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Maternity services are not meeting the needs of immigrant women of non-English speaking background: Results of two consecutive Australian population based studies

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ABSTRACT

Background: women of non-English speaking background who migrate by choice or seek refuge in developed countries such as Australia have notably poorer perinatal outcomes than local-born women. Using data collected in two consecutive population-based surveys conducted in 2000 and 2008, the objective of this paper is to compare the views and experiences of immigrant women of non-English speaking background (NESB) giving birth in Victoria, Australia with those of women who were born in Australia.
Methods: consecutive population-based surveys of women giving birth in Victoria, Australia conducted in 2000 and 2008. Questionnaires were distributed to women giving birth in a two-week period in 2000 and a four-week period in 2008 by hospitals and home birth practitioners. Surveys were mailed to women at five to six months post partum.
Findings: completed surveys were received from 67% of eligible women in 2000 (1616/2412), and 51.2% in 2008 (2900/5667). Compared to Australian-born women, immigrant women of NESB were more likely to report negative experiences of antenatal, intrapartum and postnatal care. In 2008, 47.1% of immigrant women expressed dissatisfaction antenatal care compared with 26.8% of Australian born women (Adj OR 2.17, 95% CI 1.7–2.7). Similarly, 40.5% of immigrant women were dissatisfied with intrapartum care compared with 25.5% of Australian born women (Adj OR 1.81, 95% CI 1.4–2.3), and 53.5% of immigrant women rated their postnatal care negatively compared with 41.0% of Australian born women (Adj OR 1.52, 95% CI 1.2–1.9). There was no evidence of improvement between the two surveys. Immigrant women were more likely than Australian-born women to say that health professionals did not always remember them between visits, make an effort to get to know the issues that were important to them, keep them informed about what was happening during labour or take their wishes into account.
Conclusion: data from repeated population-based surveys of recent mothers provides one of the few avenues for gauging whether changes to the organisation of maternity services is making a difference to immigrant women's experiences of care. Our findings showing no change over an eight year period – during which there were major efforts to increase access to midwifery led models of care and provide greater continuity of caregiver – suggest that different approaches, more specifically tailored to the needs of immigrant families are needed to enhance women's experiences of care and improve outcomes.

Background

Women of non-English speaking background who migrate by choice or seek refuge in developed countries such as Australia have notably poorer perinatal outcomes than local-born women. Immigrant mothers are over-represented in Australian, UK and European maternal mortality statistics, (Stirbu et al., 2006; Knight et al., 2009,

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Centre for Maternal and Child Enquiries, 2011). Several studies have documented poorer mental health among immigrant mothers (Allotey, 1999; Small et al., 2003), and although maternal death is now rare in developed countries, maternal depression and severe psychological distress in pregnancy are thought to be a factor explaining observed inequities in maternal mortality data (Centre for Maternal and Child Enquiries, 2011). There is also evidence from studies undertaken in the UK, Norway and Australia showing that women of likely refugee backgrounds have higher rates of stillbirth, fetal death in utero and perinatal mortality (Paxton et al., 2011; Drysdale et al., 2012). Findings such as these have prompted repeated calls for improvements in the way that maternity services approach care for immigrant families.

In Australia, there have been sustained efforts to restructure and reform maternity care over the past two decades. Predominantly, policy and service initiatives have focussed on promoting greater continuity of caregiver and increased access to midwifery-led care, rather than tailoring initiatives to specific population groups, such as immigrant women or women of refugee background (Victorian Government Department of Human Services, 2002). There has been limited evaluation of these initiatives assessing the extent to which they meet the needs of specific populations. Drawing on data collected in two consecutive population-based surveys of women giving birth in the state of Victoria, Australia, the aims of this paper are (1) to assess the impact of changing maternity care policy and practice on immigrant women's experiences of maternity care over time; (2) compare immigrant women's experiences of maternity care with those of Australian born women; and (3) consider the implications of the findings for health system reform designed to reduce health inequalities for migrant populations.

