SCANLON FOUNDATION RESEARCH INSTITUTE

NARRATIVE 13
OCTOBER 2024

Lost in translation:

Having a baby in Australia when English isn't your first language

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Introduction

In recent years, there has been growing awareness of the influence of gender in health experiences and outcomes. Increasing evidence indicates that women often experience poorer health outcomes throughout their lives, including delayed diagnoses, over prescription of medication, and a failure to properly investigate symptoms. These systemic issues in healthcare delivery and medical research disproportionately affect women. While women tend to live longer than men, they are more prone to chronic health conditions and experience higher rates of mental health issues. Women and girls in socio-economically disadvantaged and marginalised communities the disparity in health outcomes is even greater. A signification proportion of these women come from non-English speaking backgrounds.

Unlike men, women have specific sexual and reproductive health needs that evolve over their lives, which may impact or exacerbate other health conditions. Discussing women's healthcare services, experiences and outcomes through the lens of pregnancy therefore serves as a gateway to broader conversations about women's health and wellbeing in Australia, especially in communities with higher numbers of non-native English speakers.

In Australia, pregnancy often marks the first significant interaction with the medical system for many of these women, making it a vital entry point for women to discuss with medical professionals other aspects of their health such as the need for regular check-ups, preventative care, family planning and menopause care. This is especially important given research shows that despite Australia's relatively high maternal and new-born health outcomes compared to other OECD countries, women from non-English speaking backgrounds experience stillbirth and perinatal mortality rates two to three times higher than Australian-born women. Additionally, they are at higher risk for pregnancy-related conditions such as preeclampsia and gestational diabetes mellitus (GDM), which can lead to serious complications for both mother and child.

What this highlights is the urgent need for a comprehensive reassessment of how Australia delivers healthcare to women whose first language is not English. This narrative aims to address this complex issue by focusing on the pregnancy journey, from the moment a woman learns she is expecting, through to the postpartum period. This phase often involves intense interaction with the medical system and offers healthcare professionals a crucial opportunity to identify, and hopefully correct, any other health issues that affect women's overall wellbeing beyond reproductive health.

It wasn't until I stumbled upon an episode of SBS's podcast T*he Too Hard Basket: Migrant women and the health system*, that I realised just how many barriers exist for Australian women whose first language is not English, whose cultural roots are not Western, and whose experiences — often more diverse than anyone born in Australia can imagine — deeply impact the way they access and receive healthcare.

Despite the scientific advances of the last century, women continue to face discrimination, whether consciously or unconsciously, in almost every part of the medical system. For women whose first language isn't English, these struggles are magnified. Not only are they navigating the world as women, but as women who have left their countries of birth – sometimes by choice, sometimes not – and now must learn a new system of rules, often unfamiliar and overwhelming. At the heart of this sense of dislocation is the inability to understand or articulate what is happening to them on a fundamental level, because they lack the words to express themselves.

Language and literacy are crucial to effective healthcare, and research shows that language barriers in healthcare settings can lead to significant problems, including delays or even denial of services, issues with medication management, and under-utilisation of preventive care. Communication difficulties also hinder doctors' ability to fully understand their patients' symptoms and concerns, affecting the type and quality of care provided. In culturally and linguistically diverse countries like Australia, the added layer of cultural differences and nuances further complicates access to effective healthcare.

In Australia, non-native English speakers of both genders can have significant problems being heard in medical settings. But it is women – and especially women from non-English backgrounds – who tend to have the most difficult time communicating their needs and having these needs acknowledged and met. Even when people speak English near-fluently, misunderstandings can arise when communicating with English speakers from other countries due to differences in accents and cultural norms. For example, the same word or phrase might be used differently across English-speaking regions, leading to confusion even when both parties believe they are using standard English.

Cultural differences further complicate communication, as language is deeply intertwined with social norms, values and expectations. Indirect communication styles common in some cultures might be misinterpreted as vagueness or indecision by those from cultures that favour directness. In contrast, a more direct approach might be perceived as rude or abrasive in cultures that prioritise politeness and subtlety. These cultural nuances are often implicit, making them difficult to navigate even for fluent English speakers, particularly in cross-cultural interactions where each party's cultural context may not be fully understood by the other.

In medical and healthcare settings, these challenges can have serious implications. Clear communication is essential for accurate diagnosis, treatment and patient care. However, accents and cultural differences can lead to misunderstandings that compromise patient comfort and safety. A healthcare provider from one country might misinterpret a patient's description of symptoms if the patient's accent or cultural way of expressing discomfort is unfamiliar.

Similarly, patients may misunderstand medical advice or instructions if they aren't attuned to the provider's accent or idiomatic expressions. Cultural differences in expressing pain, giving consent, or discussing certain health issues can also lead to miscommunication, potentially resulting in inadequate care or non-compliance with treatment.

This essay seeks to address these issues by drawing on insights from experts and the voices of women themselves, with the hope of finding ways for a country like ours, with its hundreds of languages and ethnicities, to improve the delivery of essential healthcare services to women.

Navigating Australia's reproductive health system with limited English

Credit: rudi_suardi

If you're an Australian citizen or a permanent resident, it's difficult to understand how expensive and complex healthcare in Australia is — and this includes pregnancy care. Medicare, Australia's health insurance scheme which gives citizens and permanent residents access to healthcare (including a wide range of health and hospital services at no or low cost), is widely regarded and acknowledged to be one of Australia's greatest successes.

It underpins our entire health system, including access to good reproductive healthcare. Broadly speaking, general practitioners (GPs) are the first point of contact in Australia's health system, and are relied upon to provide information and refer families to specialist care, including a shared antenatal care or a hospital antenatal clinic. This is especially important for families – particularly women – from non-English communities, as pregnancy and early childhood a time of intense engagement with the healthcare system, and is often their first experience of Australian healthcare over a sustained period.

Maternity care in Australia is provided via two main models – private and publicly funded. Public care is funded by Medicare and incurs no additional cost for citizens and permanent visa holders. This care is generally provided by GPs in the community and midwives in public hospitals. Private maternity care is usually funded via a mix of private health insurance and Medicare-funded components, with the 'gap' or out-of-pocket expenses paid by individuals. Private care enables individuals choice over their maternity provider.

Low-risk pregnancies (deemed uncomplicated by a doctor) involve antenatal clinics with midwife-led care and periodic doctor reviews. During labour, birth and postpartum, midwives mainly provide primary care in consultation with hospital doctors.

According to Australian Institute of Health and Welfare data, in 2022, nearly 900 maternity 'models of care' were in use across 251 Australian maternity services, categorised into 11 major types. The most common is public hospital maternity care (40%), followed by hospital and GP shared care (15%), midwifery group practice caseload care (15%) and private obstetrician (specialist) care (11%). High-risk maternity care in public hospitals accounts for around 5% of models.

Less common categories include general practitioner, obstetrician care (4%),

Credit: Kermal Yildirim

combined care (3%), team midwifery care (2%) and private midwifery care (2%). Group Pregnant Care, designed for certain groups of women, will be discussed later.

Australia is a receiving nation, and our migration patterns change with global events. Between 2013 and 2018, migrants from South and Central Asia almost doubled, while those from Western Europe and Oceania regions decreased by around 25%.

In 2017, 27% of women giving birth in Australia were born in non-English speaking countries, up from 18% in 2007. Although refugee resettlements from Africa remain steady, it has been overtaken by conflict-impacted countries in the Middle East.

This shift significantly impacts healthcare for people from non-Western and non-English speaking backgrounds. Health policy must evolve to reflect changing evidence and demographics. As more people from these backgrounds arrive, addressing public health, particularly the complex nature of women's reproductive health, is crucial. Considering cultural beliefs and, in anthropological parlance, the 'lifeworld' – the sociocultural context in which meaning is generated, or, more simply put, the understandings, concepts and beliefs people bring to the medical encounter – of each woman is key to delivering comprehensive care.

About a third of women giving birth in Australia were born overseas, most from non-English speaking backgrounds. It is a mistake to view these women as homogenous: migrants and refugees have different experiences and needs. Yet studies show that both groups often rate their maternity and pregnancy care poorly compared to Australian-born women. English language proficiency plays a vital role in maternity care, affecting overall wellbeing over time.

Pre- and post-natal care offer opportunities for medical professionals to address social risk factors like isolation, stress, trauma, low health literacy, family violence and smoking. Guidelines in the US, UK, and Australia recommend starting antenatal care in the first trimester with a minimum of seven visits to promote health and screen for medical conditions. While in Australia, this course of pregnancy care is largely understood by women from Anglo and Western cultures, this is not always the case for everyone starting a family. Culture plays a significant role in the understanding and acceptance of certain healthcare practices. The ability to communicate and comprehend what these practices are, and why they are being delivered or recommended, lies at the heart of effective healthcare.

While English is technically not the official language of Australia, it has, since British settlement, become the de facto national language. It is also the "lingua franca", or international language of medicine, developed and influenced by Greek and Latin medical traditions over the past 2,500 years, as well as the spread of Western culture through British and American influences.

"Medicine uses one lingua franca but speaks with many tongues," wrote researcher Christopher Baethge in a weekly German language medical magazine, The Deutsches Ärzteblatt, in 2008. *"Just as Latin emerged after the Renaissance beside the regional European languages as the unifying language of the healing arts, so has English now assumed a leading role as the international language of medicine."*

It wasn't always so: Baethge points out that until the beginning of 20th century, medical sciences also used German and French, along with English. Yet the rise of American influence since the world wars and the spread of globalisation put an end to this triumvirate, declaring English the successor.

Today, international communication among clinicians and scientists takes place almost exclusively in English, and most studies are published in English, in academic journals staffed by English writers and editors.

Credit: A boy and the sea

The rise of English as the medical lingua franca has coincided with immense development in science and technology, leading to new discoveries being published primarily in English. In the West – and in many other parts of the world – we have been led to believe that the English language, and the medical system expressed through it, are divorced from cultural and traditional influences – in effect, neutral. In Australia, this is the healthcare model we adhere to.

We also have our own medical customs, which are heavily influenced by language, culture, government policies and prices. For people who do not speak English or have a limited command of it, and who may have come from places where healthcare is non-existent or different, assimilating into Australia's system poses many challenges – we should never forget that.

When Austrian mother of two, Marie Alessi, gave birth to her first son in Australia 16 years ago, her level of English proficiency was high. Having studied English from age five, she had no problems speaking the language when she immigrated to Sydney in 2004. But when it came to using English daily, the cracks started to appear.

"You can speak English well, but you only realise how much you're missing when you start working and living in a language," says Marie. *"It's all those little things, so many words that you don't learn at school, that become the problem."*

Marie experienced 'second language attrition', a situation where the formal learning of English does not fully prepare someone for the nuances and demands of daily communication in an English-speaking country. This gap was highlighted when Marie became pregnant.

"Going to appointments, I suddenly realised I only knew my anatomy in my mother tongue. And here I was, sitting there and dealing with pregnancy and words I'd never heard used in English before." While her Australian-born (of Mauritius and Italian background) husband helped, Marie remembers the process as difficult and discombobulating. "It didn't help that the whole medical system in Australia is so different," she recalls. "In Austria you do everything through an obstetrician while here, you go to a GP first. It still confuses me," Marie says.

In many ways, Marie was lucky. Her English was good enough to get her through her pregnancy appointments, and she was aided by her Australian-born husband when it came to figuring out our health system's idiosyncrasies. But for many other women whose grasp of the language – or of Australia's mainstream culture – is more tenuous, appointments that are not well or clearly handled by medical professionals can lead to disengagement from the broader health system.

