Women and Birth 29 (2016) 128–137

Contents lists available at ScienceDirect

Women and Birth

journal homepage: www.elsevier.com/locate/wombi

ORIGINAL RESEARCH – QUALITATIVE

Perceptions of pregnancy experiences when using a community-based antenatal service: A qualitative study of refugee and migrant women in Perth, Western Australia

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ARTICLE INFO

Article history:
Received 21 May 2015
Received in revised form 17 August 2015
Accepted 7 September 2015

Keywords:
Pregnancy
Community-based antenatal care
Refugee and migrant women
Culturally and linguistically diverse (CaLD)

ABSTRACT

Background: Equality of care in pregnancy is important for all women, however can be difficult for healthcare providers to achieve. It has been found that culturally and linguistically diverse women born overseas generally have lower satisfaction with pregnancy care than women born in the host country.
Aim: Using a phenomenological framework, and models of care as a conceptual framework, this study explored the perceptions of care experienced by refugees and migrant women of culturally and linguistically diverse backgrounds who had participated in a community-based antenatal programme specialising in maternity care of multicultural women.
Method: Informants were twelve women aged between 23 and 44 years of age; one woman was 33 weeks pregnant, other women had given birth in the six months prior to data collection. Semi-structured interviews were conducted, using interpreters for women who spoke little or no English. Data were analysed using thematic analysis.
Findings: Four main themes were identified; Social Support, Gaining of Knowledge, A Holistic Service, and New Opportunities.
Conclusion: Using a community-based antenatal service specialising in maternity care of women from culturally and linguistically diverse backgrounds enabled the needs of refugee and migrant women to be recognised and met, and therefore enhanced their perception of the pregnancy experience.

1. Introduction

Achieving equality of care in pregnancy for all women is important; however it may be difficult for healthcare providers to ensure.[1] Increasing ethnic and cultural diversity can present many challenges to healthcare providers.[2] Shafiei et al.[3] commented that women born overseas generally had lower satisfaction with pregnancy care than women born in the host country. In particular, women from non-Western backgrounds living in Western countries often perceive they are treated with less respect and have less understanding about their care.[4] Negative attitudes of staff can also affect perceptions of care.[3] Lack of English language ability, inability to attend appointments and a reduced social network may also result in a decreased perception of the quality of care.[1] Women from ethnic minorities are generally more likely to be poor and have smaller social networks, thereby making them more vulnerable.[4] It has been posited that vulnerable women are not well supported in pregnancy by the current Australian healthcare system; they present late for antenatal care, attend fewer appointments, have lower satisfaction with their pregnancy experience, and poorer maternal and infant health outcomes.[4–7]

2. Literature review

2.1. Changing demographics in Australia

Cultural diversity in Australia is increasing.[8,9] In the year ending June 2013, there were 190,000 migrants to Australia.[10] Australia also granted 20,019 visas under the Humanitarian Program, 60% of which were granted to refugees.[11] Most of the offshore visas granted in 2012–2013 were issued to people from Iraq (32.5%), Afghanistan (19.4%), Burma (Myanmar; 18.8%), Bhutan (8.2%), and

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http://dx.doi.org/10.1016/j.wombi.2015.09.003
1871-5192/

the Congo (DRC; 3.9%).[11] Of the humanitarian visas granted by the Australian government, 49.3% were to women.[11] Many women who migrate either voluntarily or involuntarily to Australia are of childbearing age;[1,9,12] therefore provision of appropriate pregnancy services for this group is important. Moreover, over 60% of the Australian population who were born overseas were from a country in which the primary language is not English.[9]

2.2. Factors that influence access to antenatal care for migrant women of culturally and linguistically diverse (CaLD) backgrounds

Pregnant women of culturally and linguistically diverse (CaLD) backgrounds who have recently arrived in Australia face additional challenges, such as adapting to life in a new country and possible pre-migration trauma; the prospect of motherhood can also be daunting if unsure of local services.[13] Priorities such as resettlement, housing and finances may be considered more important than their pregnancy.[14] The Western medical model of pregnancy and care may not be sufficient to manage these significant and important issues. Therefore an alternative model of care – one in which there is provision of mental health services, social work and community support[9] – is required.

