Government of Western Australia
Department of Health

Improving maternity care for refugee and migrant women in Western Australia: Report from 2013–2014 workshops

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Important Disclaimer:

Contents

Executive summary

The Womens and Newborns Health Network (WNHN) is committed to improving maternal and child health outcomes in Western Australia (WA). A priority for the WNHN is the development and implementation of models of maternity care which focus on choice and continuity of care/r for women and families. The WA Health *Improving Maternity Services: Working Together Across Western Australia, A Policy Framework* (2007)[1] states that "it aims to expand options for maternity care in WA, enabling more choice and greater continuity of care for a woman and her family".

Western Australia's maternity health care system has a strong record of providing quality care, however care is not always consistently delivered. Outcomes and experiences for refugee and migrant women can be markedly different from the general population. In September 2012, the WNHN in collaboration with Community Midwifery WA (now BumpWA), ISHAR Multicultural Women's Health Centre and Women's Health and Family Services convened to run a workshop to bring together key stakeholders working with and advocating for refugee and migrant women (RMW). The aims of the workshop were to identify and map current service delivery; to develop an optimal pathway for support and service provisions across preconception, pregnancy, birth and postnatal care; to consider education and training of people working with RMW and families; and to consider information sources that exist/or are required.

In October 2012, the WNHN Continuity of Care Working Group established the Refugee and Migrant Women Working Group (RMWG) to support and inform the development of the maternity continuity of care/r models for all women in WA based on the outcomes of this initial workshop.

In order to support and understand the specific needs for RMW and families accessing maternity care and the services providing this care, workshops were held at three maternity hospitals – King Edward Memorial Hospital (KEMH), Armadale Health Service (AHS) and Osborne Park Hospital (OPH). The workshops were seen as an opportunity to share knowledge and experience by existing services with the aim to inform the development of maternity models of care in WA. Over the three workshops, in excess of 670 comments were received from stakeholders**.**

Thematic analysis was used to identify recurring themes that represented common views of the respondents from the three workshops. The findings presented in this report are a descriptive account of the qualitative data and identifies key issues including:

- use/access of interpreter services
- inadequate recorded history
- lack of identification of cultural-specific issues (i.e. female genital mutilation)

Also highlighted are the numerous social issues such as high incidence of domestic-violence; anxiety, trauma and parity.

The RMWWG reconvened to discuss the findings from the workshop and develop recommendations for further action. The five recommendations were discussed with the Continuity of Care working group to propose to the Executive Advisory Group of the WNHN for further consideration in 2015.

1. Background

The RMWWG has been established by the WNHN Continuity of Care Working Group to address the recommendations with respect to continuity of care/r for these two policy frameworks:

- The Review of Home Births;[2] and
- The WA Health Primary Care Strategy [3]

The group will utilise, as its basis, the following documents:

- Improving Maternity Services: Working Together Across Western Australia - A Policy Framework[1]
- The National Maternity Services Plan[4]
- The Review of Homebirths in Western Australia [2]
- Motherhood After Migration (report from Telethon Institute for Child Health Research)[5]

The principal goal of the RMWWG is to lead, support and facilitate the identification and implementation of maternity continuity of care/r models for RMW in all health services across WA Health. Continuity of care/r models will be accessible to all refugee and migrant pregnant women across the continuum of care irrespective of risk or other factors. In order to support and understand the specific needs for RMW accessing maternity care and the services providing this care, workshops were held at three hospitals providing maternity services.

Each workshop aimed to determine the optimal care pathways for RMW from preconception to post natal care where participants identified and mapped service models needed to deliver access to continuity of care/r models for RMW across the continuum of care. The workshops also considered workforce, training, professional education and resource requirements.

Participants included site-specific hospital staff and support organisations working with RMW ranging from government departments, non-government and community organisations including Women's Health centres and primary health care providers.

2. Purpose of the workshops

The purpose of the workshops was to bring together key stakeholders working with and advocating for RMW to facilitate the development of continuity of care/r models of maternity care in WA. The workshops provided an opportunity to share information, knowledge and ideas to develop service models and resources which would support a maternity continuity of care/r model for RMW.

The aims of the workshop were to:

- Identify and map existing or additional education and training needed for people working with RMW and families;
- Identify and map existing or additional resources (information, technology etc.) necessary to improve maternity services and care to RMW and families;
- Support the development of an optimal pathway for support and service provision across the maternity journey; and
- Identify and map current “site-specific” maternity care.

3. Methodology

3.1 The workshops

To support and understand the specific needs for RMW accessing maternity care and the services providing this care, workshops were held at three hospitals providing maternity services:

- King Edward Memorial Hospital (KEMH) on 2 August 2013
- Armadale Health Service (AHS) on 13 December 2013; and
- Osborne Park Hospital (OPH) on 10 March 2014

Two workshops were timed at KEMH and AHS on the same day to increase opportunity for staff attendance. Potential participants were informed of the workshops via a range of methods including but not limited to e-mail communication, flyers and executive meetings. A sample flyer is provided in Appendix 1.

3.2 Workshop program

The workshop aimed to determine the optimal care pathways for RMW from preconception to post natal care where participants identified and mapped service models needed to deliver access to continuity of care/r models for RMW across the continuum of care. The workshop also considered workforce, training, professional education and resource requirements.

A sample program is provided in Appendix 2.

3.3 Workshop participants

Participants included site-specific hospital staff and support organisations working with RMW ranging from government departments, non-government and community organisations including Women’s Health centres and primary health care providers. In total, across all three workshops over 85 participants attended who primarily provide a range of services to RMW and families from social support to maternity and broader health services.

