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Cultural safety and belonging for refugee background women attending group pregnancy care: an Australian qualitative study

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Abstract

Background: Refugee women experience higher incidence of childbirth complications and poor pregnancy outcomes. Resettled refugee women often face multiple barriers accessing pregnancy care and navigating health systems in high income countries.

Methods: A community-based model of group pregnancy care for Karen women from Burma was co-designed by health services in consultation with Karen families in Melbourne, Australia. Focus groups were conducted with women who had participated to explore their experiences of using the program, and whether it had helped them feel prepared for childbirth and going home with a new baby.

Results: Nineteen women (average time in Australia 4.3 years) participated in two focus groups. Women reported feeling empowered and confident through learning about pregnancy and childbirth in the group setting. The collective sharing of stories in the facilitated environment allowed women to feel prepared, confident and reassured, with the greatest benefits coming from storytelling with peers, and developing trusting relationships with a team of professionals, with whom women were able to communicate in their own language. Women also discussed the pivotal role of the bicultural worker in the multidisciplinary care team. Challenges in the hospital during labour and birth were reported and included lack of professional interpreters and a lack of privacy.

Conclusion: Group pregnancy care has the potential to increase refugee background women's access to pregnancy care and information, sense of belonging, cultural safety using services, preparation for labour and birth, and care of a newborn.

Key words: Refugee, group pregnancy care, cultural safety

Introduction

Maternal mortality ratios in humanitarian crises are among the highest in the world due to poor access to health services, disruption of support networks, poor sanitation, and violence (1, 2). Women fleeing these situations are at increased risk of childbirth complications and poor perinatal outcomes, may have unmet reproductive needs (3, 4) and may experience physical and psychological trauma (5). Refugee women resettled in high income countries have greater health and social concerns than women born in the host nation (6-8). Further, social and cultural factors important to refugee women are often neglected (9).

Barriers that limit resettled refugee women's access to pregnancy care include: difficulty navigating health care, unfamiliarity with preventative care, low health literacy, poverty, lack of transportation and inadequate language support (9-11). Yet, pregnancy offers an important opportunity for preventive health care and is often women's first sustained encounter with health services in a high income country (9). Some refugee women feel stereotyped and patronised during the pregnancy and birth process, which can be highly distressing (12, 13). Social isolation, poor mental health, family difficulties and disrupted kinship networks can further compound the pressures felt by women (12, 13).

The delivery of health care to groups of women is showing promise as a model that can increase health promotion knowledge and social support leading to behaviour change and improved perinatal outcomes (14). A Cochrane systematic review of group pregnancy care versus individual care found no statistically significant differences for preterm birth, small-for-gestational age and perinatal mortality but was underpowered to detect these differences. However, maternal knowledge was higher among women allocated to group care (15). Other studies have also identified positive outcomes (16-20) and reduced costs of health care provision (21). Non-randomised studies have demonstrated reductions in social isolation and improvements in women's social and emotional well being (22-24). Studies have demonstrated both financial sustainability and cost effectiveness of group pregnancy care (25, 26), however, they have not included women of refugee background. This paper reports the findings of a qualitative study involving resettled Karen women from Burma, about their experiences of group pregnancy care in Melbourne, Australia.

Methods

Co-design of group pregnancy care

People from the Karen ethnic group of Burma (Myanmar) have a long history of persecution and displacement. Many Karen have lived in refugee camps on the Thai-Burma border and have experienced extensive human rights abuses, with a high prevalence of violence against women (1, 27). Approximately 5000 people from Burma have settled in the state of Victoria, the majority are Karen (28). An Australian partnership called Bridging the Gap (27) agreed to explore whether providing culturally sensitive group pregnancy care could help to overcome some of the challenges experienced by Karen families.

Developing the model of group pregnancy care began with community consultation with Karen mothers and fathers who had recently had a baby in Melbourne. The identified community needs included: pregnancy care provided close to home (due to limited access to transport); access to professional interpreters; meeting other people from the community also having a baby; learning about what to do for a healthy pregnancy, and what to expect in labour and childbirth in a hospital, particularly if induction or caesarean were required. The program was named 'Healthy Happy Beginnings' (Karen translation: Oh Su Tha Pwee Ah Dah Sah Taw Tha) by the community.

