Maternity health care: the experiences of Sub-Saharan African women in Sub-Saharan Africa and Australia

Abstract

Background:

Increasing global migration is resulting in a culturally diverse population in the receiving countries. In Australia, it is estimated that at least four thousand Sub-Saharan African women give birth each year. To respond appropriately to the needs of these women, it is important to understand their experiences of maternity care.

Objective:

The study aimed to examine the maternity experiences of Sub-Saharan African women who had given birth in both Sub-Saharan Africa and in Australia.

Design:

Using a qualitative approach, 14 semi-structured interviews with Sub-Saharan African women now living in Australia were conducted. Data was analysed using Braun and Clark's approach to thematic analysis.

Findings:

Four themes were identified; access to services including health education; birth environment and support; pain management; and perceptions of care. The participants experienced issues with access to maternity care whether they were located in Sub-Saharan Africa or Australia. The study draws on an existing conceptual framework on access to care to discuss the findings on how these women experienced maternity care.

Conclusion:

The study provides an understanding of Sub-Saharan African women's experiences of maternity care across countries. The findings indicate that these women have maternity health needs shaped by their sociocultural norms and beliefs related to pregnancy and childbirth. It is therefore arguable that enhancing maternity care can be achieved by improving women's health literacy through health education, having an affordable health care system, providing respectful and high quality midwifery care, using effective communication, and showing cultural sensitivity including family support for labouring women.

Statement of significance

Problem or Issue

Access to maternity care may be problematic in any context. The maternity experience of Sub-Saharan African women in Australia is poorly understood.

What is Already Known

African women's experiences of maternity care in Africa and western countries are influenced by cultural beliefs and traditional practices, the attitudes of health care workers, and access to care.

What this Paper Adds

This paper shows that regardless of how well a health care service is resourced, issues which can hinder a woman's access to care always exist. The key messages are the importance of: health literacy, affordable health care systems, respectful and high quality midwifery care, clear and effective communication, and cultural sensitivity including family support for labouring women.

Keywords

Sub-Saharan Africa, Australia, Maternity, Midwifery care, birth experience, access to care

Introduction

Cultural and ethnic diversity has been shown to pose challenges for the delivery of health care services, especially maternity care.[1] In recent years, Australia has experienced a rise in the number of immigrants from Africa, with approximately 70% of asylum seekers being from Sub-Saharan Africa.[2] Moreover, about one-third of refugee and humanitarian entrants to Australia are women of childbearing age.[3] Using the Australian Bureau of Statistics migration statistics,[4] and the Australian crude birth rate, it is estimated that at least four thousand Sub-Saharan African women give birth each year in Australia.

Maternity health outcomes in Sub-Saharan African countries are vastly different to those in Australia and are related to health service provision and access. Sub-Saharan African maternal mortality is on average 500 per 100,000 live births,[5] compared to 6.8 per 100,000 live births in Australia.[6] It is possible that the different rates of uptake of antenatal and postnatal care is the cause of (or contributes to) differing mortality rates between countries. Research has shown that in Sub-Saharan Africa 71% of pregnant women attend at least one antenatal visit, 46% gave birth with a skilled birth attendant, and 31% received postnatal care within 2 days.[7] This fails to meet the World Health Organization's recommended minimum standards for maternity care.[8,9] In comparison, recent statistics show that in South Australia, over 99% of women attended at least one antenatal visit, 91 % had seven or more antenatal visits, 99.95% gave birth with a skilled health care professional in attendance, and all received postnatal care.[10]

Despite greater availability of maternity health services in western countries, including Australia, Canada and the United Kingdom, research has found that African women experience problems accessing these services.[11,12] Therefore, as the number of African women in Australia increases, it is important to recognise the issues they may face in experiencing maternity care in this context. This paper presents the findings of a study which examined the experiences of Sub-Saharan African

women in relation to maternity care in their home Sub-Saharan Africa countries and in Australia. In order to understand the findings, we draw upon an existing conceptual framework of dimensions of access to care. This study highlights that past experiences influence women's perceptions and subsequent care seeking behaviours. Recommendations for ways to improve access to maternity services for Sub-Saharan African woman are presented.

Review of the literature

An integrative literature review of Sub-Saharan African women's experiences of maternity care in Africa and western countries was conducted using the following databases: Medline, Cumulative Index to Nursing and Allied Health (CINAHL), PsychInfo, and Google Scholar. Five themes describing the women's experiences were identified: cultural beliefs and traditional practices; attitudes of health care workers; access to care; experiences of childbirth; and support and postnatal experiences.