Risk factors associated with migration for CaLD women can include reduced social networks and social support, life stressors related to migration and settlement, and mental health issues such as depression and post-traumatic stress disorder.[1] Issues relating to the migration process itself may be barriers to seeking healthcare; these include financial difficulties, poor host language ability, negative attitudes of those within the healthcare system, and cultural differences.[1,4] For example, many CaLD women are affected by low socioeconomic status, which might impact on their health by not having the means to attend appointments. This can operate in concert with other factors, such as lack of facility with the host language, making access to public transport more difficult.[9] It is well-established that attendance at antenatal appointments facilitates early recognition and treatment of potential or actual pregnancy complications and other health issues.[5]

Lack of confidence in the host language is a key factor. Poor communication or miscommunication can potentially be dangerous with problems being mis- or undiagnosed, or the migrant woman not understanding information which could be vital to their own welfare and that of their child.[1] In a systematic review of non-Western women in industrialised Western countries, Boerleider et al.[5] found poor language ability was a frequent reason for reduced attendance at antenatal clinics.

In addition, many women from refugee backgrounds might have physical and psychological issues related to trauma or sexual violence[15,16] and associated mistrust of medical staff and people in authority. There are also cultural differences in concepts of health and pregnancy that can result in mistrust of medical staff or services. For example, migrants and refugees originating from less developed countries may not be accustomed to receiving continuous antenatal care since pregnancy may not be viewed as a medical condition in their country of origin.[8,12]

Finally, lack of social support through reduced networks is a common problem faced by migrant and refugee women from CaLD backgrounds.[9,17] For those separated from extended family, pregnancy can be distressing and detract from their psychosocial wellbeing.[2] This might be in part because it is more difficult to maintain traditional customs, such as those relating to staying indoors for a specified time after giving birth or eating particular foods,[8,13] without the help of other female family members. It is also more likely that migrant women will spend more time at home alone, during and after giving birth, which could impact on the health of the new mother.[13]

In these circumstances, support and information from healthcare providers will be all the more important.[2,4,13] Continuity of care-provider is also critical when social support is lacking; it can facilitate better understanding of a pregnant mother's culture and regular contact will also enable the development of a trusting relationship.[9,17] However, in a systematic review of qualitative studies, Balaam et al. found that poor communication and a lack of connection with both healthcare workers and the community was common.[2] This could result in women not receiving information required for a healthy pregnancy and child development, together with feelings of stigmatisation and isolation.[1] It is also evident that perceptions of healthcare providers as disrespectful or hostile can result in decreased attendance at appointments.[2,16]

These barriers may result in women from CaLD backgrounds receiving, or perceiving that they receive, lower quality of care.

2.3. Models of care: the medical model and social models

The model of care implemented has been found to be an important factor in minority women's use of health care services, and can influence women's perceptions of care.[7,15] The medical model of care is now very influential within Western healthcare.[18,19] It has been argued that medical models are disempowering for all women, irrespective of cultural or migration background, because choice and/or control are generally managed by the 'healthcare system'.[18,20] Due to the power of medical practitioners in this model, pregnant women may feel unable to ask questions or make comments regarding quality and safety. For migrant women who have language difficulties and are not accustomed to the concept of antenatal care, this may be even more difficult.[4] In addition, models of care associated with western medicine may appear strange to many migrant women, especially those who come from a culture where childbirth is considered to be a natural phenomenon and not a medical procedure, as noted earlier. Traditional cultural practices may not be recognised and this may cause the migrant woman distress and impact negatively on her psychological well-being.[13] A clear power imbalance exists in access to Australia's healthcare system and this can be exacerbated when migrant pregnant women of CaLD backgrounds are faced with a medical model that is Western, exclusive and based around Eurocentric notions of pregnancy.

Health encompasses more than just medical needs; as described by World Health Organisation[21] in 1948, physical, mental and social wellbeing are all components of health. Environmental, political, and economic factors also impact on health.[19] If there is no consideration of an individual's social situation then appropriate action might not be initiated.[22,23] Due to the increasing number of women from CaLD backgrounds requiring pregnancy services in Western societies, a model of care which provides appropriate services is vital.[9] A social model of care adopting a more holistic approach and which considers social, emotional and psychological needs, as well as physical needs, will be more appropriate for pregnant migrant women of CaLD backgrounds. In addition, it is important to provide a culturally sensitive model of care, which has been demonstrated to improve satisfaction with care.[8]

Whilst providing a service which specialises in care for CaLD women may initially appear costly, it enables resources to be allocated more appropriately. A Cochrane Review of maternity care found that midwife-led care should be open to all women in preference to other models since better continuity of care was offered, with improved clinical outcomes and fewer medical interventions; it also concluded that women with low-risk pregnancies should be encouraged to use community-based midwife-led models since they result in higher satisfaction with care.[24] Stapleton et al. suggested community-based clinics may