Improving maternity care for refugee and migrant women in Western Australia

Report from 2015 consumer focus groups

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# Executive summary

This report builds on the work previously undertaken by the Refugee and Migrant Womens Working Group (RMWWG) to support and understand the specific needs for Refugee and Migrant Women (RMW) and families accessing maternity care and the services providing this care.

## Workshops

In 2014 workshops were held at three maternity hospitals – King Edward Memorial Hospital (KEMH), Armadale Health Service (AHS) and Osborne Park Hospital (OPH). The workshops were seen as an opportunity to share knowledge and experience by existing services with the aim to inform the development of maternity models of care in WA. There were a number of themes identified from the workshops including:

* resource allocation
* information
* interpreter availability
* education and training
* barriers to care.

The RMWWG reconvened to discuss the findings from the workshops and develop recommendations for further action. The group identified that in order to ensure a complete understanding of the issues and to validate the findings from the health service providers’ workshops, consumer engagement was a vital step in determining an effective model of service delivery. This could be achieved by undertaking consumer focus groups or workshops where refugee and migrant women in the community are involved in shaping culturally appropriate maternity services.

The validated findings would then be used to inform the development of a toolkit of resources (Toolkit) for maternity care providers for refugee and migrant women.

## Consumer focus groups

Seven consumer focus groups were undertaken between May–August 2015, with 211 responses received from 61 women. The key themes identified from the consumer focus groups were:

* healthcare literacy and access to information
* language services and communication
* isolation and psychosocial support
* navigating antenatal care in a new country – GPs as first point of contact
* care in the community
* access issues – transport and appointments
* understanding of culture
* continuity of care.

These findings resonate the themes identified by health service providers at the workshops and will ensure the resources provided in the Toolkit will reflect what refugee and migrant women want and need during their maternity care experience.

# Background

The RMWWG was re-established in 2015 by the Womens and Newborns Health Network (WNHN) Continuity of Care Working Group to address two of the five recommendations from the *Improving Maternity care for refugee and migrant women in Western Australia:
Report from 2013–2014 workshops*.1

1. Consumer engagement to determine model of service delivery.
Consumer workshop where RMW in the community are involved in shaping culturally appropriate maternity services. The workshop format could include asking women to review the themes from the maternity services workshops and seek validation; ask questions in relation to barriers to care, experience of care provided in the maternity setting and whether care was culturally appropriate.
2. Develop a toolkit of resources.

Developed for health professionals to deliver timely, safe, quality and competent care for RMW. Inclusive of mapping of GP’s services that offer language specific services, mapping of services providing women’s health care from a psychosocial perspective and establish care pathways with these services for example, link with the language service at Royal Perth Hospital.

A project plan was developed which provided detail in relation to consumer engagement and an appropriate timeframe. There was consensus amongst the group that the best format for obtaining information was to hold consumer focus groups rather than workshops. The information obtained from the consumer focus groups would be compared to the findings from the health service providers’ workshops to determine points of similarity. These themes would then be used as the framework for the Toolkit.

# Purpose of the consumer focus groups

The purpose of the consumer focus groups was to ask refugee and migrant women in the community their thoughts and experiences on health services that they accessed during pregnancy and birth. There were two clear objectives of these consumer focus groups:

* Explore how women who have recently had a baby in Western Australia experience health services during and after pregnancy.
* Validate the findings from the *Improving Maternity care for refugee and migrant women in Western Australia: Report from 2013–2014 workshops*1which will inform the development of the Toolkit of resources.

Refugee and migrant women who were aged 18 years or older, and who had recently had a baby in Western Australia (under two years of age) were eligible to take part in the study.

# Literature review

A review of literature consolidating existing knowledge about refugee and migrant women’s experiences of antenatal care in Australia was conducted to contextualise the findings of this report. Literature was sourced from journals, websites of women's health agencies, key organisations and government departments. The results of the consultation process largely align with the information gathered in the literature review.

The Literature Review can be found at [Appendix 1](#_Appendix_1:_Literature).

# Methodology

## Consumer focus groups

In 2011, 19.1% (N = 6061) of women giving birth in Western Australia came from countries where English is not the first language.2 From this information the RMWWG were able to determine the top eight countries of birth for the mother:

* Vietnam
* Sudan
* Central/West Africa
* Korea
* Afghanistan
* Burma (Myanmar)
* Iraq
* Iran.

This strategy was used to ensure the focus groups captured as many of these ethnicities as possible.

## Consumer focus group program

Members from the RMWWG nominated to attend the consumer focus groups with one member asking questions and initiating prompts (facilitating) and two members recording responses (scribing) to ensure reliability and validity. The RMWWG developed an introduction sheet and a series of questions for the facilitator (see [Appendix 2](#_Appendix_2:_Introduction)). The questions were reviewed by the Health Networks Research and Development team who considered them appropriate for the purpose of the consumer focus groups.

## Consumer focus group participants

Women were invited to participate if they were over 18 years of age, were pregnant at the time of the consumer focus group or have had a baby in the previous two years in Western Australia. The discussions were voluntary and no payment was offered for participation. No demographic data was collected; however country of origin was elicited from the cultural group activities they were participating in.

