Perinatal Care for Women from Africa with Refugee Backgrounds: Intersections with Psychological Wellbeing

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DECLARATION

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Perinatal Care for Women from Africa with Refugee Backgrounds: Intersections with Psychological Wellbeing

Literature Review

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Abstract

People with refugee backgrounds face poorer psychological outcomes than general populations post-resettlement. Contributing to these outcomes are post-migration challenges including experiences with healthcare services. These services include perinatal healthcare, which is essential for many refugee women living in Australia; many of whom are from Africa. Positive perinatal healthcare experiences are pivotal for ensuring women's access to ongoing care and healthy psychological outcomes. However, disparities persist between refugee and non-refugee populations. This review will critically evaluate the evidence regarding African refugee women's psychological wellbeing following experiences with perinatal healthcare services, and will inform an empirical study in the Australian context.

Overview

It is well known that people with refugee backgrounds have significantly poorer mental health outcomes than general populations post-resettlement (Porter & Haslam, 2005), with Posttraumatic Stress Disorder (PTSD), depression and anxiety highly prevalent (Morina, Akhtar, Barth & Schnyder, 2018; Turrini, Purgato, Ballette, Nosè, Ostuzzi & Barbui, 2017). Psychological wellbeing – involving the subjective evaluation of one's life – is an alternative measure of mental health which can be viewed by its protective capacity against psychological problems (Amerijckx & Humblet, 2014; Reed, Fazel, Jones, Panter-Brick & Stein, 2012). Wellbeing amongst refugees has been shown to be impacted by post-migration challenges including access to, and experiences with, health care services (Hou et al., 2019). Perinatal healthcare is one such service essential for many refugee women in Australia, around 30% of whom per year are of child-bearing age (Correa-Velez & Ryan, 2012). Globally, disparities in maternal health outcomes exist between women of refugee backgrounds and non-refugee backgrounds, including inequalities in maternal morbidity, preterm births and stillbirth rates (Carolan, 2010; Collins, Zimmerman & Howard, 2011; Ahmed, et al., 2017; Kentoffio et al., 2016; Kandasamy, Cherniak, Shah, Yudin & Spitzer, 2014; Drysdale et al., 2012; Gibson-Helm et al. 2014). Whilst contact with maternal health care providers is highly valued (WHO, 2016), challenges persist in responding to the complex needs of refugee women in Australian healthcare settings, including understanding the impacts of psychological trauma, and ethnicity and norms surrounding childbirth (Yelland et al., 2014; Riggs et al., 2012). Many refugee women in Australia are from the African continent, and have previously experienced trauma such as sexual abuse, torture, and female genital mutilation (Carolan, 2010; Correa-Velez & Ryan, 2012; Schweitzer et al., 2018; Jakubowicz, 2010). These experiences are likely to affect engagement with perinatal services in complex, and currently poorly understood, ways.

A small amount of national and international research has identified barriers to perinatal healthcare, and specifically to care that is more responsive to the needs of refugee women (Brown, Carroll, Fogarty & Holt, 2010; Brown, Sutherland, Gunn & Yelland, 2014; Gibson-Helm et al., 2014; Kentoffio et al., 2016). However, few refugee-focused perinatal services currently exist in Australia, nor comprehensive guidelines for best-practice perinatal care for refugee women, particularly in consultation with women. Furthermore, few studies have examined the relationship between perinatal care and psychological wellbeing in this population. Understanding this relationship is crucial given the unique experiences of this group and the known disparities in perinatal outcomes. As such, the aim of this review is to provide a critical overview of current literature on this topic, and to identify areas for future research.

Terminology

Refugee. The term 'refugee' refers to peoples who, due to well-founded fear of persecution, are declared unable to seek protection within their country of origin (Amnesty International, 2019; UNHCR, 2016). In Australia, they are granted permanent protection following referral to the Australian Government for resettlement by the United Nations High Commissioner for Refugees (Department of Home Affairs, 2020). This review aims to specifically focus on women with refugee backgrounds. However, due to a small evidence base, existing literature discussed in this literature review also includes the experiences of migrants (individuals who have voluntarily chosen to resettle in an alternative country to their origin) and asylum seekers (individuals whose claims to asylum are yet to be processed; Amnesty International, 2019; UNHCR, 2016). Whilst it is noted that migration experiences (and the labels they attract) are not the sum of ones' identity, this literature review will appropriately refer to peoples based on their migration status for purposes of brevity.

Health. Health is a multifaceted construct which typically includes the measurement of individuals' physical, psychological, and social health. The World Health Organisation (WHO) assert that it is not merely the absence of disease or ill-health, but a more complex concept consisting of both objective and subjective elements (WHO 2013; 2020). This review focuses on the intersection between perceived physical (specifically, perinatal) and mental health, which is increasingly conceptualised using the holistic term 'wellbeing'.

Africa. Africa is a large continent consisting of 54 different countries, though is also sometimes conceptually separated into two or five regions (North Africa and sub-Saharan Africa, or Southern, Central, East, North, and West Africa; Amzat & Razum, 2018). Each country and cultural group (a multitude of which may exist in each country) have their own social structures, languages, histories, religions, and traditions (Amzat & Razum, 2018; Jakubowicz, 2010). This review refers to peoples from various African countries. Where studies included in the review discuss peoples from multiple countries, reference will be made to the African continent, and where known and appropriate, reference will be made to the specific countries where individuals reside or come from.

Previous Literature

Health Beliefs Amongst African Cultures

Australia is a multicultural country, where in South Australia alone, roughly 24,253 people are resettled as migrants per annum (ABS, 2019). Australia wide, around 13,500 people arrive as Humanitarian entrants each year (DIAC, 2010). Many humanitarian migrants arrive from the African continent (over 48,000 between 2001 and 2011), and as such Australia has become home to a diverse and growing African community (Jakubowicz, 2010; JSCFADT, 2011).

Culture and health share a well-established relationship, making it important to understand how African cultural beliefs may influence how individuals make sense of their

illness experiences (e.g. interpretation of symptoms), express pain and discomfort, how and when they seek care, and their care preferences. Much as the geographical and cultural composition of the African continent is complex, so too are its health beliefs and norms, consisting of both collectivist and individualist elements. Broader African culture is said to rely on the 'collective conscience', which informs social capital and resources, and consequently may support wellbeing (e.g. ensuring quality of life for vulnerable group members such as the elderly) and determine access to health resources (e.g. ensuring that fellow group members access healthcare by contributing to their hospital bills, baby-sitting their children, or helping with household duties; Amzat & Razum, 2018). In resettlement settings, too, social support amongst African refugees contributes significantly to coping and healthcare utilisation (Gladden, 2012; Simmelink, Lightfoot, Dube, Blevins & Lum, 2013). The collective conscience also informs the belief in many African cultures that physical and mental health are not simply located within the individual, but are inseparable from family and kinship members (Baird, 2012; Peltzer, 1998; Tempany, 2009).

Despite embedment in a collectivist system, however, there is diversity between the health behaviours and beliefs of different ethnic or cultural groups and individuals. Examples include ratios of use of traditional and Western health practices (i.e. informal home treatments versus formal medical services; Amzat & Razum, 2018), superstitions around pregnancy in Ugandan culture (Namboze, 1983), beliefs and stigma regarding infections and vaccinations in sub-Saharan Africa (Sheikh-Mohammed, MacIntyre, Wood, Leask & Isaacs, 2006), and beliefs in possession as a cause for mental illness and the Qur'an as a treatment method in Somali culture (Bettmann, Penney, Clarkson Freeman & Lecy, 2015).

Mental Health and Psychological Wellbeing Amongst Refugee Populations

The mental health of refugees is often complex, impacted by experiences of war, torture, and strenuous migration journeys, in conjunction with post-resettlement challenges including

discrimination and isolation, restricted economic opportunities (including employment), language barriers, acculturative difficulties, and poor access to appropriate social and health services (Hou et al., 2019; Porter & Haslam, 2005; Wylie et al., 2018). Furthermore, separation from family and pressures to financially support those left behind is an ongoing source of stress and sadness (Savic, Chur-Hansen, Mahmood & Moore, 2013). International meta-analyses and systematic reviews report that refugees suffer significantly poorer mental health outcomes compared to those classified as 'migrants' and general non-migrant populations (Beiser & Hou, 2017; Porter & Haslam, 2005). Amongst resettled refugees, Post-Traumatic Stress Disorder (PTSD), depression and anxiety are commonly reported psychological disorders (Kien et al., 2018; Morina, Akhtar, Barth & Schnyder, 2018). African refugee populations also face alarming rates of mental illness including PTSD, adjustment disorder and dysthymia (Huemer et al., 2011). PTSD has attracted the most research globally, with refugees resettled in countries considered 'Western' at a ten-fold greater risk than general populations (Fazel, Wheeler & Danesh, 2005; Onyut, Neuner, Ertl, Schauer, Odenwald & Elbert, 2009). However, recent research has reported depression and anxiety to be as prevalent as PTSD amongst refugees (Turrini et al., 2017). Less common disorders have attracted little research, though experiences of those including schizophrenia and psychosis among some populations – including migrant and refugee women living in Canada – have been explored (Donnelly et al., 2011). As such, more research regarding alternative disorders amongst refugee populations is required (Giacco & Priebe, 2018; Kien et al, 2018; Morina et al., 2018; Turrini et al., 2017).

