Maternity Care Service Provision for Women from Refugee Backgrounds Victoria

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THIS REPORT WAS PREPARED AS PART OF A GRADUATE LEARNING TEAM PROJECT.

IT DOES NOT REPRESENT THE VIEWS OF THE DEPARTMENT/S OF HEALTH, HUMAN SERVICES OR THE VICTORIAN GOVERNMENT.

THE ELECTION OF A NEW VICTORIAN GOVERNMENT IN NOVEMBER 2010 HAS CHANGED THE POLICY CONTEXT OF THIS REPORT. THEREFORE PROVIDES INFORMATION ABOUT THE MATERNITY SERVICE SYSTEM IN VICTORIA AT A POINT IN TIME.

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Executive Summary

Introduction

This report provides an analysis of maternity care services available to women from a refugee background in Victoria. The report is to be used as a briefing document for a Victorian Refugee Health Network working group to be established in 2011 which will examine the status of maternity care service provision for women from a refugee background. The report may also be used to inform discussions and development of policy reforms in the area of maternity care service provision by the Department of Health.

Maternity care policies and models of care in Victoria

Part one of this report provides an overview of the current policies and models of care that relate to the provision of maternity care services in Victoria. The first section provides a snapshot of Victorian government policy context in regard to maternity care services and the provision of services to people of refugee backgrounds. There are currently no Victorian Government policies that make specific recommendations related to maternity care services for women from a refugee background. However, existing policies require that government services assess and respond to the health and wellbeing needs of vulnerable groups within Victorian society, which includes persons of a refugee background.

Part one also describes the different models of maternity care that are currently available in Victoria and the location of publicly funded services that provide each model. This section informs discussion regarding the types of care available in Victoria and where there may be limitations on women’s ability to access particular models of care due to the limited availability of some models and their geographical location.

Provision of maternity care services to women from refugee backgrounds – data analysis

Part two of this report provides an overview of the current status of maternity care service provision to humanitarian entrants in Victoria. The purpose of the data analyses included is to inform readers of the current trends in maternity care services accessed by women from refugee backgrounds in Victoria and assist maternity care delivery and development planning.

The first section is an analysis of 2009-2010 data from the VAED data set, accessed through the Department of Health. The countries of origin incorporated in the data analysis have been identified as the 20 most common countries of origin among humanitarian entrants settling in Victoria between 2006 and 2010, and act as a proxy for people likely to be from refugee backgrounds. The data omits China, even though China is featured among the top 20 humanitarian countries. This is because humanitarian entrants (typically Uighurs and Tibetans) make up only a very small proportion of total migration from China to Victoria. The majority of Chinese-born new arrivals come to Victoria on other visa types, such as skilled and family migration streams. The data does not otherwise distinguish between persons from refugee and non-refugee backgrounds.

The data analyses show the average age of women from these 20 countries of origin at the time of birth; the hospitals that women attend during labour categorised by country of origin and region of residence; the proportion of
caesarean versus vaginal births categorised by country of origin; and the interpreter requirements of Victorian hospitals.

**Resources for women from refugee backgrounds**

Part three of this report outlines various maternity care resources targeted to the needs of women from a refugee background, that are currently provided by Victorian community and women’s health organisations and tertiary health services.

This section is provided to inform readers of the extent to which the information needs of women are being met, and where there may be gaps in women’s ability to access the information or support they require. It will also be used as a referral tool for care providers to facilitate information sharing and referral pathways.

**Experiences of care provision**

Part four of the report contains an analysis of existing research related to the maternity care services experiences of women from refugee and migrant backgrounds. The studies incorporated are based upon research conducted with women from a variety of different migrant and refugee backgrounds in a number of Western countries of resettlement.

A key theme evident across the studies is the crucial impact that the sensitivity, respectfulness and friendliness of care providers have on women’s overall satisfaction with maternity care services they access. The studies collectively highlight the importance of good communication through:

- access to appropriate interpreters (this was identified in both number of interpreters available, gender of the interpreter, and the language/cultural background of the interpreter)
- access to appropriate and translated information
- effective and respectful communication.

This section incorporates a case study of a rural Victorian health service that provides maternity care to women from refugee and migrant backgrounds. The case study illustrates some of the challenges that service providers can experience when providing maternity care to women from refugee backgrounds, as well as some of the strategies that can be adopted to improve client’s experiences.

**Conclusions and recommendations**

The report identifies that provision of maternity care in keeping with the standards outlined in relevant Victorian Government policies can be difficult to provide when working with clients from a refugee background. This can be due to challenges arising from:

- limited resources and cultural competency among health care practitioners
- client’s limited health literacy and/or English proficiency, and unfamiliarity with Victoria’s health care system and the roles of health care providers
- differing cultural norms regarding health and medical interventions.

An examination of the available literature reveals that it is the attitude shown by service providers that has the greatest impact on women’s satisfaction with the maternity care they receive.

In light of the findings in this report, it is recommended that the working group explore the need to:
1. conduct targeted research examining the maternity care service experiences of women from a refugee background in Victoria and reasons for the varying rates of caesarean births in Victorian hospitals among women from different countries of origin

2. amend current maternity care data collection procedures to enable greater clarity regarding the interpreting needs of women from NESB and ability of hospitals to meet demand

3. increase professional development opportunities for maternity care service providers, including cultural clinical competency, awareness of the impact of trauma and torture, and recognition of the impact of sensitivity and respect

4. facilitate links between maternity care services and service providers that regularly work with clients from refugee backgrounds, in order to share learnings and improve care coordination. This may be aided by the development of Refugee Maternity Care Partnerships

5. develop English language workshops to teach women with limited English sufficient vocabulary to understand what is being said around them during pregnancy, as a tool to empower women during birth

6. further develop service models that respond to the needs of women from refugee backgrounds

7. increase access to the different types of maternity care service models that are currently provided in limited areas only.
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1 Introduction

1.1 Background and context

Definitions

The 1951 Refugee Convention recognises a refugee as someone who, owing to a well-founded fear of persecution due to race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable to, or due to this fear, unwilling to gain protection from that country. While migrants choose to come to Australia, refugees by definition are forced to leave their country to seek protection in other countries. The term asylum seeker refers to people who are seeking protection but have not had their refugee status determined. For the purpose of this report, the term ‘refugee’ is used to refer to both people from a refugee background and asylum seekers.

Australia accepts refugees in accordance with its international obligations under the UN Refugees Convention, through the Commonwealth Humanitarian Program. Every year approximately 3500 people from refugee background settle in Victoria and about ten percent settle in rural Victoria.

Provision of health and maternity care services

Refugees are often unable to access health and maternity care services for prolonged periods prior to arrival in Australia, and frequently arrive with greater and more complex health care needs than other Australians. The Victorian Government is responsible for providing all Victorians, and especially vulnerable groups including people from a refugee background, with access to health and maternity care services that are responsive to their needs. However, there are ongoing challenges to achieving sustainable health services that effectively respond to the needs of clients from refugee backgrounds. These challenges are compounded by the increasingly dispersed settlement of new arrivals and the constantly changing demographic of humanitarian entrants to Australia.

The most pressing needs for Victorian health services are to:
• build the capacity of primary health and specialist services, particularly in regional and outer metropolitan areas
• improve service co-ordination, particularly for newly arriving persons from a refugee background during the early period of settlement
• address particular health issues such as sexual and reproductive health, nutritional deficits leading to sometimes serious chronic and acute health conditions, mental health and child and adolescent health issues.

The role of the Victorian Refugee Health Network

The Victorian Refugee Health Network (VRHN) was established in June 2007. The network aims to bring together key stakeholders to work on building the capacity of the health sector to provide more accessible and appropriate services for people from a refugee background.

The Department of Health in collaboration with the Victorian Refugee Health Network have identified a need to better understand the maternity care experiences of women from a refugee background in Victoria, in order to ensure services are meeting women’s needs. Women from refugee backgrounds can experience a
variety of challenges when seeking health services, and maternity care services in particular.

These can include:

- unfamiliarity with service options and the notion of preventative care
- unfamiliarity with the roles of different health care professionals
- transport difficulties
- language and literacy barriers, coupled with limited availability of interpreters and translated information
- different cultural practices and beliefs relating to childbirth
- the impact of common refugee experiences, including torture and other forms of trauma
- a lack of cultural competency among some existing service providers.

In light of the need to further understand and address maternity care service provision in Victoria, the Refugee Health Network is planning to establish a working group in 2011 that will explore maternity care service provision to women from a refugee background in Victoria. The working group will consider this report in conjunction with additional information regarding the status of maternity care provision to women from refugee backgrounds in order to:

- identify gaps and barriers to the provision of care
- explore ways to address existing gaps
- share information regarding best practice and resources
- promote collaborative approaches and partnership to improve service coordination
- formulate recommendations to Government regarding relevant programs and policies where appropriate.

1.2 Purpose and scope

This report will be used as a briefing document for a Refugee Health Network maternity care working group to be established in 2011. The report will also be used to inform discussions and development of policy reforms in the area of maternity care service provision.

The report contains an overview of the Victorian Government policy context surrounding maternity care and provision of care to people of refugee background; models of maternity care available in Victoria; trends in tertiary care service use among women from refugee backgrounds; and an overview of maternity care resources and programs available to women currently. The report also includes an analysis of available research examining the experiences of women from refugee backgrounds with maternity care services provided to them in Western countries of resettlement, and a case study exploring the challenges experienced and strategies adopted by a rural maternity care service in Victoria when providing maternity care to clients from refugee backgrounds.

1.3 Methodology and limitations

The information utilised in this report has been gathered from the following sources:

- Victorian government policies
- the Australian Bureau of Statistics
- the Victorian Admitted Episodes Data (VAED) set, accessed through the Department of Health
• face to face and phone interviews with service providers
• existing research literature providing personal accounts of service experiences among women from a refugee background
• resources from maternity care libraries at the Royal Women’s Hospital and the Multicultural Centre for Women’s Health.

Interviews with women from refugee backgrounds were not undertaken as part of this report.
2 Maternity care in Victoria - Victorian Government Policy Context

A Fairer Victoria 2010

The Victorian Government launched A Fairer Victoria 2010 in May 2010, which outlines the Government’s commitment to improving the health and wellbeing of the Victorian community.

A Fairer Victoria is a whole of Government social policy action plan to address disadvantage and promote inclusion and participation. It commits $1.35 billion to protect vulnerable Victorians and address social disadvantage through a range of initiatives. Four target priority areas have been identified for 2010. The priority area most relevant to the topic of this report is Priority Area 3, ‘Improving health and wellbeing’. This priority area outlines the need for continued improvement in the detection and prevention of antenatal and postnatal depression. This is to be achieved through the National Perinatal Depression Initiative, which will see continued expansion of antenatal and postnatal service provision.

Victorian Women’s Health and Wellbeing Strategy 2010-2014

The Victorian Women’s Health and Wellbeing Strategy 2010-2014 highlights that women from refugee backgrounds may have experienced sexual violence and coercion prior to their arrival in Australia and require informed and sensitive approaches in the provision of post arrival sexual and reproductive healthcare.

The Strategy also identifies an ongoing need for culturally appropriate sexual and reproductive health education, and incorporates an examination of different cultural attitudes and the challenges that people from refugee backgrounds face. The Strategy also makes reference to the concerns associated with Female Genital Mutilation (FGM), including the link between FGM and increased risk of birth complications.

Victorian Quality Council (VQC) Strategic Plan

The Victorian Quality Council (VQC), now in its third term, was first established in 2001 as an expert strategic advisory group to lead the safety and quality agenda for Victorian health care services. The Department of Health VQC Strategic Plan aims to achieve safer, better health care for all Victorians. The VQC has developed a third term, four year plan that outlines their values, vision, mission and objectives.

This third term plan is focused on improving patients’ journeys through the health system, and emphasises the importance of patient-centred care. The aims of the VQC are to achieve the following by 2012:

- initiate strategic advice to the Minister for Health on trends in quality and safety, and on emerging problems or issues
- respond to requests for advice from the Minister with useful suggestions on how to address emerging problems or issues
- inform and influence the safety and quality agenda in Victoria
- establish relationships with external bodies to improve the Council’s capacity to meet its objectives
- engage with consumers and act in response to consumers identified needs
- support clinicians in providing safe, patient-centred, evidence-based care
- support leadership development in quality and safety.
Victorian Refugee Health and Wellbeing Action Plan 2008-2010

The vision of Refugee Health and Wellbeing Action Plan 2008-2010 is to ensure that refugee communities in Victoria attain the best possible health and wellbeing. The plan provides a range of strategies and strategic priorities for the ongoing improvement of service delivery to refugee communities that have settled in Victoria.

