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Finding our own ways of working together: reflections on implementing and facilitating a multidisciplinary and equity-oriented model of Group Pregnancy Care for women of refugee background

Ms Fran Hearn[a,*], Dr Laura Biggs[a], Professor Stephanie Brown[a,b,c,d], Ms Ann Krastev[a], Mr Josef Szwarc[e], Associate Professor Elisha Riggs[a,b]

[a] Murdoch Children's Research Institute, Intergenerational Health, 50 Flemington Rd, Parkville, VIC, 3052, Australia
[b] University of Melbourne, Department of General Practice, Swanston St, Parkville, VIC, 3052, Australia
[c] University of Melbourne, Department of Paediatrics, Swanston St, Parkville, VIC, 3052, Australia
[d] South Australian Health and Medical Research Institute, Adelaide, SA, 5001, Australia
[e] The Victorian Foundation for Survivors of Torture Inc., Brunswick, VIC, 3056, Australia

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ABSTRACT

Objective: This paper explores professional staff experiences of implementing and facilitating a multidisciplinary equity-oriented model of Group Pregnancy Care for women of refugee background. This model was the first of its kind in Australia and one of the first worldwide.
Design and Setting: This exploratory descriptive qualitative study reports the process evaluation findings from the formative evaluation of Group Pregnancy Care for women of refugee background. Data were collected in Melbourne, Australia between January and March 2021 via semi-structured interviews, and analysed using reflexive thematic analysis.
Participants: Purposive sampling was used to recruit twenty-three professional staff involved in the implementation, facilitation, or oversight of Group Pregnancy Care.
Findings: This paper reports five themes: knowledge sharing, bicultural family mentors – the critical link, finding our own ways of working together, power dynamics at the intersection of community and clinical knowledge, and system capacity for change.
Key conclusions: The bicultural family mentor role contributes to the cultural safety of the group, and increases the confidence and competence of professional staff through cultural bridging. Multidisciplinary cross-sector teams that collaborate well can provide cohesive care. It is possible for hospital and community-based services to establish cross-sector equity-oriented partnerships. However, there are challenges sustaining partnerships in the absence of explicit funding to support collaboration, and in context of organisational and professional inflexibility.
Implications for practice: Investing in change is necessary to achieve health equity. Creating explicit funding pathways for the bicultural family mentor workforce, multidisciplinary collaboration, and cross-sector partnerships would strengthen service capacity to provide equity-oriented care. Working towards health equity also requires a commitment to continuing professional development for professional staff and organisations to increase knowledge and capacity.

Introduction

Inequity during the perinatal period

Despite widespread recognition of the inequitable burden of adverse perinatal outcomes experienced by families of refugee-background, disparities continue (Gibson-Helm et al., 2015; Rogers et al., 2020). In Australia, women of refugee background experience higher rates of stillbirth (Davies-Tuck et al., 2017; Rumbold et al., 2020; Yelland et al., 2019), preterm birth, congenital anomalies, admission to neonatal intensive care units, and poor maternal mental health (Gibson-Helm et al., 2015; Navodani et al., 2019; Rogers et al., 2020). In 2021–22, 11,545 visas were granted to refugees (and others in humanitarian need) living overseas, to come and settle in Australia (Australian Government Department of Home Affairs, 2022). Common settlement experiences,

* Corresponding author: Ms Fran Hearn, 50 Flemington Rd, Parkville, VIC, 3052.
E-mail address: fran.hearn@mcri.edu.au (M.F. Hearn).

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such as limited social support, financial hardship, social isolation, and not speaking English add to the complexity of providing high quality perinatal health services for families of refugee background (Owens et al., 2016; Riggs et al., 2016, 2012; Yelland et al., 2015, 2014). Several studies show that health services can struggle to meet the social, emotional, and health care needs of women of refugee-background, particularly in large public hospitals (Brandenberger et al., 2019; Yelland et al., 2021, 2016, 2015, 2014), where most urban Australian women and families receive pregnancy care and give birth (Australian Institute of Health and Welfare, 2022a). As Marmot et al. (2012) and others have argued, meaningful changes to the way perinatal care is provided are necessary to achieve health equity. There is evidence that collaboration and coordination between hospital and community-based services may increase the capacity of the health system to provide high-quality integrated perinatal care (Narain et al., 2019; Reno et al., 2021).

