pilot clinic was a success and evaluated well. A more extensive service is planned for this year's Ramadan.

Problems and Aims

The aims were:

- ❑ To provide an alternative clinic time for Muslim clients during this important Holy period
- ❑ To provide a culturally and linguistically appropriate service
- ❑ To address non-attendance at clinic

Problems to be solved:

- ❑ Low attendance at clinic during Ramadan
- ❑ The need for an alternative time for women to attend clinic to fit in with their changed daily routines
- ❑ The need for cultural, clinical and linguistic support

Target Group

The target group is all Muslim pregnant women who wish to use this alternative service. In 2003, 48% of the 5,300 clients using the Maternity Services in Bradford were from minority ethnic groups, mainly Muslim Pakistanis. Approximately 3000 of this group would be pregnant at any one time, giving around 1,400 Muslim women who could be offered the service.

Prerequisites

Premises

It was decided to run the clinic at the central maternity unit because it was familiar to all women in Bradford, and it offered space, adequate parking and security.

Technical facilities

Few required as the Ante natal clinic was equipped and set up but unused at this time.

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Advertising the clinic was initiated via the Trust press officer who notified the local press and arranged an interview on local radio with two midwives and a bilingual health support worker. Posters were placed in local clinics and surgeries and midwives were given flyers with all clinic details to offer to Muslim women. When a Muslim woman was given an appointment to attend an antenatal clinic during Ramadan she would also be given details of the Ramadan clinic as an alternative. A method of informing the woman's named midwife was devised via a communication sheet.

Education and training

None required as the midwives and bilingual health support worker involved were very experienced in care provision for Muslim women.

Staffing

On a rota basis two midwives were available to run each clinic. A bilingual health support worker was also in attendance for cultural and linguistic support.

Budget

The implications for the budget were two midwives and one bilingual health support workers for two hours each week.

Process description

During the month of Ramadan all healthy Muslims are required for religious reasons to fast from sunrise to sunset. Pregnant women can be exempt from fasting, but often choose to fast alongside their families as making up a month of fasting at a later date may be difficult.

The daily routine of Muslim women may change drastically during Ramadan; women often rise very early to provide their families with breakfast before sunrise and may keep late hours to open their fast after sunset, often breaking the fast with relatives and friends. This may result in women needing to sleep during the day, especially during pregnancy when they suffer from increased tiredness (Schott, Henley 1996).

As a result non attendance at antenatal clinics during Ramadan is higher than average; attendance at early morning appointments is very poor due to women having to rise early to prepare and eat with their families and then return to bed to rest.

Also some women choose not to have blood taken while fasting as they believe that this will nullify their fast.

These issues were recognised by the community midwives and the changing needs of women at this time were identified.

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Setting up and running the clinic

In 2002 Ramadan ran from November 6th to December 5th. Clinics were held weekly, and the timing was from 18.30 until 20.00 hours, to allow for the women to break the fast with their families prior to attending clinic. No appointment times were necessary as it was decided to run the clinic on a drop in basis.

In 2003 Ramadan will run from 27th October until 25th November with sunset being sometime between 1600 & 1740 hrs. This means that the clinic times will need to be later in the evening than in 2002.

When Ramadan occurs in the Summer months sunset can be as late as 2130 and the feasibility of running such a late clinic will need to be explored in future years.

Women attended for various reasons:

- Full antenatal check
- Blood taking
- Booking interview
- First available appointment with a midwife
- For general advice and support regarding pregnancy and fasting in Ramadan

The midwives and bilingual health support worker were all experienced in working with Muslim clients and could discuss the benefits, problems and clinical implications of fasting during Ramadan, giving advice and support where necessary.

