The relationship between maternity care and mental health for women from Africa with refugee backgrounds

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This thesis is submitted in partial fulfilment of the Honours degree of

Bachelor of Psychological Science (Honours)

School of Psychology

University of Adelaide

October 2019

Word Count: 9,473 words

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Abstract

In Australia, women with a refugee background from the African continent face a unique set of challenges during the perinatal period. While postnatal depression rates are higher in women from a refugee background, few studies have provided understanding as to broader psychological distress in the perinatal period, particularly for women from Africa who may be at greater risk. There is also no evidence concerning the impact of models of maternity care on perinatal mental health for this group of women. This study provides insights into the perspectives of maternity care providers. Using a qualitative research design, this study investigated the current perinatal mental health care provision to women with a refugee background. Specifically, health care providers were interviewed regarding their experiences and thematic analysis was conducted on the data. Findings indicated a lack of consent and control for women in making decisions regarding their pregnancies, a need to provide woman- and family-centred care, and a need to understand the stressors women are likely to experience in resettlement contexts. However, it was considered by many that, with the right practical and social supports, Australian maternity care may be a psychologically protective factor.

Conference presentations based on the data from this thesis

Winter, Amelia (2019, July). Exploring the perinatal mental health needs of African refugee women: Maternity service providers' perspectives. Presentation at the University of Adelaide Undergraduate Research Conference, University of Adelaide, South Australia.

Declaration

This thesis contains no material which has been accepted for the award of any other degree of diploma in any University, and, to the best of my knowledge, this thesis contains no material previously published except where due reference is made.

I give permission for the digital version of this thesis to be made available on the web, via the University of Adelaide's digital thesis repository, the Library Search and through web search engines, unless permission has been granted by the School to restrict access for a period of time.

Amelia Winter

October 2019

Acknowledgements

In essence, this thesis is about the need for every woman to have a village. Thank you to the following people for being my village.

First and foremost, thank you to my supervisor, Dr Clemence Due. Clemmi, you have guided me, supported me, and taught me so much this year. I'm so grateful to have had the opportunity to be supervised by such a brilliant researcher.

To Logan, my star, you were the real MVP this year. When I said I was going to go back to uni, you supported me 100%, and even when things got harder while I wrote this thesis, you were there every day encouraging me and picking up the slack. I love you.

To Stirling and Harvey, my beautiful boys, how lucky am I to have you?! Thank you for your patience and encouragement this year. I promise Mummy will have more time to play now!

To the rest of my family, thank you for the pep talks, the babysitting, the dinners, and the grocery runs. You guys gave life to the term "all hands on deck" and it made all the difference.

To my tribe of amazing women: thank you for your hugs, your understanding, and the coffee/snacks/wine/chocolate you supplied. Thank you for making me feel human again on the tough days. I'm so lucky to be able to call you my friends.

Lastly, and most importantly, thank you to the inspiring health professionals who gave their time so willingly to make this project happen, and for so honestly and compassionately sharing your experiences with me.

CHAPTER 1: Introduction

1.1 Background

In Australia, approximately a third of people with refugee backgrounds are women of childbearing age (Correa-Velez & Ryan, 2012). Women with refugee backgrounds are more likely to experience mental illness in the perinatal period (e.g. Ahmed, Bowen & Feng, 2017; Collins, Zimmerman & Howard, 2011; Schmied, Black, Naidoo, Dahlen & Liamputtong, 2017) and are more likely to experience barriers to accessing both general maternity care (Benza & Liamputtong, 2017; Riggs et al, 2012) and specific perinatal mental health services (Ahmed et al 2017; Firth & Haith-Cooper, 2018). Crucial, though limited, current evidence shows the benefit to mental health of culturally competent, refugee-specific perinatal care provision that provides continuity of care and understanding of traditional pregnancy and birth practices (Stapleton, Murphy, Correa-Velez, Steel & Kildea, 2013). While this research area is growing, little is known about the factors needed to improve perinatal mental health outcomes for women from a refugee background in Australia, especially those from Africa. This study aims to 1) outline the specific perinatal mental health needs of women with refugee backgrounds from Africa, including the barriers and facilitators to service provision they may experience in the Australian context, and 2) to investigate the impacts that maternity care has, both positive and negative, on the psychological wellbeing of this group of women. These questions will be explored through interviews with maternity care providers.

1.2 Terminology

1.2.1 Psychological wellbeing

The World Health Organisation defines psychological wellbeing (used interchangeably with the term ‘mental health’) as a state of wellbeing in which a person can cope with stressors, realise one’s own potential, and contribute to one’s community (WHO, 2013). Conversely, mental illness is a state in which a person experiences morbidity, disability or suffering due to impaired mental health (WHO, 2013). This definition will be used in this thesis.

Importantly, much of the existing literature on perinatal mental health focuses on specific clinical mental health conditions, such as postnatal depression. This thesis, however, focuses on psychological wellbeing in order to present a holistic view of mental health that considers not just biological factors but also the psychological and social context of individual women. While the literature on specific mental health conditions in the perinatal period will be referred to, the purpose of this thesis is to investigate the broader psychological and social impacts of maternity care for women from Africa with a refugee background (Haith-Cooper & Bradshaw, 2013).

1.2.2 Migrants, vulnerable migrants, asylum seekers, and refugees

It is important to note the difference between the terms ‘migrant’, ‘vulnerable migrant’, ‘asylum seeker’, and ‘refugee’. Use of the term ‘migrant’ is most commonly in reference to a person who has permanently resettled in a separate country to their country of origin. Within studies discussing migrants, the term ‘vulnerable migrant’ is sometimes used. The United Nations High Commissioner for Refugees (UNHCR) defines a vulnerable migrant as someone who encounters a high level of risk before, during or after migration, such as an asylum seeker or refugee, however this term may also include trafficked persons or migrants with other

vulnerabilities (UNHCR, 2018). The term ‘asylum seeker’ is used to indicate a person who is awaiting a decision regarding their application for refugee status, while ‘refugee’ is the term used for a person who has been declared unable to seek the protection of their country of origin due to fear of persecution (UNHCR, 2018).

While this study focuses specifically on women with a refugee background, the existing evidence base is small and much of the literature focuses on migrants or vulnerable migrants without stipulating whether a person is a refugee. This is particularly so in studies on maternity care. Because of the limited literature, it is necessary to refer to studies concerning migrants, vulnerable migrants, and asylum seekers as well as refugees. The appropriate terminology will be used throughout.

1.3 Mental health in pregnancy and postnatally for the general population

The psychological wellbeing of women can be dramatically affected by pregnancy and the postnatal period, due to the physical, psychological and social changes and resulting stress women may experience during this time (Razurel, Kaiser, Sellenet & Epiney, 2013). The World Health Organisation has declared the need to improve maternal mental health, acknowledging that the link between adverse maternal mental health and maternal mortality and morbidity is clear (WHO, 2008). For example, a significant relationship has been found between feeling in control during labour and emotional wellbeing after birth (Green & Baston, 2003), and maternal exhaustion from lack of sleep has been linked to higher stress levels (Kennedy, Gardiner, Gay & Lee, 2007). However, to date these more general influences on psychological wellbeing have

been underexplored, with the majority of research being conducted on clinically diagnosable conditions (Alderdice & Gargan, 2019).

In terms of diagnosable conditions, approximately 13% of women worldwide will suffer from a psychological disorder such as depression or anxiety in the perinatal period (Austin, Middleton, Reilly & Highet, 2013; Bauer, Knapp & Parsonage, 2016) and roughly one to two women per 1000 will experience an episode of puerperal psychosis – psychosis during the first month postpartum, when the body is still recovering from birth (Austin et al, 2013). It is estimated that less than 50% of women experiencing psychological disorders in the perinatal period will be clinically diagnosed and that of the women diagnosed with perinatal anxiety or depression, only 40% receive effective treatment (Gavin, Meltzer-Brody, Glover & Gaynes, 2015). In some cases, it is possible to identify women at higher risk according to pre-existing psychological disorders; for example, antenatal anxiety is a strong predictor of anxiety and other mood disorders in the postnatal period (Grant, McMahon & Austin, 2008). Notably, statistics relating to postnatal depression (PND) and other psychological disorders in the perinatal period are highly variable and likely an underestimate, because screening practices such as the Edinburgh Postnatal Depression Scale (EPDS), while implemented around the world, have been designed for women in Western cultures (Zubaran, Schumacher, Roxo & Foresti, 2010).

Additionally, previous research on midwives' experiences providing mental health care has identified a range of barriers women may encounter when in need of perinatal mental health services. In particular, midwives may lack the necessary training to provide mental health support and may view perinatal mental health as outside their scope of service provision, they may lack knowledge of the specific services available, and may also be unsure of how to approach perinatal mental health cross-culturally (Higgins et al, 2018; Viveiros & Darling,

2019). At times the necessary support services may not even exist (Viveiros & Darling, 2019). Additionally, perinatal mental health issues may be normalised within the community. Research suggests mothers – particularly first-time mothers or women experiencing isolation – may find it difficult to identify the need for, or to be able to obtain, the necessary treatment or support (Bowen et al, 2012; Viveiros & Darling, 2019). If women do identify mental health concerns in the perinatal period, they may experience challenges in accessing care from services outside their scheduled midwifery services.

1.4 General mental health situation for women with a refugee background

Women with a refugee background may have faced a variety of traumatic situations in their countries of origin and during resettlement that have the potential to impact negatively on mental health. Pre-migration risk factors include war, gender-based violence, persecution, and the loss of loved ones (Collins et al, 2011; Firth and Haith-Cooper, 2018). Post-migration factors include social isolation (Collins et al, 2011), possible immigration status uncertainty in the case of asylum seekers (Collins et al, 2011; O'Mahony & Donnelly, 2013), and financial stress (O'Mahony & Donnelly, 2013). Displaced women are at greater risk of intimate partner violence as their displacement brings economic instability, changed social status and a loss of social supports (Wachter et al, 2017). This is particularly the case if migrating from a country with highly patriarchal cultural norms (Sabri et al, 2018). These experiences can lead to anxiety, depression and post-traumatic stress disorder (Firth and Haith-Cooper, 2018), which may be further complicated by barriers that keep women from seeking help, including: a lack of understanding – and sometimes fear – of Western biomedicine, a lack of services that suit their

specific needs, fear of discrimination and stigmatisation, and a fear of unknown consequences such as deportation or losing their children have been reported (Donnelly et al, 2011).

1.4.1 Mental health situation for women from Africa

While few studies have addressed the issue of whether women with refugee backgrounds are at greater risk, or even explored women's mental health specifically in the context of resettlement, interviews with women from South Sudan who resettled in the United States of America showed that, when women had the opportunity to support themselves financially, master skills such as English language proficiency, driving, or maintaining employment, they felt more confident and experienced more positive psychological outcomes (Baird, 2012; Baird & Boyle, 2012). Similarly, research on people with a refugee background from Ethiopia living in the United Kingdom suggests that women may adapt better than men to life after resettlement (Papadopoulos, Lees, Lay & Gebrehiwot, 2004). This may be due to the likelihood of women being able to participate more fully in public life than in Ethiopia (Papadopoulos et al, 2014).

A recent study on the mental health of women-at-risk with a refugee background (defined as women who had entered Australia on women-at-risk visas or who otherwise met the criteria to be considered at-risk) found that women from Africa were likely to have lower anxiety or depression scores overall than women from other regions (Schweitzer et al, 2018). However, having children, degree of previous trauma experienced, and access to social supports were all predictors of psychiatric symptomatology regardless of ethnicity (Schweitzer et al, 2018). Women from Africa with a refugee background are likely to be single parents, and the experience of parenting multiple children, maintaining a home, and ensuring financial stability

are all factors that may add to the heavy psychological burden of the refugee experience (Akinyemi, Owoaje & Cadmus, 2016).

