

**Exploring Sub-Saharan African
women's experiences of maternity
care in their home countries and in
Australia**

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Abstract

Increasing global migration is resulting in a culturally diverse population in the receiving countries. This diversity is also seen in the maternity health care settings in the host countries like Australia. In South Australia, hundreds of women from Sub-Saharan Africa give birth each year. To respond appropriately to the needs of these women, it is important to understand their experiences of maternity care. Despite the increase in Sub-Saharan African women using maternity care in Australia, there is limited Australian literature that explore the experiences of maternity care from the perspective of these women. Instead there are studies on women's experiences of maternity care in other western countries. To bridge this gap in literature, this study aimed to examine the experiences of Sub-Saharan African women in relation to maternity care in their home countries and in Australia.

A qualitative approach was used to obtain an in-depth understanding of the women's experiences of maternity care. Semi-structured interviews with fourteen women from Sub-Saharan Africa living in Adelaide who had birthed in Sub-Saharan Africa and in Australia were conducted. Thematic analysis of data using Braun and Clark's method of analysis yielded four themes: 1. Access to services including health education; 2. Birth environment and support; 3. Pain management and; 4. Perceptions of care. The study found that the participant women's previous experiences of maternity care in Sub-Saharan Africa influenced their experiences in Australia. The women experienced barriers in accessing maternity care. In Australia, they had communication problems and lack of familiarity with the Australian maternity care system while in Sub-Saharan Africa they were faced with the lack of availability of services, long distance to facilities and long waiting times which affected their access to maternity care. The study used an existing conceptual framework on access to care to clearly explain the findings on how the women experienced maternity care.

The study provides an understanding of the women's experiences of maternity care. The findings of this research indicate that women from Sub-Saharan Africa have special maternity health needs shaped by their cultural and social orientation to pregnancy and childbirth. Therefore, this study suggests improvements in

communication and provision of culturally appropriate maternity care to cater for these women's needs. Further research on midwives' experiences of caring for women from Sub-Saharan Africa has been recommended to broaden the understanding of the provision of maternity care for these women.

Declaration of authorship

I certify that this thesis does not include without my acknowledgement, any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where reference is made to it in the text.

Hlengiwe Mohale

CHAPTER ONE: INTRODUCTION

Introduction

Coming from Sub-Saharan Africa myself, I have always been moved by the poor pregnancy outcomes in this region. One of the strategies to improve these outcomes is to provide better maternity care for pregnant and birthing women. Practising as a registered midwife in Swaziland at a hospital where more than 10,000 births take place every year, I have attended to many women giving birth. Seeing the women carry their babies upon leaving the maternity ward post-birth sparked an interest in understanding what they thought about the care they had received throughout their journey of childbirth. Occasionally, I would hear them talk about their experiences of childbirth to one another in the postnatal ward. Recounting both their positive and negative experiences suggested to me that the care they had received did not adequately meet their needs; however, there was no evidence for this. After travelling to Australia and seeing the quality of Australian midwifery, I wanted to understand more about maternity care in Australia, but from the Sub-Saharan African women's perspective. Knowing that some of them had babies in Africa, I wondered if, and how, their previous experience of birth in Sub-Saharan Africa had an influence on their experience in Australia. Therefore, this study explores the experiences of maternity care of Sub-Saharan African women in their home countries and in Australia. As an experienced clinician, I was a novice researcher doing a degree to learn and extend my professional capabilities. This study was done as a research degree to learn how to be a researcher.

This chapter presents the background to the experiences of Sub-Saharan African women in relation to maternity care. It further explains the problem statement, and the purpose/aim and significance of the research. The chapter concludes by presenting an overview of the thesis according to the layout of the chapters.

Background

In recent years, Australia has experienced a rise in the number of immigrants from

Africa, with about 70% of asylum seekers being from Sub-Saharan Africa (Smith 2006). This population movement and immigration has resulted in an even greater level of cultural diversity within Australian society. About one-third of refugee and humanitarian entrants to Australia are women of childbearing age, being 12 to 44 years (Correa-Velez & Ryan 2012). It is likely that many of these women would become pregnant and require maternity services during their stay in Australia. What is known is that in 2012, Sub-Saharan African women accounted for about 1.9% of births in South Australia, similar to the 2.2% from China and 1.2% from Vietnam (Scheil et al. 2015). This means that there are significant levels of cultural diversity in the use of maternal and child health services in South Australia.

Population migration has implications for health service delivery, especially maternity care for migrant women (Small et al. 2014). Maternity care refers to care provided to women during pregnancy, labour, childbirth, and for the first six-week's post-partum. African women in other western countries, such as the United Kingdom, Canada, and Sweden have been found to have problems accessing maternity health services (Berggren, Bergström & Edberg 2006; Higginbottom et al. 2013; Straus, McEwen & Hussein 2009). Therefore, as the number of Sub-Saharan African women in Australia increases, it is important to recognise the issues they face in accessing maternity care.

Sub-Saharan African women come from a context in which the maternal mortality ratio is on average 500 per 100,000 live births (WHO 2012), while in Australia, the maternal mortality ratio for the period 2006 to 2010 was only 6.8 per 100,000 (Australian Institute of Health and Welfare 2014). These statistics show that maternal health and pregnancy outcomes in the Sub-Saharan African context are poor. The level of maternity care in Sub-Saharan Africa is very different to Australia. For instance, in Sub-Saharan Africa, statistics show that attendance at antenatal care for at least one visit is 71%, skilled birth attendance 46%, and postnatal care within 2 days is 31% (Kinney et al. 2010). Compared to at least seven antenatal care visits for women with uncomplicated pregnancies in Australia, the recommended antenatal care in Sub-Saharan Africa is four visits for women with uncomplicated pregnancies (UNICEF 2015). This data shows how maternity care in Sub-Saharan Africa is different from such care in Australia.

Migrants undergo a transitional process as they adjust to their new environment in the host country (Hennegan, Redshaw & Miller 2014). Such adjustment may include re-establishing themselves in the new society, and encounters with the Australian healthcare system which is significantly different from what they are familiar with in their home countries. The existing literature suggests that migrant women are in a vulnerable state when pregnant and giving birth due primarily to communication difficulties (Balaam et al. 2013). While pregnancy requires antenatal care, Carolan and Cassar (2010) found that, for African women, the establishment of themselves and their family in the new country was a greater priority than attending antenatal care.

The current evidence suggests that access to maternity services by African women in western countries can be influenced by a number of factors, including language difficulties, lack of knowledge about the health services available to them, the availability of interpreting services, and the women's cultural beliefs (Carolan 2010; Murray et al. 2010). Although migrant women are not deprived of access to maternal child health services, they may not be aware of the available services or have ready access to them (Murray et al. 2010). As a result, migrants often present to healthcare providers late with obstetric complications which may affect their pregnancy and birth outcomes (Gibson-Helm et al. 2014b; Hayes, Enohumah & McCaul 2011). Studies have reported an association between African women migrants and poor pregnancy outcomes (Gagnon et al. 2009; Gibson-Helm et al. 2014b). Hence, it is important to recognise the issues they face with accessing maternal healthcare in Australia.

Expectations around pregnancy, childbirth, and child-rearing for women from migrant backgrounds are often shaped by their experiences in their country of origin or transit (Benza & Liamputtong 2014; Pell et al. 2013). Some of the women's previous experiences may include unattended births, traumatic and unsafe abortions, poor sanitation, and high rates of infant mortality which may have an influence on their attitudes towards maternity services (Victorian Refugee Health Network 2012). Since previous experiences influence women's perceptions of maternity care, it is important to understand their experiences in their Sub-Saharan African home countries. The research indicates that many women from refugee backgrounds commonly arrive in Australia with minimal exposure to healthcare (Benza &

Liamputtong 2014). A lack of familiarity with healthcare may affect their use of maternity care services, especially when they do not understand the health system in their new country.

Child-bearing occurs in a social and cultural context and is shaped by the views and practices of that culture (Murray et al. 2010). Therefore, practices surrounding childbirth are influenced by the woman's own culture and beliefs. Carolan and Cassar (2010) stated that as African women settle in Australia they adjust from perceiving pregnancy as a natural process which requires no particular attention from healthcare, to the valuing of continuous antenatal care. Studies on women's experiences of antenatal care have found that Sub-Saharan African women hold some beliefs which may differ from the realities of the Australian health system, and they may have different expectations about antenatal services (Carolan & Cassar 2010; Mrisho et al. 2009). Understanding the culture and beliefs of Sub-Saharan African women is important as they influence the way they experience maternity care. However, this can be a challenge considering the diversity in culture and beliefs of women from Sub-Saharan Africa. Therefore, women should be treated as individuals and encouraged to make decisions about their care and not be stereotyped according to their culture.

It has been noted that despite the increase in the Sub-Saharan African population in Australia, there is a lack of research that explores the experiences of maternity care from the perspective of these women. Most of the literature that explores the experiences of African-born women receiving maternity care is from the United Kingdom, North America, and Europe (Berggren, Bergström & Edberg 2006; Higginbottom et al. 2013; Straus, McEwen & Hussein 2009). Therefore, this study intends to bridge this gap in the literature. Furthermore, the few studies on maternity care of African women living in Australia that do exist have focused on antenatal care, and have left out intrapartum and postnatal care, which are important aspects of maternity care, especially because most complications occur during childbirth or immediately after giving birth (Ehiri 2009). Moreover, some studies have investigated refugees only, whereas Sub-Saharan African women in Australia also include non-refugees. Therefore, this study explores the experiences of the entire perinatal period; that is, pregnancy, labour, and postnatal care. To the researcher's

knowledge, there is no existing research that has explored the experiences of Sub-Saharan African women's experiences of the entire perinatal period in Australia. Instead, research has been conducted in Melbourne and Brisbane which has focused on African refugees' perspectives of only antenatal care, and the birth process (Carolan & Cassar 2010; Murray et al. 2010).

Problem statement

The increase in cultural and ethnic diversity in the Australian population poses challenges for the delivery of healthcare services, especially maternity care (Balaam et al. 2013). Achieving optimum maternal health and pregnancy outcomes for a culturally diverse society may be difficult for healthcare providers. To respond to increasing migration, understanding migrant women's experiences of maternity care is important. As people's past experiences influence their utilisation of services positively or negatively, it is important to also consider their previous childbirth experiences, particularly when they are from another country. If women have negative experiences of maternity care, they may be less inclined to use the services which may result in poor pregnancy outcomes, and this in turn may affect the maternal and neonatal morbidity and mortality rates in Australia. Whilst maternity care in Australia is of good quality (Save The Children 2015), if it is not culturally-sensitive and acceptable to Sub-Saharan African women, it may not be utilised and this could potentially have an impact on maternal and neonatal outcomes.

Aim of the research

The main aim of this study is to examine the experiences of Sub-Saharan African women in relation to maternity care services in their home countries and in Australia. This aim will be achieved through the following research objectives:

1. To explore how Sub-Saharan African women experienced maternity care in the Sub-Saharan African countries where they gave birth.
2. To explore how Sub-Saharan African women experienced maternity care in Australia.
3. To identify barriers to the utilisation of maternity services by Sub-Saharan

African women in Australia.

4. To identify ways in which maternity care services in Australia can be improved for Sub-Saharan African women.

Significance

This study will provide information about the experiences of maternity care by Sub-Saharan African women in Australia. The findings of the study will encourage midwives and other healthcare staff to provide maternity care that addresses the needs of women from a Sub-Saharan African background. Understanding the needs of these women will improve maternity care and, in turn, will motivate them to use the services. Interpretation of the women's experiences will assist in developing a basis for culturally-sensitive maternity care. Knowledge of strategies to improve access to care will improve the use of services and, in turn, improve maternal and neonatal health outcomes for Sub-Saharan African women in Australia. Knowledge arising from the study may also help in developing approaches to achieving woman-centred maternity care in a culturally-diverse society. Since women are the experts of their own experiences, it is through exploring their perspectives of maternity care that future needs can be identified.

Conclusion

Population migration is increasing, resulting in greater cultural diversity in the use of maternity care. In order to provide maternity services acceptable to migrant women, it is important for healthcare professionals to understand the women's experiences and needs, and the issues they face while accessing services. The aim of this study is to examine the experiences of Sub-Saharan African women in relation to maternity care services in their Sub-Saharan African home countries and in Australia. Previous studies have shown that Sub-Saharan African women face challenges in accessing maternity services in their host countries. However, despite the increase in the population of Sub-Saharan Africans in Australia, there is a lack of literature on the women's experiences of maternity care in Australia. Therefore, the study will bridge this gap in the literature.

Overview of the thesis

This thesis is arranged into six chapters. This initial chapter has introduced the study. It first presented the background information pertaining to Sub-Saharan African women's experiences of maternity care in western countries, including Australia, followed by the problem statement, and the purpose and significance of the study. The background literature led to a discussion of the problem statement, the significance, and the aim of the study. The chapter now concludes with the thesis overview. Chapter Two will present an integrative literature review of Sub-Saharan African women's experiences of maternity care. The literature review is organised in terms of the themes that emerged from the reviewed studies. Chapter Three details the research methodology, the processes, and the steps that were followed in conducting the study, while Chapter Four will present the findings of the data analysis. An overview of the demographic details of the participants will be provided followed by a discussion of the themes that were developed from the thematic analysis of the data. Chapter Five will discuss the findings in relation to the existing literature, as well as relate it to a conceptual framework on access to care. Chapter six will present the conclusion of the thesis, the contributions of the study, limitations and recommendations of the study.

CHAPTER TWO: LITERATURE REVIEW

Introduction

Chapter One introduced the study and outlined the research problem, aim, and significance of the study. The background information on Sub-Saharan African women's experiences of maternity care in western countries, including Australia, was also highlighted. This chapter presents an integrative review of the current literature on the experiences of Sub-Saharan African women in relation to maternity care in Sub-Saharan Africa and in western countries, including Australia. The purpose of this review is to identify what is already known in this area and to identify the gaps in the literature. The chapter begins by outlining the search strategy used to identify the relevant literature, followed by a critique of the research articles, which identified a number of methodological gaps and knowledge limitations that informed the need for this study. The literature review is organised in terms of the themes that emerged from the reviewed studies. The chapter concludes with the limitations of the literature review and a concluding overview of the chapter.

Search strategy and terms

A systematic search was used to locate relevant literature on African women's experiences of maternity care in Sub-Saharan Africa and western countries. A comprehensive search was conducted using the following databases: Medline, Cumulative Index to Nursing and Allied Health (CINAHL), PsychInfo, and Google Scholar. These electronic databases were searched using the following keywords: 'African women', 'African mothers', 'maternity care', 'maternity care services', 'perinatal care', 'Adelaide', and 'Australia'. The search using these terms yielded seven articles. Therefore, the researcher broadened the search by using the following terms: 'labour', 'birth', 'childbirth', 'pregnancy care', 'antenatal care', 'Sub-Saharan Africa', 'Africa and Australia'. These keywords were searched in various combinations using the Boolean search terms OR and AND. A full list of the search terms can be found in Appendix 1. Overall, this search yielded 151 research articles.

An inclusion/exclusion criteria was used to limit the search, based upon research approach, language and year of publication. Both qualitative and quantitative research studies that addressed the experiences of pregnancy, childbirth, and motherhood of women from Sub-Saharan Africa met the inclusion criteria. These studies were published in English between 2006 and 2015. Research articles were included if they were written in English, peer-reviewed, and if they referred to maternity care by midwives rather than by doctors or obstetricians. Originally, the researcher intended to include only primary research articles, but due to the dearth of evidence, literature reviews were also included. After applying the inclusion and exclusion criteria, and limiting the search to publications within the last ten years, 102 articles were identified. However, after reading the abstracts of these articles, most were found to be either irrelevant to the proposed research or were duplicates. Therefore, 94 articles were excluded and eight were retrieved, as they were relevant to Sub-Saharan African women's experiences of maternity care.

Given the low number of articles located, two additional approaches were used. Firstly, a manual search of the reference lists from the retrieved articles was conducted to locate further relevant articles. Secondly, further database searching using individual country names (including Nigeria, Ghana, South Africa, Kenya, and Somalia) with the previous search terms was also undertaken, given that the term 'Sub-Saharan' Africa is a region and not a specific country. Fifteen further articles were found through these additional search processes. In total, 23 research articles are included in this literature review, which have been critically appraised and thematically analysed.

Critical appraisal of the studies

A research critique is a cautious evaluation of the strengths and weaknesses of a study (Polit & Beck 2012). The research articles identified as being relevant to the review were evaluated using appropriate appraisal tools to determine their quality for final inclusion in the review. Of the 23 research articles selected, there were fourteen qualitative, four quantitative, and one mixed-methods study, while four were literature reviews. Although literature reviews are secondary sources, they are included in this review because they provide important information on women's experiences of

pregnancy and childbirth in western countries. The Critical Appraisal Skills Programme (CASP) tools (Critical Appraisal Skills Programme) were used for the qualitative, quantitative, and literature review studies. These tools are used to assess the research process, as well as the strengths and weaknesses of the identified articles. For the mixed-methods article, the McGill mixed-methods appraisal tool was used because there is no CASP tool relevant for such studies. The McGill mixed method tool was chosen because of its appropriateness in appraising the mixed-methods component of this review. Each research article was appraised using the relevant evaluation tool. Appraising the articles assists with evaluating the value and trustworthiness of the research (LoBiondo-Wood & Haber 2014).

Generally, the research articles were of a good quality. The qualitative research articles (Appendix 2) used appropriate methodologies to answer the research questions and ethics approval was obtained before the commencement of each study. Although some of the articles had limitations in relation to the sampling strategy and researcher reflexivity, they were included because they provided valuable findings on Sub-Saharan African women's experiences and the limitations were not so significant as to exclude them from this review. Furthermore, the aim of these research studies was consistent with this review and the data analysis process was clearly stated. The quantitative articles (Appendix 3) focused on African women's use of maternity services in Sub-Saharan Africa and Australia, and used appropriate methodology for each of the studies. The mixed-methods research article (Appendix 4) integrated and analysed the data well to explore maternity care for refugee women in Australia. The literature reviews (Appendix 5) used relevant studies and clearly stated how they identified the included articles.

The studies included in this review were conducted in Sub-Saharan African countries, Australia, North America, and Europe. While the research question for this review focuses on women's experiences in Sub-Saharan Africa and Australia, studies from Sweden, Canada, and the UK were included because very few studies were found about childbearing Sub-Saharan African women in Australia. Furthermore, it was considered that maternity care in these countries is similar to the Australian healthcare system and were therefore deemed to be relevant.

Framework used to structure the review

An integrative framework was used for this review. The integrative literature review enables the researcher to evaluate the strength of the scientific evidence, identify gaps in the existing research, identify key issues in the area of study, and to identify the need for further research (Russell 2005). The findings from the research articles were analysed using a thematic analysis. A summary of all the articles included in the review are shown in Appendix 6 The initial step in this analysis was to identify the recurring issues or findings from the literature. These findings were then organised into descriptive categories according to their interpretation. Finally, the categories were interpreted and analysed by making connections between them. This resulted in five themes which described the maternity care experiences of Sub-Saharan African women. This process of analysing findings is consistent with the thematic synthesis of qualitative studies, as stated by Ring et al. (2011). The five themes that emerged from the findings are: Cultural beliefs and traditional practices of the women; attitudes of healthcare workers; access to care; experiences of childbirth; and support and postnatal experiences. All the themes and their associated categories are shown in Appendix seven.

Cultural beliefs and traditional practices of the women

Culture, and traditional beliefs and practices influence women's behaviour throughout childbirth. Brighton et al. (2013) and Murray et al. (2010) identified culture and beliefs as a barrier to accessing maternity care services in both Sub-Saharan Africa and Australia. In these studies, pregnancy complications were associated with evil spirits, immorality, and witchcraft. Hence, the women would not seek medical help because they believed that the complications could not be cured medically. Evidence also suggests that women's beliefs about the healthcare system affect their utilisation of services (Mrisho et al. 2009). In their study of women's and health-care providers' perceptions of antenatal and postnatal care, Mrisho et al. (2009) revealed that women believed that health facilities are associated with childbirth complications and caesarean section. Therefore, women refrained from giving birth at health facilities to avoid having a caesarean section. This evidence supports the view that the woman's decision to seek maternity care is influenced by her beliefs.

Sub-Saharan African women's beliefs sometimes conflict with professional healthcare practices and/or advice. Brighton et al. (2013), in their study of women and communities' perceptions of obstetric care, reported that the community perceived a strong woman as one who gives birth at home without any professional assistance. Such conflicting ideas affect the use of health services. This finding partially explains why skilled attendance at birth in Sub-Saharan Africa is very low at only 47% (World Health Organization 2014a). However, the community's beliefs conflict with the WHO's goal that all women should have a skilled professional attendant at birth in order to reduce maternal mortality especially in the Sub-Saharan African context. Likewise, in studies by Murray et al. (2010) and Renzaho and Oldroyd (2014), the women's beliefs clashed with healthcare practices. Murray et al. (2010) found that African women held the belief that the newborn should sleep with the mother; however, this was not encouraged by the Australian healthcare providers, stating that it was not safe for the baby.

In Renzaho and Oldroyd (2014) investigation of migrant women's experiences in Victoria, Australia, it was found that tensions arose with healthcare staff when family members performed traditional practices when visiting the women after childbirth. However, these mothers had accepted western culture and were willing to forgo these traditional practices to avoid such conflict. Cultural adjustment is supported by Carolan and Cassar (2010) who stated that African women adjust from a culture of perceiving pregnancy as a natural process requiring no medical assistance, to the valuing of continuous antenatal care. These findings show that Sub-Saharan African women may face a challenge, or a dilemma, of choosing between their traditional beliefs and western maternity care, although both are important to them. While the women are educated on the importance of maternity healthcare services, the education may not be supported by their families and their community. Consequently, women who depend on their husbands for financial assistance, for example (Iyaniwura & Yussuf 2009), will not access the services if the partner's beliefs are against the services.

Female Genital Mutilation

Female genital mutilation (FGM) is one traditional practice cited in most studies to

have an influence on Sub-Saharan African women’s experiences of maternity care in western countries (Berggren, Bergström & Edberg 2006; Lundberg & Gerezgiher 2008; Stapleton et al. 2013; Straus, McEwen & Hussein 2009). According to the World Health Organization (2008), FGM comprises all procedures involving partial or total removal of the external female genitalia, or other injury to the female genital organs for any reason other than for therapeutic purposes. Four types of FGM are shown in Table 1. Women from some parts of Sub-Saharan Africa have FGM for cultural, religious, and/or social reasons. However, some types of FGM pose obstetric risks for the women at childbirth.

Table 1: Types of female genital mutilation
Adopted from World Health Organization (2008, p. 5)

Type of female genital mutilation	Description
Type I: Clitoridectomy	Partial or total removal of the clitoris and, in very rare cases, only the prepuce
Type II: Excision	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora
Type III: Infibulation	Narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris
Type IV: Other	All other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping, and cauterizing the genital area

Women with FGM have been found to experience a range of complications during pregnancy, childbirth, and in the postnatal period (Carolan 2010; Gibson-Helm et al. 2014a; Lundberg & Gerezgiher 2008; Straus, McEwen & Hussein 2009). Such complications include neonatal death, stillbirth, caesarean section, and postpartum haemorrhage. Lundberg and Gerezgiher (2008) conducted a qualitative study of 15 Eritrean women in Sweden. The purpose of the study was to explore the women’s experiences of pregnancy, childbirth, and the postnatal period in relation to FGM. They found that the women experienced severe pain during pelvic examination antenatally, during labour, and after childbirth. It was also reported that in their home country, the women had infected wounds, bleeding, and urinary incontinence after the stitches had been cut during childbirth (Lundberg & Gerezgiher 2008). These

findings were supported by Benza and Liamputtong (2014) who stated that women who had undergone FGM suffer extensive perineal trauma during childbirth.

Although it is not clear how FGM leads to increased complications during childbirth, one possible explanation is that the scar tissue that results from cutting and re-suturing of the external genitalia is relatively inelastic. The scar therefore leads to obstruction and tearing of the tissues around the vagina during childbirth. Obstruction can lead to prolonged labour, which increases the risk of caesarean section, heavy bleeding, distress in the infant, and stillbirth (Carolan 2010; Gagnon et al. 2009). This obstruction may possibly be the reason why Somali women were reported to have a high risk of caesarean section and poor birth outcomes, such as low Apgar scores and stillbirths (Gagnon et al. 2009).

A study by Straus, McEwen and Hussein (2009) revealed that healthcare providers stereotyped women with FGM as unable to give birth vaginally. This perception resulted in unnecessary caesarean sections. This view supports Sub-Saharan African women's beliefs that healthcare facilities are associated with caesarean section delivery. However, it has been established that women with FGM can give birth vaginally without complications if managed properly (Wuest et al. 2009).

Healthcare providers' lack of skill in managing FGM at birth has been reported in the literature (Benza & Liamputtong 2014; Berggren, Bergström & Edberg 2006; Straus, McEwen & Hussein 2009). In Straus, McEwen and Hussein (2009) study of Somali women in the UK, it was established that the risk of intrapartum complications in women with FGM was worsened by providers' lack of skill in managing FGM. This finding was supported by Berggren, Bergström and Edberg (2006) and Carolan (2010) who report that healthcare providers lack the knowledge and skill to manage women with FGM at childbirth. The lack of skill in managing FGM results in women feeling insecure, helpless, and vulnerable, especially because they prefer to give birth vaginally (Straus, McEwen & Hussein 2009). On the other hand, Lundberg and Gerezgiher (2008), in their study of Eritrean women in Sweden, reported that the women felt confident and happy to be cared for by healthcare professionals who are knowledgeable about female circumcision. However, these studies were conducted in the UK and Sweden, and there is a lack of literature on this area in Australia;

therefore, there is a need for further research on the experiences of Sub-Saharan African women with FGM in Australia. It is also necessary for healthcare providers involved in the maternity care of Sub-Saharan African women to receive appropriate training on the management of FGM during pregnancy and childbirth in order to provide quality care for these women.

The evidence suggests that the issue of female genital mutilation is not discussed between women and healthcare providers prior to giving birth (Berggren, Bergström & Edberg 2006). Avoiding the discussion of FGM at antenatal care until the time of birth can be stressful for women and result in birth complications and biased caesarean sections (Straus, McEwen & Hussein 2009). Berggren, Bergström and Edberg (2006) explored the maternity care experiences of women from Somalia, Eritrea, and Sudan. They found that women are reluctant to discuss FGM with healthcare staff in their country of reception because they perceive it to be a private matter. In addition, the women felt ashamed to raise the issue of FGM in front of healthcare providers which is contrary to their experience in their country of birth where FGM is accepted and upheld. Such feelings may hinder the seeking of maternity care at birth, and may further increase the risk of poor neonatal and maternal birth outcomes. Furthermore, the women may not know the complications that may occur due to FGM, and therefore, healthcare providers need to discuss FGM during antenatal care.