Group Pregnancy Care

Group Pregnancy Care [GPC] is an innovative model of care that has the potential to improve health equity for women of refugee-background (Australian Government Department of Health, 2020; Riggs et al., 2021, 2017). Between 2014 and 2020, the Intergenerational Health group at the Murdoch Children's Research Institute [MCRI] and the Victorian Foundation for Survivors of Torture [Foundation House] facilitated the codesign and evaluation of two GPC programs for women of refugee background in Melbourne, Australia – in partnership with two public hospitals, two community-based maternal child health services, and a community-based refugee agency. These programs were codesigned with and for Karen and Assyrian Chaldean communities (Riggs et al., 2021). GPC for refugee-background women aimed to address existing inequities through the integration of culturally safe and trauma-informed support, and by improving maternal health literacy and self-efficacy (Riggs et al., 2021). Papers about women's experiences of attending GPC and the codesigned multimethod evaluation protocol have been published in detail elsewhere (Riggs et al., 2021, 2017). The formative evaluation and associated outputs are available via the study website (Stronger Futures Centre of Research Excellence, 2022). In brief, local partnerships were established between public maternity hospitals, maternal child health services, and refugee agencies. Groups were located in a setting close to where families lived – with an aim to provide an accessible community-oriented space. Fortnightly group information sessions were held for two hours, co-facilitated in women's preferred language/s by a midwife and bicultural family mentor. As well as sharing information to prepare for pregnancy, birth, and breastfeeding, women were supported to learn about a range of other topics that were of interest to them – such as finance management, dental care, and more. Antenatal visits were held as per the hospital schedule, conducted one-to-one with a midwife and interpreter, in a private room adjacent to the group space – to ensure women had adequate opportunity to raise any issues they weren't comfortable discussing in the group. Continuity of care was embedded antenatally and up to four months postnatally.

GPC for women of refugee background enabled services and professional staff to provide women with straightforward access to a multidisciplinary cross-sector team of professionals. The service also aimed to reduce the burden of navigating care within an unfamiliar and complex health system (Riggs et al., 2021). Multidisciplinary teams included an interpreter, a bicultural family mentor, two midwives, and a maternal child health nurse. One team also integrated a parent support worker. Interpreters enabled pregnancy appointments and group discussions to be conducted in women's preferred language/s. Bicultural family mentors provided support for women through shared culture and language, facilitated culturally safe and supportive connections to health, maternity, and early childhood services, and ensured women understood their rights when interacting with these services. Midwives provided clinical maternity care and education. Maternal child health nurses facilitated an early link to the maternal child health service, which tracks child growth and development over the first five years of life, and helped women to prepare for breastfeeding and parenting beyond the immediate postpartum period. Parent support workers assisted women and their families to identify any challenges and enhance parenting strategies and family connections, and provided support and referrals for other children of the women and families attending.

Cross-sector equity-oriented partnerships

Implementing and facilitating GPC for women of refugee background required a commitment to health equity by participating services and professional staff including the formation of new cross-sector partnerships, the investment of time and other resources, and an openness to practice and system change. There is a longstanding body of research demonstrating that positive collaboration between services offers important benefits (Hilts et al., 2021; Loban et al., 2021; Riggs et al., 2014). Services that work together are better equipped to meet the needs of specific populations, such as women of refugee background, by establishing common goals, sharing resources, diversifying reach and scope of practice, and improving cross-sector communication and referral networks (Browne et al., 2018; Hilts et al., 2021; Loban et al., 2021; Riggs et al., 2014). The formation of new cross-sector partnerships can also be challenging, particularly when grappling with conflicting organisational priorities, entrenched institutional policy or practice norms, inflexible funding pathways, and systemic issues such as hierarchical power imbalances and institutional racism (Browne et al., 2018; Narain et al., 2019; Reid et al., 2021; Reno et al., 2021). These challenges can make cohesive collaboration difficult, particularly if relationship building and capacity exchange between services is not explicitly funded. Funding is generally allocated to services individually, rather than collaboratively, which can impose a systemic barrier to the sustainability of partnerships (Browne et al., 2018; Reno et al., 2021).