The first theme describes cultural beliefs and practices and how these influence maternity care. Brighton et al.[13] and Murray et al.[14] identified culture and beliefs as barriers for African women to access maternity care services in Sub-Saharan Africa and Australia respectively. In these studies, women associated pregnancy complications with evil spirits, immorality, and witchcraft. Hence, the women would not seek medical help because they believed that the complications could not be cured medically. Carolan and Cassar[15] have shown that as African women settle in Australia they undergo a cultural shift from perceiving pregnancy as a natural process which requires no particular attention from health professionals, to valuing continuous professional antenatal care. Evidence also suggests that women's beliefs about the health care system affect their utilisation of services.[16] Traditional beliefs have been identified as challenging in Australia, with Renzaho and Oldroyd[17] highlighting a rise in tensions in health care staff when family members performed traditional practices which did not align with western based health care philosophies.

The second theme relates to the attitudes of health care workers and, in particular, of midwives. Negative attitudes of staff towards African women have been identified as a barrier to accessing health care services.[13,18,19] In one study on barriers to the utilisation of maternity services in Uganda it was reported that the poor relationship between health care providers and the community, and disrespect demonstrated by staff, affected uptake of health services[19]. Conversely, positive experiences of maternity care were enhanced when women were treated with respect and kindness.[14,20]

The third theme is Sub-Saharan African women's access to maternity care. The research evidence suggests that uptake of care is influenced not only by the availability of the facilities in the community but also the specific resources, communication and knowledge about services. Some of the hindrances to accessing maternity care for African women relate to physical, sociocultural, emotional, and financial barriers.[16,21,22] The physical barriers faced by women in Africa when accessing maternity services include travelling long distances to health care facilities, transport, and lack of equipment.[13,19] A number of studies have found that language difficulties hinder good communication and understanding between African women and their caregivers in western countries.[11,14] Furthermore, language difficulties and lack of information about available services have been found to increase the difficulty in accessing maternity services.[14,23] Indeed, in a study of migrant mothers in Australia, Renzaho and Oldroyd[17] established that a lack of understanding of the health care system resulted in confusion about where to access services. Similarly, understanding the health system and having knowledge of available services were identified as essential factors influencing Sub-Saharan African women's access to care in the United Kingdom.[11]

The fourth theme evident in the literature exploring Sub-Saharan African women's experiences of maternity care was their previous childbirth experiences. Previous research has established that migrant women's expectations of pregnancy and childbirth in western countries are shaped by their previous experiences in their country of origin.[14,21] Research has identified that it is common for

African women to perceive labour pain as natural and that they prefer giving birth naturally.[23,24] Negative birth experiences of Sub-Saharan African women have been shown to result from negative interpersonal relationships with caregivers, lack of information, and neglect and abandonment by healthcare professionals during labour.[25,26] Consequently, the quality of services provided in western countries is appreciated by migrant women.[20,21]

The final theme of the literature review is related to social support and, in particular, support during labour and in the postnatal period. Whilst support during labour is known to enhance the physiology of labour and the woman's feelings of control and competence throughout childbirth,[27] labour support is not routine in African countries. Chadwick et al.[26] found that the women who had no support person at birth expressed feeling neglected, abandoned, and unsafe throughout the process of labour. Similarly, migrant women giving birth in western countries experience isolation, loneliness, and depression due to a lack of support from their extended family.[11,21]

It has been noted that despite the increase in the Sub-Saharan African population in Australia, there is a lack of research that explores the experiences of maternity care from the perspective of these women. Most of the literature that explores the experiences of African-born women receiving maternity care is from the United Kingdom, North America, and Europe.[11,12,18] Furthermore, the few studies on maternity care of African women living in Australia that do exist have focused on antenatal care[15] and intrapartum care,[14] and have left out postnatal care, which is an important aspect of maternity care.[28] Therefore the aim of this study is to examine the experiences of Sub-Saharan African women in relation to maternity care services in their home countries and in Australia, across the pregnancy and childbirth continuum.

Methods

A qualitative research design was used as it enables generation of meaning and understanding of the women's experiences.[29,30] Qualitative methods provide rich data which could not be gained through

98 quantitative methods.[29] Ethics approval to conduct the study was obtained from the Flinders
99 University Social and Behavioural Human Research Ethics Committee.

100 Purposive sampling[31] was used to identify participants now living in metropolitan South Australia,
101 who have the requisite experience and willingness to share their experiences, which was further
102 supplemented with snowball sampling.[32] Recruitment of participants was stopped upon reaching
103 data saturation. According to Creswell,[33] data saturation is a point in the data collection whereby no
104 new information comes from the data. Women were eligible to participate in this study if they were
105 born in a Sub-Saharan African country, over 18 years old, had experienced pregnancy and childbirth
106 in both Sub-Saharan Africa and in Australia, and spoke English. The study was advertised by posting
107 recruitment flyers on African community organisations' notice-boards. The organisations' leaders
108 also raised awareness of and promoted the research during community meetings. A researcher
109 attended the community meetings and distributed the information packs to the potential
110 participants. Potential participants were provided with a letter of introduction, an information sheet,
111 and a consent form to enable informed consent. Interested respondents then contacted the
112 researchers directly to arrange an interview.

