

*EACH Social and Community Health*

*The pregnancy and post birth experience  
of women from refugee backgrounds living  
in the Outer East of Melbourne*



*A Healthy Mothers Healthy Babies Research Report 2011*

*Project Worker: Maria Nicolaou (Health Promotion Officer)*



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## *Steering Committee:*

- ***Andree O'Donnell***  
Settlement Case Manager, AMES Settlement Services
- ***Emma Dunstan and Narrelle Quinn***  
Primary Health Integration Program Officers, Melbourne East Division of General Practice/  
Inner East Melbourne Medicare Local
- ***Heather McMinn***  
Clinical Services Manager, EACH
- ***Katrina Stevenson***  
Manager Health Promotion Unit, Eastern Health
- ***Merilyn Spratling***  
Eastern Refugee Health Nurse Coordinator- EACH
- ***Raelene Cameron***  
Well women's Clinic/ Refugee Health Nurse, EACH
- ***Robyn Kilpatrick***  
Settlement Worker, Migrant Information Centre
- ***Vicki Middleton***  
Acting Team Leader Maternal Child Health, Maroondah City Council

The recruitment and piloting of questions could not have been possible without the contributions of the following:

- Esera Maung – Karen Community Member and Bi-Lingual Settlement Worker, Migrant Information Centre
- Ngun Thla Hnem – Hakha Chin Community member
- Sawm Thang Suante – Settlement Worker, Migrant Information Centre

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## *Abbreviations:*

AMES	Adult Migrant Education Services (Refugee Humanitarian Settlement Service)
DIAC	Department of Immigration and Citizenship
EACH	EACH Social and Community Health Service
HMHB	Healthy Mothers, Healthy Babies
MCHN	Maternal and Child Health Nurse (Program)
RHN	Refugee Health Nurse (Program)

## *Terminology:*

Antenatal:	Existing or occurring before birth- relating to the period of pregnancy
Postnatal:	Of or occurring after birth, especially during the period immediately after birth

# Executive Summary

Australia continues to become more culturally diverse and the need to provide and ensure equitable health care service provision is becoming increasingly important (Jentsch et al., 2007). This is evident in the Outer Eastern Metropolitan Region, which includes the local government areas of Maroondah, Yarra Ranges and Knox, with recent arrivals from Burma being one of the largest groups settling in the region. The service provision for women before (antenatal) and after the birth (postnatal) of their children play a large role in the health and wellbeing of themselves and their families. Both national and international evidence suggests that women of refugee backgrounds are particularly at risk of poor pregnancy outcomes and suffer higher rates of maternal complications (Carolan, 2010). Research also indicates that many women from refugee backgrounds commonly arrive to Australia with minimal exposure to formal hospital based antenatal care and that their birthing experience will have been shaped by the views and practices of that culture (Murray et al, 2010; Hoang & Kilpatrick, 2009).

The Healthy Mothers, Healthy Babies (HMHB) State Government Program aims to reduce the burden of chronic disease by addressing maternal risk behaviours and providing support during pregnancy. It targets pregnant women who are unable to access antenatal care services or require additional support because of their socioeconomic status, culturally and linguistically diverse background, are of Aboriginal and Torres Strait Islander descent, of an at risk age or live in residential areas located some distance to services.

A recent innovation grant from this program was received by EACH Social and Community Health to research women's access and attendance at antenatal and postnatal services in the eastern metropolitan region. The main objective was to develop key recommendations for a service delivery model that would be appropriate, accessible and effective in meeting the antenatal and postnatal needs of this target group in the east. A steering committee was formed with key stakeholders in the outer eastern metropolitan region to exchange ideas; and provide appropriate representation and guidance in the development, implementation and dissemination of findings. A process of consultation was implemented to identify key recommendations for the region. This included consultation with women of a refugee background living in the area and local health care providers. The consultation objectives aimed to identify

the strengths and areas for improvement of relevant services; cultural practices; barriers experienced; and identification of possible strategies for improvement. Ethics approval for the research project proposal was approved by the Department of Health's Ethics Committee (06/11).

Focus groups and semi-structured interviews were utilised to obtain this information. There were a total of 42 women from refugee backgrounds that participated in eight focus groups and two interviews. Women were from Hakha Chin, Karen, Matupi, Zomi, Tidem, and Sudanese backgrounds. A total of 34 health service providers and key informants participated in four focus groups and five interviews. All professionals worked in the outer east and included midwives, maternal child health nurses, lactation midwives, general practitioners, a female Chin interpreter and a teacher well known to the Burmese community.

The data obtained from these methods underwent a thematic analysis by the principle researcher.

The four major themes that emerged from the data provided by mothers of refugee backgrounds focusing on: communication, antenatal education, postnatal care, and cultural practices. The main themes identified by the local health service providers also included communication, along with referral pathways-continuity of care and professional development for staff working with refugee clients.

To support these improvements, recommendations include:

- A review of policies and procedures around the use of accredited interpreters in antenatal and postnatal care;
- Medical terminology training provisions for accredited interpreters working with the newly arrived refugee communities;
- An exploration of options to further develop relevant visual communication resources;
- Identification of avenues to run antenatal education classes for women of refugee backgrounds with an accredited interpreter and translated material;
- Feasibility of increasing local ethnic specific mothers groups and the provision of sustainable cultural competency professional development for local health service providers.

# Literature Review:

## *Introduction – Identification of the issue*

Australia continues to become more culturally diverse and the need to provide and ensure equitable health care service provision is becoming increasingly important (Jentsch et al., 2007). Experiences of people coming in on refugee, and asylum seeker/humanitarian visas, results in this group being particularly vulnerable and likely to suffer from even poorer health and wellbeing outcomes than voluntary migrants (Murray et al, 2010).

According to the United Nations 1951 Convention, a refugee is: 'Someone who has left his or her country of origin and cannot return to it owing to a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion'. The service provision for women before (antenatal) and after the birth (postnatal) of their child/ren play a large role in the health and wellbeing of themselves and their families. Current evidence suggests that access to such services can be influenced by a number of factors including the availability of interpreting services and the level of education provided to women regarding procedures, models of care and the health care system. Other influential factors identified have included level of staff cultural competency and the degree of care or perception of care offered by health care staff (Correa-Velez & Ryan, 2011).

This review explores the issues relating to women of a refugee background giving birth in the Australian health care system. It proposes recommendations and highlights gaps in the published and grey literature that would assist in further improving the health and wellbeing of this target group. The knowledge and research gaps provide a rationale for the local consultation that took place in the eastern metropolitan region of Melbourne.

## *Search methods –*

The literature search was conducted using the following Ebsco Host electronic databases: CINAHL, Global Health, Academic Search Complete, MEDLINE, Maternity and Infant Care, Psyc INFO. Official government, agency and universities were viewed for web-based searches of relevant reports/evaluations.

Search terms included “pregnancy or antenatal or postnatal”; “refugee or migrant or asylum seeker”; “health service or service or access”; “Burma”; “Australia”.

Search parameters/inclusion criteria:

- Articles published in English
- Articles published between 2000-2011 (chosen as pertinent to the current wave of refugee settlement nationally and to include current research findings)
- Relating to antenatal and postnatal service access and relating health issues
- Relating to women from migrant, refugee, humanitarian backgrounds giving birth and or raising young children in a new home country

## *Findings –*

### *Local Perspective/ Demographics:*

As a signatory to the 1951 UN Convention on Refugees, The Australian Government has an allocation of approximately 13,750 refugees each year as part of its Humanitarian Program. In Victoria there were 1,555 (cases) of people from refugee and special humanitarian visas settling in Victoria from January to December 2010 (AMES, 2010) with more than 23,000 people settling in this state between 2005-2010 (Department of Immigration and Citizenship, 2010, 2011). More specifically, in the five years to 2010, the outer eastern metropolitan region, which includes the local government areas of Maroondah, Yarra Ranges and Knox has seen a total of approximately 1,332 new arrivals. From January to December 2010, there were 309 people settling in this area with a Humanitarian visa (Department of Immigration and Citizenship, 2010). During the last five years, 68% of those arriving were born in Burma, 10% in Thailand and 4% in Malaysia. It is also important to note that many refugees born in Thailand and Malaysia are of Burmese origin and have been living in refugee camps or awaiting resettlement in Malaysia. As is evident with the above demographics, the large majority of people from refugee backgrounds resettling in the outer east of Melbourne, are fleeing Burma (also known as Myanmar). The remaining 18 percent have come from countries such as Iraq, Iran, Afghanistan and Sudan (Department of Immigration and Citizenship, 2010)

## *The Refugee Experience:*

It is important to acknowledge that there is no standard refugee experience. There are however a variety of experiences that are common among refugees (McDonald et al, 2008). All refugees have experienced violations of their human rights, and this is often a result of war (Agier, 2008; McDonald et al., 2008). Many refugees have experienced discrimination and persecution, frequently associated with their race, gender or their religion (Agier, 2008; Stein, 1981). Refugees are exposed to traumatic events, including loss and separation from family through displacement and execution (McDonald et al., 2008). They are then forced to leave their country of origin and embark on a dangerous journey in search of safety (Stein, 1981; McDonald et al., 2008). Throughout this journey there is frequently a lack of access to healthcare and education (Sinnerbrink, Silover, Manicavasager, Steel, & Field, 1996). Refugees then experience uncertain status in countries of first asylum, which often involves extended periods in refugee camps and detention centres (Silove, 2002, 2004). This frequently exacerbates conditions of trauma as they are often forced to live in substandard conditions, where they experience further violations of their human rights (Silove, 2002).