Methods

Sample and procedure

The samples for the surveys comprised all women giving birth in Victoria in two weeks in 1999 and four weeks in 2007, excluding women who had a stillbirth or known neonatal death. Women were posted a questionnaire six months following the birth, together with a covering letter, and a reply paid envelope for returning the completed questionnaire. All women received a brief explanation of the study in four languages other than English accompanying the 2000 Survey (Vietnamese, Turkish, Chinese, Arabic) and six languages accompanying the 2008 survey (Arabic, Vietnamese, Cantonese, Mandarin, Somali, Turkish). Translating the questionnaire into these languages was found to be an unsuccessful strategy for promoting participation in the first Victorian survey of recent mothers. The approach of providing information about the study in languages other than English has been used in all four Victorian surveys, and from past experience it was anticipated that some mothers would ask a friend or family member fluent in English to assist them in completing the questionnaire. Women were encouraged to do this if they wanted to, but the instructions also explained that it was not necessary to return the questionnaire if they decided not to complete it. Languages were selected to reflect the largest non-English speaking immigrant groups in Victoria at the time of each survey. Two mailed reminders were sent at two-week intervals; the second of these included another copy of the questionnaire.

Research ethics approval was granted by the Victorian Department of Human Services and La Trobe University for the 2000 survey and the Victorian Department of Human Services and the Royal Children's Hospital for the 2008 survey.

Questionnaires

The questionnaires used in both surveys collected information on women's views and experiences of care during pregnancy, labour, birth and the postpartum period. Information was also collected on maternal socio-demographic characteristics, reproductive history and events in the index pregnancy. Women were asked to name the country in which they were born; if English was their first language; and if not, how well they could speak English. In the 2008 survey, women born overseas were asked the length of time they had been in Australia.

Women's experience of care

Women's views of antenatal, intrapartum and postnatal care were assessed using standardised measures that included a combination of global and specific questions, drawing on earlier Victorian surveys (Brown and Lumley, 1997, 1998; Bruinsma et al., 2003). An overall rating of women's experience of antenatal care was derived from a question which asked 'On balance, how would you describe your care in pregnancy?' Women were asked to choose between five responses: 'very good', 'good', 'mixed', 'poor', or 'very poor'. Separate questions – using a similar format - were used to elicit overall ratings of intrapartum care and postnatal care in hospital.

The 2008 questionnaire also included items asking about the extent to which antenatal caregivers: made an effort to get to know what issues were important to women in pregnancy, used words and explanations women could understand, listened to what women had to say, spent enough time with them, remembered them between visits, and how confident women were that information would be kept confidential. With respect to labour and birth, women were asked about the extent to which they were informed about what was happening during labour and birth, and whether caregivers: explained what was happening during labour and birth, explained options for managing their labour and birth, and took their wishes into account. Women were also asked if caregivers were encouraging and reassuring, and if they ever felt that the caregivers talked down to them. In all cases, response options were: 'always', 'most of the time', 'sometimes', 'rarely', 'never'. Women's experiences of hospital postnatal care were assessed using a different format and not reported in this manuscript.

Sector of maternity care

Women were categorised as receiving public or private maternity care based on responses to a series of questions which asked about location of pregnancy check-ups, care providers (general practitioners, midwives, obstetricians), extent to which women saw the same care provider at each visit, health insurance status, admission status (public/private) and place of birth. Australian public maternity care is provided by publicly funded hospital-based midwives and medical practitioners as primary care providers, and in shared care arrangements with general practitioners (GPs). Women receiving private care attend a specialist obstetrician for antenatal care and generally give birth in a private hospital, necessitating private health insurance cover.

Data analysis

To assess the representativeness of women responding to each survey, the social and obstetric characteristics of participants were compared with routinely collected Victorian perinatal data for all women giving birth in the study period for each survey.

Women born overseas in countries where English is not the national language were categorised as being of non-English speaking background (NESB), taking an approach to the identification of the countries consistent with Victorian routine data collection. Given that a previous Victorian survey of recent mothers identified that the views and experiences of immigrant women from English speaking countries is the similar to those of Australian born women (Brown et al., 2005; Davey et al., 2005), women born overseas of English speaking background were excluded from further analysis.