113 In-depth face-to-face interviews with fourteen Sub-Saharan African women living in Adelaide who
114 have given birth in Sub-Saharan Africa and Australia were conducted. Table 1 presents the
115 demographic characteristics of the research participants. Fifty percent were from South Sudan, while
116 the others were from five different countries in southern, eastern, and western Africa. The age of
117 the participants ranged from 26 to 49 years, while the length of stay in Australia was between one
118 year nine months and 11 years. A semi-structured interview guide was used to collect the data in
119 order to obtain a deep understanding of the phenomenon being studied.[34] Participants chose a safe
120 meeting place where privacy and confidentiality could be maintained. The researcher (HM) used an
121 interview guide with a list of open-ended questions to guide the discussion. The questions were
122 formulated to focus the interview on the research aim, however, the sequence of the questions was

fluid, in order to allow the participants to lead the discussion. As English was not their first language participants sometimes required questions to be expressed differently to enable comprehension, or to have specific terms explained. Interviews lasted approximately 60 minutes each.[33] The interviews were audio-recorded and transcribed verbatim by one researcher, allowing her to become familiar with the data and commence the data analysis process.[35] During the transcription process, names and places were de-identified with the application of a pseudonym to ensure confidentiality and anonymity. Through transcribing the data as it was collected, the researcher identified a number of issues for further exploration in subsequent data collection and could determine when saturation had occurred.

The data were managed with NVivo 10 and subjected to a thematic analysis using the process outlined by Braun and Clark.[35] Using descriptive coding, the data were classified into meaningful codes. Coding is a cyclic act of summarising the essence of a portion of data.[36] The codes emerged from what was deemed significant within the data, and were then categorised by grouping similarly coded concepts. While the coding was completed as an initial step, the principal researcher continued to code and recode the data throughout the analysis stage as she drew meaning from the incoming data. From these codes and categories, four main themes were identified. The codes, categories and themes were regularly presented to the research team for discussion and consensus was achieved.

Findings

The interpretive analysis of the data resulted in four themes based on the maternity experiences of the participants in Sub-Saharan Africa and in Australia. These themes were labelled: access to services and health education; birth environment and support; pain management; and perceptions of care. Each of these themes will now be presented.

Access to maternity services and health education

The participants all experienced challenges in accessing maternity services both in Sub-Saharan Africa and Australia. However, the barriers were not the same in these settings. In Australia, the challenges of access stemmed predominantly from communication and a lack of familiarity with the maternity care system, whereas in Africa, the barriers included the long distances to the facilities, and problems with transport, waiting times, and inadequate resources.

The distance to facilities in Africa affected women's abilities to seek health care, as explained:

> *I can't go as regularly as they ask me to go… because of the distance. Even when I went through labour, it was really hard because the hospital is so far where I have to go for check-ups and all that. (Participant 12).*

The problem of distance was compounded by the problem of available transport. Transport in Africa was unavailable, too costly, or the options were inconvenient for the women, especially when they were in labour.

> *The man takes the bike and he carry me. I have to sit on the bike, but if it's pain in the road, I will stop him, I will come [off] from the bike, sit down until the pain stop. And then I go back on the bike. (Participant 13)*

In Africa, having travelled long distances to the health care facilities, the participants had long waiting times to see the midwives for antenatal care. Waiting times were associated with the large numbers of women attending antenatal care in the facilities at the same time and the absence of a timed-booking system.

> *[In Africa], you would go in the morning and you could stay until 1 o'clock before being attended … (Participant 4)*

Lack of resources in Africa was evident for commonly needed supplies. In many cases, the limited resources were due to the health system not having access to them, but other examples were provided whereby despite their being available, they were not provided within the health system funding and the women did not have the financial capacity to pay for specific resources or care. One participant recalled how she survived a postpartum haemorrhage in hospital, even though she did not receive a blood transfusion because she could not afford to buy the blood she needed.

> *It was a lot of blood [coming out]. They put to the bucket. Full bucket…but no blood for me [because]. You know blood from Africa there you buy… yes, you buy (Participant 14)*

While access to care and resources were, in principle, available in Australia, communication hindered the participants' access to maternity care. Even though they could speak some English, they found the Australian health care providers spoke quickly and used unfamiliar words. Although interpreters were made available in Australia, some participants would not use them, as they were concerned about confidentiality.