1.5 General maternity care provision for women from Africa with a refugee background

A key theme in the literature on of maternity care for women with refugee backgrounds relates to women's ability to express their feelings and preferences regarding labour and delivery. This is important because cultural beliefs and expectations have the power to shape women's attitudes towards their labour and the broader perinatal period (Newnham, McKellar & Pincombe, 2017). For example, women with a refugee background may be more likely to have their first obstetric appointment after 12 weeks gestation and to have fewer obstetric appointments (Kentoffio, Berkowitz, Atlas, Oo & Percac-Lima, 2016). While this is not necessarily concerning in the context of cultural expectations, it may be that low levels of hospital use reflect the multiple barriers that prevent refugees from accessing healthcare services. Additionally, families may not be asked about their circumstances. This is reflected in interviews with Afghan men and women engaging in maternity services in Melbourne, and maternity service providers (Yelland et al, 2014). Afghan families reported significant hardship in the perinatal period, but often not being asked about their social health.

However, while refugee and immigrant women may be at greater risk of delaying prenatal care, they are more likely to make use of postpartum care options (Kentoffio et al, 2016). Potentially, given the likelihood of low rates of health literacy among women from a refugee background (Riggs, Yelland, Duell-Piening & Brown, 2016), and the specific social

rituals that surround the perinatal period for many of these women, it may be the case that women are unaware of the available and necessary services during pregnancy, but they seek more assistance in the postnatal period due to an expectation of support.

1.5.1 Specific issues faced by women from Africa with a refugee background

Refugee women from Africa face their own unique challenges in relation to pregnancy and maternity care. For example, women with refugee backgrounds from Sub-Saharan Africa are at greater risk of pregnancy complications including a higher risk of low birth weight infants (Kandasamy et al, 2014), and increased infant and maternal deaths (Carolan, 2010). Sub-Saharan women are also likely to have undergone female genital mutilation/cutting (FGM), which may lead to other obstetric and gynaecological complications in the perinatal period, as well as emotional and psychological issues (Carolan, 2010; Correa-Velez & Ryan, 2012).

Many providers in countries of resettlement are unlikely to have treated women who have undergone FGM before and may react negatively. This can lead to feelings of alienation for women, especially if providers advise the need for high-risk care or medical interventions due to FGM with no consideration given to the woman's preferences for care (Scammell & Ghumman, 2019). A systematic review and meta-synthesis of studies exploring women's maternity care in resettlement countries in relation to their FGM status found that many women report feeling vulnerable, disrespected, and traumatised by racist comments or judgements from providers when their FGM status is disclosed (Turkmani, Homer & Dawson, 2019).

Additionally, women with refugee backgrounds from countries in Africa may also face specific barriers to accessing maternity services in countries of resettlement – including racism and discrimination based on skin colour, language barriers due to low literacy and education

levels, limited health literacy, and lack of understanding of a woman's context from health care providers (Carolan, 2010). For example, in a qualitative study of 15 Zimbabwean women living in Melbourne, Benza and Liamputtong (2017) found that women experienced added stress during the perinatal period due to experiencing community disapproval and discrimination because they were of African origin. An overall theme in this study concerned the experiences of maternity care in Australia, with women reporting racial stereotyping as a major concern for them in the perinatal and child healthcare setting. Additionally, a retrospective observational study by Gibson-Helm et al (2014) found that in Australia, women from Africa with a refugee background tend to live in lower socio-economic areas and to require an interpreter, and they may also face difficulty in acquiring transportation to get to appointments with care providers. Women also face cultural differences in expectations concerning pregnancy and childcare – including the loss of support networks (Newnham et al, 2017).

Focus group interviews with Sudanese women living in Canada identified that women view pregnancy and childbirth as natural events that do not call for medical intervention (Higginbottom et al, 2013). As such, women may feel uncomfortable with the increased medicalisation and intervention of the Western maternity care model. Similarly, research on Somali women in the United States found many women expressed strong opinions about the need for birth without interventions, and particularly expressed fear regarding the possibility of having a caesarean section (Brown, Carroll, Fogarty & Holt, 2010). This was due to many women giving birth in Somalia without medical attendance, and the comparatively high rates of complications, including maternal death, of caesarean sections in Somalia (Brown et al, 2010).

Women from sub-Saharan Africa have also expressed the belief that pain relief will interfere with the natural progression of their labour and negatively affect their baby (Carolan,

2010). Relatedly, childbearing women in Uganda and Nigeria expressed the need for nurturing, encouraging and compassionate midwives who made them feel safe and respected in their decision-making (Bohren et al, 2018). While it is important to advise women on common obstetric procedures and actual risks, it's also important that maternity care providers listen to women and understand their concerns (Brown et al, 2010).

1.6 The intersection of refugee status, psychological wellbeing, and maternity care provision

Overall, the current literature provides evidence of the interplay between the refugee experience and pregnancy care and psychological wellbeing outcomes. However, the link between these two factors and psychological wellbeing is less clear, as the existing focus is on diagnosable mental disorders rather than broader psychological health. Brown-Bowers, McShane, Wilson-Mitchell and Gurevich (2015) argue that the current focus on individualised risk factors and treatments for PND fails to consider the migrant experience. In particular, an emphasis on hormonal, cognitive and emotional factors pathologises distress, while the de-emphasis on structural or societal factors minimises contextual elements related to wellbeing (Brown-Bowers et al, 2015). This narrative is problematic because it hinders efforts to provide culturally-competent, socially located care to women during their pregnancies and in the postnatal period. This viewpoint is consistent with the concerns expressed by women from sub-Saharan Africa in relation to their childbirth preferences (Brown et al, 2010; Higginbottom et al, 2013). Given the link between control over pregnancy and childbirth preferences and psychological wellbeing (Green & Baston, 2003) it is likely that concerns discussed by Brown-

Bowers et al (2015) in relation to postnatal depression extend to psychological health more broadly in the perinatal period.

While the focus on diagnosable mental health conditions is problematic, it nevertheless tells an important story about distress for women with refugee backgrounds during the perinatal period. For example, a systematic review of the literature on PND rates in migrant women more broadly conducted by Collins, Zimmerman and Howard (2011) showed that rates of PND were as high as 42% in migrant women, which is much higher than the global average of 13% (Austin et al, 2013). Similarly, a 2008 Canadian study found that migrant, asylum seeker, and refugee woman were approximately three times more likely to screen positive on the EPDS (Stewart et al, 2008). A systematic review and meta-analysis of adverse perinatal mental health rates in migrant women found that, while migration itself is not a risk factor for depression, several associated risk factors were prevalent in migrant women, as noted above in section 1.4. These factors have been found to also increase not only the risk of PND, but also anxiety and post-traumatic stress disorder in vulnerable migrant women (Firth & Haith-Cooper, 2018). Lack of host country language skills, poor understanding of the host country healthcare system, and cultural differences are some of the barriers women face when attempting to access perinatal mental health services (Ahmed et al, 2017). Conversely, social support from family and friends, spiritual involvement, and a welcoming community have all been found to be protective factors (Ahmed et al, 2017).

Interviews with health providers have found similar themes. Healthcare workers in Toronto, Canada identified practical barriers to maternity care for migrant women, such as language and knowledge of services, as well as cultural barriers, such as stigma or dismissal of symptoms by their social circle (Teng, Blackmore & Stewart, 2007). Healthcare workers

themselves expressed uncertainty regarding appropriate perinatal care for women from a different cultural background during the perinatal period. Professional limitations were also identified, including a lack of technical training in some instances or adequate assessment tools (Teng et al, 2007). Providers, meanwhile, expressed uncertainty around supporting the non-clinical needs of their clients (Yelland et al, 2014). Similarly, researchers at the Monash Health refugee-specific perinatal clinic in Melbourne note that while health providers and women seeking health services alike believe screening tools such as the EPDS should be used consistently to assess all women for symptoms of postnatal depression, health care providers expressed concerns over a lack of knowledge about perinatal mental health and skills to administer screening tools and refer or treat women who screen positive (Nithianandan et al, 2016). Similar themes were found in a Canadian study in which healthcare workers also expressed that, while they had some understanding of the necessity of providing transcultural, trauma-informed care to people with refugee backgrounds, they felt inadequately trained to do so (Wylie et al, 2018). Healthcare providers were often unfamiliar with the transcultural sections of the DSM and also expressed concern over a lack of culturally specific assessment tools (Wylie et al, 2018). For example, the EPDS was developed and mostly tested in Western countries, with limited studies validating the EPDS in African countries (Zubaran et al, 2010; Tsai et al, 2013). A more culturally-relevant version, the Perinatal Depression Screening (PDEPS) has been developed in Kenya but is still being validated (Green et al, 2018).

Many women will have experienced previous births either in their countries of origin or in other countries before settling in Australia, and these experiences are likely to have been vastly different. Women from Africa describe birth in Australia as being medicalized, and feeling scared or intimidated by the clinical settings of Australian hospitals, and reported feeling

lonely if they found it difficult to approach their health care providers (Murray, Windsor, Parker and Tewfik, 2010).

However, Riggs et al (2017), in their qualitative study on the experiences of women with a refugee background attending a group maternity care model, found that group pregnancy care using bicultural workers could potentially increase cultural safety and a sense of belonging for women. This allowed women to navigate the new health system with confidence and to build trusting relationships with healthcare workers and other members of the community.

1.7 Aims and research question

While a relatively small body of literature exists on the perinatal mental health needs of women with a refugee background, very few studies have considered the relationship between maternity care and broader psychological wellbeing. In particular, there is little evidence concerning the psychological wellbeing of women from Africa with a refugee background during the perinatal period, which is crucial due to the unique background context of this group of women. This study aims to explore the interactions between maternity care and mental health for women from Africa with a refugee background, and in doing so, contribute to the understanding of best practice maternity care in relation to psychological wellbeing.

This study aims to explore such care through interviews with maternity care providers such as obstetricians, midwives, nurses, and general practitioners.

CHAPTER 2: Methods

2.1 Participants

Participants were seven South Australian healthcare providers with experience providing maternity or mental health care for women from Africa with a refugee background. Participants were from specialist refugee health and support services. Six of the participants worked in one specialist health service, while one participant had previous specialist maternity and mental health experience with the target population. Inclusion criteria for care providers were experience providing maternity care to women from Africa with a refugee background as either a midwife, nurse, obstetrician or general practitioner, or a refugee health provider with experience working with women with a refugee background from the African continent.

Of the seven participants, two did not provide their age. Other participants ranged in age from 38 to 59 (M = 52 years; see Table 1 for further details). All participants were female.

