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South-Asian women's experiences of earlier additional, fetal monitoring to reduce stillbirth: An exploratory qualitative study

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ABSTRACT

Background: In an attempt to reduce the rates of stillbirth at term among South-Asian born women, Victoria's largest maternity service, Monash Health, implemented a new clinical guideline in 2017 that recommended additional earlier, twice weekly monitoring to assess fetal wellbeing from 39 weeks for South-Asian women. In acknowledging the importance of woman centred, culturally responsive care, this study aimed to understand South-Asian women's, experiences, of the additional earlier fetal monitoring.

Methods: An exploratory qualitative study was conducted using semi-structured phone interviews six weeks postpartum, across June and July 2021, with South-Asian born women who underwent the earlier monitoring from 39 weeks. Women were asked questions regarding their understanding of the monitoring, their experiences of the monitoring process and any impact the monitoring or results had on their pregnancy, labour and birth. Interviews were recorded and transcribed verbatim. Data were analysed using a thematic approach and an inductive coding strategy.

Results: Seventeen women from India, Sri Lanka, Pakistan and Afghanistan were interviewed. The main themes were: gaining peace of mind, need for better communication, did the women really have a choice? and comparisons to maternity care in the country of origin. Women experienced positive reassurance of their baby's wellbeing from the monitoring and were happy with the earlier, extra care. However, women described receiving variable explanations of the purpose of the monitoring. Ineffective communication and logistical barriers were highlighted to negatively impact women's ability to engage in shared decision making and their overall experience of the earlier monitoring.

Conclusions: The additional monitoring is reported by these women to have an overall positive impact on their maternity care. Future work should explore the experiences of non-English speaking South-Asian women and those who declined monitoring.

Statement of Significance

Problem

Women of South-Asian background experience elevated rates of stillbirth at term compared to other women.

What is Already Known

Victoria's largest maternity service implemented additional earlier monitoring (twice weekly cardiotocography (CTG) and amniotic fluid index (AFI) monitoring from 39 weeks) for South-Asian women to reduce their increased risk of stillbirth. Diverse frameworks of pregnancy and cultural values influence a woman's maternity care experiences and expectations.

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What this Paper Adds

Earlier monitoring was positively experienced by South-Asian women however communication challenges impacted women's ability to engage in choice, shared decision making and informed consent. Future strategies to reduce stillbirth in South-Asian women need to consider these issues.

Introduction

In high income countries, South-Asian born women experience stillbirth at up to twice the rate as locally born women [1–6]. In Australia, South-Asian people currently represent the largest migrant group, with over 120,000 arrivals in 2019–2020 compared to 79,000 in 2014–2015 [7]. In 2019, 5.4 % of births in Australia were from Indian-born women, the highest percentage of all non-Australian born mothers giving birth [8]. Reducing rates of stillbirth in South-Asian women is, therefore, central to reducing the national stillbirth rate [9].

While underlying drivers of higher stillbirth rates are likely multifactorial, earlier fetoplacental maturation may be a significant contributor. This accelerated fetoplacental maturation in South-Asian women is evidenced by a shorter duration of pregnancy [1], increased rates of fetal compromise at term [10] and intrapartum [11], more functionally mature infants when born preterm [12], and an earlier and more rapid increase in the risk of stillbirth at the end of pregnancy when compared to other women [1]. The rate of stillbirth for a South-Asian born woman at 39 weeks' gestation is similar to an Australian born woman at 41 weeks [1].

With the principle aim of reducing the risk of stillbirth, current Australian and New Zealand national guidelines suggest it may be reasonable to offer routine ultrasound assessment and/or induction of labour at 41 weeks for all women [13]. For South-Asian born women this may be too late. In that regard, the updated 2021 UK National Institute for Health and Care Excellence pregnancy care guidelines [14] highlighted that Asian woman, including South-Asian women, may benefit from closer monitoring due to their elevated stillbirth risk. However, there was no formal advice specifying what and when closer monitoring should be used.