Attitudes of healthcare workers

The second theme of this literature review addresses the attitudes of healthcare workers and, in particular, of midwives. Maternity care providers' attitudes play a major role in the experiences of pregnant and labouring women. These attitudes can negatively or positively influence women's healthcare seeking behaviour. A friendly attitude was reported more frequently in the Australian setting than in the Sub-Saharan African setting. Negative attitudes of staff have been identified as a barrier to accessing healthcare services in both Sub-Saharan Africa and western countries (Berggren, Bergström & Edberg 2006; Brighton et al. 2013; Bulman & McCourt 2002; Ekott et al. 2013; Murray et al. 2010; Wilunda et al. 2014). In a study on barriers to the utilisation of maternity services in Uganda, Wilunda et al. (2014) reported that the

poor relationship between health staff and the community, and disrespect demonstrated by the staff, affected access to health services. Therefore, if the women know that they will not be treated well at the health facilities, they will not report for antenatal care or give birth in these facilities. Unfortunately, this may have negative consequences for maternal and neonatal morbidity and mortality. Such negative behaviour was also reported by Ekott et al. (2013) in their quantitative study of 410 pregnant women at a Nigerian hospital. The purpose of the study was to determine the women's perceptions and satisfaction with the antenatal care provided in the facility. They found that unfriendly staff attitudes are a barrier to attending antenatal care. However, the sampling strategy for this study was not specified and the sampling size was small; therefore, the findings cannot be generalised to all Sub-Saharan African women. Furthermore, the focus of the study was only on antenatal care, leaving out intrapartum and postnatal care; hence, the need for further research in these areas.

Contrary to the negative experiences, the presence of friendly staff contributes to women's satisfaction with maternity health services. Positive experiences of maternity care are enhanced when women are treated with respect and kindness (Hennegan, Redshaw & Miller 2014). Similarly, a study by Carolan and Cassar (2010), aimed at examining the experiences of African women receiving antenatal care in Melbourne, revealed that the friendly atmosphere at the antenatal care facilities encouraged them to regularly attend antenatal appointments. This study however, did not discuss the experiences of intrapartum and postnatal care. Furthermore, the participants were limited to women from only the horn of Africa, leaving out women from other parts of Sub-Saharan Africa. Therefore, there is a need to explore the experiences of intrapartum and postnatal care for Sub-Saharan African women. Nevertheless, these studies do highlight that women like to be treated with respect and dignity throughout the course of childbearing.

Access to care

The third theme from the literature relates to access to maternity care. Accessibility of maternal services is more than simply the availability of the facilities in the community. Access involves knowledge about the services, equal access, and being

within reach. Some of the hindrances to accessing maternity care relate to physical, sociocultural, emotional, and financial barriers (Benza & Liamputtong 2014; Berggren, Bergström & Edberg 2006; Gibson-Helm et al. 2014a; Iyaniwura & Yussuf 2009; Mrisho et al. 2009). The physical barriers faced by Sub-Saharan African women when accessing maternity services include having to travel long distances to healthcare facilities, transport, and lack of equipment (Berggren, Bergström & Edberg 2006; Brighton et al. 2013; Iyaniwura & Yussuf 2009; Stapleton et al. 2013; Wilunda et al. 2014). Stapleton et al. (2013), in their study of women attending antenatal care at a special clinic for refugees in Australia, found that while the women were satisfied with the services in the facility, its central location affected access because they had to travel long distances to attend the facility. Travelling to the facility was a problem because of language difficulties, as the women could not communicate properly with transport providers resulting in them missing antenatal appointments. Therefore, there is a need to understand the ways in which access to facility-based healthcare could be improved for Sub-Saharan African women in Australia.

A number of studies have found that language difficulties hinder good communication and understanding between Sub-Saharan African women and their caregivers (Hennegan, Redshaw & Miller 2014; Murray et al. 2010; Renzaho & Oldroyd 2014; Stapleton et al. 2013; Straus, McEwen & Hussein 2009). Furthermore, language difficulties and lack of information about available services make it difficult to access maternity services (Murray et al. 2010; Renzaho & Oldroyd 2014; Stapleton et al. 2013; Straus, McEwen & Hussein 2009). Straus, McEwen and Hussein (2009), in their study of Somalian women in the UK, reported that interpretation services helped to breach the communication barrier between women and their healthcare providers. However, the use of interpreters may interfere with confidentiality between the client and the midwife. Other studies have found that a verbal form of health education is lacking among healthcare providers, despite it being deemed necessary for some women (Straus, McEwen & Hussein 2009; Yakong et al. 2010). For instance, the Somali 'oral culture' requires that information be transmitted verbally. Hence, despite having pamphlets and posters, health education needs to be provided verbally and complemented with written material to

enhance women's understanding. Straus, McEwen and Hussein (2009) found that effective communication was affected by the use of medical terminology which the women could not understand; however, this was not found to be a problem in Australian maternity care.

Understanding the health system and having knowledge of available services were identified as essential factors influencing access to care (Straus, McEwen & Hussein 2009). Renzaho and Oldroyd (2014) and Straus, McEwen and Hussein (2009), in their studies of African women in Australia and the UK respectively, established that a lack of understanding of the healthcare system results in confusion about where to access services. This confusion is further complicated by conflicting messages from primary and secondary healthcare providers and a lack of knowledge about when to access hospital services (Renzaho & Oldroyd 2014). This problem is probably due to the fact that the healthcare system in Australia is different from the Sub-Saharan African system in which women independently report to the hospital if they have problems.

Previous studies have found an association between continuity of midwifery care and positive women's maternity experiences (Murray et al. 2010; Stapleton et al. 2013; Straus, McEwen & Hussein 2009). When examining refugees' birthing experiences in Brisbane, Murray et al. (2010) found that the women experienced a lack of continuity of care at antenatal care services. This resulted in frustration as they encountered different staff members with each antenatal care visit and had to explain themselves afresh each time. Straus, McEwen and Hussein (2009) also found that women were concerned about lack of continuity of care as they preferred one provider throughout pregnancy and childbirth. These findings were different from those reported by Stapleton et al. (2013) where the women were satisfied with the continuity of care throughout the antenatal period. However, there was a lack of continuity found from antenatal care to labour and childbirth. Therefore, continuity of care is important for the delivery of female-centred care.

Experiences of childbirth

Theme four was about the childbirth experiences of Sub-Saharan women. It has

been established that migrant women's expectations of pregnancy and childbirth in western countries are shaped by their previous experiences in their country of origin (Benza & Liamputtong 2014). Murray et al. (2010) stated that previous birth experiences influenced their perceptions of maternity care in Australia. The evidence suggests that Sub-Saharan African women prefer giving birth naturally (Benza & Liamputtong 2014; Gibson-Helm et al. 2014a; Stapleton et al. 2013). This finding is supported by Higginbottom et al. (2013) in their study of Sudanese women's experiences of maternity care in Canada. They found that women conceptualise birth as a normal and natural process such that they resisted any practice which they interpreted as being unnatural, such as instrument birth and caesarean section. The women would even delay going to hospital when in labour due to their fear of caesarean section. This finding may partially explain why African refugees in Gibson-Helm et al. (2014a) study had high rates of giving birth before arrival at healthcare facilities.

It was further established that African women perceive labour pain as a natural expectation and that they prefer normal labour without pain relief (Benza & Liamputtong 2014; Gibson-Helm et al. 2014a; Higginbottom et al. 2013; Stapleton et al. 2013). However, these findings cannot be generalised to all Sub-Saharan African women because these studies involved only African refugees. While the women refrained from pain medication during labour, they preferred the traditional methods of relieving pain such as walking, or drinking hot or cold tea (Murray et al. 2010). This could be due to their previous experience in their country of birth where they did not receive pain-relieving medication (Murray et al. 2010). However, the reason for not receiving pain relief in Africa could be lack of availability and the fear of complications associated with some of the medications. It is therefore important to discuss pain relief with clients during pregnancy as part of their preparation for childbirth, so that they are aware of the various ways of relieving pain during labour and the benefits and risks of pharmaceutical analgesia or anaesthesia.

The influence of socialisation in relation to labour pain also affects women's experiences of childbirth. Higginbottom et al. (2013) studied Sudanese women's experiences of maternity care in Canada and found that they are expected to refrain from crying during labour as this is associated with failure and seen to be a sign of

weakness. The women in the study perceived crying as shameful and a waste of energy that would be needed at the time of birth. These same women who do not display any expression of pain do not receive pain relief. The non-expression of pain may be confusing to healthcare providers who are unaware of the women's cultural background. Therefore, it is important to understand the women's cultural orientation towards labour pain.

The quality of services provided in western countries is appreciated by African women (Benza & Liamputtong 2014; Hennegan, Redshaw & Miller 2014), particularly the advanced technology and continuous foetal monitoring. However, Chadwick, Coper and Harries (2014), in their qualitative study of women postnatally, identified a number of factors which contributed to negative birth experiences in South Africa. They reported that negative birth experiences were a result of negative interpersonal relationships with caregivers, lack of information, and neglect and abandonment. This finding is supported by McMahon et al. (2014) in their cross-sectional study of women's experiences of childbirth in Tanzania. They found that women felt ignored and neglected to the extent of giving birth on their own while in the healthcare facility. However, these studies did not report on the positive experiences. This means that there is a need to explore women's positive experiences of maternity care in Sub-Saharan African countries. These negative experiences are contrary to the continuous monitoring reported by migrant women in Australia (Hennegan, Redshaw & Miller 2014).

Social support

The final theme evident in the literature was related to social support and, in particular, support during labour and in the postnatal period. Support during labour has been found to enhance the physiology of labour and the woman's feelings of control and competence throughout childbirth (Hodnett et al. 2011). However, labour support is not routine in Sub-Saharan African countries. Chadwick, Cooper and Harries (2014) highlighted this in their qualitative study of the factors associated with negative childbirth experiences in South Africa. They found that the women expressed feeling neglected, abandoned, and unsafe throughout the process of labour. The lack of support from healthcare providers was worsened by the absence

of a labour companion which the women would have appreciated. As mentioned previously, there is a need to research both the positive and negative childbirth experiences of Sub-Saharan African women. The evidence suggests that childbirth experiences can be enhanced by the presence of a labour companion. This view is supported by Hennegan, Redshaw and Miller (2014) who reported that migrant women in Australia appreciated a support person being allowed in the labour facilities which did not occur in the Sub-Saharan African setting. Hence, women should be enabled to have a support person during labour if they wish.

Although becoming a mother can bring joy, it can also be stressful in the absence of a support network. Most studies found that women giving birth in western countries experienced isolation, loneliness, and depression due to a lack of support (Benza & Liamputtong 2014; Renzaho & Oldroyd 2014; Stapleton et al. 2013; Straus, McEwen & Hussein 2009). These feelings were mostly observed during the postnatal period when the women take on the motherhood role. Renzaho and Oldroyd (2014) conducted a qualitative study of migrant women's perceptions of pregnancy and the postnatal period, and found that the women had difficulties during the postpartum period due to separation from their extended families. These experiences are contrary to what the women experienced in their Sub-Saharan African countries. This view is also supported by Mbekenga et al. (2011) in their qualitative study of postnatal experiences in Tanzania. They reported that the women enjoyed motherhood as they received respect and support from their families and their community. Furthermore, Balaam et al. (2013) argued that pregnant women in host countries need information and social support to achieve a safe pregnancy and birth; therefore, it is important that midwives understand these women's needs, provide support, and refer them to multicultural community support groups for further social support.

Discussion

Sub-Saharan African women have been reported to experience barriers to accessing maternity services in western countries such as Australia, including language difficulties; culture, beliefs and traditional practices; staff attitudes; physical barriers; and a lack of knowledge about the healthcare system. The evidence suggests that

there is a need to improve access to health services for child-bearing Sub-Saharan African women. Access can be achieved through the education of healthcare workers on the needs of Sub-Saharan African migrant women. Healthcare providers' awareness and understanding of Sub-Saharan African women's culture can also help in the provision of culturally-appropriate maternity care to improve access. Secondly, healthcare providers can improve Sub-Saharan African women's understandings of available health services by providing information through health education and raising awareness through community organisations. Thirdly, interpreters can assist in bridging the language barrier; however, they need to adhere to ethical principles of confidentiality in their practice so that the women feel comfortable in using their services.

The traditional practice of female genital mutilation appears to be a challenge for Sub-Saharan African women in accessing maternity care in western countries. Female genital mutilation is associated with obstetric complications and is further complicated by healthcare providers' lack of knowledge and skill in managing FGM at childbirth. This problem can be dealt with by in-service training of staff about FGM and childbirth. Due to the increasing number of Sub-Saharan African women in Australia, it may be suggested that FGM be included in midwifery education. Attitudes of healthcare staff have also been found to affect women's experiences of maternity care. Friendly and supportive staff promote women's motivation to attend antenatal consultations (Carolan & Cassar 2010). On the other hand, negative staff attitudes hinder access to care.

This review suggests that Sub-Saharan African women in western countries experience feelings of isolation, loneliness, and depression due to a lack of support. This lack of support may even result in emotional distress posing a risk of postnatal depression. Although midwives may not provide total support for these mothers, they can refer them to available African community organisations for support. Further research is warranted to explore post-partum depression among Sub-Saharan African migrant women in western countries. Continuity of care was found to be appreciated by the women resulting in positive experiences of maternity care. On the other hand, a lack of continuity of care frustrated many of them as they had to retell their story to each different staff member. Studies have found that Sub-Saharan

African women's previous experiences of childbirth influence their expectations of childbirth in Australia. As Sub-Saharan African women have a cultural orientation that influences them to prefer natural labour without pain relief, to not cry during labour, and to give birth vaginally, Australian midwives need to understand that the non-expression of pain does not mean that the women are not in labour or not experiencing pain. Positive experiences of maternity care can be enhanced by discussing pain relief with clients during pregnancy as part of their preparation for childbirth so that they are aware of the various ways to relieve pain during labour.

Limitations

Most of the research studies in this review are qualitative with small sample sizes; therefore, the findings may not be representative of all Sub-Saharan African women. There is no research on the topic from some Sub-Saharan African countries, as very few countries have conducted studies on women's experiences of maternity care. This lack of research further affects generalisation of the findings to the overall population of Sub-Saharan African women.

The review excluded non-published studies; hence, there is a possibility of missing information from unpublished studies. Furthermore, limiting the selection to particular years of publication excluded research articles which could have been informative to the study despite presenting older information. Although this review highlights the literature on Sub-Saharan African women, only Carolan and Cassar (2010) and Murray et al. (2010) have specifically focused on African women's experiences of antenatal care and childbirth respectively in Australia. Most of the literature that explores the experiences of African-born women receiving maternity care is from the United Kingdom, North America, and Europe, which indicates that there is only limited literature in Australia on this topic. Therefore, there is an established need for this study of Sub-Saharan African women's experiences of maternity care in their home countries, and in Australia, that focuses on the entire perinatal period.

Conclusion

This chapter has presented the research evidence on Sub-Saharan African women's

experiences of maternity care in Sub-Saharan Africa and in Australia and other western countries. The search strategy used to identify the literature and the critical appraisal of the studies was discussed. Evidence from the studies suggests that cultural beliefs and staff attitudes influence access to maternity care. The review has established that Sub-Saharan African women's experiences of childbirth and postnatal care in Australia have not been adequately explored and this gap in the literature signifies the importance of exploring this area of maternity care. Therefore, the proposed research will contribute knowledge in an area that has not been well addressed in the literature, as it will explore Sub-Saharan African women's experiences of the entire perinatal period in Sub-Saharan Africa and in Australia. The following chapter presents the methodology used to conduct the study.

CHAPTER THREE: METHODOLOGY

Introduction

The aim of the study is to examine the experiences of Sub-Saharan African women in relation to maternity care services in their home countries and in Australia. Chapter Two discussed the literature related to the experiences of Sub-Saharan African women in relation to maternity care in their countries of migration. This chapter presents the methodology and the processes and steps that were followed to address the research question. It covers the research paradigm, research methods, and recruitment of the participants, data collection, and data analysis. The rigour of the study will also be explored before concluding the chapter.

Paradigm

Research is guided by the researcher's view of the world, which is known as the paradigm (LoBiondo-Wood & Haber 2010). The chosen research paradigm for this study is the qualitative paradigm, which is appropriate as it generates meaning and understanding of the phenomenon under scrutiny from the participant's perspective (Liamputtong 2013; Parahoo 2014), thus enabling the participants to be involved in the construction of knowledge.

People's experiences change over time and from one context to another, and therefore, cannot be generalised. Hence, a qualitative design is appropriate for this study as it does not seek to generalise the findings. Unlike quantitative research, which seeks to discover a single truth, qualitative research acknowledges that there are multiple realities (Erlingsson & Brysiewicz 2013), and that therefore, there cannot be a single truth to women's experiences, as they are interpreted differently by each individual. As this study intends to understand women's experiences, a qualitative approach was therefore deemed to be appropriate.

Furthermore, a qualitative approach allows the researcher to explore the women's experiences holistically. Parahoo (2014) suggested that, with qualitative research, participants can describe their experiences of the phenomenon being studied in

totality according to their own meaning rather than the researcher's specified variables. Since the aim of the study is to obtain an in-depth understanding of Sub-Saharan African women's maternity experiences, and that little is known about Sub-Saharan African women's experiences of maternity care, it was appropriately explored using an inductive approach (Parahoo 2014; Polit & Beck 2012). An inductive approach begins from specific observations to establish generalisations about the studied phenomenon (Polit & Beck 2012).

Methodological approach

According to Carter and Little (2007), the research methodology is determined by the research question and objectives, and the methodology subsequently determines the research methods to be used for the study. This research study used an interpretive methodology following the tenets of interpretive phenomenology. Phenomenology is a qualitative approach which seeks to describe and interpret 'the lived experience' (Flood 2010). The basis of an interpretive approach is that people are complex beings who bring unique meanings and perspectives to any given situation, according to their own individual realities. Consistent with the aim of this research, interpretive methodology seeks to describe and interpret participants' experiences (Polit & Beck 2012).

Since the researcher is a Sub-Saharan African woman herself, it would not have been possible to approach this study from a neutral mindset, or to completely bracket the researcher's beliefs and preconceptions. In response, the researcher's preconceptions will be fully acknowledged. This approach is supported by Tuohy et al. (2013) who stated that, in interpretive approaches, the researcher needs to be aware of the factors that may influence his/her understanding and interpretation of the phenomenon, such as past experiences. Likewise, Flood (2010) highlighted that it is not possible for the researcher to rid himself/herself of what he/she knows. Being a midwife from Sub-Saharan Africa, the researcher was aware that her culture could influence the research process; however, having such a background did enable her to probe in order to gain a deeper understanding of the women's childbirth experiences. Following the decision on the methodology, the next step in the research process was to choose an appropriate method for the collection of the data.

Methods

The selection of an appropriate research method is important in order to meet the objectives of the research study (Parahoo 2014). Research method refers to the activities carried out when conducting the research, which include the recruitment of participants, data collection, data management, data analysis, and report writing (Carter & Little 2007). Therefore, being a qualitative research study, qualitative methods including semi-structured interviews were chosen to explore the participants' lived experiences and to allow the researcher to probe deeper into these experiences (Parahoo 2014). This interview approach was appropriate for providing a deeper understanding of the phenomenon (Gill et al. 2008) as the participants could talk openly about their experiences. As well, it encouraged the free flow of ideas while keeping the conversation on track (Roberts & Taylor 2001).

Ethical considerations

Ethics approval to conduct the study was obtained from the Flinders University Social and Behavioural Human Research Ethics Committee (Approval number 6978). The ethics approval is included in Appendix 8. Potential participants were provided with an information pack which explained the research process so that they could make an informed decision about whether to participate in the study or not. The information pack included a letter of introduction (Appendix 9), an information sheet (Appendix 10), and a consent form (Appendix 11). Before the commencement of each interview, the researcher explained the information in these documents, and told the participants that participating in the study was voluntary and that they were free to withdraw at any time if they wished to without any consequences. Verbal clarification was sought for women who had language and literacy deficit. Following this, written consent was obtained, including whether they agreed to be recorded or not.

To ensure privacy and confidentiality, the participants decided on a safe meeting place where privacy and confidentiality could be maintained. Pseudonyms were also used on the written interview notes and in the thesis itself to ensure confidentiality. Finally, the data were stored on the researcher's laptop which is password-protected

during the study, and will also be stored digitally for five years at the university.

Research setting and recruitment

The research was conducted in the Adelaide Sub-Saharan African community. Recruitment of participants was conducted through African community organisations in Adelaide, including the African Community Council of South Australia (ACCSA), the Ugandan community, and the African Women's Council of Australia. Recruitment through these diverse organisations helped the researcher to obtain a sample of participants with diverse backgrounds and maternity care experiences. To gain entry into the African communities for recruitment, the researcher gained endorsement from the leaders of each of the different communities.

Following ethics approval, the researcher advertised the study by posting recruitment flyers on the African community organisations' notice-boards. The organisations' leaders also promoted the research during community meetings by raising awareness about the study. The researcher attended the community meetings and distributed the information packs to the potential participants. Interested respondents then contacted the researcher directly to arrange to be interviewed.

To ensure a successful data collection process, the researcher identified a sampling strategy that would provide participants who would be suitable for the study. Purposive sampling was the primary method of recruitment to identify potential participants. Since the study used an interpretive methodology, data were sought from people who had experienced the phenomenon being studied (Englander 2012) and who would be willing and able to share their experiences. In congruence with qualitative research procedures, participants were selected purposively as the intention was to gather in-depth information on the research topic rather than to obtain a representative sample as required in quantitative research (Carter & Little 2007). Participants were selected if they met the eligibility criteria of giving birth in Sub-Saharan Africa and in Australia. Similarly, the aim of the research is not to generalise the findings but to understand the participants' experiences; therefore, the sample did not need to be representative of the population. In addition, in interpretive research, the researcher is not interested in how many times the participants have

had the experience, and therefore, there is no power calculation required (Englander 2012).

The purposive sampling was supplemented with snowball sampling. According to Polit and Beck (2012), snowball sampling can complement purposive sampling in order to access participants who may be difficult to identify. Furthermore, both purposive and snowball sampling have been identified by Watson et al. (2008) as suitable sampling strategies for phenomenological studies. Through snowball sampling, the initial participants were requested to refer other women who met the selection criteria to contact the researcher if they were interested in participating.

For effective recruitment, the setting of inclusion criteria is important to find participants able to share in-depth information about their experiences (Polit & Beck 2012). Women were eligible to participate in this study if they were born in one of the Sub-Saharan African countries, over 18 years old, had experienced pregnancy and childbirth in both Sub-Saharan Africa and in Australia, and were able to speak English. Women were excluded from the study if they could not speak English or had not had the minimum of two maternity experiences. The inclusion criteria are shown in Table 2 below.

Table 2: Inclusion and exclusion criteria for recruiting participants

Inclusion	Exclusion
Born in Sub-Saharan Africa	Born outside Sub-Saharan Africa
Aged 18 years or above	Aged below 18 years
Experienced childbirth in Sub-Saharan Africa and in Australia	Had less than the two minimum maternity experiences
Able to speak English	Unable to speak English

Data collection

In-depth face-to-face interviews using a semi-structured interview guide were used to collect the data. In accordance with a phenomenological approach, interviews allow the researcher to explore and understand the participants' experiences (Minichiello, Aroni & Hays 2008). This view is supported by Polit and Beck (2012) and Flood (2010), who stated that interviews are the primary method for data collection in phenomenology. The responses that can lead to in-depth understandings of the women's experiences can be obtained by interview data collection; these same responses cannot be readily gathered through alternative methods, such as a survey. As the participants were from different cultural backgrounds, and sometimes required questions to be expressed differently to enable comprehension, or to have specific terms explained, semi-structured interviews also allowed the researcher to modify the questions (but not the meaning) to suit the participant's understanding.

Before commencing data collection, the researcher carried out a pilot interview to evaluate her interviewing skills, which was reviewed with the supervisors. This resulted in a number of changes to the interview technique and some modification of the interview questions. Initially, the researcher determined that the interviews lacked probing questions to gain richer insight into the women's experiences; therefore, after each interview, the researcher undertook a reflective process and improved the questioning approach in the subsequent interviews.

The researcher used an interview guide with a list of open-ended questions to guide the discussion. The questions were formulated to focus the interview on the research objectives. However, in order to enable the participants to lead the flow of the discussion, the sequence of the questions was not necessarily followed. The interview guide can be found in Appendix 12. As the data collection and data analysis occurred concurrently, a number of questions were added to the interview guide based on the concepts that emerged from the previous interviews. Thus, carrying out data collection together with the data analysis helped to inform the forthcoming data collection.

Fourteen interviews were conducted with women who had given birth in Sub-

Saharan Africa and Australia. Further recruitment of participants was stopped upon reaching data saturation. According to Creswell (2013), data saturation is a point in the data collection whereby no new information comes from the data. Although the number of participants may appear small, it is consistent with interpretive phenomenology design as it is the individual's experiences that are the basis of the analysis rather than the number of times an experience was mentioned (Polit & Beck 2012). This view is supported by Guest, Bunce and Johnson (2006) who conducted a study in Ghana and Nigeria to establish the number of interviews required to reach data saturation.

The interviews were conducted at a place that was convenient and preferred by the women, which was usually in their own homes, in public libraries, or a cafe. The interview that took place at a café was conducted in the morning hours when it was not busy and less noisy. In the public library, separate rooms were used for the interviews. The duration of the interviews ranged from 35 to 100 minutes with an average duration of 60 minutes. Petty, Thomson and Stew (2012) stated that an interview duration of between 30 and 90 minutes is appropriate, whilst Gill et al. (2008) suggested that interviews can take 20-60 minutes depending on the research topic and the participants.

The interviews were audio-recorded using a digital recorder to capture a complete record of the data. One participant initially refused to be recorded as she was not sure if she would be able to provide the required information. Therefore, notes were initially taken; however, during the interview, once she understood the questions, the participant allowed the recording to be undertaken. Audio-recording enabled the researcher to provide the participants with her undivided attention and allowed the participants' freedom of discussion without interruption (Patton 2014). Similarly, having the data recorded facilitated an accurate transcription of the data as the entire discussion was captured. In addition to recording the data, notes were taken of key points that needed to be explored in greater detail, and the researcher used these notes to ask follow-up questions. This enabled the researcher to allow the participant to talk without being interrupted.

The researcher transcribed the audio interviews verbatim herself which allowed her

to become familiar with the data and to start the data analysis process. Transcription and commencement of data analysis was informed by the principles described by Braun and Clarke (2006). Through transcribing the data, the researcher identified a number of issues that needed to be explored further in the subsequent data collection and analysis. The transcripts were also double-checked for accuracy by re-listening to the audio while checking the transcripts. The data were managed through the use of N-Vivo 10, a computer program used to organise qualitative data (Sweet 2008). Using N-Vivo 10 helped the researcher to organise the data, as it could be retrieved easily and was very time-efficient (Erlingsson & Brysiewicz 2013).

Data analysis

Data analysis in qualitative research is undertaken to draw meaning from the data (Polit & Beck 2012). In this study, the data were analysed through a thematic analysis using the process outlined by Braun and Clarke (2006). According to Clarke and Braun (2013), thematic analysis is suitable for research questions that seek to understand people's experiences, and thus, was deemed suitable for the research aim of this study, which was to understand the experiences of maternity care of Sub-Saharan African women. Likewise, thematic analysis is consistent with the interpretive methodology used in this study and is also the fundamental method of qualitative analysis (Braun & Clarke 2006; Polit & Beck 2012). The researcher was guided by the six steps of data analysis outlined by Braun and Clarke (2006); however, the process was not sequential as the researcher moved back and forth between the phases.