3.4 Data collection

At the workshops, a maternity continuum (pre-conception to post natal care) was set up around the perimeter of the venue with RMWWG members stationed at each stage to facilitate discussions with roving participants. Participants were able to move freely from one station to the next to discuss issues, offer suggestions and provide comments towards identifying and improving health services, access and outcomes for RMW and families in WA .

Themes that were identified in the initial Stakeholder workshop (September 2012) were used as a starting point for discussion. These included:

- Optimal pathway (continuity of care)
- Barriers to care (obstacles and solutions) for staff and clients
- Existing services/resources and future needs
- Workforce needed to deliver improved maternity services
- Education, training and resources current and future needs

Discussions at each station and key points noted by participants were documented and collated with a copy of data collected from each workshop forwarded to participants post workshop.

3.5 Data analysis

Qualitative data was analysed using the software program NVIVO9 (QSR International). Thematic analysis was used to identify recurring themes that represented common views of the respondents.

3.6 Interpretation of results

The results presented in this report are predominantly a descriptive account of the qualitative data.

4. Results – workshop themes

Over the course of the three workshops, in excess of 670 comments were received. Recurring themes were identified (to varying degrees of significance) at each stage across workshops. These can be seen in Figure 1 below.

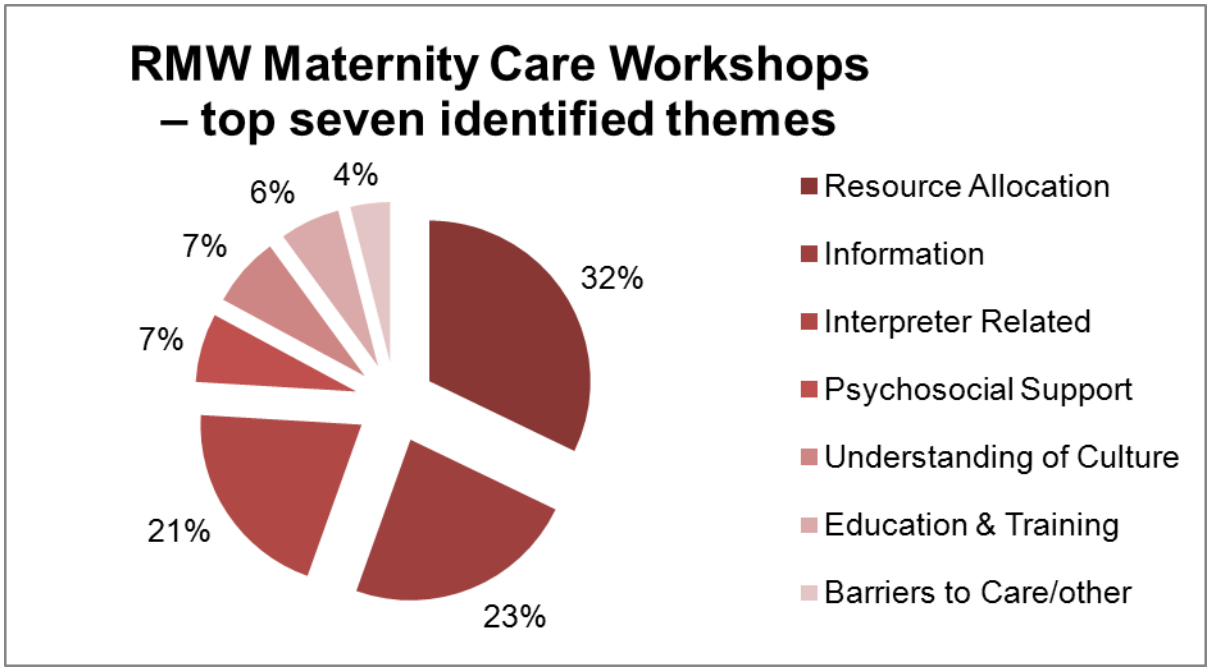

Figure 1 – RMW Maternity Care Workshops: Top Seven Identified Themes.

Resource allocation

Resource allocation was the most common recurring theme from the workshops, This was specifically in relation to staff (clinical and non-clinical), time and cost restrictions with the need for improved model/s of care to optimise these resources for the benefit of RMW and families, as well as the clinical and non-clinical staff providing maternity care and services in the hospital environment.

Information

Information was the next most common theme, particularly in relation to access to interpreter information/interpreters, making up over 40% of the comments received.

Interpreter availability

Interpreter availability and sourcing of information in various languages on general maternity subject matter was a common theme identified. Better utilisation of technology to access specific language resources 24/7 for hospital staff and agencies whilst providing support to this vulnerable cohort of women and families was discussed extensively at all workshops.

Psychosocial support

Psychological support to RMW from allied health staff and support agencies and identifying and assisting victims of domestic abuse, violence, trauma (female genital cutting, multi-parity – previous conditions/outcomes etc.) to better support RMW across the maternity journey from pre-conception to post natal care and in the community was also a recurring theme.

4.1 Maternity continuum

4.1.1 Preconception

There were 73 comments and suggestions noted in relation to preconception. Major common themes related to information and resources with fewer suggestions around education and training and psychosocial support. Information specifically related to contraception and resources specifically referred to engagement of services within the community and coordination and information within these services.

The first question was used to initiate conversation around the beginning of the maternity continuum was “what information isn’t currently given that RMW could be directed to, to help them before conceiving e.g. services, choices etc.?”