In July 2017, in an attempt to address the elevated rates of stillbirth in Victoria at term, and in recognition of potential earlier fetoplacental maturation, Victoria's largest maternity service adapted a prolonged pregnancy management policy, recommending earlier additional fetal monitoring (twice weekly cardiotocography (CTG) monitoring and amniotic fluid indexing (AFI)) for South-Asian women from 39 weeks' gestation rather than the 41 weeks it had previously been, and remained for all other women [15]. All other aspects of prolonged pregnancy care remained the same. The impact of this policy on clinical outcomes [16] and clinicians' experiences [17] have been previously reported, however the experiences of women subject to this policy have not been examined [17,18]. Migrant women may have additional care requirements including challenges with communication [18,19] lack of understanding of a new health care system [20,21] and social isolation arising from immigration [22]. Any policy or care that identifies specific groups based on ethnic background may be perceived as being discriminatory, as was observed following the draft NICE guidelines [23–25]. Therefore, the aim of this study was to explore and highlight the experiences of South-Asian women who received the additional earlier fetal monitoring to reduce their risk of stillbirth to evaluate the change in care. In addition, the findings may also assist health services and clinicians to provide more culturally responsive care to South Asian born women.

Methods*Study design and setting*

A qualitative exploratory study was chosen to gain an in-depth understanding of South-Asian women's experiences of maternity care [26] with respect to the additional earlier fetal monitoring from 39 weeks for South Asian women at Monash Health [14]. Monash Health is Victoria's largest metropolitan university-affiliated teaching hospital, caring for approximately 10,000 women per year across three separate hospital sites.

This study was approved by The Human Research Ethics Committee of Monash Health (RES-20-0000-686A) from the 8th April 2021 and the Monash University Human Research Ethics Committee (Project Number: 29395). All study related procedures were carried out in accordance with the research protocol that was approved by the Monash Health ethics committee.

Description of the clinical practice change

The Monash Health Prolonged pregnancy guideline was amended to include a specific pathway for women who were of South Asian background (based on a woman self-identifying their background regardless of where they were born). The original clinical guideline recommended twice weekly fetal surveillance with cardiotocography (CTG) and measurement of amniotic fluid at 41 weeks' gestation. The change to the guideline recommended that the monitoring takes place earlier, from 39 weeks' gestation, for women from South Asia. The fetal surveillance monitoring remained unchanged for all other women. For all women, including South Asian women, an induction of labour is recommended from 41 weeks and close to 42 weeks unless sooner as clinically indicated.

Participants

Women who were born in South-Asia or who self-identified as South-Asian; were pregnant with a single baby at term; were receiving antenatal care along and who underwent the additional earlier monitoring and were booked to give birth at Monash Health were invited to participate in the study.

Women who were under the age of 18; had insufficient English fluency and were unable to provide informed consent were excluded from the study.

Sampling approach and data collection

Convenience and purposeful sampling of eligible women in the waiting room of the fetal monitoring unit at Monash Medical Centre in Clayton prior to their monitoring appointment was undertaken. Women who consented to participate were followed up six weeks after birth to arrange a phone interview with a mobile number they provided. Due to the COVID-19 social distancing regulations, individual, semi-structured interviews were conducted with participants over the phone across June and July 2021. The interviews were all recorded on the researcher's phone and then deleted once transferred to a secure cloud platform at Monash University. The first three interviews were supervised by MT, an experienced qualitative researcher and debriefs were held post interview. The interviews were semi structured and led on from participant responses to facilitate an environment of open, informal communication.

An interview guide was developed with questions developed from the Monash Health prolonged pregnancy guideline along with the literature on what is already known about culturally responsive care. This included questions such as "what were you told about the extra monitoring?", "how did you feel during the monitoring?" and "in what way did the monitoring affect your ability to incorporate your cultural

traditions into your maternity journey?” The phone interviews varied in length from 10 to 35 min as some women went into more details than others. All interviews were conducted in English and transcribed verbatim. Maternal demographic data were accessed from the hospital electronic database.