Table 1

Participant characteristics

Name	Age	Occupation	Experience
[redacted]	-	Nurse/Midwife	30+ years
[redacted]	50	General Practitioner	14 years
[redacted]	57	Bicultural Worker	7 years
[redacted]	-	Nurse/Midwife	13 years
[redacted]	38	General Practitioner	7 years
[redacted]	59	Nurse/Midwife	14 years
[redacted]	55	Mental Health Clinician	30+ years

Participants have been assigned pseudonyms

2.2 Procedure

This study is part of a broader project which aimed to explore maternity care more generally for women with refugee backgrounds from Africa, in partnership with a number of refugee services and hospitals. This project was given approval by the Women's and Children's Health Network (WCHN) Human Research Ethics committee on 9th April 2019, approval number [redacted] The primary researcher for this thesis was subsequently added to the project; approval for this amendment was granted on 27th May 2019. The University of Adelaide Human Research Ethics Committee provided ethics approval on 21st June 2019. In accordance with SA Health human research ethics policy, a Site Specific Assessment or Research Governance Review was sought by the primary researcher and the academic supervisor for each of the health networks participating in this study: WCHN, The Northern Adelaide Local

Health Network (NALHN), and the Central Adelaide Local Health Network (CALHN). Once governance approval had been obtained, interviews could commence. CALHN provided governance approval on 3rd July 2019, while NALHN and WCHN did not provide approval in time for participants from those networks to be included in the study.

Information regarding the study (Appendix A) was disseminated electronically to thirteen private generalist, obstetric, and psychology practices in Adelaide. Flyers (Appendix B) were also handed out in person to three generalist medical practices in Adelaide. The Information Sheet invited potential participants to email or call the researchers to express interest in participation. However, the response rate was low; only two providers responded, both indicating that they did not have experience caring for the target population. The Information Sheet was also sent to a specific refugee health service that disseminated information on the study to their networks, which resulted in six participants. The seventh participant was obtained through snowball sampling.

At the beginning of each interview, consent was provided. It was explained to participants that the data would be recorded, transcribed and deidentified, and stored on a secure computer at the University of Adelaide. Participants could withdraw at any time. After the interviews, participants were emailed a deidentified transcript of their interview and given the opportunity to make any changes or clarifications.

All interviews were conducted in July and August 2019 by the primary researcher, with assistance by the academic supervisor for the first interview. The first interview was assessed to ensure the questions asked were relevant and appropriate; it was decided that subsequent interviews could commence in the same format (see Appendix C for interview questions).

Length of interviews ranged from 25 minutes (this interview was interrupted) to 55 minutes, with an average length of 36 minutes. Interviews were recording using a digital recording device and conducted in person at the participant's place of employment, with the exception of the first interview which was conducted by telephone. Interviews were transcribed verbatim, including pauses and laughter, to capture all relevant contextual information according to the orthographic method (Braun & Clarke, 2006).

Demographic information such as age, time in role, and specific role were collected at the end of each interview if this information was not made clear during the interview. Interviews took a semi-structured approach, with a set of prescribed open-ended questions for each interview from which the researcher could prompt the participant to elaborate on key points (see Appendix B for interview questions). After each interview, the researcher reflected on the interview experience and interview questions were refined very minimally as needed to ensure clarity for participants.

Data saturation was achieved by the sixth interview, however one more interview was conducted with a participant in working in a different health service. No new themes were identified in the data.

An audit trail was kept by the primary researcher according to Tracy's (2010) "Big Tent" criteria for enhancing methodological rigour in qualitative research. The audit trail consisted of reflections on the interview process, codes and themes as they became evident, and copies of communications with participants, ethics committees and other researchers involved. According to the principle of self-reflexivity, it is important for the author to acknowledge their own situation and be self-aware in conducting research (Tracy, 2010). The author is an Australian-born female, married with two young children. The researcher's experiences and knowledge of

maternity care in the South Australian health system may have influenced the way interviews were conducted. Similarly, the researcher's own experiences and decisions may have affected the data analysis.

2.3 Data Analysis

A qualitative design was used to examine service providers' experiences with providing perinatal services to African refugee women. Specifically, the six steps of Thematic Analysis (Braun & Clarke, 2006) were followed by the researcher to understand and analyse the interview data.

Collection and analysis of data was approached using a critical realist epistemological perspective, whereby participants' lived experience was considered key to the research question, and no further meaning was assumed or applied (Braun & Clarke, 2006). A combination of inductive and deductive approaches were used; the deductive approach initially allowed the researcher to analyse the data according to the research question specifically related to the relationship between maternity care and mental health – that is, all relevant data was first identified and this was the subset of data which formed the corpus for this thesis. Once this preliminary identification of data was complete, the identified dataset was analysed using an inductive approach to dictate codes and subsequent themes (Braun & Clarke, 2012).

Firstly, familiarity with the data was achieved through listening, transcribing and reading through the data. Preliminary ideas, or codes, were then generated by grouping the codes according to patterns in the data that represented the research question. Once all interviews had been coded, the codes were collated into themes. Themes were then reviewed to generate a 'map' of data relevant to the research aims. These themes were named and refined to ensure

relevance. Lastly, extracts from the data deemed particularly relevant or compelling were extracted to include in the report.

The academic supervisor cross-checked the codes and resultant themes, confirming the analysis of the primary researcher. This process is recommended by Braun & Clarke (2006; 2013) as a way to improve trustworthiness and consistency in Thematic Analysis.

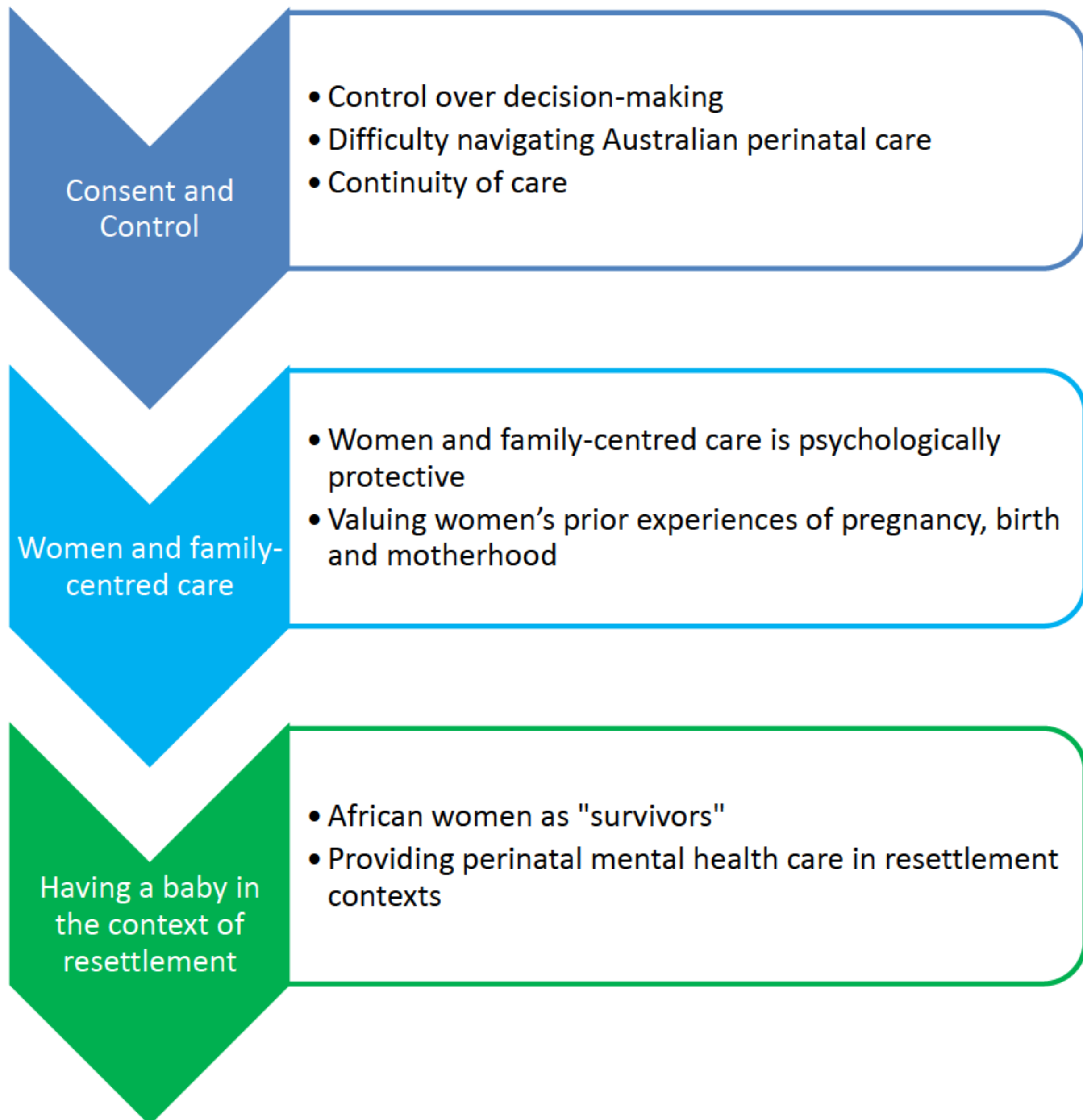
CHAPTER 3: Results

3.1 Overview

Three themes were identified in the data that speak to the research questions outlined in Chapter 1 (see Figure 1 for a Thematic Map). Specifically, section 3.2 discusses the experiences women from Africa with a refugee background may have when accessing maternity care. Here, the theme is consent and control: how women understand the different care options applicable to them, how they give informed consent, and how they exert control over their own care. Section 3.3 explores the paradigm of women-centred care, and discusses the need for providing care to women while considering their whole-family context. In section 3.4, the discussion surrounding resilience of women from Africa is presented within the context of resettlement, and perinatal experiences both in Australia and in their country of origin. Recommendations for possible improvements to perinatal care are discussed throughout.

Figure 1

Thematic Map



3.2 Consent and control

Women's ability to understand the available health care options, give informed consent for procedures, build trusting relationships with their health care providers, and advocate for themselves were seen by participants as critical in providing care that promotes psychological wellbeing. Conversely, when women did not have such opportunities, participants expressed the possibility of women experiencing psychological distress. These issues are discussed in this theme, under the subthemes of 'Control over decision-making', 'Difficulties navigating Australian antenatal care', and 'Continuity of care'.

3.2.1 Control over decision-making

Throughout the interviews, participants expressed concern over whether all available options were explained well, so women understood the nature of the care options they were given and the consequences of each option. For example, ██████ talks about a "loss of control" women may feel over decision-making during the perinatal period as a result of misunderstanding.

> "And as much as I'm sure people will say that they've explained things, very often people from refugee-like backgrounds might just nod and say "yeah I understand, sure, got it" but not really thoroughly understand the options they've been given, and so might have that sense of loss of control over the pregnancy and the birthing options."
> (██████ lines 180-183)

The ability of a woman to make decisions for herself and give informed consent over what happens to her body is particularly important in the context of maternity care, where plans may

need to change rapidly. Such changes may have broad impacts over a woman's satisfaction with the birthing process and her psychological wellbeing during and after delivery:

> "And the nature of course of maternity care is that things change very quickly and sometimes emergency decisions are made and that's difficult for anybody, but extra difficult when you're from that background where you can't just access all things we can, like talking to somebody and asking your friends. So I think it's, it probably does impact on anxiety and maybe like lack of satisfaction about how things have gone. You know, maybe even some loss that they didn't have that control over what they wanted to happen during the pregnancy."
>
> (lines 183-188)

Some interviewees relayed the misconceptions women from Africa may have about maternity care in Australia. Participants said that such misconceptions may lead to anxiety for women or feelings of apprehension or mistrust of the care they receive. Participants expressed that a clear explanation is key to ensuring women have the ability to give informed consent for procedures, thereby giving women control over what happens to their body. This was particularly important for major procedures such as caesarean sections. For example, and recalled instances where women had expressed concern over the rate of caesarean deliveries in Australia, and Naomi discussed the need to explain why caesareans may be necessary:

> "I have heard that African women say we do… everyone has a caesarean here. You know, we don't do that in Africa, why does everyone have caesareans here? Why don't babies get delivered normally in Australia?"