In total the number of women attending the consumer focus groups who met the criteria was 61, with the smallest group of attendees being three and the largest being 20 attendees. The women came from a number of ethnic groups including Burmese, Afghani, various ethnic groups from Africa, Indian and Somalian (see Figure 1).

Burmese women represented the majority of participants (38%), followed by Afghani women (21%), and Somalian women (10%).

Figure 1 – Breakdown of cultural groups who attended the focus groups

## Data collection

Seven consumer focus groups with refugee and migrant women were conducted between May and August in 2015. Overall 61 women with various cultural and linguistic backgrounds and English language proficiency were interviewed for the purposes of this study. The consumer focus groups were planned around existing cultural group activities, such as playgroups, sewing classes and English education programs (see [Appendix 3](#_Appendix_3:_Focus)). Accredited interpreters of various language groups were available to interpret if and when required. The RMWWG nominated a lead facilitator and various members of the group transcribed. The lead facilitator also made supplementary comments. Consumer focus group activities took approximately one hour to complete with key themes identified at the conclusion. Supplementary comments and observations were included in the data and thematic analysis. The data collected is an indicative sample, rather than a truly representative sample, which is appropriate for an exploratory study.

## Data analysis

Thematic analysis was used to identify recurring themes that represented common views of the participants. The purpose of thematic analysis is to identify patterns of meaning across a dataset that provide an answer to the research question being addressed. Patterns are identified through a rigorous process of data familiarisation, data coding, and theme development and revision. Three members of the RMWWG with knowledge of qualitative data analysis reviewed, coded and themed the responses ([Appendix 4](#_Appendix_4:_Thematic)).

Overall 211 comments were received from the seven consumer focus groups. Saturation was achieved by the sixth focus group as the participants were repeatedly providing the same information; there were no new concepts or ideas surfacing.

# Results

The results presented in this report are predominantly a descriptive account of the qualitative data. The consumer focus group participants noted their appreciation of the level of care available to them in Australia and they were generally positive about their interactions with health service professionals. Participants reported that health service professionals were kind, particularly midwives and their general practitioners (GP’s). There was significant gratitude for the information and support provided by maternal and child health nurses. Key themes that emerged from the qualitative data are summarised below (Figure 2). The themes are ordered according to the number of times they were recorded, based on the thematic analysis. The top five themes are:

1. Health Literacy and Access (24%)
2. Language Services and Communication (19%)
3. Isolation and Psychosocial Support (16%)
4. GPs as first point of contact (13%)
5. Care in the Community (12%).

Figure 2 – Key themes identified from the Consumer Focus Groups

## Health literacy and access to health information

One of the aims of the consumer focus groups was to examine refugee and migrant women’s information needs including; where and how women access information about pregnancy, birth and having a young baby, and what form this information takes.

Most participants reported that the GP was the main source of information about their health during and after pregnancy. Overall, most participants considered that the information they were able to access during their antenatal and postnatal care was useful. They were very appreciative of the information they were able to access about topics such as nutrition in pregnancy, breastfeeding, caring for a newborn and general health issues. There was, however, a lack of consistency in the range and content of information that was made available to study participants.

Participants reported that the birth of their child was another time when they were given a considerable amount of information. Although many participants did not recall receiving information about postnatal health care or available support services before leaving hospital, many did report receiving ‘lots and lots’ of pamphlets and verbal information. Overwhelmingly participants reported that information given to them in this way was difficult to ‘take in’ at the time. Also, the routine reliance on friends, family and husbands as translators during hospital stays was seen as a problematic and inadequate communication strategy.

Participants rarely received written health information in their own language and information tended to be given verbally by health professionals. However, as with any group, the provision of translated written materials alone is unlikely to address the information needs of all. For example, some participants had limited reading and writing literacy in their first language and the provision of translated written materials in these circumstances is likely to have limited benefit.

Overall, participants reported that their inability to access a broad range of information limited their ability to gain a deeper understanding of, and be well prepared for labour, birth and the postnatal period. It was also clear from the stories shared by participants that their previous birth experiences and cultural background had an impact on their current expectations of, and access to, health information resources and support services.

**Sample of comments**

* Written information from the doctors is often difficult
* Hospital information is good, if you can understand English (i.e. Breast Feeding)

## Language services and communication

For refugee and migrant women who speak limited English, language was identified as one of the major barriers affecting their use of health care services in WA, with many of the participants indicating they required an interpreter while attending services during pregnancy and after birth.

Participants identified the need for ‘appropriate’ interpreters to be provided when they attended the GP and in hospital – e.g. an interpreter of the right age, language and gender. When appropriate interpreter services were available, participants found it easier to attend antenatal care appointments and reported a better understanding of procedures and options.

Most of the participants indicated that their husbands frequently attended the antenatal care appointments and provided interpreting support. This need for interpretation support increased significantly during labour and birth. Many participants reported that communication during labour was difficult, even if a husband or relative was available to interpret, and there was potential for information to be distorted and/or inaccurately conveyed.