The issues faced by refugees are not immediately resolved by being granted refugee status, as this marks the beginning of a sometimes stressful resettlement process (Clinton-Davis & Fassil 1992; McDonald et al., 2008). In the country of resettlement many refugees experience a lack of social support due to the absence of family members (McDonald et al. 2008). Furthermore, there is considerable stress associated with learning a new language, a new culture, and the reality of establishing a life in a new and unfamiliar country (Clinton-Davis & Fassil, 1992). As a result, people from refugee backgrounds experience mental health problems at increased rates to the broader Australian population (Omeri, Lennings, & Raymond, 2006; Silove, 2002).

## *The health and wellbeing issues:*

Although pregnancy and childbirth is a universal biological event, childbirth and delivery practices do differ and are not similar for all women. 'Birth experience particularly occurs in a cultural context and is shaped by the views and practices of that culture' (Hoang & Kilpatrick, 2009, p.2). International evidence suggests that refugee women are particularly at risk of poor pregnancy outcomes and suffer higher rates of maternal complications such as gestational diabetes, post natal depression, birth complications, higher rates of Caesarean Sections, post partum hemorrhage and perineal trauma (Jentsch et al., 2007; Carolan, 2010; Murray et al, 2010; Gibson et al, 2010).

While there are specific details of the events that happened during birth, universal themes reported in the literature remain consistently vivid. These themes include control, pain and interaction with caregivers. These areas have been found to universally influence the satisfaction women have with their birth experience and can override issues such as age, socioeconomic status and medical interventions (Murray et al, 2010, p.459). Literature from African research participants highlighted and expanded the issue of control. Participants from one study felt a sense of 'fear, loneliness and not knowing during the birthing experience, as often they had no prior contact with the Australian health care system' (Murray et al, 2010). They also felt they had little or no knowledge of their rights in relation to standard treatment, hospital policies and the health education opportunities. All participants felt that what was happening in the hospital environment was not adequately explained to them (Murray et al, 2010).

A key focus of discussion and research regarding this topic were themes of access and experience of services. Limited access to services and late attendance for antenatal care is discussed in the literature as important issues for refugees, especially of a sub-Saharan background in host countries, including Ireland, Britain and Australia (Harris et al., 2006). Common barriers to effective access include: communication/language difficulties; limited health literacy; limited financial resources; and poor knowledge of services available to them (Carroll et al., 2007; Carolan, 2010; Murray et al., 2010; Phiri et al., 2010). Bulman and McCourt (2002) explain that many women who feel uncomfortable with services may choose not to attend appointments. This limited access and late attendance were also linked to poorer



neonatal outcomes, as well as the health implications for the mother (Bulman and McCourt, 2002). Hoang and Kilpatrick (2009) also point out that it is not only the lack of English skills but also the reticence in speaking out that affects communication between healthcare providers and migrant women, limiting their access to resources. Consequently, these women have fewer opportunities to receive the services they are entitled to. They are also less able to access health information and services available to the general population.

Continuity of care has also been raised in the literature in its ability to increase women's satisfaction, improve communication and enhance women's overall sense of control and ability to make informed choices (Correa-Velez & Ryan, 2011). In a number of different studies, women have encountered many different staff members during the course of their pregnancies and found it challenging and exhausting to try and explain themselves to each new staff member. Many women saw midwives as professionals with more clinical knowledge and experience than themselves, which made them shy and reluctant to question their plan of care (Murray et al, 2010). It is important to point out here that whilst women from culturally and linguistically diverse backgrounds (CALD) do not appear to be generally disadvantaged in their use of obstetric/antenatal services in Australia, they may simply not be aware of available services or have ready access to them (Germov, 2002). Sheik-Mohammed et al. (2007) adds to this point by explaining that in a study of 34 African refugee families, 32 interviewed were satisfied with the health care services they were provided. Of these women 31 preferred to be cared for by western health care systems and practices. 'Most studies however, report that refugees feel a sense of estrangement from Western health care systems and practices and a feeling of alienation was identified among African refugee women who accessed care at a large Melbourne Hospital' (Mater Mothers Hospital, 2009, p.20).

Post birth, the main health service accessed by women and their newborn children in the Australian context centres on a Maternal and Child Health model of care. In Victoria, this is a free service for all Victorian children under six assisting families in giving a child a good start to life. The service offers information and access to professional advice on child behaviour, nutrition, breastfeeding, family planning and an opportunity to identify any health and development issues (Department of Education and Early Childhood

Development, 2006). KPMG undertook an evaluation of the Victorian Maternal Child Health Services (MCHS) in 2006. They reported on the use and satisfaction of CALD people, including those of a refugee background. This evaluation found that the MCHS were substantially achieving their objectives as described above, for most Victorian parents and their children. The report did however find that 'MCHS were less accessible and less able to service its CALD client's base due to issues relating to language barriers and cultural responsiveness- resulting in clients discontinuing to use the service' (KPMG, 2006, p.49). This 'lower level of service utilisation and satisfaction of CALD families demonstrates that this population group are not receiving a level of service equivalent to that of the rest of the population' (KPMG, 2006, p.49).

A number of strategies and recommendations have been identified in the literature to address the issues relating to service access and antenatal/postnatal health and wellbeing needs of women and their families from migrant and refugee backgrounds. Broadly these recommendations include specific efforts to provide information and improve understanding of available health services (Carolan, 2010; Smith, 2006; Mater Hospital, 2009). 'Models of maternity care that offer a forum for communication and education can not only enhance women's understanding of antenatal and postnatal care, breastfeeding and child care, but also improve organisational cultural competency and awareness of what it means to be a maternity patient from a refugee background' (Correa-Velez & Ryan, 2011). The Mater Hospital in Queensland reviewed their services for women of a refugee background in 2009. They recommended and have now implemented a dedicated Refugee Maternity Service at the hospital. This service is staffed by a multidisciplinary team including a lead obstetrician, a midwife, social worker and interpreter for continuity of care (Mater Mothers Hospital, 2009). Carolan (2010) identified provision of centralised services as a strategy in her local Victorian research as an important issue for refugee-background clients. This approach was deemed to offer more specific interventions to meet the needs of the population group such as interpreter services and medical expertise. Other strategies identified in the research include extended appointment times, clustering of women in their language groups, education of all clinical and allied health staff across maternity services, provision of cultural competence training, translated information and appropriate referral

pathways between community nurses and GP's (Mater Hospital, 2009; Carolan, 2010; Smith 2006).

Whilst it is valuable to identify the research described above in relation to our topic area, it is important to note that they come with some methodological challenges. One challenge noted is a lack of clarity around defining different migrants on the particular visa they enter their new home country with (Rowe and Garcia, 2003; Gibson et al, 2010). For example, the health and wellbeing needs of those entering the country through skilled migrant visas are different to those who have been forced to leave their home country and have a well founded fear of persecution should they return to that country (refugee status) (Department of Immigration and Citizenship, 2010). Studies often deal with these groups as if they shared a single homogenous nature. They also fail to distinguish between those whose families have resided in a country for several generations and those who, under a range of circumstances have only recently arrived (Rowe and Garcia, 2003). Another challenge is generalising the data available to all women of refugee background. Cultural differences can contribute to misunderstandings between healthcare providers in the host country and migrant patients, and this can affect the quality and efficacy of the care provided (Hoang & Kilpatrick, 2009). It is important to note however that focusing simply on aspects of culture around beliefs and values can 'increase the risk of stereotyping patients and developing recipes of care that may not be in the best interest of the individual receiving care (Williamson & Harrison, 2010, p.762).' Clear, value free, open and respectful communication is fundamental in identifying and acknowledging the women's requirements when planning and providing care' (De & Richardson, 2008, p.40).