Data analysis

The interview transcripts were uploaded into the NVivo program [26]. Thematic analysis utilising an inductive coding strategy was used. This involved creating codes as they emerged from the data and grouping similar codes into themes. Inductive coding allows for the development of predominant themes in the raw data without restraint of structured methodology [27]. ET independently generated codes for ten transcripts and one transcript was analysed by all members of the research team, allowing for comparison of coding consistency and consensus on discrepancies. Further coding and generation of themes occurred at several meetings (MDT, MT, EF, ET).

Researchers' characteristics and reflexivity

ET works as a midwife and as part of her clinical role discusses the option for additional fetal monitoring with women during their pregnancy and refers them as indicated. None of the women in the study had received any clinical care from ET. ET was guided by experienced qualitative researchers who oversaw study related tasks to monitor for quality and rigour. Participants were reassured during recruitment and prior to the interview that their expressed opinions will have no impact on the care that they receive. Other researchers were not involved in the clinical care of the participants.

Results

Interviews were conducted with 17 women. The characteristics of the women are presented in Table 1. Interviewed women were from India (n = 8), Sri Lanka (n = 4), Pakistan (n = 3) and Afghanistan (n = 2). Most women were primiparous (n = 11, 66%), with a median age of 32 (Inter quartile range (IQR) 25–36), gestation 40 + 3 (IQR 39 +3–41 +4) weeks at the time of birth and experienced at least one post-dates monitoring appointment. Of the women who previously had children, five had their first baby in Australia, mostly at a Monash Health facility, and one had her child overseas in Bahrain. No women had a baby in their country of birth.

Four themes were identified: Gaining peace of mind, need for better communication, Did the women really have a choice? and comparisons to maternity care in the country of origin.

Table 1
Characteristics of recruited women.

Maternal Country of Birth	N = 17
India	8 (47 %)
Sri Lanka	4 (23 %)
Pakistan	3 (17 %)
Afghanistan	2 (11 %)
English Speaking	17 (64 %)
Primiparous	11(64 %)
Gestation at birth median (IQR)	40 ⁺ 3 (39 ⁺ 3–41 ⁺ 4)
Maternal age at birth median (IQR)	32 (25–36)
Number of post-dates monitoring appointments median (IQR)	3 (2–4)
Onset of labour	
Spontaneous	8(47 %)
Induced (total)	8(47 %)
From complications found during monitoring	3(17 %)
No Labour	1(6 %)

Gaining peace of mind

Many women had a positive experience of the monitoring and felt that it was beneficial for their pregnancy and their own peace of mind. They appreciated the extra reassurance of knowing their baby was well.

“So I feel that it’s more safe, and my baby and me are in good hands, and they are taking good care of me” (Participant 3).

There was variation among women’s views of progressing into the 39th week, which subsequently influenced their feelings towards the monitoring. One woman thought that it would be better to be induced, rather than wait and something “bad” happens. Some women felt that knowing their pregnancy was being monitored and that they are safe helped them with their stress of being “overdue”. One woman described that seeing the pattern of reducing fluid levels confirmed the need to have an induction for her. She was reassured by the trend being presented at each appointment and the explanation of the results.

“the extra monitoring part I am happy with that because otherwise I would have thought always that they didn’t listen to me...I actually needed this you know, this is for me, they were helping me.” (Participant 10).

Need for better communication

Women had varied experiences of communication with healthcare staff. Explanation of care, previous knowledge or experiences of extra fetal monitoring and word choice had a variety of impacts on women’s maternity journeys and their understanding of the care being offered.

Explanations of the monitoring provided to women varied. Some women recalled being informed that the monitoring was offered to them because they were from a South-Asian background and have a higher risk of complications including stillbirth and reduced placental function after 39 weeks. Some reported experiencing increased stress when discussing their risk, which was subsequently lessened with the explanation of the monitoring. Overall women did not elaborate on the findings of the monitoring and mostly their reflections were that they were told the baby is doing well.