(lines 85-88)

"What they say sometimes is that in Australia they get more c-sections than it used to be. And sometimes they don't understand. But when they tell you it's, they need to save a life or two lives, sometimes then yeah."

(lines 48-50)

3.2.2 Difficulties navigating Australian perinatal care

Many women from Africa with a refugee background who give birth in Australia have given birth previously in their country of origin, often with little or no formal medical support (WHO, 2019). Participants reflected on this process and expressed that navigating the Australian model of maternity care could be difficult and confusing for women.

"Well I think most, many of the women we see here never ever had any antenatal care, and have delivered babies at home, on their own or with someone there. So, the whole concept of antenatal care can be quite foreign."

(lines 55-57)

As a result, participants expressed that women may experience some culture shock when navigating the Australian health system, especially when they would otherwise consider themselves healthy and therefore not in need of hospital care. and discussed the process of familiarising oneself with the Australian maternity model, particularly in a clinical setting, and the possibility that this process may compound any feelings of being overwhelmed that many women are already experiencing.

"It's having you explain, well I have explained that they're gonna have appointments to see the doctor, they have to have bloods done, they will be seen by a midwife as well, and they will do these things. And they sort of look at you as, why am I doing this? Because they don't understand that this is the best care. Some who have been in camps a long time may have had this, along this line of care but maybe not as frequently seen, so it's um, a lot of what we see is culture shock as well."

(█████ lines 84-89)

"I think, I think medically they're quite happy, like with the blood tests and the ultrasounds and the, that sort of, side of things. I think the thing they find most difficult is the seeing a new person each time, a new environment, so the hospital environment is quite different, 'cos they're healthy people, it just seems a bit weird for them to be in hospital. So that takes a little bit of getting used to. And then not having the familiarity of the same person each time I think makes that worse. So it seems like a very clinical setting I think. So there can be a little bit of, not fear but unsure, they're unsure around that."

(█████ lines 102-108)

3.2.3 Continuity of care

Continuity of care was consistently identified by participants as an element of health care that women from Africa from a refugee background need, particularly in relation to their mental health. A lack of continuity of care makes it difficult for women to build a relationship with their care provider and be able to trust them. This can make women feel uncomfortable because a

relationship is lacking. Without this trusting relationship, women may find it difficult to disclose information pertinent to their care, such as a history of rape or trauma, or whether they have undergone FGM.

> "And you create a kind of confidence with your doctor, and then when you get transferred to a hospital and you don't get to see the same doctor or professional each time, so each time you have to restart again. And you have to tell the same story, you have to... and yeah that kind of creates a kind of, yeah you don't want to tell everything, because you need to, to get the ... relationship with your professional, and they don't get it because you don't see the same person each time. Each time you go there it's someone different."
>
> (█████ lines 62-69)

> "So I guess the main barriers for women engaging in, in any care service particularly maternity, are around their previous experience with the hospital system so using interpreters, they're perceiving that things haven't been explained well, confusion, being passed from one person to another – like a real lack of personal care I guess. And so I think that that's probably a barrier to them trusting and engaging with us, with the system. So somehow helping them see that the system is different would be helpful. And yeah then them being able to get familiar with a particular person or service I think would be really helpful as well."
>
> (████ lines 163-169)

A lack of continuity of care can also be a problem in perinatal care due to the nature of information a woman is given. Participants related that women were sometimes given conflicting information, exacerbating the already confusing maternity care situation women found themselves in due to language barriers and health literacy issues.

> "Yeah so I think that they, they would expect that they'd get to see the same person and get to know, you know, what to expect going forward in their pregnancy and what their birth options are, and you know, get as much information as possible. But I think they then probably get, because they see different people from, you know, different backgrounds, some different messages and sometimes they're not entirely sure what the best thing is for them."
>
> (████ lines 110-114)

Many interviewees expressed that women were unlikely to complain if the care they received was below standard. Interviewees expressed a desire for women to have someone to advocate for them, and that sometimes a sense of control could come from having an advocate. In the context of women's previous experiences, where antenatal care was unlikely and there were more pressing concerns such as safety and security, Denise said that women were unlikely to raise issues or concerns. This was because they may not believe it would change anything, because they are unsure of the procedure, or because they are simply unaware they received care that would be considered poor in Australia.

> “Our clients are not people who complain. Unfortunately. You know, they have to have advocates for them. They have to understand that probably what they went through is not up to the standard it should be anyway.”
>
> (█████ lines 124-126)

Participants said that the use of bicultural workers was an option that gave women more of a voice, and therefore more control over the health care they received. Bicultural workers also provided cultural insight that allowed health care providers to be more understanding to a woman’s cultural and social needs. For example, █████ discussed frequently seeking the advice of bicultural workers, who would assist in understanding and addressing health concerns from an appropriate cultural perspective.

> “But if we have any issue we’ll talk to them first, and say you know, what’s the best way around this, what should we do? And they give it to us from a cultural perspective … So, you know, it’s taught us as service providers to communicate effectively with people from different cultures. And I mean they’re our right hand, our bicultural workers. We could not provide the service we do without them.”
>
> (█████ lines 112-121)

3.3 Putting women and their families at the centre of their care

Ensuring that women receive care that is tailored to their individual needs, culturally sensitive, and places women as active decision-makers in their own care was viewed by participants as being key to providing care that is psychologically protective. Additionally, participants saw value in family-centred care that takes into account the needs of a woman’s

whole family. These issues are discussed in this theme, under the subthemes of 'Women and family-centred care is psychologically protective', and 'Valuing women's prior experience'.

3.3.1 Women- and family-centred care is psychologically protective

Maternity care providers saw a need for women-centred care or family-centred care: care that focuses on the whole woman rather than just in the context of reproduction, or care that took a woman's social and familial context into account. They also understood the value of consulting with family units rather than just individuals. In particular, participants repeatedly discussed "following up" on women and ensuring women knew their care providers understood a woman's circumstances and individual pregnancy. ████ discussed taking a "holistic view" of each woman and her family:

> "Yeah we have longer appointment times, we see people as part of a family, at least to start with, so you really get a nice holistic view of their situation and we follow them up as a family as well. So between the GPs and the nurses we follow families through their journey until they're transitioned. And they have regular contact with us. So I think all of that just makes it much easier to be aware of what's going on and what things they might need. And what would be most helpful."
>
> (████ lines 290-294)

In addition, most interviewees acknowledged that Australia's health system has many benefits, including giving them reassurance over the health of a pregnancy, and answers when things go wrong. Because of this, it was viewed by many that, with the right practical and social supports,

the rigorous evidence-based maternity care provided in Australia may be a psychologically protective factor.

> "It's very, very common for women to have lost children in birth or you know, shortly thereafter, so the kind of relief and gratitude of you know, being welcomed into a first-rate health system is also evident. And I you know I've seen women be very, you know, relieved and happy to be referred for pregnancy management soon after arrival."
> (█████ lines 164-167)

> "It's a good thing because back in Africa or a refugee camp or wherever they were, sometimes you, you miscarriage, you don't know why. Anything can happen but you don't know why. So it's a good thing to see a doctor, at least you know and you are, you know that someone is following up on you. And whatever comes, you get treatment, it's a good thing."
> (█████ lines 35-38)

However, it was important to acknowledge while women-centred care is psychologically protective, maternity care could have negative psychological impacts if delivered without sensitivity.

> "I think that maternity care can either strengthen a woman in her mental health, or it can damage a woman in her mental health. And the sense of safety for women is really impacting on their mental health. So a service can be responsive and caring to a woman, and that makes her resilient and makes her stronger to birth. But if their experience in the

maternity is judgement or criticism or being flagged or any way to a system, that can be really damaging to women."

(■■■ lines 321-326)

In order to provide a psychologically protective service, care providers saw a need to consider the other events and obligations in a woman's life, such as caring for other children, when providing antenatal care. ■■■ discussed important details, such as whether a woman had another adult family member in the home to help with her other children, often being "missed" when taking a woman's history, potentially leading to stress for a woman if she has no one to care for her other children when she is in hospital.

> "Often they have much larger families than naturalised Australians. They will often have more psychosocial issues. So, not always of course, but they might be managing multiple situations at once and often won't tell people what's going on for them until it all falls apart. And a lot of women, a lot of families that come from, that we see, from various African countries are coming on women at risk visas, so they're often female-headed households, and may not have another parent. So that's a really big thing that seems to get missed, where basically someone's about to have a baby and they're going to go home to a house where there's no one else to look after their entire family."
>
> (■■■ lines 59-66)

Participants considered women-centred care as of critical importance because of the likelihood that women from Africa with a refugee background had undergone FGM. In particular, participants expressed that medical staff needed to be more sensitive and aware when discussing

obstetric and gynaecological issues, especially in the context of FGM. ██████ discussed midwives being unprepared to encounter women who had undergone FGM, and the negative psychological implications for a woman when this occurs.

> "Particularly for African women not lumping everybody all together but making sure that there's very sensitive history taking around FGM and proper kind of birth planning and support if that's really different because my experience or what I know is that most midwives kind of run a mile rather than talk to women sensitively about history of FGM. And there's been some incidences where you know it hasn't really been approached very sensitively and there's been no proper birth planning and history taking and staff have reacted very poorly in a clinical situation."
>
> (██████ lines 202-208)

Woman-centred care ensures a culturally sensitive approach that anticipates the needs of an individual woman when providing care, which is of particular importance when discussing FGM with women (Turkmani et al, 2019). ██████ discussed situations where women had not been approached at all about FGM, potentially creating the situation ██████ described, where women would likely experience confusion and a sense of shame.

> "Well I've seen women here who no one's ever asked them about it [FGM] at the hospital but we've made a point of asking, you know, have you had this? You know just to see if there's going to be any impact when they deliver. But no one had asked them at the hospital."
>
> (██████ lines 39-42)

While all participants acknowledged the role previous trauma had to play in the shaping of a woman's pregnancy, childbirth and parenting experiences, and gave clear examples of the bidirectional relationship between trauma and maternity care. Naomi described incidences of women having flashbacks of previous traumatic experiences, while Wendy described the insensitivity of particular maternity practices such as internal examinations when a woman has experienced violence. Again, participants called for woman-centred care that fosters sensitivity and understanding in health care professionals.

> "Yeah sometimes like, women who have been raped or who saw whatever things in the war, when they are pregnant it can come back and lead to mental [illness] ... They can have flashbacks of what they saw or they, what happened. It can lead to mental [illness]."
> (lines 176-179)

> "But you know lying on your back with your legs open with a man standing over the top of you kind of talking at you, you know it's a pretty violating experience for any woman let alone a woman who's been held down and raped."
> (lines 249-252)

Participants expressed ideas that may help to provide a more culturally-competent, continuous model of care. Of particular note was discussion around midwifery group practices, a model of care that exists in Australian hospitals but may need finessing to be more specific to women from Africa with a refugee background.

"Yeah I think it [midwifery group practice] would be really good … maybe their options are not explained, like maybe they don't understand their options so well at the beginning … But yeah I think that would be, they would probably do quite well with that."
(█████ lines 148-153)

"I think it's [midwifery group practice] a good model, it's been proven internationally that it's a good model, it's very person-centred, you know … And I think from, for women from a refugee background I think it would be the best fit, really, for a lot of them … certainly the more vulnerable and marginalised in that group, it would be a better model."
(██████ lines 55-59)

3.3.2 Valuing women's prior experiences of pregnancy, birth and motherhood

Participants reflected that many women had prior experience with pregnancy, birth, and raising children, and that caregivers needed to be careful not to invalidate a woman's prior experiences. While this is key to providing women-centred care, this was also seen as important for women to exert control over decision-making during the perinatal period. For example, █████ discussed giving women the opportunity to "let them do what they know works".

