# Ending preventable stillbirths among migrant and refugee populations

Engaging migrant communities and health professionals is critical for eliminating disparities in preventable stillbirth

The Senate committee report on stillbirth research and education[1] puts a spotlight on the tragedy of preventable stillbirth. Public health attention to this devastating but low visibility issue is long overdue. As more coordinated efforts are made to end preventable stillbirth in high income countries, it is critical to ask what steps are being taken to reduce persistent equity gaps in stillbirth rates. More specifically, what role can health services play in ensuring that campaign messages and clinical responses benefit populations vulnerable to poor perinatal outcomes.

In Australia and in other high income countries, there are marked socio-economic disparities in stillbirth rates. Aboriginal and Torres Strait Islander people and people from some low and middle income countries, particularly those coming as humanitarian entrants to Australia, are among the most likely to experience stillbirth.[2–5] The reasons for this are multifaceted, with emerging evidence that difference in gestational length and fetal growth restriction explain a proportion of stillbirths to migrant women from South Asian countries.[6] Barriers to access and engagement with antenatal care and limited health literacy are also likely to be on the pathway to stillbirth.[7] More distal risk factors include complex social determinants of health and the cumulative impact of stressful life events and social disadvantage.[2]

One-third of all women giving birth in Australia are born overseas, with the majority of migrant women coming from a country where English is not the main language.[8] This equates to over 80 000 women of non-English speaking background giving birth in Australia each year. Migration and settlement experiences are often characterised by social isolation and economic disadvantage. Individuals of refugee background with experiences of torture and trauma face additional hardships around the time of pregnancy, exacerbated by limited English proficiency and low health literacy.[9] These factors may limit the reach and relevance of campaign messages for a sizeable proportion of the population.

There is a call for action to end preventable stillbirth in high income countries by improving the health status of women, addressing quality improvement in maternity care, and reducing social inequities.[2] Strategies to end preventable stillbirth require both a focus on communities at risk and health service innovation, as reflected in the work of the Stillbirth Centre of Research Excellence (www.stillbirthcre.org.au). For migrant and refugee women, overcoming

communication barriers is key. Women of migrant and refugee background are at risk of missing critical information about ways to optimise their health and that of their baby. Messages about sleep position, smoking cessation, management of diabetes, warning signs of pregnancy complications, and when and how to seek help need to be communicated in ways that will be both easy to understand and meaningful in the context of women's lives and prior experiences of health services. Without interpreters, time and attention to building relationships and understanding, information may be misunderstood. Women taking part in our study reported limited access to understandable information and explanations about routinely conducted tests and procedures and test results.[10]

Stronger evidence to inform the development of tailored strategies to overcome communication barriers in perinatal care is urgently needed. Digital recording of consultations — trialled successfully in oncology settings[11] — has not been tested in maternity care or in interpreter-mediated conversations. Patient-held recordings of consultations conducted with an interpreter have the potential for non-English speaking women to replay consultations in their own language and listen to them or watch them with family members. In collaboration with Victorian public hospitals, maternal and child health services, and settlement services, our group is currently evaluating group pregnancy care provided by a multidisciplinary team as an innovative way to overcome communication barriers and improve access to high quality antenatal care. The multidisciplinary team comprises clinical midwives, maternal and child health nurse, an interpreter and a bicultural worker, and has been co-designed with local community input. Early findings suggest that the combination of care close to where women live, access to both an

**Jane Yelland**[1,2]
**Elisha Riggs**[1,2]
**Josef Szwarc**[3]
**Stephanie J Brown**[1,2]

**1** Intergenerational Health Research Group, Murdoch Children's Research Institute, Melbourne, VIC.
**2** University of Melbourne, Melbourne, VIC.
**3** Victorian Foundation for Survivors of Torture, Melbourne, VIC.
Jane.Yelland@mcri.edu.au

doi: 10.5694/mja2.50199

**Podcast** with Jane Yelland available at https://www.mja.com.au/podcasts

interpreter and a bicultural worker, and the orientation to provide information in ways that is asked for by women are resulting in greater uptake and retention of health information, including information about when and how to seek help related to pregnancy.[12]