Sample of comments

“Contraception (as part of orientation to Australia)” – All workshops

”Provide information about midwives and services provided at community events (service providers engage/link with communities)” – KEMH

“Information available through work companies providing visas” – AHS

“Audio and visual files linked to information sheets (also for sight impaired)” – OPH

4.1.2 Pregnancy (< 20 weeks antenatal care)

There were 130 comments noted (including repeated comments) across all three questions relating to pregnancy before 20 weeks gestation.

The first question related to resources RMW can be directed to, in order to assist them in making informed decisions was “what information/resources can RMW be directed to, to help them make informed decisions?”

There were 71 comments and suggestions noted. Major common themes related to information and resources with fewer suggestions relating to psychosocial support. Information specifically relates to referral services and translator information. This was closely followed by resources including specialist care information, website and social media.

Sample of comments

“Communication of available resources – social media” – KEMH

“Linking with/of services” – KEMH

“Website links to translated material/information” – KEMH

“Encourage more consideration for FGM reversal antenatally – AHS

“Refer to Community Midwifery Refugee support program” – AHS

“Translated information sheets on pregnancy education, diet, frequency of visits, ultrasounds, medications (Vit D), blood tests – which ones and why” – OPH

“A dedicated migrant and refugee antenatal clinic” – OPH

The second question participants were asked if they were “happy with the information provided by General Practitioners (GPs) to refugee and migrant families for booking in?”

There were 32 comments and suggestions noted. Major recurring themes related to resources, with suggestions including a dedicated RMW antenatal clinic (ANC) and midwives. Information specifically relates to quality of referral services and information that is easy to follow and available on other resources. Other suggestions included GP education and training.

Sample of comments

“Need info re AMBULANCE FUND (to avoid excessive bills)” – KEMH

“GP referrals – need more information in referrals – often stretching info” – KEMH

“Many GPs don’t use interpreters and the referrals into ANC really bad” – AHS

“Information not pitched at appropriate level of understanding i.e. medical language used” – AHS

“No, not detailed information – GPs sometimes don’t have the experience” – OPH The third question was directed at what staff required in-order to improve their experience of providing care to RMW. Participants were asked the question “what would make your experience better when a RMW is referred to hospital (KEMH, AHS, OPH) site?”

There were 27 comments and suggestions noted. Major recurring themes related to resources, with suggestions including dedicated refugee clinics, longer consulting times and updating ANC shared care guidelines to include what RMW need. Following this, information and psychosocial support were also mentioned relating to more social work input as well as early and planned hospital visits.

Sample of comments

“Update antenatal shared care guidelines to include what RMW need” – KEMH

”Interpreters on staff” – KEMH

“Specialised triage midwife for RMW” – KEMH

“Female GPs” – AHS

“Continuity of Care” – AHS

“More background information on woman i.e. country of birth, specific language etc.” – AHS

“More time and access to literature in other languages” – OPH

4.1.3 Booking in

There were 156 comments noted (including repeated comments) across the following five questions relating to booking in. Major recurring themes across all five questions related to interpreter services, resources, barriers to care, education and training, more time and support

and psychosocial support. “Insufficient time” was cited as the major issue when booking-in interviews with RMW and was discussed extensively at all workshops. More time to build rapport and increase ability to identify issues, background (as related to family), domestic violence or exposure to trauma/abuse prior to arriving in Australia (to ensure appropriate referral for assisted care) were also major issues raised.

The first question participants were asked was “what issues do you see RMW facing at booking in?” There were 69 responses to this question with the majority identifying resource issues such as more time for consultations, translations and community education being the main suggestions. This was closely followed by information which specifically refers to translated information, information in various forms and community education, then interpreter services, such as family members being used as interpreters. Education and training of staff and families and understanding cultural background was also raised.

Questions two, three and four explored accessing an interpreter for interviews and issues associated with this, if participants felt they need further support screening for family domestic violence (FDV) or if this process could be improved, and if participants or their staff need additional support or training for booking in a RMW. Collectively, there were 78 responses to this question with participants identifying the recurring themes of interpreter services and difficulty with phone interpreters, resources and language specifically ANC sessions, continuity of care, understanding cultural background and presence of family members and more time and support.

Question five identified that RMW have often experienced some form of abuse and trauma. Participants were then asked “how would you identify, discuss and manage this issue” (AHS & OPH only). This question was initiated by a Senior Social Worker at AHS and highlighted the additional needs of this especially vulnerable group and increased need for compassion and assistance through professional support and access to appropriate resources. There were nine responses to this question with resources being identified as the main theme. This included continuity of care and continuity of care/r with the midwife and the need for psychosocial support.

Sample of comments

“Discussing information about contraception at booking (laying foundation for culturally sensitive way) and continues on throughout pregnancy, birth to child health to school nurse.” – KEMH

“Need an interpreter present rather than on the phone when doing booking in and follow up visits.” – AHS

“More time necessary for the whole interview session – double normal time would be appropriate.” – AHS

“Most interpreter services are very good and have improved over last 10 years.” – AHS

“Some interpreters are active members within their communities/ethnic groups here in Perth. Patients often don’t feel comfortable with these people as their interpreters as the client often doesn’t understand ‘confidentiality’ and wary that interpreter will discuss them with community members.” – OPH

4.1.4 Pregnancy (> 20 weeks antenatal care)

There were 102 comments received around antenatal care after 20 weeks gestation. Lack of time and need for team approach including midwives, allied health and interpreters were repeatedly raised as issues. This is also usually the first contact (through referral) that RMW may have with hospitals/agency as beginning of antenatal care. Some of the solutions included use of webinar recordings accessible remotely or whilst waiting for antenatal appointment.