"As a midwife and having worked in the system, even acknowledging that they have got different ways of doing things, if they've had seven children before and they've breastfed all of them they will do what they have done with the others. You can give them advice but also let them do what they know works. So it's, it's being aware of their culture and

> their background, and it might be different to what you, or the hospital policy says you must be doing."
>
> (lines 102-106)

acknowledged that the Australian health system seems not to value the prior experiences of women, and therefore leads to care that fails to consider the woman and put her at the centre of her own care. Again, this also diminishes the control women have over their own outcomes.

> "Women from refugee background, they come with their own experience and their own understanding of you know, pregnancy and delivery, which I feel isn't really valued in our systems. And not taken into account when the women are in hospital or receiving care, you know?"
>
> (lines 64-67)

In particular, participants discussed the complexities of providing women-centred care that values a woman's prior birth and parenting issues in the context of parenting practices that are actively encouraged or discouraged in the Australian health system. discussed the different views women may have on co-sleeping, breastfeeding, or other parenting issues, and alluded to the stress women may experience if they are 'struggling' with activities such as breastfeeding and not receiving enough support.

> "You know, things like shared sleeping, I can't remember what that term is, but you know, when you sleep with the baby, that's... around feeding issues, so that if women are struggling with breastfeeding, and um, you know, there's very little support that's culturally appropriate and you know accessible for women if they're struggling around

> those issues postnatally. And, um, yeah so there's, because we don't offer that really close postnatal support there's sometimes some real gaps around that."
>
> (lines 116-121)

When support exists, participants expressed that it may not be culturally appropriate. For example, felt that current services offered within Australia's maternity system had a particular focus on parenting skills, which is not what women from Africa with a refugee background require. She acknowledged that most women are confident parents with strong ideas on how they wish to raise their children.

> "I don't, I think lots of that stuff is seen around being able to parent. And what our systems flag as problems are where there's sort of, identified problems around parenting. And I don't think in African community that's ever an issue. 'Cause they parent differently, but they don't question their ability to parent."
>
> (lines 415-418)

also acknowledged the cultural contexts behind the different ways African women may parent their children, and their commitment to doing what they feel is right.

> "In my experience African women are most likely to breastfeed, they just breastfeed. Because they do it. Because they've seen it in the community, it's like a genetic knowing. This is what you do. And they have a strong commitment to it. So they just do it. They put their babies on their backs, you know, because that's what you do. They can tell you about all these things. Now they parent their children to become quite independent really early, so that's a different thing, and they're often very harsh when their children are

older. You know, really strict sort of stuff. But this is this survival stuff again. I think it has context. I've been into African households where, you know, the two-year-old's got a knife, cutting up the veggies. You know, we would never give a two-year-old a knife. But that's a cultural context, you know."

(█ lines 209-217)

3.4 Having a baby in the context of resettlement: African women as survivors

In previous themes, issues of control, advocacy, and expectations of care have been shown to potentially impact negatively on women's mental health in the perinatal period. However, all participants discussed tensions between such impacts and the protective factors women from Africa with a refugee background are likely to experience or exhibit. These issues are discussed in this theme, under the subthemes of 'African women as "survivors"', and 'Providing perinatal mental health care in resettlement contexts'.

3.4.1 African women as "survivors"

Many participants framed women from Africa as being "survivors". They discussed the experiences women have had in their countries of origin and on their resettlement journeys, particularly regarding the trauma many women have experienced, and compared these experiences to that of having a baby in Australia. For example, █ discussed this trauma and survivorship and expressed that it would be difficult to understand the realities of such experiences. She considered that the context of the refugee experience, particularly women's

potential trauma experiences, played a part not only in any negative feelings women may have regarding the perinatal period, but also the positive feelings:

> "So I think that women come with real trauma stories, and that, in my experience African women are really survivors. So when they come to Australia they have survived, they've survived all sorts of things. And I don't even think that we can even understand, you know..."
>
> (■■■■ lines 113-115)

Similarly, participants reflected on women's previous experiences of trauma and suggested that pregnancy and childbirth is normalised for African women. Many participants noted that the cultural orientation to motherhood is different for women from Africa, and that this has consequences for the way women experience the period of time surrounding the birth of a new baby. For example, ■■■■ talked about the possibility of pregnancy being "business as usual" for many women in Africa within the context of their previous stressors. Specifically, the joy of having a baby was the focus for women, and therefore ■■■■ expressed that experiencing psychological distress would be unlikely at this time.

> "First of all women from Africa, they are very resilient. So they've gone through so many things, back in Africa, and sometimes with pregnancy it's business as usual *(laughs)* you know? And sometimes they, even if they, like when they ask like you know the questions they usually ask after birth, how do you feel? Of course I'm happy I have a baby! You know? So mental health in pregnancy or post, I don't think it's common in women from Africa, African background."

(███ lines 77-81)

While all participants stressed the high levels of resilience and strength exhibited by women from Africa with a refugee background, again framing women as survivors both in the context of their past experiences of trauma, several participants also noted the psychologically protective elements of the act of mothering itself for women from Africa with a refugee background. Participants suggested that mothering led to increased satisfaction with their experiences and a decreased likelihood of experiencing clinical disorders such as postnatal depression or anxiety. Specifically, participants compared the way women from Africa see their role as mothers, and the way they approach the practicalities of being a mother and caring for their children, to the approaches of women from a Western background. Participants suggested that women from Africa may be at less risk of psychological distress in the perinatal period because they may focus more energy on caring for their child and less energy on being concerned about their home, careers, or other issues not related to their infants.

> "The women we see are incredibly strong and survivors as well, so that's the flip side of it. And they, so sometimes you know despite all that trauma you know having a baby is like, oh I've got a baby. I think their perceptions are quite different to ours as well ... Whereas I actually think postnatal depression in some ways is more of a problem in our culture, where we want to have the house perfect and we want to go back to work … I think African women are better at just looking after that baby and, and this is you know, and putting everything into looking after that baby. So in some ways I think they're better off. You know they, there's maybe less risk in some ways."
>
> (███ lines 162-172)

While the discussion of cultural orientation to motherhood, and therefore mothering as a protective factor, was common throughout the interviews, there were caveats to this that were expressed by some participants. For example, ███ agreed that postnatal depression and anxiety was less likely to occur for women from Africa with a refugee background, and that women's resilience was a major influence in this regard. However, she noted that, due to trauma, when women did experience clinical mental health conditions in the perinatal period, they were likely to be severe.

> "To be honest we haven't had a lot of women during pregnancy or who have been pregnant that have had a lot of mental health issues, but when they have them, they're big. You know, psychoses and major depression and things like that. So it's like it's from one extreme to the other. Because the resilience is so high for the majority of our women … it's, you know, it's all relative to what their past is."
>
> (███ lines 200-205)

While participants' views varied on the likelihood of women from Africa experiencing diagnosable mental health conditions during the perinatal period, all participants made the distinction between depression and stress clear and discussed the role stress plays in psychological wellbeing. Participants recalled that often, women are in a situation where they "are managing multiple different things" (███ lines 51-52): women have many other stressors in life and are giving birth and raising children within a context of additional physical, social and financial burdens. In particular, participants juxtaposed the resilience of women and their cultural orientation to mothering with the challenges of other stressors that were part of the resettlement process. For example, ███ discussed the physical and mental toll of having a child in a new

country, and said the mental burden of having a family in a new country with no familial support can be high.

> "I don't see much of the mental [illness] in women from Africa connected to the pregnancy or... the only mental health [issues] can come after birth and maybe the overwhelming of the task of a new mum in a new country when you have to deal with everything by yourself. Because in Africa, when you give birth you are surrounded by the family and they help with everything. And here, you are here, if you are lucky to get to be living with your husband or partner, they can help. Otherwise it's just you."
>
> (███ lines 155-159)

3.4.2 Providing perinatal mental health care in resettlement contexts

A range of opinions were evident across participants on the place mental health care had in antenatal care for women from Africa with a refugee background. Participants who considered mental health from a 'psychological wellness' perspective, and acknowledged an interaction between physical and psychological wellbeing, were more likely to see mental health care as being crucial to any best practice of maternity care. Many participants acknowledged that this was necessary not only for the mother, but for the health of the infant as well.

> "Well it's [mental health care] essential because you know, that person's past experiences, their current mental health state, all has an impact on their pregnancy and the outcomes afterwards. So it's absolutely essential to incorporate mental health into it."
>
> (███ lines 153-155)

> "Oh, I think it [mental health care] should just be a part of it [perinatal care]. It's not a question to me ... It's part of health care. I think every single physical ailment, and you know, even normal events, processes like pregnancy are impacted by mental health. It should absolutely be a part of... *(trails off)"*
>
> ([redacted] lines 196-200)

However, some participants considered that, while mental health care had a place in perinatal care, it may not be a focus for women, particularly in the context of different cultural ideas surrounding mental health:

> "A lot of our clients have got mental health, with mental health issues, do not see it as a problem because in their (*inaudible... culture?)* it's not a, not something you discuss. Or you go to an elder and discuss it with. They don't understand the need for a, someone, specialist, who may see it as you need to come in."
>
> ([redacted] lines 62-65)

Finally, one participant, who had expressed that she saw less need for a strong mental health focus in perinatal care models for women from Africa, acknowledged a need for prevention strategies, although she was unsure as to what these prevention strategies would look like.

> "You know it's always, maybe put in place, put in place methods to prevent for it to happen, that would mean connect to women with the community and get more skills in multitasking, maybe, I don't know."
>
> ([redacted] lines 163-165)

CHAPTER 4: Discussion

4.1 Overview

This study investigated the impact maternity care may have on the psychological wellbeing of women from Africa with a refugee background. This study also explored current service provision of maternity care to women from Africa with a refugee background. Thematic Analysis of the interview data resulted in the identification of three themes relevant to the research questions: ‘Consent and control’, ‘Women and family-centred care’, and ‘Having a baby in the context of resettlement: African women as survivors’. Consistent with the existing literature (Carolan & Cassar, 2007; Correa-Velez & Ryan, 2012; Murray et al, 2010; Riggs et al, 2012), the results of this study indicate that women from Africa with a refugee background experience additional stressors within their perinatal care, and this can impact upon psychological wellbeing.

Supporting previous research on the centrality of consent and control in the perinatal period to psychological wellbeing (Green and Baston, 2003), this study found that processes and procedures during perinatal care are not always adequately explained to women and that the inability to exert control over their care and to give informed consent may cause psychological distress. Meyer (2013) describes four attributes of control that influence childbirth satisfaction and subsequent emotional wellbeing: decision-making, access to information, personal security, and physical functioning. When women are active participants in the decision-making progress and therefore have control over their bodies (whether with pain relief or not), women are likely to feel positive about their experiences and less likely to experience negative psychological outcomes (Meyer, 2013). Similarly, the findings of this thesis are in line with previous literature

on the importance of continuity of care (Correa-Velez & Ryan, 2012). Continuity of care was considered to be of utmost importance in providing women the space to learn about their pregnancies, ask questions, and make informed choices (Balaam et al, 2013; Lillrank, 2015; Riggs et al, 2017), particularly with regard to misconceptions women from Africa may have about elements of maternity care in Australia such as caesarean sections or epidural anaesthesia (Brown et al, 2010; Higginbottom et al, 2013). Building a relationship with care providers was also seen by participants as critical to disclosure of issues that may impact a woman's pregnancy and birth, such as FGM or trauma. Such findings are reflective of current literature regarding the need for continuity of care and the impacts of mismanagement of care, particularly with regard to FGM, on the psychological wellbeing of women (Straus, McEwen & Hussein, 2009). While limited research has explored the concept of control over birth for women from Africa with a refugee background (Higginbottom et al, 2013), the relationship between consent and control during the perinatal period, and psychological wellbeing for women from Africa with a refugee background, has been under-researched.