From the analysis of the research provided in this review, it is evident that there are a limited number of studies concentrating on the health needs of women from refugee groups, or on maternity provisions for them (Drennan and Joseph, 2005; Gibson et al, 2010; Jentsch et al, 2007). Although the studies that do concentrate on this population group provide valuable information, they are often limited in their generalisability due to their small sample sizes (Hoang & Kilpatrick, 2009). It is important to note however, that even though quantitative studies are scarce, the qualitative data from interviews and focus groups do provide valuable insights into issues that are relevant

to consider when assessing the need for maternity service reform and provision. They are also effective at providing the individual voice to maternity services (Gibson et al, 2010).

The underlying factors effecting access to services, as well as challenges in the provision of quality care mentioned in the literature above have not been systematically and comprehensively investigated (Jentsch et al.2007). Many of the studies analysed above have also involved participants originating from the sub/Saharan/African region. These issues add to the difficulties in generalising data for specific population groups. What is important however is an understanding of the refugee experience and what that means for service providers working with these groups and how they are quite different to other migrant groups. This is especially important considering the expectation that we will continue to have new and emerging refugee groups arriving in Australia.





## *Methodology:*

This study employed qualitative research design and data collection methods to explore the experiences of the refugee. Through qualitative methods, researchers can gain an insider's perspective, as participants present their lived experiences from their point of reference (Baum, 2008; Blaikie, 2009). Qualitative methods are flexible and well suited to understanding the experiences of vulnerable groups (Liamputtong, 2007; Schweitzer & Steel, 2008). Therefore, qualitative methods enabled this research to hear the voices of a group that are largely silenced by the dominant social order (Liamputtong, 2007). Furthermore, the varying levels of literacy among the sample population would have made it difficult to conduct a quantitative study, further justifying the selection of qualitative methods.

A steering committee was established with key stakeholders, including the Migrant Information Centre, Adult Migrant Education Service: Humanitarian Settlement Services, Eastern Health- Health Promotion Unit, Melbourne East General Practice Network, EACH- Clinical Services and Maternal Child Health- Maroondah. Members provided appropriate representation, exchange of ideas, valuable feedback and guidance in the development and implementation of research and support for the dissemination of findings. The Victorian Foundation for Survivors of Torture (Foundation House) were funded separately to provide a secondary consultation role to assist with networking, offer expertise and support with implementation and dissemination of findings.

The selection and piloting of key themes and interview questions for focus groups and interviews were carried out using a literature review and interviews with key informants. The literature review identified a number of similar focus groups and semi-structured interviews carried out with women from refugee backgrounds in relation to antenatal and postnatal health care. Review of these tools assisted in the development of questions before they were used with community members (Mater Hospital, 2009; Carolan, 2010; Smith, 2006). Piloting of questions took place with a female Chin Hakha interpreter who works in the Eastern Region and a local female Karen bi-lingual worker from the Migrant Information Centre. Questions and themes for health professionals were reviewed and tested by steering committee members, other local midwives and maternal child health nurses.

Recruitment of women from refugee backgrounds was undertaken through purposive sampling undertaken in partnership with the Migrant Information Centre's Women's Groups and specific invitations. Recent research in the refugee health field highlights the use of people known to potential participants in the engagement and recruitment process as a culturally competent and well established strategy (Eide & Allen 2005; Gibbs et al. 2007; Keyzer et al. 2005). It is also argued that women who are approached by someone unknown to them can increase the likelihood of coercion. This population group are more likely to express their opinions and feel comfortable in declining to participate in any activities when they are approached by someone that they know (Gifford et al. 2007). Recruitment of health service providers were undertaken through the acceptance of an invitation to participate from the principle researcher of the project.

Ethics was obtained from the Department of Health's Ethics Committee (06/11) and conformed to the 'National Statement on Ethical Conduct in Human Research'. All participants gave informed consent and anonymity was maintained in collated findings.

# Results and Discussion:

## *Participant Background*

There were a total of 42 women from refugee backgrounds that participated in eight focus groups and two interviews. Women were from Hakha Chin, Karen, Matupi, Zomi, Tidem, and Sudanese backgrounds. On average, the majority of women interviewed had settled into the outer east (predominately living in Ringwood, Croydon and Mooroolbark areas) over two and half years ago, with settlement dates ranging from as recently as two months to six years. Apart from women who came from Sudan (who have been living in the area the longest), all other participants were originally from Burma and had been either living in refugee camps in Thailand; had fled to Malaysia/India before arriving in Australia; or had arrived under the split family provision directly from Burma. The continuing human rights abuses in Burma means that many people are forced to flee to a neighbouring country to find safety and food security. The decades of military rule has resulted in severely compromised provision of health and education services (Robson, 2011). As depicted in the range of ethnic groups involved in the consultation, there are many ethnic minorities from Burma. In the outer east, the two most common groups are either Chin or Karen backgrounds. Although there are some cultural similarities, including collective societal structure with an emphasis on family, there are also a number of differences. Neither groups are homogenous, with both the Chin and Karen cultures speak many different dialects. It is also a misconception that all people from Burma are able to speak Burmese. Speaking and understanding English was also very limited for most participants. Understanding these critical communication points has large implications for the provision of culturally appropriate service delivery and access to accurate language services (Robson, 2011). In relation to child birth, almost all participants had given birth to one child in Malaysia, Burma or Sudan and had also given birth to one or more children at either the Box Hill or Angliss hospitals within Eastern Health.

A total of 34 health service providers and key informants participated in four focus groups and five interviews. All professionals work in the outer east and included midwives, maternal and child health nurses, lactation midwives, general practitioners, a female Chin interpreter and a teacher well known to the Burmese community.

The following sections outline the major themes that emerged from the analysis of all focus groups and interviews. The four major themes that emerged from the data provided by mothers from refugee backgrounds were: communication, antenatal education, postnatal care, and cultural practices. The main themes identified by the local health service providers also included communication, along with referral pathways-continuity of care and professional development. For each section there is discussion on aspects of the experience that were positive and aspects detailing areas for system improvement. Although the findings have been categorised into themes, it is also important to note the overlapping and interrelated nature of the data provided.

## *Findings and Discussion from Mothers of Refugee Backgrounds:*

### *Communication:*

The most prominent theme regarding access and experience of antenatal and postnatal care centred on *communication*. Positive experiences and access to services were related to the level of understanding gained through the information provided by the health services. When there was access to accredited interpreters of the correct dialect and medical concepts could be interpreted, women felt less anxious and reported a better understanding of the procedures and care provided. There were many instances where the appropriate access to accredited interpreters had taken place and therefore the effectiveness of communication between client and health professional occurred. It also meant that significant health issues could be identified and addressed as explained below:

*"They found out I had diabetes, and I was glad I am here. In Burma you do not get this and it was probably why I was very sick with my first baby"*

Many women also expressed gratitude in the way some service providers, particularly nurses, were conscious of the use of their vocabulary and body language to communicate:

*"For some of us that have been here a few years we have 'everyday English' and when the nurses speak slowly to us and use their hands we can understand so much more. It is so much better than those who speak very fast and or speak about us when we are in the room"*

On a number of occasions when there was a communication breakdown (often due to a lack of an accredited interpreter available) there were increased feelings of anxiety and an inability of the woman to communicate their needs at the time, such as pain.

Many participants explained that an accredited interpreter was not always available for them at antenatal appointments, during the birthing experience, when completing consent or information forms, or during the initial home visits undertaken postnatally. In a number of cases, the accredited interpreters booked spoke a different dialect to the client or who were not familiar with relevant medical terminology:

*"I would have liked a better interpreter because sometimes the medical meanings were missing or I was confused with what they meant".*

*"The first time I was asked if I wanted an interpreter but I thought because I had a little English I should say no. I did not realise that a lot of information I did not understand and then I felt embarrassed and did not ask for one after that, but it would have been good".*

*"When I had a cesarean I did not have an interpreter. I was by myself in the room with the doctor and nurses. I would have liked one there, especially to explain all the anaesthetics things and what was going to happen, actually for many things".*

*"It was hard sometimes to understand nurses after the baby was born so I just smiled".*

*"For me I was overdue, so I went by myself to the hospital and they gave me medication. I think it was for the pain but I was not really sure".*

It is well highlighted in the literature that it is not only the lack of English skills but also the reticence in speaking out that affects communication between health care providers and women from refugee or migrant backgrounds, limiting their access to resources. Consequently this can lead to fewer opportunities to receive the services that are available to the general population (Hoang & Kilpatrick, 2009).

Literature states that professional accredited interpreters improve clinical outcomes for patients with limited English proficiency (Karlner, Jacobs, Chen, & Mutha, 2007). Accredited interpreters are equipped with technical, clinical and lay knowledge, and therefore, they ensure effective communicative transactions between patients and physicians. Improved patient comprehension has been associated with increased consent for testing, attendance at follow-up appointments, and adherence to recommended treatments (Angelelli, 2004; Karlner et al., 2007). Subsequently, using interpreters is correlated with enhanced health outcomes, and therefore it is necessary to ensure that patients with limited English proficiency have access to interpreters as a means of providing equitable care. It is important to note that due to the recent arrival of the Burmese community in Victoria and the eastern region, there is a lack of accredited interpreters available and this creates difficulties for health service providers.

