Group Pregnancy Care
for women of refugee background

Formative Evaluation: Executive Summary

Group Pregnancy Care Partners

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Group Pregnancy Care for women of refugee background

Formative Evaluation: Executive Summary

Women from refugee backgrounds giving birth in Australia experience a range of poorer outcomes. Several factors are known to influence these outcomes. These include: communication and language barriers, lack of familiarity with Australian health care, low health literacy, ongoing impacts of trauma associated with flight from war and persecution in countries of origin, and challenges of settlement in a new country.

Group Pregnancy Care

The provision of effective high quality care during pregnancy is critical for the promotion of maternal and infant health. Group Pregnancy Care (GPC) is an innovative model of antenatal care, co-designed with refugee background communities and other key stakeholders. The program aims to create culturally safe places for women to connect, access information, and strengthen health literacy and self-efficacy, while also contributing to improved birth and family health outcomes.

Evaluation of Group Pregnancy Care

We evaluated two Group Pregnancy Care programs - *Healthy Happy Beginnings* involving the Karen community in Werribee, and *Happy Mothers* involving the Assyrian Chaldean community in Craigieburn.

Women participating in both Group Pregnancy Care programs were invited by MCRI bicultural researchers to participate in individual interviews. Interviews were conducted when women were approximately 30 weeks pregnant, and again approximately 4 months after the birth of their child. A total of 45 women took part in interviews; 27 completed interviews during pregnancy and 43 took part in postnatal interviews. Each interview was undertaken in women's preferred language.

We also used routinely collected hospital birthing data to monitor outcomes over the course of the evaluation.

Access and engagement with pregnancy care

117 women received pregnancy care as part of the *Healthy Happy Beginnings* program associated with Hospital A, and 108 women received pregnancy care as part of the *Happy Mothers* program associated with Hospital B.

More than 75% of women reported that:

- they enjoyed being part of the group
- they were listened to by the GPC team
- they felt comfortable asking for explanations
- the GPC team used words they understood
- the GPC team remembered them between visits
- they were confident that the things they said were kept confidential
- they got enough time with midwives

Access and engagement with pregnancy care

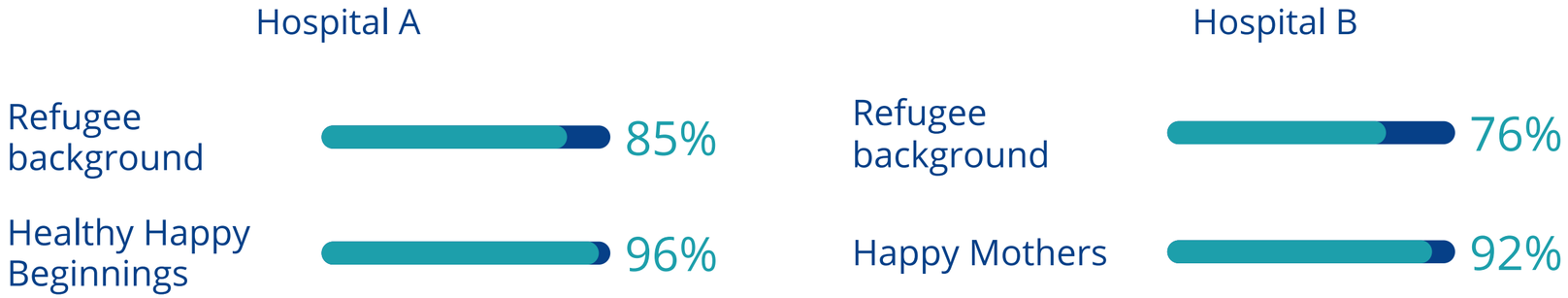
We compared women attending GPC at each site with other women receiving standard public hospital antenatal care in relation to key indicators of access to antenatal care.

The findings suggest that GPC has increased women's access to antenatal care. The results for both sites consistently show that women attending GPC more commonly attended the recommended number of visits and had care at an earlier stage of pregnancy than women attending other models of care.

Overall, the findings suggest that GPC is succeeding in making antenatal care more accessible and engaging for families of refugee background.

Women's access to pregnancy care

>7 pregnancy visits



'...when my children don't listen to me and I get angry - my tears come down easily' (GPC participant)

The importance of inter-agency partnerships and multidisciplinary teams

The bicultural worker played a critical role in facilitating women's participation in the program, strengthening social connections and improving health literacy.

The combination of the inter-agency collaboration and multidisciplinary team care enabled GPC teams to support women experiencing a range of stressful events and social health issues.

