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Language and Cultural Barriers of Asian migrants in Accessing Maternal care in Australia

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Abstract

***Background**: Being a migrant and a new mother in a new land creates many difficulties for migrant women. They have to face a new language, culture and healthcare systems. In addition, these women bring with them their own, often times very different, cultural beliefs and practices associated with childbirth, which are unfamiliar to health care professionals in their new land. Consequently, migrants may not get access to the health services that are available for them due to lack of language, information and differences in cultures.*

***Aim**: To investigate the barriers encountered by Asian migrants living in rural Tasmania when accessing maternity care.*

***Method**: A qualitative study was conducted to find the barriers encountered by Asian migrants living in rural Tasmania when accessing health care. Ten Asian women from diverse backgrounds were invited to participate in this study. A semi-structured interview with open-ended questions was conducted with each participant. Data gathered was analysed using NVivo.*

***Results**: The findings reveal that Asian migrants in Tasmania have faced language and cultural barriers when dealing with the health care system. The study makes recommendations for policymakers and community organisations to overcome these barriers.*

***Keywords:** language barrier, cultural barrier, migrants, health care.*

Introduction

Living in a new country is never easy for migrants as they have to face a new environment with a new culture and quite often a new language being completely different from their own. As Schott and Henley (1996, p. 23) stated: '*For many, life outside the security of the home becomes a series of exhausting compromises and adjustments, many of them touching people's deepest feelings and undermining their confidence. The personal and social skills that worked in their own culture may no longer be effective. And it can be hard for them to understand those that are effective in the new culture and harder still to adopt them.*'

For migrant women, being a new mother in a new country makes a woman's experience more complex because for most immigrant women this may be the first time they interact with the health care system. For the first time they have to deal with a system which is completely different from that which they have or would have experienced in their own cultural settings. Being unfamiliar with the new language, new culture and new health care system, might prevent many migrants from accessing health care services in general and maternal care in particular when having a baby in the new land.

Background

Current literature suggests that non-English-speaking background (NESB) women experience less adequate and appropriate health service provision in their new country. Studies underlined universally, that minority patients have an unequal access to health care in host countries (Durieux-Paillard & Loutan, 2005). There are some significant areas of concern with respect to NESB women in relation to access to maternity care services such as late and poor attendance at clinics. Research found that

Asian women were less likely to schedule a cervical pap smear while under obstetric care, were less informed about reproductive health issues such as the advantages of breastfeeding and the need for breast self-examination. They made less use of services such as parenting classes or postnatal exercise groups than their non-Asian counterparts in Scotland (Firdous & Bhopal, 1989). McLachlan and Waldenstrom (2005) found that Vietnamese women used less pain relief, but reported more pain, and described childbirth overall more negatively than Australian women. Small (2002, p. 266) further confirmed that '*What immigrant women wanted from their maternity care proved to be extremely similar to what Australian-born women—and women the world over— want. Unfortunately, immigrant women were much less likely to experience care that gave them what they wanted.*' These issues raise the question 'what prevents migrant women from accessing adequate and appropriate health care in their new land?'

This study was conducted to seek the answer to that question to find the barriers that prevent Asian migrants living in rural Tasmania from accessing health care. The project aims to help the Tasmanian healthcare system understand the difficulties of Asian migrants when dealing with a new health care system. The study makes some recommendations to policymakers and community organisations to overcome the barriers and improve health care services for Asian migrants.

Method

A qualitative research method with semi-structured interviews was employed to investigate the barriers that Asian migrants living in rural Tasmania have encountered in accessing maternity care. Ten participants recruited through ethnic communities in Tasmania were interviewed. The interviews were conducted chiefly in English since most participants are conversant in English. However, two interviewees spoke only limited English and the researcher asked bilingual ethnic community members to participate and help interpretation during the interviews. To represent the diversity of Asian migrants in Tasmania, women from different ethnicities were selected including Chinese, Filipina, Japanese, Korean and Vietnamese. The selection criteria were:

1. female;
2. living in rural Tasmania;
3. of Asian background, that is born in Asia and still maintaining their Asian cultures, beliefs and practices; and
4. having a birth delivery experience in Australia or in both their country of origin and Australia.