One initiative of particular relevance to this report is the aim to build the capacity and expertise of mainstream and specialist health services and health care practitioners in the area of refugee health care\(^1\), particularly in outer-metropolitan and rural and regional Victoria. The plan describes how the majority of medical practitioners with experience in working with refugee communities are based in major metropolitan hospitals. Practitioners in outer-metropolitan and rural areas may find it particularly challenging to provide the best possible care for women from a refugee background.

In response to the Plan, the Department of Health has funded the establishment of a Refugee Medical Fellows Program. These fellows, based at Royal Melbourne and Royal Children's hospitals, provide secondary consultation and professional development to general practitioners and specialists across the state. Through the fellows program, there is an opportunity to extend greater support to maternity care service providers.

The Victorian Refugee Health Network, referenced in the Action Plan, is also a source of support and training for rural and regional health service providers working with people from refugee backgrounds.

Another strategic priority of relevance is the provision of language services for new and emerging communities.\(^2\) The strategy lists the Department of Human Services (DHS) Language Services Policy as an important resource and guide for the provision of language services. The policy covers both DHS and DH. The Plan provides several examples of actions being taken by Government to improve language services available to newly emerging communities.

The Refugee Health Nurse Program (RHNP) is also a component of the Action Plan. It is described in greater detail in the resource section of this report.

Future Direction for Victoria’s Maternity Services

Future Direction for Victoria’s Maternity Services highlights actions being undertaken by Government to work towards high quality birthing services. The policy stresses the importance of adopting a multidisciplinary approach, and the need to ensure women are informed and empowered to make choices about their pregnancy care. The policy provides that women should be able to feel they are in control of what is happening during pregnancy and childbirth, based on their individual needs and having discussed issues fully with their care providers.

VQC Strategic Plan Term 3 2008-2012. Pages: 4-6.  

This has important implications for the provision of maternity care services to women from refugee backgrounds. Service providers may need to make additional efforts to ensure that women from refugee backgrounds are able to make fully informed decisions relating to their maternity care, in light of challenges resulting from cultural differences, unfamiliarity with the Australian health system, health terminology and English language.

It is also identified in this policy that seeing the same caregiver throughout pregnancy, labour, birth and afterwards is important to many women. Without this continuity women often feel less confident to ask questions and are more apprehensive about what to expect when they present at hospitals in labour. Continuity of care can be provided through a teamwork approach and can lead to:

- greater choice for women about their maternity care and control of their birthing experience
- increased access to appropriate levels of clinical expertise
- better use of the complementary skills of midwives, general practitioners and obstetricians.

The policy outlines the Victorian Government’s plan to establish primary maternity care services in metropolitan Melbourne; support the provision of maternity services in rural Victoria; and invest in tertiary maternity care services and workforce training and support, which will entail recruiting more General Practitioners in obstetrics and anaesthetics and particularly in rural birthing services.

Another strategy being adopted by the Government is to provide emergency consultation and co-ordination to provide ready advice to maternity care providers. This measure is designed to assist providers to make decisions about possible transfers and to provide more comprehensive care before, during and following transfer.

**Cultural Diversity Guide 2006**

The *Cultural Diversity Guide 2006*, published by DHS, identifies a range of strategies to assist programs and agencies to respond to cultural diversity in Victoria. The guide also covers DH and its funded agencies. Although refugees are not directly identified in the policy, reference is made to culturally and linguistically diverse (CALD) communities, which include people from refugee backgrounds.

The policy outlines strategies to better understand and respond to CALD client needs, and highlights the importance of working in partnership with multicultural and ethno-specific agencies. The Guide also illustrates the need to:

- develop and maintain a culturally diverse and aware workforce
- ensure access to timely and effective interpreting and translation services
- encourage client’s participation in decisions about care or treatment.

Some examples of what would constitute good practice as described in the guide include:

- Several health and welfare agencies in a small rural town join together to develop culturally sensitive approaches for delivering services to newly arrived refugee community members.
- A rural shire council establishes a multicultural advisory group to provide advice to the council on multicultural issues.
- A metropolitan community health centre collaborates with the local multicultural agency to produce an annual cultural plan.
- A metropolitan shire council ensures its staff recruitment and selection policies result in a diverse workforce.
• An aged care service provider assesses clients for language needs to ensure that interpreters are routinely arranged for client appointments.
• A metropolitan community service organisation provides a dedicated meeting space in the community for informal contact between bilingual staff and clients, to encourage discussion of issues and concerns.
3 Models of maternity care and where models can be accessed

There are many different models of maternity care provided by different hospitals around Victoria. These models of care can be broadly brought into three key categories.

Shared care

Formal arrangements exist for shared care between GPs, Obstetricians and a public hospital antenatal clinic.

Typically a woman whose pregnancy is of normal risk would have 2 hospital visits and 7 GP/Obstetrician visits. Additional visits would be scheduled for women deemed to be at higher risk.

Public maternity care

Public maternity care includes all antenatal care that is provided by hospital based clinics.

Traditional maternity care clinics are staffed by obstetricians and registrars, as well as other specialists as required.

Midwife clinics are located within a hospital or community based clinic.

Continuity of care midwifery led clinics involves caseload or team models.

These models are normally available through publicly funded services.

Private Maternity Care

Private maternity care refers to antenatal and intrapartum care provided to women who are private patients of obstetricians or GP obstetricians. Intrapartum care is provided in a private hospital or as a private patient in a public hospital.

This type of care is not normally available through publicly funded services.
4 Provision of maternity care services to women from non-English speaking backgrounds

Tertiary care service statistics among women from refugee backgrounds

4.1 Limitations of the data set

The data used in the following analyses is from the VAED data set. All the below data has been gathered from this source. There are a number of limitations with the data which have implications for the analyses conducted. These limitations are outlined below.

1. Like most data sets, ‘visa’ or ‘refugee status’ is not collected as part of the VAED set, so it is difficult to identify clients from a refugee background. The data item ‘country of birth’ has been used as a proxy. For the purpose of this report, the countries of birth which represent the 20 most common countries of birth among humanitarian entrants settling in Victoria between 2006 and 2010 were selected. This was based on information from the DIAC settlement database, which includes both country of birth and visa status.

2. Country of origin does not necessarily align with cultural heritage. Many persons of refugee background flee their country, and are forced to remain in neighbouring countries for prolonged periods of time. In many circumstances children may have been born in the country of first asylum of their parents, and would consequently be categorised in the data set as being of that country of origin. However, it is more likely that they would identify as being of the same cultural heritage as their parents.

In particular Thailand, Egypt, Kenya, and Malaysia have large populations of refugees from neighbouring countries seeking protection either in refugee camps or among the local population. Many children are born in these transit countries and are subsequently categorised as being of that country of origin. For example, almost all of the humanitarian entrants from Thailand are from the Karen and Chin ethnic groups from Burma. Table 1 outlines the likely ethnicity of humanitarian entrants from several countries or origin included in the data set.

3. Although China appears in the top 20 countries of birth among humanitarian entrants to Victoria, there is a large proportion of people from China who come to Victoria on Skilled or Family visas. This is distinct from the other 19 countries of origin included in the data analyses. The numbers of humanitarian entrants from China is, by comparison, very small. Consequently, including ‘China’ in the analyses would result in the findings being distorted. China has therefore been removed from the analyses.
Table 1: Likely ethnicity according to registered country or origin

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<thead>
<tr>
<th>Country of Mothers Birth</th>
<th>Ethnicity</th>
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<tr>
<td>Thailand</td>
<td>Burma</td>
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<td>Malaysia</td>
<td>Burma</td>
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<td>Egypt</td>
<td>Sudan</td>
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<tr>
<td>Kenya</td>
<td>Sudan</td>
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<tr>
<td>China</td>
<td>Tibetan &amp; Uighur</td>
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<td>Uganda</td>
<td>Sudan</td>
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4.2 Age of women at time of birth

Figure 1 shows the average age of women at the time of birth for 2008-09 and 2009-10. In 2008-09, women from the Democratic Republic of Congo are shown to have the lowest average age (approximately 27 years) at the time of birth among the countries listed. This does not appear to have changed in 2009-10. In 2009-10, women from Bhutan, the Democratic Republic of Congo, and Sierra Leone had the lowest average age at the time of birth among the countries included in the analysis. This contrasts with the median age at the time of birth among Victorian women more broadly in 2005, was 31.5 years.

It is notable that with the exception of Zimbabwe, the average age at time of birth decreased in the year since 2008-09 for all countries included in the analysis. The greatest change occurred among women from Bhutan. In 2008-09 the average age at time of birth for women from Bhutan was 31, whereas in 2009-10 it was 26.

Figure 1: Average age of women at time of birth
Figure 2 includes a subset of countries from Figure 1. The countries included are the 11 countries of origin with the greatest number of births among women under the age of 21.

**Figure 2: Count of age of mothers 21 years and below by country of birth**
4.3 Place of birth

Figure 3 lists the number of births that occurred in 2009-10 in Victorian hospitals, categorised by country of origin. The most frequented hospitals among women from the specified countries of origin are Dandenong (428 births), Sunshine (431 births) and the Royal Women’s (667 births).

Comparable data from 2008-09 reveals that the number of births that took place in 2009-10 among women from the identified countries of origin is considerably greater than the number that took place in 2008-09 for certain hospitals. This is most notable in regard to Box Hill Hospital (increase of 29 births in 2009-10); the Northern Hospital, Epping (increase of 47 births in 2009-10); and Sunshine Hospital (increase of 70 births in 2009-10).

It is also notable that the number of births that took place among women from the specified countries of origin at Dandenong Hospital in 2009-10 (428) was significantly less than the number that took place in 2008-09 (555).

This information can be used to target specific services according to the demand at individual hospitals.
Figure 3: Number of births by hospital 2009-10

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</table>
Figure 4: Residential region and hospital attended

Figure 4 shows the most common hospitals attended by women in 2009-10 according to their region of residence. The data provides an indication of the distance that women must travel to receive care at a required, or preferred, hospital. The regions listed correlate with the regions identified by the Department of Human Services.

<table>
<thead>
<tr>
<th>Region / Hospital</th>
<th>North-West Metro</th>
<th>Southern Metro</th>
<th>Eastern Metro</th>
<th>Hume</th>
<th>Barwon-South Western</th>
<th>Loddon Mallee</th>
<th>Gippsland</th>
<th>Grampians</th>
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<tbody>
<tr>
<td>TOTAL</td>
<td>2182</td>
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<td>657</td>
<td>87</td>
<td>76</td>
<td>41</td>
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<td>Albury Wodonga Health – Wodonga</td>
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<td>Angliss Hospital</td>
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<tr>
<td>Ballarat Health Services [Base Campus]</td>
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<td>Bass Coast Regional Health</td>
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<tr>
<td>Benalla &amp; District Memorial Hospital</td>
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<td>Goulburn Valley Health [Shepparton]</td>
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<td>South West Healthcare [Warrnambool]</td>
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<td>Sunshine Hospital</td>
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<td>Swan Hill District Hospital [Swan Hill]</td>
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<tr>
<td>West Gippsland Healthcare Group [Warragul]</td>
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</table>
Figure 5 shows the number of Caesarean and Vaginal births that took place in 2009-10 among women from the identified countries of origin. It is apparent that, in light of the total number of births that took place, a much greater proportion of women from particular countries have caesarean births compared to women from other cultural groups. Most notably, 45 per cent of women from Ethiopia and Iran, and 43 per cent of women from Sri Lanka who presented in labour in 2009-10 had caesarean births. In contrast, only 13 per cent of women from Libya and 17 per cent of women from Bhutan had caesarean births.

It is also notable that 50 per cent of women from the Congo, and 78 per cent of women from Sierra Leone had caesarean births, although these figures may be unreliable given the small number of births that took among women from these countries overall.

The reason for this variation between countries is unclear, and it is not recorded in the data whether or not the caesarean births that took place were clinically indicated.