"We know that people from diverse language and cultural backgrounds are less engaged in health services than the general population," says Dr Sarah Verdon, an associate professor in speech language pathology at Charles Sturt University. *"Most Australians live under the assumption that our health service is fantastic and easy to access for everyone. Yes, you can go to the emergency department and a general practitioner and be bulk billed through Medicare, but everything else — any advanced and specialist care — costs a huge amount of money."*

Verdon points out that despite 5.6 million people (22%) speaking a language other than English at home (according to the 2021 census) health services in Australia continue to be delivered largely in English, despite evidence showing that the language barrier between healthcare providers and patients is a major reason why Australians from culturally and linguistically diverse backgrounds are less likely to access health services.

"The key things we are finding that makes the recent refugee experience different to the generalised migrant population is trauma," says Dr Verdon. *"Migrants that come to Australia due to economic reasons, or on working visas, may be highly educated and have some degree of choice and forewarning of the countries they are migrating to. People seeking refugee do not have that choice; they don't have the time to research the system, to learn the language. They don't even know where to start."* Many come from refugee camps (some are even born there and have never stepped foot

outside) and see unimaginable horrors. *"They see people give birth and children die, and they don't know why. So of course, when they come to Australia, they are fearful of anything that can harm them or their babies,"* she adds.

Dr Verdon, who lives in a rural area, has witnessed first-hand the gaps between policy and reality. As part of their visa requirements, people from refugee backgrounds must undertake a certain number of English lessons. This may work – albeit imperfectly, and in some cases not well at all, as the previous Scanlon Narrative on the topic found – in large cities with ample public transport and availability of English classes. However, in rural and remote areas, where often only one bus services an entire community, it is nearly impossible to make work. *"In Wodonga, for example, there is literally one bus a day. If you can't drive, you actually can't get anywhere,"* Dr Verdon points out. *"We forget that to get a licence, you have to rack up 120 hours of practice driving, and when – and how – can these people do that?"*

This conundrum was further highlighted when it became clear that women from refugee backgrounds in the area were not taking advantage of the free childcare initiative.

"The authorities were shocked that women weren't taking their kids there, even when it was free. What they didn't realise is that these women also had to attend the English TAFE course, often at a similar time – and in the opposite direction – to get their Centrelink payments. That was a 90-minute round trip. How were they supposed to go there and drop their kids off in the opposite direction? Some mothers managed to walk their kids there first, a 45-minute walk one way, but they just couldn't go if it was raining or too hot."

The situation is further complicated for people who have not yet been declared refugees by the Australian Government. For this cohort, no such support exists. Until they are officially granted protection, people seeking asylum in Australia (who do not hold the right visa) are not entitled to access the English program. They are left to navigate on their own or rely on various free, often volunteer-run English

Marie Alessi and her sons.

programs offered in the community. Scheduling clashes, inconvenient locations and the formality of these courses are often cited as reasons why many women –busy raising children, caring for their families and working – choose not to enrol.

Learning English is a often a complex process for people whose first language is not English, especially for those coming from conflict-ridden regions. Many carry years of trauma, severe mental health issues, illiteracy (particularly among women), and other issues stemming from their displacement. As a result, prioritising language classes and practice is difficult. For many new arrivals, the demands of settling into Australia – navigating bureaucracy, understanding welfare systems and managing the daily responsibilities of family life – leave little time or energy for learning English, making it a low priority or even overlooked entirely.

Often, women are the ones who miss out. Responsible for running the household, caring for children and sometimes looking after elderly family or community members, women frequently struggle with class scheduling clashes, inconvenient locations and the formality of many English courses.

While this is not the case for all women, this scenario highlights the significant challenges faced by people from non-English communities and the complexities involved in designing and providing language and communications services for such a diverse group of people.

Reproductive health resources: Knowing who to talk to, and where to find good pregnancy care

Credit: allanswart

A crucial part of providing health services is ensuring that the right people – such as the women and their families – know where to find them, and feel safe and respected when attending. Involving non-English speaking women in their pre- and post-natal care is, surprisingly, a relatively new concept at the system level. Different states offer varied programs to help people from non-English speaking backgrounds, particularly women, and many services collaborate across state lines. However, without a coordinated, standardised national health policy, it will remain difficult for governments and service providers to efficiently – and compassionately – meet the complex needs of this Australian population.

Take the state of Victoria as an example. The maternal and child health (MCH) service in Victoria is a joint local and state government-operated, cost-free and comprehensive service available to all mothers of children aged 0 to 6 years. However, findings from a 2012 study suggest that "language and cultural barriers influence access, resulting in people with lower levels of English feeling less positive about the usefulness of their visit to the MCH, and less likely to continue using the service". The study suggests that these issues can be mitigated through culturally responsive services.

The study also found that for new arrivals to Victoria, *"awareness of the MCH service can be challenging, as there is no formal mechanism for MCH nurses to be notified of these families. Services initially engage culturally and linguistically diverse (CALD) and single and/or young mothers well, but subsequent disengagement results in reduced levels of service utilisation and satisfaction"*. Similar to many other evaluations and studies, the paper found that universal health services, including maternal health nurses, need to better understand the experiences and needs of disadvantaged and/ or vulnerable women, children and families, and particularly the factors that facilitate or hinder decisions to accept or access these services.

This situation is further complicated by confusion around what people are are entitled to under the Medicare system. Many members of non-English speaking backgrounds (which includes migrants and refugees on certain visas) are ineligible for either a Medicare or Centrelink Health Care Card, which means the services Australians may take for granted– including the Pharmaceutical Benefits Scheme (PBS), under which the federal government subsidises the cost of some medicines – are out of reach.

"If the client is a refugee (so has a permanent humanitarian visa, and therefore is a permanent resident with Medicare) or an asylum seeker with Medicare, and they went via a public hospital in their catchment, then the cost of pregnancy and complications would be bulk billed to Medicare," explains Clare Brotherson, the operations manager at Mater Refugee Health, which oversees the Mater Refugee Complex Care Clinic (MRCCC) in Queensland.

"However, there are other expenses that are not covered for pregnancy by Medicare, such as some scans and the NIPT test (blood test), which is an optional test that costs upwards of $400, and is not covered by either Medicare or private health rebates. So, potentially, women from migrant and refugee communities, and all women who have significant financial insecurity, may often not be able to access these diagnostic tests." Brotherson points out the same is applicable for medications required during pregnancy such as pain relief, supplements (i.e. folate), medications to treat gestational diabetes, thyroid issues and many more. *"If you are unable to afford these medications, this can be a high risk to both mother and baby,"* she adds.

Comprehensive maternity and reproductive health services extend far beyond the childbearing period. Dr Rachel Clayton, one of four part-time doctors who works at the Mater Refugee Complex Care Clinic, highlights that women need check-ups for a range of issues, including menstrual health and abnormalities including irregular periods and heavy bleeding; pelvic pain assessment, which can include assessment for endometriosis; contraception; termination of pregnancy; sexual health issues including STIs; cervical and breast screenings; immunisations; fertility concerns; pregnancy planning and more.

Awareness of these services and their importance in a woman's overall health is a fundamental right. However, for many women from non-English speaking backgrounds, this right remains inaccessible. The perinatal period is a significant transitional stage in life, often marked by increased vulnerability to physical and mental health issues. For women from non-English speaking backgrounds, this time is particularly challenging, especially when it comes to health outcomes for themselves and their children. Research shows that they are more likely to face language barriers, cultural isolation, and discrimination when accessing essential reproductive services.

"When we treat someone, we look at the whole picture – cultural beliefs, social support and housing – because providing a holistic type of care for patients is something important to all of us," says Dr Clayton.

Putting the issue of access temporarily aside, it takes a certain level of language, literacy, confidence and cultural understanding to get the above information in the first place. Associate Professor Elisha Riggs, the Murdoch Children's Research Institute's (MCRI) Senior Research Fellow and Leader of the Refugee and Migrant Research Program, Intergenerational Group, has a long history of working with migrant and refugee communities, and has spent the past 12 years looking at how to improve the health experiences of non-English speaking women.

"We started by working on a project with the Afghan community in south-east Melbourne," says Dr Riggs. "We know there are poorer maternal health outcomes for women from these communities – mental health, stillbirths, low birth weight babies and preterm births – compared to the general population."

"We embarked on a partnership with Foundation House, a specialist refugee trauma agency, to understand what was happening for women, men and families at the time of having a baby." The project, which drew extensively from engagement and involvement with the Afghan community, laid the groundwork for the next 10 years of the research, says Dr Riggs.

In response to the lack of evidence regarding the experiences of women and men from non-English speaking backgrounds, particularly within refugee communities, when using universal maternity and early childhood health services, as well as to address concerns of health professionals, the researchers conducted interviews with 16 Afghan women and 14 men with a baby aged between four and 12 months, along with 34 health professionals.

"Some of the key learnings were that many women lacked understanding of how the maternity system works, and how to access understandable information. There is lack of access to interpreters during maternity care and during childbirth, as well as postnatally," Dr Riggs says. *"Another issue for the Afghan community was not having a choice in the gender of interpreters – women prefer female interpreters, especially when it comes to women's health issues. In addition, there can be social isolation experienced after having a baby which can impact access to information and local knowledge about services."*

Armed with information gleaned from the *Having a baby in a new country: The views and experiences of Afghan families and stakeholders* report, Dr Riggs and her colleagues wanted to establish a program that would provide a wrap-around service for refugee women and their families. The result was the group pregnancy model – a world-first.

The group pregnancy model includes a team of five multidisciplinary staff running a group session for two hours every fortnight for a specific group of pregnant women. During this time, women can ask or talk about anything: their baby, pregnancy, family life, financial situation, health issues, other children, even filling out paperwork. No topic is off limits. The program operates outside the hospital and in the community, and includes time for maternal health nurses and pregnancy appointments.

Two programs started in 2017 – one for the Karen community in Werribee and the other in Craigieburn for the Assyrian community. Post-pandemic, the Karen program has moved online.

"We are testing the model and evaluating them," Dr Riggs says. "We know women enjoy this program, health professionals enjoy it – there is less burnout and higher staff retention. The problem is, we have not secured funding to trial it with other communities on a larger scale, or even to do a longitudinal follow up of these women and their babies to see whether their outcomes are improving over time."

‘Happy Mothers’: a new type of pregnancy care

Craigieburn is a satellite suburb located on the urban-rural fringe of Melbourne, 25 kilometres north of the city centre.

Marie Treloar is a midwife and childbirth educator, runs the Happy Mothers group specifically for Assyrian/Chaldean women (from Iraq and Syria) in Craigieburn. She works with a team of professionals, including a maternal and child health nurse, an interpreter, a parent support worker and a bicultural worker. The Assyrian/Chaldean populations, mainly displaced from Iraq, comprise a large sector of the non-English speaking population in the northern suburbs of Melbourne. The 2021 census found that Assyrian Neo-Aramaic and Chaldean Neo-Aramaic are two of the most commonly spoken languages in Craigieburn (4.8% and 4% respectively). Almost half (40%) of all residents of the City of Hume (the local government area within which Craigieburn lies) were born overseas, hailing from 156 different countries and speaking more than 150 languages.

Because of its large refugee population, the area was selected by the Murdoch Children’s Research Institute to be one of four regions in Melbourne to pilot an innovative approach to antenatal and postnatal care. The Happy Mothers group evolved from the pilot in 2017, and continues to take place fortnightly at the Craigieburn Centre, addressing topics related to pregnancy, childbirth, parenting, breast feeding, contraception, and health and wellbeing.

It is considered an innovative model of care that not only provides women with standard clinical pregnancy care (carried out by the midwife), but also culturally appropriate preventive health care, aided by an interpreter and a bicultural worker who offer women support and information in their own language, and through the prism of their own cultural experience.

When I arrive, the team is already waiting in a small, beige room just off the main clinic. Treloar is running late so I introduce myself, take a seat at the table in the centre and eagerly await the arrival of the expecting and new mothers. Unfortunately, it is not to be.

