

Exploring the health visiting service from the view of South Asian clients in England: a grounded theory study

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Abstract

The fact that health inequalities disproportionately affect the minority ethnic population is not new and projections are that the minority ethnic population will continue to increase. The importance of early intervention and the key role that health visitors can play in attempting to reduce health inequalities is well documented as is the requirement for health providers to establish culturally sensitive services. To date much of the research has focused on the perspectives of health care professionals caring for minority ethnic clients in hospital based settings and very little is known about the perspectives of minority ethnic clients regarding the health visiting service. The aim of this study was to explore the perspectives of South Asians regarding their experiences with the health visiting service. The study was conducted in a small town in the South of England between March and June 2013. A qualitative approach was selected using a grounded theory approach to capture the perspectives of this group regarding their interactions with the health visiting service. The sample consisted of 15 participants and data was collected through audio-recorded semi-structured interviews and analysed using constant comparative approach. Three key categories were identified: ‘the journey to understanding the health visitor’s role’, ‘the relevance of the service’ for the participants and ‘the significance of family’. It was found that South Asian clients distinguish between health and parenting advice, being more likely to accept health advice from their health visitor and more likely to accept parenting advice from their family. The findings, although limited in their generalizability, offer important insights into how South Asians perceive the service and will equip health visitors with a better understanding of how best to improve the experience of South Asian clients accessing the health visiting.

Keywords: Health visitor, minority ethnic clients, qualitative, South Asian, cultural sensitivity, public health nursing

What is already known?

- Health inequalities are rising and disproportionately affect minority ethnic clients
- There is a clear obligation on NHS trusts to reduce health inequalities
- Little is known about the perspectives of minority ethnic clients regarding the health visiting service

What this paper adds?

- One-to-one support from a health visitor is valued by South Asian clients, particularly when suffering emotional distress
- South Asian clients who live with extended family can experience tension between the advice given by health visitors and that provided by the family.
- There are indications that South Asian clients are likely to accept health advice from their health visitor but are more likely to accept parenting advice from their family.

Introduction

Adapting and responding to the changing needs of an increasingly multi-cultural society is a challenge faced by those providing healthcare in the United Kingdom (UK) as in other developed countries. In the latest UK Census (Office for National Statistics 2013), white British had decreased from 87% in 2001 to 80% by 2011, and remaining ethnic groups had increased, giving health care workers caseloads with greater diversity than ever before. Health services in the UK have legal responsibilities to uphold the rights of individuals to healthcare that meets their needs, without prejudice, and to tackle inequalities (Human Rights Act 1998, Equality Act 2010). Health inequalities, defined as preventable and unjust differences in health status that impact on health in terms of shortened life expectancy and quality of life, disproportionately affect the minority ethnic population (Bhopal 2007, Liu *et al.* 2012).

In England, the health visiting service (HVS) is a universal service providing all new parents with a named health visitor whose role is to assess the health needs of families, support new parents, and tackle issues such as child protection, social isolation and domestic violence. Broadly, it aims to improve the health outcomes of children and their families and to tackle the impact of health and social inequalities through working closely with at-risk or deprived groups and in partnership with other specialist services (Department of Health (DH) 2011). Expansion of the service is currently underway through the recruitment and training of an additional 4,200 health visitors under the Coalition Government's policy, *Health Visitor Implementation Plan 2011-2015* (DH 2011). This was a direct response to Marmot's Review (DH 2010) which highlighted the importance of early intervention in attempting to reduce the cycle of deprivation and the key role that health visitors can play in family centred

interventions and community based public health. To qualify, registered nurses or midwives undertake an approved degree level programme typically lasting 1 year full time (www.nhscareers.nhs.uk).

UK policy emphasises the importance of assessing the impact of services on vulnerable groups, such as the minority ethnic population (DH 2007). There is therefore a need to explore the perspectives of minority ethnic clients to understand whether the health visiting service is meeting their needs.