In many instances, various aspects of care and the birthing experience did not seem to have been sufficiently explained to the participants. For example, during the consumer focus groups some participants found it difficult to explain the medical procedures they had undergone, such as caesarean section, and were unclear about the reasons for their procedures. Some participants also had limited knowledge of commonly used medical terminology.

Some participants indicated that the offer of an interpreter was made only if their pregnancies were considered complex by the staff caring for them, and that antenatal care was administered without an interpreter if a pregnancy was progressing normally.

**Sample of comments**

* Difficulty with interpreter in labour, try to get a friend to go with you. As practical information can be understood ( i.e. Call bell) however it is the more in depth information that is difficult to understand
* Husband always interpreted so understanding was never an issue
* Interpreter only provided if there was a complex issue

## Isolation and psychosocial support

A number of participants reported that they currently live in a nuclear family (with their spouse and children only) even though an extended family was the typical family unit in their native culture (i.e. living with grandparents, aunts, and uncles, cousins etc). Participants reported many negative impacts associated with living in a smaller family unit including a sense of isolation and loneliness and a lack of ‘hands on’ support with managing a new baby. By contrast participants who were living within larger units, either with extended family or friends from the same cultural background, identified this arrangement as an important source of support for managing a new baby and other children.

Participants also reported differences in the scope of care provided by health professionals. For example, some participants reported that social issues and circumstances were more likely to be asked about by maternal and child health nurses, community-based health care providers and migrant resource services. This focus on social issues was highly valued and praised by many participants and was especially valued when provided close to home. By contrast, midwives and GPs were seen as less likely to discuss the social issues and other life circumstances considered important by participants.

The need for psycho-social support was especially acute for participants during the post-natal period, particularly in the period after discharge from hospital. The participants identified that maternal and child health services were especially important to them at this time. Participants also mentioned that maternal and child health service providers appeared to be more flexible in their approach to care. Aspects of this care that were highly valued included: longer appointment times, being visited at home or that clinics were located close to home, the availability of an interpreter, and having the opportunity to establish a relationship with a maternal and child health nurse over a number of visits. Many participants also mentioned that they felt more at ease to disclose personal information about their emotional health and wellbeing during consultations provided by maternal and child health services.

**Sample of comments**

* For those that don’t have family support or friends having an elder come to the home to discuss, educate and assist with baby would be most beneficial
* You can feel very isolated in the early months so you need support then

## Navigating antenatal care in a new country and GPs as first point of contact

Many participants identified the resettlement experience as a factor in limiting access to care. Newly arrived women often lacked familiarity with the health system, and antenatal services in particular, which in turn limited their ability to access the maternity and services that were available to them. Participants reported that access for newly arrived women was also constrained by: structural and environmental barriers, language and cultural barriers, social isolation, lack of awareness of health services and a lack of culturally and linguistically appropriate services.

GPs were identified as the first point of contact for participants when pregnant. Many participants were clearly reliant on these practitioners for information on options for care and decision-making regarding booking at a hospital for birth and enrolment in one of the models of maternity care. The majority of participants were referred to GPs who were accredited shared care providers, or to specialist obstetricians. In general participants were very accepting of their GP’s referral, valuing the medical care that was provided for their pregnancy. However some participants indicated they were not made aware of any alternative options for care.

Overall, the participants interviewed reported being satisfied with their care, grateful to the health professionals who took care of them (particularly the midwives) and felt privileged to have access to Western Australian health services. However, in general, participants articulated an overwhelming state of ‘not knowing’. Even after experiencing pregnancy care and birth in Western Australia, participants were still unsure what they would tell family or friends should they find themselves pregnant and newly arrived in WA.

**Sample of comments**

* Go to your GP as pregnancy can be difficult and GP will help this
* Go to the Doctor/GP for pregnancy care, to get vitamins, for ultrasound,
* blood tests

## Care in the community

Home visits by midwives after birth were widely appreciated by the study participants. Most reported that they had received at least one home visit from a midwife or maternal and child health nurse after the birth of their baby, with many reporting they received more than one home visit. There were however, a number of participants who reported being sent home from hospital with instructions to return to the hospital for postnatal check-ups.

**Sample of comments**

* Community centres are so helpful-ISHAR was great
* Child Nurse very helpful
* Home visits were great

## Time related access issues

The study participants also identified long waiting times at hospital appointments and childcare commitments as factors affecting access to care. In many instances participants reported these factors coexisted and prevented them from either attending or arriving on time for their antenatal and postnatal care appointments.

## Transport issues

Participants often experienced difficulties accessing transportation, particularly public transport. Many participants did not have a valid driver’s license, and if their husband/families could not drive them, they were required to catch two or three buses and/or a train to attend appointments. For participants with young children this was particularly challenging as they often had to bring the children with them. Some participants felt this was a significant barrier to them attending appointments and believed they would be better able to attend antenatal care if it was closer to home.

## Appointment issues

Although generally positive about the quality of their interactions during appointments, some participants raised issues related to the structure, length of time and administration of appointments. Some participants indicated that the time allocated for antenatal appointments was too short and/or the hospital midwives attending them were very busy. Participants also reported long wait times for their antenatal appointments and the lack of child care support before and during appointments were significant challenges.