“We recently swapped bicultural workers, and we think this has disrupted the dynamic of the group,” says maternal and child health nurse, Bronwyn, after about 20 minutes of waiting. “They’re basically the community engagement,” Treloar explains. “They’re the ones that have that direct contact with the community through apps like WhatsApp. So if a new person comes in, or one of the existing mums brings in a new person, they join that group and the bicultural worker organises it all, sends out reminders, checks on how everyone is doing.”

A bicultural worker is an invaluable addition to any health team, and one whose role is firmly rooted in evidence. According to several papers evaluating different models of pregnancy and

postnatal care in Australia, bicultural workers support service navigation, enhance communication between service providers and women, and enable continuity of care and culturally appropriate support. When evaluating a similar program to Happy Mothers taking place in Sydney during 2017 — researchers from the University of New South Wales and the University of Technology concluded that *"...the Cross-cultural Workers (CCWs) service was highly regarded by service providers, and perceived as supporting access to health and community-based services, and improving the healthcare experience for women through the ability of the CCWs to act as a bridge to health ... by forming close supportive and trusting relationships with clients".*

Jasmine Phillips, who leads the bicultural program at cohealth, a not-for-profit community health organisation providing services in Melbourne's CBD, northern and western suburbs, says bicultural workers are an extremely important, yet under-funded and under-valued resource within the broader healthcare system. *"Most refugee communities are mistrustful of mainstream services, so they are unlikely to report family and sexual violence, mental health issues and more,"* she explains. *"Bicultural workers help build that trust between the community and services, supporting system navigation, facilitating referrals, and most importantly they advocate for cultural safety etc."*

Treloar says her recently departed bicultural worker also went above and beyond. *"She did a lot more than she really she needed to. If something came up for the women, like needing new clothes, going to the doctor, post office etc, they would contact her and she would make the time to help,"* Treloar says. *"She really had this beautiful relationship with them,"* she adds.

The role of bi-cultural workers in women's health

We've already seen that Western healthcare systems can be poorly structured to meet the cultural and linguistic needs of many women in Australia — and even the needs of immigrants whose first language is not English.

This is where bicultural workers like Fidelite Nkurunziza come in: they are fundamental to the way refugees experience healthcare delivery in Australia. Without them, important and nuanced information gets lost, and even simple exchanges can become difficult. Effective communication goes beyond mere words: it allows for the transference of values and beliefs into a seemingly separate context, which, if done sensitively, contributes to better outcomes for both the patient and healthcare professional.

Nkurunziza first came to Australia as an asylum seeker in 2008. The Burundian national, who speaks French, Kirundi, Swahili and Burundi (an African language of the Bantu family spoken in Rwanda, and used officially in administration, schools and media along with French and English) became interested in interpreting when she realised the unmet need within the central-east African community in Australia.

"I realised there weren't many interpreters here for my language groups, so I applied and started to work with (interpreting service) ABC Multilingua," Nkurunziza says. *"During this time, I was getting a lot of jobs at Refugee Health Service, so when they announced they were recruiting for bicultural workers I applied. Here I am, 11 years later."*

The Refugee Health Service (RHS), is a specialist state-wide health service for newly arrived refugees and asylum seekers in South Australia. Nkurunziza's work here is vital: not only does she translate complex health and administrative information for people who may have been living in refugee camps for as long as 40 years, but she is often brought in to buttress interactions in a culturally safe and appropriate manner. *"It's part of my job to introduce the Australian health system to our new arrivals,"* she says. *"Our clients come from so many different countries and backgrounds, and their experiences with healthcare range from poor to good, depending on where they've been."*

Many people from non-English speaking communities find it surprising that GPs play such a central role in the delivery of health care in Australia. In other countries, Nkurunziza explains, people can see a specialist without first seeing a GP, and hospitals are considered places where you only go when very sick. *"I tell new arrivals about how the health system works, that the first contact will be your GP."* She also emphasises respecting appointment times when booking to see a health professional.

"Because most of our clients need interpreters, it's important they show up on time to see the doctor so that we don't have to reschedule the appointment," Nkurunziza tells me. *"This is not because they are being rude: some patients just don't understand why they have to attend a follow-up appointments after a blood test or scan when they're not sick."*

Nkurunziza's role is extremely important; and yet, what constitutes a bicultural worker varies significantly, as does their implementation in maternity and reproductive healthcare. Broadly speaking, the role of a bicultural worker extends beyond that of an interpreter: often they act as a resource of cultural and community knowledge for service providers, helping new refugees navigate the complex requirements of our healthcare system.

A 2022 review of the experiences of women from Myanmar found that bicultural workers improve health literacy skills and knowledge for Karen women (an ethnolinguistic group of Sino-Tibetan language-speaking peoples who live mainly in southern and south-eastern Myanmar) by having unique insight into the needs of their peers, and acting as cultural health brokers.

Back at the Happy Mothers meeting, I'm told it's not just the absence of the bicultural worker that's proving an obstacle to attendance this week. The women who attend are often left without transport (many can't drive, and some don't want to learn lest it make them too 'independent' for their husbands' or family's liking, the team says); it's school holidays, so their older kids are with them; or they may have simply forgotten. English is not their first language – some of the women don't speak a word and don't want to even learn, again out of fear of becoming too independent, as well as too embedded within the wider Australian community.

"For many of these women, it's like living in small Syria or Iraq," says Shatha, the interpreter. *"They think, we don't need to speak English to get around: all the shops I visit, the doctors — even the dentist and teachers at my kids' schools — speak Arabic."* And it's not just the Assyrian community who seeks a more gated life. *"I know many older immigrants from Greek and Italian communities, for example, who have been here for 50 or 60 years and still don't speak English,"* adds Treloar. *"They get by. I don't know how many times I do a home visit and the children are doing the interpreting. It's slightly uncomfortable and unacceptable, but you get by."*

All five women believe that learning English, even the most basic words, would help these vulnerable women learn to better navigate a system that is difficult even for the Australian, English-born population. It would help women state their preferences around birth and maternity care, and help articulate important information such as cultural beliefs and preferences around the involvement of the father in pregnancy and childbirth, acceptance of tests and interventions, willingness to be cared for by a midwife rather than a doctor or a woman rather than a man, understanding of dates and times of appointments, and knowledge about medical aspects of pregnancy.

"I still think English is a skill that would help them to assimilate into society and make friends," Treloar adds. *"Our role is to encourage that, and to encourage that confidence and independence."* She and her team often encourage the women who participate to practice their English while they are there. Many women shake their heads and smile shyly, either too embarrassed to speak or unable to.

"There's one 23-year-old young mother who has really surprised us," Treloar says. *"She doesn't want to learn English, get her licence or go to work. She quite likes being dependent on her husband and doesn't have ambition beyond that, because she grew up with certain values that are shared by her husband and family."* Low English proficiency, especially in the context of pregnancy, severely limits a woman's capacity to ask questions, provide information to health professionals, understand what is happening and make informed decisions. It also restricts health professionals from imparting important information.

And yet, many women either choose not to learn, or are prevented from doing so by lack of support, both institutional and family. *"Women already start off on an unequal playing field when they arrive,"* Treloar continues. *"They don't know the language, they have no access or don't know the system, so of course they are going to remain with whatever their circumstances are. Many feel the system is already against them, and they don't feel comfortable."*

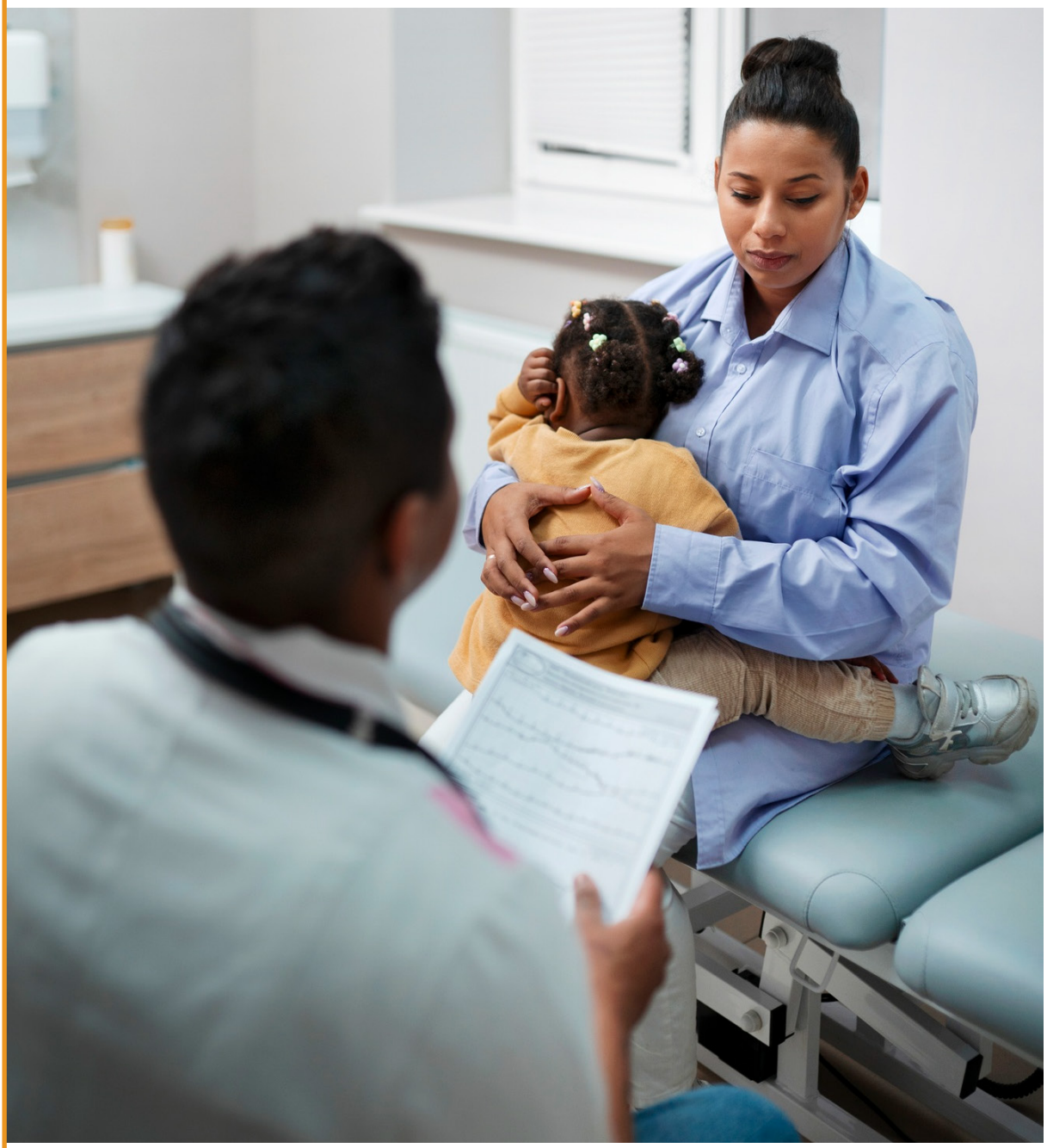
"But unbeknownst to them, we are planting the seed for them. We encourage them to speak English, which is a skill that would help them assimilate into society and make friends. If you speak English, then you're have more opportunities to build relationships with co-workers, with other people. It's a vital skill."

Communication difficulties have consequences for both mother and child, and can even result in death, especially if lack of English proficiency affects a woman's understanding of when and how to seek emergency care (one of the contributing to maternal deaths from ectopic pregnancy and stillbirth).

In a 2022 analysis which examined 27 studies to determine how women from non-English speaking backgrounds perceive and experience the continuum of maternity care in Australia, the

researchers identified 24 findings, many of which had to do with language barriers. Issues such as being unable to give informed consent for treatment due to not understanding what the treatment was or why; being unable to make or keep healthcare appointments, which further contributed to the women's distress; being unable to assert wishes and ask questions of staff due to lack of language skills; and not being offered translated health resources, often contribute to a refugee woman's pregnancy and postpartum journey.