A cross-sectoral working group made up of representatives from the maternity hospital, maternal and child health service, state government, community health, settlement services, and researchers, designed the model to address needs identified by the community. They also developed objectives, values and principles to underpin the program (Table 1). The program aimed to provide access to care and information that is woman-directed, culturally appropriate and in women's language to address issues of health literacy and social isolation.

A multidisciplinary team delivered the program, including a 'caseload' midwife, a maternal and child health nurse, and a community specific bicultural worker. A caseload midwife was involved in order to enhance continuity of carer. Women had individual antenatal appointments (according to the hospital schedule) with the midwife and either a telephone or on-site professional interpreter, alongside fortnightly group information sessions. These sessions were co-facilitated by the midwife, bicultural worker and maternal and child health nurse and the antenatal appointments were held in the same building (Tables 2 and 3).

As a community-based and socially-inclusive program, Karen women were invited to the group information sessions regardless of length of gestation, parity, clinical risk, or booked hospital for birth. Program flyers were displayed at local services. The program was located in a well-known community health centre in the neighbourhood where women lived and was free to attend.

Women's experiences of group pregnancy care

Focus groups were suggested by the bicultural worker as a culturally appropriate data collection method that would enable women of all literacy levels to participate. All women who participated in the first year of the program and had given birth, were invited by the bicultural worker to participate in one of two scheduled focus group discussions. The aim of the focus groups was to explore women's experiences of the program, what they liked or disliked, and whether it had helped them feel prepared for childbirth and going home with a newborn. A semi-structured question guide was developed, with questions including: 'How did you find out about the program?' and 'Did you feel comfortable to talk about any concerns as part of the group'? Information was collected about participants such as: year of arrival in Australia, number of children, health issues during pregnancy and birth weight of recent child.

The focus groups were conducted by two of the authors (ER, SM). The first was conducted with an external agency interpreter, and the second with the program bicultural worker (WT). An information sheet and consent form were provided in both Karen and English. As reading levels for both languages were low, the forms were read aloud in Karen. Verbal consent was obtained which involved the bicultural worker ensuring that women understood what was involved in taking part, and that they were free to withdraw at any time. Both focus groups took approximately 2 hours and concluded with a shared lunch. Women received a $30 shopping voucher.

Both focus groups were conducted in English and interpreted concurrently. The English questions and interpreted responses were transcribed from the audio files to produce verbatim transcripts in English. Manual thematic analysis was completed by two researchers (ER, SM), who used open coding to code the transcripts, codes were then categorised, and the emerging themes were cross-checked by discussion with the bicultural worker. Themes were finalised through discussion with members of the working group. The Royal Children's Hospital human research ethics committee approved the study protocol.

Results

Thirty women were invited to take part in focus groups, and 19 women (age 19-40 years) participated. Reasons for non-participation included moving to another area and not being available on the selected days. Of the 19 women, most were born in refugee camps on the Thai-Burma border, with the majority migrating directly to Australia as part of the Humanitarian program. Three women had lived in other countries (United States and Malaysia) prior to settlement in Australia. The average length of time in Australia was 4.3 years (range 6 months to 10 years). Nine women were first-time mothers and ten multiparous, 9 of whom had previously given birth in a refugee camp.

Therefore, for 18 women it was their first contact with Australian maternity services. All women were living in their own house, shared with nuclear and/or extended family members in the neighbourhood. Most women walked to the community health centre; some came by car or bus.

Most women heard about the group via the bicultural worker. Others were told about it by friends or family members already involved in the program. Some women were referred by their General Practitioner, or maternity hospital.

Four overarching themes arose from the focus group discussions: 1) learning together; 2) social and emotional support; 3) trusting relationships; and 4) challenges in the hospital.

Learning together: informed, prepared, confident and reassured

For the women who were first-time mothers, the reassurance and encouragement they received from the care team and their peers helped to reduce anxiety and normalise the process for them.

> *'It was my first time, I was a first*-time mum, so I would come here and speak to the *facilitators, and they gave me advice and just made me feel better…Very reassuring and encouraging.'*

Women agreed that the opportunity to talk to and ask questions of the staff in a comfortable environment enabled them to feel confident about giving birth and having a new baby.

