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Born in another country: Women's experience of labour and birth in Queensland, Australia

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ABSTRACT

Background: Women born outside Australia make up more than a fifth of the Queensland birthing population and like migrants in other parts of the world face the challenges of cultural dislocation and possible language barriers. Recognising that labour and birth are major life events the aim was to investigate the experiences of these women in comparison to native-born English speaking women.
Methods: Secondary analysis of data from a population based survey of women who had recently birthed in Queensland. Self-reported clinical outcomes and quality of interpersonal care of 481 women born outside Australia who spoke a language other than English at home were compared with those of 5569 Australian born women speaking only English.
Results: After adjustment for demographic factors and type of birthing facility, women born in another country were less likely to be induced, but more likely to have constant electronic fetal monitoring (EFM), to give birth lying on their back or side, and to have an episiotomy. Most women felt that they were treated as an individual and with kindness and respect. However, women born outside Australia were less likely to report being looked after 'very well' during labour and birth and to be more critical of some aspects of care.
Conclusion: In comparing the labour and birth experiences of women born outside the country who spoke another language with native-born English speaking women, the present study presents a largely positive picture. However, there were some marked differences in both clinical and interpersonal aspects of care.

1. Background

Since 1996 the overseas-born population of Australia has grown by 40.7% in contrast to 16.2% in the Australian-born population. In 2010, 28.1% of women who gave birth in Australia were born overseas.[1] Individuals and families move to high income countries like Australia for a variety of reasons, ranging from skilled migration programmes to humanitarian refugee entry. This growing migrant population has implications for health service delivery. Migrant women may face many challenges in navigating pregnancy and childbirth, such as isolation from family and friends, ethnic minority status, discrimination, differences in cultural practices, and in many cases a language barrier. In a review of epidemiological studies, migrant women in European countries were found to have poorer outcomes compared to native-born women on all aspects considered, including birth weight, preterm delivery, perinatal mortality and congenital malformations, even after adjusting for maternal age, mode of delivery, and parity.[2]

Ethnic minority women represent an increasing proportion of the migrant population of Australia with migration from Asia and Africa rising.[3] In a range of Western countries ethnic minority women have been found to have poorer clinical outcomes,[4–7] to access antenatal care later, and to have fewer antenatal checks.[8,9] Research on experiential aspects of care is largely qualitative and has indicated that ethnic minority women may experience poorer interpersonal care, with women reporting more care was needed, negative staff attitudes and care lacking cultural sensitivity.[9,10] Language and cultural differences may be pronounced for ethnic

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minority women born in another country and this group has been identified as being particularly disadvantaged, reporting significantly poorer quality of care even after adjustment for parity, mode of delivery, socio-economic status, age, and partner status.[8]

Research in general health care suggests that English fluency may be a more important factor in disadvantage than ethnic minority status.[11,12] Language difficulties represent a significant barrier to care and patients with limited English proficiency have consistently reported experiencing poorer care.[13] As such, migrant women speaking a language other than English may face a greater challenge navigating care. The pregnancy, childbirth and postnatal experiences of migrant women who speak a language other than that of the receiving country have begun to receive attention in the literature, using largely qualitative interview methods.[14] An interview based study conducted in Victoria, Australia of Vietnamese, Turkish, and Filipino women's views of maternity care found that poorer English fluency was associated with a more negative experience and that women expressed more concern about negative or unsupportive treatment than care providers' knowledge of cultural practices.[15] A more recent small scale, mixed-methods study of Afghan women's experience emphasised the importance of interactions with care providers on overall care satisfaction, with mixed reports of care quality and 70% of women rating intrapartum care positively.[16] The study did not, however, compare their maternity care experience with that of native-born women.