Attendance improved with each session

Implementation Pathway

Tasks

- 1) Identify the problems of non/low attendance at antenatal clinic during Ramadan and differing cultural needs.
- 2) Consult closely with women, bilingual health support workers, and other staff e.g. Muslim Chaplaincy as to how to provide an appropriate service.
- 3) Obtain management support.
- 4) Practicalities, such as premises, staffing, budget and training implications must be addressed
- 5) Advertise early and frequently in the right areas in as many different mediums as possible, e.g. word of mouth, radio, flyers, posters using appropriate community languages. In this case the main languages were Urdu, Punjabi and Bengali.
- 6) Ensure full cultural and linguistic support available to achieve good communication.
- 7) Pilot the clinic
- 8) Make changes along the way if necessary.
- 9) Evaluate attendance and outcomes, including views of women and staff.

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- 10) Make necessary changes and adjustments for next year, e.g. earlier advertisement and extend service to involve women and midwives in all areas of the city.

Evaluation of Model

Criteria for Success

- Women's attendance at the clinic
- Women's satisfaction with the service

Measurement Instruments

Numbers of attendances at clinic and trends

Women were asked to feed back about the clinics and comments were recorded for audit purposes.

Available Evaluation

Table of attendance numbers and reasons for attendance

DATE SESSION	NUMBER ATTENDING	FULL ANTENATAL CHECK	BLOOD TAKING	BOOKING INRTERVIEW	FIRST AVAILABLE APPOINTMENT WITH A MIDWIFE	
12/11/02	1	1				
19/11/02	5	1	3	1		
26/11/02	6	2	4			
03/12/02	10	5	2	1	2	

Womens' Comments

- Easier to attend an evening clinic during Ramadan due to fasting
- Did not want to give blood and break fast during daytime clinics
- Early morning appointments inconvenient during Ramadan
- Husband appreciated opportunity to attend clinic with wife without needing to take time of work.

Midwives Comments

- Midwives expected teething problems
- Some initial resistance within the midwifery team, due to unsocial/extra hours
- All midwives in the team now feel this service for Muslim women should continue



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This year's clinic is now being planned and will be advertised throughout September and October.

REFERENCES

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Pearce A. (2003): *Provision of Antenatal Care during Ramadan; A new Bradford experience Submitted to British Journal of Midwifery*. As yet unpublished.



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Auger Communications / Aprendo Press Detailed model description 3

Overview of the ‘Teach with Stories’ Model for Prenatal Education

Introduction

Our goal is to help improve the health and well-being of women and their families. We want to be a strong link in the chain of community health workers that reaches across generations. We want to promote and support not just the physical but the spiritual, emotional and intellectual health of all our neighbors.

Our special focus is in helping those with the greatest need and often the least access to health information and resources. Hand-in-hand with these external barriers is often an inner sense of disempowerment. Poverty and many conditions associated with migrant living contribute to this sense of helplessness. It demeans one’s spirit and erodes one’s health and the health of our families and communities. We want to help break this cycle, to nourish the spirits and unique gifts that exist within each of us.

A woman’s pregnancy offers a natural window to renew the spark of life within herself, her family and community. An increasing number of studies show that health promotion significantly improves short term infant morbidity and mortality and long term maternal and child health. There is still much research to be done regarding the effectiveness of specific health promotion strategies. Researchers and providers have learned that effective health promotion must be comprehensive, including education and counseling with psychological and behavioral components.

‘Teaching with stories’ is one of the oldest forms of education, found in all cultures around the world. The act of sharing stories imparts information, cultivates relationships between the listeners and storytellers, and can motivate one to act with wisdom and insight. We want to harness the power of the universal “woman to woman” circles that have traditionally formed around mothers to be. As Dr. Clarissa Pinkola Estés (1992) writes,

“The older women were the arks of instinctual knowing and behavior who could invest the young mothers with the same. Women give this knowing to each other through words, but also by other means. Complicated messages about what and how to be are sent simply through a look, a touch with the palm of the hand, a murmur, or a special kind of “I cherish you” hug... It is this way among healthy creatures and among healthy humans. In this way the child-mother is swept across the threshold into the circle of mature mothers, who welcome her with jokes, gifts and stories.”

