Migrant mothers' and health professionals' views and experiences of the Australian perinatal health care system and its influence on their mental health

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Declaration

I herewith declare that this thesis is my original work and has not been submitted in any form for another degree or diploma at any other tertiary education institute. Information derived from the published and unpublished work of others has been acknowledged in the text, and a list of references is given in the bibliography.

Signed: 

Elaine Cristina dos Santos

Date: 17/10/2023

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Abstract

Background: Perinatal depression (PD) is an illness that affects about 20% of women in Australia. Migrant women are particularly vulnerable and at risk of developing PD for many reasons, including lack of social support, language barrier. This study intended to avoid the generalisation of culture and focused on migrant women from different backgrounds living in Australia. This research analysed the views of migrant women that shaped their perinatal care experiences in Australia. It also explored the views of health professionals providing perinatal care and diagnosing migrant women with PD in Australia.

Method: This study used thematic analysis through inductive coding. In-depth interviews were conducted between 2015 to 2018. There were seven migrant women from Hamilton, Victoria and ten migrant women from Canberra, ACT. All participants were selected through recruitment flyers, letters and through snowball sampling. In addition, there were four health professionals, one key informant in Hamilton, and nine health professionals in Canberra.

Results: Participants living in Hamilton reported overall satisfaction with their perinatal care and had a strong social support network. In contrast, participants from Canberra reported dissatisfaction with the lack of continuity of care through the public maternity shared care model and social support. Migrant women from both cities reported that the postnatal care health checks primarily focused on their babies' physical wellbeing. Health professionals interviewed in both cities believed they provided the best evidence-based care despite challenges such as low health literacy and language barriers. Yet, some health professionals in Hamilton stated that they might not use accredited interpreting services because it can be time-consuming. Health professionals in both cities reported that they do not routinely use the EPDS to diagnose

PD. Health professionals in Hamilton reported quick responses to their referrals by the perinatal mental health services. Nonetheless, health professionals in Canberra acknowledged challenges with long waiting list for an assessment with the perinatal mental health services. They addressed that through referrals to community psychologists in parallel to the submission of referrals to perinatal mental health services.

Conclusions: Participants in Hamilton had positive experiences with perinatal care in Australia due to a combination of continuity of care and social support. Meanwhile, participants in Canberra had difficulty building rapport with health professionals due to the lack of continuity of care leading to the recommendation to expand access to Birthing Centers. Migrant women in Canberra reports of health professionals not being responsive to their needs, might mute their voices, limit their visibility and representation in perinatal care. It also may diminish the meaning of their suffering and distress. While the explanations for the dissatisfaction in Canberra may be locale-specific, this study points to the need for communities of support for migrant mothers rather than focusing on medical programs alone. Moreover, this study highlights the importance of culturally safe health practices, adoption of routine use of the EPDS and interpreting services. It also recommends further studies with a larger number of participants.

List of Abbreviations

ACT	Australian Capital Territory
ASGC-RA	Australian statistical geographic standard remoteness
ATAPS	Access to Allied Psychological Services
CALD	culturally and linguistically diverse background
CMOS	Canberra Maternity Options Services
COPE	Centre for Perinatal Excellence
CSIRO	Commonwealth Scientific and Industrial Research Organisation
DSM-V	Diagnostic and statistical manual of mental health disorders 5th edition
DSM-IV	Diagnostic and statistical manual of mental health disorders 4th edition
ED	emergency department
EPDS	Edinburgh Postnatal Depression Scale
GP	General practitioner
HPA	hypothalamic-pituitary-adrenal axis
LGBTIQA+	lesbian, gay, bisexual, transgender, gender diverse, intersex, queer, asexual and questioning
MBS	Medicare Benefits Schedule
n-3 PUFA	n-3 polyunsaturated fatty acids
NHMRC	National Health and Medical Research Council
NPDI	National Perinatal Depression Initiative
PANDA	Post and Antenatal Depression Association

PCC	patient-centre care
PD	perinatal depression
PEHP	Perinatal Emotional Health Program
PHQ-9	Patient Health Questionnaire-9
PTSD	post-traumatic stress disorder
SCID	Structured Clinical Interview for DSM-IV Axis I Disorders
US	The United States of America
WHO	World Health Organization

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Chapter 1. Introduction

This PhD journey began from an idea that grew from my negative experiences with the Australian perinatal health services, especially from my experiences when trying to access the perinatal mental health services in Canberra. The drive to embark on a PhD journey was to attempt to make a positive contribution to the way perinatal care is provided to migrant women.

I used the term 'migrant women' to establish the participants in this study coming from culturally and linguistically diverse (CALD) backgrounds who did not meet the 1951 Convention and Protocol Relating to the Status of Refugees. The term 'asylum seeker' was used in this study and refers to 'someone who is seeking international protection but whose claim for refugee status has not yet been determined' (Phillips 2015).The United Nations High Commissioner for Refugees (1951) defined the term 'refugee', which is recognised by international law as:

> …someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion (United Nations High Commissioner for Refugees 1951: 3).

On the other hand, legally the term 'migrant' does not have a universal definition, therefore this study adopts the term 'migrant' which is based on the United Nations Migration Agency's definition. The United Nations Migration Agency (2022) determined that it is an 'umbrella term, not defined under international law, reflecting the common lay understanding of a person who moves away from his or her place of usual residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons'. They stated that migrants tend to move aiming to improve their quality of life, socioeconomic status and security. Amongst the reasons for migrants to migrate are better working conditions and remuneration, better job prospects, educational opportunities, and to reunite with family members and

relatives. Migrants can chose to return home and can continue to be protected by their home country (United Nations High Commissioner for Refugees 2016; United Nations Migration Agency 2022).

In 2014, I identified a gap in the literature on perinatal care for migrant women living in Australia that did not exactly focus on a particular ethnic group. Since then, there has been some promising research into perinatal care for migrant women. For example, Billett et al. (2022) conducted a systematic review of the qualitative evidence for the perceptions and experiences of migrant and refugee women as consumers of perinatal care services in Australia. The authors emphasized the studies in this area tend to narrow their research into the study of specific ethnicities. They also highlighted that while understanding the needs of minority groups it is also important to understand the experiences of a migrant and refugee women from a broader perspective.

This thesis sets out to explore migrant women's expectations, views and experiences of the perinatal period, with a particular interest in mental health and the culturally safety of the perinatal health care delivered to women coming from minority groups in Australia. I also explore the views of health professionals delivering perinatal care to these women, the process to identify perinatal depression (PD) in this population and their referral pathways to perinatal mental health services.

The aim of this thesis is to try to capture the Australian perinatal care experiences of migrant women from a variety of culturally and linguistically diverse backgrounds (CALD), including the challenges they faced. The thesis explores the views of participants and health care providers views in two different geographic locations, in a regional and in a metropolitan city. Thus, it was

possible to observe and analyse the impacts of any differences between these locations in terms of how perinatal care was delivered.

The value of this study is that it includes both sides of the parties involved in this system: migrant women as consumers and health professionals as providers of care. As such, this study contributes to a better understanding of the Australian perinatal health care system. This study aims to understand the difficulties that health professionals might face when delivering perinatal care to minority groups in Australia. Such insights should assist health professionals to adjust their practice to better engage with migrant women and consequently promote better health outcomes.

Finally, I wanted to give a voice to women from minority groups and to provide data to health care providers and policy makers to possibly enhance culturally safe health practices in perinatal care mitigating health complications for women coming from CALD backgrounds. The Australian Health Practitioner Regulation Agency Medical Board established that:

> [c]ultural safety involves understanding what individual patients and/or their families believe is culturally safe. Culturally safe and respectful practice requires genuine efforts to adapt your practice as needed, respect diversity and avoid bias, discrimination and racism. It also involves challenging assumptions that may be based on, for example, gender, disability, race, ethnicity, religion, sexuality, age or political beliefs. A culturally safe practice, like all good medical practices, does not require doctors to provide care that is medically unsafe or inappropriate (Australian Health Practitioner Regulation Agency Medical Board 2020).

1.1. Research questions

This thesis aims to answer the following questions:

- What are the views of migrant women living in Australia about the perinatal care they received in Australia?
- What are the views of health professionals about the challenges of delivering care to migrant women living in Australia?
- What are the health professionals' pathways to identifying migrant women with perinatal depression and subsequent referral to perinatal mental health services?

1.2. Thesis structure

In this thesis, there are seven chapters. Chapter 2 sets out the literature on health literacy and it impacts on women coming from CALD backgrounds and utilising perinatal care services in Australia. The chapter also continue to provide background about culture, cultural norms and its relationship dynamics with health care. It includes the discussion about the impact of culture in the communication between health professionals and patients especially regarding the negotiation of care needs. It then discusses culturally safe practices guidelines in Australian perinatal care. The literature review presents information about PD, its history and prevalence in Australia. It presents factors associated with the development of PD, especially in migrant women living in Australia. It explores several plausible biological triggers, lack of social support and community, and the impact of religion on a mother's mental health and help-seeking. It also analyses the influences of the environment that women live in on the development of PD. Chapter 2 also describes the Australian perinatal care system and its model of care. It discusses the economic impact of PD in Australia.

Chapter 3 describes the methodology adopted for this study. It highlights three theories used as the framework of the thesis: invisible communities theory, muted groups theory, and the cultural meaning of suffering and distress. It defines the fieldwork sites in Australia and the rationale for researching Canberra and Hamilton. Additionally, it specifies the study design including the participants, the data collection, data analysis and its interpretation.

Chapter 4 is a reflection about my position as an insider-researcher and its implications and influence in this thesis. I explore my own biases and how it affected the analysis of the data collected.

Chapter 5 describes the findings from this study from both cities and it is presented according to the three stages of perinatal care: antenatal care, childbirth and postnatal care. It highlights some of the discrepancies in the narratives of participants in each city. Furthermore, Chapter 5 presents the participants perceived importance of their social network during the perinatal period. Chapter 5 presents the health professionals views about the use of interpreting services, the use of the Edinburgh Postnatal Depression Scale (EPDS) and their referral pathways to mental health services when women are diagnosed with PD.

Chapter 6 brings in the discussion of the common themes identified from the interviews in Canberra and Hamilton. The themes are divided into the three stages of perinatal care: antenatal, childbirth and postnatal care. It also discusses themes present across the three stages of perinatal care. It highlights that migrant women were satisfied with their perinatal care in Hamilton. It also discusses the importance of social support regarding migrant women's wellbeing and health outcomes. It explores the dissatisfaction that migrant women in Canberra felt with the lack of continuity of care in the shared maternity care and their difficulties

negotiating their health care needs, especially regarding choosing an elective caesarean section. This chapter also examines the impact of traumatic birthing experiences. It follows this with analyses of the postnatal care migrant women receive and their satisfaction with this model of care, and the observations that the focus of postnatal care has on the health of their baby. This chapter examines health professionals' perceptions of the perinatal services they offer, interpreting services, the use of the EPDS in their practice and the referral pathway to mental health services in both cities. Additionally, Chapter 6 finishes with the identified strengths and limitations of this study.

Finally, Chapter 7 concludes this study and its contribution to improving antenatal care, childbirth, and postnatal care. The theoretical and practical implications of this study's findings are outlined and recommendations for further work are presented.

Chapter 2. Literature review

2.1. Health literacy and language

Simonds (1974) introduced the term health literacy while discussing the need to update the United States of America's (US) health education policies to promote better health outcomes and reduce mortality rates of their population. Since then, the term health literacy changed and is currently defined by the World Health Organization (WHO) as the 'cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health' (Nutbeam and Kickbusch 1998). The World Health Organisation (2016) updated their stance on health education and highlighted the importance of health literacy as a priority in policy making. 'Health literacy is founded on inclusive and equitable access to quality education and life-long learning. It must be an integral part of the skills and competencies developed over a lifetime' (World Health Organisation 2016).

According to the 2018 Australian Bureau of Statistics Health Literacy Questionnaire, only 26% of the participants were confident navigating the Australian health system (Australian Medical Association 2021). Low health literacy can impact individuals ability to safely engage with and navigate health care services (Monani et al. 2021; Muscat et al. 2023). Migrant women are more likely to experience poor health outcomes in their host country due to low levels of health literacy. This may be caused by a variety of factors including socioeconomic background, educational levels and previous health literacy skills in their country of origin (Bains et al. 2021a; Billett et al. 2022; Monani et al. 2021; Willey et al. 2020b). Health literacy can be also significantly impacted by difficulties with language proficiency, social isolation and conflicting cultural health practices in the host country, all leading to poor communication between patients and health professionals. All of these can affect migrant women's access to health

care but also their ability to negotiate and advocate for their health care needs (Bains et al. 2021a; Billett et al. 2022; Vigod et al. 2017).

Additionally, low health literacy can affect patients' engagement with health services, treatment plans, management of medications and acceptance of interventions (Bains et al. 2021a; Billett et al. 2022; Willey et al. 2020a). Low health literacy can disempower individuals attempting to take ownership of their care and make informed decisions about the management of their health (Billett et al. 2022; Monani et al. 2021; Stoll et al. 2021). The idea 'doctors know best' is still present nowadays (Staffieri and Farrell Leontiou 2020). Despite the growing efforts and advocacy for patient-centred care (PCC), there is still an unequal relationship between health professionals and patients. In Canada, Stoll et al. (2021) discussed how women who declined health professionals' recommendations and procedures during their perinatal care suffered some form of backlash with the health system. Participants in the study by Stoll et al (2021) stated they felt invisible because health professionals continued to pressure them to agree to procedures they had initially refused, such as fetal monitoring and administration of antibiotics. Conversely, Thompson and Whiffen (2018) discussed how Latin American migrants living in the US preferred to receive care from a paternalistic doctor. They felt that doctors hold the knowledge and should be respected, just as they have strong respect for family elders.

The social isolation that life in a new country can create can be a distressing experience for migrant women. It is common for them to feel lost in a unfamiliar society with a different language and to become dependent on someone else to interpret and explain consumer health information (Bains et al. 2021b; Billett et al. 2022; Small et al. 2003). Even looking for maternal health services is difficult when one does not speak or understand the local language (Bains et al. 2021b; Billett et al. 2022). This is especially the case where migrant women might have limited social support to attend antenatal appointments at a hospital. For example, Carolan

and Cassar (2010) found in their study that migrant women from sub-Saharan Africa see pregnancy as a 'routine' event that does not require medical monitoring. In some cases, sub-Saharan African women may feel afraid of having an antenatal ultrasound done because this is a foreign technology to them, and they may believe that it will harm the baby.

Bains et al. (2021b) describe how language can be a significant challenge for refugees seeking health care. In several situations, the patient's acceptance of treatment has been jeopardised because of a misunderstanding about the doctor’s prescribed treatment and the actual diagnosis (Navodani et al. 2019; Stanzel et al. 2022). Unfortunately, the difficulties with English are not exclusively related to the consultation with the doctor but are prevalent throughout the entire healthcare system (Bains et al. 2021a; Carolan and Cassar 2010; Stanzel et al. 2022). For example, many migrant women have reported that it is hard to understand the pharmacist's explanations about the prescribed medication at the pharmacy counter. Further, even booking an appointment with a doctor is a difficult task for many because the receptionist may not speak their language (Billett et al. 2022; Morris et al. 2009; Stanzel et al. 2022). Hence, migrant women may seek medical assistance only in extreme cases of illness (Bains et al. 2021a; Morris et al. 2009).

Australian health professionals in private practice have free access to the Australian government-funded interpreting service (The Royal Australian College of General Practitioners 2016). Patients with limited English proficiency have the right to request interpreting services for their health care. In 2012, The Australian Institute of Interpreters and Translators INC (AUSIT) published their updated code of ethics, which states that interpreters ‘have to maintain professional detachment, impartiality, objectivity and confidentiality’ while interpreting (Australian Institute of Interpreters and Translators Inc 2012).

Interpreting can be done via remote telephone interpretation, in-person, or via videoconferencing. This guarantees that patients can have full access to the details about their care and the health professionals' rationale about the chosen treatment. It also ensures that the patient is fully informed about the pros and cons of specific procedures and can have an informed decision before consenting to them (Billett et al. 2022; Yelland et al. 2015). Access to an interpreter also empowers patients to participate in the decision-making process of their health care, avoiding a passive stance to health professionals' orders. Patients can express their needs in their language, increasing help-seeking and health care participation (Beagley et al. 2020; Phillips 2013; Phillips and Travaglia 2011).

Videoconferencing has been a very effective communication and interpreting tool for patients, health professionals and interpreters (Beagley et al. 2020; Pathak et al. 2021). Videoconferencing has an advantage over telephone interpreting because it can be done remotely and allows visual input and body language recognition (Locatis et al. 2010; Pathak et al. 2021). However, videoconferencing may not be accessible to all patients due to limited infrastructure compatible with videoconferencing, poor internet connection in remote areas, and the patient's low technological skills (Pathak et al. 2021). In addition, Billett et al. (2022) noted that migrant women often had difficulty accessing interpreting services due to staff shortages and insufficient interpreters for their language needs.

Although interpreting services are a crucial resource for both patients and health professionals, the latter still underutilise them, in part due to time constraints and the perceived notion that they can manage without a certified interpreter (Kwan et al. 2023; Morris et al. 2020; Phillips 2013; Phillips and Travaglia 2011). Bains et al. (2021b) reported in their study that similarly to Australia, Norwegian health professionals still underutilise interpreting services for migrant women during perinatal care appointments. They discussed that health professionals were

more likely to utilise interpreters during antenatal appointments due to its predictable nature. They were able to book interpreters based on a set time and date. However, the authors found that about 19% of the participants in their study would have benefited from an interpreter during their postnatal care. Nonetheless, on several occasions interpreters were not offered by health professionals probably due to time constraints.

2.2. Culture and health

> Culture is not a thing; it is a process by which ordinary activities acquire emotional and moral meaning for participants. Cultural processes include the embodiment of meaning in habitus and physiological reactions, understanding what is at stake in particular situations, developing interpersonal connections, religious practices, and the cultivation of collective and individual identity (Kleinman 2004:3).

Culture is likely to significantly influence all aspects of an illness, such as help-seeking, the interaction between the health professional and patient, the acceptance of an official diagnosis, and the treatment. For example, the concept of depression is expressed differently in each culture. Tousignant (1984) described the Ecuadorian concept of *pena*, which can be translated into English as ‘sorrows’ and can be defined as the ‘state of mind characterised by a mixture of sadness and anxiety as well as … an illness state resembling depression’ (Tousignant 1984:381). The author describes how *pena* is present in every aspect of Ecuadorian lives, such as small landowners who experience *pena* when there is no rain or when the crops do not develop and their families go hungry. The accumulation of daily sorrows leads to the manifestation of psychological and physical illness. This process tends to be progressive, and the manifestation of *pena* can ‘move’ from one part of the body to another, such as a headache turning into a heart illness. It all depends on the affected person's interpretation of their sorrows.

There are important cultural rituals linked to pregnancy and postpartum care, which involve a series of proscriptions and prescriptions (Dekel et al. 2016; Demirel et al. 2018; Thoppil et al. 2005). These rituals can be a positive preventive factor against perinatal depression. For example, in some Middle Eastern societies, motherhood is highly regarded, and often women are offered practical and emotional support by immediate and extended family members. Similarly to some Asian cultures, Middle Eastern women are recommended to rest for forty days after childbirth (Seeman 2008). During this period, the new mother receives practical support with caring for her new baby and daily chores (Dekel et al. 2016; Demirel et al. 2018). Women gather together to form a strong bond in which they are generally highly supportive of each other, which provides a degree of emotional support post-birth (Dekel et al. 2016; Stuchbery et al. 1998). Therefore, the absence of practical and emotional support during pregnancy and after birth, where such women are separated from their traditional communities of support, may lead to the development of perinatal depression (Billett et al. 2022; Chojenta et al. 2016; House et al. 1988).

The lack of emotional and practical support from the partners of migrant women during pregnancy and postpartum can also trigger depression (Billett et al. 2022; Eastwood et al. 2017; Navodani et al. 2019). In patriarchal societies where women do not necessarily receive this emotional support from their partners, they may feel more isolated if they do not have other sources of community or familial support (Dekel et al. 2016; Prusa et al. 2019; Samara and Da Costa 1997; Stuchbery et al. 1998). For example, several participants in this study were from Brazil, which is predominantly a patriarchal society, where fathers are most likely to be responsible for financial provision and women care for the young children (Prusa et al. 2019; Sifuentes 2014). Moreover, a problematic marital relationship, especially one which includes domestic violence, can aggravate maternal depression (Navodani et al. 2019; Ogbo et al. 2018; Small et al. 2003). In the absence of social support from relatives, the mother's partner

should in theory play an essential role as a close confidante with whom the woman can share her frustrations or fears about parenthood (Macpherson et al. 2010).

Migrant women can also rely on community social support groups such as the initiative of The Northern Health Hospital in Melbourne, an institution where I work as a physiotherapist. They have successfully launched the ‘Happy Mothers Program’ in partnership with the Murdoch Children's Research, which caters for Assyrian Chaldean migrant mothers who live in the Northern suburbs. This pioneering program in Victoria has had positive feedback from the mothers and partners. The program focuses on the women's individual needs during the perinatal period, but also considers their cultural needs as women from an Assyrian/Chaldean background (Northern Health 2019).

The Happy Mother's Program aims to improve breastfeeding rates and enhance women's health literacy and social interaction with peers from the same cultural background. Each education session runs for two hours and focuses on emotional and physical wellbeing. The program adopts a more holistic approach and encourages women to continually engage with the Happy Mother Program until their children reach four years old. Another comprehensive aspect of the program is that women have access to parental support work, a bicultural worker, and an interpreter in each session. The education sessions have a semi-structured format and take a flexible approach to issues arising from women's discussions, needs, and feedback, which are relevant to each perinatal stage's challenges. Therefore, it adopts the PCC approach, where the participants are in charge of the direction of each session. Consequently, it increases participants’ health literacy levels and social support in the community. These are important factors in the prevention of the development of mental health illness (Deering et al. 2016; Elsenbruch et al. 2006; House et al. 1988). There is a lower incidence of depression in stronger communities as individuals can count on others (Chen et al. 1995; Diniz et al. 2015;

Doble et al. 2011; Ley et al. 2009; Mcleish and Redshaw 2019; Small et al. 2011; Umberson and Karas Montez 2010).

In another example about cultural rituals, Yoshida et al. (2001) discussed how a Japanese cultural ritual *satogaeri bunben* can be oppressive and can influence the development of perinatal depression. The term *satogaeri bunben* is the name given to the period post-birth, lasting up to 35 weeks, where a new mother receives support from her family. In this period, the mother moves with her newborn baby to her parents' home to rest physically and emotionally. The mother then becomes socially isolated and, therefore, the theory goes, entirely dedicated to the baby and her recovery. However, Yoshida et al. (2001) argue that women who adopted *satogaeri bunden* may feel anxious and insecure about their child's care after 35 weeks. The authors also stated *satogaeri bunden* may negatively impact the couple's relationship because of the long period that the husband is absent, which also impacts the development of the bond between the father and newborn.

Roomruangwong and Epperson (2011) argue that Western studies on perinatal depression do not consider specific Asian factors highly associated with the development of perinatal depression. These include being pregnant before marriage, which could be considered a dishonour upon the woman's family and create division between the pregnant woman and her elders. Furthermore, in many cases, the mother-in-law has specific rituals regarding pregnancy and motherhood that can be ‘forced’ onto the new mother. This can increase the pressure on the new mother and the stress of being respectful to her mother-in-law even when there is a clear difference in expectations and standards regarding motherhood (Dekel et al. 2016; Demirel et al. 2018). Finally, issues arise over the strong preferences relating to the newborn's gender, such as in China, where the one-child policy is no longer in place, but parents may still have a gender preference towards males (Roomruangwong and Epperson 2011).

In Brazil and India, the term ‘midwife’ is also used to describe traditional home birth attendants, who might not have any medical training and may even be illiterate (Garces et al. 2012). In Brazil, midwifery has struggled to develop as an independent profession (Gualda et al. 2013), and birth attendance is far more likely to be provided by obstetricians who are almost eight times more numerous than midwives. In 2014, Brazil had nearly 23,000 registered obstetricians and less than 3,000 registered midwives (United Nations Population Fund 2014). The same model obtains in India, which decommissioned its independent training of midwives after Independence, and still has a low number of registered midwives whose roles is conceived as ‘auxiliary to doctors’ (Chhugani and Hamdard 2014). There is evidence in the literature that in low- and middle-income countries, home birth attendants have an important role in their societies, where there is limited access to qualified perinatal care (De Oliveira et al. 2019). Nevertheless, this association creates a negative image of the midwifery profession in these countries with underdeveloped trained midwifery professions, and migrant women may be reluctant to access midwifery services in Australia because of their pre-existing prejudices.

Besides cultural and linguistic differences, a migrant woman in Western societies must also face the reality of motherhood, which can be confused with commercial misrepresentations of motherhood (Meng 2020). In Western society, the idealisation of motherhood is everywhere — from celebrity magazines to supermarket shelves. An example of the contemporary notion of motherhood is the exhibitionism of ‘celebrities’ who, soon after giving birth, have photos showing their skinny frames emblazoned on the covers of magazines and social media (Barclay and Kent 1998; Kirkpatrick and Lee 2022). These photos are typically printed with accounts of how these celebrity mothers have the happiest time of their lives and how they are in shape and healthy, without difficulties. This type of media portrayal can provoke a sense of

failure in ‘real life’ mothers for not fulfilling these motherhood stereotypes of happiness and health (Chae 2015; Kirkpatrick and Lee 2022; Meng 2020). There is guilt about not losing weight quickly and not looking as sexy as the celebrity models and actresses, contributing to a reluctance to accept the natural body transformation for most women post-childbirth (Meng 2020). Even though the media is a powerful tool to disseminate information about perinatal depression widely, this information can be misleading when used in a sensationalised way. This can provoke the opposite effect to what is intended and stigmatise mental illness (Francis et al. 2005; Kirkpatrick and Lee 2022).

The reality shock, post-delivery, is another factor that can trigger perinatal depression in women (Barclay and Kent 1998; Kirkpatrick and Lee 2022). Social beliefs around ‘being a good mother’, can often push mothers into feeling ashamed of any thoughts and actions regarding motherhood that go against expected social norms (Demirel et al. 2018; Meng 2020; Willey et al. 2020a, b). These social norms may expect women to feel overjoyed at being a new mother, to the point where there is no space for disclosure by women who are feeling overwhelmed and unhappy at being a mother. Women who disclose these ‘negative’ views of motherhood are typically described as being depressed or having ‘the baby blues. As a result, many women tend to mask and hide their feelings and pretend they are coping to avoid social stigma (Barclay and Kent 1998; Goodman 2009; Goodman et al. 2013; Misri 2007; Misri et al. 2010; Small et al. 2003; Tardy 2000; Theodorou and Spyrou 2013).

2.2.1. Culturally safe health practices

Yelland et al. (2015) discussed in their study that migrant women in Australia found it difficult to communicate with health professionals. This was associated with poor health outcomes such as low adherence to prescribed treatment and engagement with health services (Bains et al. 2021a; Billett et al. 2022). The authors reported that language was the main barrier

affecting health literacy and self-advocacy. Secondly, participants disclosed that their positive experiences with their perinatal care was due to health professionals showing patience, support and expression of understanding of their cultural needs. There is both empirical and anecdotal evidence that if women are supported during the perinatal period, there are better maternal and child health outcomes in the short and long term (Ley et al. 2009; Small et al. 2011; Taft et al. 2011) There is also evidence in the literature that formal peer support can benefit individuals suffering from mental health illnesses (Mahlke et al. 2014; Tsivos et al. 2015; Wisner et al. 2014). Furthermore, these programs can improve participants' health outcomes, improve health literacy, reduce the need for hospital admissions, reduce stigmatisation, and improve quality of life (Deering et al. 2016; Fieldhouse et al. 2017; Mahlke et al. 2014; Naslund et al. 2016; Tse et al. 2017; Vandewalle et al. 2016).

The Australian Health Practitioner Regulation Agency Medical Board (2020) establishes the importance of cultural safety for all patients whatever their background. It highlights how doctors should put aside their prejudgements based on their values to provide the best health care to individuals from all community backgrounds. Cultural safety is one of the aspects of perinatal care that is largely discussed in the literature as a protective factor against the development of PD (Curtis et al. 2019; Gray et al. 2021).

The PCC framework states the importance of considering the patient's spiritual beliefs or absence of them. It also acknowledges the impact of spirituality and religious beliefs in accepting therapeutical interventions, such as Jehovah's Witness members' rights to decline blood transfusions despite this being a possible life-saving procedure (Beckford 1975). It allows patients to bring their religious views and worries into the discussion of their care. When patients can voice their needs, they can make an informed decision when discussing their care with health professionals. For example, Carolan and Cassar (2010) studied African migrant

women in Melbourne, noting great heterogeneity among their participants in experiences and practices. Some women from Somalia argued that antenatal ultrasounds were potentially damaging to their foetus.

> Sometimes magic goes into woman's stomach where the baby is sleeping … so it is dangerous to see the baby before it comes out. I don't see why the doctor wants to look inside (ultrasound) …. (W17) (Carolan and Cassar 2010:196).

Cultural safety is an endorsed aspect of pregnancy care. For example, in 2017 the World Health Organization published its recommendations for maternal health care. Its report recommends the provision of 'culturally appropriate skilled maternity care':

> Ongoing dialogue with communities is recommended as an essential component in defining the characteristics of culturally appropriate, quality maternity care services that address the needs of women and newborns and incorporate their cultural preferences. Mechanisms that ensure women's voices are meaningfully included in these dialogues are also recommended (WHO 2017:20) .

Health professionals are encouraged to put aside their own beliefs and cultural background to be receptive to women's cultural needs. This is a vital part of the relationship between health professionals and patients during care. It is essential that women feel safe to disclose their beliefs and needs to health professionals without feeling judged, especially if these beliefs conflict with Western's clinical practices or with the health professional's own values and beliefs.

Additionally, doctors have the right to invoke their conscientious objection to conducting or being part of a particular legal procedure according to their personal beliefs and values. This does not affect the patient's right to receive care (Australian Medical Association 2019). It is

legal for organisations that provide health care to invoke conscientious objection based on a set of values. For example, Catholic-run health care organisations such as St Vincent's Hospital in Melbourne do not cater for women delivering a child through altruistic surrogacy. Despite surrogacy being a legal practice in Australia, St Vincent's Hospital has a public policy declining to deliver babies through surrogacy. Their policy is based on ethical grounds in accordance with those espoused by Catholic Health Australia (Catholic Health Australia 2001).

Open communication between both parties allows a healthy discussion about current evidence-based practice in pregnancy care and how it might be possible to tailor clinical practices to accommodate cultural beliefs. Furthermore, it is necessary to provide adequate information about why certain practices and procedures are not recommended in Australian pregnancy care. Cultural safety training is becoming mandatory for healthcare professionals. The training aims to raise awareness about the diversity of patients' cultural needs and bridge gaps in care provision to individuals from a CALD background and Indigenous Australians (Curtis et al. 2019; Downing et al. 2011; Gray et al. 2021).

For example, in their study of African migrant mothers in Melbourne, Carolan and Cassar (2010) reported that African migrant women were happy with the explanations provided by midwives and nurses, especially where they felt more confident because of the cultural safety practices of the health workers. However, the women in the study mainly attended a specialist African Women's Clinic. They avoided mainstream maternity services because they are generally busier, and they felt discriminated against for not being white Australians. As the authors reported, participants often felt that the staff at mainstream centres were impatient with their struggle accepting Western antenatal care. Therefore, the authors recommended creating more antenatal services dedicated to migrant women. They also recommended more training of health workers, such as midwives and nurses, in the cultural background of African women.

In another example, Rochat et al. (2011) studied perinatal depression in rural South Africa. The authors adopted a culturally-oriented research methodology to explore the clinical presentations of the illness. The study focused on the participants' discourse regarding childbearing to avoid the Western classification of depressive symptomatology. The authors described the common symptoms of the participants as disturbance of mood, loss of interest in life, suicidal thoughts, concentration difficulties and feelings of worthlessness. The same study showed that most of the confirmed cases of perinatal depression in their research were considered severe or chronic. Accordingly, the authors argued that mere social intervention would not be enough, and that psychotherapy would be a more effective resource for treating perinatal depression in migrant women.

Rochat et al. (2011) discuss the barriers to help-seeking, diagnosis and the treatment of antenatal depression in rural South Africans. The authors reveal several factors that lead to this circumstance, including lack of resources, long waiting lists for maternal health care appointments, insufficient public transport to attend these appointments, and financial issues among the women. The authors also identify that inappropriately trained health professionals and a lack of awareness regarding perinatal depression were barriers to diagnosing and treating the disease. As a result, pregnant migrant women had to wait long periods to see a specialist. Consequently, many women developed more severe perinatal depression and postnatal depression.

2.3. Migration and its health impacts

The healthy migrant hypothesis suggests that individuals who migrate from low-income countries to high-income countries are generally expected to be physically and mentally

healthier than the existing population in the host nation (Fuller-Thomson et al. 2015; Riosmena et al. 2015; Wallace and Kulu 2018). Whether migrants are genuinely physically and mentally healthier than the general population has been the subject of a great deal of debate. The 'healthy migrant' phenomenon is observed in developed countries such as the US, Canada, United Kingdom, Italy and Sweden (Andersson and Drefahl 2017; Di Napoli et al. 2021; Lu 2008; Lu and Qin 2014; Wallace and Kulu 2014).

A possible explanation for this is that this is due to the selective migration system of developed countries, which generally includes rigorous rules regarding health checks and proof of financial capacity before a visa is granted (Diaz et al. 2016; Helgesson et al. 2019; Puschmann et al. 2017). This explanation is supported by the fact that the 'healthy migrants' are predominantly young adults who are seeking better education, professional qualifications, and enhanced work opportunities (Andersson and Drefahl 2017; Di Napoli et al. 2021; Fuller-Thomson et al. 2015; Wallace and Kulu 2018). Another explanation for this phenomenon is that sick people intentionally screen themselves out. Ill people may not be willing to travel to a developed country seeking better treatment and better quality of life if private medical treatment in a developed country is not affordable (Di Napoli et al. 2021; Helgesson et al. 2019; Wallace and Kulu 2014).

The second line of argument is that the 'healthy migrant' phenomenon is fictitious and reflects measurement bias. Can people be considered 'healthy' because they meet visa requirements? Many temporary visa holders do not need to have medical assessments at all. The financial burden of private medical assistance in Australia can be a significant factor for migrants, who may not seek treatment while ill. This would mean that migrants who do not seek medical help would still be assessed as 'healthy' when they are not – leading to an overall underestimation of the relative illness of the migrant community. There is also the fact that migrants might not

seek medical help due to fears around losing their jobs or money (Helgesson et al. 2019; Wallace and Kulu 2014).

Lu (2008) explored the healthy migrant hypothesis through Indonesia's internal migration longitudinal data collected via the Indonesia Family Life Survey. The authors had difficulty establishing what could be a strong health indicator for the study due to the complexity of people's perceptions of what constitutes 'good health'. The authors opted for choosing activities of daily living as an outcome measure for health status. The study showed that health, defined thus functionally, can be a determinant of migration as 'health does not place an impediment to migration, and good health may even foster their ability to make migration a gainful experience.' The authors found younger individuals seeking migration are favoured due to their 'good health', and aims to join the workforce and address the job market shortages. Meanwhile, older individuals may seek migration in order to access better health services and support from relatives.

Another version of the undercounting explanation is presented by the 'salmon bias effect' hypothesis, which states that migrants return to their homeland when they are ill, that is, they have a compulsion, as salmon do, to return to their origin when they suspect death is imminent. There is limited data to support a salmon bias effect in countries such as the United States of America, England, Wales, Sweden, Scotland and Italy (Di Napoli et al. 2021; Diaz et al. 2016; Helgesson et al. 2019; Wallace and Kulu 2018). However, emigration back to the home country is usually associated with the voluntary return of healthy individuals after reaching their goals, such as achieving higher education and earning money in a country with a stronger currency than their homeland. There is also a strong relationship between emigration and the need individuals have to reunite with their families (Di Napoli et al. 2021; Diaz et al. 2016; Wallace and Kulu 2014).

Finally, the ‘healthy migrant’ phenomenon may be temporary, considering the influence of a migrant's acculturation, which can be defined as ‘the process by which migrants adopt the attitudes, values, customs, beliefs and behaviours of a new culture’ (Abraído-Lanza et al. 2005). Culture shock is a significant factor that impacts negatively on some migrant's health. But as time passes, migrants tend to assimilate the positive and negative health conditions commonly associated with their new country and abandon or at least modify their grip on their cultural values and traditions (Delavari et al. 2013; Helgesson et al. 2019; Wallace and Kulu 2014). For example, Latinos who migrate to the US tend to develop more cardiovascular illness due to the adoption of unhealthy lifestyles such as smoking, high alcohol intake and unhealthy diet that are more prevalent in the US (Abraído-Lanza et al. 2005; Riosmena et al. 2015; Wallace and Kulu 2014).

2.4. Perinatal depression

2.4.1. Definition of perinatal depression

In 1994, the term ‘Major Depressive Disorder with postpartum onset’ was finally included in the Diagnostic and Statistical Manual of Mental Disorders, 4th ed. (DSM-IV). It defined the postpartum onset of the manifestation of depressive symptoms from childbirth until four weeks post-labour (Matthey and Ross-Hamid 2011). Then in 2013, the Diagnostic and Statistical Manual of Mental Disorders, 5th ed. (DSM-V) changed the specifier from ‘postpartum onset’ to ‘peripartum onset’, expanding the manifestation of depression to during pregnancy, occurring either or both in the third trimester of pregnancy and in the first four weeks postpartum. The DSM-V definition of the onset of postpartum depression does not cover those women who develop postpartum depression symptoms later on in the first-year post-childbirth.

In classifying it as depressive disorder, DSM-V focuses on the following symptoms:

> A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
>
> 1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (Note: In children and adolescents, can be irritable mood.)
>
> 2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
>
> 3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month) or decrease or increase in appetite nearly every day. (Note: In children, consider failure to make expected weight gain.)
>
> 4. Insomnia or hypersomnia nearly every day
>
> 5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
>
> 6. Fatigue or loss of energy nearly every day.
>
> 7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
>
> 8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
>
> 9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide (American Psychiatric Association 2013:160-161).

The peripartum onset is defined as a specifier for the diagnosis of depressive disorders:

> With peripartum onset: This specification can be applied to the current or, in full criteria are not currently met for a major depressive episode, most recent episode of major depression if onset of mood symptoms occurs during pregnancy or in the 4 weeks following delivery…. (American Psychiatric Association 2013:187).

