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# Women from migrant and refugee backgrounds' perceptions and experiences of the continuum of maternity care in Australia: A qualitative evidence synthesis

Hannah Billett*, Martha Vazquez Corona, Meghan A. Bohren

*Gender and Women's Health Unit, Centre for Health Equity, School of Population and Global Health, University of Melbourne, Carlton, VIC, Australia*

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ABSTRACT

*Background:* Women who were born overseas represent an increasing proportion of women giving birth in the Australian healthcare system.
*Problem:* Women from migrant and refugee backgrounds have an increased risk of poor pregnancy and birth outcomes, including experiences of care.
*Aim:* To understand how women from migrant and refugee backgrounds perceive and experience the continuum of maternity care (pregnancy, birth, postnatal) in Australia.
*Methodology:* We conducted a qualitative evidence synthesis, searching MEDLINE, CIHAHL, and PsycInfo for studies published from inception to 23/05/2020. We included studies that used qualitative methods for data collection and analysis, that explored migrant/refugee women's experiences or perceptions of maternity care in Australia. We used a thematic synthesis approach, assessed the methodological limitations of included studies, and used GRADE-CERQual to assess confidence in qualitative review findings.
*Results:* 27 studies met the inclusion criteria, representing women in Australia from 42 countries. Key themes were developed into 24 findings, including access to interpreters, structural barriers to service utilisation, experiences with health workers, trust in healthcare, experiences of discrimination, preferences for care, and conflicts between traditional cultural expectations and the Australian medical system.
*Conclusion:* This review can help policy makers and organisations who provide care to women from migrant and refugee backgrounds to improve their experiences with maternity care. It highlights factors linked to negative experiences of care as well as factors associated with more positive experiences to identify potential changes to practices and policies that would be well received by this population.


Statement of significance

**Problem or issue**
Women from migrant and refugee backgrounds represent an increasing proportion of women giving birth in Australia.
**What is already known**
Overseas-born women have an increased risk of poor pregnancy outcomes and services may not be adequately serving them.
**What this paper adds**
A rigorous synthesis of existing studies. An analysis of patterns concerning the experiences and perceptions of women from migrant and refugee backgrounds across the continuum of maternal healthcare.

## Background

### Context

Due to trends in globalisation and migration, an increasing proportion of women giving birth in high-income countries are born overseas themselves [1]. In 2017, women born in non-English speaking countries made up 27% of women giving birth in Australia, up from 18% in 2007 [2]. Australia's migration patterns are changing, with the number of migrants from South and Central Asia almost doubling between 2013 and 2018, while migration

* Corresponding author at: 207 Bouverie St, Carlton, VIC 3053, Australia.
*E-mail address:* hg.billett@gmail.com (H. Billett).
@meghanbohren (M.A. Bohren)

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from the Western Europe and Oceania regions decreasing by around 25% [3]. The rates of refugee resettlements in Australia from Africa remain consistent but have been overtaken by conflict-impacted countries in the Middle East [4]. These trends are significant because migrant populations in Australia experience barriers to accessing healthcare, which are most challenging for migrant groups not fluent in English [5]. Since more women from non-English speaking backgrounds are giving birth in Australia, this represents an important public health issue.

Pregnancy and childbirth are complex because they are both biomedical yet also hold deep cultural significance for women and their families [6]. How women perceive care they experience during this time is informed by their cultural background and conceptions of motherhood [7]. Cultural values influence what women understand as their role as a mother, their preferences for pregnancy and childbirth, and what is appropriate behaviour for health workers, their family members and themselves throughout pregnancy and birth [8]. Given the sizable proportion of women giving birth in Australia who were born overseas, it is important that the Australian healthcare system and its policies are responsive to the needs of these women. This is because it is not only ethical for health workers and authorities to ensure that healthcare is culturally competent, but it is necessary to build trust with migrant populations and ensure they will access appropriate care when needed to prevent poor health outcomes [9]. It is critical we improve understanding of how this population perceives and experiences the continuum of maternity care in Australia [10].

*How this review supplements what is already known in this area*

Women from migrant and refugee backgrounds are more likely to have additional challenges during the maternity period compared to Australian-born women, such as language barriers, isolation from culture and family, and discrimination when accessing services [11]. Migrant women have described the process of seeking maternity care in Australia as confusing and distressing [7,12], particularly when medical advice conflicts with traditional practices [13]. Women who are born in non-English speaking countries, particularly those from refugee backgrounds, are at higher risk of poor underlying health which can make maternal care more complex [14]. Further, there is evidence that migrant status is associated with an increased risk of poor maternal health outcomes, especially with regard to post-partum depression and intimate partner violence [1].

There are also disparities with regards to maternal health service utilisation. Women from non-English speaking countries are less likely to have an antenatal visit in the first trimester compared to Australian-born women [2]. A potentially related issue of concern is that migrant status is associated with a higher risk of having low birth weight babies even after being resettled for some time [14], suggesting that these inequities persist over time after resettlement. Female migrants from certain settings are also more likely to have undergone female genital mutilation or cutting (FGM/C) than the general population, which requires specialised management during childbirth [15]. Together, this suggests that women from migrant and refugee backgrounds are a population particularly susceptible to poor maternal health experiences and outcomes.

Primary qualitative studies exploring the experiences of women from refugee and migrant backgrounds giving birth in Australia have typically focused on specific communities, and are often limited to women from a specific country or region and currently residing in a particular geographical area of Australia. While this provides valuable cultural context and information for developing targeted interventions, it is challenging to draw broader conclusions about migrant and refugee women's experiences with maternity care in Australia and, therefore, to develop state-wide or national strategies. Mainstream health services in Australia cater to diverse communities so there is a need to understand the experiences of these populations more broadly.

*Why is it important to do this review?*

With women born outside Australia making up an increasing proportion of women giving birth in the Australian medical system [2], it is important to understand their experiences and perceptions of care. Memories associated with pregnancy and birth are often powerful and long lasting [16] and experiences can influence how women perceive and engage with health services going forward [13]. To our knowledge, no systematic reviews have focused solely on the experiences of women from refugee and migrant backgrounds who experience maternal health care in Australian. Policies, practices and attitudes related to both maternal health care and migrant and refugee communities differ between countries, so it is important to develop a comprehensive and specific understanding of the issue in the Australian context to identify avenues for improvement. Therefore, we have conducted a qualitative evidence synthesis (QES; systematic review of qualitative studies) to explore how women from migrant and refugee backgrounds perceive and experience the continuum of maternal health care, including pregnancy, birth and the first year postpartum, in Australia. This QES places migrant women's experiences as articulated in their own words at the heart of the analysis. While clinical data and statistics are useful for measuring some outcomes, qualitative data and analysis is best placed to develop an understanding of how women think and feel about the care they receive and how this impacts them on a personal level.

## Objectives

This QES aimed to understand how the continuum of maternal healthcare in Australia, through pregnancy, birth and the first year with a new baby, is perceived and experienced by women who were born outside Australia. It had the following objectives:

1 To describe, assess and synthesise qualitative evidence regarding the experiences and perspectives of migrant and refugee women about pregnancy, birth and the postnatal period in the Australian context;
2 To explore how the findings of this QES can be used to inform policy and strategy and clinical practice.

## Method

This QES was conducted according to the Cochrane Effective Practice and Organisation of Care template [17] and reported according to the ENTREQ (Enhancing transparency in reporting the synthesis of qualitative research) statement (see Appendix 1) [18].

*Criteria for considering studies*

*Types of studies*

Studies were eligible for inclusion if they were published primary research that used qualitative methods for both data collection (e.g. interviews, focus groups and document analysis) and data analysis (e.g. thematic analysis, content analysis and grounded theory). Studies which analyse qualitative data using quantitative methods, (e.g. using descriptive statistics), were excluded. Mixed-methods studies were eligible for inclusion if it was possible to isolate the qualitative data. Studies were eligible for inclusion if they were in the published academic or grey literature.

*Topic of interest*

Studies were eligible for inclusion if they had a primary focus on women from migrant and refugee backgrounds and exploring their experiences and perceptions of maternity care in Australia. Types and stages of care encompassed in the continuum of maternal healthcare included: antenatal care, perinatal and childbirth care; and postnatal or postpartum care, up to 12 months after birth [12]. This includes care that occurs in public and private clinics and hospitals, as well as at home. We initially planned on including the pre-conception period and fertility or contraceptive services. However, during the search and screening processes it become clear that this would make too large a number of studies eligible for inclusion, and thus threaten the integrity of the analysis. While studies which included one or more participants who experienced health complications during pregnancy and birth were eligible for inclusion, studies that exclusively focused on issues such as diabetes were excluded as they were not focused on maternal health care. These exclusions are indicated in the PRISMA diagram (Fig. 1).

*Types of participants.* Studies were eligible for inclusion if their primary participants were women from migrant and refugee backgrounds residing in Australia. We focused on migrants who resettled in Australia after being born in another country regardless of the age that migration occurred or how long ago they arrived [10]. A refugee is defined as someone who meets the above conditions but also arrived in Australia under a humanitarian program after leaving their birth country due to conflict, natural disaster or other crisis situation [14].

*Search methods for identification of studies*

*Electronic searches.* Electronic searches were conducted in the Medline, CINAHL and PsycINFO databases on 23 May 2020. The search strategy for each database was developed based on the inclusion criteria and research objectives, and in consultation with a research librarian, and is available in Appendix 2.

