Women from refugee backgrounds and their experiences of attending a specialist antenatal clinic. Narratives from an Australian setting

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Abstract

Problem: In response to an identified need, a specialist antenatal clinic for women from refugee backgrounds was introduced in 2008, with an evaluation planned and completed in 2010.

Question: Can maternity care experiences for women from refugee backgrounds, attending a specialist antenatal clinic in a tertiary Australian public hospital, be improved?

Methods: The evaluation employed mixed methods, generating qualitative and quantitative data from two hospital databases, a chart audit, and surveys and interviews with service users, providers and stakeholders. Contributions were received from 202 participants.

Findings: The clinic was highly regarded by all participants; continuity of care throughout the antenatal period was particularly valued by newly arrived women as it afforded them security and support to negotiate an unfamiliar Western maternity system. Positive experiences decreased as care transitioned from the clinic to labour and postnatal wards with women reporting that traditional birthing and recuperative practices were interrupted by the imposition of Western biomedical notions of appropriate care. The centrally located clinic was
problematic, frequently requiring complex travel arrangements. Appointment schedules often impacted negatively on traditional spousal and family obligations.

**Conclusions:** Providing comprehensive and culturally responsive maternity care for women from refugee backgrounds is achievable, however it is also resource intensive. The need for culturally appropriate and translated information, taking account of languages which are only rarely encountered, is problematic, whilst cultural competency programs for staff, ideally online, require regular updating in light of new knowledge and changing political sensitivities.

**Keywords:**
Refugees, evaluation studies, midwifery, interpreter, cross cultural, continuity of care

**Introduction**
The authors were invited to undertake an evaluation of a dedicated antenatal clinic for women from refugee backgrounds attending a large Australian tertiary maternity hospital. The evaluation, which was completed in 2010, sought to explore how such women described their experiences of attending the specialist antenatal clinic, and to identify possible improvements in future service provision. The service operates two days/week and is located within the hospital’s mainstream antenatal clinic. The all-female staff, comprising a midwife, obstetrician and social worker, were encouraged to develop a ‘best practice’ model of care (1) which included psycho-social support, interpreting services, and a program of staff training; clinical remit was limited to the antenatal period and contracted hours were on a part-time basis. The evaluation, which was commissioned by hospital management, funded by the Sisters of Mercy and undertaken after the first year of operation, aimed to identify facilitators and barriers to the delivery and quality of care. Recommendations for future provision were made.

**Literature review**
Although recognised as a world leader in refugee resettlement, the number of allocations Australia offers is amongst the fewest since the inception of the Refugee and Humanitarian Program in 1977, with critics arguing that expansion in national wealth has not benefitted some of the most vulnerable people (2). That said, an expert in multiculturalism has recently positioned Australia alongside Canada as the world’s most successful country for migrant integration and racial harmony (3). Approximately 30% of Australian humanitarian visas granted in 2010 were to women of childbearing age (4). The ‘Woman at Risk’ category assists female refugees susceptible to sexual and gender-based violence and the grant rate for this visa subclass is typically higher than any other (5). Women from refugee backgrounds face particular challenges in their routes to resettlement as they are less likely to have had access to educational opportunities and hence will generally possess lower English language proficiency than their male counterparts. Lack of basic language skills hinders adjustment processes in the host country (6) making it harder for women to negotiate access to health care (7), including reproductive health services (8). Pregnant women from refugee backgrounds are considered a particularly vulnerable group (9) with research confirming an increased incidence of childbirth complications and generally poor pregnancy outcomes (10), including higher rates of stillbirth (11), maternal (12), and perinatal (13), mortality.

Previous studies, including a systematic review (14), associate continuity of midwifery carer with improving women’s overall maternity experience, specifically regarding control and satisfaction, communication with staff, and helping to ensure an environment conducive to informed decision-making, particularly for women from minority ethnic groups (15). Failure to provide a culturally competent service impacts negatively on refugee women’s maternity experiences, including those resettled in Australia (16), as does institutional discrimination and/or racism (17). Antenatal attendance is known to improve when structural problems such as lack of childcare facilities, difficulties with transport, and women’s preferences for clinic
location, are addressed (18). Such issues are of particular concern for impoverished refugee women with limited resources and inadequate social support.