> *Communication is a big problem with me because my English is not good. Every time I speak to them, they don't understand me I think they don't get my English very well… I don't really like interpreters because sometimes they don't keep the information [confidential]. (Participant 8)*

Similarly, unfamiliarity with the Australian maternity health system influenced access to care as some women were not aware of where to go for care, often resulting in late attendance. While the maternity system in Australia is different from that in Africa, some women went to the hospital for care without a booking because they were not aware of the different expectations and processes.

> *Because it was my first time having a child here, and I don't know exactly the places I have to go like hospitals. And so I didn't think that it is important to go to the hospital for check-ups.*

So I stayed at home until I was 7 months pregnant, I hadn't been even to first check-up (Participant 12)

Even in Australia waiting times were an issue for the participants. Despite having a booked appointment time, the women found the waiting times in Australia excessive. The waiting times frustrated them such that it influenced the choice of facility they would attend for antenatal appointments with subsequent pregnancies

At [Hospital A, Australia] the waiting was just too long… because sometimes I parked where it is two-hour parking. Then I would be thinking of going to change. That's why after I had my daughter when I got pregnant for the little boy; I preferred to be seen by the GP or the other antenatal clinic at [Hospital B] because there, their waiting times are much shorter… (Participant 4)

Continuity of care was described by the participants as a good strategy, as it would enable them to build a trusting relationship with the midwives, and to provide consistency. While midwifery-led continuity of care models did exist in some hospitals in Australia, the participants did not access these services because they were not aware of their availability. When they learnt about them, it was usually quite late in their pregnancy and too late to access such care.

Somebody told me it is your choice; you can have the same midwife until you give birth. But in my case, I didn't have… I didn't know about that. (Participant 10)

It is apparent that access to care is influenced by women's needs and their understanding of these. Health education is an important strategy to address women's health and wellbeing and an integral component of contemporary midwifery care. Health education was evident as a sub-theme of access to care for the women. It is evident from the participants' experiences, that health education in African maternity care may be deficient or insufficient resulting in a lack of preparation for labour, birth and care of the baby. Antenatal education classes were uncommon in Africa. Despite antenatal

classes being available in Australia the participants did not attend as they thought that the classes were not important to them as they were already mothers.

> *I didn't go there because it wasn't my first time to have a baby. So, I didn't see the whole point of going there (Participant 10)*

Although attendance at antenatal classes was offered to the women, the way they were told about the classes often resulted in a lack of attendance, as it was portrayed as optional and not necessary.

Furthermore, communication was influenced by the reception of information related to the participants' ability to understand and read English. Information was often provided in written form and the participants felt that they missed it because they could either not read, or if they could, they preferred the information to have been provided verbally first, and then in written form as a reminder. Importantly, the participants noted one's ability to communicate verbally in English does not always imply that the person can read.

> *…some people just speak [English], but they can't read, (Participant 12)*

Birth environment and support

The second theme relates to the birth environment and the support available to the women during labour and birth. A birthing environment that allows the presence of family support was valued by the participants. However, in most hospitals in Africa, the family were excluded, resulting in the women opting to give birth at home. Birthing at home in Africa usually means giving birth without a skilled birth attendant, as there are no formal government-funded home-birth schemes. As participant 9 describes:

> *The people were supporting me. The house was full. One holding here, one holding my hands… one was there waiting, everybody wanted to participate to have the baby survive (Participant 9)*

In contrast, in Australia, families were allowed and encouraged to be present in hospitals to give support to them in labour which was appreciated by the participants.

> *They [in Africa] don't allow, like in Australia, they allow others in the room with you, they [in Africa] don't allow it. (Participant 1)*

However, there was also some negativity towards the Australian system. In Africa, the women were free to move around and walk to improve the progress of their labour, whereas in Australia the participants reported experiencing some restriction of movement during their labour, due to continuous fetal monitoring and an expectation of labouring in bed.

> *…in Africa, you are allowed to walk around. But here, [in Australia], once you get to the hospital, you should be on your bed you lie down. It is painful; because when you are in pain, you don't want to be in one position. (Participant 8)*

Even though there were restrictions in movement when in labour in Australia, the women reported giving birth in their preferred positions.

Pain management

The participants conceptualised birth as painful, although the pain experience varied from one woman to another. The participants reported that their maternity experiences in Africa led them to accept labour and birth pain as normal and natural, and that they were therefore expected to be strong and endure the pain.

> *Because I think it is natural. You have to feel that pain. I have to go through the pain. It is something I wanted (Participant 1)*

The participants reported different expressions of pain which ranged from crying and screaming, to being silent. The women who used silence to cope with their pain, reported that they disliked or

were agitated by noisy environments. They preferred a quiet environment with less frequent checks, especially vaginal examinations. In Australia, the women who chose to be silent and not show any obvious signs of being in pain reported being misinterpreted as not being in true labour.