*Searching other resources and grey literature.* We reviewed the reference lists of included studies in order to identify any additional qualitative studies relevant to this review and conducted a forward citation search of included studies in Google Scholar. We searched for grey literature using OpenGrey (www.opengrey.eu/) and The Grey Literature Report (www.greylit.org/). Inclusion criteria for grey literature was the same as for journal publications.

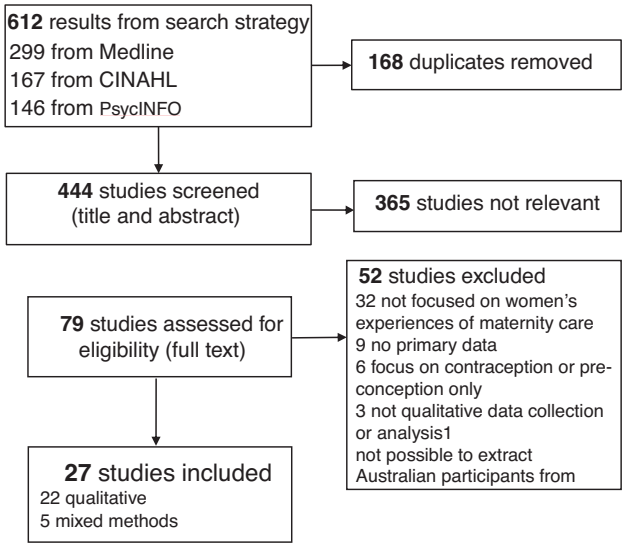


**Fig. 1.** PRISMA diagram depicting the flow of included studies from search strategy, exclusions and final inclusions.

*Selection of studies*

Two review authors (HB and MVC) independently assessed the titles and abstracts of the identified records using Covidence [19] to evaluate eligibility. We then retrieved the full text of all the papers identified as potentially relevant, and two review authors (HB and MVC) assessed these papers independently using Covidence. Any disagreements were resolved by discussion or by involving the third author (MAB).

*Data extraction*

Relevant data from each study was recorded in a data extraction form tailored for this QES. The data extraction was conducted by two authors (HB and MVC) and crosschecked for accuracy. Extracted data included:

- Descriptive information about the study objectives and the stage or stages of the maternal care continuum it focuses on;
- Descriptive details about the participants, including birth country;
- Descriptive information about the setting and context;
- Information about the study design; and
- Qualitative themes and findings identified by the authors and participant quotations.

*Assessing the methodological limitations of included studies*

Two review authors (HB and MVC) independently assessed each included study for methodological limitations using an adaptation of the Critical Appraisal Skills Programme (CASP) tool [20], which includes the following domains:

1 Was there a statement of the aims of the research?
2 Given the aim of the study, was a qualitative methodology appropriate?
3 Was the research design appropriate to address the aims of the research?
4 Was the recruitment strategy appropriate to the aims of the research?
5 Was the relationship between the researcher and participants adequately considered?
6 Have ethical issues been taken into consideration?
7 Was the data analysis sufficiently rigorous?
8 Were the findings supported by the evidence?
9 How valuable is the research?

The two authors conducting the assessment (HB and MVC) compared results and resolved any discrepancies through discussion or by involving the third author (MAB).

*Data management, analysis and synthesis*

This QES utilised a thematic synthesis approach to conducting a qualitative evidence synthesis as described by Thomas and Harden [21]. This method is an adaptation of thematic analysis, which is a common technique performed on primary qualitative data, and involves familiarisation with the data, coding the results of the primary studies, developing themes and using this to conceptualise further understanding and hypotheses [21].

**Table 1**
Summary of qualitative findings table and CERQUal assessments.

| # | Summary of review finding | Studies contributing to the review finding | CERQual assessment (confidence in the findings) | Explanation of CERQual assessment |
|---|---|---|---|---|
| Factors influencing communication and understanding | | | | |
| Language Barrier | | | | |
| 1 | Communication - Limited English proficiency made it challenging for women to communicate during appointments and hospital care as well as to receive maternal health education. This limited proficiency in turn contributed to distress and fear as women were unable to understand what was happening and how to request services. | Carolan and Cassar, 2007, Chu, 2005, Hoang et al., 2009, Liamputtong and Watson, 2006, Mohale et al., 2017, Murray et al., 2010, Niner et al., 2013, Owens et al., 2016, Renzaho and Oldroyd, 2014, Riggs et al., 2012, Riggs et al., 2017, Small et al., 1999, Stewart et al., 1998, Yelland et al., 2016, Stapleton et al., 2013 | Moderate confidence | No to very minor concerns on coherence, minor concerns on methodological limitations, minor concerns on relevance and minor concerns on adequacy. |
| 2 | Informed consent - The language barrier impeded some women's ability to give informed consent for treatment, as they did not understand what treatment they were going to receive or why it was recommended. | Liamputtong and Watson, 2006, Niner et al., 2013, Shafiei et al., 2012 | Low confidence | No to very minor concerns on coherence, minor concerns on methodological limitations, moderate concerns on relevance (all studies Victorian and urban; only South East Asia and Middle East represented in area of birth) and serious concerns on adequacy (3 of 27 studies included; 1 relatively thin, 1 relatively thick and 1 thick data). |
| 3 | Translated health resources - Translated health resources were often not made available to women who needed them either because they did not exist or women were not informed they had the option of reading information in their preferred language. | Correa-Velez and Ryan, 2012, Hoang et al., 2009, Riggs et al., 2012, Stewart et al., 1998 | Low confidence | No to very minor concerns on coherence, minor concerns on methodological limitations, minor concerns on relevance and serious concerns on adequacy (4 of 27 studies included; 1 thin, 1 relatively thick and 2 thick data). |
| 4 | Assertiveness - Women often experienced challenges in asserting their wishes and asking questions of staff because they were not proficient in English or thought it inappropriate to question health workers, who were viewed as authority figures. | Chu, 2005, Hoang et al., 2009, Liamputtong and Watson, 2006, Murray et al., 2010, Niner et al., 2013, Riggs et al., 2017, Shafiei et al., 2012, Small et al., 1999, Tsianakas and Liamputtong, 2002, Turkmani et al., 2020 | Moderate confidence | No to very minor concerns on coherence, minor concerns on methodological limitations, minor concerns on relevance and minor concerns on adequacy. |
| Interpreters | | | | |
| 5 | Value of interpreters - Women valued interpreters as they allowed women limited English proficiency to engage with health workers and to have greater input into their care. | Carolan and Cassar, 2007, Correa-Velez and Ryan, 2012, Joseph et al., 2019, Small et al., 1999, Yelland et al., 2016 | Low confidence | No to very minor concerns on coherence, minor concerns on relevance, moderate concerns on methodological limitations (study design, recruitment, reflexivity, ethics and data analysis) and serious concerns on adequacy (5 of 27 studies included; 2 thin and 3 relatively thick data). |
| 6 | Appropriate interpreters - When they were available, interpreting services are not always perceived as appropriate due to the demographics or dialect of the interpreter, or a general mistrust in the service. | Correa-Velez and Ryan, 2012, Mohale et al., 2017, Small et al., 1999, Yelland et al., 2016 | Low confidence | No to very minor concerns on coherence, minor concerns on relevance, moderate concerns on methodological limitations (study design, reflexivity, ethics and data analysis) and serious concerns on adequacy (4 of 27 studies included; 2 thin, 1 relatively thick data and 1 thick data). |
| 7 | Absence of interpreters - Despite their value, interpreters were frequently not present during appointments and hospital care. This absence often left women distressed and without agency, unable to communicate with their carers or understand the treatments they were receiving. | Carolan and Cassar, 2007, Correa-Velez and Ryan, 2012, Hoban and Liamputtong, 2013, Liamputtong and Watson, 2006, Murray et al., 2010, Niner et al., 2013, Riggs et al., 2012, Riggs et al., 2017, Shafiei et al., 2012, Small et al., 1999, Yelland et al., 2016 | Moderate confidence | No to very minor concerns on coherence, minor concerns on methodological limitations, minor concerns on relevance and minor concerns on adequacy. |
| 8 | Informal interpreters - In the absence of a professional interpreter, husbands and other family members often served as informal interpreters during appointments. The use of informal interpreters was comfortable and acceptable for some women but concerning to others about due to embarrassment over sharing sensitive health matters or the family member incompletely relaying information. | Hoban and Liamputtong, 2013, Murray et al., 2010, Owens et al., 2016, Riggs et al., 2017, Small et al., 1999, Yelland et al., 2016 | Moderate confidence | No to very minor concerns on coherence, minor concerns on methodological limitations, minor concerns on relevance and moderate concerns on adequacy (6 of 27 studies included; 1 thin, 1 relatively thin, 2 relatively thick and 2 thick data). |
| Factors influencing experiences of and satisfaction with care | | | | |
| Accessibility | | | | |
| 9 | Transport - Some women experienced transport-related barriers to accessing care due to an inability to drive or lack of access to a vehicle. | Hoban and Liamputtong, 2013, Murray et al., 2010, Owens et al., 2016, Riggs et al., 2017, Small et al., 1999, Yelland et al., 2016 | Low confidence | No to very minor concerns on coherence, minor concerns on methodological limitations, minor concerns on relevance and serious concerns on adequacy (5 of 27 studies included; 2 thin, 1 relatively thin, 1 relatively thick and 1 thick data). |
| 10 | Appointments - Some women found the practice of attending appointments to be challenging due to unfamiliar expectations around timeliness and long wait times. | Chu, 2005, Correa-Velez and Ryan, 2012, Mohale et al., 2017, Owens et al., 2016, Riggs et al., 2012, Shafiei et al., 2012, Stapleton et al., 2013 | Moderate confidence | No to very minor concerns on coherence, minor concerns on methodological limitations, minor concerns on relevance and moderate concerns on adequacy (5 of 27 studies included; 2 thin, 1 relatively thin, 1 relatively thick and 3 thick data). |