In this paper, we report findings from an exploratory descriptive qualitative study (Daly et al., 2007), which reports the process evaluation findings from the broader formative evaluation of GPC. This element involved asking professional staff to reflect on their involvement with GPC for women of refugee background. In this paper, we use the language 'professional staff' to refer to the range of clinical and social care staff, stakeholders, and leaders involved in the implementation, facilitation, or oversight of GPC for women of refugee-background. To maintain confidentiality and prevent participant identities from being deduced by local readers, professional roles, names, and organisations are not included. Although there is a considerable amount of research depicting the benefits and challenges of cross-sector equity-oriented partnerships at a leadership-level (Loban et al., 2021; Narain et al., 2019), little has been published specifically from the perspectives of those who are providing equity-oriented health and/or social care. Furthermore, to the best of our knowledge, GPC for women of refugee background is the first model of its kind in Australia and one of the first in high-income countries worldwide (Ahrne et al., 2023). There are no other peer reviewed papers published that address the experiences of professional staff involved with this model.

Research aims

This study aimed to: (i) explore professional staff experiences of cross-sector collaboration and program delivery; (ii) explore perceptions of the bicultural family mentor role; and, (iii) understand from the perspective of professional staff what can be learned from their experiences of implementing GPC for women of refugee background to inform future work in this area.

Methodology

This study was theoretically informed by constructivism, a research paradigm that considers 'reality' to be individually rather than universally defined, and supports researchers to hear and think openly (Birks and Mills, 2014; Guba and Lincoln, 1982). Given this study was undertaken across a number of cultural boundaries, it was important for researchers to be able to understand co-constructed realities and hold differing complex understandings of the same program.

Methods

Sampling, eligibility, recruitment, and consent

Purposive sampling was used to facilitate the recruitment of eligible participants (Liamputtong, 2020), including past and present professional staff from partnered organisations. Twenty-nine eligible participants received an individualised email with a hyperlink to a research electronic data capture [REDCap] survey (Harris et al., 2019), where they could express interest in participating. Twenty-three participants electronically registered their interest, two declined to participate due to workload pressures, and four did not respond (23/29, 79%). Informed e-consent was obtained prior to each interview.

Ethical considerations

Ethics approval was obtained from the Royal Children's Hospital Human Research Ethics Committee. Assurance was provided to all participants that high standards of confidentiality would be maintained, and that data obtained from interviews would not be shared in a way that could enable identities to be deduced. Secure storage of participant data was achieved using REDCap (Harris et al., 2019). Due to COVID-19 workplace restrictions, all interviews were conducted via telephone or Zoom video software (Liamputtong, 2020; Sipes et al., 2019).

Data collection

Data were collected by two researchers [FH, AK] between January and March in 2021, via semi-structured interviews lasting 30–90 min (Liamputtong, 2020; Sipes et al., 2019). Interviews were audio recorded with consent. Two participants declined to be audio recorded and detailed notes were taken in lieu, with permission. Professional services transcribed audio data. Transcripts were checked for accuracy by the interviewers [FH, AK].

Data analysis

Data were analysed using Braun and Clarke's (2022a, 2019) method of reflexive thematic analysis, which complements constructivist principles (Braun and Clarke, 2022b; Byrne, 2021). In reflexive thematic analysis, interpretation of data is considered to be a subjective rather than objective process that requires the researcher to interrogate the possible influence of their personal assumptions (Braun and Clarke, 2022a, 2022b). Reflexivity encourages a stronger level of interpretation throughout the analysis, potentially improving the quality and rigor of study findings (Braun and Clarke, 2022a). To become immersed in the data, the lead author [FH] first read each transcript while listening to the corresponding audio recording (Green et al., 2007). Two transcripts were iteratively coded using NVivo (QSR International Pty Ltd., 2018), with labels that used interpretation and meaning to organize sections of the text (Braun and Clarke, 2021; Green et al., 2007). A senior researcher on the study team [LB] and the lead author [FH] critically examined these early codes and discussed meanings, thinking, and positionality – with an aim to reach new insights rather than agreement between researchers. Two cycles of coding and categorization were then applied to all transcripts using the same coding technique and reflexive position [FH]. Themes were derived from the data using a combination of writing, rewriting, visual mapping, group discussion, critical reflection, and consideration of study aims [FH, LB, SB, AK, JS, ER] (Braun and Clarke, 2022a, 2021; Green et al., 2007).