**Sample of comments**

* Difficult to get to the doctor/hospital if not driving as have to catch public transport
* Rely on husband to drive me to appointments
* Waiting times in hospitals are too long
* Appointment times are too early when you don’t drive and have to drop other
children at school and have no family to help in the mornings
* Appointments closer to home

## Understanding of culture

Participants did not describe any significant concerns related the capacity of services to accommodate their native cultural beliefs and practices. Although none of the participants recalled being asked by a health professional if there were any particular cultural practices or customs they wished to follow, this was not raised as a concern. Instead many participants looked for opportunities and assumed responsibility for observing their traditional cultural practices upon arrival home from the hospital.

**Sample of comments**

* “A nurse made a very inappropriate comment about ‘African women’s breasts’. I was very upset but didn’t know what to do. I just kept quiet”.
* Be prepared for ice cold jugs of water rather than hot drinks.
* Need for a female doctor/interpreter.

## Continuity of care

Study participants who encountered a number of constantly changing maternity care providers reported feeling overwhelmed by the experience. By contrast, participants who experienced continuity of care reported many benefits including increased satisfaction with the level of communication and support provided to them and a more positive birthing process overall.

**Sample of comments**

* Not seeing the same doctor or midwife was difficult as I had to keep repeating what I had already said
* I expected to be able to look in the telephone directory and locate a midwife who would look after me during my pregnancy and birth…I was very surprised and disappointed to find out this was not the case

# Discussion of Themes

Themes from the consumer focus groups were compared with the themes from the health service providers’ workshops to identify areas of commonality and variance. As discussed previously the themes from the workshops were identified as:

* resource allocation
* information
* interpreter availability
* education and training
* barriers to care.

The themes from the consumer focus groups can be aligned under these headings as proposed in the following diagram:

Figure 3 – Validation of themes

# Next steps

The development of the Toolkit for maternity health care professionals to deliver timely, safe, quality and competent care for refugee and migrant women will be informed from the findings of this project and the ‘*Improving Maternity care for refugee and migrant women in Western Australia: Report from 2013–2014 workshops’* report.1 The Toolkit could include GP services that offer language specific services, services providing women’s health care from a psychosocial perspective (for example, the language service at Royal Perth Hospital). The format of the Toolkit will reflect the themes identified across both projects – Information; Language Services; Education and Training; and Barriers to care.

# References

1. Western Australian Department of Health. Improving maternal care for refugee and migrant women in Western Australia: Report from 2013–2014 workshops. Perth: Health Networks Branch, Western Australian Department of Health; 2014.
2. Hutchinson M, Joyce A. Western Australia’s mothers and babies, 2011: Twenty-ninth Annual Report of the Western Australian Midwives’ Notification System. Perth: Western AustralianDepartment of Health; 2014.

# Appendices

## Appendix 1: Literature Review

Navigating the maternity care system as a refugee and migrant woman

The literature review provides a number of insights into the experiences of refugee and migrant women when accessing maternity care services. While the various studies undertaken incorporate women from a range of cultures, and are based upon research regarding different types of maternity care service provision, they share a number of commonalities. The following key themes can be identified:

* Clinical care provided by maternity services in Australia is of a high standard.
* Access to timely, appropriate and suitably qualified interpreters is essential to clear communication and better outcomes for refugee and migrant women.
* Timely, appropriate and translated information/resources are required to communicate the purposes of procedures and clinical processes; options during birth; and the availability of support services.
* Good communication and the effective dissemination of information require culturally competent health care providers and systems of care.
* Continuity of carer assists the process of effective communication and information sharing and delivers better outcomes for refugee and migrant women.
* Services that provide a social model of care (community based, culturally competent staff, longer consultations, female staff, bi-cultural workers, less waiting time) are valued by refugee and migrant women and deliver good medical and psycho-social outcomes.

The literature shows that women’s experiences of antenatal care are shaped by a number of socio-cultural factors including access to health related information and services, the dynamics of the migration experience and gender and cultural norms that exist in various communities. It also reveals a significant heterogeneity among refugee and migrant women and their experience of antenatal care. Women bring with them the knowledge and practices from their home countries.1 Expectations of early antenatal attendance, for example, vary between countries.1 Expectations of the birth experience are also strongly influenced by cultural views and practices.2 Refugee women are more likely than other women to have complex medical and psychosocial problems and may face additional barriers in accessing antenatal care.3

The majority of studies available on the topic of refugee and migrant women’s access to and experiences of antenatal care do not distinguish between the experiences of migrant women and women of refugee background. While many of the issues and experiences raised by migrant women may be similar to those experienced among women of refugee backgrounds most studies are not able to provide specific insight into the distinct experiences of refugee and migrant women. The majority of studies available are also qualitative rather than quantitative, which limits the extent to which generalisations can be drawn concerning maternity care services as a whole. However, qualitative studies provide valuable insights into issues that are relevant to consider when assessing the accessibility and responsiveness of services. Qualitative studies are also effective at providing the individual ‘woman’s voice’ to maternity services. Also, many existing studies are more than five years old, and do not focus upon the Western Australian maternity setting. As such, the studies may not be an accurate reflection of an area of our health system that has seen significant reform and investment over the past number of years.