> *'I felt more confident coming here, and sharing my experience.* Before I had the baby, I *didn't know what to do, so I ended up coming* here and talking to the people here. I think it *was very helpful.'*

Notably, women reported feeling empowered through learning about pregnancy and childbirth in the group setting and recounted feeling prepared.

> *'All of the information I have learnt, and all the new information I have, I feel stronger… so I feel like I know more about what's happening.'*

Women reported gaining useful knowledge, such as diet and exercise during pregnancy, information about tests, and terminology used in the hospital during labour and childbirth. They felt their questions were answered, providing reassurance.

> *'If we don't understand anything, we can ask questions and then they explain it to us again.'*

Information provided in the group was tailored to make it meaningful and to increase knowledge of key words in English. Women were grateful for this, reflecting particularly on instances where they didn't have access to an interpreter and could draw on what they had learnt.

'I learnt the terminologies and, when the doctors are speaking to me, I learnt how to respond *to that. Like the word 'push'.'*

However, being able to converse in their own language was valued.

'Being able to speak the same language and share stories in the same language was good for me.'

Importantly, the group was often the first point of contact when women had worries or concerns.

'When I was pregnant, I felt that my baby wasn't breathing or moving, so I asked the midwife here about it and got a check-*up… She gave me advice and made me feel better.'*

Women appreciated the community venue, reporting that the location and familiarity facilitated participation. Women could get to the centre without having to depend on someone for transportation and found the space suitable for their other children. Some husbands/partners occasionally attended, and several women indicated they would have liked their partners to participate because they felt they would also benefit.

'It would be good if they [fathers] could come, it would help them understand about *pregnancy.'*

Social and emotional support: sharing stories and experiences

The program afforded opportunities for women to support each other. Women talked about friendships that developed and the comfort gained from sharing.

'In the beginning, being new to this group, I was a bit shy because I didn't know anyone. But as the program rolled out and the more time we spent together, I was able to open up, and *share with the group…I was more comfortable.'*

Sharing stories in the facilitated environment enhanced women's learning and their sense of being cared for.

'The best thing about coming was seeing each other, sharing stories, sharing problems. And hearing stories, hearing other people's journeys, I liked hearing them very much.'

Women felt comfortable asking staff questions in the group setting and recognised that others benefited from the same questions and discussions. Women agreed that this was because they were all going through the same experience, regardless of whether this was their first child or not:

'Everybody is in the same situation, everybody is pregnant…good experience to hear everybody else's stories.'

Women reported that they were comfortable discussing personal topics in the group and that there was not an occasion when they couldn't ask something that was on their mind.

> *'I wouldn't be uncomfortable…I feel better when I share my story with the group, it makes me feel better.'*

Trusting relationships: continuity of care and care provider

Building a relationship with a familiar care team was vital for women. For some, it helped to feel supported during labour and birth, and provided the feeling of being more in control of the process.

> *'I felt prepared…Because you know what to do, and you know that there's someone there for you. Like the midwife, she's there for you, so you don't feel nervous.'*

The continuity of care from the antenatal period to postnatal care at home was an especially valued component of this model. Consistency with the bicultural worker and MCH nurse postnatally was an aspect that women appreciated. On occasion, the caseload midwife was at the birth of a baby the night before or had a birth she had to attend during the group information session, meaning she wasn't able to attend the group. Despite this, women valued their relationship with the staff, noting this shaped their experience of health care in their new country compared to their previous experiences.

> *'When we were in our country or in the camp, after we delivered the baby, when we went* home no one came and visited us. Here, after we went home, we have our nurses come and visit us after two days. They came and check on us, and after that she [the bicultural worker] *visited us.'*

The bicultural worker was pivotal to the functioning of the group and it was her adaptability that enabled the group to be inclusive regardless of the hospital women were booked to attend. Many women heard about the program through social networks of the bicultural worker who encouraged them to attend the group which often facilitated their access to antenatal care. The support provided by the bicultural worker was an integral part of women's care and coordinating the myriad of 'non-clinical' administrative tasks that were unfamiliar to women.