Having transcribed the interviews herself, the researcher had an initial understanding of the data. The transcripts were checked against the audio-recordings for accuracy. In the process of familiarising herself with the data, the researcher read the transcripts a number of times to better understand the content and to search for overall meaning within the data. With this repeated reading, notes were made of the interesting points which helped in the overall analysis.

Using descriptive coding, the researcher classified the data into meaningful codes. Coding is a cyclic act of summarising the essence of a portion of data (Saldana

2009). The codes emerged from what was deemed significant within the data, and were then categorised by grouping similarly coded concepts. While the coding was completed as an initial step, the researcher continued to code and recode the data throughout the analysis stage as she drew meaning from the incoming data. This process resulted in a number of codes becoming redundant or merging into other codes. The transcripts and the developing codes and categories were discussed with the research supervisors for further interpretation. From these codes and categories, the researcher identified four themes by summarising the meaning of the women's experiences. According to Grbich (2013), meaning is found through identifying themes in the transcripts through thematic analysis. Developing themes from the data is consistent with phenomenology, whereby the themes emerge from the data rather than from preconceived categories (Liamputtong 2012). Relevant data extracts were attached to the associated theme and the symbol [] was used for words inserted by the researcher 'to correct' the language, to make it more readable without changing the meaning or intent, as English was not the participants' first language.

Following the thematic analysis, the findings were reconsidered against the literature. At this time a conceptual framework by Levesque, Harris and Russell (2013) was identified, and was used to enable a deeper and more detailed discussion of the findings in the context of how maternity care was experienced by the women. Levesque, Harris and Russell's (2013) five dimensions of accessibility of healthcare services were consistent with the principles of primary healthcare and therefore applicable to this study.

Limitations of study design

As is to be expected with all research, there are limitations to this study. As with most qualitative research, the findings of this study cannot be generalised to all Sub-Saharan African women. Secondly, the interpretive methodology relies on participants' verbal interpretations which may be a challenge when studying people who cannot express themselves well (Gerrish & Lacey 2013), which in this case may have been because English was their second language. Therefore, the interpretation of the women's experiences of maternity care was dependent on finding participants

who were willing and able to describe their experiences. Considering that English literacy may be common with educated Sub-Saharan African women, it is likely that the participants were from a higher socio-economic background or have studied English in Australia. Therefore, the inclusion of women who could speak English may have skewed the data as such women are likely to have experienced skilled birth attendance. While efforts were made to recruit women from as many Sub-Saharan countries as possible, it so happened that there was a high representation of women from South Sudan. Recruitment and data collection occurred concurrently. Also, the women's experiences were strictly limited to what the women actually said in the interviews, as their experiences were not observed. Therefore, the study is retrospective, based on people's memories of the past, and the participants may not have recalled every detail of their experience.

Rigour

According to Liamputtong (2012), rigour refers to the evaluation of the quality of research. A common framework used to evaluate rigour in qualitative research is trustworthiness (Mateo & Kirchhoff 2009). Therefore, the quality of this study has been determined by assessing its rigour or trustworthiness using the four criteria of credibility, dependability, transferability, and confirmability.

- a. Credibility or truth value: this criterion measures the accuracy of the results in terms of how accurately they reflect the experiences of the participants (Mateo & Kirchhoff 2009). Firstly, the credibility of this study was enhanced by audio-recording of the interviews to ensure that the researcher captured exactly what was said by the participants. Original audio interviews were used to double check the transcripts. Secondly, there was constant discussion of the findings with the supervisors. The supervisors have deep expertise in qualitative methodology and they reviewed the transcripts to determine if there was consistency between the data, the codes, and the identified themes. They also reviewed the study before it was finalised. Finally, the findings, or the researcher's interpretations, are supported by quotes from the participant interviews which, as stated by Erlingsson and Brysiewicz (2013), further adds credibility to the interpretation.

Although member checking is a useful technique for ensuring credibility, it was not undertaken for this study. This was based on the understanding that participants may narrate experiences in the interview, and later change their minds about what they said; not because it does not reflect their experience, but because they may regret saying it. This is a view supported by Angen (2000) who stated that if participants do not agree with the researcher's interpretation, it may result in confusion instead of confirmation. Furthermore, participants' views about the same data may vary; therefore, confirmation of a transcript by the participants may not be useful.

- b. Dependability: this criterion evaluates the consistency of the research methods, so that the study can be repeated (Petty, Thomson & Stew 2012). The researcher described and justified the methodology and research methods used for this study so that the research process used can be replicated by other researchers who may want to conduct a similar study. However, it is acknowledged that due to the nature of phenomenology, and the variations in the context and time, the study may not be replicable.
- c. Transferability: this criterion evaluates if the results can be applied to other settings (Liamputtong 2012). To ensure transferability of this study, the researcher has provided a detailed description of the sample and the study setting in which the research was conducted. According to Petty, Thomson and Stew (2012), purposive sampling of participants is another strategy to ensure the transferability of a study. However, it should be noted that qualitative research does not intend to generalise findings, but instead, to describe the phenomenon under scrutiny within the given context.
- d. Confirmability is a criterion for ensuring that the findings are derived from the data rather than from the beliefs or biases of the researcher (Liamputtong 2012). Tappen (2010) suggested that confirmability is not relevant in phenomenological studies. However, according to Petty, Thomson and Stew (2012), confirmability can be achieved through the use of a detailed audit trail, triangulation, reflexive journal keeping, and member checking. Throughout this research, reflexive notes were kept and the supervisors of the research project examined the interview data and findings to confirm that the findings

were indeed derived from the data.

Conclusion

This chapter has discussed the methodological approach used in this research as well as the rigour of the study. Ethics approval was obtained prior to data collection, and the study followed sound ethical principles of conducting research, including informed consent and maintaining confidentiality and anonymity. A qualitative research methodology was adopted using in-depth individual interviews to collect the data, which were then transcribed and thematically analysed. The findings of the analysis will be discussed in the next chapter.

CHAPTER FOUR: FINDINGS

Introduction

Chapter Three discussed the methodology and the process used to conduct the research for this thesis. This chapter presents the findings from the data analysis. Initially, the demographic details of the participants will be provided, followed by a discussion of the themes derived from the thematic analysis of the data.

Participant's demographic characteristics

Fourteen (14) Sub-Saharan African women who have given birth to children in both Sub-Saharan Africa and Australia were interviewed for the study. Table 3 (over page) presents the demographic characteristics of the research participants. Fifty percent were from South Sudan, while the others were from different countries in southern, eastern, and western Africa. The age of the participants ranged from 26 to 49 years, while the length of stay in Australia was between 1 year nine months and eleven (11) years.

The interpretive analysis of the data resulted in four themes based on the differences found by the participants between giving birth in Sub-Saharan Africa and in Australia. These themes are: access to services and health promotion; birth environment and support; pain management; and perceptions of care.

Table 3: Demographic characteristics of participants

Participant	Age	Home country	Period living in Australia (years)	Maternal age at first birth	Parity	Children's sex; Year of birth; Country of birth						
						Child 1	Child 2	Child 3	Child 4	Child 5	Child 6	Child 7
P1	36	Liberia	8	19	3	Male 1999 Liberia	Female 2001 Liberia	Female 2015 Australia				
P2	36	Uganda	8	27	4	Female 2006 Uganda	Female 2011 Australia	Male 2013 Australia	Male 2015 Australia			
P3	49	South Africa	9	19	3	Male 1996 South Africa	Male 1999 South Africa	Male 2009 Australia				
P4	32	Malawi	8	20	3	Male 2004 Malawi	Female 2010 Australia	Male 2011 Australia				
P5	32	Liberia	1.5	19	2	Male 2002 Liberia	Female 2015 Australia					
P6	33	Burundi	11	18	3	Female 2001 Burundi	Male 2006 Australia	Male 2012 Australia				
P7	40+	South Sudan	10	not known (teenager)	6	Female Unknown Uganda	Female 1990 Uganda	Male 2001 Uganda	Male 2002 Australia	Male 2007 Australia	Female 2009 Australia	
P8	26	South Sudan	4	22	3	Female 2011 Uganda	Female 2013 Australia	Female 2015 Australia				
P9	30	South Sudan	Not known	16	4	Female 2001 Uganda	Female 2003 Uganda	Male 2006 Australia	Female 2008 Australia			
P10	unknown	South Sudan	4	unknown	4	Male 2004 Kenya	Female 2007 Kenya	Male 2013 Australia	Female 2014 Australia			
P11	33	Uganda	11	14	6	Female 1996 Uganda	Male 1998 Uganda	Male 2002 Uganda	Female 2005 Australia	Female 2008 Australia	Female 2015 Australia	
P12	26	South Sudan	9.5	15	5	Female 2005 South Sudan	Female 2008 Australia, died	Male 2009 Australia	Male 2010 Australia	Male 2010 Australia		
P13	38	South Sudan	6	24	4	Male 2001 Uganda	Male 2003 Uganda	Male 2007 Uganda	Female 2014 Australia			
P14	33	South Sudan	10	13	7	Female 1994 South Sudan	Male 1999 Uganda	Female 2000 Uganda	Male 2004 Uganda	Male 2005 Uganda	Male 2008 Australia	Male 2009 Australia

Access to services including health education

The first theme is about access to maternity services and health education. The participant women's experiences suggest that there were challenges in accessing maternity services both in Sub-Saharan Africa and in Australia. However, the barriers were not the same in these settings. In Sub-Saharan Africa, the barriers

included the long distances to the facilities, and problems with transport, waiting times, and inadequate resources, while in Australia, the challenges of access stemmed from communication and a lack of familiarity with the maternity care system.

The long distance travel to healthcare facilities in Sub-Saharan Africa was cited by a number of participants as a barrier to accessing maternity care services. Participant 12 explained that she could not attend antenatal appointments as expected because the hospital was too far from her residence.

Yeah, not like as often because of the distance. So I can't go as regularly as whatever they ask me to go... Even when I went through labour, it was really hard because the hospital is so far where I have to go for check-ups and all that. Yeah, so that's why I find it really hard (Participant 12).

Others shared similar experiences:

Sometimes, maybe the hospital will be far away from you... Because it was far from us [so she could not give birth in the hospital] (Participant 5).

You know the hospitals, like in my country, are far away and people cannot go there... In Africa, it is not easy... hospital is too far away (Participant 7).

While healthcare facilities in Sub-Saharan Africa were far from the women's homes, transport was also a problem, as it was unavailable, too costly, or inconvenient for the women, especially when they were in labour. The transport issues resulted in lengthy journeys to the facilities, exposing the women to the risk of giving birth along the way without professional assistance.

Transport is walking, [it] is long distance. You walk... It is long. Because like if you leave the house sometime, you get there at one if you left the house in the morning. You arrive there at 1 or 2 [in the afternoon] (Participant 12).

The man takes the bike and carry me. I have to sit on the bike, but if it's pain in the road, I will stop him, I will come [off] from the bike, sit down until the pain stop. And then I go back on the bike. Maybe it takes two hours in this

way. ...I just move from here, when little bit... start pain (Participant 13).

Once the women had negotiated their means of attending the Sub-Saharan African maternity health service, the next access concern was that of waiting times. In Sub-Saharan Africa, having travelled long distances to the health facilities, often on foot, the participants had long waiting times to see the midwives for antenatal care. Waiting times in Sub-Saharan Africa were associated with the large number of women attending antenatal care in the facilities and the absence of a time-booking system. Nevertheless, the participants continued to attend antenatal care when they could, despite the waiting times being a deterrent.

I had to keep on visiting the antenatal clinic, but the line was too long. Like you would go in the morning and you could stay until 1 o'clock before being attended. ...the waiting was just too long (Participant 4).

It is really not good because people have to sit a long [time], you know, you move, move, in a queue (Participant 9).

...it depends also which area you live, because some are very long with many pregnant women, so you have to wait, and it depends what time you went there. If you don't have anything serious, you can wait for the line pretty much for long [time]. But if you have something serious, that is when they can see you quickly (Participant 10).

The participant's experiences of waiting for healthcare in Australia had some similarities. A number of participants reported experiencing long waiting times in some hospitals in Australia. However, the waiting times varied, and if they had a booked appointment, the waiting times were shorter than if they presented without a booking. In Australia, most women travelled by car or bus to the health services and the waiting frustrated them as they were concerned about exceeding the parking time limits. As a result, waiting times influenced the choice of facility they would attend for antenatal appointments with subsequent pregnancies.

...the waiting times, I didn't like... at the [Hospital A]. I could sit there waiting. And sometimes with the parking, because sometimes I parked where it is two-hour parking. Then I would be thinking of going to change. That's why after I

had my daughter when I got pregnant for the little boy; I preferred to be seen by the GP or the other antenatal clinic at the [Hospital B] because there, their waiting times there, at least they are much shorter... (Participant 4).

...the only thing I didn't like was the way I would have to wait. The waiting time was a little bit longer. But the [Hospital A], they have a very long waiting period. I don't know now how it is, but I used to wait up to 2 and a half hours (Participant 6).

The next category within the theme of 'access to care' is the availability, or lack thereof, of resources for effective care. The lack of resources in Sub-Saharan Africa was linked to experiences of unsafe clinical practices which exposed the participants to complications. The lack of resources in Sub-Saharan Africa was evident for commonly needed supplies, such as medications.

...sometimes even if you are sick, they can't help you because there is no medication they can give you, they can take you to the ward to admit you but there is no proper medication (Participant 10).

In many cases, the limited resources were due to the health system not having access to them, but other examples were provided whereby despite their being available, they were not provided within the health system funding and the women did not have the financial capacity to pay for specific resources or care. One participant recalled how she survived a postpartum haemorrhage in hospital, even though she did not receive a blood transfusion because she could not afford to buy the blood she needed.

No, you know blood from Africa there you buy... yes, you buy (Participant 14).

Financial problems were identified as limiting access to care and as a barrier that resulted in poor attendance at antenatal care.

I went a couple of times and then I stayed home because thinking that if I always follow the appointments, I will probably wouldn't make it because I gonna have to get time for myself like to look for work to get money (Participant 12).

Comparing the availability of services in Sub-Saharan Africa and Australia, the participants reported that the services in Australia were accessible, financially available as they were covered by the health system, and technologically advanced with skilled personnel. They appreciated the availability of the resources, and services such as ultrasound, which they could not access in Sub-Saharan Africa.

Because when you go for scan, of course they will check everything. They will check the brain, they check how the child done movement... I compared the care between Australia and back home, Sudan. Australia is much better. Because the technology is going beyond, it is beyond [Africa] (Participant 12).

But so far here is like there is a proper check-up, like when you are pregnant, there will be some of the things or defects that a child can have, can be prevented during that pregnancy. But in Malawi, we don't have those... we didn't have those monitor, like here they could monitor with a computer and what, but there they just did and they just instructed me on what I had to do and I followed... Some sort of tests that they do here to see and to tell like the Downs Syndrome thing, and those like the neuro-defects they don't [have in Malawi]. So here it was ok because from the time that I realised that I was pregnant, I had to undergo a series of tests (Participant 4).

So, while access to care and resources were, in principle, available in Australia, the participants stated that communication hindered their access to maternity care. Even though they could speak some English, they had to adapt to the Australian way of speaking. For example, some healthcare providers would speak quickly, and the participants described missing some of the conversation.

I was speaking little English, but then English from Africa is different. We speak European English; here they speak a bit fast. I don't know how to say. In Africa, if you mean something, we tell more, here very short (Participant 11).

That's why many women they are scared. There is lack of speaking English, it make them..., they can't [stand up for themselves] or ask for something (Participant 12).

Communication is really big problem with me because my English is not good. Every time I speak to them, they don't understand me and I would be like 'Ah, why me...' I think they don't get my English very well (Participant 8).

Depending on the women's needs, interpreters were made available in Australia. However, a number of participants would not use them, as they were concerned about confidentiality. Participant eight explained her experience with an interpreter who breached confidentiality. As a result, she changed her attitude towards interpreters.

I don't really like interpreters because sometimes they don't keep the information. So, most of the time, I try to be strong and try to explain as much as I can... there was this lady that was interpreting [for] one of the community woman, and then one day we went and sat together in a community meeting. She was saying all this thing out to others. And I was there and I know this lady. Yes, she was the interpreter. And I know this woman. And I say 'oh they say this is gonna remain confidential' but then what she is doing, she is not doing the right job (Participant 8).

Consequently, language barriers can have serious implications for Sub-Saharan African women's care and health-seeking behaviours. Participant 12 explained that the lack of understanding of English is sometimes inappropriately interpreted as discrimination by some Sub-Saharan African women.

There is lack of speaking English, it make them... they can't understand or ask for something... and when they don't get that, they start to say 'they are racism, they hate us'. It is not that. It is lack of speaking English that's the main thing. But when you speak, you ask them, you will never be disappointed. You will definitely get what you ask. It is really, really... I have seen a lot... I am just saying that it is not about racism, it is just lack of knowing or understanding that this person, who of course doesn't speak [good] English (Participant 12).

Whatever the cause, it was clear from the participants' experiences that language barriers posed problems. The following woman's experiences suggest that she might

have misinterpreted the information provided to her about the condition of the baby in utero and the care she was consequently given or the information was miscommunicated.

The thing that I was not happy is because they were stressing me up, saying this is not good, when it is good... telling you 'oh your baby is not well' and at the end of the day, the baby is well. Which is not really good (Participant 8).

Access to care was also influenced by the women's understandings of the Australian health system. Unfamiliarity with maternity health services in Australia posed a challenge to some women, as they were not aware of where to go for care. While the maternity system in Australia is different from that in Sub-Saharan Africa, some women went to the hospital for care without a booking because they were not aware of the different expectations and processes.

Even when I had this one, I went there myself, and they said no it is good if I can visit my family doctor first and then he will be the one to refer me to the hospital (Participant 8).

Similarly,

I knew that there is Hospital A because of the buses, but I didn't know anything much apart from that. No, I didn't hear much because my parents they have never given birth to a child here. Of course, they knew about the hospitals here, but I don't know if they were aware that at the Hospital A, we can do this, I don't know. Because, for the first time, I wasn't aware about Hospital B doing the check-up antenatal clinic. I heard it when I was pregnant for the second one (Participant 4).

Lack of knowledge about maternity care services in Australia contributed to late bookings for pregnancy services. Participant 12 explained why she delayed booking until she was seven months pregnant.

Because it was my first time having a child here, and I don't know exactly the places I have to go like hospitals. And so I didn't think, you know, that it is important to go to the hospital for check-ups. So I stayed at home until I was 7

months pregnant, I hadn't been even to first check-up (Participant 12).

It is evident from the participants' experiences that maternity care in Sub-Saharan Africa included only antenatal and intrapartum care. The women expected that midwifery care would end just after giving birth because they had no experience of postnatal care. After birth in Sub-Saharan Africa, maternity care consisted only of immunisation for the babies, while the mothers received no postnatal care at all.

Yeah, you only go there to give birth and that's it... Normally in my country, if you give birth, when you are ok, you go home. That's the end between you and the midwife... I had to go home and then that was the end of it... It's risky I think (Participant 1).

When I left hospital that was it. There was no follow-up or anything. ...I can say that I didn't get any more support once I left the hospital from the midwives or the medical team... I didn't attend [postnatal care] because I don't think there was any provided (Participant 2).

In Australia, postnatal care following discharge from hospital was provided in the women's homes (home visits). Access to this was easy and suited the Sub-Saharan African women, as their culture does not allow them to leave the house for three or four days post-birth.

The midwives come home... maybe 2 or 3 times, it depends. If they find anything wrong, they either take you back to the hospital, or the doctor has to come and see you (Participant 10).

From the time when I deliver the baby, I stay home like one day, two days they came. And then they stay for two days, three days, four days, they came. They came here three times to make sure everything goes right (Participant 11).

Some participants mentioned continuity of care as a good strategy, as it would enable them to build a trusting relationship with the midwives, and to provide consistency. While midwifery-led continuity of care models did exist in Hospitals A and B, the participants did not access these services because they were not aware of their availability and how they could access them.

Maybe just like it is good to continue with the same midwife because I hear like some people they can be allocated a midwife and that midwife would carry on until the day they give birth. But me, I was seeing different people even during check-ups. It was only at Hospital B that I had the same midwife, but at Hospital A each and every visit I could see a different person. And they were not consistent, I don't know about now, because that was in 2010. But at that time I was seeing different midwives... So, sometimes I think it is good to maintain with the same midwife and to establish a trust and relationship, so that during the labour you can be able to open up and say this. Because sometimes when it is just strange faces, like a total stranger you would wonder, you don't know her reactions. So, that was the only thing, if they can be consistent, like allocate a patient to one midwife, if that is possible. Of course, I know that people can go on leave so, they may not be present throughout, but at least if they can be consistent (Participant 4).

However, midwifery-led care, as a choice, was becoming better known amongst the women.

But they say I don't know, somebody told me it is your choice, you can have the same midwife until you give birth. But in my case, I didn't have... I didn't know about that. I was just told you can have the same midwife. You can say I need to have this midwife even the day you give birth if you are happy with that (Participant 10).

Previous experiences of childbirth and maternity care had an impact on the participants' decision to seek care. Such decisions in Australia were related to the individual's experience of care in Sub-Saharan Africa. Although health services were available, some women chose not to access them, or did so with great trepidation.

It [the negative experience in Africa] affected me, because I thought maybe it is going to be the same. That's why I was really scared... I was a little nervous, like, I didn't know what to expect (Participant 4).

Participant 14 explained how she associated complications of labour and birth with hospital care. She made this association following her first birth in a hospital where

she had a postpartum haemorrhage, and since she knew of other women who gave birth without professional assistance who did not have complications, she blamed the hospital care for her situation.

Because I thinking maybe I go to hospital, that's why the blood come a lot [sic]. Maybe better to born the baby [at home] because the people [give birth] in road... what about me. I went there, something happened to me. Maybe better to born [in] my house. That's why I still born the kids in my house (Participant 14).

Early antenatal care attendance seemed to be influenced by whether the woman was comfortable with the services or not.

I didn't go earlier because I wasn't somehow comfortable (Participant 6).

Yes, [I attended ANC] because I learn from the other one, the one already gone [died], I learn from it (Participant 12).

It is apparent that access to care is influenced by various factors which need to be addressed in order to meet the women's needs. One of the need expressed by the women was that of health education.

Health education

Health education is an important strategy to address women's health and wellbeing and an integral component of contemporary midwifery care. Health education was evident as a sub theme of access to care for the participant women. In this study, health education refers to health information sharing from a health professional. Health education empowers women to make informed choices about their own care and that of their babies. From the participants' experiences, it shows show that heath education in Sub-Saharan African maternity care may be deficient or insufficient. This included a lack of preparation for labour and care of the baby.

Actually no, nobody tell me that when the baby [labour] start, is doing like this is start pain like this, nobody tell me (Participant 13).

...nothing about when you get into labour. The pain and all that you have to

expect, they didn't tell us about that (Participant 12).

In terms of educating me what to do at home, it was very minimum compared to what I experienced here (Participant 2).

Lack of preparation was related to the assumption that caring for a baby is natural for women. However, this assumption seemed unrealistic at times. As a result, some of the women struggled with basic parenting tasks, such as breastfeeding.

In my knowledge, there wasn't much support. I really suffered actually because I was living far away from my family and I didn't know what to do. I didn't know how often should I feed the baby and I didn't know if this is not working, what should I try, or if this is what is happening to me, what should I do, where should I go. I didn't have any of that (Participant 2).

At hospital, they did not even show me how to breastfeed, so I had to teach myself because there was no-one to teach me, so I had to teach myself. I remember the first time it hurt. The milk wasn't coming out. And I started feeling bad. Even when the child was trying to suck the breast, sometimes I could remove it. So yah it was a painful experience... (Participant 4).

The women's Sub-Saharan African experiences showed that they were not aware of when or where to seek help if they encountered problems after birth. This lack of information resulted in despair and delayed care. Participant 2 reported that she suffered postnatal depression and did not know if she could seek healthcare or not.

I also suffered from postnatal depression which I didn't know. I didn't even know what it was, I just wasn't feeling well. But I didn't even know what postnatal depression was or what was wrong with me... So I had no knowledge of what postnatal depression is so that means even when we were attending antenatal clinic there was no mention of it... because at least I could have known what it was about (Participant 2).

In Australia, the experience was different as the participants reported that they were educated about baby care, and they also had the midwives' support during postnatal home visits.

Yeah, even though it wasn't my first child, they were like teaching me how to get the baby, how to breastfeed the baby, and that was good. I breastfed even though I don't have very good breast... (Participant 1).

I had good support in terms of follow-ups from the hospital team and I had education on what to do when I get home. I was told where to go when I need specific help... and I had midwives visiting at least three times... (Participant 2).

As a result, the participants felt empowered by the health education they received and they felt in control of their pregnancy and their early parenting. Living in Australia was viewed by some participants as empowering because of exposure to different situations and their improving ability to express themselves.

You know, when you do not open to talk, you know, it is the way we grow up, the way we open up. We are hard to talk, and when we experience things. The more we experience things, the more it gives you words. You talk because you have seen this already. But when you did not see a lot, you have got nothing to write, nothing to say. Everything is ok (Participant 9).

Antenatal education classes were not often available in Sub-Saharan Africa. Despite recognising this gap in Sub-Saharan African maternity care, some participants did not attend antenatal classes in Australia. They thought that the classes were not important to them as they were already mothers and felt that they had other personal commitments, such as taking care of the children or working, so they did not have time to attend.

Because it wasn't the first time to have a baby. So, I didn't see the whole point of going there (Participant 10).

I actually didn't attend because I was busy studying, not studying I was working. I just didn't attend them (Participant 6).

Other participants found the invitation to attend to be either down-played by the midwife or non-existent. Although attendance at antenatal classes is a woman's choice, the way they were told about the classes often resulted in a lack of attendance. In the Sub-Saharan African context, the expression "if you want" can be

interpreted as not necessarily having to attend. Participant 10 mentioned the importance of attending the classes as they were in a different country, because issues may be handled differently, and therefore, they needed to know about this, but still she did not attend.

They were saying I have to attend classes, but I was telling them I really need to go [home]. They say if you want. Because here it is a different country, there is a different way of handling things, there is a different way of dressing, how you can shop, and how to breastfeed the baby, and how to change the nappies. All those things were there. And then there were books were given of how the baby grows, the different stages, and all those things. But me, I didn't go there. Because it wasn't the first time to have a baby. So, I didn't see the whole point of going there (Participant 10).

The reception of information appeared to be related to the participants' ability to understand and read English. Information was often provided in written form and the participants felt that they missed it because they could not read, or even if they could, they would have preferred the information to have been provided verbally first and then in written form as a reminder.

If we can be told in details, because maybe sometimes they assume that we are going to read all the information... They just assume just because they have put it in writing then people will read... So sometimes, it is good like just to brief us on what is being written (Participant 4).

Similarly, one's ability to communicate verbally in English does not always imply that the person can read.

...When you go to the hospital, some people just speak, but they can't read, some people read but they can't speak. So, it really doesn't matter when you see someone, like oh she speaks but she can't read, so you can explain to her things. Thus, you provide her with information... if I can speak, I still need to have something written down, even somebody can read for me. Because she can tell me something now and a few seconds later I forget everything. So at least if there is something written down, I can get someone to sit with

me and read and explain to me everything (Participant 12).