Studies comparing the maternity experiences of migrant women from non-English speaking backgrounds with native-born women have commonly focused on postnatal care and found that migrant women wanted more practical and emotional support than native-born women after returning home.[14] A study of women in Victoria found that migrant mothers from non-English speaking backgrounds had similar obstetric outcomes to Australian born mothers but reported greater psychological distress, less emotional satisfaction with their partner, and more relationship problems in the first three months after birth.[17] They also found that despite an equivalent level of postnatal contact with care providers, migrant women were less likely to be asked about their emotional wellbeing. This is important in the context of higher rates of postnatal depression reported for migrant women, particularly refugee and asylum seekers, compared with native-born women.[18]

In recognizing the potential impact of migration and the importance of communication with health professionals for parturient women, the aim of the present study was to investigate the experience of labour and birth care in women born outside Australia who spoke a language other than English at home, comparing this with that of English speaking native born women, with the broader goal of understanding how the needs of both groups may be better addressed.

2. Methods

2.1. Data collection and participants

This study involved secondary analysis of data collected in a 2010 population based survey of women who gave birth in Queensland, Australia between February and May 2010.[19] Excluding those who had a stillbirth or neonatal death, women were mailed a copy of the survey by the *Queensland Registry of Births, Deaths and Marriages* four to five months after birth. Two weeks later women were mailed a reminder postcard. Survey packages included: an introductory letter, information sheet, a paper copy of the survey, a reply paid envelope and a sheet with instructions in 20 languages for contacting an interpreter. Women could also complete the survey online (in English) or over the phone with a trained female interviewer (or an interpreter if required). Ethical approval for the survey was received from the Behavioural and Social Sciences Ethical Review Committee of the University of Queensland.

2.2. The survey instrument

The survey covered pregnancy, labour and birth, postnatal care and demographics, with women self-reporting clinical and interpersonal aspects of care. Survey items were developed in consultation with maternity consumer groups and health professionals, building on national surveys in the UK and North America.[8,20,21]

2.3. Demographics

Demographic information and obstetric history was self-reported or derived using information provided. Women indicated whether they were born in Australia or another country and reported country of birth in free text. Countries were coded consistent with categories used in state-level perinatal reporting.[22] Women were asked what language(s) they spoke at home and these were coded into groups based on the Australian Bureau of Statistics (ABS) Australian Standard Classification of Languages (ASCL).[23] No data were collected on recency of migration.

Accessibility/Remoteness Index of Australia (ARIA) scores and Australian Standard Geographical Classification[24] groupings were derived using reported suburb/town and postcode. The Socio-Economic Indexes for Areas' (SEIFA) Economic Resources Index (ER) was used as an indicator of participant socio-economic status. The ER index is derived from Census variables related to economic resources including income, housing expenditure and assets of households.[25] Postcodes were used to determine SEIFA-ER area ranking quintile. Women were asked about the highest level of qualification they had completed[26] and a dichotomous variable created, based on completion of secondary school education (year 12 or equivalent) or not. Type of birthing facility was self-reported and cross-checked with the name of the birthing facility provided. A variable representing birth in a public or private facility was created which reflected the organisation of Australian health care in which publicly funded and privately run hospitals operate in parallel.[27]

2.4. Clinical aspects of labour and birth

Responses to structured self-report items describing labour and birth care included induction, the use of electronic fetal monitoring, and mode of delivery. Women were also asked 'What position were you in when your baby was born?' with response options: standing, squatting or kneeling, propped up or sitting, lying on my side, lying flat on my back and other. A dichotomous variable: lying on back or side, or more upright positions (standing, squatting, kneeling, propped up or sitting) was used. Women were asked about location for birth with response options: on a bed, on the floor, on a birthing stool, in the shower, in water (a pool or bath) or other. The responses were grouped into 'on a bed' or 'other'. Women were also asked if they had an episiotomy, a tear, or stitches near their vagina in separate items. Perineal trauma was coded if they had an episiotomy or tear and further coded as occurring with or without stitches.

2.5. Perceptions of care

Women used a 3-point Likert type scale: 'not at all', 'some of the time' and 'all of the time' to rate different aspects of interpersonal care during labour and birth. This included being treated with