The DSM-V definition also states ’between 3% and 6% of women will experience the onset of a major depressive episode during pregnancy or in the weeks or months following delivery.’

(Psychiatric Association 2013). Studies conducted using self-reported questionnaires in developed countries such as the United States of America, Canada, and the United Kingdom found similar figures regarding the prevalence of perinatal depression in their populations (Gavin et al. 2005; Mann et al. 2010). International studies generally lack data from low-income countries (Hahn-Holbrook et al. 2017; Shorey et al. 2018). Several scholars have affirmed that migrant women coming from a low-income background are more likely to be affected by perinatal depression, in view of the fact that financial hardship can lead to uncertainty and trigger anxiety about being able to provide for their children and themselves (Hahn-Holbrook et al. 2017; Leung and Kaplan 2009; Shorey et al. 2018; Woody et al. 2017). Low literacy is also linked to the development of PD causing poor engagement with health care services, difficulty understanding medical recommendations and negotiating care. Language barrier also play a significant role in the vulnerability of migrant women from low-income backgrounds to PD. It impacts on their ability to navigate the health system and advocate for their care needs (Eastwood et al. 2017). But it also contributes to migrant women's ability to return to the work force and their chance to improve their socioeconomic status. Additionally, women coming from low-income backgrounds may lack social psychosocial support and therefore be more vulnerable to PD (Bains et al. 2021b; Billett et al. 2022; Navodani et al. 2019). Further epidemiological studies in low-income countries to determine a more accurate prevalence of PD in low and middle-income countries are recommended.

2.4.2. History of perinatal depression

Hippocrates (who probably lived between 460 BC and 370 BC), an ancient Greek physician who is considered the father of medicine, described people's depressive symptoms as melancholia, which he defined as an excess of black bile leading to the afflicted person being fearful and having hysteria (Hippocrates 1923).

Hippocrates was the first to speculate about postpartum depression and notice that women in the puerperal period presented some melancholia. In his Epidemics III studies, Hippocrates presented two cases studies related to melancholia post-birth. Case II:

> In Thasos the woman who lay sick by the Cold Water, on the third day after giving birth to a daughter without lochial discharge, was seized with acute fever accompanied by shivering. For a long time before her delivery, she had suffered from fever, being confined to bed and averse to food. After the rigor that took place, the fevers were continuous, acute, and attended with shivering.
>
> Eighth and following days. Much delirium, quickly followed by recovery of reason; bowels disturbed with copious, thin, watery and bilious stools; no thirst.
>
> Eleventh day. Was rational, but comatose. Urine copious, thin and black; no sleep.
>
> Twentieth day. Slight chills, but heat quickly recovered; slight wandering; no sleep; bowels the same; urine watery and copious.
>
> Twenty-seventh day. No fever; bowels constipated; not long afterwards severe pain in the right hip for a long time. Fevers again attended; urine watery.
>
> Fortieth day. Pain in the hip relieved; continuous coughing, with watery, copious sputa; bowels constipated; aversion to food; urine the same. The fevers, without entirely intermitting, were exacerbated irregularly, sometimes increasing and sometimes not doing so.
>
> Sixtieth day. The coughing ceased without any critical sign; there was no coction of the sputa, nor any of the usual abscessions; jaw on the right side convulsed; comatose; wandering, but reason quickly recovered ; desperately averse to food; jaw relaxed; passed small, bilious stools; fever grew more acute, with shivering. On the succeeding days she lost power of speech, but would afterwards converse.
>
> Eightieth day. Death.
>
> The urine of this patient was throughout black, thin and watery. Coma was present, aversion to food, despondency, sleeplessness, irritability, restlessness, the mind being affected by melancholy. (Hippocrates 1923:261-263)

And case XIV:

> In Cyzicus a woman gave birth with difficult labour to twin daughters, and the lochial discharge was far from good.

> First day. Acute fever with shivering; painful heaviness of head and neck. Sleepless from the first, but silent, sulky and refractory. Urine thin and of no colour; thirsty; nausea generally; bowels irregularly disturbed with constipation following.
>
> Sixth day. Much wandering at night; no sleep.
>
> About the eleventh day she went out of her mind and then was rational again; urine black, thin, and then, after an interval, oily; copious, thin, disordered stools.
>
> Fourteenth day. Many convulsions; extremities cold; no further recovery of reason; urine suppressed.
>
> Sixteenth day. Speechless.
>
> Seventeenth day. Death (Hippocrates 1923:281-283).

He considered two possible reasons. Firstly, there may have been an excess of vaginal fluids post-birth, which might somehow have been inhibited. The build-up of an excess of fluid would eventually reach the woman's head, leading to mania, agitation and delirium. He established that the symptoms were similar to delirium. Secondly, he suggested a cause for melancholia post childbirth could be accumulation of blood on women's breasts, causing madness (Hamilton 1962; Hippocrates 1923).

Between the 5th century and the 15th century AD, there was a substantial shift in perspectives on the causes of mental health illness. Under the influence of Christianity, Hippocratic theories about a physiological cause of postpartum depression were abandoned and replaced by religious beliefs. Women presenting depressive symptoms during the Middle Ages who were not deemed an ‘idiot from birth’ would be classified as witches and believed to be possessed by demons (Roffe and Roffe 1995). Consequently, they had to face the fatal consequences of this label, often through public executions at the hands of inquisitors. Individuals who were considered to have an intellectual disability from birth would be abandoned and ostracised by society. Some of these individuals were the target of exploitation or would become ‘court fools’ (Neugebauer 1996; Roffe and Roffe 1995).

In 1438, Margery Kempe, a middle-class English Christian mystic, dictated her autobiography called The Book of Margery Kempe. It is considered the first autobiography written in the English language; it has survived the medieval period and was rediscovered in 1934. Her recollections shine some light on how mental health disorders and their symptoms were attributed to spiritual disturbances, drifting away from Hipprocates' early remarks. The main focus of Margery's book was her spiritual journey and persecution by the church. She told of her experiences and difficulties in the eight months after delivering her first child. Her auditory and visual hallucinations had a heavy religious theme, involving apparitions of Christ and the Virgin Mary. Some of the voices she heard asked her to abandon her child, family, and faith and commit suicide. The symptoms she describes and their proximity to her first childbirth indicate that she might have suffered postnatal psychosis. Her public displays of emotional lability and preaching led to numerous arrests and trials for heresy by the Church. Luckily, she was acquitted of all accusations and ended up with 14 living children (Kempe 1996).

In the 15th and 16th centuries, European doctors were influenced by the Renaissance in Italy and gradually shifted to a focus on natural sciences. This eventually led medieval doctors to revisit Hippocrates' observations about mental health illnesses and slowly move away from the religious influence on medicine and persecution of individuals suffering from mental illnesses (Neugebauer 1996).

> In the 1,000 years after the fall of the Western Roman Empire, 400-1400 AD... there was a prevalence of religious beliefs in the understanding and treatment of mental illness . . . Renaissance views of the mentally ill were influenced by a pervasive fear of witchcraft, which began in 1486 with the publication of a book, Malleus Maleficarum (Witches' Hammer)…The Malleus ... suggested that almost any mental or physical affliction of a male or female could be a sign of witchcraft, and it prescribed inquisitorial procedures of mental or physical torture. (Neugebauer, 1996:1)

Gooch (1820) and Esquirol (1838) were the first obstetricians to document insanity during the perinatal period. Gooch stated that women could be afflicted by insanity during pregnancy or the puerperal period, covering the first six weeks post-birth. Gooch also stated that insanity could be present during the so-called lactational period, which was characterised by symptoms presenting after the initial six weeks postpartum and related to breastfeeding. Macdonald (1847), an American physician, established that it was unnecessary to subdivide insanity into stages because the symptoms were interrelated. There was a high incidence of puerperal insanity in this period; over time, scholars opted to use the term puerperal insanity for insanity during any perinatal stage. Furthermore, in contrast to medieval alienists, who were doctors responsible for the treatment of mentally ill individuals, nineteenth-century scholars focused on the physical and psychosocial aspects of puerperal insanity (Jones 1903).

Victorian scholars' causal hypotheses for puerperal insanity stressed the influence of heredity, previous history of puerperal/lactational insanity, the impact of living in poverty, and previous traumatic experiences. It also established puerperal insanity as a physical ailment due to a gynaecological disorder linked to the natural process of pregnancy, childbirth and breastfeeding. Alienists of the time focused on the fact that a great majority of puerperal insanity presentations were poor women (Jones 1903). There were some exceptional cases where puerperal insanity was linked to an excess of luxuries. In 1850, John Connolly studied a young woman's journey to Surrey County Lunatic Asylum, Britain, due to puerperal mania. Her diagnosis and progress were documented with the assistance of psychiatrist and photographer Dr Hugh Welsh Diamon. Figure 2.1 shows the categorisation of the woman's photographs into four stages of puerperal insanity: melancholy, excited (mania), convalescent (relapse) and eventually well (recovery) (Hamilton 1962; Marland 2003; Nickel 2005; Riecher-Rössler et al. 2005).

Figure 2.1: Nineteen-century representation of puerperal insanity from left to right: melancholia, excited (mania), convalescent (relapse) and well (recovery). Psychiatric photographer Dr Hugh Welsh Diamon photographed the patient on 19th June 1858. (Source: Nickel 2005:67)

In 1858 French alienist Louis Victor Marcé published a treatise on insanity in pregnant, postpartum, and lactating women (Marcé 1862). In his extensive work, he identified that perinatal depression has a set of causes and symptoms separate from the umbrella term depression. He acknowledged that perinatal depression was linked to a combination of psychological factors and intrinsic physical changes post-childbirth. His work is recognised as the catalyst for the development of perinatal psychiatry (Trede et al. 2009).

2.4.3. Prevalence of perinatal depression

Woody et al. (2017) in a systematic review identified a higher prevalence of PD from the data than reported previously by those studies and by using the DMS-V. The authors affirmed that women coming from low income and middle-income countries have a two-fold increase in the prevalence of PD compared to women coming from high-income countries. Women coming from low and middle-income countries have a prevalence of 19.2% during the prenatal period and 18.7% in the postnatal period. In comparison, women from high-income countries have a prevalence of respectively 9.2% and 9.5 %.

These figures are compatible with the 2011 findings by the Australian Institute of Health Welfare, which estimated, through 29,000 returned surveys, that 10% of childbearing women living in Australia were diagnosed with depression from pregnancy until the first 12 months postpartum (Adhikari and Cooper-Stanbury 2012). Fully 4% of these women were explicitly diagnosed with antenatal depression (Adhikari and Cooper-Stanbury 2012). There is also a strong correlation between women diagnosed with antenatal depression and the likelihood of developing postnatal depression (Milgrom et al. 2007). Several authors agree that antenatal depression is a major trigger of postnatal depression (Eastwood et al. 2017; Ogbo et al. 2018; Shorey et al. 2018; Small et al. 2003; Woody et al. 2017).

The whole family dynamic can be affected by perinatal depression. The distress and the disruption to family life caused by maternal depression can also trigger depression in approximately 10% of partners (Habib 2012; Ly 2010; Mccauley 2012; O'brien et al. 2017). In particular, first-time fathers can face the same social pressures and high expectations that women suffer. Even though fathers do not necessarily go through the intense physical transformation that women endure through pregnancy and childbirth, men can still experience an intense emotional roller coaster while adapting to fatherhood and its responsibilities. Thus, fathers may also experience high levels of stress, anxiety and depression at seeing their partners suffering from perinatal depression and its consequent misery (Habib 2012; Hall 2012; Paulson et al. 2016)

Edwards et al. (2008) published a study showing a higher incidence of 29.7% of antenatal depression in disadvantaged suburbs in Adelaide, Australia. The authors collected data from 421 women who attended antenatal care appointments at the Lyell McEwin Health Services and answered the Antenatal Psychosocial Questionnaire and the EPDS. Based on their results, they were able to identify risk factors for the development of antenatal depression, such as a history of family violence and child abuse. They also identified protective factors such as peer support.

The available international research suggests that antenatal and postnatal depression are similarly prevalent in childbearing women (Chojenta et al. 2016; Gelaye et al. 2016; Woody et al. 2017). Indeed, reports indicate that, at some point in the gestational period, around 9% of women living in developed countries are affected by antenatal depression, which can negatively influence their lives and those of their offspring in the short and long term (Eastwood et al. 2017; Leigh and Milgrom 2008; Milgrom and Gemmill 2013). Early diagnosis and

treatment during the antenatal period can avoid the onset of postnatal depression or decrease the severity of its symptoms (Faisal-Cury and Menezes 2012; Faisal-Cury et al. 2021; Goodman 2009; Leigh and Milgrom 2008; Reay et al. 2011; Segre et al. 2013).

However, antenatal depression remains globally underdiagnosed and understudied (Bowen et al. 2009; Faisal-Cury et al. 2021; Gawley et al. 2011; Ko et al. 2012; Legere et al. 2017). Faisal-Cury et al. (2021) conducted a cross-sectional study in Brazil, surveying 22,445 women using a self-reported questionnaire and the Patient Health Questionnaire-9 (PHQ-9). The study aimed to identify underdiagnosed antenatal depression amongst the Brazilian population. Their study showed that 13% of the participants presented with antenatal depression, and 71.2% of these women had antenatal depression symptoms but were not diagnosed by a health professional.

The underdiagnosis of perinatal depression can be primarily attributed to stigma and inadequate screening during antenatal visits to health professionals (Faisal-Cury et al. 2021; Gawley et al. 2011; Ko et al. 2012). Limited screening could be attributed to the difficulty in separating antenatal depression symptoms from symptoms usually associated with pregnancy and hormonal changes, such as disturbed sleep pattern, mood swings, and fatigue (Bowen and Muhajarine 2006; Faisal-Cury et al. 2021; Gawley et al. 2011; Legere et al. 2017).

2.4.4. Biological factors associated with the development of perinatal depression

There are several factors attributed to the development of perinatal depression. Biological explanations are frequently linked to the hormonal changes that women endure in the perinatal period. However, it is reductive to pinpoint hormonal fluctuation as the sole cause of perinatal

depression. More plausibly, several factors interact with each other to form a complex dynamic between hormonal changes, genetic predisposition to mental illness, deregulation of the hypothalamic-pituitary-adrenal axis (HPA), and external factors that can trigger perinatal depression such as life stressors, domestic violence, religion, cultural beliefs, social isolation, and lack of emotional and practical support (Nazzari et al. 2019; Osborne and Monk 2013).

Childbearing women face several hormonal changes as soon as the embryo implantation triggers the continuous production of progesterone to guarantee the endometrial viability of the pregnancy. There is also a crucial interaction between the woman's hormonal production, her placenta, and the foetus, which occurs to maximise the chances of a successful full-term pregnancy and birth (Feldt-Rasmussen and Mathiesen 2011).

A genetic predisposition to mental illness can contribute to the manifestation of depression at some point in life. The development of mental illness may be triggered by significant life events such as pregnancy and childbirth. A history of depression or anxiety disorders before childbearing can increase the chance of developing perinatal depression fivefold (Goodman et al. 2011; Meltzer-Brody 2011). It is also well known that a previous history of mental illness, child abuse, trauma, and domestic violence can influence the HPA system and is closely linked to the development of perinatal depression (Eastwood et al. 2017; Leigh and Milgrom 2008; Schmied et al. 2013; Shorey et al. 2018).

There is evidence in the literature that infants who were exposed in utero to maternal depression and/or anxiety are more susceptible to anthropometric measurement changes such as in height, and poor psychological outcomes, both in the short-term and later on in their lives (Field 2011; Khashan et al. 2014; Nazzari et al. 2019). The rationale is that elevated maternal

cortisol levels during the antenatal period can transpose to the placenta and lead to changes in the offspring's neuro-regulatory systems. The changes can consequently increase the offspring's cortisol levels, which can provoke low foetal growth and emotional and behavioural issues immediately after birth and later on in life (Nazzari et al. 2019; Rakers et al. 2020). However, further studies are necessary to better understand the complex mechanism of cortisol transfers from mother to offspring, including the gestational stage when the offspring is exposed to elevated levels of cortisol and the role of inflammatory markers (Hayes et al. 2013; Muzik and Borovska 2010; Rakers et al. 2020).

Some studies theorise that a malfunction of the HPA causes perinatal depression (Leung and Kaplan 2009; Nestler et al. 2002). The HPA belongs to a complex neuroendocrinal system responsible for controlling human reactions to stress and regulating mood and emotions (Rakers et al. 2020). The neurotransmitter serotonin, which is responsible in part for the regulation of stress, can be diminished due to HPA dysfunction. High levels of cortisol and low levels of serotonin are associated with the manifestation of depression (Leung and Kaplan 2009; Nestler et al. 2002; Rakers et al. 2020).

Likewise, it has been proposed that low levels of n-3 polyunsaturated fatty acids (n-3 PUFA) are associated with perinatal depression. (Ciappolino et al. 2017; Jans et al. 2010; Kobayashi et al. 2017; Leung and Kaplan 2009). It has been reported that women have an expected reduction of n-3 PUFA during pregnancy through transfer of these acids to the foetus, supporting foetal growth, and postpartum while they are breastfeeding (Ciappolino et al. 2017; Jans et al. 2010; Kobayashi et al. 2017; Leung and Kaplan 2009). The principle is that n-3 PUFA has an important role, acting in ‘photoreceptor membrane biogenesis, cellular differentiation and active synaptogenesis’ (Ciappolino et al. 2017:33).

Other perinatal disorders such as gestational diabetes can also be associated with the development of perinatal depression. In this case, the glycaemic and thyroid dysfunctions caused by diabetes can affect the HPA and consequently the synthesis of the stress hormone cortisol. Women with gestational diabetes can also be affected psychologically, due to the hardship associated with the daily management of diabetes and a preoccupation with the possible adverse effects of diabetes on their offspring (Kozhimannil et al. 2009).

2.4.5. Domestic violence and perinatal depression

Domestic violence is a critical factor that can influence the development of perinatal depression. Women coming from a vulnerable financial and social background are more at risk of being victims of domestic violence. The victims of domestic violence often manifest psychological distress, which can result in depression (Taft et al. 2011). Physical and emotional abuse does not exclusively affect women; it can also impact children and the rest of the family. Women who are not the direct target of the abuse can take on a burden of distress at seeing their children suffering domestic violence (Meltzer-Brody 2011; Taft et al. 2011). There are also devastating implications for women who have suffered sexual abuse during their childhood and adult lives.

Especially during the vulnerable periods of pregnancy and postpartum, women need to feel secure in their environment. Domestic violence may lead affected women to live under constant physical and psychological threat and fear for their lives and those of their children. Unfortunately, domestic violence is still underreported by women and their relatives, due to fear of retaliation by the aggressor, social stigma, and fear of others' disbelief. Primary health care professionals and other authorities such as community leaders and religious figures can also fail to report domestic violence, which can strongly contribute to the severity of the

women's depressive symptoms and therefore, to associated tragedy such as suicide (Taft et al. 2011).

Tsai and Tomlinson (2012) discuss the effects of domestic violence on the perinatal mental health of women in Khayelitsha in Cape Town, South Africa. Their research aimed to improve maternal mental health to achieve better infant health outcomes, mainly because they linked perinatal depression in women with their children being malnourished and underweight. Tsai and Tomlinson argue for intervention at the individual level through the implementation of screening, as well as at the structural level by enhancing the economic power of these women. This is an exciting idea, but the article fails to propose tangible solutions to change the underlying cycle of domestic violence in Khayelitsha, one of the critical factors affecting perinatal mental health in this community. Unfortunately, this is a recurrent issue in the research into perinatal depression, especially in developing countries. Several studies have been dedicated to identifying the causality of perinatal depression, which obviously could be a structural problem, but so far, no real solutions have been established or even proposed (Buist 2006; Collins et al. 2011; Zelkowitz et al. 2004).

Being an asylum seeker is another factor that can contribute to the development of perinatal depression. Most asylum seekers have been exposed to highly stressful situations such as war, experiencing and witnessing torture, violence, rape, and famine. There is also the ongoing fear for their wellbeing and that of their loved ones due to political instability, economic disadvantage, and the fact of belonging to a particular religious group in their homeland (Carolan and Cassar 2010; Hunt et al. 2012). Several authors have pointed out the adverse outcomes associated with being an asylum seeker or refugee woman (Billett et al. 2022; Navodani et al. 2019; Vigod et al. 2017). This category is at exceptionally high risk of developing mental illnesses such as post-traumatic stress disorder (PTSD), depression and

anxiety disorders, potentially leading to suicide (Billett et al. 2022; Collins et al. 2011; Navodani et al. 2019; Yelland et al. 2015). Emotional and physical trauma is often associated with the development of post-traumatic stress disorder (PTSD) (De Graaff et al. 2018; Slade et al. 2020). Trauma can also trigger the development of perinatal depression; it is well known that women with a previous history of mental illness, including PTSD, are more vulnerable to the manifestation of perinatal depression (De Graaff et al. 2018; Hunt et al. 2012; Nestler et al. 2002; Rochat et al. 2011).

Throughout history, women were seen as a physical means for men to reproduce and their property (Romanis et al. 2020). There has been a shift in gender equality in the twentieth century, in women's rights, and the quality of perinatal care received (Romanis et al. 2020). However, despite the improvements in women's role in society, many researchers argue that health professionals still have a leaning towards controlling women's bodies during pregnancy and a focus on the foetus more on than the mother's well-being (Chervenak and Mccullough 2017; Fleischman et al. 1998; Harris 2000; Hollander et al. 2016).

2.4.6. Influence of religion

Religion is part of the complex dynamic between a person's beliefs and attitudes towards their health and treating an illness. According to the Australian Bureau of Statistics (2012), sixteen significant religions are followed in Australia. There are three dominant religions within the Australian migrant community: Buddhism, Islam, and Hinduism. These different religions will interpret depression and mental illness in different ways. Religious beliefs and the intrinsic rituals involved in each religion can negatively or positively influence the diagnosis and treatment of illness such as depression. It can play a protective role by providing the basis for emotional resilience through hope and the sense of being 'looked after' by superior forces beyond their control (Demirel et al. 2018; Keefe et al. 2016).

The delicate balance between religious beliefs and medical treatment is not unique to any particular religion. Indeed, religious faith nearly always affects the approach taken to mental health, although this will occur in different ways and to varying degrees according to the faith in question and the devoutness of the individual. Several religions, including Islam, the Brazilian Spiritism movement and Judaism, commonly attribute illness to God testing people's faith, or as a challenge requiring even greater religious adherence to overcome it (Barmania 2017; Lucchetti et al. 2012). Thus, individuals with chronic illness such as diabetes can believe they are punished by God and feel cursed by a lifelong illness, impacting their emotional state further (Braghetta et al. 2011; Collins et al. 2011; Lucchetti et al. 2012).

For instance, in most Brazilian protestant churches, the symptoms of depression can be seen as the manifestation of 'bad spirits' and a lack of devotion to the religion. In the African-influenced Brazilian religion called Candomblé, depression is believed to be caused by someone's sorcery, and *trabalhos* (religious rituals) are thought necessary to cure the person. To them, medical treatment is not always the first choice when women present with depressive symptomatology (Braghetta et al. 2011).

Sakina et al. (2021) discussed the experiences of women living in Pakistan semi-urban areas who were diagnosed with perinatal depression. Some participants disclosed that they believe that their PD symptoms were caused by ‘tension’ and they were not aware of the term ‘depression’. Participants associated this ‘tension’ with their social interactions with family members and relatives. They stated that some relatives did black magic against them, which led to the development of the PD symptoms.

Ali et al. (2004) published an important paper about the relationship between the Islamic faith and psychology. This study strongly suggests that knowledge and understanding of the particular characteristics of the Islamic faith are important to Western health professionals when treating migrant women from an Islamic background. The authors reveal that some Muslims recognise depression, yet they prefer to 'treat' the illness through Islamic practices such as the five daily prayers and social support. Barmania (2017) discussed how in his interpretation some practising Muslims may consider the symptoms of depression are as an illness attributable to weak faith and heart. Such beliefs can contribute to stigmatisation of mental health illness and impacting help seeking. The author also comments on the difficulties that health professionals may face with identifying suicidal risk in depressed patients because, according to Islam, suicide is a prohibited and criminal act. Consequently, psychologists need to create a strategy during therapy to ensure that they ask appropriate and sensitive questions that would provide information about suicidal thoughts.

Demirel et al. (2018) argued that in Turkey around 70% of Muslim women continue to practice traditional practices in the postnatal period. Some of these traditional practices includes 'wrapping the new mother's belly, not leaving her alone in the household, abstaining from sexual intercourse, practices to prevent puerperal fever, swaddling the infant, salting the infant' (Demirel et al. 2018:67). According to Demirel et al. (2018) 78.3% of participants reported that they follow traditional practices in the believe that evil can lead to puerperal fever, which aligns with the symptomatology of postnatal depression including crying and loss of appetite. Therefore, to prevent puerperal fever these women might adopt traditional practices such as 'not leaving the household for 40 days, wearing a red ribbon or red nightgown, not being alongside another new mother, not being alone with the infant for 40 days and 40 nights, keeping a talisman and the Quran at hand, putting scissors or a knife under their pillow and hanging onions or garlic near their bed' (Demirel et al. 2018:67). The authors stated that the increase in social support during the 40 days postpartum is a protective factor against the

development of PD. The authors found that overall traditional practices were linked to lower EDPS scores. At the same time, Turkish traditional practices aiming to increase milk supply were associated with higher EPDS scores.

Keefe et al. (2016) conducted a qualitative study in the US analysing the views of African American and Latin American new mothers about their perceptions of how their religion impacted their management of PD. All 30 interviewed women identified themselves as Christians and reported that their faith was a tool to manage PD. These mothers stated that through prayers they were able to feel less stressed, lonely and helpless. They reported that God would listen to their concerns and trust that there is a reason for their troubles brought them peace and calmness. Additionally, these mothers revealed that when they attended church they felt socially and emotionally supported by other church members. Therefore, religion can also have a positive impact in the management of PD (Dekel et al. 2016; Demirel et al. 2018; Keefe et al. 2016).

In another example, Rahman (2007) describes the antenatal health care situation in Rawalpindi, Pakistan. Unfortunately, the studied area has a significant lack of health care resources to attend to 3.5 million people. There are only three psychiatrists to support the whole district, and there are no psychologists. Lady Health Workers (LHWs) conduct the main maternal health work; they are community members trained to provide preventive maternal and child health services and education. A consequence of the lack of health personnel is the low perception of depression and other mental illnesses in the community, compounded by the stigma associated with mental disorders. Pakistani women living overseas can have different perceptions of depressive symptoms and be fearful of being stigmatised if they reveal their symptoms to anyone. Consequently, perinatal depression can remain undiagnosed.

A curious aspect not explored by Rahman (2007) was how the LHWs describe and perceive mental disorders. From my point of view, if the stigma starts with the LHWs who provide education and health services to the community, how would a diagnosis of perinatal depression be made, and how is effective treatment provided? Regarding the LHWs, the researcher focused only on the delivery of the proposed interventions. Interestingly, the study did not consider how the Islamic faith can influence the diagnosis and treatment of perinatal depression. According to some interpretations of Islamic doctrine, the development of a mental disease means the person is 'negligent' in their spiritual life.

Some Islamic scholars emphasise that Western medicine can be used only in association with the Islamic tradition. Regarding psychotherapy, a Muslim woman might need to consult and include her whole family in the therapy process (Fonte and Horton-Deutsch 2005). Consequently, health professionals need to be aware of these specific aspects of the Islamic faith as expressed in some cultures to deliver a more appropriate and effective treatment of perinatal depression to pregnant women who adhere to this religious tradition.

2.4.7. Area-level factors in Australia and perinatal depression

Eastwood et al. (2011) discussed the influence of the geographic area that women live in and the manifestation of perinatal depression. The authors point out that there is a large settlement of migrants, asylum seekers and refugees in south western Sydney where their study was conducted. Thus, south western Sydney has a variety of different cultures living in the same area, which can be a negative factor, insofar as there is no sense of belonging to a community with a shared culture, language and faith. Also, south western Sydney is one of the poorest regions in Australia, and financial difficulties are highly linked to perinatal depression. Ogbo et al. (2018) focused their study in south western Sydney and the influence of in New South Wales. Moreover, due to the poverty, this area has a high incidence of crime, which, amongst

other things, can cause women to feel unsafe, stressed and worried, therefore contributing to the development of perinatal depression (Eastwood et al. 2011; Ogbo et al. 2018; Tannous et al. 2008).

Edwards et al. (2008) conducted a study into antenatal depression psychosocial risk factors in Adelaide, South Australia. They explored the link between women living in low socioeconomic areas and the development of antenatal depression. They stated that the circumstances of women coming from a specific region, where there is a higher incidence of socio-economic issues such as low per capita income, higher unemployment rate, substance abuse, single parenthood and financial hardship put women at more risk of developing antenatal depression. The authors emphasised that women coming from disadvantaged geographic areas are more likely to suffer domestic violence leading to complicated pregnancies and poor postnatal health outcomes for themselves and their children.

2.5. Australian perinatal health care services

The Australian perinatal health care system is detailed according to the published 2019 clinical practice guidelines in pregnancy care, commissioned by the Australian Government Department of Health and prepared by an expert advisory committee led by Professor Caroline Homer. The National Health and Medical Research Council (NHMRC) oversaw the publication of these guidelines, aiming to guarantee a standardised national approach to perinatal health care in Australia (Australian Government Department of Health 2019). The current models of perinatal care in Australia are:

- Public hospital care: the woman attends the hospital for all aspects of her antenatal care and receives care from hospital doctors and midwives.
- GP care: the woman sees her GP throughout her pregnancy.

- Private obstetrician or private midwife care: the woman sees her private obstetrician or midwife throughout her pregnancy.
- Private obstetrician and private GP: the woman see her GP regularly during the antenatal period with specific visits to an obstetrician.
- Shared care: several health professionals are involved in the care of a woman during pregnancy, often in the context of a formal arrangement; health professionals involved may include GPs, midwives, other primary care health professionals, specialist obstetricians and hospital practitioners.
- Midwife care: midwives are the primary providers of care for the woman; this may be through a team of midwives being responsible for care of a small number of women (team midwifery) or a woman receiving care from one midwife or his/her practice partner (caseload midwifery). (Department of Health 2019:49)

Despite the NHMRC standardised guidelines, regional perinatal health care services are generally more limited than in the metropolitan areas. One of the reasons for that is the difficulties with recruitment and retention of staff in regional areas. Another challenge is the geographic distance between services providers, lack of transport and difficulty accessing weather afflicted areas due to floods and bushfires (Longman et al. 2017; Rolfe et al. 2017). Therefore, women in remote areas frequently have to travel long distances to seek alternative perinatal care out of their catchments. This can affect their continuity of care and engagement in care due to the logistic barriers. As a result, women in regional areas may have poorer perinatal health outcomes than women in metropolitan areas (Longman et al. 2017; Rolfe et al. 2017).

After a gestation of eight or more weeks, women in Canberra can access the Canberra Maternity Options Service (CMOS), which provides advice on perinatal services, with the most frequent option taken up by women being public perinatal care (Australian Capital Territory Health 2018). The care is provided between midwives from the North Canberra (formerly Calvary) Hospital or The Centenary Hospital for Women and Children in conjunction with women's GP of choice. The public shared maternity care is an optional program and might vary depending on its provider. However, core guidelines are that perinatal care can be shared

between midwives, GPs and obstetricians. Brown et al. (2014) found that women generally found that they received very good antenatal care in Victoria and South Australia. From 2469 returned completed questionnaires, 69% reported that the antenatal care they received from their GP was a positive experience and 74% of the participants stated that they received very good antenatal care by midwives in the public system.

In Hamilton, patients can choose the shared care with their GPs and the Hamilton Model of Midwifery Care at the Hamilton Base Hospital (Western District Health Service 2021). Evidently the size of the team of health professionals delivering perinatal care to women in Hamilton is smaller in comparison to Canberra. This may represent an advantage for women regarding continuity of care during their perinatal care due to the consistency of staff providing care through the public system. Women using the perinatal care services might see the same midwife throughout their whole pregnancy despite being under the public shared care model.

Another popular program is the Continuity of Midwifery Care Birth Centre, which is covered by Medicare through the public system and a small team of midwives (caseload midwives) who provide perinatal care to women presenting with low-risk pregnancies (Australian Capital Territory Health 2018). They can refer women to a GP or a specialist if there are any medical concerns or complications during care. An exclusive midwife is allocated to each woman and will manage the whole pregnancy, labour and postnatal care. The benefits of this system are that women can establish a strong relationship and trust with a particular health professional and better continuity of care. Home birth can also be arranged for women with low-risk pregnancies and they are managed by accredited midwives, though this is a private option in Canberra (Australian Government Department of Health 2019). The birth centres in Canberra (both at the Centenary Hospital and the North Canberra Hospital), where births are entirely managed by midwives in ‘home-like’ environments have a limited number of appointments

available because their limited staff and resources and the exclusive nature of their services (Australian Capital Territory Health 2018).

Therefore, not all women who opt for this model of care will be able to access it. In Canberra, there is a waiting list for this program and places are not guaranteed (Australian Capital Territory Health 2018). Forster et al. (2016) discussed in their study in Melbourne that women receiving perinatal care by an allocated midwife through the case load midwifery program reported better satisfaction in comparison to women who had multiple rostered midwives during the perinatal care under the standard shared care program. The authors discussed that caseload midwives were able to provide better continuity of care to women and recommended the expansion of its model for women with low risk pregnancies (Forster et al. 2016).

Additionally, in this study two participants in Canberra opted for private care through a private GP and private obstetrician. This option is financially more accessible through the payment of private health insurance with cover for pregnancy and childbirth. Using this option, women can choose to give birth in one of the two public hospitals but be admitted as private patients, or they can choose the Calvary John James Private Hospital or Calvary Bruce Private Hospital. Meanwhile, in Hamilton, women opting for the private pathway can use the public Hamilton Base Hospital as a private patient or travel to St John of God Warrnambool Hospital. The St John of God Warrnambool Hospital is also responsible for the provision of perinatal mental health services to Hamilton and referrals are normally actioned in 24 hours.

2.5.1. Patient-centred care and holistic care

The Australian clinical practice guidelines in pregnancy care adopt a patient-centred care (PCC) approach, in which the patient's needs and wishes are prioritised in the clinical context.

It improves not only patients' and their families' satisfaction with the health system, but also their health outcomes. It also improves the satisfaction of staff working for an organization that adopts PCC (The Picker Institute 2019). This approach was first defined by Carl Rogers in 1961 in psychotherapy sessions, establishing that patients are in charge of their therapy because they know themselves best. The psychotherapist is only a guide in therapy sessions (Rogers 1961). Then, in 1993 the Picker Institute established the PCC framework and developed a holistic approach to meet patients' needs, defined in eight dimensions.

I. Fast access to reliable healthcare advice
II. Effective treatment delivered by trusted professionals
III. Continuity of care and smooth transitions
IV. Involvement of, and support for, family and carers
V. Transparent information, communication, and support for self-care
VI. Involvement in decisions and respect for preferences
VII. Emotional support, empathy and respect
VIII. Attention to physical and environmental needs. (The Picker Institute 2019)

The World Health Organization (WHO) has endorsed the PCC framework. According to the Australian Charter of Health Care Rights, in the past ten years it has been adopted in Australia, in Victoria and the ACT (Coulter et al. 2008; Delaney 2018). It aims to improve health outcomes and increase the PCC features in health professionals' training in their studies curriculum and recurrent training for staff working in health organisations. The advantage of the PCC approach is that women have an active voice in their health care decision-making process, rather than being a passive spectator where health professionals dictate the care in a paternalistic approach, where 'doctor knows best' (Delaney 2018). Nonetheless, some clinicians may work in the same position and institution for years and do not necessarily upskill or acquire the most up-to-date knowledge about PCC. This may lead to disempowerment of women to make their own informed medical decisions (Bashook and Parboosingh 1998; Drazen and Weinstein 2010; Koblinsky et al. 2006; Solnes Miltenburg et al. 2018).

The 2019 clinical practice guidelines in pregnancy care highlight the importance of acknowledging that women experience pregnancy in different ways depending on multiple factors, such as level of health literacy, financial means, cultural background, family dynamics, religious beliefs, mental health issues, trauma, history of sexual abuse, domestic violence, co-morbidities, disability, unplanned pregnancy, and more (Australian Government Department of Health 2019). Therefore, the recommendation is that health professionals be aware that each pregnancy is unique, and consequently, it is essential to adopt a holistic approach when planning a mother's and baby's care. If an issue is beyond a health professional's particular scope of practice, appropriate referrals should be made promptly to mitigate risks and promote better patient health outcomes (Australian Government Department of Health 2019).

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) recommends that an elective Caesarean section for non-medical reasons be discussed in detail between health professionals and patients (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists 2021b). Patients have the right to be informed about the short and long-term health implications of a Caesarean section to the mother and baby.

Brazil (where most participants from Canberra came from) and India have relatively high rates of elective Caesarean sections, exceeding the WHO's recommended rate of between 10 and 15 percent of the total childbirths per country (World Health Organisation 2018). In Brazil, 56% of all live births are delivered by elective Caesarean section has reached 56%, surpassing vaginal deliveries (Boerma et al. 2018; Escobal et al. 2022); Caesarean sections are performed across all Robson classification, including those which would pose favourable conditions for vaginal birth (Rudey et al. 2020). In India, 21.5% of deliveries are by elective Caesarean

sections each year (Neethi Mohan et al. 2023), an increase from 17% five years ago (International Institute for Population Sciences 2017).

The rationale for health professionals to decline women's requests for elective Caesarean sections is that Caesarean section is a surgery that carries potential risks such as infection, possible damage to the urethra, and scarring of the uterus, leading to possible complications with future pregnancies (Escobal et al. 2022; Wagner 2000). Elective Caesarean sections also increase the risk of Caesarean sections for future pregnancies – one of the major drivers of the escalation of Caesarean sections in Brazil (Rudey et al. 2020). In Brazil, Caesarean section is an independent risk factor for maternal mortality (Rudey et al. 2020).

2.5.2. Diagnosis of perinatal depression and Australian guidelines

The diagnosis of perinatal depression can be challenging, because the usual physical symptoms associated with pregnancy, such as fatigue, lack of appetite, and changing sleep patterns can also be associated with depression and anxiety (Pearlstein 2008). However, several authors argue that antenatal depression is still underdiagnosed and under-reported, due to health professionals' lack of awareness, combined with women's fear of social stigma and tendency to avoid consulting a qualified health professional for fear of being judged or labelled as a bad mother (Buist 2006; Judd et al. 2013; Stanley et al. 2006; Willey et al. 2020a)

Doctors can vary in their willingness to prescribe antidepressants for antenatal depression. This is particularly because of the rare but possible side effects of antidepressants during pregnancy, its potential teratogenic effects on the foetus and discontinuation symptoms experienced by the neonate if they are prescribed in the last trimester. This contributes to the

uncertainty that midwives express regarding the treatment of antenatal depression (Brogan 2013; Buist 2008; Byatt et al. 2013).