Reflexivity

All authors of this paper [FH, LB, SB, AK, JS, ER] have aimed to operate with a high level of professional accountability to participants and partner organisations. Reflexive practices that increase awareness of beliefs or assumptions have been embedded systematically within the study protocol, and incorporated at each stage of the research process. For example, team-based reflexive activities included regular attendance at project meetings, group reflection and critical enquiry, and contemporaneous feedback processes to progress thinking, analysis, and writing. The first author of this paper [FH] is a midwife by background – currently working in research on projects that are geared towards health equity, such as Group Pregnancy Care for women of refugee background. In addition to these group practices, FH maintained a reflexive position via regular reflective supervision and journaling.

Results

Participant demographics

Interviews were completed with twenty-three clinical and social care professional staff involved in the implementation, facilitation, or oversight of two GPC programs for women of refugee background in Melbourne, Australia. Hospital, maternal child health, and community services that implemented GPC were located in the northern and western suburbs of Melbourne. As stated in the introduction, given the unique nature of this model, geographical context, and small staff teams – participant identities will be easily deduced by local readers if further participant information is disclosed. However, it is important to note that two staff members from the same professional group did not participate, citing pandemic-related stress in context of local lockdowns and professional changes. At the time of these interviews, the Australian health care system was in the midst of adapting to the COVID-19 pandemic (Bradfield et al., 2021). Please see the 'Limitations' section for further information. These findings report five key themes, which are summarised in Table 1 below:

1. Knowledge sharing

The implementation and delivery of GPC required a multidisciplinary cross-sector team of professionals to work together to establish new relationships, new systems, and a new way of providing pregnancy care for women of refugee background. This opportunity enabled different types of knowledge to be shared between professionals, and between women.

Table 1
A summary of the research findings.

Theme	Summary
1. Knowledge sharing	In a cross sector and multidisciplinary group environment, knowledge can be shared between professional staff and also between women.
2. Bicultural family mentors – the critical link	The presence and support of bicultural family mentors in the group can establish cultural and emotional safety for women, and cultural bridging can improve connections between women, their families, and professional staff.
3. Finding our own ways of working together	For GPC to meet the needs of local communities and participating services, professional staff need sufficient time and autonomy to establish effective and respectful ways of working together.
4. Power dynamics at the intersection of community and clinical knowledge	It can be difficult for professional staff to establish trust and share power, particularly when community and clinical knowledge intersect.
5. System capacity for change	There are important differences in how hospital and community-based health systems are funded and structured, which affect the capacity of systems and the people working in them to change, and to re-orient towards equity.

Knowledge sharing between professionals

Knowledge sharing between professional disciplines simplified access to a wide network of referrals, which could enable teams to plan care for women holistically.

> *"…we had the knowledge and the information that we needed to provide information for whatever the women came up with."* (201)

Participants noticed it felt more straightforward for families to access the support they needed, such as social work or material aid. The success of their collaboration within the group was perceived to be evident in how many women returned for a subsequent baby and/or encouraged their pregnant friends and family members to attend. For participants, experiencing the impact of these synergistic connections was rewarding.

> *"And just makes the work of myself and the team much more easy when those connections happen and you feel that sense of satisfaction that you're achieving something, helping the family achieve something in a very short period of time."* (101)

Knowledge sharing between women

Knowledge sharing between women was another feature of the group. Participants considered peer learning (for example, woman-led discussion and information sharing) key to capacity building and self-determination for women attending the group, and observed the need to step back and make space for women to learn from each other. The opportunity to facilitate, witness, and be part of these interactions between women felt professionally meaningful.