**Table 1** (*Continued*)

| # | Summary of review finding | Studies contributing to the review finding | CERQual assessment (confidence in the findings) | Explanation of CERQual assessment |
|---|---|---|---|---|
| Women's experiences of care | | | | |
| 11 | Specialist services - Women who had access to specialist clinics and services, such as an African women's clinic, a co-designed program for women from refugee backgrounds or dedicated maternal and child health centres, viewed these more favourably than mainstream services. These specialist services were appreciated due to understanding staff, appointment flexibility and a friendly atmosphere | Carolan and Cassar, 2007, Carolan and Cassar, 2010, Owens et al., 2016, Riggs et al., 2017 | Low confidence | No to very minor concerns on coherence, minor concerns on methodological limitations, minor concerns on relevance and serious concerns on adequacy (4 of 27 studies included; 1 relatively thin, 2 relatively thick and 1 thick data). |
| 12 | Continuity of carer - Women valued continuity of carer because of the ability to develop trusting relationships with health worker. Women who did not experience continuity of care lamented having to engage with unfamiliar health workers at each appointment. | Correa-Velez and Ryan, 2012, Mohale et al., 2017, Murray et al., 2010, Owens et al., 2016, Rao et al., 2019, Riggs et al., 2012, Riggs et al., 2017, Stapleton et al., 2013, Turkmani et al., 2020 | Moderate confidence | No to very minor concerns on coherence, minor concerns on methodological limitations, minor concerns on relevance and minor concerns on adequacy. |
| 13 | Time with health workers - Women sometimes felt they did not get sufficient time with health workers in mainstream healthcare settings. This prevented them from asking questions about their care, receiving additional information and being able to talk about their emotional wellbeing. | Carolan and Cassar, 2007, Carolan and Cassar, 2010, Murray et al., 2010, Owens et al., 2016, Shafiei et al., 2012, Shafiei et al., 2015 | Moderate confidence | No to very minor concerns on coherence, minor concerns on relevance, minor concerns on methodological limitations and moderate concerns on adequacy (6 of 27 studies included; 2 thick and 4 thin data). |
| Experience with health workers | | | | |
| 14 | Midwives and doctors - Midwives and nurses were generally viewed as kind and helpful by women. Midwives and nurses were sometimes contrasted favourably with doctors who were sometimes seen as rushed and less personable. | Carolan and Cassar, 2007, Carolan and Cassar, 2010, Murray et al., 2010, Owens et al., 2016, Shafiei et al., 2012, Shafiei et al., 2015 | Moderate Confidence | No to very minor concerns on coherence, minor concerns on methodological limitations, minor concerns on relevance and minor concerns on adequacy. |
| 15 | Social support - Migrating to Australia means that some women lacked the social support during pregnancy, birth and the post-partum period they might have expected in their home country. This made the relationship with between women and health workers more important. | Joseph et al., 2019, Owens et al., 2016, Rao et al., 2019, Stapleton et al., 2013 | Low confidence | No to very minor concerns on relevance, no to very minor relevance on coherence, minor concerns on methodological limitations and serious concerns on adequacy (4 of 27 studies included; 2 thin, 1 relatively thick and 1 thick data). |
| Trust | | | | |
| 16 | Trust in health workers - Health workers in Australia were trusted by some women, who viewed them as highly knowledgeable. However, others held concerns about their intentions. | Carolan and Cassar, 2007, Carolan and Cassar, 2010, Correa-Velez and Ryan, 2012, Liamputtong and Watson, 2006, Niner et al., 2013, Owens et al., 2016, Riggs et al., 2017, Rolls and Chamberlain, 2004, Shafiei et al., 2012, Tsianakas and Liamputtong, 2002, Turkmani et al., 2020, Joseph et al., 2019, Murray et al., 2010, Russo et al., 2015 | Moderate Confidence | No or very minor concerns on coherence, minor concerns on methodological limitations, minor concerns on relevance and minor concerns on adequacy. |
| 17 | Trust in medicine and technology - Some women expressed mistrust and scepticism towards modern Western medical technology and drugs due to concerns these interventions could be harmful to their babies. Meanwhile, others appreciated having access to more advanced medical care than would be available in their birth countries. | Carolan and Cassar, 2010, Correa-Velez and Ryan, 2012, Murray et al., 2010, Stewart et al., 1998, Tsianakas and Liamputtong, 2002, Niner et al., 2013, Rolls and Chamberlain, 2004, Russo et al., 2015, Shafiei et al., 2012 | Low confidence | No or very minor concerns on coherence, minor concerns on relevance, moderate concerns on methodological limitations (study design, ethics, reflexivity, analysis and evidence) and moderate concern on adequacy (9 of 27 studies included; 6 thin and 3 thick data). |
| Discrimination | | | | |
| 18 | Hostility and discrimination - Many women reported experiencing hostile treatment which was characterised by some as discrimination while others references a more vague sense of being unwelcome. | Carolan and Cassar, 2007, Carolan and Cassar, 2010, Chu, 2005, Murray et al., 2010, Niner et al., 2013, Riggs et al., 2017, Russo et al., 2015, Shafiei et al., 2012, Shafiei et al., 2015, Small et al., 1999, Stewart et al., 1998, Tsianakas and Liamputtong, 2002 | Moderate confidence | No or minor concerns on coherence, minor concerns on relevance, minor concerns on adequacy and moderate concerns on methodological limitations (study design, recruitment, ethics, reflexivity, analysis and evidence). |
| Navigating cultural crossroads | | | | |
| Preferences and expectations for care | | | | |
| 19 | Female health workers - Women from a broad range of cultural backgrounds expressed a strong preference for female health workers due to cultural beliefs about appropriate behaviour between men and women. Women who had male health workers often found the experience uncomfortable and distressing. | Murray et al., 2010, Owens et al., 2016, Russo et al., 2015, Shafiei et al., 2012, Shafiei et al., 2015, Stewart et al., 1998, Yelland et al., 2016 | Moderate confidence | No or very minor concerns on coherence, minor concerns on methodological limitations, minor concerns on relevance and moderate concerns on adequacy. |
| 20 | Pain relief - Many women held strong preferences for vaginal birth and traditional, non-pharmacological pain relief. This was because they perceived the pain associated with labour and vaginal birth to be an important element of their experience as women. | Carolan and Cassar, 2010, Mohale et al., 2017, Murray et al., 2010, Shafiei et al., 2012, Turkmani et al., 2020 | Low confidence | No to minor concerns on coherence, minor concerns on methodological limitations, minor concerns on relevance and serious concerns on adequacy (5 of 27 studies; 3 thick and 2 thin data) |

**Table 1** (*Continued*)

| # | Summary of review finding | Studies contributing to the review finding | CERQual assessment (confidence in the findings) | Explanation of CERQual assessment |
|---|---|---|---|---|
| 21 | Medical interventions - Women preferred to avoid medical interventions during the labour process, such as induction, augmentation and caesarean section, as much as possible because these were seen as largely unnecessary, even during extended labour. | Carolan and Cassar, 2010, Liamputtong and Watson, 2006, Murray et al., 2010, Shafiei et al., 2012, Stapleton et al., 2013, Turkmani et al., 2020 | Moderate confidence | No or very minor concerns on coherence, minor concerns on methodological limitations, minor concerns on relevance and moderate concerns on adequacy (6 of 27 studies included; 1 thin, 1 relatively thin, 2 relatively thick and 2 thick data). |
| 22 | Traditional practices - Most women wanted and expected to be able to maintain traditional practices related to pregnancy, birthing and post-partum, such as keeping themselves warm, limiting bathing and confinement, within the context of the Australian healthcare system. An inability to maintain these traditions was associated with sadness and anxiety. | Chu, 2005, Joseph et al., 2019, Liamputtong and Watson, 2006, Niner et al., 2013, Renzaho and Oldroyd, 2014, Russo et al., 2015, Small et al., 1999, Stewart et al., 1998, Turkmani et al., 2020 | High confidence | No or very minor concerns on coherence, minor concerns on methodological limitations, minor concerns on relevance and minor concerns on adequacy (9 of 27 studies included; 1 thin data, 1 relatively thin data and 7 thick data). |
| Dealing with conflicting beliefs and practices | | | | |
| 23 | Cultural conflict - Women frequently reported struggling with whether to comply with advice from Australian doctors and midwives, who were seen as knowledgeable professionals, that contradicted traditional cultural practices which were often passed on by respected older female relatives. Women reported having a deep appreciation for care that allowed them to combine both traditional and Australian biomedical approaches to maternal healthcare. | Carolan and Cassar, 2010, Chu, 2005, Hoang et al., 2009, Joseph et al., 2019, Liamputtong and Watson, 2006, Murray et al., 2010, Niner et al., 2013, Rao et al., 2019, Renzaho and Oldroyd, 2014, Russo et al., 2015, Small et al., 1999, Stapleton et al., 2013, Stewart et al., 1998 | Moderate confidence | No or very minor concerns on coherence, no or very minor concerns on adequacy, minor concerns on methodological limitations and minor concerns on relevance. |
| 24 | FGM/C - Women who have undergone FGM/C almost universally reported negative experiences with Australian health workers who they perceived as being surprised and unequipped to deal with their condition, making the women feel abnormal and anxious as a result. | Carolan and Cassar, 2007, Correa-Velez and Ryan, 2012, Murray et al., 2010, Stapleton et al., 2013, Turkmani et al., 2020 | Moderate confidence | No or very minor concerns on coherence, minor concerns on methodological limitations, minor concerns on relevance and moderate concerns on relevance (5 studies included; 3 thick and 2 thin data). |

We chose three high quality studies [8,16,22] that have a clear connection to the QES objectives to serve as the basis of our initial code list [23]. We proceeded to conduct line-by-line "free" coding to assist in the translation of concepts between studies and build up the code bank as more studies and themes are analysed [21]. We coded themes and sub-themes from original data (such as direct participant quotes) and instances when authors have summarised original data. This data was typically found in the results section. We did not code author comments in the discussion section. Some included studies also featured quotes and summarised data from health workers, but these were not extracted as the focus of this synthesis is on women's experiences from their own perspectives. Coding was conducted in NVivo [23]. All text assigned the same code was examined and a hierarchical tree structure of relationships between themes was created [21]. This was used to develop hypotheses about maternal care experiences and perceptions that go beyond the original findings of the included studies to develop new ideas [21].