Buist et al. (2007) found that obstetricians in Australia had limited contact with perinatal depression because the onset of perinatal depression symptoms occurred after the six-week postnatal check-up. Women also felt that disclosure of the perinatal depression symptoms should be made to a different health professional than the obstetrician, especially because appointments with specialists have a time constraint. In contrast, appointments with midwives tend to be longer. In a separate study, Buist et al. (2006) analysed the responses of professionals from three healthcare cadres about perinatal depression in Australia — general practitioners (GPs), maternal and child health nurses (MCHNs), and midwives. The authors identified that professionals from all three categories were primarily aware of postnatal depression. However, the antenatal period seems to be when health professionals often dismiss the depressive symptoms. On the other hand, maternal and child health nurses have been found to have high awareness of perinatal depression and are more likely to refer the mothers to a medical service to confirm a diagnosis of perinatal depression (Buist et al. 2007; Jones et al. 2012).

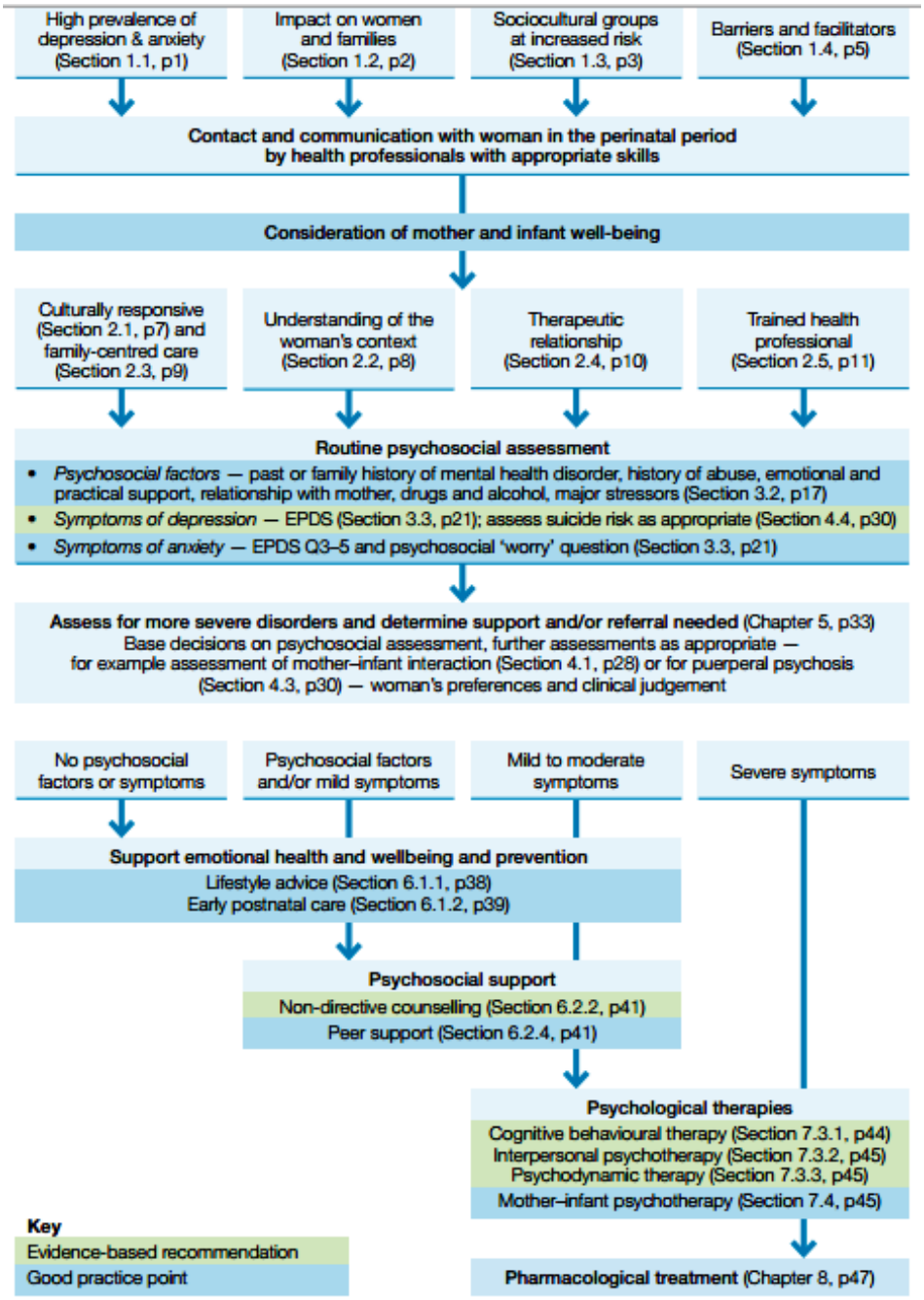
In a bid to tackle depression and perinatal depression in the Australian community, in 2001, the Commonwealth and Victorian governments funded Beyond Blue, the national depression initiative. Beyond Blue was launched to raise public awareness about depression, tackle the stigma around mental illness, and provide reliable information and training on mental health. This initiative also receives financial contributions from other states and territories. (Buist et al. 2007; Highet et al. 2006; Jorm et al. 2005). In 2008, the Commonwealth government announced:

> The Australian Government will provide ongoing policy leadership for coordination, implementation and evaluation of the National Perinatal Depression Initiative. It will work in partnership with State and Territory Governments, through the Mental Health Standing Committee, to develop a National Perinatal Depression Initiative framework.
>
> The Australian Government has committed to a contribution of $55 million over five years towards the National Perinatal Depression Initiative (NPDI), which includes: $30 million to State and Territory Governments to contribute to the roll-out of routine and universal screening, support services, and training for health professionals; $5 million to Beyond Blue to support implementation; and an additional $20 million to the Access to Allied Psychological Services (ATAPS) program to build the capacity of Divisions of General Practice to support better treatment for women with perinatal depression. (The Australian Health Ministers' Advisory Council 2008:3-4)

The 2018 Parliamentary inquiry into perinatal services in Victoria reported that the NPDI funding was withdrawn by the Commonwealth government in 2015 despite its recommendation to continue to fund the program. During Tony Abbott's government, the program was cut because, as stated by Ms Ley, the former Minister for Health, the program was designed for training purposes and not for ongoing services. The lack of longitudinal care in perinatal mental health services generates a risk of underdiagnosing PD at different stages of the perinatal period leading to poor recovery and aggravation of symptoms.

While the Commonwealth government has funded the creation of Beyond Blue's Clinical Practice Guidelines for Perinatal depression as a point of reference for health practitioners, there is no compulsory or uniform model of perinatal mental health care in Australia. Each state and territory are responsible for its policies on perinatal mental health care. Beyond Blue's guidelines systematically detail gold standard practices regarding assessment and the psychological and pharmacological treatment of perinatal depression, as illustrated in Table 2.1 (Austin et al. 2011:xviii).

Table 2.1: Beyond Blue's guidelines for assessment and treatment of perinatal depression. (Source: Austin et al. 2011:xviii)



These extensive guidelines reinforce the importance of health professionals adopting culturally safe health practices while caring for women from multicultural backgrounds. In addition, the guideline dedicated to 'socio-cultural groups at increased risk of depression and related disorders in the perinatal period' includes immigrant women. The guidelines also describe the recommended paths for 'effective care of mental health in the perinatal period', as seen in Tables 2.2 and 2.3 (Austin et al. 2011).

Table 2.2 Beyond Blue's types of perinatal mental health care. (Source: Austin et al. 2011:14)

Mental health care in the perinatal period	Type of care	Aim	Actions
	Routine antenatal or postnatal care	Assessment for psychosocial factors	Provide information Assess psychosocial factors Identify appropriate health professional to provide follow-up care
		Detection of depression and anxiety symptoms	Provide information Administer EPDS Identify appropriate health professional to provide follow-up care
	Care of women experiencing psychosocial factors and/or symptoms	Prevention of depression and related disorders	Triaging to determine severity of psychosocial factors and/or symptoms Collaborative decision-making on psychosocial support Ongoing monitoring
	Care of women experiencing depression or related disorders	Management of depression and related disorders	Triaging to determine severity of disorder Possible referral to a psychiatrist Collaborative decision-making on psychosocial/ psychological intervention and/or pharmacological treatment Ongoing monitoring

Table 2.3: Beyond Blue's recommendations for perinatal care. (Source: Austin et al. 2011:15)

☐ **Support women's cultural safety in health care** — Develop local networks with health professionals who may be able to assist in the care of women from Aboriginal and Torres Strait Islander or culturally diverse backgrounds (e.g. an Aboriginal and Torres Strait Islander health worker) and with people who may assist with communication (e.g. interpreters).
☐ **Establish context** — Gain a full understanding of a woman's situation by exploring her exposure to social factors that may increase the likelihood of mental health problems.
☐ **Take a family-centred approach** — Ask women who they would like to be involved in their care and, with the woman's consent, seek this involvement early. Be aware of the emotional wellbeing of significant others and offer support if needed.
☐ **Have appropriate information available** — Promote awareness of depression and related disorders in the perinatal period (e.g. through posters in waiting rooms). Have available written information on the subject that is suitable to women and their families in your community (e.g. locally adapted materials, translations).
☐ **Identify means of accessing care in your setting** — When appropriate services are not available locally seek alternative means of accessing care (e.g. through telemedicine, support lines and online services). While there is no single approach to matching available resources to effective care provision, explore existing models that have worked in your community.
☐ **Consider complexity** — For women with a co-occurring mental health or physical condition or ongoing sociocultural or psychosocial stressors, explore options for case planning by a multidisciplinary team.
☐ **Consider risk of harm to woman or infant** — In all contacts with women in the perinatal period, regard should be given to the wellbeing and safety of the woman and infant.
☐ **Develop referral pathways** — Develop a local plan, identifying appropriate health professionals (e.g. GPs, mental health nurses) and support groups that are accessible to women in your area. Have processes in place to follow-up on referrals.
☐ **Develop a professional support network** — Identify health professionals and resources that may assist you, women and their significant others with specialist advice and support.

In 2013, the Centre for Perinatal Excellence (COPE) was created following the success of the NPDI and the end of its funding from the Australian Federal Government, despite protests from perinatal mental health care providers. Health professionals previously linked to the NPDI and its research migrated to COPE. As a result, COPE is recognised as the principal source of expertise in Australian perinatal mental health. In 2017, COPE released an updated version of the Australian perinatal mental health guidelines, which was funded by the Australian Department of Health (Austin et al. 2017), and differed from the NPDI in having more focus on early identification of mental health disorders in the antenatal period, and the inclusion of schizophrenia and borderline personality disorder.

The COPE guidelines emphasise the importance of cultural safety and safety for migrant women using perinatal mental health care services and highlight the crucial role of health professionals in women's engagement in perinatal mental health care. In addition, the guidelines emphasise the role of a mother.

> Factors that improve a woman's experience of accessing and engaging with mental health care in the perinatal period include being given the opportunity to develop trusting relationships with health care professionals who acknowledge and reinforce the woman's role in caring for her baby in a non-judgmental and compassionate manner, and foster hope and optimism about treatment (Austin 2017:20)

Women from migrant communities are highly vulnerable to the development of perinatal depression (Collins et al. 2011; Guintivano et al. 2018; Navodani et al. 2019; Yelland et al. 2015). However, Australian consumer information regarding perinatal depression has limited information for minority groups such as women coming from CALD backgrounds and Indigenous Australian women (Bandyopadhyay et al. 2010; Downing et al. 2011; Garrett et al. 2010). There are several negative implications arising from the lack of information on perinatal depression for minority groups in Australia such as low health literacy, poor engagement with health services and poorer health outcomes. This highlights the inequality between people coming from minority groups and mainstream Australia (Burfitt 2023; Downing et al. 2011; Garrett et al. 2010; Rissel et al. 2023). Given this dearth of information, women from minority groups can suffer from depression in silence during pregnancy and/or postpartum (Garrett et al. 2010; Sivertsen et al. 2020). These challenge the Australian principles of welcoming migrant people to this country and providing adequate health support and supporting the emotional wellbeing of all citizens. It also shines a light on the way Indigenous Australian women are supported during their perinatal care in Australia. Indigenous Australian women are still more at risk of poor health outcomes during their perinatal care in comparison to mainstream

Australia (Rissel et al. 2023; Sivertsen et al. 2020). There are estimated 7.8 years reduced life expectancy for Indigenous Australian women in comparison to mainstream Australian women (Australian Government 2020). Life expectancy predictors are based on health and social factors such as educational levels, health literacy, geographic residence, financial situation, violence and risk-taking behaviours (Australian Government 2020).

The exclusion of minority groups from consumer information on perinatal depression reflects how these groups are largely invisible within broader Australia society (Billett et al. 2022). This exclusion of minority groups within different mediums also contributes to a lack of inclusion in health policy. If a non-dominant group is not able to influence decision-making, then there is little impetus to include them in public policy considerations. For a society to be more inclusive, especially in terms of mental health care, it is not only necessary to make financial investments to provide a better health care model. Such investment must be combined with actions such as the development of translated materials that are culturally sensitive, the provision of adequate health care services by trained professionals, and other measures to avoid the misdiagnosis of illness due to cultural and language barriers (Beagley et al. 2020; Billett et al. 2022). Nevertheless, Australian born women have also been facing the challenges of being diagnosed of PD and having limited access to perinatal mental health services (Charmayne 2022). This can be explained by lack of investments in mental health services, lack of trained clinicians and staff shortages (Brown 2020).

2.5.3. Edinburgh Postnatal Depression Scale (EPDS)

The NPDI recommends that health professionals use the Edinburgh Postnatal Depression Scale (EPDS) when they deal with pregnant women and/or postnatal women (Brooks et al. 2009; Fisher et al. 2012; Khanlari et al. 2019; Milgrom and Gemmill 2013; Willey et al. 2020b). In addition, the WHO guidelines for pregnancy, childbirth and postpartum care recommend the

administration of the EPDS to every woman on their first antenatal visit (World Health Organisation 2015). However, health professionals are free to decide what tools to use to diagnose perinatal depression.

In 2011, Beyond Blue released the Clinical Practice Guidelines for Depression and Related Disorders in the Perinatal Period, which was endorsed by the Australian National Health and Medical Research Council (Austin et al. 2011; Jones et al. 2012). Each Beyond Blue recommendation is graded from A to D according to the strength of scientific evidence. The use of EPDS in the diagnosis of perinatal depression is highly recommended. EPDS is a self-reporting questionnaire largely used for its sensitivity and specificity, which are widely recognised in the medical literature and amongst health professionals. This questionnaire has ten questions with four options of response for each. The questions refer to how the respondent felt over the previous seven days, and each has a value of between 0 and 3. The score from the ten responses is added to give a total score. The clinical threshold for depression is normally considered less than 12 points (Brooks et al. 2009).

The EDPS has been translated into 23 languages apart from English (Fisher et al. 2012; Melo et al. 2012; Meltzer-Brody et al. 2013; Santos et al. 2007; Small et al. 2007; Tsai et al. 2013). It has proven to be cross-culturally reliable and consistent. For example, the EPDS translation into Vietnamese and Arabic has been acknowledged as culturally adequate (Barnett et al. 1999; Small et al. 2007). Another case of successful translation of the EPDS is from English to Brazilian Portuguese (Cantilino et al. 2007; Santos et al. 2007). Nevertheless, there is also criticism about the validity of using a standard measuring tool such as the EPDS across different cultures (Buist et al. 2007; Jones et al. 2012). For example, Andajani-Sutjahjo et al. (2007) argue that the prevalence of perinatal depression in Indonesia is similar to Western countries. However, Indonesian women describe the meaning of perinatal depression and its

symptoms differently. Further, Indonesian women tend to use Javanese expressions that cannot be translated into English to express their emotions and distress during the perinatal period.

Ing et al. (2017) conducted an analysis of the acceptability of the EPDS among 532 Karen women and 128 Burmese women living as immigrants and refugees in Thailand's refugee camps. The study discussed the perceptions of maternity health professionals from the Shoklo Malaria Research Unit who use the EPDS to diagnose PD in migrant women living on the Thai-Myanmar border. The overall response from staff was negative, because they reported that the EDPS takes a long time to complete and does not correctly represent women's answers. The staff's major challenge was explaining the EPDS questions in Karen and Burmese, especially the differences between the responses regarding the frequency of symptoms such as quite often, sometimes, and very often. The interviewed health professionals' feedback was that they felt that the EPDS questions did not accurately translate into Burmese and Karen and the tool was not an adequate choice to get a clear picture of the migrant women's symptoms.

The EPDS questions were more challenging to translate into Karen than Burmese, because Karen has a more limited vocabulary for mental health illnesses such as depression. The health professionals in Thailand providing perinatal care to Karen and Burmese women reported being more likely to use the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID), because they found the questions more straightforward to interpret than the EPDS.

Like Australia, the US is a major destination for asylum seekers and other immigrants. However, in the US, diagnosis of perinatal and postnatal depression in these groups is inadequate. For example, a study conducted by Harrison and Sidebottom (2008) investigated

the American systems for prenatal screening of depression. The authors found that American health professionals were unprepared or did not have enough time to conduct screening for mental illness. Additionally, there was no systematic screening for psychological disorders. The authors commented that of those scales used, the EPDS is the one most used in the US to screen depression

In another study, Melo et al. (2012) investigated the incidence of perinatal depression in the north-eastern Brazilian city of Recife and the south-eastern city of Campinas. These cities were chosen to represent the less privileged and more privileged regions of Brazil, respectively. The authors were the first to use the EPDS in a study in Brazil, which was validated in 1999 in that country. Melo et al. reported similar findings regarding risk factors such as a previous history of mental illness, sexual violence, and general relationship problems. Melo et al. recommended adopting a universal policy of screening for depression in the prenatal and postnatal periods.

In Australia, some culturally-specific tools, such as the Kimberley Mums Mood Scale, have been developed for Indigenous women (Carlin et al. 2020), though none specifically for CALD women.

2.5.4. Economic implications of perinatal depression

In 2012, Deloitte Access Economics was commissioned by the Post and Antenatal Depression Association (PANDA) to conduct a study to estimate the financial impact of perinatal depression in the Australian economy. Deloitte reported that in 2012 alone, PD caused $78.66 million direct health costs to government and privately, which are detailed in Table 2.4 (Deloitte Access Economics, 2012:iv). This figure, combined with indirect costs, reached $433 million, which negatively impacted the Australian economy.

Table 2.4: Estimate of the direct health costs of PD to the Australian economy. (Source: Deloitte Access Economics 2012:iv)

Table ii : Summary of direct costs of PND* in Australia ($ million)

Cost category	Maternal PND				Paternal PND**				Total PND			
	Govt	PHI	Ind	Tot	Govt	PHI	Ind	Tot	Govt	PHI	Ind	Tot
Primary care	5.04	n/a	0.50	**5.54**	1.53	0.25	0.10	**1.87**	6.57	0.25	0.60	**7.41**
Psychiatrist & allied health services	4.70	0.69	2.14	**7.53**	3.84	0.90	1.63	**6.38**	8.54	1.59	3.77	**13.91**
Medications	1.79	1.79	1.68	**3.48**	3.79	0.04	3.48	**7.31**	5.58	1.83	5.17	**10.78**
Hospitals***	14.42	20.33	5.67	**40.42**	1.77	0.48	0.16	**2.42**	16.20	20.82	5.83	**42.84**
Community services	3.64	n/a	0.07	**3.72**	n/a	n/a	n/a	n/a	3.64	n/a	0.07	**3.72**
Total	**29.60**	**21.02**	**10.07**	**60.68**	**10.93**	**1.67**	**5.37**	**17.97**	**40.52**	**22.69**	**15.44**	**78.66**

Notes:
*No costs were estimated for AND, due to data limitations.
**Cost estimates for paternal PND are indicative only, due to data limitations.
***Hospital costs reflect inpatient costs only for maternal PND and outpatient costs only for paternal PND.
PND=Postnatal Depression; Govt=governments; PHI=private health insurance; Ind=Individuals; Tot=Total.

Chambers et al. (2018) published retrospective data from women accessing perinatal mental health consultations between 2006 and 2010. The authors found that the total costs for provider fees, Medicare Benefits Schedule (MBS) rebates, and out-of-pocket expenses in 2007 were $17.5 million, and in 2010, these costs had reached $29 million, which represented an increase in costs of $11.5 million. The breakdown of the perinatal mental health consultations is detailed in Table 2.5.

Table 2.5: Perinatal mental health services MBS consultations costs (Source: Chambers et al. 2018:518)

The perinatal period is pregnancy to end of the first postnatal year, therefore access to mental health consultations were captured from March 2006 to December 2011. Numbers may not tally due to rounding. n.s., not significant

	2007	2008	2009	2010	P^A
Total cost of mental health MBS consultations for women treated in their perinatal period (national, all ages)					
Provider fees (millions)	$17.4	$23.1	$25.8	$29.0	<0.001
Medicare benefits (millions)	$15.0	$19.9	$22.3	$25.1	<0.001
Out-of-pocket expenses (millions)	$2.5	$3.2	$3.5	$3.9	<0.001
Average cost of mental health MBS consultations (per woman) treated in their perinatal period					
Provider fees	$685	$679	$672	$689	n.s.
s.d.	$42	$21	$25	$17	
Medicare benefits	$589	$586	$581	$596	n.s.
s.d.	$36	$18	$23	$14	
Out-of-pocket expenses	$97	$93	$90	$93	<0.001
s.d.	$7	$4	$4	$6	
Average cost of a mental health MBS consultation (per service) for women treated in their perinatal period (national, all ages)					
Provider fee	$138	$134	$133	$133	<0.001
s.d.	$3	$2	$2	$3	
Medicare benefits	$119	$115	$115	$115	<0.001
s.d.	$3	$2	$2	$2	
Out-of-pocket expenses	$20	$18	$18	$18	<0.001
s.d.	$1	$0	$1	$1	
Percentage of consultations bulk-billed	44%	47%	51%	52%	<0.001

[A]Tests for linear trends were carried out on all 53 birth-months using ordinary least-squares regression, with a *t*-test performed on the slope of the regression line.

In 2009, a Canadian study revealed the high economic impact of untreated depression during pregnancy on the Canadian health care system. Using an economic evaluation based on data from Federal Canadian reports, the study found that 'an estimated CAN$20,546.982 is spent annually in Ontario on untreated maternal depression' (O'Brien et al. 2009:406). An alarming aspect of this estimate is that this analysis reflects only the direct costs of the untreated perinatal depression cases formally diagnosed by Canadian health professionals. In addition to direct costs, there is a cascade of indirect costs caused by the lack of treatment of antenatal depression due to the increased severity of the depressive symptoms postpartum. One example is the direct cost of maternal hospitalisation caused by severe depression during pregnancy. There is also the link between untreated antenatal depression and illicit substance and alcohol abuse, which implicates another series of health illnesses that can affect mothers and their newborns in the short and long-term (O'brien et al. 2009). The authors also discuss the potential for pregnant women with depression to withdraw from any antenatal health services, which could further impact their health after childbirth and their newborn's health.

There are also the costs associated with the treatment of the newborns of these clinically depressed mothers. These newborns have a higher incidence of low birth weight and premature birth. If their mothers were also dependent on drugs and alcohol during pregnancy, there is a risk of these newborns requiring treatment for opiate withdrawal, and having foetal alcohol syndrome. Consequently, the cost of the prolonged hospitalisation of these newborns is added to the economic burden assumed by the Canadian health system, reaching an estimated total of CAN$14,449.069 per year (O'brien et al. 2009). Finally, there is lost economic opportunity for the family and the state arising from depressed mothers being away from the workforce.

2.6. Summary

Chapter 2 presented the literature review for this study, beginning with a description of health literacy and how it can impact consumers with their engagement with perinatal health care providers and the negotiation of their care to include their cultural needs. The influence of migration and its impact on migrants' health was discussed, considering the healthy migrant theory and the salmon bias effect hypothesis. Cultural norms and lack of social support are possible factors associated with PD development. Language barriers can lead to social isolation and the development of PD. This chapter discussed the fact that migrant women in Australia are entitled to receive culturally safe health practices and to have access to free interpreting services.

The chapter followed with the history of PD, which was originally called puerperal insanity. It then proceeds with the definition of PD according to DSM-V, which is the standard diagnostic definition used in Australia and other countries. The implications of PD in the nuclear family of

affected women were discussed. This chapter then described the financial impact of PD in the Australian health system.

The chapter then explored possible factors associated with the development of PD especially in women from CALD backgrounds. The biological factors linked to the development of PD include a genetic predisposition to the development of mental health illnesses, exposure in-utero to maternal depression and anxiety, increase in cortisol levels, malfunction of the HPA system, low levels of n-3PUFA, and gestational diabetes. Domestic violence and trauma are also factors that contribute to PD. The role of religion and associated rituals in PD development in migrants was reviewed. The last causal factor discussed in this chapter is the relationship between migrants' geographic location in Australia and poor mental health outcomes.

Then Chapter 2 reviewed the current Australian perinatal care system based on the Australian clinical guidelines in perinatal care, including the options in maternal care that women can choose from. The Australian clinical guidelines and those of WHO for perinatal care encourage patient-centred care and cultural safety when dealing with patients from a CALD background. The process of diagnosing PD and the awareness of cultural safety and training were outlined, and the EPDS tool and its use in diagnosing PD reviewed.

In Chapter 3, I will present the methodology of this study. I will then detail the theoretical framework used in this thesis and the study design.

Chapter 3. Methods

This chapter defines the methodology applied to this study. The theoretical framework is justified in the first section of this chapter, followed by an outline of the study design including the recruitment adopted in both cities. Chapter 3 then describes the data collection methods, the coding tree and the themes identified from that. Subsequently, it presents the data analysis process utilised in this study.

3.1. Literature search strategy

I completed a comprehensive literature review utilising multiple databases through the Australian National University library printed and electronic collections such as ProQuest Health, Cochrane Library, Science Direct, PubMed, Medline and MD Consult. Some of the keywords used in the search are ‘perinatal care’, ‘childbirth’, ‘traumatic childbirth’, ‘perinatal depression’, ‘postnatal depression’, ‘antenatal depression’, ‘patient centred care’, ‘migration’, ‘domestic violence’, ‘motherhood’, ‘parenthood’, ‘religion and health’, ‘Edinburgh Postnatal Depression Scale’, ‘interpreting services’, ‘health literacy’, ‘minority groups’, ‘muted groups’, ‘dominant groups’, ‘invisible communities’, ‘cultural practices’, ‘health literacy’, ‘social support’.

I conducted a grey literature search containing the World Health Organization and the Australian government policies, guidelines, statistics and reports on perinatal care, culturally safe practices in health, the utilisation of interpreting services, census data and the economic costs of perinatal depression. Table 3.1 shows the list of policies, guidelines, statistics and reports utilised in this thesis.

Table 3.1: Policies, guidelines, statistics and reports reviewed in this study

Published year	Organisation	Document
2022	Australian Bureau of Statistics	Australian Historical Population Statistics
2021	Australian Department of Education Skills and Employment	Location of enrolled international students
2021	Australian Medical Association	Health literacy
2021	National Capital Authority	The early history of the ACT
2021	The Parent-Child Mother Goose	Our history: helping families bond
2021	The Royal Australian and New Zealand College of Obstetricians and Gynaecologists	Breech presentation at the end of your pregnancy
2021	Western District Health Service	Maternity
2020	Australian Health Practitioner Regulation Agency Medical Board	Good medical practice: a code of conduct for doctors in Australia
2020	The Centre for Culture Ethnicity and Health	Victorian Government Health Translations
2020	United Nations Population Fund	Female genital mutilation (FGM) frequently asked questions
2019	Australian Government, Department of Health	Clinical practice guidelines: pregnancy Care 2019 edition
2019	Australian Medical Association	Conscientious objection
2019	Migrant & Refugee Women's Health Partnership	Guide for clinicians working with interpreters in healthcare settings
2019	Monash University and Queensland University	Victorian Places
2019	Northern Health	Happy Mothers Program Launched

2019	Family and Community Development Committee, Parliament of Victoria	Inquiry into the perinatal services in Victoria
2019	Post and Ante Natal Depression Support and Information (PANDSI)	Submission to the Legislative Assembly for the Australian Capital Territory inquiry into the maternity services in the ACT
2019	The Picker Institute	Principles of person centred-care
2018	Australian Capital Territory Health	CatCH Program - Continuity at Centenary Hospital
2018	The State of Victoria, Department of Health and Human Services	Victoria's mental health services annual Report
2018	State of Victoria, Department of Health and Human Services	Brazil-born: Victorian community profile 2016 Census
2018	World Health Organization	WHO recommendations on non-clinical interventions to reduce unnecessary caesarean births
2016	Australian Bureau of Statistics	Census of population and housing: reflecting Australia - stories from the census
2016	Australian Bureau of Statistics	Census QuickStats Canberra
2016	The Royal Australian College of General Practitioners	Curriculum for Australian General Practice 2016
2017	Centre of Perinatal Excellence	Mental health care in the perinatal period: Australian clinical practice guideline
2017	World Health Organization (WHO)	WHO recommendations on maternal health: guidelines approved by the WHO Guidelines Review Committee
2015	World Health Organization (WHO)	Pregnancy, childbirth, postpartum and newborn care: a guide for essential practice 3rd ed

2015	The State of Victoria, Department of Health and Human Services	Victoria's 10-year mental health plan
2013	Australian Bureau of Statistics	Australian Statistical Geography Standard (ASGS): Volume 5 - Remoteness Structure
2012	Australian Bureau of Statistics	Reflecting a nation: stories from the 2011 Census, 2012-2013
2012	Australian Institute of Interpreters and Translators INC	AUSIT Code of ethics and code of conduct
2012	The State of Victoria, Department of Health and Human Services	Postnatal care program guidelines for Victorian health services
2012	Deloitte Access Economics - PANDA	The cost of perinatal depression in Australia: final report
2011	Beyond Blue	Clinical Practice Guidelines for Depression and Related Disorders in the Perinatal Period
2010	Commonwealth of Australia Department of Health and Ageing	National maternity services plan
2008	The Australian Health Ministers' Advisory Council	Framework for the national perinatal depression initiative 2008-09 to 2012-13
2005	State Government of Victoria	State Government of Victoria
2001	Catholic Health Australia	Code of ethical standards for Catholic health and aged care services in Australia

3.2. Theoretical framework

3.2.1. Invisible communities theory

Invisible communities theory hypothesises that minority groups are constantly excluded in research on perinatal depression. This hypothesis relates to the theory of the 'social construction of target populations' described by Schneider and Ingram (1993). The authors define this process as based on 'stereotypes about particular groups of people that have been created by politics, culture, socialization, history, the media, literature, religion, and the like' (Schneider and Ingram 1993:335). This theory could explain why health policymakers, researchers, and educators seemingly exclude minority groups, including non-English speaking migrant women. These groups lack representation, not only in terms of research, but also in regard to decision-making. For example, since public policy often has electoral implications, the interests of the dominant groups may be prioritised. Likewise, it is much more economically viable to address issues based on a broader audience, even though this has as a collateral effect the exclusion of individuals from minority communities.

Kruske et al. (2006) argue that cultural needs are, incorrectly, mainly associated with minority groups rather than both minority and dominant groups. Thus, migrant women are frequently excluded in the public discourse on perinatal depression; while dominant groups hold specific needs associated with cultural background, gender differences, sexual orientation, religion, economics, and politics, they tend to assume that their conditions and beliefs are 'normal' (and therefore not culturally influenced) when compared to minority populations. Therefore, any deviation from 'normal social standards' contributes to the individual's invisibility inside the broader community. Thus, public policy can be affected by the norms established by dominant groups and can limit, for example, the maternal health care services delivered to minority groups such as refugees, asylum seekers, and migrant people, based on the assumptions associated with the constructed social norms imposed by mainstream Australia (Colvin 2010).

There is a debate in the scientific community about how research ethics and 'invisible communities' in relation to health care policy affect women from minority groups who suffer perinatal depression. Several studies point out the urgent need to become more inclusive in research, to avoid creating a parallel society of non-dominant groups that are vulnerable and invisible (List 2005) (Grady 2009; List 2005). Therefore, it is both critical and necessary to review the inclusion criteria in health research.

The concept of 'vulnerable people' has been critiqued as a paternalistic label that researchers widely apply in their studies' definitions of research populations (Grady 2009). Groups such as 'children, prisoners, pregnant women, mentally disabled persons, or economically and educationally disadvantaged persons' are identified as vulnerable (List 2005:54).. This definition is created by dominant groups that tag people as particularly at risk in research due to their physical and socio-economic circumstances – and their deviation from normative categories. In List's (2005) view, this definition can lead to the removal of minority groups' rights in the name of being 'protective.' Indeed, the justification often advanced for the apparently systematic exclusion of 'vulnerable people' from much research is based on the prejudgment that such groups are at risk of being manipulated, or cannot be adequately briefed on the processes, risks and benefits of the research project, within the standard constraints of a research project. The definition of 'vulnerable people' arose after World War II, partly in response to Axis programs of research explicitly focused on participants deemed surplus to the state, such as the Nazi medical experiments. The ethical emphasis on protection of the vulnerable still influences the way people conduct health research and construct health policies (List 2005). An unfortunate side-effect of this desire to avoid egregious exploitation of some groups is that they may be benevolently sidelined from participating in research and policy

discussion about policy and service matters that are of most concern to them. They may become structurally invisible under the guise of protecting them.

3.2.2. Muted groups theory

The hypothesised exclusion of non-dominant groups in health research and therefore, from perinatal depression care services can also be explained through the framework of muted groups theory. The scholars Shirley and Edwin Ardener described this theory in 1978 (Ardener 1978a; Ardener 1977, 1978b). Later, in 1981, the muted groups theory was applied to feminist studies by Cheris Kramarae (Kramarae 1981). Rather than employing the structural focus of the invisible communities theory, muted groups theory focuses on the communication between dominant and non-dominant groups and describes how the voices of minority groups are silenced in mainstream society through the influence of power and culture (Orbe 1996). The non-dominant groups are classified as a group of people 'traditionally' marginalized as part of a monolithic 'minority' that includes migrant people, the lesbian, gay, bisexual, transgender, gender diverse, intersex, queer, asexual and questioning (LGBTIQA+) community, women in patriarchal societies, and people with disabilities (Orbe 1998). These non-mainstream groups tend to adapt how they communicate to be heard and recognised by dominant groups.

Hecht et al. (1993) argue in their study of Mexican Americans (or Chicanos) and their communication with Anglos that research on minority groups should address individual opinions and needs rather than the labels they often carry simply as a result of being non-Anglo in a white society. The dominant group, in this case, white Americans, constructed these labels based on prejudgments and their views on Mexican Americans. Consequently, the Mexican Americans started to define themselves based on these cultural prejudgments, resulting in an identity crisis about ascribed and authentic identity. Thus, the needs of minority groups that do not fit into the constructed rules of dominant groups are not considered. As a

result, minority groups have to accept and adapt their customs and practices to those of the dominant group. This could help explain why there are few perinatal mental health care services with any focus on diversity in Australia, with the available services mainly designed to raise awareness among white English-speaking women.

3.2.3. The cultural meaning of suffering and distress

Kleinman (1997) speaks about the complex nature of the cultural representation of suffering, and his insights underpin part of the theoretical framework of this study. Kleinman (1997) argues that, as with pain, people experience suffering and express it in different ways and with varying intensity. Therefore, in the case of perinatal depression, women will experience the burden of this illness to varying levels, and the way that they will respond to the onset of its symptoms will differ. Consequently, it is fundamental for health professionals to customise the treatment of perinatal depression, taking into account that each individual will experience the illness differently and respond to treatments in varying ways (Curtis et al. 2019; Kleinman 1997).

To understand and respect the different experiences of human suffering, it is crucial to 'avoid essentializing, naturalizing, or sentimentalizing suffering' (Kleinman and Kleinman 1996:2). There is a delicate balance between the dramatisation and the essentialisation of suffering. Kleinman makes the point that suffering can be a lucrative commodity. The dramatisation of suffering can be a powerful political weapon; for example, the images of violence in war-torn areas can expose the horrors of war and its victims. On the other hand, it can also be used as political propaganda to justify, for example, military invasions.

At the same time, suffering has been systematically homogenised as an 'economic indicator' without considering vital cultural aspects that can influence social suffering. Such economic indicators are used in the allocation of funds to health programs. More than a decade has passed since the publication of Kleinman and Kleinman (1996) paper on the cultural appropriation of suffering; the idea that human suffering is a lucrative commodity is still valid and undeniably present nowadays.

Kleinman and Kleinman (1996) did not venture into gendered aspects of suffering, but the suffering related to perinatal depression, while commodifiable (see the section on economic costs in Chapter 2) is not fully realised in current policy making, particularly when it comes to the suffering of migrant women. The suffering of perinatal depression is rarely subjected to dramatization in order to publicise and expose its impacts, and even less so for women from migrant backgrounds. Instead, it is often essentialised as part of the rite of passage of motherhood.

3.3. Study design

This was a qualitative study using in in-depth interviews and participant observation. Human ethics clearance to conduct this research was acquired from the Human Research Ethics Committee, Office of Research Integrity, The Australian National University, protocol number 2014/769. Informed written consent was obtained from all the participants before starting the interviews. The participants were able to withdraw from the process at any time without consequences of any kind. As the primary investigator, only I have access to the data gathered. The identity of the participants will not be revealed in this study and future reports.

3.3.1. Recruitment

3.3.1.1. Migrant women

The participants were recruited at random through the recruitment flyer presented in Appendix A. These flyers were displayed in Canberra at Centenary Hospital for Women and Children's wards and the antenatal clinic, The Calvary Hospital, Canberra City library, Dickson Library, Gungahlin Library, Dickson Maternity and Child Health Centre, the Multicultural Youth Centre, and the Multicultural Health Care Consumers Network. In Hamilton, the flyers were displayed at the city's library, Uniting Church Mother Goose Playgroup, Frances Hewett Community Centre, and the Hamilton Base Hospital.

Snowballing was not initially selected as the chosen method of recruitment. However, recruitment through flyers was not very effective, so snowball sampling was used to increase the number of recruited participants. I am based in Melbourne and travelled to Canberra intermittently to conduct the interviews. I received phone calls from three women who came across my recruitment flyers in between these fieldwork travels. All the other participants were recruited through snowball sampling. I brought one of my children to several face-to-face interviews. This naturally assisted with building rapport with the interviewed migrant women, because they could see I understood what they went through.