> *"We were just there facilitating it, but they looked after each other."* (114)

> *"I love the women being able to actually educate other women…"* (201)

2. Bicultural family mentors - the critical link

Bicultural family mentors were understood by participants as essential to the development and sustainability of cultural and emotional safety within GPC. In practice, this role included building community trust in the model, supporting women to navigate the often-unfamiliar Australian health care system, and providing an environment where women could talk about and sustain cultural practices and traditions within their pregnancy care.

> *"… all that breaking down of those barriers through* [the bicultural family mentor's] *experience and her knowledge of her own community is really invaluable, and can't be replicated by someone who's not part of that culture."* (108)

The unique position and skillset of the bicultural family mentor, as both a member of their community and someone with formal qualifications relevant to the professional mentor role, enabled them to facilitate cultural bridging between women and clinicians, and offer guidance about culturally safe approaches to pregnancy care.

> *"I love the fact that* [the group has] *got the bicultural* [family mentors] *who are this kind of middle ground…"* (301)

> "[The bicultural family mentor is] *the one who knows the stories…"* (103)

> *"I think* [the] *bicultural* [family mentor] *is the absolute essence of the program."* (105)

3. Finding our own ways of working together

Participants stressed that for the model to work well and to meet the needs of their local community, they needed to find their own ways of working together. Professional autonomy and respectful relationships were important to professional staff bringing the new model of care to life.

The right fit

To support professional staff working in a new model of care, both GPC teams attended facilitation training provided by the Groupwork Centre (2022). The opportunity to connect across sites and discuss their work highlighted important differences between each group, such as the different professional roles involved in each team, approaches to facilitation, and venue of the group. Participants appreciated the way their own group felt like the right fit and observed that when implementing a new model of care, the needs of each community and participating services are unique. Differences between GPC programs such as those listed above, were viewed as a strength to be harnessed for any new group to work well, to meet the needs of women attending, and to align with service capacity.

> *"We realised that although we were providing the same service, we were delivering it in different ways […] each GPC program will be different because you will adapt it to your particular community."* (201)

> *"…there's* [public hospital service] *constraints and cultural needs that have to be met."* (301)

Respectful relationships

Participants also reflected that respectful professional relationships were key to success. Factors that encouraged respectful relationships included the ability to value different kinds of knowledge, proactive teamwork, and goodwill.

> *"For a team to work well, it really requires that everybody is on the same page, communicating well, and respecting each other and*

stuff like that. I think that has been the beauty of this program, and that is what has gelled it together, even during the pandemic period." (101)

4. Power dynamics at the intersection of community and clinical knowledge

Through these interviews, it was clear that all participants were invested in developing and sustaining positive relationships across agencies, sectors, and disciplines. Participants acknowledged that all members of the partnership contributed valuable resources and expertise fundamental to the intent and heart of GPC.

"…I see how all the professionals, they respect each other, their space, their opinion, their values." (101)

It was sometimes difficult for participants to establish trust and share power across sectors, particularly in scenarios where community and clinical knowledge would intersect. When there was a mismatch in expectations or understandings, effective collaboration was inhibited. For example, the different professional boundaries and scope of practice of bicultural family mentors and interpreters sometimes caused confusion about roles. Clinicians relied on both team members for assistance when interacting with women, but were generally more familiar with interpreters. Compared to interpreters, bicultural family mentors have a wider scope of practice and are trained to provide advice and support on a range of topics. At times, when bicultural family mentors were seen to go beyond interpreting what a clinician had stated, some participants viewed these interactions unfavorably. There was an apparent mismatch in expectations – with the bicultural mentor acting within their scope of practice, but some participants perceiving that the bicultural mentor was not qualified to provide information and advice.

"… there were lots of discussions over scope of practice and whose job it is to inform certain things…" (303)

For some participants, there appeared to be a shift in perception over time, with growing recognition of the importance of teamwork and what is possible to achieve when teams work in partnership.

