

MATERNITY CARE FOR WOMEN FROM REFUGEE BACKGROUNDS

Evidence is emerging of significant disparities in maternity outcomes for Victorian women from refugee backgrounds as compared with the rest of the Victorian population. While maternity service initiatives targeted at women from refugee backgrounds do exist they are limited in their scope and reach.

Disadvantages that women from refugee backgrounds experience are multilayered, emanating from their pre-migration experiences, time spent in transit countries (potentially decades) and stressors related to resettlement.

The experiences and living conditions that women from refugee backgrounds have endured contribute to obstetric complications and may cause increased anxiety in relation to receiving maternity care in Australia. These experiences may include unattended births, traumatic and unsafe abortions, the use of unsterilized equipment, poor sanitation, and high rates of infant mortality (VFST 2005).

AUSTRALIAN REFUGEE PROGRAM

Australia accepted 13,423 people via the humanitarian resettlement program in 2009/2010 financial year, of which 3,895 people settled in Victoria (DIAC Settlement Database extracted 15/2/2011). People are provided with a humanitarian visa because “owing to a well founded fear of persecution” they have left their homeland (The Convention Relating to the Status of Refugees UN, 1951). The refugee flight and resettlement places great stress on individuals and families, such as changing roles and responsibilities, financial difficulties, anxiety due to continuing bad news from country of origin, guilt associated with family left behind and challenges arise due to being a minority in a dominant culture. These factors can compound the psycho-social impacts of a history of torture and other forms of trauma that are inherent to the refugee experience (Kaplan 1998).

EXISTING RESEARCH & PROJECTS

Existing research and practice based projects that the Victorian Foundation for Survivors of Torture (VFST) and Victorian Refugee Health Network (VRHN) have undertaken, are undertaking and/or actively supporting, working collaboratively with health services and refugee background communities include:

- Rintoul (2010) a public health fellow from La Trobe University undertook a study focusing on the mental health and wellbeing of Afghan women in South East Melbourne with a particular focus on pregnancy and childbirth, with VFST as industry supervisors in partnership with Southern Health.
- Healthy Mothers Healthy Babies innovative grants program (time limited funding), involves four local projects based in community health services focusing on:
 - Eastern Access Community Health – developing a service model for pregnant women of Karen and Chin ethnicity living in the outer East

- Southern Health – service mapping to improve care coordination for women of refugee backgrounds in Dandenong-Casey.
- Ballarat Community Health Service – developing a parenting resource with the Sudanese and Togolese communities
- Western Region Health Service – developing a parenting support program in partnership with community organizations that already have engaged with women from refugee backgrounds

VRHN has been funded to provide secondary support to these projects, given its recognized expertise in refugee health issues.

- Department of Education and Early Childhood Development have funded VFST to work with the Chin community in Brimbank to increase early childhood preparation for school. Local service providers have been engaged and a community advisory group has been established. The “Network Model”, developed during the Family Strengthening project at VFST to support strong consumer participation, is the framework being utilized for this project.
- Qualitative research is being undertaken by Melbourne University McCaughey Centre, commissioned by VFST entitled “Supporting Health and Wellbeing for Families with Children of Refugee Backgrounds: Understanding the needs of families and services”, with a particular focus on maternal and child health services. For completion December 2011, this research is based in Hume (Assyrian-Chaldean communities) and Wyndham (Karen community). The findings of this research will inform Phase 2 of this proposal.
- “Maternity Care Service Provision for Women of Refugee Backgrounds in Victoria” is a DHS graduate project, jointly sponsored by DHS and VRHN (Gibson, Attrya et al. 2010). This report brought together maternity admission data, settlement data, a review of relevant Victorian legislation, a summary of existing maternity service models and summaries of maternity research. The report also provided a summary of key programs and resources targeted at women from refugee backgrounds.
- “Raising Children in Australia” is a multilingual DVD in a number of African languages developed by VFST and the Horn of Africa Community Network funded by the Australian Government designed for community and professional education.
- VFST have extended expertise in staff learning and development including: VFST is funded to provide continuing professional development to the Refugee Health Nurse program; VFST have developed a 6 hours GP active learning module focusing on refugee assessment and care.

LITERATURE REVIEW

Australian health research focusing on people from refugee backgrounds is sparse due to the cost of providing interpreters and perceived methodological difficulties (NHMRC 2005 as cited in Davis, Riggs et al. 2010). While some studies do include culturally and linguistically diverse (CALD) participants, they may not necessarily differentiate migrants (those that have chosen to relocate)

from refugees (as defined under the UNHCR 1951 convention). This makes it difficult to elicit the particular experiences, strengths and needs of refugee backgrounds communities. Furthermore health data collection often does not allow for visa category, country of birth or ethnicity to be collected making it difficult to establish service usage patterns of clients from refugee backgrounds and collate prevalence data.