Question one explored the pressing issues faced when working with RMW and families. There were 45 responses to this question with resources being identified as the main theme. This can be further explored in relation to translating of information, continuity of care, updated language and website in different languages and more time for consultations.

Other recurring themes included information specifically related to translated information, interpreter services and understanding of cultural backgrounds.

Question two and three went on to explore confidence of participants working with RMW and families and resources that may assist with this. There were 57 responses, again with resources, barriers to care, education and training or staff and lack of cultural knowledge all specifically discussed.

Sample of comments

"No written information regarding "premature" deliveries available in other languages" – KEMH

"Newly arrived women face issues around: transport to appointments, making appointments, understanding letters they receive; if attending pathology for tests – no interpreter service provided. Need case/social worker to help them navigate" – KEMH

"Interpreter regular/on site face to face – advantage is knowledge gained about different medical conditions - invaluable i.e. gestational diabetes and diet." – KEMH

"Establishing rapport and then educating from that base needs time" – AHS

"Lack of continuity of care is an obstacle" – AHS

"What about webinar recordings of antenatal classes e.g. run with an interpreter so they can be shown to or accessed by RMW either remotely (from home) or when visiting and waiting for antenatal appointment" – AHS

"Communicating expectations e.g. visiting partners staying" – AHS

"More information on emerging cultural groups" – OPH

"Complexity of issues/multiple issues – need for "core staff" when dealing with RMW in specific areas" – AHS

"Care in crisis situation what is appropriate/not appropriate? – OPH

4.1.5 Labour/birth

There were 94 comments relating to labour and birth. Recurring themes looked at interpreter issues, availability of resources and technology and continuity of care.

Question one specifically asked “what pressing issues do you face when working with RMW during labour/birth?” Question two explored the interpreter issues and asked participants for suggestions for working with interpreters during labour/birth.

There were 55 comments identified. These included but were not limited to availability and resources and issues with interpreters, specifically mentioning access, specific languages, female interpreter and suggestions to improve the use of this service needed at this crucial time for women, families and staff including continuity of care.

There were 39 issues related to working with RMW during labour raised. The major themes included understanding of cultural background, information and resources, psychosocial care and use of family members as interpreters.

Sample of comments

“When am I going to have time to upskill…PD already required plus mandatory training on top. No time given for mandatory training” – KEMH

“Central website of information for health providers” – KEMH

“Interpreters not available 24/7 – need them more than once for different stages of labour or need them for longer periods.” – AHS

“Difficult to get a female interpreter or any interpreter” – AHS

“Consider developing group of ‘Women’s Health Interpreters’ in the most common languages who have role in service rather than booking via general interpreting service (possibly cheaper!!!) – AHS

“Situations change very quickly, no time to use interpreter” – OPH

“Women don’t want interpreter as a known person in their community (afraid of gossip) – OPH

4.1.6 Post natal care

In relation to postnatal care, 124 comments were received. Question one explored how we can best equip RMW and families while they are in hospital. The 66 responses highlighted a variety of themes including information specific to translator and information in different forms, resources specific to use of technology, use of non-government organisations (NGOs), culturally appropriate services and health services based in the community. Importantly, issues such as not using substitutes for interpreters, understanding cultural background and psychosocial support to empower women were also identified.

Sample of comments

"Education channel that already exists to have 'translation' or subtitles in a variety of languages → could be available on iPad/tablet and HIRS" – KEMH

"Using "app" based smart phone/tablet translation service for "routine" enquiries – on the ward" – KEMH

"Allocation of midwives/nurses time doubled when RMW on ward (factored into patient ratios better)" – AHS

"Intranet/internet access to information – normal, routine, procedures in other languages" – AHS

"Printed resources in own languages with lots of pictures for those who do not read, postnatal women do not retain much of what we tell them initially." – OPH

Question two asked participants to identify what issues you are aware of that RMW families face when leaving the hospital environment? The 58 responses highlighted a variety of themes, including but not limited to translator information, psychosocial support and better links for those in detention, resources including continuity of care, education and training for RMW and families and barriers to care including transport and accommodation services.

Sample of comments

"Expectations of RMW and families that services are provided/services are free" – KEMH

"Local services available to them – written and translated information, frequency of expected child health nurse visits, GP check- up, phone numbers etc." – OPH

"RMW need explanation of what a prescription form is (e.g. contraception pill, how to fill prescription, what 'repeats' are and why she should keep them." – KEMH

"Lack of follow up" – AHS

"Community isolation" – AHS

4.1.7 Questions specific to AHS and OPH only

Two questions were initiated by the Senior Social Worker at AHS to address two specific issues that required discussion and received the following feedback: The first asked participants, "how confident are you in identifying RMW who have experienced female genital mutation (FGM) and do you feel confident discussing the Australian legal perspective of FGM with RMW?"

FGM specific (AHS & OPH)

"Need more education in this area – e.g. how to approach the question as a midwife, social worker etc." – AHS

"Prompts to ask the question – but only once." – AHS

"Terminology – culturally appropriate."- OPH

"More education on clinical pathways in identifying FGM e.g. 'As per policy should be referred to social worker" – AHS

"From a cultural perspective it may not be appropriate for a male to have this discussion with a female (i.e. can be shameful to the woman)" – OPH

"Confident to ask the question about her experience, but very difficult to explain Australian legal perspectives without seeming to pass judgement on culture" – OPH

The second asked if "women from different cultural backgrounds often have strong feelings regarding Caesarean birth. Do you feel that enough education is provided prior to birth about why a caesarean may be required as opposed to a natural birth?"