*Assessing our confidence in the QES findings*

Two of the authors (HB and MVC) used the GRADE-CERQual (Confidence in the Evidence from Reviews of Qualitative research) approach to assess confidence in each review finding [17]. CERQual assesses confidence in the evidence, based on four key components.

1 Methodological limitations of included studies: the extent to which there are concerns about the design or conduct of the primary studies that contributed evidence to an individual review finding [24].
2 Coherence of the review finding: an assessment of how clear and cogent the fit is between the data from the primary studies and a review finding that synthesises those data. By cogent, we mean well supported or compelling [25].
3 Adequacy of the data contributing to a review finding: an overall determination of the degree of richness and quantity of data supporting a review finding [26].
4 Relevance of the included studies to the review question: the extent to which the body of evidence from the primary studies supporting a review finding is applicable to the context (perspective or population, phenomenon of interest, setting) specified in the review question [27].

After assessing each of the four components, we made a judgement about the overall confidence in the evidence supporting the review finding as high, moderate, low, or very low [28]. The final assessment was based on consensus among the authors. All findings started as high confidence and were graded down if there were important concerns regarding any of the CERQual components [29].

*Review author reflexivity*

The QES was conducted primarily as part of one author's (HB) Master of Public Health (MPH) research project. HB chose this topic after discovering limited maternal health policies to support women from migrant and refugee backgrounds at both governmental and organisational levels. As such, she comes to this QES with the assumption that the needs of this population are not adequately met and therefore need further exploration. This may have influenced her interpretation of the data, so the assistance of additional authors (MVC and MAB) was engaged. We discussed the importance of being aware of our biases and committed to regularly assess these throughout the process. Further comments on reflexivity are included in the results section.

## Results

The PRISMA flow diagram (Fig. 1) documents the search results and the process of screening and selecting studies for inclusion [29]. In total, 27 studies met the inclusion criteria and were included [6,8,12,13,16,22,30–50]. These studies took place between 1998 and 2020. Appendix 3 reports the characteristics of included studies.

Twenty two studies used qualitative methods only [6,8,12,13,16,22,30,31,33–41,46–50], typically interviews and focus group discussions. Five used mixed methods [32,42–45], typically qualitative interviews and surveys or clinical data. Included studies were assessed for methodological limitations using CASP [20]. Key concerns which emerged were typically in relation to reflexivity, research design and ethical considerations. The full critical appraisal table is available in Appendix 4.

Six studies focused only on the antenatal period [8,13,30,39,45,47], five focused only on the perinatal period [16,22,36,44,46] and seven focused only on the postpartum period [31,33,34,37,38,41,43]. The remaining nine studies covered two or more periods [6,12,32,35,40,42,48–50]. Almost all studies focused on the public healthcare system or community-based services, but one study also explored experiences in the private system [37].

All states and territories in Australia, except the Northern Territory, were represented. We included one study each from the Australian Capital Territory [37], New South Wales [48], South Australia [35], Western Australia [8] and Tasmania [6], six from Queensland [16,31,32,34,45,46], and sixteen from Victoria [12,13,22,30,33,36,38–44,47,49,50]. Only one study was conducted in exclusively rural settings [6], one took place in both urban and rural areas [40] and 25 were conducted in urban or suburban contexts [8,12,13,16,22,30–39,41–50].

Participants came to Australia as migrants or refugees from 42 different countries of origin across Africa, Asia and the Middle East. Most studies focused on participants from countries classified as low and middle income, with only three representing high income countries [6,31,47]. While studies with participants from high-income European and North American countries were eligible for inclusion, no such study met the criteria for inclusion, despite these countries being considerable sources of migration to Australia [3]. For a complete overview of countries represented by each study, see Appendix 3. Nine studies exclusively focused on women from refugee backgrounds [30,32,34,36,38,39,41,45,50]. For some studies, it was not stated whether the participants were refugees or non-humanitarian migrants, while for others, both groups were included as participants. Migrants and refugees are not a homogenous population, but, because we did not have enough information to accurately categorise most participants, our analysis does not separate them into subgroups based on this factor.

### *Confidence in the review findings*

Of the 24 review findings below, one was graded as high confidence, 14 as moderate confidence and nine as low confidence using the CERQual approach [17]. Full assessments for each finding are available in Table 1.

## Qualitative evidence synthesis

This section presents the QES findings (Table 1) arranged under three emergent domains: factors influencing communication and understanding, factors influencing experiences of and satisfaction with care and navigating cultural crossroads (Fig. 2).

### *Factors influencing communication and understanding*

Themes relating to communication and understanding were present in almost all studies. This reflects its centrality to how women experience and perceive care. Sub-themes analysed include the language barrier related to English proficiency and experiences with and access to interpreters.

*Language barriers*

Finding 1: Communication - Limited English proficiency made it challenging for women to communicate during appointments and hospital care as well as to receive maternal health education. This limited proficiency in turn contributed to distress and fear as

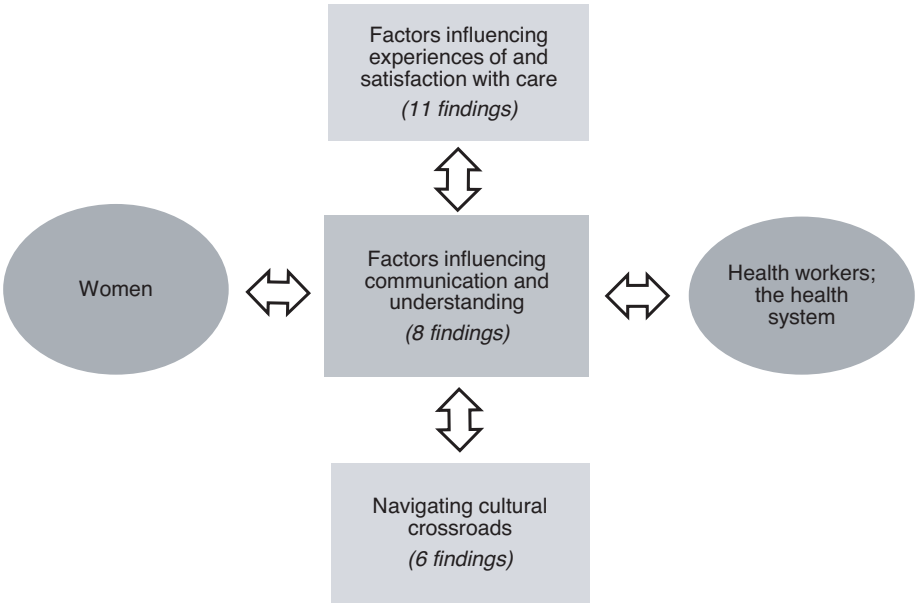


**Fig. 2.** Diagram describing the relationships between the key themes and findings, women and the health workers and the healthcare system, emphasising the centrality of communication and understanding.

women were unable to understand what was happening and how to request services (Moderate confidence) [6,8,12,16,22,30,31,35,36,38,39,44–46,48,49]. This came from the difficulty both in understanding what was being said [12,16,22,44] and the ability to be understood themselves [36,38,44]. Limited English proficiency made routine aspects of maternity care, like booking appointments or attending antenatal classes, intimidating and caused some women to forgo these altogether [6,38]. Women describe communication challenges as exacerbating the anxiety and fear the already felt about labour and birth [16,36,38,44,45]. Some found the experience of being unable to communicate, especially during labour, to be "scary" and isolating [16,36,38,44,45].

Finding 2: Informed consent - The language barrier impeded some women's ability to give informed consent for treatment, as they did not understand what treatment they were going to receive or why it was recommended (Low confidence) [22,36,42]. Several studies include accounts of women who did not fully understand the potential risks and benefits of the procedures they were agreeing to due to their lack of English proficiency and inadequate allowances for this made by healthcare providers [22,36,42]. Sometimes the women's husbands signed consent forms on their behalf [22,42], but they also did not comprehend or explain to their wives the nature of procedure, including for serious procedures like hysterectomy [42].

Finding 3: Translated health resources - Translated health resources were often not made available to women who needed them either because they did not exist or women were not informed they had the option of reading information in their preferred language (Low confidence) [6,32,38,46]. If information in the woman's preferred language was available from healthcare providers, this was not always offered and women did not know to ask for it [6,32,38]. In one case, a participant found out later that there were translated resources available in her language, indicating that materials which do exist may not be proactively offered [6].