In light of these higher rates of mental ill-health, researchers have explored individual- and systemic-level determinants and rates of health care access for refugees in resettlement countries. Determinants of healthcare seeking at an individual level include: (1) mental health beliefs that are incongruent with those dominant in the host country, such as attributing spirit possession to mental ill-health and understanding depression as collectively derived and

experienced (Bettmann et al., 2015; Kokanovic, Dowrick, Butler, Herrman & Gunn, 2008; Tilbury, 2007); (2) negative past experiences with healthcare services that instil fear (Donnelly et al., 2011); (3) interpersonal barriers between patients and practitioners, often fuelled by insufficient transcultural and trauma-informed training and experience (Wohler & Dantas, 2017; Wylie et al., 2018), and; (4) preferences for alternative coping mechanisms such as suppressing problems, self-care, social support networks and faith in religion (Adedoyin et al., 2016; Bentley, Ahmad & Thoburn, 2014; Donnelly et al., 2011; Gladden, 2012; Goodman, 2004; Khawaja, White, Schweitzer & Greenslade, 2008; Luster, Qin, Bates, Johnson & Rana, 2008; Monteiro & Wall, 2011; Omar, Kuay & Tuncer, 2017; Tempany, 2009). Determinants of healthcare seeking at a systemic level include: (1) logistical and communicative ease (Wohler & Dantas, 2017); (2) access to culturally appropriate services, information, and assessment methods (Donnelly et al., 2011; McCann, Mugavin, Renzaho & Lubman, 2016; Wamwayi, Cope & Murray, 2019; Wylie et al., 2018), and; (3) financial, bureaucratic, and political processes within health organisations (McCann et al., 2016; Wylie et al., 2018). The provision of holistic care encompassing respect for cultural, religious and family values, access to safe and confidential environments, dissemination of appropriate information, care continuity, and practitioner self-awareness and reflexivity has been recommended (Donnelly et al., 2011).

Whilst many refugee studies have focused on the construct of mental health via classification of disorders, a growing body of research promotes psychological wellbeing as a more holistic measure. This approach may provide better understandings of the factors contributing to refugees' health-related outcomes post-resettlement whilst avoiding clinical overdiagnosis (Jepsson & Hiern, 2005; Tilbury, 2007). Rather than assuming that mental ill-health is an 'outcome of the refugee experience', the psychosocial challenges faced by refugees post-resettlement – such as those associated with socioeconomic disadvantage and cultural

dislocation – that impact their overall wellbeing should be acknowledged (Bentley, Thoburn, Stewart & Boynton, 2012; Murray, Davidson & Schweitzer, 2010; Ziaian, de Anstiss, Antoniou, Puvimanasinghe & Baghurst, 2016). Exploration of wellbeing also allows for individuals' strength and resilience to be considered as determinants; particularly important for refugees who have likely overcome immense, unprecedented and ongoing physical, social and psychological challenges (Abur & Mphande, 2019; Babatunde-Sowole, DiGiacomo, Power, Davidson & Jackson, 2020; Omar et al., 2017). For example, much research on the psychological wellbeing of refugees (especially those from Africa) has focussed on social support as a key determinant of wellbeing outcomes (Abur & Mphande, 2019; Beiser & Hou, 2017; Carswell, Blackburn & Barker, 2011; Correa-Velez et al., 2010; Davidson et al., 2008; Omar et al., 2017; Newman, 2013; Newman, Nielsen, Smyth & Hirst, 2018; Sulaiman-Hill & Thompson, 2012; Wohler & Dantas, 2017; Yalim, 2020).

Wellbeing for Women with Refugee Backgrounds

Women of refugee backgrounds are especially vulnerable to poor wellbeing in resettlement countries, and face unique risk factors. In addition to experiences of uncertainty, poverty, lack of safety, exposure to violence and loss of loved ones during migration, many women are subject to gender-specific violence (including sexual torture, rape and human trafficking), and face additional resettlement challenges including caring for children and elders (often without their spouses) whilst adapting to new environments (Baird, 2012; Haffejee & East, 2016). In Australia, many girls and women resettled as refugees have experienced multiple traumatic incidents which increased their vulnerability to poor wellbeing (Department of Social Services, 2013). Gender-based violence is often overlooked or not discussed within community and healthcare settings, particularly where such experiences attract pervasive stigma, social isolation and rejection (Byrskog, Olsson, Essén & Allvin, 2014; Yohani & Okeke-Ihejirika, 2018). In some African communities, women who have suffered

sexual violence are considered ‘tainted’ or ‘damaged’ and consequently are subjected to life-long shame and diminished self-worth (Yohani & Okeke-Ihejirika, 2018). Moreover, women face pressures not to disclose their experiences from community members who may have been implicated in the sexual violence (e.g. as a witness, a victim, someone known to the victim, or a potential victim living in fear), as they may experience similar shame and rejection (Yohani & Okeke-Ihejirika, 2018). Even after resettlement, many women from patriarchal cultures continue to suffer from gender-based violence or oppression, where women are considered the property of male heads of families; sometimes reinforced using visa or citizenship status to control, manipulate or dominate women who are dependent on their partner’s status, as found via systematic review (Baird, 2012; West, 2016). Women in these situations with limited resources of their own are thus less likely to seek mental health support, where practical needs and economic self-sufficiency take precedence (Haffejee & East, 2016; West, 2016; Yohani & Okeke-Ihejirika, 2018).

Qualitative findings have informed recommendations for improving refugee women’s wellbeing through access to appropriate healthcare services, for example by prioritising mental health assessments, offering home visits, ensuring interpreter access, offering trauma counselling and gender sensitive services (e.g. female practitioners and escorts to appointments), and recruiting female staff with multicultural interests and facilitating cultural awareness staff training (Department of Social Services, 2013). However, to determine the true prevalence of gender-based violence in resettlement contexts and subsequently determine how to improve the reporting of such experiences, further research is required using larger sample sizes to expand generalisability and detect meaningful differences between groups (e.g. culture, gender, and immigration status), which will require strong, ongoing relationships and research involvement of bicultural community members (West, 2016).

Mental Health During the Perinatal Period

Prevalence rates of psychological illness during the perinatal period are difficult to determine, due in part to the fact that defining symptoms such as fatigue and sleeplessness are associated with expectations of pregnancy and motherhood (WHO, 2008a). Moreover, in low- and middle-income countries, a paucity of research and issues with methodological design has made prevalence rates of perinatal mental ill-health particularly difficult to estimate (Fisher et al., 2012). However, it is clear that women who are socially and economically disadvantaged face the highest risks for illness, as well as those impacted by gender-based restrictions (Flach et al., 2011; Howard et al., 2013; Schmied et al., 2013). However, existing research does suggest relatively high rates of maternal mental illness across populations; particularly in the postpartum period. It was previously estimated that one-in-three to -five women in developing countries, and one-in-ten in developed countries had experienced a significant mental health problem during the perinatal period (WHO, 2008a). More recently, consistent findings across countries have reported depressive symptoms amongst 10-20% of women, clinical diagnoses of anxiety amongst 9.9% of women, and experiences of PTSD amongst 4% of women (Cook, Ayers & Horsch, 2018; Dennis, Falah-Hassani & Shiri, 2017; Schmied et al., 2013). Suicide is the leading cause of maternal deaths in developed countries, and of death amongst women of reproductive age in India and China; the world's two most populous countries (Miranda & Patel, 2005).