Background

Cultural sensitivity in healthcare refers to respect for diversity and an awareness of how one's own culture, background and values may influence care delivery (Starr & Wallace 2011). There is a lack of agreement over how best to improve cultural sensitivity as 'having cultural knowledge is necessary but not sufficient for the provision of culturally competent care' (Engebretson *et al.* 2008, p.176). Cultural competence requires a combination of appropriate skills, cultural knowledge and awareness (Suurmond *et al.* 2010). However, there is a need to recognise and expect diversity within, as well as between, ethnic groups in order to prevent unhelpful stereotyping (Engebretson *et al.* 2008). Models of cultural competency have been criticised for oversimplifying cultural differences and for focusing on practitioner-client relationships to the exclusion of political, structural and systemic practices that may regulate this behaviour and influence inequalities (Culley 2006, Green *et al.* 2006). In contrast, too heavy a focus on identifying organisational practices that perpetuate institutional racism within health services is criticised for failing to account for individual agency (Bradby 2010). These arguments illustrate a lack of clarity over how cultural competence operates at the individual and organisational level, raising questions about how best to improve clinical practice.

A range of factors is known to contribute to inequitable health care for ethnic minorities. Ability to access healthcare can be adversely influenced by language barriers, location and family choice, (Douglas 2012, Green *et al.* 2006). In relation to provider characteristics, inadequate communication, lack of involvement of clients in decision-making and negative or inappropriate interpersonal styles have been identified as key contributors to experiences of disparity in healthcare for minority ethnic clients (Starr & Wallace 2011). A survey of health

visitors (n=75) in England revealed a tendency towards an ethnocentric approach (Knight Jackson 2007), and that some health visitors lacked the skills required to assess and treat people from minority ethnic groups effectively (Donetto *et al.* 2013). Similar findings in other settings question the cultural sensitivity of healthcare workers (Vydelingum 2000, Leishman 2004, Garrett *et al.* 2008). Spence's (2001) study of nurses' experiences of nursing people from cultures other than their own in New Zealand highlight the tensions faced by nurses when encountering cultural differences and their struggles to deliver culturally appropriate care when faced with uncertainties and difference.

Given that the minority ethnic population of the UK is predicted to rise to twenty percent by 2051 (Wohland *et al.* 2010), there is a need for more research in this area. The health visiting workforce is expanding (DH 2011) and there is a requirement for health providers to collaborate with service users to define and establish culturally sensitive services (DH 2007:4).

This paper reports on a study which aims to explore the perspectives of South Asian clients regarding the health visiting service. It was envisaged that a study would illuminate the extent to which the health visiting service is meeting the clients health needs in order to inform future practice and the design of health visiting services regarding minority ethnic clients.

Method

Design

A qualitative interview study was undertaken as part of post graduate study by the principal researcher who was working as a health visitor. A classic grounded theory approach was chosen, Glaser (2002), in designing analysing and interpreting the data because of its emphasis on allowing emergent theory from the participant's perspective. It was felt that the inductive approach of grounded theory was best suited to address the aims of the study because of the lack of research on minority ethnic client's perspectives regarding the health visiting service.

Participants

Whilst aware of the criticism that the term South Asian may overemphasise the homogeneity of the group (Bradby 2003), the term South Asian has been employed in this small scale

study to describe a person whose ancestry is in the countries of the Indian subcontinent, including India, Pakistan, Bangladesh and Sri Lanka (Bhopal 2004).

Participants were identified from the caseloads of health visitors and from weekly health visitor clinics within 1 geographical area in the South of England. Recruitment from the researcher's own case load was avoided to reduce potential influence of a prior relationship or coercion.

Potential participants were given a participant information leaflet and then telephoned within 2 weeks by the researcher to see if they wished to take part in the study. The recruitment criteria included participants who: (1) were parents between eighteen and sixty years, of South Asian origin, (born in the United Kingdom or overseas), (2) had an interaction with the health visiting service within the last two years, (3) could speak conversational English, (4) had a child not less than eight weeks of age and (5) agreed to participate.

Data collection

Face to face semi-structured interviews were undertaken between March and June 2012 by the first author. An interview prompt outlining themes was designed which included understanding of the health visitor's role, relevance of information given to their cultural background, the level of support given by the health visitor and any effect this had on parenting as well as overall impressions of how helpful the service had been. Interviews lasted between 45 to 60 minutes and were audio recorded and transcribed verbatim. A reflective diary was written immediately following each interview.