The ‘teaching with stories’ process incorporates evidence-based research and modern influences such as contributions from educators Paulo Freire and Malcolm Knowles. Their belief that that we are all teachers and learners, worthy of respect as equal human beings is one shared by our native elders and healers and is at the

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heart of this approach. True teachers are helpers to others. According to Dr. JT Garrett, a teacher of Cherokee medicine, humility is the first and the last lesson of one who is to be an effective teacher. “Strength, power or mastery first starts with being humble enough to listen and learn from the teacher...and we are all teachers.” The success of this model hinges on our ability to be humble teachers and from our willingness to really listen to the women and families in the community, our ‘other’ teachers.

Project Description

In the early 1990’s an increasing number of healthcare providers in North Carolina’s health department system requested assistance from the state health department to better serve the growing number of Latino clients.

Clinic and Outreach Programs:

Participants for classes were often recruited from clinics. The fact that many Latino women entered prenatal care late or not at all presented two problems. First, many women missed the educational opportunity. Second, a typical ‘medical model’ class structure made it difficult to accommodate immediate learning needs of new participants.

The few educational programs in Spanish were poorly attended. This led to a common perception (misconception) that Latinos did not like or wouldn’t go to classes.

Outreach efforts were difficult since many women spoke only Spanish and there was a shortage of bilingual, bicultural staff.

The predominantly poor, rural geographic regions in North Carolina also posed a problem for programs and outreach. Public transportation is often limited or nonexistent. Families often shared transportation (if a vehicle was available). Men typically were given first priority so they could get to work. Most women were stranded at home with young children, often with no phone. The transient lifestyle also posed barriers to reaching and maintaining contact with women and families. Existing programs and teaching methods were designed for people with higher reading levels. Typically, they had a strong emphasis on the written word, e.g., handouts, flip charts, posters and pamphlets with written descriptions (often high reading levels, small print, little white space). Programs were needed to address health literacy needs specifically.

The few successful prenatal programs that we identified for Spanish speaking clients relied heavily on the strengths of individual providers, their personal relationships and reputation in the migrant community. This made the programs difficult to replicate and sustain with staff turnover.

Materials:

A national literature search in 1993 revealed that there were few culturally and linguistically appropriate materials for Latinos on prenatal care topics (in Spanish or bilingual). We were unable to find any photonovels for prenatal care.

Some local staff indicated that they would not purchase nor distribute materials that they could not review and approve personally since they were professionally liable. Therefore, since they only spoke English, they were not comfortable approving or distributing any but bilingual materials.

Many local staff did not like or find the common ‘flip over’ bilingual format helpful since this made it difficult to navigate between languages.

Local staff indicated that they did not have the expertise or funds to develop and/or evaluate existing materials in Spanish to ensure that materials were culturally and linguistically appropriate for Latino families.

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Many locally produced materials we reviewed were in fact simply ‘translated’ from English, with little or no attention to the cultural or linguistic appropriateness of the messages.

Problems To Be Solved

- Difficulty finding skilled, Spanish-speaking people to provide prenatal education
- Poor or no attendance in prenatal education classes
- Difficulty educating women with late or sporadic attendance to classes
- Poor attendance and ‘no-shows’ to prenatal appointments; limited opportunity and/or resources to provide in-depth education during medical visits
- Difficulty accessing and providing services to young Latino children
- Cultural and linguistic barriers, including cultural and language differences between Spanish-speaking countries, low educational levels, different body of ‘health knowledge’
- Isolation of women and Latino community-at-large (geographically, culturally, linguistically, socially, emotionally, financially, etc.)
- Difficulty accessing literacy classes in the community
- Poor utilization of available health and social services
- Domestic violence and substance abuse problems among families
- Intimidating/negative reputation of the healthcare clinic and other services (e.g. police department, court system)
- Frustration, helplessness, sense of inadequacy of healthcare providers who see unmet needs, limitations, and problems repeatedly going unresolved
- Lack of positive reinforcement and support of healthcare providers

Target Group

The Latino women in our field-testing sites were from a wide range of Latin American countries. The majority of the women were young (ages 17-35), monolingual, with low educational levels. Some could not read in Spanish or English. First-time mothers, mothers with other children and fathers attended classes and were involved in the development and testing of the photonovels. The mothers were often cut off from their family support systems and traditional way of life. Most women were first generation immigrants, involved with migrant work or they may have recently ‘settled out’ in the community. In general, many Latino women do not know about the importance of prenatal care. If they do seek care, it is often late in their pregnancy or at delivery in a hospital emergency room. Cultural differences and environmental changes Latinos experience when they come to the United States contribute to their isolation and health problems.