Cultural framework of care

Culture can include ethnic identity, traditions, education, nationality, gender, economic position, religion, sexuality, language, and a myriad of other elements.4 In addition, culture is shaped by ideas, meanings and beliefs, which contribute to an individual's knowledge and understanding of the world.4 This is the framework within which a woman perceives and prepares for her birthing experience. Each culture has its own values, beliefs and practices related to pregnancy and birth. Refugee and migrant women bring with them a multitude of cultural frameworks about health care provision and childbirth.5 Expectations around pregnancy, child birth and child rearing for refugee and migrant women are often shaped by their experiences in their country of origin or transit.5 As a result of their relocation women from refugee and migrant backgrounds lose information sources and they become more dependent on health professionals.5

Many women who come to Australia have a pragmatic attitude to traditional practices, and may not be interested in following them here; or at least not to the extent that they once would have.6, 7 Other women may consider it important to adhere to traditional pregnancy and birth practices.6, 7 Either way, literature provides evidence of the need for procedures to be fully explained and understood within different cultural frameworks.8-10

In a qualitative study of the antenatal care perceptions of pregnant African women attending maternity services in Melbourne women struggled to understand the need to attend appointments early in pregnancy, and to see the utility of screening tests.9 Induction of labour was a particularly troubling concept and one that the women had not encountered previously. Many were afraid of technology, such as ultrasound, and were confused when advised to behave in a way contrary to their traditional practices.9

This highlights the strong need for cultural practices and beliefs to be appreciated and understood by health practitioners and for medical procedures to be explained fully, and understood, within different cultural frameworks. Qualitative research also reveals that routine procedures or testing can cause concern and distress to women from refugee backgrounds due to “cultural and religious beliefs”.10 Medical procedures may in some instances trigger memories of past torture and other forms of trauma, for women from refugee backgrounds which require sensitivity and understanding by health practitioners.11 These and other examples clearly demonstrate that communication goes beyond the use of interpreters: time must be allowed for sensitive exploration of women’s belief systems that may be influenced by many factors including education, culture and religion.

A study by Murray et al12 highlights the reluctance of refugee and migrant women to ask questions of health professionals, which, in turn, meant that their support needs, were misunderstood or overlooked. Elsewhere it is argued that cultural incompetency can lead to poorer health outcomes because refugee and migrant women may be less inclined to discuss sensitive health issues (i.e. history of sexual abuse or female genital mutilation (FGM)[[1]](#footnote-1)§ if a mutually respectful relationship is not established).13, 14

The literature shows that women interpret and act on health information using different frameworks; which is why cultural competence in the delivery of care is crucial to good outcomes for refugee and migrant women.15 Culturally competent care is generally associated with improved attendance at antenatal appointments and increased understanding of health information.15 Cultural competence is a term used “to explain a particular compilation of behaviours, attitudes and policies within a working context that ensure that professionals have the capacity to work in cross cultural situations”.16 Wells and Dietsch argue that cultural competency is an evolving process that depends on health care providers’ capacity for self-reflection, self-awareness and acceptance of difference.17

According to Wells and Dietsch,17 cultural awareness and acceptance facilitate greater access to care among refugee and migrant women and is essential to the provision of culturally safe care. In addressing the issue, Sobo18 and Ming-Cheng and Stacy19 propose an approach to cultural competent care that incorporates effective communication, an awareness of available support services, and patient-centred decision-making to address the sense of powerlessness that refugee and migrant women often experience in health care settings.

The capacity to gather information about treatment from health professionals and participate in decision-making is a fundamental aspect of control over one’s health.12 Sobo18 argues that because of the commonly encountered language barriers clinicians need to be not only ‘culturally competent’ but have ‘communicative competence’; whereby, for example, they effectively utilise interpreter services to communicate procedures in lay terms, and to determine a patients level of understanding and concerns.

Various definitions of culture, diversity, cultural diversity and cultural competence arose throughout the literature. Cultural competence in healthcare has emerged partially as a strategy to address disparities that may lead to health inequalities. National and international studies have documented the benefits of a culturally competent health care system to potentially reduce health disparities among populations from refugee and migrant backgrounds. Some studies suggested that in order to minimise risks, health care organisations needed to integrate cultural competence into their internal quality improvement activities.

In a review of policy and reporting frameworks for cultural diversity written by the Institute for Community, Ethnicity and Policy Alternatives, Victoria University20 it was found that models of cultural competence need to be embedded within organisational processes. An example from the Migrant-friendly Hospitals Project highlights the initiative of the European Union in putting culturally competent health care and health promotion higher on the European health policy agenda, and in supporting other hospitals through compiling practical knowledge and instruments. The recommendations from this project were launched as the ‘Amsterdam Declaration towards Migrant Friendly Hospitals in an ethno-culturally diverse Europe’. A core recommendation from this declaration is the need to define what cultural competence means; and at a service level to:

* ‘find consensus on criteria for migrant-friendliness, cultural competence and diversity competence that are adapted to their specific situation
* to integrate them into professional standards and to enforce their realisation in everyday practice’ (cited in Institute for Community, Ethnicity and Policy Alternatives20).