### ***Antenatal care and education:***

The second theme evident in the focus group discussions encompassed *antenatal care and education*. This included whether the women involved in the research were informed or aware of the process involved with having a baby in the Australian hospital system. Many women specifically commented on how fond they were of the frequent antenatal appointments throughout pregnancy as well as home visits from the hospital and maternal child health nurses (when an interpreter was present).

*"The nurses really looked after you"*

*"It was great to have regular checks to see how the baby was growing and if it was healthy"*

While there were some positive reflections, it was clearly evident in the focus group discussions that the majority of women had minimal or no exposure to any formal hospital based antenatal care. The majority of women did not attend any antenatal classes, yet when these classes were identified and explained, most were very receptive to the idea of them, especially if an accredited interpreter were to be present along with some basic translated material. This was also echoed in the consultation with the refugee health nurses, midwives, GP and maternal child health nurses. In a handful of cases, where the women felt they had a little English and attended the antenatal classes run through

the local maternity hospital, all had reported that there was some very helpful information presented, however felt they could only understand a small amount of the content.

*"When we got all the information and we gave it to our friends to tell us about what we need to bring and what is going to happen here, but they don't understand all the words".*

*"Sometimes I feel like there is too much information and not sure what is going to happen, even after the baby is born. It would be very good to have it in our language".*

*"More education about the caesarean would have helped. In Burma, when someone has a caesarean, the doctor or nurse tells them what to do and what to lift and not to lift. Here no one told me what I should do or not do".*

*"When I was pregnant there was no one to tell me which foods I should eat, which I should not eat. No one told me anything about how to look after myself before and after the baby and what was going to happen after I had the baby".*

A number of previous studies undertaken with women from refugee backgrounds have also indicated the need for adequate education programs for women regarding antenatal and postnatal care (Correa-Velez & Ryan, 2011). Participants from previous studies felt they had little or no knowledge of their rights in relation to standard treatment, hospital policies and the health education opportunities (Murrey et al, 2010).

In a similar Victorian research project exploring the Afghan experiences of mothering in 2010, the majority of participants involved had indicated that they initially accessed the Australian health system for antenatal care under the direction of a previously settled Afghan community member. This community member assisted them with understanding and navigating the process, as it was in stark contrast to the process in Afghanistan. It is evident that an introduction to a local hospital or general practitioner would benefit these women (Russo, 2011).



### *Postnatal care:*

The area specifically surrounding *postnatal care* was another theme that emerged from the qualitative data. This included access to Maternal and Child Health Services (MCHS), to other postnatal services where applicable and a keen interest to join community play groups with other women who spoke the same dialect. Overall it was the access to local, regular, low cost or no cost services where the health of the baby and mother are regularly monitored which were strongly acknowledged in the discussions.

Many women were very happy with the care that they received from MCHS and were appreciative of the routine care provided to their babies and children. When asked about the role of MCHS, the majority of women explained that the service involved monitoring the health (including the growth and development) of their babies or children. Where it was applicable to respond, the majority of women had utilised the service regularly for the first four years of their infants' life. With regard to the 'maternal' component of care, few women were aware that the service was also there to assist their postnatal health care needs. Those that were aware spoke of the beneficial referrals to physiotherapy for their pelvic floor muscles and education with breastfeeding. The major barrier identified was based around communication, including language difficulties, lack of translated material provided and cultural responsiveness to issues surrounding co-sleeping. On a number of occasions an interpreter was not present at the home visits by domiciliary nurses or maternal child health nurses, despite the needs of the mother. In some instances, a family member or partner was home, however this was not always the case. In those cases where they did have their partner home, women had felt there was minimal discussion occurring and some of the conversations were lost in translation.

*"They tell us very good advice about how our children are going".*

*"I had very sore nipples and could not feed my baby and then on my next check up for the baby the Maternal Child Health Nurse, the nurse saw and helped me to go to doctors to get medicine straight away"*

This lady was unaware that she could have contacted the nurse through an interpreter to see the nurse about her sore nipple. She was also unaware of the lactation clinic at the Box Hill Hospital.

The KPMG evaluation of the Victorian Maternal and Child Health Services (MCHS) in 2006 found that the program was less accessible for women from CALD backgrounds due to language and cultural barriers. While this research is unable to comment on the overall usage pattern, the women were receptive to the maternal child health nurses with the barriers again centred on the theme of communication as outlined already in this results section.

One of the postnatal service gaps identified by the women was the need for more social support that could not only assist in the social and language development of the mothers but also assist in the cognitive and behavioural development of their children. The following quote illustrates this need:

*"We have lots of babies up to two years at home by ourselves and we are getting bored and depressed, this is not good. We would like some sort of playgroup once a fortnight. This could also help us with English speaking and give our babies songs and activities to do too. We could practice these activities at home with them and help them get ready for school".*

There is a well-established association between depression and social support (Cox, 1996) and these women were able to identify this area as something that would be of benefit to themselves and their families. Further exploration into the type of support models that could be implemented for these mothers in Australia is needed. This could involve exploring the feasibility of ethno-specific 'mother groups' and support for the continued practice of post-birth celebrations.

### *Cultural practices:*

Much of the research undertaken since the 1970's has indicated fairly rapid acceptance of the host nation's practices in the area of childbirth and it has often been related to economic imperatives. This research specifically identified that some women did follow certain cultural practices which they felt were important to vocalise and explain, yet others were happy not to follow any or adapt them in some way to suit their needs and desires. Throughout the discussion on culture, the women's contentment during their antenatal and postnatal period of care was largely dependent on the opportunity provided or the comfort they felt to speak out or act on these cultural practices if they wished to do so. The cultural practices that were commonly followed in the antenatal period included a strong dislike of consuming cold water.

*"We feel that cold water relaxes the baby and it will slow down contractions".*

*"We think that cold water makes the baby shiver and could give it and me a cold".*

Some women wanted it emphasised that the experience of pain can differ and that this needs to be recognised by health professionals:

*"For us, even if is very painful, we stay very quiet and do not scream. It is shame to scream. This is why we stay quiet- so many times nurse is not aware of our stage of labor"*

One concerning theme that emerged was that some women had been encouraged not to comfort their infant when they were crying and that it seemed to them as though this reflected a cultural practice difference between Australia and their country of origin:

*"Culturally we hold the baby when they cry".*

*"I was told to leave the baby and not pick it up when it cried. I was not happy to leave it cry".*

One common area discussed within the focus groups was the role of husbands. Some women were insistent that they should not be present during delivery, other women were receptive to having their husbands involved, while some were ambivalent.

Another area where there was diversity in opinion was related to co-sleeping:

*"We like to sleep all together with the children. This is how we slept in the camps and also in the village".*

*"Here nurses says not to sleep with the baby because it won't be able to breath and could die. In our culture, we know how to grow up our children".*

The literature discussing co-sleeping is equivocal; there are no well-established findings to endorse or discourage this practice (Blair, Sidebotham, Evason-Coombe, Edmonds, Smith & Fleming, 2009; McKenna & McDade, 2005). Therefore, whether women conform to Australian 'standards', or continue the practices that are common in their culture is not the issue. Ambivalent findings make this issue benign and there is no clear evidence of risk for either approach. More important than the sleeping arrangement is the issue of supporting women to make their own choices.

This aspect of choice is the common element across all aspects of cultural practice. The diversity within these findings demonstrates that women from similar ethnic and cultural backgrounds must not be considered a homogenous group. Whilst a large proportion of participants indicated that they comfortably and willingly comply with the recommendations of the nursing or maternal staff, other participants have indicated they feel unsupported in their decision to continue the practices of their first culture. Feeling pressured to unwillingly adopt aspects of a second culture is likely to cause culture conflict. This has the potential to place stress on the individual, which is correlated with mental health issues including anxiety and depression (Berry, 1989). Health staff must respond to the unique and individual needs of women from CALD backgrounds and support them in either practicing their cultural norms, or adopting the ways of their second culture accordingly. Literature identifies cultural competence as being comprised of an awareness of one's own cultural position, a knowledge and understanding of cultural differences, and skills to effectively interact with individuals from different cultures (Gow, 1999; Van Hoover, 2003). Cultural competence is therefore integral to quality, appropriate healthcare provision, and the findings of this research suggest that health staff need to have an understanding of different cultural practices and be cognisant of the need for women to choose which practices they would like to follow.