Caesarean specific (AHS & OPH)

"More education prior to birth" – AHS

"More information and counselling risks of deciding caesarean" – AHS

"More continuity of care will streamline information through intrapartum care" – AHS

"No and we are not obtaining informed consent as women in emergencies are being rushed into decisions they don't understand. If they were given antenatal translated information on all birth options they would understand non-elective lower segment caesarean section (NELUSC) more." – OPH

"Explore the reason for fear (e.g. in some countries you go to theatre, you often don't survive) and then explain why it is sometimes necessary and can be very safe option here." – OPH

Collective comments from all of the stakeholder workshops can be seen in Appendix 3.

5. Evaluation of workshops

Participants were thanked and an opportunity for additional comments, feedback and suggestions regarding the workshop was disseminated via email.

There were only 8 feedback forms received from the 85 participants that attended the workshops. An example of the Evaluation Form is provided in Appendix 4.

Based on feedback received, respondents indicated that they were able to participate in the workshop, their attendance at the workshop was a valuable use of time and that their contribution was valued. The majority of those who responded said they were very satisfied with the structure of the workshop and for the opportunity to share experiences and ideas.

Participants valued the networking opportunity to stimulate ideas working together in a non-threatening informal way. They valued the collaborative effort between agencies as a start of initial conversation that focused on RMW's health, not just on care during labour and birth. They also valued the opportunity to see the world from the women's perspective whilst also seeing a range of issues and possible solutions.

6. Next steps

Presently the WNHN are working collaboratively with the KEMH library to improve access to existing interpreted language documents for non-government agencies. The high participation at these three workshops is a strong indicator that improving the maternity experience and outcomes for RMW and families by strengthening and creating relationships within Health and with non-government organisations is a shared priority.

Subsequent to the workshops, the following has been identified as possible next steps:

- A consolidated report from the three workshops
- The consolidated report from all workshops to be circulated to members of the RMWWG and any other subsequent groups guided by the Continuity of Care working group
- The Continuity of Care working party will reconvene in near future to look at outcomes and priorities from the group

Further information can be sought through Health Policy by emailing healthpolicy@health.wa.gov.au.

7. Recommendations

The RMWG reconvened to discuss the findings from the workshop and develop recommendations for further action. The five recommendations were discussed with the Continuity of Care working group to propose to the Executive Advisory Group of the WNHN for further consideration in 2015.

1. Consumer engagement to determine model of service delivery.
   Consumer workshop where RMW in the community are involved in shaping culturally appropriate maternity services. The workshop format could include asking women to review the themes from the maternity services workshops and seek validation; ask questions in

relation to barriers to care, experience of care provided in the maternity setting and whether care was culturally appropriate
2. Review of interpreter services including: accessibility/efficiency and organisation of interpreter services and the mode of delivery of the identified services, availability of written information and new technology for one on one patient care, a snap shot of bilingual health professionals working in WA, and their willingness to participate in possible training opportunities
3. Develop a toolkit of resources for health professionals to deliver timely, safe, quality and competent care for RMW. Inclusive of mapping of GP's services that offer language specific services, mapping of services providing women's health care from a psychosocial perspective and establish care pathways with these services for example, link with the language service at Royal Perth Hospital
4. Disseminate the report to workshop participants.
5. Activity Based Funding recognises the increased time and resources required when delivering maternity services to culturally and linguistically diverse women. To apply the relevant ABF pricing group to propose the additional time required be included

8. References

1-5

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9. Appendices

Appendix 1: Sample of flyer from Osborne Park Hospital workshop

Government of Western Australia
Department of Health

Womens and Newborns Health Network

Invites you to a workshop

Improving Maternal Care for Refugee and Migrant Women in WA

Monday 10th March 2014

(Staff Dining Room – Osborne Park Hospital)

Workshop 2:00pm – 3:30pm

Afternoon tea and light refreshments will be available

The **Womens and Newborns Health Network** is committed to helping improve maternal and child health outcomes in WA.

The Continuity of Care Working Group is working towards developing continuity of care models based on improving access and choice of maternal care to meet the diverse needs of women and their families in WA.

Who should attend: The workshop is open to ALL staff (clinical and non-clinical) and other health workers and organisations that support and assist refugee and migrant women and families (not just through the maternal journey).

Objective: The objective of this workshop is to enhance the WA Health experience for Refugee and Migrant women and families.



Delivering a **Healthy WA**

Appendix 2: Sample Program – Osborne Park Hospital

Womens and Newborns Health Network

Maternity Care Workshops August 2013 – March 2014 (Refugee and Migrant Women)

King Edward Memorial Hospital, Armadale Health Service & Osborne Park Hospital

Time	Sample Program	Osborne Park Hospital
2.00pm – 2.05pm	Registration and coffee	
2.05pm – 2.10pm	Introduction and Acknowledgement to country	Janet Hornbuckle/ Graeme Boardley
2.10pm – 2.15pm	Purpose of the workshop	Janet Hornbuckle/ Graeme Boardley
2.15pm – 2.25pm	Poster Presentation	Christine Rowcliffe
2.25pm – 3.25pm	Mapping Exercise • Optimal Pathway • What services/resources currently exist • Workforce needs to delivery maternal services • Education, Training and Resource needs • Barriers to care • Suggestions to improve service to RMW	All
3.25pm – 3.29pm	Wrap up, next steps	Janet Hornbuckle/ Graeme Boardley
3.30pm	Close	

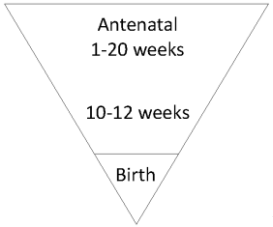
Appendix 3: Collective comments from stakeholder workshops