> *I feel the pain, [but] I [do] not talk… I don't want…someone also sitting next to me talking too much. If you talk too much, I send you out. I need to be quiet…the way I stay [silent], people think I am not in labour. They say to me… '[Labour] is not real, baby not coming now, [it] may take time. Maybe you need to go back home. Then you will come back when the pain ready'. [After this] It [doesn't] take even one hour and I get baby (Participant 11)*

While labour pain was perceived as normal, a number of participants still wanted pain-relief. In Africa for most women, pain-relief was not available. When giving birth in Australia, multiple forms of pain-relief were available; however, the women's experiences of pain management varied. Some women did not get pain-relief because they were unaware the different types of pain-relief they could request. The women mentioned that they did not ask for pain-relief, but instead, expected it to be offered by the midwives. Furthermore, they felt they were expected to know the types of pain-relief and to be specific with their requests. However, a lack of education about pain-relief deprived them of this, as they had no knowledge of the different types of pain medication.

> *When it comes to pain-relief… they want you to ask them what sort of pain-relief you want. So now if you are not literate… how are you going to know? Because us from African background, most of the women are not literate. So, how will you know that there is something available if you need it? (Participant 2)*

If the women were effectively informed about pain-relief in the antenatal period, they would have been able to make informed decisions in relation to pain-relief. It is therefore evident from these experiences that a lack of knowledge about pain management was a key experience which also influenced access to care and can affect the way in which women perceive care.

Perceptions of care

Theme four shows that good maternity care was not only attributed to services provided, but more importantly the attitude of the care providers. Whether it was in Africa or Australia, the ways in which the individual women were treated had a strong impact on their perceptions of care. As the participants appreciated and valued being treated with respect, the behaviours and attitudes of the midwives had either positive or negative impact on their satisfaction with care.

> *…because pain can be there but… it is the good manners [that matters]. But when I came here, my first child that I have here in Australia, I was really treated with care, respect, and everything. I [mean], they were providing for me (Participant 10)*

Negative treatment in Sub-Saharan African health care facilities were reported by the participants. Participant 12 suggested that in Africa women were often persecuted by health care providers for giving birth at home.

> *Yeah, they accuse you. For them, it doesn't matter when something [wrong] happens at the hospital. At least it happened at the hospital. But if it happens at home, they will still accuse you and say you should have gone to the hospital. I remember the experience, it was my cousin, she gave birth at home and that was her first child… she didn't go to hospital the following morning, [not until] 3 or 4 days and her [perineal] wound was getting really, really rotten. It was really bad and as I said really it was smelly. The wound didn't heal; she was tired so badly. She was meant to be stitched, but she never knows such thing and nobody attend to her [at the hospital] because of the smell (Participant 12)*

The level of maternity care and using advanced technology in Australia was perceived by the participants as being of a high standard compared to what they had experienced in Africa. Moreover, the participants perceived the midwives in Africa to be lacking in skills and training, especially with managing complications.

But in Africa, not like that. Most people got to pass away when they got to deliver the baby. There [Africa] they cannot check properly… (Participant 7)

The women also shared stories of poor care, mistreatment and ineffective relationships with their care providers in Sub-Saharan Africa.

… some people can be scared and yell, [if you are scared and] the baby is about to come, the African midwife can say 'you [are scared]' and they can hit you (Participant 5).

Whilst women shared different experiences of mistreatment which varied in severity, there is potential for improvement in midwifery practice.

Discussion

This study supports and adds further evidence to the existing knowledge of Sub-Saharan African women's experiences of maternity care, as evident from the literature review. Our findings resonate with the themes identified in the literature review including cultural beliefs and traditional practices; attitudes of health care workers; access to care; experiences of childbirth; and support and postnatal experiences. Moreover, our thematic analysis findings are similar to what was previously known about African women's experiences, with access to health care and health education, birth environment and support, pain management and perceptions of care being the significant experiences of women in this study. However, across the four themes there were significant differences in the maternity care experiences identified by the participants, which are summarised in Table 2. Additional supporting information highlighting the variation in the workforce statistics is also included to show the contextual difference and possible explanation for the diversity in care experiences.

Insert Table 2 here

The study found that the participants experienced challenges with their maternity care in both Sub-Saharan Africa and Australia despite the vast contextual differences of staff to woman ratios. Even though there were significant differences between the women's maternity experiences, access to care was evident and woven through each of the four identified themes. These access to care issues existed regardless of the location during pregnancy and birth, and had health care consequences for both the women and their babies. However, the reasons for their issues with access to care varied, as access is a multilevel, complex and dynamic concept. Levesque et al.[37] define 'access' as "the opportunity to reach and obtain appropriate health care services in situations of perceived need for care" (p4). They demonstrate how access is dependent on the characteristics of individuals, households, social and physical environments, health systems, organisations and providers.[37] In order to understand the concept of access to care, Levesque et al.[37] have identified five dimensions of accessibility of health care services and five corresponding abilities of how populations interact with these dimensions to generate access (see Figure 1).