A number of protective factors against perinatal mental ill-health have been identified, including positive partner relationships, access to quality healthcare services, and positive relationships between women and their midwives. Global systematic reviews have found more positive mental health outcomes in women whose partners are supportive of their pregnancy and assist in health service utilisation (Fisher et al., 2012; Yargawa & Leonardi-Bee, 2015). Meaningful support from midwives to women experiencing perinatal mental health challenges

can result in improved outcomes (e.g. reduced birth fear and birth flashbacks), and act as a key source of referrals to additional support services (Honikman, Van Heyningen, Field, Baron & Tomlinson, 2012; Fenwick et al., 2015; Schmied et al., 2013). Respectful, women-centred care and quality patient-practitioner relationships are paramount in these instances (Holt, Caglia, Peca, Sherry & Langer, 2017; Mannava, Durrant, Fisher, Chersich & Luchters, 2015). Ongoing access to quality perinatal (and) mental healthcare services is essential, yet is difficult for many women, particularly those in low- and middle-income countries who face barriers to service use at three stages: initial decision-making to seek care; gaining access to care, and; receiving care (Lassi, Middleton, Bhutta & Crowther, 2019). In countries with fewer resources, women's physical perinatal health needs typically become prioritised over their mental health needs (Banke-Thomas, Banke-Thomas & Ameh, 2017; Kathree, Selohilwe, Bhana & Petersen, 2014).

Perinatal Care and Mental Health for Women with Refugee Backgrounds

Given the high rates of mental ill-health and barriers to care amongst pregnant women and mothers in general populations, those with refugee backgrounds face additional and surmounting risks due to added responsibilities and vulnerabilities regarding raising children in unfamiliar and often resource-limited environments (Schweitzer et al., 2018). Whilst studies in the African context in particular reveal high rates of maternal mental health problems across countries including Ethiopia, Nigeria, Senegal, South Africa, Uganda and Zimbabwe (WHO, 2008b), less evidence is available regarding associations between perinatal health and mental health amongst refugee populations post-resettlement. A larger pool of research including systematic reviews has explored maternal and mental health amongst migrant women, attributed to the increased movement of female migrants of childbearing age across borders in recent years, making perinatal health a key priority for many governments (Gagnon, Zimbeck, Zeitlin & Roam Collaboration, 2009; Nilaweera, Doran & Fisher, 2014). The research largely mirrors previously mentioned outcomes, including: (1) increased risk of perinatal mental

disorders due to migration-related stressors (Fellmeth, Fazel & Plugge, 2017); (2) high rates of perinatal depression, impacting one in three migrant women in low and middle income countries and 42% of migrant women in developed countries (Collins et al., 2011; Fellmeth et al., 2017; Firth & Haith-Cooper, 2018; Higginbottom et al., 2013a; Schmied, Black, Naidoo, Dahlen & Liamputtong, 2017); (3) limited research on the prevalence or burden of less common disorders (Anderson, Hatch, Comacchio & Howard, 2017; Fellmeth et al., 2017), and; (4) emphasis on social factors as key determinants of perinatal mental ill-health, with recommendations for better healthcare access and practitioner risk awareness, cultural competence, and support skills (Collins et al., 2011; Nilaweera et al., 2014). However, much research utilises broad or vague definitions of 'migrants' which encompass refugees within study samples, making it difficult to determine differences in experiences or outcomes between groups.

Of refugee-specific research, findings suggest that refugee and asylum seeker status in itself is a risk factor for perinatal mental ill-health (Anderson et al., 2017). Such women face higher risks of maternal medical complications (e.g. obstetric issues and infant mortality), facing a double burden of inequality when coupled with psychosocial stressors including visa status, subjection to racism, cultural differences, and economic disadvantage (Gewalt, Berger, Ziegler, Szecsenyi & Bozorgmehr, 2018; Heslehurst, Brown, Pemu, Coleman & Rankin, 2018). In Canada, refugees were more likely than non-refugees to have postpartum contact with emergency departments, outpatient services, and to require psychiatric hospitalisation postpartum (Vigod et al., 2017), and in the Netherlands, asylum seekers had a four- to five-fold increased risk of severe acute maternal morbidity (van Hanegem, Miltenburg, Zwart, Bloemenkamp & Van Roosmalen, 2011). Similar to research on general and migrant populations, some evidence surrounds perinatal depression, with higher rates and risk of complications amongst refugees (Ahmed, Bowen & Feng, 2017; Brown-Bowers, McShane,

Wilson-Mitchell & Gurevich, 2015; O'Mahony & Donnelly, 2013). Despite these findings, however, routine screening for depression, anxiety and PTSD amongst refugee women is not routine in Australia (Boyle et al., 2019; Nithianandan et al., 2016).

Some (mainly qualitative) research has documented refugee women's experiences with maternal healthcare services, where poor maternity and perinatal care experiences on top of migration-related pressures can impact physiological and psychological pregnancy outcomes (Bohren et al., 2018; Straus, McEwen & Hussein, 2009). In the UK, mental health challenges were a prominent theme in asylum seeking women's maternity care experiences, and in Finland experiences were separated by those considered 'good', dramatic and disappointing, and tragic (Lillrank, 2015). Two main aspects of care have been repeatedly highlighted via refugee women's experiences with maternal services across studies: social factors (connections with other women, and interactions with healthcare providers), and; cultural competency of healthcare providers. Socially, 16 studies reported 'caring relationships' as a source of strength during pregnancy and childbirth (Balaam et al., 2013). Social groups for pregnant refugee women were noted as one way of facilitating caring relationships, where connections with other women and healthcare practitioners from similar backgrounds instilled empowerment and confidence whilst learning about pregnancy and childbirth, and also increased women's access to maternal services via an increased sense of belonging and safety (Riggs et al., 2017). Interactions with healthcare providers were similarly impactful, where staff attitudes had the greatest impacts on refugee women's satisfaction with maternity and perinatal care in Victoria (Gibson, Attreya, Bennett & Brook, 2010). Negative interactions included those where women felt discriminated against, whilst positive interactions encompassed reciprocal relationships where women were recognised as equal partners in care (Bohren et al., 2018; Lillrank, 2015; McKnight, Goodwin & Kenyon, 2019; Murray et al., 2010). Negative experiences were especially common amongst women with backgrounds of female genital mutilation (FGM) due

to negative attitudes and stigma from healthcare providers (Scammell & Ghumman, 2019; Straus et al., 2009; Turkmani, Homer & Dawson, 2019). Such experiences have been reported in Australia, particularly in encounters with healthcare providers with poor cultural competency and understandings of FGM (Murray, Windsor, Parker & Tewfik, 2010).

Moreover, cultural competency is essential for ensuring positive healthcare experiences for patients and providers, and encouraging service use (Riggs et al., 2012). In many developing countries such as those in Africa, despite strong emphasis on reproduction and the importance of large families to continue the family line, sociocultural inequalities (e.g. gender disparities and limited healthcare access) oftentimes compromise perinatal health and access to relevant services (Amzat & Razum, 2018; Namboze, 1983). Such norms have long-term impacts on individuals' attitudes towards perinatal health help-seeking. Moreover, childbirth comes with fears and apprehensions for many women, particularly amongst those from developing countries with higher rates of mortality, which may manifest in behaviours misinterpreted by health practitioners as resistance to care (Brown, Carroll, Fogarty & Holt, 2010; Higginbottom, Safipour, Mumtaz, Chiu, Paton & Pillay, 2013b). In the US, a proportion of Somali women avoided healthcare interventions due to fears of obstetrical interventions including caesarean section (Brown et al., 2010). In Canada, a sample of Sudanese women avoided many procedures based on the belief that pregnancy and childbirth are natural events without need for intervention (Higginbottom et al., 2013b). Professional development opportunities to learn about cultural health beliefs which inform patient apprehension are therefore necessary to improve refugee women's perinatal care use and experiences (Brown et al., 2010). This was successful for pregnant African born women living in Melbourne, who progressed from believing that pregnancy was not a 'special' event worth fussing over, to valuing continuous antenatal care case following culturally sensitive care (Carolan & Cassar, 2010). This approach must be community-wide and ongoing to avoid disruptions to cultural

sensitivity and thus of positive care experiences when transitioning to different wards or care facilities (Stapleton, Murphy, Correa-Velez, Steel & Kildea, 2013). As such, despite some exploration of refugee women's experiences with maternal health services, few studies have discussed the links and impacts of those experiences with women's psychological wellbeing, nor in relation to African women of refugee backgrounds, especially those living in Australia where there are currently few refugee-specific perinatal care services.

Future Research

As discussed in this review, much evidence highlights disparities between the mental health of refugee and other culturally diverse populations compared to general populations. The literature also documents additional challenges and gender-based inequalities faced by women of refugee backgrounds. Less research has documented this in relation to pregnant women and mothers of refugee backgrounds, particularly from Africa, who face greater risks of maternal complications and mental ill-health. Importantly, this review also presented limitations of focusing solely on diagnosis of psychological conditions, instead suggesting wellbeing as an alternative measure which can be utilised to explore associations between maternal healthcare experiences and mental health amongst refugee women.