Health education offered in a way that is acceptable to the women empowers them to take care of themselves and their babies and to make informed decisions to seek healthcare when needed. The provision of health education is an important component of midwifery care and therefore warrants recognition in access to care.

Birth environment and support

The second major theme relates to the birth environment and the support available to the women during labour and birth. It is evident from the women's birth stories that the place they chose for the birth was strongly related to the ability to have the presence of their preferred support people which, in most cases, were family members. The inclusion or exclusion of family to provide care and support in labour influenced the women's place of birth.

The presence of family is very important to Sub-Saharan African women. In Sub-Saharan African hospitals, the family is often excluded from the labour ward. As a result, it was common for many of the participants to give birth at home as they were able to get the support of family, relatives, and neighbours in this environment. Therefore, the place of birth was partly chosen because of the support available to them.

I didn't go to hospital, I laboured at home. Yeah [all three children were born at home] (Participant 7).

The people were supporting me. The house was full. One holding here, one holding my hands... one was there waiting, everybody wanted to participate to have the baby survive (Participant 9).

The participants explained that the ability to give birth with family present was valued more highly by them than the actual place of birth. Participant 5 explained that this maternal choice was paramount.

Africans when they are about to give birth... they are not going to hospital. They have the baby at their home when the baby is good or the baby is not

good (Participant 5).

The participants described that, in Australia, families are encouraged to be present to give support to women in labour.

They [in Africa] don't allow, like in Australia, they allow others in the room with you, they [in Africa] don't allow it (Participant 1).

So, birthing in the hospital in Australia was not a problem in terms of family support for the participants.

I was not scared because there are family, there are people supporting me (Participant 11).

The presence of a support person during labour was greatly appreciated by the participants as it gave them courage.

In Sub-Saharan Africa, the norm is to exclude family from providing support to women in labour which is sometimes due to multiple women labouring and birthing in the same room; however, there were some exceptions to this. Excluding relatives/family in the care of the woman in labour in Sub-Saharan Africa seems to be a practice that is not accepted by some people. Participant 13 described how her mother negotiated entry to the labour ward, as she feared complications and wanted to support her daughter in labour.

Always they don't allow anyone. They say it's their job, they don't allow it but they allowed my mom, because my mom talked to them that 'I will never leave my daughter alone. Who want my daughter die when I was not there? Never, I will be there because this is my first time' (Participant 13).

When the presence of a support person was encouraged, it was usually the mother or sister who was present. No men were reported as being present during labour in Sub-Saharan Africa. In Sub-Saharan Africa, it is a cultural practice that men are not to see a woman giving birth. Participant 11 explained:

Although I stay here for all my life, I am not feel well because my culture... not

men, even your husband if you deliver baby is not allowed to come and see you (Participant 11).

In Australia, both male and female relatives were encouraged in the labour room. The participants were happy to have their partners with them; however, they described that the men would stay with them during labour, but not at the actual time of giving birth.

They come sit next to you. If the baby coming someone next to you, even at home like if I am sick I am just starting pain now, my husband can sit next to me. If someone come, anyone, even neighbour wife comes, friend come, he will leave me now, go somewhere separate until you deliver. (Participant 11).

Participant 13 stated that it was important to her that men saw the process of labour to better understand the women's experience.

Yeah, he was there, I tell him 'this is our first baby, you have to see how I suffering, so next time you will know, you will support the woman. Because if you didn't see, you will never support me. You will say, you are joking or you are not telling the truth. So I need you to see with your [own] eyes what is gonna pain women. He agreed with me, he is good. You see there his first time to see that thing, I cry out loud and then I push the baby. He tell me when I come back home that he was thinking I am gonna die. It is the first time; he doesn't know he is also gonna cry (Participant 13).

While on a cultural basis, Sub-Saharan African men do not attend birth, it is evident that there has been a shift in beliefs about the male's role in labour in Australia.

Although the women enjoyed giving birth at home for the family support it afforded them, 'home-birth' was not viewed as an 'acceptable' option in Sub-Saharan Africa, as women were expected by the government to give birth in hospital. Home-birth in Sub-Saharan Africa means giving birth at home usually without any skilled birth attendant, as there are no formal government-funded home-birth schemes. Therefore, women who have a home-birth may give birth alone, with their family members, with a traditional birth attendant or, if they could afford it, a private midwife.

You know in the Sudan, the woman in the Sudan, they can deliver without midwife. They can deliver normal. There are some people with strong heart they can deliver people with. One of my relatives, one of my brother's wife can deliver just alone, no-one to help (Participant 7).

No-one, only me myself inside. The time I am feel really, really like baby coming, I just lock the door with my mom-in-law outside (Participant 11).

There is a strong expectation by Sub-Saharan African healthcare providers that women will go to hospital to give birth. Participant 12 suggested that women were often persecuted by healthcare providers for giving birth at home.

Yeah, they accuse you. For them, it doesn't matter when something [wrong] happens at the hospital. At least it happened at the hospital. But if it happens at home, they will still accuse you and say you should have gone to the hospital (Participant 12).

Giving birth without the presence of a healthcare provider had negative consequences for some of the women. The participants described having complications which were not recognised and therefore not managed appropriately. In Sub-Saharan Africa, it is a cultural practice that women remain at home, or if they give birth in the hospital, they stay at home for at least three or four days after the birth, depending on the sex of the child. This means that for women who give birth at home, they cannot attend a clinic or hospital for postnatal care for this period of time. As a result, if they had problems or complications, they were not treated for four days. Participant 12 reported an experience of a woman who sustained a perineal tear at birth which was not sutured because she gave birth at home without professional assistance. She presented for postnatal care on day four when she was very sick and her perineal tear had become septic.

I remember the experience, it was my cousin, she gave birth at home and that was her first child. And then after that, she didn't go to hospital the following morning. She stayed home for like 3, 4 days and her wound was getting really, really rotten. It was rotten really badly like really stink... It was really bad and as I said really it was smelly. The wound didn't heal, she was tired so

badly. She was meant to be stitched, you know, but she never know such thing that and nobody attend to her because of the smell (Participant 12).

For those participants who received support at birth from healthcare staff, they perceived the midwives to be lacking in skills and training.

I think if they were well educated, if they really know what they were doing, they will know how to look after someone properly (Participant 1).

The participants were of the opinion that the people who cared for them were probably midwives when, in fact, they might not have been. For instance, they often referred to non-trained providers, such as traditional birth attendants, as midwives. Traditional birth attendants usually have no formal training but do have experience in delivering babies.

The 'midwives' are ok, but because they are not educated, they are local. You know, in the village there are women that can help you give birth the same way the midwife here does, but just them... they do not have the certificate to show that they are qualified to do what they are supposed to do, but they are doing everything (Participant 10).

No, they don't go to school, they just practicing themselves. They learn by themselves how to help people to give birth when they are in labour. So they just practising and they just know it by themselves (Participant 5).

Although the women generally appreciated the care provided by the qualified midwives in Sub-Saharan Africa, they believed that they were not trained to the Australian standard.

I really doubt [if they are trained], some of them are, but not to this level, they are not trained to the Australian standard. They may be trained as midwives but not much... They do not have the skill for it. They did not go to school for it. They are just doing it traditional (Participant 10).

A number of issues around healthcare providers' skills include the ability to support the woman through labour and birth, but also to appropriately assess and manage

any complications that arise. This includes engaging in referral in a timely manner for optimal outcomes. In Sub-Saharan Africa, as the education of the healthcare staff was highly variable, the skills to provide support, assessment, and referrals were also highly variable and resulted in unpredictable outcomes for the women. On the other hand, in Australia, with hospital births, the level of education and training of the midwives, and the well-funded system, there were no problems with the management and referral of the women.

Here, if there is anything that the midwives are just concerned about, they just refer you immediately to be seen by the gynaecologist (Participant 3).

I went to check me, then I come back, they didn't check like here they can tell that baby is going to [be born] now. But there[Africa] they cannot check properly... because the womb sometime is not like the baby come normal, but if you here, you go to hospital, they check and you know you cannot deliver the baby normal but you can have caesarean. Because the womb is too small, you can't deliver baby without caesarean. But in Africa, not like that. Most people got to pass away when they got to deliver the baby. Because even if you cut, the baby cannot come out. You have to cut... up there [abdomen] and do operation and the baby can come out. But that one is not in Africa. The people in Africa really, really suffering (Participant 7).

The participants reported experiencing some restriction of movement during their labour in Australia, whereas in Sub-Saharan Africa, the women were free to move around and walk to improve the progress of their labour. Although being free to walk around (in Sub-Saharan Africa) was appreciated by some women, others perceived it as negative treatment by the midwives.

[In Australia] you lie down. But in Africa, we don't do that, you are allowed to walk around to stretch your... yeah to move around so that the baby can come quick, but here, once you get to the hospital, you should be on your bed (Participant 8).

I don't know if that [midwife on] that day [was] not happy or what. I don't know [if] she is tired or what. She tells me that 'get up from this room if you cry, you

think the baby will come now? Get up, go and walk. Go, move around in the compound there. Stay there until the time for baby [to] come (shouting) (Participant 13).

Even though there were restrictions in movement when in labour in Australia, the women were encouraged to give birth in their preferred positions. Some preferred, and were encouraged to adopt, the kneeling position.

I am in bed but you know what, I kneel by my leg down. I just kneel like this. [If I lie down]... I just feel like something gonna break, I don't like it (Participant 11).

Another form of support valued by the participants was that provided by the family. Some of the participants reported that they were missing or lacking family and community support in Australia, as their extended families were not with them. In Sub-Saharan Africa, they received support and informal education about pregnancy and childbirth from relatives and the community.

Well, because back home, because it was my first child, I didn't know very much, but I suppose having mom there, my relatives, my parents-in-law, and my sisters-in-law, and stuff like that. And living in such core neat family, I kind of made it easy I suppose in a way that they would be saying 'you need to be eating this so that the baby can grow, you need to do that'. It was quite nice. Yes, all the support from relatives and the community (Participant 6).

Participant 6 further explained how she missed family and community support after giving birth in Australia.

Because here, I have my husband and my one child. That was pretty much my family. That is all I had... So, it is not like back home where you can say 'mom, I want this.' And they would make sure that they bring that, or mom would say 'oh she needs to be having that or stuff like that', but here it is not like that. So, until the baby was at least 3 months, I never bathed the baby. So here, the first thing I worried about was how I will hold the baby. And again that informal system because you have like your mom, and your.., you have a lot of support compared to here (Participant 6).

Participants 11 and 12 also concurred:

The only thing is that I didn't get support much because I don't have family here, only friends (Participant 11).

Not really, no. As I said in previous, when I had my first child in Africa, my mother was close to me, but when you reach here, it's different. When I have my three kids in Australia, she is not even talking to me (Participant 12).

While there are community groups for the African population in Australia, some of the participants expressed a lack of social support from them.

...I do know them but even though you ask them for any help, support, you won't get it. Now this, everybody is overtaken with jealousy, 'if I help someone, she gonna be better than me.' When we are back home, we are very close to each other, we help ourselves. Sometime you have nothing in the house, you can run to the neighbour, borrow something. Even not to borrow, but to have someone to talk to, share this. You have trouble, you run to someone else, that person gives even advice. It means a lot. But here I feel like every day just breaking apart (Participant 12).

Although the women experienced good family support in Sub-Saharan Africa, this was not the case with a teenage pregnancy. Of the fourteen participants, eight became pregnant between the ages of 14 and 19, and one had two teenage pregnancies. The participants reported experiencing family rejection when they had teenage pregnancies, such that they could not attend antenatal care.

The family didn't support me. They had their own belief. Like it was an embarrassment for them that I was pregnant while I was not married, so they like ... abandoned me... I was staying with on my own... That is why I ended up going to hospital with my cousin (Participant 4).

It was not an easy thing for me as for my case, because I was afraid and my family was not supporting saying why did I accept. No-one... because, it was a kind of neglect. My parents were not happy. I brought bad names. In Africa, people believe in that kind of thing, names, my family, my daughter is now in

school. And if something happens, they say 'oh my God' they think more of regret. ...they all sit back and say no. You know, you do it yourself because you know you made us not feel good anymore. And I was by myself, 8 days. It was terrible; I didn't know what to do... Even if the baby cries, my mom would say ah... ah, who sends you? (Participant 9).

Absence of family support during pregnancy and birth can have negative implications on the women. A birthing environment that allows presence of family support was valued by the participants valued however, in some hospitals in Sub-Saharan Africa, the family was often excluded resulting in the women opting to give birth at home.

Pain management

The participants conceptualised birth as painful, although the pain experience varied from one woman to another. They perceived labour pain and birth as normal and natural, and therefore, requiring no pain relief. This perception comes from being socialised in Sub-Saharan Africa to be strong and to endure the pain. These beliefs are evident in the following quotes:

Because I think it is natural. You have to feel that pain. Yes that's natural. I have to go through the pain. It is something I wanted (Participant 1).

And I feel like, as an African woman, we have to go natural (Participant 12).

Participant 3, who was a registered midwife in Sub-Saharan Africa and a birthing mother, also explained that pain is a temporary phenomenon:

No pain medication is given during labour because they say that it is a normal pain which is going to finish when the baby is born. Being a midwife, you don't give anyone anything because it is a normal pain that will happen, even if you are given anything, it is not going to take the pain away (Participant 3).

While labour pain was perceived as normal, a number of participants still wanted pain relief. However, in Sub-Saharan Africa for some women, pain relief was not available. Despite requesting it, they were denied.

I don't know that there is something there for helping pain in that hospital. I stay there, I got 3 children, I don't know anything (Participant 13).

And then, despite the level of the pain, they could not give us any pain relief (Participant 4).

The expression of pain varied from one woman to another, ranging from crying and screaming, to being silent which may have had an impact on offering pain relief.

I was just in pain. I was crying (Participant 12).

I feel the pain, [but] I am not talk, if the baby wants to come out, I am not talk (Participant 11).

Another way the women coped with the pain was by walking around rather than lying in bed. However, in Australia, they felt bound by the monitors which limited their mobility and kept them in bed.

But here, once you get to the hospital, you should be on your bed. It is painful; it is painful because when you are in pain, you don't want to be in one position (Participant 8).

The women who used silence to cope with their pain, disliked or were agitated by the noisy environments. They preferred a quiet environment with less frequent checks, especially for the vaginal examinations.

...because I am not talk... I don't want to see someone also sitting next to me talking too much. If you talk too much, I send you out. I lock myself, I need to be quiet (Participant 11).

Sometimes when the pain kick, I say no, no, no. I don't like anybody talk to me or touching me (Participant 12).

In Australia, the women who chose to be silent were misinterpreted as not being in true labour as they did not show any obvious signs of being in pain.

...the way I stay [silent], the people think I am not in labour. There was a student and they were thinking there is no pain here yet. They say to me...

thing [labour] is not real, baby not coming now. [It] may take time. Maybe you need to go back home. Then you will come back when the pain ready. [After this] It [doesn't] take even one hour and I get baby (Participant 11).

The women's beliefs and experiences in Sub-Saharan Africa shaped their behaviours in Australia. Those who gave birth without pain relief in Sub-Saharan Africa felt that they could also do so without pain medication in Australia, even though it was available.

When giving birth in Australia, multiple forms of pain relief are available; however, the women's experiences of pain relief management were variable. Some of the women could not get pain relief because they were unaware of its availability and of the different types of pain relief they could request.

And the only thing which concerns me a little bit with the way they do things here is that when it comes to pain relief... they want you to ask them what sort of pain relief you want. Yes, they ask you to tell them if you want a stronger one. They normally offer Panadol, but it is up to you to ask for a strong one. So now if you are not literate... how are you going to know? Because us from African background, most of the women are not literate. So, how will you know that there is something available if you need it? Because they always just come and give Panadol and ask you if you need something stronger. Normally, you ask for it actually (Participant 2).

The participants described an assumption by the Australian midwives that the women knew about the pain relief options, and that they would be able to ask for it themselves, rather than to be offered. However, the women mentioned that they could not ask, and instead, expected it to be offered. Furthermore, they felt they were expected to know the types of pain relief and to be specific with their requests. However, a lack of education about pain relief deprived them of this choice, as they had no knowledge of the different types of pain medication.

It is only that I wasn't really aware that I could ask for the pain relief. Yah, I was not taught properly that I can ask for the pain relief. So, I suffered with this little girl to come out... I didn't know, I was thinking like the hospital can

decide when they see the way a woman is struggling. That's what I thought. I didn't know that we had to actually ask... (Participant 4).

Furthermore, some of the participants sometimes misconstrued information about pain relief, particularly from friends who also lacked an understanding and shared a belief that all pain relief slows down the process of labour and has an adverse effect on the baby. Lack of knowledge about pain relief is probably due to information being provided in written form, and the fact that the women's understanding of the facts is not checked.

Yes because there is all this myth that we have about it. Some people say 'ah, it drags labour for ever; some people say 'ah it affects the baby.' I don't have any proof that this epidural slows the labour or this, but I am still a bit sceptical about it anyway (Participant 2).

The women tended not to read the pamphlets and preferred the information to be given verbally and then supplemented with the pamphlets. If they were effectively informed about pain relief in the antenatal period, they would have been able to make informed decisions in relation to pain relief.

...if we can be told in details because maybe sometimes they assume that we are going to read all the information. Because most of us, we are lazy to read (Participant 4).

But with the boy at least, the midwife told me that there are several methods of pain relief so I can ask for any... At least that one she opened my eyes. Because I ended up having an epidural when the pain was just so bad (Participant 4).

Although the women lacked knowledge about pain relief, most of them did not attend antenatal classes where they could have been taught about the pain relief options. It is likely that the importance or value of antenatal classes was not well explained to the participants and, as a result, they thought it was an option they could do without.

Although the women who received pain relief viewed it as helpful, some perceived it as not being effective in stopping the pain.

Of course the midwife gave me the gas when there is a contraction that I should breathe, but it didn't help... But I kept going until I had my daughter. But the labour was bad, painful (Participant 4).

As for the tablets, I didn't see much effect. If you like, you can take that gas, and the gas only making you drunk but the pain is still there (Participant 10).

...because that is a normal pain that will happen even if you are given anything, it is not going to take the pain away. Of which is true, even here I was given, it subsided just a little bit; it was still there when the contraction, when the uterus is contracting, there is no other way, you are going to have the pain (Participant 3).

...it was bad like a week, until I was punched with epidural. That one was the worst thing on earth (Participant 9).

Instead of relieving the pain, the medication resulted in side-effects such as dizziness. The experience of side-effects from the pain relief medication was cited as one of the reasons for choosing not to use pain relief in subsequent childbirths. Participant 9 explained that her experience with an epidural influenced her decision to use pain relief medication in subsequent pregnancies.

Because I was having double-strength for this one, and I said... no epidural. What I felt with epidural taught me. This one, no medication, no nothing. This baby will come I believe without tablet (Participant 9).

Non-pharmacological pain relief strategies were not part of the Sub-Saharan African experience. The participants first experienced these strategies in Australia, including massaging, rubbing, and breathing. Despite trying these for the first time, some of the women felt that they were not helpful and they preferred not to be touched.

Yeah, they tried, but with me I didn't really believe it works... Because it was my first time having that massage. But anyway, there is this lady, she was really with me, rubbing my back (Participant 8).

For others, but for me, I don't want anyone to touch [me] (Participant 11).

Women from Sub-Saharan Africa often believe that birth is painful but normal, and

therefore, natural. Since pain relief in Sub-Saharan Africa was often not available, pain relief in labour was not a well-understood concept. Therefore, when giving birth in Australia, although multiple forms of pain relief were available, some of the women did not receive any because they were not aware of the options. As well, the Australian midwives assumed that the women knew about these options and would ask for pain relief when needed. It is therefore evident from these experiences that a lack of knowledge about pain management was a key experience which also influenced access to care and can affect the way in which women perceive care. The next theme to be discussed is 'perceptions of care'.

Perceptions of care

It is evident from the participants' views that quality maternity care was important to them. While there was some variation in perceptions, they generally reported many positive perceptions of care throughout their childbearing experiences. The participants highlighted examples of interactions with maternity care providers which had either positive or negative impact on their satisfaction with the care.

Perceptions of maternity care providers

The participants' experiences showed that good maternity care was not all about having the services provided, but more importantly, was about the attitude of the care providers. Whether it was in Sub-Saharan Africa or Australia, the ways in which the individual women were treated had a strong impact on their perceptions of care.

Yeah, and the time she came, the baby was already out, just hanging in my legs. She was already out. And then, instead of her helping, she is making a joke, she said 'oh my God where is this, where am I from, curses from Khakwa where I am from... She is just making a joke, is not serious, because when you give birth, baby is out, you wanna make sure the baby is fine and she wasn't (Participant 12).

So they took her to the hospital. Instead to be seen, they [midwives] ignore her. Until she fight hard and they offer her the bed and then they just leave her there, no-one checked on her... and nobody attend to her because of the

smell. Everybody fearing coming close to her (Participant 12).

The participants' perceptions of care were strongly related to the behaviours and attitudes of the midwives. Those who had a positive attitude had a positive impact on the participants' emotional status as it relieved them of the tension and anxiety of being in a strange environment.

It's good and just another lady is not good. [She] just comes and say "why did you get baby, who told you to get baby? Now you cry for people." And the other lady [midwife] come and say 'you don't talk like that with people you have to be nice to people'... The good one was still with me until I born baby (Participant 14).

I think the best thing is the attitude. I don't know how I can explain to you, but when someone says 'how are you, are you ok, how you feel? You know you'll get there, it won't be long' and stuff like that. That's good. You feel cared, you feel that they care (Participant 6).

...because pain can be there but... it is the good manners [that matters] (Participant 10).

The positive attitude of the midwives in Australia was also viewed as comforting and reassuring to the women.

And they were so good, they were encouraging me, they were talking to me. You know, it feel like you are in a place [where] people are really caring for you. You feel more relaxed (Participant 12).

Although the quality of care and the skills of the personnel were considered to be important, the women differentiated between the good and the bad midwives by the manner in which they were approached by them. According to the participants, good midwives were caring, attended to their needs, respected them, and made them feel valued/valuable.

But when I came here, my first child that I have here in Australia, I was really treated with care, respect, and everything. I [mean], they were providing for

me (Participant 10).

...because the way they welcome you, they make you feel like [you're] alive [valuable] (Participant 4).

Respect was also valued by the participants. They appreciated being respected and regarded as human beings rather than as objects. Australian midwives did not behave as experts telling the participants what to do, and they valued the women's opinions and empowered them to make their own decisions.

...they were asking for my opinion because they don't wanna let the child really suffer... But if someone says no, that have to be understood, respected. That's the main thing I feel is important (Participant 12).

...what you say have to be respected because that is what you like to be done to you. Like if somebody asks what do you want me to do for you? You will say, ok this is what I want. And they have to offer you. When I get there, they say can we give [pain medication]? I said no, [because] I know myself. The baby was about to come (Participant 9).

The participants' views demonstrate that they had a good relationship with the midwives in Australia and that they felt free to discuss their problems.

They are good, very good. They talk to you good. Anything you want to know, you ask them, they tell you (Participant 11).

I had good care. Although my baby had to be in the nursery for seven weeks, the midwives there were amazing. I don't have any complain up to this day (Participant 2)

Facilitating the midwife-woman relationship was the midwives' ability to listen to the women and to respond to their individual needs.

...they are good, they care a lot. They take your need seriously (Participant 10).

You know they are always willing to attend and they are always willing to

listen to you (Participant 12).

Contrary to the freedom to discuss their issues with the midwives, in the doctors' consultations, some of the women felt rushed and that the issues were not well explained to them. This sense of feeling rushed was perceived as an assumption that the participants would already know certain things, whereas in fact they often did not. It was also felt that the sense of time pressure was related to the observation that Australians are rapid and brusque in their mannerisms and behaviours, while Sub-Saharan Africans tended to explain more, and were less time-oriented.

The thing is, they don't give you much time to explain your problem. ...the doctor will not have much time to chat with you until [although] you have this problem that you need to explain... because you know when you asking someone, someone has to pay attention and to take what you are telling them seriously and to put into consideration. ...they don't give you much time to talk to them... (Participant 8).

The presence of the midwives and their availability when needed were very important to the participants. It made the women feel safe and 'in good hands'.

It was really good because I was surrounded with the nurses. ...when you are lucky, you get the good nurse who will always be there to look after you (Participant 12).

There I give birth, they look after me well. They are good, they talk good, and they make me happy. Even I cry, I know they are looking after me. Yeah, they do everything good (Participant 13).

They sit next to you, they are not gonna leave you alone. When the other one [African midwife] go outside, they leave someone else until you get baby (Participant 11).

The participants' positive experiences of maternity care in Australia demonstrate that they appreciated maternity care and the support from the Australian government as the services were provided for free.

In Africa, we don't have that much support, but here we have Centrelink, so it is a big difference (Participant 4).

Everything is free unless you choose to go private. Of which there is no need especially if you are going to give birth. For other things yes, like medical, but not birth (Participant 6).

Perceptions of maternity care

The women's perceptions of the midwives and maternity care in Sub-Saharan Africa also affected their seeking of maternity care services. Although Participant nine did not mention it directly, her comment implied that midwives' negative attitudes influenced her decision to refuse to attend antenatal care.

I was a little bit nervous at first, and I was afraid like they will say something... I don't know. Like you don't want to lie down quick and when they ask you, answering the questions is like hard. I was feeling like shy (Participant 9).

On the contrary, maternity care in Australia was perceived by the participants as being of a high standard and as using advanced technology compared to what they had experienced in Sub-Saharan Africa. Participant 12 who had a baby with a congenital heart problem stated:

That day I went for that [first] check-up [at seven months], straight away they knew that something was not right... And everybody was helping to me and calming as well... I feel lucky and I am thinking if I could be in Africa and I have this child, [she would] die... I really enjoyed my pregnancy in Australia. Because I was well looked after... the technology here is really great. It makes you feel happy and safe (Participant 12).

I felt so good because the Australian they are really, really helping. They are doing good because the thing I did not experience in Africa I now experience here. They are helping the pregnant woman, encouraging them, they are helping if they are in pain, talking to them. It was so good, it is so nice (Participant 5).

Participant 6 explained how advanced management of her complications by skilled

personnel in the post-birth period saved her life. Reflecting on her experiences, she thought that such complications could have resulted in death in Sub-Saharan Africa.

It was serious. I end up in a cardiology unit, where they monitor... thank God I am in a country like this. I would have died if I was in Africa. Because straight away, they got the cardiologist to come and put the ECG to check (Participant 6)

The participants were impressed with the diagnoses conducted in Australia, especially during pregnancy to detect foetal abnormalities, as well as the management thereafter.

But, so far, here is like there is a proper check-up like when you are pregnant there will be some of the things or defects that a child can have, can be prevented during that pregnancy... Some sort of tests that they do here to see and to tell like the Downs Syndrome thing, and those like the neuro-defects... I had to undergo a series of tests and then I could know what to expect, like what kind of a child, the progress of the pregnancy even in advance I could be able to tell like oh, I was carrying a healthy child (Participant 4).

While the participants appreciated the screening and testing conducted in the Australian maternity care system, six of them felt that there was too much blood drawn for tests during antenatal visits. They appeared to lack an understanding of why many different specimen bottles were drawn and that the purpose was for their care.