Lauren was a key player in the recruitment of participants in Hamilton. She migrated from Malaysia to Melbourne with her husband and two daughters in 2010 and then moved to Hamilton in 2012. Lauren is a very active woman in the Hamilton community. She stated that she met all the migrant women in the city through her daughters' school, church, swimming classes, or tennis. She is a very talkative, funny, upfront and proactive woman. When I

mentioned my research to her, she quickly made phone some friends and asked if they wanted to be interviewed. Organically other participants recommended the research to their friends. One of Lauren's friends was a young doctor, Doctor O, who works at the local hospital, who also agreed to be interviewed. Lauren reported that she appreciated the fact that the doctor-friend is from Malaysia because she can understand her and her culture. Lauren described the popularity of the GP, who is of South African origin, and the nurse working at the practice, because of their friendliness approach and knowledge.

Lauren's two children were born in Malaysia, and her younger child was four when she moved to Hamilton. My interviews with her were crucial to understanding the city's dynamic, especially regarding the relationship between health professionals and migrants. She gave me valuable insights into the strong social support that local Asian migrants gave to each other in Hamilton. For example, Lauren told me that she 'discovers' new Asian migrants in town and she checks if their interests are compatible with the others from her social network. Eventually, if she determines that they are a match, then she invites them to their weekly Monday dinner party, which they affectionately call the 'Asian Party'. She revealed that the 'Asian Party' is a way to share feelings and experiences with friends, to talk about family and children's problems. Members of the group rely on each other for health advice. Members provide both practical support with children when others are sick or overwhelmed, and emotional support when needed.

In the last 100 years, Australia's population size has grown from nearly 4 million people to 23.4 million people. Overseas migration is the main contributor to this population increase, with 28% of the total population of Australia being born overseas (Australian Bureau of Statistics 2022). The top four migrant nationalities in descending ranking order are from England (3.9%), New Zealand (2.2%), China (2.2%), and India (1.9%). About 5.8% of the Australian population

comprises small pockets of minority groups from a vast range of nationalities (Australian Bureau of Statistics 2016a). The 2016 Census identified more than 300 non-Indigenous languages spoken in Australia and over 100 religions. Migrant women who are not necessarily linked to a larger cluster of an ethnic group in Australia are more likely to fall through the gaps of this system (Billett et al. 2022). For example, despite the substantial growth in arrivals of Brazilian migrants in Australia, they still represent only 0.44% of the total number of migrants living in Australia. Therefore, their voices can be easily muted among other minority groups larger in numbers and representation. In addition, migration can be a volatile and challenging process, and subject to changes in visa conditions. Overall, minority groups can substantially grow in ten years, adding complexity to the Australian health system. For example, the number of migrant Brazilians arriving in 2006 was 4,400, and in 2016 it grew to 27,630 (The State of Victoria Government 2018).

The 'top ten languages' focus used in public communications – whereby public interest material is translated only into the top ten languages other than English reported to be spoken in the census – exacerbates this muting of other migrant groups. The top ten languages other than English include many with high numbers of people who also speak English as a second language fluently. Tagolog, for example, has featured in the top ten languages for more than a decade. However, most Tagalog speakers can also speak English as it is one of the national languages of the Philippines. Farsi does not rank in the top ten, but many Farsi speakers have no background familiarity with English. Failure to incorporate people's actual language needs in public messaging results in further muting of many migrant groups.

The nationality of all participants is listed in Table 3.2. While various nationalities were recruited in Hamilton, in Canberra six of the ten interviewed women were Brazilian. This can be explained by the fact that I am Brazilian by birth and came to Australia when I was 25 years old, and

there is a small community of Brazilians in Canberra. Additionally, the language and culture we shared helped in building the rapport with the participants.

In total, seventeen migrant women were recruited for this project, seven in Hamilton and ten in Canberra, as per Table 3.1. The participation criteria involved being older than 18 and to have lived in Australia for at least twelve months. In Canberra, most of the interviewed mothers were in their 30s and only one in her 20s. In Hamilton, their range varied from the 20s to the 40s. Due to privacy reasons, I have decided to omit their exact age to avoid accidental revelation of their identities based on their age and discourses. They did not necessarily have to hold an Australian permanent visa or Australian citizenship. For example, in Hamilton, most participants were on a working visa; others held dual citizenship.

The participant mothers came from a varied range of socioeconomic backgrounds. For the Canberra participants, each of the participants lives in a different suburb and is from different professional backgrounds: accountant, food service assistant, administrative assistants, physiotherapist and one full-time stay-at-home mother. Additionally, they had to have used the Australian perinatal healthcare services in approximately the past five years before their interview to give insight into their experiences with Australian perinatal healthcare services. This timeframe was established to ensure that the participant could recall their experiences with the perinatal care they received in Australia. Takehara et al. (2014) established in their longitudinal study comprising 1168 women that they were able to recall their childbirth experiences after a period of 5 years postpartum. In addition, the participants needed to be able to understand the questions and to answer them. Finally, none of the interviewed migrant women requested to drop out of the study.

Table 3.2. List of participants – migrant women

Pseudonym	Raised in	Age	City	Interview Mode
Lurdes	Spain	30s	Canberra	Telephone
Maria	Brazil	30s	Canberra	Face-to-face
Luisa	Brazil	30s	Canberra	Face-to-face
Marta	India	30s	Canberra	Face-to-face
Andrea	Brazil	30s	Canberra	Face-to-face
Helena	Brazil	30s	Canberra	Face-to-face
Rosa	South Africa	30s	Canberra	Telephone
Rafaela	Brazil	30s	Canberra	Face-to-face
Tamara	Brazil	30s	Canberra	Face-to-face
Vivian	Cambodia	20s	Canberra	Telephone
Isabel	China	20s	Hamilton	Face-to-face
Lauren	Malaysia	40s	Hamilton	Face-to-face
Camila	China	40s	Hamilton	Face-to-face
Jean	Burma	30s	Hamilton	Face-to-face
Georgia	Bangladesh	30s	Hamilton	Face-to-face
Debra	Sri Lanka	30s	Hamilton	Face-to-face
Lorena	Malaysia	30s	Hamilton	Face-to-face

3.3.1.2. Health professionals and key informant

Health professionals were recruited through letters presented in Appendix B. I sent the recruitment letters to the reception in Canberra at Centenary Hospital for Women and Children's wards and the antenatal clinic, The Calvary Hospital, Dickson Maternity and Child Health Centre and the Companion House. In Hamilton, I sent the recruitment letters to the Frances Hewett Community Centre, the Hamilton Base Hospital, Hamilton Family Practice and Hamilton Medical Group. Snowballing was also not initially selected as the chosen method of recruitment for participants who were health professionals. Nonetheless, the recruitment letter

did not yield many participants. In total thirteen health professionals and one key informant were recruited for this PhD project: four in Hamilton and nine in Canberra, as per Table 3.3. In Hamilton, despite the small number of participants, it was possible to obtain an interview with at least one health professional for each specialty, providing rich information about the perinatal care services in the city. The study selected health professionals responsible for the antenatal and postnatal care of participants. The list of health professionals involved could include physicians, general practitioners, obstetricians, practice nurses, midwives and maternal and child health nurses. In addition, I decided to interview the Parent-Child Mother Goose's playgroup coordinator as a key informant. Her name was suggested by one of the playgroup volunteers as a good source for the thesis as she lived in the city for 20 years and had assisted several migrant women to settle in the community. The contact details of the key informant were passed on to me from one of the volunteers with consent from the key informant. Interestingly, some health professionals were very brief in their answers, and the interview process felt like a traditional 15-minute medical appointment. This matter will be further discussed in detail in the limitations of this study.

There was no minimum or maximum age limit for the health professional participants. Not establishing an age limit enabled me to collect a broader spectrum of views by Australian health professionals, including both contemporary and traditional Australian views.

Table 3.3. Participants' list – health professionals and key informant

Name	Profession	City	Interview Mode
Doctor O	General Practitioner	Hamilton	Face-to-face
Nurse B	Nurse/Midwife	Hamilton	Face-to-face
Doctor C	Gynaecologist	Hamilton	Face-to-face
Midwife D	Midwife	Hamilton	Face-to-face
Fabia	Playgroup Coordinator	Hamilton	Face-to-face
Nurse E	Nurse/Clinical Educator	Canberra	Telephone
Nurse F	Lead Practice Nurse	Canberra	Telephone
Doctor G	General Practitioner	Canberra	Telephone
Doctor H	General Practitioner	Canberra	Telephone
Doctor I	General Practitioner	Canberra	Telephone
Doctor J	General Practitioner	Canberra	Telephone
Doctor L	Obstetrician	Canberra	Telephone
Doctor M	General Practitioner	Canberra	Telephone
Doctor N	General Practitioner	Canberra	Telephone

3.3.2. Data collection

3.3.2.1. Location

I collected data from a major city and an inner regional city by snapshotting the views of migrant women and health professionals about perinatal care services in these two different Australian regions. I attempted to identify possible discrepancies in the migrant women's views of the perinatal care services, the adequacy of perinatal care to their needs, and if they recalled being screened for PD. Data collection happened gradually between July 2015 and August 2018. I was based in Melbourne and travelled between these cities with my small children. This was logistically complex, and required a great deal of organisation and coordination. Telephone interviews proved to be particularly useful when interviewing health professionals due to their busy schedules.

The Australian Statistical Geographic Standard Remoteness ratings (ASGC-RA) by the Australian Bureau of Statics 2016 were used to certify that the chosen cities represent a major city and a regional city. The ASCG-RA determines a city's remoteness according to its population obtained from the latest Census of Population and Housing. The ASCG-RA values are as follows: 1) major cities of Australia; 2) inner regional Australia; 3) outer regional Australia; 4) remote Australia; 5) very remote Australia; and 6) migratory (Australian Bureau of Statistics 2013)

Hamilton is a rural city located about 275km west of Melbourne, on the traditional lands of the Gunditjmara people (Tout-Smith 2004). According to the Australian Bureau of Statistics (2016), it is classified as ASGC-RA 2, inner regional Australia.

The 2016 Census reported that Hamilton has 9,974 inhabitants; 85% of its population were born in Australia and 15% overseas, and the top answers in regard to country of birth, other than Australia, were: England 1.9%, New Zealand 1.2 %, India 0.6%, Netherlands 0.5%, and South Africa 0.4 %. These numbers corroborate the distribution of interviewed migrant women who received their perinatal care in Hamilton or one of the surrounding rural cities such as Warrnambool. Additionally, the 2016 Census revealed that 91.4% (9,114) of Hamilton's population spoke English at home. From a total of 3.9% (165) of non-English speakers at home, the main spoken languages were Mandarin 0.4%, Malayalam 0.3%, Afrikaans 0.2%, Dutch 0.2%, and Punjabi 0.2%.

Warrnambool, located 100km from Hamilton, is the largest city on the Great South Coast; in the 2016 Census, it had a population of 29,661. Warrnambool Base Hospital is the referral

hospital for Hamilton Base Hospital, and has a public mental health service. Warrnambool also hosts the private St John of God Warrnambool Hospital which also provides perinatal mental health services and support to Hamilton.

Hamilton was chosen for this thesis as a representative of an inner regional city predominantly composed of white Australian citizens, which would provide rich information about how migrant women navigate the regional Australian perinatal health system when they are a minority group. Additionally, Hamilton was chosen for this research because of my family link with my children's great-grandmother who was once a volunteer in the city's major playgroup called Mother Goose, run by the local Uniting Church. Therefore, it was easy to access migrant mothers living in the city through her connections in the town.

Canberra is Ngunnawal Country and is the only city in the Australian Capital Territory (ACT). It is the capital city of Australia, and the Ngunnawal people are the traditional owners and custodians of the land. The first influx of European settlers happened in 1823 (National Capital Authority 2021). It was chosen to represent the public perinatal care services provided in a major city because I have lived there for six years and it is where I applied for my PhD in 2014 and planned to collect data. I also was a consumer of the public perinatal health care system and the perinatal mental health services in 2010 and 2013. Therefore, I knew well the perinatal care system and how to navigate it. It is a tranquil metropolitan city, with the atmosphere of a country town, but with a very diverse multicultural population. According to the 2016 Census, Canberra had 397,397 residents, and 32% were born overseas (Australian Bureau of Statistics 2016b). The Australian Federal Government established Canberra as the Australian bush capital to dissolve conflicts between Sydney and Melbourne, which were duelling to be nominated as the Australian capital. The affectionate nickname, the Bush Capital, arose because the city is composed of about 50% national parks (National Capital Authority 2021).

Canberra has a large concentration of governmental offices and politicians frequently flying in and out of the state. The city's major industry is tertiary education. In October 2021, ACT had 10,138 enrolled international students (Australian Department of Education 2021). The city houses students coming from all states and overseas to attend one of the four local universities, but especially the Australian National University. There is also an influx of students attending vocational studies and English courses for international students. Therefore, the population of Canberra can be transient, which can impact its temporary citizens' ability to create connections and build relationships, leading to social isolation.

Together with Victoria and Western Australia, the Australian Capital Territory has had a population growth of 11% since 2011 (Australian Bureau of Statistics 2016b). This statistic highlights how crucial it is to increase health services in these states substantially. Nevertheless, Canberra's health services have struggled to cope with its steadily increasing birth rates and demand for perinatal care services, especially perinatal mental health services.

Participants were provided with a background of the study. They were invited to participate in a voluntary in-depth interview for an average length of one hour. The interview schedule for migrant mothers and health professionals were respectively attached in Appendix C and D. The questions were open-ended so that participants had more control of the interview process due to the sensitive topic. Despite having prepared an interview schedule, at times I had to probe some when an answer was very brief. There were not any excepted interview questions from members of either participant group and none of the questions had to be reviewed.

Because the flow of each interview was different, some women wanted to focus their stories on various aspects of their perinatal care, and some were more focused on the birthing process and associated traumatic experiences. Others wanted to highlight how support from peers was crucial during the perinatal period. The same applied to the interviews with health professionals, as some, for example, focused their answers on the Australian perinatal mental health services. The interviews with health professionals varied, with some participants being more open to discussing their experiences, while others were busy and had limited availability to be interviewed between patients' appointments.

The sessions were tape-recorded, and I also took written notes. The participants provided consent via a signed consent form. Participants could also opt for only written notes to be taken. Only one migrant mother in Hamilton preferred to not be recorded but authorised notes to be taken during the interview. All participants gave consent for a pseudonym to be used. As the principal investigator, I conducted all the interviews in English and, when necessary, in Portuguese. Interpreters were not required in this study as the women could communicate in English. However, the interviews with Brazilian women were conducted in Portuguese as per the participant's preference and because I am a native Portuguese speaker, then translated to English by me. All the recorded interviews were transcribed into a Word document by me. I quote verbatim from these interviews to allow participants to voice their experiences throughout this thesis. This method supported the themes identified and provides to the reader of this study the chance to relate the narratives to my interpretations. All recorded data was stored safely as per human ethics guidelines.

All the interviewees were welcoming and receptive. They were open about their experiences and were happy to share their stories. The participants were even eager to share their painful

moments, personal worries about the perinatal care they received, and to discuss challenges to motherhood in a different country.

I conducted all the interviews with health professionals in Canberra over the telephone at their preferred date and time. As expected, they were busy, and I was unsuccessful at organising face-to-face appointments during several fieldwork days in Canberra. Therefore, the telephone interviews offered flexibility to both me and the participants. The disadvantage of telephone interviews may include the inability to read and interpret body language and facial expressions. However, an advantage is that some people might feel more relaxed on the telephone than face-to-face.

The data collection in this study was completed before the widespread use of video conferencing which has been in more prominent use since the COVID-19 pandemic. To interview health professionals from different settings, I had to accommodate the time and date that suited them better due to time constraints because of the nature of their work. Some doctors had a small window in their diaries that enabled them to talk to me. Often, they called me during their lunch breaks, and some reported that they had a long shift at the hospital and were tired. Some of the interviews were reasonably brief because of the participants' limited time — indeed, some of the interviewed doctors presented as very direct and impatient with my questions. I handled that through asking them to expand their answers so I could understand their views about perinatal care in Canberra and Hamilton. I also offered to organise a second interview, if necessary, but none of the participants requested it.

3.3.2.2. Participant observation

I was invited by one of the participants to attend the Mother Goose playgroup in Hamilton. I contacted one of the volunteers who runs the sessions to seek authorisation and she was agreeable to let me attend the sessions with my son. I attended three sessions to better understand the popularity of this playgroup as it was mentioned by several participants, and to also observe the dynamics between migrant women, their children, and the Australian elder volunteers who run the group. I attended the group with one of my sons, who at that stage was two years old. The decision to bring him along was based on my desire to experience the group as an insider and build rapport with the women that I would interview. The participant observation during the Mother Goose grew organically from the participant's invitation. Nonetheless, the same did not happen in Canberra due to the lack of opportunity.

There was one participant observation in Canberra while interviewing Rafaela in Luisa's house. The initial research design was founded on interviews with participants. However, once the opportunity arose for two participant observations, I decided to incorporate it to the study. Luisa was first interviewed by me and mentioned the study to her friend Rafaela. Both are Brazilian nationals and moved to Canberra due to work and studies. Luisa spontaneously organised an afternoon tea at her house so I could be introduced to Rafaela and to complete the interview. We spend about an hour having tea while their children played, and we talked about life in general as an ice breaker. Then, the interview with Rafaela was completed in a different room of the house in privacy. In Hamilton, there was only one participant observation, when Isabel and Camilla asked to be interviewed at Camilla's house during afternoon tea. The participant observations gave me insight about the relationships of new migrant mothers in Canberra especially for women not having their extended family in Australia, highlighting how they rely on each other for support.

I also draw on my personal experiences as a Brazilian migrant living permanently in Australia and a user of Canberra's perinatal health care services. The impact of my position as insider-researcher is discussed in the chapter ‘Reflexivity’.

3.3.3. Data analysis

This thesis is qualitative research adopting thematic analysis as a methodological approach using inductive coding (Richard 1998). Thematic analysis ‘is a method for describing data, but it also involves interpretation in the processes of selecting codes and constructing themes’ (Kiger and Varpio 2020:847). Additionally, this thesis follows an interpretative approach; hence my goal to inductively reconstruct the perceptions of the research participants (Schwartz-Shea and Yanow 2012). Throughout my research project I decided to broaden my scope of employed methods and I adopted a multi-modal approach, including in-depth interviews and participant observation during home interviews and attendance to Hamilton’s playgroup Mother Goose. I chose to give participants a voice through the use of direct quotes in order to capture their views and experiences (Kiger and Varpio 2020; Pearson et al. 2012; Younas et al. 2023).

This study utilises thick description for the purpose of not only given voice to the participants but also to allow the transferability of this thesis’s findings to other researchers (Kuper et al. 2008; Nowell et al. 2017; Slevin and Sines 2000). Younas et al. (2023:1) explains the meaning of thick description in qualitative research as:

> Thick description refers to giving a thorough account of the participants’ views, intents, circumstances, motives, meanings, and understandings. However, as individuals do not exist in isolation, thick description also requires accurately describing the context of the observations, including the psychological, institutional, sociological, and anthropological dimensions of the phenomenon being studied (Younas et.al 2023:1).

The thick descriptions in this study can assist the transferability of this study to give insight into the sociocultural environment of migrant women participants and its importance during their perinatal period (Younas et al. 2023).

I was the only coder of the data collected and this research utilised inductive coding allowing common themes to arise from the participants' interviews instead of having the narratives allocated to pre-determined themes. Through the use of interpretative research I did not employ pre-established themes but instead identified themes in the data itself (Schwartz-Shea and Yanow 2012). The inductive codes showed on table 3.4 were allocated into the period of care: antenatal care, childbirth and postnatal care. These codes led to the development of the themes aligned to my research questions aiming to understand the views and experiences of migrant women utilising the perinatal care services in Australia and the views of health professionals providing care to these women.

Table 3.4. Coding tree and themes

Period of care	Code	Theme
Antenatal care	• Positive antenatal care experiences in Hamilton	Positive antenatal care
	• Lack of continuity of care in the shared care model	Lack of continuity of care
	• Underutilization of interpreting services	Interpreting services
	• Lack of social support from family • Social isolation in Australia • Extended family live overseas • Supportive community in Hamilton	Social support
	• Negotiation of caesarean section • Negotiation of care • Mother's perception of loss of autonomy on decision making	Cultural safety health practices
	• Limited use of EPDS by health professionals • Mothers limited recollection of being asked questions about their mood	Use of EPDS
Childbirth	• Paternalistic approach from health professionals • Negotiation of caesarean section • Mother's perception of loss of autonomy on decision making	Culturally safe health practices
	• Underutilization of interpreting services • Interpreter not offered	Interpreting services
	• Traumatic childbirth experience	Traumatic childbirth
Postnatal care	• Positive experiences in Canberra and Hamilton	Postnatal care at home
	• Baby was the focus of midwives and child health nurse during health care checks	Postnatal care at home
	• Limited use of EPDS by health professionals	Use of EPDS
	• Limited screening for PD by health professionals	Screening for perinatal depression
	• Underutilization of interpreting services	Interpreting services
	• Referral to perinatal mental health services • Referral to psychologists • Referral to support services	Health professional's referral pathway to mental health services

3.4. Summary

In summary, this chapter recounted details of the conceptual framework and methodology applied in this study. It also explored the settings where data was collected and why Hamilton and Canberra were selected as snapshots of the perinatal health care services in rural and metropolitan cities.

I provided the study design including how both groups of participants were recruited in both cities. I explained how snowballing organically underpinned the recruitment of participants. I detailed my connections with the chosen fieldwork locations and how they facilitated the data collection. In addition, I detailed the data collection for both type of participants in both cities.

Finally, I explained the data analysis utilising thematic analysis through inductive coding. I provided the coding tree that led to themes that will be discussed in Chapter 6 Discussion. In the next chapter I reflect upon my position as an insider-research and the how this can influence bias.

Chapter 4. Reflexivity

4.1. Insider-researcher advantages

My position as an insider-researcher allowed me to connect with participants' narratives from a subjective point of view. The thematic analysis allowed the subjective interpretation of these narratives and to some extent researcher and participant intertwine, as the researcher belongs to the world that the participants live in (Schwartz-Shea and Yanow 2012). In the interpretative approach the data are 'co-generated by actors and researcher together' (Schwartz-Shea and Yanow 2012:80). At the same time, I was able to position myself as a spectator capturing the interviewees' narratives and analysing it through the lens of an outsider-researcher. Among the advantages of being an insider-researcher are:

> …having access to participants that you already have a relationship or rapport with (e.g. industry partner); ability to draw on understanding and experience when asking questions or probing in interviews; access to inside knowledge; a pre-existing understanding that assists in analysis and interpretation of data; and the knowledge generated is intended to be useful or relevant to the researcher's own practice. (Fleming 2018:319)

My background as an insider-researcher is multi-layered. Firstly, I am a migrant woman, born and raised in Brazil until I was 25 years old, who used the public perinatal care system in Canberra in 2010 and then in 2013. Additionally, in 2010, I used Canberra's public perinatal mental health services. The exposure to these services as a consumer gave me valuable insight into the negative and positive aspects of what migrant women coming from minority cultural background clusters face while living in Australia and attempting to use the Australian perinatal health care services. It also was a driving force to pursue this research and further learn about the perspectives of other migrant women and the health professionals' views about the perinatal care services they provide to them. These perspectives are crucial to improving

perinatal health care services in Australia, especially when caring for women who are more prone to the development of PD.

My positioning as an insider facilitated my navigation between different multicultural backgrounds, including multiple religions, beliefs, or their absence. Being a non-white South American woman, proved helpful in gaining the trust of the migrants living in Hamilton. I was married to an Australian-born man, and my children's grandmother, Eneida, was an Australian white woman who has been heavily involved in the local Uniting Church services, particularly with their playgroup Mother Goose, the largest and most popular playgroup in the city.

Eneida is the neighbour of a young migrant family from Malaysia. The neighbouring family came to Australia with a regional working visa because the father of two worked with information technology and accepted a job in a local consulting firm. Lauren, the mother of the two children is a housewife in her 40s with a bubbly personality; her way of coping with social isolation was to find other migrant women living in the city and make friends with them. She met other migrants via her daughter's primary school, music classes, the library, church, tennis club and local shops. Because she came from a culture where elders were supposed to be looked after by their family members, she saw the neighbours as someone she should look after, because Eneida was living alone.

When I started my PhD, while visiting Eneida in Hamilton, I mentioned my studies to Lauren and the idea of finding a small city to collect data. Lauren suggested Hamilton and said that she knew several migrant women in the town who could be interviewed. From that point, it was easier to make contacts in the local community, as Lauren was well regarded in the migrant community. She put me in contact with her friend Isabel who recommended other friends to

my study. They opened their houses and shared their stories. These interactions will be discussed the next chapter as I explore the participants' narratives.

4.1.1. Boundary crossing and bias

It is important to consider that the insider-researcher needs to remain at certain distance from the participants of the study in an effort to be impartial in data collection and analysis (Nowell et al. 2017; Slevin and Sines 2000). This is crucial to guarantee the trustworthiness of the study (Kiger and Varpio 2020). I consciously intended to allow the participants' voices to be heard in this research, allowing that it was not viable to completely distance myself from their narratives. I frequently discussed these issues with my supervisors and acknowledged that my negative personal experiences may influence my thesis. My preconceptions and experiences raised the possibility of me seeking confirmation bias.

> Key challenges for insider researchers include: minimizing the potential for implicit coercion of participants; privacy and confidentiality; identifying potential biases and ensuring trustworthiness, transparency and rigor; acknowledging preconceived ideas and the desire for positive outcomes; ensuring tacit patterns and regularities were not taken for granted and examined more closely; and being aware of the potential of professional conflicts in the dual roles of being an academic and researcher within the same context. (Fleming 2018:319)

Therefore, my assumption that other migrant women may have encountered the same difficulties as mine may have influenced the analysis of the data. To counter the possibility of such bias, I have sought the guidance of two supervisors who work in health care in Australia and one external advisor who has experience in social sciences in the United Kingdom. Through supervision I was able to receive professional feedback to minimize biases and to engage in critical reflection about my own preconceptions and beliefs. In this thesis there was not an identifiable power imbalance between researcher and participant minimizing the chances of coercion

4.2. Summary

Chapter 4 presented my reflections about my role as an insider-researcher and its implications for this thesis. It discussed the advantages of being an insider-researcher with my background as a migrant women and consumer of perinatal care in Australian. This gave me inside knowledge about the Australian perinatal care system but also assisted with building rapport with the participants. I also explored boundary crossing and the risk of bias related to my pre-conceptions and own experiences while interviewing migrant women.

The following chapter will reveal the results of this study in Canberra and Hamilton. The results are divided into the three periods of perinatal care: antenatal care, childbirth and postnatal care. The chapter details the migrant women's views and experiences about the perinatal care they received in Australia. It will also explore their recollections about screening for PD antenatally and postnatally, negotiation of care, the use of interpreters and their social support during the perinatal period.

Chapter 5 will also detail the views of the health professionals I interviewed who provide perinatal care services in Canberra and Hamilton to migrant women. It explores their views on possible challenges in providing care to migrant women and cultural safety practices. It also explores the use of interpreting services, the screening of PD and use of the EPDS. Finally, Chapter 5 reveals how health professionals refer women to perinatal mental health services.

Chapter 5. Findings

Chapter 5 presents the data collected from fieldwork in Hamilton and Canberra. I explore the experiences and views of migrant women and health professionals around perinatal care in Australia and divide it into three stages: antenatal care, childbirth, and postnatal care. The postnatal care section includes the immediate care received in the hospital after childbirth as inpatient and postnatal care as an outpatient.

I present the positive and negative experiences of participants from Hamilton and Canberra in each of the above-mentioned stages of perinatal care. I also reveal the differences they disclosed in their satisfaction with service providers and health professionals. The chapter recounts traumatic childbirth stories of some participants in Canberra but also reveals positive birth stories in both cities.

In this chapter, I present the information about the importance of social support for migrant women in both cities and how participants in Hamilton were able to build a strong social network in the absence of their extended families. I also present participants' recollections about utilizing interpreting services in both cities.

The chapter presents the views of health professionals in both cities about the use of interpreting services and its challenges. They also disclosed their preferences about the use of the EPDS and referral pathway if women have been diagnosed with PD.

5.1. Antenatal Care

The majority of participants from Canberra (6 out of 10) in this study opted for public shared maternity care. Under this care program, participants might see a different midwife at each appointment and some participants in Canberra reported frustration at repeating their stories multiple times. None of the participants from Hamilton disclosed any issues related to lack of continuity of care under shared maternity care.

> Antenatal care was always very quick but efficient. The midwives were very helpful and friendly. I was very surprised that in Australia, they do everything and not the doctor. It was all very well done. (Lurdes)

> I had different midwives, but they were fantastic, very good. It is very different from South Africa. Over there, if you don't have private care, then it is very bad. At the beginning of the pregnancy, I was very anxious, but the [midwives] were very educated. I did not have family around, but the course of the pregnancy was normal, and I got educated by the midwives. Education was phenomenal; they always asked for permission for everything and gave a lot of information. They did the EPDS pre- and post-care. (Rosa)

Some participants from Canberra in this study felt that having numerous midwives providing perinatal care was not reassuring, and they sometimes felt that the midwives did not listen. If an issue arose during an appointment and needed to be followed up, they would need to come back, and the problem was still unresolved due to a lack of continuity of care. Although some of the participants in Canberra revealed their frustration with the lack of continuity of care in the maternity shared care model, overall, however, all the participants in this study had positive experiences of the antenatal care they received, mainly provided by midwives and GPs through the shared maternity care program.

> The antenatal care was done by my normal family doctor and midwives. They treated me well, but every time I went to the clinic, it was a different midwife, which was very annoying because I had to repeat the same story over and over again. The midwives sometimes were very bossy and insensitive. At every appointment, they insisted on a normal [vaginal] delivery, and I had to explain that I didn't want to because I was traumatised by my first experience, which ended up in a C-section anyway. (Helena)

> Each time [appointment], it was a different midwife, which was very strange. My mum in Brazil said to me to avoid them because it wasn't a good idea. Midwives in Brazil aren't common and aren't qualified as Australian midwives. (Luisa)

Luisa's comment is technically incorrect: midwives are trained and regulated in Brazil, but as they are a very small profession with 1.4 midwives per 100,000 population (United Nations Population Fund, 2023). Luisa's mother is likely to have known about registered midwives only through hearsay. On the other hand, there is a positive aspect to having input from different health professionals. Women can seek second opinions about their care and receive education from multiple professionals. A doctor from Canberra, Doctor J, discussed the story of a pregnant patient from Ethiopia who had complications; her pregnancy was classified as at high risk and needed to be closely monitored by the Canberra Hospital Fetal Medicine Unit. The information provided to the patient by different health professionals was crucial for a positive outcome for both mother and child. As the doctor recalled, additional information provided allowed the patient to make an informed decision about the care she received and to consider her fears and cultural beliefs. The patient was involved in the decision-making process and had the opportunity to see different health professionals.

> I once saw a woman from Ethiopia, she was pregnant with her second child, and this time there were complications. She was receiving shared care and input from the Fetal Medicine Unit. They were all keen to do an elective surgery [Caesarean section]. She felt that it was interfering with God's decision; if he wanted to take the baby again, it was not their role to save it. We had lots of talk about that. We did our best to be the bridge, explaining that life and death are very close together and God might want to take the baby away, and we are here to protect life and stand for life. In the end, she ended up deciding to have the C-section, and it all went well. (Doctor J)

Only two women in this study accessed the midwife-led Birth Centre in Canberra. Their experiences were similar when there were complications in their pregnancies. The service is designed for low-risk pregnancies, and women have limited appointments with their GPs. Women must rely on the midwives' judgement and experience to communicate any clinical concerns to a GP or the Fetal Medicine Unit. Maria liked that she had an exclusive midwife for her antenatal appointments; she also had a student midwife and she consented to have her observing her perinatal care. However, her perception of the service changed once she thought that her midwives could not provide complete reassurance that her baby was in a safe position. I will discuss her childbirth story in detail in the next section.

Andrea had used the Birth Centre for both her pregnancies and had a similar experience to Maria when things went according to plan, but her low-risk pregnancy developed complications. Andrea had enjoyed care from an exclusive midwife at the Birth Centre in her first pregnancy. She found it beneficial that the service was very flexible, and the midwife was able to come to her. She worked full-time as an accountant and had a health professional who was able to be flexible with her appointments, which meant she did not have to ask for personal leave to attend antenatal care.

Andrea saw the same midwife the whole pregnancy and only saw her GP twice. This helped her build trust in her care and ease her worries as a first-time mother. She liked that she could reach the midwife at any time with any concerns or questions. However, she started having contractions early. Her waters broke one week before her due date while she was attending a wedding in the small rural town of Milton in New South Wales, which is located about 200 kilometres east of Canberra. Her husband was in Canberra, and she drove herself to Milton Hospital, where she ended up delivering the baby without him or any social support present in

an unfamiliar health care setting with health professionals she had never met. However, her worries about being alone in a small rural hospital were eased because of the quality of care. Nonetheless, she would have preferred better communication with the health professionals who cared for her when she requested an epidural. I will discuss Andrea's experiences during childbirth in this chapter's next section.

Andrea defined her initial experience with antenatal care at Birth Centre as wonderful. However, her perception changed significantly when she got pregnant with her second child.

> I had the same midwife as for my first son at the Birth Centre. But throughout the gestation always something was wrong during the appointments. Often the midwife couldn't find the heart rate or the baby's position. The midwife seemed not focused. She couldn't remember the stage of the pregnancy and said that I didn't need more appointments when I actually needed [that]. She looked like a different person. She said that she had problems in her personal life. She used to forget records. It was like her head was in the clouds. (Andrea)

Only two participants in this study opted for perinatal care provided privately by an obstetrician of their choice. While coming from different cultural backgrounds, one from India and the other from Brazil, they shared their concerns about relying on midwives for their perinatal care based on their preconceptions that pregnancies should be monitored by a doctor – a position that reflects the low prestige held by registered midwives in Brazil and India (Chhugani and Hamdard 2014; Gualda et al. 2013).

Marta was born and raised in India and migrated to Australia to study and work in administration. She met her husband in Australia; he is also a citizen of India. While both of their extended families are in India, in Canberra they chose to maintain a limited social network, mainly relying on each other for support. As Marta explained, the couple preferred a more

private, quieter lifestyle. She stated that she ‘prepared herself during the pregnancy and that she ‘shouldn't need to rely on anyone’ (Marta). Marta was concerned about having different health professionals providing care to her, mainly because it was her first pregnancy. She believed that she could minimise any possible negative outcome in her first pregnancy if she had an exclusive doctor.

> I went to a private hospital. The experience was great. I got a lot of brochures and flyers about the pregnancy. I saw an obstetrician, the same person the whole way [pregnancy, birth and postnatal]. Because it was my first baby, and I don't have any family here. I thought it would be a better idea, rather than having a different doctor every time they treat you. (Marta)

One of the participants in Canberra, Tamara, was not eligible to register for Medicare due to her visa restrictions. They did not have any family support in Australia and decided to come to Australia when her husband was offered a place as an international PhD student at the Australian National University. In 2013, she came to Canberra from Brazil on her husband's student visa. There was minimal financial support from the Brazilian government through a scholarship. They had restricted financial means, and although they had health insurance, they were surprised to get an invoice for the services of the anaesthetist who provided the epidural, which was not covered by the insurance. She explained that she has a very supportive husband, but he had to return to work one week after the birth of their first child. Tamara's husband was sole income provider in their household. His role as breadwinner was a standard expectation from his family. After the birth of her child, Tamara felt uneasy every time her husband left the house to work:

> My husband is my only family in Australia, and when he went back to work, I was afraid to be alone. I did not want to get out of the house with the baby because I was scared to drive with the baby. My main fear was not knowing what to do if something happened to the baby. For example, one time, the baby had a fever, and I was alone. The baby kept spitting out the Panadol, but I persisted and had to manage it alone. (Tamara)

Tamara stated that the only difficult part of having a baby in Australia was to have to deal with the health insurance provider because of its restrictions. However, she was able to find a GP at the University of Canberra and use the maternity shared care at the Calvary Hospital. She reported that overall, she had a very positive experience with the whole perinatal care. However, she could not recall the midwives asking about her emotions or completing the EPDS during the antenatal appointments.

Vivian, a Cambodian woman, contacted me over the telephone from Canberra while I was in Melbourne. She found my flyer in the city library and wanted to share her story and her frustration about the perinatal care system while on a temporary visa. Vivian was five months pregnant when we had the interview. She revealed that she was very anxious and worried about her future in Australia, especially whether she could have a baby in a public hospital. She was on a bridging visa, and her Medicare card would expire before her due date. She went to Centrelink, and after a long wait, she did not receive a straightforward answer about her Medicare entitlements. She felt confused by the paperwork requirements, and her husband could not make sense of it. Her stress was amplified by a previous miscarriage and a negative experience with the Australian perinatal care system. Vivian lived in the border town of Queanbeyan which is in New South Wales. While women in New South Wales can deliver in the ACT, this usually requires referral into the system, something that would have been more complex given her visa status.

> The Canberra Hospital doesn't welcome me because my house is in Queanbeyan. The Queanbeyan hospital is very quiet, with no receptionist, and they did not know how to explain the [health] system and if I have to pay for the delivery of the baby because my Medicare card is going to expire. It is very hard at the moment because of the visa stuff, Medicare, the miscarriage, very scared. (Vivian)

As a courtesy, I ended up assisting her and reviewing the requirements for renewing her Medicare card while she was on a bridging visa. Holders of bridging visas can experience arbitrary stoppage of their Medicare cards during a period of renewal of visa, and people can experience months without entitlements to state-funded health care. The wording on the Medicare website is difficult to understand, and the entitlements and conditions to accessing Medicare while on a bridging visa are not clear. I had to call the Department of Home Affairs to confirm her entitlements. Finally, I pointed her in the right direction and assisted with filling out the correct paperwork. After a while, she sent me an email confirming that the renewal process worked, and she felt more optimistic about her future.

All the interviewed women had positive experiences with antenatal care in regional Victoria. The participants also stated that the local health professionals understood their cultural needs during perinatal care such as resting for 40 days without strenuous activities, avoiding living the house and not having visitors post childbirth. All participants reported that these health professionals were very kind and patient in explaining Western medical procedures that were unfamiliar to them, so that they did not feel like outsiders or unheard and unseen in the environment. The participants explained that one particular GP clinic, where they received the GP shared perinatal care model, was extremely popular due to its professionals' caring nature and the friendly environment. They were particularly happy with the GP, an immigrant from South Africa, and the nurse from his practice. Camila received her perinatal care through Hamilton's shared maternity care. She chose the same GP as the other three participants for her perinatal care. Unfortunately, despite my attempts to recruit the GP to this study, he did not agree to participate.