## *Findings and Discussion from Health Service Providers:*

### *Communication:*

Communication also emerged as a prominent theme with health providers, as it had been with mothers from refugee backgrounds. The issues raised around communication were comparable to those expressed by the mothers involved in the research, while others were relevant to the care provisions of health service providers. Many health care providers had found that a number of medical terms had been difficult for the accredited interpreters to explain, evident through client confusion. This issue created concern amongst the health providers from both a professional accountability perspective and uncertainty of how much information their clients had understood. This difficulty seemed to occur more often with newly arrived communities, including clients who spoke Burmese and dialects such as Hahka Chin, Karen and Matpui, as depicted in the quotes below:

*"We have some really technical words that need to be interpreted and often the interpreter does not know the words in their language".*

*"It is really evident that medical terminology needs to be taught to the interpreters to support them further in their roles and therefore provide better outcomes for the clients".*

Another difficulty experienced by both midwives and maternal child health nurses was the use of family interpreters in a number of situations when an interpreter was not present. This was particularly noted as an issue during the first 48 hours of care post birth, during which there are many occasions when communication is integral to care and it is not feasible for an interpreter to be present for the entire duration, if available at all. On many of these occasions, there was an increase in the use of family or friends as interpreters. The use of a family member to interpret was also common during first time home visits by the domiciliary nurse from the hospital or maternal child health nurse. Use of a family

member as an interpreter can result in concerns about the effectiveness of information and communication exchange between clients and health care providers. The following quotes illustrate some examples:

*"The difficulties are that we can't always access interpreters. Sometimes they don't turn up and we are guessing a lot of the time"*

*"This happens often (use of family interpreters), especially if the woman is in labour in the middle of the night- you just don't have exact time frames and it is difficult to know what time you need an interpreter to book one".*

*"Sometimes it can take a while to get an interpreter. Often one of the family members who speaks a little bit of English are the ones that interpreter for the women"*

*"In one example we thought that the woman would need an emergency caesarean as the baby was in foetal distress. We couldn't get consent from her due to her limited English and the husband did not want to give consent. They were confused. So we really had no way of communicating with the woman and it was a decision we needed to make then and there. As it turned out the baby's heart rate improved and the women gave birth naturally"*

Evidence suggests that trained and accredited interpreters were 70% less likely to have errors than those untrained and commonly known to the client. The likelihood of medical errors specifically, increased with the length of the concept and decreased with the provision of vocabulary (Gany et al, 2010)

In all the discussions surrounding complexities or difficulties experienced by providers, successful strategies of service provision that could be implemented were also identified. One strategy included the block booking (where it was possible) of women who spoke the same dialect. Other strategies identified were dependent on availability of more resources:

*"I think we really just need to give them (women from refugee backgrounds) more time".*

*"A pm clinic would be great or even double/triple appointments if we had the resources".*

One of the most vocal strategies echoed across all disciplines involved in the research was the need to expand on the provision of tested visual aids/ resources specifically designed for antenatal and postnatal care and easier access to appropriate translated material. Many health care providers felt that the advantage of visual resources was their ability to be used with any language groups and their flexibility to aid in communication between the client and health care provider in cases where an interpreter is not present. Comments reflecting these issues include:

*"I think it would be really useful to have flash cards for common concepts we need to communicate to the women about while they are here in our care".*

*"Visual resources explaining basic concepts would be a great way to communicate with any language".*

*"Having diagrams can often make it a lot easier to explain something, even with an interpreter".*

A number of health care providers highlighted the gap in availability of relevant translated material to provide to clients of refugee backgrounds. In some maternity wards, folders had been collated with relevant material and providers were advocating for an expansion of these including the suggestion that they should be made electronically available for staff.

*"It's not about reinventing the wheel, it's about finding out what is out there are and making it as easily as possible to access".*

## *The referral pathway (system review) and continuity of care*

The overlapping nature in the findings of this research was evident in the discussion surrounding referral pathways, specifically continuity of care and communication. The strategies identified by many health professionals to assist in improving communication during the period of antenatal and postnatal care include both system reviews and provision of resources.

The strategies reviewed revolved around procedures that provide communication with other services and enhancing referral pathways. One such example involved the process of sending birth notices from the maternity unit to the maternal and child health services. On many occasions, MCHN's received the notice identifying that an accredited interpreter was required, however there was no further information regarding the dialect spoken. This then created difficulty in booking an accredited interpreter to be present during the first home visits. Many MCHN's then needed to find other means to aid communication, which often meant asking if a partner, family or friend would be present at the time of the visits. Another suggestion focussed on enhancing communication between the initial General Practitioner, shared care visits to antenatal and postnatal services ensuring improvement of client information between services.

*"In many cases we receive minimal information regarding the client's history from General Practitioners".*

*"Discharge information can be limited. It is such a rush; we could do this a lot better".*

One of the roles of the refugee health nurse (RHN) here in outer east (as in many areas across the state) is the completion of a refugee health assessment that is undertaken within four weeks of a clients arrival and works through a number of social and medical questions. A report is produced with this assessment to highlight the main social and medical areas that need referral of follow up with either a GP or other allied health service providers. The explanation of the RHN's role and initial health assessment had promoted great interest and discussion with the health providers. There was a mixture of providers who were aware of the role and the assessments and others that were not familiar. It was suggested by many midwives and MCHN's (if it is not already common practice) for the refugee health assessment and report to be included in all referrals from GP to maternity hospital and maternity hospital to MCHN's.

## Findings: Results and Discussion: continued

Continuity of care was another strategy raised by many health service providers, especially regarding antenatal and postnatal care in hospital:

*"It would be great for them to see the same midwife through their antenatal period and the dream would be during birth as well and really be able to develop that trust and rapport".*

*"You can see this in a couple of shifts you have with the same patient- they are willing to use the little language we share to say whatever there is they need to say. When you meet them for one shift- this just does not happen".*

*"It would be great to have designated midwives working with women of refugee backgrounds. I think interpreters would then be used in a more beneficial way and the midwife would be more interested an empathetic"*

*" The refugee women that the special maternity services area see provides the women with more time and continuity of care"*

Current research has highlighted the increased satisfaction, improvement of communication and the enhancement in a women's overall sense of control and ability to make informed choices when there is continuity of care (Correa-Velez & Ryan, 2011).

## Professional development

There was overwhelming support and interest for professional development in relation to caring for women from refugee backgrounds, especially if this could be built into the policies and practices of the service area, to ensure sustainability.

*"Professional development would be really great, we really need it, it has been so long".*

*"We need the practical tools to communicate with women on the ward- visual cards and translated information. This goes hand in hand with professional development".*

*"It's all about breaking down the barriers, especially if you have not had much experience with looking after women from Burma".*

*"I think we need to be reminded that care needs to be women centred, we need to support individual choices. It's not really about what country they come from"*

*"We want to be more respectful of cultural differences rather than feeling a bit bias about it- if I can say it that way"*

The majority of health service providers involved in the research felt that professional development would assist them in further improving the care of women from refugee backgrounds. Evidence suggests that sustainable professional development such as regular cultural competency training incorporated into policies and procedures improves knowledge, attitudes and skills of health professionals as well as having an impact on patient satisfaction (Correa-Velez & Ryan, 2011). It is important to note however that there is a danger of focusing on the cognitive aspects of culture as this can 'increase the risk of stereotyping patients and develop recipes of care that may not be in the best interest of the individual receiving care' (Williamson & Harrison, 2010, p. 761). Professional development is suggested to be more effective if it incorporates a broader understanding of culture and emphasises an individual's social position and choices as important contributions to clients health and wellbeing outcomes (Correa- Velez & Ryan, 2011). Eastern Health provides specific cultural and language education sessions on request for staff and also has visual Cue Cards to assist with communication.

# Recommendations:

## System review

1. Investigate provisions for health service orientation that focuses on antenatal and postnatal services in the outer east. The Australian health system starkly contrasts any health services available within Burma or Sudan and therefore women arrive in Australia with no perception of what is available to them and are unaware of what to expect. In many occasions, women are relying on members within the community to inform, orient and in many cases interpret for them within the current system. Where appropriate, the provision of this orientation within settlement areas could ensure all families are aware of the services available to them and more accurate information can be provided. Exploration of strategies that encourage newly arrived women from refugee backgrounds to seek advice provided by settlement services that offer support and orientation in this area may be one strategy.
2. Ensure that birth notices sent to services such as Maternal and Child Health Centres are completed with details of all languages/dialects spoken by the client.
3. Where appropriate and relevant, increase comprehensiveness of social and medical history of clients from refugee backgrounds when referring them (or discharging) to both antenatal and postnatal services, this may include the Refugee Health Assessment and report.
4. Explore feasibility of providing women from refugee backgrounds with an increase in continuity of care, especially within the antenatal and postnatal care in the maternity hospital. This may include referring them into the Specialist Maternity Services (SMS) provided within Eastern Health.
5. Investigate opportunities (where relevant) to refer women from refugee backgrounds into the regional 'Healthy Mothers, Healthy Babies' program. This program aims to improve the health and wellbeing of mothers and their babies by working with pregnant women and local antenatal and postnatal services regarding both access and education.