5. System capacity for change

Differences between hospital and community-based systems, including funding pathways and service flexibility, affected the capacity of these systems to adapt to new ways of working. While it is beyond the scope of this paper to provide a detailed explanation of Australian health care arrangements, it is important to note for context that hospital and community-based services share the responsibility of providing perinatal care, but are funded and structured differently. Importantly, GPC was implemented within the existing budgets of maternity and maternal child health services with a view to supporting the long-term sustainability of the model.

Hospital-based systems

Despite their strong commitment to GPC, reflections shared by hospital-based participants demonstrate how perceptions of funding constraints and service inflexibility can limit organisational capacity for change. Participants were apprehensive about the cost associated with providing hospital-employed midwives and interpreters for GPC. They were concerned that less funding would become available long-term if antenatal care was provided for fewer women in the group, compared to standard hospital-based care. Given that the research outcomes, including possible benefits for women and babies and associated cost savings were unknown at this stage of the project, participating in a study could feel unsettling.

"…the cost of sending two midwives out for essentially only being able to deliver six appointments… it's terribly expensive." (304)

"It [GPC] *was viewed as a very expensive model if you're just looking at the health economics of it. Which, you would think that the greater story is yet to be told around the savings that you do make with the good outcomes."* (109)

Participants reflected that public hospitals sometimes struggled to support GPC. The entrenched nature of institutional funding and service priorities did not align well with equity-oriented care, and it was often necessary for participants to justify the value of the model to colleagues and management working outside of the study.

"…they were the challenges, navigating those, I guess, systemic ideas and entrenched behaviours … there's been many examples over the years where I had to go and go in, really advocating for this as that it's not purely about the numbers we see, and because we haven't got those clinical outcomes yet." (305)

When organisational priorities felt incongruent with the equity-oriented aims of GPC, participants did not feel empowered or supported to bring about the changes that would enable the model to be financially or culturally integrated to the hospital environment more easily.

"…if you truly got it and you truly valued it then you wouldn't be fighting over that couple of hours in the afternoon." (303)

"We've been talking about different ways of funding, you know, Victorian [a state in Australia] *health services for years. It's not flexible. It's just not flexible…"* (109)

Meaningful change takes time, and GPC offered an important opportunity for professional staff working in hospital-based systems to learn how to re-orient services towards equity.

"So I think it [GPC] *has created different conversations and the ability to think differently and show we can do things differently. It doesn't have to always be the same thing. It hasn't been easy, but we are still there."* (305)

Community-based systems

Participants working in this sector valued the capacity of community-based services to operate flexibly at a grassroots level and engage directly with communities. The different structure and funding of community-based services appeared to foster deeper recognition of community needs and a greater capacity to tailor care for women with complex requirements.

"…we have a high degree of flexibility and we're still accountable and we're still professional, but we don't have such rigid, strict restrictions on what we can and can't do." (108)

Participants generally considered funding to be either adequate, or a tension to live alongside, rather than a stressor specific to implementing GPC.

"… we weren't constrained by money [to implement a GPC program]*."* (110)

Different funding mechanisms and service structures also appeared to influence participant perceptions of success, and what it takes from systems to successfully establish a new group in the community. For example, when the number of women attending the group varied from week to week, community-based participants were not overly concerned and emphasised that it does take

time to build awareness and trust in the communities they are working with.

> *"…you've got to give programs time to develop their roots in the community and for the community to come forward."* (106)

Discussion

The reorientation of health and social care services towards achievement of health equity is a global health priority (Marmot et al., 2012; World Health Organization, 2018). Our findings provide new evidence that bicultural family mentors working in a multi-disciplinary model of Group Pregnancy Care have the potential to make a critical contribution towards this goal. Bicultural family mentors foster and enable culturally safe perinatal care by facilitating cultural bridging and capacity building for professional staff who work with women of refugee background. Our study demonstrates that cross-sector equity-oriented partnerships are possible, and when multidisciplinary professional staff work closely together, the co-ordination and scope of care they provide can be improved. However, findings also show that there are significant challenges navigating these partnerships – particularly with regards to prioritising the amount of time needed for people and organisations to establish effective ways of working together. It is also clear that different sectors vary in their capacity to embrace equity-oriented innovation. In this study, community-based services demonstrated greater capacity for system change than hospital-based services.