Data analysis

The data was managed adopting the approach of Strauss and Corbin (1998) which employs simultaneous collection, coding and analysis of data. Transcription began the data analysis process and promoted early immersion in the data, followed by hand labelling texts using a system of open, axial and selective coding. Constant comparison was used as a way of maintaining a connection between the codes and a constant re-examining of the text to ensure consistency of the application of that particular code and to ensure that codes and categories developed to fit the data. Analysis included search for deviant cases but none were found. A modified version of theoretical sampling was used whereby emerging categories from early data was used to refine questioning in subsequent interviews. The two co-authors then

checked the coding and emerging categories independently for consistency and the process of analysis was reviewed and discussed together with the first author.

Ethical considerations

Ethical approval for the study was obtained through the NHS local ethics committee and the University of Surrey with local research governance obtained for the appropriate NHS site. Written consent was obtained by the first author and the researcher was equipped to refer to appropriate professional community based services who could provide psychological support if required.

Rigour

Rigour was enhanced by the two co-authors independently checking the subsequent fit between the emerging categories and theoretical understanding for consistency (Beck 1993). In keeping with grounded theory methodology, interview questions were adapted as concepts emerged and participants' meanings validated against emergent concepts, (Chivotti and Piran 2003). With an interest in delivering healthcare to minority ethnic groups, the researcher attended an ethnic minority parent and child playgroup prior to the study to increase awareness of existing specialist services and the needs of the local population. The researcher kept a reflexive diary to heighten awareness of blurring between professional and research roles.

Findings

A sample of 15 female participants was recruited aged between 20 and 37 years, see table 1 for more detail of participant characteristics. Data analysis resulted in three categories: 'the journey to understanding the health visitor's role', 'how relevant is this for me?' and 'the significance of family'. Categories are illustrated by anonymised quotations.

1. Understanding the role of the health visitor

Not understanding the role of the health visitor was the starting position that participants (n=14) described when they first met the health visitor. Participants expressed feelings of being unsure of how and when to access the service, and uncertainty regarding the role of health visitors in relation to other healthcare professionals and their level of training. A reason articulated by more than half of the participants for their lack of understanding was that there was no comparable service in their homeland.

“There’s no set up like this in my country. What should I ask? It seems the health visitor wants you to ask questions” (PP6)

This uncertainty continued even after their initial meeting with the health visitor, with participants feeling unable to evaluate whether they had received the full service or not.

“I don’t know what their job is. So I cannot say if something has been left out or not because I don’t completely know what she is supposed to do....” (PP7)

Without clarity regarding the health visitor’s role, participants were left to navigate their way in a ‘sea of confusion.’ The system was described as confusing and difficulties were reported in identifying the most appropriate service to use.

“For a long time I was looking for someone to check her weight. I don’t know where I should go. Then I take her to the GP and they said the baby weight checking day is Wednesday..... At the clinic, other than weighing I don’t know what other services they do...” (PP6)

Participants also felt reprimanded when, they tried to access the system at the ‘wrong’ juncture:

“I think it’s complicated to know who to call.... There was this kind of blur as to where does this end and where do I go next, it’s so complicated and they make you feel it’s obvious who you should call. It might be obvious to them, but if I knew who to call or where to go I wouldn’t have gone to the wrong place would I?” (PP5)

Despite the uncertainty over what the health visiting service could provide, nearly all participants expressed confidence and trust in the system.

“I was just going to wait and see what they were there for. I trust the system here so I thought everyone has their job to do in this process at a particular time” (PP5)

Although participants began to gain insight into the service if and as their exposure increased, there was a sense that they remained on the ‘back foot’ throughout their trajectory with the HVS.

2. Sensitivity of services

This category explores the relevance and cultural sensitivity of different aspects of the health visiting service and the impact on participants in relation to language, cultural differences and relationships. Findings suggest that explanations given about the health visiting service were not meaningful to all participants.

‘Lost in translation’ describes the situation whereby an original meaning cannot be translated perfectly word for word into another language and needs to be rephrased into something the recipient can make sense of. Despite speaking conversational English, half of all participants seemed to lack confidence in questioning the health visitor, and seeking out more meaningful explanations:

“They wrote his weight down in the red book. If they didn’t say anything I just thought everything must be OK” (PP7)

In addition, several participants mentioned that they avoided telephone contact because of concerns that people would not understand their accent or that they might not be able to understand the health visitor.