Finding 4: Assertiveness - Women often experienced challenges in asserting their wishes and asking questions of staff because they were not proficient in English or thought it inappropriate to question health workers, who were viewed as authority figures (Moderate confidence) [6,16,22,31,36,39,42,44,47,48]. Many participants cited not speaking English proficiently as the primary cause of these difficulties, being more comfortable as passive participants in their care rather than attempting to take on a more active role by communicating in a language they were not fluent in [16,22,36,42,48]. Other reasons were also given, such as in one study with participants from Asian backgrounds described their lack of assertiveness as a cultural trait [6]. Further, a number of participants expressed a feeling that questioning health workers was impolite, as they were viewed as authority figures with higher social status [16,39,47,48].

*Interpreters*

Finding 5: Value of interpreters - Women valued interpreters as they allowed women limited English proficiency to engage with health workers and to have greater input into their care (Low confidence) [30,32,34,44,49]. When made available, professional interpreters were positively received by most women [30,32,34,44]. Having an interpreter also decreased fear and confusion for some women as the interpreter was able to explain what was happening and why medical staff were taking the actions they were [30,34].

Finding 6: Appropriate interpreters - When they were available, interpreting services are not always perceived as appropriate, due to the demographics or dialect of the interpreter, or a general mistrust in the service (Low confidence) [32,35,44,49]. Women who did have an interpreter present during their birth or appointments sometimes reported feeling uncomfortable with the service provided. Women cited a range of reasons for this, including the provision of male or very young interpreters, who were not viewed as culturally appropriate [32,49], interpreters from a different dialect background [32,49], incorrect relaying of information [44] and a mistrust in the confidentiality of the service [35].

Finding 7: Absence of interpreters - Despite their value, interpreters were frequently not present during appointments and hospital care. This absence often left women distressed and without agency, unable to communicate with their carers or understand the treatments they were receiving (Moderate confidence) [16,22,30,32,33,36,38,39,42,44,49]. Women often gave birth and received treatments without an interpreter present to facilitate communication with staff [16,22,30,32,33,36,38,39,42,44,49]. Sometimes participants recount being told that interpreters were not available [22,36,44,49] or there was significant waiting required [30,38], and the unavailability may be exacerbated in the evenings or weekends. In one study it was stated that interpreting services were available but participants were not aware of this [16].

Finding 8: Informal interpreters - In the absence of a professional interpreter, husbands and other family members often served as informal interpreters during appointments. The use of informal interpreters was comfortable and acceptable for some women but concerning to others about due to embarrassment over sharing sensitive health matters or the family member incompletely relaying information (Moderate confidence) [8,16,33,39,44,49]. When the woman's English was not proficient enough to allow her to communicate with staff, their husbands [8,16,33,39,44,49] or other family members [16,33,49] often interpreted during appointments and labour instead of a professional interpreter. While some women found this an acceptable or even preferable alternative to formal interpreters as they were more comfortable with someone they had an existing relationship with compared to a stranger [16,44,49], others identified issues with this form of interpreting. These included discomfort with discussing private matters through their husband or family member as they would not normally share intimate health concerns with them [16,49]. Women whose husbands interpreted for them noted that they didn't always interpret the entire conversation, either because they did not understand or because they only relayed the information they wanted their wife to know [8,44,49].

*Factors influencing experiences of and satisfaction with care*

What women experienced across the continuum of maternal healthcare and how they perceived its suitability and quality was naturally a prominent theme. This broad theme includes a large number of factors which influenced study participants' perception and experience of the care they received. Sub-themes analysed include the accessibility of services; women's experiences with different models of care; experiences and preferences regarding health workers; trust in health workers and medical technology; and experiences of discrimination.

*Accessibility*

Finding 9: Transport - Some women experienced transport-related barriers to accessing care due to an inability to drive or lack of access to a vehicle (Low confidence) [8,31,32,38,45]. Several struggled with using public transport, which proved difficult to navigate especially with young children [8,31,32,38,45], while others relied on their husbands to drive them, which typically required the husband to take leave from work and sacrifice income

[8,45]. Conversely, conveniently located clinics were favoured as women could reach them via simple bus trips or by walking [30,39].

Finding 10: Appointments - Some women found the practice of attending appointments to be challenging due to unfamiliar expectations around timeliness and long wait times (Moderate confidence) [8,31,32,35,38,42,45]. Prompt attendance at specific appointment times was a new expectation for some women whose previous pregnancies had been in countries where drop-in appointments without bookings were standard [8,32,35,38,45]. Women also expressed frustration that despite being required to attend appointments at particular time, they often experienced long wait times, which they did not plan for and caused significant disruption to their other responsibilities [31,32,35,42,45].

*Women's experiences of care*

Finding 11: Specialist services - Women who had access to specialist clinics and services, such as an African women's clinic, a co-designed program for women from refugee backgrounds or dedicated maternal and child health centres, viewed these more favourably than mainstream services. These specialist services were appreciated due to understanding staff, appointment flexibility and a friendly atmosphere (Low confidence) [8,13,30,39]. These services were designed to accommodate the needs of their target population, often with community participation, and featured flexible appointment times, bicultural health workers and interpreters [8,13,30,39]. The positive attributes associated with these specialist providers was linked to women's greater satisfaction with the care they received in that context as opposed to in the hospital [8,13,30,39].

Finding 12: Continuity of carer - Women valued continuity of carer because of the ability to develop trusting relationships with health worker. Women who did not experience continuity of care lamented having to engage with unfamiliar health workers at each appointment (Moderate confidence) [8,16,32,35,37–39,45,48]. Having consistency in health workers engendered trust and confidence, as well as reducing the need to recount personal history which sometimes included traumatic events [8,16,32,35,39,45,48]. Conversely, frequently changing health workers created discomfort and frustration in having to explain things multiple times or receiving different advice, with a participant describing this process as "really exhausting" [8,16,35,37,38,48].

Finding 13: Time with health workers - Women sometimes felt they did not get sufficient time with health workers in mainstream healthcare settings. This prevented them from asking questions about their care, receiving additional information and being able to talk about their emotional wellbeing (Moderate confidence) [8,13,16,30,42,43]. Short appointment times and rushed staff at mainstream hospitals and clinics, who focused mainly on biomedical aspects of care rather than psychosocial and emotional issues, were contrasted with longer visits at specialist clinics [8,30]. Longer appointments were associated with holistic and comprehensive care [8,48].

*Experience with health workers*

Finding 14: Midwives and doctors - Midwives and nurses were generally viewed as kind and helpful by women. Midwives and nurses were sometimes contrasted favourably with doctors who were sometimes seen as rushed and less personable (Moderate confidence) [13,16,30,36,37,39–43]. The preference for midwives and nurses over doctors was linked to the health workers' attitudes and being able to spend more time with them [16,36]. It is also possible that this preference was related to gender as all midwives and nurses mentioned were women [13,16,30,36,37,39–43], and that they felt more socially equal to midwives and nurses, as opposed to doctors who were viewed as authority figures [22,44,47]. However, other participants reported unfriendly or inappropriate behaviour from midwives or nurses [16,36,42,44,46,47].

Finding 15: Social support - Migrating to Australia means that some women lacked the social support during pregnancy, birth and the post-partum period they might have expected in their home country. This made the relationship with between women and health workers more important (Low confidence) [8,34,37,45]. While it is traditional in many countries of origin that the mother is supported by female friends and family members [8,45], migrants and refugees in Australia often only have their husband [8], meaning they rely on their health workers for emotional support as well as medical support, especially during labour and birth [8,34,37,45]. Home visits were especially beneficial for women whose culture encouraged them to stay at home for some time after the birth to recover and promote breastmilk production, meaning the visiting midwife would provide the support and companionship role that female friends and relatives would have traditionally occupied [34]. The importance of this relationship is further demonstrated by the way some women viewed midwives as friends [8].

*Trust*

Finding 16: Trust in health workers - Health workers in Australia were trusted by some women, who viewed them as highly knowledgeable. However, others held concerns about their intentions (Moderate confidence) [8,13,16,22,30,32,34,36,39–42,47,48]. Some women stated that they knew the health workers would "take care" of them because there were "good" people, indicating an implicit trust [8,22,30,32,36,38,39,42]. Sometimes this trust took time, good experiences and evidence of competence to build [8,32,34,48]. However, other participants continued to mistrust the intentions of health workers, which often seemed to be based on misunderstandings and a lack of communication about why certain treatment decisions were made or how sensitive personal information would be stored [16,22,36,41,42,47,48]. Time since resettlement and English proficiency may be factors as those who were more established in Australia and were more comfortable using English were better able to engage, and thus build trust, with health workers [34,46].

Finding 17: Trust in medicine and technology - Some women expressed mistrust and scepticism towards modern Western medical technology and drugs due to concerns these interventions could be harmful to their babies. Meanwhile, others appreciated having access to more advanced medical care than would be available in their birth countries (Low confidence) [13,16,32,36,40–42,46,47]. Some participants expressed an appreciation that healthcare in Australia included advanced monitoring, technology and medicines, often comparing this favourably to their countries of origin where the services were more rudimentary [36,40–42,47], while others expressed a fear that such interventions could hurt or even kill their child [13,16,32,46,47]. In explaining their mistrust of medical technology, some women referenced "magic" and God, indicating that their scepticism may be linked to a spiritual understanding of pregnancy as opposed to the biomedical understanding associated with Western models of care [13,47].