Insert Figure 1 here

The framework depicts how an individual goes through a series of steps in accessing care, progressing from perceiving health care needs and desiring care, seeking health care, reaching health care, obtaining or using health care services, to actually benefiting from care that is appropriate to their needs.[37] The individual's progress through this continuum of access depends on the dimensions of access (shown above the steps in Figure 1) and the corresponding abilities of the individual (shown below the steps in Figure 1). Exploring this conceptual framework of access to health care allows us to understand the participants' experiences in the present study, and identify opportunities to improve women's experiences in the future. Each of the six steps will now be explained and linked to our findings.

Health care needs

The continuum of access commences with an individual having a health care need[37]. It is globally recognised that every woman should have professional health care during pregnancy, childbirth and the postnatal period regardless of age, parity or concomitant medical conditions.[9,37] The international standards set by the World Health Organization state that every pregnant woman should have at least four antenatal visits, a skilled attendant at birth, and three postnatal care visits with a trained health professional to achieve optimal outcomes for mother and baby.[9,38] Therefore it is evident that all of the participants in this study, having experienced pregnancy in Sub-Saharan Africa and in Australia, had health care needs to enter the access to care continuum.

Perception of needs and desire for care

Perception of needs and desire for health care is influenced by an individual's health literacy, health beliefs, trust and expectations, as well as the services' approachability.[37] The women in this study described how, when in Sub-Saharan Africa, they did not have sufficient knowledge or information to realise the need for maternity care and had minimal health literacy to identify a problem warranting health care. This lack of knowledge, coupled with their beliefs that pregnancy was normal and therefore did not require health care, influenced their perceptions of need, and desire for care. This finding concurs with previous research identified in the literature review.[15,16]

In both Sub-Saharan Africa and Australia, there were also differences in what the health care system stated that women needed, and what the women themselves thought they needed. For example, in their subsequent pregnancies in Australia, they recognised the benefits of professional health care and none of them considered having no health care in Australia. However, their health literacy remained low and impacted on the timing of their perception of need. The women did not perceive antenatal classes to be of value to them in preparing for the labour and birth because of their previous maternity experiences, however recognised that their lack of knowledge of pain-relief

options would have been addressed had they attended classes. In Australia, the women lacked information about the Australian health care system, including the need to book-in for care. Therefore, approaching maternity services was a challenge for them. These findings contribute to the body of knowledge previously presented describing Sub-Saharan African women's lack of knowledge of health systems.[11,14,17,23]

Health care seeking

Upon realising a need or desire for health care, the next ability is to seek care. Levesque et al.[37] show that an individuals' decision and ability to seek care is influenced by personal and social values, culture, gender and autonomy, as well as the acceptability of the health care services. Health care seeking is identified as the first of three delays in accessing care by the World Health Organization.[39] The women in the present study described how in Sub-Saharan Africa, there was tension between personal, societal and professional expectations of care. A significant factor for health care seeking was the midwives' attitudes and the presence of family support. For instance, the women highly valued the presence of a family support person during labour. As this was restricted in most African services, the services were deemed unacceptable and women gave birth at home without skilled assistance. In Australia family support was encouraged during labour and resulted in positive health care seeking behaviours. However, the cultural perception of labour pain as normal influenced the women ability to seek pain-relief, regardless of their location.

Furthermore, when they experienced or heard stories of others receiving mistreatment, such as being yelled at or hit during labour, they lost trust in the system and resisted seeking care, with some opting to birth at home either alone or with family providing supportive care. This finding concurs with that described by Wilunda et al.[19]

Health care reaching

Once the decision to seek care is made, the next ability is to reach health care facilities[37]. Levesque et al.[37] show that an individuals' ability to reach care is influenced by living environments, transport, mobility and social support, as well as the availability and accommodation of health care services. The World Health Organization recognises reaching care to be the second of three delays in accessing care.[39] In this study, the problems of reaching care in Africa were due to the long distances to the health facilities, transport availability and cost and concur with previous studies.[13,19] These barriers affected access at different points along the access continuum. When they sought care, the women's ability to reach the care was dependent on the geographical location, the way in which the services operated, and the travelling time. The condition of the roads was poor and transportation on foot or by bike was not appropriate for women in labour, being both logistically difficult and expensive. To improve access to maternity care in Africa, there is a need to improve infrastructure such as roads and transport to healthcare facilities.[40] Sometimes, when the women did reach a health care facility, birthing services were not available forcing them to travel to other facilities for health care. As described by the participants in this study, when unable to reach appropriate health facilities, they would birth without a skilled birth attendant, increasing their risk for complications. Therefore, ensuring that all women have access to skilled attendance at birth can contribute to a reduction in the high maternal mortality rates in Sub-Saharan Africa.[41]