Aims

- Provide prenatal education in a way that:
 - builds community (on multiple levels: among women and in community)
 - instills confidence in oneself and among the women as a group
 - increases participants’ skills in managing one’s environment and resources.
- Improve understanding, retention and integration of important health messages for mothers, children and families. This will ultimately improve their health and well-being and reduce mortality and morbidity



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- Improve health literacy among healthcare providers and community members
- Improve the level of cultural competency of staff members and the organization. This will improve access to and quality of care for all women and their families.

Estés, C.P. (1992). Women who run with the wolves. pp.179-180. New York: Ballentine Books.



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The Problem – theoretical and empirical background

Why specific attention to improving health care and health promotion for migrants and ethnic minorities?

European populations are becoming increasingly more diverse in the 21st century. As for other Europeans, health is a central issue for people with a migration or ethnic minority background, especially as migrants and ethnic minorities often find themselves in socially disadvantaged situations, negatively affecting their health. Appropriate health care, including equal access, and health promotion furthering health literacy are particularly important for people with different ethnic backgrounds.

Health care and health promotion for migrants and ethnic minorities do not always run smoothly. There is a wide range of scientific evidence that in many areas not only health status of minority groups is worse than that of the majority population but also that health care provision is unequal (see a current review of the literature, Bischoff 2003, pp. 97). Problems can be located on both sides: Migrants' health literacy, e.g. their knowledge of European health care systems, can be limited, and the health services are frequently not tailored to accommodate diversity.

Why invest in improving culturally sensitive patient information and training?

Migrant and ethnic minority women are a particularly important target group for hospitals. Their birth rate being significantly higher than those of women in Western societies, they often present a large share of the clients at maternity departments (eg. Khan 2003). Equality and diversity is central to be taken into account in all service planning and development. Mother and child health for migrants and ethnic minorities has been highlighted as an area of particular concern for health policies and programmes (International Organization for Migration 2001; Gardner, Blackburn 1996; Siem 1997) for several reasons:

- Migrant status is associated with low birth weight (Jeffers 1993) and higher infant mortality (Bollini 2000). Ethnic minority status has been shown to be one of the main predictors of severe maternal morbidity, including haemorrhage, preeclampsia, sepsis, and uterine rupture (Waterstone, Bewley et al. 2001). Studies show that immigrant status is a highly significant predictor for postpartal depression (PPD) (Glasser, Barell et al. 1998)
- Access to and quality of care is influenced by the fact that women are very often first generation immigrants with little or no education, a limited command of the local language and low social-economic status (Bollini 2000). Migrant women were found to more frequently receive inadequate or no antenatal care (15% as compared with 8% of native women, *ibid*).

Patient information and training helps raising the health literacy and ability to act. As improvements in the health of mothers and children require a high awareness

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among the patents-to-be of services available, pre- and postpartal care and health behaviours relevant for the health of mother and infant it is a key intervention, especially for the phase after childbirth, when young mothers need to cope a new situation in their daily life.

Studies show that mothers comprehension of common terminology associated with the care of a newborn baby could be improved (DiFlorio 1991)

Why invest in culturally sensitive patient information and training in hospital setting?

Most childbirths in Europe take place in maternity wards in hospitals. Therefore the setting of the hospital offers the chance to reach the majority of parents to be for information and training. Courses for the ante-, peri-, and postpartal care and behaviour are part of the services of most maternity wards in hospitals. They can be used as starting points for developing migrant tailored courses.

Why invest in culturally sensitive information material and skills of trainers?