Currently, health-related research on refugee populations is limited, particularly due to heterogeneity amongst research samples, settings, methods and outcomes. Without focusing on more specific refugee samples (e.g. culture, gender, immigration status and time since resettlement, sexual preference, etc.), and unified methods, it is difficult to conclude whether heterogenous outcomes reflect genuine clinical differences, or methodological inconsistencies (Bogic, Njoku & Priebe, 2015). Moreover, there is a clear need to define and separate labels of 'migrants' from 'refugees' in research settings due to likelihood that the two groups of people may have experienced different levels of exposure to traumatic events, and since they are typically eligible for different services in resettlement countries (Gagnon et al., 2009;

Heslehurst et al., 2018). More generally, involving bicultural community workers and bilingual community members in the research process is recommended for ensuring accuracy in definitions, ease of recruitment, representation of communities, and accuracy of presenting findings (West, 2016). Furthermore, whilst many systematic reviews have been conducted on topics including the prevalence of specific psychological disorders amongst multicultural populations, there is a particular need to consider perinatal-specific challenges and culturally diverse outcomes. In addition, more studies are required that explore subjective wellbeing outcomes (rather than simply clinical diagnosis) following women's experiences with healthcare services during and after pregnancy.

This review summarises a multitude of compelling and crucial reasons to advocate for consideration of the intersections between perinatal care and psychological wellbeing amongst women of refugee backgrounds; particularly amongst those from the African continent. Exploring the experiences and needs of women through research is essential for improving both physical and mental perinatal health outcomes for women and their children, and for minimising pervasive – and overlooked – health inequalities within Australian society.

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Perinatal Care for Women from Africa with Refugee Backgrounds: Intersections with Psychological Wellbeing

Research Article

[redacted]

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Abstract

Experiences with healthcare services, including perinatal healthcare services, contribute to refugees' psychological wellbeing post-resettlement. To address the paucity of literature examining the relationship between perinatal healthcare and psychological wellbeing in women with refugee backgrounds from Africa, this study aimed to: (1) understand the relationship between psychological wellbeing and perinatal healthcare amongst this population, and; (2) identify areas for improved perinatal healthcare services to ensure positive psychological wellbeing outcomes in this population. Sixteen women from nine African countries participated in interviews which were thematically analysed, resulting in identification of five key themes. Most notably, the results highlighted needs for changes to perinatal healthcare provision at the systems level, including implementing a continuity of care model, and ensuring women's access to individualised, trauma-informed perinatal services which attend to the cultural and psychosocial resettlement needs of this population. These findings informed recommendations for improved perinatal healthcare services, leading to better psychological outcomes – and in turn broader health outcomes – for African mothers with refugee backgrounds.

Introduction

While Australia accepts a relatively large number of refugees each year (between 13,500 and 22,000 over the past 10 years) people with refugee backgrounds living in Australia are at greater risk of poor health outcomes – including mental ill-health – compared to the general population (Beiser & Hou, 2017; Porter & Haslam, 2005; RCOA, 2019). However, their use of healthcare services post-resettlement is impacted by various individual and systematic factors; contributing further to such mental health disparities. Moreover, experiences with healthcare services impact refugees' psychological wellbeing in particular (Hou et al., 2019; Mannava, Durrant, Fisher, Chersich & Luchters, 2015). Perinatal healthcare is one such service essential for many refugee women in Australia, around 30% of whom are of child-bearing age (Correa-Velez & Ryan, 2012). Whilst refugee status is a risk factor for perinatal mental ill-health (and additional obstetric and other complications), challenges persist in responding to the needs of this population in Australia (Anderson, Hatch, Comacchio & Howard, 2017). To address the paucity of literature examining the relationship between perinatal healthcare and psychological wellbeing in refugee women – specifically those from the African continent – this study aimed to: (1) understand the relationship between psychological wellbeing and perinatal healthcare amongst this population, and; (2) identify potential improvements to perinatal healthcare services to ensure positive psychological outcomes amongst this population.

Terminology

Refugee. The term 'refugee' refers to peoples who, due to well-founded fear of persecution, are declared unable to seek protection within their country of origin (Amnesty International, 2019; UNHCR, 2016). In Australia, refugees are typically granted permanent protection following referral to the Australian Government for resettlement by the United Nations High Commissioner for Refugees (Department of Home Affairs, 2020). Whilst this

study may refer to participants based on their refugee status for brevity, it is important to acknowledge that refugee experiences are not the sum of ones' identity.

Wellbeing. The complexities of human health – including physical, psychological and social elements – can be conceptualised holistically by the term 'wellbeing'. Exploration of psychological wellbeing is most appropriate in this context as it also acknowledges protective factors and subjectivity in perceptions of health status (Amerijckx & Humblet, 2014; Reed, Fazel, Jones, Panter-Brick & Stein, 2012).

Perinatal period. The perinatal period describes a portion of time which, according to the World Health Organisation (WHO), commences at 22 weeks of gestation and seven days following childbirth (WHO, 2020). Perinatal health is explored in this study as it is closely related to maternity health and captures the healthcare experiences of women who are more likely to be receiving formal maternity-related healthcare prior, during, and following birth.

Background and previous literature

Globally, refugees face poorer mental health outcomes compared to general populations, attributed to complex factors including exposure to various sources of trauma, strenuous migration journeys, and resettlement challenges (Hou et al., 2019; Porter & Haslam, 2005; Wylie et al., 2018). Numerous international meta-analyses and systematic reviews examining post-resettlement mental health have reported Posttraumatic Stress Disorder (PTSD), depression and anxiety as highly prevalent (Kien et al., 2018; Morina, Akhtar, Barth & Schnyder, 2018; Turrini, Purgato, Ballette, Nosè, Ostuzzi & Barbui, 2017). PTSD has attracted the most research globally, with refugees resettled in countries considered 'Western' at a ten-fold greater risk than general populations (Fazel, Wheeler & Danesh, 2005; Onyut, Neuner, Ertl, Schauer, Odenwald & Elbert, 2009).

However, focusing solely on clinical symptomology and diagnosing mental health conditions arguably labels mental ill-health 'an outcome of the refugee experience', which

suppresses the complexities of individuals' lives (not always manifesting in diagnosable psychiatric conditions; Ziaian, de Anstiss, Antoniou, Puvimanasinghe & Baghurst, 2016). An alternative measure of mental health – psychological wellbeing – offers a more holistic approach, involving the subjective evaluation of one's life which can be viewed by its protective capacity against psychological problems (Amerijckx & Humblet, 2014; Reed et al., 2012). Wellbeing amongst refugees has been shown to be impacted by post-migration challenges including gender role changes, language proficiency, unemployment, and social isolation, which are each uniquely mediated by individuals' strength and resilience (Abur & Mphande, 2019; Babatunde-Sowole, DiGiacomo, Power, Davidson & Jackson, 2020; Omar, Kuay & Tuncer, 2017).

In addition to post-migration resettlement challenges, experiences with healthcare services in countries of resettlement also affect refugees' psychological wellbeing post-resettlement, which previous research suggests is determined by systemic and individual factors (Hou et al., 2019; Mannava et al., 2015). Systemic factors include logistical and communicative hurdles, few available culturally sensitive services, and financial, bureaucratic and political obstacles within healthcare organisations (Donnelly et al., 2011; McCann, Mugavin, Renzaho & Lubman, 2016; Wohler & Dantas, 2017; Wylie et al., 2018). Individual factors include differing health beliefs around help-seeking (Bettmann, Penney, Clarkson Freeman & Lecy, 2015; Kokanovic, Dowrick, Butler, Herrman & Gunn, 2008; Tilbury, 2007), fear and apprehension following previous healthcare experiences (Donnelly, Hwang, Este, Ewashen, Adair & Clinton, 2011), and preferences to manage healthcare needs in alternative ways (Gladden, 2012; Goodman, 2004; Luster, Qin, Bates, Johnson & Rana, 2008; Monteiro & Wall, 2011; Tempany, 2009). Each of these factors may contribute to refugees' psychological wellbeing both in the healthcare setting, and also as a result of experiences with healthcare services.