Staff reported that attending professional development together facilitated a shared understanding of the philosophy of Group Pregnancy Care and its aims.

Need for trauma-informed approaches to care

33% of women reported three or more stressful events or social health issues during pregnancy

78% of women experienced at least one stressful event or social health issue during pregnancy

More than one in six women experienced post traumatic stress symptoms during pregnancy

More than one in six women experienced intimate partner violence during pregnancy

One in three women experienced depressive symptoms during pregnancy

More than one in six women experienced anxiety symptoms during pregnancy

Need for trauma-informed approaches to care

Services need to be aware of the many different ways in which trauma and social adversity may impact the health and wellbeing of pregnant women and their families.

Given the hidden nature of many of these issues, it is important for health services to support staff to implement trauma informed approaches to care.

'Because of the other women attending the group I feel that I have someone with me and I am not lonely' (GPC participant)

Embed community engagement, evaluation and reflective practice

Community engagement is critical for co-design of Group Pregnancy Care, and for ongoing program refinement and program evaluation.

A flexible approach to the implementation of Group Pregnancy Care is important to meet community and service needs.

This was evident in the capacity of the Group Pregnancy Care teams to adapt the group program to be delivered via a virtual platform in response to the social distancing restrictions associated with the COVID-19 pandemic.

Building capacity with bicultural researchers

This project would not have been possible without the involvement of research staff from refugee backgrounds linguistically and culturally matched to each Group Pregnancy Care program. Mentoring and training to build research capacity were central to the conduct of the study. We drew on the bicultural researchers' cultural knowledge, language skills and community networks to establish cultural safety and support women to participate in the evaluation. This involved establishing Community Advisory Groups, conducting community consultation and completing individual interviews with women in their preferred language.

Towards the end of the project, we conducted interviews with the bicultural researchers. The interviews conveyed a sense of pride, strength, and resilience in their reflections around what it means to be a bicultural researcher. Bicultural researchers felt empowered to represent their communities and advocate for their needs, contributing to meaningful programs to support pregnant women.

Reflections from staff and managers on implementing a trauma-informed model of care

Interviews were conducted with 23 Group Pregnancy Care staff and stakeholders in clinical and managerial roles across both Group Pregnancy Care sites. Staff reported that engaging the community in an authentic and meaningful way is integral to establishing group safety and trust.

However, it was evident that there were challenges. Community-based organisations and hospitals provide care in different ways and have different guidelines and practice norms. Hospital-based staff reflected that it felt easier to provide trauma-informed care in a community-based setting where they had greater flexibility in how they used their time, worked in a multidisciplinary team, and the environment was more welcoming.

'...A lot of care, a lot of listening... and just believing that what they've been through is really important...'
(GPC staff)

Reflections from staff and managers on implementing a trauma-informed model of care

All staff, and some managers, participated in professional development provided by Foundation House (Trauma Recovery Framework – a trauma informed way of working with refugee background people). Overall, feedback about the training was very positive. The training reminded staff why the program existed, why a different approach was required for specific cohorts of women, and gave staff opportunities to discuss the common goals they shared in the care of women and families. Managers reflected that individual staff were at different stages of learning and understanding about what it means to practise in a trauma-informed way. For this reason, managers thought it would be helpful for some staff to have the opportunity to attend further training.

We recommend

1.Group Pregnancy Care is sustained at existing sites and expanded to other refugee background communities and health services where there is evidence of need

2. Group Pregnancy Care staff, including interpreters and management, are supported to attend professional development on trauma-informed approaches to care and group facilitation

3. Group Pregnancy Care staff have protected time to check-in, reflect and develop integrated approaches to care and team-work

4. The broader maternity workforce, including all those who have contact with women and families, should participate in professional development on trauma-informed approaches to care

5. Co-design with community and stakeholders is critical to the development and implementation of new GPC programs

6. The expansion of GPC to other refugee background communities and health services is accompanied by concurrent evaluation, including economic evaluation, to support continued improvement and refinement of the model

7. Further research is warranted to test acceptability and feasibility with other groups of women known to experience barriers to access and/or poor perinatal outcomes e.g., younger mothers, Aboriginal women, women living in regional areas

8. That funding of public hospitals be modified to account for the costs of providing multidisciplinary team-based models of care for families that are vulnerable to poor maternal and child health outcomes, including families of refugee background. Funding needs to cover the costs of interpreter services and bicultural workers as integral members of multidisciplinary teams

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