*Discrimination*

Finding 18: Hostility and discrimination - Many women reported experiencing hostile treatment which was characterised by some as discrimination while others references a more vague sense of being unwelcome (Moderate confidence) [13,16,30,31,36,39,41–44,46,47]. This behaviour included being talked down to, treated differently from Australian-born women and made to feel like a nuisance, which led to feelings of

disappointment and frustration [13,16,30,31,36,39,41–44,46,47]. Characterising experiences as discrimination usually took the form of participants contrasting their experiences unfavourably with the treatment of Australian-born women [36,39,46]. One woman identified her Muslim faith and wearing a hijab as the reason her doctor did not seem interested in helping her [43]. Others did not explicitly describe their experiences as discriminatory, instead making allusions to unfriendly treatment and attitudes, it had a negative impact on their experience with service providers [13,16,30,31,41,42,44,47]. Some women who experienced this kind of behaviour appeared to experience shame and blame themselves for being the subject of unfriendly treatment [13,16,30].

*Navigating cultural crossroads*

Narratives of the cultural implications of giving birth in a new country and unfamiliar medical system were consistently present in included studies. These often focused on a gap between expectations for pregnancy and birth and the reality of the experience women have in Australia. Sub-themes analysed included the preferences that women held and conflicts between cultural practices and Australian maternity care.

*Preferences and expectations for care*

Finding 19: Female health workers - Women from a broad range of cultural backgrounds expressed a strong preference for female health workers due to cultural beliefs about appropriate behaviour between men and women. Women who had male health workers often found the experience uncomfortable and distressing (Moderate confidence) [8,16,41–43,46,49]. Vaginal examination performed by a male doctor was cited as being particularly troubling [42,46]. Further, some women were uncomfortable speaking openly to a male doctor, which would exacerbate existing language difficulties [43]. Conversely, women who had access to female doctors appreciated that they were made available [8,42]. However this was not a universal experience as some women were satisfied with male doctors because they accepted that this was normal in Australia [16].

Finding 20: Pain relief - Many women held strong preferences for vaginal birth and traditional, non-pharmacological pain relief. This was because they perceived the pain associated with labour and vaginal birth to be an important element of their experience as women (Low confidence) [13,16,35,42,48]. The pain of labour and birth were viewed as a necessary rite of passage to motherhood and intrinsically linked to their identity as women, as opposed to a medical problem to be treated [13,16,35]. Most women preferred to deal with pain through non-medical methods such as moving around or creating a quiet calm atmosphere, or through traditional aides such as herbal teas [13,16,35]. Not all women subscribed to this conception of pain management, with participants in one study wishing they had been told about the pain relief options available [35].

Finding 21: Medical interventions - Women preferred to avoid medical interventions during the labour process, such as induction, augmentation and caesarean section, as much as possible because these were seen as largely unnecessary, even during extended labour (Moderate confidence) [13,16,22,42,45,48]. While women who had experienced lifesaving intervention were appreciative for this option being available [22,36], there was a clear preference to attempt a natural birth first [13,16,22,42,45,48]. A long labour was not viewed as an issue requiring intervention [13,16]. One woman reported labouring at home for as long as possible as she thought this would prevent doctors from performing a caesarean section, which she saw as deeply undesirable [16]. However this was not universal, with some participants from one study expressing happiness that their caesarean section provided for a “smooth” experience [22].

Finding 22: Traditional practices - Most women wanted and expected to be able to maintain traditional practices related to pregnancy, birthing and post-partum, such as keeping themselves warm, limiting bathing and confinement, within the context of the Australian healthcare system. An inability to maintain these traditions was associated with sadness and anxiety (High confidence) [12,22,31,34,36,41,44,46,48]. While participants held a wide variety of beliefs about appropriate behaviour for pregnant and post-partum women, they shared a desire to maintain these traditional practices in their new country [3,6,9,12–17]. These beliefs included wearing warm clothes and not getting wet to regain warmth that was “lost” during the birth, eating culturally specific foods to support lactation and staying indoors for the first month of the baby’s life [12,34].

*Dealing with conflicting beliefs and practices*

Finding 23: Cultural conflict - Women frequently reported struggling with whether to comply with advice from Australian doctors and midwives, who were seen as knowledgeable professionals, that contradicted traditional cultural practices which were often passed on by respected older female relatives. Women reported having a deep appreciation for care that allowed them to combine both traditional and Australian biomedical approaches to maternal healthcare (Moderate confidence) [6,12,13,16,22,31,34,36,37,41,44–46]. It is evident that many women felt torn in their loyalties and experienced doubt about which decision was “right” for themselves and their baby [6,13,34,37,41,46]. Women often felt "judged" and were “expected to do things differently” than their cultural traditions advised [41]. Conversely, women who experienced compassionate care from health professionals that allowed them to follow these traditions within the confides of the Australian healthcare system were grateful for this opportunity [12,13,16,34,35,47,51]. Some women described a process of reconciling traditional and biomedical practices by “picking and choosing” which elements of each approach they preferred [12,34].

Finding 24: FGM/C - Women who have undergone FGM/C almost universally reported negative experiences with Australian health workers who they perceived as being surprised and unequipped to deal with their condition, making the women feel abnormal and anxious as a result (Moderate confidence) [16,30,32,45,48]. While a small number of participants reported that they received culturally sensitive care around this issue [45,48], the majority perceived doctors and midwives to be unequipped and uneducated with regards to FGM/C [16,30,32,45,48]. Some women experienced shyness about discussing their FGM/C and tried to hide it from health workers [30,45]. Others characterised the reactions of health workers to their FGM/C as shock and panic, perceiving that they were unsure or even scared about dealing with a woman who had undergone the practice [16,48]. Women expressed a desire that health workers in Australia be better trained in how to help women with FGM/C during labour and birth, explaining that this would make both the health workers and themselves more relaxed and confident about the experience [16,32,48].

*Reflexivity*

The first author (HB) is a Caucasian Australian-born woman who remained aware of her status as an outsider through this review process. Having extensive experience with the Australian medical system meant it was challenging for her to understand how institutions and practices which are familiar to her may be alien to the participants in included studies. She benefited from

ongoing discussions with the other authors (MVC and MAB), who were both born outside Australia, in this process as well as utilising their personal and professional expertise in reviewing and providing feedback. We were mindful of wanting to let the participants and studies speak for themselves, but acknowledge that it is not possible to completely distance ourselves from our expectations for what constitutes good maternity care, influenced by our backgrounds, studies and work. We regularly engaged in critical self-reflection about how our existing beliefs and biases may influence our work.

## Discussion

This QES identified a broad range of patterns regarding the perceptions and experiences of women from migrant and refugee backgrounds in Australian maternity care. Women frequently experienced distressing communication challenges related to low English proficiency and inadequate access to professional interpreters. Women's experiences of care were often linked to the friendliness and understanding of health workers, as well as models of care which allowed them to develop rapport and trust in health workers and the medical technology available. Instances of discrimination and hostility were reported, as were difficulties in following traditional practices in an Australian healthcare setting. Women responded well to care which let them choose to incorporate traditional practices and respected their preferences for low-intervention vaginal births, non-pharmacological pain relief and female health workers.

Some of the findings of this QES relate to factors that are specific to women from migrant and refugee backgrounds, such as language barriers and unfamiliarity with Australian health care systems and practices [52]. However, there are also similarities to the experiences of Australian-born women. Regardless of their birth country, women who experience maternity care in Australia want to understand the care they receive and play an active role in decision making [51]. Australia-born women also frequently report dissatisfaction with the interpersonal care they received in hospital [11], which is consistent with perspectives offered by participants in the included studies. The desire to maintain traditional cultural practices is clearly influenced by a woman's migrant of refugee background, but reported themes regarding the conflict between these traditions and modern Australian biomedical approaches share similarities with the experiences of Aboriginal women [53], who also wish to be able to incorporate cultural practices into their maternity care [54].

While this QES is the first of its kind to focus on Australia, its results support other reviews that have previously been published in other settings. Qualitative and scoping reviews focusing on women from migrant and refugee backgrounds experiences of maternity care in Europe and Canada respectively reported similar themes of communication challenges, confusion and discrimination as impacting upon women's experiences [55,56]. Moreover, the Canadian review also introducing the idea of traditional patriarchal gender roles being an additional burden for women to navigate in a new context. A QES on the experiences of women with FGM/C living in high-income countries also identified that this these women have poor maternity care experiences [57], indicating that this is not an issue isolated to Australia. A number of studies and reviews used quantitative methodology to describe the poorer health outcomes that women from migrant and refugee backgrounds experience, which the barriers to accessing appropriate care described in our QES may contribute to, as well as a high rate of existing health issues that make timely and appropriate maternity care more critical [14,51,52,58]. Finally, a global review examining models of care designed to serve women from migrant and refugee backgrounds found that approaches which incorporated continuity of carer, cultural competence and effective communication practices were valued by women, which mirrors the findings of our QES, and could potentially improve infant and maternal outcomes [59].

A key limitation of this review is the lack of studies that include women from rural and regional areas. This is especially concerning given that there are numerous Australian Government initiatives to encourage, or even require, migrants to settle in rural and regional areas [60]. The specialist cultural clinics are unlikely to be available or feasible in regional settings. Moreover, 16 of 27 studies took place in Victoria [12,13,22,30,33,36,38–44,47,49,50], despite Victoria not having a substantially higher proportion of residents born overseas than any other Australian state or territory [61]. This unbalanced geographic spread makes it possible that important experiences in other states were missed.

