2019

An Evaluation of the Refugee Experience of Liminality and the Impact of Best Practice Models of Care

Hanna Erickson
Augsburg University

An Evaluation of the Refugee Experience of Liminality and the Impact of Best Practice Models of Care

By Hanna Erickson, PA-S

Advisor: Jenny Kluznik MPH, PA-C

Paper Submitted in Partial Fulfillment

Of the Requirements for the Degree

Of Master of Science

Physician Assistant Studies

Augsburg University

Date: 08/05/19

Introduction

Globalization presents massive challenges for healthcare providers and the blend of language, expectation and cost creates increased risk for all patients. Refugees are among the most vulnerable of populations when overall health outcomes are measured and access to healthcare is analyzed.[1] This is due to rapid modernization of health care systems and the fact that refugees are typically leaving a volatile place of origin and migrating to a wealthier, more stable country where different modalities are used to access care. Women of childbearing age comprise a huge portion of refugees and will be the population of focus examined here.

A refugee is a person who is fleeing their country of origin due to a well-founded fear of being persecuted.[2] Once their asylum claim is accepted in a host country, refugees have legal rights and access to healthcare. However, worse maternal outcomes are consistently reported in refugees that have been resettled in high income countries when compared to non-immigrant groups.[3] Many times, these outcomes are due to miscommunication or failure to understand expectations either on the part of the patient or the provider.

Research is currently being done to develop a best practice model of care that can facilitate communication and increase satisfaction of refugee patients and their providers in the urban, high income communities settings where refugees have been resettled.[1] Researchers Ignacio Correa-Velez and Jennifer Ryan propose the following aspects be included in care models for refugee populations in countries of resettlement going forward: continuity of care, quality interpreting services, cultural competence and mental health screening.[1] This paper will explore the concept of liminality among refugees and how this impacts the perinatal experience. Through this lens, aspects of a best practice model of care in the maternal refugee population will be explored and priorities of implementation will be recommended. Finally, a discussion

will conclude with how this care model can contribute to increased satisfaction rates for both providers and patients.

Background

Liminality

The lived experience of displacement situates refugee mothers at the epicenter of risk as they approach the challenges of motherhood and resettlement simultaneously. Women in the perinatal period, defined as conception to the first twelve months post-birth, bear the burden of navigating a new cultural reality and a new health system.[3] Without the cultural support of their homelands, they are forced to confront a new set of health expectations for themselves, their children and their families.[4]

The maternal refugee experience presents unique challenges for the patient. Refugee women describe the feeling of living "in between" and not feeling tied to their country of origin or the high income country where they find themselves resettled.[5] This phenomenon is termed liminality and is a ubiquitous feeling for women fleeing the unrest of home. Liminality impacts refugee women's negotiation of motherhood and maternity care to such a high degree, that it was studied extensively in a 2019 meta-ethnographic synthesis of qualitative research involving eight different high income countries including the United Kingdom, Australia, Sweden, Canada and the United States of America.[5] In total, the study included 607 participants and three common themes emerged: constructing maternal identity across cultures, understanding in practice and negotiating care. These findings are summarized by Figure 1 in Appendix A.

Constructing Maternal Identity Across Cultures

The first theme encompassed how to construct maternal identity across cultures. Most women tend to adopt recommendations for maternal care practices in the country of resettlement but this creates a tension of not knowing which practice is best.[5] One mother described her confusion during childbirth with synthesizing her familial beliefs with those of the hospital staff, "…and I was thinking, should I listen to my mum, or to my doctor? I think, my mum is uneducated, doctor is educated, what should I do? First time I was like, sometimes listening to my mum, sometimes listening to my doctor. The second time all I did was… listen to my doctor, nothing else. And I did and find it really good…" [4]

Whatever choice a mother makes regarding her health and family, it constitutes a fundamental shift in maternal identity that is both necessary and difficult. Parenting practices that work well and are accepted in the country of origin do not always translate well to the country of resettlement. The way a mother grew up may not even be possible for her children due to the new context.[4] Mothers worry about a child having no memories of their culture, the lack of tradition and the lack of community support. Patterns of birth and parenting could change and women express how difficult it is to find a healthy balance.[5]

A qualitative study in Melbourne, Australia focused on the mental health of Afghani refugee mothers. Thematic analysis reveal that these women express significant isolation, loneliness and grief surrounding raising a child in a different context than the one the mother grew up in. The lack of supportive relationships and female kin during early motherhood were additional challenges. The combination of these factors leads to complex mental health dynamic as Afghani women try to understand their place in a new Australia.[3]