“I didn’t understand everything she said. She spoke quite fast and I didn’t want to make her late for her next visit ...” (PP3)

Cultural challenges were reported, including differences in what is considered gender appropriate conversation and different cultural style encountered from the health visiting service compared to that of their homeland. Cultural differences also extended to the delivery of the service which, other than clinics, used appointment systems for home visits or health visiting led courses which a client must book onto in advance:

“It’s just all more formal here. You have an appointment and then the health visitor who you’ve never met comes to your home and asks you so many things..... Back home it’s simple; here there are a lot more rules...” (PP2)

The majority of participants confirmed that they had not attended any health visiting led group and indicated that lack of familiarity with attending groups was a factor in their decision not to attend. It was also found that advice given was not always attuned to the participant’s cultural stance and the lifestyle changes they might experience as they adjusted to living in the UK:

“The first time I met her she said a bit about going out for walks and joining things. Traditionally in India you wouldn’t go out for the first 14 days at least. She said I should take the baby out for fresh air and that lots of mothers are out and about by now. I told her that in India you would probably just keep yourself covered and stay indoors as much as possible. If I tell my mother in law I’m going out for a walk with a two week old baby in March she will think I have gone crazy. I don’t think the health visitor wanted to hear that” (PP9)

Half of all participants felt that the health visitor gave priority to standardised advice, leaving participants feeling that their own customs were considered incorrect.

“Sometimes she makes me feels as if I’m not doing it right.... I feel as if she doesn’t approve of the way I’m doing things... I get the feeling that they want everything done a certain way” (PP11)

Throughout the study participants expressed feelings of ‘a disconnect’ between what they knew from their homeland and what they were now experiencing, yet two thirds of participants described the contact they had with a health visitor as being helpful. While some participants expressed reluctance to allow a ‘stranger’ into their home, relationships with health visitors were valued once they had developed and this increased their readiness to engage with the service.

“Now that I know I can ask when she will be in clinic I would prefer to go and see her before just calling the GP” (PP5)

This relationship was most valued by participants who found themselves without their extended family nearby:

“I did feel she understood I was alone here. With the first baby I got depression... and the good thing is she came and taught me baby massage....and we used the coconut oil from back home. I remember that because normally we use it for the girls’ hair but the health visitor said it was fine as long as he didn’t have any allergy to it. I remember I felt a lot better after those visits” (PP4)

This participant reveals the powerful impact of being understood by a health visitor during her period of postnatal depression and being able to bring her two worlds together, using coconut oil from her homeland to massage her baby in her current home.

3. The significance of family

Participants attached great value to the involvement of their family in childrearing, whether the extended family lived in the UK or in their homeland. This was reflected in the common use of the term ‘we’ referring to the family, as opposed to ‘I’ being the mother. All participants had expectations of their family to help them when they had a baby, and that this was shaped by the family structure and their experiences of their homeland:

“Back home it’s just family, mothers and aunties helping you, and it would be a shame on them if they didn’t help you” (PP3)

It was noted that participants referred to home as the place where their extended family lived and that none mentioned a network of local friends. This reliance on family as a social network was at odds with health visitor goals to encourage new parents to attend health visiting led groups.

“I don’t know what you have to do when you get there. Is it something like a talk? ... I don’t tend to go out for things like that, not on my own.....at the weekends my husband will take us out so that we don’t need to worry about going out in the week...” (PP7)

In contrast, for those participants whose extended family lived overseas, the health visitor role was described as important for providing support and reducing isolation and loneliness.

“I never imagined that I would be on my own all day when I had my baby. Back home there is always someone to help you, aunties, cousins even neighbours...Here it’s really hard, completely different, everyone keeps to themselves, so just having the health visitor visit for an hour makes a difference otherwise I might go the whole day without talking to someone until my husband got home” (PP4)

There was general agreement that the health visiting service did not fully understand the significance of family involvement in childrearing the South Asian context. Those living with their extended families unanimously used the phrase “they don’t understand” or “misunderstand” when referring to the health visitor.

“They don’t understand that in our culture a baby is part of a whole family and everyone helps out, not just the mother” (PP8)

There was a feeling that health visitors preferred to focus attention on the mother alone and sometimes made incorrect assumptions that the extended family would interfere.