The quality and accessibility of information, especially regarding diagnostic tests and procedures, is of considerable importance to non-English speaking populations (19). Whilst the availability and appropriateness of interpreter provision affects women’s willingness to attend for antenatal care, there is evidence to suggest that establishing a relationship of trust with a care provider is a better indicator of quality, than mere accuracy of translation (20). Finally, recent research suggests that continuity for culturally and linguistically diverse women, across all maternity care providers, in conjunction with appropriate community support, was likely to be more beneficial than the provision of intensive obstetric services alone (21).

Participants and Methods

Setting

A specialist antenatal clinic situated within the mainstream clinic of a large tertiary hospital.

Participants

Overall, 202 participants contributed to the evaluation through the completion of surveys and/or individual interviews or focus groups (FGs): 42 service users, 147 hospital staff, clinic staff (n=3), Hospital managers (n=3), interpreting co-ordinators (n=2), and key stakeholders (n=5).

Design

Mixed methods, now well established in health services research were chosen for the potential to add rigour to the evaluation process and strengthen the significance of results (22). Combining qualitative and quantitative approaches is particularly well suited to studying populations from refugee/immigrant backgrounds (23).
Data collection and analysis

Six Peer Research Assistants (PRAs) were recruited from the five main countries represented in the clinic, including: Somalia, Sudan, Afghanistan, Burundi and Liberia. The PRAs were settled in Australia at least ten years and were all mothers who had completed at least one maternity episode in Australia; they were either accredited interpreters or had recognised English translation skills. All received training in basic research skills, including the ethical conduct of research, and were employed for the duration of the evaluation. The PRAs recruited service users, arranged and facilitated survey completion and interviews, including translation and transcription processes. The appointment of the PRAs thus provided an essential ‘brokerage’ role in all aspects of research activities.

Data were obtained from two obstetric databases (MatriX and Obstetric CRS), a clinical chart audit, surveys containing a mixture of open-ended (free-text) questions and Likert-type responses, and interviews. The hospital databases provided clinical and psychosocial data for the 190 women who had attended the specialist clinic between the opening (January 2009) to the end of the evaluation (May 2010). Data were compared with the broader population of women [n=4158] giving birth at the same public hospital in 2008.

Quantitative data were collated and analysed using Microsoft Excel (2002 and 2007) and SPSS (Version 17. Chicago: 2008). Chi-square tests were used to compare maternal and neonatal clinical outcomes (proportions) between the two cohorts. Binomial confidence intervals were generated using the Wilson method (24).

All maternity staff were alerted to the survey via information on the hospital online portal and through direct email from managers. The PRAs disseminated information through family and community networks, with clinic staff informing eligible service users who then completed surveys (n=42), which were translated by the PRAs. Service users were offered the choice of
completing a survey and/or FG participation; 18 women participated in four FGs, held in their homes in their preferred languages, and facilitated by a PRA. Written consent was obtained prior to commencing interviews; consent was implied by survey completion.

All Interviews were audio recorded and transcribed verbatim immediately in order to inform subsequent interviews, and to facilitate data analysis in tandem with further collection. The PRAs first translated the audio file into English, which was then professionally transcribed and verified by individual PRAs. The first two named authors read and re-read transcripts and independently created coding systems. Precise descriptors were written for each code to minimise coding errors. Codes for individual FG interviews were subsequently compared, with minor modifications made to include data which was relevant to the topic, but which was not necessarily discussed by all participants. Coded transcripts were entered into Nvivo (Version 8) and the researchers proceeded with thematic analysis by examining associations and discrepancies in the coded data (25). Triangulation of data was achieved in number of ways: i) non-verbal cues noted by the FG facilitator were verified with the relevant PRA, ii) FG transcripts were independently coded by the first two authors, and iii) the PRAs confirmed the researchers’ interpretations.

A small number of ‘inconsistencies’ were identified in the raw data which primarily related to inter-group differences in beliefs and cultural practices, most of which were not concerned with the topic under discussion (i.e. maternity care for refugee women). The first two authors discussed the relevant inconsistencies, for example the positioning of male household members which was not the same for all FG participants and incorporated these data into the final coding system. Coded transcripts were entered into Nvivo (Version 8) and the researchers proceeded with thematic analysis by examining associations and discrepancies in the coded data (25).
Ethical approval was granted from the Hospital Human Research Ethics Committee (Ref: 1488M).

Findings

This section presents relevant quantitative data in order to contextualise the qualitative findings which follow, and which highlight a number of areas for future service development.

Suggestions for improvement included the (re)location of the clinic and more flexible appointment times, information production and dissemination, and differences in socio-cultural and medical understandings of pregnancy and birth-related norms.