The participants experienced long waiting times in Sub-Saharan Africa due to the high numbers of women attending, the absence of a booking appointment time and very few midwives. In Australia, reaching care was also an issue as there was a restricted booking system, car parking time limits were problematic, and the participants still experienced long waiting times. Despite the existence of midwifery continuity of care, no participants received this model of care whether because of their geographical location or because it was fully booked. System issues experienced by the participants add new understandings to the known hindrances to accessing care.[16,21,22]

Health care utilisation

Upon reaching the services, Levesque et al[37] suggest that the next ability is health care utilisation. The authors posit that an individuals' ability to use care is influenced by income, assets, social capital and health insurance, as well as the affordability of health care services[37]. Receiving care is the World Health Organization's third delay in accessing care which can lead to maternal death.[39] The women described how in Africa, utilisation of care was sometimes compromised by lack of resources within the service itself, or the personal cost of specific services. An example of this was a woman who suffered a post-partum haemorrhage and should have had a blood transfusion but could not afford to pay for it. Finlayson and Downe[42] have shown that the cost of healthcare hinders access to care and the seeking of healthcare in subsequent pregnancies.

In Australia, the women recognised and valued that the affordability of services was not a problem due to the Commonwealth supported medical insurance scheme (Medicare). They were impressed with the level of care which they had not been afforded before.

Health care consequences

Upon using services, Levesque et al.[37] suggest that the next ability is to engage in health care which then determines the health care consequences. Levesque et al.[37] show that an individuals' ability to engage in care is influenced by empowerment, information, adherence and caregiver support, as well as the appropriateness of health care services. The women in the present study described instances of empowerment and disempowerment, respectful and disrespectful care, describing mistreatment in Africa and poor communication in Australia. For example, in Australia the women faced difficulties with communication and cultural misunderstandings, disempowering them in labour. Their non-expression of verbal and non-verbal signs of pain was often interpreted as not being in labour, which restricted the offering of analgesia and affected their satisfaction. Whilst previous studies have shown that African women preferred natural birth without analgesia[12,22,23]

participants reported that they wanted pain relief options. Education and information about pain relief during pregnancy is important to help women understand the different pain relief options that are available, and thus be empowered to make choices during labour.

Participants described some Sub-Saharan African health care providers as having a lack of knowledge and skills in the early identification and timely management of complications. This has the potential to affect the appropriateness of care, and limit timely access to the recommended comprehensive obstetric care.[43] Mistreatment such as verbal and physical abuse, neglect, and disrespectful care was also reported by participants and suggested to hinder utilisation. These results are consistent with studies conducted in Ethiopia, Tanzania, and Uganda on Sub-Saharan women's experiences of maternity care[19,25,44,45]. Bohren et al.[46] identified the contributing factors to the mistreatment of women during childbirth to include insufficient staffing, lack of supervision of staff, poor working conditions, and a lack of resources. As demonstrated in Table 2, Australia has on average ten times more midwives per population that the Sub-Saharan average.

Previous research has identified communication difficulties as influencing care consequences.[11,17,23,47] Our findings have shown that it is important for healthcare providers to recognise that Sub-Saharan African women may not be able to express their needs or to ask for the care they desire. Some participants perceived misinterpretation as discrimination and this affected their perceptions of the care provided. These findings support previous findings that language difficulties hindered good communication and understanding between African women and their caregivers.[14,21] Time constraints and the sense of being rushed compounded the participants' dissatisfaction, affecting their trust in the health care system and hindered their use of maternity services.

Enhancing Sub-Saharan African women's maternity experiences

Our thematic analysis findings identified four themes relating to Sub-Saharan African women's maternity experiences in Sub-Saharan Africa and Australia: access to health care and health education, birth environment and support, pain management and perceptions of care being the significant experiences of women in this study. Levesque et al's[37] framework on access extends our understanding of these findings, by identifying how they all influence access to care. As shown, there are many and varied aspects that influence women's access to care, which have the potential to cause long-term health consequences for women and their families.[37] Poor access may lead to maternal dissatisfaction with care, poor maternal health, and poor pregnancy outcomes.[37] Attending to the factors that affect access to care in terms of perceiving need, seeking, reaching, and utilising care could then lead to positive consequences for childbearing women. Our findings are significant as they contribute to previous understandings but add how access to care is problematic for these women regardless of their location. We have shown that regardless of how well a health care service is resourced, issues that may hinder a women's access to care always exist. Whilst previous knowledge is based on studies across developed countries, our study focused on maternity care experiences in Sub-Saharan Africa and Australia. It is therefore the first study to explore Sub-Saharan African women's experiences of the whole spectrum including antenatal, labour and birth and postnatal care in Australia. The key messages we take from our findings that have the potential to improve access to care are the importance of: health literacy, affordable health care systems, respectful and high quality midwifery care, clear and effective communication, and cultural sensitivity including family support for labouring women.