We believe that understanding what matters to women and communities new to Australia is fundamental to health care reform to end preventable stillbirth. It is clear that new clinical and service interventions will only work when informed by service staff and health consumers, and both are engaged in the process of change.[13,14]

**Acknowledgements:** We acknowledge the support of the Victorian Government's Operational Infrastructure Support Program. Jane Yelland is supported by a National Health and Medical Research Council (NHMRC) Translating Research into Practice Fellowship (2018–2019). Stephanie Brown is supported by an NHMRC Senior Research Fellowship (2016–2020).

**Competing interests:** No relevant disclosures.

**Provenance:** Not commissioned; externally peer reviewed. ■



References are available online.

1 Parliament of Australia. Senate inquiry on stillbirth research and education. Canberra: Parliament of Australia, 2018. https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Stillbirth_Research_and_Education/Stillbirth/Report (viewed Sept 2018).

2 Flenady V, Wojcieszek AM, Middleton P, et al. Stillbirths: recall to action in high-income countries. *Lancet* 2016; 387: 691–702.

3 Ravelli AC, Tromp M, Eskes M, et al. Ethnic differences in stillbirth and early neonatal mortality in The Netherlands. *J Epi Comm Health* 2011; 65: 696–701.

4 Ekeus C, Cnattingius S, Essen B, et al. Stillbirth among foreign-born women in Sweden. *Euro J Public Health* 2011; 21: 788–792.

5 Mozooni M, Preen DB, Pennell CE. Stillbirth in Western Australia, 2005–2013: the influence of maternal migration and ethnic origin. *Med J Aust* 2018; 209: 394–400. https://www.mja.com.au/journal/2018/209/9/stillbirth-western-australia-2005-2013-influence-maternal-migration-and-ethnic

6 Davies-Tuck ML, Davey MA, Wallace EM. Maternal region of birth and stillbirth in Victoria, Australia 2000–2011: a retrospective cohort study of Victorian perinatal data. *PLoS ONE* 2017; 12: e0178727.

7 Australian Institute of Health and Welfare. Perinatal deaths in Australia: 2013–2014. Canberra: AIHW, 2018. https://www.aihw.gov.au/getmedia/78784f2e-2f61-47ea-9908-84b34441ae0a/aihw-per-94.pdf.aspx?inline=true (viewed Sept 2018).

8 Australian Institute of Health and Welfare. Australia's mothers and babies 2016 — in brief. Canberra: AIHW, 2018. https://www.aihw.gov.au/getmedia/7a8ad47e-8817-46d3-9757-44fe975969c4/aihw-per-97.pdf.aspx?inline=true (viewed Sept 2018).

9 Yelland J, Riggs E, Wahidi S, et al. How do Australian maternity and early childhood health services identify and respond to the settlement experience and social context of refugee background families? *BMC Pregnancy Childbirth* 2014; 14: 348.

10 Yelland J, Riggs E, Fouladi F, et al. Having a baby in a new country: the experience of Afghan families and stakeholders. Final report. Melbourne: Murdoch Children's Research Institute, 2013. https://www.mcri.edu.au/research/projects/bridging-gap/news-and-publications (viewed Sept 2018).

11 Pitkethly M, MacGillivray S, Ryan R. Recordings or summaries of consultations for people with cancer. *Cochrane Database of Syst Rev* 2008; (3): CD001539.

12 Riggs E, Muyeen S, Brown S, et al. Cultural safety and belonging for refugee background women attending group pregnancy care: an Australian qualitative study. *Birth* 2017; 44: 145–152.

13 Duckett S. Targeting zero: supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care. Melbourne: Victoria State Government, 2016.

14 Greenhalgh T, Robert G, Macfarlane F, et al. Diffusion of innovations in service organizations: systematic review and recommendations. *Milbank Q* 2004; 82: 581–629. ■