Key:

- KEMH
- ✓ KEMH second session
- ○ AHS
- – OPH

Preconception	
What information isn't currently given that RMW could be directed to, to help them before conceiving? i.e. services, choices etc.	• What community resources are available for RMW? • Preconception counselling – high risk pregnancies (KEMH). – pre-existing conditions (access from general hospital) • RM midwifery coordinator? Triage → services in KEMH • Info about the WA Health system • Central medical migrant centre (possibly mobile) • Social media – to advertise resources • Like "STREET DOCTOR" → MOBILE MIGRANT/REGUFEE "CLINIC" • Visit hospitals/hospital "open days" (similar to antenatal tours – link with Harmony Week or Refugee Week • Provide info about "midwives" and services provided at community events (service providers engage/link with communities) • Contraception (as part of orientation to Australia) ✓✓ • Access to improve general health literacy/assistance in navigating health services • Timely access for women with history of torture and trauma to appropriate counselling opportunities • Complex previous pregnancy → refer • Preconception counselling clinic KEMH • Cost – who should advise? ○ Orientation/education of Australian health system and processes ○ Language education ○ Information available through work companies providing visas✓✓✓ ○ Drug and alcohol support services✓✓✓ ○ Contraception ✓✓✓✓✓ ○ Longer time frame for booking in ○ Pre-conception health✓✓✓✓

	○ Interpreter based discussion of services✓✓✓✓✓✓✓ ○ Education and support – domestic violence – how to approach the question ✓✓✓ ○ Link in with existing community for support/info ✓ ○ Multilingual resources both in paper form and on-line (easily accessible, clear) - Information on STI's, health and nutrition etc... – Describe differences in expectations of health service, e.g. frequent antenatal appointments, blood tests and ultrasounds and why they are needed – informed consent.✓✓✓✓ – Utilise Skype, video consults with interpreters – Audio and video files linked to info sheets (also for sight impaired)✓ – Information/resources in pictures/diagrams✓✓ – Need more refugee interpreter friendly GPs other health services – How to deal with opportunity to make active choices in own care – How to deal with isolation – Engage relevant support groups to visit – Find out what community wants – engage leaders✓✓
Pregnancy <20 weeks	
What information/resources can RMW be directed to, to help them make informed decisions?	• RM – dedicated team or ANC w/ interpreters booked • Develop a WA website w/ details on how, where, when to access info and services • Available resources in the community ✓ • Linking with/of services ✓ • Access to interpreter service in time when it counts ✓✓ • Communication of available resources – social media ✓ • Websites links to translated material/info • Meeting basic needs first (egg housing) • Nutrition info in pregnancy in different languages w/ visuals important egg Dietary guidelines in pregnancy pamphlet ○ Refer to Community Mid Refugee support program ✓✓ ○ Refer to social work – more comprehensive history✓✓ ○ If FGM, refer to female specialist obstetrician ✓✓✓✓✓✓✓ ○ Educate church staff of resources available for women✓ ○ Encourage more consideration for FGM reversal antenatally. ✓✓✓ – Translated information sheets on pregnancy education, diet, frequency of visits, ultrasounds, medications (vitamin D),

	blood tests, which ones and why✓✓ – Community groups, information sessions re maternity care, expectations care options – Why induction of labour (IOL) at 40+10 weeks - explain accurate dating of pregnancies.
Are you happy with the information provided by GPs to refugee and migrant families for book in?	• Need info re AMBULANCE FUND (to avoid excessive bills) • GP's information just a formality for booking! ✓ • GPs or government funded to employ midwives from hospital group practice to get women early and provide appropriate info early to ↓ complications, misunderstandings • GP referrals – need more information in referrals – often stretching info • GP services and medical practices – interpreter services awareness/availability needs to be mandatory – or they fail accreditation • Educate GPs to refer • Team visiting GPs monthly or more to give info and refer to other resources ○ Some GPs use interpreters – rushed limited information ○ Many GPs don't use interpreters and the referrals into ANC really bad ✓✓ ○ Information not pitched at appropriate level of understanding i.e. medical language used ✓✓ ○ FSH – set up specific service to provide care – draw on KEMH service experience: ○ group antenatal classes/appt common language ○ Midwifery Group Practice (with specific focus on RMW ○ Easily accessible resources ○ Links to community resources – No, not detailed information – GPs sometimes don't have the experience – A dedicated migrant and refugee antenatal clinic ✓✓✓✓✓✓✓✓
What would make your experience better when a RMW is referred to hospital (KEMH/AHS/OPH) site?	 • ← Invert pyramid of care • Early attendance to hospital – plan and discuss hospital visits – pregnancy before 20 weeks • Specialised triage midwife for RMW • Interpreters on staff ✓✓✓