Including bicultural family mentors in perinatal services

While there is scant evidence evaluating the role and contributions of bicultural family mentors in perinatal care (Lutenbacher et al., 2018; Riggs et al., 2017; Rogers et al., 2021), research has clearly established that when women are unable to access good-quality information and care in their own language, they are less likely to engage with services and are at risk of experiencing adverse outcomes (Billett et al., 2022; Duckett et al., 2016; Yelland et al., 2016). Closing the health-equity gap for women of refugee background requires improving the cultural safety and responsiveness of perinatal health care services (World Health Organization Regional Office for Europe, 2018), and bicultural family mentors have a critical contribution to make in this space. The bicultural family mentor role often varies in title and scope between organisations, which potentially contributes to the lack of awareness surrounding the position and precludes greater involvement in mainstream health care services. Titles used in the literature to describe similar roles include but are not limited to: cross cultural workers (Rogers et al., 2021), peer mentors (Lutenbacher et al., 2018), bicultural workers (Cohealth, 2022), and community liaison workers (Wei et al., 2021). Professional recognition and inclusion are likely to be further inhibited by structural power dynamics and racism, that privilege white and western knowledge of health, values, practices, and priorities (Needham et al., 2022).

Findings from this study show how bicultural family mentors in the GPC multidisciplinary team encouraged professional staff to feel more confident and competent providing culturally and emotionally safe care. In particular, they facilitated meaningful cross-cultural understanding and connection – or what we call cultural bridging. Bicultural family mentors are uniquely qualified to provide culturally specific information and advice that facilitates two-way capacity building for professional staff and for community members (Wei et al., 2021). A mixed-methods evaluation by Rogers et al. (2021) explored service provider perceptions of a cross cultural liaison worker program in Sydney, Australia. In this study, cross cultural workers employed in a multidisciplinary health care team provided support to women from migrant, refugee, and asylum-seeking backgrounds accessing and navigating services throughout pregnancy and the early parenting period. The paper reports that service providers felt better able to connect and communicate well with women, due to the continuity, presence, and support of cross cultural workers (Rogers et al., 2021). There are potential benefits for women and their babies, as well as professional staff, as reported by Lutchenbacher et al. (2018) in a randomised controlled trial that tested the efficacy of a peer mentor home visiting program with postnatal Hispanic women in Tennessee, United States of America. Peer mentors had a similar scope of practice to bicultural family mentors in GPC, and were trained to provide health education, social, and emotional support, and referral to community services. This study reported a significant improvement in a range of outcomes for women and families who had access to peer mentors (Lutenbacher et al., 2018).

Time needed for cohesive teamwork and collaboration

In Australia, the health care system is fragmented and information is shared poorly or not at all between organisations (Duckett, 2022). This lack of coordination between services and disciplines is known to increase the risk of substandard care provision and ineffective identification of safety issues (Duckett et al., 2016). The multidisciplinary, cross-sector approach of GPC seeks to overcome inherent challenges in the organisation of Australian perinatal services by facilitating a more integrated approach to care provision. Our study findings show that when professional staff were able to establish positive relationships, it was easier to share information, plan care, and make referrals. Study findings also highlight what it takes for multidisciplinary cross-sector relationships to work well. Importantly, it takes time for people to get to know each other, develop collaborative work practices and to understand and incorporate new knowledge into practice (Browne et al., 2018; Reid et al., 2021; Reno et al., 2021). Appreciation of the role of the bicultural mentor was not immediate for all team members, but did change over time.