## Communication

1. Review the policies and procedures associated with accredited interpreter use in all antenatal and postnatal services in the outer east to ensure effective communication is provided to women of refugee backgrounds
2. Explore avenues to provide medical terminology training for accredited interpreters working with newly arrived refugee communities.
3. Explore options for developing visual communication resources specifically designed to support antenatal and postnatal care.
  - 3.1. Explore feasibility of further expanding the Eastern Health Cue Cards to incorporate medical terminology in regards to antenatal and postnatal concepts and care where required and in consultation with key stakeholders
  - 3.2. Investigate avenues to increase access to relevant electronic translated documents and/or links to documents for local maternity antenatal clinics and postnatal wards.

## Antenatal Education

1. Identify avenues to run antenatal education classes for women of refugee backgrounds with the involvement of an accredited interpreter and translated material where appropriate.

**Option a:**  
Explore potential to run smaller classes within the maternity hospitals

**Option b:**  
Explore potential to run antenatal classes within the community environment, such as community or not for profit organisations that already have classes available in English, ensuring use of accredited interpreters, were required.

**Option c:**  
To provide a partnership of English language classes and perinatal support classes in the same venue or in close proximity to allow women to access both simultaneously.

### *Postnatal Support*

1. Further exploration into feasibility of increasing local ethno specific 'mother groups' that incorporate strategies for not only improving cognitive and behavioural development of the children, but also provide postnatal support and English language practice for mothers. There are currently two playgroups now running in the outer east (Ringwood and Mooroolbark), however it is recognised that they need to increase in number.

### *Professional Development*

1. Increase provision where required and review the cultural competency training for health service providers working within the antenatal and postnatal services in the Outer East. Findings of this research suggest that this training should be focused on building staff capacity to respond to the unique needs of clients at an individual level, reinforcing that cultural groups are not homogenous. Regular sustainable training should promote upholding the value of choice, particularly when working with potentially vulnerable clients. Staff should understand the benefits of supporting CALD clients within their decisions to continue cultural practices, or adopt Western models, as directed by them. The Migrant Information Centre offers such training as part of their professional development.

# References:

- Agier, M. (2008). *On the Margins of the World: The Refugee Experience Today*. Polity Press. United Kingdom.
- Bollini, P., Pampallona, S., Wanner, P., Kupelnick, B. (2009) 'Pregnancy outcome of migrant women and integration policy: A systematic review of the international literature', *Social Science and Medicine*, (68): 452-461
- Bulman, K & McCourt, C. (2002) 'Somali refugee women's experiences of maternity care in west London: A case Study', *Critical Public Health*, (12): 365-380
- Carolan, M. (2010) 'Pregnancy health status of sub-Saharan refugee women who have resettled in developed countries: a review of the literature', *Midwifery*, (26): 407-413
- Carroll, J., Epstein, R., Fiscella, K., Gipson, T., Volpe, E., Jean-Pierre, P. (2007) 'Caring for Somali women: Implications for clinician-patient communication', *Patient Education and Counselling*, (66): 337-345
- Clinton-Davis, Y., & Fassil, Y. (1992). Health and social problems of refugees. *Social Science and Medicine*, 35(4), 507-513.
- De, D., & Richardson, J. (2008) 'Cultural safety: An introduction', *Paediatric Nursing*, 20(2): 39-44
- Department of Immigration and Citizenship (DIAC) (2010) Settlement in the Eastern Region by Migration Stream 2009-2010, Retrieved February 14th 2011, <[http://www.immi.gov.au/settlement/#sr=show\\_report](http://www.immi.gov.au/settlement/#sr=show_report)>
- Department of Immigration and Citizenship, 'Visas Immigration and Refugees', Retrieved 14th February, 2011, < <http://www.immi.gov.au/visas/humanitarian/>>
- Eide P, Allen C (2005). 'Recruiting Transcultural Qualitative Research Participants: A Conceptual Model'. *International Journal of Qualitative Methods*, 4:1-10
- Gagnon, A., Dougherty, G., Platt, R., Wahoush, O., George, A., Stanger, E., Oxman-Martinez, J., Merry, L., Stewart, D. (2007) 'Refugee and Refugee-claimant Women and Infants Post-birth', *Canadian Journal of Public Health*, 98(4): 287-291
- Gany, F., Gonzalez, C., Basu, G., Hanson, A., Mukherjee, D., Datta, M., Changrani, J. (2010) 'Reducing Clinical Errors in Cancer Education: Interpreter Training', *Journal of Cancer Education*, 25: 560-564
- Gibson, K., Attraya, A., Bennett, S., Brook, A., (2010) 'Maternity Care Service Provision for Women from Refugee Backgrounds Victoria', Working Group Brief for Departments of Health and Human Services: 1-63
- Harris, M., Humpheries, K., Nabb, J. (2006) 'Asylum seekers: delivering care for women seeking refugee', *RCM Midwives Journal*, (9): 190-192
- Hoang, H & Kilpatrick, H. (2009) 'Having a baby in a new land: a qualitative exploration of the experiences of Asian migrants in rural Tasmania, Australia', *Rural and Remote Health*, (9): 1-11
- Hollowell, J., Oakley, L., Kurinczuk, J., Brocklehurst, P., Gray, B. (2011) 'The effectiveness of antenatal care programs to reduce infant mortality and preterm birth in socially disadvantaged and vulnerable women in high-income countries: a systematic review', 11(13): 1-20
- Correa-Velez, I., & Ryan, J. (2011) 'Developing a best practice model of refugee maternity care', *Women and Birth*: 1-10
- Earnest, J., Joyce, A., de Mori, G., & Silvagni, G. (2010) Are universities responding to the needs of students from refugee backgrounds? *Australian Journal of Education*, 54(2), 155-174
- Gibbs L, Abebe M, Riggs E ( 2010). Preventing Childhood Obesity. Chapter 32: Working with minority groups in developing countries. Blackwell publishing. pp:276-282.
- Gifford, S. M., Bakopanos, C., Kaplan, I., & Correa-Velez, I. (2007). 'Meaning or measurement? Researching the social contexts of health and settlement among newly-arrived refugee youth in Melbourne, Australia'. *Journal of Refugee Studies*, 20(3), 414-440.
- Green J, Waters E, Haikerwal A, O'Neill C, Raman S, et al. (2003). 'Social, cultural and environmental influences on child activity and eating in Australian migrant communities', *Child: Care, Health and Development*, 29:441-8
- Jentsch, B., Durham, R., Hundley, V., Hussein, J. (2007) 'Creating consumer satisfaction in maternity care: the neglected needs of migrants, asylum seekers and refugees', *International Journal of Consumer Studies*, (31): 128-134
- Joyce, A., Earnest, J., de Mori, G., & Silvagni, G. (2010) The Experiences of Students from Refugee Backgrounds at Universities in Australia: Reflections on the Social, Emotional and Practical Challenges. *Journal of Refugee Studies*; doi: 10.1093/jrs/feq001
- KPMG (2006) 'Evaluation of Victorian Maternal and Child Health Services- Department of Human Services Early Years Services Office of Children':1-153
- Mater Mothers Hospital, (2009) Refugee Maternity Project, Mater Misericordiae Health Service Brisbane Limited: 1-25
- McDonald, B., Gifford, S., Webster, K., Wiseman, J., & Casey, S. (2008). *Refugee Resettlement in Regional and Rural Victoria: Impacts and Policy Issues*. Vic Health. Retrieved 15 April, 2011, from [www.mccaugheycentre.unimelb.edu.au](http://www.mccaugheycentre.unimelb.edu.au)
- Murray, L., Windsor, C., Parker, E., Tewfik, O. (2011) 'The experience of African women giving birth in Brisbane, Australia', *Health Care for Women International*, (31): 458-472
- Omeri, A., Lennings, C., & Raymond, L. (2006). Beyond Asylum: Implications for nursing and health care delivery for Afghan refugees in Australia. *Journal of Transcultural Nursing*. 17 (1) 30-39
- Phiri, J., Dietsch, E., Bonner, A. (2010) 'Cultural safety and its importance for Australian midwifery practice', *Collegian*, (17): 105-11
- Rowe, R. & Garcia, J. (2003) 'Social class, ethnicity and attendance for antenatal care in the United Kingdom: a systematic review', *Journal of Public Health Medicine*, (25): 113-119
- Russo, A (2011) Exploration of Afghan women's experiences of mothering. Health Social Science Honours Thesis.
- Silove, D. (2002). The asylum debacle in Australia: a challenge for psychiatry. *Australian and New Zealand Journal of Psychiatry*, 36, 290-296.
- Sinnerbrink, I., Silove, D., Manicavasagar, V., Steel, Z., & Field, A. (1996). Asylum Seekers: General Health Status and Problems with Access to Health Care. *Medical Journal of Australia*, 11(12), 634-7.
- Smith, M. (2006) 'Refugees in Australia: changing faces, changing needs', *Medical Journal of Australia*, (185): 587-588
- Stein, B. (1981). The refugee experience: defining the parameters of a field of study. *International Migration Review*, 15(1), 320-330.
- Thomas, P, Beckman, M., Gibbons, K. (2010) 'The effect of cultural and linguistic diversity on pregnancy outcome', *Australian and New Zealand Journal of Obstetrics and Gynecology*, (50): 419-422
- Williamson, M., Harrison, L. (2010) 'Providing culturally appropriate care: a literature review', *International Journal of Nursing Studies*, 47: 761-9

# Appendix A

## Focus group/ interview questions

### Focus Group Questions for Community Participants

An overview of the project, together with the Participant Information and Consent Form will be carried out and completed prior to commencement of group discussion.