There have been some notable changes in the proportion of women that have caesarean births between 2008-09 and 2009-10. There has been an increase in the proportion of women who have caesarean births from Ethiopia (24 per cent in 2008-09, 45 per cent in 2009-10), Iran (23 per cent in 2008-09, 45 per cent in 2009-10) and Sierra Leone (40 per cent in 2008-09, 78 per cent in 2009-10). There has also been a notable decrease in the proportion of women from Libya who have had a caesarean birth (36 per cent in 2008-09, 13 per cent in 2009-10). The reason for these changes is unclear.
Interpreter requirements

Figure 6 illustrates which Victorian hospitals had the largest requirements for interpreter services during 2008-09 and 2009-10. There are 7 hospitals which consistently stand out due to the comparatively large number of interpreters required. The hospital with the greatest need for both years is the Royal Women’s Hospital, as would be expected given their large client base. Interpreter requirements may be due to a large number of births during the year, or due to certain hospitals being preferred by women from specific language groups.

This graph shows a dramatic increase in demand in 2009-10 compared to 2008-09. As noted above, this may be a result of increasing need, or alternatively, may indicate that the interpreter requirements of patients are being better recognised and recorded.
5 Resources for Women from Refugee Backgrounds

Information incorporated

This section outlines maternity care resources—specialised staff, programs and educational materials available in Victoria that are targeted for women from a refugee background. The educational materials listed are those produced by the relevant organisation and do not incorporate resources that organisations access from other sources.

Only programs that explicitly target women from refugee backgrounds, or which target persons or groups from one or more of the 20 most common countries of origin (excepting China) among humanitarian entrants to Victoria between 2006 and 2010, are incorporated. Similarly, the educational materials listed are those which either explicitly target women from refugee backgrounds, or have been translated into any of the 20 most commonly spoken languages among humanitarian entrants to Victoria between 2006 and 2010. These languages, and the most common countries or origin among humanitarian entrants, are outlined in Appendix 1.

This resource is not exhaustive. Organisations that incorporate Refugee Health Nurses, Family and Reproductive Rights Education Program (FARREP) workers or Healthy Mothers Healthy Babies Program Workers in particular were targeted for enquiry. Resources designed for health care professionals are not included in this database.

Overview of maternity services incorporated

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Role</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>RHN</td>
<td>Refugee Health Nurse</td>
<td>The Refugee Health Nurse Program was established in 2005. It aims to: • increase refugee access to primary health services • improve the response of health services to refugees’ needs • enable individuals, families and refugee communities to improve their health and wellbeing. Refugee Health Nurses are located in 16 community health services in Victoria in areas of significant refugee settlement. Their role is to: • work directly with refugee communities • support timely access to health assessment, particularly GPs • support optimal care co-ordination • advise other health practitioners on refugee health and wellbeing matters.</td>
</tr>
<tr>
<td>FARREP</td>
<td>Family and Reproductive Rights Education</td>
<td>The Family &amp; Reproductive Rights Education Program aims to work with communities that practice female genital mutilation (FGM) in order to:</td>
</tr>
</tbody>
</table>
| Program | • strengthen their knowledge about FGM and support changes to their attitudes about the practice to prevent its occurrence  
• increase access to timely and appropriate sexual and reproductive health services by women and girls from communities that could practice FGM  
• build the capacity and expertise of mainstream and specialist sexual and reproductive health services to deal with women and girls affected by or at risk of being affected by FGM  
FARREP workers sometimes provide direct counselling care or may undertake health promotion activities. |
| --- | --- |
| HMHB Healthy Mothers Healthy Babies Program | The Healthy Mothers, Healthy Babies Program aims to improve the health and wellbeing of mothers and babies. The program provides:  
• assistance to women to access antenatal, postnatal and other health and human services  
• support women throughout their pregnancy  
• key health promotion messages that support healthy behaviours in pregnancy and beyond.  
The program targets pregnant women who are unable to access antenatal care services or require additional support because of their socioeconomic status, culturally and linguistically diverse backgrounds, Aboriginal and Torres Strait Islander descent, age or residential distance to services. |
## 5.1 Community Health Centres

### Eastern Metropolitan Region

<table>
<thead>
<tr>
<th>LGA</th>
<th>Sites</th>
<th>Organisation</th>
<th>Resources</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Banyule</td>
<td>Heidelberg West Greensborough</td>
<td>Banyule Community health</td>
<td><strong>Staff</strong>&lt;br&gt;• FARREP Worker&lt;br&gt;• Community midwives – midwives are also maternal and child health nurses which facilitates continuity of care <strong>Programs supporting maternity care</strong>&lt;br&gt;• Community midwifery program – shared care arrangements, one on one appointments and information sessions. No formal antenatal classes due to small number of women requiring classes <strong>Educational materials</strong>&lt;br&gt;• Some information produced in Somali</td>
<td>Sharlene Cook&lt;br&gt;Maternal &amp; Child Health Nurse&lt;br&gt;Midwife&lt;br&gt;pH: (03) 9450 2048</td>
</tr>
<tr>
<td>Brimbank</td>
<td>St Albans Taylors Lakes Deer Park Sunshine</td>
<td>ISIS Primary Care</td>
<td><strong>Staff</strong>&lt;br&gt;• Refugee health team comprising 3 part time RHNs (total 2EFT) and 1 part time social worker (0.6EFT). <strong>Programs supporting maternity care</strong>&lt;br&gt;• HMHB Program&lt;br&gt;• Outreach antenatal consultation sessions supplied by Sunshine Hospital on Fridays at centre. African worker, fluent in Dinka and Arabic attends for afternoon</td>
<td>Marie Welham&lt;br&gt;RHN&lt;br&gt;Sunshine&lt;br&gt;Ph: (03) 9313 5012&lt;br&gt;Email: <a href="mailto:Marie.Welham@isispc.com.au">Marie.Welham@isispc.com.au</a>&lt;br&gt;W: Mon, Wed and Thurs</td>
</tr>
<tr>
<td>Maroondah</td>
<td>Ringwood East Croydon Healesville Lilydale Ferntree Gully Yarra Junction Wantima South Box Hill</td>
<td>Eastern Access Community Health</td>
<td><strong>Staff</strong>&lt;br&gt;• RHN <strong>Programs supporting maternity care</strong>&lt;br&gt;• Well Women’s Clinic</td>
<td>Raylene Cameron&lt;br&gt;RHN&lt;br&gt;Ringwood&lt;br&gt;Well Women’s Clinic and RHN&lt;br&gt;Ph: (03) 9837 3999</td>
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## Southern Metropolitan Region

<table>
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<tr>
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<th>Sites</th>
<th>Organisation</th>
<th>Resources</th>
<th>Contact</th>
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<tbody>
<tr>
<td>Cardinia/Cahey</td>
<td>Cranbourne, Doveton, Berwick, Pakenham, Cockatoo</td>
<td>Cardinia Casey Community Health Service - Southern Health</td>
<td><strong>Staff</strong>&lt;br&gt;• Bilingual (Arabic, Urdu, Hindi, Dari) Afghani outreach worker in Healthy Mothers Healthy Babies Program&lt;br&gt;• RHN (0.5EFT)&lt;br&gt;<strong>Programs supporting maternity care</strong>&lt;br&gt;• HMHB: Provide bilingual one to one and group pregnancy information sessions&lt;br&gt;• Afghani outreach worker provides community information sessions on women’s health</td>
<td>Nida Iqbal Outreach Worker HMHB Cranbourne ph: (03) 5990 6789</td>
</tr>
<tr>
<td>Greater Dandenong</td>
<td>Springvale</td>
<td>Greater Dandenong Community Health Service - Southern Health</td>
<td><strong>Staff</strong>&lt;br&gt;• RHN (2 EFT)&lt;br&gt;• Community Development Workers and qualified interpreters&lt;br&gt;• FARREP worker&lt;br&gt;<strong>Programs supporting maternity care</strong>&lt;br&gt;• Community Midwives Program targeting newly arriving communities&lt;br&gt;• African and Burmese childbirth education classes&lt;br&gt;• HMHB&lt;br&gt;• Two nurse-run refugee health clinics that provide pre-pregnancy counselling and education as well as information on sexual and reproductive health, fertility, and immunisation. Provide some maternity care also through these clinics. Dandenong hospital provides antenatal classes for Afghani women and has a Refugee Health Clinic: a medical outpatient clinic with focus on complex medical issues and infectious diseases which incorporates an asylum seeker medical clinic&lt;br&gt;<strong>Educational materials</strong>&lt;br&gt;• Southern Health have some maternity care materials i.e. caring for your baby translated into Vietnamese, Cambodian and Arabic.&lt;br&gt;• Burmese Interpreter is a qualified translator and has translated additional documents as required</td>
<td>Suzanne Willey RHN ph: (03) 85589000 Email: <a href="mailto:suzanne.willey@southernhealth.org.au">suzanne.willey@southernhealth.org.au</a>&lt;br&gt;Jane Berryman Community Midwifery Program Manager ph: (03) 85589137 Email: <a href="mailto:jane.berryman@southernhealth.org.au">jane.berryman@southernhealth.org.au</a></td>
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## North and West Metropolitan Region

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<th>Organisation</th>
<th>Resources</th>
<th>Contact</th>
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<tr>
<td>Darebin</td>
<td>East Reservoir</td>
<td>Darebin Community Health</td>
<td><strong>Staff</strong>&lt;br&gt;• RHN (1EFT)  &lt;br&gt;<strong>Programs supporting maternity care</strong>&lt;br&gt;• Nil  &lt;br&gt;<strong>Educational materials</strong>  &lt;br&gt;• Website <a href="http://www.dch.org.au/">http://www.dch.org.au/</a> available in Arabic</td>
<td>East Reservoir&lt;br&gt;pH: (03) 8470 1109&lt;br&gt;(medical line)&lt;br&gt;0409 337 784</td>
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<tr>
<td></td>
<td>Reservoir</td>
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<td></td>
<td>Hume</td>
<td>Dianella Community Health</td>
<td><strong>Staff</strong>&lt;br&gt;• RHN (1EFT)  &lt;br&gt;<strong>Programs supporting maternity care</strong>&lt;br&gt;• HMHB program - offer a variety of programs for different language groups, most recently a 6 week program in Nepalese, Arabic, Urdu  &lt;br&gt;• Community Midwifery Program  &lt;br&gt;<strong>Educational materials</strong>  &lt;br&gt;• Maternity care brochures translated into Arabic and Turkish  &lt;br&gt;• Utilise translated internet resources</td>
<td>Glenys Janssen&lt;br&gt;Coordinator&lt;br&gt;HMHB&lt;br&gt;Glenroy&lt;br&gt;pH: (03) 8345 5344&lt;br&gt;Email: <a href="mailto:glenys.janssen@dianella.org.au">glenys.janssen@dianella.org.au</a></td>
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<td>Melton/Moorabool</td>
<td>Djerriwarrh Health Service / Melton Health</td>
<td><strong>Programs supporting maternity care</strong>&lt;br&gt;• HMHB</td>
<td>Mary Little&lt;br&gt;Unit manager&lt;br&gt;pH: (03) 53679615</td>
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<td>Western Region Health Centre</td>
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<td>Lindy Marlow&lt;br&gt;State-wide RHN facilitator&lt;br&gt;Footscray&lt;br&gt;pH: (03) 8398 4100&lt;br&gt;Cath Bevan&lt;br&gt;RHN&lt;br&gt;Footscray&lt;br&gt;Email: <a href="mailto:cathb@wrhc.com.au">cathb@wrhc.com.au</a></td>
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<td>Location</td>
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</table>
| Melbourne / Moonee Valley | Kensington Moonnee Ponds Niddrie Nth Melbourne | Doutta Galla Community Health Service    | **Staff**                                                            | • RHN (1EFT)  
• FARREP worker                                                      |
|                   |                             |                                           | **Programs supporting maternity care**                               |                                                                                     |
|                   |                             |                                           | • One to one childbirth education using pictorial information        |                                                                                     |
|                   |                             |                                           | • Outreach women’s health information sessions to Horn of Africa      |                                                                                     |
|                   |                             |                                           | and Somali women’s groups                                            |                                                                                     |
|                   |                             |                                           | • Well women’s clinic - operates Thursday afternoons                  |                                                                                     |
|                   |                             |                                           | **Education materials**                                              |                                                                                     |
|                   |                             |                                           | • Website provides brochure for the clinic in Farsi and Arabic        |                                                                                     |
| Melbourne / Yarra  | Fitzroy Collingwood Carlton | North Yarra Community Health              | **Staff**                                                            | • FARREP worker (Carlton)  
• Community midwives                                                      |
|                   |                             |                                           | **Programs supporting maternity care**                               |                                                                                     |
|                   |                             |                                           | • HMHB                                                                |                                                                                     |
|                   |                             |                                           | • Community Midwifery Program with priority given to women           |                                                                                     |
|                   |                             |                                           | from refugee backgrounds. It provides support, information,         |                                                                                     |
|                   |                             |                                           | liaison and advocacy throughout pregnancy until 6 weeks post     |                                                                                     |
|                   |                             |                                           | pregnancy. Have shared care arrangements with Mercy and             |                                                                                     |
|                   |                             |                                           | Royal Women’s Hospitals. Provide in-home visits with               |                                                                                     |
|                   |                             |                                           | interpreters, and aim to use same interpreter throughout         |                                                                                     |
|                   |                             |                                           | pregnancy where possible. There are no restrictions on the        |                                                                                     |
|                   |                             |                                           | number or length of appointments. Midwives have developed        |                                                                                     |
|                   |                             |                                           | close working relationships with RHN.                               |                                                                                     |
| Whittlesea        | Epping Whittlesea Mill Park | Plenty Valley Community Health            | **Staff**                                                            | • Community health nurse focused on refugee health                               |
|                   | Thomastown                  |                                           | **Programs supporting maternity care**                               |                                                                                     |
|                   |                             |                                           | • HMHB                                                                |                                                                                     |
|                   |                             |                                           | • Community Midwifery Program with priority given to women         |                                                                                     |
|                   |                             |                                           | from refugee backgrounds. It provides support, information,        |                                                                                     |
|                   |                             |                                           | liaison and advocacy throughout pregnancy until 6 weeks post     |                                                                                     |
|                   |                             |                                           | pregnancy. Have shared care arrangements with Mercy and           |                                                                                     |
|                   |                             |                                           | Royal Women’s Hospitals. Provide in-home visits with               |                                                                                     |
|                   |                             |                                           | interpreters, and aim to use same interpreter throughout         |                                                                                     |
|                   |                             |                                           | pregnancy where possible. There are no restrictions on the        |                                                                                     |
|                   |                             |                                           | number or length of appointments. Midwives have developed        |                                                                                     |
|                   |                             |                                           | close working relationships with RHN.                               |                                                                                     |
| Wyndham *also operate from various | Hoppers Crossing Werribee | ISIS Primary Care                              | **Staff**                                                            | • Four RHN (Werribee site) (2EFT)                                                |
|                   |                             |                                           | **Programs supporting maternity care**                               |                                                                                     |
|                   |                             |                                           | • HMHB                                                                |                                                                                     |
|                   |                             |                                           | • Antenatal care classes for Karen women                            |                                                                                     |
|                   |                             |                                           | **Education materials**                                              |                                                                                     |
|                   |                             |                                           | • Website provides brochure for the clinic in Farsi and Arabic        |                                                                                     |
|                   |                             |                                           | **Contact Cheryl Cambell for further information**                 |                                                                                     |
| sites in Hobson’s Bay and Brimbank |  |  |  |
## Grampians Region