Implications for midwifery practice

The study has a number of implications for midwifery practice. Enhancing women's health literacy will improve their ability to determine their own health needs and promote timely health care seeking. Health education is an important intervention to address access to care and empower

women to make choices for their own care. Acceptable health care allowed family support during labour and birth. Maternity care services in Africa should consider women's desires for the presence of family support during labour to minimise women's decisions to birth without a skilled attendant. Attitudes and behaviours of health care providers impacted on women's satisfaction with care and their subsequent health care seeking behaviours. Acceptable respectful care should be the goal of all midwives and health care facilities. Similarly, availability and affordability of care are of significant concern in low resourced countries. All midwives should advocate for women and maternity services to ensure the minimum standards of care are accessible. Furthermore, there appears to be a need for upskilling of midwives in Sub-Saharan Africa in emergency obstetric care, as per the World Health Organization's recommendations.[48] Communication influences women's ability to express their needs and to interact with health care providers. Midwives should be mindful that women's verbal literacy may not reflect their reading comprehension and therefore efforts should be made to ensure the understanding and gain their trust. Cultural beliefs and practices influence women's behaviours. All midwives need to explore women's understandings of pregnancy and birth, particularly when the midwife and woman are from different cultural backgrounds. Only then can women-centred care be provided.

Limitations of the study

As a qualitative study, the concept of transferability is used instead of generalisability. Quality and trustworthiness have been achieved through the collection of high quality rich data, the rigorous analysis process, and thick description and interpretation. While every effort was made to recruit women from as many Sub-Saharan countries as possible, the participants came from just six countries. However, data saturation was reached which suggests that the sample size was adequate and suitable for meeting the research aims. Given the retrospective nature of the experiences there is a potential for recall bias, with participants more recent maternity experience in Australia possibly biasing their recall of their earlier experience in Sub-Saharan Africa. We also recognise that

maternity care is not static and that some service improvements may have taken place over time, therefore the experiences of women today may be different from those described in this study.

Conclusion

This study has explored how Sub-Saharan African women experienced maternity care in Sub-Saharan Africa and Australia. With increasing numbers of Sub-Saharan African women giving birth in Australia, it is important for midwives to understand the needs of these women and to provide culturally-appropriate maternity care that meets their needs. The findings of this research provide an understanding of the experience, but also of the challenges faced in accessing care. While there were differences in the African and Australian experiences, the women's valuing and expectations of maternity services were similar. Regardless of the place of birth, the women valued family support, effective communication and being treated with dignity and respect. To improve Sub-Saharan African women's access to care, it is important to enhance their health literacy, affordable health care systems, respectful and high quality midwifery care, clear and effective communication, and cultural sensitivity, including family support for labouring women.

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors. The research was made possible through a Department of Foreign Affairs and Trade (Australia) student scholarship.

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Table 1: Participant Characteristics

Participant	Age	Country of origin	Years in Australia	Number of births in Africa	Number of births in Australia
1	36	Liberia	8	2	1
2	36	Uganda	8	1	3
3	49	South Africa	9	2	1
4	32	Malawi	8	1	2
5	32	Liberia	1.5	1	1
6	33	Burundi	11	1	2
7	Over 40	South Sudan	10	3	3
8	26	South Sudan	4	1	2
9	30	South Sudan	Unknown	2	2
10	Unknown	South Sudan	4	2	2
11	33	Uganda	11	3	3
12	26	South Sudan	9.5	1	4
13	38	South Sudan	6	3	1
14	33	South Sudan	10	5	2

Table 2: Differences in maternity care experiences between Sub-Saharan Africa and Australia.

Women's Experiences	**Sub-Saharan Africa**	**Australia**
Barriers to accessing care	Long distance to facility, lack of resources, lack of transport	Unfamiliarity with the health system, communication difficulties
Health education	Lacking	Provided
Family support person in labour	Not usually allowed	Allowed and encouraged
Pain-relief – pharmacological	Often not available	Multiple options available
Quality of midwifery	Highly variable from nil to registered practitioner	High standard – all registered practitioners
Midwifery workforce statistics	**Sub-Saharan Africa**	**Australia**
Midwives per population	10.7 per 10,000 population[49]	10.6 per 1,000 population = 106 per 10,000 population[50]
Registered midwife/woman ratio in labour	1:20[51]	1:1

Figure 1: A conceptual framework of access to health care.

Source: Levesque, Harris and Russell (2013), Reproduced with permission[37]