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Cambodian migrant women's postpartum experiences in Victoria, Australia

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ABSTRACT

Objective: to explore the postpartum experiences of Cambodian born migrant women who gave birth for the first time in Victoria, Australia between 2000 and 2010.
Design: an ethnographic study with 35 women using semi-structured and unstructured interviews and participant observation; this paper draws on interviews with 20 women who fit the criteria of first time mothers who gave birth in an Australian public hospital.
Setting: the City of Greater Dandenong, Victoria Australia.
Participants: twenty Cambodian born migrant women aged 23–30 years who gave birth for the first time in a public hospital in Victoria, Australia.
Findings: after one or two home visits by midwives in the first 10 day postpartum women did not see a health professional until 4–6 weeks postpartum when they presented to the MCH centre. Women were home alone, experienced loneliness and anxiety and struggled with breast feeding and infant care while they attempted to follow traditional Khmer postpartum practices.
Implications for practice: results of this study indicate that Cambodian migrant women who are first time mothers in a new country with no female kin support in the postpartum period experience significant emotional stress, loneliness and social isolation and are at risk of developing postnatal depression. These women would benefit from the introduction of a midwife-led model of care, from antenatal through to postpartum, where midwives provide high-intensity home visits, supported by interpreters, and when required refer women to professionals and community services such as Healthy Mothers Healthy Babies (Victoria Department of Health, 2011) for up to 6 weeks postpartum.

Introduction

Becoming a mother brings tremendous joy to women, and most women would attest to this (Liamputtong, 2006; Mbekenga et al., 2011; Kakyo et al., 2012). But under certain circumstances, it can be distressful for women (Chan et al., 2009; Wilkins et al., 2009; Darvill et al., 2010; Westall and Liamputtong, 2011; Kakyo et al., 2012). This is particularly so for those without a support network such as immigrant women (Liamputtong, 2006). They often have to deal with the double transition of their lives, not only as mothers but also as displaced people during this critical period of life (Liamputtong, 2006, 2007a).

Literature suggests that the postpartum period is the time that a new mother is most vulnerable to emotional turmoil. It is the time that women recover from birth and begin to take on a new role. It is during this period that most women have mixed feelings, not only excited but also 'emotionally fraught' (Woollett and Dosanjh-Matwala, 1990: 178; Mbekenga et al., 2011; Razurel et al., 2011; Kakyo et al., 2012). According to Nelson (2003), the early postpartum months are physically and mentally exhausting for the new mothers. In their study with Australian women, Barclay et al. (1997) point out that the women, particularly first-time mothers, were unprepared for this period. In the early weeks and months after giving birth, women had overwhelming feelings about what was expected of them. A similar result has also been reported in a recent study by Darvill et al. (2010) in the UK.

The postpartum period has also been identified as the most important period of childbirth in cross-cultural studies (Liamputtong Rice et al., 1999; Liamputtong Rice, 2000; Whittaker, 2002; Santos-Torres and Vasquez-Guribay, 2003; Holroyd et al., 2004; Liamputtong, 2007a,b; Raven et al., 2007; Piperata, 2008). In many cultures, including the Cambodian culture, a new mother is perceived to be in a stage of vulnerability of harmful agents, natural and supernatural (Whittaker, 2002; Liamputtong, 2004; Hoban, 2007; Piperata, 2008; Eberhard-Gran et al., 2010; Lundberg and Thu, 2011). Within these cultures, there are numerous proscriptions and prescriptions that a new mother must observe in order to avoid negative health consequences. In order to observe traditional practices successfully, support from significant others, particularly

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family members, is crucial (Hung and Chung, 2001; Liamputtong, 2007a,b; Eberhard-Gran et al., 2010). Therefore, the postpartum period is an event where not only traditions are deeply involved, but a time that requires appropriate social support, and these can have great impact on the health and well-being of the new mothers and their newborn infants (Liamputtong, 2004; Bogossian, 2007; Raven et al., 2007; Eberhard-Gran et al., 2010; Mbekenga et al., 2011).

Immigrant women who reside in western societies where traditional postpartum practices are not recognised face difficulties when they give birth in their new settings (Kim-Goodwin, 2003; Chu, 2005; Groleau et al., 2006; Liamputtong, 2007b). Often, they have to rely on the medical model of care and are isolated from familiar faces during this critical time. The lack of acceptance of traditional postpartum practices and social support in their new homeland can impact on the well-being of many new mothers from immigrant backgrounds (Liamputtong, 2007b). Numerous studies which have documented the postpartum experiences of immigrant women have pointed to this difficulty (Yelland et al., 1998; Liamputtong Rice et al., 1999; Liamputtong Rice, 2000; Kim-Goodwin, 2003; Chu, 2005; Groleau et al., 2006; De Souza, 2007).