> I think the service was pretty good, because when I was pregnant I was 35 years old and it is a bit risky, I was old to be pregnant. They [midwives] were pretty good. The doctor checked every month. And I also had pregnancy diabetes, and I had to manage

> my eating. So during pregnancy, no problem. It was very similar to China. My sister said that in China, sometimes it is similar. They also do the check-up and ultrasound; yeah, it is similar. Just different [there] in hospital because of the size of the population, it is too busy. (Camila)

Camila recommended the same GP to Isabel, who chose that practice and the shared maternity care for her two pregnancies in Hamilton. Isabel struggles with spoken English at times because she lacks practice. She often asked Eneida to assist her with practising English. However, she was not offered an interpreter by her treating health professionals. She was happy to use her husband as an interpreter during her medical appointments.

> My English isn't very good, so the doctor and the nurse were very patient with me. I still need help from my husband to help translate. They [health professionals] are very good to me here in Hamilton. I don't need an interpreter because I use my husband. They [health professionals] didn't offer one [interpreter] because I think my case isn't that bad [laughs]. I can understand the majority of things. (Isabel)

In Hamilton, I discussed their use of interpreting services with health professionals. Doctor O has been working as a general practitioner focusing on gynaecological and obstetrics care. We had a very rushed interview in her consulting room at the hospital. She scheduled her interview between her appointments at the end of a very busy day. I waited about an hour in the waiting room and saw numerous patients going in and out of their appointments with Doctor O. She was visibly tired and did not expand her answers. Several times she looked annoyed at being interviewed, but still polite. This was a common feature of interviews with health professionals in Hamilton and most interviews in Canberra. During the interview, Doctor O stated that even though she can communicate in Mandarin in social settings, she is not confident to use the language in a medical context. Nevertheless, she said she might use her Chinese language skills to 'pass by' during some consultations but not when asking for consent for a medical procedure.

> I actually had to deal a lot with Chinese people here, but I can pass by enough without an interpreter. But It was not to ask about consent to any procedure, so I did not use it [interpreter]. (Doctor O)

Doctor C, also from Hamilton, also stated that she might try to manage without a professional interpreter for her appointments with patients from CALD backgrounds. She is a migrant from Malaysia who came to Australia to study medicine. She was friendly, but similarly to Doctor O, her interview was conducted in the consulting room at the hospital. Doctor C's answers were equally fast and short, she kept looking at her watch, and I reassured her that I would not take too long.

> Well, we do not have a huge migrant population here, I think there were a couple of them, but I do not remember them having mental health issues. Generally, I can pass by without an interpreter. The one [patient] that I had [who needed an interpreter] used her husband as an interpreter and also had a psychologist in Geelong. So, she already had a follow-up plan there. (Doctor C)

Midwife D has nearly 20 years of midwifery experience and works in Hamilton. She reported that she saw many women from different cultural backgrounds at the antenatal clinic and the delivery ward. She was initially reserved during the early part of our interview but opened up over time. She changed to a more friendly tone of voice as she discussed her experiences caring for migrant women in Hamilton. She also spoke about the use of interpreters in Hamilton and agreed with the interviewed mothers' comments about being offered interpreters during their appointments.

> We [antenatal clinic] had patients from Thailand, Burma, India and China and sometimes they don't have much English language. But they are happy to use their husband as interpreters. We had to use also the phone interpreting service. We had to book it, and it wasn't a very good outcome because we had to book a time that the

> woman had to turn up. She [patient] got a female family member to translate at the end. Usually, we have had to use interpreters. But what we can tell is that women seem happy and can understand what we are saying through the person with her anyway. (Midwife D)

Jean reported that she struggles with English but always declines an offer to have an interpreter present during her medical appointments. She stated that the Burmese government or the Australian government might try to know about their personal situations and those of others. She felt that she would not have any privacy if she used an interpreter.

> It was very hard for me, but they [the doctor] called the interpreter for me, the second time no interpreter. Sometimes it is confusing and hard to understand, but I don't like interpreters because there are no secrets [with them]. They [government] might know our situation and the others, no privacy. The hospital just gave us a phone number to get help with Centrelink paperwork, and we asked a friend to help, not the hospital. It was very hard, and my husband forgot to put the right paper with Centrelink, and we didn't have money for a while. (Jean)

Nurse B is one of the Hamilton's most senior maternal and child health nurses and midwives. I interviewed her in her consulting room. She was very welcoming towards me and receptive. She was eager to assist in my research and was very open about her work in Hamilton. She also showed me a range of pamphlets with services to assist mothers and children. These pamphlets were in the waiting room at the community centre, but none of them was offered in other languages than English. All the interviewed women mentioned how caring and supportive she was, and that she assisted them with multiple issues related to their infants and toddlers. She explained that if a service is not available in Hamilton than she can request assistance from the St John of God Warrnambool Hospital.

> Usually, they come with a husband or a partner, so we didn't use an interpreter so far. I was thinking about one lady [with whom] we should have used the interpreter, but the husband helped. Often, if we see the family doesn't speak English and is struggling,

> we would use a support worker from Warrnambool. I had a couple of clients that I knew were struggling, and the support worker visited them at home. It is called a parenting support worker. There aren't any costs, and it is also linked to child protection when they need extra help. (Nurse B)

Lorena is currently on leave from academia to focus on raising her children. She is a dietitian by background and did her post-doctoral studies at the Commonwealth Scientific and Industrial Research Organisation (CSIRO) in Adelaide. She had moved from Malaysia to Adelaide in 1997 because of her husband's work in international consultancy, which requires frequent out-postings to several countries. She stayed in Adelaide for ten years and built a strong social network. However, her husband got transferred back to Malaysia for one year. She stated that she had to leave everything behind to support her husband, and once they arrived in Malaysia, she discovered she was pregnant. She commented that at least she had the support of her family during pregnancy. She experienced the perinatal care system in Malaysia and gave some insight into the system. Lorena reported that the health system is consumer-driven and she stated the quality of care is linked to financial means.

> In Malaysia it was very consumer-driven. If you have the money, you can pay for the best doctor and even if you have enough money to pay for a good doctor, the doctor isn't necessarily surrounded by an equally well-trained team. And nurses are very underappreciated and because of that it doesn't attract very talented people, the salary is small. It is just not professional enough; young girls who look like they just got out of school are your nurses… Very low level of health literacy, and I know that because I am an allied health professional... The doctor was brilliant, but you saw him for a short period of time. The doctor was from Ireland, and that is what you pay for. (Lorena)

When her son was six months old, Lorena and her husband returned to Australia to live in Warrnambool. She became pregnant with her second child two years later and gave birth in Warrnambool at South West Healthcare, the Warrnambool hospital. The hospital had undergone major improvements in perinatal care after receiving funds from the state government (State Government of Victoria 2005). Lorena recounted her positive experiences

with receiving perinatal care in a regional city in Australia and her satisfaction with using the regional public perinatal care services.

> I wonder if the service was better because we were in the countryside. The hospital was newly built, we had ocean views. In Malaysia, we had to pay thousands of dollars for the birth of my son. But in Warrnambool, my daughter was born through the public system with five stars treatment. They have a very well-trained staff because there is only a small amount of babies being born at the same time. I felt very well cared for (Lorena).

Lorena also reported that she developed antenatal depression while pregnant with her second child. She struggled to form friendships when she moved to Warrnambool, and she did not feel welcome. Additionally, she had difficulties dealing with her son, who presented some challenging behaviours.

> At that time, I was at home a lot, but my husband suggested that I create some structure in my life and take my son every day to a different place. I think that a lot of my depression started with my son because he was and still is actually a very difficult toddler. He is very negative, stubborn, drives anyone nuts, and I was also struggling with my pregnancy as well. And I didn't have friends. So, building structure to my life, something to look for to, get exposed to sunshine, fresh air. So, I forced myself out of the house, and eventually, I got over it. And then morning sickness was also stopping. I only saw the lady from PANDA a couple of visits apart. And then I saw her for a couple of months. (Lorena)

She stated that only when she moved to Hamilton she was able to make friends. She felt that Hamilton was more welcoming of new residents, especially migrants. In Hamilton, she was soon able to create a strong social network with other Asian migrants. She is also part of the 'Asian Party', and she was happy to have Isabel present during her interview.

> I think Hamilton is such an outstanding town. It is a very welcoming culture, there is a sense of people trying to accept you, but Warrnambool people didn't try at all. So the

> problem wasn't the health services but the community that was bad. I have a postdoc colleague from Egypt who said the same thing: it is difficult to have friends in Warrnambool. My husband's boss from Hungary had the same opinion. In Hamilton, I guess I get a lot of social support from the church, talking to people, the kids running around. (Lorena)

However, she had a positive experience in Warrnambool accessing the PANDA services. Lorena has high health literacy as an allied health professional, and she was able to identify her depressive symptoms and anxiety. This worked in her favour, as she knew how to access the community's perinatal mental health care assistance to receive early support. She was able to initiate help seeking to early on address her PD. Additionally, she felt that the support and the reassurance from a clinician with specialised in PD was crucial to her recovery.

> The care in Warrnambool was very, very good. When I discovered I was pregnant, I was very depressed to the point I thought I needed to talk to someone about it. So, I called PANDA, and I told them that I had these symptoms and I didn't know if it was something wrong. And then, in the next couple of days, PANDA sent someone to have a chat with me. The lady was very kind and checked on me several times. And I managed to sort out some strategies alone, and the lady from PANDA served as a listener. And then I got better. She [counsellor from PANDA] was very open about what she was. She was casual, and she was a midwife. She was passionate about it, and she loved helping women. It was free of charge. I was very impressed with the level of the services. After some months, someone assessed me over the phone after my daughter was born and said that it was normal. Because I was paranoid, but they reassured me and told me to handle the baby to someone else when I was feeling overwhelmed. According to PANDA, I wasn't depressed after she was born, I was tired, and they were very accurate with the scenario. (Lorena)

Lorena reported that despite feeling depressed during the antenatal period and having contacted PANDA for support, the midwives who cared for her in Warrnambool did not screen her for PD. During our interview, I asked if she mentioned in her appointments with the GP and midwives that she had reached out to PANDA because of depressive symptoms. She stated that she did not mention it because they did not ask about her mood.

> I was very adamant not to go on drugs [antidepressants], and she [clinician from PANDA] didn't refer me to a doctor. The midwives didn't ask about depression. I don't think they did. They were [more] straight up with physical things than emotional things. (Lorena)

On the other hand, the interviewed midwives and doctors from Hamilton all reported that they routinely use the EPDS as a tool for diagnosing PD in conjunction with getting to know their patients' stories. For example, Nurse B stated that she routinely screened women for PD during appointments. However, she commented that women might have difficulties seeking the assistance they require. Hence the importance of health professionals screening for PD. Thus, even if women are not deemed vulnerable and more at risk of developing PD, they complete the EPDS.

> It is a routine process we go through to use the EPDS. We ask how they [migrant women] are feeling at four weeks, and we use the EPDS in the routine assessment, and we are encouraged to do it on a more regular basis if we feel there is a need. If the women access the services, sometimes it is hard for them to make that initial contact. They might not be aware of their symptoms or that they are emotionally unwell. But it is hard to make the initial phone call to make the appointment. (Nurse B)

Using EPDS as a routine assessment, health professionals can identify PD and refer the patient's care needs to the perinatal mental health team. Doctor C, gynaecologist and obstetrician from Hamilton, also stated:

> We do what we normally call the depression scale EPDS. If there is an issue, if they [women] have a high score, they [clinicians from the team] usually let me know, and I raise [it] with the patient during the consult and check if we think it needs to be escalated. I can refer them to the mental health services team. And they can access it there. It all depends on the level of the patient's needs. (Doctor C)

Both Isabel and Camila recall receiving education about perinatal depression during their antenatal care appointments. But the main focus was to raise awareness of the risks of

developing postnatal depression. Nonetheless, they felt that their emotional wellbeing was checked during the pregnancy.

> During the pregnancy check-up, they said that it is normal to feel sad after having a baby. They [health professionals] asked some questions about it. (Isabel)

Midwife D explained the perinatal mental health referral pathway in Hamilton. She also stressed that she does not rely on the EPDS alone to communicate her concerns about women presenting depressive symptoms during the perinatal period. She highlighted that if woman is identified at being at risk of developing PD after discharge she will likely be monitored in the community. Midwife D will notify the woman's GP if there are concerns and will also rely on the input from midwives conducting the postnatal home visits.

> We do the EPDS. If it is over 13 [score], we write a letter to the GP to let them know. Normally we give the Beyond Blue booklet to every woman. If the woman is over 13, we give this one [PANDA pamphlet], we tell them we have councillors here in town in the community centre. But often, women have a case manager or someone they have been talking to, like a psychiatrist, and we contact the person. But if it is a fresh diagnosis, we write the letter and do the referral. If they don't want the referral, we give these [Beyond Blue booklets] and then they have to self-refer when they are ready. Otherwise, these girls [patients] have been visited [by midwives] too at their homes. So I do follow them up if it's very high on EPDS. We might do the EPDS again later in the pregnancy and if the stress is still occurring because you just have that seven days with the test [EPDS]. If you ask them now, they might say, 'my husband has the kids, and I am fine'. But if you ask them a month later, things might be different. And a lot of these women are on antidepressants anyway, so they [mothers] work with the doctor to keep them well. (Midwife D)

Nurse B also talked about available mental health services in Hamilton. The perinatal mental health service in Warrnambool provided through St John of God Warrnambool Hospital is called Perinatal Emotional Health Program and is responsible for Hamilton's catchment area. Nurse B said that referred patients are seen substantially faster in comparison to the reported

perinatal mental health services in Canberra due to lower number of women accessing the service.

> Doctors [at the hospital] initially refer to the GP, then the GP recommends the counselling services here [community centre]. They also refer to the counselling services that are based in Warrnambool. They [women] are referred from GP or hospital. Sometimes the referral comes from there [antenatal clinic]. We got at least four counsellors here, and the hospital also has a psychologist. The perinatal mental health program is for the region, and it is only one person [psychiatrist]. They [perinatal mental health team] need to do triage, but they [patients] are seen in probably a day or two. It isn't a huge waiting list. But If they have a diagnosis of psychosis, they can go to a hospital in Melbourne or Werribee where they can stay. (Nurse B)

Only two participants in Canberra stated they were asked by health professionals about their emotional state during the pregnancy. All the other interviewed women in Canberra and Hamilton reported that in their antenatal appointments there were not asked about their emotional state. These two women also remembered completing the EPDS during each appointment with midwives. Some of the interviewed clinicians in Canberra stated that they do not necessarily use the EPDS because they find it challenging to use when treating women from CALD backgrounds. For example, Doctor M in Canberra works mainly with women from CALD backgrounds, especially refugees and asylum seekers. As she explained, she prefers to have a more holistic understanding of the patients' mental health and believes that the EPDS does not add value to the diagnosis of PD.

> I don't screen [perinatal depression] with EPDS because I have known my patients for a long time. And basically, with most of my patients, I talk about their mental health. I do not use any tools such as EPDS because there is no point in doing it because it is in English. And the majority of women I see do not speak English. (Doctor M)

An interviewed clinician, Doctor G from Canberra, expressed a similar response and approach as Doctor M.

> I do not often use the EPDS. I only do it in a more red flag situation. I can use the counsellors at the clinic if it is necessary. Lots of my patients have anxiety and depression, and they already receive counselling with our counsellors. (Doctor G)

When I asked Doctor J and Doctor N about what tools they use to diagnose PD in their practice, they gave a similar answer:

> Nowadays, I do not necessarily screen for depression with EPDS, only if the woman has some sort of risk factor. And postpartum, I check about their mood and how they are going. (Doctor J)

> I would normally screen for antenatal depression if there are red flags and any past history [of mental health illness], and then I will use the EPDS. I might start them [patients] on medication if I need to while they wait for the perinatal mental health services. (Doctor N)

None of the participants in this study had their extended family living in Australia while they were pregnant. Nine out of ten interviewees reported that not having their family around was one of the most challenging parts of being pregnant in a different Country. They also found it emotionally and physically more demanding towards the end of the pregnancy, especially when they were more likely to be tired or have difficulties with their mobility and their ability to complete housework tasks was limited. The lack of emotional support from their extended family due to the physical distance was frequently mentioned by the interviewed women.

> I feel upset that my son won't grow up with family around him, like playing with cousins. Friends in Canberra are very helpful, but the majority don't have kids yet. (Andrea)

> My mum didn't come from Spain during the pregnancy because it was a good pregnancy. But I needed someone after the delivery. My husband had to go back to work straight away because we aren't Australians, and we need to make money. (Lurdes)

The interviewed women from both cities shared the thought that pregnancy was a critical time in their lives, and it would have been beneficial if they had their mothers around to help them prepare for the baby's arrival. In addition, they wanted to have their mothers present to give guidance during the pregnancy and to have a companion to attend medical appointments with. Participants in Canberra discussed that friendships in Australia became stronger because they relied on each other for support, primarily due to the lack of extended family. These statements highlight the importance of addressing social isolation in a new country to mitigate the risk of developing PD (Billett et al. 2022; Navodani et al. 2019).

> The baby was very hungry all the time, and I wasn't sleeping enough, and I was too tired. And I didn't have to go to a mother's group because I have a lot of friends in Canberra. They had babies at the same time as me, so we would catch up daily and support each other. (Maria)

> The mum's group was crucial. My two friends in Canberra supported me like family. We checked on each other, and we exchanged ideas about what we were experiencing, what was normal, and we went through the same things. (Rosa)

> After I came back from Brazil, it was all good, and I didn't feel isolated. The only thing that I needed was a cleaner. The mother's group was very important, and I had friends who had babies at the same time as me, and I didn't feel isolated. (Luisa)

Migrant women reported that they bonded with friends despite differences in their cultural backgrounds. The main bond was that of being a mother and a migrant. Participants stated that they understood each other despite differences in their place of origin. They felt that they

were put in the same category in Australia: migrants. The participants reported that navigating a different health care system than they were used to, in a language that was not their native one, were the main challenges.

Only one participant in Canberra, Andrea, preferred that her mother was not around during the pregnancy and childbirth because they had a difficult relationship. She felt that her mother would impose her ideas about what care she should receive during pregnancy and what to do during childbirth. Because in Brazil midwives are not a common profession, Andrea reported feeling anxious about her mother reminding her of that. The participant did not want her mother to invade her personal space. She felt that her mother would interfere with her relationship with her husband and their decisions about pregnancy and childbirth. Similar to other interviewed women from both cities, Andrea preferred to rely on her social network especially in the postnatal period to tackle social isolation.

5.2. Childbirth

Migrant women in Hamilton reported positive views and experiences with childbirth in Australia. Nonetheless, one participant had some issues with a particular request. Camila revealed that because she had only one child, it was very important for her and her husband to collect the blood from the baby's umbilical cord. They wanted to keep it stored in case the child needed stem cells. However, the local hospital had never previously undertaken private banking of umbilical cord blood.[1] Camila stated that it was her only stressful moment in dealing with

[1] Private umbilical cord banking is not a common procedure in Australia. Most umbilical cord banking is done through the national public blood bank service run by Red Cross

Hamilton's perinatal care system, especially because she could not have a vaginal delivery and ended up having a Caesarean section and needed the surgeon's authorisation.

> One thing important, I wanted to collect the umbilical cord blood. But, it is very difficult in country areas, because they aren't used to it. So I had to apply to the hospital. Then, I had to have a meeting for my surgeon to get approved, and a nurse came from Sydney to collect it. She belongs to the company that stores the blood. But, the surgeon didn't want to allow the nurse to come into the theatre. He said it was dangerous for him. And I asked why? He said because of the risk of the process. And he didn't want anyone from outside interrupting his team [laughs]. It wasn't complicated, so I had to complain to the hospital because it was important for me. The company organised everything, and they said that it had never happened before [that] a doctor refused it. (Camila)

Another interesting aspect of Camila's birthing experience was that while attempting a vaginal delivery, her midwife used traditional Chinese medicine to assist with the pain. Camila reported that this was a nice surprise, mainly because the midwife was not Chinese. This statement illustrates that participants who felt that health professionals treated them with kindness and support were more likely to perceived their received perinatal care as a positive experience (Bains et al. 2021a; Billett et al. 2022)

> I had a C-section because the baby's head was up [breech]. Even the midwife used traditional Chinese medicine, and I was surprised. It is a very special traditional medicine. They burn something and put it on your feet [Isabel and Camila, at this stage, talk in Chinese, trying to find the words to explain the procedure]. They put that burning thing in some points. I was surprised that she gave it to me, but it didn't help the pain [laughs]. Her name is [midwife's name], she is very good and experienced. (Camila)

Isabel stated that she felt unprepared for the arrival of her first child because he was one month premature. Nonetheless, she had a positive experience with the health professionals at the local hospital. She ended up using her husband as interpreter even to sign consent forms for an epidural. She stated that was not offered an interpreter at any time in her perinatal care.

> He was a premature baby, he came in July, and he was supposed to come in August! So, it was a bit of a shock. But, because I think my water was broken, the people in the hospital did everything to help me quickly. It was a normal birth [vaginal delivery], and I had an epidural. They [doctors] explained the procedure to my husband, and he translated it to me, and I had to sign a paper because of the epidural's side effects, but it was in English. (Isabel)

Isabel was born in the US and then returned to Taiwan. She explained that she is able to compare the Australian perinatal care system with Taiwan's, based on her family's and friends' experiences with the services over there.

> I was born in the US, and my mum said that the system is good there. But, there isn't a midwife. Here they have one, and they come to your house to check if you and the baby are okay. My brother was born in Taiwan, and my mum said it isn't good. She needed to have a baby in the hospital and ended up having a baby in the car, and it is messy. In Taiwan, they [citizens] aren't happy about the treatment. (Isabel)

Lorena also compared the Malaysian to the Australian perinatal care system. Her first son was born in Malaysia, and she explained in her opinion the type of care she received in Malaysia was based on the amount of money she was willing to spend. Lorena stated that in Australia she had the opposite experience and fell reassured by Australian health professionals especially regarding lactation.

> It was very hard during the delivery in Malaysia because it was so consumer-driven. The doctor said: 'it is taking too long'. Then I thought, wow, he is a professional, and if he said that is taking very long, it is. I wasn't experienced and thought that maybe I needed help to get the baby out, and surprisingly he said: 'do you want any help?'. Because everything you had during the delivery then it adds more money. If you use forceps, more money, epidural more money. For me, I tried to stick with medical advice, but he was talking to me as a consumer and asking what I wanted. (Lorena)

In comparison, during one of the interviews, midwife D explicitly talked about stereotypes in her perinatal health care unit and her views about migrant women using the perinatal care service in Hamilton.

> There are a lot of Indian ladies here [in Hamilton], and they prefer caesareans. I think because they are busy, they reach 40 weeks, and they have a caesarean. Other women are having their second baby here, and the first one they had was like in the Philippines, so they are happy with how things are done here. Maori girls [living in Hamilton] do not see a doctor or see a midwife. They give birth to their babies; naturally, they are beautiful breast feeders, it is so natural for them. But the Indian girls want caesarean, cut me up, do all these stuff, but the New Zealand ones are quite natural. They will try anything to try to give birth to the babies and give me more time to avoid the C-section. (Midwife D)

Some of the interviewed women in Canberra described negative childbirth experiences. They felt that their birthing expectations were not met, and health professionals did not meet their needs as health consumers. In addition, they did not think they had an active voice in the decision-making process of their care.

A common theme among the participants in Canberra was that they often felt that their concerns and requests were not listened to by health professionals, especially during the birthing process. For example, Andrea believed that she had inadequate pain relief during the birth of her first child in Milton, NSW. She stated that when she requested an epidural, the doctors and midwives caring for her declined. However, they did not explain the reason why. The midwives only discussed it after she delivered her son, and she felt that her opinion did not count.

> When I had strong contractions, I asked for an epidural, and they said no. Only after my son's birth, they told me that if they had given me the epidural, it would have slowed

> down the process. I think that they should have been sincere about the pain relief and not only said it afterwards. The communication was not very good in relation to pain relief and what I needed. (Andrea)

In Canberra, Maria detailed the delivery of her first child. She is a Brazilian national and made all her antenatal appointments through the public system at the Birth Centre. She had the same midwife during her pregnancy and had built a good rapport with her. Her pregnancy was categorised as a low-risk pregnancy. Nevertheless, at 30 weeks of pregnancy, a student midwife accompanying her appointment on the day noticed, ‘the baby was in a strange position’ (Maria). Her primary midwife examined her and concluded that the baby's position was as expected. However, at the 34-week antenatal appointment, her midwife confirmed that the baby was in a ‘strange position’ (Maria). The midwife had decided to request a pelvic ultrasound, but the equipment at the Centenary Hospital for Women and Children was unavailable on that day. Then, two other midwives were called to check the baby's position; they reached a consensus that the baby was fully engaged and what they were noticing during the palpation was only ‘the baby's hard bottom’ (Maria).

Maria was concerned but reassured by the three midwives that it was normal and she need not have any concerns. Unfortunately, the ultrasound was then cancelled against Maria's will. But again, she felt reassured and because it was her first time using the perinatal health care system in Australia, she thought it was standard practice. Nonetheless, she could not understand why the ultrasound was not rescheduled for another date.

Finally, at the 38-week gestational period, she entered into labour at her house. She called her primary midwife, but she was on personal leave. She never had met the on-call midwife who came to her house, but they managed to build rapport on the day. The midwife examined Maria and noticed that the baby was in a breech position; ‘Breech presentation occurs when your

baby is lying bottom first or feet first in the uterus (womb) rather than the usual head first position' (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists 2021a). A breech position in the late stage of pregnancy can lead to complications during childbirth and increase the risk of an emergency caesarean section (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists 2021a). Maria reported losing trust in the midwives and the health care system from that moment.

> The major problem was when I was in labour. The waters broke at 4 am, 6 am the labour started, at 7 am it was painful. I called my main midwife, who was sick and then I met a completely new midwife. Then I thought it wasn't normal because it [labour] was too fast. The new midwife arrived at my place and did an internal examination, and I was 7cm dilated. And the baby was breech. He was breech since I was 30 weeks [pregnant], and no one noticed. [Her voice rose at this point and showed anger]. (Maria)

She stated that she was scared and angry that the baby had been in the wrong position since the 30-week mark, and none of the midwives had diagnosed it, dismissing her requests to go ahead with the ultrasound examination.

> I was scared. I told them that the Birth Centre was wonderful until the moment [when] it is [not] normal [no abnormalities during gestation and partum]. For a low-risk birth, it is wonderful. But they don't have the ability to act when it isn't. No one noticed the breech position [still showing anger in her voice]. (Maria)

Consequently, an ambulance was called, she went to the Birth Centre, and the midwife stated that she should not push the baby. However, she was scared and panicked because without even trying, she pushed and continued to do so as the contractions increased. Finally, a doctor arrived and opted for an emergency caesarean section. Maria said she then lost trust in the nurses and midwives. She believed that the postnatal health care was only good because the staff were afraid she would complain about the prenatal care.

> When she (the baby) arrived here, she was good, but we lost trust in midwives because of the mistake. Every time they arrived in the room; we rolled our eyes. But the midwives in the Canberra Hospital who helped us in the postnatal care were excellent. Unbelievable. Maybe because they were scared we would cause any problem to the hospital, like suing them. Next time I will definitely go private straightaway and use an obstetrician and also try to do a public delivery, because [that] was good. The legend says that when you have a breech baby you have a high chance of a breech again. (Maria)

A positive experience using the perinatal care system can change if women feel they do not have a say in their own health care. The interviewed mothers expressed their perception that the birthing process was exclusively under their health professionals' control and they did not have agency in the decision-making process. They often stated that they felt powerless and that their voices were not heard. For example, Helena, a Brazilian migrant living in Canberra, noted that the delivery of her first daughter was very traumatic for her.

> The birth was a C-section emergency. I could not dilate, and they had to induce the birth. It was way too painful. Then they gave me the epidural. But then my baby's heart rate was too low and then high, above 200. Then, the doctor decided on a C-section. Then everything was so fast, they started to puncture me all over the place, very fast and did not even care if it was painful or not. It was horrible, very painful, and then they took my baby very fast from my womb, and everything was a worry. She did not come to me straightway post-birth. She had tests done, and she had loads of tubes around her. (Helena)

She remembers how scared she was and how the doctors did not explain what was happening while she was in labour at the hospital.

> I believe they [staff] should not let me reach this emergency point. Because the baby was in a bad situation and the doctors insisted on normal delivery. I did not have conditions for a normal delivery because I did not have enough dilation. But they kept insisting and inducing me. And at the end, I was desperate because I saw in the doctor's eyes how worried she was, and then I got even more desperate. That was what desperate me more, not even the birth or the pain, but the worry and desperation in the doctor's eyes. Then, thank God it was all right in the end. This is something they have

> a thing that I think is wrong, that Australian professionals insist on normal delivery when it isn't going well. It is traumatic for the child and me. The child doesn't want to get out, and they want to take the child off. (Helena)

It creates a sense of distrust and fear of future pregnancies. When Helena became pregnant again in 2015, she was determined to have a caesarean section again and did not even want to discuss the chance of a vaginal delivery.

> I do not recommend normal delivery to anyone. Maybe if you don't have any issues, then okay, but for me, it was terrible. It was traumatising. They initially tried to convince me to go for normal delivery. But I said, do not even want to talk about it, I do not care, I want a C-section. But they kept asking me to try, and I said no. It was stressful to me because they insisted on normal delivery, and I said no so many times. (Helena)

Doctor G in Canberra explained the complexity of assisting women in participating and taking ownership of the care they receive and making informed medical decisions, due to cultural differences.

> My experience with women coming from different ethnicities is the difficulty of understanding the Australian health system. For example, I had a young girl yesterday who had a miscarriage, and there were three options: 1) we could wait and see what happens, 2) to use medication to assist, and 3) dilation and curettage. Moreover, my job is to be sensitive, explain and orient about their decision. It is difficult and complex, depending on the age of the patient. Another example is an Assyrian lady coming from a very educated background. And she knows the pros and cons of everything, and she gets second opinions. In their home country, they investigate and analyse all the options. There is another example, like very educated midwives from Afghanistan, who were midwives back there and they are married to lawyers and doctors. They are refugees at the same time. So, they express their opinions, and they are prepared to listen to the current research and the evidence. (Doctor G)

All interviewed health professionals agreed that women are happy to adopt Western medical values once their care planning is discussed with them and the rationale behind therapeutic

approaches is explained. Doctor M highlighted in her interview that education is one of her main tools when she discusses discrepancies between migrant women's expectations and their particular requests about their health care and the actual Australian medical approach to elective surgery such as the Caesarean section. Her focus is on providing education about the Australian health system and the evidence about medical procedures, highlighting the differences between countries.

> They usually [migrant women] want a C-section, but it is up to the antenatal clinic, and I explain that in Australia, it is not common to have a C-section if there is no medical reason for it. I explain the pros and cons and how the Australian health system works. Then, I wait to see the treating antenatal care people have a conversation with the patient and then come back to her and talk again about it. I explain to them [migrant women] that different countries have different rates and different situations in terms of C-section. More common than asking for C-section is people typically coming and asking about antibiotics for everything because back in their country, they do that. But it is more about the health system than the immigrant. (Doctor M)

The health professionals' persistence in recommending women to have a vaginal delivery was a recurrent theme in my research. For example, Helena expressed again how, during several antenatal visits for her second pregnancy, her doctor kept discussing a vaginal delivery even though she strongly objected to it.

> They [health professionals] could not force me, but they insisted, and I got irritated and stressed with that. The latest talk with the doctor was just so stressful. I had an assistant [student midwife] to write down everything. She came to the appointments with me. The doctor was so rude because she was insisting on the normal delivery. Not only, she insists, but it looked like I was being weak for not having a normal one. Because she said to me: but you do not have any disease, or that or this. So I have to say: you do not know how painful it was for me. But she said it is painful for every woman. (Helena)

Tamara stated that despite having a positive experience with the Australian perinatal care system, she would have opted for an elective Caesarean section if she had known the labour

would be lengthy. It was a very protracted birthing process, which was exhausting and, in her view, unnecessary if there is an option of Caesarean section.

> The labour was too painful, and I didn't have dilation. I tried everything like sitting on the ball, showers and bath. But the pain in my back was too intense. I got morphine when I arrived in the hospital, which was terrible. After 18 hours of labour, the doctor gave me antibiotics, and I vomited a lot because I had an allergic reaction. I had an epidural, and Medibank didn't pay for it afterwards. After 26 hours of contractions, I was able to push, and the baby arrived. If I was in Brazil, I would have had a C-section because of the amount of time in labour. (Tamara)

Doctor N from Canberra stated that she is open to discussing women's particular cultural needs. However, there are specific procedures that she does not recommend and she prefers to give women the chance to consult with a specialist for a more informed decision.

> You always have to find out why they are asking it. Usually, there is a good reason, especially regarding multicultural patients and previous experiences. Some people might have past trauma during childbirth. Circumcision [of the baby] is the only thing I am most against, so typically, I do a referral to a paediatrician to discuss it. (Doctor N)

Doctor N also reported that some women from particular cultures might ask for procedures not legal in Australia, such as female genital mutilation (FGM). According to the United Nations Population Fund, in 2020, 29 African countries are still practising FGM. It is also reported that the practice still occurs in parts of Asia, the Middle East, Eastern Europe and South America. In Australia, it is a criminal offence to perform the mutilation of any part of the female genitalia or to surgically narrow the vaginal opening of either a child or adult (Matthews 2011). Therefore, if an adult asks their Australian health care professional for any form of FGM, it would be unlawful to grant it.

> Those are things that people ask at [practice name] that I never see at other practices. There was one case that someone was going to travel to their home country for female mutilation. Moreover, we explored that in detail during our appointments in Australia. (Doctor N)

Andrea, another Brazilian mother from Canberra, did not have any particular needs regarding her culture. But she identified that there were different cultural expectations between Australians and Brazilians regarding health professionals providing perinatal care. She related her experience during the labour of her first child. She was initially concerned about having a baby in Australia because of her mother's concerns over the fact that midwives provide care during labour and not a doctor. In Brazil, midwifery is not a common profession.

> My mother thought it was a bad idea because, in Brazil, we had an obstetrician. She said: how come on earth you will go only with a 'parteira' [slang for midwife] and not a doctor? But I did not give her much space to influence me. Because my pregnancy did not have problems or risks, I did not need a doctor, and they also said that if I needed a doctor at any moment, it would be offered. (Andrea)

She also had a low-risk pregnancy. All her prenatal care was done in the Birth Centre as part of the Centenary Hospital for Women and Children, which offers consistent midwives to a selected group of women. Although Andrea had her prenatal care in Canberra, she entered early labour while attending a family function in Milton (New South Wales). Even though Milton Hospital is significantly smaller than the Centenary Hospital, Andrea was happy with the treatment and reassurance from the medical team there.

> I was spending the day in NSW (Milton) for a wedding, and everything happened very fast in the local hospital. A very small hospital did not have any facilities, but they told me if something happened, they would airlift me. But to be sincere, I was very happy to have done the delivery there. First of all, here in Canberra, everybody told me that as soon as you have the baby, they push you out of the door. But there, in a small hospital. I was very comfortable, and it was very intimate. I liked the midwives. They also had an obstetrician. They had three ladies having a baby at the same time, and

> the obstetrician was walking from one room to the other. But I loved it, it was wonderful. (Andrea)

Andrea became pregnant again two years after her first pregnancy. Her second experience with the Australian perinatal care system shifted from positive to traumatic. She was allocated the same midwife from her first pregnancy at the Birth Centre. She reported that she felt that her midwife was not concentrating during her appointments. Still, because it was supposed to be a low-risk pregnancy again, she decided to continue to receive care from the same midwife.

She sought assistance from her GP to go through her clinical concerns. When she was 21 weeks pregnant, she fell while walking her dog and required a surgical intervention to repair a hernia caused by it. The pregnancy progressed as expected, but she started to have contractions at 34 weeks of pregnancy. Her GP and midwife stated that Braxton-Hicks contractions are expected during the second and third trimester of pregnancy. She requested an ultrasound, but her GP declined it.

> I wanted to have an ultrasound because I was worried. My sixth sense was saying to me that something was wrong. The baby wasn't moving as much. But the doctor said no; he said it was because I had an anterior placenta, which is why he [baby] didn't move as much. He said that women had given birth without an ultrasound for thousands of years. (Andrea)

Andrea shared that her second childbirth ended up as an emergency, which she believes was preventable if her doctor had listened to her request for an ultrasound, which then would identify the baby's cranial anomaly.

> Then at 40 weeks, I had contractions for two days that I thought were Braxton-Hicks because it wasn't too intense. And the midwife came to check at home, and I was seven

> centimetres dilated. I went to the hospital and from 8 pm to 5 am, the baby's heart rate was up and down, and they had to put the monitor internally because the baby was very high up. Then, my waters broke, and there was lots of meconium, and then I told my husband to stand up for me because I didn't have more energy. After all, the doctors didn't want to do the C-section. After he said to them to do the C-section, they agreed. The surgery was quick, but then the doctor said that he had never seen a baby's head so big. They didn't explain anything to my husband or me. My husband was feeling unwell because there was a lot of blood to the point it was dripping out of the table. The doctors just said that they were going to fix the things because there was damage to the urethra and haemorrhage. The urologist came and put liquid dye, and the urethra was cut. They then fixed it and also did a blood transfusion. (Andrea)

Andrea's second childbirth was traumatic, and she had to ask her support person to advocate on her behalf. Understandably, health professionals want to avoid a Caesarean section without a clinical indication. However, all the patients who had a Caesarean section reported a power struggle between them and their health professionals. Participants stated that doctors from the public system did not want to proceed with a Caesarean section despite their multiple requests during childbirth. This is a matter that concerns not only migrant women but women in general. The aggravating factor is that migrant women may face extra difficulty advocating for their needs in a second language and in a different health system from what they are used to in their home country. The lack of clear communication between health professionals and the patient can be damaging and anxiety-provoking.