<table>
<thead>
<tr>
<th>LGA</th>
<th>Sites</th>
<th>Organisation</th>
<th>Resources</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ballarat</td>
<td>Ballarat Sebastopol Wendouree</td>
<td>Ballarat Community Health Centre</td>
<td><strong>Staff</strong>&lt;br&gt;• RHN (Sebastopol site)</td>
<td>Ph: (03) 53384500</td>
</tr>
</tbody>
</table>

## Hume Region

<table>
<thead>
<tr>
<th>LGA</th>
<th>Sites</th>
<th>Organisation</th>
<th>Resources</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shepparton</td>
<td>Shepparton</td>
<td>Goulburn Valley Community Health Service</td>
<td><strong>Staff</strong>&lt;br&gt;• RHN (0.5EFT)</td>
<td>Anne Warren&lt;br&gt;RHN&lt;br&gt;Ph: (03) 5823 3200&lt;br&gt;Katrina Popper&lt;br&gt;Integrated Health Coordinator</td>
</tr>
</tbody>
</table>
### Loddon Mallee Region

<table>
<thead>
<tr>
<th>LGA</th>
<th>Sites</th>
<th>Organisation</th>
<th>Resources</th>
<th>Contact</th>
</tr>
</thead>
</table>
| Mount Alexander | Castlemaine      | Castlemaine and District Community Health Service | **Staff**  
  - RHN (1 day per week)  
  - Bilingual Sudanese Health Worker - employed in partnership with Castlemaine Health and the Maternal and Child Health Nurses (soon to commence)  
**Programs supporting maternity care**  
**Educational materials**  
  - Bilingual DVD to inform Sudanese about local health organisations, incorporating information about Castlemaine Health Birthing Unit (in production) | Jac Griffiths  
Refugee and Women’s Health Nurse  
Multicultural & Early Years Community Health Nurse  
Castlemaine & District Community Health  
Ph: 5479 1000  
Email: jgriffiths@cdch.com.au |
### Gippsland Region

<table>
<thead>
<tr>
<th>LGA</th>
<th>Sites</th>
<th>Organisation</th>
<th>Resources</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bass Coast</td>
<td>Wonthaggi San Remo</td>
<td>Bass Coast Community Health Service</td>
<td><strong>Staff</strong></td>
<td>RHN (1/2 day per week)</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td>Cultural planning group – staff members (one from each team) set goals about improving access to and providing care for CALD and indigenous clients</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td><strong>Programs supporting maternity care</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Enhance home visiting – outreach maternity care</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Contact</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Rebecca Reagan Ph: (03) 5671 9200 Email: <a href="mailto:Rebecca.egan@bchs.com.au">Rebecca.egan@bchs.com.au</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Annette Reed pH: (03) 5671 9222</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Tammy Charles RHN (3 hours/week) Sanrimo Mobile: 0409 188 919</td>
</tr>
<tr>
<td>Latrobe Valley / Gippsland</td>
<td>Bairnsdale Churchill Korumburra Moe Morwell Sale Traralgon Warragul</td>
<td>Latrobe Community Health Service</td>
<td><strong>Staff</strong></td>
<td>RHN (0.5EFT)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Contact</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Oferiya Kitcheni RHN Traralgon pH: (03) 5171 1400</td>
</tr>
</tbody>
</table>
## Barwon South Western Region

<table>
<thead>
<tr>
<th>LGA</th>
<th>Sites</th>
<th>Organisation</th>
<th>Resources</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colac-Otway</td>
<td>Winchelsea, Beeac, Rokewood, Bannockburn</td>
<td>Hesse Rural Health Service</td>
<td><strong>Staff</strong>&lt;br&gt;• RHN (1 day per week)</td>
<td>Ph: (03) 5267 1280 (Rokewood Centre) Nurses: 0429182209</td>
</tr>
<tr>
<td>Greater Geelong, Surfcoast, Colac/Otway, Warrnambool</td>
<td>Corio, Belmont, Newcomb, Torquay, Anglesea</td>
<td>Barwon Health</td>
<td><strong>Staff</strong>&lt;br&gt;• Community health clinic has a RHN (0.5EFT)</td>
<td>Christopher Johnston&lt;br&gt;RHN&lt;br&gt;Geelong Hospital&lt;br&gt;pH: (03) 5226 7111 Email: <a href="mailto:christopher.johnston@barwonhealth.org.au">christopher.johnston@barwonhealth.org.au</a></td>
</tr>
<tr>
<td>Warrnambool* also operate from various sites in Camperdown, Lismore and Macarthur</td>
<td>Warrnambool</td>
<td>South West Healthcare</td>
<td><strong>Staff</strong>&lt;br&gt;• Hospital has a RHN (1day/week) and Community Health Nurse&lt;br&gt;• Community health clinic has a RHN (0.5EFT)&lt;br&gt;&lt;strong&gt;Programs supporting maternity care&lt;/strong&gt;&lt;br&gt;• Hospital provides a continuity Midwife Program that prioritises providing care for refugee women</td>
<td>Moya Mahony&lt;br&gt;Refugee and Community Health nurse&lt;br&gt;pH: (03) 55644188 Email: <a href="mailto:mmahony@swh.net.au">mmahony@swh.net.au</a></td>
</tr>
</tbody>
</table>
## 5.2 Women’s Health Services

<table>
<thead>
<tr>
<th>Region</th>
<th>Sites</th>
<th>Organisation</th>
<th>Resources</th>
<th>Contact</th>
</tr>
</thead>
</table>
| Southern Metropolitan| Dandenong   | Women’s Health in the South East                       | **Staff**  
  - Afghan bilingual worker who runs information drop in sessions on women’s health | Ph: (03) 9794 8677                           |
| Western Metropolitan | Footscray   | Women’s Health West                                   | **Staff**  
  - FARREP worker  
  - Educational materials  
    - African women’s health pamphlet (Amharic, Somali, Tigrigna, Arabic) with sections on mother and baby care, pregnancy care, childbirth, female circumcision, and existing health centres, hospitals and interpreter information  
    - Translated brochures in the process of being developed  
    - Pregnancy care manual for service providers – ‘Mama and Nunu’: pregnancy care for African women | Teresia Mutisya  
  FARREP  
  pH: (03) 9689 9588 |
| Northern             | Collingwood | Multicultural Centre for Women’s Health                | **Staff**  
  - FARREP worker  
  - Bilingual community health educators  
  **Programs supporting maternity care**  
    - Industry visits, health education sessions and community workshops, held in location convenient for women in their preferred language (available in Amharic, Arabic, Dari, Farsi, Somali, Tigr, Tigrigna, other)  
    - Information stalls on women’s health  
  **Educational materials**  
    - Bilingual website  
    - Support above programs with written resources in language of group  
    - Multilingual library with resources developed by MCWH and externally (Arabic, Arabic, Khmer, Portuguese, Somali, other)  
    - Factsheets on pregnancy and birth (Amharic, Farsi, other) (in production)  
    - DVD – Having a baby in Australia (Arabic, Persian, Tamil, | Amira Rahmanovic  
  Education & Training Programs Manager  
  Ph: (03) 9418 0918  
  Email: programs@mcwh.com.au |

Pauline Gwatirisa  
National project and advocacy office  
Ph: (03) 9418 0915  
Email: |
<table>
<thead>
<tr>
<th>Maternity Care Service Provision for Women from Refugee Backgrounds</th>
</tr>
</thead>
<tbody>
<tr>
<td>other)</td>
</tr>
<tr>
<td>• DVD – You are not alone: Emotional health for mothers</td>
</tr>
<tr>
<td>(Amharic, Arabic, Dinka)</td>
</tr>
<tr>
<td>• DVD – Understanding Gestational Diabetes (Arabic, other)</td>
</tr>
</tbody>
</table>

Medina Idriess  
FARREP community worker  
ph: (03) 9418 0919  
Email: medina@mcwh.com.au

pauline@mcwh.com.au

Medina Idriess  
FARREP community worker  
ph: (03) 9418 0919  
Email: medina@mcwh.com.au
### 5.3 Additional information sources

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Available resources</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Planning Victoria</td>
<td><strong>Staff</strong>&lt;br&gt;• FARREP program co-ordinator&lt;br&gt;&lt;br&gt;<strong>Educational materials</strong>&lt;br&gt;• Manual on child birth in simplified English</td>
<td>Clare Naffah&lt;br&gt;Co-ordinator FARREP program</td>
</tr>
<tr>
<td>NSW Multicultural Health Communication Service</td>
<td>Internet Directory providing multilingual resources on maternity care, available in Arabic, Farsi, Khmer and Tamil.&lt;br&gt;Prenatal&lt;br&gt;• Parenting with HIV&lt;br&gt;• What to bring to hospital&lt;br&gt;• Ultrasound preparation&lt;br&gt;• Stages of pregnancy and labour&lt;br&gt;• Smoking and pregnancy (several resources)&lt;br&gt;• Rubella&lt;br&gt;• Prenatal tests&lt;br&gt;• Pelvic floor&lt;br&gt;• Maternity care options&lt;br&gt;• Genetic counselling&lt;br&gt;• Having a baby</td>
<td><a href="http://www.mhcs.health.nsw.gov.au/publicationsandresources/topics.asp">http://www.mhcs.health.nsw.gov.au/publicationsandresources/topics.asp</a></td>
</tr>
</tbody>
</table>
### Maternity Care Service Provision for Women from Refugee Backgrounds