In relation to the impact maternity care may have on the psychological wellbeing of women from Africa with a refugee background, the concept of woman-centred care was discussed frequently by participants as an element of care that improved the psychological wellbeing of women seeking care. According to the Nursing and Midwifery Board of Australia (NMBA), woman-centred care involves cultural sensitivity, promoting the normalcy of birth, and the right of women to self-determination and self-care (NMBA, 2018). This reflects previous discussion in this thesis regarding the need for women to be active participants and decision-makers in their own care. However, a lack of universal adoption of such a definition, combined with a lack of literature regarding the adoption of such practice, contributes to confusion

regarding the implementation of women-centred care in maternity care settings (Brady, Lee, Gibbons & Bogossian, 2019).

Participants expressed a desire for a midwifery-led maternity service that incorporates bicultural workers and a community element, a model that has found preliminary success in Melbourne, Australia, with Karen women from Burma, particularly with regard to empowering women and providing a sense of cultural safety (Riggs et al, 2017). Few studies have explored the specific role midwives should play in supporting mental health and psychological wellbeing of women in the perinatal period (Alderdice, McNeill & Lynn, 2013), although preliminary research suggests midwifery-led care is beneficial in the broader population (Fenwick et al, 2015). Reflecting previous research, this study found that women may range from viewing antenatal care as unnecessary because pregnancy is a 'normal' process, to valuing perinatal care for the educational opportunities it provided regarding caring for themselves and their babies (Carolan & Cassar, 2010). However, this process may be mediated by cultural beliefs and whether the perinatal care women received was sensitive to women's cultural contexts (Carolan & Cassar, 2010; Grant & Guerin, 2018). Participants in this study expressed that while thorough perinatal care can be a protective factor for women's psychological wellbeing, it is imperative that caregivers act sensitively and possess a background understanding of women's social and cultural contexts. The impact of midwifery-led, woman-centred care for women with a refugee background represents an important direction for future research.

While a key finding of this study is the psychological benefits of women-centred care, the results of this study add to the previous literature in the discussion of woman-centred practice versus family-centred practice. While the benefits of women-centred practice are supported by the existing literature (Brown et al, 2014), participants in this study also described a need for the

whole family to be considered. Participants working in a refugee-specific health service discussed the benefits of consultations with whole families rather than individuals, to gain a broader picture of the psychosocial elements contributing to clients' health and wellbeing, such as housing, finances, or limited social supports (Merry, Gagnon, Kalim & Bouris, 2011). While research has investigated the benefits and considerations of a family-centred care model in general maternity and paediatric settings (Arabiat, Whitehead, Foster, Shields & Harris, 2018; Chalmers, 2017) little research has been conducted on a family-centred approach in a refugee health context, nor in a refugee maternity care context. Additionally, participants in this study suggested that, while some family-centred support programs exist, they may not be relevant to the needs of women from Africa with a refugee background. However, the current evidence, though limited, suggests that positive parenting programs may be beneficial for families from Africa with a refugee background, to help them navigate parenting in a new culture (Deng & Pienaar, 2011; Renzaho & Vignjevic, 2011).

Most participants stressed the resilience of women from Africa with a refugee background, and felt it was important to note that their strength came from their culture as well as from previous trauma. Participants talked about women in terms of being "survivors" and, consistent with Brown-Bowers et al (2015), suggested that acknowledging the strength and resilience of women is important in providing care for women that is psychologically protective and does not pathologise a woman or her lived experience. Additionally, while the current body of evidence suggests an increased likelihood of adverse perinatal mental health outcomes for women with refugee backgrounds (Ahmed et al, 2017; Collins et al, 2011; Schmied et al, 2017) participants in this study expressed that, while women from Africa with a refugee background may experience additional stressors during the perinatal period, owing to this sense of survival,

women may be less likely to experience adverse mental health in the perinatal period. Further research is warranted that considers psychological wellbeing, rather than mental illness, for women from Africa with a refugee background.

4.2 Strengths

Despite a great deal of literature on post-natal depression, there is little in the way of research looking at overall psychological wellbeing in the perinatal period (Felder, Lemon, Shea, Kripke & Dimidjian, 2016). Additionally, the majority of literature on mental health for people with refugee backgrounds focuses specifically on the psychological consequences of trauma rather than psychological wellbeing (Ellis et al, 2016; Khawaja, White, Schweitzer & Greenslade, 2008) or positive mental health (Beiser & Hou, 2017). In particular, few studies have focused on the psychological wellbeing of women with a refugee or asylum seeker background during the perinatal period (Gewalt, Berger, Ziegler, Szecsenyi & Bozorgmehr, 2018), and no studies have considered psychological wellbeing perinatally for women from Africa specifically. This study therefore makes a valuable contribution to the evidence surrounding the perinatal care women from Africa with a refugee background receive in Australia during the perinatal period, and the impacts such care may have on their psychological health.

The exploratory nature of qualitative thematic analysis allowed for rich data to be collected during this study. Such data and analysis led to findings that added to the current literature and were at times not anticipated by the researchers. For example, discussion regarding women from Africa being less likely to experience psychological distress was not anticipated.

Consequently, this thesis presents a more nuanced broader picture of the needs of women from Africa with a refugee background and the context in which they seek perinatal care services.

Tracy's (2010) "Big Tent" criteria for qualitative research was followed when conducting this research. An audit trail was employed by the researcher to ensure rigorous and transparent research, and the opportunity for self-reflexivity added to this transparency. Participants were given the opportunity to reflect on their transcribed interviews and make any changes or additions if necessary; four participants engaged in this opportunity and all expressed satisfaction with the results, enhancing the credibility of the data. Most importantly, the perinatal mental health needs of women from Africa with a refugee background presents an interesting research topic that is particularly relevant given the increasing numbers of refugees worldwide.

4.3 Limitations

Time limitations and lengthy ethical approval times meant that the sample was small and predominantly from one refugee-specific health service in Adelaide. Additionally, due to the nature of their work, participants in this study may have been particularly motivated to participate. While the experiences of these specialist health professionals are invaluable, this study did not interview any care providers working in busy maternity wards where the experience and limitations of providing care would be vastly different. This is a potential future direction for research.

Given the specificity of the target population, generalisability is limited in that cultural factors will differ between women from Africa and women from other parts of the world. It is also important to note that women from Africa are not a homogenous group and that individual experiences of women must be at the centre of their care. Specifically, the nature of the

interviews with health providers did not afford the opportunity to record women's countries of origin, or their background medical and social histories. Similarly, while the insight of health care workers is important, this study did not gather data from women themselves due to ethical constraints. Further study that triangulates data from health care providers and families experiencing maternity care is warranted.

4.4 Implications

This study has several implications. Firstly, results found that continuity of care, social and practical supports, and women-centred and family-centred care that understands a woman's cultural backgrounds, family context, and life experiences are central to psychologically protective perinatal care. A strong call for midwifery practice services specific to women with a refugee background was of particular note, as was the employment of bicultural workers. These elements represent an important direction for future research.

Results identified that maternity care could be both a psychologically protective and a psychologically damaging factor for women from Africa with a refugee background, depending on the nature of care provided. Participants also expressed that the particular physical and social stressors this group of women may experience are the most likely to impact on her psychological wellbeing. The overarching finding is one of reframing the conversation around perinatal mental health: rather than pathologizing women and focusing on diagnosable mental health conditions, future research must address the interplay between stressors, culturally competent perinatal care, and the psychological wellbeing of women. The results of this study indicate that, while mental health care should be incorporated into any best practice model of perinatal care for refugee women from Africa, what is most important is that women are in control of their bodies and can

make informed decisions, that women are listened to and understood, and that women are practically and socially supported in a way that acknowledges their strength and resilience. If these practices are incorporated into a future best practice of maternity care, women may be less at risk for adverse psychological health.

4.5 Conclusion

This study has provided important insight into the relationship between maternity care provision in Australia for women from Africa with a refugee background, and psychological wellbeing. This study found that maternity care may or may not be psychologically protective, depending on whether a woman has control over her body and the ability to give informed consent, whether she and her family are understood in the context of their culture and lived experience, and whether a woman has access to social and practical supports that can alleviate some of the additional stressors that women from Africa with a refugee background are likely to face. As such, this study has provided evidence of the impact maternity care has on the psychological wellbeing of women from Africa with a refugee background, and provided a foundation upon which further research can be built to develop a best practice model of maternity care for women from Africa with a refugee background in the future.

References

Ahmed, A., Bowen, A. & Feng, C.X. (2017). Maternal depression in Syrian refugee women recently moved to Canada: a preliminary study. *BMC Pregnancy and Childbirth*, 17, 240. DOI: 10.1186/ s12884-017-1433-2

Akinyemi, O.O., Owoaje, E. & Cadmus, E. (2016). In their own words: mental health and quality of life of West African refugees in Nigeria. *Journal of International Migration and Integration.* 17(1), 273-287. DOI: 10.1007/s12134-014-0409-6

Alderdice, F. & Gargan, P. (2019). Exploring subjective wellbeing after birth: A qualitative deductive descriptive study. *European Journal of Midwifery*, 3. DOI: 10.18332/ ejm/104679

Anderson, F.M., Hatch, S.L., Comacchio, C. & Howard, L.M. (2017). Prevalence and risk of mental disorders in the perinatal period among migrant women: a systematic review and meta-analysis. *Archives of Womens Mental Health*, 20, 449-462. DOI: 10.1007/s00737-017-0723-z

Arabiat, D., Whitehead, L., Foster, M., Shields, L. & Harris, L. (2018). Parents' experiences of family centred care practices. *Journal of Pediatric Nursing*, 42, 39-44. DOI: 10.1016/j.pedn.2018.06.012

Austin, M.V., Middleton, P., Reilly, N. & Highet, N. (2013). Detection and management of mood disorders in the maternity setting: The Australian Clinical Practice Guidelines. *Women and Birth*, 26, 2-9. DOI: 10.1016/j.wombi.2011.12.001

Baird, M.B. (2012). Well-being in refugee women experiencing cultural transition. *Advances in Nursing Science*, 35(3), 249-263. DOI: 10.1097/ANS.0b013e13826260c0

Baird, M.B. & Boyle, J.S. (2012). Well-being of Dinka refugee women of southern Sudan. *Journal of Transcultural Nursing*, 23(1), 14-21. DO: 10.1177/1043659611423833

Balaam, M., Akerjordet, K., Lyberg, A., Kaiser, B., Schoening, E., Fredriksen, A., Ensel, A., Gouni, O. & Severinsson, E. (2013). A qualitative review of migrant women's perceptions of their needsand experiences related to pregnancy and childbirth. *Journal of Advanced Nursing*, 69(9), 1919-1930. DOI: 10.1111/jan.12139

Bauer, A., Knapp, M. & Parsonage, M. (2016). Lifetime costs of perinatal anxiety and depression. *Journal of Affective Disorders*, 192, 83-90. DOI: 10.1016/j.jad.2015.12.005