> I noticed that my son's head was strange, but I thought it was normal because of the long hours of labour it was squeezed. But then one neurologist came to examine him, then another one came, and they didn't say anything or explain why they were there for. They only said that they were there to check the baby's reflexes. When the third doctor came, I started to worry and asked him to tell the truth about what was going on. He then said that he believed that the baby's head was fused and that he would ask his supervisor to check him. His supervisor came and confirmed it even before doing the scan. (Andrea)

Andrea's experience with the health system during childbirth and its complication lasted for months while she faced multiple health appointments for her son. He was diagnosed with

craniosynostosis, a ‘premature fusion of one or more of the cranial sutures’ (Governale 2015:394). Andrea had also to deal with health professionals who were not used to his condition. One of her nurses incorrectly associated Andrea’s Brazilian citizenship with the fact that in Brazil since 2015 there is a high incidence of neonates born with microcephaly after their mothers were infected by the Zika virus during pregnancy (Musso and Gubler 2016). The Zika virus ‘is transmitted through the bite of infected mosquitoes’ (Musso and Gubler 2016:509) and has been linked to microcephaly. Andrea’s nurse’s comments were insensitive and misinformed, especially because her newborn clearly did not present with microcephaly and she had not been back in Brazil for more than a decade.

> The worse thing was having to hear the comment of one of the midwives from the hospital who asked me if I was from Brazil and if the baby's head was that way because of the Zika virus. (Andrea)

Rafaela recounted her experience delivering her son through Canberra's public shared care system. She reported that her contractions started, and she went to the hospital, but she did not have any dilation. She stayed in the hospital for a couple of hours, but by the end of the day, she felt tired and accepted the midwives' suggestion to go home and have a rest. The next day, the contractions were too strong, and she could no longer manage at home. They returned to the hospital, and upon the midwives' internal examination, she learned that her cervix was not dilated. She stated that the medical team decided ‘to speed up her labour’, and she remembered that she received an intravenous medication, which eventually only increased the pain. There was no further dilation of the cervix. Rafaela reported that the midwife ruptured the amniotic sac to induce the labour further. She stated that the pain continued to be intense, and she received morphine twice, followed by an epidural. However, after hours of labour, she still not dilated and she requested a Caesarean section, which the doctor declined.

> I asked for the C-section several times, one doctor asked me to wait, and he said he was going to check with someone else, but then he came back and said no. I was very scared because I started having a fever. (Andrea)

Once Andrea developed a fever, she stated that she was very nervous because she knew something was wrong. She also reported that she relied on her husband as the support person and interpreter of what the medical team was saying in English to make sure she understood. She had conversational English, but she remembers that her pain was so intense that she could not think in English and spoke only in Portuguese. Even though she trusted her husband to assist with interpreting, she felt that because of his ‘soft’ personality, he did not advocate enough for her needs. Instead, he let the medical team make the decisions on her behalf. She was distraught that after having requested a Caesarean section for hours and having it initially declined by the medical team, they later decided to conduct an emergency Caesarean section.

> During the emergency C-section, I had pre-eclampsia. When it was finished, the Doctor came to me and said that I made the right decision because I didn't have enough amniotic fluid for the baby, and I had a uterine infection. But it wasn't my decision; they made the decision when they wanted. (Rafaela)

Rafaela's needs were not listened to despite her right to request a Caesarean section. Her experiences are reflected in the views of health professionals interviewed in this study who stated that they try to educate mothers requesting elective Caesarean sections.

> Generally, a C-section for first-time mothers would be referred to the doctor's clinic, and they talk to her. But a midwife tries to talk about the benefits of having a normal birth. The manager of the birth suite talks to women about the C-section and the adverse effects, and what it means. And how a normal delivery can be supported, such as with an epidural. However, if the person at the end of the day will be traumatised if her C-section is denied, they will do it. But they have an open discussion first and education

> about the risks and benefits of a C-section. The senior obstetrician has weekly meetings with the midwives. They have an open discussion about case management in case of C-section and a healthy discussion about the women's rights to go ahead with a C-section. Also, we do a C-section if there is a history of trauma, then we go ahead without much discussion. (Nurse E)

Despite Rafaela's communication difficulties with health professionals, all health professionals from Canberra stated that they frequently use telephone interpreting services because it gives immediate access to multiple languages without the difficulty of finding a face-to-face interpreter for a last-minute appointment.

> If there is something very sensitive, I insist on using telephone interpreting. I do not use many face-to-face interpreters daily, I use the telephone interpreter, and I have had good experiences. If someone is doing some routine procedure and the patient is keen to use a family member, she has no problems. (Nurse F)

> Normally I use phone interpreting. It depends on how women present, but I don't exclusively do the CALD clinic. I see women as they come. I use the phone. It is really easy, and I use it even at [the] birth [process]. (Doctor L)

The interviewed health professionals agreed that it is better to avoid having a family member as an interpreter. Still, they do not have a problem allowing it if the patient gives consent and is comfortable with it. The main concern is that the patient may not disclose important information about their health and social issues before a family member, or if there are indications of domestic violence, and the perpetrator is present. Several health professionals stated that often there is an unbalanced relationship of power between the migrant women and their spouses. They say that they are also sensitised to noticing if there is an underlying social issue or noticeable discomfort from the patient while a family member is present during appointments. In these circumstances, health professionals will insist on using a professional

interpreter. They try to empower patients to have a voice and use their rights to confidentiality and access to professional and impartial interpreting.

> I generally use phone interpreters, as it is easier to arrange than face-to-face. If the woman wants a family member to interpret, she will allow it, but it can be complicated, especially [with] red flags. I always tried to ask if the woman really wanted it. For example, a very young Sudanese woman wanted her husband to interpret, and he was much older. In some cultures, women believe that they have to have the husband interpreting and present. That is the cultural difficulty, and you don't really know if the woman wants to do it. So, it is intuitive and is complicated by language. (Doctor G)

> I use a lot of telephone interpreters; on-site ones take too long. Some women use family members, I take it as it comes, but if I am not quite sure about the social situation, I might use a phone interpreter. (Doctor J)

Doctor H pointed out that some migrant women might be afraid of using the interpreting services during their perinatal care in Australia, due to complex cultural and political considerations. They may be afraid that their private and personal information will be shared with governmental agencies in their home country, leading to persecution of their family and relatives living overseas.

> Often women do not want an interpreter, and they prefer to use family or a relative. Chinese women don't want interpreters because they are worried about the Chinese government, in case they can sometimes discover what they are doing in Australia or having a baby in Australia. So, they avoid talking about things, and you have to build trust. (Doctor H)

Problems with interpretation arose in the case of Rafaela, whose communication with the medical team was fractured because she had to rely on her husband to convey her needs and worries. She was not offered a Portuguese interpreter at any stage while she was in the hospital. She cannot recall the health professionals asking if she was happy to have her

husband as her interpreter. She could not build rapport with the people caring for her due to the language barrier. Often, health professionals will not use interpreters because it can be time-consuming and requires a certain amount of organisation to access this service, especially if it was decided to use a face-to-face interpreter.

Nevertheless, telephone interpreting would be available. In an emergency scenario, when time is precious, not finding an interpreter on time may be justifiable. However, in Rafaela's case, she was in labour for hours and theoretically, it would have been possible to find a telephone interpreter.

During the emergency Caesarean section, Rafaela's condition deteriorated. Her husband was removed from the surgical theatre. She felt that her communication with the medical team was completely lost and she did not have a support person to advocate on her behalf or explain what was happening. She remembered desperately asking for her husband to return to be with her multiple times, but she felt that no one was listening to her.

> They took the baby away, and they took me to another room with lots of doctors. And no one reassured me or told me what was happening. I spent a lot of time in this room. I woke up feeling very hot and pulling everything [intravenous equipment]. And then I could understand that one doctor asked the other: How much magnesium you gave her? And then he said that it was too much and that it was why I was reacting that way. Then they put wet towels on me and gave me more IV [intravenous] medication. Afterwards, I had hypertensive peaks, and I had to stay in hospital for ten days trying to adjust the medication. The baby was also not very well, and he had a fever, but the doctors did not give him antibiotics. (Rafaela)

Rafaela stated that the birth of her child was very traumatic, and the experience still haunts her. She stated that if she decided to have another child one day, she would return to Brazil

and have it at home, where, if she decided to have a Caesarean section, she would have it instead of it being repeatedly denied.

> I was shaken after this ordeal [of childbirth] because of the forceful way it was done to have normal [vaginal] delivery. I felt guilt and a failure as a mother. What made me angrier was the doctor saying that I had made the right choice, but I didn't have a choice. (Rafaela)

The lack of communication with the health professionals was disclosed by some participants in Canberra.

> My husband was asking several times to see me and know what was going on. After insisting a lot, he saw me in ICU with lots of wet towels over my body, and lots of doctors around me and no one explained what was happening. Then he got upset and asked someone to explain what was going on, which then they finally did. When he talked to me, the doctors suspected I had a stroke because I couldn't speak properly and had slurred speech. Then my husband took action and made sure I got proper treatment (Rafaela)

Providing reassurance and emotional support to the support person is also crucial. It is understandable that during an emergency, the medical team has to focus on the patient, but additional team members can reassure the support person that once the situation is under control, the medical team will provide a handover to them.

> In the hospital, they [medical team] sent a social worker to talk to me about my whole experience. She came and just gave me some paperwork and brochures about postnatal depression and difficult birth. But I was very disappointed with the whole system. Mum said that I should complain about the doctor. (Rafaela)

Lurdes shared similar concerns about the lack of communication between the medical team when her labour progressed to an emergency Caesarean section.

> I was in labour for 21 hours and ended up having an emergency C-section. It was a weird experience because I had contractions, and the [midwives] asked me to return home. I followed the instructions and called the hospital several times, and when the contractions were too strong, I went to the hospital again, and when I arrived there, they told me to go home again. I was then upset and felt that I was doing something wrong. Then they say I could stay. I was also disappointed because the pain was too much, and I asked for an epidural, the doctor was late, and I was pushing without dilation. Once he finally arrived, I got the epidural, and I was able to feel a bit better and rest. But then because I became distressed and there was a lot of doctors around, maybe around 15 people and no one explained what was going on and I thought it was very strange. I was very scared in the theatre. There was no baby, no husband, and I kept asking about what was going on, and the midwives just kept saying they were preparing the room. The baby had a blood incompatibility, and they took him away, and I didn't know the truth about the baby until much later on. (Lurdes)

There is a concern that women experiencing difficult childbirth are more likely to experience negative mental health outcomes in the postnatal period. Nurse E outlined that she is particularly aware that if women have traumatic birthing experiences, they are more at risk of developing PD. Therefore, she does not routinely use the EPDS but will use it if patients have adverse situations.

> [The clinician] uses EPDS only as required if a woman had a difficult birth, or someone expressed concern, then repeats EPDS or if she sees that woman lacks interest in the baby. People might have a normal EPDS during the antenatal period but might have a traumatic birth experience and probably score high on the EPDS. EPDS is only a snapshot of time, and the situation might change quickly. (Nurse E)

5.3. Postnatal

Participants in Hamilton unanimously stated they had good experiences with the postnatal care services in town. Midwife D explained how the postnatal care work is divided between the hospital midwives and the maternal and child health nurses.

> We [midwives from the hospital's antenatal clinic] do home visits as well. We look after them until the babies are two weeks old, so we do the home visits. Normally they have three visits. Sometimes the migrant ones [mothers] have more visits, sometimes because the baby is small, or have jaundice, or the breastfeeding isn't coming in. So they may have more visits. We are midwives looking after those babies and mums, normally they would be in hospital, but the government has a certain number of days of stay. And we send them home so they can relax back in their home environment. While the nurses across the road [community centre] do a home visit in the first two weeks to introduce their services like baby sleeping arrangements, bed and safety. And the mums book these appointments, so they aren't looking after the mum. If we know they are coming, they can weigh the baby. But they are still under our care, so they visit to assess the home and introduce themselves and back to our care. They [maternal and child health nurses] do immunisations and playgroups. (Midwife D)

Midwife D said that some migrant women she sees are on working visas, which do not give them access to Medicare. Therefore, they have to organise their finances and manage the costs of delivering a baby in Australia. She also highlighted that some migrants are transient in town, and they often return to their home country to give birth. For example, Debra and her family came to Australia on a working visa and are not entitled to Medicare benefits. However, they have private health insurance as part of their visa requirements. She stated that she had no problems using Hamilton's maternal and child health services and had positive experiences with their services. Her husband is a paediatrician, and she tends to use him for check-ups informally.

Camila had a positive experience with health professionals in Hamilton in the postnatal period, especially midwives. She pointed out that postnatal depression was not routinely discussed in health appointments in China, which is something that she believes is better in Australia.

> The midwives came here [home] a few times. After the baby is born, you go to the clinic and get the baby vaccinated and check the baby. The midwives were pretty good and very kind. They asked about postnatal depression. I think in China, talking about postnatal depression is a recent thing like 20 years. It is quite common for the mum to know that they have depression. Before, they didn't know, and young mums would suicide. (Camila)

Lorena drew further on her experiences in the postnatal period in Malaysia and compared them to the care she received in Hamilton. She emphasised that Australian postnatal care was superior to Malaysian. The main differences were the level of experience of the health professionals and the evidence-based care in Australia compared to consumer-driven care in Malaysia.

> The doctor [in Malaysia] gave me an episiotomy, and I think they didn't sterilise the instruments properly, and the cut was infected. I was in pain for about a week until my sister took me to the emergency department, and they said it wasn't looking good and referred me back to my doctor to sort it out. I had problems with breastfeeding, and the nurses weren't very trained. They [nurses] aren't trained in how to overcome those problems. What is worse is that you have nurses level A at night, which aren't even 'real' trained nurses. They are like personal assistants in Australia. It really shows in the services they [Malaysian health professionals] provide. Like I had one nurse at night, and she keeps saying that the baby didn't stop crying, what do you want me to do? In a sense, she was trying to get my consent to give formula. I'd just had the baby. I was tired, and I told her to give whatever and do what you have to do. I then had a feeling she gave a formula that night. I was crying. It wasn't working, then my other sister from Australia found a lactation consultant, and she helped get over the difficulties and then I managed to do exclusive breastfeeding. In Australia, I spoke to the maternal and child health nurse; that is also something I missed in Malaysia. This nurse was very kind and very reassuring. (Lorena)

Some participants in Canberra were dissatisfied with the inpatient postnatal care service. The main dissatisfaction was they felt discharge from the hospital was rushed even though they felt there were issues with either the baby or themselves that were not thoroughly addressed. Some participants reported that some of their midwives were far too insistent for mothers to breastfeed even though they were presenting difficulties.

> My husband works at the hospital café, and the hospital couldn't wait for him to finish his shift to pick us up. The hospital told me I had to go home in a hurry because they

> needed the room. Then, they put me in a waiting room like a living room. I feel like it wasn't an excellent way to do it [discharge] to a new mother with a C-section and a new baby. At that moment, I felt down and needed my family around me. I felt very lonely. (Lurdes)

> The midwives in the hospital were only focused on the baby, and they were very busy. I remember three women giving birth on the same night as me. The doctor was in between rooms. I was afraid to bring the baby home, and I was afraid he wouldn't sleep. But the midwife that came home was more attentive. She taught me about how to help the baby to sleep. She came for the first five weeks, but I wish she had come more times because I felt that I needed more reassurance. (Andrea)

Some mothers in Canberra reported feeling guilty that they could not exclusively breastfeed and felt that midwives were judging them.

> The midwives were trying without a rest to help me with breastfeeding, which wasn't working, because the milk wasn't coming. Then my husband had to intervene because they didn't want to give bottle milk [formula] to the baby. The baby lost weight and that is why I had to stay longer. Because, they want to force the breastfeeding and they were worried. Then, my husband insisted on giving the formula. The baby was crying. He had to be angry and said 'It isn't working! You need to the give formula'. But it was after a while, after the baby losing weight they [midwives] gave the formula, which was worrying. The midwives kept saying 'no, we cannot do formula, we can't!'. Then, they [midwives] decided to give it. The breast milk came a little bit and I was desperate trying to express it but it didn't work. (Helena)

On the other hand, three participants in Canberra reported during the interviews that they were satisfied with the education provided while inpatients at the hospital and the care they received.

> The midwives came and taught me about everything like changing nappies. They also gave me lots of tips about breastfeeding and different ways to stimulate the baby to attach properly. (Tamara)

> The education about breastfeeding was very good. The midwife told me to massage around the baby's mouth and kind of gently stretch it. It helped with attaching the baby to the breast. (Rosa)

> The humanised birth in Australia is more advanced than Brazil. The midwives encourage the skin-to-skin contact after the birth. They delayed the clamp of the umbilical cord. They encourage you to breastfeed. (Luisa)

In Canberra, Lurdes called me after receiving the flyer on the hospital's maternity ward after delivering her child. She described an uneventful pregnancy, but she felt sad and anxious while in the hospital delivering her first child. She was then given the flyer about my study by one of the midwives who stated that 'it might help her somehow with her anxiety'. I believe that the midwife wanted to assist Lurdes by offering her a chance to participate in my study because of her reported anxiety while in hospital. However, my recruitment flyer did not mention PD or assistance to women diagnosed with PD. The optimal clinical practice would have been for the midwife who handled the flyer to Lurdes to suggest that she share her feelings of being sad and anxious while she was an inpatient. Then, if it was clinically appropriate, a referral to the perinatal mental health team could have been completed, avoiding the aggravation of Lurdes' symptoms.

> There wasn't a bed for my husband at the hospital. I felt alone and scared because he wasn't there. I had to be alone with the baby for the first time. It was really bad [way] to adapt to motherhood. I wasn't expecting it to get bad when the baby arrived. I felt sad. (Lurdes)

Jean from Hamilton had her children in Melbourne, but her comments illustrate the conflicting ideas a migrant woman may have about how to behave after delivering a child. Due to cultural differences, some health professionals' requests and education might contradict their own beliefs, and migrant women may feel uneasy, especially first-time mothers in a different country and health care system.

> In here (Australia), after having the caesarean, they [health professionals] want you to walk, to have a shower. It is very hard, and we are scared. For the first time, after the caesarean, I woke up and didn't see my son, my son was in another ward, and the nurse came to see me, and they told me to walk for the exercise, and then my son came back from the nursery and stayed with me, to feed. (Jean)

Midwife D explained that there are some particular requests from women from specific CALD backgrounds. Her midwifery experiences dealing with migrant women in an Australian country town exemplify how migrant women can be judged for their cultural beliefs. This is concerning, because migrant women may feel obliged to comply with Australian health professionals and feel guilty for not following their family recommendations and cultural rituals. As discussed in Chapter 2, adaptation to a new culture is not easy. Furthermore, when the stress of the adapting to a new culture is added to the management of perinatal health, it can lead to the development of anxiety disorder and depression.

> For example, in women from India, often a family member comes, the grandmother is typically the first one that put honey on the finger and gives it to the baby instead of breastfeeding. Hence, it interferes when we check the baby's blood sugars. Then they [migrant women] talk to their mothers and explain why they should not do it. (Midwife D)

I inquired whether the midwife's team grants some migrant women's health care requests, and she expanded on her experience in negotiating procedures with patients. She said that 'negotiation' about patient care happens with both white Australian patients and patients from CALD backgrounds. However, in her view, there was no discrepancy between migrant women's and Australian women's requests. Her central point was that some women agreed with health professionals and obeyed their directions and there were some whose requests deviated from the policies and standard perinatal care. In this sense, whatever their

background, women are the minority group trying to negotiate with the Australian health system as a dominant group, wanting to have their needs and voices heard.

> We had an Australian girl, and she was pushing, and she asked: cut me out, cut me out [episiotomy]! And we did cut, and she was Australian. A lot of the Indian girls here are nurses, and when they do their training, they think a cut heals better than a natural tear. Because it is like they can control, but naturally, it might be only a tiny cut that we do not even need to stitch out. But the others normally listen; sometimes they've had one [episiotomy] before and want it again. But not because they ask it; we will do it. Because we can see the indication anyway. Usually, you talk through things, and they are happy. (Midwife D)

She shared her experiences with migrant women from some Asian cultures and how health professionals will 'teach' Western perinatal health care to migrant women. The idea of teaching the Western way to migrant women reflects a paternalistic approach to delivering health care, muting the voice of minority groups and putting pressure on migrant women to acculturate, to belong to the host society.

> Sometimes like the Chinese have things like the grandmother, it is here for six months, and they [mothers] get fed, often like an egg a day, and they ask me if it is all right. The dietary things or like the dentist's wife with the risk of SIDS[2] [sudden infant death syndrome] things because they [mother and child] do not want to get cold, and I have to tell them they do not need to keep the house warm like this [very hot]. They still said that they should not have a shower after delivery. Like the dentist's wife did not brush her teeth, and she was the dentist's wife, for God sake. Then, she brushed afterwards, after I explained that it was okay. I think they are more in conflict with what their mothers are saying to them. (Midwife D)

[2] Sudden infant death syndrome is complex and multifactorial but highly associated with sudden death during sleep. Therefore, midwives are concerned with the preventable risk factors linked to this syndrome such as the environment the newborn is place in for sleep. For example, there is a preoccupation with avoiding putting the newborn in a cot with several blankets and pillows, overheating the room and putting the newborn in a prone sleep position (Duncan and Byard 2018).

Isabel said she avoided going out with her newborn baby for the first month. She and Camila reported that this is the traditional Chinese four-week protective period post-birth. She refrained from having visitors and found it strange that women allow visitors in the first days they have a baby in Australia.

> In our culture we have 30 days' rest, we don't have many visitors because the mum needs to rest. Because we still feel weak. I found that they don't do that here and they do a lot of visiting. A lot of my friends in Melbourne got a lot of visitors as well, and they were exhausted. We prefer to be quiet. (Isabel)

Camilla and Isabel discussed the importance of their parents being present during the final stages of their pregnancies and after birth. In addition, both women had their parents or parents-in-law coming from overseas to assist in the postnatal period. Isabel reported that she did not feel socially isolated after her parents-in-law returned to Taiwan because she had her neighbours. Nonetheless, they also described that there was some conflict between their parents' cultural expectations and the recommendations from Australian health professionals.

> My parents don't like the baby crying in our culture, but when I was training the baby to sleep, I had to let him cry. In China, the grandparents like to hold the baby and don't let them cry. So I called the lady [specialised nurse] who comes to your home and helps the baby sleep overnight, but my parents said no more [laughs]. (Camila)

Nonetheless, she reported that she faced some adjustments to motherhood in the first month when her social support got reduced. Camila also said that she only started to go out more often about six months after her son was born. She stated that it was the hardest part of being a mother while living overseas and away from her home country.

However, she reported a positive experience with her postnatal care and stated that her midwife checked her emotional and physical wellbeing.

> The parents-in-law can help prepare a meal and washing. The first month was very sad because breastfeeding was very tiring. I think it happens to every mother [laughs]. The midwife visited me in the first week after having my son, and she asked if I was feeling well. I think the midwife was very caring for me, and I felt very good. She suggests I rest more. After one month, I had more energy, and you know what to do, and the baby is in a routine. After three months it was really better. (Isabel)

She was also slightly frustrated because of her inability to drive when her first child was born. Isabel told me that she only started to attend the mothers' group when her son was one year old, and she obtained her driver's licence. She was quite proud to drive me around the town and show her success at passing the drivers' test.

> I felt a bit bored when I stayed at home too much. But here I have nice neighbours, so I felt good. If the neighbours weren't so friendly, I might feel isolated. I didn't go to the mother's group until my son was one year old when I got my licence. (Isabel)

Jean from Hamilton also recounted that she felt homesick once her first child was born. She felt sad and teary, but she couldn't recall being asked about postnatal depression during the midwives' first weeks of home visits. She said that she never heard women talking about postnatal depression; she was not aware of what that meant. But she recalled being asked about her mood during the check-up with the maternal and child health nurse.

> No, she [midwife] didn't ask about postnatal depression. When she came to my house, she asked about the baby sleeping, feeding, and sleeping in my bed. When I went to nurse [maternal and child health nurse] appointment, she asked lots of questions about depression. (Jean)

The perinatal outpatients' services can offer a less rushed service in comparison to the inpatient postnatal care. Therefore, health professionals have more time to build adequate

rapport and provide a more holistic approach. Nonetheless, there is sometimes a missed opportunity to address early signs of mental health illness in the postnatal period.

> The midwives visited me several times. Some were very quick, others not. They were more focused on the baby. I was sad and anxious more and more, but the [midwives] did not ask much about how I was feeling. (Lurdes)

> The midwives came to my house to check the baby, not me. So they didn't check if I was happy or not. But I was feeling well and happy. (Helena)

> I think the postnatal could do better in asking how I was feeling [after childbirth]. But they gave me some flyers from PANDSI. They should at least ask in case someone had postpartum depression. (Marta)

All the participating mothers from Canberra stated that they had a positive experience with the maternal and child health nurses during postnatal visits. They expressed appreciation for receiving daily home visits by the nurses to check the baby's health. Nonetheless, they felt that the focus was on their babies' health and that the nurses just asked general questions about their physical and emotional health.

> I liked the nurse for the development check. I liked her because she looked worried and caring, but the hospital was completely different, the opposite. She asked me if I was okay [emotionally]. In the beginning, I was scared to get out of the house on my own. (Rafaela)

> The daily visits from midwives were wonderful and helpful to check the baby. (Helena)

Other interviewed women from Canberra recalled being screened for PD and found the postnatal home checks a valuable service. They also reported a positive experience with the

community's maternal and child health nurse, especially for first-time mothers who had several questions about breastfeeding and sleeping patterns.

> I had six different midwives in six days of home visits because my wound got infected. They were good but I thought it was strange to have so many different midwives. So, I had to tell every midwife that came the whole story again. But, they checked if I was physically well and if I had postnatal depression. They asked several questions. (Maria)

> The home midwives came for a week, every day. They checked my wounds and stitches. They asked about sadness, my mood, and they asked everything. They did the EPDS survey, and they gave me a booklet about PANDSI. Then the community nurse was also great, and she talked about playgroups. She also explained that it was okay to sleep with the baby, and I thought it was bad, but I got a midwife with an open mind. (Rosa)

Despite the recommendation for screening for PD in the postnatal period, there were varied practices among health professionals on whether or not they screened for PD and on the use of the EPDS. Andrea stated that after her second child's birth, she preferred the GP for her postnatal care because of the baby's cranial abnormality. But she thought the GP did not check her wellbeing much, although she found this normal because she believed that he was the health professional and if he thought she needed to be checked for mental health illness, he would have done it. This expressed trust reflects the belief that 'doctors know best', as previously discussed. Although it is recommended that health professionals screen for PD and make appropriate referrals if needed, Andrea trusted that they could exercise their clinical judgment if they feel that the screening is unnecessary.

Lurdes stated that her midwives did not screen for PD in her postnatal appointments, and she could not recall answering the EPDS. She had a history of depression during her teenage years. The fact that she had a past medical history of mental health illness should have

triggered the attention of the health professionals who cared for her, and she should have been monitored and appropriately screened for PD. According to the Australian Clinical Practice Guidelines for Perinatal Depression (Austin et al. 2017), individuals who suffer from mental health illness before pregnancy are more likely to develop PD. Some women like Lurdes might delay help-seeking due to fear of judgement from family members and peers.

> My husband was supportive but judgmental, like when the baby was crying and I started crying too because I wasn't coping. He would say things like: Why are you crying? Why are you reacting this way? And because I was sad, he would say that I was doing some[thing] wrong [and] that was why I was feeling sad. Then, once I was diagnosed [with anxiety and PD], the GP explained to him what I was feeling wasn't my fault. Then he understood. (Lurdes)

Nurse E stated that women with a history of mental health illness usually are closely monitored after delivering their children. They might even keep them an extra couple of days in the hospital to make sure there are no signs of PD, and make sure that they have adequate social and practice support at home. Often the perinatal mental health services will provide input to women in the postnatal ward and request a prolonged hospital admission in order to monitor their symptoms. Nurse E has access to psychologists and social workers in the practice she works in. These health professionals can refer the patient to perinatal mental health services, which has a team of psychiatrists, mental health trained nurses, and psychologists. Typically, they do an initial telephone triage and, if necessary, will schedule an appointment face-to-face with the psychiatrist.

> Yes, I use a perinatal assessment tool, which also assesses for domestic violence. I then might use the EPDS only at 26 weeks [gestation] and repeat postnatally if necessary. I only do the EPDS before that period if women have a history. It is the traditional model, which is more a fragmented model. Therefore, the doctor might have to check for perinatal depression before the women do their first midwife visit. But the midwives in the Birth Centre might do the EPDS earlier, because the midwife will see them [women] at the 12 week mark. (Nurse E)

Lurdes, later on, was diagnosed with anxiety and postnatal depression by her GP after her husband insisted that she did seek assistance. She got referred to the Perinatal Mental Health Services and Post and Ante Natal Depression Support and Information (PANDSI). She stated that her GP prescribed her an antidepressant and completed a mental health plan, which assisted with the subsidy for 10 sessions with a psychologist.

> I was waiting until I felt normal again. But I wasn't normal. I was scared, sad and down. And I checked with my husband, and he said to go to the GP to talk about it. The doctor told me to call PANDSI and a psychologist. So I called PANDSI, and they called me every week to check on me, and I think it was very helpful. I am coping more now but still not feeling well. I am going out more now because I understand what I have. I was afraid that people were going to judge me. I was scared of bad thoughts. I couldn't sleep when the baby was sleeping. I was afraid to tell my husband about what I was feeling, and he was very worried and working a lot. (Lurdes)

All the interviewed health professionals in Canberra had experience of referring patients to the perinatal mental health services at the Centenary Hospital for Women and Children. They said that they put in place an action plan while their patients waited for their referrals to be actioned by the perinatal mental health services team.

> I use perinatal mental health services, and I do ring perinatal mental health services' psychiatrists and get phone advice about how to proceed and if we manage within the community. Sometimes, I have to send the referral to him. I often contact the Canberra Hospital multicultural team, and they are brilliant. It is set up with more time for appointments, and there are multilingual doctors and midwives. Or they use their interpreting services. It is quite multicultural over there and understanding. (Doctor H)

> It [perinatal mental health services] wasn’t very helpful when I used it. It is a little hard to find the referral pathway. It took too long for patients to be seen, extensive waiting lists and sometimes the patient doesn’t meet the criteria and doesn’t get accepted into the service. Sometimes people might be under the care of the birth [team] and it is hard to know how patients are managing under this pathway. (Doctor J)

> It depends, I might use the counsellors from [practice name] or the perinatal mental health services. Sometimes I use the perinatal mental health services, [but] by large terms it is too slow but given the system [it] is satisfactory. (Doctor G)

Some of the practitioner interviewees had an in-house psychologist and social worker who could assist with PD management. They stated there was a substantial waiting period for women to be assessed by the perinatal mental health service. As a result, they often attempted to advocate on the patient's behalf.

> In the antenatal appointments I refer to PANDSI in Canberra and the PANDA website. It all depends where women live. I also use the consultant at [practice name] and I refer to a private psychologist. I don't refer much to the perinatal mental health services because it takes too long, I rely more on psychologists. (Doctor I)

Doctor H revealed that some women might be reluctant to accept help and action their referral, delaying necessary treatment, so sometimes the doctor might try different strategies.

> Sometimes talking directly with the psychiatrist at Canberra Hospital and see if we can avoid the waiting list. Sometimes he can give advice, and I manage the patient in the community, but sometimes I can bypass the waiting list. It can also delay women seeing the psychiatrist, particularly women that aren't particularly at high risk, such as struggling to be pregnant without support. A lot of women are resistant to a mental health plan, and they don't know if they should trust me and talk about their problems. So, the referral might be lost in the process as they don't proceed with it. There was a South American lady whose brother had disappeared, and she was terrified about talking to anyone and putting mum and sister at risk because they still live in her home birth country. I tried to upskill and be a support person and let them know it is safe to talk to people. At [practice name], I have the privilege to have a psychologist and social worker in the building. I can take them [patients] to the corridor and talk to the psychologist, which is about trust. (Doctor H)

5.3.1. Parent-Child Mother Goose

Migrant mothers' experiences in Hamilton were not only affected by the care they received but also by the social networks. During my fieldwork in Hamilton, I was able to participate in activities of one of the playgroups, the Parent-Child Mother Goose, or simply Mother Goose. Part of Nurse B's work as a maternal and child health nurse is to recommend playgroups and mothers' groups to new mothers. Those groups are a way for mothers and their children to socialise and bond.

> The town has three main playgroups: the library, the Mother Goose, and Mainly Music. But the most popular one is Mother Goose. It is run in the church hall, but you don't need to be religious. It is a very supportive community, the Mother Goose, because it is small and easy to access. (Nurse B)

All participants reported that the Parent-Child Mother Goose is the most popular playgroup in town. The program was created in 1984 by Canadian social worker Barry Wilson. He worked for the child protection services and identified a need to facilitate the bonding between parents and children from families at risk (The Parent-Child Mother Goose 2021). The program has been active in Hamilton since 2011 through the Uniting Church. It is free of charge and caters for individuals whatever their religious background or lack of it. Each session has an official 30 minutes duration and focuses on rhymes, songs and dancing. In addition, there is a morning tea break, which is also provided by the program. Participants are encouraged to bring a piece of fruit to share. Normally, there are around 24 children in each session.

I attended three sessions with my youngest son, who was two years old. The program had a very welcoming and relaxing atmosphere. Three elderly volunteers assisted with running the session. They were all very caring and energetic. The group had a mix of Caucasian Australian participants and migrants. Questions were not asked, and all people were welcomed. Living

as a migrant in Australia, I had encountered several situations where I felt uncomfortable with the number of questions about my origins during playgroups or mother's groups. Such questions focused on my background rather than on me being a mother trying to bond with other women in the same circumstances, and most importantly, trying to provide an interaction with other children for my son.

The program has a local coordinator, Fabia, whom I also interviewed. I conducted Fabia's interview in her residence. She is a retired teacher and was very welcoming and warm. She was flattered by my invitation to interview, which was lengthy and rich in details.

> The Uniting Church has an umbrella, the main one Uniting care, and they had the program [Mother Goose] going from there and came to Hamilton and helped set up the program. The lady came here every week for six months, and then the four of us tried by ourselves. In the beginning, it was very small with only about four children, and now if everybody comes, there are 24 children. Usually, we are referred through word of mouth. We don't promote and don't want to promote because there would be too many children. There is a brochure at the library and in the Francis Stewart Centre, which is part of the hospital. There is a lady in welfare services who deals with that. Same time we get referrals from the Department of Human Services because they work with disadvantaged families, and sometimes it would be good for mothers to get out of the house. (Fabia)

She was happy to learn that all participants in this study found participation in the Mother Goose a positive experience and a valuable social outlet. Fabia explained the structure of the program, and how Mother Goose might seem a simple group, but it is a well-structured and evidence-based program.

> There are a lot of things in Hamilton. Other churches have groups, but ours is more structured. The library also has a storytime group, and the hospital has one group for the very first mother. Mother Goose was first designed in Canada for mothers and families that don't engage much with their children. And just leave them in front of the television. It encourages eye contact, early speech development. They want the

> children to look at the mother's face, how the mothers say words, we do things in syllables, we clap. It gives little strategies when you are at doctors and in the car, like an incy wincy spider with your fingers. It also has the culture of using old stories and nursery rhymes that were lost and to keep the culture alive. (Fabia)

I asked if Fabia identified any barriers for women to attend the program, especially because Mother Goose is run inside the Uniting Church. She said that all songs and rhymes are in English, but it is not a barrier to migrant women from CALD backgrounds. She also stated that the group is fairly accommodating and not discriminatory, which makes migrant women comfortable, despite coming from a different religious faith. Some women will attend the session with their newborn babies, others have multiple children, and they will have a mix of ages in the groups. Children often attend the group until they are four years old, when they have socialisation through kindergarten.

> That is a safe place, they are welcomed, and they will come and feel accepted, not judged. A really lovely thing that I found with Mother Goose, we have 30 nursery rhymes; it is a very well structured first 30 minutes. We have 15 minutes of morning tea, and the last 15 minutes is playtime. The mothers sit with the children, and the kids just get swapped around; someone holds the baby of someone else, it doesn't really matter, and it really shows that they are accepted. We do everything twice, the songs, we do fairly slowly [with the] children, but there isn't anything written. (Fabia)

Fabia also discussed her experience with migrant women living in Hamilton. She was a high school teacher for 35 years and taught literacy classes for migrants in Hamilton at the Southern Grampians Adult Education. She stated that several women migrated to Australia to work on farms and were socially isolated. Therefore, they would come to learn English and for social interaction and companionship. However, the education centre closed down due to low attendance numbers.

> There aren't many immigrant people in town, not in Hamilton at all. It is a very culturally sterile place, I suppose, it is because of the nature of the work, employment. We have quite a few South African immigrants who work at the hospital, but we don't have any [South Africans] at Mother Goose. The nationalities we get at Mother Goose are the lady from Burma, whose husband works at the dairy farm, one lady from China whose husband is a music teacher, the Ethiopian who was adopted by an Australian couple, and another one, Chinese, the father is a dentist. I would really love the lady from Bangladesh to come, she never came. It is terrible, she lives in this tiny little unit. I know her because she is my neighbour, but I asked her so many times to come to the group. She knows it would be really good for her to meet somebody, she is very smart, she has a high education. (Fabia)

I interviewed Georgia from Bangladesh at her home. Lauren introduced her to my study, and she was happy to participate. Georgia was very reserved and soft-spoken. She came to Australia due to her husband's work. Initially, they lived in the Adelaide countryside, forming a social network of friends from Bangladesh. She gave birth to both her children in Adelaide. Eventually, her husband was transferred to Hamilton when her youngest child was one year old, and she felt socially isolated. They are Muslim and found it difficult to find friends from the same background. Her husband is very particular about their friendships and prefers to meet people from the same faith, preferably from Bangladesh. He had been applying for jobs in Melbourne to find a bigger community of Bangladesh expatriates. Georgia stated that Lauren and Fabia keep inviting her for social gatherings and attending the Mother Goose, but she does not feel like getting out of the house. She stated that her daughter used to cry and scream, and she found it difficult to get out of the house. She also has low self-esteem because she was obese during her pregnancy and recently lost 80 kilos of body weight.

One participant stated that despite the Mother Goose being a good program, it did not suit her personality, and her children did not seem interested in participating. Instead, she preferred to meet her friends at the church or during the 'Asian party', where the adults talked, and the kids were free to play with each other without a structure.