Demographics and clinical outcomes

A total of 22 language groups and 24 countries were represented by service users. Of the 190 women who attended the clinic over the evaluation period (January 2009 - May 2010), 77.8% were born in Africa and 19.5% in the Middle East. Key maternal and neonatal clinical outcomes are presented in Table 1. Overall, 52.1% of women were aged between 25 and 34, 5.8% were less than 20 years and 21.1% were 35 or older. Recent stresses, including financial difficulties, loss/death, and/or significant isolation, were reported by 58.0% of women; 44.2% had minimal or no support following birth. Statistically significant numbers of women were identified as at risk of being depressed. Sixty percent of women required interpreter services. Table 1 also reveals that women from refugee backgrounds attending the specialist clinic were more likely than their mainstream counterparts to be multiparous, have spontaneous onset of labour, a normal birth (including following a previous caesarean), and an intact perineum.

Analysis of qualitative data yielded two key themes presented below in accordance with COREQ criteria (26). Pseudonyms are used for direct quotes, as indicated by the notation PRA1, 2 etc. Where text has been removed to condense a quotation, this is indicated: [...]. In keeping with qualitative traditions (27, 28) participants’ words remain in the original form.
i. Service provision: models of care, access, and appointments

All participants confirmed that a major strength of the clinic was the provision of continuity throughout the antenatal period, which reduced the need for women to revisit traumatic memories and facilitated the development of trusting relationships. Continuity of carer also resulted in less time conferring with an interpreter over historic events, leaving longer to discuss current concerns. Unaccompanied women, especially those newly arrived in Australia, appreciated the support and sense of stability provided by a model of maternity care which acknowledged their social and personal circumstances, as well as medical matters.

Clinic staff operated an ‘open door’ policy which was greatly appreciated by women and their families, although not without implications for work-loading:

*Women do end up ringing me or dropping in. They know that I work in this particular room and come in […] because they’ve lost a form […] or they’re looking for a bit of support. […] I don’t say no to those women, so that takes time.* (Clinic Staff)

A corresponding issue was reported by interpreters, whose services were sometimes requested in lieu of social support, rather than for language need:

*I have had a scenario where a refugee woman became attached […] and then begged her (interpreter) to stay as she had no support […] the interpreter was being paid as a support person, not because she was necessary for interpreting.* (Staff survey)

We suggest that an ‘open door’ policy makes it difficult for women, and their families, to appreciate the limitations on service provision. An additional issue for clinic staff concerned hospital recording systems, which were insufficiently flexible to account for the time they
spend servicing ad hoc requests. Unscheduled appointments and impromptu access to staff also contrasted with the practices of the community-based organisations many of the women accessed, where strict eligibility and access criteria were applied, not least to protect finite resources and to ensure they were equitably distributed.

The central location of the hospital was problematic as many women resided in outer city suburbs and hence faced lengthy, and expensive, commutes by public transport; 55% reported difficulties attending antenatal appointments for these reasons. Despite these problems, however, 56% of women reported that they preferred attending the hospital rather than a community-based facility. This may be explained by the fact that women attending the clinic, especially those without previous experience of health care in a Western context, tended to view hospitals as the pinnacle of clinical excellence and the centre of medical expertise.

Few women had access to the private vehicles used by males in the household for work or study-related travel. Limited English language added another layer of complexity for women negotiating public transport systems. Delays and cancelations were not uncommon leaving women (and accompanying infants/children) stranded, arriving late, or failing to attend, their clinic appointments. Regular, and prompt, clinic attendance was also an unfamiliar expectation for many women, and one which significantly impacted on family life. The need for women identified as ‘high risk’ to attend clinic more frequently, compounded problems.

The scheduling of appointments, and particularly the designation of women as ‘high risk’, thus had significant economic impact on families, most of whom were already struggling financially. Husbands who preferred that their wives did not travel alone on public transport had no option but to act as chauffers, taking time off paid work or college (English language) classes. Clinic appointments also needed careful management to avoid disrupting household routines, which were generally reported as rather rigid and inflexible. Women considered that
‘good appointments’ were those that took account of their domestic responsibilities, including delivering and collecting children from school, food purchase, and meal preparation. Afternoon appointments were particularly disliked as they interfered with cooking and having food ready to eat when husbands returned home in the evening. Women with school-aged children disliked sending them to school alone, or arriving late to collect them, because they feared being perceived as irresponsible mothers by those in authority:

… we have to pick up and take children to school. Sending children to school alone there may be trouble. We may be in trouble with the police. (Participant, Burundi FG)

By way of circumventing ‘trouble’, mothers sometimes interrupted children’s schooling and took them on clinic visits, however such absences were frowned upon by school authorities. Unscheduled time out of school also disrupted children’s social relations with their peer group, and parents’ relations with teachers and school managers.

ii. Socio-cultural and medical norms: differences between home and host country

Women reflected on reproductive norms in their countries of origin; Female Genital Mutilation (FGM) or deinfibulation, was frequently mentioned. Although the (female) clinic staff reported trying to discuss this issue sensitively, their clientele nonetheless often viewed their efforts as intrusive and inappropriate, regarding it as “women’s business” and a private matter. The need for staff to ask questions and gather factual data in anticipation of labour was not well understood and women reported feeling pressured or upset when the subject was broached:

I just told the person that it is my culture. You know what it is my culture. You cannot force me to tell you why. (Participant, Liberia FG)

Women who would normally have been accompanied in labour by female kin described feeling isolated when their usual support networks were unavailable, perhaps because these
relatives were no longer alive or had been unsuccessful in lodging a claim for refugee status. Women occasionally transgressed gendered socio-cultural norms by inviting their husbands to accompany them in labour:

*If you were at home would you have your men around at birth? No, No it’s just here (in Australia).* (PRA 2)

Although the presence of men is now viewed as normative in Western maternity settings, their active participation in pregnancy and in childbirth as labour supporters, is relatively recent.

A minority of women expressed a preference for managing labour alone, perceiving it as an event to be endured, with the outcome largely in the hands of ‘God’ and/or medical staff:

*In our culture, when you’re really in the pain […] we prefer to pray and ask God for help and see Doctor there. Doctor and you and the God […] we don’t need anyone else, that’s all (PRA 1).*

The experience of labour and birth, and especially pain management, frequently challenged women’s traditional beliefs and customs. Many voiced frustration with what were viewed as ‘Western’ (i.e. highly medicalised) practices, including induction and augmentation in labour, and a perceived over-enthusiasm for advocating pharmacological pain relief. Caesarean section was widely regarded as a decision which was made prematurely and without due regard for women’s individual histories and their responses to labouring in what was often a new and unfamiliar environment.

Clinicians strove to ensure the information they provided to women was up to date and
evidence-based, and that it was disseminated in an equitable and timely manner. This was problematic however, within the context of a small, but rapidly expanding, service where women spoke approximately 22 different languages. Uncertainty was also voiced about the context in which the available evidence had been generated, and to what degree it was applicable across the diversity of refugee populations accessing the clinic. These logistical barriers also hindered information delivery through traditional routes such as antenatal/parenting classes.

Clinic staff understood information provision as not only concerned with prevailing socio-cultural and medical norms associated with having a baby in an Australian context, but also with the Western agenda of ‘rights’ and ‘responsibilities’, which obliges citizens to be well-informed about available options, and to make ‘appropriate’ choices. Time scarcity, however, frequently prevented the in-depth discussions clinicians indicated they needed to ensure women understood this rather more complex dimension. Interestingly, when women were asked about their preferred topics for discussion, few referred to the usual ‘menu’ covering pain relief in labour or mode of birth, but rather wanted practical details about where to purchase items required for their in-patient stay. Failure to understand what was required for their forthcoming hospital admission generated considerable anxiety, even for women with reasonable English language skills:

*I didn’t know what to put in the baby bag. I didn’t know what to put in my mother’s bag […]*

*Even though I read and write, but I still had issues.* (Participant, Liberia FG)

The ‘mother’s bag’ referred to included items essential for hospitalisation and which could not necessarily be purchased within the hospital or indeed, locally. First time expectant mothers expressed concern about the cost of equipment such as baby carriers and car seats. Some requested information about second hand outlets, and how they could be certain that such products were safety compliant.
Discussion

Whilst women’s narratives described overwhelmingly positive experiences with regards to the antenatal care they received, lack of continuity during labour and the postnatal period provoked disappointment and worry. Women anticipating first-time motherhood, who were newly arrived, and/or without female support, were more likely use clinic staff, including interpreters, as sources of advice unrelated to their maternity care, or to ameliorate feelings of distress. Informal access outside scheduled appointments increased staff workloads, and created difficulties for managers attempting to balance the allocation of finite resources. Clinic staff also expressed concern that over-reliance on their knowledge and expertise may result in the de-skilling of their mainstream colleagues.