	• Update AN shared care guidelines to include what RMW need ○ Longer consultation times ✓✓✓✓ ○ Female GPs ✓✓✓ ○ Continuity of care ○ Refugee clinic✓✓✓ ○ More social work input ○ Background information about the woman i.e. country of birth, specific language etc. – More time and access to literature in other languages
Pregnancy >20 weeks	
Are you confident working with women/families from migrant/refugee background?	○ Establishing rapport and then educating from that base needs time✓ ○ Need more cultural information✓✓✓ ○ Don't know enough about them e.g. past, cultural needs/expectations✓ ○ Lack of continuity of care is an obstacle – Sometimes – Becoming more confident through experience – Yes, it also depends from each health professional's experience
If not, what resources/information do you need to help you?	• No written info regarding "premmie" deliveries available in other languages! (to my knowledge) • I find it incredibly difficult to communicate with women via phone translation • Difficulty with access to in person interpreter service – due to limited numbers for certain dialects/languages • Resources as in printed ones in different subject and language • Proper line of contact w/ these women • Maybe two speaker phones in each ward/unit • Website for different language – sign posters not all staff aware of this website/posters • Language services policy – everyone needs to be aware of this • Language policy WNHS to be updated • In-service by Charlie Anderson • Info/letters sent out available in other languages • Interpreter regular/on site face to face – advantage is knowledge gained about different medical conditions is invaluable egg gestational diabetes and diet • Resource developed at KEMH dieticians Gestational Diabetes and diet – PowerPoint presentation with pictures to

	explain GD – assists both interpreter/clinician and patient – i.e. visuals are valuable teaching tools for everyone! ○ Extra time ○ Identify interpreter needs before they attend✓ ○ On line resource – guidelines ○ What to do after hours referring? ○ More information on background ○ Specific refugee clinic days ○ Continuity of care✓✓✓✓ ○ Client based literature translated information e.g. vitamin K, new born screening etc. ✓✓✓ ○ General cultural information about main RMW groups – what should we as health providers be aware of, key issues ✓ – More information on emerging cultural groups – Translated consent and informed choice sheets. AN for epidurals and L/B's procedures – Quality of translators variable – Cultural norms re pregnancy/birth – what is considered the "norm" in their country/culture? – Need more time allocated to the patient.
What pressing issues do you face when working with RMW and families?	• Physical aches and pains rather than identifying depression and anxiety – group/body work to provide support • All staff to be made aware of PN support groups – MIRRABOOKA? South of the river? • Newly arrived women face issues around: transport to appointments; making appts; understanding letters they receive; if attending pathology for tests – no interpreter service provided. Need a case worker/social worker to help them • Post natal education to be commenced on day 1 onward – not to be left for day 5! • Info on costs available and alternatives i.e. bulk billing GPs • Funds available in the community for specific nutritional products we suggest • Dedicated case managers for each patient would be good ○ Communication breakdown – interpreter needs and rapport✓✓ ○ Extra time for communication✓✓ ○ Communicating expectations, visiting partners staying etc.✓✓ ○ Immigration/visa issues ○ Lack of continuity✓✓ ○ Complexity of issues/multiple issues – need for 'core staff' when dealing with RMW in specific areas – Care in crisis situations → what is appropriate/not appropriate? – Time management✓

	– Late pregnancy – educated understanding by caregiver; RMO not always best to educate/inform these women; Women from own group best suited to deliver this information alongside experienced midwife – Need longer appointment for interpreters sometimes e.g. at times one interpreter booked for several patients who all need to see several team members.
Booking in	
Do you know how to access an interpreter for interviews? Interpreter issues, suggestions, i.e. specific language days?	• Can't get onsite interpreter need for 'skilling training'. Over the phone no good • General info in one info session in language w/an interpreter • Assign cultural mediator from beginning of journey • Discussing information about contraception at booking (laying foundations for culturally sensitive way) and continues on throughout pregnancy, birth to child health to school nurse • Have triage midwife then antenatal clinics by language w/ time • Interpreters in small community face to face no appropriate • Training and recruiting new interpreters in emerging languages ○ Need an interpreter present rather than on the phone when doing booking and follow up visits✓✓ ○ Telephone interpreter number is widely available in all clinical areas ✓✓ ○ Time is major issue ○ Interpreter sometimes doesn't understand medical terms✓ ○ Most interpreter services are very good and have improved over last 10 years✓✓ ○ More female interpreters – often only have access to males and this may not be culturally acceptable/appropriate – Done by clerical staff – but depends on GP communicating need for interpreter – Interpreters not always available – Asked to justify cost – Perhaps info sessions/mini antenatal classes as well as specific language clinic sessions✓ – Some interpreters are active members within their communities/ethnic groups here in Perth. Patients often don't feel comfortable with these people as their interpreters as the client often does not understand "confidentiality" and wary that the interpreter will discuss them with other community members
What issues do you see RMW facing at booking in?	• In booking no one asked about FGM, so when a woman presented in early labour it was very difficult for midwife, husband and woman • So "standard" bloods/ultrasound/discussion may take much longer • Allowing more time for booking visit. 45 mins normal, need to allow 1-2 hours esp. w/ an interpreter. Closed room for privacy and to minimise distraction; noise

	• Midwifery/social work input into pregnancy as GP may only be monitoring physical health. Team approach needed including midwifery, social work, clinic psych services, etc. • Information sheets/translated picture books/voice recording/iPad (nice if in language) esp for procedures requiring informed consent e.g. induction of labour • GP not using interpreter to explore issues/to explain procedures • Be aware of poor physical health esp amongst refugee women so allow more time for booking visits • Need for using female interpreters not using male interpreters • When family members are used as interpreters – is this the woman's choice? Can an interpreter be used at least once? • Male not allowing/facilitating info, attendance to appts, info sessions etc. – so important to do community based stuff • More outreach (doing booking in at home visit) • Community education on health pregnancy, health literacy (anatomy_ so appts are understood as to why important (Very important ✓✓) • English classes more access and longer time to learn English • Resource topic by language available on database – 9340 1100 M-F 9-12 & 1-3 – women's and newborn health library • Lack of transport and lack of knowledge about how to access, bus, train, etc. – home visits would help • Asking about home birth when booking and facilitating if yes – helps with continuity of care • All staff in organisation need to be aware of and have access to ways to assist RM women and families attending KEMH – Frontline staff, patient care assistance • Women not knowing about pre-natal testing e.g. for Downs syndrome. • Education for staff on how to screen e.g. DV – GP/ nurse practitioner. Handle difficult male partner who says they will interpret for wife • Better screening at booking in- not just because migrant/refugee • For social work short staffed (80% of social work is now child protection). Issues w/: FGM, DV, homelessness, mental health • Be aware woman may speak English fairly well to very but need vocabulary on common issues e.g. itch, symptoms, anatomy, names, cervix – info sheets or booklets • Women may not be aware of costs or that the hospital services covered by Medicare. Needs to be explicitly stated so women will access medical care more frequently. • Early booking at 10-12 weeks so organise/plan pregnancy early intervention to facilitate services provided • Differentiate between services needed for these women: housing, psych issues, FDV, financial help, FGM, lack of family support