Perinatal healthcare is one such service essential for many refugee women in Australia, around 30% of whom are of child-bearing age (Correa-Velez & Ryan, 2012). Globally, disparities in maternal health outcomes exist between women of refugee backgrounds and non-refugee backgrounds, including inequalities in maternal morbidity, preterm births and stillbirth rates (Carolan, 2010; Collins, Zimmerman & Howard, 2011; Kentoffio et al., 2016; Kandasamy, Cherniak, Shah, Yudin & Spitzer, 2014; Drysdale et al., 2012; Gibson-Helm, Teede, Block, Knight, East, Wallace & Boyle, 2014). Moreover, refugee status is a known risk factor for perinatal mental ill-health, with many having experienced uncertainty, poverty, risks to safety, exposure to violence, loss of loved ones, gender-specific violence, and resettlement challenges (Anderson et al., 2017; Baird, 2012; Haffejee & East, 2016). It is therefore essential that women of refugee backgrounds receive ongoing perinatal healthcare of a high standard post-resettlement. Some research has explored refugee women's experiences of perinatal care, including in Australia (Carolan & Cassar, 2010; Correa-Velez & Ryan, 2012; Gibson-Helm et al., 2014; Grant & Guerin, 2018; Murray, Windsor, Parker & Tewfik, 2010; Riggs et al., 2012; Riggs et al., 2017; Stapleton, Murphy, Correa-Velez, Steel & Kildea, 2013). Two key care aspects persist across studies: social factors (e.g., connections with others and interactions with healthcare providers), and culturally responsive healthcare.

However, whilst contact with perinatal healthcare services is highly valued (WHO, 2016), research suggests that the needs of refugee women in Australian healthcare settings are not always met due to challenges including understanding ethnicity and norms surrounding childbirth, and the impacts of psychological trauma (Carolan, 2010; Correa-Velez & Ryan, 2012; Jakubowicz, 2010; Riggs et al., 2012 Schweitzer, Vromans, Brough, Correa-Zelez, Murray & Lenette, 2018; Yelland et al., 2014). A small amount of research has been conducted nationally and internationally to address identified barriers to perinatal care and to facilitate care that is more responsive to the needs of refugee women (Brown, Carroll, Fogarty & Holt,

2010; Brown, Sutherland, Gunn & Yelland, 2014; Gibson-Helm et al., 2014; Kentoffio et al., 2016). However, refugee-focused perinatal services in Australia are limited, as well as comprehensive guidelines for best-practice perinatal healthcare for refugee women. Furthermore, few studies have examined the relationship between perinatal healthcare and psychological wellbeing among refugee women from Africa, which is crucial given their population in Australia and known disparities in perinatal outcomes. In response to this gap, this project aimed to: (1) understand the relationship between psychological wellbeing and perinatal healthcare amongst refugee women from the African continent, and; (2) identify areas for improved perinatal healthcare in Australia in relation to the psychological wellbeing of this population.

Method

Study Design

This study formed one component of a larger qualitative study concerning the maternal health needs of pregnant and post-natal women from African refugee backgrounds.

Participants

A total of sixteen women with refugee backgrounds from Africa participated in the study (N = 16). Participants were recruited via community connections of the primary supervisor for this research. Eligibility criteria included that women had arrived in Australia as refugees, had been in Australia for 10 years or less, were born in an African country, and were either pregnant or had a baby in Australia in the past 3 years. The participants had arrived in Australia from nine different African countries: Democratic Republic of Congo (*n* = 3), Liberia (*n* = 3), Sierra Leone (*n* = 3), Ethiopia (*n* = 2), Burundi (*n* = 1), Ghana (*n* = 1), Guinea (*n* = 1), Nigeria (*n* = 1) and Somalia (*n* = 1). All participants were aged between 19 and 43 (*M* = 31.68, *SD* = 6.29), and had lived in Australia from 11 months to 16 years (*M* = 10.43, *SD* = 4.92).

Eight participants were interviewed during the third trimester of their pregnancies (five of whom also had additional children; some born in Australia and some born in Africa), and eight were not pregnant but had previously given birth in Australia in the last 30 months (M = 13.44, SD = 8.60; five of whom also had additional children born in Australia and Africa). Specific details for each participant cannot be provided for reasons of anonymity.

Procedure

The Women's and Children's Hospital Human Research Ethics Committee approved the study (approval number HREC/19/WCHN/29). After providing informed verbal consent, participants took part in face-to-face and telephone interviews with a research assistant. All participants were offered the use of a professional interpreter, with two utilising a professional interpreter and two utilising family members. In cases of distress, participants were offered information on mental health, perinatal health, and refugee support services, and were followed up by the researcher in line with stated protocols.

The interview questions explored women's perinatal and general health backgrounds, health beliefs, experiences of perinatal care in Australia, the impacts of those services on their psychological wellbeing, and their recommendations for improved care. Women who had previously had a baby in Australia were asked to retrospectively respond in relation to their experiences during the perinatal period. Interview lengths ranged from 20 to 70 minutes (M = 37.87, SD = 11.83). Upon data saturation (with no new themes evident), interviews were ceased at sixteen participants. Interviews were recorded and transcribed verbatim by the research assistant, and then cross-checked by the researchers. As suggested by Tracy (2010), an audit trail was maintained throughout interviewing, ensuring transparency and self-reflexivity by documenting notes on methodology and reflections on interviews. It should be noted that none of the researchers were refugees or from the African continent, and two members of the research team had children, while the student researcher did not.

Interpretation of Data

Qualitative research was chosen for this study as it facilitates partnerships between researchers and communities to build understandings of key issues, and enables the voices of women themselves to be foregrounded. Thematic Analysis (TA) was employed to analyse the data, using Braun and Clarke's (2006) approach of: (1) transcribing data; (2) familiarisation with the data; (3) coding and identifying dominant themes; (4) reviewing themes against the whole data set and producing a thematic map; (5) naming and defining themes, and; (6) finalising the analysis through writing. Data coding was conducted both manually and using the program NVivo 12. Initially, a deductive approach was employed to identify the data relevant to the research question (the relationship between perinatal care and psychological wellbeing). An inductive, latent theme identification approach then enabled exploration of participants' perceptions regarding their perinatal healthcare experiences; guiding formulation of themes and subthemes, and the direction of this study (Braun & Clarke, 2006). The researchers each cross-checked the resulting codes and themes, as recommended by Braun & Clarke (2006; 2013) to ensure consistency and trustworthiness.

Results

Thematic Analysis of participants' interview data identified five main themes pertinent to the research questions: previous experiences in countries of origin are formative of perinatal healthcare perceptions and preferences post-resettlement; system-level factors impact psychological wellbeing; women want to be recognised as equal decision-makers in their perinatal care; social support is not only valued, but is essential for perinatal wellbeing, and; negative perinatal healthcare experiences have long-lasting psychological implications beyond the perinatal period. These themes explore a range of factors with diverse impacts on participants' psychological wellbeing.

Previous experiences in countries of origin are formative of perinatal healthcare perceptions and preferences post-resettlement

Many participants noted that, in their home countries in Africa, perinatal resources are often minimal. Given this, along with cultural expectations concerning motherhood, pregnancy and birth were typically accepted as a routine duty by participants:

> *In our country again some women, they can't go to hospital to give birth, they just give birth in their house … one of my Aunts when we were there, she just wake up, she cook everything for her kids. She clean her house. After 30 minutes, like when we are doing something, when we come back she said she give birth and she had a baby … One hour. – Eshe (from Ethiopia; pregnant with her fourth child).*

Corroborating Eshe's views, other participants' cultural and religious beliefs informed the notion of 'what will be will be', which underpinned their preferences for natural birthing experiences. For example, Lulu, from Liberia, who was Muslim and pregnant with her third child, said:

> *We don't know where we come from. Who created me? Is Allah. Who create you? Is Allah. Allah is one who create us. So whoever He want to be we can be … you can't change. If you say you're going to be disabled no one will change it … No one will change. So they say, "your child will be disabled so we need to take your baby out". I say, "no, you can't take my baby out. Whoever – whoever going to be I will take care of my baby".*

Despite now living in Australia where pregnancy is subject to more medical intervention, many participants felt that childbirth should occur 'naturally' without medical intervention. For example, Dahlia (from Liberia, and who was pregnant with her third child), said:

> *However the child is meant to come, that is how the child is going to come. That's like the mentality of a lot of people from my cultural background. We don't have all these machines*

> *to do check-up, to do this, to do that. You get pregnant and you just carry it for the nine months. Some people have up to ten kids with no problems.*

On the other hand, for some participants, experiences of perinatal care in Australia and the medical intervention which came with that were reportedly more positive. For example:

> *Here [in Australia] there is a lot of opportunity where you go do ultrasound. You get to see your baby. You get to know what gender you're having, where[as in] Africa, you just go on with it. You get to see your baby when your baby comes out, so there's a lot of opportunity here, because seeing your baby gives you peace of mind. – Jamilah (from Sierra Leone; pregnant with her first child)*

In addition to cultural norms, experiences as refugees influenced perceptions and appraisals of perinatal healthcare. Participants, including Zoya (from the Democratic of Congo, who had given birth to five children in Africa and was pregnant with her sixth child), expressed appreciation for the higher standard of medical support experienced in Australia. This included practitioners caring for both her wellbeing, and that of her family:

> *The level of care [in an African refugee camp] was very, very poor. If you don't really have a relative or somebody to take care of you when you go to deliver baby and assist you with that, many women [remain fearful that they will] die while giving birth … If I compare the care I am receiving here [in Australia] and what I was getting in [African country, name removed], the care here is very good. They are concerned about the progress through the pregnancy. They're caring about my and my baby's health as well, and the other children.*

Participants' experiences as refugees also determined their perinatal care preferences in Australia (along with cultural norms). For many participants, this strengthened their preferences for natural birthing techniques, especially amongst participants who held apprehension towards Caesarean sections. Sabra (from Sierra Leone), for example, had a Caesarean section during the birth of her first child in an African refugee camp 18 years ago,

after which she remained in the hospital for six weeks without sufficient food or water, whilst in significant pain. One year prior to the interview for the current project, she was again asked to have a Caesarean section during the birth of her second child in Australia, as she recalls:

> *I was very stressed [when I was told to have a Caesarean section again]. I was … I don't know what's the English word I have to use, but when you feel that, just I become like … how do I have to say? Very anxious? … That's how I was feeling when I feel like, when I think of it … Because I know what I went through … I told [one of my surgeons] that I don't want to do it, and if there's any option that they can do (.) anything else they can do, I will … I don't want to go through it again.*

Overall, this theme demonstrates the impacts of past experiences – in terms of both cultural norms, and experiences as refugees – on women's subsequent perceptions, preferences and appraisals of perinatal healthcare in post-resettlement contexts like Australia.

System-level factors impact psychological wellbeing

Participants discussed a number of system-level factors that impacted their psychological wellbeing in the perinatal context. Firstly, their relationships with midwives and other health practitioners were impactful; particularly for women with limited social supports in Australia. Neema (from Sierra Leone, and who previously gave birth in Australia and Africa), discussed:

> *When I got pregnant here, I got a midwife who was really good. She was a perfect lady; she looked after me. In fact, because she knows that my condition is not like people who do have difficulties, so she was always visiting at home … I gave birth …. That was very good after that.*

Secondly, continuity of care was suggested to contribute to participants' psychological wellbeing, due to: (1) enabling relationship building between patient and provider, and; (2) providing medical accountability. However, few women received perinatal care from the same

midwife. Tanesha (from the Democratic Republic of Congo, and who gave birth in Australia four months prior), recalled her experience:

> *I did see different people [midwives], unfortunately … One, at least, or two familiar faces, that would have been better. But it was different people (.) I remember seeing one for a particular appointment, in a particular week. When I went back, it was a few months when I saw her again. It was different people all the time.*

Furthermore, participants discussed continuity of care in the context of post-partum at-home care, during which time the challenges of caring for a newborn were noted as overwhelming. Whilst participants who received this care were grateful, they also suggested it to be somewhat superficial and short-lived, as Tanesha explained:

> *[Ideal perinatal care for me would include] increasing the visits of midwife … I was talking with a friend who's in Canberra the other day, and she says, they get that visitation for almost two months … Here it's like two or three times, and it's done. For me, I was like, I'm expecting more (.) expecting more, because despite having family around you, you need also people with experience and knowledge in that field, to ask questions.*

Along with continuity of care, culturally responsive care was also valued by many participants. A number of elements were suggested to constitute culturally responsive care; many of which were not present in the care experiences of women in Australia. Firstly, some women described how health practitioners often did not understand the ways in which cultural norms informed women's healthcare preferences. Dahlia discussed this in the context of apprehension towards attending medical appointments and assumptions of neglect:

> *I think our mentality and cultural way of thinking should really, really be considered when dealing with African backgrounds … [For example] some people refuse or are very reluctant on going to appointments because of this mentality … With the medical people, I feel like they respond to it as a neglect … but I feel like we're both right. From my side,*

> *I have the right to think like that … in my country we do a lot of traditional what do you call it? Herbs and stuff like that when you're pregnant … With a medical, they don't know that [our beliefs] and they don't understand that [our culture] so it's like "oh, she don't want to come for her appointments (.) We're going to call her, if she doesn't come, forget it" … I think it's lack of understanding on both side.*

Furthermore, participants reported a variety of culturally insensitive perinatal healthcare practices, particularly in relation to privacy regarding disclosure or care for women previously subjected to female genital mutilation. Sabra recalled:

> *She [a midwife] asked me some question. She did ask me about my, how some women have a women circumcision in Africa. If I'm part of it, and 'how did I feel?' (.) I think those question was personal, and I told her that, "I don't feel comfortable of you asking me to answer those questions" … The other question that she asked me, she knows that African, they have all these domestic violence things. "Have I gone through anything that will cause damage to my having the baby?" I told her that, "I don't need to talk to you about those things. I think I'm here for my health" … There, she just says that, "look, it's part of the government need to know about you (.) the individual", but this is (.) Australia is a multicultural country. Everybody have their own culture. Whatever have happening with me, my own culture issue … It's my privacy.*

Some participants felt that, due to experiences of cultural insensitivity by healthcare practitioners, they would always be disadvantaged and receive suboptimal perinatal care. Dahlia commented:

> *I feel like mostly when you are of a different cultural background … they don't give you much attention … this is what I hear a lot of people saying from my cultural background and even for me personally. Yeah, so they don't give you much attention. Another thing is [when you're of a different cultural background], I feel like they give you more of a learner … when you go to give birth, you are a guinea pig, basically. So they use some,*

> *someone that has not that much experience … They're like "oh, you can go and experience this. You can go and learn from that person".*

Other participants also felt that due to their cultural background, they were powerless in seeking or receiving quality perinatal care. For example, Ada (from Liberia, and who gave birth in Australia seven months prior), suffered a traumatic stillbirth experience in an Australian hospital six years before her interview, but felt that she was disadvantaged in her ability to seek justice due to her background:

> *Each time I think about it I promise myself to never go to that hospital because I was so scared of them. My family talk to me, "oh just leave it, you don't know how to speak English. You are African. This is the hospital. It's the government hospital. If you sue the government, you won't get power".*

Moreover, alongside culturally responsive perinatal healthcare, *refugee* responsive care was highlighted by participants as essential for their wellbeing. Refugee responsive care refers to the need for practitioners to understand the implications of holding refugee status, and the psychosocial challenges faced by refugee women in particular, as Hasina (from Nigeria, and who was pregnant with her first child) described:

> *I just have a friend, she had a baby and her mum couldn't come because their visa wasn't granted … It was really hard for her. Coming back home she has to start everything all by herself, nobody is there to help her. The hospital do come to assists but it's just once in a week … it's really very hard … her husband has to go to work … because the bills are there. They have to pay. It's not as safe where – like us now, we are not permanent residents so we're not getting anything from the government at all. So it's not easy.*

This theme summarises a number of system-level factors which contributed to participants' experiences of perinatal healthcare, and in turn to women's psychological wellbeing. Positive relationships with healthcare providers – and continuity of care with those providers – are key

mechanisms for ensuring positive psychological outcomes. Alongside this, culturally and refugee responsive care were emphasised by participants as requiring significant improvement.

Women want to be recognised as equal decision-makers in their perinatal care

Participants considered each pregnancy and birth experience as unique and as requiring individualised care. However, they expressed frustration following experiences of perinatal care in Australia in which their pregnancies were not treated as such, as Dahlia expressed:

> *With each different pregnancy, there's different experiences … I don't care if you have 20 kids or whatever, each child comes with their own experience. So each pregnancy should be treated appropriately, according to how the person is feeling and stuff like that.*

Many participants felt that they were not adequately acknowledged or cared for at their perinatal appointments – in some cases resulting in feelings of neglect – as stated by Sabra:

> *I wasn't feel like I was listened to … it's just like when you go, they tell you, "hop on the bed, check that, and come down. Oh, the baby is fine". That's it. Sign you off, and you leave … So I feel neglected, actually.*

Moreover, some participants felt that their requests were outwardly ignored by medical staff, and thus their care preferences were not met. This can have serious implications for women's attitudes towards utilising perinatal health services. Dahlia discussed this in the context of her preference for a female midwife (a preference held by multiple participants):

> *I just requested not to have a male because again, when it comes to my body and pregnancy, I just personally feel more comfortable with a female. So having the male every time (.) I did have a female and then they switched without telling me. Then when I came in, it was a male. Then I said no, I don't want to see a male as a midwife. I want a female but even up until now, when I go, I still see male. So it's basically, I personally feel like it's just take whatever you get … that's why now, even I was on Tuesday, I was supposed to go for one*

> *of my appointments … but I just felt like "no". I didn't go … I don't feel like going and they even said they want to induce me this week, which is probably today.*