The paper also found that women *"... valued (appropriate) interpreters, as they allowed women with limited English proficiency to engage with health workers and to have greater input into their care".* When made available, professional interpreters were well-received by most women, helping to reduce fear and confusion.



The role of interpreters in reproductive health care

It's not always possible to have a trained interpreter present, and sometimes, doctors or patients may choose to rely on other methods of communicating, such as Google translator and/ or family members. Neither option is optimal, and pose significant drawbacks for the healthcare women of non-English background receive.

"Informal interpreters are not accredited, which is not generally permitted in healthcare," says Dr Riggs. "The problem is when there is a new and emerging community, where there's often no interpreters available in the right language, which is when services and clinicians tend to rely on informal interpreters."

For the professionals themselves, encountering women who struggle to communicate in English can also prove to be a wake-up call about their own service delivery. Because many GPs have a limited amount of time per consult, they are often unable to provide adequate care for populations who struggle with English; whose past experiences with authority have left them scarred and unable to effectively communicate; and who may not be comfortable relaying certain health conditions to doctors of the opposite gender.

These interactions are therefore crucial for health professionals to address gaps in their own communication style and delivery of care, and to more seriously consider the role of professional interpreters and translators as a regular part of their service delivery.

It's important to distinguish between formal interpreters – qualified professionals who enable communication between people who speak or sign a different language – and translators, who only deal with written information. Interpreters are usually the ones called to help women of non-English speaking background, and their job is to interpret everything that is said or signed without adding, modifying or excluding information.

Interpreting is also not a word-for-word situation: some concepts may not exist in other languages and may need further explaining. Sometimes it also means interpreting statements even if they are incoherent, nonsensical or unclear in the original language. In Australia, hospitals provide free access to interpreters, either in person or over the phone. The Australian Government also offers a free dedicated Translating and Interpreting Service (TIS National) for people who do not speak English and for organisations, including medical and health practitioners, and emergency services, that need to communicate with their non-English speaking clients or service users.

Most importantly, professional interpreters are trained to be as impartial as possible, whereas family members – and programs such as Google translate – are open to bias, confusion and misunderstandings.

As a result, many issues can arise. A recent study looking at the provision of interpreters in South Africa states that using family members, friends or neighbours as interpreters in a medical setting *"...poses serious challenges related to confidentiality, impartiality, increased errors in interpretation, and may distort the message due to cultural reasons or personal agendas".*

The nature of the industry itself is a problem: interpreters come from a highly casualised and unstable workforce, often working for multiple contracting companies, which means no continuity for women and families and for the doctors who request them. This is especially problematic in maternity care services, which tend to be 15-minute appointments.

"Even if an interpreter is booked for an appointment time, appointments often run over time, or the interpreter is back-to-back that day with various organisations and can't always wait around," Dr Riggs says. *"Just expecting an interpreter to slot in isn't always feasible, especially in childbirth, which is often unpredictable. There are many events that are unpredictable and you can't always have someone pre-booked, so you have to rely on connecting to an interpreter via telephone."*

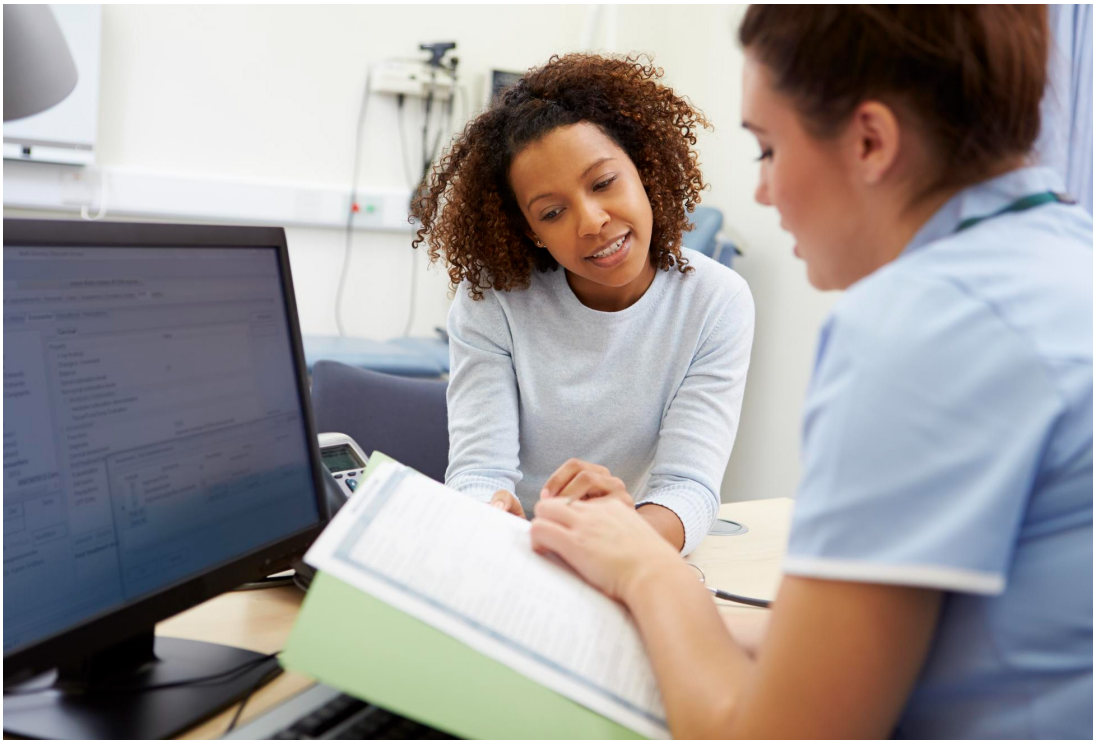
The use of children as intermediaries between doctors and their parents is particularly problematic, and many experts believe they should only be used in emergencies. Even in unavoidable situations, using children requires careful consideration of the context: for example, asking a 10-year-old son to take a menstrual history from his mother, is very different from having a 16-year-old daughter inquire about her father's diabetic medication.

Dr Riggs also highlights the persistent perceptions in the health workforce that continue to be barriers to accessing formal interpreting services. "Some believe the interpreter service is expensive," she says. Nationally, there is also the Free Interpreting Service (FIS), which is available for specific service providers that are not substantially government funded. These include medical practitioners when delivering Medicare-rebatable services in private practice, pharmacies, non-government organisations (NGOs), and eligible allied health professionals providing Medicare-rebatable services within specific local government areas and more.

"We also hear that patients might avoid requesting an interpreter because they feel like it is a burden to the service," Dr Riggs says. There are ways to solve these problems, and they require thoughtful and deliberate action.

"The skills and competence of interpreters is important," she says. "*And the ability of the clinician to work effectively with an interpreter is just as important. They need to be able to have time to discuss concepts that lack direct translations or specific medical terminology, such as stillbirth or depression, and decide how to approach these linguistically and in a culturally safe way."*

Again, this issue largely revolves around the availability of interpreters, and an understanding of their value, particularly in a medical setting. Dr Riggs says that employing interpreters directly (like Shatha at Happy Mothers) is an effective way to ensure ongoing access to interpreters, and can build positive relationships between clinicians, interpreters and patients.
"It works well when interpreters are employed directly by the service and embedded in the maternal health team – the interpreter gets to know the clinicians and vice versa, this stability enables them to become part of the team." This arrangement also allows clinics and health services to operate more flexibly, which is crucial in maternity care, Dr Riggs says.



Culture matters: delivering culturally responsive reproductive health care

Credit: Sergey Dolgikh

“Dear health professional,

I hope this letter reaches you before tomorrow’s appointment. My health and safety and the health and safety of my baby are important to me. So I want you to know what good culturally safe care looks, feels and sounds like to me.

Sometimes when I receive health care, health professionals treat me like I don’t belong. Some people here don’t understand or respect me. Not just because of how I look and talk, but because people don’t understand me as a Karen woman. If I can share my story with you, maybe you’ll understand who I am and where I’ve come from. You could even ask me, because I want to tell you my story. I want to know yours too.

Through storytelling, I can look back at what I’ve become. What I’ve overcome and what I’ve achieved. I’m so proud of myself. I know I can come to people like you for help and support. I want to be welcomed into pregnancy care that makes me feel good, even after I leave. But if you treat me like I’m different to you and make me feel like I don’t belong, I may find another way to help myself. I can do anything I put my heart to.

I have strong connections to my family and my community. When times are challenging, they make me feel good and remind me that I actually do belong. When I feel like I belong, my heart feels good. If you welcome me to your care, I know I will have a happy heart.

I understand you will have had different life experiences from me. Still, it would mean a lot if I could see that you understand my story and my journey. If you show me kindness, empathy and compassion, despite our differences, we could celebrate me, my culture and yours too, together.

I share this with you in the hope that you will understand what a good pregnancy experience means to me. Because when I can be my true self with you during my pregnancy, I know I can feel safe and believe that I belong.”

This letter, read out in S'gaw Karen by Karen woman May at the unveiling of the photovoice study Refocus, illustrates the deep-set desire of women from non-English speaking backgrounds to be heard and respected during one of the most vulnerable and significant periods of their lives.

May – one of the participants of Refocus – is heavily pregnant with her second baby, scheduled to be delivered the next day. Despite this she moves lithely, smiling warmly at everyone who congratulates her.

May is one of five Karen women (Karen people are Indigenous to the Karen State, located in the country formerly known as Burma) living in the municipality of Wyndham in Melbourne's outer west who participated in an Honours study aimed at understanding what culturally safe pregnancy care is to Karen women.

The study, called Refocus, is the brainchild of Rowena Coe, a midwife, graphic designer and research coordinator within the Refugee and Migrant Health Research Program at the Murdoch Children's Research Institute (MCRI). Refocus uses the photovoice research method, where participants take and select photographs to reflect upon and explore the reasons, emotions and experiences behind their chosen images. The study invited five Karen women who have had a baby in Victoria to explore their understanding of cultural safety in pregnancy care through group discussions and photos from their own communities.

"We talk about cultural safety in the midwifery program, without asking women what it means to them," Coe says. *"And that's the main issue: only the person receiving care can determine if their care is culturally safe."*

Having identified a significant gap in the literature which showed that no studies had asked women of refugee and non-English speaking background what culturally safe pregnancy care is to them in Australia, Coe wanted to work closely with a particular community to find out exactly what they considered to be culturally safe care.

Working extensively with the local Karen community, she invited professional photographer Kim Landy to give the five participants a basic photography skills workshop, inviting the participants to take photos of things that signified, or helped them talk about, safe pregnancy care.

"What surprised me the most was that women shared what was safe to them by sharing what was unsafe, such as the inherent disrespect they can feel from other people, including from their body language," Coe says.

The Karen people have suffered terribly at the hands of the Burmese military since the 1940s. Due to this sustained oppression by the military, thousands of Karen families have faced genocide and persecution, forced to flee their homes in neighbouring countries such as India, Bangladesh, and Thailand. Fifty-three per cent (7,165 people) of the Karen community in Australia have resettled in Victoria, and, with unresolved conflict in Burma, will continue to be forcibly displaced and seek asylum in countries such as Australia.

Shadow Toke is a PhD candidate at MCRI and former bicultural worker, who also acted as translator to May as she read the letter. Toke is the youngest of five daughters from a very active Karen family in Melbourne's west. During her speech introducing May, she talked about how working with Coe and MCRI has given her a purpose, a chance to help her community.