Another limitation of this review is that many of the studies included focused participants who are not fluent in English, so interviews were typically translated. Given the one of the benefits on qualitative research is its ability to use participants' words to create meaning and understanding [8,37,46], it is important to acknowledge that some nuance may have been lost in the interpreting process due to underlying meanings behind word choices that cannot be fully translated [62]. It is also important to acknowledge that women from migrant and refugee backgrounds are not a homogenous group. Included studies demonstrate the range that exists with regard to factors such as English proficiency [8,13,16,31,36,46], education [13,35–37,40,41], and employment and income [8,13,31,36,37,40,45], which can impact women's perceptions and experiences of maternity care. While this review provides an overview of common themes in the evidence, individual experiences will vary based on these factors amongst others.

This QES also has some key strengths. We used the Cochrane EPOC guidance for conducting QES, which provides a reliable and systematic approach to synthesising qualitative evidence. We used the GRADE-CERQual approach to assess confidence in review findings, which is a transparent approach that encourages the usability of QES findings.

### *Implications for practice*

This review can serve as a comprehensive synthesis of the evidence on how women from migrant and refugee backgrounds perceive and experience maternity care in Australia. There are a number of specific learnings that health workers can readily apply to their own practice. Given that women sometimes struggle to proactively ask questions during clinical encounters, health workers should ask women if they have any questions to help them feel comfortable doing so. Similarly, health workers should not assume that women are aware of services and should instead be sure to clearly explain women's options for care and the variety of supports available to them. Health workers should ask whether a woman wants an interpreter upon her first contact with the clinic or hospital and should ensure that an interpreter is present at subsequent presentations. The use of informal relative interpreters may be the only option, but health workers should recognise that these people are not professional interpreters and the woman's perspective and preferences may not be accurate communicated, and info from health worker may not be fully communicated to the woman. Continuity of carer models are typically well received by women and help to build trust, so this should be incorporated into hospital and clinic service delivery where possible. Hospital and clinic management should ensure that staff are appropriately trained in culturally competent care and identifying and minimising implicit bias, as well as develop policies which maximise women's ability to maintain traditional practices within the

Australian hospital context. Health workers should proactively ask women if there are traditional cultural practices they wish to incorporate into their birth to assure them that this welcome. While health workers should keep in mind that women from migrant and refugee backgrounds may wish to have low-intervention births with non-pharmacological pain relief, not all women subscribe to this perspective and all women should have their options described to them so they are able to choose. Due to the low confidence CERQual grading of many findings, additional research may be beneficial to address areas where there is limited evidence, such as culturally-appropriate informed consent, strengthening community engagement and building trust in medicine and technology, and experiences with specialist services.

*Implications for further research*

This QES has identified a number of areas for potential future research. The lack of studies which included women living in rural or regional areas is concerning. Future primary data collection focusing on this subpopulation would be useful in elevating the voices and experiences of women living in these areas. Since the Australian Government is encouraging migrants to settle in regional areas [60], it is important to understand whether they have access to appropriate services. Two other subpopulations which warrant further research are women from China and India. These two countries are the second and third most common birthplaces of overseas-born Australian citizens and residents [3], yet only three studies in this QES included Chinese women [6,12,31] and only one included Indian women [37].

Women are often being denied access to interpreters because of logistical challenges, and these challenges have been known for decades. Given the difficulties with current models, exploratory research looking at alternative models of interpreting services, including those utilising telehealth practices, is needed to understand the feasibility and acceptability of such services.

Another finding compared the experiences that women had in specialist cultural clinics and mainstream public hospitals, with the former being preferred by women. Research could be conducted looking at how mainstream hospitals could incorporate aspects of the clinics' practices into their own. This could include looking at how to institute flexible appointment times, increase the cultural competence of staff and utilise bicultural workers. Further, given the consistently poor experiences and unprepared health workers reported by women with FGM/C, research into how to better equip the health workforce to support this sub-population.

## Conclusion

This QES sought to understand the perspectives and experiences of women from migrant and refugee backgrounds across the continuum of maternal healthcare in Australia. Evidence from 27 studies was synthesised into 24 findings, covering a broad range of factors which can influence how women perceive and experience maternity care. These includes factors relating to communication and language challenges, interpreters, access to care, experiences with health workers, trust in healthcare, cultural preferences for care and conflicts between traditional and Western medical practices. While this QES cannot replace meaningful community consultation and co-design, it can be used as a resource by policy-makers and practitioners who are reviewing and seeking to improve aspects of maternity care in Australia. It analyses not only challenging and disappointing experiences with maternity care, but also factors which are associated with positive and well-received care across the continuum. With a growing proportion of women receiving maternity care in Australia coming from migrant and refugee backgrounds [2], changes will be needed at both a system level and by individual health services to improve the quality and acceptability of maternity care for these women.

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## Appendix A. Supplementary data

Supplementary material related to this article can be found, in the online version, at doi:https://doi.org/10.1016/j.wombi.2021.08.005.

## References

[1] T. Navodani, D. Gartland, S.J. Brown, E. Riggs, J. Yelland, Common maternal health problems among Australian-born and migrant women: a prospective cohort study, PLoS One 14 (2) (2019)e0211685.
[2] Australian Institute of Health and Welfare, Australia's Mothers and Babies - 2017 in Brief, AIHW, Canberra, 2019.
[3] Australian Bureau of Statistics, Main Features—Net Overseas Migration Available from:, Commonwealth of Australia, Canberra, 2019. https://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/3412.0Main%20Features42017-18?opendocument&tabname=Summary&prodno=3412.0&issue=2017-18&num=&view=.
[4] Department of Home Affairs, Discussion Paper: Australia's Humanitarian Program 2019-2020, Australian Government, Canberra, 2020.
[5] H. Hoang, Language and cultural barriers of Asian migrants in accessing maternal care in Australia, Int. J. Lang. Soc. Cult. (28) (2008) 55–61.
[6] H.T. Hoang, Q. Le, S. Kilpatrick, Having a baby in the new land: a qualitative exploration of the experiences of Asian migrants in rural Tasmania, Australia, Rural Remote Health 9 (1) (2009) 1084.
[7] S. Benza, P. Liamputtong, Becoming an' Amai': meanings and experiences of motherhood amongst Zimbabwean women living in Melbourne, Australia, Midwifery 45 (2017) 72–78.
[8] C. Owens, J. Dandy, P. Hancock, Perceptions of pregnancy experiences when using a community-based antenatal service: a qualitative study of refugee and migrant women in Perth, Western Australia, Women Birth 29 (2) (2016) 128–137.
[9] J.R. Betancourt, J. Corbett, M.R. Bondaryk, Addressing disparities and achieving equity: cultural competence, ethics, and health-care transformation, Chest 145 (1) (2014) 143–148.
[10] C. Metusela, J. Ussher, J. Perz, A. Hawkey, M. Morrow, R. Narchal, et al., "In my culture, we don't know anything about that": sexual and reproductive health of migrant and refugee women, Int. J. Behav. Med. 24 (6) (2017) 836–845.
[11] J. Hennegan, M. Redshaw, S. Kruske, Another country, another language and a new baby: a quantitative study of the postnatal experiences of migrant women in Australia, Women Birth 28 (4) (2015) e124–33.
[12] A. Renzaho, J. Oldroyd, Closing the gap in maternal and child health: a qualitative study examining health needs of migrant mothers in Dandenong, Victoria, Australia, Matern. Child Health J. 18 (6) (2014) 1391–1402.
[13] M. Carolan, L. Cassar, Antenatal care perceptions of pregnant African women attending maternity services in Melbourne, Australia, Midwifery 26 (2) (2010) 189–201.
[14] M. Carolan, Pregnancy health status of sub-Saharan refugee women who have resettled in developed countries: a review of the literature, Midwifery 26 (4) (2010) 407–414.
[15] N. Varol, A. Dawson, S. Turkmani, J.J. Hall, S. Nanayakkara, G. Jenkins, et al., Obstetric outcomes for women with female genital mutilation at an Australian hospital, 2006-2012: a descriptive study, BMC Pregnancy Childbirth 16 (1) (2016) 328.
[16] L. Murray, C. Windsor, E. Parker, O. Tewfik, The experiences of African women giving birth in Brisbane, Australia, Health Care Women Int 31 (5) (2010) 458–472.
[17] S. Lewin, A. Booth, C. Glenton, H. Munthe-Kaas, A. Rashidian, M. Wainwright, et al., Applying GRADE-CERQual to qualitative evidence synthesis findings: introduction to the series, Implement. Sci. 13 (Suppl 1) (2018) 2.
[18] A. Tong, K. Flemming, E. McInnes, S. Oliver, J. Craig, Enhancing transparency in reporting the synthesis of qualitative research: ENTREQ, BMC Med. Res. Methodol. 12 (181) (2012) 1–8.
[19] Veritas Health Innovation, Covidence Systematic Review Software, Veritas Health Innovation, Melbourne, Australia, 2020.
[20] CASP. CASP Checklists 2018 Available from: https://casp-uk.net/casp-tools-checklists/.