<table>
<thead>
<tr>
<th>Service Provider</th>
<th>Services</th>
<th>Language Availability</th>
</tr>
</thead>
</table>
| Family planning NSW                                    | Has several translated fact sheets to do with reproduction health. Available in variety of languages, including:  
  - Arabic  
  - Assyrian  
  - Burmese  
  - Dinka  
  - Farsi  
  - Swahili  
  Also have links to maternity care reference books in Arabic. | [http://www.fpnswnsw.org.au/](http://www.fpnswnsw.org.au/)  
  Ph: 1300 658 886 |
| The Victorian Foundation for Survivors of Torture (Foundation House) | Provides direct services to survivors of torture and trauma in the form of  
  counselling, advocacy, family support, group work, psycho-education, information sessions and complementary therapies. Also provides training and education to strengthen capacity of service providers and communities.  
  **Educational materials**  
  - Making a healthy start in Australia: An overview of the Australian health care system including how to access services and interpreters and referral information provided in simplified English.  
  - Sexual Violence and Refugee Women from West and Central Africa (2005)  
  Email: info@foundationhouse.org.au |
| NSW Department of Health                               | **Educational materials**  
  - Educational DVD - Your Pregnancy Your Health (Somali, Dinka, Arabic) | Gordana Kostadinovska  
  Ph: (02) 87593828  
  Email: Gordana_Kostadinovska@wsahs.nsw.gov.au |
### 5.4 Tertiary care resources

<table>
<thead>
<tr>
<th>Royal Women’s Hospital</th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Location</strong></td>
<td>Parkville</td>
</tr>
</tbody>
</table>
| **Contact** | Jenny Timms  
Women’s Health Information Centre  
ph: (03) 8345 2000 |
| **Resources** |  |
| **Staff** | • FARREP worker  
• A newly established de-infibulation Clinic |
| **Programs** | • Hospital tours  
• Antenatal classes – for different language groups can arrange for one on one or group sessions with interpreter  
• Healthy Mothers Healthy Babies Program |
| **Educational materials** | • Women’s Health Information Centre  
• Pregnancy packs containing brochures, factsheets and information in Arabic. Women from other language groups are provided with available translated materials and referred to Multicultural Centre for Women’s Health  
• Large variety of factsheets on miscarriage and pregnancy loss, pregnancy and birth, etc. available from website (Amharic, Arabic, Assyrian, Filipino, Hindi, Khmer, Somali, Tigrinian, Eritrean) |
| **Guidelines FGM** | • FGM clinical management guidelines  
• Female Genital Mutilation (FGM) Resource Manual for Health Professionals (in development)  
• FGM management guidelines |
| **Interpreter use** |  |
| **Policy** | • Must use professional interpreters – agency provider  
• Out of hours – phone interpreting  
• Staff interpreters available during business hours for some languages |
| **Performance indicators (2007-2008)** | • Rate of women assessed for interpreter requirements 99 %  
• Rate of women provided with appropriate interpreter services 81 % |
<table>
<thead>
<tr>
<th><strong>Mercy Hospital for Women</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Location</strong></td>
<td>Heidelberg</td>
</tr>
<tr>
<td><strong>Contact</strong></td>
<td>Natalija Nesvadba Manager Multicultural Services</td>
</tr>
<tr>
<td></td>
<td>Parent Education: pH: (03) 8458 4255 Email: <a href="mailto:nnesvadba@mercy.com.au">nnesvadba@mercy.com.au</a></td>
</tr>
<tr>
<td><strong>Resources</strong></td>
<td><strong>Staff</strong></td>
</tr>
<tr>
<td></td>
<td>• FARREP / African liaison worker</td>
</tr>
<tr>
<td></td>
<td>• Some interpreters on staff</td>
</tr>
<tr>
<td></td>
<td>• Somali social worker (on placement)</td>
</tr>
<tr>
<td></td>
<td>• Emphasis currently on building workforce capacity to provide services to different cultural groups</td>
</tr>
<tr>
<td><strong>Programs</strong></td>
<td>• Through FARREP program provide one on one direct care, as well as pregnancy education and hospital tours.</td>
</tr>
<tr>
<td></td>
<td>• Parent education office provide group antenatal classes in Vietnamese and Chinese, otherwise provide one on one antenatal information with interpreters</td>
</tr>
<tr>
<td></td>
<td>• Multicultural Services provide professional development for antenatal care staff to increase their cultural competence.</td>
</tr>
<tr>
<td><strong>Educational materials</strong></td>
<td>• Rely on information provided by Royal Women’s and NSW websites tabled above.</td>
</tr>
<tr>
<td></td>
<td>• Some in house publications (cost prohibitive - provide services to 70 different language groups)</td>
</tr>
<tr>
<td><strong>Guidelines</strong></td>
<td></td>
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<tr>
<td><strong>FGM</strong></td>
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</tr>
<tr>
<td></td>
<td>• Clinical practice guidelines</td>
</tr>
<tr>
<td></td>
<td>• Ongoing professional development program around FGM for staff provided by FARREP program</td>
</tr>
<tr>
<td><strong>Interpreter use</strong></td>
<td><strong>Policy</strong></td>
</tr>
<tr>
<td></td>
<td>• Professional interpreters should be used at critical points of care.</td>
</tr>
<tr>
<td></td>
<td>• No person under the age of 18 can be used as an interpreter.</td>
</tr>
<tr>
<td></td>
<td><strong>Performance indicators (2007-2008)</strong></td>
</tr>
<tr>
<td></td>
<td>• Rate of women assessed for interpreter requirements 100%</td>
</tr>
<tr>
<td></td>
<td>• Rate of women provided with appropriate interpreter services 82%</td>
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</table>
### Monash Medical Centre – Southern Health

<table>
<thead>
<tr>
<th><strong>Location</strong></th>
<th>Clayton</th>
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</thead>
</table>

| **Contact** | Kerrie Papacostas  
Midwifery Coordinator  
Women's & Children's Program  
Ph: (03) 9594 2545  
M: 0404 833437  
Fax: (03) 9594 6031  
Kerrie.Papacostas@southernhealth.org.au |

| **Resources** | • Refer women to Greater Dandenong Community Health Centre (Southern Health) for bilingual antenatal classes |

| **Guidelines FGM** | • No FGM guidelines at present. Draft guidelines in development |

| **Interpreter use** | **Policy**  
• Interpreter policy overview attached Appendix 6  
• Professional interpreters – NAATI accredited where possible – should be used at critical points of care  
**Performance indicators (2007-2008)**  
• Rate of women assessed for interpreter requirements 100%  
• Rate of women provided with appropriate interpreter services 51% |
6 Experiences of care provision

Maternity care service experiences among women from a refugee background

This section provides an analysis of studies on the experiences of women of refugee backgrounds, and migrant women, accessing maternity services. As well as some of the barriers that women of refugee backgrounds, and migrant women, can experience when trying to access appropriate care. The studies incorporated are set in chronological order and are not just based upon maternity services within Victoria, but extend to maternity services within Australia and internationally.

The majority of studies available on this topic do not distinguish between the experiences of migrant women and women of refugee background. While many of the issues and experiences raised by migrant women may be similar to those experienced among women of refugee backgrounds, these studies are not able to provide specific insight into the experiences of women of refugee backgrounds. The majority of studies available are also qualitative rather than quantitative, which limit the extent to which generalisations can be drawn concerning maternity care services as a whole. However, qualitative studies provide valuable insights into issues that are relevant to consider when assessing the need for maternity service reform and provision. Qualitative studies are also effective at providing the individual ‘woman’s voice’ to maternity services.

The analysis has also revealed the shortage of available literature on experiences of maternity services by women of refugee backgrounds in Victoria. Some of the studies detailed below are more than five years old, and do not focus upon the Victorian maternity setting. As such, the studies may not be an accurate reflection of an area of our health system that has seen significant reform and investment over the past number of years. In order to gain a more current understanding of maternity service provision for women of refugee backgrounds in Victoria, it may be necessary to conduct new research on women of refugee backgrounds experiences of, and barriers to accessing, maternity services in Victoria.

(Please note: a reference in the below summaries to refugee women, includes women from refugee backgrounds. The terminology utilised is that as provided in the original study.)

The voices and concerns about prenatal testing of Cambodian, Lao and Vietnamese women in Australia

The study provides insight into genuine communication and information issues for women of refugee backgrounds/migrant women, and, highlights the important role information plays in providing choice to women when accessing maternity services. A patients’ understanding of medical testing and medical procedures within any health service provision is important for overall best practice and community satisfaction with the health service.

The voices and concerns about prenatal testing of Cambodian, Lao and Vietnamese women in Australia, is a qualitative study that explores the experiences of women from South-east Asia of pre-natal testing in Victoria. The study was conducted over the years 1997-1998 and involved 67 women in total.
Importantly, the vast majority of the women interviewed, 41 in total, were of refugee backgrounds. However, the study does not differentiate between women of refugee and non-refugee backgrounds.

The findings from the study indicate 'women mentioned the need to know about the health of their unborn baby as the most important reason for them to have prenatal screening'. As one woman described;

'Is good. It helps me know that my baby is normal.'

'When asked about their feelings after having prenatal screening, the majority of women said...they ‘felt normal’ or ‘felt nothing’ about it. This was usually because they believed that prenatal screening was a routine part of pregnancy care in Australia.' However, the study goes on to describe that even though the women understood the importance of testing for the babies health, and generally accepted the need for prenatal testing 'it is evident that the women interviewed did not fully understand the purpose of the testing...nearly all of them said they did not understand the tests or why they were offered to pregnant women, apart from being a routine part of maternity care. One woman explained;

The doctor just sent me to have the ultrasound. They checked the baby and gave me the photo. But I didn’t know why they did the test and when pregnant women should have the test. They did not tell me.'

Further to this issue, 'Despite little knowledge about the test, women said they felt good, as they had done what they were supposed to do during pregnancy.'

Other communication issues raised in the study were examples of when women felt they were requesting a particular service, such as an ultrasound, but did not receive that service.

Another issue, highlighted by one woman, was that she felt the use of the interpreter was to pressure her into agreeing with the doctor, rather than to assist her to make an informed choice on the issues discussed.

**What women from an Islamic background in Australia say about care in pregnancy and prenatal testing**

This study provides an important insight, as it demonstrates the principle of individualised care within the maternity care service. Maternity services should accept that women will come from a variety of cultural backgrounds, but this does not automatically mean that they will require specialised or added care. As such, maternity services should avoid drawing assumptions based on a woman’s cultural background. This study similarly highlights the importance of communication in the maternity service setting.

'What women from an Islamic background in Australia say about care in pregnancy and prenatal testing,' was a study conducted in 1999.

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5 Liamputtong, Pranee and Watson, Lyndsey. Page 308
6 Liamputtong, Pranee and Watson, Lyndsey. Page 309
7 Liamputtong, Pranee and Watson, Lyndsey. Page 309
8 Liamputtong, Pranee and Watson, Lyndsey. Page 309
Unfortunately, the study does not provide an indication of whether the women interviewed were from refugee backgrounds. Further, the majority of women in this study had advanced English literacy and had studied at a tertiary level.

The importance of this study is that it reveals that despite women in the study having generally high levels of English language literacy/understanding, ‘women felt that because they wear a hijab or nekab, health providers do not perceive them on an equal level to themselves.

A common, automatic reaction was that the women needed an interpreter or someone to explain to them, as they would be unable to understand on their own. This creates frustration and anger among many women as they felt that they should not be judged because of their appearance’.

**Negotiating Cultural Change and Maternity Care**

This study highlights the important need for translated information that can be readily accessed by individuals from different cultural backgrounds. Further, the overall provision of maternity services was regarded as positive, and was recognised as important, by the women interviewed.

This study, published in 2000, titled ‘Negotiating Cultural Change and Maternity Care’ is a qualitative study in which 14 women from the Horn of Africa were interviewed in 1998 at Victoria’s Mercy Hospital.

The study stated that eight of the women entered Australia as refugees however the length of stay of the women averaged between 12 months and 12 years.

While this qualitative study provides many examples of valid and interesting first-hand accounts of the maternity experience, the page titled ‘Horn of Africa Women’s suggestions for Best Practice’ provides some valid observations for the purposes of this report. These observations are set out below:

‘Tell them we need more information and to behave friendly. Sometimes we are not comfortable to ask. We can be shy. Give more information about what they are going to do. Explain what it is all about.’

‘If they see we are Muslims, for emergencies it doesn’t matter if it is a male or a female doctor. It is no big deal. The religion will allow this, so do not delay.’