> *'She* [bicultural worker] is very important*, because if we don't have her, we don't know how* to do the paperwork for the baby, like the name registration for the baby and [*]Centrelink *papers. She helps us with everything.'*

[*]Centrelink is an Australian Government agency responsible for delivering services and unemployment benefits to those who find themselves on a low income or without an income.

Women felt that the greatest benefit in having a bicultural worker involved, as opposed to an external professional interpreter, was developing a relationship with her.

'She is always here, she understands us more'.

Challenges in the hospital: communication and privacy

The only negative aspect of women's care related to their experiences in the hospital at the time of childbirth. This was mostly the experience for women booked to another hospital where the case-load midwife did not work. Women were rarely provided with an interpreter during labour and birth. A few women indicated this was because their husbands were present and spoke enough English to interpret. Some reported trusting the staff and therefore were not overly concerned about communicating in their language.

'It doesn't matter because the nurses are good carers for us, so even if we don't know what's going on, that's okay.'

Some women learnt a few key words in English, but this was usually women who had been in Australia longer and had a better grasp of English compared to newly arrived women.

'I learnt the key words in English…because they didn't have an interpreter [during labour and childbirth], I knew what the doctors were saying.'

Women mentioned lack of privacy in hospitals as a significant issues of dissatisfaction. In particular, women mentioned they felt they had received inadequate care when people walked in and out of their room without prior consultation, and when students were bought in to 'watch' or sometimes perform procedures.

*'Other doctors and nurses would come in and that was rea*lly uncomfortable for me. They *didn't do anything, but they looked, and that was really uncomfortable.'*

In these instances, women felt their preferences were ignored. This was compounded by women's reticence to advocate for themselves, leading them to feel voiceless.

'They would ask questions and I didn't want to answer it straight away, because I don't feel comfortable with them…I didn't feel comfortable to say to them 'Why are you here?''

Women perceived that women of other backgrounds seemed to have their requests for greater privacy respected.

'With other nationalities or cultures, they might get more privacy because they probably sign forms saying they want more *privacy.'*

Asking women beforehand and obtaining consent was a suggested solution.

> *'If there was some sort of agreement form that would make it easier, prior to just walking in and saying 'Is it okay?'*

Discussion

To our knowledge, this is the first model of group pregnancy care that has been designed for a resettled refugee community. Our findings provide evidence that a collaboratively developed group pregnancy care program can be tailored to meet the needs of refugee background women. Overall, women's experiences were positive. Women reported feeling prepared, confident and reassured, with the greatest benefits coming from shared learning and storytelling with peers, and developing trusting relationships with a team of professionals, all supported by communication in their language.

Participants reported that care providers were welcoming, valued them, listened and responded to their needs. The program offered a safe place where women had a sense of belonging and could connect with others and talk in their own language about shared experiences. The study findings also afford salient lessons for the roles and responsibilities of the multidisciplinary team.

Migrant women in high income countries have consistently been dissatisfied with their maternity care (29). In this study, women complained about a lack of privacy during their intrapartum care. This may indicate a lack of knowledge about their rights and therefore reluctance to express their feelings about their care experience. Previous research suggests that Karen women's low self-efficacy, previous experiences of traumatic events and cultural tendencies to 'graciously accept' when receiving care, may contribute to their reluctance to complain (30). Health care providers need to be mindful that some client groups are hesitant to voice any worries and concerns they may have about their care.

In conflict zones women find comfort and solidarity and form support networks with other women (31). Other research has found that women's groups facilitated by non-clinical local women offer opportunities for participatory learning and action and are cost-effective (14). The women in this study valued fostering social relationships that provided connections to culture and shared experiences.

Internationally, there is evidence supporting the integration of Community Health Workers (CHWs) in the maternal and child health context, as they facilitate access to health care and information (32, 33). In this study, it was evident that the role of the bicultural worker was critical and instrumental for supporting women to navigate their way into maternity care and broker communication and

trusting relationships with clinical staff. Women valued seeing the bicultural worker both before and after their baby was born.