Factors impacting on poor maternal health & wellbeing

Existing evidence does however point to some significant disparities in maternity outcomes for women from refugee backgrounds and the wider community:

- Data from Dandenong in Melbourne suggests that women from refugee backgrounds are more likely than those from other backgrounds to be discharged from regional public hospitals with diagnoses related to obstetric complications (female genital mutilation or circumcision, foetal death in utero and still births) (Cheng, Russell et al. 2011).
- A Finnish study looking at still births and infant deaths in industrialized countries found that women from refugee backgrounds were the most vulnerable group (Gissler M, Alexander S et al. 2009).
- Small et al (2008) in their meta-analyses comparing post-migrated Somali women to the rest of the population of the receiving country, including Australia, found women of Somali ethnicity in industrialized countries had a much higher rate of caesarean section birth and still birth. Small and colleagues concluded that these disparities were not readily explained calling for a review of maternity care practices and targeted strategies to reduce these disparities.

Disadvantages that women from refugee backgrounds experience are multilayered, emanating from their pre-migration experiences, from their time in transit countries (potentially decades) and their experiences in their country of resettlement.

The experiences and living conditions that women from refugee backgrounds have endured contribute to obstetric complications and may cause increased anxiety in relation to receiving maternity care in Australia. These experiences may include unattended births, traumatic and unsafe abortions, the use of unsterilized equipment, poor sanitation, and high rates of infant mortality (VFST 2005). Table 1 contains data which illustrates some women's pre-migration experiences. The data has been collated for the top six countries which have comprised the Victorian humanitarian intake for the past five years (1 July 2005 - 30 June 2010).

Table 1: Data source http://www.unicef.org/statistics/index_countrystats.html and <http://www.immi.gov.au/settlement/>

| Country of Birth | Victorian Humanitarian Settlement Intake (Jul 2005 – Jun 2010) | Pre-migration experiences | | | | | | | | |
|------------------|--|---------------------------------|------------------------------------|--|---|----------------------------|---|---|--|--|
| | | Life Expectancy at birth (2008) | Fertility Rate (2008) ¹ | Under 5 Mortality rate (2008) ² | Maternal Mortality Rate – pregnancy related (2005) ³ | Adult Literacy (2003-2008) | Adult literacy: females as a % of males (2003-2007) | Antenatal care coverage: at least once (2003-20008) | Delivery Care Coverage: Skilled attendant at birth (2003-2008) | Delivery Care Coverage: Institutional Delivery (2003-2008) |
| Australia | | 82 | 1.8 | 6 | 4 | - | - | 100% | 100% | - |
| Burma/ Myanmar | 3562 + 1247 ⁴ | 62 | 2.8 | 98 | 380 | 90% | 92% | 76% | 57% | 16% |
| Iraq | 3024 | 68 | 4.1 | 44 | 300 | 74% | 76% | 84% | 80% | 65% |
| Sudan | 2607 + 297 ⁵ | 58 | 4.2 | 109 | 450 | 61% | 73% | 64% | 49% | 19% |
| Afghanistan | 2750 | 44 | 6.6 | 257 | 1800 | 28% | 29% | 16% | 14% | 13% |
| Sri Lanka | 701 | 74 | 2.3 | 15 | 58 | 92% | 96% | 99% | 99% | 98% |
| Ethiopia | 651 | 55 | 5.3 | 109 | 720 | 36% | 46% | 28% | 6% | 5% |
| Iran | 511 | 71 | 1.8 | 32 | 140 | 85% | 88% | 98% | 97% | 96% |

When considering this data it is important to bear in mind that humanitarian entrants are from persecuted communities and may not have had the same access to health and education institutions. Many people of refugee backgrounds may have spent years in transit countries in either camps or urban settings, it is difficult to obtain good data from refugee camps or transit countries. The statistics demonstrate diversity in experiences; the common thread being a consistent trend of women facing significant inequality in their country of origin with regards to access to education.

Expectations of child birth & child rearing

Women and families from refugee backgrounds will bring with them a multitude of cultural frameworks about health care provision and childbirth. Expectations around pregnancy, child birth and child rearing, for women from migrant backgrounds, are often shaped by their experiences in their country of origin or transit (Desouza 2006). As a result of their relocation women from migrant backgrounds lose information sources and they become more dependent on health professionals (Desouza 2006). This is magnified for women from refugee backgrounds who through chaotic flight may have lost their parents and traditional knowledge sources at an early developmental age. Rintoul's research is one of very few studies that explores the experiences of women from refugee backgrounds in Victoria. It highlights the many interrelated factors that impact women's mental health and wellbeing during the antenatal and postnatal period. Themes include changing family dynamics, isolation, resettlement challenges and traditional birthing and postnatal practices some of

¹ The number of children that would be born per woman if she were to live to the end of her child-bearing years.

² Probability of dying between birth and exactly five years of age expressed per 1,000 live births.

³ Annual number of deaths of women from pregnancy-related causes per 100,000 live births.