> I actually prefer more real friends' things, catching up with Isabel, Lauren and Camila, rather than organising things with strangers. I am not the motherly type of person (laughs). I found difficult this environment where you have to sing, and the kids don't seem interested anyway. Can you believe that the only thing that my daughter was interested in the playgroup was to eat the chicken sandwich? [Laughs]. She didn't want to play; she just wanted to stay eating at the table. We have strict diet restrictions because I am a dietitian, and 10:30 am isn't time for my kids to eat chicken sandwiches [laughs]. (Lorena)

Jean has attended the Mother Goose since her son was six months old. She is hard-working and never misses an opportunity to connect with others. Despite her difficulties with speaking English, she has been trying to network with the volunteers from Mother Goose to find a job. I attended one session with her and her two-year-old son. She asked the volunteers If they knew of any opportunities in the city to work as a volunteer and gain experience working in Australia. Eneida knew a friend who volunteers at the hospital kitchen organising the Meals on Wheels to the community and thought this person perhaps could assist Jean. We drove Jean there to discuss an opportunity to deliver the meals, and she was extremely happy at having the opportunity to do some work in Australia. She said it has been very hard to get a job because she came on a refugee visa and had no work experience. Nevertheless, the Mother Goose was a good starting point for socialising with other mothers and practising English. Her mother came to Hamilton and attended English classes at the Adult Education centre where Fabia used to teach. But because of its cost, she decided to stop. Therefore, her mother lost confidence in going out without her.

> She [Jean's mother] doesn't speak English. She was doing English classes, but she didn't want to do it anymore. Because my mother is old and she would arrive home and forget what she learned. And we have to pay money too. If they had volunteer teachers, it would be better. Because when I lived in Melbourne, I had a volunteer English teacher, she was Aussie, and she wasn't working. She just stayed home. She came to teach me at home, and I asked her about Australian life. I had the volunteer teacher for two to three years, and I got a lot of confidence with the teacher, I asked everything I didn't know about Australia, and she was very helpful. It would be nice if they had this in Hamilton. (Jean)

5.4. Summary

The mothers in this study from both cities generally found the antenatal care they received was adequate and a positive experience. They felt that the midwives were very nurturing and helpful. The shared maternity care model was the most used amongst the participants, who reported that its only negative side was not having access to an exclusive midwife throughout their perinatal care.

In reflecting on antenatal care, I discussed the migrant women's and health professionals' use of interpreting services and how it was normal for migrant women to decline the services for privacy reasons. Further, some health professionals would attempt to get by without an interpreter, based on their language skills and due to the perceived difficulty in organizing an interpreter. Overall, migrant woman in Hamilton were very satisfied with their perinatal care. The health professionals' interactions with migrant women were described, including the process of negotiating medical procedures in a medical system that attempts to prioritise vaginal birth, such as an elective caesarean section. Regarding the screening of PD in the antenatal period, all health professionals reported using the EPDS tool and tended to ask about the mother's emotional state during pregnancy.

Even though the Australian Clinical Practice Guidelines for Perinatal Depression recommends routine screening of PD in the perinatal period, only a couple of participants remembered being asked about their mood in the perinatal period. Furthermore, even a participant with traumatic birthing experiences was not screened for PD. It is possible that women may not have remembered the screening process, or that the questions were incorporated into the consultation more organically rather than using the direct questions of the EPDS.

I explored the participants' experiences of delivering a child in the public system. The participants' most negative experiences with the Australian perinatal care system were about the birthing of their children and mainly happened in Canberra. These participants felt that they were not included in the decision-making process and that health professionals did not meet their needs. Four of the participants from Canberra had traumatic birth experiences that impacted their health decisions about their future pregnancies and their confidence in the Australian perinatal health care system. In Hamilton only one participant recalled having difficulties during childbirth but it was around requesting to collect the blood from the umbilical cord of her newborn son for private cord cell banking. The procedure was a novelty to the hospital. The surgeon responsible for her Caesarean section was reluctant to authorise the entrant of a third party into the operating suite (the representative of the private cord collection firm). Eventually, she was able to get approval for the procedure after self-advocating with the hospital's administration.

Only one participant was diagnosed with perinatal depression. However, she was referred to the Perinatal Health Care Services and was still waiting for one appointment with their team. Nonetheless, her GP had put a mental health plan in place, with access to PANDSI services and sessions with a psychologist.

I reviewed the experiences of migrant women using postnatal services as inpatients and outpatients in both cities. Participants in Hamilton reported that the care they received was outstanding in both settings. Participants in Canberra had overall a positive experience with the postnatal outpatient service but had some negative views about the inpatient postnatal care related to the difficulty with breastfeeding. I also explored the screening of PD and the use of the EPDS as a tool. Finally, I described the health professionals' referral pathway for women diagnosed with PD in both cities.

The concluding account covers the Parent-Child Mother Goose program, which is very popular in Hamilton. The program is free of charge and an important place for migrant women to socialise with other parents. It is also a good resource for parents who are struggling to bond with their children. In addition, the group was crucial for some of the participants to get out of the house and avoid social isolation.

In Chapter 6 I will discuss the results from this thesis utilizing the three theoretical frameworks: invisible communities theory, muted groups theory and the cultural meaning of suffering and distress.

Chapter 6. Discussion

This chapter presents the discussion of the results of this study. It is divided by themes identified in each perinatal care stage: antenatal care, childbirth and postnatal care. It also discusses themes common across perinatal care. The first theme discussed relates to the public shared care model, where women may encounter multiple midwives. Using Ardener (1977) muted groups theory, I argue that this process can result in the muting of the voices of migrant women, particularly if those women do not have trust in midwives, or if interpreters are not used.

This is followed by a discussion by migrant women in Canberra who reported having to negotiate medical procedures that were important for them such as a Caesarean section especially if they experienced traumatic childbirth. The chapter also discusses the views of the interviewed health professionals about being open to discussing medical requests.

In the section on postnatal care I discuss that overall, the interviewed migrant women from both cities had a positive experience with community-based postnatal care. However, I highlight that many participants reported that the postnatal care was focused on their babies. While they reported that they considered their emotional and physical wellbeing as secondary during the appointments.

I then proceed to discuss the positive influence of social support on migrant women's perceptions of their lives in both cities. I explore the positive aspect of intergenerational volunteers and peer support in the community as protective factor for migrant women.

This chapter also discusses culturally safe practices and how they can benefit migrant women to improve their health literacy and empower their ability to make informed medical decisions. I also discuss the importance of keeping health professionals updated about cultural safety and awareness of migrant women's cultural needs during perinatal care. Some health professionals reported the use of ad-hoc interpreters. This can impact on the quality of the information being interpreted and reduced the confidence of migrant women to disclose their concerns in front of a family member.

Another theme identified across the perinatal care was the lack of consistency regarding the screening for PD. There was also an inconsistency in the interviewed health professionals about the use of EPDS screening tool for PD. One of the challenges reported by health professionals was that the EPDS was difficult to administer with women from CALD backgrounds. As a result, they often relied on symptoms of PD and past medical history to diagnose and monitor PD. Finally, I discuss the health professionals' comments about the referral pathway to their local perinatal mental health services in some of the differences between both cities.

6.1. Antenatal care

In Canberra, participants pointed out that the lack of continuity of care in the antenatal period might have impacted their ability to develop trust in their health professionals, especially in midwives in general. Women using the Australian public health system do not have the option of having their perinatal care exclusively managed by an obstetrician (Department of Health 2019). One participant of Indian origin had purchased private health insurance to guarantee that she could access an obstetrician instead of a midwife. This was motivated in part by the fact that, like Brazil, most births are attended by traditional birth attendant who have limited training (Garces et al. 2012), and tend to be regarded as the birth attendants of the poor. The

independent profession of midwifery remains in its infancy in both these countries, with most middle-class women being attended by obstetricians, generally the same obstetrician. The participant from India preferred to have an exclusive doctor managing her pregnancy instead of relying on a midwife. Another example was a participant in Canberra who mostly used her GP to answer questions about the pregnancy because she did not trust the opinion of her midwife.

The Australian universal health care system ensures that all women have attended deliveries, in which obstetricians are used for complicated deliveries, and midwives for normal deliveries. In larger cities (such as Canberra) women are likely to see multiple midwives through their pregnancy. Preconceptions that midwives are a lesser cadre of health professional may impact on the rapport building between midwives and migrant women in Australia, especially if migrant women do not have the financial means to opt for a private obstetrician. These women might initially be reluctant to engage with an Australian midwife and experience difficulty with rapport building, which may be exacerbated if there are multiple midwives involved in their care. It can also potentially lead to poor engagement with health care providers (Billett et al. 2022; Yelland et al. 2015). Ardener's muted groups theory (1977) would suggest that the voices of migrant women are muted through multiple mechanisms in the Australian systems of management of pregnancy, from failure to speak a common language, to impedances for rapport, and health literacy concerns about the competency of providers. Midwives can validate migrant women's concerns about the cultural differences about midwifery and provide reassurance through education about the role of the profession in Australia. Adopting culturally safe practices and improving health literacy can assist migrant women to unmute their voices, have their concerns acknowledged and promote trust in their Australian health professionals.

The lack of continuity of care during the antenatal period is not exclusive to migrant women. Non-Indigenous Australian and Indigenous Australian women face the same issue when accessing the public system via the shared care model (Billett et al. 2022; Forster et al. 2016). Additionally, Indigenous Australian women still face a substantial gap in their perinatal health outcomes in comparison to non-Indigenous Australians (Kruske et al. 2006; Rissel et al. 2023; Sivertsen et al. 2020). This study did not aim to analyse the perinatal health outcome to Indigenous Australian women, and I do recommend further studies in this area to address the gap in their perinatal health outcomes.

Migrant women have to navigate a foreign perinatal care system, made more complex by multiple care providers, the lack of social support in a new country, language proficiency, low health literacy and cultural differences regarding expectation of care. The needs of migrant women may not be met due to their invisibility in the community (Schneider and Ingram 1993). Perinatal health programs are often tailored to address the needs of mainstream Australia (Colvin 2010; Kruske et al. 2006). In comparison to Australian women, migrant women in this thesis faced additional difficulties due to the lack of continuity of care.

Participants in Canberra such as Rafaela, Helena and Andrea recall having to recount their negative medical events repeatedly due to lack of continuity of care in the antenatal period. Having to recount these negative events can lead to distress and disempowerment. Each culture is likely to experience suffering and distress in different ways (Kleinman 2004; Kleinman and Kleinman 1996). Therefore, migrant women may experience and express the impact of having to recount negative experiences to multiple health professionals in ways that may be not clear to health professionals, for example by becoming angry or by becoming withdrawn. The reiteration of past birthing traumas or medical events may have mental health implications

long term especially regarding increased anxiety about this current pregnancy and birth – particularly if the woman feels her concerns are not being heard (Billett et al. 2022)

Migrant women from Hamilton interviewed for this thesis were able to have the same midwives and GP throughout their pregnancies and reported being happier and more confident with their care than the group in Canberra. It is likely that the difference between migrant women in Canberra and Hamilton was due, in part, to the smaller number of health professionals available, which enabled participants from Hamilton to receive care from the same health professionals. Migrant mothers in Hamilton reported that they felt that they were well cared for and built rapport with health professionals providing antenatal care. Participants reported that the presence of the same health professionals enabled them to be listened and feel cared for. Participants in Hamilton reported being more receptive to medical advice and recommendations from midwives because of the rapport they were able to build.

Nowadays, it is easier for migrant women to search online and identify GPs that can provide shared maternity care and have some insight about their care style through reviews of other women who used their services. However, I argue that if the English language is a barrier, migrant women may be more likely to choose a clinic that has doctors who speak their language, or a clinic located conveniently close to them. In my experience as a physiotherapist at Northern suburbs, I had several CALD patients who did not have a good relationship with their doctors, but they persisted in using their services. This was either because it was hard to use the internet due to their inability to read in English, and so they could not find another doctor, or in some circumstances, their doctors were recommended by peers from their CALD community because they could speak their language.

6.2. Postnatal care

All the interviewed women in Hamilton and Canberra had positive experiences of postnatal care, with the home visits provided by midwives. They reported feeling supported during the transition from hospital to home. Participants stated that the reassurance provided by midwives put their worries at rest. It had a substantial positive impact on participants who were first-time mothers and required extra support with looking after a newborn. Additionally, in the participant's own interpretation, the support of health professionals in the postnatal care empowered migrant women during their vulnerable while adapting to motherhood. From the perspective of the goals of this study feeling of empowerment are important because they can enable minority groups coming from CALD backgrounds to have move visibility in the community and in policy making, allowing them to advocate for better health care and having a voice in decision making.

Nonetheless, the participants from both cities reported they felt that during postnatal home visits, the midwives focused mainly on the baby. They described that the midwives would thoroughly examine their babies, and their questions and worries were related to the baby's wellbeing. But not many questions were asked about how the mothers were coping with the newborn, their mental health status and physical wellbeing. Participants recall receiving pamphlets about PD, but these were not discussed with the midwives. The visits focused more on checking boxes that education about PD was provided rather than assessing whether the mothers were experiencing those symptoms. What migrant mothers referred to, implies that is important that health professionals empower and ensure education is provided in the postnatal period about postnatal depression to reduce stigma about postnatal depression and to encourage help-seeking if women develop PD symptoms. In the case of migrant women there is the extra need of making sure that if they do have PD symptoms migrant women know how to navigate the perinatal health care system. In addition, it is crucial to adopt PCC and be

sensitive of migrant women's particular cultural meaning of distress and suffering and how it can impact the diagnose and treatment of PD, thereby unmuting migrant women's voice in terms of their cultural needs and what they view as distressing and how health professionals can provide assistance to address it.

I argue that perinatal health services frequently focus on women as a birthing receptacle and their role as carers for their baby and minimise the women's needs as individuals. According to the participants in both cities during postnatal home visits, there was minimal interest in the women's ability to cope in their new role as mothers and the management of their identity in this process. Health professionals should stress the importance of self-care and that looking after their emotional and physical wellbeing is not a selfish act but an essential part of managing their role as mothers. Often, mothers claim to feel guilty for trying to return to work or wanting to pursue their academic goals after having a child. This is not an issue isolated to migrant women but can also affect non-migrant women in Australia. However, migrant women have the added complexity of trying to navigate an unfamiliar perinatal care system, language barrier, social isolation and sometimes low literacy (Billett et al. 2022). Nonetheless, I recommend that the improvement of postnatal care not only bear in mind migrant women but also the needs of other minority groups such as Indigenous Australian women and non-migrant women. Further studies about the views of non-migrant women about the perinatal care they receive and studies with Indigenous Australian women and the main challenges and needs in perinatal care.

Pregnancy management still heavily focuses on the outcomes and implications of the mother's behaviour towards the baby and perinatal care for the foetus's health. It is a complex relationship for health professionals to manage and can be challenging for women to self-advocate for their rights and autonomy in their care, while being aware of the effects of their

decisions on the unborn child. Additionally, in this complex relationship, health professionals have to cater to women coming from a variety of CALD backgrounds, and they have to navigate a range of expectations depending on each culture. Consequently, it is important to invest in health professionals' professional development in cultural safe practices.

6.3. Childbirth

6.3.1. Negotiating a Caesarean section and traumatic childbirth

Several migrant women in Canberra reported having requested Caesarean sections after prolonged childbirth or attempting to negotiate it during their antenatal appointments. They were unable to have their requests granted, and some of them ended up having emergency Caesarean sections anyway. Some of the participants in Canberra, like Andrea and Rafaela, felt that they were patronised by health professionals, especially during childbirth, when they requested a Caesarean section. The reluctance to arrange an elective Caesarean section was regarded by the women as tantamount to a determined refusal to listen to them.

There are many potential interpretations of this challenging negotiation of Caesarean section. It is possible that migrant women's low English literacy may have contributed to their difficulty advocating for their wishes. Health literacy concerns also come into play with beliefs that it is reasonable to expect that the health system should support Caesarean sections be available on request (a situation which had obtained in the private system in some of the other countries women had migrated from). Migrant women may disagree with their health professionals' recommendations but are unlikely to argue with them due to worry that they might upset them (Niles et al. 2021; Stoll et al. 2021). Migrant women might perceive health professionals especially doctors as an authority figure who know what is best for their health (Staffieri and Farrell Leontiou 2020; Wisner et al. 2014). Arguing with them may have implications for their

health care. My data suggests, however, that women who wished to have an elective Caesarean did argue for the procedure but were not supported by their professionals. This position is affirmed by the health professionals I interviewed.

It is possible that health professionals did not appreciate the extent of the distress, even dread, that women held at the prospect of a vaginal delivery. In accordance with the theory of cultural meaning of suffering and distress (Kleinman 1997, 2012), there may be discrepancies between what migrant women perceive as distressing and what health professionals believe it is important or relevant for their care. Thus, migrant women's suffering and distress before and during childbirth may not be recognised or addressed adequately by health professionals in line with the invisible communities theory (Schneider and Ingram 1993).

Women who had traumatic birth stories, like Rafaela and Andrea, reported feeling a failure – not because their labour had ended in surgery, but because they had not been able to access the surgery early enough. Some stated that they felt shame for not coping with the birth experience and its surgical outcome. Traumatic birthing experiences can also lead to anxiety and fear that 'something bad' might happen in future. Three participants reported feeling heightened anxiety and worrying about their newborn's wellbeing. In addition, they reported feeling disempowered by the health professionals who provided their care. According to them, the triggering factor was that their treating medical team declined their requests for elective Caesarean sections, but their prolonged labours progressed to emergency Caesarean sections, which increased their distrust of their health professionals. The three participants in Canberra who had traumatic Caesarean sections stated that they had failed as women. They did not develop PND, but they discussed how they were afraid of future pregnancies and distrusted health professionals. Women who underwent traumatic birthing may feel physically

torn, bruised, and in pain post-delivery, especially if they had an emergency Caesarean section with complications (Slade et al. 2020).

The migrant women in Canberra who requested a Caesarean section through the public system stated that they had difficulty starting a dialogue with health professionals about opting for an elective Caesarean section. They reported that midwifes quickly established that a healthy mother and does not need a Caesarean section. Participant Helena stated she felt traumatised by her first delivery and had to assert herself to receive an elective Caesarean section for her second pregnancy.

Participants who had traumatic birthing experiences reported that the worst aspect of their negative birthing experience was the lack of two-way communication with health professionals. According to the participants, they felt that their needs were not considered and they were kept in the dark about their clinical situation. They felt that they were not involved in the decision-making process for their care and that health professionals were in charge. Especially during an emergency, they found that the team focused on the clinical procedures but forgot to keep the patient aware of what was happening. In my workplace at a North Melbourne suburban hospital, I observed that health professionals who keep the patient informed about their clinical deterioration and need for intervention tend to establish a good rapport with patients through reassurance and trust.

Some participants reported that the health professionals responsible for their care discussed their health and care with each other, ignoring the fact that the participants were awake and able to listen to them. This reinforces a loss of autonomy in their care and distrust in the health system (Ali et al. 2016). For example, Rafaela from Canberra reported that throughout her

traumatic childbirth experience, she could hear the doctors discussing her clinical deterioration without directly talking to her. She said that she felt afraid for her life, and she felt alone in the operating theatre without her husband who was acting as her interpreter. Consequently, she decided to do not have more children due to this experience. She said she feels she cannot trust the Australian health system. In her recounting of her birth experiences in Canberra, Rafaela emphasises the traumatic emergency Caesarean section, rather than the eclampsia which clearly had been life-threatening for her, as indicated by the snippets she heard about treatment being offered to prevent fitting (Magnesium infusion) and the fact that she had woken up in intensive care.[3] Rafaela's account indicates that the failure to be offered an early or elective Caesarean fundamentally breached her sense of trust in the clinicians, even if they had undertaken a life-saving procedure.

There is increasing recognition that many Australian women overall experience birth as traumatic and violating. In a large survey of 8546 women who gave birth in Australia, 11.6% reported that 'Yes' or 'Maybe' to a question about traumatising events, and gave detailed descriptions of their experiences (Keedle et al. 2022). 10.8% of the women born overseas and 11.7% of women born in Australia reported traumatising experiences, summarised by the term *obstetric violence* by the authors. Women from the Middle East and Africa, and Maori and New Zealand women were more likely to report *obstetric violence* than other groups. The survey notes that models in which the woman could not form a sustained trusting relationship with a provider were more likely to result in the experience of obstetric violence.

[3] The fact that her husband could not stay with her through the Caesarean section which was conducted under an epidural/spinal is also consistent with the procedure being high risk for the mother.

The health professionals interviewed in this study emphasised that their priority is to deliver the best evidence-based perinatal care to women, which implies that they had to guide them about the risks and benefits of medical procedures. A Caesarean section confers a small but appreciable extra risk upon the mortality of the mother and baby, all things being equal, and the guidelines in Australia encourage women to deliver vaginally if possible. Professional disputes between midwives and doctors in Australia often include a statement that midwives favour natural birth, and doctors sometimes default unnecessarily to Caesarean sections.

Health professionals in both Canberra and Hamilton stated that they were willing to negotiate a Caesarean section with women in general. However, if they could not convince women through education to avoid an elective Caesarean section, they would refer women to the obstetrician to further discuss their request. The obstetrician most likely would then convince women to avoid the elective Caesarean section. Nonetheless, Doctor C from Hamilton was asked about women's requests for an elective Caesarean section based on cultural practices or preferences. Doctor C stated that she does not accept the request straightaway but schedules several appointments with these women to provide education about the risks of the procedure and give time for them to think about and digest the information before making a final decision. Her explanation highlights how health professionals can empower migrant women to make informed decisions through the provision of education, giving a voice to migrant women who otherwise might be silenced (Ardener 1977, 1978b).

The RANZCOG reinforces that it should be an informed decision, and it is the right of the patient to request an elective Caesarean section (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists 2021b). Nonetheless, women have difficulty advocating for their needs and right to request a Caesarean section, especially in the public health system (Escobal et al. 2022; Romanis 2019; Romanis and Nelson 2020), especially if

they are migrants with limited English (Billett et al. 2022). In practice, it seems that the decision to grant an elective Caesarean section ended up being based on women's financial power and ability to afford top private health insurance cover, allowing the choice of a private obstetrician who will perform it.

Participants requesting an elective Caesarean section in the public health system did not have their care needs tailored to them. This research does not endorse having unnecessary medical procedures against medical recommendations. However, I identify the value of Doctor C's approach to these requests: to listen the patient, provide education and extended time to absorb the information and then reach an informed decision. Otherwise, migrant women will continue to be invisible in the delivery of health care and will have to adjust to mainstream practices. Migrant women in Canberra reported that they felt that if women had financial means to afford private health insurance with obstetrics cover, they could choose to have an elective Caesarean section. This belief is affirmed by the overall statistics for private and public Caesarean sections in the ACT. Between 2014 and 2016, 48.5% of private patients and 26.9% of public obstetrics patients delivered through a Caesarean section (Australian Capital Territory Health 2019). Otherwise, through the public system, it was close to impossible without a medical reason.

The interviews with the participants in Hamilton show that they had developed a good rapport with their health professionals and were satisfied with the care they received during the whole perinatal care. Therefore, they were more likely to accept the directive statement of a doctor on the grounds that 'doctors know best'. This is mainly due to a trusting relationship with people who provide care (Thompson and Whiffen 2018). Another aspect influencing this is cultural background. In some cultures, figures of authority are highly respected (Thompson and

Whiffen 2018). In addition, they referred to the cultural perception that the doctor's imposition of treatment was like receiving advice from elder family members.

In contrast, during fieldwork in Hamilton, I came across some health professionals' discourses that stigmatised migrant mothers. Unfortunately, some health professionals still informally stereotype women as 'weak' or 'lazy' for not wanting a vaginal delivery. Stereotyping is disempowering and may directly or indirectly affect women's mental health (Gavin et al. 2011; Hunt et al. 2012; Wisner et al. 2014). For example, women might feel that they are a failure for not having a normal delivery. However, none of the interviewed migrant women in Hamilton reported negative feelings about how their childbirth proceeded.

Issues of culture can be exemplified by midwife D from Hamilton, who drew attention to the stereotypes of bad and good mothers. The 'good patients' deliver babies without complaint about the Australian perinatal health care policies and procedures and are 'good' at following medical orders. Meanwhile, the 'bad mothers' will request Caesarean sections and episiotomy. Such stereotypes exemplify the challenges that migrant women face in receiving perinatal care in Australia. They display the relationship imbalance between the dominant culture and non-dominant groups. Further, the use of such stereotypes by health professionals goes against the Australian perinatal care health care guidelines discussed in Chapter 2. Health professionals have a duty to respect patients' cultural backgrounds, personal values and beliefs without prejudgement and stereotyping based on the professional's values and views.

Doctors have the right to end their clinical relationship with patients if they do not believe they are the best fit to deliver care. This can be justified when doctors think that they cannot assist with a patient's care because it is beyond their scope of clinical practice. Doctors do not need

to act against their personal beliefs to deliver care to a patient, but they should respect their views. In both circumstances, doctors can refer patients to other clinicians who can better assist the patient. Doctors who decline care due to conscientious objection have to ensure that the patient can seek alternative care through another health care provider via referrals and appropriate handover (Australian Medical Association 2019).

The case for conscientious objection needs to be transparent to the patient and the institution that employs the health professional invoking it. However, doctors have to make sure that they express their values and beliefs in such a way that they do not cause any distress to patients or deny emergency care that could be lifesaving (Australian Medical Association 2019).

In summary, there appear to still be discrepancies between the recommendations from health agency regulators in Australia that health professionals avoid imposing their values and beliefs in patients' health care and the actual practical delivery of perinatal health care to migrant women.

6.4. Themes arising across the perinatal care

6.4.1. Social support

As mentioned in Chapters 5, participants from Canberra and Hamilton created a solid social network with other migrant women to help them thrive while raising a young family in Australia. Despite feeling homesick, participants found the companionship of other migrants a positive strategy to fill the void of not having their extended family nearby. The positive influence of friendship was a common narrative between participants from both cities. They stated that despite the difficulties with having children in Australia, they felt content with their lives in Australia because of their social support. These social relationships can be formed through

family ties, peers, work, religious organisations, and not-for-profit groups such as the Mother Goose Program in Hamilton. Participants in both cities relied heavily on their peers and sometimes their parents for support if they were available, especially during difficult times.

Migrants frequently face difficulties establishing a social support system in a new country. Often, there is a lack of sense of community in metropolitan cities. Being in small regional cities such as Hamilton in Victoria, which has a welcoming community, can positively influence migrant mothers' perinatal experiences based. This is based on the existing evidence that citizens who feel that they belong to a community are less isolated, because social relationships can positively influence mental health and overall happiness (Diniz et al. 2015; House et al. 1988; Umberson and Karas Montez 2010). Having available practical help and emotional support can be a protective factor in mental health (Anderson et al. 2017; Doble et al. 2011; Hagaman et al. 2021; Mcleish and Redshaw 2019; Mendelson et al. 2013).

Migration to another country can itself be a major challenge, in so far as it requires adjustment to a new culture, especially in situations where a migrant person might feel socially isolated (Delavari et al. 2013; Morris et al. 2009; Renzaho et al. 2008). The decision to leave the home country and move to a new one can be a traumatic experience for some individuals (Beneduce 2016; Guintivano et al. 2018; Vigod et al. 2017). The acculturation process by individuals should not be underestimated as an easy process. It can be a significant challenge for any migrant, whether healthy or not. Cultural heritage loss, lack of opportunities to practice traditional rituals, identity loss, and lack of social support from individuals coming from the same ethnic background are all major stresses (Delavari et al. 2013; Riosmena et al. 2015). This challenge is added to the physical and emotional changes that a migrant woman may go through during pregnancy and postpartum, potentially creating a possible additional trigger for perinatal depression and anxiety disorders (Collins et al. 2011; Navodani et al. 2019)

Access to social support can also be influenced by the mother's background. Some of the interviewed mothers come from patriarchal societies such as Brazil, where the social norm is that women are expected to be the primary carers of children. Brazilian men are more likely to earn the largest part of the family's income (Samara and Da Costa 1997; Sifuentes 2014). Therefore, there is a social acceptance that fathers from a Brazilian background have limited involvement with the practical side of raising a child. Their focus is to return to work and guarantee financial provision to the family (Prusa et al. 2019). The father's work responsibilities and necessary absences are another reason that participants relied on friends to avoid social isolation while their primary focus was raising their children. While the nationality of several participants influenced their experiences, it is worth emphasising that this study did not aim at researching individuals coming from any particular nationality. Instead, it focused on understanding how migrant women, in general, navigate the Australian perinatal health care system. Nonetheless, I discussed in Chapter 3 that one of the limitations of this study was the difficulty of gathering the experiences and views of migrant women from a range of CALD backgrounds.

I found that the 'Asian Party' strongly impacted the Hamilton participants' satisfaction with the local perinatal health care system, as evidenced in the support and advice members of the 'Asian Party' provided to each other. The migrant women from the group who had experience with the health system assisted others. For example, Isabel, a first-time mother, used to ask Camila questions about antenatal care, as Camila had already given birth in Hamilton. They used their friendship circle to ask for recommendations about health care providers in the city and general advice about looking after a newborn child. Fiona, one of the very active participants in Hamilton's migrant group, was a key support person to several participants in this study. She assisted with their queries about the health system in Hamilton. This

demonstrates that the social support assisted migrant women to navigate the Australian perinatal care system and empower them to seek health professionals that where likely to listen to their needs and they felt comfortable with. Subsequently, giving migrant women in Hamilton visibility in the perinatal health care system and in their view a positive perinatal care experience.

Intergenerational support was another characteristic of the social dynamics in Hamilton. Women who attended the Mother Goose program reported that the elderly volunteers assisted them with English, such as filling out forms for Centrelink and Medicare. The support from these elderly volunteers enabled migrant mothers to navigate the perinatal health care system in Hamilton and find a place in Australian society. They said that they belonged to the city, and the city was welcoming. Some of the participants in Hamilton, like Lorena, had previously experienced life in other regional and metropolitan cities that were not welcoming to migrants. They reported that this impacted their ability to create social connections and settle happily. Eventually, these participants decided to aim for a better quality of life, and Hamilton was where they decided to settle permanently after finding a sense of belonging there. Therefore, volunteers and peers played a significant role in enabling migrant women to thrive in the community and empower them to navigate the Australian health system. This study endorses programs involving peer and volunteer support to migrant women navigating the perinatal health care and to avoid social isolation. For example, The Mother Goose program was an important social outlet for migrant women in Hamilton. The role of community support groups is crucial in preventing mental health illness and social isolation (Deering et al. 2016; Elsenbruch et al. 2006). Similarly to the Mother Goose program in Hamilton, the Happy Mothers Program in Melbourne caters to Assyrian Chaldean mothers in the Northern suburbs and tackles their social isolation and improves health outcomes during the perinatal period (Northern Health 2019).

One participant from Hamilton said she felt socially isolated. Despite multiple attempts of other migrant mothers in the city and the Mother Goose coordinator, the participant preferred to socialise only with other families from Bangladesh, or at least from the Muslim faith. Her husband heavily influenced this decision and expected her to stay at home to look after the children. Because of the lack of social options, the participant remained reclusive. The couple were searching for jobs in larger regional cities or metropolitan areas with a higher density of expatriates from Bangladesh; their cultural needs were not met in Hamilton. The feelings of acceptance and contentment in a new country and city are subjective and variable. All the other participants from Hamilton felt that their cultural needs were met, and they felt accepted. However, although Hamilton had a welcoming culture towards migrants, migrants might still feel they do not belong.

Migrants from a minority group without family support or a strong social network in Australia might face challenges to understanding the perinatal care system and making sense of its rules and procedures (Hoban and Liamputtong 2013). Minority cultural groups' insights and how they face the Australian perinatal care system, how they navigate it without assistance, and the barriers to access care need to be taken into account in planning and policies (List 2005) – particularly the needs of individuals with low health literacy or poor understanding of the Australian health system. Therefore, policymakers should consider the narratives of the people who are affected by their decisions and policies. This is supported by Orbe (1998) interpretation of muted groups theory, which argues that individuals from minority groups, especially from a CALD background, are not sufficiently recognised in the policy process. For example, during elections, the interest of minority groups are dismissed, and policies are designed to attract voters from dominant groups (Kleinman 2004; List 2005; Orbe 1998).

Organised peer support is one option to address migrant women's social isolation during the perinatal period, improve health literacy about the Australian perinatal care and lead to better health outcomes (Fieldhouse et al. 2017; Mahlke et al. 2014; Naslund et al. 2016; Wisner et al. 2014). Therefore, I argue that organising a peer support program overseen by qualified health professionals can be beneficial to support migrant women using the Australian perinatal health care services, as reported by Tsivos et al. (2015). Further, peer support in perinatal health can improve migrant women's health literacy and facilitate their navigation of the Australian perinatal health care system, similar to informal social networks, which many migrant women might have difficulty forming.

6.4.2. Culturally safe health practices

The interviewed health professionals in both cities were certain that they are open to discussing patients' particular cultural requests related to their perinatal care. The only discrepancy between the health professionals' views was of midwife D in Hamilton, who disclosed her perceived views of migrant women stereotypes especially regarding their childbirth preferences. Such attitudes can lead to the essentialisation of culture and dismissing what migrant women might perceive as important for them while receiving perinatal care. Additionally, health professionals preconceptions and assumptions about a patient's CALD background might lead them to ignore what the patient might perceive as distressing (Curtis et al. 2019; Kleinman 1997). Although midwife D expressed her views against requests by migrant women for elective episiotomies and Caesarean sections, the interviewed migrant women in Hamilton were very satisfied with her care. From the perspectives of the interviewed migrant women in Hamilton, midwife D had continued to provide sensitive perinatal care; she did not express her essentialising beliefs to them. It may be that she set these beliefs aside while following competent care. However, the interviewed women win Hamilton did not seem

to have any specific issues during their perinatal care that they needed to advocate for in comparison to the interviewed women in Canberra.

The experiences of the participating migrant women from Canberra differed from the interviewed health professionals especially regarding childbirth. This because some participants felt that they had to argue with multiple health professionals to be heard. This study revealed that for several women in Canberra what was important for them was dismissed by some health professionals. I would argue that there was an element of power imbalance between patient and health professional and what they considered important during the perinatal care (Delaney 2018).

Moreover, these migrant women's concerns were not heard or dismissed as not important led to situations of distress, which to some women was carried over to future pregnancies. Another possible explanation is that some health professionals over time might become settled on their role and be reluctant to change and adapt to the influx of new cultures and ideas into their workplace (Koblinsky et al. 2006; Solnes Miltenburg et al. 2018). This study highlights the important on continuing investment in the education to health professionals about culturally safe practices aiming to build better rapport with patients and consequently better health outcomes.

The interviewed health professionals in Hamilton and Canberra reported that they understand that education is fundamental when providing care to migrant women. This is so because migrant women may have different expectations of the Australian health care system than of their country of origin. Some women had had children overseas, and it was the first time they were pregnant in Australia. They might need assistance understanding how Australian

perinatal health care works and procedures they might not feel comfortable with. Rapport needs to be built between health professionals and patients. Often, migrant women have limited English, and it may be challenging to find reliable resources in their native languages with information about how the Australian perinatal care system works (Billett et al. 2022). In Australia, health professionals have access to resources and educational material from reliable and verified sources translated to several languages to provide to patients. It is their choice to disseminate these resources to patients or not. Furthermore, this study emphasise the importance of health professionals adopting culturally safe practices in their clinical work.

6.4.3. Interpreting services

This thesis found that interpreting services were underutilised amongst the interviewed migrant women in Hamilton and Canberra, supporting findings from other studies (Beagley et al. 2020; Kwan et al. 2023; Morris et al. 2020; Phillips 2013; Phillips and Travaglia 2011). The interviewed migrant women especially in Hamilton reported that often they were not offered an interpreter by the health professionals looking after them. Instead, there was a general assumption that the patient could understand enough or the expectation that they would use the patients' family as interpreters.

By contrast, all interviewed health professionals from both cities knew of the interpreting services and their free of charge use. The discourses from the interviewed health professionals from both cities reinforced other studies' findings that organising an interpreter was perceived as time consuming and often participants opted to use the patient's family member as an ad hoc interpreter (Beagley et al. 2020; Billett et al. 2022; Morris et al. 2020). Nonetheless, they stated that they did that when they perceived that there was not a conflict of interest between the parties and asked consent to the patient to do so. The interviewed health professionals

from Canberra stated that when they use accredited interpreters, they prefer to use telephone interpreting due to its easy access in comparison to trying to organise a face-to-face interpreter.

Additionally, the interviewed health professionals from Hamilton reported that they often try to pass by without an interpreter, due to the perceived difficulty with the logistics of organising an interpreter in a regional city – a belief which seems to highlight that the health professionals were prioritising face to face interpreters over telephone interpreters, who can be contacted in a less than five minutes. Similarly to other studies, I would argue that that the assumption that migrant women fully comprehend what has been discussed without an interpreter can mute migrant women's voices and their participation in the care they receive (Kwan et al. 2023; Morris et al. 2020; Stanzel et al. 2022). The absence of an interpreter can impact on migrant women's informed decision making regarding their perinatal care (Billett et al. 2022; Yelland et al. 2015).

It also impacts the communication between health professionals and patients, leading to difficulty with rapport building. For instance, one participant from Canberra who had a traumatic childbirth experience was not offered an interpreter and relied on her husband for interpreting. Once he was removed from the operating theatre, she lost the communication channel with the health professionals looking after her because of her clinical deterioration. She reported that she was in despair over not being informed of what was happening. Her account indicates that there was a great deal going on in the operating theatre to save both the baby and the mother. This created a situation of distress to her but due to lack of communication, at the very point when she most needed calming communication from someone in the room.

Despite this frightening event which resulted in an ICU admission, she stated that she was not offered debriefing by any of her treating team, beyond a statement that 'she was right' to request a Caesarean section. When adverse events occur, health professionals should be sensitive to their impact on the patient and how it is crucial to have an open communication with an interpreter present for migrant women coming from a CALD background about their clinical situation. In this case, the decision not to include a trusted interpreter in the room had resulted in escalation of her distress. Considering her Caesarean section was for eclampsia should have been considered in developing a plan for delivery, and should have resulted in prioritising elective Caesarean where language support could have been incorporated into the plan in advance. In this case, relying on her husband for language support was fraught as he could not be incorporated into an emergency Caesarean response.

It is important to highlight that migrant women have also the right to decline the use of an accredited interpreter. One migrant woman from Hamilton pointed out that she prefers to not have an accredited interpreter due to fear that the Government from her home country might be listening to it. This suggests that the acceptance of interpreting services may be constrained by fear of breach of privacy, despite health professionals' reassurance of the contrary (Billett et al. 2022). Nonetheless, it is recommended that health professionals should at least give the choice to migrant women to decline an accredited interpreter and avoid the assumption that it is not needed or would not be welcomed.

In summary, this study recommends further education to health professionals about the importance of the utilisation of accredited interpreters when providing care to migrants. This aiming to improve rapport building, informed decision making, reduce length of hospital admission and to improve health outcomes (Beagley et al. 2020; Kwan et al. 2023; Morris et al. 2020; Phillips and Travaglia 2011).