In addition, a pivotal need for many participants was also to be recognised as knowledgeable throughout their pregnancy and childbirth, yet some felt that they were not treated as such by medical staff. In some cases, this lack of consideration of mothers and their knowledge was perceived to have catastrophic consequences, as Ada recalled:

> *The midwife ring the department and told them that "oh the lady (.) the African lady is here, she been crying that oh she's ready to give birth but water is not breaking. But now I have checked on her, the baby head is right there. She's ready to give birth". They [the medical staff] refuse … So they sent me home. When they send me home my baby pass away. Three days in my stomach … the day they [the medical staff] was ready for me to give birth the baby's gone.*

Another issue concerning control during perinatal care expressed by multiple participants was insufficient consent regarding the presence of student midwives. Tanesha expressed her frustration:

> *The fact that they [the medical staff] didn't even ask me [if a placement student could act as my midwife] (.) [They] tell me "this person is going to check and do everything", I was just like, "no, you don't do that. You always have to ask permission". I'm from a background where … someone who's young, immediately, they start (.) especially student, [I think] "oh my God, she's inexperienced" … I felt a bit disrespected. Ask me. I don't have anything against this student, but ask me if I feel okay for her to check [me].*

Individualised care, granting of needs and requests, acknowledgement of personal expertise or knowledge, and a thorough consent process were all discussed in this theme as contributing to a sense of autonomy and respect amongst participants. Without such needs being met, participants felt that they were not treated as equal decision-makers in their perinatal care, which impacted their appraisal of services and psychological wellbeing. Importantly, experiences of minimal

autonomy also deterred some women from returning to formal perinatal healthcare services, which in turn contributes to the pervasive health inequalities experienced by refugees in Australia.

Social support is not only valued, but is essential for perinatal wellbeing

Some participants were grateful to have close friends and social supports in Australia who helped them to manage tasks and challenges throughout the perinatal period. However, many women described their perinatal experiences as lonely, particularly in comparison to collectivist traditions surrounding pregnancy and motherhood in their countries of origin. Hasina discussed such feelings in the context of her pregnancy:

> *If it was back in my country you will have people around you to help you, to support you and stuff like that. But here it's completely different because it's just me and my husband here and my brother-in-law. So it's not really like we have too many people there. It was really very bad at the first – the first four months [of my pregnancy].*

Shani (from Guinea and who gave birth in Australia two years prior) purported similar feelings in the period following birth:

> *When you have baby [in Guinea], the family come visit to you. After seven days after, on the seven day morning, they do they baby [unclear] celebration … Then give name … [It's] not the same [in Australia] … they [my family and friends] do some video and send me. I can't see [that well]. I'm so sad.*

The individualistic nature of Australian culture was further alluded to by some participants (who had previously given birth in Australia) as contributing to feelings of isolation in the perinatal period. For example:

> *[In Australia] we don't have that time … Maybe only doctor can visit you and you have friend that can come visit you … No time … it can feel lonely. – Uma (from Liberia; gave birth in Australia two-and-a-half years prior).*

Participants' backgrounds as refugees may have further contributed to feelings of isolation given that many also described psychosocial challenges (such as few formal and informal supports) as consequences of refugee status (as seen in the previous theme). The present theme emphasises the impacts of social connection on the psychological wellbeing of women both during pregnancy and following birth.

Negative perinatal healthcare experiences have psychological implications beyond the perinatal period

Negative experiences with perinatal healthcare services in Australia were found to have significant and enduring impacts on participants' psychological wellbeing far beyond the perinatal period. For some women, mental health challenges were a result of traumatic birth experiences, such as Ada's experience of stillbirth described above:

> *Since then [the stillbirth of my baby] I'm not normal anymore. To be honest. I'm making myself stronger because for my kids.*

Like Ada, other participants discussed their use of psychological coping mechanisms to manage their own distressing experiences. Lulu (from Burundi, and who gave birth in Australia eight months prior), reported suppressing difficult thoughts and memories in order to cope:

> *My mental health I can say is good because I don't feel anywhere pain … if something make me [feel] pain [mentally] I don't think about that. I throw out … I don't keep in my mind. Always put away because if I think about it I kill myself so put away.*

For participants who had had babies in Australia, negative experiences with perinatal healthcare services – and the extensive impacts on their psychological wellbeing – catalysed two responses. For some women, the trauma and emotional impacts of their experience instilled determination to pursue better future outcomes, both for themselves and for other women:

> *Even it's [unclear] year I would not forget this hospital. This is a [record]. I would fight for my right what they do to me. I would never forgive them. They make me go mad and make me depressed. They make me commit suicide for my son. I cry. – Ada*

> *[My perinatal care experience] was very hurtful… I think, with this experience I have, if I get pregnant again, I'll not close my mouth again, because I went through a lot. – Sabra*

For other participants, the extent of their dissatisfaction with care created hesitation around seeking formal perinatal healthcare in the future. Underpinning this apprehension was a perception that perinatal healthcare of a high standard is 'lucky' to find, as Dahlia explains:

> *When I get my clients [from Africa] … almost all of them have kids. So they're like "oh no, you're lucky to be in the [hospital name removed]". I'm like, "what do you mean?" Because if you're with the hospital in at [suburb removed] area … a lot of people would be like, "oh they're so racist". That's how they will say to me … "they're so bad, they don't even care about you. They don't" (.) Yeah, so they're always telling me I'm lucky to be at the [hospital name removed] … I don't understand how I'm lucky.*

From the data, it is clear that the impacts of negative experiences with Australian perinatal healthcare services have enduring psychological impacts that span beyond the perinatal period itself. This theme identifies how those experiences – which may compound previous trauma associated with the refugee experience – can shape the status of women's mental health and wellbeing into the future, as well as instil apprehension towards utilising services.

Discussion

The presented themes provide valuable insights into participants' experiences with perinatal healthcare services in Australia and how they impact their wellbeing. The results highlighted how participants' experiences and norms in their countries of origin, system-level factors, a sense of autonomy throughout care, social support, and the psychological impacts of care all determine psychological wellbeing outcomes amongst refugee women from Africa

post-resettlement. These themes largely corroborate the findings of past literature (as discussed below), whilst also adding novel contributions to the evidence base in the Australian context and informing key recommendations for improved perinatal healthcare for this population.

The results highlighted the enduring influence of cultural norms and experiences of perinatal care prior to coming to Australia on appraisals of Australian perinatal healthcare services, and in turn, on psychological wellbeing. Some participants felt that pregnancy was a routine 'duty' amongst other tasks and responsibilities, reflecting previous research with African-born women in Australia (Carolan & Cassar, 2010). Consistent with this, 'natural' births were strongly preferred by some participants due to their cultural and religious beliefs, and fear of repeating the traumatic incidents they encountered in Africa (e.g. having caesarean sections in settings with minimal resources). Other studies of refugee women in Australia, Canada, and the United States similarly reported ambivalence towards obstetrical and pharmacological interventions due to fears of birthing complications (often stemming from experiences in their countries of origin and during migration) including harm and mortality (Brown, Carroll, Fogarty & Holt, 2010; Higginbottom, Safipour, Mumtaz, Chiu, Paton & Pillay, 2013; Murray et al., 2010). Conversely, for some participants, Australian perinatal services and medical interventions during pregnancy, advancing technology, and greater resources for care provided reassurance, reflecting individual differences in perinatal care preferences.

Perinatal healthcare system-level factors in Australia also affected participants' psychological wellbeing; a particularly key finding with significant practice implications. Participants stated that how they were treated by medical staff was impactful, reflecting previous research (Balaam et al., 2013; Murray et al., 2010; Gibson, Attreya, Bennett & Brook, 2010). Equally, negative care experiences have been reported to cause notably poor wellbeing outcomes including apprehension amongst patients to disclose their feelings, wishes and needs;

thereby placing women in a position of vulnerability (Balaam et al., 2013; Dennis & Chung-Lee, 2006; Murray et al., 2010).

Continuity of care constituted another key subtheme representing perceived best-practice perinatal care. Previous research also notes its importance for relationship-building, detecting mental health and other issues, improving wellbeing outcomes, increasing maternal health literacy, and providing reassurance for women in an unfamiliar healthcare system (Balaam et al., 2013; Higgins, Downes, Monahan, Gill, Lamb & Carroll, 2018; Shaw, Levitt, Wong, Kaczorowski & McMaster University Postpartum Research Group, 2006; Stapleton et al., 2013). However, few participants in this study experienced care continuity; instead seeing various practitioners throughout their perinatal care. Participants who previously gave birth in Australia also discussed at-home follow-up care during the perinatal period after birth, which attracted a diversity of reviews and recommendations for longer-term access. Further research into the efficacy of these services for African refugee women is required, although positive wellbeing outcomes have been suggested among other populations (Shaw et al., 2006).