Understanding in Practice

The second theme of liminality surrounds communication and understanding the practices of the new host country. Patients and providers share the feeling of mutual misunderstanding when different cultural perspectives are at play. This leads to frustration on the both the side of the provider and the patient. Additionally, the patient may also experience a large amount of fear at the interventions that are recommended or implemented without knowing the full reason why. Refugees often have experienced the trauma of war, exploitation and political and social unrest. By the end of 2017, 68.5 million people around the world had been forcibly displaced due to conflict, persecution or generalized violence.[5] Hospitalization can inadvertently cause re-traumatization when patients feel a lack of control.[5]

Miscommunications can stem from differences in prenatal expectations or the guidelines of the country of resettlement. For instance, one father described how prenatal classes are offered in the United States but inaccessible as a Somali refugee due to the mixed-gender format which is not allowed for Somali patients who practice Islam. Somali men in a 2015 study stated that prenatal classes were a missed opportunity to understand the American health care system.[6]

Technology also poses significant challenges to refugees seeking care in high income countries. Refugees who flee from areas of unrest to high income countries may encounter ultrasounds or fetal heart monitors for the first time. Although these are viewed by the non-immigrant population as a positive, refugee mothers may be confused by monitoring systems or even feel threatened. This can be an obstacle for both patient and provider.[5]

The misunderstanding of technology leads to the larger concept of understanding in practice. Evidence based medicine is an idea that most high income countries take for granted but may not be a familiar concept for a new refugee. This takes significant time and effort on the behalf of providers to explain why an intervention is recommended and important. Especially

when their non-immigrant patients have no problems with the same intervention. In this context, refugees can be viewed as difficult patients that are refusing care or non-compliant with interventions. Although a patient can be perceived this way, this may not always be true. They may just not understand the rationale, especially when they never saw their mother or friends complying with such a recommendation.[7]

This paradox of misunderstanding can be painfully obvious in a prenatal setting. Women are constantly weighing the recommendations of the health care provider against the experiences of their mothers and peers. Prenatal vitamins and adjusting diet during pregnancy is an example of an evidenced-based recommendation that most providers suggest to their patients. In a 2015 descriptive phenomenology study a Somali mother stated, "Back home women have babies without taking any pills when pregnant. I had three kids in Kenyan refugee camp, all vaginal births; I had no problems. With my fourth kid, in the US… I decided to not take the pills and the baby was born normal like my other kids."[6]

Negotiating Care in a High Income Country

The third theme of liminality is negotiating care in a high income country. Negotiating care typically diverges into two groups of women. Many refugee women regard the care they receive in a high income country to be clearly superior when compared to their country of origin. This group often approaches the health care system with a sense of implicit trust or a sense of indebtedness to their providers. The second group of women feels that their lack of knowledge and lack of familiarity with the healthcare system places them in a regrettable power imbalance. This contributes to a sense of powerlessness and overall fear or suspicion when obtaining care.[5]

Cultural Conviction

Throughout the negotiation of perinatal care, most refugee women maintain a sense of cultural conviction. This conviction is the belief that practices from the country of origin are beneficial even if the country of resettlement does understand the meaning or value of said practices.[5] Regardless of the group that a refugee mother falls into, these convictions can drive a feeling of resistance or not wanting to engage with the medical system. This can persist even if refugees hold the high income country's healthcare system in high regard.[5]

Coping Mechanisms

Refugee mothers demonstrate a remarkable ability to develop innovative coping mechanisms. Many refugees have an incredible capacity for resourcefulness. This is seen most often in their ability to seek out independent sources of information and support. Access to education, social networks and language learning are all way that refugee women feel empowered.[5]

Some refugee mothers cope by developing coping mechanisms of stoicism and self-reliance.[5] This in itself is a unique form of strength in the face of incredible harshness and suffering. The Karen women reference this idea often as they discussed motherhood and displacement in a 2014 qualitative ethnographic study. Findings revealed that Karen women felt that personal suffering was not important when compared to the larger community. Feelings of sadness and depression were ignored. Although these qualities are admirable, they place women at high risk for mental health problems to be missed.[8]

The final coping mechanism is hope. Relying on family, religious beliefs and cultural tradition is often the anchor that refugee women need as the navigate motherhood in a new country. Those that view resettlement as an opportunity for a better life tend to feel more motivated as they approach the challenges of a new country.[5] Healthcare providers that can

recognize and build on this sense of hope are in a unique position to positively impact the lives of these women and their families.

Best Practice Model of Care

Now that liminality and the challenges of motherhood as a refugee are more thoroughly understood, the focus can shift to developing strategies to increase the overall satisfaction of refugee patients and their providers. Research shows that the goals of patients and providers are most often the same. Both parties want a healthy outcome. However, disagreements arise about how best to arrive at that end goal. Providers want their time and expertise to be respected.[1] Patients want their cultural beliefs and values to be honored.[6] When either party feels that actions are in violation of these core desires, conflict arises. Disagreements often arise because either the patient or provider does not feel heard or that their perspective was not taken into account.