6.4.4. Screening for perinatal depression

All interviewed women in Canberra and Hamilton remembered being screened at least once for their mood during the perinatal period and filling out questionnaires about their mental health provided by their midwives and doctors. There was inconsistency in the responses for when the interviewed migrant women from both cities were asked about their mental health. Some participants were checked during the antenatal appointments but only received pamphlets about PD in the postnatal check-ups. Other women received pamphlets in the antenatal period but then had a discussion with the nurses in the postnatal period. Nonetheless, majority of the participants felt that during the postnatal home visits for health checks, the health professionals were more interested in the babies' wellbeing. The great majority of women did not remember being screened or questioned about their emotional wellbeing postnatally. They had clear recollection of the postnatal appointments, both at home and at the maternal and child health centre, focusing on how their babies physically examination, sleeping patterns, feeding routine and to check if the migrant women had concerns about their babies.

Health professionals from both cities reported that they were aware of the symptoms of PD, but they tended to worry more about it if women presented with a previous history of mental health illness and family violence - whereas early detection of antenatal depression is crucial to a better prognosis and avoiding an increase in the severity of symptoms and recurrence of depression in the postnatal period. Women who have high health literacy levels have the advantage of recognising the early signs of PD. They may still feel the stigma of perinatal depression, which can deter them from seeking assistance even if they have high literacy levels. Women tend to prefer support from informal services than formal help from health professionals, which is often associated with fear of being judged and stigmatisation

(Macpherson et al. 2010). Some women might even be afraid to share their concerns and worries with close family members and peers. The stigmatisation of PD is one of the barriers that discourage women from reaching out to family members (Faisal-Cury et al. 2021; Gelaye et al. 2016; Goodman 2009; Goodman et al. 2013; Legere et al. 2017; Misri 2007; Misri et al. 2010; Small et al. 2003; Willey et al. 2020a). For example, one of the participants in Canberra did not want to disclose to her husband and family her negative thoughts and anxiety immediately after her son was born. She said that she was afraid that others would judge her, and she would be categorised as a ‘bad mother’ for not enjoying motherhood. At first, her husband could not understand why she was not enjoying life as a new mother because he believed it should be her happiest moment. After her doctor explained that she was suffering from PD, he understood that PD was an illness and not a choice. If migrant women's voices are unmuted, and health professionals are open to listening to their needs, the treatment of postnatal depression can be more effective, especially when women are involved in the decision-making process.

Different cultures' perceptions of mental health disorders can be a solid barrier to identifying depressive symptoms. Barclay and Kent (1998) discussed the necessity of being aware that Western views and descriptions of mental illness sometimes cannot be easily translated into non-Western cultures. The authors stress that the stigmatisation of depression is different in Western and non-Western societies. This stigma can drastically impact women's lives in the short and long term. For example, Seeman (2008) wrote about the case of a Chinese immigrant living in Canada who had a previous history of psychotic symptoms. The woman became pregnant in Canada and received adequate antenatal care in a hospital, which was then closed temporarily due to an epidemic of the severe acute respiratory syndrome. The woman gave birth in an unfamiliar hospital. Even though she had an easy labour and a healthy baby girl, the staff thought she did not ‘react as expected’ by Western standards. The new mother acted according to Chinese culture, following her values and principles, which included

not talking with strangers and resting and avoiding cold food for forty days. The Western health professionals did not consider these specific Chinese beliefs regarding postpartum and insensitively decided that the woman was mentally unfit to look after her new baby. Seeman's (2008) article illustrates the dangerous outcome of unprepared, ill-informed health professionals treating migrant women with needs and beliefs. The scenario outlined above could happen in any hospital worldwide and could be avoided by training health professionals about the particularities and beliefs of different cultures.

The support from health professionals to validate women's symptoms of PD, especially early on, is crucial to reduce stigmatisation and empower migrant women to discuss their symptoms with their health providers and engagement in treatment. Therefore, it is important to reinforce education to health professionals about the importance of culturally safe practices aiming to build rapport and trust with patients (Willey et al. 2020a, b). This can favour migrant women's visibility in health care in order to advocate for their perinatal care needs. Perinatal psychiatry should adopt a cultural approach to providing more effective treatment for mental health diseases, especially among non-Western patients. This is significant, because the perspectives on depressive symptoms change dramatically between cultures (Kleinman 1997). Consequently, it can be argued health professionals adopting culturally safe health practices and empowering migrant women to improve health literacy and help-seeking can lead to improvement in the representation of women coming from CALD background in research and health care policies.

The interviewed migrant women clearly remembered the large number of pamphlets they received about postnatal depression without discussion by health professionals about it. They were given the pamphlets to read at home and to seek assistance if needed. This is a current practice among health professionals in Australia. The pamphlets carry information about

valuable range of services that mothers can access if they notice any depressive symptoms and anxiety. One of the migrant women from Hamilton was able to recognise the PD symptoms and contacted PANDSI from one of the pamphlets she received to seek support. This participant came from a health background and had high health literacy. I would argue that I also recognised that in between the foggy moments that depression can bring, it might be hard for migrant women to go through several pamphlets in English, make sense of them and dial the numbers to book an appointment (Edge 2011). There is a missed opportunity from health professionals to provide support and education about the identification of PD's symptoms, its management and advice about the appropriate support services in the community for each case. Better education and support could empower migrant women to the navigate the Australian health care system.

6.4.5. Use of EPDS

The interviewed health professionals in Canberra stated that they do not frequently use the EPDS. The rationale was that the EPDS is sometimes difficult to administer to women from CALD backgrounds and with limited English. Clinicians can easily access the EPDS in 23 different languages through the Victorian government website (The Centre for Culture Ethnicity and Health). This scale is used to investigate cognitive and affective symptoms. However, EPDS is not appropriate for investigating somatic symptoms such as changes in sleep patterns, fatigue, and alterations to appetite (Small et al. 2003; Zelkowitz et al. 2004). There is a debate in the literature about using EPDS in the antenatal period (Melo et al. 2012; Stanley et al. 2006). As a screening instrument, the EPDS can overestimate the true prevalence of depression. Any type of scale used inappropriately without a deep analysis of the context of the patient can mislead health workers to a false positive diagnosis (Melo et al. 2012; Stanley et al. 2006). On the other hand, using EPDS and creating screening programs can provide

information to health professionals regarding women at high risk of developing depression and lead to correct diagnosis where depression occurs (Khanlari et al. 2019).

The interviewed health professionals from both cities stated instead of completing the EPDS for all their perinatal patients they base their assessment on the patient's history, evidence of risk factors for PD and presenting symptoms. Understandably, clinicians must build rapport with patients, and it naturally takes time for patients to develop trust in their chosen health provider. This allows patients to feel comfortable with sharing their mental health struggles and symptoms. Nonetheless, the interviewed migrant women in Canberra who used the shared maternal care model had difficulty building rapport with their midwives because the lack of continuity of care. I argue that clinicians should continue to use their holistic approach to diagnose PD in patients but also utilise the EPDS routinely. They can build rapport over time and add the EPDS to their routine assessment to strengthen their diagnosis and provide evidence-based care aligned to the Australian population whatever their cultural background, while allowing for cultural differences in understanding and expression.

The findings of this study also reveal the importance of using standardised and validated tools such as the EPDS, guaranteeing that women receive the best practice care whatever their cultural background. On the one hand, clinicians are ‘unmuting’ patients from the moment they take time to know their history and needs and adopt a holistic approach to managing mental health illness. But, on the other hand, the deliberate choice of not using a standardised tool to diagnose PD with women from CALD backgrounds may end up reinforcing their invisibility in the community by not offering a comprehensive and standardised approach in their assessment. This findings are consonant with the invisible communities theory, where disadvantaged groups are less represented in the design and structure of care (Schneider and Ingram 1993) .

6.4.6. Health professional's referral to mental health services

There were slight variations in the way health professionals in Hamilton and Canberra refer women to the perinatal mental health services. Nonetheless, all the interviewed health professionals expressed confidence about diagnosing PD and referring patients to mental health services. Hamilton relies on the perinatal mental health services located in Warrnambool. According to Nurse B, a senior maternal and child health nurse in Hamilton, referrals submitted from Hamilton requesting a perinatal mental health assessment in Warrnambool are normally actioned in 24 hours. The Perinatal Emotional Health Program (PEHP) provides the service, and their practitioners travel to Hamilton to provide care. The PEHP does not rely on referrals from health professionals; individuals can self-refer, reducing the barriers to help-seeking and early intervention. This model differs from the perinatal mental health services in Canberra, which only accepts referrals directly from healthcare professionals and normally has a long waiting list.

All the interviewed health professionals in Canberra reported that they are aware of the difficulties women face in accessing perinatal mental health services and the lengthy waiting periods. Therefore, these health professionals might refer migrant women with diagnose of PD to a psychologist in the community through the completion of a mental health plan and in parallel submit a referral to the perinatal mental health team. The interviewed doctors stated that they might prescribe antidepressants if clinically necessary and appropriate. Perinatal mental health referrals in Canberra are triaged by a nurse over the telephone. I argue that it is already difficult for women to initiate help-seeking and disclose their negative thoughts towards their newborns. It carries a heavy load of shame, a sense of failure as a mother and a stigma (Willey et al. 2020a, b). A triage over the telephone can be deceptive, and women might downplay their symptoms. It would be more beneficial to have an appropriate face-to-face

appointment in order to allow women to build rapport with health professionals and feel comfortable at disclosing their symptoms (Willey et al. 2020b). It is important to note that this study was conducted before the COVID-19 pandemic. Because of the pandemic, care delivery had to be quickly adapted. Telehealth is a valuable tool to bridge the challenges the health system faces with restrictions to face-to-face appointments.

Although several studies have pointed out the importance of perinatal mental health services for parents, there is still a shortage of these types of services in Australia (Burfitt 2023; Charmayne 2022; The Australian Health Ministers' Advisory Council 2008). Furthermore, there is a slow development of perinatal mental health clinics, especially due to the lack of trained personnel and funds (The Australian Health Ministers' Advisory Council 2008). Stanley et al. (2006) reported the same scenario happens in the United Kingdom, where the lack of mental health clinics for women is linked with an absence of screening for perinatal depression. The lengthy waiting periods for women to access the Australian perinatal mental health services affects women in general and not only migrant women. Therefore, this study highlights that the lack of support services when women are diagnosed with PD affects majority and minority groups. Nevertheless, migrant women are more vulnerable to the development of PD due to additional risk factors in comparison to Australian born women such as loss of social support, language barrier and different cultural needs (Milgrom and Gemmill 2015; Navodani et al. 2019).

6.5. Strengths and limitations of the study

This study presents the views and experiences of two type of participants: migrant women using the Australian perinatal care services and health professionals delivering these services. One of the strengths of this study is that it gives voice to participants to express their views and perceptions of the perinatal care in Australia using direct quotes (Pearson et al. 2012),

elevating the voices of individuals who belong to non-dominant groups as discussed in the muted groups theory (Ardener 1978a; Ardener 1977, 1978b). Additionally it also provides visibility in research to minority groups such as migrant women who are structurally invisible (Schneider and Ingram 1993).This is possible through qualitative research adopting thematic analysis using inductive coding. Following Orbe (1996) who stresses that traditional quantitative research is not adequate for the study of the needs of minority groups, I have attempted to interpret the participants' narratives to uncover rich, individualised insights into these experiences. Orbe (1996) argues that the quantification of migrant women's responses about perinatal care would not be sensitive to the specific cultural needs of minority groups, nor would it allow these non-dominant groups to express their views about the perinatal care they received in Australia (Orbe 1996). The reality of the Australian public health system is that it will attempt to cater to the broadest population possible, and so to capture the voices of migrant women research targeted at migrant women's experiences is vital.

Although there are several studies on perinatal health services to migrant women living in developed countries, these tend to focus on particular ethnic groups. While this is essential to a deep understanding of the needs of specific cultures (Hunt et al. 2012; Small et al. 2003; Wisner et al. 2014), it may not enable us to examine the broader 'migrant' experience, and how health care services may or may not cater to migrants. The benefit of choosing a diverse sample is that researchers can come closer to capturing the full spectrum of experiences of migrant women using the perinatal care services (Billett et al. 2022; Navodani et al. 2019). I attempted to capture the views of migrant women living in Australia, whatever their cultural background, on the perinatal health care they received. Through their narratives I tried to understand how migrant women navigate the perinatal care services and their experiences about it, including if they were screened for perinatal depression during their care and were diagnosed with PD.

As a means to increase the transferability of the findings from this study I have provided a thick description of the participants and myself throughout this thesis - detailing the experiences and views of migrant women who had given birth in both cities. The thick description of the participants and their communities can assist other researchers to better understand the full picture of the participants' backgrounds and their complex experiences in perinatal care (Younas et al. 2023). I described the migrant women's community in detail and provided a reflexion of my position as an insider-research in the reflexivity Chapter 4. These reflexions and the transparency about being an insider-researcher contributed to the trustworthiness of this study (Kiger and Varpio 2020; Nowell et al. 2017). In addition, these can facilitate other researchers to transfer the findings of this thesis into their own settings (Kuper et al. 2008; Nowell et al. 2017; Slevin and Sines 2000).

Qualitative research is a powerful tool to gather meaningful data, especially to capture individuals' perceptions and views about a particular topic. Nonetheless, the difficulty of reproducing such a study, due to its interpretative sociological nature and the unique set of data, may be considered a limitation. Thus thematic analysis often faces a trade-off between validity and detailed specific analysis with can impact on reliability (Nowell et al. 2017; Slevin and Sines 2000). It is possible that my own background has influenced the thematic analysis, though I have tried to be transparent in my positionality to enable others to understand and consider my analysis in the light of this (Nowell et al. 2017; Slevin and Sines 2000)

Another limitation of this study is that despite my recruitment efforts in both cities via posters in several health centres, libraries, hospitals, and maternal and child health centres, the most efficient recruitment strategy proved to be a snowballing potentially leading to sampling bias. As a result, the migrant women recruited for this study had similar socioeconomic backgrounds and the ability to communicate in English.

Of all the migrant women interviewed in Hamilton only one did not come to Australia due to work purposes. This participant initially came to Australia on a refugee visa and was settled in Melbourne. Eventually, her husband was able to find work in Hamilton, which provided better working conditions, salary, and affordable accommodation. This is heavily linked to the fact that since 1945 the Australian Government migration program has prioritised processing visas of skilled migrants, and the resettlement of refugees to regional cities in order to address workforce shortages (Spinks 2021).

The small sample size limits the ability of this study to truly represent the views of migrant women living in Australia and the health professionals providing perinatal care to these women. This is attributable to the difficulty with recruitment of migrant women especially in Canberra. During the recruitment process I realised that despite my attempt to recruit migrant women from diverse CALD backgrounds my own background attracted more women from Brazilian background. Moreover, in Canberra, six out the ten migrant women interviewed in this study were from Brazil. Since I am a dual citizen of Brazil and Australia, I used my own background to reach out to this specific community and to use snowball sampling. Thus, this impacted on the diversity of my data and provided a partial picture of migrant women's experiences with the perinatal care in Australia. The focus in my study on the impact of denial of elective Caesarean sections may reflect the over-representation in my study of participants from countries with low numbers of registered midwives and high numbers of obstetricians (reflected in globally high rates of elective Caesarean sections among middle-class women).

I was not able to fulfill my goal to completely obtain data from a diverse range of cultural backgrounds. However, the dissemination of my data can assist future researchers to create larger studies to generate a country wide representation of these experiences.

This study also had a limited number of participants in Hamilton, yet I was able to identify and interview every migrant woman in town who at least in the past five years was a consumer of the perinatal care services. Other migrant women in Hamilton did not meet the inclusion criteria of being a consumer of the Australian perinatal care services in the past five years. Although this study aimed to recruit participants from a diverse range of background cultures, the recruitment in Hamilton yielded' only participants from Asia. Even though, this study was impacted by the low number of participants and the limited cultural representation I focused on giving a voice to the participants through their narratives and their experiences resulting in rich data about the Australian perinatal care services. This provided valuable insight into the experiences of the migrant women living in Hamilton.

Nonetheless, the reduced number of participants is a limitation of this study and I do recommend further studies with larger samples to provide a comprehensive representation of migrant women in Australia.

The interviews with health professionals were also only possible through snowballing and my face-to-face requests at the Hamilton Base Hospital and Maternal Child Health Centre. Face-to-face requests creates trust and enabled participants to open about their experiences. The snowballing recruitment of health professionals in Canberra happened via professionals working at the Canberra Companion House, a comprehensive non-governmental community service to refugees, asylum seekers, and migrants who had suffered and experienced trauma and torture and are now living in Australia. Therefore, there was a risk that health professionals linked to services to people coming from different CALD backgrounds would be more aware of cultural safety while providing perinatal care services, which might create a bias in the findings. Nevertheless, there was a rich amount of information revealing the differences between the

interviewed health professionals' beliefs and approaches to perinatal care services, especially mental health services, for women from different ethnic groups.

Another limitation of this study was the fact that some interviews with health professionals were brief due to clinician's time constraints. Therefore, this highlighted the pressures experienced by professionals especially in the public health system. I have also experienced this pressure when working in Melbourne's public health system for the past seven years. I have first-hand experience of the pressure health professionals face with limited resources and staff shortages. Nonetheless, overall, I was still able to collect rich data from all the interviews with health professionals and the key information.

This study cannot provide a comprehensive review of perinatal mental health services in both cities because of the difficulty of recruiting migrant women living in Canberra and Hamilton who had experienced antenatal and postnatal depression. This can be explained by the fact that mental illness is still highly stigmatised. It might also be due to the reluctance of participants to talk about their negative perinatal experiences. Even positive perinatal experiences are often hard to communicate because this is a highly private moment in women's lives. Nonetheless, this study did not focus on participants diagnosed with perinatal depression and their views about it. It aimed at gathering the perinatal care experiences of migrant women from different cultural backgrounds living in Canberra and Hamilton.

6.6. Summary

Chapter 6 reflected on and analysed the common themes identified in this study. The discussion was divided by the identified themes in each specific perinatal stage and also themes across the perinatal care. In the antenatal period I discussed the dissatisfaction among

some migrant women in Canberra using the public maternity shared care services with the lack of continuity of care and the high turnover of midwives providing perinatal care. On the other hand, migrant women in Hamilton had a positive view of the antenatal care service due to its continuity of care and supportive staff. I then discussed migrant women's reported challenges during childbirth in Canberra and that the interviewed participants had difficulty negotiating their needs with Australian health professionals, especially elective caesarean sections. I also discussed that migrant women in Hamilton had overall a positive experience during childbirth and felt that their needs were met.

Nonetheless, I discussed the one example of a health professional in Hamilton who disclosed some stereotypes of migrant women during childbirth requesting for example medical interventions. However, all interviewed health professionals in both cities reported being open to discussions about medical procedures and requests from migrant women. Additionally, I reported that some women had traumatic childbirth experiences that led to emergency caesarean sections. Participants who had traumatic experiences stressed that it impacted their mental health and self-esteem and led to a feeling they had failed as women.

I then proceeded to discuss that all participants from both cities reported overall satisfaction with their inpatient postnatal care. However, they revealed that the only negative aspect of the postnatal care once discharged from hospital was that health professionals focused on their newborn's wellbeing, and there was limited attention to their emotional and physical wellbeing as new mothers. I therefore recommend a holistic approach in the health checks in the postnatal period including screening for PD.

I followed with the discussion about the positive impact of migrant women's social relationships on their emotional and physical health outcomes throughout the perinatal period. The study found that the migrant women participants formed a strong social network in the absence of the physical presence of their close relatives and this positively impacted participants' understanding of the perinatal care system and their adaptation to it. It also reinforced the importance of peers and volunteers support in the community and its positive impact on migrant women's wellbeing. I discussed that the lack of continuity of care might contributed to the participants' difficulty building rapport with health professionals, making them feel insecure and anxious when they had to recount their painful stories several times.

I also outlined the positive influence of the PCC and health professionals' cultural safety when providing perinatal care to migrant women living in Australia. I highlighted that health professionals' beliefs should not influence the treatment provided to patients and the importance of empowering migrant women to make informed decisions about their health care.

The participants' experiences using Australian interpreting services were reviewed. Canberra's health professionals agreed that they frequently use interpreters, especially over the telephone, through the translating and Interpreting Services. However, health professionals in Hamilton often attempted to 'pass by' without an interpreter because they felt that interpreting services are time-consuming. Interviewed migrant women in Canberra and Hamilton were not offered an interpreter and often relied on their partners for interpreting. I stated that the interpreting services might be still underutilized in Australia despite being free of charge for health professionals. Health professionals from Hamilton reported that often it is time consuming to organise an accredited interpreter and they might utilise an ad-hoc interpreter such as family members. Health professionals in Canberra reported being familiar with telephone interpreting and using this as their preferred interpreting method.

Afterwards, I discussed whether health professionals from both cities are aware of PD and the EPDS. Nonetheless, the majority of health professionals stated that they tend to screen PD women who might present risk factors such as history of mental health illness, trauma and violence. They stated they do not necessarily use the EPDS as part of their routine perinatal care appointments.

The interviewed health professionals reported that they screen migrant women for PD. The EPDS was not regularly used amongst the interviewed health professionals, who often relied on the patient's history and symptoms. Their reason to limit the use of EPDS was that they believed that the tool is difficult to apply to women from CALD backgrounds. I discussed the recommendation of a standardized approach for screening for PD including the consistent use of the EPDS.

I then examined the referral pathway interviewed health professionals chose once they diagnosed migrant women with PD. I found that women living in Hamilton had quicker access to PEHP services due to the easier availability of these services. The main difference was that Hamilton had reported quicker access to perinatal mental health services in comparison to Canberra. In addition, women can self-refer to PEHP and do not have to rely on health professionals to initiate the referral. Meanwhile, health professionals in Canberra tend to prepare a mental health plan, use the medication if applicable, and in parallel, they complete a referral to Canberra perinatal mental health services because of their long waiting lists.

Finally, in this chapter, I discussed the study’s strengths and limitations. The next chapter gives an addresses the practical and theoretical implication of this research.

Chapter 7. Conclusion

This research project produced several findings that addressed the following research questions: What are the views of migrant women living in Australia about the perinatal care they received in Australia? What are the views of health professionals about the challenges of delivering care to migrant women living in Australia? What are the health professionals' pathways to identifying migrant women with perinatal depression and subsequent referral to perinatal mental health services?

This research focused on two locations: a regional city (Hamilton, Victoria) and a metropolitan city (Canberra, ACT). This study did not focus on any particular culture and aimed to investigate how migrant women from different cultural backgrounds navigate the Australian perinatal care system. Treating cultural influence as relevant but not a key explanatory factor enabled this research to avoid essentialisation of the culture itself.

This study addressed a gap in the literature and research into the representation of minority groups' opinions in the perinatal care they receive in Australia. The desire to contribute rich, case-based data to current understandings on the position of such groups during perinatal care was one of the driving forces to my study.

The research findings support the idea that social support is crucial to migrant women during the perinatal period It also finds that continuity of care is crucial to migrant women along with culturally safe practices. The rest of this chapter explains the conclusions of the research regarding the perinatal care in its three different periods: antenatal care, childbirth and postnatal care, and how this can potentially affect the way perinatal care is delivered to migrant women in Australia.

7.1. Antenatal care

Overall, the interviewed migrant women perceived the antenatal care as positive in both cities. The dissatisfaction of some participants in Canberra with their antenatal care was due to the lack of continuity of care while using the maternity shared care model. Participants in this model reported that they saw several midwives throughout their antenatal care, and at times it was difficult to build trust in them. Additionally, participants in this group found particularly challenging having to summarise their history every time they went to an antenatal appointment, especially because part of their stories were painful or complex. Therefore, I suggest the expansion of the maternal care model with exclusive midwives as in the system in the Birth Centre to assist with continuity of care. It is understandable that this would pose a challenge to the health care system due to shortage of staff and funds. Nevertheless, it is an alternative that could be further explored in future studies and review of current health policies. This would allow migrant women to build better rapport with the health professionals tending to their perinatal care needs but also empowering them. This model would support migrant women to have a stronger voice to advocate for their needs and be more visible in research and policy making.

The health professionals interviewed did not routinely screen for perinatal depression using the EPDS. They might use the EPDS if the patients have a history of mental health disorders, belong to vulnerable groups, or struggle during the antenatal period. It is not common to use the EPDS in all postnatal check-ups. Therefore, there is a chance that women are not screened for perinatal depression in some cases, as they may not present with symptoms or factors that could lead to the development of PD, such as a history of mental health illness. It appears there is a missed opportunity to identify PD in early pregnancy. The consensus of the 2019 Australian Perinatal Care Guidelines established that it is strongly recommended to complete the EPDS in one of the first prenatal appointments and then repeat it in later stages of the

pregnancy. Consequently, it is recommended to invest in training for health professionals involved with the diagnosis of perinatal depression to use the EPDS and routine screening of PD even in the absence of PD symptoms.

7.2. Childbirth

In contrast to the migrant women's positive experience in the antenatal period, some of them reported negative experiences during childbirth, especially of prolonged labour and emergency Caesarean section. Some migrant women from Canberra felt that they were not listened to during childbirth, and medical procedures were not properly explained, especially if medical emergencies were in place. In contrast, participants from Hamilton felt that the childbirth was not rushed, and their needs were listened throughout the whole process. In their perceptions, the health professionals involved in their babies' care were supportive and kind. The remarkable finding is not that Canberra women reported a difficult time in childbirth. The recent report by Keedle et al. (2022) would suggest that their experiences are shared by a large number of migrant and immigrant women. Rather, the remarkable finding is that women in Hamilton did not report distressing childbirth experiences.

Some women living in Canberra felt pressured into a type of childbirth that they no longer agreed with, such as in the case of more than 24-hour labours that proceeded to emergency Caesarean sections. These women felt that health professionals did not fully explain procedures or debrief them after the emergency Caesarean sections. Participants in Canberra also reported that lack of explanation increased their anxiety and created distress while undergoing labour. This in turn provoked negative outcomes in the postnatal period. For example, participants reported a lack of confidence in looking after a newborn and feelings of failure for not having a vaginal delivery. As a result, one of the interviewed women developed PD.

On the other hand, the interviewed health professionals were confident that they are sensitive to migrant women's needs and challenges while navigating the Australian perinatal health system. For example, health professionals in both cities reported that they could negotiate and mitigate requests that are not compatible with the best evidence-based treatment, such as elective Caesarean sections. Nonetheless, they stated that they might refer migrant women to different services to decide about the procedure they are requesting. In practice, though, women are generally more likely to be granted elective caesarean sections if they have private health insurance. This finding suggests that health professionals may be overly sanguine about their ability to support women in labour in ways that are enabling and positive.

Thus, I suggest a revision of the education and training provided to health professionals regarding open communication with patients, and the reinforcement of PCC and patient's autonomy to make informed decisions about their care. This could potentially assist with the reduction of migrant women's experiences of traumatic childbirths and feeling that their needs are not met by health professionals. The creation of specific childbirth advocates employed by hospitals may provide a way to support women before delivery and create a more open environment in which women can express their needs and have them heard.

7.3. Postnatal care

The migrant women's narratives revealed that after childbirth, health professionals focused on the baby and that minimal attention was reserved for the mothers. In addition, participants reported that health professionals only vaguely checked their emotional wellbeing and physical recovery postpartum. Accordingly, I recommend further education and training for health professionals about the importance of routine assessment of mother's physical and emotional

wellbeing in the postnatal period. This would increase the ability to capture any potential risk factors for the development of postnatal depression. This measure could also impact on non-migrant women who face the similar issues in the postnatal care.

In general practices the six-week baby check and the post-natal check are usually combined into one item charged to the mother. Since the postnatal baby check is structured around the many items which need to be checked for a baby (tests for hip dysplasia, cardiac health, neurological development, infant settling, hearing and vision, in addition to growth), the specific checks for a mother – which include discussion of breastfeeding and family planning – often are telescoped. A longer bespoke Medicare Benefits Schedule item on Postnatal health should be considered in addition to the baby check which would incorporate the EPDS. This would be analogous to the Heart Health Check item, used for age groups at most risk of cardiac ill-health.

Overall, the study reveals that migrant women living in Hamilton were well supported by their local community and felt they belonged. If necessary, these women could access the perinatal mental health services quicker than in metropolitan city such as Canberra. Usually, regional cities have limits on resources in health care and new migrants might have difficulty integrating into small communities. The positive examples of social support for migrant women are key indicators that social support programs are beneficial and should be further expanded. Hence, my recommendation for additional funds to social support services during the perinatal care period, especially the use of volunteer and peer support programs for migrant women.

7.4. Applied implications of the findings

7.4.1. Practical implications

Social support is vital to all migrant women living in Australia. It positively impacts their emotional wellbeing and empowers them to navigate the Australian perinatal health system. Therefore, this research indicates that it would be beneficial to invest in peer support programs during the perinatal period. Additionally, volunteer elders could assist with supporting women at risk of developing PD or even as a routine practice during perinatal appointments, similarly to the way student midwives are paired with women during their perinatal care.

As my research shows, women are dissatisfied with how care in the postpartum period focuses only on the baby's health and their wellbeing seems to be secondary, as if women are only a receptacle. Therefore, it is crucial to increase awareness of the necessity of providing holistic care in the postnatal period. This is more than an issue of training; it requires formalising the role of mental health screening in post-partum care, and creating a longer assessment item under the Medicare Benefits Schedule, or a capitated payment for practices for people who had assessed women after birth using the EPDS.

The model of support offered by PANDSI in the ACT is a successful example of practical support that can be offered to women and families suffering perinatal depression. PANDSI offers support groups where women can share their stories and give hope to each other. There are also exercise groups available where mothers can bring their babies and undertake some physical activity of their own.

These support groups could be expanded to target non-English speaking women, similar to a trial run conducted by Northern Health in Melbourne and developed by Murdoch Children's

Research Institute. In July 2017, the hospital launched the Happy Mothers Assyrian/Chaldean Group Pregnancy Care Program at their Craigieburn Centre. The program targets newly migrant women or refugees, especially from Iraq (Northern Health 2019). These women are normally more at risk of developing negative perinatal outcomes, as navigating a foreign health system can be overwhelming and complicated due to language barriers. The group not only focuses on perinatal care but also aims to tackle women's social isolation and enable better early childhood health.

Another practical measure to support migrant families struggling with perinatal depression would be the creation of volunteer groups that would visit these families at least once a week, similar to the postnatal visits that nurses do in the ACT. However, these visits should focus on women's perinatal depression. The aim of this program should be to promote emotional wellbeing and social support for women diagnosed with perinatal depression, without having to rely on public perinatal mental health services, where there are generally long waiting lists. This research study highlights the importance of reducing waiting periods for women diagnosed with PD to receive care through the perinatal mental health services.

Finally, it is crucial to invest in and guarantee further training of health professionals involved in the perinatal care of migrant women to raise awareness of providing a more holistic approach during postnatal care. The women in this study felt that the focus of postnatal visits was on the baby. Training in and awareness of the use of interpreting services is another recommendation to Australian health professionals, because this study identified that migrant women were not offered an interpreter during their perinatal care.

7.4.2. Theoretical implications

Even though women might belong to a minority group, the muted groups theory does not necessarily apply if services are adequately put in place and if, for example, the local community is supportive and welcoming of new immigrant people. This conclusion arises from this research's interpretative study of Hamilton. In Hamilton, the influence of intergenerational volunteers that were willing to support new migrant women living in their city is shown to be beneficial. All the interviewed participants in Hamilton unanimously reported that the support of the Australian older women in their community was a major boost to their confidence in being a mother and helped them to feel accepted as migrant women in a predominantly Anglo-Saxon community. Further, volunteers helped the participants to navigate the Australian health system also enabled them to 'fit in' the Australian society without leaving their customs and beliefs behind. The result of my thesis expands understanding of the theories about Invisible communities and muted groups theory. I recommend that further studies in perinatal health care to migrant women adopt these theories especially when analysing a larger cohort of participants.

On the other hand, the migrant women interviewed who were living in a metropolitan city with minimal or no family support were silenced by the needs of majority groups. They seemed to be lost in the mainstream and in a perinatal health care system that is under pressure due to a substantial increase in population in metropolitan areas. This growth in numbers and needs, unfortunately, is not directly translated into more funds to support the increase. It is important to highlight that even women not coming from a CALD background might struggle to access the perinatal mental health care system (Longman et al. 2017; Rolfe et al. 2017). Not only do migrant women have difficulty accessing perinatal mental health services, but Australian women also do, especially if they come from vulnerable backgrounds which may include

violence, drug and alcohol abuse, unsupported single parenting and women with a history of mental health illness.

7.4.3. Future Research

Further research should be conducted to investigate health professionals' perceptions of the work they deliver in perinatal care against the reality of their outcomes. This is especially relevant to this study's findings regarding the migrant women's narratives about the perinatal care they received and discrepancies between these and the health professionals' views of the perinatal care they offer to women coming from CALD backgrounds.

Social support was a key theme in this study, and participants unanimously reported that their social network had a positive influence on their well-being and feeling of belonging in the community. Therefore, peer support is a valuable tool for people suffering mental health challenges to facilitate their recovery and is a cost-effective and efficient way to bridge the gap of limited mental health services available in Australia. This study's finding on the positive impact of older Australian women who volunteered in the Mother Goose program in Hamilton on the lives of new mothers, especially migrant women who are at risk of developing PD, demonstrates that further research into and investment in peer support in perinatal care and perinatal mental health care are necessary.

It would be beneficial if future projects focus on gaining the views of a larger number of participants from different Australian metropolitan cities and regional cities. This would provide a better insight into the difficulties migrant women face in different Australian states and territories, and the approaches that health professionals adopt to provide perinatal care to migrant women.

Appendix A. Recruitment flyer

Australian National University

Medical School - The Australian National University

Calling for mothers willing to participate...

Do current models of health care for new mothers meet the needs of immigrant women?

The purpose of this study is to critically assess the current model of perinatal health care services in Australia from the perspectives of immigrant women and health professionals

Who are we seeking?

✓Immigrant mothers who had their baby in Australia

✓It is necessary to be older than 18 years

✓Mothers coming from a diverse cultural background

What does participation involve?

Participation involves a confidential face to face interview with the researcher for approximately 1 hour. You will be asked a series of questions associated with your experience of having a baby in Australia and things that should be improved.

Your participation in this project **is voluntary** and you may, without any penalty, decline to take part or withdraw from the research at any time prior to publication without providing an explanation. In the event that you decide to withdraw from this research, all information you provide will be destroyed.

You are also invited to pass the enclosed information to friends, acquaintances and/or family members who may be interested in learning about this research study. You are under no obligation to share this information and whether or not you share this information will not affect your participation in this study. Potential volunteers should contact the researcher directly.

What to do next if you are interested in participating

To book an appointment or for more details please contact **Ms Elaine Santos** on [redacted] email [redacted]

Appendix B. Recruitment letter

Do current models of health care for new mothers meet the needs of immigrant women?

My name is Elaine Cristina dos Santos and I am a PhD student at the Australian National University (ANU). I am writing to invite you to participate in this study, which aims to critically assess the current model of perinatal health care services in Australia from the perspectives of immigrant women and health professionals.

I am interested in talking to doctors and nurses who have looked after immigrant women during and after pregnancy on their views and experiences of perinatal health care for immigrant women – areas of risk, areas that work well, areas that could be improved on.

Interviews can be undertaken at a time and place of your choosing, and would be entirely confidential. This project has been approved by the ANU Human Research Ethics Committee (protocol 2014/769).

I have attached a participant information sheet, which describes more about the project. Please contact me if you would like to participate, or if you would like further information.

Yours sincerely,

Ms Elaine Cristina dos Santos,

Principal Investigator: The Australian National University, ANU House, 52 Collins St, Level 11, Melbourne VIC 3000,
Email:

Supervisor: A/Prof Christine Phillips The Australian National University, Medical School, Medical School, 54 Mills Road, Acton ACT 2601, Tel: 02 6125 7655 and Email: Christine.phillips@anu.edu.au

Appendix C. Interview schedule for migrant mothers

Interview Schedule for Migrant Mothers

Protocol Number: 2014/769

ABOUT PARTICIPANT:

How long have you been living in Australia? Where did you live before this?

What is your profession?

What is the age of your children?

EXPERIENCE OF HAVING A BABY IN AUSTRALIA

Did you have any family members living near you during your pregnancy and postpartum?

Did you have help with practical daily chores and/or help with the baby?

What kind of support did you receive from family members and/or close friends during your pregnancy and/or postpartum? [Probes: help with chores, advice on looking after the baby, taking care of the baby for brief periods]

Did you receive perinatal care from a public or private setting in Australia? When was that?

Can you describe your experience of having a baby in Australia?

Did you find that Australian health practices differed from your home country?

What are your views about Australian health practices related to your pregnancy care and postpartum period?

Do you use interpreters or a family member when visiting a health professional?

Did you find that you could understand the health professionals language/instructions about things to do in your pregnancy and postpartum period?

PERINATAL CARE EXPERIENCE

What were your experiences after the birth of the baby? How did you feel?

[If the person describes feeling sad] Did you tell anyone about this? Or seek help? [Why? Why not?] Did you get what sort of help?

What sort of things do you think could have made your experience easier about having a baby in Australia? [Probes: visits from an emotional support person? Longer time in hospital? More aware doctors and nurses?]

Appendix D. Interview schedule for health professionals

Interview Schedule for Health Professionals

Protocol Number: 2014/769

ABOUT YOU:

How long have you been a [health professional]? Do you speak any languages other than English? If so, do you consult in those languages?

ABOUT YOUR GENERAL PRACTICE POPULATION:

Can you describe your general practice population? What proportion of them would be from a multicultural background? What backgrounds?

ABOUT WORKING WITH NEW MOTHERS FROM MIGRANT BACKGROUNDS:

What considerations (if any) do you think would impact on your care for women from a multicultural background in the first year after their baby is born?

What is your approach to people who don't speak English well? [Probes: If they came with a friend or family member, would you use that person? Would you use a telephone interpreter? Not use one, but inform the mental health services so that they can use one?]

What is your approach when dealing with women from a culture/language that you have never had contact with professionally or personally? What are the major challenges?

Have you had experience diagnosing perinatal depression in women from a multicultural background? What do you think of the standard diagnostic instrument, the Edinburgh Post Natal Depression screening tool?

DIAGNOSIS AND TREATMENT:

What is your treatment approach for migrant mothers who appear to be struggling?

Do you need to adapt your recommended treatment when dealing with women from multicultural backgrounds?

How do you respond if a woman disagrees with your recommendations/prescriptions due to her cultural/religious beliefs or practices?

Could you describe the current ACT/Victoria current model of perinatal mental health care? What do you think about this model? How do you refer migrant women to this service?

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