“They said that because the Asian women, they have stillbirth babies. That’s why we want to make sure that everything is fine, the fluid and the heartbeat.” (Participant 1).

A couple of women did not know that their South-Asian background was the reason the monitoring was being offered to them and some did not recall receiving an explanation of the monitoring rationale at all. Moreover, some women stated that they understood the monitoring to be offered because of other pregnancy related events like reduced fetal movements or diabetes. On one occasion a woman who did not know about the additional monitoring was advised to do her own research.

“I didn’t know much about it. they told me to research things personally” (Participant 3).

One woman was scared when she was disrespectfully told by a doctor she had just met that her baby could die.

“when she said that the baby might die, that scared me. And to be honest, I wasn’t thinking about myself.” (Participant 2).

Many women received the monitoring at a different hospital than they were booked to give birth at. This different location introduced a new physical space, new staff and an increased transport time, causing some disappointment and increased stress due to the additional logistical challenges. However, practically, women were overall satisfied with the short waiting time and appointment length.

Did the women really have a choice?

Women had different experiences and expectations of choice in participating in the monitoring and subsequent care recommendations. Some women mentioned that the monitoring was recommended to them by staff, and they were happy to do it, particularly for the wellbeing of their baby.

“all these medical interventions, I don’t see that these are all forceful.”

Anything that's good for the delivery of the baby I think that should be taken so I didn't need to be given a choice here." (Participant 16).

In contrast, some felt that they had little choice in their care and that it was something that they were required to do. Some stated that it was recommended by the doctor or that they "had to do it" because the doctor said so.

"I wasn't given a choice as I remember they said like, we are monitoring... I don't remember if I have been asked whether I wanted to do it." (Participant 4).

A few women also described feeling pressure to do the monitoring from staff and subsequent judgement if they did not attend.

"I felt the pressure that time...because they say it's for your sake. They discuss the risk... So I think I've found that time, depression and anxiety the same time." (Participant 2).

"They said, whether you take our advice or not we will not be responsible if something wrong happens if that is the case, so I was like no, no I can't take any of this risk, so do whatever you feel right for me." (Participant 10).

Many women voiced opinions on different aspects of their maternity care but rarely did they express the feeling of being able to self-advocate. Some women stated the monitoring should only be once a week or not needed at all if they were feeling their baby move. They did not elaborate if this was something they felt able to discuss with their care team.

Many women discussed the additional fetal monitoring with their female relatives and to a lesser extent their partner. Many women also discussed the monitoring with their social circle for advice and support. Most women had not heard of their increased pregnancy risk towards their due date before. Others remembered it from previous pregnancies at Monash Health. Some went away and did further research either online or within their social circle.

"And I was thinking, and I called my sisters." (Participant 1).

Some women stated that their families were worried about them progressing beyond their due date because that doesn't happen often in their country of origin. One participant mentioned that their family was worried about the extra monitoring and the risk of radiation.

"They had their questions and then I said, "See, they are doing this extra monitoring, so you don't have to worry". (Participant 15).

Comparisons to maternity care and traditions in the country of origin

When asked about whether there were any culturally significant traditions related to their maternity journey, most women did not describe any. Where cultural traditions existed, women did not feel that the fetal monitoring had an impact. Although none of the women interviewed had given birth in their country of origin, many knew of maternity practices common in their country of origin that differed to their received care in Australia. Particularly, women from India mentioned that it was common in their country to have an induction of labour or caesarean at term. One woman discussed that in India if women do not progress spontaneously, their labours are induced to minimise the chance of adverse outcomes at 38 weeks. This created stressful feelings for some women who were all over 39 weeks. As a result, they felt that the monitoring was necessary.

"In India normally 38–39 week they are admitted in their hospital and doing the inducing but they're very scared about going to the till 40 weeks." (Participant 17).