"I grew up here in Australia, and mainly focused on studies," says Toke. *"As I got older and started working, I focused mainly on the jobs I needed to get. Although my family members were well embedded in the community, I, as the youngest, still hadn't found my purpose or duty for my people and community. Then I started working at the Murdoch Children's Institute as a community researcher within the Karen community. Little did I know going into that role would open the floodgates to the passion and purpose I'd find".*

Culture plays a major role in everything that we do, and that includes our relationship with the healthcare system. As Victorian researchers point out in their 2020 study exploring the critical barriers to English language learning for Afghan refugee women in Australia, women from this cohort tend to come from a strict patriarchal society that does not prioritise the education of women, and largely confines them to domestic roles.

"Since the 1979 Soviet invasion, few women in Afghanistan have had the chance to receive formal education," the researchers write. *"When the Taliban ruled much of Afghanistan between 1996 and 2001, girls over the age of eight were banned from attending school. A severe lack of infrastructure further restricted many women's access to education. As a result, only around 12% of women over the age of 15 were literate in 2012".*

While this is not the case for all non-English speaking communities, a lack of exposure to education impacts many women. Combined with different belief systems and understandings of medicine and science, one can see how arriving in a country governed by Western science can be confusing — and even triggering.

Because Australia's health system is shaped by scientific principles underlying Western medicine, at the upper levels of bureaucracy, we often fail to consider the significance of personal experiences, interactions with others, information from mass media and the internet, and membership of social class, gender or generational groups, as well as racial or ethnic groups, when setting policies – including health policies.

While many Westerners believe that preventive care, regular doctor visits and taking strong pharmaceuticals are the norm, these beliefs are not universal. They reflect what we value within our broader Western culture — and, perhaps more tellingly, within our microcosm of Western culture.

As Australian researchers point out, *"... pregnancy and childbirth are complex because they are both biomedical, yet also hold deep cultural significance for women and their families."*

When culture and traditional practices meet Australia's Western health system

When many of us think about the medical system underpinning Western countries, we tend to view it as scientific, a system divorced from cultural and traditional influences. The perinatal journey is heavily managed, with regular scheduled appointments, blood tests, ultrasounds and a host of other consultations throughout the prenatal and antenatal period, depending on the complexity of the pregnancy.

Yet, assuming that the West's health practices are solely based on science and separate from culture is not only incorrect, but can be damaging when dealing with people who come from non-Western, non-English speaking backgrounds. As University of New South Wales Professor Deborah Lupton explores in an article for The Conversation, linking 'culture' with 'medicine' can lead to a 'culture crash' between doctor and patient, especially if it is assumed that people from non-Western backgrounds hold fundamentally different beliefs about the causes and treatments of illness to 'science-informed' Westerners.

Despite the objectivity implied by the scientific principles underlying Western medicine, *"...it is still underpinned by a host of assumptions and beliefs developed through living in Western culture,"* Professor Lupton writes. *"The white coat worn by doctors is a potent symbol of efficiency and hygiene ... and the bleeping medical machines found in the hospital setting convey their own meanings of high technological prowess."*

Yet not everyone is comforted by a white coat or being admitted to hospital. These beliefs reflect what is valued within our broader Western cultural context – and, perhaps more tellingly, within our microcosm of Western culture.

"A comparative study showed that the French tend to be less obsessed with germs and hygiene, but are more focused on the health of their livers, and their doctors treat them accordingly," Professor Lupton writes, adding that Americans, on the other hand, *"are generally germ-aversive and favour 'fighting' disease aggressively. Their doctors have a highly technical, 'no-holds-barred' approach to testing for and treating disease".*

In Australia, we have our own medical customs, which are heavily influenced by culture, government policies and prices. For people who are new here or who were not born into the culture, these customs and practices are not as self-evident as we may think.

Pregnancy, traditions and cultural considerations

Pregnancy and childbirth are already extremely complex events, even from a 'traditional' Western healthcare perspective. They are complex because they're biomedical – meaning they involve medical doctors and other healthcare professionals to treat symptoms using drugs, surgery etc – yet also hold deep cultural significance for women and their families.

The way a woman perceives care at this time in her life is influenced by not only her cultural values (such as preferences for pregnancy and childbirth, what is appropriate behaviour for health workers, their family members and themselves throughout pregnancy and birth) but also her conception of motherhood.

In a 2022 paper looking at non-Western women's perceptions and experiences of maternity care in Australia, researchers came up with 24 findings for policy makers — one of which focussed on trust in medicine and technology. *"Some women,"* the researchers write, *"expressed mistrust and scepticism towards modern Western medical technology and drugs, citing concern that these interventions could harm their babies."*

Some women also 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 healthcare.

When working with women who come primarily from non-Western, non-English

speaking backgrounds, it's vital to consider how culture shapes women's decisions and abilities to access care, their trust in healthcare providers, as well as interpreters and their need for confidentiality during the healthcare encounter.

It's also important to acknowledge that in more traditional societies, childbearing may be the most important role in a woman's life, and that a variety of practices and rituals exist to protect and support the new mother and baby, such as warding off the 'evil eye' in Middle Eastern cultures, and the avoidance of 'cold' foods for 40 days post-partum in many Asian cultures.

That said, while some women may express mistrust and scepticism towards modern Western medical technology and drugs because of concerns they could be harmful to their babies, other women appreciate having access to more advanced technology. Assuming that people from certain cultural backgrounds hold unilateral views of pregnancy and healthcare is the first step to miscommunication, which can result in profound implications for everyone involved.

This was the sense I got from my conversations with the women at Happy Mothers: while some welcomed the interventions and were surprised there weren't more, others were happy to be left alone to enjoy their pregnancy in a less biomedical way. What is important here is that these women had agency over their care; they were more informed, they felt part of a wider community where support was readily accessible and delivered in a non-judgemental manner.

The significance of explaining the intricacies of Australia's model of healthcare – and pregnancy and post-natal care – to women of non-English background cannot be overstated, as evidenced by another 2010 Australian study, published in Midwifery journal and exploring the experiences and concerns of African-born pregnant women receiving antenatal care in Melbourne.

In that paper, Victoria University researchers Professors Mary Carolan and Loris Cassar note that many participants expressed *"...shock and surprise at what they were asked to do, e.g. vaginal swabbing for group B streptococcus. Many women had never contemplated such an idea but were tolerant of procedures once they were explained to them."*

The women related misunderstandings and misgivings about common Western practices, including the use of tampons during menstruation, which are not used in some cultures. The use of internal ultrasound equipment can also be a source of confusion and fear.

"Sometimes magic goes into the woman's stomach where the baby is sleeping, so it is dangerous to see the baby before it comes out," one woman told Carolan and Cassar. *"I don't see why the doctor wants to look inside".*

Carolan and Cassar also note that for the most part, these women (most of whom came from the Horn of Africa and were principally from Dinka and Amharic cultural and linguistic backgrounds) understood childbearing as something women did simply because they were women.

"They approached childbearing in a fatalistic and pragmatic way, accepting it as God's will and their natural purpose in life," they write. *"As such, pregnancy was not considered special or as needing special consideration... When entering antenatal care for the first time in Australia, the women had difficulties understanding the different approach and were confused by the attention. Most participants had had babies in Africa and had received minimal antenatal care."*

Although the women all had experienced foetal or baby loss, either directly or indirectly, they nonetheless had little understanding of the purpose of screening tests or the need to monitor early pregnancy. *"In my country, we don't have this thing (Down syndrome). Maybe it is just in Australia,"* one participant commented.

Birth and language: how do non-English speaking women communicate during labour?

Credit: CraigRJD

Given the significant proportion of women giving birth in Australia who were born overseas, it is important that the Australian healthcare system and policies are responsive to the needs of these women. According to the latest data from the Australian Institute of Health and Welfare's National Women and Babies report, one in three women who gave birth in 2019 was born outside of Australia. For many of them, English is not their first language.

"If you don't know English well, it's that much more difficult for you to get an interpreter during labour and birth," Dr Riggs from MCRI says. *"Often, in childbirth, the husband and family members are relied upon to translate and interpret during the birth, which is problematic when it comes to signing forms around consent, for things like caesarean operations and medications."*

For Brazilian scientist Larissa, 43, the birth of her son in 2021 in Canberra, during peak COVID lockdowns in Australia, proved to be an extremely traumatic experience – and language was at the heart of it. She was rushed into an emergency caesarean after five hours of her baby being in distress, as the doctors were determined to pursue a natural birth. At one stage, she was in so much pain she started calling for "anaesthesia".

"When rushed to the surgical theatre, I was saying please give me anaesthesia, and they thought I was asking for someone called Anastasia," Larissa recalls. *"It was horrible. I was in pain and was devastated as I thought my baby had died ... and the nurses thought I was trying to ask for someone called Anastasia."* The language problems continued after she woke up following the C-section, panicked and desperate to see if her son was alive. *"My husband had our baby with him. But the anaesthetic switched my brain and I was speaking Portuguese only, and it took me a while to be able to switch back to English."*

What Larissa experienced was foreign language syndrome, a phenomenon where patients switch from their native language and fixate for a period of time on a second language. *"The baby was alive, I was so happy, but I couldn't speak in English and my husband, who is Australian, couldn't understand. But he saw I was pointing at our son and he gave him to me."*

Larissa's experience echoes that of thousands of women Australia-wide. Distressed, exhausted and left without a voice, she was forced to resort to gestures to be understood. But unlike those women whose English language skills are not just temporarily lost – but non-existent – Larissa was able to share her story. Her experience also highlights the need for interpreters in birth settings, often an impossibility as discussed earlier.

A paper looking at engagement of interpreters for women during labour found that while Australia has standards and guidelines for the use of professional interpreters in healthcare, evidence suggests that services fall well short of meeting these standards.

This gap in Australian maternity care was highlighted by a 2016 study (co-authored by Dr Riggs) which explored Afghan women and men's experience of language support during pregnancy, labour and birth, as well health professionals' experiences of communicating with people of refugee background with low English proficiency.

"Very few women who required language support at the time of labour had access to a professional interpreter," Dr Riggs and her co-authors write, adding that *"men commonly interpreted for their wives, and health professionals noted challenges when men were interpreting in the context of birth".* The paper also highlights that it is common to use a family member – even a child – to interpret in a healthcare setting, despite evidence this practice can lead to errors and adverse clinical outcomes.

The researchers also discovered that many doctors thought that using interpreters for women in early labour would cost too much, and that offering an interpreter to a woman in labour was not *"acceptable practice".*

"The gender of the interpreter is often important for women in general, and especially during pregnancy and labour,

as this is a time where sensitive topics are being discussed, often considered 'women's business'," says Dr Riggs.

Other issues with interpreting include the risk of re-traumatising the interpreter themselves. *"People don't realise that interpreters are often of refugee background themselves and interpreting for others from their community can impact their own mental health,"* Dr Riggs says. *"There's little support for interpreters in terms of their own de-briefing and mental health support regarding what they're hearing, witnessing and interpreting".*

The consequences of not being able to effectively communicate during birth were captured in an ABC article, which relayed the experiences of a 36-year-old mother who does not speak English. 'Liz', who has a background in medicine and dentistry, migrated from China to Australia in 2019 and gave birth to her son in January 2020.

She told the publication that the decisions she had made were not being followed in the delivery room but could not communicate it to the doctors. She said that while she had consented to anti-inflammatory medicine during the birth of her son, she had not agreed to be given Syntocinon — a synthetic oxytocin drug used to induce labour in women. *"I agreed they [could] give me anti-inflammatory drugs, but I did not agree ... that they could add oxytocin,"* she said. As a result, her birth was very fast and painful, and the language barrier made it a traumatic experience.

Larissa and her newborn son.

In lieu of formal interpreters, multi-lingual nurses – even if they do not speak the specific language of each woman they care for – are another valuable resource.