The review concludes that effective ‘outcomes of integrating cultural competence into health services can be achieved by developing and implementing a customised holistic approach and embedding it into the organisational context with an ongoing monitoring and review system’.20

Language and communication

The extent to which language barriers constrain communication is widely acknowledged in the literature; as is the recognition that the depth to which communication barriers exist is seriously underestimated in day-today service delivery.21-23

The literature also demonstrates that the issue of language and the use and availability of interpreters in the clinical setting continues to be an enormous challenge for refugee and migrant women in accessing health information. Within Australian maternity settings, communication breakdowns often leave refugee women feeling increasingly anxious, frustrated, isolated and disempowered.24 A study by Phiri et al14 revealed that refugee and migrant women can feel “removed from the management of pregnancy and birth processes due to the inability to communicate effectively”. As a result, interpreter services and translated materials are strategies commonly used to overcome communication and language barriers between health care providers and refugee and migrant women.13

The Australian and State government provides funding for interpreter services. A federally funded translating and interpreting service provides a national, 24 hour, seven-days-a-week telephone interpreting service. Nonetheless, it is evident in the literature that there are many occasions when health practitioners do not use qualified interpreters when seeing clients who are not proficient in English. Consequently, too often clinical interactions are conducted in the absence of adequate mutual understanding between women and health workers.

Refugee and migrant women in many existing studies often use their husbands and friends to interpret for them. This raises significant ethical concerns regarding: women’s privacy and capacity to speak openly; and the appropriateness of the content should the family member be less than 18 years of age. Also, studies demonstrate that family members cannot be relied upon to reliably transfer information or accurately relay a woman’s perspective to a health care provider.25 Furthermore, accuracy of (particularly medical) information is an issue when non-professional interpreters are used. In a review of the international literature examining the impact of medical interpreter services on the quality of health care substantial evidence was found to support the conclusion that when patients with limited English require but do not receive the services of qualified health interpreters, their quality of care and related health outcomes are significantly compromised.26

A study by Rintoul27 in 2010 demonstrates that barriers to accessing services can include expectations by Afghan men and women that husbands accompany their wives to appointments and interpret. Cultural practices (the husband attending maternity care appointments and in some instances appearing to control the appointment, or limiting what can be discussed by the women by virtue of their physical presence) can raise barriers for women accessing maternity services.27 The findings of this study reveal the difficulty overcoming this barrier to open and accessible communication due to the complex transitions and social change required by refugees and migrants upon arrival in Australia. Practices around pregnancy and birth in Afghan cultures, for example, usually involve relatively intensive support of the extended family. This means that in Australia the husband plays a greater role due to the absence of the family network.27 The consequent over-reliance on husbands to be the conveyors of information may be problematic.

A study focussing on the sexual and reproductive health needs of refugee and migrant women revealed that one of the most important factors for them in making health decisions is that information is provided to them in their own languages.28 Aside from the provision of multilingual written information, this can only occur in a clinical encounter if a qualified interpreter is used. When professional interpreters are required but not provided, health practitioners can also suffer as they cannot provide the same diagnostic expertise and quality of care.28

A study by Murphy et al, ‘Negotiating Cultural Change and Maternity Care’29 highlights the important need for translated information that can be readily accessed by individuals from different cultural backgrounds. Women in this study reported that they needed more information about the pregnancy care they were receiving and procedures. Women wanted it ‘explained’ to them; and would like this to occur without them having to ask (because ‘we can be shy’). The study reveals that ‘of significance is the indication by women of a relative lack of knowledge about the pregnancy and birth process and a sense of isolation and shyness with regard to obtaining accurate, relevant an reliable information’.29 Further, the study demonstrates the relatively uniform experience of women not having timely access to translated or interpreted information that is clear and relevant to their obstetric care.29

The recurrent issue – relayed by women in various studies – of poor communication as a result both of unsuitably qualified interpreters and of poor cross-cultural communication demonstrates the importance for maternity care processes and procedures to be explained fully, and, for an awareness to exist within maternity care providers that often routine procedures or testing can cause concern and distress to women of refugee and migrant background.30, 31 An absence of clear communication and information sharing between a client and health care provider can adversely affect the quality of medical care.25

Accurate interpretation has been shown to improve the quality of health care and a reduction in adverse outcomes.32, 33 Thus Hayes et al25 emphasise the importance of providing mechanisms for effective communication between refugee and migrant women and health care providers where a language barrier exists. Although interpreter services greatly aide to overcome communication and language barriers, health care providers need to be aware of potential disadvantages that may arise with these services. For some cultures, for example, it may be improper to employ a male interpreter, or some women may feel uncomfortable talking about sexual and reproductive issues or personal matters in the presence of a very young interpreter.13, 14

Communication is more likely to occur if interpreters are “socially, ethically and politically acceptable to the patient and family”.13 It is also important that interpreters are able to accurately communicate medical terms and meanings. Utilising culturally appropriate interpreters knowledgeable in maternal health and medical terms is known to improve refuge and migrant women’s comprehension and clinical outcomes.14

Continuity of carers

Continuity of carers was found to be important for refugee and migrant women as it leads to the development of a trusting relationship with their midwives.27 This trusting relationship underpins quality care and can reduce women’s feelings of isolation during this period of their life when extended family may not be able to play a pivotal role in maternity care.27 Rintoul’s study describes how continuity of care can aid communication, increase the likelihood of positive accounts of the birthing process, reduce the number of professionals that women see, and enhance women’s experiences of support.