Unfortunately, not all GPC services allocated sufficient time for professional staff to plan, debrief, and establish collaborative practices. Tensions arose when participants were unable to develop trusting relationships with their colleagues. During the study period, there was minimal explicit funding available to partners for their work establishing and maintaining partnerships. This is a common constraint encountered in cross-sector partnerships (Browne et al., 2018; Reno et al., 2021). Lack of funding can constrain organisational capacity, making it harder to collaborate and share information, especially in the context of an already fragmented system. While GPC presented an opportunity for professional staff and organisations to work differently, system changes to overcome fragmentation and foster cross-sector collaboration are needed in order to realize the full potential of this model of care (Duckett et al., 2016). Establishing a safe space for ongoing proactive dialog between multidisciplinary team members and managers is important, enabling teams to identify and respond to tensions as they arise (Browne et al., 2018). Having difficult conversations is a necessary part of the process, especially when working to establish cultural safety (Browne et al., 2018). When people with different types of power work together, respectful and authentic communication can also help to prevent and address harm (Reid et al., 2021).

Reorienting services to promote health equity

Health inequities are usually attributed to factors such as poverty, low access to education, and ethnicity – rather than to decisions made on how to fund and provide care (Karger et al., 2022)

Funding arrangements are an institutional determinant shaping the priorities, structure, and potential of health care systems (Duckett, 2022; Hanson et al., 2022). In Australia, the distribution of public health care funding is complex, differs between organisations, and includes overlapping obligations at State and Federal government levels (Australian Institute of Health and Welfare, 2022b; Duckett, 2022). A recent Lancet Global Health Commission on financing primary health care noted that the successful reorientation of existing resources to prioritise equity is a pertinent, convoluted, and political issue, potentially influenced by large-scale social and economic factors (Hanson et al., 2022). The Commission's position is that change requires high-level, resolute, ethical, and pragmatic commitment (Hanson et al., 2022). This view resonates with the experiences of participants in this study, who felt that while their work inside GPC supported health equity, organisational priorities were often incongruous.

Strengths and limitations

This is the first study to explore the perspectives of professional staff involved in the implementation, facilitation, and oversight of GPC for women of refugee-background. The GPC programs were implemented with two different communities, in two separate sites in different geographical areas of Melbourne. Semi-structured interviews were conducted over a three-month period, allowing sufficient time for the researchers to incorporate strong reflective and reflexive practices, to pursue new lines of questioning, and identify new understandings. Although the majority of professional staff involved in GPC chose to take part in an interview, two people from the same professional group declined to participate. Although the professional group cannot be named to protect confidentiality, it is important to note that the views of those who did not participate were unable to be included in the analysis, which is a limitation of this paper. Pandemic-related stress and fatigue were barriers to participation for some. Healthcare system and funding structures differ globally, which limits the applicability of some findings to international settings.

Conclusion

This study has generated new knowledge regarding the experiences of professional staff involved in the implementation, facilitation, and oversight of GPC for women of refugee-background in the northern and western suburbs of Melbourne, Australia. Recommendations for change that would strengthen the capacity of services to achieve health equity include the creation of explicit funding pathways for the bicultural family mentor workforce, cross-sector partnerships, and multidisciplinary collaboration. Findings also demonstrate the need for a culture shift in health care, so that systems and workplaces can make equity part of their core mission.

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Authors' contributions

ER conceived the study in collaboration with SB, LB, FH, and AK. FH and AK undertook data collection. FH led the data analysis with support from LB, SB, and ER. FH, LB, SB, and ER wrote the manuscript. FH, LB, SB, AK, JS, and ER reviewed and contributed to earlier versions of the manuscript and approved the final version. All authors have read and agreed to the final published version.

Ethical approval

Ethics approval was obtained from the Royal Children's Hospital Human Research Ethics Committee (HREC/17/RCHM/66).

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

CRediT authorship contribution statement

Ms Fran Hearn: Conceptualization, Investigation, Formal analysis, Writing – original draft, Writing – review & editing, Project administration, Methodology. **Dr Laura Biggs:** Conceptualization, Formal analysis, Writing – original draft, Writing – review & editing, Methodology. **Professor Stephanie Brown:** Conceptualization, Formal analysis, Writing – original draft, Writing – review & editing, Funding acquisition. **Ms Ann Krastev:** Conceptualization, Investigation, Writing – review & editing, Project administration. **Mr Josef Szwarc:** Writing – review & editing. **Associate Professor Elisha Riggs:** Conceptualization, Formal analysis, Writing – original draft, Writing – review & editing, Funding acquisition, Supervision.

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