#### 1. Introductions:

- 1.1 Facilitator to introduce themselves and as a way of getting to know each other will share how long they have lived in Australia and the Eastern Region, how many babies they have had.
- 1.2 Facilitator will then ask participants to introduce themselves by addressing: amount of time they have lived in Australia/East and number of babies they have had and if they had them here and or overseas.

#### 2. Identifying the antenatal and postnatal services used in the Eastern Region- including referral pathways and identify their strengths, areas of improvement and barriers to access.

- 2.1 When you were pregnant which health services did you see (use)? (Here in the Eastern Region)
- 2.2 When you gave birth to your baby, which health services did you see (use)?  
*(PROMPTS: local doctor, hospital, community health service)*
- 2.3 How did you know where to go and how did you get there?  
*(Prompts: Was transport an issue? / Communication/ making an appointment/ feelings at the time, role of community guide or case manager in assisting you)*
- 2.4 How did you feel about the care you received at these services?  
*(Prompts: Interpreter access/communication, information given about labour, instructions given, specifically during and after the birth of the baby, staff care, awareness of process involved)*  
*(If participants find this open ended question difficult to answer, ask the more specific questions listed below)*
  - What did you like about these services?
  - Did you experience any difficulties with these services? (Prompt: Medications, treatment, immunisation)
  - Is there have been anything else that would have helped you when using these services?
- 2.4 Since your baby has been born, who have you seen to help with the care of your baby?  
*(Prompt: Tell me about the help you got after the baby was born- who was it from? Maternal Child Health Service/nurses- how long to they use this service for and are they able to access it, community health, local doctor)*
- 2.5 How did you find out about these services and how did you get there?  
*(PROMT: Was transport an issue?)*
- 2.6 How did you feel about the care you were provided at these services?  
*(If participants find this open ended question difficult to answer, ask the more specific questions listed below)*
  - What did you like about these services?
  - Did you experience any difficulties with these services?
  - Is there have been anything else that would have helped you when using these services?*(PROMTS: Communication/interpreter access, information given, instructions, appointments medication, immunisation)*

#### 3. Identifying culturally specific antenatal and postnatal practices and needs of women from a refugee background.

- 3.1 What is the experience of being pregnant and giving birth to a baby in the country you are from?  
*(Prompts: Does anything change when you find out you are pregnant? Do you see any health professionals? Where do you have the baby? What is the role of the husband/mother/grandmother? Religious practices, rituals after during and after the birth)*
- 3.2 (For those women who have given birth in Australia and overseas)  
How do you find the differences of giving birth overseas and giving birth here?
- 3.3 How do you feel about these differences?
- 3.4 After a baby is born overseas, how do women keep themselves and their baby healthy?  
*(PROMTS: Signs of good health, food, staying indoors, physical activity, mastitis, tearing-wound)*

#### 4. Recap main objective- linked to headings of focus group questions

- 4.1 Was there anything else you would like say?

#### 5. Recap next steps as identified in consent form and ask permission to return for a follow up discussion on the findings and final suggestions that will be given to the service providers.

#### 6. Thank participants for their time and input- gift card as token of appreciation and effort will be handed out.

## Focus group and Semi-structured interview questions for Health Professionals and other stakeholders/key informants

An overview of the project, together with the Participant Information and Consent Form will be carried out and completed prior to commencement of group discussion.

### 1. Introductions

- 1.1 Facilitator to introduce themselves, work role and responsibilities and length of time they have been working in the area.
- 1.2 Participants asked to introduce themselves, role/specific area of work at the service, duration of time they have worked there.

### 2. What experiences have you had in working with women of refugee background at your service/ward/clinic?

### 3. What difficulties have you encountered or perceive to be an issue for population group in relation to access and their level of experiences at the service?

*(Prompt: Communication/interpreters, information provided, instructions, birthing, supports)*

### 4. What strategies have you found to be helpful for women of a refugee background in relation to their access, care and experiences at the service?

*(Prompt: Communication/interpreters, translated material referral to other services- MCH, family support, antenatal education)*

### 5. Do you feel adequately educated in providing services to meet the needs of women from a refugee background?

- 5.1 Would you be interested in additional professional development opportunities in relation to the provision of antenatal and postnatal care for women from a refugee background?

*(PROMT: What training would be useful?)*

### 6. What strategies do you feel could be provided to assist you and your service in meeting the needs of women and their families who come from a refugee background- within the current system and budget?

### 7. What strategies do you feel could be provided to assist you and your service to meet the needs of women and their families who come from a refugee background- if there were further resources provided?

### 8. Are there any other issues, comments or suggestions you would like to add regarding this topic area?

### 9. Recap next steps as identified in consent form and ask permission to return for a follow up discussion on the findings and final suggestions that will be given to the service providers.

Thank participants for their time and input.

# Appendix B

## Resources and Contacts for health service providers

### Relevant services and key contacts for outer east metropolitan region

(NOTE: As available in November 2011)

Organisation	Contact Details	Services specific to report content
Adult Migrant Education Service: Settlement Services	A: Suit 13, 45-51 Ringwood St Ringwood 3134 T: 9870 7820 <a href="http://www.ames.net.au/settlement-services">http://www.ames.net.au/settlement-services</a>	Case Management- consisting of needs assessment, transit assistance, reception, property induction and initial food provision, essential registrations, orientation, health services and accommodation services
Australian Chin Community (eastern Melbourne)	Ringwood. T: 0419 496 717	Community based group providing support and activities for the Chin community. Works to promote greater knowledge of the Chin culture and community- free membership
Bor Community Association of Australia	Suite 16, 27 Bank Street, Box Hill VIC T: 0411 148 901	Community based group to assist the Bor community. Languages spoken are Dink and Sudanese Arabic- free membership
Croydon Hills Baptist Church	2-8 Bemboka Raod, Croydon Hills, VIC T:9876 4503 <a href="http://www.chbc.org.au">www.chbc.org.au</a>	Monthly support group, homework club, women's tutoring, various activities to support the Karen community.
EACH Social and Community Health Refugee Health Program	75 Patterson Street Ringwood East, VIC 3135 T: (03) 9837 3999 Refugee Health Nurse Co-ordinator Merilyn Spratling <a href="mailto:mspratling@each.com.au">mspratling@each.com.au</a> T: 9837 3980 Women's Health Nurse/Refugee Health Nurse Raelene Cameron <a href="mailto:rcameron@each.com.au">rcameron@each.com.au</a> T: 9837 3999	Refugee Health Nurse Program: <ul style="list-style-type: none"> <li>- Initial Refugee Health Assessments</li> <li>- Mantoux Clinic</li> <li>- Immunisation catch up clinics</li> <li>- Complex Care Management Health Support</li> <li>- Secondary Consultations</li> <li>- Response to referrals received post-initial settlement period</li> <li>- Advocacy and Liaison</li> <li>- Professional Development</li> <li>- Health Education Sessions</li> </ul>
<ul style="list-style-type: none"> <li>■ Community Dental Health Clinic</li> </ul>	124 Mt Dandenong Road Ringwood, VIC 3134 T: (03) 9259 4900	Priority for people of refugee backgrounds/pregnancy
<ul style="list-style-type: none"> <li>■ Optometry Clinic</li> </ul>	75 Patterson Street Ringwood East, VIC 3135 T: (03) 9837 3999	Priority for people of refugee backgrounds/pregnancy
<ul style="list-style-type: none"> <li>■ Well Women's Clinic</li> </ul>	75 Patterson Street Ringwood East, VIC 3135 T: (03) 9837 3999	Culturally sensitive services- screening programs, planned and unplanned pregnancy counselling, advice and care regarding contraception, STI's, abuse, relationships, sexuality. Accredited interpreters can be arranged on request