Participants in a study by Murray et al12 experienced frustration over a lack of continuity of care, as they encountered many different staff members during the course of their pregnancies. This meant explaining themselves to each new person they encountered, which was described as “really exhausting telling each one,” and “very hard and challenging”.12 Continuity of interpreter was also reported as a barrier to relationship building between refugee and migrant women and their health care provider; and a factor that exacerbated communication difficulties.34

A qualitative study conducted in 2006–2007 with 18 women of African background9 discusses women’s experiences of maternity services at an African women’s clinic, which is largely facilitated by culturally sensitive and supportive services. The women in the study indicated that they initially returned for antenatal appointments simply because the atmosphere at the clinic was friendly and accepting. In receipt of supportive services, over the course of several visits, women came to value the care offered.9 Further, feeling welcome and accepted at the antenatal clinic was very important, in terms of communication within the maternity service. The availability of interpreters and the provision of interpreter-mediated education services was also a salient factor in keeping women engaged in services.9

A recent report demonstrates the success of the Shared Care Antenatal Service model practiced at Ishar (a Multicultural women’s service in Mirrabooka, Perth, Western Australia).35 This service practices a social model of health that works with the personal, social, cultural, economic, race, age and gender-related issues affecting refugee and migrant women’s health and wellbeing and pregnancy journey. Ishar clients have access to accredited interpreters, longer consultations and bi-cultural workers. This study reveals the effectiveness of this model of care for refugee and migrant women in terms of engaging women and keeping them engaged; and in achieving good health and psycho-social outcomes.

In addition, continuity of care and carer within maternity settings is known to increase refugee participation in decision-making processes, which lessens communication difficulties, promotes client ability to make informed decisions and improves antenatal and postnatal outcomes and attendance.3, 13 Again, this continuity is also recommended when utilising interpreters, which can enhance communication for both the care provider and client.3, 13

In the literature, continuity of carer is viewed as a strategy that yields many positive outcomes for both health care providers and women, and models of care that promote this continuity can be utilised to address the cultural and communication barriers refugee and migrant women face with receiving effective maternity care.14

Psycho-social issues affecting access to and experiences of antenatal and post-natal care

Women’s migration journeys and subsequent settlement experiences are important determinants of both physical and mental health.27, 36 Research into postnatal depression shows that the experience of stressful life events either prior to or during pregnancy is as a common risk factor among refugee and migrant women.36 Certain aspects of women’s migration history may increase their experience of stress and anxiety and therefore the risk of postnatal depression.36 Women who are particularly at risk of perinatal mental health disorders are those with a history of mental illness, limited emotional and social support, stressful life events or losses, change in role and identity, and those women with compromised socio-economic status.37 Limited language skills increase the risk of perinatal mental health disorders due to difficulties in verbalising depressive symptoms and expressing emotion. Shame and culturally driven reluctance to confide in others because of stigma further compound problems.37

Various studies show that refugee and migrant women recognise that after the birth of their baby they feel depressed; but often they do not understand why, and subsequently do not know where to go for help. Several studies have shown that a lack of social support is a contributor to postpartum depressive symptoms among refugee and migrant women. Lanskara et al38 argue that this necessitates direct inquiry to enhance women’s opportunities to receive support addressing the underlying causes of their emotional distress.

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## Appendix 2: Introduction sheet and series of questions for facilitators

My name is xxxxxx and my writer is xxxxxx. We are working with the Department of Health to ask women in the community their thoughts and experiences on health services for women during pregnancy and childbirth. The Department of Health will use this information to help to improve the care given to women during pregnancy and childbirth.

To participate you need to be a woman 18 years or older. You also need to either be pregnant now or have had a baby in the past two years in WA. These discussions are voluntary and there is no payment for your participation.

* We will be asking many small groups of women such as yourselves the same questions. These are called focus groups. There are no right or wrong answers.
* You do not have to answer all of the questions we ask in the focus group.
* The focus group will take about 45-60 minutes. If you want to talk for longer, we are happy to spend extra time so you can say everything you need to say.
* We will take some notes about what you say.
* At any time during the focus group you can stop. After the focus group, you can ask for the question you answered not to be included in the project. You do not have to give a reason.
* You can choose to join in the focus group or not to join in the focus group. Your choice will not change any services you get from the Department of Health.
* When we write reports about the project, we will not use your real name or include information that would let people know who you are.
* If you would like more information, there are some cards here for your information