They take so much blood... almost every visit, blood. Even they take 5, 6 of those full specimens... I am so tired because they are taking blood, now it is almost there is none left for me. Every time they are taking blood. How can they, they are taking all those big, big bottles. Do they sell the blood or what? (Participant 6).

...they take a lot of blood, it is really so annoying, really not good. ...there are 4 bottles normally, and they will fill these bottles up. They keep taking blood until you have the baby and... I don't know why they are doing that... They

don't even explain... It is too much blood and they don't even tell you why they are taking the blood (Participant 8).

Perceptions of mistreatment

The participants expressed concern over the negative attitudes and behaviours displayed by some midwives. Although negative experiences were reported for both Sub-Saharan African and Australian maternity care, the majority were experienced in Sub-Saharan Africa. This mistreatment included verbal and physical abuse, non-caring and judgemental attitudes, negligence, and not listening to the women.

The midwives' negative behaviours were sometimes associated with staffing levels and workloads which resulted in high levels of frustration.

Some of them good, some of them according to what you give them. If you give them too much stress, they will not look after you good... sometimes [what the women do is] too much, also you can't take it. They swearing at you like you they want to take the thing to (Participant 11).

...because of stress, you know, people are screaming because of pain... I think they [midwives] feel overwhelmed so they... sometimes act like we are bothering, some of the nurses were like "I am going to quit the job because of you" (Participant 4).

It is evident from the women's experiences that communication is an important aspect of the woman-midwife relationship. The manner in which midwives communicated with the women had an impact on their perception of care. For instance, the provision of family planning for these women both in Sub-Saharan Africa and in Australia was unacceptable because of poor interpersonal communication.

The other thing again in Africa, the nurses, the midwives have the attitude like you have so much, so many babies, why are you having so many babies? (Participant 3).

Because any nurse [in Australia] come to you says you need to stop, do you

want this one, do you want these pills? Which family planning do you want to take because we don't want to see you again? And there is a lady who told me 'we don't want to see you here again madam, so which one do you want'. And I was stupid, I said ok maybe Mirena or something... And there is a lady [midwife] who told me 'we don't want to see you here again madam, so which one [contraceptive] do you want' (Participant 9).

Listening to the women's views on what they felt was important to maintain a trusting relationship between the midwives and the women. The participants reported instances in which they were not taken seriously by the midwives when reporting what they felt. For example, participant 6 had an induced labour in Australia, and when the labour started, she told the midwife. However, according to the participant, the midwife did not believe her because she (midwife) did not expect the labour to start so soon.

They expect that it will take 8 hours for the labour to start... they put it at six, but by 9 o'clock my labour had started... I could feel that it was getting intense... I told the midwife that my labour has just started. She said 'no, fine that's normal.' And so she went... she didn't believe what I was saying... they thought it [labour] will start next morning. ...they tend not to listen. Then I called the midwife again and said the baby is coming, baby is coming (Participant 6).

She further reported feeling unwell just after giving birth and was not taken seriously again until she became very weak.

While I was speaking, my heart start racing. I told the midwife, my heart is racing a lot and she said 'oh, it is normal, it is just that you just had a quick delivery.' I said my heart is just beating a lot I want to vomit... Then she realised I had just become weaker... then she called medical emergency... By the time the room was full of doctors, I could not see... (Participant 6).

Participant 10, who was also induced for a post-dates pregnancy, had a similar experience as her labour had progressed rapidly and the midwife could not believe that she could give birth so soon. Thus, it is important for midwives in Sub-Saharan

Africa and Australia to understand that each woman responds differently to induction and that each labour is unique.

...the pain was too much, the baby was pushing through my back... I was in a point to give birth, the baby want to come and I keep telling her [the midwife] that I want to push the child, but she said no, you don't need to do that, you still have some hours to go. You are not going to give birth now... until it got to a point I could not even talk... the baby head was already out (Participant 10).

A number of participants reported some form of verbal and/or physical abuse at the hands of midwives in Sub-Saharan Africa.

...some midwives, they're if you like you scary, [if you are scared and] the baby is about to come, some people can be scared and yell, so the African midwife can say you [are scared] and they can hit you (she demonstrates slapping) (Participant 5).

Even in the hospital... they can hit you (Participant 7).

If you say I can't push, I can't push, I am tired I can't push, she will slap you until you push the baby... she slaps 4 times (Participant 13).

Another form of mistreatment reported by the participants was negligence. Although women were encouraged by Sub-Saharan African health departments to give birth in health facilities, some of the participants were ignored by the midwives. Some were neglected because of their financial status and health condition.

Because some women, they come in and they really want to be seen. But they [midwives] just ignore them; they don't really pay attention to them. ...my cousin give birth at home... didn't go to hospital [until] her wound was getting really, really rotten. So they took her to the hospital to be seen... Instead, they ignore her... nobody attend to her because of the smell. Everybody fearing coming close to her and the midwife, she came once, 'oh my God', they start insulting her, even spitting (Participant 12).

So, when you are very low, I think you can even see in the hospital in Africa,

when you go like you got nothing... nurses... will actually leave you there and take care of someone who has something, or who looks better, like those who come by bike or car. And this one has to wait until when there is nothing... go and treat that one that has just come now maybe who they ride with the bike or maybe a car or at least having something. People will attend to that person more than the one that is helpless. Nobody [was] attending to me, it was like neglect (Participant 9).

In Australia, dissatisfaction with care was associated with delays in provision because they were not booked in to give birth in a particular hospital. Participant 13 was three months pregnant and had not booked herself in to give birth at the hospital, despite having attended antenatal care. When she experienced pain and bleeding, she went to the hospital and was referred to Hospital C in a quite distant suburb. Below, she explains how she had to wait to be attended to.

Here, I come in Adelaide, I get pregnant again but I have miscarriage. When I start feel[ing] pain, I go hospital... in [Suburb A] ... I tell to that [midwife] and she send me there... in Hospital C. And then we stay there for six hours, nobody see me. After six hours... they check me after that they sending me home. The following day, I start feel pain again. That is very worse and the blood comes more. They find that that one is not gonna live anymore... one nurse come and tell me that you have miscarriage already (Participant 13).

The participants' perceptions of care were mostly related to the midwives' behaviours and attitudes. Paying attention and appropriately responding to what the women say they are experiencing is important in building a trusting relationship between the midwives and the women. The women however, shared stories of poor care, mistreatment and ineffective relationships with their care providers. Whilst these varied in severity between Sub-Saharan Africa and Australia, there is potential for improvement in both.

Conclusion

This chapter has presented the findings of the study. The findings on the women's experiences were presented through four themes, access to services including

health education, birth environment and support, pain management, and perceptions of care. The findings show that there were differences between maternity care in Sub-Saharan Africa and Australia. Most of these differences were related to barriers to accessing care, support during labour, and the management of pain. The next chapter will present the discussion of these findings.

CHAPTER FIVE: DISCUSSION

Introduction

The previous chapter presented the findings of this study. This chapter summarises these findings and discusses them in relation to the reviewed literature on Sub-Saharan African women's experiences of maternity care. This study aims to examine the experiences of Sub-Saharan African women of maternity care services in their home countries and in Australia. The objectives of the study were to: 1. explore how Sub-Saharan African women experienced maternity care in the Sub-Saharan African countries where they gave birth; 2. explore how Sub-Saharan African women experienced maternity care in Australia; 3. identify barriers to the utilisation of maternity services by Sub-Saharan African women in Australia; and 4. identify ways in which maternity care services in Australia can be improved for Sub-Saharan African women. These objectives form the basis of the following discussion. A discussion on maternity care as a form of primary healthcare is also included which draws on an existing framework to clearly explain the findings.

Summary of the research findings

This study provides an understanding of Sub-Saharan African women's experiences of maternity care in Sub-Saharan Africa and Australia. The study found that the participants experienced challenges with maternity care in Sub-Saharan Africa, but made the most of what was available. When the women moved to Australia, they found a system that they were unfamiliar with which resulted in issues around access to care; not because the services were unavailable, but because they did not know what was available or how to access the care. Once they understood the services that were available to them, it was usually quite late in their pregnancy and too late to access some of the services, such as continuity midwifery-led models of care that they could have benefited from. A birthing environment with family support was of great importance to the women, and they preferred to be treated with respect.

While labour pain was perceived as normal, the participants had different experiences of pain management in Sub-Saharan Africa and Australia. In Sub-Saharan Africa, they did not receive pain relief because it was unavailable, whereas in Australia, it was available, but the usage was variable among the women because they were not informed about its availability. The women’s experiences of maternity care in Sub-Saharan Africa influenced their perceptions of care and their health-seeking behaviours in Australia. Women who had negative experiences of care in Sub-Saharan Africa thought they might experience the same in Australia and so they delayed seeking care. The study also found that there were significant differences in the women’s experiences of maternity care in Sub-Saharan Africa and Australia. These are summarised in Table 4 below, with additional supporting information highlighting the differences in the services also included. Despite the wealth of literature about female genital mutilation among some Sub-Saharan African women, this issue was not raised by the participant women in this study.

Table 4: Differences in maternity care experiences between Sub-Saharan Africa and Australia.

Women’s Experiences	Sub-Saharan Africa	Australia
Barriers to accessing care	Long distance to facility, lack of resources, lack of transport	Unfamiliarity with the health system, communication difficulties
Quality of midwifery education	Highly variable from nil to registered practitioner	High standard – all registered practitioners
Pain relief – pharmacological	Often not available	Multiple options available
Family support person in labour	Not usually encouraged	Encouraged
Health education	Lacking	Provided largely in antenatal classes
Midwifery workforce statistics	Sub-Saharan Africa	Australia
Midwives per population	^10.7 per 10,000 population	^^10.6 per 1,000 population = 106 per 10,000 population
Registered midwife/woman ratio in labour	*1:20	1:1

Sources: ^ World Health Organization (2016c); ^^ World Health Organization (2015a); *Jones et al. (2015).

Discussion of the findings

Experiences of maternity care in Sub-Saharan African countries

The participants in this study faced a number of challenges with accessing maternity care in Sub-Saharan Africa. These challenges included long distances to health facilities, transport problems, inadequate resources, limited services, disrespectful care, and long waiting times in the nearest facility. Similar access issues have been reported by Levesque, Harris and Russell (2013) in their conceptual framework of access to health care. These barriers affected attendance at antenatal care sessions and in giving birth in health facilities. Transport to the facilities was often problematic, especially when the women were in labour as they had to travel on a bike or walk. These findings concur with Iyaniwura and Yussuf (2009) and Wilunda et al. (2014) who found that transportation and distance to health facilities were barriers to accessing maternity care in Nigeria and Uganda. To improve access to maternity care in Sub-Saharan Africa, there is a need to improve infrastructure such as roads and transport to healthcare facilities (Murawski & Church 2009). The participants in this study who could not access health facilities, gave birth at home alone, or with family or traditional birth attendants. This was despite the World Health Organization's recommendation in 2002 that all women should have skilled attendance at childbirth (World Health Organization 2002). Birthing without a skilled birth attendant may cause a delay in obtaining emergency treatment if complications arise, thereby increasing the risk of maternal death. Therefore, ensuring that all women have access to skilled attendance at birth can contribute to a reduction in the high maternal mortality rates in Sub-Saharan Africa (World Health Organization & UNICEF 2015). To ensure the availability of services, it is suggested that women in the community should have access to a community midwife who can attend home births and recognise the early signs of complications (World Health Organization 2003).

The findings highlight that access to healthcare is still a problem in Sub-Saharan Africa, especially in rural areas where about two-thirds of the Sub-Saharan population live (United Nations Development Programme 2013). Lack of access to healthcare and health education poses a challenge to achieving the World Health

Organization recommendation of birthing with a skilled healthcare provider. This points to a need to improve equity of access to services, as stated in the WHO principles of primary healthcare (World Health Organization 2003). In some instances, even if the resources were available, the participants were expected to pay upfront for treatments they could not afford. This suggests that the cost of treatment may have serious implications for the women. This supports Finlayson and Downe (2013) and Levesque, Harris and Russell (2013) that the cost of healthcare hinders access to care and the seeking of healthcare in subsequent pregnancies.

The World Health Organization recommends that all women should have access to basic maternity care (World Health Organization 2015b). Basic essential obstetric care refers to the services necessary for the management of women experiencing normal and complicated pregnancy, birth, and the postnatal period (World Health Organization nd). These services include parenteral antibiotics, oxytocic drugs, sedatives for eclampsia, and the manual removal of the placenta and any retained products. Accordingly, basic obstetric care needs to be available and affordable for all women.

The participants also experienced delays in accessing labour and birth care because of a lack of knowledge of the services provided by the facility. The participants' experiences of being turned away when in labour from a healthcare facility, from which they had received antenatal care, suggests that a birth preparedness plan was not discussed during the pregnancy. As some facilities do not provide birthing services, women need to be informed about the services offered in their local facility, and they need to discuss a birth preparedness plan during their antenatal care so that it is clearer where birthing services are and are not offered. It is the World Health Organization recommendation that all pregnant women should have a plan for birth and that it should be discussed with the healthcare providers, so that they are adequately prepared for childbirth and any emergencies that may arise (World Health Organization 2006a). Birth preparedness and complication readiness (BPACR), as a safe motherhood strategy, is necessary as it reduces delays in accessing skilled attendance and emergency obstetric care in case of complications (Acharya et al. 2015). Hence, timely access to maternity care is most likely to result in better pregnancy outcomes and positive experiences for the women. The

participants in this study did not receive postnatal care in Africa because it was not provided. Maternity care ended after birth. This is despite the World Health Organization (2014b) recommendation of three postnatal visits to assess mothers and newborns. This is a concern as most maternal and infant deaths occur around childbirth and in the postnatal period (James et al. 2010).

The participants felt that health education on labour and birth was lacking in Sub-Saharan Africa. They felt unprepared for childbirth and motherhood, and relied on information from family and friends. While such family information and advice may have been helpful, there may be misconstrued and incorrect information which needs to be clarified with health education from professional healthcare providers. Similar findings have been reported in Ghana, showing that despite women's desire for information, there was no health education provided (Yakong et al. 2010), because the clinicians only focused on routine medical care. Preparation for labour and childbirth via timely education can reduce anxiety during labour and improve the experience of childbirth (Dahlen, Barclay & Homer 2010). Inadequate health education has been cited as a potential barrier to the utilisation of maternity care services (Ganga-Limando & Gule 2015). The evidence suggests that pregnant women are often receptive to information and need health education to make appropriate choices for themselves and their babies (Fahey & Shenassa 2013). Therefore, health education programs and timely health education in the antenatal period in relation to pregnancy, birth, and baby care may strengthen women's knowledge and better prepare them for birth and the postnatal period.

This study has established that Sub-Saharan African women valued family support during labour and childbirth. However, in Sub-Saharan Africa, having a support person during labour was not the norm in the maternity hospitals. This non-supportive birth environment influenced the women's decision to give birth at home in order to have the support and encouragement of their family. While a labour companion can be a professional such as a midwife, in this study, the women referred to their labour companion as a non-professional support person such as a family member or a friend. In some Sub-Saharan African maternity hospitals, multiple labouring women occupy the same room which does not allow for the presence of a support person. Previous studies conducted in Sub-Saharan Africa

have reported that the absence of a labour companion resulted in women feeling alone, neglected, abandoned, and dissatisfied with the care they received (Bohren et al. 2015; Chadwick, Cooper & Harries 2014). Bohren et al. (2015) stated that labour companions are often banned by hospital policies, as the hospital administration believed that they were a hindrance to the provision of care. However, there is evidence that highlights the benefits of having a supportive companion during labour and birth, including a shorter duration of labour, lower rates of intervention, increased tolerance of pain, and increased maternal satisfaction (Hodnett et al. 2007). Furthermore, the tolerance of pain in labour is enhanced when the woman is comfortable, relaxed, and feels safe (Van Der Westhuizen 2011), and this can be achieved in the presence of a supportive labour companion. Kungwimba, Maluwa and Chirwa (2013) also found that women value the presence of family companions during labour. Since it is common in Sub-Saharan Africa for two midwives to care for 40 women in labour at the same time (Jones et al. 2015), midwives cannot provide one-on-one support to the women; therefore, birth companions can provide this beneficial continuous support instead.

Lack of midwife support is partly due to the low ratio of 10.7 midwives per 10,000 population in Sub-Saharan Africa, compared to Australia with 106 per 10,000 population (World Health Organization 2015a). According to the World Health Organization (2005), in developing countries with a high maternal and newborn mortality ratio, the standard births attended annually per midwife is 175, or six midwives per 1000 births per year (ten Hoop-Bender et al. 2011). However, the number of midwives per population does not always imply quality maternity care; other factors such as the availability of resources, workforce planning, and the midwives' attitudes and levels of education influence the quality of care. The main goal should be to ensure that there are enough skilled healthcare providers to provide basic and comprehensive obstetric care. For adequate accessibility of care, the recommended level for emergency obstetric care is five emergency obstetric facilities per 500,000 population, one of which should provide comprehensive care (WHO, UNFPA & UNICEF 2009). The services provided in comprehensive emergency care are illustrated in Table 5 below. Therefore, to improve women's satisfaction with maternity care, health services should ensure an environment that

encourages the presence of a labour companion. It can be suggested therefore that hospital policies need to be reviewed in relation to the provision of labour companions, as supported by the evidence.

Table 5: Signal functions used to identify basic and comprehensive emergency obstetric care services.

Source: Adapted from WHO, UNFPA and UNICEF (2009).

Basic emergency services	Comprehensive emergency services
<ol style="list-style-type: none"> 1. Administer parenteral antibiotics 2. Administer uterotonic drugs (i.e., parenteral oxytocin) 3. Administer parenteral anticonvulsants for pre-eclampsia and eclampsia 4. Manual removal of placenta 5. Removal of retained products (manual vacuum extraction, dilatation, and curettage) 6. Assisted vaginal delivery (e.g. vacuum extraction, forceps delivery) 7. Basic neonatal resuscitation care 	<p>Perform signal functions 1-7, plus:</p> <ol style="list-style-type: none"> 8. Perform surgery (e.g. caesarean section) 9. Perform blood transfusion
<p>A basic emergency care facility provides functions 1-7. A comprehensive emergency care facility performs functions 1-9.</p>	

While the participants in this study perceived labour pain and birth as normal, some women still wanted pain relief. However, in Sub-Saharan Africa, pharmacological pain relief was either not offered or not available. The perception of pain as something normal has been reported in previous studies on African women (Benza & Liamputtong 2014; Gibson-Helm et al. 2014a), finding that they are socialised to endure pain and not to express feelings of pain through behaviours such as crying (Higginbottom et al. 2013). Some participants in this study expressed being distressed by the non-availability of pain relief, which was made worse by their lack of information on childbirth and what to expect, how to behave and cope during labour, and the lack of a support person. Some of the women coped with labour pain by walking around, as they could not remain in bed when in pain. These findings indicate that pain relief strategies, both pharmacological and non-pharmacological, need to be made available for those women who need them.

Many participants in this study reported that they experienced mistreatment during

childbirth in Sub-Saharan Africa. This included verbal and physical abuse, neglect, and disrespectful care. These negative behaviours of healthcare providers were met with different responses by the women. Some women chose to give birth without a healthcare providers' assistance as a result of prior mistreatment. These findings are consistent with those of qualitative studies conducted in Ethiopia, Tanzania, and Uganda on women's experiences of maternity care (King et al. 2015; King et al. 2016; McMahon et al. 2014; Wilunda et al. 2014). Neglect in McMahon's study was so serious that the women either gave birth without a skilled birth attendant or returned home without being attended to by a healthcare provider. In the current study, homebirths without healthcare providers were common, and complications were often not recognised due to a lack of understanding of danger signs. When these women presented for professional healthcare after a home-birth, they were again made to wait for lengthy periods before being attended to, which they perceived as punishment for giving birth at home. Such behaviour from healthcare providers drove the women away from the healthcare system, so that in subsequent pregnancies, even if complications arose, they were hesitant to, or would not, seek healthcare (King et al. 2016). This increases the risk of maternal and neonatal morbidity and mortality which is a significant health concern. Bohren et al. (2015) identified the contributing factors to the mistreatment of women during childbirth to include insufficient staffing, lack of supervision of staff, poor working conditions, and a lack of resources. These factors are linked to high workloads which frustrate healthcare providers, who then behave negatively towards the women. Therefore, the negative treatment of the women could also be related to the health system's failure to provide adequate staffing. Bohren et al. (2015) argued that due to staffing shortages, midwives are unable to care for all the women during childbirth which may be interpreted by the women as neglect. Therefore, increasing the midwifery workforce numbers, and providing in-service education to midwives on appropriate and supportive communication with patients, can contribute to women's positive experiences of maternity care.

The current study has also found that women of low socio-economic status perceived that they were mistreated by healthcare providers in favour of wealthier women in Sub-Saharan Africa. This phenomenon of preferential treatment was not

identified in the literature review, and it is generally expected that midwives should practice in a way that midwifery care is not compromised by social status, age, or any other factor (ICM 2013). This finding therefore raises concerns that such treatment, or perceptions of treatment, takes away women's trust in the healthcare system and the midwifery profession, and again, hinders future use of maternity services. Consequently, it increases the gap between wealthy and poor women in terms of access to maternity care. Therefore, regardless of the reasons, the mistreatment of women is unacceptable, and every woman has the right to receive quality care with respect and dignity (Tunçalp et al. 2015). Hence, in both Sub-Saharan Africa and Australia, for maternity care to be accessible, acceptable, and utilised, all women should be treated with respect and equity.

Experiences of maternity care in Australia

The participants in this study expressed appreciation of the access to, and availability of, maternity care and the associated resources in Australia. Access to maternity care was facilitated by the affordability of the services as they were covered by the publicly funded healthcare system. For a start, antenatal appointments in Australia were more frequent than in Sub-Saharan Africa. The World Health Organization recommends a minimum of four antenatal visits while, in Australia, the women had access to more than eight such visits. The women in this study attended a greater number of antenatal visits in Australia, possibly due to the ease of access in terms of transport, free services, and the friendly attitude of the midwives. These findings support those of Carolan and Cassar (2010) who found that African women in Melbourne valued continuous antenatal care and were motivated by friendly healthcare providers to regularly attend antenatal appointments. The participants in the present study also reported better antenatal tests, more advanced technology, and better skills of the maternity care provider in the Australian health system. They also expressed appreciation for the screening for foetal abnormalities which was not often available in Sub-Saharan Africa, and the general clinical management throughout their pregnancy. Liamputtong (1999) reported similar findings in her study of Thai immigrant women in Australia, who expressed appreciation of the antenatal screenings, as these tests informed the mothers about the condition of the baby in utero. While the participants' experience

of maternity care in Sub-Saharan Africa only included antenatal, intrapartum, and immediate postnatal care, in Australia they were also provided with postnatal care in the hospital and in their homes. This was convenient and acceptable to the women, as their culture does not allow them to leave the house for at least four days post-birth. Therefore, postnatal home visits in Australia enhanced the positive maternity experiences of Sub-Saharan African women.

While maternity services in Australia are predominantly available and affordable, some women experienced barriers in accessing care. These challenges were different from those experienced in Sub-Saharan Africa and included issues of communication and unfamiliarity with the Australian healthcare system. Lack of knowledge about the healthcare system in Australia appeared to contribute to delays in seeking maternity care during pregnancy. One participant had her first antenatal visit at seven months gestation. When the participants sought care, they referred to their Sub-Saharan African experience and went directly to the hospital without booking the necessary appointment. Similar experiences have been found by Straus, McEwen and Hussein (2009), and Renzaho and Oldroyd (2014). The women in Renzaho and Oldroyd's (2014) study were frustrated when they failed to 'navigate' the health system, particularly in relation to when to seek primary or secondary care services. Normally in Australia, pregnant women consult with their general practitioner who then makes a booking with the hospital, or alternatively, they make an online booking or book-in themselves. These findings indicate a need for Sub-Saharan African mothers who are new to Australia to be informed about the Australian healthcare system, and how to access care in order to improve their utilisation of services. Raising awareness about the healthcare system through the African communities can further facilitate the transfer of information, as some of the women received support from their communities in navigating the health system. Organisations such as the African Communities Council of South Australia (ACCSA) organises for African communities to obtain information on and how to access health services (Mwanri, Hiruy & Masika 2012). Increasing awareness of healthcare services has been found by Hoang, Quynh and Sue (2009) to improve the use of maternity care and to enhance women's positive experiences of childbirth. Long waiting times were also reported by some participants, although this was often

associated with not booking an appointment. However, the waiting times were shorter than those experienced in Sub-Saharan Africa. Waiting times in Australia influenced the women's decisions to use the same hospital for maternity care in subsequent pregnancies. Long waiting times have been identified as one of the causes of dissatisfaction with healthcare (Novick 2009).

Some of the participants in this study had language difficulties which hindered their communication with healthcare providers and their utilisation of maternity care services. They expressed becoming frustrated by their inability to be understood as English was not their first language. Although they could speak some English, they had to adjust to the way Australians speak in terms of speed and accent. Previous research has identified communication difficulties as a barrier to accessing maternity care (Renzaho & Oldroyd 2014; Stapleton et al. 2013; Straus, McEwen & Hussein 2009). The women in Renzaho and Oldroyd (2014) study overcame communication problems by getting assistance from their neighbours to interpret for them. Although interpreters were available through the hospitals, some participants in the present study did not use them because they had previous experiences with interpreters who had breached confidentiality. The use of interpreters requires trust by both the women and the healthcare provider that the interpreter will practice ethically and be able to interpret medical terminology appropriately. A lack of trust in the ability of an interpreter to maintain confidentiality may also hinder the disclosure of important information to healthcare providers (Higginbottom et al. 2015b). Due to the sensitivity of the information shared during maternity care, the interpreters used by these services should be professionally trained and should maintain confidentiality. Furthermore, it is important for healthcare providers to recognise that, due to the language barrier, some Sub-Saharan African women may not be able to express their needs or to ask for the care they require. Hence, interpreting services may need to be offered rather than being provided upon request.

Another consequence of the language difficulties was the lack of understanding, and misinterpretation, of information provided by healthcare providers in relation to women's care. Some of the women considered there to be a lack of consistency between what the healthcare providers had told them and the outcome of their pregnancy. For example, some of the participants reported being told that their baby

was 'not well', but at birth, the baby had no problems. This could have been poorly explained and therefore misinterpreted. Misinterpretation was also perceived as discrimination by some participants and this affected their perceptions of the care provided. These findings support the work of Benza and Liamputtong (2014) and Murray et al. (2010) who indicated that language difficulties hindered good communication and understanding between African women and their caregivers. This lack of understanding often created a sense of fear for some women (Benza & Liamputtong 2014).

Further compounding the misunderstanding of information in the current study was the issue of time constraints. Some of the women felt that they were rushed during their appointments and, because they could not express themselves well, they did not ask for clarification. Murray and Skull (2005) indicated that poor communication can affect people's understandings of their condition, and therefore, their compliance and satisfaction with the treatment. Hence, this communication gap needs to be addressed as it can affect the women's trust in the healthcare system and hinder the use of maternity services. This is supported by Akhavan (2012) who stated that miscommunication was associated with low levels of trust.