‘When I had my baby I wanted to breastfeed but there was a man there so I couldn’t because I am Muslim. Sometimes there are male cleaners also and this is not appropriate for us, we need to be able to breastfeed.’

‘I suggest that there will always be interpreters. They should ask every woman what they prefer, an interpreter or a friend.’

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10 Tsinaskas, Vicki and Liamputtong, Pranee Page 32.
12 Murphy, Liz et al. Page 41.
13 Murphy, Liz et al. Page 60.
The study reveals that ‘of significance is the indication by women of a relative lack of knowledge about the pregnancy and birth process and a sense of isolation and shyness with regard to obtaining accurate, relevant and reliable information’.\(^{14}\) Further, ‘the relatively uniform experience of women not having timely access to translated or interpreted information that is clear and relevant to their obstetric care...’\(^{15}\) This was compounded by the fact that ‘some women were unclear as to their right to access interpreters and were unaware that they would not be personally charged for the cost of the service.’\(^{16}\) Clearly, the provision of information about maternity care was of most pressing concern to the women in this study, as was in understanding the full range of maternity services available.

Overall, the women interviewed conveyed positive experiences of the maternity services they had received, and ‘consistently spoke of their beliefs about the value of regular check ups and hospital care, prior to the birth of their babies. Women showed an understanding of the risks of not utilising maternity services available and saw the utilisation of medical care as their own responsibility and separate to their religious beliefs.’\(^{17}\)

The experiences conveyed above indicate that of most concern among women was the provision of information regarding the birthing process and available maternity services/birthing options.

**Does continuity of care matter to women from minority ethnic groups?**

The study emphasises the importance of continuity of care for migrant women in maternity services. In particular, it stresses the importance of women knowing and developing a relationship with their midwife.

This paper, published in 2000, titled ‘Does continuity of care matter to women from minority ethnic groups?’\(^{18}\) is based upon a study of the United Kingdom maternity service system.

The report describes how continuity of care can aid communication, increase the likelihood of positive accounts of the birthing process, reduce the number of professionals that women see, and enhance women’s experiences of support.\(^{19}\)

**Birthing and post-natal practices of African communities in Victoria**

This report highlights the importance of relationships and trust for Somali women experiencing the birthing process. Further, the importance for Somali women to feel supported and special in the process of birthing. The report demonstrates important and valid cultural factors to be considered within any thinking upon maternity service provision.

\(^{14}\) Murphy, Liz et al. Page 63.  
\(^{15}\) Murphy, Liz et al. Page 64  
\(^{16}\) Murphy, Liz et al. Page 64  
\(^{17}\) Murphy, Liz et al. Page 68  
This report, which formed part of a conference proceeding in 2001, is called 'Birthing and post-natal practices of African communities in Victoria'. Although this paper was not specifically focused upon African women from refugee backgrounds, it does provide an example of the ways in which the birthing customs of different cultures can vary.

The paper focuses on the issue of post-natal depression (PND), and explains that there is no term for PND in most African languages, the word in Somali literally translates to "craziness afterbirth" "umulmar". Due to the availability of communal and extended family care/support in their countries of origin, women did not traditionally seek clinical or other PND assistance. This would perhaps highlight the need for an emphasis within maternity care services to provide adequate information in regards to post natal depression to women of Somali background.

The paper also describes cultural practices where 'the umul' (new mother) is kept confined to her bedroom and mostly lies flat for forty days. Other people in the community are responsible for protecting the (new mother) from noise, stress and strain. (New mothers) have everyone's support, including that of their neighbours and other community members. During this time, the husband will live separately or avoid contact with the (new mother) for the prescribed forty days. Such practices may not be clinically supported in maternity care models within Victoria, and would be difficult to replicate. However, they do provide important insights into cultural and relationship factors for women of Somali background.

**Interviews with Vietnamese born women**

This study illustrates the importance of caregivers being sensitive, keeping women informed of what is happening during pregnancy and ensuring women feel supported during the birthing process. This also has similarities with some of the trends of earlier studies.

This study, published in 2003, titled 'Interviews with Vietnamese born women', involved interviews with 75 women of Vietnamese background from 2002-2003 in Victoria. Seventeen of these women identified as being from refugee backgrounds. However, the report does not distinguish between the experiences of the women from migrant or refugee backgrounds.

The study provides an in-depth analysis across various stages of maternity services, and provides an excellent analysis of women's ratings of care. The study reveals that, 'two thirds of the Vietnamese women were very happy with their care in labour...

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(Further) two thirds of the Vietnamese women interviewed attended care through the Springvale Community Health Service (SCHS) or shared care... (and) around three quarters of the women attending SCHS and shared care reported that the caregivers took their concerns seriously, caregivers were sensitive and they were kept informed of what was happening during pregnancy. However, 'very few women were asked if they wished to follow any traditional cultural practices before, during or after the birth of their baby'. This is an interesting observation, given the overall high ratings of care generally. Perhaps indicating the sensitivity of the maternity service, and provision of relevant information, was more important to the women in this study than following cultural practices.

The study also noted that 'during labour and birth nearly all of the Vietnamese women felt that the midwives were always there when needed. Two-thirds of the Vietnamese women felt that the midwives were very helpful, around half reported that the doctors were very helpful.' The results of interpreting services were mixed, with no obvious relevant trends for the purposes of this report.

**Sudanese women’s experiences of child rearing in Western Sydney in comparison to their experiences in Sudan**

English language workshops, designed to teach women the language used during the birthing process, was one option mentioned among the women in the below study. This is an interesting proposal for future maternity service enhancements.

A study conducted in 2004 titled ‘Sudanese women’s experiences of child rearing in Western Sydney in comparison to their experiences in Sudan’ reveals that many of the experiences of women of refugee backgrounds, relating to maternity service provision, are not unique to the Victorian health care system. This study involved a focus group of 30 refugee-background Sudanese women at the Blacktown Migrant Resource Centre, another focus group of 10 refugee-background Sudanese women at the Blacktown Anglican Church and five in-depth interviews with refugee-background Sudanese women (two in Blacktown, two in Merrylands and one at the Liverpool Migrant Resource Centre).

The findings of this study are difficult to summarise, as the study often doesn’t make clear whether the findings are from a majority of all women used in the study, majority of all women interviewed or a mixture of both depending on geographic location. However, several broad themes can be provided.

The study raises a number of communication issues identified by the women involved. One issue concerns a lack of knowledge about antenatal (maternity care) classes, and difficulty accessing classes conducted in Arabic, however it is unclear if all the women within the study were Arabic speakers.

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24 Yelland, Jane et al. Page 51
26 Yelland, Jane et al. Page 53

Another study, published in 2008, titled ‘Somali women and their pregnancy outcomes post-migration: data from six receiving countries’ looked to the pregnancy outcomes of migrant Somali women from 1997-2004 in six Western countries. This study provides intriguing insights into pregnancy outcomes, and interesting data on some discrepancies between Somali women and country of study-born women. However, for the purposes of this report, there was no direct collation of the Somali women’s experiences of maternity services and as such this report was not explored in the discussion here.
Another communication issue to emerge was the apparent lack of information provided to women on what was going to occur during birth and available options, such as pain relief, caesarean section and deinfibulation/infibulation (for women who are circumcised). This lack of information also extended to information on birthing options, such as labour unit or birthing centre.

**Reproductive Health for Resettling Refugee and Migrant Women**

This study highlights the strong need for cultural practices and beliefs to be appreciated and understood by health practitioners, and, for medical procedures to be explained fully, and understood, within different cultural frameworks.

This study, published in 2004, titled ‘Reproductive Health for Resettling Refugee and Migrant Women’\(^29\) is a qualitative study focused upon reproductive health in Victoria more broadly.

The study included 255 participants and was conducted over three years. The study involved women from a broad range of cultural backgrounds, including Somalia, Ethiopia, Eritrea, Sudan and Nigeria (the study states that most of the women from these countries were recently arrived refugees).

The study also included women from Lebanon, Iraq, Jordan, Saudi Arabia and Syria (however, with the exception of Iraqi women, the study states these participants were less likely to be from refugee backgrounds). The report does not distinguish between women from refugee and non-refugee backgrounds.

The study provides insights into the issue of Female Genital Cutting (FGC), also described as Female Genital Mutilation (FGM) in other sections of this report. The report states ‘women in the study had a high level of understanding and acceptance of Australian legislation (that FGC is an illegal practice in Australia) and a strong awareness of the Family and Reproductive Rights Education Program (FARREP). Women expressed concern about the sensationalised portrayal of FGC in the media as barbaric, which they believed resulted in public and highly intrusive discussions of a private aspect of women’s lives.’\(^30\)

Another concern raised in the report was that, ‘for many, cultural and religious beliefs were cited to explain the inappropriateness of procedures performed routinely in antenatal care such as ultrasound and screening for foetal abnormalities. One participant said:

"[It is] bad luck to anticipate a gift you are about to be given. It’s not like you can say you will give it back if it’s not what you want."\(^31\)

In relation to communication within the maternity service setting, ‘most women said they would prefer a professional interpreter of whom they had no other expectations. This was not always an option as 69% described at least one occasion when they were not able to gain access to an interpreter.’\(^32\)

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\(^29\) Allotey, Pascale et al. Health Issues. Number 78. Pages 12-17. 2004
\(^30\) Allotey, Pascale et al. Page 13
\(^31\) Allotey, Pascale et al. Page 14
\(^32\) Allotey, Pascale et al. Page 15
A recurrent issue relayed by women was experiences of ‘poor communication as a result both of unavailability of interpreters and of poor cross-cultural communication… (One example of this issue follows)

For her [interviewee] the worst aspect of the ordeal was that although she was fluent in English, she was largely ignored, even when she asked directly for explanations of what was happening.

The overall experience for her was sufficiently unpleasant for her to express her determination to avoid any obstetric or gynaecological examination or procedure for the rest of her life. In spite of pressure from her husband and extended family, she reported that she would not have any more children if she had to have them in Australia.33

The above study illustrates a number of issues, communication and cultural awareness would appear to be most important to the woman of this study.

Antenatal care perceptions of pregnant African women attending maternity services in Melbourne

This study demonstrates the importance for maternity care processes and procedures to be explained fully, and, for an awareness to exist within maternity care providers that often routine procedures or testing can cause concern and distress to women of refugee backgrounds. Such awareness may create more supportive and accepting maternity care provision.

The ‘Antenatal care perceptions of pregnant African women attending maternity services in Melbourne’34 is a qualitative study conducted in 2006-2007 with 18 women of African background. Most of the women were from the Horn of Africa and all but one is in Australia on a refugee or family re-unification visa. All women attended the African Woman’s Clinic in Melbourne. This study is one of the most recent and targeted studies conducted on women of refugee background experiences of maternity services in Victoria. The findings provide the clearest summary of the themes and observations that arose.

The study discusses that the African womens’ experiences of maternity services ‘is largely facilitated by culturally sensitive and supportive services...they (women in the study) initially returned for appointments simply because the atmosphere at the clinic was friendly and accepting. In receipt of supportive services, participants attended antenatal appointments and, over the course of several visits, came to value the care offered.’35 Further, ‘feeling welcome and accepted at the antenatal clinic was very important, and most found it easy to attend knowing that they would not be judged harshly, even if they inadvertently behaved inappropriately.’36

In terms of communication within the maternity service, one factor that ‘improved attendance at antenatal appointments...included the availability of interpreters and the provision of interpreter-mediated education services.’37

33 Allotey, Pascale et al. Page 15
35 Carolan, Mary and Cassar, Loris. Page 197
36 Carolan, Mary and Cassar, Loris. Page 197
37 Carolan, Mary and Cassar, Loris. Page 197
This was highlighted as an important factor as the women in the study ‘generally described a lack of English language skills as the most significant difficulty they faced in Australia.’

In terms of the service provided to the women in this study, they were ‘satisfied with their care and felt privileged to avail of Western services.’

However, while the women appreciated the care they received, ‘most struggled to understand the need to attend for appointments early in pregnancy, and to see the utility of screening tests. Induction of labour was a particularly troubling concept and one that the women had not encountered previously. Many were afraid of technology, such as ultrasound, and were confused when advised to behave in a way contrary to their traditional practices.’

Creating consumer satisfaction in maternity care: the neglected needs of migrants, asylum seekers and refugees

This paper demonstrates that many of the challenges that women of refugee background and migrant women experience, in regard to maternity care service provision, are not unique to Victoria.

