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Developing a best practice model of refugee maternity care

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Abstract
Background: About one third of refugee and humanitarian entrants to Australia are women age 12—44 years. Pregnant women from refugee backgrounds may have been exposed to a range of medical and psychosocial issues that can impact maternal, fetal and neonatal health.
Research question: What are the key elements that characterise a best practice model of maternity care for women from refugee backgrounds? This paper outlines the findings of a project which aimed at developing such a model at a major maternity hospital in Brisbane, Australia.
Participants and methods: This multifaceted project included a literature review, consultations with key stakeholders, a chart audit of hospital use by African-born women in 2006 that included their obstetric outcomes, a survey of 23 African-born women who gave birth at the hospital in 2007—08, and a survey of 168 hospital staff members.
Results: The maternity chart audit identified complex medical and social histories among the women, including anaemia, female circumcision, hepatitis B, thrombocytopenia, and barriers to access antenatal care. The rates of caesarean sections and obstetric complications increased over time. Women and hospital staff surveys indicated the need for adequate interpreting services, education programs for women regarding antenatal and postnatal care, and professional development for health care staff to enhance cultural responsiveness.
Discussion and conclusions: The findings point towards the need for a model of refugee maternity care that comprises continuity of carer, quality interpreter services, educational strategies for both women and healthcare professionals, and the provision of psychosocial support to women from refugee backgrounds.

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Introduction

Over the past ten years, refugee and humanitarian entrants to Australia have come mostly from Africa, Middle East and Southeast Asia. Around 13,500 arrive in Australia every year,[1] and about 30% are women aged 12–44 years.[2] Women from refugee backgrounds are likely to have experienced ethnic and religious persecution, rape, torture, mutilation, sexual slavery, coercion of liberty and deprivation.[3] Prevalent health problems among refugee populations are malnutrition, anaemia, and infectious and parasitic diseases such as schistosomiasis.[4] A further range of health issues may impact upon pregnancy of women from refugee backgrounds, including high parity[5]; existing untreated complications related to pregnancy and childbirth[6]; physical and emotional issues related to sexual violence[7]; and the presence of female circumcision. Female circumcision in particular has been associated with a range of gynaecological, obstetric, urinary, emotional and psychological issues.[8,9]

Despite the range of health issues that are prevalent among people from refugee backgrounds, the use of hospital services among this population living in Victoria was found to be no higher than that of people born in Australia.[10] Low levels of use may reflect the multiple barriers that prevent refugees from accessing health care services.[11] Access to adequate heath care can lead to significant improvements in reproductive health outcomes among displaced refugee women.[12] However, disparities in obstetric outcomes between women from refugee backgrounds resettled in Western countries and women born in the receiving countries have been reported.[13] Although Somali-born women living in six Western countries were less likely to give birth preterm or to have low birthweight infants, they were more likely to have caesarean sections and stillbirths when compared with receiving country-born women.[13] Previous qualitative research conducted in the Netherlands has identified three key elements that characterise refugee women's experiences of reproductive health care in a resettlement context[14]: (i) the status of women as newcomers/non-citizens; (ii) their status as refugees; and (iii) their gender status and roles in the context of both their own ethnic communities and their new country. Moreover, access to reproductive health care among refugee women living in Western countries can be influenced by the level of cultural competence of staff,[15–17] the degree of care or the perception of care offered by health care staff,[17–19] the availability of appropriate interpreting services,[16,20] the degree to which intrinsic racial discrimination occurs within the institution,[17,18,21] transport and accessibility to childcare services,[20,22] and the level and appropriateness of education provided to women about the health care system, diagnostic tests and procedures, and the models of care.[7,23]

When reviewing the existing models of care available to women from refugee and immigrant backgrounds settled in industrialised English-speaking countries, a number of key issues appear. Firstly, continuity of carer increases women satisfaction, improves communication, and enhances women's sense of control and ability to make informed decisions.[16,21] Continuity of care giver has also been identified as an important element of maternity care in the general population.[24] Secondly, models of maternity care that offer a forum for communication and education can not only enhance women's understanding of antenatal and postnatal care, breastfeeding, and childcare, but also improve organisational cultural competence and awareness of what it means to be a maternity patient from a refugee background.[8,25] Thirdly, models of care which take into account accessibility of the service in terms of location, ease of transport, and ease of childcare, improve attendance and patient satisfaction.[20]

The Mater Mothers' Hospital (MMH) is the site of some 9500 deliveries per year, with approximately 4700 of these occurring in the public hospital. It is the largest maternity centre in Brisbane (Australia) with 88 maternity beds and 16 birthing rooms for non-insured patients. The hospital provides tertiary services for women and babies including obstetrics, gynaecology, neonatology, maternal fetal medicine, obstetric medicine, perinatal outreach education, and midwifery group practice. In response to the increase in the number of African-born women from refugee backgrounds birthing at the MMH between 2003 and 2006, and the issues associated with delivering quality of care to this group of women, the MMH embarked in 2007 on the project reported in this paper. A research question was identified: What are the key elements that characterise a best practice model of maternity care for women from refugee backgrounds? The project aimed at developing and implementing such a model at the MMH. The project was multifaceted and cut across areas of clinical service delivery, allied health including social work, and interpreting services. This paper reports on the findings from consultations with key stakeholders, a maternity chart audit of African-born women, and surveys with both African-born women birthing at the hospital, and hospital staff. The best practice model of care developed at the MMH is then discussed in the context of these findings and the broader literature on refugee maternity care.

Participants and methods

In addition to the above literature review, the development of a best practice model of maternity care also involved: (i) consultations with key stakeholders; (ii) an assessment of hospital use by African-born women from refugee backgrounds in 2006 that included their obstetric outcomes; (iii) a survey of African-born women from refugee backgrounds who had birthed at the MMH; and (iv) a survey of MMH staff members. Ethics approval was obtained from the Mater Health Services Ethics Committee. The research conformed to the "National Statement on Ethical Conduct in Human Research" by the National Health and Medical Research Council of Australia. All participants gave informed consent and anonymity was preserved.

Stakeholders' consultations

Broad consultations with key stakeholders were conducted by the project coordinator through the establishment of a project steering committee and a project reference group. The steering committee involved senior managers of MMH administration and maternity services, a hospital ethicist, and representatives of the funding body, the African-Australian women's community, general practice, and non-governmental organisations providing services to refugee