⁴ Burmese ethnic minorities born in camps in Thailand

⁵ Sudanese born in Egypt

which contradict accepted post-natal care and advice for new mothers in Victoria. Women need to negotiate these complex issues sometimes soon after arrival.

People from refugee backgrounds bring enormous strength, wisdom and knowledge about pregnancy, birthing and child rearing. Bandyopadhyay and colleagues (2010 as cited in Davis, Riggs et al. 2010) in a survey based study, found that women who were non-Australian born were more likely to be breast feeding at six month after their baby were born and possessed equal confidence to their Australian counterparts in caring for their babies.⁶ International studies also highlight strengths in immigrant populations, including cultural practices and norms which encourage healthy parenting attitudes and behaviors (Guendelman 1999 as cited in Davis, Riggs et al. 2010).

Communication

Despite literature providing evidence of the need for procedures to be fully explained and understood, within different cultural frameworks (Tsianakas and Liamputtong 2002; Allotey, Pascale et al. 2004; Carolan and Cassar 2010), this often is missed in a busy maternity department where interpreters may not be provided and women may have very limited health literacy or understanding of maternity care provision in Victoria.

Increased attendance of women has been found when interpreters were available (Carolan and Cassar 2010). However, communication goes beyond the use of interpreters; time must be allowed for sensitive exploration of women's belief systems that may be influenced by many factors including education, culture and religion. Qualitative research based in Victoria highlighted that routine procedures or testing can cause concern and distress to women from refugee backgrounds due to "cultural and religious beliefs" (Allotey, Manderson et al. 2004).

Maternity practitioners however cannot make assumptions based on a woman's ethnic backgrounds, rather respectful enquiry about cultural practices and beliefs should inform care planning (Tsianakas and Liamputtong 2002; Allotey, Pascale et al. 2004; Allotey, Manderson et al. 2004). Practitioners need to possess insight into their own cultural beliefs, including their significant values rooted in the scientific and biomedical approaches to childbirth. Culturally competent practitioners acknowledge that there are many ways to view health, child birth and child rearing, they use this knowledge to negotiate a path between the dominant culture and that of the women and families that they are working with. Further to this medical procedures may in some instances trigger memories of past torture and other forms of trauma, for women from refugee backgrounds which requires sensitivity and understanding by health practitioners (VFST, 2007).

Effective service elements

Continuity of carers was found to be important with communities from migrant backgrounds as it led to developing a trusting relationship with their midwife (McCourt and Pearce 2000), that allows for a greater exploration of cultural practices and understandings. One such cultural practice is

⁶ Unfortunately this study did not distinguish between women from refugee backgrounds and broader migrant population.

female genital mutilation/cutting (FGM/FGC) which is illegal in Australia, however practiced in 28 countries in Africa and the Middle East. It is vital that maternity services are able to conduct a sensitive assessment and refer for a specialist consultation if required (The Women's 2009). Developing trust is also important as women from refugee backgrounds may feel very isolated during this period of their life given extended family often plays a pivotal role in maternity care. Rintoul (2010), in her report "Understanding the mental health and wellbeing of Afghan women in south east Melbourne" described the important role of extended family in maternity care which is no longer available to many women of refugee backgrounds, due to family separation and/or death of close relatives.

A trusting relationship is also important as women of refugee backgrounds may also be survivors of sexual violence. Sexual violence is very common in regions where social order has broken down and in camps or in transit countries that do not afford protection. Physicians for Human Rights reported sexual violence is being used by the Burmese military in Chin state as a tool to "persecute and demoralize" the Chins. The 2011 report states that men, women, and children reported sexual violations by government soldiers, almost 30 percent of rape survivors were under the age of 15 (IRIN 2011). Sexual violence has many physical and psychological sequelae, pertinent for maternity services to consider is that pregnancies may be a result of rape and routine investigations may trigger difficult memories (VFST 2005).

The challenge of developing a responsive service system was taken up by the Mater Hospital in Brisbane. The aim of the Mater Hospital Refugee Maternity Project was to develop a best practice model of maternity services for women of refugee backgrounds birthing hospital. Key components of effective service provision identified include: contracted suitably qualified interpreters, extended appointment times, clustered women in language groups, staff development regarding medical and cultural competency, referral processes and partnerships with settlement organizations and primary care, employed women from refugee backgrounds who had traditional birthing practice expertise to provide staff development and provided childcare services. This project also recognized the pivotal role of engaging with communities from refugee backgrounds to build their capacity to connect with isolated women and to receive their feedback about the performance of the service (Mater Hospital 2009).

Women, families and communities from refugee backgrounds are the experts of their own experiences. It follows then that in order to further develop service systems it is vital to better understand their experiences, strengths and needs, their access issues and their motivations for accessing services (Schmied et al. 2008 as cited in Davis, Riggs et al. 2010; Cheng, Russell et al. 2011).

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