Beiser, M. & Hou, F. (2017). Predictors of positive mental health among refugees: Results from Canada's General Social Survey. *Transcultural Psychiatry*, 54(5-6), 675-695. DOI: 10.1177/1363461517724985

Benza, S. & Liamputtong, P. (2017). Becoming an 'Amai': Meanings and experiences of motherhood amongst Zimbabwean women living in Melbourne, Australia. *Midwifery*, 45, 72-78. DOI: 10.1016/ j.midw.2016.12.011

Bohren, M.A., Titiloye, M.A., Kyaddondo, D., Hunter, E.C., Oladapo, O.T., Tunçalp, Ö., ... Mugerwa, K. (2018). Defining quality of care during childbirth from the perspectives of Nigerian and Ugandan women: A qualitative study. *International Journal of Obstetrics and Gynaecology*, 139(1), 4-16. DOI: 10.1002/ijgo.12378

Bowen, A., Bowen, R., Butt, P., Rahman, K. & Muhajarine, N. (2012). Patterns of depression and treatment in pregnant and postpartum women. *Canadian Journal of Psychiatry*, 57(3), 161-167. DOI: 10.1177/070674371205700305

Brady, S., Lee, N., Gibbons, K & Bogossian, F. (2019). Woman-centred care: An integrative review of the empirical literature. *International Journal of Nursing Studies*, 94, 107-119. DOI: 10.1016/ j.ijnurstu.2019.01.001

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77-101. DOI: 10.1191/1478088706qp063oa

Braun, V. & Clarke, V. (2012). Thematic Analysis. In H. Cooper (Ed.), *APA Handbook of Research Methods in Psychology Vol. 2*. USA: American Psychological Association.

Brown, E., Carroll, J., Fogarty, C. & Holt, C. (2010). "They get a C-Section... They gonna die": Somali women's fears of obstetrical interventions in the United States. *Journal of Transcultural Nursing*, 21(3), 220-227. DOI: 10.1177/1043659609358780

Brown, S.J., Sutherland, G.A., Gunn, J.M. & Yelland, J.S. (2014). Changing models of antenatal care in Australia: Is current practice meeting the needs of vulnerable populations? *Midwifery*, 30, 303-309. DOI: 10.1016/j.midw.2013.10.018

Brown-Bowers, A., McShane, K., Wilson-Mitchell, K. & Gurevich, M. (2015). Postpartum depression in refugee and asylum-seeking women in Canada: A critical health psychology perspective. *Health*, 19(3), 318-335. DOI: 10.1177/1363459314554315

Carolan, M. (2010). Pregnancy health status of sub-Saharan refugee women who have resettled in developed countries: a review of the literature. *Midwifery*, 26, 407-414. DOI: 10.1016/j.midw. 2008.11.002

Carolan, M. & Cassar, L. (2010). Antenatal care perceptions of pregnant African women attending maternity services in Melbourne, Australia. *Midwifery*, 26, 189-201. DOI: 10.1016/j.midw.2008. 03.005

Chalmers, B., (2017). An introduction to family-centered care. In Chalmers, B. *Family-centered perinatal care: Improving pregnancy, birth, and postpartum* care (pp 9-14) Cambridge, UK: Cambridge University Press.

Collins, C.H., Zimmerman, C. & Howard, L.M. (2011). Refugee, asylum seeker, immigrant women and postnatal depression: rates and risk factors. *Archives of Womens Mental Health*, 14, 3-11. DOI: 10.1007/s00737-010-0198-7

Correa-Velez, I. & Ryan, J. (2012). Developing a best practice model of refugee maternity care. *Women and Birth*, 25, 13-22. DOI: 10.1016/j.wombi.2011.01.002

Deng, S.A. & Pienaar, F. (2011). Positive parenting: Integrating Sudanese traditions and New Zealand styles of parenting. An evaluation of strategies with Kids - Information for Parents (SKIP). *The Australasian Review of African Studies*, 32(2), 160-179.

Donnelly, T.T., Hwang, J.J., Este, D., Ewashen, C., Adair, C. & Clinton, M. (2011). If I was going to kill myself, I wouldn't be calling you. I am asking for help: Challenges influencing immigrant and refugee women's mental health. *Issues in Mental Health Nursing*, 32(5), 279-290. DOI: 10.3109/01612840. 2010.550383

Ellis, B.H., Abdi, S.M., Lazarevic, V., White, M.T., Lincoln, A.K., Stern, J.E. & Horgan, J.G. (2016). Relation of psychosocial factors to diverse behaviors and attitudes among Somali refugees. *American Journal of Orthopsychiatry*, 86(4), 393-408. DOI: 10.1037/ ort0000121

Felder, J.N., Lemon, E., Shea, K., Kripke, K. & Simidjian, S. (2016). Role of self-compassion in psychological well-being among perinatal women. *Archives of Women's Mental Health*, 19(4), 687-690. DOI: 10.1007/s00737-016-0628-2

Fenwick, J., Toohill, J., Gamble, J., Creedy, D.K., Buist, A., Turkstra, E., Sneddon, A., Scuffham, P.A. & Ryding, E.L. (2015). Effects of a midwife psycho-education intervention to reduce childbirth fear on women's birth outcomes and postpartum psychological wellbeing. *BMC Pregnancy and Childbirth*, 15, 284. DOI: 10.1186/ s12884-015-0721-y

Firth, A.D. & Haith-Cooper, M. (2018). Vulnerable migrant women and postnatal depression: A case of invisibility in maternity services? *British Journal of Midwifery*, 26(2), 78-84. DOI: 10.12968/ bjom.2018.26.2.78

Gavin, N.I., Meltzer-Brody, S., Glover, V. & Gaynes, B.N. (2015). Is population-based identification of perinatal depression and anxiety desirable? A public health perspective on the perinatal care continuum. In: Milgrom, J., Gemmill, A.K. (Eds.) *Identifying Perinatal Depression and Anxiety: Evidence-based Practice in Screening, Psychosocial Assessment and Management*. Wiley-Blackwell. ISBN: 978-1-118-50965-4.

Gewalt, S.C., Berger, S., Ziegler, S., Szecsenyi, J. & Bozorgmehr, K. (2018). Psychosocial health of asylum seeking women living in state-provided accommodation in Germany during pregnancy and early motherhood: A case study exploring the role of social determinants of health. *PLoS ONE*, 13(12), e0208007. DOI: 10.1371/journal. pone.0208007

Gibson-Helm, M., Teede, H., Block, A., Knight, M., East, C., Wallace, E.M. & Boyle, J. (2014). Maternal health and pregnancy outcomes among women of refugee background from African countries: a retrospective, observational study in Australia. *BMC Pregnancy and Childbirth*, 14, 392. DOI: 10.1186 /s12884-014-0392-0

Grant, J. & Guerin, P.B. (2018). Mixed and misunderstandings: An exploration of the meaning of racism with maternal, child, and family health nurses in South Australia. *Journal of Advanced Nursing*, 74, 2831-2839. DOI: 10.1111/jan.13789

Grant, K., McMahon, C., & Austin, M. (2008). Maternal anxiety during the transition to parenthood: A prospective study. *Journal of Affective Disorders*, 108, 101-111. DOI: 10.1016/j.jad.2007.10.002

Green, J.M. & Baston, H.A. (2003). Feeling in control during labor: Concepts, correlates, and consequences. *Birth*, 30(4), 235-247. DOI: 10.1046/j.1523-536X.2003.00253.x

Green, E.P., Tuli, H., Kwobah, E., Menya, D., Chesire, I. & Schmidt, C. (2018). Developing and validating a perinatal depression screening tool in Kenya blending Western criteria with local idioms: A mixed methods study. *Journal of Affective Disorders*, 228, 49-59. DOI: 10.1016/j.jad.2017.11.027

Haith-Cooper, M. & Bradshaw, G. (2013). Meeting the health and social care needs of pregnant asylum seekers; midwifery students' perspectives: Part 3; "The pregnant woman within the global context"; an inclusive model for midwifery education to address the needs of asylum seeking women in the UK. *Nurse Education Today*, 33(9), 1045-1050. DOI: 10.1016/j.nedt.2012.04.016

Higginbottom, G.M.A., Safipour, J., Mumtaz, Z., Chiu, Y., Paton, P. & Pillay, J. (2013). "I have to do what I believe": Sudanese women's beliefs and resistance to hegemonic practices at home and during experiences of maternity care in Canada. *BMC Pregnancy and Childbirth*, 13(51). DOI: 10.1186/1471-2393-13-51

Higgins, A., Downes, C., Monahan, M., Gill, A., Lamb, S. & Carroll, M. (2018). Barriers to midwives and nurses addressing mental health issues with women during the perinatal

period: The Mind Mothers study. *Journal of Clinical Nursing*, 27, 1872-1883. DOI: 10.1111/jocn.14252

Kennedy, H.P., Gardiner, A., Gay, C. & Lee, K.A. (2007). Negotiating sleep: A qualitative study of new mothers. *Journal of Perinatal and Neonatal Nursing*, 21(2), 114-122. DOI: 10.1097/01.JPN. 0000270628.51122.1d

Kentoffio, K., Berkowitz, S.A., Atlas, S.J., Oo, A.A. & Percac-Lima, S. (2016). Use of maternal health services: comparing refugee, immigrant and US-born populations. *Maternal and Child Health Journal*, 20, 2494-2501. DOI: 10.1007/s10995-016-2072-3

Khawaja, N.G., White, K.M., Schweitzer, R. & Greenslade, J. (2008). Difficulties and coping strategies of Sudanese refugees: A qualitative approach. *Transcultural Psychiatry*, 45(3), 489-512. DOI: 10.1177/1363461508094678

Lillrank, A. (2015). Trust, vacillation and neglect: Refugee women's experiences regarding pregnancy and birth giving in Finland. *Nordic Journal of Migration Research*, 5(2), 83-90. DOI: 10.1515/njmr-2015-0009

Merry, L.A., Gagnon, A.J., Kalim, N. & Bouris, S.S. (2011). Refugee claimant women and barriers to health and social services post-birth. *Canadian Journal of Public Health*, 102(4), 286-90. DOI: 10.1007/BF03404050

Meyer, S. (2012). Control in childbirth: A concept analysis and synthesis. *Journal of Advanced Nursing*, 69(1), 218-228. DOI: 10.1111/j.1365.2648.2012.06051.x

Murray, L., Windsor, C., Parker, E. & Tewfik, O. (2010). The experiences of African women giving birth in Brisbane, *Australia. Health Care for Women International*, 31, 458-472. DOI: 10.1080/ 07399330903548928

Newnham, E.C., McKellar, L.V & Pincombe, J.I. (2017). Paradox of the institution: Findings from a hospital labour ward ethnography. *BMC Pregnancy and Childbirth*, 17(2). DOI: 10.1186/ s12884-016-1193-4

Nithianandan, N., Gibson-Helm, M., McBride, J., Binny, A., Gray, K.M., East, C. & Boyle, J.A. (2016). Factors affecting implementation of perinatal mental health screening in women of refugee background. *Implementation Science*, 11, 150. DOI: 10.1186/s13012-016-0515-2

Nursing and Midwifery Board of Australia (2018). Midwife Standards for Practice. Melbourne, Victoria, Australia. Available at: https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx [accessed 11 September 2019]