The central location of the clinic was problematic insofar as it caused women, who were often accompanied by small children, to endure lengthy and complicated journeys on public transport. Lack of English language proficiency imposed additional burdens for women needing to negotiate multiple transport changes en route to and from the clinic, or when they needed to convey information to clinic staff in the event buses/trains being delayed or cancelled. A more flexible appointment schedule might also help to resolve associated problems including the ‘school run’ and dilute the widely held perception that women needed to constantly demonstrate they were responsible and caring mothers. A proposal currently under discussion by the hospital managers concerns the relocation of the clinic, or the provision of outreach service, in women’s areas of residence. The introduction of a Midwifery Group Practice, to improve continuity throughout the maternity episode, is also under consideration. Whilst these are laudable aims, and will undoubtedly ease the aforementioned problems, women may nonetheless need to be persuaded that excellent care is deliverable outside the hospital environment.
Participants across all FGs were concerned that the norms of the Australian maternity culture devalued, or indeed disregarded, the intergenerational knowledge they viewed as both precious and essential, and which they understood offered the best protection for themselves and their infants. Women frequently reported that their traditional labour and birthing practices were rendered inaccessible by the dominance of an obstetric model which typically regarded them as ‘high risk’. Rapid ‘throughput’ of labouring women in a busy birth suite was prioritised; indicators of ‘successful’ outcomes were clinically driven thus largely discounting women’s views and voices. Failure to appreciate the substantial differences in prevailing cultural norms created difficulties as women often failed to comprehend the need for (urgent) intervention. A widespread perception that caesarean section was undertaken too frequently, and without adequate explanation to enable women and their families to appreciate the necessity, has been reported elsewhere (29).

The need for high quality translated materials which were culturally specific and evidence-based was widely acknowledged by all staff. Information which enabled women to formulate realistic expectations about the clinic, and what staff could (and could not) provide was also wanted. Producing accurate and high quality information however, is extremely resource intensive, made more challenging by the increasing diversity of languages and dialects spoken by consumers, and because significant numbers of women from refugee backgrounds are semi-literate or illiterate in their mother tongue (6).

Women also wanted information about material objects including the items they would need for their hospital stay following admission in labour, and baby items including car seats and baby carriers. Material goods signified women were ‘good’ consumers, and by analogy, ‘good’ mothers who were well-prepared and wanted the best for their babies (30). Many also associated purchasing the ‘right’ products with successful assimilation. Although such forward planning helped to reduce anxieties, it was also something of anathema to many women, especially those from countries with traditionally high rates of infant mortality. A
widely circulating discourse, that “something could go wrong”, which was grounded in previous (intergenerational) experiences of fetal-maternal loss, worked against women from refugee backgrounds emulating the consumerist patterns of their Australian-born peers. Self-imposed demands to demonstrate satisfactory adjustment to the values of the host country created tensions as participants strove to project an image of themselves as capable and competent mothers who complied with policy regulations. The requirement for infant car seats as evidence that they understood the relationship to culturally derived notions of child safety may be regarded as a potent emblem in this regard.

Conclusions
The findings from our evaluation confirm that the although the provision of specialist maternity services was highly valued, it is also highly resource intensive. The logistical difficulties of striving for excellence and equity in service provision for small numbers of consumers is always likely to be problematic, especially for providers in regional areas struggling with staff recruitment and retention. An added difficulty is the dynamic nature of refugee populations which fluctuate in response to political upheaval and government policies regarding visa allocation and resettlement procedures. These factors make forward planning extremely difficult.

Our findings reiterated the need for ongoing, accessible, and mandatory, cultural responsiveness programs for staff, with a particular focus on the beliefs and practices of populations accessing the local maternity service. Finally, whilst the provision of dedicated services may improve clinical outcomes and significantly benefit the populations served, this must not be at the expense of de-skilling of mainstream staff.

Limitations
Although the sample of women was representative of the main language groups accessing the clinic at the time the evaluation was undertaken, we acknowledge bias insofar as the
views of women from rarer languages were excluded. We also accept that focus group discussions may be intimidating, especially for women who are unused to sharing their experiences or opinions. Finally, we concede that participants' loyalties towards clinic staff may have hindered frank disclosures, especially about aspects of the service they disliked.

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References


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