Although the women did not receive continuity of maternity care in Sub-Saharan Africa, after they had been educated about the benefits and availability of continuity of care in Australia, many expressed an interest in having a known midwife through this model. The reasons cited for wanting continuity of care were the ability to develop a trusting relationship with the midwife and consistency in the provision of care. However, many of the participants could not access continuity of care because they became aware of it too late in their pregnancy, or it was not offered to them at an appropriate time. These findings correspond with other Australian and British studies which confirmed that women preferred one provider throughout their pregnancy and childbirth, and in the postnatal period (Murray et al. 2010; Stapleton et al. 2013; Straus, McEwen & Hussein 2009). Continuity of care has been found to assist women to better adapt to the healthcare system of their new country (Stapleton et al. 2013). Lack of continuity of care among minority groups has also been reported upon in the literature (National Collaborating Centre for Women's Children's Health 2010; Straus, McEwen & Hussein 2009). Sub-Saharan African

women new to Australia need to be informed about the different midwifery models of care available to them in order to make informed decisions about their choice of the model of care. The findings from this study highlight a need for continuity of care to be made more accessible for Sub-Saharan African women.

The participants' experience of health education in Australia was also different from their Sub-Saharan African experience. They reported being educated about nutrition, pregnancy health, childbirth, and baby care in the antenatal period, and they also received support from midwives and further education during postnatal home visits, which was not their experience in Sub-Saharan Africa. This finding is consistent with Ekott et al. (2013), who found that Sub-Saharan African women appreciated antenatal health education. Likewise, it is generally known that health education is necessary for ensuring good health (World Health Organization 2015c). It was interesting to note that the women in this study did not attend antenatal classes in Australia, as they assumed that they were not important to them, as they had previously given birth. Some were also not encouraged to attend. In hindsight, however, the women realised that they would have had a better understanding of what to expect in their adopted health system if they had attended the classes.

The subject of Sub-Saharan African women's attendance at antenatal classes has not been well-explored, but similar findings have been reported about immigrants in general. Higginbottom et al. (2015a), in their study of immigrant women's experiences in Canada, found that they were less likely to attend antenatal classes because of language barriers, lack of transportation, and negative perceptions about the lessons provided. Pairman (2015) argued that women do not attend antenatal classes because they lack an understanding of their purpose and importance. The participants in the current study stated that the manner in which they were told about the classes did not encourage them to attend, as they were told to attend only if they wanted to. In the African context, the expression of "if you want to" means that it is optional, and therefore, acceptable to not attend. If it was their first birth in Australia, attending antenatal classes would be of benefit to increase their understanding of their own health, and of the services, clinical practices, and choices available to them during labour and birth, particularly when having moved from the Sub-Saharan African context, as the care is so different. Therefore, the findings suggest that Sub-

Saharan African women should be encouraged to attend antenatal classes, even if they are multigravidas. As with all pregnant women in Australia, they should be encouraged to attend a refresher antenatal class during subsequent pregnancies. As the participants did not attend antenatal classes, they only received health education during their antenatal consultations; however, due to time limitations during the consultations, some topics were not discussed at all, and much of the information was provided in written form only. Even when verbal health education was provided, the participants described the information being given in a hurried manner without checking their understanding. While some information was provided in the form of pamphlets, it was found that some of the women did not read these due to their lack of English reading skills. This suggests that, although some Sub-Saharan African women may speak limited English, this does not automatically mean that they can read it. These findings are consistent with those of Straus, McEwen and Hussein (2009) who found that verbal forms of communication were more important to Somalian women than the written form. Therefore, the provision of information should take into account the women's ability to understand English. Information needs to be provided in both a verbal and a written form for those who can read, or they need to be translated into their language if possible. Alternative methods of health education, such as through the use of pictures, may also help in providing information to women who are illiterate.

The findings from this study have shown that the participants had a largely positive experience of the birthing environment and process in Australia. Contrary to their Sub-Saharan African experience, families and friends were encouraged to provide them with support during labour. This finding is consistent with a study on women born outside Australia, indicating that they appreciated having support people during labour and birth (Hennegan, Redshaw & Miller 2014). The present study has also found that in the Sub-Saharan African culture, men are not allowed to see the birth of the baby. However, there was a shift in the women's cultural beliefs upon settling in Australia, as the men commonly supported their partners during labour and birth. The participation of Sub-Saharan African men in childbirth has not been well-explored. Benza and Liamputtong (2014) found that migrant women adopted the western culture of having their partners present during labour and childbirth to

provide physical and emotional support. For some women in the current study, having their partners participate in the birth of their babies was a way of helping them to understand what they experienced as women during childbirth so that they could support them even after giving birth. These findings highlight the importance of understanding Sub-Saharan African women's culture. While it is necessary to understand the women's cultural norms in relation to childbirth, women should also be enabled to make decisions about their care and not be stereotyped according to their culture, as this may change over time.

The participants in this study indicated concern over the restriction of movement during labour under the Australian maternity care system. They reported being restricted to their bed due to the monitors connected to their bodies. Hennegan, Redshaw and Miller (2014), in their study of the experiences of migrants, also found that these women were more likely than Australian-born women to have constant electronic foetal monitors which would restrict their movement. For the women in the current study, walking was a way of coping with their pain. While lying in bed allows midwives to easily monitor the progress of the labour and the condition of the foetus, walking significantly reduces the duration of the first stage of labour, the intensity of the pain, and the chances of a caesarean birth (Ben et al. 2010). Based on these findings, it can be suggested that if labour is progressing well, and the maternal and foetal condition is satisfactory, women should be encouraged to have upright movement with intermittent checks as necessary, and to assume comfortable positions during labour.

The participants were pleased to be able to give birth in their preferred birthing position in Australia. This finding is contrary to the experiences of Sudanese women in Canada who had to give birth in a supine position, regardless of their desire to squat or kneel (Higginbottom et al. 2013). Similarly in Brisbane, African women could not give birth in their preferred squatting position (Murray et al. 2010); however, it was not clear whether the women tried to negotiate their position. The semi-recumbent position is widely used by healthcare providers because it is convenient and allows them easy access to assist the birth. Nieuwenhuijze et al. (2013) argued that women's choice of birthing position makes them feel in control and contributes to a positive experience of birth. In light of providing women-centred care, women

should be encouraged to give birth in their position of choice that is most comfortable for them.

The participants' orientation to labour pain and their previous birth experiences in Sub-Saharan Africa influenced their behaviour in Australia. The expression of pain also varied from one woman to another. In this study, some of the women who showed no outward signs of pain and distress were misinterpreted by healthcare providers as not being in active labour, or not experiencing significant pain. However, the women 'listened' to their bodies and used their previous experience to assure themselves that they were in labour. This is consistent with an earlier study on Sudanese women in Canada (Higginbottom et al. 2013). The Sudanese women did not express pain, as in their culture, this is associated with weakness and failure. Furthermore, the current study found that the women who were silent during labour preferred a quiet environment with minimal disturbances. It is therefore important for healthcare providers to be aware that, due to cultural beliefs and practices, some women may not express obvious signs of pain. Basically, the intensity of labour cannot be judged by the woman's physical expression of pain. It is suggested that a calm environment with dim lights be considered for such women. If possible, they should also be encouraged to go through labour in their own separate rooms to enable them to experience what Blix (2011, p. 691) referred to as "her own little world of birth".

It appeared that the availability of pain relief in Australia did not change some of the women's beliefs about the necessity of pain relief during labour. Their cultural orientation to pain, and their previous experience of birthing without pain relief in Sub-Saharan Africa, influenced their behaviour in Australia. They believed that pain medication would not stop the pain of labour, and they therefore went through labour without pharmacological pain relief. These findings support previous studies which showed that African women preferred natural birth without analgesia (Gibson-Helm et al. 2014b; Higginbottom et al. 2013; Stapleton et al. 2013). While some women wanted pain relief, they did not receive it because they were not aware of its availability. It seems like healthcare providers expected the women to ask for the specific type of pain relief they wanted whereas, in fact, the women did not know what to ask for. While the reviewed literature indicated that African women did not

receive pain relief medication during labour (Gibson-Helm et al. 2014b), a lack of knowledge about it was not stated as a reason. This highlights the fact that women from Sub-Saharan African backgrounds may not know about pain relief, and are therefore not able to choose the type they want. It is suggested that Sub-Saharan African women should be educated about pain relief during pregnancy so that they can understand the different pain relief options that are available, and thus be able to make choices well in advance of giving birth. Health education can also correct any misconstrued information that the women have about pain relief. Midwives should also be aware that women from Sub-Saharan African backgrounds may not be assertive enough to ask for pain relief, and that it therefore should be offered instead. Furthermore, some women may not appear to need pain relief due to being silent during labour; therefore, midwives should ask them how they are coping.

Maternity care as primary healthcare and a focus on accessibility

This section of the discussion evaluates the care experienced by the participants as evidenced in this study in relation to the principles of primary healthcare, particularly access to services. Considering that midwifery is a primary healthcare profession (Nursing and Midwifery Board of Australia 2006; Pairman et al. 2010), the care that midwives provide throughout pregnancy, childbirth, and in the postnatal period must meet the principles of primary healthcare. The World Health Organization defines primary healthcare as:

Essential healthcare based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (World Health Organization 2016b).

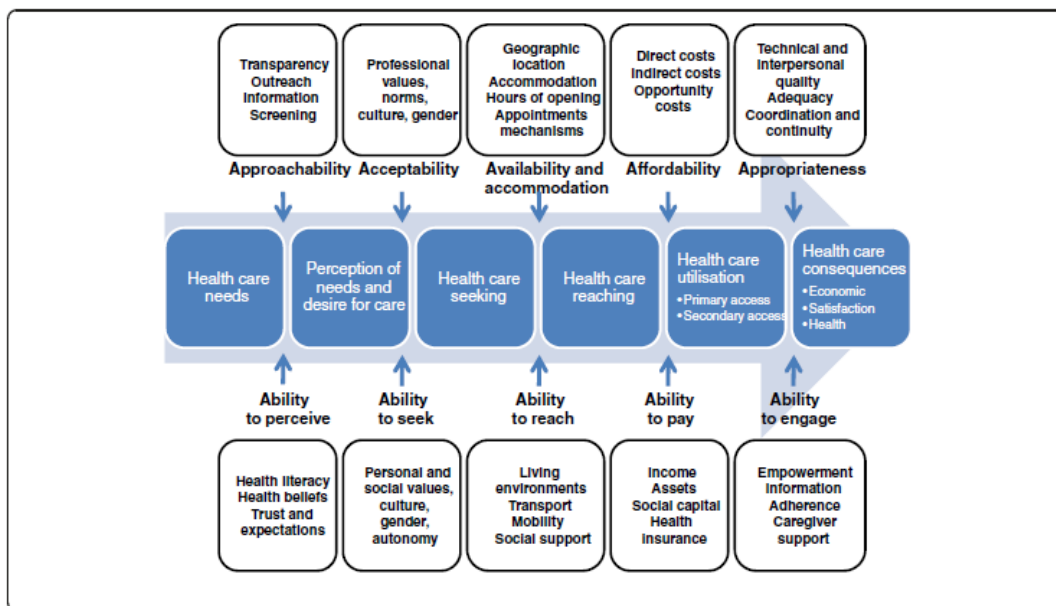
The principles of primary health care that are particularly significant to maternity care are: 1. access to care and acceptability; 2. equitable distribution of services; 3. community participation; and 4. self-reliance and self-determination (Pairman et al. 2010; World Health Organization 2003) One of the core tenets of primary healthcare

is access (Primary Health Care Research & Information Service 2016), and access to maternity care and education were major themes in the experiences of the participants in this study. Moreover, the concept of access may also explain the other themes evident in the findings of this study specifically birth environment and support, pain management, and perceptions of care.

A conceptual framework by Levesque, Harris and Russell (2013) has enabled a deeper and more detailed discussion of the findings in the context of how maternity care was experienced by the women. Levesque, Harris and Russell (2013) identified five dimensions of accessibility of healthcare services which are consistent with the principles of primary healthcare and which encompass each of the themes of this study. These are approachability, acceptability, availability and accommodation, affordability, and appropriateness, which are shown in Figure 1.

Figure 1: A conceptual framework of access to health care.

Source: Levesque, Harris and Russell (2013)



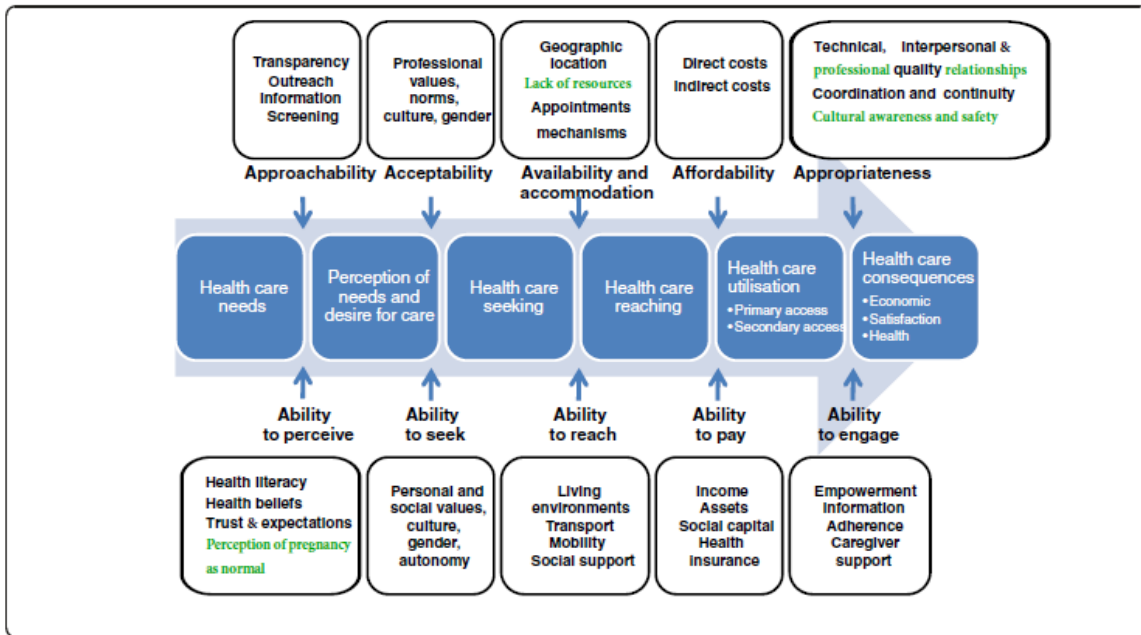
Approachability of services relates to services being known by the community. Acceptability refers to the cultural and social aspects that influence the individual's acceptance of care, and which is judged by the person's perception of the appropriateness of the care. Availability and accommodation means that the care exists and can be reached in a timely manner (Levesque, Harris & Russell 2013).

Appropriateness relates to whether the care meets the women's needs or not. This framework for access further identified the following five abilities of the population that correspond with the dimensions of accessibility: ability to perceive; ability to seek; ability to reach; ability to pay; and ability to engage. For instance, the affordability of services is dependent on the cost of the services as well as the clients' ability to pay for the services (Levesque, Harris & Russell 2013). The framework depicts how an individual goes through a series of steps in accessing care, progressing from identifying healthcare needs, seeking healthcare, reaching healthcare, obtaining or using healthcare services, to actually benefiting from care that is appropriate to their needs. The client's progress through this continuum of access depends on the dimensions of access and the corresponding abilities of the individual.

How the findings fit within the conceptual framework of Access

Access is influenced by many different factors as demonstrated in the women's experiences in this study, and in Levesque, Harries and Russell's conceptual framework. Figure 2 below, shows an adapted framework of access that illustrates how the findings of the study fit in Levesque, Harries and Russell's conceptual framework. The changes made to the original framework are shown in green. Even though there were significant differences between the women's Sub-Saharan African and Australian experiences, there were access issues regardless of where they were located during their pregnancy and birth, and these all had healthcare consequences. However, the reasons for the access difficulties were different and these are outlined below.

**Figure 2: An adapted conceptual framework of access to health care.
Adapted from Levesque, Harris and Russell (2013)**



Health care needs

Pregnant women have health care needs that can be met through maternity care services, including antenatal, labour and birth, and postnatal care. The World Health Organization has stated that every woman should have at least four antenatal visits with a trained health professional, a skilled attendant at birth (World Health Organization 2006b), and three postnatal care visits with a midwife, on day three, between seven and fourteen days, and at six weeks (World Health Organization 2014b). However, for the women in this study, accessing care was dependent on their ability to perceive the need and to take steps to access the care. In Sub-Saharan Africa, the women viewed pregnancy as normal and sometimes did not recognise the need for healthcare, or they received only minimal healthcare below the recommended standards. For their subsequent pregnancies in Australia, they recognised the benefits of professional health care and none of them considered having no health care in Australia.

Perception of needs and desire for care

Perception of needs and desire for care were dependent on the women's health literacy, and their beliefs and expectations about health. The participants recognised that in Sub-Saharan Africa they did not have the education and health literacy, or information to realise the need for maternity care. This lack of knowledge, coupled

with their beliefs about pregnancy being normal and therefore not requiring medical care, influenced their perceptions of their need for care in Sub-Saharan Africa. There were also differences in what the healthcare system stated that the women needed and what the women thought they needed. In Australia, they lacked information about the Australian healthcare system, including the need to book-in for care. Therefore, approaching maternity services was a challenge for them. Similarly, the women did not realise the need for antenatal classes because they lacked an understanding of its importance, particularly because they had all previously given birth.

Health care seeking

Upon realising their need for healthcare, the women were then in a position to seek care. Health care seeking is one of the three delays in accessing care, as identified by the World Health Organization (2016a). The women's decision and ability to seek care was influenced by personal and social values, culture and autonomy, and the acceptability of healthcare. Part of the acceptability of healthcare regardless of location was the midwives' attitudes and the presence of family support. For instance, the women valued the presence of a family support person during labour; however, this was often not encouraged in the Sub-Saharan African maternity care system. This made the services unacceptable such that some women did not seek professional care and gave birth at home without skilled assistance. In Australia family support was encouraged and resulted in positive health care seeking behaviours. The cultural perception of labour pain as being normal also influenced some of the women to not ask for pain relief, regardless of their location. In Australia, some of the women wanted pain medication; however, they did not ask for it because they were not aware of its availability or they assumed that it would be offered if it was available.

Health care reaching

Once the decision to seek care is made, the women have to reach the healthcare facilities. The World Health Organization (2016a) has identified a second delay in accessing care related to reaching the care. In this study, the problems with reaching care in Sub-Saharan Africa were due to the long distances to the health facilities,

transport availability and cost. These barriers affected access at different points along the access continuum. When they sought care, their ability to reach the care was dependent on the geographical location, the way in which the services operated, and the travelling time. The condition of the roads was poor and transportation on foot or by bike was not appropriate for women in labour, being both logistically difficult and expensive. Sometimes, when they did reach a healthcare facility, birthing services were not provided and they had to travel to other facilities. The women also experienced long waiting times due to the high numbers of women and the very few midwives. In Australia, some women were not aware of the booking system which affected their health care reaching. Upon reaching the facilities, parking time limits were another problem, especially when the women experienced long waiting times. Furthermore, when the women became aware of midwifery continuity of care, they could not access it because of their geographical location or because it was fully booked.

Health care utilisation

Upon reaching the services, the women were sometimes unhappy with the care. When it was provided, it did not meet their needs nor satisfy their healthcare expectations. Having gone through wanting, seeking, and reaching care, utilisation of care in Sub-Saharan Africa was sometimes compromised by a lack of resources and the unaffordable cost of the services. In addition, the healthcare providers' negative attitudes and behaviours, and/or their mistreatment, were inappropriate and unacceptable. These affected the women's satisfaction with the care and had a negative influence on their future use of maternity care. Negative maternity care experiences in Sub-Saharan Africa affected the women's trust in the healthcare system, even after they arrived in Australia.

Also affecting the appropriateness of care in Sub-Saharan Africa was the healthcare providers' lack of knowledge and skills in the early identification and timely management of complications. This meant that the women could not access comprehensive obstetric care when there were complications. Hence, there is a need for training of midwives in emergency obstetric care, as per the World Health Organization's recommendations (WHO, UNFPA & UNICEF 2009). In Australia, the

health services were free; therefore, there were no issues with affordability. The women were also treated with respect which made the services appropriate and acceptable, and therefore facilitated their participation in the care. However, the women faced difficulties with communication and cultural misunderstandings of their expression of pain. Their non-expression of verbal and non-verbal signs of pain was often interpreted as not being in labour. These experiences rendered the services inappropriate and unacceptable, which affected their engagement in the care.

All these issues influencing access to care have long-term health consequences for women and their families, such as maternal dissatisfaction with care, poor maternal health, and poor pregnancy outcomes. The framework on access informs an understanding of the actual and potential delays in accessing care. Attending to the factors that affect access to care in terms of seeking, reaching, and utilising care can have positive consequences. These include approachability, acceptability, availability and accommodation, affordability, and appropriateness of maternity healthcare.

Conclusion

This chapter has discussed the findings on women's experiences of maternity care in Sub-Saharan Africa and Australia in relation to the relevant literature. The findings were discussed in relation to a primary healthcare approach to maternity care, and an adapted framework on access to care which emphasised the barriers that the women faced when accessing care both in Sub-Saharan Africa and in Australia. The next chapter reviews the key findings of the research, outlines the limitations of the study, discusses the implications of the study, makes recommendations for future research, and draws final conclusions from the study.

CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

Introduction

This study has explored the experiences of Sub-Saharan African women in relation to maternity care in Sub-Saharan Africa and Australia. The first chapter presented an introduction to the study. The second chapter provided an integrative literature review of Sub-Saharan African women's experiences of maternity care. A detailed discussion of the methodology used to conduct the study was presented in Chapter Three. Chapter Four presented the research findings which were then discussed in detail in Chapter Five. This concluding chapter summarises the key findings of the study, and outlines the limitations of the study. The chapter then goes on to present the contribution of the study to the existing body of midwifery knowledge and the implications for midwifery practice, as well as providing a number of recommendations for improving health service provision. The chapter closes with an overall conclusion to the thesis.

Summary of key findings

The aim of the study was to examine the experiences of Sub-Saharan African women in relation to maternity care services in their home countries and in Australia. The study found that the participants' previous experiences of maternity care in Sub-Saharan Africa influenced their experiences in Australia. Social expectations and cultural beliefs had a major influence on the women's expectations and experiences of care. The perception of pregnancy and childbirth as normal processes influenced the seeking of care and the participants' behaviours during labour and childbirth. Some aspects of care that the women valued, such as the presence of family support during labour which were not experienced in Sub-Saharan Africa, influenced the women's decision to seek maternity care in subsequent pregnancies. Another factor influencing the use of maternity care was the interpersonal relationship that existed between the women and the healthcare providers. Positive experiences were related to being treated with respect and dignity, while negative experiences were related to mistreatment and the negative attitudes of healthcare providers. Barriers to

accessing maternity care have been identified and suggestions for improvements in Australian maternity health services for Sub-Saharan African women have been presented.

Contributions of the study

The integrative literature review presented in Chapter Two found that while Sub-Saharan African women's experiences of maternity care in western countries have been studied, there is no research literature existing which explores Sub-Saharan African women's experiences of the whole perinatal period in Australia. This study has therefore addressed this gap in the research literature by providing an understanding of Sub-Saharan African women's experiences of maternity care in both Sub-Saharan Africa and Australia. This study supports some of the findings of the previous research on women's experiences of maternity care and also provides a comparison of the experiences from two different contexts. It is the first known study to investigate, in detail, the experiences of women over the entire spectrum of childbirth in these two different contexts.

Limitations of the study

There are a number of limitations that need to be taken into account when applying the findings of this study. Firstly, while every effort was made to recruit women from as many Sub-Saharan countries as possible, the participants came from just six countries, with the majority being from South Sudan. The exclusion of women who cannot speak English due to a lack of interpreting services made the recruitment of participants from some countries difficult. The researcher recognises that a different perspective of the experiences could have been obtained from non-English speaking Sub-Saharan African women, particularly in relation to the barriers to accessing Australian maternity services; however, their inclusion in the study was not logistically possible.

In addition, the study cannot be generalised to the experiences of women from all Sub-Saharan African countries due to the small sample size, the exclusion of non-English speaking women, and the qualitative nature of the research. As a

retrospective study, the data included experiences dating back to 18 years previously, and therefore, there is a potential for participant recall bias. Also, considering that maternity care is not static and that some service improvements may have taken place in both Sub-Saharan Africa and Australia over time, the experiences of women today may be different from those described in this study. Although the care may have improved, the participants' experiences still have an impact on the way they perceive their maternity care in the present. Despite these limitations, the aim of the study was achieved and, as a result, the research provides a number of recommendations for midwifery practice, education, and further research.

Implications of the study

The findings of this study have widespread implications for midwifery practice in Sub-Saharan Africa and Australia, maternity service provision, education, and further research.

Implications for practice

The findings of the study provide midwives with a better understanding of the maternity care needs of women from Sub-Saharan Africa and how maternity care can best be provided to meet these needs. It provides midwives with an awareness that women from Sub-Saharan Africa have diverse experiences which have an impact on the care they receive and the problems they face when accessing care.

It is evident from this study that Sub-Saharan African women value family support during labour and birth, regardless of the country they give birth in. Maternity care services in Sub-Saharan Africa therefore need to consider women's individual wishes and allow the presence of a family support person during labour. The study has also found that the attitudes and behaviours of healthcare providers have an impact on women's satisfaction with care. The participants' experiences of mistreatment in Sub-Saharan African maternity care affected their use of maternity services. Therefore, such negative treatment of women by healthcare providers should be avoided. Previous experiences of maternity care were also found to have

an impact on the women's decision to seek care for subsequent pregnancies. Therefore, it is important to provide high quality acceptable care that will have a positive influence on the women's future use of the services.

The study also indicated that English language difficulties had a negative impact on the women's ability to express their needs and to interact with healthcare providers in Australia. The women identified that the available interpreters did not always maintain confidentiality which affected their trust in the system and their use of services. This indicates a need for professional interpreters to maintain confidentiality and to be available during all phases of maternity care provision. This and other available services may need to be offered to the women, rather than waiting for them to ask, as many women may not be assertive enough to ask for the services, or they may not even know they exist.

The study also demonstrated that Sub-Saharan African women have specific needs which could benefit from the services of the same midwife from pregnancy, childbirth and postnatal period through midwifery continuity of care. Therefore, Australian midwifery continuity of care services need to be expanded to provide access to women from Sub-Saharan Africa. Furthermore, midwives in Australia should be mindful that women who have given birth outside of Australia might not have knowledge of pain relief. Together with the women, the midwives need to explore their understandings of the pain relief options and provide them with health education so that they are empowered to make choices before and during labour and birth. The information should be explained verbally and complemented with written materials. Health education targeting the African communities can also help to inform Sub-Saharan African women who are new to Australia of the services available to them. Once they start antenatal care, the women should be encouraged to attend antenatal classes. The findings indicate that antenatal classes should include topics such as the labour room experience, pain medications, the importance of antenatal visits, and the use of interpreters, maternity service availability, and the care they can expect from healthcare providers.

Implications for education

The participants described midwives in Sub-Saharan Africa as lacking in knowledge and skills in identifying and managing complications. Therefore, this study suggests the need for the upskilling of midwives in Sub-Saharan Africa in relation to early identification, management, and timely referral of women with complications. In Australia, students in pre-service education and practising midwives should be educated about providing culturally-appropriate midwifery care to migrant women, including women from Sub-Saharan Africa, based on the findings and recommendations of this study.