Ozge Fettahlioglu, a Turkish mother of two in her late 40s, tells me the diverse nurses present at her first birth in Newtown, Sydney, were amazing. *"When English is your second language, you can understand people from non-English speaking backgrounds better,"* she says. While she has no complaints about her Australian nurses, Ozge says their *"thick Australian accents"* were sometimes difficult to understand, especially in a stressful situation like birth.

"Your brain works differently when you speak a couple of different languages; you pay more attention to body language, to facial expressions. When some of the nurses saw I didn't understand something that would demonstrate it until I did."

Ozge's experience shows the importance of having ethnic and cultural diversity in health settings on yet another level. It's about incorporating that mindset that comes from having lived as a migrant yourself, or having family members who come from another country, when dealing with people from non-Western, non-English speaking backgrounds with nuance and sensitivity.

Ozge Fettahlioglu, husband and newborn.

Community help: what it takes to accurately deliver health information to women without English

This is where the role of community becomes crucial. As researchers, clinicians and governments increasingly realise, bridging the cultural divide often requires input from the community itself. Happy Mothers, which combines community participation with mainstream health advice, exemplifies how both can result in culturally sensitive and informative healthcare for women from non-English backgrounds.

When I return for a second session, Michelle, the parent support worker from last time is here, as is Bronwyn, the midwife. Marie Treloar, program head, is sick today. There are two other women that I don't know (I suspect one is the new bicultural worker). Michelle tells the pregnant woman – 'Mary' – that I'm here to observe their discussion and ask questions, if she is ok with that. Satha translates and Mary smiles at me and nods.

The women continue their discussion. Mary, who has been diagnosed with gestational diabetes and is 28 weeks pregnant, wants to know if being given 20 units of insulin is a lot. Bronwyn looks a bit surprised and says Mary may end up developing diabetes outside of pregnancy and to be careful.

They discuss Mary's diet (she wants to know if she can have brown rice, pasta and bread sometimes) before moving onto how she's feeling physically. Mary groans and laughs awkwardly. She is sore, her back hurts and she is finding it difficult to run around after her two young daughters.

"Are you exercising at all?" Bronwyn asks. Satha translates and Mary shakes her head before breaking into rapid-fire Arabic. *"She says she is worried about further damaging her back and hurting the baby,"* Satha says. The experts then suggest Mary go swimming, but have to convince her that it won't hurt her baby. The atmosphere is relaxed: there is banter, a goodwill that is lovely to witness. Clearly, Mary is comfortable and she feels safe.

Towards the end of the session, I ask her some questions (through Satha) about her previous pregnancies and how the care in Australia compares to that overseas. *"My first child was born in Lebanon and the second was born in Iraq. While in terms of care and appointments, Lebanon was really good, but Australia is better,"* Mary replies.

Here, she feels supported and encouraged to ask questions. There are, however, many appointments to attend. *"In Iraq, you go to your appointment, your doctor sees you and off you go,"* Mary recalls. *"Here there's all these follow-up appointments; it's hard to attend them all."*

She is very aware of her pregnancy, her health and what is good for her and the baby but acknowledges that she is more curious and engaged than other women in her community.

Next, we call another regular attendant (let's call her Rdita), who would usually attend but is currently looking after sick kids. Rdita, who arrived in Australia in 2019, is a confident and independent mother of three: a 10-year-old, a 2-year-old and an 8-month old. Two of them were born in Australia under the stewardship of the Happy Mothers group.

"This group was a great help to me when I was pregnant, after giving birth and even with a toddler," Rdita says. She has no complaints about her pregnancy care in Australia (only that the appointment waiting times take too long).

The session flows by, the women sitting in comfortable camaraderie. Every few minutes someone asks a question and laughter breaks out, followed by quiet contemplation. It strikes me that none of this would have been possible without Satha and the bicultural workers who give up their time for free – and make room in their hearts – for some of Australia's newest arrivals.

Effective communication is only possible when there is warmth, trust and understanding between people. Language, too, is not just a means of expressing our thoughts and ideas; it also carries cultural values, attitudes and identity. As such, those who interpret act beyond a mere language conduit, becoming a cultural liaison between the patient and the provider.

Trauma-informed care

One of the biggest issues preventing Australia from bridging the women's health gap between non-English speaking communities and the rest of society is a lack of, and sometimes unwillingness to understand, the unique perspectives and past traumas of the patients our health professionals serve.

The Western medical model on which Australia's is built relies on specific cultural norms that often differ from those of refugee and migrant backgrounds. Moreover, non-English speaking communities are diverse, comprising various regions, economic statuses, cultural, linguistic, educational and religious backgrounds, each with different views on authority.

"As a doctor, you often share the same assumptions as other Australians (who have been raised here) when interacting with the medical system, which is generally seen as benevolent," says a Melbourne-based surgeon. She has agreed to talk frankly but anonymously about how her profession interacts with patients who have not been born here, and whose first language is often not English.

"We [the health professionals] don't consider that people are actively suspicious of us most of the time, whereas many refugee and even some more established migrant communities have historical contexts or personal experiences that would make them deeply suspicious of the organisational aspects of healthcare."

She recalls a time when a woman, deeply traumatised from a war injury, was reluctant to enter an ambulance. *"Seeing the ambulance uniforms was terrifying, because it reminded her of military people picking people off the street and taking them away."*

"This is one example: we see many populations, some of whom have been very mistreated by our government on the way here. This undermines that relationship between healthcare professionals because we are seen as functionaries of the government who may have put some of these people in detention."

In its submission to the NSW Inquiry Into Birth Trauma, the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) highlights the impact of torture and trauma on many non-English speaking communities. STARTTS, which helps survivors of torture and trauma – mainly refugees or asylum seeks due to organised violence and state terrorism – argues that such experiences, alongside resettlement challenges, significantly influence pregnancy, birth and postnatal

experiences.

The submission highlights the importance *"...of women having access to a safe birthing environment"*, and notes that *"the modern, biomedical birth spaces commonly used in Australia may not sufficiently create a sense of safety. This is due to the biomedical space commonly functioning as a place for medical interventions to occur, where the woman is under surveillance, with minimum opportunities for privacy, or access to fresh air and scenery. In such an environment, a woman can become passive, hypervigilant and distressed."*

Labour and birth: the doulas that help

Entering labour and the birth ward without a good grasp of the English language can be traumatic, and while interpreters are technically available, they are a scarce resource that must often be arranged in advance.

As a result, many women rely on their husbands, family members, and sometimes a friend or neighbour. These scenarios are not ideal, and hospitals often lack adequate resources to meet their needs.

This is where organisations such as Birth for Humankind, step in. This not-for-profit provides doulas for women of refugee and migrant backgrounds who generally do not speak English.

"More than 80% of our clients have no other support person," says CEO Red Dearnley. They cite a young mum at Royal Woman's Hospital in Melbourne who was struggling with mental health after recently losing her mother and moving to Melbourne.

"A social worker at the hospital saw that the mum had no social support, so she referred her to us for continuous support from a trusted professional."

Nearly two-thirds of Birth for Humankind's referrals come from social workers at public hospitals; more than 25% are of refugee or asylum seeker background.

"We serve diverse populations: last financial year, our clients spoke 27 different languages – 21% of all clients required an interpreter – with Arabic, Farsi, Oromo and Vietnamese being the most common," says Dearnley. While the organisation cannot provide doulas in every language *("most of our doulas are volunteers")* all doulas are trained to provide culturally sensitive, trauma-informed care and work with interpreters.

A doula provides individualised, responsive care. That means they support the client to articulate their own, unique needs and circumstances – and to find the confidence to advocate for themselves and their rights.

Doulas are not midwives and don't duplicate the role of midwives – they complement clinical midwifery care with additional personal, emotional, practical, social support skills. But all the women who volunteer as community-based doulas that Dearnley works with are trained birth professionals, either having completed Birth for Humankind's doula training program, already being trained doulas, or being trained midwives. The most important thing, Dearnley stresses, is that they understand the system and have the skills to provide stable, trustworthy and informed support.

"A community-based doula helps people navigate an unfamiliar system with confidence and this support is known to improve birth experiences and outcomes. That could be as simple as having someone explain in advance what will happen during an appointment or procedure and take the time to break down then things that may otherwise get lost in translation in a quick appointment.

Having someone else there listening, to talk through the appointment, to help them search through options," they say. *"It's having someone talk through options with you, such as what having an induction practically means and practically involves (she says some people think it's just an injection, as an example)"*

Farzana Parwizi, a doula with Birth for Humankind, first became acquainted with the organisation when she fell pregnant soon after arriving in Australia from

Afghanistan in 2016. With limited English and no idea how to navigate Australia's health system, her GP referred her to the doula program.

"I went there, liked the way they gave me all the information and helped me get familiar with the hospital, birthing room and all the appointments," says the now 34-year-old. Assigned a doula from that point on, Parwizi says her experience would have been *"so lonely and tough without any support".*

"When they found out I was a midwife back home, Birth of Humankind asked me to join them as a volunteer doula in 2017. I had some training before I started having clients. It made me very happy to have a job similar to that of a midwife, to go into hospital with new-born babies and mums."

Her clients are mainly women who have recently arrived in Australia, and who have no family or other support network to help them through the labyrinth that is our maternity system. Parwizi's role is to explain the system as best as she can (if the language barrier is too difficult, she relies on the company's internal interpreting service), to hold the women's hands through all the appointments, to be connected to the midwives, nurses and doctors, and to provide support during labour and the birth.
"I love my work and I am still enjoying it," she says.

Farzana Parwizi, a doula with Birth for Humankind

Being forced to shower post-birth is also common, which goes against certain cultural preferences. Many agreed that Australia must do better when it comes to providing a safe birthing environment for the women, which may not be the hospital's biomedical space. A stark environment with bleeping noises, constant monitoring, visible metal instruments and drugs can terrify some women, who, due to language and cultural barriers (many women feel shame when seen and touched by male doctors and nurses) as well as past experiences, may not feel safe or in control of their own body at a time when she is most vulnerable.

Resources for postpartum women: how does Australia care for non-English speaking new mothers?

As any woman who has given birth will know, the period immediately after a baby is born is fraught, happy, delirious, painful, confusing and so many other emotions in between. For new mothers, it is the inflection point between being a non-mother and a mother – the change of a lifetime. For repeat mothers, while perhaps not as unknown, it is still a period of tremendous effort and dedication. Hormones are raging, milk is filling up sore breasts, there are cramps, bleeding, potential infections and the onset of a gamut of other conditions, including postpartum depression and anxiety. The post birth period is the time when a woman's body goes through changes to return to its pre-pregnancy state and is divided into three stages: the initial or acute state; the sub-acute state; and the delayed post-partum period. The acute stage lasts up to the first 12 hours post birth, and is a time of potentially immediate problems such as heavy bleeding, uterus turning inside out, amniotic fluid entering the bloodstream and seizures.

The sub-acute stage can last up to 6 weeks, and involves major changes in the body's blood circulation, recovery of the reproductive and urinary systems, metabolism and emotions; while the third stage, characterised by more gradual changes which see muscle tone and connective tissue usually restored to pre-pregnancy levels, can last up to six months. In all three stages, there is potential for major issues, and while women usually become more attuned to their bodily changes as the post-partum period progresses, it is nevertheless an important health period that requires sensitivity and awareness of one's body and health.

While postpartum care in Australia is the domain of each state, it largely follows a similar model. After being discharged from hospital, a maternal and child nurse (MCH) will usually contact the mother within a week to arrange a home visit to check on the woman's and child's mental and physical wellbeing. The nurse will also provide valuable information such as the location of the nearest MCH centre, information about further visits (of which there are 10, starting from 2 weeks to 4 weeks, 8 weeks, four months, eight months and so on until three-and-a-half years), as well as how to contact MCH nurses at any time.

During these visits, the nurses continue to support the mother and child, offering information, advice and support on topics such as parenting, development and learning, breastfeeding, mental and physical health etc), help with sleeping, organise parenting groups and additional services based on each family's needs, and more.