Some women also mentioned that in their country of origin, the doctor would traditionally decide their care.

"because in India the doctor, don't wait for the 40 weeks after 38 weeks they decided to take caesarean." (Participant 8).

Some women also discussed that the monitoring wouldn't have been done in their birth country and expressed gratitude to the Australian healthcare system for the additional care.

"So, back home, people don't have much monitoring as here, and I thought, I like the monitoring at the end." (Participant 11).

Discussion

Overall, South-Asian women reported the additional fetal monitoring to be positive. However, there were differences in their experiences of how their increased pregnancy risk and the rationale for the additional monitoring was communicated with them by health professionals. Moreover, shared decision making, and informed consent experiences varied. Finally, while women shared their socio-cultural influences regarding maternity care, they did not feel the additional monitoring impacted them.

A measure of the success of any healthcare policy, aside from clinical outcomes, is a positive experience by its target demographic [28]. Not everyone will desire the same care and what positive care encompasses varies between individuals [29]. Reassuringly, we found that women had positive feedback about their earlier monitoring experience and any impact that it had on labour was also framed in a positive way. Our findings are consistent with studies that have shown antenatal fetal monitoring gives women increased peace of mind, reassurance and enhanced mother-baby bonding [30,31]. In a randomised controlled trial of 508 women over 41 weeks pregnant undergoing either induction of labour or fetal surveillance every third day, over 95 % of women felt reassured to continue their pregnancy if the fetal surveillance (CTG and Ultrasound) were reassuring [30]. Despite this, of those in the fetal monitoring group only 38 % reported they would prefer the same management in a subsequent pregnancy compared to 74 % in the induction group [28]. We did not ask women if they would have preferred to be offered an induction of labour rather than the monitoring. However, some women did share that if they were in their country of origin, their labours would be induced earlier. Flexibility in clinical guidelines to offer either earlier fetal monitoring or induction of labour for South-Asian women may be preferable, particularly in the context of a lack of evidence to support either approach. It is also possible that the positive experiences of women reflect increased interaction with midwives and doctors rather than the monitoring itself. Continuity of midwifery care (CoC) reduces the risk of both stillbirth and neonatal death [32] and a study of one CoC program in the UK reported lower rates of stillbirth among disadvantaged migrant women when compared to population estimates [33]. The role of CoC to improve care and outcomes for South Asian women should be explored.

Effective communication between health care providers and women is central to providing safe, quality, woman-centred care [34]. Barriers towards effective communication including use of medical jargon, underutilisation of interpreters and time constraints are experienced more amongst migrant women [35]. Concerningly, we found that women in this study reported varied understanding of the monitoring rationale. Health care providers at Monash Health have previously highlighted their concerns on communicating the rationale for the additional post dates monitoring policy to South-Asian women who, due to linguistic barriers, may not fully understand their explanation [29]. Whilst inadequate explanation of procedures has been shown to cause apprehension for migrant women [36], women who did not receive an explanation of the monitoring rationale did not express any additional fear or uncertainty compared to the women who did receive a more thorough explanation. This may be due to multiple factors such as women potentially accepting the care offered without questions, lack of awareness of their increased risk, or poor recall of the conversation. Communicating pregnancy risk is an important aspect of woman centred care [37]. Effective techniques utilised by midwives to communicate risk aim to advocate and empower women [37]. Migrant women may have additional barriers when discussing stillbirth risk such as not necessarily having a direct translation for the word "stillbirth" in their native language [38]. It may also be that clinicians feel uncomfortable with discussing potentially stressful pregnancy risks with women, despite its researched importance [37]. Concerningly, one woman reported evidence of a disrespectful statement about her baby dying. Many women in our study remember being told specifically about their

increased risk of stillbirth. A few, however, did not recall being told this and were not aware of prevention strategies offered such as attending the offered monitoring. Increased antenatal discussion of stillbirth with women can increase the uptake of protective behaviours against stillbirth [37]. This highlights the importance of discussing both the risks of stillbirth and the monitoring concurrently.