An ethics application was submitted and approved by the Human Research Ethics Committees prior to the interviews.

Data Analysis and Results

The study employed a thematic or grounded analysis approach in which data was coded and categorised as the researcher started to see emerging patterns. Theory was developed throughout the research process as data interpretation took place and comparison of that interpretation was made with new data collected (Strauss & Corbin, 1990). Computer software Nvivo version 8 was used to assist in the analysis. Recordings of interviews were transcribed for detailed analysis. Each participant was coded according to their ethnicity and a participant number was given. In the transcripts, particulars of the women's views were highlighted, categorised and organised according to the focus of this study, which then enabled information interpretation. The following themes were derived from the interviews.

Language barriers

Communication is an important factor in effective maternity care. Good communication enables migrant women to understand and participate fully and confidently in their own care. For migrant women who come from a non-English speaking background, English proficiency is a basic requirement for communication (Shi, 1999). Five out of ten participants in this study had good English skills. Three of these could communicate well in English with health care professionals partly because they were mar-

ried to English speaking husbands. The other two women had no problems in communicating in English as they had taken postgraduate studies in Australia.

The remaining participants could not speak English very well. Most of them had to rely on their husbands in arranging healthcare, finding out information and interpreting for them.

> *'We went to public hospital for health care services. I did not understand what they said, but my husband understood and translated it for me. My husband took me to hospital and asked all the information and arranged care for me.' (Vietnamese participant 3)*

One woman with limited English skills chose to communicate with her health care provider by gestures, without any talking.

> *'Very first time we went to the specialist, my husband came with me and told the doctor that I cannot understand English very well. From the second time I went by myself…I did not talk much. Doctor just felt my tummy and said OK see you again in a month' (Japanese participant 1)*

English proficiency is not only an important factor for migrant women to communicate with health care providers but is also the reason why they had difficulties in accessing services and information. In the study four women attended antenatal classes conducted by hospitals in Australia. Six did not attend for different reasons, including two who claimed that their English was not good enough to attend.

> *'I did not go to ante-natal classes because my English was not good. When I came to see the midwives, they could not understand me and I could not understand them.' (Chinese participant 2)*

Antenatal classes which were conducted in English in hospitals in Australia by health care providers could be very difficult for migrants with limited English. Another woman really wanted to attend antenatal classes as that was the first time she had had a baby in Australia but she had to give up because of her difficulty with English.

> *'I did not go (to antenatal classes) because my husband cannot go with me all the time and I did not speak English very well. If he did not go with me, I could not understand what they said.'(Vietnamese participant 3)*

All participants reported that they received a lot of booklets and brochures from hospitals and health care providers but most of them were written in English. Due to their limited English proficiency, some migrant women could not read and get information from them.

> *'I went to hospital to find out the information about health care. They gave me few booklets to read. I did not understand well because my English was not good. I could not read the booklets because they were all in English' (Chinese participant 2)*

One woman, who could read English, still preferred the information in her own language for a better understanding: 'My English was not too bad at that time but if it was in Vietnamese I would understand it better.'(Vietnamese participant 2)

Cultural barriers

Language is not the only barrier that prevents migrants from accessing services and information available to them. The study also found another barrier exists, a cultural barrier. Most Asian cultures teach women to be unassertive and inhibitive from childhood. Thus, Asian women were often reluctant or ashamed to express their needs or inquire about services. One woman in the study commented: '*Because we are Asian we are very reluctant to ask someone for more information.'* (Filipino participant)

One woman expressed her regret when later she found out that the hospital she was in had information in Vietnamese but she did not ask about it.

> *'When my husband came to hospital…, he brought home a lot of brochures and booklets in English that I could not read… Later we discovered that the hospital had all the booklets in Vietnamese but because we did not ask, they did not offer us. What a pity! If I had them in Vietnamese I would be able to read them and get a lot of information from it.' (Vietnamese participant 3)*

Lack of assertiveness prevents women from expressing their preferences. They followed whatever the health professionals asked them to do, even when the services were against their practices. One woman wanted to follow her mother's advice of not having a shower immediately after childbirth but was reluctant to follow the nurse's instruction:

> *'After my baby was delivered, the nurse asked me to have a shower immediately. I knew I was not supposed to do it but I was reluctant to do it because I did not want to be against what they told me' (Vietnamese participant 2)*

Reluctance to query what happened to them also made one interviewee suffer a long period of pain:

> *'After I had the baby, I had a bad tear. At first I thought the suturing would take a few minutes but it actually took more than two hours. I kept crying because it was too painful and had lasted for too long. The doctor who did it for me was not good. She kept doing it again and again. Later she admitted that it was the first time she had done it.' (Vietnamese participant 1)*

Lack of English skills and reticence about speaking out affected the communication between health care providers and migrants and limited access to resources. Consequently, those migrant women had less opportunity to receive the services they were entitled to. They also had less chance to access the health information and services available to the general population.

Discussion

Lack of English is seen as one of barriers for migrants gaining access to healthcare and other services (Documet & Sharma, 2004; Durieux-Paillard & Loutan, 2005; Garrett, Treichel, & Ohmans, 1998). It can be frustrating for both health care providers and migrant women when they come to communicate with each other. One woman in Douglas's study (1999) told a story about the failure of communication between the medical staff and herself during her visits to a hospital in Melbourne which left her carrying an unwanted pregnancy.

> *'Having been in Australia for only a short period, I did not want to have another baby too soon. I already have two girls and I wanted to get into the workforce. But the hospital failed me. I ended up keeping the unwanted pregnancy because I could not express myself very well and there was no interpreter to facilitate the communication.' (Douglas, 1999, p. 44)*

Language barriers also presented many other difficulties for non English speaking background women such as reading menus, finding their way round the hospital and even recognising their name when it is called out in the waiting room by staff who are unfamiliar with the pronunciation of their name (Cape, 1999). Although the Australian Government provides some free English class to new migrants, not all of them can attend the class due to difficulties such as work, family commitments, transport difficulties and childcare problems. For those who can attend the class, the allotted learning period is often not enough for women to develop adequate language skills.

Trained interpreters can assist in addressing these language problems. However, although interpreting services were available at most of the hospitals, women interviewed in the study reported difficulties in accessing interpreters. This was because booking for an interpreter was not always easy due to long waiting times. Therefore some women had to rely on their partners or family members to interpret for them. As reported in the interview results, some women relied on their husbands for interpreting but once again they were faced with another obstacle as husbands could not come with them to all the routine checkups and antenatal visits due to work or study commitments.

Language barriers lead to a lack of knowledge about services in Australia which did not exist in their original country. Hospitals run a series of antenatal education programs conducted by different health professionals and provide a range of information related to pregnancy and childbirth. Generally, antenatal education classes conducted by health care providers during pregnancy include six sections of a program which covers a range of topics in maternity health care services (Shi, 1999). Most of the information relating to pregnancy and childbirth is covered in antenatal classes through the use of pamphlets, lessons and videos. If women attend the antennal classes, they should obtain useful information for themselves and an awareness of the services and resources available. However, these antenatal classes are normally only run in English without an interpreter. Due to lack of English skills, Asian women tend to avoid antenatal classes, and therefore are uninformed of available services and their rights as consumers.

Being unfamiliar with both the English language and the Australian health care system, information is very important for migrant women. However, there is a lack of accessible information. Women in the study reported that they received bundles of booklets and pamphlets about maternal care and services but most of them were in English that they could not read or had difficulty in understanding. Further, in women expressed their regret that they were not aware that there were alternative options of antenatal care such as shared care, midwives clinics and specialists. They said they would have saved a lot of money and may have made time for other things in their life if they were informed about the different care options that they were entitled to. The findings of this study on language barriers are

similar to which Cape (1999) found in her study of Vietnamese women in Victoria, and Shi (1999) in her work with Chinese women in Brisbane.

While lack of language presented many difficulties for migrant women, the lack of interpreting services and appropriate information relating to the health system also affected migrant women in accessing maternal services. In addition to these difficulties, differences in culture may also cause difficulties and misunderstandings when dealing with the health care system.