“It was almost like the health visitor decided as soon as she saw them [the family] that they would be interfering? And I was just like ‘No I don’t find them interfering, in fact it really helps me that they’re here’.” (PP11)

As the family played a significant role in providing and/or making decisions about childcare, the majority of participants reported instances where they had to manage conflicting advice from the extended family and the health visitor. Conflict often featured over what is acceptable to feed a baby, with several Hindu participants mentioning their mothers wish to give the baby a taste of honey or almond paste which is contrary to current health visiting advice based on Department of Health recommendations:

“Back home it’s very common to put a little taste of honey on the baby’s tongue. Fortunately my in laws haven’t pushed it ...or maybe they just did it when I wasn’t looking?” (PP10)

Some participants reported feelings of stress as they tried to reconcile two contrasting cultural models of parenting, not wishing to displease family members. Extended families did however appear to be more accepting of advice that was health related, for example, concerning vitamins, immunisations and attending developmental checks, rather than parenting advice which was considered to be their domain.

“I mean from a health point of view the family like the advice but some things, like maybe how to raise a kid, they will listen but I know they will do their own thing, that’s the way they know..” (PP15).

Discussion

Overall, while these South Asian clients expressed few direct concerns, there were difficulties and barriers that disrupted their journey through the HVS.

It is widely acknowledged that language can be a barrier for ethnic minorities in accessing health care (Henderson 2011, Yu 2011). While able to speak English, lack of confidence in its use was a deterrent to accessing and understanding services for some participants. Similar barriers have been reported among Chinese migrant workers, including those fluent in English (Green *et al.* 2006). As participants in this study spoke conversational English,

translation services would not have been offered, however research suggests these services are not universally offered when required, and where provided such translation services have been found to be problematic (Alexander *et al.* 2004).

With little previous knowledge of HVS, a major disadvantage was in not knowing what to expect and how to navigate NHS systems. Difficulty in understanding how health systems work, and when and how to access services, are also barriers for asylum seekers in the UK (O'Donnell *et al.* 2007). While these difficulties are not specific to ethnic minorities (for example, lack of knowledge about HVS is common amongst first time parents (Donetto *et al.* 2013)), confusion remained over time for some participants, indicating continuing communication barriers. Donetto *et al.* (2013) argue that an understanding of how best to use the HVS is gained through a process of reciprocal exchange and the development of trust between provider and client. This can be achieved through a range of attitudes, skills and activities in what Cowley *et al.* (2013) identify as a health visitor 'orientation to practice'.

Ineffective provider communication is considered a key reason that minority ethnic clients experience health disparities and consequently are unable to fully participate in decision making (Garrett *et al.* 2008, Starr & Wallace 2011). This study identified instances of power in-balance whereby clients wanted to question the health visitor and check their understanding but perceived this to be inappropriate. Advice given was sometimes at odds with cultural values and health visitors were seen as reluctant to accept challenges to this advice. This is reminiscent of ethnocentric and monocultural approaches to health described in previous studies, (Vydelingum 2006, Knight Jackson 2007). As with previous research (Donetto *et al.* 2013), negative experiences in past encounters with health professionals had left a lasting impression on participants, however where HVs were flexible and client led, such an approach was found to be both effective and empowering for the client.

Services were not always perceived to be aligned to participants' cultural values and beliefs around, for example, sensitivity about revealing personal matters to strangers and involving men in women's health issues. Similar differences in gender appropriate topics of conversation amongst ethnic minorities are reported elsewhere (Grewal *et al.* 2005, Frey *et al.* 2013) and can influence service use. The concept of attending health visitor led groups was especially at odds with the cultural reliance on extended families as a source of guidance, coupled with a strong reluctance to discuss 'private' matters with strangers. This contrasts with findings reported by Donetto *et al.* (2013) where the majority of service users found

local child health and breast feeding clinics an especially useful addition to home health visiting services. Paying greater attention to the acceptability and accessibility of services to minority ethnic groups is important in order to improve health outcomes for the minority ethnic population (Szczepura 2005). One solution to this, for example, is the provision of female only community based groups.

It was consistently reported that health visitors did not fully grasp the importance of the extended family in South Asian culture and the concept that their families were operating as a whole. Elsewhere it has been reported that consensus among family members is an important aspect of decision making in Asian families (Bowman and Singer 2001, Grewal *et al.* 2005), however in this study, health visitors were sometimes perceived to be uncomfortable involving family members in consultations. According to Puzan (2003), nursing discourse has been based on entrenched patterns of cultural dominance, which is perhaps reflected here with regard to the invisibility of extended families. The same participants also described the service as being helpful, and so were able to differentiate this from the rest of the service they received. Participants who felt isolated because their family were far away responded most positively to the health visitor's input and reported feeling supported and understood.