[21] J. Thomas, A. Harden, Methods for the thematic synthesis of qualitative research in systematic reviews, BMC Med. Res. Methodol. 8 (2008) 45.
[22] P. Liamputtong, L.F. Watson, The Meanings and Experiences of Cesarean Birth Among Cambodian, Lao and Vietnamese Immigrant Women in Australia, Women Health 43 (3) (2006) 63–82.
[23] M.A. Bohren, H. Munthe-Kaas, B.O. Berger, E.E. Allanson, Ö. Tunçalp, Perceptions and experiences of labour companionship: a qualitative evidence synthesis, Cochrane Database Syst. Rev. 12 (2016) 1–10.
[24] H. Munthe-Kaas, M.A. Bohren, C. Glenton, S. Lewin, J. Noyes, O. Tuncalp, et al., Applying GRADE-CERQual to qualitative evidence synthesis findings-paper 3: how to assess methodological limitations, Implement. Sci. 13 (Suppl 1) (2018) 9.
[25] C.J. Colvin, R. Garside, M. Wainwright, H. Munthe-Kaas, C. Glenton, M.A. Bohren, et al., Applying GRADE-CERQual to qualitative evidence synthesis findings-paper 4: how to assess coherence, Implement. Sci. 13 (Suppl 1) (2018) 13.
[26] C. Glenton, B. Carlsen, S. Lewin, H. Munthe-Kaas, C.J. Colvin, O. Tuncalp, et al., Applying GRADE-CERQual to qualitative evidence synthesis findings-paper 5: how to assess adequacy of data, Implement. Sci. 13 (Suppl 1) (2018) 14.
[27] J. Noyes, A. Booth, S. Lewin, B. Carlsen, C. Glenton, C.J. Colvin, et al., Applying GRADE-CERQual to qualitative evidence synthesis findings-paper 6: how to assess relevance of the data, Implement. Sci. 13 (Suppl 1) (2018) 4.
[28] S. Lewin, M. Bohren, A. Rashidian, H. Munthe-Kaas, C. Glenton, C.J. Colvin, et al., Applying GRADE-CERQual to qualitative evidence synthesis findings-paper 2: how to make an overall CERQual assessment of confidence and create a Summary of Qualitative Findings table, Implement. Sci. 13 (Suppl 1) (2018) 10.
[29] C. Glenton, M. Bohren, S. Downe, E. Paulsen, S. Lewis, EPOC Qualitative Evidence Synthesis: Protocol and Review Template, Norwegian Institute of Public Health, Oslo, 2019.
[30] M. Carolan, L. Cassar, Pregnancy care for African refugee women in Australia: attendance at antenatal appointments, Evid. Based Midwifery 5 (2) (2007) 54–58.
[31] C.M. Chu, Postnatal experience and health needs of chinese migrant women in Brisbane, Australia, Ethnicity Health 10 (1) (2005) 33–56.
[32] I. Correa-Velez, J. Ryan, Developing a best practice model of refugee maternity care, Women Birth 25 (1) (2012) 13–22.
[33] E. Hoban, P. Liamputtong, Cambodian migrant women's postpartum experiences in Victoria, Australia, Midwifery 29 (7) (2013) 772–778.
[34] J. Joseph, P. Liamputtong, W. Brodribb, Postpartum breastfeeding experiences in the traditional-biomedical crossroads: a qualitative study using drawing with Vietnamese and Myanmarese refugee women in Australia, J. Adva. Nurs. 75 (11) (2019) 2855–2866.
[35] H. Mohale, L. Sweet, K. Graham, Maternity health care: the experiences of Sub-Saharan African women in Sub-Saharan Africa and Australia, Women Birth 30 (4) (2017) 298–307.
[36] S. Niner, R. Kokanovic, D. Cuthbert, Displaced mothers: birth and resettlement, gratitude and complaint, Med. Anthropol. 32 (6) (2013) 535–551.
[37] V.S. Rao, H.G. Dahlen, H. Razee, Indian migrant women's experiences of motherhood and postnatal support in Australia: a qualitative study, Women Birth 18 (2019) 18.
[38] E. Riggs, E. Davis, L. Gibbs, K. Block, J. Szwarc, S. Casey, et al., Accessing maternal and child health services in Melbourne, Australia: reflections from refugee families and service providers, BMC Health Serv. Res. 12 (2012) 117.
[39] E. Riggs, S. Muyeen, S. Brown, W. Dawson, P. Petschel, W. Tardiff, et al., Cultural safety and belonging for refugee background women attending group pregnancy care: an Australian qualitative study, Birth 44 (2) (2017) 145–152.
[40] C. Rolls, M. Chamberlain, From east to west: Nepalese women's experiences, Int. Nurs. Rev. 51 (3) (2004) 176–184.
[41] A. Russo, B. Lewis, A. Joyce, B. Crockett, S. Luchters, A qualitative exploration of the emotional wellbeing and support needs of new mothers from Afghanistan living in Melbourne, Australia, BMC Pregnancy Childbirth 15 (1) (2015) 197-.
[42] T. Shafiei, R. Small, H. McLachlan, Women's views and experiences of maternity care: A study of immigrant Afghan women in Melbourne, Australia, Midwifery 28 (2) (2012) 198–203.
[43] T. Shafiei, R. Small, H. McLachlan, Immigrant Afghan women's emotional well-being after birth and use of health services in Melbourne, Australia, Midwifery 31 (7) (2015) 671–677.
[44] R. Small, P.L. Rice, J. Yelland, J. Lumley, Mothers in a new country: the role of culture and communication in Vietnamese, Turkish and Filipino women's experiences of giving birth in Australia, Women Health 28 (3) (1999) 77–101.
[45] H. Stapleton, R. Murphy, I. Correa-Velez, M. Steel, S. Kildea, Women from refugee backgrounds and their experiences of attending a specialist antenatal clinic. Narratives from an Australian setting, Women Birth 26 (4) (2013) 260–266.
[46] D.E. Stewart, V. Das, M. Seibold, Birth and empowerment: A qualitative study of the childbirth experience of Filipino migrant women in Brisbane, Australia, Asia. Pac. J. Public Health 10 (2) (1998) 64–69.
[47] V. Tsianakas, P. Liamputtong, Prenatal testing: the perceptions and experiences of Muslim women in Australia, J. Reprod. Infant Psychol. 20 (1) (2002) 7–24.
[48] S. Turkmani, C.S.E. Homer, A.J. Dawson, Understanding the experiences and needs of migrant women affected by female genital mutilation using maternity services in Australia, Int. J. Environ. Res. Public Health 17 (5) (2020) 26.
[49] J. Yelland, E. Riggs, J. Szwarc, S. Casey, P. Duell-Piening, D. Chesters, et al., Compromised communication: a qualitative study exploring Afghan families and health professionals' experience of interpreting support in Australian maternity care, BMJ Qual. Saf. 25 (4) (2016) e1.
[50] J. Yelland, E. Riggs, S. Wahidi, F. Fouladi, S. Casey, J. Szwarc, et al., How do Australian maternity and early childhood health services identify and respond to the settlement experience and social context of refugee background families? BMC Pregnancy Childbirth 14 (2014) 348.
[51] R. Small, C. Roth, M. Raval, T. Shafiei, D. Korfker, M. Heaman, C. McCourt, A. Gagnon, Immigrant and non-immigrant women's experiences of maternity care: a systematic and comparative review of studies in five countries, BMC Pregnancy Childbirth 14 (152) (2014).
[52] L.M. Almeida, J. Caldas, D. Ayres-de-Campos, D. Salcedo-Barrientos, S. Dias, Maternal healthcare in migrants: a systematic review, Matern. Child Health J. 17 (8) (2013) 1346–1354.
[53] S. Parker, L. McKinnon, S. Kruske, 'Choice, culture and confidence': key findings from the 2012 having a baby in Queensland Aboriginal and Torres Strait Islander survey, BMC Health Serv. Res. 14 (2014) 196.
[54] R. Marriott, T. Reibel, J. Coffin, J. Gliddon, D. Griffin, M. Robinson, et al., "Our culture, how it is to be us" — listening to Aboriginal women about on Country urban birthing, Women Birth 32 (5) (2019) 391–403.
[55] N. Khanlou, N. Haque, A. Skinner, A. Mantini, C. Kurtz Landy, Scoping review on maternal health among immigrant and refugee women in Canada: prenatal, intrapartum, and postnatal care, J. Pregnancy 2017 (2017)8783294.
[56] F. Fair, L. Raben, H. Watson, V. Vivilaki, M. van den Muijsenbergh, H. Soltani, et al., Migrant women's experiences of pregnancy, childbirth and maternity care in European countries: a systematic review, PLoS One 15 (2) (2020) e0228378.
[57] M. Scamell, A. Ghumman, The experience of maternity care for migrant women living with female genital mutilation: a qualitative synthesis, Birth 46 (1) (2019) 15–23.
[58] F.B. Belihu, M.A. Davey, R. Small, Perinatal health outcomes of East African immigrant populations in Victoria, Australia: a population based study, BMC Pregnancy Childbirth 16 (2016) 86.
[59] H.J. Rogers, L. Hogan, D. Coates, C.S.E. Homer, A. Henry, Responding to the health needs of women from migrant and refugee backgrounds-Models of maternity and postpartum care in high-income countries: a systematic scoping review, Health Soc. Care Community 28 (5) (2020) 1343–1365.
[60] Australian Government, Regional Migration [cited 2020 13 October]. Available from:, Australian Government, Canberra, 2020. https://immi.homeaffairs.gov.au/visas/working-in-australia/regional-migration.
[61] Australian Bureau of Statistics, Migration Available from:, Australian Government, Australia Canbrra, 2020. https://www.abs.gov.au/statistics/people/population/migration-australia/latest-release.
[62] F. van Nes, T. Abma, H. Jonsson, D. Deeg, Language differences in qualitative research: is meaning lost in translation? Eur. J. Ageing 7 (4) (2010) 313–316.