Implications for further research

This study has highlighted a significant number of issues relating to women's experiences of maternity care in Sub-Saharan Africa and Australia which warrant further research. While this study has found that most of the participants did not attend antenatal classes in Australia, the reasons for this have not been explored in detail. Furthermore, there is no research that has been identified that investigates midwives' experiences of caring for women from Sub-Saharan Africa. Exploring midwives' experiences would provide further insight into the provision of appropriate maternity care for Sub-Saharan African women.

Recommendations

The findings from this study can be used to make a difference in maternity care in Sub-Saharan Africa and Australia, as a number of areas for potential improvement have been identified. The recommendations relate to midwifery practice, education, and further research. Recommendations to improve maternity care for Sub-Saharan African women include improving midwives' knowledge, skills, and attitudes, and enhancing access to maternity services. There is also a need for pre-service and continued training of midwives in Sub-Saharan Africa about the benefits of allowing support persons during labour, and the identification and management of complications during pregnancy, labour, and in the postnatal period. Access to maternity care in Sub-Saharan Africa can be improved by increasing the availability of services and adding to the skilled midwifery workforce.

Even though midwifery practice in Australia is of a higher standard than in Sub-Saharan Africa, improvements can still be made through addressing issues of communication in relation to all aspects of pregnancy and maternity care, understanding Sub-Saharan African women's cultural expressions of pain, and providing them with continuity of care. As the participants expressed their desire for midwifery continuity of care, it is suggested that Sub-Saharan African women who are new to Australia be informed about the different maternity care options so that they can choose the model that can benefit them the most. Furthermore, the findings indicate a need for midwifery continuity of care to be expanded to improve access to care from a known midwife.

Based on the findings, the researcher recommends the following:

Recommendations for midwifery practice

In Sub-Saharan Africa

- In-service training of midwives in Sub-Saharan Africa on interpersonal communication, and early identification and management of complications.

In Australia

- Encouraging Sub-Saharan African women's attendance at antenatal classes
- Expansion of midwifery continuity of care to improve access for Sub-Saharan African women
- Provision of in-service education to improve midwives' understandings of different cultural expressions of pain

Recommendations for research

While there are a number of issues which would warrant further investigation, it is recommended that the following be explored in the first instance:

- The factors influencing Sub-Saharan African women's attendance at antenatal classes in Australia
- Non-English speaking Sub-Saharan African women's experiences of maternity care in Australia
- Research on midwives' experiences of caring for women from Sub-Saharan

Conclusion

This study has explored how Sub-Saharan African women experienced maternity care in Sub-Saharan Africa and Australia. Woman-centred maternity care recognises each woman's unique needs and expectations. With increasing numbers of Sub-Saharan African women giving birth in Australia, it is important for midwives to understand the needs of these women and to provide culturally-appropriate maternity care that meets their needs. The findings of this research provide an understanding of Sub-Saharan African women's experiences of maternity care and the challenges they face while accessing care. The women's needs can be identified from the challenges they faced, and addressing these challenges can improve the provision of maternity care, and therefore, maternal and neonatal health outcomes. While there were differences in the Sub-Saharan African and Australian experiences, the women's valuing and expectations of maternity services were similar. Regardless of the place of birth, the women valued family support and being treated with dignity and respect, although this was not often achieved especially in the Sub-Saharan African maternity system. Their cultural orientation to pregnancy and childbirth also had an impact on their experience of care, and therefore needs to be considered in the provision of maternity care in both contexts.

The study has presented a number of implications and recommendations for midwifery practice, education, and further research. The implementation of these recommendations can contribute to the improvement of maternity care resulting in greater satisfaction with care, and positive pregnancy outcomes for Sub-Saharan African women.

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APPENDICES

Appendix 1: List of Search Terms

Key	Search terms	Findings CINAHL	Medline	PsychInfo
1	"African women"	229	1263	1 220
2	"women from Africa"	72	192	187
3	"African mothers"	18	69	68
4	"maternal care"	183	1711	1663
5	"maternity care"	1675	2304	2 256
6	"maternal health care"	115	518	492
7	Maternal health services" OR "maternal health care services"	9320	10623	11 108
8	"maternity health care services" OR "Maternal Health Services"	4417	10663	10 518
9	Maternity health care services	5	10626	5
10	"perinatal care" OR (MH "Perinatal care (Saba CCC)")	2106	4371	4 275
11	"Perinatal" OR perinatal care or perinatal Nursing	13484	55363	54 592
12	(MH "Intrapartum care") OR labour care OR labor care OR birth care	0	24913	599
13	Intrapartum care	1180	173	438
14	Postnatal care	2737	4775	4 675
15	Lab* care OR intrapart* care OR intrapartum	0	1273404	6 437
16	Labour care	21	40	40
17	Labour OR labor care	4 535	24016	102 084
18	Labour OR labor OR labour support OR management of labour	9 505	117725	22 732
19	Delivery obstetric OR labour support	3 821	21641	21 666
20	Birthing	1 306	1748	1 720
21	Prenatal care OR antenatal care	8 234	28178	44 623
22	Postnatal OR postpartum OR puerperium OR post delivery	0	134298	100 385
23	Postnatal OR postnatal care OR postnatal period	10 668	85335	83 934
24	Puerperium OR obstetric patients	731	8712	8 667
25	Post delivery	127	801	779
26	Antenatal OR antenatal care	361	24752	24 315
27	Africa South of the Sahara OR Africa western OR Africa Southern OR Africa eastern OR Africa central	1 678	18843	16 206
28	Africa western OR sub Saharan Africa	5 983	15692	108 725
29	Sub Saharan women	2	0	15
30	Sub Saharan African mothers OR expectant mothers	15 045	678	168 288
31	Sub Saharan African women	10	49	47
32	Adelaide	495	1940	1 924
33	Australia OR South Australia	47 897	113258	111 822
34	Perceptions	32 294	79321	60 785
35	Experiences OR life experiences	59 077	127756	125 619
36	S1 OR S2 OR S3	309	1482	1 434
37	S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR	47 442	147048	305 940

	S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14 OR S15 OR S16 OR S17 OR S18 OR S19 OR S20 OR S21 OR S22 OR S23 OR S24 OR S25 OR S26			
38	S27 OR S28 OR S29 OR S30 OR S31	21 168	27553	272 605
39	S32 OR S33	47 971	113845	112 403
40	S34 OR S35	86 231	199324	179 355
41	S36 OR S38	21 383	28745	272 950
42	S37 AND S40 AND S41	490	203	1 879
43	S39 AND S42	28	6	117
44	S43 Limiters – published date 2006-2015; English language.	16	5	81

Appendix 2: Evaluation of qualitative research studies included in review

Author and Date	Q1 - clear research aims	Q2 - Qualitative approach appropriate	Q3 - Research design appropriate	Q4 - Recruitment strategy appropriate	Q5 - Data collection methods appropriate	Q6 - Researcher bias recognised	Q7 - Ethical issues considered	Q8 - Data analysis rigorous	Q9 - Findings clearly stated	Q10 - research is valuable
Berggren, Bergström and Edberg (2006)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Carolan and Cassar (2010)	Y	Y	Y	Y	Y	Not clear	Y	Y	Y	Y
Chadwick, Cooper and Harries (2014)	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
Higginbottom et al. 2013	Y	Y	Y	Y	Y	Not clear	Y	Y	Y	Y
Lundberg and Gereziher (2008)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mrisho et al. (2009)	Y	Y	Y	Not stated	Y	Y	Y	Y	Y	Y
Murray et al. (2010)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
McMahon et al. (2014)	Y	Y	Y	Y	Y	Not clear	Y	Y	Y	Y
Pell et al. (2013)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Renzaho and Oldroyd 2014	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
Straus, McEwen and Hussein (2009)	Y	Y	Y	Y	Y	Not clear	Y	Y	Y	Y
Wilunda et al. (2014)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Yakong et al. (2010)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mbekenga 2011	Y	Y	Y	Y	Y	Not clear	Y	Y	Y	Y

Appendix 3: Evaluation of quantitative studies included in review

Author and date	Q1- Issue is clearly focused	Q2- Quantitative approach appropriate	Q3- Recruitment strategy appropriate	Q4- measurements reduced bias	Q5- Data collection methods appropriate	Q6- Sample size appropriate	Q7- Results well presented	Q8- Data analysis rigorous	Q9- Findings clearly stated	Q10- Results are applicable	Q11- Research is valuable
Ekott et al. (2013)	Y	Y	Not clear	Y	Y	Y	Y	Y	Y	Y	Y
Gibson-Helm et al. (2014a)	Y	Y	Not clear	Y	Y	Y	Y	Y	Y	Y	Y
Hennegan, Redshaw and Miller (2014)	Y	Y	Y	Not clear	Y	Y	Y	Y	Y	Y	Y
Iyaniwura and Yussuf (2009)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

Appendix 4: Evaluation of mixed method study included in review

	Q1 Clear mixed method question	Q2 qualitative data relevant	Q3 source of quantitative relevant	Q4 sampling strategy appropriate	Q5 analysis of quantitative appropriate	Q6 analysis of qualitative appropriate	Q7 Is mixed method appropriate	Q8 integration of data relevant	Q9 consideration of limitations
Stapleton et al. (2013)	Y	Y	Y	Y	Y	Y	Y	Y	Y

Appendix 5: Evaluation of reviews included in the study

Author and date	Q1 clear focused question	Q2 right type of studies	Q3 are all important studies included	Q4 quality of studies assessed	Q5- results of studies combined	Q6- Is the discussion clear	Q7 Is confidence interval reported	Q8 applicability of results	Q9 were all outcomes considered	Q10 are benefits worth harms and costs
Brighton et al. (2013)	Y	Y	Not clear	Not clear	Y	Y	N/A	Y	Y	Y
Benza and Liamputtong (2014)	Y	Y	Not clear	Y	Y	Y	N/A	Y	Y	Y
Carolan (2010)	Y	Y	Y	N	Not clear	Y	N/A	Y	Y	Y
Gagnon et al. (2009)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

Appendix 6: Summary of articles included in the review

Author and Date	Aim/ Objective	Sample and Setting	Methodology and methods	Major Findings	Strengths/ Limitations	Rigour/ Validity	Significance to the issue
Berggren, Bergström and Edberg (2006)	To explore the experiences of women from Somalia, Eritrea and Sudan who were done FGM of maternity care in Sweden.	Setting: Sweden. Sample: 21 women from Eritrea, Somalia and Sudan.	Qualitative study using interviews to collect data. Data analysed using content analysis.	Poor access to care due to transportation problems, lack of equipment and supplies. Midwives in Sweden are friendly. Health care providers lack knowledge and skill in managing FGM at birth such that women felt insecure, helpless and vulnerable. The issue of FGM is not discussed prior to giving birth due to language difficulties and that FGM is a sensitive issue. Women experienced fear of c/s. Attitudes of health care providers affected ANC attendance. Adapting to new cultural context – in Africa not being done FGM was shameful while in Sweden they felt ashamed that they were done FGM.	Ethical approval was obtained prior to study. Trustworthiness was ensured by member check and. Sampling bias from snowball sampling-sample not representative of population. Some information might have been lost due to interpretation and translation.	Trustworthiness ensured through member check.	Barriers to accessing care leads to poor utilisation of health care leading to negative maternity experiences. The issue of FGM is not discussed with women during ANC which leads to anxiety about complications related to FGM resulting in negative experiences. Healthcare providers' lack of knowledge and skill in managing FGM at birth contribute feelings of insecurity and anxiety and negative experience of maternity services.
Brighton et al. (2013)	To explore the perceptions of women and communities to identify barriers to the uptake of obstetric services.	Used secondary data	Literature review. Thematic analysis used to analyse findings.	Identified barriers to antenatal health care services such as cultural beliefs, community attitudes and attitudes of health care providers. Culture and traditional beliefs influence women's perceptions and use of	Trustworthiness not stated It is not stated if the included studies were assessed for quality.	It is not clear how trustworthiness was evaluated.	Barriers to accessing antenatal services affect women's experience of health care. Women may not attend antenatal care (ANC). Women may experience pregnancy complications.

Author and Date	Aim/ Objective	Sample and Setting	Methodology and methods	Major Findings	Strengths/ Limitations	Rigour/ Validity	Significance to the issue
				maternity services.			Culture and traditional beliefs influence women's experiences of maternity care either positively or negatively. However, the study only focused on barriers to utilisation of antenatal services leaving out labour and childbirth. Some of the studies in the review were conducted in a different context from that of the proposed research.
Benza and Liamputtong (2014)	To synthesize qualitative studies on experiences of migrant women on maternity care in western countries	Studies on migrant women's experience of pregnancy, labour & birth and motherhood published in 2003-2013.	Metasynthesis. In-depth data analysed using a thematic analysis. Data from 11 qualitative studies 7 of which were conducted in Australia.	Experiences of childbirth were shaped by previous experiences in their countries of birth. Anxiety due to trauma & complications from child birth as midwives lacked skill in managing birth in FGM. They appreciated improved quality of life, advanced technology, nutrition, labour companion They missed family support and traditional rituals after childbirth. Labour pain is perceived as natural and preferred natural birth or use traditional practices to relieve pain to avoid adverse effects on baby. Conflict with staff concerning birth positions, birth instruments, use of analgesia. Fear and isolation; lack of support, abandonment,	Quality of research papers was assessed by two researchers. Most studies' participants were only refugees therefore not representative of all immigrants.	In depth analysis of studies. Findings were relevant to practice.	Women's experiences of pregnancy and childbirth are influenced by societal norms and cultural beliefs therefore their needs should be considered in the provision of maternity care. Lack of support contribute to negative experiences of pregnancy and childbirth. Quality of services enhance positive experience of health care. The perception of labour as an expectation encourages women to refuse pain medication during labour. However, out of the 15 studies reviewed, only 7 were conducted in Australia. Some of the women in the studies were from non-African countries. Only 2 were about African migrants in Australia. Context of some

Author and Date	Aim/ Objective	Sample and Setting	Methodology and methods	Major Findings	Strengths/ Limitations	Rigour/ Validity	Significance to the issue
				insensitive comments, compromising their beliefs to avoid intimidation. Positive experiences too.			studies is different from context for research. Study participants included only refugees.
Carolan and Cassar (2010)	To examine the experiences of African women who attended antenatal care at Melbourne	Setting: African women's clinic in Melbourne. Sample: 18 African women (from Horn of Africa)	Qualitative approach. Purposive sampling population. Semi-structured interviews conducted.	African women attending ANC at Melbourne experienced adjustment from a traditional culture of viewing pregnancy as normal requiring no particular attention from health services to a view that pregnancy required continuous ANC. The friendly atmosphere in the ANC facilities encouraged them to regularly attend ANC.	Researchers could not audio record interviews therefore some data could be lost while taking notes. Participants were experiencing their first ANC in Australia which could not give enough experience. Findings cannot be generalised to all African women. Ethical approval obtained prior to the research. Good application of qualitative design and thematic analysis.	Themes emerged from participants' views, were not predetermined by researcher. It is not stated whether the data was evaluated with participants to confirm if it reflected what they said.	Adjusting to western culture and embracing ANC contribute to positive experience of maternity health care. Friendly staff enhance positive experience with health care and motivate women to attend ANC. The study lays a foundation for proposed study but there is need to explore experiences of the other aspects of maternity care such as intrapartum and postnatal care which this study did not address. Participants were mainly from refugee camps and were all from one part of Africa (Horn of Africa – different context). No participants from the sub Saharan African countries, thus will require some adaptation in order to answer the research question.
Carolan (2010)	To examine health status and likely pregnancy complications among Sub-Saharan refugees	83 study papers and 3 WHO documents.	Literature review.	-poor maternal health prior to pregnancy, co-existing diseases -cultural practices such as FGM; FGM associated with C/S, obstructed labour,	It is not stated if the included studies were appraised for quality. Only focused on refugees.		Poor access to services is associated with poor pregnancy outcomes and negative experiences. Women with FGM likely to have negative experiences of

Author and Date	Aim/ Objective	Sample and Setting	Methodology and methods	Major Findings	Strengths/ Limitations	Rigour/ Validity	Significance to the issue
	attending maternity services in host countries			prolonged labour, PPH, infant resuscitation, prolonged maternal hospital stay, stillbirth/neonatal death -pregnancy complications such as anaemia, high parity, high infant morbidity and mortality rates. -women had limited access to care; needed social support -experienced unsympathetic maternity services -carer knowledge of FGM management.			childbirth due to complications and providers lack of knowledge of FGM. Study only focused on pregnancy complications among SSA refugee women leaving out non-refugees.
Chadwick, Cooper and Harries (2014)	To explore the factors associated with negative birth experiences of women in public maternity settings in South Africa.	Setting: Cape Town, South Africa. Sample: 33 women.	A qualitative study. Unstructured interviews used to collect data. Thematic approach used to analyse data.	Factors which contribute to negative birth experiences included negative interpersonal relations with caregivers, lack of information, neglect and abandonment and the absence of a labour companion.	Study did not report on the positive narrative experiences. Study focused on a small geographical area of South Africa. Selection bias as the women in study were already receiving home visit support which is not a common practice	Transferability of findings may be limited due to sampling bias.	Negative birth experiences can lead to non-use of maternity services; women would give birth without skilled professional assistance leading to poor birth outcomes. Factors contributing to negative outcomes should be dealt with to enhance positive experiences. The study focused only on intrapartum care and left out pregnancy care and post child birth - positive experiences not included -conducted within study context of proposed research i.e. in SSA.
Ekott et al. (2013)	To identify pregnant women's perception	Setting: at a hospital in Nigeria. Sample: 410 pregnant women.	Quantitative research. Questionnaire used to collect data. Data	Women were satisfied with care even though they experience some delays in receiving care.	Ethical approval obtained. Sample size is small for generalisation of	Questionnaire was pretested before use.	Staff attitudes can be a barrier to accessing health services lead to negative experience of health care.

Author and Date	Aim/ Objective	Sample and Setting	Methodology and methods	Major Findings	Strengths/ Limitations	Rigour/ Validity	Significance to the issue
	of the antenatal services they received at the centre and their satisfaction with the care	Sampling strategy not stated.	analysed using statistical analysis.	Delayed attention was experienced across all service points but were mostly at point of accessing laboratory services, medical consultation and pharmacy. Health education was particularly appreciated by the women. Unfriendly attitude of staff affected utilisation of services. Perceived quality of care was a determining factor to using services	findings. Sampling method not stated therefore generalisation of findings is questionable.		Quality of care provided positively influence use of maternity health services. Health education equips women to have positive experiences during pregnancy and childbirth. This study partly responds to the question by detailing experiences of pregnancy care in a Sub Saharan African context. However it focused on one aspect of the research question, pregnancy care neglecting the labour and childbirth and postpartum care.
Gibson-Helm et al. (2014a)	To describe and compare maternal health, pregnancy care attendance and pregnancy outcomes among migrant women from Africa.	Monash hospital. 2173 birth records of African women at Monash from 2002-2011	Quantitative; non-experimental descriptive study. Data was obtained from database Birthing Outcomes System at Monash hospital. Statistical analysis of data.	The maternity health needs of African refugee women are greater compared to women from non-refugee background and they are associated with negative pregnancy outcomes e.g. stillbirths were more common in African women and were much more common among refugees; most African women start ANC late in their pregnancies; refugees preferred natural birth without analgesia not elective c/s; serious perineal trauma in Sudanese women (FGM); Refugees associated with high rate of BBAs	The system where the authors retrieved data did not capture appointments with non-hospital service providers therefore data was incomplete as some women might have had such appointments. Age could be a confounding factor. Detailed data analysis.	Large population size increase possibility of representation and generalizability of findings. Detailed data analysis	African migrant women are prone to negative experiences due to poor pregnancy outcomes. Women who have FGM may have negative experiences of extensive trauma at childbirth if FGM is not properly managed. Maternal problems in refugee women and non-refugee African women vary therefore there is a need to include both in study. There is a gap in knowledge of barriers to early booking (first pregnancy ANC consultation).
Hennegan, Redshaw and Miller (2014)	To compare maternal care experiences of	An analytical ecological, multi-group study.	Secondary analysis of data from survey.	Immigrant women had communication problems. - Preferred one care provider	Immigrants who could not speak English were not included in study,	Used a large sample size. Ethical consideration	Allowing labour companion contribute to positive experience of childbirth.

Author and Date	Aim/ Objective	Sample and Setting	Methodology and methods	Major Findings	Strengths/ Limitations	Rigour/ Validity	Significance to the issue
	women born outside Australia and Australian unborn English speaking women.	Secondary analysis of data from databases		throughout labour and birth They appreciated that presence of support people was encouraged during labour. They were treated with respect and kindness. - Privacy and decision respected. Their wellbeing was cared for. Good maternity care environment. -Continuous foetal monitoring	sample not representative of population. No data on time of migration.	not mentioned. Validity and reliability of tool not mentioned.	Treating women with respect leads to satisfaction with maternity care. Continuity of care is associated with positive women's experiences of maternity care. However the study also included women from other countries outside Africa.
Higginbottom et al. (2013)	To explore maternity experience of Sudanese women in Canada	Setting: at a community setting in Canada. Sample: 12 Sudanese women. Purposive sampling of Sudanese pregnant women and those in post-natal period.	Qualitative study using focused ethnography approach. Study was part of a larger research. Data collected through focused group interviews. Thematic analysis using Roper and Shapira's framework for analysis of data	They conceptualise birth as a normal and natural process which allow them to resist practices which they interpret as abnormal or unnatural, such as analgesia and instrument birth & C/S. Preferred labour without pain relief. Believed in ability to control themselves during labour and not to cry. Resisted some traditional beliefs and resumed sexual relation shortly after childbirth while breastfeeding. Resistance to other health care practices which are against their beliefs. Forced to bottle feed babies against their wish.	Ethical approval and consent were obtained. Findings cannot be generalised due to purposive sampling and nature of qualitative study. Excluding women in late pregnancy and immediate postpartum might have resulted in loss of valuable data.	Trustworthiness: findings reflect what was said by the participants. Ethnography involves observation which was not done in this study.	Childbirth experiences may change in a different context where beliefs are different from what the women are familiar with. Recognising and respecting women's beliefs may contribute to positive experiences of maternity care. The research explored maternity experiences of women from SSA, however it focused on women from one country. Whilst it answers the research question, the context is different as it was conducted in Canada not Australia and healthcare in Canada may be different from that in Australia.
Iyanwura and Yussuf (2009)	To determine the factors that influence	Setting: Nigeria. Sample: 392 women.	Quantitative approach. Design: descriptive cross	The women's perception of quality service was a determining factor in choosing	Study was conducted at a semi urban while majority of the sub	The questionnaire was piloted for validity and reliability.	Quality service provision contributes to positive experience of maternity

Author and Date	Aim/ Objective	Sample and Setting	Methodology and methods	Major Findings	Strengths/ Limitations	Rigour/ Validity	Significance to the issue
	Nigerian women's decision to use maternity services	Cluster sampling of the research setting and random sampling of participants.	sectional study. Data collected using structured questionnaire	the facility to receive maternity care Education, religion and financial income influenced use of services. Husbands influenced decision of seeking maternity services and women depended on them for financial assistance. Hindrances to utilisation of government facilities included long waiting times, poor attitude of staff, distance to facilities and transportation problems	Saharan African population is in rural areas, therefore the findings cannot be generalised to the Sub-Saharan Africa.		services and promote the use of the services. Dependence on spouse for financial assistance may affect experiences of maternity care if the partners are not supportive. Barriers to utilisation of services contribute to negative experiences and non-use of services. Study was conducted within the context of sub Saharan Africa.
McMahon et al. (2014)	To understand the experience with and response to abuse during childbirth	Setting: a community in Tanzania. Sample: 112 women, their partners and community leaders.	Qualitative study using Grounded theory. Data collection: semi-structured interviews. Data Analysis using principles of Grounded Theory.	Women experienced satisfaction with facility-based childbirth while at the same time describe being discriminated against, ignored or verbally abused. Women felt ignored and neglected to the extent of giving birth on their own. Reported verbal and physical abuse as they were scolded for giving birth at home.	The study relied on reported experiences rather than observed. Some of the women have had childbirth months before study and may have recall bias. Sampling strategy not clearly stated.	Researcher's recognition of own bias not stated. Data triangulation done. More than one author analyse data.	Satisfaction with maternity services contribute to positive experiences and compliance maternity care consultations. Poor interpersonal relationship with staff results in negative experiences and women may not use the services leading to complications and increased morbidity and mortality. The study explains women's experiences of childbirth which is one aspect of maternity care. It was done in Sub Saharan African context, however it focused in one country. It also explored only the negative aspect of childbirth and neglected the positive experiences.

Author and Date	Aim/ Objective	Sample and Setting	Methodology and methods	Major Findings	Strengths/ Limitations	Rigour/ Validity	Significance to the issue
Murray et al. (2010)	To examine the birthing experiences of African refugees in Brisbane	Setting: Brisbane. Sample: 10 African Refugee women. Sampling strategy: purposeful, snowball sampling.	Qualitative study using phenomenology approach. Interviews were conducted. Data analysed by thematic analysis using Amedo Giorgi's method.	Barriers to access to care included language, lack of information about available services, cultural/ traditional practices e.g. FGM. Education and previous birth experience in Australia influenced their perception of maternity care. Interpersonal relationship between women and providers was considered as a major part of the experience. Sometimes staff were not available because they were busy/short staffed. Negative comments from midwives in relation to high parity. Lack of continuity of care at ANC.	Participants came from only 4 African countries, and they were all refugees. Use of interpreter could have affected participants' responses. Cultural diversity between researcher and participants could affect researcher-participant relationship.	Good application of the philosophical framework. In-depth exploration of experiences	Barriers to accessing services have negative impact on women's experiences of maternity care. Attitudes of health care staff can positively or negatively affect women's experiences of maternity health care. Previous experiences influence perception of maternity care. Study focused on birth only not covering pregnancy care. It partially answers the research question by exploring birth experiences of African women in Australia. However, the sample was only refugees not representative of Africans in Australia.
Mbekenga et al. (2011)	To explore postnatal experiences of first-time mothers in Tanzania	Setting: Tanzania (lower-income areas). Sample: 10 first-time mothers. Purposive sampling.	A qualitative study. Data collection: interviews.	Women enjoyed motherhood and the respectful status from families and community. Learning about and recovering from bodily changes Maintaining partner relationship and sharing responsibilities Adhered to culture of abstaining from sex, however, doubted partner's faithfulness and use of contraceptives	Ethics approval obtained. Sample excluded professionally employed mothers – not representative of population.	Transferability of study findings should be made with caution since all participants had attended ANC and had delivered at a health care facility, which is unusual in low-income countries.	Support from families and community contribute to experience of respect and satisfaction with motherhood. Culture and traditional beliefs have impact on women's experiences of the postnatal period. The study gives basis of understanding of postpartum experiences of African women.
Mrisho et al. (2009)	To examine perceptions and	Setting: Tanzania. Purposive	Qualitative study. Methods used: in-	Women have a positive attitude towards ANC and	Findings cannot be generalised due to	The information collected from	Barriers to accessing care affect women's attendance

Author and Date	Aim/ Objective	Sample and Setting	Methodology and methods	Major Findings	Strengths/ Limitations	Rigour/ Validity	Significance to the issue
	experiences of women and health providers of antenatal and postnatal care	sampling of 74 women and health care providers.	depth interviews and focused group discussions	PNC, however, lack of money, fear of wild animals along the way to health facility, distance to the facility hinder use of services. Lack of privacy in delivery room and fear of complications which will result in C/S deliveries hinder birthing at health facilities. PNC perceived as care for babies only. Women were scolded for late ANC initiation.	purposive sampling.	interviews and focus group discussion was examined with the participants to increase validity	of ANC and skilled birth attendance resulting in negative experience of child bearing. Lack of understanding of services can negatively affect women's experience of health care. However, the study did not cover intrapartum care.
Gagnon et al. (2009)	To compare the perinatal health outcomes between migrant women and host country born women.	133 reports were used for analysis. 53 articles used for meta-analysis. The studies were selected if they compared migrant women with host country women.	A Systematic review of literature.	Health promoting behaviour and birth weight outcomes were better among migrants than with the comparison group. African women, had an increased risk for preterm birth and for feto-infant mortality. In the analysis, migrants are not seen as at risk poor perinatal health outcomes. Effects of migration on perinatal health may differ. Migrant women had better perinatal outcomes in terms of birthweight and preterm births, however, they had worse outcome in terms of feto-infant mortality. Somali women had a greater risk of c/s and poor birth outcomes such as low Apgar score and stillbirth; however, they also had low risk of preterm birth and low birth weight.	Publication bias, studies were from few publications. Few studies were used for meta-analysis. The meta-analysed studies only focused on 3 perinatal outcomes, i.e. birthweight, feto-infant mortality and preterm birth.	Meta-analysis results of the study are more rigorous as they adjusted for the confounding variables.	Migrant women are likely to have negative experiences due to poor perinatal outcomes. Women with FGM may have negative experiences from obstetric complications associated with FGM. Although the study did not focus only on African women, some of the studies reviewed reports were from Australia.