O'Mahony, J.M. & Donnelly, T.T. (2013). How does gender influence immigrant and refugee women's postpartum depression help-seeking experiences? *Journal of Psychiatric and Mental Health Nursing*, 20, 714-725. DOI: 10.1111/jpm.12005

Razurel, C., Kaiser, B., Sellenet, C. & Epiney, M. (2013). Relation between perceived stress, social support, and coping strategies and maternal well-being: A review of the literature. *Women and Health*, 53(1), 74-99. DOI: 10.1080/03630242.2012.732681

Renzaho, A.M.N. & Vignjevic, S. (2011). The impact of a parenting intervention in Australia among migrants and refugees from Liberia, Sierra Leone, Congo, and Burundi: Results from the African Migrant Parenting Program. *Journal of Family Studies*, 17, 71-79. DOI: 10.5172/jfs.2011.17.1.71

Riggs, E., Muyeen, S., Brown, S., Dawson, W., Petschel, P., Tardif, W., Norman, F., Vanpraag, D., Szwarc, J. & Yelland, J. (2017). Cultural safety and belonging for refugee

background women attending group pregnancy care: An Australian qualitative study. *Birth*, 44, 145-152. DOI: 10.1111/ birt.12272

Riggs, E., Yelland, J., Duell-Piening, P. & Brown, S.J. (2016). Improving health literacy in refugee populations. Medical Journal of Australia, 204(1), 9-10. DOI: 10.5694/mja15.01112

Sabri, B., Nnawulezi, N., Njie-Carr, V.P.S., Messing, J., Ward-Lasher, A., Alvarez, C. & Campbell, J.C. (2018). Multilevel risk and protective factors for intimate partner violence among African, Asian, Latina immigrant and refugee women: Perceptions of effective safety planning interventions. *Race and Social Problems*, 10, 348-365. DOI: 10.1007/s12552-018-9247-z

Scammell, M. & Ghumman, A. (2019). The experience of maternity care for migrant women living with female genital mutilation: A qualitative synthesis. *Birth*, 46, 15-23. DOI: 10.1111/birt.12390

Schmied, V., Black, E., Naidoo, N., Dahlen, H.G. & Liamputtong, P. (2017). Migrant women's experiences, meanings and ways of dealing with postnatal depression: A meta-ethnographic study. *PLoS ONE*, 12(3), e017238 DOI: 10.1371/journal.pone.0172385

Schweitzer, R.D., Vromans, L., Brough, M., Correa-Velez, I., Murray, K. & Lenette, C. (2018). Recently resettled refugee women-at-risk in Australia evidence high levels of psychiatric symptoms: individual, trauma and post-migration factors predict outcomes. *BMC Medicine*, 16, 149. DOI: 10.1186/s12916-018-1143-2

Stapleton, H., Murphy, R., Correa-Velez, I., Steel, M. & Kildea, S. (2013). Women from refugee backgrounds and their experiences of attending a specialist antenatal clinic. Narratives

from an Australian setting. *Women and Birt*h, 26, 260-266. DOI: 10.1016/j.wombi.2013.07.004

Stewart, D.E., Gagnon, A., Saucier, J-F., Wahoush, O. & Dougherty, G. (2008). Postpartum depression symptoms in newcomers. *Canadian Journal of Psychiatry*, 53(2), 121-124. DOI: 10.1177/ 070674370805300208

Straus, L., McEwen, A. & Hussein, F.M. (2009). Somali women's experience of childbirth in the UK:Perspectives from Somali health workers. *Midwifery*, 25, 181-186. DOI: 10.1016/ j.midw.2007.02.002

Teng, L., Blackmore, E.R. & Stewart, D.E. (2007). Healthcare worker's perceptions of barriers to care by immigrant women with postpartum depression: an exploratory qualitative study. *Archives of Women's Mental Health*, 10, 93-101. DOI: 10.1007/s00737-007-0176-x

Tsai, A.C., Scott, J.A., Hung, K.J., Zhu, J.Q., Matthews, L.T., Psaros, C., Tomlinson, M., (2013). Reliability and validity of instruments for assessing perinatal depression in African settings: Systematic review and meta-analysis. *PLoS ONE,* 8(12), e82521. DOI: 10.1371/ journal.pone.0082521

Turkmani, S., Homer, C.S.E. & Dawson, A. (2019). Maternity care experiences and health needs of migrant women from female genital mutilation-practicing countries in high-income contexts: A systematic review and meta-synthesis. *Birth*, 46, 3-14. DOI: 10.1111/birt.12367

United Nations High Commissioner for Refugees (UNHCR) (2018). 'Refugees' and 'Migrants: Frequently asked questions. Available at: https://www.refworld.org/docid/ 56e81c0d4.html [accessed 10 September 2019]

Viveiros, C.J. & Darling, E.K. (2019). Perceptions of barriers to accessing perinatal mental health care in midwifery: A scoping review. *Midwifery*, 70, 106-118. DOI: 10.1016/j.midw.2018.11.011

Wachter, K., Horn, R., Friis, E., Falb, K., Ward, L., Apio, C., Wanjiku, S. & Puffer, E. (2017). Drivers of intimate partner violence against women in three refugee camps. *Violence Against Women*, 24(3), 286-306. DOI: 10.1177/1077801216689163

World Health Organisation (2008). Improving maternal mental health. Available at: https://www.who.int/mental_health/prevention/suicide/Perinatal_depression_mmh_final.pdf [accessed 10 September 2019]

World Health Organisation (2013). Investing in mental health: evidence for action. World Health Organisation, Switzerland.

World Health Organisation (2019). Maternal mortality fact sheet. Available at: https://www.who.int/en/news-room/fact-sheets/detail/maternal-mortality [accessed 22 September 2019]

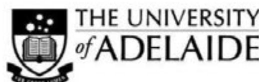
Wylie, L., Van Meyel, R., Harder, H., Sukhera, J., Luc, C., Ganjavi, H., Elfakhani, M. & Wardrop, N. (2018). Assessing trauma in a transcultural context: challenges in mental health care with immigrants and refugees. *Public Health Reviews*, 39(22), 1-12. DOI: 10.1186/s40985-018-0102-y

Yelland, J., Riggs, E., Wahidi, S., Fouladi, F., Szwarc, J., Duell-Piening, P., Chesters, D. & Brown, S. (2014). How do Australian maternity ad early childhood health services identify and respond to the settlement experiences and social context of refugee background families? *BMC Pregnancy and Childbirth*, 14, 348. DOI: 10.1186/1471-2393-14-348

Zubaran, C., Schumacher, M., Roxo, M.R. & Foresti, K. (2010). Screening tools for postpartum depression: Validity and cultural dimensions. *African Journal of Psychiatry*, 13, 357-365.

Appendix A

Participant Information Sheet



INFORMATION SHEET FOR INTERVIEW WITH SERVICE PROVIDERS

Title: 'Maternal health for pregnant and post-natal women from refugee backgrounds: What are their needs and what models of care will improve outcomes?'

Investigators:

Dear Participant,
You are invited to take part in a research project exploring maternal health for pregnant and post-natal women from refugee backgrounds.

What is the project about?
The project aims to examine the maternity and post-natal health needs of women from refugee backgrounds from the African continent. This includes an exploration of the facilitators and barriers in accessing appropriate health care for pregnant and post-natal women from refugee backgrounds and the best practice in specialised maternity services.

Who is undertaking the project?
Researchers from the University of Adelaide and the Southgate Institute for Health, Society and Equity at Flinders University are undertaking the project.

This research will also partly form the basis for the thesis component of completion of the degree of Bachelor of Psychological Sciences (Honours) at the University of Adelaide under the supervision of .

Who is being invited to participate?
You are being asked to participate if you are a service provider (midwife, obstetrician, shared care GP, or a refugee health provider who has experience working with refugee women from the African continent).

Purpose of the project:
The purpose of the project is to provide evidence concerning the maternal and primary health care needs of pregnant and post-natal refugee women; to map current South Australian maternal health practice for refugee women during pregnancy and the initial post-natal period; to explore barriers to maternal service use for pregnant and post-natal refugee women; and to outline national and international best practice in specialised refugee maternity services.

What will I be asked to do?
You will be asked to take part in a 60 minute face-to-face interview with during which time you will be asked for your professional insights on the ante- and post-natal health care needs of refugee women.

We would also like to record the interview so that we can write up the findings in a research report and in academic journal articles. We will ask for your permission to record the interview to use for research. We will ask you to sign a consent form before the interview begins. You can decline to participate if you wish.

Are there any risks associated with participating in this project?
The only risk is the burden of time it will take to participate in the interview.

Will my identity be shared by being involved in this study?
There are a number of ways that we will protect your privacy. We do not need to record your name. We will delete any information which could identify you from the audio recording, and make sure it isn't included in the results. The transcribed file will be stored on a password-protected computer that only the people listed above will have access to. Your comments will not be linked directly to you in any way in any reports we write about the study.

What are the benefits of the research project?
You may not benefit directly from participating in the project aside from having the opportunity to contribute to research designed to improve employment and social inclusion maternal health outcomes for a particularly vulnerable group.

Can I withdraw from the project?
Agreeing to have your interview recorded and used in the research project is voluntary. If you agree to participate, you can withdraw from the study at any time.

What will happen to my information?
You will not be able to be identified in any publications and we will not pass on your answers to the program co-ordinators. Only the researchers will have access to your interview data, and data will be stored for 5 years on a password protected computer, at Flinders University and The University of Adelaide, and then deleted. The findings will be included in [redacted] thesis, journal papers and reports and we will send you a copy of the report.

How will I receive feedback?
If you would like to see the findings of the study, you can tell the researchers and they can take your contact details and send them to you when they are ready.

If I have questions or want to participate, what do I do?
If you are interested in participating or you have any questions about the project please contact [redacted]

Yours sincerely,

[redacted]

[redacted]

This research project has been approved by the Women's and Children's Hospital Network

For more information regarding ethical approval of the project the Executive Officer of the Committee (Mr Luke Fraser, 08 8161 6521)

Appendix B

Participant Flyer

Researchers from the Southgate Institute for Health, Society and Equity at Flinders University and The School of Psychology at The University of Adelaide are conducting a study called:

'Maternal health for pregnant and post-natal women from refugee backgrounds: What are their needs and what models of care will improve outcomes?'

We are looking for health providers (e.g., midwives, obstetricians, shared care GPs, refugee health service providers) to participate in an interview about best-practice maternity care for refugee women, with a focus on those from the African continent.

The interview will last for approximately 60 minutes.
We can conduct the interview at a place and time that are convenient for you.

If you are interested in participating or would like more information, please contact [redacted] on [redacted] or via email at [redacted]

Appendix C

Interview Questions

Question themes for service providers (midwives, GPs etc.)

Their experience in this area

What they think is done well in SA or Aust more broadly for maternity care (pre- post- and delivery) for refugee women

What they think is done less well/poorly. Could you provide any examples/case studies without identifying patients/clients?

Any specific issues they see in their practice for refugee women (and also women from the African continent – cultural issues/linguistic issues/etc.) which need to be taken into account in maternal health service provision?

- What specifically for African women?
- What about perinatal mental health?

What about community experiences and attitudes to maternity care more broadly?

- Refugees?
- Women from Africa?
- Mental health?

What sorts of support do you think this group of women would like to have? How does this compare to what they do have?

What would best-practice look like?

What health system barriers/facilitators to this/these ideas have they identified?

Mental health questions

To what extent do you think experiences during maternity care impact upon mental health for women? How and why?

To what extent should mental health care be incorporated into best practice maternity services for refugee women?

What sort of mental health issues do you see in this group of women?