Strengths and limitations

The use of focus groups to collect data adhered to the values and principles of the program and built upon the safety established in the group processes. It is possible that women who did not like the program may have chosen not to participate in a focus group, yet feedback was that non-participation was due to unavailability. The decision to involve the bicultural worker in the second focus group was based on our experience of the first group, where women were hesitant to provide detailed responses. Women were more comfortable describing their experiences with the bicultural worker present. The bicultural worker supported women to share their experiences both positive and negative. Other studies have reported that data collected may be enhanced through involving trusted members of the community in the process (34). This has important implications for design of studies involving 'vulnerable' populations. Other limitations include the lack of information regarding experiences and perspectives of the care team and fathers. Research that synthesises user and provider perspectives is needed. This study captures the views of only one refugee community, thus limiting the generalisability of our findings. Finally, monitoring perinatal outcomes will be important for determining whether this model can lead to improved outcomes for this population.

Conclusion

This is the first example of group pregnancy care designed to meet the needs of refugee background families. The findings provide evidence that group pregnancy care has the potential to increase women's access to pregnancy care and information, cultural safety and sense of belonging, and preparation for labour and birth and care of a newborn. Women's reported experiences show the benefits of co-design, and in particular, health care agencies and multidisciplinary teams working together with communities to benefit vulnerable populations.

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Table 1. Program objectives, values and principles

Objectives	Values	Principles
• Provide culturally appropriate care, centred on the woman and what she wants to know • Provide community-based care, close to home, enhancing access	• Clear program goals • Good co-facilitation • Respect • Communication processes • Time management • Ensure everyone is heard	• Community consultation and engagement • Establish rapport with the woman and when present, her family • Giving women time and space to ask questions;

• Be welcoming of women, her family and her community • Identify complex obstetric and/or psychosocial needs earlier, respond appropriately with referral as necessary and follow-up • Promote continuity of provider/s and consistency of information; ensure women are fully informed of choices and options • Provide integrated pregnancy care that introduces and transitions women to the maternal and child health service and ongoing primary health care • Build capacity of all staff to work with and care for families of refugee background in a collaborative and multi-disciplinary team	• Accountability • Collaborative planning and decision making • Being open minded • Commitment to innovation • Advocacy and mentoring	check understanding and consent for medical tests and other procedures • Provide an on-site interpreter for pregnancy appointments • Continuity of care including interpreters and Refugee Family Mentor, where possible • Support women and her family's pathway through the health system • Promote women's understanding of preventative health • Respect, empathy, openness and sensitivity to cultural difference • Recognise and understand the refugee re-settlement experience • Work within a social model of health • Outreach, referral and service co-ordination • Client feedback and evaluation

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399 **Table 2 Key elements of antenatal and postnatal universal services in Victoria**

Key elements of antenatal care	Key elements of postnatal care in first year
• First antenatal check-up in first trimester (35) • At least 7 antenatal check-ups during pregnancy for women giving birth at term • Identification and intervention during pregnancy to support women (and their unborn children) at risk of adverse medical and/or psychosocial outcomes	• Hospital domiciliary midwife visit in first days after hospital discharge • Home visit in first 10 days by MCH Nurse*, followed by Key Age and Stage Visits with MCH Nurse when child is aged 2, 4 and 8 weeks, 4, 8, 12 months (36) • Identification, support and referral in relation to child health and development and maternal health issues

*Maternal and Child Health Nurse

Table 3 Role descriptions

Worker	Role
Caseload midwife (Sector: Public Hospital)	• A midwife who has an agreed number of women (caseload) per year for whom she is the primary caregiver • First point of contact/reference for these women throughout their pregnancy, labour and birth and during their postnatal period • Maximising continuity of care is the underpinning principle of the caseload midwifery model
Bicultural worker (Sector: Refugee Settlement)	• Provide direct support and cultural advice to service providers, e.g. knowledge of specific cultures and parenting practices • Encourage and assist families to access, navigate and utilise universal primary health care and other services • Provide information to families about other relevant services, e.g. social welfare, housing, English classes • Provide support beyond the translation of language, so their role is different to that of an accredited interpreter
Maternal and Child Health nurse	• Provide support and information to families with children aged from birth to school age, including child health, nutrition, breastfeeding, maternal

(Sector: Local Government)	and family health and parenting • Hold specialist qualifications in midwifery, maternal and child health, and immunisation

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