This paper, published in 2007, ‘Creating consumer satisfaction in maternity care: the neglected needs of migrants, asylum seekers and refugees’ provides insights into barriers that migrant/women of refugee background experience in accessing maternity services globally. The study notes that ‘the complexity of the health system has been identified as a major barrier to accessing care, with women lacking knowledge of the services available and the potential costs involved.’ Further, some of the ‘barriers to identifying the needs of migrant women include the fact that they sometimes have poor language skills, are less likely to speak English or are illiterate.

Referring to maternity services more generally, the author suggests maternity services can alienate women from a different cultural background. The author demonstrates this point with reference to an example from a study conducted in the United Kingdom, which revealed that Muslim parents were insufficiently involved in maternity service provision and that Muslim woman’s choices about their treatment and care were very limited.

Language and Cultural Barriers of Asian Migrants in Accessing Maternal care in Australia

This study highlights the very important role that open and accessible communication plays in the maternity service care setting, and, of ensuring that the individual needs of women can be discussed and assessed.

‘Language and Cultural Barriers of Asian Migrants in Accessing Maternal care in Australia’ is a qualitative study conducted in Tasmania with 10 Asian migrant

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38 Carolan, Mary and Cassar, Loris. Page 197
39 Carolan, Mary and Cassar, Loris. Page 197
40 Carolan, Mary and Cassar, Loris. Page 197
42 Jentsch, B et al. Page 130.
43 Jentsch, B et al. Page 130.
44 Jentsch, B et al. Page 130.
women. Whilst the study does not specify whether the women interviewed were of refugee background, it does provide two interesting insights.

The first is that ‘all participants reported that they received a lot of booklets and brochures from hospitals and healthcare providers but most of them were written in English. Due to their limited English proficiency, some migrant women could not read and get information from them’:

‘I went to hospital to find out the information about health care. They gave me few booklets to read. I did not understand well because my English was not good. I could not read the booklets because they were all in English’.

The study also revealed that many of the women interviewed were reluctant to request information from the maternity care service. Further, they were reluctant to request their preferences in terms of kind of service and care they desired.

**Final Report for the Mater Hospital Refugee Maternity Project**

<table>
<thead>
<tr>
<th>This report identified various recommendations, for improved maternity care services to women of refugee backgrounds. Some of the most relevant of these recommendations are, Extended appointment times.</th>
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<td>- Clustering of women in their language groups.</td>
<td>- Provision of cultural competence training of administration staff.</td>
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<td>- Provision of culturally and linguistically appropriate antenatal and postnatal education.</td>
<td>- Translated information.</td>
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<tr>
<td>- Appropriate referral pathways be established e.g. Maternal Child Health, Division of GPs.</td>
<td>- Support and opportunity be considered for refugee women who were midwives in their country of birth to provide education on traditional birthing practices to the multidisciplinary staff working in maternity services.</td>
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<tr>
<td>- Volunteer services to provide childcare for women during the refugee clinic time.</td>
<td>- Partnerships with female leaders of refugee communities to explore the capacity of their own communities to provide support to isolated refugee women.</td>
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<td>- Community engagement continued through strong participation of community representatives in consultative processes.</td>
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The 'Final Report for the Mater Hospital Refugee Maternity Project' is a qualitative study that involved ‘twenty-three African women from a refugee background (who) were interviewed in April/May 2008’.

The report is based on a service provided by the Mater Hospital in Brisbane, and provides some excellent first-hand accounts of the experiences of refugee women. The comments expressed by women covered a range of issues as outlined below.

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46 Hoang, Ha. Page 57
47 Hoang, Ha. Page 57
On interpreters:

"I found it very helpful...sometimes she explains the things which are not clear to me and make me understand."

"It was difficult for me to understand the importance of medicine until [it was explained] through the interpreter."

"Interpreters from Syria and Iraq can't understand us and we can't understand them. I prefer interpreter from Sudan."

"I was provided with a young girl interpreter. I didn't feel free to tell her all my problems as she was unfamiliar with women problem... it was difficult to explain to me what they told her (…) I take this opportunity to tell you that I was unhappy when MMH organized a male interpreter for me when I had miscarriage 2 years ago. Because I had miscarriage they were to do a lot of test and examinations.

Everything was done while a male interpreter was standing beside me. I didn't like it and it took me a while to forget what happened."

On health professionals generally:

'Fifteen (65%) women considered it important to be cared for by the same health care professional as this impacted on the follow up and saved time.

"The staff will do good follow up and the same person will know exactly where and how you are progressing and it builds trust and confidence in the patient...me.”

"Every time you see a different person they have to ask same questions.”

On issues to do with the antenatal clinic:

"Long waiting hours for a pregnant lady is unacceptable."

"Time of appointments difficult because of children."

"The interpreters delay and it delay my time to pick up school children."

"Interpreter was not the right one of my language."

"Too much blood tests."

"I was not given area orientation on my visit.”

"They didn’t tell me whether the baby was a boy or a girl."

When questioned what might improve services, women mentioned the following points:

• provision of appropriate interpreters

52 Final Report for the Mater Hospital Refugee Maternity Project. Page 34-35
• more female interpreters
• greater access to translated material and information that covers the whole birthing process
• shorter waiting times
• staff who also have an African background, or who have an awareness of the circumstances of the refugee women
• staff who are aware of FGM (female genital mutilation/cutting), and
• allowance of greater family involvement.

These comments are indicative of what has been discussed in all of the studies described above.

**Understanding the mental health and wellbeing of Afghan women in South East Melbourne**

The study, 'Understanding the mental health and wellbeing of Afghan women in South East Melbourne' was published in January 2010 and was based upon ‘in-depth interviews conducted with health and community workers in contact with the Afghan community and focus group discussions held with Afghan community representatives in October and November 2009’

The report raises many examples of the experiences of migrant women, and women of refugee background, in regards to maternity services within Victoria, primarily within the Dandenong area. Broadly, ‘many Afghan participants made a point of reporting how grateful they were for the services available to them in Australia. Barriers to accessing services included expectation by Afghan men and women that husbands accompany their wives to appointments, inadequate access to and funding for interpreters, the cost of some services, problems accessing transport, and the availability of some services.’

This finding is reflected in earlier studies, where the service provided by maternity care providers is positively received. However cultural practices, (the husband attending maternity care appointments and in some instances appearing to control the appointment, or limiting what can be discussed by the women by virtue of their physical presence) and ongoing issues as to interpreters and cost of some services (especially around the cost accessing mental health services) can raise barriers for women accessing the maternity services.

Further, ‘the findings revealed complex transitions and social change required by Afghan refugees upon arrival in Australia. Practices around pregnancy and childbirth in Afghan cultures usually involve relatively intensive support of the extended family. This means that in Australia the husband plays a greater role due to the absence of the family network, and the role of maternal and child health support is crucial.’

Again, demonstrating how important it is for maternity service providers to be aware of cultural practices, how these cultural practices impact upon pregnancy, and that often the maternity care models within Victoria will be challenging to women of refugee/migrant backgrounds.

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53 Final Report for the Mater Hospital Refugee Maternity Project. Page 37-38
55 Rintoul, Angela. Page: 6
56 Rintoul, Angela. Page: 20
57 Rintoul, Angela. Page: 20-21
58 Rintoul, Angela. Page: 21-22
59 Rintoul, Angela. Page: 6
Another interesting issue was raised where 'most Afghan parents are unable to attend during business hours due to their husbands work commitments. Afghan men suggested that it would be useful to run a class for pregnant women to provide information about the range of support services available. Afghan women also said that it would useful for Afghan men to be present during the birth of children as this may support the development of respect for women.'

**Summary**

The above studies provide a number of insights into experiences that women from refugee backgrounds (and in many cases women of migrant background) have when accessing maternity care services.

Interestingly, while the above studies incorporate women from a range of cultures, and are based upon research regarding different types of maternity care service provision, they share a number of commonalities.

From the above studies the following key themes can be identified;
- the importance of access to appropriate interpreters (this was identified in both number of interpreters available, gender of the interpreter, and the language/cultural background of the interpreter),
- the importance of access to appropriate and translated information/resources,
- the importance of communication and information from the maternity service (in particular around options during birth and support services).
- An identified need for communication/information prior to birth,
- the suggestion, in one study, of provision of English language classes specifically focused on the birthing process,
- the importance of maternity care staff being culturally aware/competent,
- the importance of maternity services taking the time to listen to what women want and need,
- the importance for maternity care services to be friendly, accepting and supportive,
- the culture within the maternity service appears to have the greatest impact on women’s experiences.

- Most of the studies identified that the clinical care provided by the maternity services was of a high standard.

- However, it is vital that women fully understand and are accepting of the procedures and clinical processes that are recommended, which enhances women’s feelings of support and comfort when accessing services.
7 Service provider experiences – Case study

Goulburn Valley Health
Shepparton
- August 2010-

Kaye Gall
Associate Director of Nursing

This case study explores how maternity care is provided to women from non-English speaking backgrounds (NESB) at Goulburn Valley Health in Shepparton.

Goulburn Valley Health was chosen to case study because of its rural location and the rapid demographic change that has occurred in the Shepparton area in recent times. There is a recognised need for information about the experiences of maternity care service providers in rural regions of Victoria. Being rurally located, in conjunction with the need to adopt new strategies to meet the needs of growing numbers of people from NESB settling in the area, provides new challenges for health care providers.

Refugees in Shepparton are mainly from Congolese, Sudanese, Arabic and Afghani backgrounds. There is also a significant population of non-refugee residents from India and China.

Note: The information in the case study is not specific to the refugee women. The case study explores issues that arise when providing care to clients from non-English speaking backgrounds more broadly. Throughout the case study NESB (Non-English Speaking Background) will be used to refer to women from both non-English speaking and refugee backgrounds.

GVH: Hospital Services Summary

Goulburn Valley Health is the major provider of Maternity Care Services to the Shepparton community. Currently 1100 to 1150 births occur at the hospital annually and approximately 12 per cent of women who birth at the hospital are from CALD backgrounds. The hospital has eight neonatal beds and provides a variety of antenatal and domiciliary services.

"People from NESB may have either a Medicare card, some form of health insurance or no financial support for purchasing health care" - Kaye Gall

The Hospital does not have a specific CALD maternity services clinic or a formal procedure for distinguishing women from refugee backgrounds. Women’s language needs and individual care requirements are identified at first contact.

Maternity services provided by the hospital are available to all women and there are no services or programs provided specifically for women from CALD backgrounds. However, the hospital has an interpreter policy to cater for the needs of CALD women. The hospital also has a direct relationship with the community health service in the region where a refugee health nurse is located. This relationship enables the community health service to ‘fast-track’ women and families who need tertiary care.
Maternity Care Service Provision for Women from Refugee Backgrounds

into Goulburn Valley Health services, where they would otherwise be required to wait until they had been examined by the hospital nurse. Many women who are referred through the community health centre are deemed to be at high risk due to gynecological complications. In such cases, women are typically referred to the gynecological clinic. Women who attend the antenatal clinic initially are seen by a midwife and then booked in for an obstetric assessment.

GVH: What are the issues?

Health literacy

Women from CALD backgrounds often have limited health literacy on account of limited English ability and lack of familiarity with Western healthcare procedures and processes.

Women may not understand the medical reasons behind procedures adopted by the hospital. For example, medical complications sometimes necessitate separating women from their new-born babies. This occurs in instances when the baby is required to stay in the hospital due to birthing complications, such as being born prematurely, or health complications from diabetes or hypertension. When women are discharged without their baby it can be highly distressing, as women are not used to this being a medical requirement. Furthermore, it often conflicts with women’s cultural norms. Many women are accustomed to having their baby co-sleeping with them and being able to feed their baby at any time. Imposing a requirement that the women are discharged without the baby can conflict with the women’s cultural norms of child-rearing.

Although the Hospital endeavours to use interpreters where required, appointments with interpreters take longer than standard appointments. This can result in longer delays for other clients and an increased workload for staff, which in turn, can impact upon the quality of care that staff are able to provide.

Appointment schedules and transport

GVH staff report that women often do not turn up for scheduled appointments. They suggest this is a consequence of women being unfamiliar with appointment scheduling. It can also be difficult for women from CALD backgrounds to access transport. Many women do not have access to private transportation and have difficulty accessing public transport due to the associated cost or distance. This can be especially problematic when appointments are very early in the morning or late in the evening. A lot of women are dependent on a family member or friend providing transport to the hospital.