Shared decision making and patient choice is a key component in quality, collaborative healthcare and is highly valued amongst western healthcare professionals in a biomedical system [39]. Shared decision making with migrant women has documented challenges, arising from language barriers, different values and varying expectations of care [40]. We found that engagement with and desire for shared decision making amongst women varied. Many women in our study did not want or feel like they needed a choice in accepting the monitoring. This may stem from a cultural norm of accepting care from an authoritative figure, the desire to appear accepting and grateful or lack of understanding of the healthcare system and patient rights [41]. Migrant peoples lack of knowledge of healthcare rights may inhibit their ability to access available healthcare [42]. Our study only recruited English speaking women, most of whom have lived in Australia many years, so the total impact of barriers towards shared decision making is likely underestimated in our findings. Many participants mentioned gratitude towards the Australian healthcare system. Indeed, women may not want to appear ungrateful by refusing offered care. Some women also experienced pressure and judgement when exercising their right for choice, exemplifying the necessity of shared decision making.

Cultural influences can impact migrant women's experiences and expectations of their care and it is well documented that South-Asian women often seek advice from their female relatives and social circle in relation to their pregnancy [43]. The women in our study did not express any concern about the monitoring having an impact on their ability to incorporate traditions into their care. This is in contrast to previous literature highlighting that migrant women face barriers to incorporating their cultural traditions into their care [44]. We also found that there were logistical barriers towards women accessing their additional monitoring appointments. The challenges migrant women may experience are increased challenges with transport and social isolation. Almost no women had extended family here to assist them and therefore relied on their partners who were often working and were not able to drive them or look after their children. Indeed, with all the previously mentioned barriers that migrant women face when accessing health care, it is reasonable to advocate for removing as many barriers as possible to facilitate the uptake of offered healthcare [45].

Our study had a number of limitations. The interviewer was employed as a registered midwife at the health service where all participants received their monitoring. It is possible they did not want to cause upset or voice their concerns to a Monash Health staff member. Secondly, due to COVID-19, all interviews were conducted over the phone which may have impacted interviewer-interviewee rapport. Lastly, only English-speaking women were recruited and those who had already agreed to the monitoring. Women who do not speak English or who decline the monitoring were not interviewed and therefore findings may be biased towards the monitoring and over-report the positive perceptions. Future research should aim to address this. However, the sample recruited was representative of the broader South Asian population at the health service where ~50 % of South Asian women are born in India, 27 % in Afghanistan, 12 % in Sri Lanka, and 7 % born in Pakistan. Furthermore, no member of the research team is from a South-Asian background. Having this perspective and guidance on South-Asian culture from lived experience during the study design, data analysis and interpretation would have been beneficial.

Conclusion

In this exploratory qualitative study of South Asian women, we found that the additional fetal monitoring from 39 weeks was received

positively by women. We furthermore identified a need to ensure more effective communication pertaining to the risks and rationale of the monitoring. As the cultural diversity of women seeking maternity care in high income countries globally is increasing, a greater focus on delivering culturally appropriate care to meet the needs and desire of women is needed. The findings in our study offer insights from South Asian women themselves on experiences of care aimed at reducing their risk of stillbirth.

Ethical statement

None declared.

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Author contribution

MDT, MT, EF and ET conceived and designed this study. MT and ET were involved in data collection. MDT, MT, EF and ET performed the data analysis. MDT and MD were involved in the original research on South Asian women's increased risk of late-term stillbirth [1] that this study follows on from. All authors were involved in the interpretations of the data and manuscript preparation.

Author agreement

This article is the authors' original work and has not been published or considered for publication elsewhere. All listed authors have seen and approved the manuscript. All authors abide by the copyright terms and conditions of Elsevier and the Australian College of Midwives.

Conflict of interest

None declared.

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