<p>Eastern Health</p> <ul style="list-style-type: none"> <li>■ Angliss Hospital Maternity Unit</li> <li>■ Box Hill Hospital- Birralee Maternity Unit</li> <li>■ Yarra Ranges Health</li> <li>■ Healesville Maternity Unit</li> </ul>	<p>Albert Street, Upper Ferntree Gully VIC, 3156 T: Switchboard(03) 9764 6111</p> <p>Nelson Road, Box Hill, VIC, 3128</p> <p>25 Market Street, Lilydale, VIC 3140 T: (03) 9091 8888</p> <p>377 Maroondah Hwy, Healesville, VIC T: (03) 5962 4300</p>	<p>Antenatal and postnatal clinic, midwifery home visiting service, lactation support, mother and baby exercise programs, Specialist Maternity Services, Cord Blood Bank</p> <p>Antenatal and postnatal clinic, Specialist Maternity Services, lactation support, antenatal Cord Blood Bank</p> <p>Maternity Services- antenatal clinic, lactation, foetal and monitoring service</p> <p>Antenatal and postnatal clinics, mother and baby exercise program</p>
<p>Eastern Karen Community Association of Victoria (EKCAV)</p>	<p>T: 0422 058 348</p>	<p>Provide assistance to local Karen refugees.</p>
<p>Foundation House</p>	<p>Ringwood Office- Suite 5/45-51 Ringwood Street Ringwood, VIC 3134 T: (03) 8788 3333</p>	<p>Specialised counselling services for people of refugee backgrounds who are survivors of torture and trauma.</p>
<p>Knox Community Health Service Inc</p> <ul style="list-style-type: none"> <li>■ Knox Community Health Dental Clinic</li> </ul>	<p>1063 Burwood Hwy Ferntree Gully, VIC, 3156 T: Switchboard 97576200</p> <p>1063 Burwood Highway Ferntree Gully, VIC 3109 T: (03) 9757 6200</p>	<p>Related services include: Counselling (including family violence), allied health, family and community programs, paediatric screening services and support for families.</p> <p>10 chair clinic- no wait list for pregnant women. Accredited Interpreters can be arranged on request</p>
<p>Migrant Information Centre (MIC)</p>	<p>Suite2, Town Hall Hub, 27 Bank Street, Box Hill VIC T: 9285 4888 <a href="http://www.miceastmelb.com.au">www.miceastmelb.com.au</a></p>	<p>Aged Care and Disabilities, Employment, English Classes, Family Support, Health, Housing, Volunteering, Migration advice, Youth, Cultural Resources, Research and Publications, Client Statistics, Cultural training.</p> <p>NOTE: MIC have also recently started two playgroups.</p>
<p>Melbourne Burmese Community Church</p>	<p>Life Ministry Centre, Old Melbourne Road, Chirnside Park T: 9726 8111</p>	<p>Providing range of assistance to the Zomi community</p>
<p>Ranges Community Health</p>	<p>17 Clarke Street, Lilydale, VIC, 3140 T: (03) 9738 8801</p>	<p>Relevant services include: Family and Child Services, Allied Health, Counselling, Community Dental</p> <p>The Healthy Mothers Healthy Babies Program- (HMHB) community based service providing support to pregnant women. The service assists pregnant women to connect to services and education. The program is not a clinical pregnancy (ante-natal) service.</p> <p>The aim of the HMHB program is to improve the health and well being of mothers and their babies by working with Maternity, Maternal and Child Health, GPs and other specialist services.</p> <p>Accredited Interpreters can be arranged on request</p>



Yarra Ranges Community Health	Shop 2- 297 Maroondah Hwy, Healesville, VIC, 3777 T: 1300 130 381	Antenatal Care-Healthy Mothers, Healthy Babies Program, children's services, counselling, paediatric services, women's health clinic.  Accredited interpreters available on request
Zomi Community Association of Australia	Croydon T: 0420 800 560	Providing assistance to the Zomi community

### *Resources for service providers*

NOTE: As available in November 2011

Organisation	Topic areas (relevant translated languages listed- if applicable)	Source
EACH Social and Community Health Community Dental Health Service	General Dental Health Brochure translated in Karen and Tidem. Translated Tidem brochure also on Betel Nut	<a href="http://www.each.com.au/community-dental-health-service/">http://www.each.com.au/community-dental-health-service/</a>
Eastern Health	Cue Cards in Community Languages- This resource was developed by Eastern Health Transcultural Services to assist health professionals and clients/ carers who primarily have English language difficulties, or problems communicating with each other. The graphics on the cards are simplified and animated images that are generally accepted and also easily understood by various language groups. Available in 65 languages.  Eastern Health Translations-relevant topics to report include: pain management, your health information and you, Hepatitis B and Hepatitis C (both in Burmese, Karen and Hakha-Chin), Compliments Comments and Complaints.	<a href="http://www.easternhealth.org.au/services/cuecards/default.aspx">http://www.easternhealth.org.au/services/cuecards/default.aspx</a>  <a href="http://www.easternhealth.org.au/services/translation.aspx">http://www.easternhealth.org.au/services/translation.aspx</a>
Maternal Child Health Services- Victoria	<ul style="list-style-type: none"> <li>- Safe Sleeping- Translated in Arabic, Burmese Chin, Dinka, Karen, Sudanese</li> <li>- PEDS Response forms- Translated in Arabic</li> <li>- KAS Parent Information Card- (Caterpillar card)- Translated in Arabic, Chin, Dinka, Karen.</li> <li>- Dental Health Tip Sheets</li> </ul>	<a href="http://www.education.vic.gov.au/ecsmanagement/matchildhealth/universal/cald.htm">http://www.education.vic.gov.au/ecsmanagement/matchildhealth/universal/cald.htm</a>

<p>Migrant Information Centre</p>	<ul style="list-style-type: none"> <li>- Relevant Cultural Resources include:</li> <li>- Cultural Planning</li> <li>- Cultural Profiles</li> <li>- Demographics</li> <li>- Eastern Multicultural News (electronic newsletter)</li> <li>- Languages Services- Eg: Using interpreters and translators</li> <li>- Healthy Living in Australia- 44 page pictorial guide which includes practical education and skill development activities. The resource can easily be adapted by professionals to include cultural foods of individual communities.</li> </ul> <p>Any many more available on the website listed.</p>	<p><a href="http://www.miceastmelb.com.au/culturalresources.htm">http://www.miceastmelb.com.au/culturalresources.htm</a></p>
<p>Multicultural Centre for Women's Health (MCWH)</p>	<ul style="list-style-type: none"> <li>- Healthy Pregnancy ( available in Burmese, Karen, Arabic)</li> <li>- Keeping your baby healthy (available in Burmese, Karen)</li> <li>- Watching your child grow (available in Burmese, Karen)</li> <li>- Stages of Pregnancy and Labour, Child Health and Development, Listeria, PND, Exercises Post Birth, Having a baby in Australia, Diabetes in pregnancy, breastfeeding and more... (available in Arabic)</li> </ul> <p>Contact the Library Coordinator for a more extensive list.</p> <p>(Note: Resources are also available in other languages- see contact information.</p>	<p>Carmela Pitt  Multilingual Library Coordinator  Suite 207, Level 2, Carringbush Building,  134 Cambridge Street, Collingwood  Victoria 3066  Tel: 03 9418 0910  Fax: 03 9417 7877  <a href="mailto:info@mcwh.com.au">info@mcwh.com.au</a>  <a href="http://www.mcwh.com.au">www.mcwh.com.au</a></p> <p>Free membership provides a newsletter, report, borrowing rights to library, invites to forums and conferences and discounts on publications.</p>
<p>Pap Screen Victoria</p>	<p>Pap Screen Information  Languages: Burmese, Chin and Karen</p>	<p><a href="http://www.papscreen.org.au">http://www.papscreen.org.au</a></p>
<p>Royal Children's Hospital</p>	<p>Range of translated health information and other relevant documents. Includes topics on pap smears, Karen language services, immunisations and fact sheets</p>	<p>Clinic Coordinator: Helen Milton  Phone: RCH Switchboard on 9345 5522  Email: <a href="mailto:Helen.milton@rch.org.au">Helen.milton@rch.org.au</a>  <a href="http://www.rch.org.au/immigranthealth">http://www.rch.org.au/immigranthealth</a></p>
<p>The Royal Women's Hospital</p>	<p>Health Information fact sheets are translated in up to 16 community languages and checked for cultural accuracy and sensitivity.</p> <p>The Royal Women's Hospital Guide to Women's Health- Compiled by the Language Services at the Royal Women's Hospital.</p>	<p><a href="http://www.thewomens.org.au/MultilingualFactSheets">www.thewomens.org.au/MultilingualFactSheets</a></p> <p><a href="http://www.allgraduates.com.au/extras/downloads/">http://www.allgraduates.com.au/extras/downloads/</a></p> <p>Interpreter's%20Guide%20to%20Women's%20Health.pdf</p>