	• SOP standard operation procedure on flow chart for RMW in ANC, wards, SW • Shared information between hospitals and women. Staff to be aware health records can be accessed on ICM • More resources to take home CDs, DVDs, pens, tablet etc. – on everything ○ Time allocated✓✓✓✓ ○ Husband being present and insisting on interpreting✓✓✓✓✓✓✓ ○ Privacy for women✓ ○ Complexity of their problems and understanding of these complexities by midwives. – Education pamphlets not available in all other languages✓ – Handheld mobile medical notes in translated languages – Pictorial info for women who are illiterate in their own language✓
Do you (or your staff) need additional support/training for booking in a RMW i.e. more time to be allocated for RMW booking in process	○ Confident to book in, but need more support and time✓ ○ More time is necessary for the whole interview session – double normal time would be appropriate✓✓✓✓✓✓✓ ○ Access to cultural funding under ABF for complex/long antenatal appointments so they can be longer – May need double booking appointment as this process takes longer – Longer booking appointment for interpreters – Sometimes interpreter booked for several patients at same appointment time.
RMW have often experienced some form of abuse/trauma. How would you identify, discuss and manage this issue?	○ Need to develop rapport with woman first to develop sense of trust to discuss issue ○ Continuity of care with midwife ○ Home visit? ○ Is our idea of abuse recognised by RMW? ○ Do this at time of longer booking in interview ✓ – Continuity of care giver – ask at later appointment when trust gained✓ – Not at booking in bur during the time a medical history is discussed – very personal and requires the trust and confidence of the women – can be quite shameful for the woman✓ – Refer to specialist agencies i.e. ASETTS
Do you need further support screening for FDV or can this process be improved?	• Maybe a protocol of hospital that an occasion during antenatal care, woman on her own to ask about DV etc. – be careful but she may not come • We have tried to be so inclusive that it's difficult to see woman on own • Question sheet is very long, too much info on one page. Often husband is present. Doing in toilet. ○ Not able to support women when domineering husband/partner present e.g. asking women if any DV while they are alone in toilet! ✓✓✓✓

	○ How do we increase access to social work services whilst they are already under-resourced? ○ More training – Ward 1 – no privacy when asking questions for FDV on ward for CMP form – RMW not understanding that FDV is NOT OK in Australia even if culturally acceptable to them. ✓ – FDV not done at booking in (e.g. partner there) needs to be attempted again – not left✓ – Continuity of care where RMW will gain trust towards the health system and the person should be the standard for these women. ▪ One midwife should be able to follow the same woman through pregnancy, birth (as one of the hospital staff) and postnatally. ▪ This midwife will be on-call for this woman when at term. ▪ The trust this woman will have will allow discussion of difficult issues and barriers will be overcome. ▪ This midwife caring for this woman will have to have the support of the hospital staff. She will be able to maintain in partnership with the woman and with the hospital.

Appendix 4: Evaluation form

Government of **Western Australia**
Department of **Health**

WOMENS AND NEWBORNS HEALTH NETWORK
MATERNAL CARE WORKSHOP (REFUGEE AND MIGRANT WOMEN)
MONDAY, 10TH MARCH 2014
EVALUATION FORM

To assist with the development of future events, please take a few minutes to complete the following questionnaire.

1. **Please rate the Refugee and Migrant Maternal Care Workshop by selecting the box that corresponds to your level of agreement for each statement below.**

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1.1 I feel that I was able to contribute to the Workshop	1 ◯	2 ◯	3 ◯	4 ◯	5 ◯
1.2 I feel that my contribution to the workshop was valued	1 ◯	2 ◯	3 ◯	4 ◯	5 ◯
1.3 Attendance at the workshop was a valuable use of my time	1 ◯	2 ◯	3 ◯	4 ◯	5 ◯

2. **Please select the box that represents the workshop structure to your level of satisfaction**

	Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied
2.1 The structure of the agenda for workshop	1 ◯	2 ◯	3 ◯	4 ◯	5 ◯

3. **Please rate the venue for Refugee and Migrant Maternal Care Workshop**

	Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied
3.1 The facilities (rooms/toilets etc) at the venue	1 ◯	2 ◯	3 ◯	4 ◯	5 ◯
3.2 The access (parking/ transport) to the venue	1 ◯	2 ◯	3 ◯	4 ◯	5 ◯
3.3 The catering for the event	1 ◯	2 ◯	3 ◯	4 ◯	5 ◯

4. What did you value most about the Refugee and Migrant Maternal Care Workshop?

5. What did you value least about the Refugee and Migrant Maternal Care Workshop?

Thank you for your assistance, your feedback is appreciated.

Submit

This document can be made available in alternative formats on request for a person with a disability.