They also encourage women to get a postnatal check-up with a doctor around the 6-to-8-week mark, which offers an opportunity for women and families to discuss their own health, vaccinations, and other issues they may be experiencing.

While this service is comprehensive, it only works if the women understand its purpose and the information offered. Managing symptoms and knowing where to seek help can be especially difficult for women and families who are not fluent in English.

The less English a person speaks in English-dominant countries, the less likely they are to receive the same care as native speakers. This vulnerability is particularly pronounced during new motherhood. Linguistically and culturally diverse mothers experience lower levels of healthcare access and poorer birth outcomes than English-speaking women.

Studies show that this group is more likely to report negative care experiences and higher rates of postpartum depression. Difficulties are compounded for non-English speaking women who have recently arrived in Australia who will experience a *"double transition"*, of adjusting to a new country and motherhood. This can also apply to women who've already given birth in another country.

Norma Boules, a 63-year-old early

intervention project officer at the Community Migrant Resource Centre in Sydney's west, has worked with mothers from culturally and linguistically diverse communities for nearly two decades. She's a warm, experienced professional, whose social work and Peruvian backgrounds have greatly aided her work.

"During and after birth, most of the women I work with are depressed," she says. *"They have no relatives in Australia, and for many of these women, the birth of a baby is a big family event."*

As part of her role, Boules, along with other services and a phone interpreter, visit mothers with children aged 0 to 2 to inquire about their wellbeing, assess the threat of domestic violence, and discuss conditions such as postnatal depression and anxiety.

"Most of these women have depression and anxiety, but they don't want to talk about – especially their husbands," she says. *"But I tell them that if you're not treating the depression now, you will get sick and you will not be able to care for your child. There are just too many holes in the system, too many mums from these communities who have untreated mental health issues."*

To foster social connections, Boules encourages her patients to attend culturally specific workshops for perinatal and postnatal anxiety and depression, nutrition education, breastfeeding and more, which are run by Westmead Hospital in Sydney.

"I have four children with an Arabic husband, so I understand a lot of the issues these women are going through. I try to advise for their betterment and knowledge," she says.

When Brisbane project manager Lara, 38, was pregnant with her second daughter, she thought she would have to go home to Brazil – a country she specifically left in 2016 to start a family elsewhere. *"One of the biggest things that motivated us was having a family in a different country which was safe, had better infrastructure,"* she says. *"We just couldn't see ourselves with children in Brazil".*

However, Lara's doctor diagnosed her child as having microcephaly (a condition that may indicate poor brain development) during a routine scan at 37 weeks, all she wanted to do was go home. *"I just couldn't see myself staying in Australia if she had any mental problems or disability – I just don't have the support,"* she says.

Thankfully, her daughter *"was born perfect"*, and Lara is now a happy mother of two. And yet, her situation brings up another scenario: just what sort of support is available to women postpartum, especially those who may have language issues and different cultural needs and expectations?

Post-partum period and cultural practices: does Australia adequately address this?

Australia home to diverse cultural background, from first generation migrants to refugees. These multiple migrant and refugee generation's cultural practices influence how women and their families experience the post-birth period.

Postnatal care in Australia adheres to Western, scientific principles. However, as a multicultural nation, it is imperative to acknowledge the important role that cultural values and beliefs play in seeking medical attention by postpartum mothers. Understanding how various cultures approach caring for a newborn and caring for the mother is essential to providing effective postnatal services.

Years ago, Boules created a document on customs practised in Australia after childbirth. Titled *Cultural Birthing Practices and Experiences*, it covers 17 different cultures and religions, noting many similarities, including belief systems surrounding the importance of hot and cold, confinement periods after birth, organised support for mothers, prescribed foods, hygiene practices and infant care and breastfeeding.

For example, Burmese practices include keeping the placenta for medical purposes, eating special turmeric balls, drinking traditional medicines to encourage blood flow; and massaging babies in mustard oil. In India, mothers cannot go into the kitchen for 12 days after birth, and stay home for two months. In north Lebanon, men are not usually present at the delivery, and the mothers rest for 40 days post birth, eating specific foods.

Vietnamese and Chinese women avoid crying, reading or watching TV to prevent later eye problems, while Cambodian culture discourages strong emotions or 'thinking too much'.

Health professionals must respect the cultural differences between themselves and their patients, for better compliance with postnatal care plans.
Lara, whose baby was mistakenly diagnosed with microcephaly in utero, believes her doctor – a male obstetrician from Colombia – may have been influenced by his own culture when treating her and giving her prenatal advice.

"When I told him my father used to be an obstetrician, he would always ask me about what he [the father] thought, and not me," Lara recalls. *"It's a South American thing – maybe he thought I had a lot of money and something would happen to him if he gave me the wrong advice. When an MRI scan showed my baby was perfectly healthy, he didn't even call me to deliver the news that he'd been wrong – he got a nurse to do it.*

He was ashamed of what my father would think," she recalls.

The issue of stillbirth in non-English speaking communities: how to communicate the unthinkable

A/Prof Miranda Davies-Tuck, a perinatal epidemiologist at the Ritchie Centre in Melbourne , knows the challenges of communicating complex, important information to vulnerable groups.

Having worked in stillbirth prevention for a decade, and as co-lead of the NHMRC Stillbirth CRE equity program, A/Prof Davies-Tuck has overseen the cultural adaptation of the Safer Baby Bundle for migrant and refugee women in Australia, ensuring cultural appropriateness.

"In some cultures, there's no concept for a placenta, this makes having conversations about your placenta not working properly difficult," she says.

In October last year, a suite of culturally adapted resources, co-designed with Arabic, Dari, Dinka and Karen-speaking communities was launched. Called "Growing a Healthy Baby", these resources are available in a range of formats (videos, booklets and audio booklets) to meet the different communication needs of women. Since then, one of the resources has been further translated into another 26 languages with more planned and education for health care providers and interpreters has also been developed to support conversations about stillbirth prevention with migrant and refugee women.

According to Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and Multicultural Centre for Women's Health board member, Dr Nisha Khot, migrants often come from countries where early pregnancy care isn't the norm. These resources explain the importance of such care. *"In a lot of migrant communities, there's a sense that bad outcomes can't be prevented. Women may feel that a stillbirth might be their fault. It's important to communicate that, no, this is something that can be prevented and these are the ways of preventing it."*

In Australia, about 2,000 families experience stillbirths every year, 30% of which are preventable. Stillbirth rates are higher in migrant, refugee, and First Nations communities, with non-English speaking women having rates two to three times higher than Australian-born women. This is despite Australia's relatively high maternal and new-born health outcomes compared to other OECD countries.

Women from non-English backgrounds also face higher risks of conditions such as preeclampsia and gestational diabetes mellitus (GDM), which can lead to serious complications, including preterm birth. In 2016-2017, women born in southern and central Asia were more than twice as likely to be diagnosed with GDM, compared to Australian-born, non-Indigenous women (28% and 13% respectively).

For the last decade, A/Prof Davies-Tuck has researched why this may be the case, especially in women from mainly south Asian backgrounds (which span countries such as India, Pakistan, Sri Lanka and Bangladesh). While at the national level, there is little overall difference in rates of stillbirth between women born overseas and those born in Australia, women born in Melanesia, Polynesia, north, central and west Africa, central Asia and south Asia are much more likely to experience stillbirth. A Western Australian study found that women who migrated from India or Africa are more likely to experience stillbirth in the first two years after migration, while a Victorian study found an increased risk of stillbirth among women born in south Asia.

"If you are of South Asian background your rate of stillbirth at 39 weeks is equivalent to locally born women at 41 weeks'," Davies-Tuck says. In Australia and most of the world, we calculate the average pregnancy length as 40 weeks from the first day of the last period.

While a baby born from 37 weeks onwards is considered a term pregnancy,

many clinicians consider at least 39 weeks the optimal gestation period, suggesting that every week counts.

"Our current guidelines recommend either monitoring a pregnant woman at 41 weeks to check for fetal compromise and placenta issues or offering induction of labour" she says. *"This means South Asian women, whose babies are more functionally mature at 39 weeks, this may be too late."*

"We also see evidence that when born preterm, babies born to South Asian mothers need less support breathing- evidence that they are more mature at an earlier time in pregnancy." Monash Health updated its guidelines in 2017 to reflect these observations, and monitor these women from 39 weeks, significantly reducing stillbirth rates.

"Based on these earlier monitoring episodes, 11% of women needed to be induced," Davies-Tuck says. *"We were picking up the babies who were potentially going to get into trouble and delivering them safely. This has halved the rates of stillbirths for South Asian women, and has brought them in line with other women we see."*

A/Prof Davies-Tuck's experience highlights the need for continually updated guidelines and policies as new evidence emerges and is now planning a large clinical trial, in partnership with multicultural women to ensure the end of pregnancy care approaches we offer are not just effective but are acceptable to women themselves.

"It's not enough to just give translated pamphlets: culturally and linguistically diverse women have varying communication and literacy needs, only providing printed material may not be helpful if they have reduced literacy in their own language" she tells me. Instead, the team is working on creating audio, information that can be shared on social media, videos with appropriate cultural markers and more.

"It is so important that women can see themselves in the materials developed. For example, women of certain cultures wear certain patterns, fabrics and clothing; so ensuring all these considerations are factored into the developed materials is really important." For others, creating analogies such as using flowers and trees to illustrate concepts such as placenta, stillbirth, miscarriage is needed to bridge concepts that don't translate well. *"There are so many complicated factors that need to be considered when adapting the material beyond simply translating the words,"* she says.

The true cost of not providing adequate

help during the perinatal period is ultimately borne by the women and their families. It is a significant transitional life stage that can result in increased vulnerability to experiencing physical and mental health issues. For women from non-English speaking backgrounds, this time is particularly challenging, especially when it comes to long-term health outcomes for themselves, and their children.

Nasalifa Namwinga, a senior clinical psychologist and the founder of Pola Psychology, works primarily with marginalised people from all walks of life. The clinic's approach is deeply rooted in Culturally Responsive and Intersectional Practice (CRIP), an intersectional worldview, which acknowledges that social-political factors have an outsized (and usually ignored) impact on mental health and well-being outcomes.

Namwinga's current clients hail primarily, but not exclusively, from East Africa. *"They're a big population in Australia, and we make sure to consult with community, and combine mental health expertise with cultural nuance when treating them,"* she says.

Community engagement is at the heart of the practice, which also has a research arm dedicated to promoting diversity in research, and challenging Euro-centric research practices.

"When we create programs such as a mother's group program, we include a mental health expert in that space, as well as someone from that community who has the cultural knowledge we need to provide the best care," she says.

Delivering information to women in the postpartum period is not just about words – it's about knowing how to frame the advice and information in a way that is culturally relevant. *"During the development phase, we ask community members if they would deliver information in this way, would they use this, how would the patients absorb this information."* Namwinga says she and her team always start from the culture (or cultural practices) first, using that as a framework to inform how they deliver evidence-based mental health support, such as cognitive behavioural therapy.

"For example, when talking about postnatal mental health to some African mother groups, we start with the cultural practice of women being looked after for 30 to 60 days post birth, and the implications of that if it doesn't happen," she says. *"This is a very important time for mothers, when you stay in bed and the community comes to you, checks in on you and prepares food so that the mother can focus on bonding with her baby."*

The community is tasked with looking after the wellbeing of the mother and is often the first – and best – point of call from a general health perspective. It is here that Namwinga believes the mainstream Australian services need to start, rather than taking the same approach by checking in on the mother alone.

"Yes, we, as part of the standard services, look for symptoms of depression or anxiety, but so does the community. They are the ones who see the warning signs if something is off, and they know what's normal and what's not at that particular time."