Communication between health professionals and migrant and ethnic minority patients is not only complicated by language barriers, but also by cultural misunderstandings. (Bischoff 2003, pp. 50). Hospital staff's work is based on implicit cultural assumptions – e.g. with regard to the roles of patients and providers and the young mothers behaviour after childbirth. These often do not correspond with the expectations of migrant and ethnic minority patients who in many cases have different conceptions of birth, parenthood, health and illness, values and beliefs concerning care for their child or themselves and frequently are unfamiliar with mainstream European health systems.

On the other hand, migrant and ethnic minority patients' needs and expectations may not be understood on the part of health professionals – due to language barriers, but also due to an unawareness of values and beliefs related to the patients' cultural backgrounds. Unacknowledged and unmanaged differences in expectations and needs present also a major obstacle for the professionals in effectively performing their job, but also for hospitals' interest in efficient service provision and consumer satisfaction.

As concepts of maternity and behaviour of mothers and their partners and families are culturally different, these differences have to be taken into account to assure that women can get access to, understand and use the information they are given. To deliver useful information it is necessary to invest in information material that is expedient and feasible to a high degree for the migrant parents-to-be. Therefore real life experiences of the target group has to be the basis for developing new or for adapting existing information material. As it is likely that migrant clientele has limited literacy levels a range of non written material has to complete the written documents.

Why pay special attention to the postpartal period?

The postpartal period starts about an hour after delivery of the placenta and includes the following six weeks (World Health Organization 1998). Although there is no official definition of postpartal period the period of six weeks fits very well into many cultural traditions. Six weeks after birth the body of the woman has largely returned to the non-pregnant state and the psychosocial adaptation of the mother,

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the baby, and the family to the new situation usually has attained a new balance (World Health Organization 1998). Postpartal period covers a critical transition time for a woman, her newborn and her family on a physical, emotional and social level. Nonetheless the postpartal care is often neglected by maternity care. "The lack of postpartal care ignores the fact that the majority of maternal deaths and disabilities occur during the postpartal period and that early neonatal mortality remains high." (World Health Organization 1998). Part of a solid infrastructure for postpartal services is comprehensive and culturally sensitive parental information and training which highly responds to the needs and circumstances of the young family. WHO sees quality postpartal services as a long-term investment in the future of women and their newborn.

Care in the postpartal phase varies in different countries and regions. Several studies show that women of different ethnic descent who immigrated to developed countries experienced great differences between their cultural heritage and the care they received in hospitals. (Woollett, Dosanjh-Matwala 1990; Rossiter 1992; Kempe, Staugard et al. 1994, Brown, Lumley et al. 1994) Immigrants frequently come from cultures where women are nurtured, valued and supported at this time in their lives. These women are often isolated in their new country, within an alien health system and separated from their normal birth and postpartum practices. (Barclay, Kent 1998)

A study on postpartum depression among migrant women in Australia points out 5 problem areas that are experienced: feeling of isolation in a foreign country, inability to cope with fulfilling traditional gender roles, fear of failure, insufficient knowledge of PPD and existing support services, lack of centers that provide culturally adequate education courses. (Nahas Lopez, Hillege et al. 1999)

The WHO Technical Working Group on Postpartal Care of the Mother and Newborn formulated a wide range of recommendations for strengthening the quality of postpartal care. Many of them refer to guidelines on all aspects of postpartal care, tools on examining cultural perceptions of postpartal period events and health education material that has to be accurate, attractively presented, and of high quality (twg, 1997). Information given before and after childbirth must be consistent, simple, manageable, and meaningful to the women attending an education program. (Nahas Lopez, Hillege et al. 1999)

Studies show that parenting information is seen as an important issue both for educators and for participants in courses. Nevertheless it often is not sufficiently included in courses because of restrictions of time and the actual interest of mothers-to-be in information on pregnancy and giving birth. Additionally the cultural pressure on women that "a mother should know" gives information on postpartal topics a less high priority than the more medical ante- and perinatal care. Mothers would like to get more information about parenting but express that this information would be most helpful after birth or accessible at the point of time when really needed (Renkert, Nutbeam 2001)

To assure that parents are skilled right at time basic information on central topics of child care have to be delivered in prenatal courses. Additionally extensive information on the supporting system after birth have to be put across.

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