|  |  |  |
| --- | --- | --- |
| **Stages** | **The question to be asked?** | **Prompts to be used if needed** |
| StagePre-Pregnancy | The question to be asked?Given what you know now, if a friend were to become pregnant what would you tell them about becoming pregnant, where to go for the pregnancy and how to access care? | Prompts to be used if neededWritten, verbal, from friends internet health professionals * access to any information about pregnancy and having a baby?
* difficulties in obtaining information about pregnancy and having a baby?
* difficulties accessing care for your pregnancy?
 |
| StagesDuring Pregnancy | The question to be asked?If your friend was to become pregnant, what would you tell her during her pregnancy and when going into labour? | Prompts to be used if neededWas an interpreter always with you when you visited the doctor, or who interpreted for you? Did you need one every time* Did you understand the information you were given when you first saw your doctor (or midwife) for your pregnancy?
* What information would you have liked during your pregnancy?
 |
| StagesPost delivery | The question to be asked?If your friend was going home, what would you tell her before leaving hospital about the baby and about her? | Prompts to be used if needed* questions during the birth or shortly after to talk about the birth and understanding what was explained
* What kinds of support or services would have been helpful for you the first few months at home with your baby?
 |
| StagesGeneral | The question to be asked?What experience have you had with maternity services in Western Australia?What have been the best and worst things about the maternity and related services you have experienced in WA | Prompts to be used if needed* Accessibility (for example, on public transport).
* Appointments/flexibility (for example, giving a woman who has to get her kids to school and then catch bus an 8.30 appointment. She will not necessarily feel confident to change it and arrive late….)
 |

## Appendix 3: Focus groups planned

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Group and women** | **Bi-Cultural workers needed** | **Who is organising and when does the group meet?** | **Confirmed** |
| Name of Group and womenIshar. Postnatal group, mixture of probably Burmese and Afghani women. | Bi-Cultural workers neededN | Who is organising and when does the group meet?Nicola-Tuesday 19 May 201510.15am–12.00pm. | ConfirmedYAttended |
| Name of Group and womenWomen’s Health and Wellbeing Services in Gosnells Save the children playgroups "It takes a village" | Bi-Cultural workers neededY – 3 | Who is organising and when does the group meet?ChrisFriday 22nd May 201510.15am–11.30am. | ConfirmedYAttended |
| Name of Group and womenBrockman Community HouseMulticultural child and English program | Bi-Cultural workers neededN | Who is organising and when does the group meet?AlisonTuesday 2 June 201511:40am. | ConfirmedYAttended |
| Name of Group and womenCommunicareSouth Bentley Community Centre Hillview Place | Bi-Cultural workers neededN | Who is organising and when does the group meet?AlisonMonday June 8 20159.30am–11.30am. | ConfirmedYAttended |
| Name of Group and womenMetropolitan Migrant Resource Centre 1/14 Chesterfield Road Mirrabooka | Bi-Cultural workers neededN | Who is organising and when does the group meet?AlisonWednesday 10 June 201510.00am–12.00pm. | ConfirmedYAttended |
| Name of Group and womenLisa Ruecroft - Playgroups WA multicultural Playgroups Westminster Child and Parent Centre Marloo Rd Westminster | Bi-Cultural workers neededN | Who is organising and when does the group meet?AlisonTuesday 16 June 20159.15am–11.15am. | ConfirmedYAttended |
| Name of Group and womenCommunity Services at Assetts Playgroup-286 Beaufort Street Perth | Bi-Cultural workers neededY – 1 | Who is organising and when does the group meet?AlisonFriday 19th June 201511.00am–12.00pm | ConfirmedYAttended |

## Appendix 4: Thematic analysis

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| --- | --- | --- | --- |
| **Q1-Pre-Pregnancy** | **Q2-Pregnancy and Labour** | **Q3-Postnatal care and going home** | **Q4-Overall Experience** |
| Question 1-Pre-PregnancyGP a good source of information and support  | Question 2-Pregnancy and LabourAccess- particularly transport issues | Question 3-Postnatal care and going homePN follow-up and Information required | Question 4-Overall ExperienceStaff lack of cultural awareness |
| Question 1-Pre-PregnancyLack of Education | Question 2-Pregnancy and LabourSupport networks available in the community | Question 3-Postnatal care and going homeLack of support | Question 4-Overall ExperienceInterpreters required |
| Question 1-Pre-PregnancyAwareness of support services available PN | Question 2-Pregnancy and LabourInformation  | Question 3-Postnatal care and going homeInterpreters required | Question 4-Overall ExperienceAccess-Appointments |
| Question 1-Pre-PregnancyEducation required on emotional support and services available  | Question 2-Pregnancy and LabourImportance of GP | Question 3-Postnatal care and going homeStaff lack of cultural awareness | Question 4-Overall ExperienceTranslators |
| Question 1-Pre-PregnancyInterpreters required | Question 2-Pregnancy and LabourInterpreter required |   | Question 4-Overall ExperienceImportance of GP or care in the community  |
|   | Question 2-Pregnancy and LabourAppointments |   | Question 4-Overall ExperienceLack of support PN |
|   | Question 2-Pregnancy and LabourCultural awareness of staff |   |   |

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1. § FGM is the collective term used to describe the cultural practice of cutting or removal of either a part, or the whole external female genitalia. Some of these procedures are minor, while others involve significant change. [↑](#footnote-ref-1)