Being a woman is rewarding, but it is also complex and difficult. This is especially true for women of non-English speaking backgrounds, who face many obstacles to good healthcare in Australia and globally. While much is consistently being done by the health industry to reach out people not born in Australia, a gap remains.

Fortunately, organisations such as Pola Psychology are filling this gap by combining evidence-based health approaches with community involvement. Another charitable organisation, The Water Well Project, aims to improve the health and wellbeing of communities from migrant, refugee and asylum seeker backgrounds by improving health literacy through interactive and community-based sessions.

Raised by their parents, who were Vietnamese boat refugees, Dr Linny Phuong, Founder of The Water Well Project and Paediatric Infectious Diseases Physician, and her two sisters were taught that helping others must come first. “We did so much volunteering as a family, helping others in some shape or form,” Phuong recalls. “It’s no wonder we all ended up in caring professions: one works for the World Health Organization and the other works for the United Nations. I feel like the least accomplished sibling!” she laughs.

Starting her career journey as a pharmacist, Phuong then studied post-graduate medicine and became a doctor. Her interest in public health, passion for health equity and close engagement with diverse communities led to this award-winning side passion project: The Water Well Project.

“As a pharmacist and doctor, I encountered many patients from culturally diverse backgrounds with preventable illnesses,” Phuong says. Aware of the influence of health literacy in good health outcomes, she says “…knowledge plays a huge factor in who accesses and receives good healthcare, and then who achieves good health.”

She believes the Australian healthcare system is an excellent system, however people from diverse backgrounds often slip through the cracks. The Water Well Project aims to “put everyone on the same page” by having healthcare professionals being invited into community spaces (think playgroups, churches and even English language classes) to have a conversation with communities about common health topics. “This way, information is exchanged, misconceptions challenged and discussed, and hopefully people walk away with improved knowledge about signs, symptoms to look out for, or where to seek help when they need it”.

To date, the organisation has delivered more than 1,700 sessions in 14 years, reaching 26,000 participants in Victoria, New South Wales and Tasmania; and received a Victorian Public Healthcare Award in 2023 for Excellence in Culturally Diverse care.

“It’s about establishing a dialogue in spaces these communities meet, not spitting out key messages,” Phuong adds. “Community engagement is so important, and for it to be successful, it must take place in a safe space that is attended by the people we are trying to reach.”

Dr Linny Phuong

The Water Well Project: helping women from non-English backgrounds take control of their own healthcare

I arrive at the Wetsall Community Hub mid-morning to a room full of 12 women, mostly from South Asian and Asian backgrounds, gathered around a large table.

They range in age from their 30s to late 70s, observing a tall, blonde woman in a pink t-shirt and white, cropped jeans. Toddlers circle the table, craving attention and snacks, as older women smile and pat little hands sneaking a snack.

Suddenly, the woman turns around. *"Hi! I'm Annabel,"* she says, smiling, and indicates for me to pull up a chair. I sit a little behind the group to observe the interactive session about the most common cancers experienced by women.

"I'm a junior doctor at the Royal Women's," Annabel begins. *"I want to talk to you about some common cancers that affect women, and how regularly you should get checked out by your GP or other specialists. I might put a question to you first: who can tell me some of the diseases, or cancers, that we screen for?"* she asks the women.

"Breast," offers one woman; "cervical," says another. *"Skin?"* hedges a third, and Annabel nods. *"Lung!"* calls an older woman. *"We don't routinely screen for lung cancer, but yes, it is one,"* Annabel says. *"The main ones we would routinely screen for are breast, cervix, bowel cancer and skin cancer, but I'll discuss the first three initially. So, who can tell me where the cervix is?"* The women laugh awkwardly, gesturing vaguely to their pelvic floor and genital areas.

Annabel draws a rough diagram of female genitalia, pointing out the ovaries, fibroids, womb and cervix, and discusses the symptoms of each cancer.

The session is incredibly informative, and I'm surprised to learn how little I know. Annabel explains screening ages, always asking the women first. Many guess right: those who don't are gently corrected.

Twenty minutes later, Annabel is joined by Natalie, a fellow doctor at the Royal Women's Hospital in Melbourne. As the women warm up they share personal stories: one describes how it took her being in labour for three days for her husband to realise how much pain women suffer in childbirth; another adds that *"women are so strong, so much stronger than men".* Everyone whoops.

When the conversation turns to menopause, everyone groans. *"You're officially in menopause when you haven't had a period for 12 months,"* Natalie explains. *"It's basically nature's way of saying you're done. It's not fun, I won't lie, and men don't get it. It's very unfair."*

The women continue to sharing stories as the doctors address questions and recommend some women see their GP and skilfully correct certain views. Natalie recounts some of the issues she's seen in labour wards, such as husbands demanding attention while their wives moan in agony, and others refusing an epidural for their wives, telling doctors that "we" don't want one. Some women gasp, others nod resignedly.

Afterwards, there is tea, Tim Tams, fruit and various baked goods. Toddlers gleefully mash them together. This is just one of many classes offered by Water Well, relying on a network of dedicated medical practitioners like Annabel and Natalie, who volunteer their time to help close the healthcare gap.

Conclusion

The journey of pregnancy is a crucial period in a woman's life, a juncture where language, communication and cultural nuances interweave with the landscape of healthcare.

Often the first interaction with the Australian medical system for non-native English speakers, pregnancy and the postpartum period serve as gateways to broader healthcare discussions.

This narrative highlights the challenges faced by non-native English speakers, particularly women, navigating Australia's healthcare system.

Language, an intricate tapestry of expression and understanding, is the cornerstone of communication. Yet, within the realm of healthcare, it is not merely the language spoken but the combination of verbal cues, non-verbal expressions, cultural norms, and contextual understanding that define effective communication.

Individuals facing language barriers encounter a complex interplay of cultural beliefs and values shaping interactions in medical settings.

For women, especially those from non-English backgrounds, this challenge is amplified, with disparities in healthcare experiences and outcomes. They face higher rates of stillbirth, pregnancy-related conditions, and poorer maternal and child health outcomes compared to their Australian-born counterparts. These disparities, rooted in systemic issues compounded by limited English proficiency, underscore the urgent need for a re-evaluating healthcare delivery.

Healthcare professionals play a pivotal role in in addressing these gaps, necessitating a transformative shift in service delivery. Professional interpreters and translators must be recognised as integral members of the healthcare team. The reliance on ad hoc solutions, like using family members as interpreters, often worsens health disparities.

The narrative underscores the need for a holistic approach to women's healthcare, addressing comprehensive health needs from family planning to menopause care, especially for communities with many non-native English speakers. The prenatal period, while a focal point, serves as a conduit to discuss these broader topics with women.

Beyond the individual, these insights beckon a reconsideration of systemic healthcare structures. From the consultation hour restraints to the lack of skilled interpreters, there is an imperative to create a more inclusive, accessible and responsive healthcare landscape for the diverse population.

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- In a 2022 analysis which examined 27 studies to determine how women from non-English speaking backgrounds perceive and experience the continuum of maternity care in Australia... Women from migrant and refugee backgrounds' perceptions and experiences of the continuum of maternity care in Australia: A qualitative evidence synthesis: https://www.sciencedirect.com/science/article/pii/S1871519221001438?via%3Dihub

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- As a result, many issues can arise. A recent study looking at the provision of interpreters in South Africa states that using family members, friends or neighbours as interpreters in a medical setting "...poses serious challenges related to confidentiality, impartiality, increased errors in interpretation, and may distort the message due to cultural reasons or personal agendas". - Do not lose your patient in translation: Using interpreters effectively in primary care https://pmc.ncbi.nlm.nih.gov/articles/PMC9982479/

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- Photo voice study Refocus: https://www.strongerfutures.org.au/refocus-photovoice

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- As Victorian researchers point out in their 2020 study exploring the critical barriers to English language learning for Afghan refugee women in Australia, - English language learning barriers of Afghan refugee women in Australia https://onlinelibrary.wiley.com/doi/epdf/10.1111/ijal.12320

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- As University of New South Wales Professor Deborah Lupton explores in an article for The Conversation.. " The cultural assumptions behind Western medicine" - https://theconversation.com/the-cultural-assumptions-behind-western-medicine-7533
- In a 2022 paper looking at non-Western women's perceptions and experiences of maternity care in Australia, researchers came up with 24 findings for policy makers — one of which focussed on trust in medicine and technology. "Some women," the researchers write, "expressed mistrust and scepticism towards modern Western medical technology and drugs, citing concern that these interventions could harm their babies."
- Women from migrant and refugee backgrounds' perceptions and experiences of the continuum of maternity care in Australia: A qualitative evidence synthesis: https://www.sciencedirect.com/science/article/pii/S1871519221001438?via%3Dihub

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- The significance of explaining the intricacies of Australia's model of healthcare–and pregnancy and post-natal care–to women of non-English background cannot be overstated, as evidenced by another 2010 Australian study, published in Midwifery journal and exploring the experiences and concerns of African-born pregnant women receiving antenatal care in Melbourne. - Antenatal care perceptions of pregnant African women attending maternity services in Melbourne, Australia - https://www.sciencedirect.com/science/article/abs/pii/S0266613808000387

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- In its submission to the NSW Inquiry Into Birth Trauma, the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) highlights the impact of torture and trauma on many non-English speaking communities. - https://www.parliament.nsw.gov.au/lcdocs/submissions/81369/0877%20NSW%20Service%20for%20the%20Treatment%20and%20Rehabilitation%20of%20Torture%20and%20Trauma%20Survivors.pdf

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- Linguistically and culturally diverse mothers experience lower levels of healthcare access and poorer birth outcomes than English-speaking women.
- Studies show that this group is more likely to report negative care experiences and higher rates of postpartum depression. - Access to appropriate health care for non-English speaking migrant families with a newborn/young child: a systematic scoping literature review- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7158115/#:~:text=This%20vulnerability%20can%20be%20particularly,%5B2%5D%2C%20as%20well%20as

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- Years ago, Boules created a document on customs practised in Australia after childbirth. Titled Cultural Birthing Practices and Experiences, it covers 17 different cultures and religions, noting many similarities, including belief systems surrounding the importance of hot and cold, confinement periods after birth, organised support for mothers, prescribed foods, hygiene practices and infant care and breastfeeding. (https://cmrc.com.au/wp-content/uploads/2020/03/cultural_birthing_practices_and_experiences.pdf)

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- Last October, she and a team of experts developed a suite of sensitively crafted, in-language resources, called 'Stronger Bubba Born' and 'Growing a Healthy Baby' to improve maternity care for Arabic, Dari, Dinka and Karen communities. — https://www.mcwh.com.au/project/growing-a-health-baby-project/#:~:text=A%20suite%20of%20sensitively%2Dcrafted,Australia%20by%2020%20per%20cent

Image acknowledgements:

istock/Fat Camera – cover image
istock/FG Trade Latin – page 5
istock/rudi_suardi – page 7
istock/Kermal Yildirim – page 8
istock/A boy and the sea – page 11
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Thank you to our interview participants who kindly provided images for use in this narrative.

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About the Scanlon Foundation Research Institute

The Scanlon Foundation Research Institute exists as a bridge between academic insight and public thought. The Institute undertakes research to help Australia advance as a welcoming, prosperous, and cohesive nation, particularly where this relates to the transition of migrants into Australian society. In doing so, the Institute links thought to action to ensure informed debate drives the agenda and empowers the critical thinking that will help drive Australia's social cohesion forward.

The Institute publishes the Mapping Social Cohesion Report, a world-leading survey, providing a comprehensive understanding of the Australian population's attitudes to multiculturalism, institutions and government, as well as to other people and neighbourhoods.

Other publications include narratives, social cohesion insights and essays, and the delivery of podcasts, webinars, and learning programs each year. Through these, the Institute seeks to provide evidence and ideas that will inform national discourses and empower communities to maintain and strengthen social cohesion.

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