Author and Date	Aim/ Objective	Sample and Setting	Methodology and methods	Major Findings	Strengths/ Limitations	Rigour/ Validity	Significance to the issue
Pell et al. (2013)	To explore the factors that influence ANC attendance across four Sub-Saharan African sites in three countries (Ghana, Kenya and Malawi).	Settings: Africa: Kenya, Malawi and northern and central Ghana.	Qualitative study. Data collected through fieldwork, interviews and focused group discussions, observations and field notes. Data analysis done using the Grounded Theory approach	ANC was perceived as a normal part of pregnancy Late initiation of ANC – 5 th month of pregnancy, however experiences of previous pregnancy complications motivated women to seek ANC in early pregnancy. Reluctant to disclose pregnancy in fear of witchcraft and losing pregnancy. Communication between women attending ANC and the health staff was limited and often instructive. Shortage of equipment and supplies at ANC. Women were wary of attending ANC because they would be informed of their HIV status and a positive result had consequences if their husbands discovered their status.	Long-term data collection, enabled analysis of a wide range of factors influencing ANC attendance. Findings are limited because exploring ANC attendance was a supplemental objective of another research.	Trustworthiness ensured by data triangulation using different methods of data collection. Data collection and analysis was carried out by more than one researcher to reduce bias.	Cultural barriers may hinder access to care resulting in negative experiences of pregnancy and childbirth. However, the study is limited to ANC, neglecting labour and childbirth.
Renzaho and Oldroyd (2014)	To explore perception of migrant women on health needs and sociocultural barriers during pregnancy and postnatal period	Conducted in Dandenong (Maternal child health services), Victoria, Australia. Sample: 35 lactating mothers from Africa, Afghanistan, China and Middle East. Only 3 were from Africa	Qualitative study. Data collection: Focused group discussions, note taking and structured interviews. Bilingual worker interpreted to participants. Data analysis: Thematic analysis.	Language was barrier to accessing health services. Social isolation due to separation from extended family. Social support from community workers during home visits & from multicultural support groups. Traditional practices conflicted with medical advice e.g. staying indoors for 1 month after birth. Cultural adjustment and	Use of language unfamiliar to researcher could have affected richness of data. No information on educational and occupational history which may influence health needs and access to care.	Ethical approval obtained. Trustworthiness not mentioned. Confirmability was necessary because of language differences	Language difficulties can contribute to negative experiences with health care and non-use of the services. Support is necessary for women to have positive experiences of pregnancy and postnatal period. The study focused on pregnancy and postnatal period neglecting intrapartum period.

Author and Date	Aim/ Objective	Sample and Setting	Methodology and methods	Major Findings	Strengths/ Limitations	Rigour/ Validity	Significance to the issue
				accepting both cultures in order to access and use MCH services. Satisfied with health services and service providers. Lacked understanding of health care system – conflicting messages from primary and secondary health care providers.			
Stapleton et al. (2013)	To explore if attending a specialist antenatal clinic can improve maternity care for refugee women	Setting: Australia at a specialist antenatal clinic for refugee women. Sample: 202 participants comprising 42 women, 147 hospital staff, 3 hospital managers, 2 interpreters, 5 community based stakeholders.	Mixed methods using focused group interviews, survey, and clinical chart audit. Audio-tape recorded	-continuity of care throughout antenatal period -support and trust -central location of facility affected access due to long distance to facility and transport becoming expensive -interpreters were also used as support persons -English language proficiency was a barrier to accessing transport -reluctant to discuss FGM with staff - seen as a private matter - lack of time affected education of women on services availability - satisfied with ANC services but disappointed by lack of continuity during labour and postnatal period. -preferred giving birth vaginally and no pain relief.	FGDs may have limited sharing of information by women who are not used to sharing experiences. Sample dominated by staff instead of service consumers as recipients of care. Presence of clinic staff in FGDs could affect women's disclosure of information about the services they did not like.	Ethical approval obtained Consent obtained from participants. Confirmability – Peer Research Assistants confirmed researcher's interpretations Transferability – is limited because (of special study setting) specialist maternity services require a lot of resources and can be quite expensive.	Continuity of care is appreciated by women and it contributes to positive experiences of maternity care. Barriers to accessing services can lead to negative experiences of pregnancy. Study focuses on improving maternity care experiences of refugee women care during labour and childbirth partially covered
Straus, McEwen and Hussein (2009)	To explore the experiences and needs of Somali women in the UK during pregnancy	Setting: UK. Sample: 8 Somali women.	Qualitative ethnography. Semi-structured interviews for data collection.	Mismanagement of women with FGM increased risk of intrapartum complications -Health care providers lacked skill in managing FGM at birth	Language and cultural differences between researcher and participants could have affected richness of	Narrative approach gave in depth understanding of experiences Ethical approval	Mismanagement of women with FGM can lead to negative experiences of maternity care. Barriers to accessing care can

Author and Date	Aim/ Objective	Sample and Setting	Methodology and methods	Major Findings	Strengths/ Limitations	Rigour/ Validity	Significance to the issue
	and childbirth		Thematic analysis of data	<p>Stereotyped FGM to inability give birth vaginally resulting in unnecessary C/S.</p> <p>-Lack of knowledge of health system</p> <p>-barriers to effective communication – use of medical terms, reluctance to use interpreters</p> <p>-Somali ‘oral culture’ – information transmitted verbally rather than written material</p> <p>-Preferred one provider throughout pregnancy and birth – lack of continuity of care.</p> <p>-judgemental attitude</p> <p>Isolation and depression -lack of family support.</p>	<p>data.</p> <p>Participants included health workers in UK only may affect generalisation of findings.</p> <p>Ethnography require observation which was not mentioned in study.</p>	<p>obtained.</p> <p>Consent obtained from participants.</p>	<p>negatively affect women’s experiences.</p> <p>However, the study was conducted in UK, therefore there is a need for research to be conducted in Australia.</p>
Wilunda et al 2014	To identify barriers to utilisation of maternity services in Moroto and Napak, Uganda.	Setting: community setting in two districts in Uganda. Sample: 459 women and 428 men. Purposive sampling.	Qualitative research. Focus group using open ended question guide and note taking. Data analysed using deductive content analysis.	<p>Barriers to use of maternity services include:</p> <p>Sociocultural factors: beliefs and practices, social role of men</p> <p>Economic inaccessibility: user fees, lack of income</p> <p>Perceived benefit/need: lack of knowledge, perceived quality of care, bas staff attitude, lack of community involvement.</p> <p>Physical inaccessibility: distance, lack of transportation means</p>	<p>Focus group sessions were not audio recorded therefore some data could be lost in the process. Focus groups were too big such that some participants would be quiet and others dominate discussion.</p> <p>Manual analysis of data could also result in loss of information.</p>	Ethics approval obtained.	<p>Barriers to use of services negatively affect women’s experiences of health care.</p> <p>However, the study focused on barriers to utilisation of birth facilities which is only one aspect of women’s experiences. The study provides a background of maternity services in SSA.</p>
Yakong et al. (2010)	To describe experiences of rural women	Setting: two remote communities in	Qualitative research, ethnography.	Women experienced intimidation and being scolded.	Ethics approval and consent received. Use of FGDs on	Trustworthiness: Transcripts, data coding, categorization	Negative staff attitudes negatively affect women’s experiences and may hinder

Author and Date	Aim/ Objective	Sample and Setting	Methodology and methods	Major Findings	Strengths/ Limitations	Rigour/ Validity	Significance to the issue
	seeking reproductive care in Ghana	Ghana. Convenience sampling of 27 women	Methods: interviews, FGDs, participant observation; field notes. Thematic analysis of data guided by Morse and Richards (2002) framework.	Poor interpersonal relationships between nurses and women affected their use of services. Women had a limited choice of where to give birth as midwives would not come to assist them in their homes. Lack of information from midwives – women preferred oral advice from midwives –	intimate issues could have made women uncomfortable sharing about their experiences – affecting richness of data.	and themes were regularly shared with the research team for cross-checking and questioning. Data triangulation was done.	the use of maternity services. Health education is appreciated by women and contribute so positive experiences. Although the findings reflect perspective of women from rural setting, a majority of women in sub Saharan Africa live in rural areas. It focused mainly on antenatal and intrapartum care and neglected postnatal care.
Lundberg and Gerezgiher (2008)	To explore Eritrean women's experiences of pregnancy and childbirth in relation to female genital mutilation in Sweden	Setting: Sweden. 15 Eritrean immigrant women.	Qualitative study using an ethnography approach. Semi-structured interview were conducted. Thematic analysis of data.	Women experienced severe pain on pelvic exam and during labour. Anxiety and fear of complications and C/S. They were impressed with quality of services. Had bad experiences in their own country. Healthcare providers knowledge of FGM made them feel confident and secure. Lacked family support, but midwives supported them. Experienced de-infibulation and re-infibulation.	Using ethnography as methodology involves observation which was not done in this study.	Trustworthiness of data ensured by having more than one researcher analysing data.	Confidence in providers' ability to manage FGM contribute to positive experiences of health care. Women who have FGM may suffer complications during pregnancy, childbirth and postnatal period. Midwives need training on FGM to be able to provide quality care to these women.

Appendix 7: Themes from Literature

Theme	Element	N	Sources
Staff attitudes <i>Total = 14</i>	Interpersonal relationship	7	Brighton et al. 2013, Mrisho et al. 2009, Iyaniwura & Yussuf 2009, Chadwick, Cooper & Harris 2014, Murray et al. Ekott et al 2013, Yakong et al 2010, Lundberg and Gerezgiher 2008
	Friendly, polite staff	3	Carolan & Cassar 2010, Hennega, Redshaw & Miller 2014, Berggren, Bergstrom & Edberg 2006
	Insensitive comments	7	Benza & Liamputtong 2014, Murray et al 2010, Mrisho et al. 2009, Strauss, McEwen & Hussein 2009, McMahan et al 2014, Yakong et al 2010, Berggren, Bergstrom & Edberg 2006
Cultural beliefs and traditional practices of women <i>Total = 14</i>	Cultural beliefs and traditional practices	8	Benza & Liamputtong 2014, Brighton et al. 2013, Carolan & Cassar 2010, Carolan 2010, Iyaniwura & Yussuf 2009, Murray et al. 2010, Renzaho & Oldroyd 2014, Pell et al 2013
	Female genital mutilation	9	Gagnon et al. 2009, Murray et al 2010, Benza & Liamputtong 2014, Gibson-Helm et al. 2014, Carolan 2010, Stapleton et al 2013, Strauss, McEwen & Hussein 2009, Berggren, Bergstrom & Edberg 2006, Lundberg and Gerezgiher 2008
Access to care <i>Total = 15</i>	Physical barriers	10	Mrisho et al. 2009, Iyaniwura & Yussuf 2009, Gibson-Helm et al. 2014, Murray et al. 2010, Benza & Liamputtong 2014, Hennega, Redshaw & Miller 2014, Stapleton et al 2013, Wilunda et al 2014, Pell et al 2013, Berggren, Bergstrom & Edberg 2006
	Socio-economic barriers	6	Gibson-Helm et al. 2014, Mrisho et al. 2009, Iyaniwura & Yussuf 2009, Carolan 2010, Wilunda et al 2014, Ekott et al 2013, Brighton et al. (2013)
	Lack of knowledge of services	6	Renzaho & Oldroyd 2014, Stapleton et al 2013, Strauss, McEwen & Hussein 2009, Wilunda et al 2014, Yakong et al 2010, Murray et al. 2010
	Communication/language difficulties	5	Murray et al. 2010, Hennega, Redshaw & Miller 2014, Renzaho & Oldroyd 2014, Stapleton et al 2013, Strauss, McEwen & Hussein 2009
	Continuity of care	4	Murray et al 2010, Hennega, Redshaw & Miller 2014, Stapleton et al 2013, Strauss, McEwen & Hussein 2009
Experiences of childbirth <i>Total = 8</i>	Natural birth	5	Benza & Liamputtong 2014, Gibson-Helm et al. 2014, Stapleton et al 2013, Higginbottom et al 2013, Murray et al. 2010
	Negative birth experiences	4	Chadwick, Cooper & Harris 2014, Benza & Liamputtong 2014, McMahan et al 2014, Lundberg and Gerezgiher 2008
Social Support and postnatal experiences <i>Total = 8</i>	Labour companion	3	Benza & Liamputt 2014, Chadwick, Cooper & Harris 2014, Hennega, Redshaw & Miller 2014
	Social support	8	Benza & Liamputtong 2014, Chadwick, Cooper & Harris 2014, Hennega, Redshaw & Miller 2014, Carolan 2010, Mbekenga et al. 2011, Renzaho & Oldroyd 2014, Strauss, McEwen & Hussein 2009, Lundberg and Gerezgiher 2008

Appendix 8: Ethics approval

From: [Human Research Ethics](#)
To: "moha0301@flinders.edu.au"; [Linda Sweet](#); [Kristen Graham](#)
Subject: 6978 SBREC final approval notice (4 September 2015)
Date: Friday, 4 September 2015 8:44:39 AM
Importance: High

Dear Hlengiwe,

The Chair of the [Social and Behavioural Research Ethics Committee \(SBREC\)](#) at Flinders University considered your response to conditional approval out of session and your project has now been granted final ethics approval. This means that you now have approval to commence your research. Your ethics final approval notice can be found below.

FINAL APPROVAL NOTICE

Project No.:	<input type="text" value="6978"/>		
Project Title:	<input type="text" value="Sub Saharan African women's experiences of maternity care in their home countries and in Adelaide"/>		
Principal Researcher:	<input type="text" value="Ms Hlengiwe Mohale"/>		
Email:	<input type="text" value="moha0301@flinders.edu.au"/>		
Approval Date:	<input type="text" value="4 September 2015"/>	Ethics Approval Expiry Date:	<input type="text" value="30 July 2018"/>

The above proposed project has been **approved** on the basis of the information contained in the application, its attachments and the information subsequently provided.

RESPONSIBILITIES OF RESEARCHERS AND SUPERVISORS

1. Participant Documentation

Please note that it is the responsibility of researchers and supervisors, in the case of student projects, to ensure that:

- all participant documents are checked for spelling, grammatical, numbering and formatting errors. The Committee does not accept any responsibility for the above mentioned errors.
- the Flinders University logo is included on all participant documentation (e.g., letters of Introduction, information Sheets, consent forms, debriefing information and questionnaires – with the exception of purchased research tools) and the current Flinders University letterhead is included in the header of all letters of introduction. The Flinders University international logo/letterhead should be used and documentation should contain international dialling codes for all telephone and fax numbers listed for all research to be conducted overseas.
- the SBREC contact details, listed below, are included in the footer of all letters of introduction and information sheets.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics

2. Annual Progress / Final Reports

In order to comply with the monitoring requirements of the [National Statement on Ethical Conduct in Human Research \(March 2007\)](#) an annual progress report must be submitted each year on the **4 September** (approval anniversary date) for the duration of the ethics approval using the report template available from the [Managing Your Ethics Approval](#) SBREC web page. *Please retain this notice for reference when completing annual progress or final reports.*

If the project is completed *before* ethics approval has expired please ensure a final report is submitted immediately. If ethics approval for your project expires please submit either (1) a final report; or (2) an extension of time request and an annual report.

Student Projects

The SBREC recommends that current ethics approval is maintained until a student's thesis has been submitted, reviewed and approved. This is to protect the student in the event that reviewers recommend some changes that may include the collection of additional participant data.

Your first report is due on **4 September 2016** or on completion of the project, whichever is the earliest.

3. Modifications to Project

Modifications to the project must not proceed until approval has been obtained from the Ethics Committee. Such proposed changes / modifications include:

- change of project title;
- change to research team (e.g., additions, removals, principal researcher or supervisor change);
- changes to research objectives;
- changes to research protocol;
- changes to participant recruitment methods;
- changes / additions to source(s) of participants;
- changes of procedures used to seek informed consent;
- changes to reimbursements provided to participants;
- changes / additions to information and/or documentation to be provided to potential participants;
- changes to research tools (e.g., questionnaire, interview questions, focus group questions);
- extensions of time.

To notify the Committee of any proposed modifications to the project please complete and submit the *Modification Request Form* which is available from the [Managing Your Ethics Approval](#) SBREC web page. Download the form from the website every time a new modification request is submitted to ensure that the most recent form is used. Please note that extension of time requests should be submitted prior to the Ethics Approval Expiry Date listed on this notice.

Change of Contact Details

Please ensure that you notify the Committee if either your mailing or email address changes to ensure that correspondence relating to this project can be sent to you. A modification request is not required to change your contact details.

4. Adverse Events and/or Complaints

Researchers should advise the Executive Officer of the Ethics Committee on 08 8201-3116 or human.researchethics@flinders.edu.au immediately if:

- any complaints regarding the research are received;
- a serious or unexpected adverse event occurs that effects participants;
- an unforeseen event occurs that may affect the ethical acceptability of the project.

Kind regards
Rae

Mrs Andrea Fiegert and Ms Rae Tyler
Ethics Officers and Executive Officer, Social and Behavioural Research Ethics Committee
Andrea - Telephone: +61 8 8201-3116 | Monday, Tuesday and Wednesday
Rae – Telephone: +61 8 8201-7938 | ½ day Wednesday, Thursday and Friday

Email: human.researchethics@flinders.edu.au
Web: [Social and Behavioural Research Ethics Committee \(SRBEC\)](#)

Manager, Research Ethics and Integrity – Dr Peter Wigley
Telephone: +61 8 8201-5466 | email: peter.wigley@flinders.edu.au
[Research Services Office](#) | Union Building Basement
Flinders University
Sturt Road, Bedford Park | South Australia | 5042
GPO Box 2100 | Adelaide SA 5001

CRICOS Registered Provider: The Flinders University of South Australia | CRICOS Provider Number 00114A
This email and attachments may be confidential. If you are not the intended recipient,
please inform the sender by reply email and delete all copies of this message.

Appendix 9: Letter of introduction



Dr Linda Sweet
Associate Professor
School of Nursing and Midwifery
Flinders University

GPO Box 2100
Adelaide SA 5001
Tel: 08 8201 3270
Fax: 08 8201
linda.sweet@flinders.edu.au
CRICOS Provider No. 00114A

LETTER OF INTRODUCTION

Dear Madam

This letter is to introduce Hlengiwe Mohale who is a master's student in the School of Nursing and Midwifery at Flinders University. She is undertaking research leading to the production of a report and journal publication on the subject of Sub Saharan African women's experiences of maternity care across countries. She would like to invite you to assist with this project by agreeing to be involved in a single interview. No more than one hour would be required.

Be assured that any information provided will be treated in the strictest confidence and none of the participants will be individually identified in the resulting thesis, report or other publications. Anonymity cannot be guaranteed as you may have shared your birth stories with other people who may recognise your story in a publication, however we will maintain your confidentiality at all times. You are, of course, entirely free to discontinue your participation at any time or to decline to answer particular questions.

Since Hlengiwe intends to make a tape recording of the interview, she will seek your consent to record the interview, to use the recording or a transcription in preparing the report and publication, on condition that your name or identity is not revealed.

Any enquiries you may have concerning this project should be directed to me at the address given above or by telephone on 82013270, or e-mail linda.sweet@flinders.edu.au

Thank you for your attention and assistance.

Yours sincerely

Associate Professor Linda Sweet

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project number 6978). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au

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Appendix 10: Information sheet



Dr Linda Sweet
Associate Professor
School of Nursing and Midwifery
Flinders University

GPO Box 2100
Adelaide SA 5001
Tel: 08 8201 3270
Fax: 08 8201
linda.sweet@flinders.edu.au
CRICOS Provider No. 00114A

INFORMATION SHEET

Title: 'Sub Saharan African women's experiences of maternity care in their home countries and in Australia'

Investigator:

Ms Hlengiwe Mohale
Master of Midwifery student
School of Nursing and Midwifery
Flinders University
Phone: 04 5197 7691

Supervisors:

Associate Professor Linda Sweet
Phone: 8201 3270
Ms Kristen Graham
Phone: 8201 3918
School of Nursing and Midwifery
Flinders University

Description of the study:

This study is called 'Sub Saharan African women's experiences of maternity care in their home countries and in Australia'. This project will investigate the experiences of sub Saharan African women of pregnancy, labour and childbirth in order to improve the care they receive during these times.

Purpose of the study:

The purpose of the study is to gather information to help us understand the experiences Sub Saharan African women go through when pregnant and giving birth in different countries. The information will help midwives to understand the experiences and needs of African women during these times so that the care provided takes into account these needs. This aim will be achieved through the following objectives:

- To explore how sub Saharan African women experience pregnancy, labour and childbirth care in their home countries.
- To explore how sub Saharan African women experience pregnancy, labour and childbirth care in Australia.
- To identify barriers to the utilisation of maternity services by sub Saharan African women in Australia.
- To identify ways in which pregnancy, labour and childbirth care services in Australia can be improved for sub Saharan African women.

Who can participate in the study?

You are being invited to participate in this if you are originally from any country in sub Saharan Africa. You should also be:

- Above 18 years old and able to speak English.
- Have given birth to a child in Sub Saharan Africa and in Australia.

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What will I be asked to do?

You are invited to attend a one-on-one interview with Hlengiwe Mohale who is a Masters of Midwifery student at Flinders University. She will ask you a few questions about your experiences of the care you received during pregnancy, labour and childbirth in Africa and in Australia. The interview will take about 60 minutes. The interview will be recorded using a small recorder to capture all the information that you provide. You have the right to request that audio recording be paused or turned off. Once recorded, the interview will be typed-up by the researcher.

What benefit will I gain from being involved in this study?

This project will have little value to you individually, however you may benefit from the knowledge that you are making a contribution to maternity service policy review and development. You may also feel a sense of having your concerns listened too and acted upon appropriately for future policy review and development.

Will I be identifiable by being involved in this study?

Participants' details will be kept confidential. Identity of each participant will be known by the researcher only; no one else will have access to the information identifying the person. Once typed, the information will be securely stored on a computer. False names will be used on the typed interview notes, in the thesis and any published information. Your comments will not be directly linked or connected to you by name. However, anonymity cannot be guaranteed if you have shared your experiences with other people who then read a publication which contains comments which they may recognise as your story. The thesis supervisors will have access to the interview notes for educational purposes. Upon completion of the thesis work, all information will be kept in a confidential manner for 5 years.

Are there any risks or discomforts if I am involved?

There are no risks anticipated for taking part in this study. It is possible that you may have strong feelings that arise during the interview as you re-tell your childbirth experience. If you have any concerns about anticipated or actual risks or discomforts, please raise them with the researcher. Should you experience any discomforts due to disclosure of sensitive information, free counselling services can be obtained from Multicultural SA, Women's Health Services by phoning 8444 0700.

How do I agree to participate?

Participation in the research is voluntary and you can withdraw at any time. Your decision to participate or not to participate will not affect you in any way. If you agree to participate, please contact the researcher on the following phone number:

Hlengiwe Mohale: 04 5197 7691

Thank you for taking the time to read this information sheet and we hope that you will accept our invitation to be involved.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project number 0076). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au

Appendix 11: Consent form



CONSENT FORM FOR PARTICIPATION IN RESEARCH BY INTERVIEW

Sub Saharan African women's experiences of maternity care in their home countries and in Australia.

I

being over the age of 18 years hereby consent to participate as requested in the interview for the research project on **Sub Saharan African women's experiences of maternity care in their home countries and in Australia.**

1. I have read the information provided.
2. Details of procedures and any risks have been explained to my satisfaction.
3. I agree to audio recording of my information and participation.
4. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.
5. I understand that:
 - I may not directly benefit from taking part in this research.
 - I am free to withdraw from the project at any time and am free to decline to answer particular questions.
 - While the information gained in this study will be published as explained, I will not be identified, and individual information will remain confidential.
 - I may ask that the recording be stopped at any time, and that I may withdraw at any time from the session or the research without disadvantage.
6. I agree/do not agree* to the tape/transcript* being made available to other researchers who are not members of this research team, but who are judged by the research team to be doing related research, on condition that my identity is not revealed. * delete as appropriate

Participant's signature.....Date.....

I certify that I have explained the study to the volunteer and consider that she understands what is involved and freely consents to participation.

Researcher's name.....

Researcher's signature.....Date.....

NB: Two signed copies should be obtained. The copy retained by the researcher may then be used for authorisation of Items 8 and 9, as appropriate.

Appendix 12: Interview Guide

“Sub Saharan African women’s experiences of maternity care in their home countries and in Australia.”

List of interview questions

1. Can you please tell me how old are you and how many children you have?
Probe: where and where were they born?
2. What country are you from and how long have you been in Australia?
3. Can you please tell me about your experience of giving birth in Sub-Saharan Africa?
Probe: During pregnancy.
During labour and childbirth.
During postnatal period.
4. Can you please tell me about your experience of giving birth in Australia?
Probe: During pregnancy
During labour and childbirth.
During postnatal period.
5. How has giving birth in Sub-Saharan Africa influenced your experience of childbirth in Australia? Probe: Can you tell me what you mean or tell me more.
6. What factors helped you to seek maternity care in Australia?
7. What factors made it difficult for you to seek maternity care in Australia?
Probe the following if needed:
 - Language
 - Finances
 - Fear
 - Midwives
 - Knowledge of available maternity services.
8. In what way do you think maternity care for Sub Saharan African women can be improved in Australia?