Being rurally located can result in additional transport challenges for women, particularly in circumstances where women are required to travel to Melbourne to access specialist services. For example, women may require access to specialists in the area of infectious diseases, who are not typically available outside of metropolitan Melbourne.

Cultural norms and preferences

Women from CALD backgrounds often request to see a female practitioner, which can be difficult for the Hospital to accommodate as there is not always a female doctor or obstetrician available. Sometimes women instead opt to attend a midwifery clinic; however this is not an option for women who are deemed to be at high risk and consequently must be seen by an obstetrician. This can be upsetting and challenging for both women and their partners.
Another challenge that Goulburn Valley Health staff have experienced relates to misconceptions about breastfeeding. Many women believe that providing babies with artificial formula is preferable to breastfeeding for the child’s health. In a local qualitative study conducted by GVH staff, in which a focus group with Iraqi women was conducted, it was found that Iraqi women often interpret artificial formula as superior to breast feeding. Women in Iraq require a doctor’s certificate to be able to artificially feed their babies, and when they see artificial formula freely available in supermarkets, they often assume this is better for the health of their children.

GVH: Strategies used that work well

Goulburn Valley Health Hospital has an interpreter policy to cater for the needs of women from CALD backgrounds.

In order to better manage the expectations of women and their partners regarding the availability of a female gynaecologist, GVH provides patients with translated information at the initial point of contact outlining their inability to guarantee a female doctor. This information is accessible in a number of languages including Arabic and Dari. Ensuring that women understand what can and cannot be provided early on has resulted in greater satisfaction among women and their families.

The hospital has also spent time training community leaders in order to facilitate community understanding and information sharing. The hospital provides training which incorporates information relating to breastfeeding and understanding the Australian healthcare system. Once trained, leaders are able to share this learning with other community members. This has led to increased trust among community members of health care providers as well as greater client satisfaction.

The hospital has also deliberately relocated antenatal clinics off site to improve accessibility. A midwife antenatal clinic is now situated in close proximity to an area that has a large population of women from Arabic speaking cultures, and attendance has increased as a result.

GVH: Measures of Success

One of the indicators of the usefulness and effectiveness of the policies used by GVH is positive feedback and reduction in complaints about the service. The GVH guidelines have now been extended to the regional shared care models at Cobram Hospital.

GVH has not yet had the capacity to undergo a formal evaluation of the service it provides to women from refugee backgrounds. There has been one focus group conducted by Maternal and Child Health nurses with women from the Iraqi community concerning the importance of breastfeeding. However, this focus group was not aimed at evaluating services or exploring women’s understanding of the services provided.

GVH: Lessons for Subsequent work

It has been recognised that GVH staff would benefit from further cultural competency training to better understand how women’s culture implicates the type of care they require. Additional training for health care professionals on the provision of maternity care to women from CALD backgrounds is also something that would be helpful in addressing knowledge deficits among staff.

The hospitals has also considered running specific antenatal sessions for women from refugee backgrounds, but have found the investment in training for community
leaders to be a more effective method of educating women about the Australian healthcare system.

Another approach being considered is to conduct focus groups with women from CALD backgrounds to gain insight into their understandings of and expectations about the care which they receive from the hospital. However, the hospital does not currently have the capacity to do this.

There is a recognised need to modify clinics to support the specific needs of women from NES backgrounds and improve the functioning of clinics.

*Being a rurally located service brings unique difficulties for some clients. Transport can be difficult to access, particularly for specialist services, some of which are only available in Melbourne.*

*A significant issue to consider when providing maternity care to women from refugee backgrounds is women’s understanding of the Australian Healthcare System, and staffs’s understanding of women’s cultural norms and preferences. Communication and engaging community leaders has proved useful for Goulburn Valley Hospital in overcoming these challenges.*
8 Conclusions and recommendations

People from refugee backgrounds are among the most vulnerable populations in Victoria. Many people from refugee backgrounds have complex health needs that must be addressed post settlement. This is often a result of previous health concerns that have not been addressed and an extended period of emotional and physical hardship in their country of origin and during the journey to Australia.

The challenge for health care providers in Victoria is to make sure that services are able to meet the needs of all Victorians, including the most vulnerable. This is particularly important for maternity care providers, who may be among the first health care providers that women from refugee backgrounds access upon arrival in Victoria.

Providing appropriate care can be difficult when clients have limited health literacy and/or English proficiency, or are unfamiliar with the Victorian health care system and the roles of service providers, as is often the case with clients from refugee backgrounds. Services must recognise and respond to differing cultural norms regarding health and medical interventions, often with limited resources and minimal experience working with people from the countries of origin most common among new arrivals.

Policy context

The Victorian Government outlines its commitment to improving the health and wellbeing of all Victorian’s in *A Fairer Victoria, 2010*. More specifically, the *Refugee Health and Wellbeing Action Plan 2008-2010* outlines a vision that refugee communities in Victoria attain the best possible health and wellbeing, and stresses the need to build the capacity and expertise of mainstream and specialist health services in order to achieve this.

In regard to maternity care service provision specifically, the Government emphasises in *Future Direction for Victoria’s Maternity Services* that women must be informed, empowered, and in control of what happens to them during pregnancy and childbirth. In circumstances where women are unfamiliar with the Victorian health system and have limited English and health literacy, this can be a difficult standard for health care practitioners to meet.

Service provision

The resource section included in this report details the types of translated materials, specialised staff and specific programs relating to maternity care that are available in Victoria. The section shows that there are limited resources available, and the materials and services currently being provided do not cater for all language groups that are common among humanitarian entrants.

It is also evident from the data analyses included that requests for interpreting services have significantly increased in just one year, and that this demand varies greatly between hospitals and language groups. It is vital to meet the interpreting needs of women in order to ensure women are in a position of control over the care they receive and procedures they undergo.
Women’s experiences

In order to determine measures that could improve service provision in maternity care, it is important to understand the experiences of women from refugee backgrounds when receiving maternity care.

The literature analysed indicates that women from CALD and refugee backgrounds are typically appreciative and positive about the maternity care they receive, and that clinical care provided is of a high standard. However, women’s satisfaction is greater when maternity care service providers do the following:

- explain medical procedures and the reasons for them, such as prenatal screening and technology and induction of labour, which women may not be familiar with
- provide accessible information on services and service choices available, translated where appropriate, and recognise that women may not always be forthcoming with requests for information
- treat all women with respect and avoid making assumptions on the basis of cultural stereotypes
- understand that women from different cultures may have different expectations and preferences regarding care, and take the time to discover whether this is the case and any implications
- provide timely access to interpreters and explain interpreting procedures
- endeavour to provide continuity of care, which can aid communication.

The case study highlights that it can be difficult for service providers to meet the needs of women in some circumstances. However, certain strategies can help achieve this. For instance, Goulburn Valley Health provide pregnancy and birthing information to community leaders to facilitate information sharing, which can help women gain an informed understanding of health care requirements and procedures. The case study also demonstrates that in circumstances where women’s preferences cannot be met by the service provider, such as requests for female care providers when none are available, women’s satisfaction is greater if their requests are recognised, discussed up front, and an explanation is provided as to why the service provider cannot fulfil this preference.

The literature available indicates that effective maternity care does not necessarily require an in depth understanding of a woman’s cultural norms, or significant changes to the standard procedures and types of care provided. Instead, the evidence suggests that the most critical factors impacting women’s satisfaction with the services they receive, regardless of their cultural background, is the extent to which staff are friendly, respectful, and sensitive.

Recommendations

In light of the findings of this report, it is recommended that the working group explore the need to:

1. conduct targeted research examining the maternity care service experiences of women from a refugee background in Victoria and reasons for the varying rates of caesarean births in Victorian hospitals among women from different countries of origin
2. amend current maternity care data collection procedures to enable greater clarity regarding the interpreting needs of women from NESB and ability of hospitals to meet demand

3. increase professional development opportunities for maternity care service providers, including cultural clinical competency, awareness of the impact of trauma and torture, and recognition of the impact of sensitivity and respect

4. facilitate links between maternity care services and service providers that regularly work with clients from refugee backgrounds, in order to share leanings and improve care coordination. This may be aided by the development of Refugee Maternity Care Partnerships

5. develop English language workshops to teach women with limited English sufficient vocabulary to understand what is being said around them during pregnancy, as a tool to empower women during birth

6. further develop service models that respond to the needs of women from refugee backgrounds

7. increase access to the different types of maternity care service models that are currently provided in limited areas only.
9 Appendix A

Focus countries and languages

Resources included in this document were those provided to women from the 20 most common language groups and countries of birth among humanitarian entrants settling in Victoria between 2006 and 2010, according to the DIAC settlement reporting database. These countries of origin and languages are tabled below.

Table 1: Top 20 countries of birth and language spoken among humanitarian entrants settling in Victoria (2006-2010)

<table>
<thead>
<tr>
<th>Top 20 countries of birth* among humanitarian entrants settling in Victoria in the period 2006-2010</th>
<th>Top 20 languages spoken by humanitarian entrants settling in Victoria in the period 2006-2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Burma</td>
</tr>
<tr>
<td>2</td>
<td>Iraq</td>
</tr>
<tr>
<td>3</td>
<td>Afghanistan</td>
</tr>
<tr>
<td>4</td>
<td>Sudan</td>
</tr>
<tr>
<td>5</td>
<td>Thailand (typically Burmese ethnicity)</td>
</tr>
<tr>
<td>6</td>
<td>Sri Lanka</td>
</tr>
<tr>
<td>7</td>
<td>Ethiopia</td>
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<tr>
<td>8</td>
<td>Iran</td>
</tr>
<tr>
<td>9</td>
<td>Liberia</td>
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<tr>
<td>10</td>
<td>Kenya</td>
</tr>
<tr>
<td>11</td>
<td>Arab republic of Egypt</td>
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<tr>
<td>12</td>
<td>Pakistan</td>
</tr>
<tr>
<td>13</td>
<td>Democratic Republic of the Congo</td>
</tr>
<tr>
<td>14</td>
<td>Somalia</td>
</tr>
<tr>
<td>15</td>
<td>(People’s Republic of China)(^{(a)})</td>
</tr>
<tr>
<td>16</td>
<td>Eritrea</td>
</tr>
<tr>
<td>17</td>
<td>Zimbabwe</td>
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<td>18</td>
<td>Sierra Leone</td>
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<td>19</td>
<td>Uganda</td>
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<tr>
<td>20</td>
<td>Bhutan</td>
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<tr>
<td>1</td>
<td>Arabic</td>
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<tr>
<td>2</td>
<td>Dari</td>
</tr>
<tr>
<td>3</td>
<td>Burmese / Myanmar</td>
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<tr>
<td>4</td>
<td>Karen</td>
</tr>
<tr>
<td>5</td>
<td>Chin</td>
</tr>
<tr>
<td>6</td>
<td>Assyrian</td>
</tr>
<tr>
<td>7</td>
<td>African Languages, nfd</td>
</tr>
<tr>
<td>8</td>
<td>Dinka</td>
</tr>
<tr>
<td>9</td>
<td>Tamil</td>
</tr>
<tr>
<td>10</td>
<td>Karen S’gaw</td>
</tr>
<tr>
<td>11</td>
<td>English</td>
</tr>
<tr>
<td>12</td>
<td>Persian</td>
</tr>
<tr>
<td>13</td>
<td>Amharic</td>
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<tr>
<td>14</td>
<td>Pashto</td>
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<tr>
<td>15</td>
<td>Somali</td>
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<tr>
<td>16</td>
<td>Farsi (Persian)</td>
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<tr>
<td>17</td>
<td>Tigrinya</td>
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<tr>
<td>18</td>
<td>Chin Haka</td>
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<tr>
<td>19</td>
<td>Chaldaean</td>
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<tr>
<td>20</td>
<td>Swahili</td>
</tr>
</tbody>
</table>

\(^{(a)}\) Although China is listed, there is a large proportion of people from China who come to Victoria on Skilled or Family visas, as distinct from the other countries listed. The numbers of humanitarian entrants from China is very small by comparison. Consequently, resources targeting women from China have been excluded from the resource section. Most persons from refugee backgrounds listed as being from China are more likely to be of Tibetan or Uighur ethnicity. Resources provided in these languages have been included.
*Note: recorded country of origin does not indicate a person’s cultural background and may be a consequence of births that take place in refugee camps in initial country of refuge.

**Note: countries are listed in order of number of arrivals, from highest to lowest number

*Source: Data extracted from Department of Immigration and Citizenship Settlement Reporting database, May, 2010*