Health agencies and health professionals in Australia are traditionally oriented towards servicing an Anglo-Australian client group(Cape, 1999; Shi, 1999). The Health Department of Victoria (1991) in their report Ministerial Taskforce on Ethnic Health stated that non-English-speaking background clients are potentially disadvantaged within the system. Furthermore, evidence gained from the literature suggests that health professionals failed to meet the needs of ethnic minorities. Issues about lack of understanding of cultural diversities (Leininger, 1978), racism and racial stereotyping (Bowler, 1993), lack of knowledge of cultural beliefs and practices (Chevannes, 2002; Shi, 1999) provide explanations for that failure.

In traditional Chinese understanding of the nature of the postnatal period, a woman is believed to be in a state of extreme imbalance toward cold due to a loss of blood and energy during labour and delivery. Therefore, traditional practices are aimed at correcting this body imbalance. Practices include keeping warm, having hot food and hot drink, staying inside to avoid draughts, resting, and avoiding showers or baths. In contrast western medicine sees illness as being caused by pathogens and emphasizes early ambulation during the postnatal period (Cape, 1999). This obviously presents a conflict between Chinese medicine theory and Western theory. Quite often in Australian hospitals, Asian women were asked to have a shower immediately after childbirth, were served icy drinking water and encouraged to become mobilised as soon as they can. These practices are against their traditional beliefs that they should have plenty of rest, keep warm, and avoid cold food and showers. Due to a lack of knowledge of cultural beliefs and practices by health care providers, migrants' unwillingness to shower was often regarded as unhygienic and evidence of uncooperative behaviour (Chu, 2005).

Most women interviewed believed in the benefits and health value of their traditional postnatal practices and had observed them to varying degrees in terms of behavioural taboos such as avoiding cold food and eating more warming food and the practice of having a good rest. Although participants in the study did not complain about the differences in practices in maternity hospitals they expressed a fear for their long term health when they were served with cold food and cold drink and told to take a shower and walk soon after birth. However, since most Asian cultures teach people to be unassertive and inhibitive from childhood, Asian women were often reluctant or too shy to express their needs or inquire about services in English.

One participant in the study who came from Vietnam suffered a long suturing process because she had an inexperienced doctor who had never done suturing before. She kept crying quietly during the process without inquiring or complaining. However, she described it as the most painful moment in her life. Apart from having an inexperienced doctor, her culture may also be a contributing factor to that long painful suturing. Enduring pain in silence and maintaining self-control has been reported as the traditional value of the Vietnamese (Nguyen, 1985; Tran, 1999), and this may have prevented the participant from complaining or questioning the health care provider even though she felt something wrong was happening. In Vietnamese tradition, emotions are typically kept to oneself, and expressions of disagreement that may irritate or offend are avoided. Vietnamese people may be in pain, distraught and unhappy, however they rarely complain (perhaps only to family or friends). Hostility is not usually expressed towards persons who are considered superior-such as parents, physicians or teachers (Nguyen, 1985). This cultural value may be misunderstood by health care professionals who may think that Vietnamese patients do not suffer much pain and so they offer less pain relief. This could seriously affect a Vietnamese women's childbirth experience.

Conclusion and recommendations

Providing interpreting services can help overcome language or communication difficulties. Firstly, it is vital for migrant women in need to be offered an interpreter, as many of them are unfamiliar with the Australian healthcare system and may not know about the availability of interpreting services. Secondly, it is also important that these services should be easily accessible and the waiting time shorter. Another solution is to provide healthcare information in different languages. There are pamphlets and

booklets about maternity care in different languages such as Chinese and Vietnamese in hospitals. Healthcare professionals and hospital staff should be informed of these resources available for migrant women in need. Access to existing information and services should be promoted.

Cultural barriers can be overcome by training staff to develop a general understanding of, and empathy for, the issues migrant women are facing. Hospitals need to provide staff with training to improve knowledge of different cultural beliefs and practices related to childbirth as this will reduce misunderstanding and mismanagement in providing care to Asian migrant women. Bilingual health workers need to be employed in maternity hospitals and community health centres if possible. These health workers with language skills can assist women from NESB backgrounds to increase their knowledge of available maternity services and have better access to these services.

Pregnancy and childbirth are among the most significant events in a woman's life. It is a period of achievement, happiness and fulfilment, and also a time of dependence and vulnerability. It is hoped that migrant women in the new land will have better access to the health care services when the barriers of language and culture are reduced.

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