The findings are in line with previous research on SA and other ethnic minority perceptions of HVSS. Extended families can provide important support, but when there is conflict in the family they can contribute to feelings of depression and isolation (Wittkowski *et al.* 2011, Chan & Leng 2004). Although negative feelings and isolation are common with post-natal depression, this was found to be further complicated by cultural, religious and family related factors in a study of South Asian mothers (Wittkowski *et al.* 2011).

For participants with extended family present, the issue of conflicting advice between the extended family and the health visitor was a frequent area of tension. When advice concerned parenting alone, family advice took precedence, however when the advice was health related, the health visitor's advice was more often accepted. Whether this was to maintain family harmony or respecting the views of elders, which is a core belief held by many South Asian families (Segal 1991), is not known. It was also noted that while participants regularly attributed their parenting approach to culture 'back home', it was evident that a variety of approaches were used by participants from similar cultural backgrounds. Further research is needed to explore these finding in relation to how concepts of ethnicity evolve and how differences between family expectations and the HVS are negotiated.

Study limitations

Participants were those already accessing the HVS and a different recruitment strategy would be required to access the views of more marginalised clients who do not access the HVS. It was also possible that colleagues unconsciously approached clients with whom they had already developed a good rapport.

The inclusion criteria had limitations in that participants had to speak conversational English due to the lack of interpreting resources, excluding a significant part of the South Asian population, and having implications on the generalizability of the study. It is possible that interviews undertaken in participants own language may have produced more detailed data.

Recommendations for practice and research

Health visitors need to consider that South Asian clients may have difficulty accessing services because of a lack of familiarity with how the service operates. In order to promote equity of access, health visitors should be proactive in asking clients about their language needs and preference for use of an interpreter.

Sensitivity to family dynamics and their importance when giving health and parenting advice is crucial for health visitors if they are to deliver an effective HVS which meets the needs of the South Asian population. This study has revealed that the HVS is at least in part using an ethnocentric approach particularly when imparting parenting advice. There is a need for education and training in cultural issues and communication with minority ethnic clients to address this finding, (Henderson *et al.* 2011).

While it is important to gain a better understanding of what constitutes culturally appropriate services for South Asian clients, this should not be at the expense of further stereotyping ethnic groups. HVS should continue to strive towards providing holistic care at an individual level, based on individual assessment (Engebretson *et al.* 2008, Donetto *et al.* 2013).

Further research involving interpreter services is required to explore the views of non-English speaking clients. Observations of clinic contact with South Asian parents as well as home visits would add to the findings of this study and could support the design of culturally sensitive services which ultimately reduce health inequalities.

Conclusion

There is a limited evidence base to inform the development of a HVS that is culturally appropriate to the needs of clients from minority ethnic backgrounds. This study contributes to understanding how HVSs in one setting in England are perceived by South Asian clients. There is no doubt that clients valued one-to-one support from their health visitor and found it responsive, particularly when suffering emotional distress. In keeping with previous research, there was evidence of poor communication and ethnocentric tendencies in the service. This largely related to language barriers, a perceived lack of understanding of the importance of extended family, and tensions between advice given by health visitors and that provided by the family. A key finding was that participants were more likely to accept health advice from their health visitor and parenting advice from their family. This study therefore makes a contribution to theoretical understanding which has an implication for health visiting practice and other health care professionals caring for South Asian clients.

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Conflict of Interest

None declared

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Table 1. Characteristics of participants

Participant	Country of Origin	Years in education	Live with extended family	Extended family in UK	Extended family overseas	Religion	First time mother
1	Bangladesh	9		yes		Islam	yes
2	Bangladesh	16			yes	Islam	no
3	Pakistan	11		yes		Islam	yes
4	India	15		yes		Hindu	no
5	Pakistan	16		yes		Islam	yes
6	India	9			yes	Islam	no
7	India	12	yes			Hindu	yes
8	India	10	yes			Hindu	yes
9	India	15			yes	Hindu	Yes
10	India	11			yes	Christian	no
11	Pakistan	9	yes			Islam	no
12	India	12			yes	Hindu	no
13	Bangladesh	10		Yes		Islam	no
14	Pakistan	9	yes			Islam	yes
15	Bangladesh	10	yes			Islam	no