Although there have been some recent publications on the postpartum experience of migrant women, such as Chinese women in Scotland (Cheung, 1997), Chinese women in Australia (Chu, 2005), Filipino, Turkish and Vietnamese women in Australia (Yelland et al., 1998; Small et al., 2002), Hmong and Thai women in Australia (Liamputtong Rice et al., 1999; Liamputtong Rice, 2000), the experience of other migrant groups is still largely neglected. In particular, the postpartum experience of Cambodian women in a western country is very limited. In this paper, the experience of Cambodian women during the postpartum period in an Australian setting is examined.

Social support and postpartum experience

In most cultures, social support is a crucial aspect of childbearing (Bogossian, 2007). Social support includes emotional, tangible and informational support (Bogossian, 2007; Ferlander, 2007; Mbekenga et al., 2011). It also includes formal support provided by health professionals and an informal support that an individual receives from her social networks such as family and other significant members.

Social support, both from significant people in a woman's life and from health professionals, has been found to increase the mother's self-confidence and assurance in her role as a mother (Oakley, 1979; Crockenberg and McCluskey, 1986; Buultjens and Liamputtong, 2007). More importantly, support for the mother's decision-making and more concrete forms of support have been shown to reduce stress experienced by new mothers. It also has been found to lead to satisfaction with their role as mothers (Tarkka and Paunonen, 1996; Beck, 2001; Buultjens and Liamputtong, 2007). However, the lack of any social support is linked with stress and depression in women (Zelkowitz and Milet, 1995; Chaya et al., 2002; Hung, 2001, 2005; Kheirabadi et al., 2009). In particular, PND has been seen as the result of a lack of social support among women who experience the illness (Hung, 2001, 2005; Beck, 2002a,b; Waldenstrom et al., 2005; Buultjens and Liamputtong, 2007; Webster et al., 2011; Westall and Liamputtong, 2011).

Darvill et al. (2010) demonstrate this in their UK study regarding women's transition to motherhood. They found that social support had an influence on the way that women experienced their transition to motherhood. Lack of support made some mothers feel vulnerable throughout the transition period. However, feeling supported allowed the women to have more confidence in their new role and perceptions of themselves as mothers. Other studies have also suggested that satisfactory and adequate social support that new mothers receive from health professionals lead to positive outcomes including the well-being of mothers during the postpartum period (Tarkka and Paunonen, 1996; Webster et al., 2000; Melender, 2002; Razurel et al., 2011). We argue in this paper that lack of support among Cambodian first time mothers results in high levels of stress among the women and this may render them susceptible to postnatal depression.

Methods

This paper is based on our larger ethnographic research which was conducted between 2009 and 2011 in the local government area of the City of Greater Dandenong, Victoria, the most culturally diverse locality in Victoria with 51.4% of residents born overseas of which 3.7% were born in Cambodia (Australian Bureau of Statistics, 2006). The study was conducted over a 24 month period with Cambodian immigrant women who had pre-school and school aged children to explore parenting among this immigrant population. Ethnography 'gives voice to people in their own local context' (Fetterman, 2010: 1). The essential core of ethnography is 'to understand another way of life' (Spradley, 1979: 3) from the participants' point of view. In this study, we attempted to understand the experiences of Cambodian women during the postpartum period in an Australian setting. Ethnographic methods employ several qualitative methods but particularly participant observation and in-depth interviews (Liamputtong, 2009). In this study, we conducted participant observations and semi-structured interviews with the Cambodian born migrant women.

Purposive and snowball sampling methods were used to recruit 35 women to the study. The sample size was not predetermined, instead recruitment stopped when we reached data saturation (Strauss, 1987; Liamputtong, 2009). Recruitment occurred with the support of key informants employed in community and health services that are in contract with Cambodian women, and through established community contacts who introduced the researcher to participants who met the selection criteria. Initially women were referred to the researchers by Cambodian community organisation staffs that were in contact with new migrant families in the City of Greater Dandenong. Women were recruited using purposive sampling followed by snowball sampling methodology (Liamputtong, 2009). Women were given a Plain Language Statement and Consent Form in the Khmer language to read and were provided with the opportunity to ask questions. If women agreed to be interviewed they signed the Consent Form. All participants were given a pseudonym to ensure anonymity and confidentiality.

The focus of this paper is from data obtained during semi-structured interviews with a sub-sample of women, i.e. 20 women whose first birth occurred in a public health facility in Victoria. In-depth semi-structured interviews, using a question guide (Serry and Liamputtong, 2010) were conducted with the 20 women. We asked the women to articulate on several issues and these include:

(1) Tell me about your return home after giving birth? Who cared for you and your newborn? What role did your family and friends play in caring for you and your newborn?
(2) Could you tell me how you felt being a first time mother in a new country? How is it similar or different to being a new mother in Cambodia?
(3) Did you experience any problems in the 6 weeks after birth? Can you please tell me about these problems?
(4) Did your newborn experience any problems in the first 6 weeks of life? What were they? How did you address these problems?