The need for improved culturally responsive care was strongly emphasised throughout participants' accounts. Participants described encounters with medical staff who had limited awareness of how culture shapes pregnancy-related experiences and preferences. This was perceived by some participants to fuel negative assumptions about them and their fitness to parent. Misinterpretations amongst healthcare practitioners in relation to culturally diverse childbirth beliefs are not uncommon (Higginbottom et al., 2013), and can lead to negative outcomes including distress, as was experienced by participants in this study. Culturally unsafe care was seen particularly in relation to a lack of respect for participants' privacy, including concerning culturally sensitive topics such as female genital mutilation; similarly documented in other Australian and international studies (Balaam et al., 2013; Straus, McEwan & Hussein, 2009; Turkmani, Homer & Dawson, 2019). Participants' experiences of perinatal care which

failed to be culturally responsive contributed to a belief that they would only ever receive disadvantaged care as a consequence of their cultural backgrounds. This corroborates other Australian studies where women with non-English speaking backgrounds were less likely to have their maternity or perinatal care needs met (Brown, Sutherland, Gunn & Yelland, 2014; Riggs et al., 2017). As shown by these results, such negative experiences, and their consequent beliefs, can have notable impacts on the psychological wellbeing of refugee women from Africa.

In addition, participants also emphasised needs for refugee-sensitive perinatal care; that is, care that acknowledges the psychosocial challenges and implications of refugee status. Post-migration stressors are known risk factors for reduced access to (and maintenance of) formal perinatal care, and increased risk of perinatal mental disorders, obstetric issues, and negative birthing experiences (Fellmeth, Fazel & Plugge, 2017; Gewalt, Berger, Ziegler, Szecsenyi & Bozorgmehr, 2018; Heslehurst, Brown, Pemu, Coleman & Rankin, 2018; Sheikh-Mohammed, MacIntyre, Wood, Leask & Isaacs, 2006; Straus et al., 2009). As such, it is crucial that perinatal practitioners understand the implications of psychosocial challenges faced by refugees in the perinatal setting (Yelland et al., 2014). Overall, greater knowledge and sensitivity amongst perinatal practitioners to ensure refugee-responsive care (alongside culturally-responsive care) is essential for ensuring positive psychological wellbeing outcomes in the perinatal period.

Another key finding from this study was participants' wishes to be recognised as equal decision-makers in their perinatal care. Some participants (many of whom had given birth previously) felt that they were provided with insufficient support, mirroring previous Australian research with African women (Murray et al., 2010). Other participants felt that they were not treated as knowledgeable or autonomous in their perinatal care, and were not listened to by hospital staff. For some women this may be especially important as pregnancy and childbirth can incite novel feelings of empowerment and control (Higginbottom et al., 2013).

There is a known relationship between feeling in control during the perinatal period and positive psychological outcomes; where validating women as experts and elevating their strength as mothers can also contribute to achieving positive postpartum health goals more generally (Green & Baston, 2003; Tully, Stuebe & Verbiest, 2017). As such, recognising women as decision-makers in their care is key for promoting psychological wellbeing. However, many participants in this study felt powerless, which was contributed to by inadequate consent processes regarding involvement of student midwives. Little research has investigated this specific issue, though some research has explored similar ethical issues regarding medical students and junior doctors in the context of pelvic examinations (Carson-Stevens, Davies, Jones, Pawan Chik, Robbé & Fiander, 2013). Supporting women to feel valued and recognised as decision-makers throughout their perinatal care is thus essential for promoting positive psychological wellbeing outcomes, and for ensuring continued service use.

Many participants discussed the challenges of living away from their friends, family and cultural communities, both whilst pregnant and after giving birth. Some participants did share caring relationships with friends and family in Australia which were a key source of support; similarly noted by Balaam and colleagues (2013) as a source of strength and wellbeing. However, other participants without strong social supports described the perinatal period as a lonely experience; a feeling shared by African women living in Brisbane who described fear, loneliness, and a sense of 'not knowing' (Murray et al., 2010). Low social support amongst migrant populations – especially refugees– is a key risk factor for perinatal mental health disorders including depression, whilst strong social support can protect against perinatal mental ill-health (Anderson et al., 2017; Fellmeth et al., 2017).

Interestingly, it was notable that whilst this study focused on women's experiences in the perinatal period, participants spoke about the psychological implications persisting beyond that, emphasising the need for further research and improvements to the provision of perinatal

healthcare in Australia. Multiple participants were deeply emotionally affected by their experiences some months and years later; with feelings of regret and anger, and suicidal ideation prominent. Suicide is a leading cause of maternal death in developed countries, making it essential that women receive quality perinatal healthcare (Miranda & Patel, 2005; WHO, 2008). For many participants, the psychological turmoil following their perinatal care experiences instilled apprehension towards seeking support in future; a result also found by Mannaya, Durrant, Fisher, Chersich and Luchters (2015). It is crucial that women are supported to seek perinatal care given the existing relationship between low service use and mental health challenges in pregnant women (WHO, 2008). In this study, participants described a community consensus that good quality perinatal healthcare was 'lucky' to find. This likely further reduces women's likelihood of seeking formal perinatal care, which further perpetuates a cycle of isolation and unfamiliarity with the Australian healthcare system, and fuels already pervasive health inequalities amongst refugees in the post-resettlement context (Balaam et al., 2013). As such, negative experiences with perinatal healthcare services can result in significant and enduring psychological impacts, which in turn exacerbates health disparities experienced by refugee women (and their families) in Australia.

Strengths, limitations and future research

This study presents a number of strengths, including use of qualitative methods which enable exploration of participants' lived experiences of Australian perinatal care services. This ensures that the perspectives of this population are included in the literature, which is currently lacking. However, potential bias within the sample of this study is a key limitation. Although every effort was made to capture the voices of society's most vulnerable, some may not have had access or means to participate, meaning the sample may represent those with particular resources or interests. It is also worth noting that the latter stages of recruitment and interviewing intersected with COVID-19 restrictions, creating challenges for recruitment (e.g.

due to social distancing policies, fear, or lack of resources) and participation (e.g. the technical and rapport-building challenges of interviewing via telephone).

The scope of this study – focusing specifically on the experiences of women with refugee status – also addressed limitations of the current evidence base where those with refugee, asylum seeker and migrant status are often combined under a singular definition (Gagnon et al., 2009; Heslehurst et al., 2018). Exploring deeper insights into the perspectives of women with refugee backgrounds offers recognition of the uniqueness of their experiences and contributes to specific recommendations for improving psychological wellbeing outcomes in the perinatal context. The findings of this study lay the foundations for future research, including deeper exploration of cultural differences amongst women from different African countries and cultures. Further research with participants of asylum seeker backgrounds would also be valuable, as those with asylum seeking status are generally less supported by healthcare systems in resettlement countries, and therefore may face additionally unique challenges in the perinatal healthcare context.

Conclusion and recommendations

With a dearth of literature on this topic and few refugee-focused perinatal healthcare services currently operating in Australia, nor comprehensive guidelines for best-practice perinatal care for refugee women, this study addresses a crucial literature gap regarding how experiences with perinatal healthcare services affects the wellbeing of African women with refugee backgrounds. In particular, support and change at the systems level is required to promote the successful implementation of practice recommendations (as highlighted by the findings in this study). Firstly, employment of a continuity of care model is recommended to ensure an unremitting, high standard of individualised perinatal care, which also recognises the role of patients in informed decision-making. Secondly, it is crucial that practitioners are educated and competent in providing culturally- *and* refugee-competent perinatal care to

patients. In doing so, women should have access to inclusive, non-judgmental and respectful services where practitioners make every effort to meet their cultural- and psychosocial-related perinatal health needs. Relatedly, practitioners should be skilled in referring women to external support services if they require, including social or welfare support organisations for women who may be isolated or facing housing or financial instability. Finally, Australian perinatal healthcare services must be equipped to provide refugee women from the African continent with tailored and trauma-informed support. This support must recognise the potential psychological impacts of perinatal healthcare experiences on women's long-term psychological wellbeing, and ensure that women receive the mental health support they require.

To conclude, the findings of this study may inform future research and practice recommendations and in turn contribute to improved psychological – and general health – outcomes for mothers of refugee backgrounds from the African continent.

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[*note:* in line with instructions specified by the journal, *Qualitative Health Research,* if this article is submitted for publishing, the Acknowledgments section will be removed during the initial review process]

Declaration of Conflicting Interests

The Authors declare that there is no conflict of interest.

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1. What do we publish?

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7. Further information

Any correspondence, queries or additional requests for information on the manuscript submission process should be sent to the *Qualitative Health Research* editorial office as follows:

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