How can these miscommunications be brought to a minimum? Efforts have been made to develop a best practice model of care where the expectations of providers and patients are shared. In this way, desires of both parties can be recognized and respected with clarity. There are four aspects to a best practice model of refugee maternity care as proposed by Correa-Velez and Ryan: continuity of care, quality interpreter services, education strategies for women and healthcare providers and mental health screening for women from refugee backgrounds.[1]

Continuity of Care

One of the primary interventions that has been shown to improve satisfaction for both providers and patients is continuity of care.[1] One-to-one midwife care allowed for mutual understanding of birth plans, better communication and a greater sense of control over shared decision making.[1] In an Australian qualitative study, Karen women reported feeling empowered and confident in the perinatal period due to a community-based model of group pregnancy care.[9]

This is a slightly different approach that involves meeting as a group over time and employs a bicultural worker to interpret not just the language but the cultural meaning and implications surrounding the conversation. The continuity built in this group illustrates how a trusting relationship with a team of professionals reduced misunderstandings and greatly increased refugee mother's ability to feel prepared for labor and birth.[9]

Quality Interpreter Services

Most refugee women do not initially speak the language in the country of resettlement. The need for quality interpreter services is a continuously emerging theme in the research surrounding refugee best practice models of care. As women try to negotiate healthcare in a new country and as providers strive to become culturally competent, interpreters are the connection point that is needed. Complaints involve interpreters that arrive late or are difficult to schedule. In addition to obtaining an interpreter in the correct language, there is the added struggle of differing dialects, beliefs or cultural convictions. Consistently, research shows that lack of interpreting services is a source of frustration for staff and patients alike.[10]

Cultural Competence

Cultural competence of staff is an area to highlight as part of the best practice model. Refugee and healthcare research demonstrates consistent gaps in cultural understanding on the part of the healthcare providers.[1] Education strategies are needed for healthcare professionals to enhance cultural responsiveness.[1]

Cultural competency can seem like an overwhelming task when faced with refugees from many different countries. In a 2014 systematic review of women's experiences of maternity care, findings were summarized with a few takeaways that can be integrated into a strong best care practice model. Researcher Rhonda Small noticed that refugee women do not expect staff to

implicitly know their culture, they are aware of the challenge of many different cultures presenting to one hospital. They just want to be asked. They would like staff to inquire about their childbirth preferences and belief and in this way, provide individualized, responsive care for each patient.[11] For refugee patients trying to negotiate life in between two cultures, cultural competence is a key element of a best practice model of care.

Mental Health Screening

Mental illness carries significant stigma in many countries. Russo's study of emotional wellbeing in Afghani refugees identified a reluctance in Afghani patients to discuss mental health with health care providers, primarily due to cultural stigma.[4] Refugees often do not know how to express their psychological distress in terms that host country providers will understand. One research article advocated for the idea of cultural translation of refugee trauma.[11] This qualitative study showed that when screening tools used cultural idioms of distress, more accurate results were found.[12] Colloquial terms were found to be an important part of mental health screening.[12]

Maternity care providers expressed discomfort with how to ask questions about depression and anxiety in the refugee population. Suzanne Willey performed a study in Melbourne, Australia, to determine feasibility in implementing a perinatal mental health screening program would be specifically for the refugee population.[3] She developed an assessment tool that combined a two forms of screening that were more interactive and involved discussion with the provider instead of the traditional nineteen question paper survey. The midwives in this study felt that this screening program opened up dialogue with their refugee patients and allowed them to have more specific conversations, something that had not been

done previously.[3] Open conversations are essential as refugee women negotiate care and understand the practices of the country of resettlement.[5]

Methods

The PubMed and ScienceDirect databases were used as the initial source of article retrieval. The keywords refugee and women were used first. The search was then refined to use the words refugee and maternal. As research progressed the terms liminality and healthcare were helpful in establishing a base of literature. To provide further specificity, an advanced interlibrary search engine through the Augsburg Lindell Library was used with the keywords refugee and healthcare, cultural competence and refugee, and lastly, continuity of care and refugee. Inclusion criteria limited article selection to those that were peer reviewed and published within the last ten years. This ensured validity and relevance. The population of interest was limited to refugees that have been resettled in high income countries.

Discussion

Given the discussion of liminality, what aspects of a best practice model would be most impactful to implement in a health system serving a large number of refugees? The following recommendations are made based on the literature review of the refugee experience during the perinatal period and current research surrounding best practice models of care.

Continuity of Care

In a traditional clinic setting, simply scheduling appointments with the same provider who has an established level of cultural understanding with a particular group can be the first step toward continuity. Continuity of care improved patient satisfaction rates in a qualitative study of 123 Somali patients.[6] When a provider or group or providers see the same patients multiple times over days and weeks, a bridge of mutual understanding can be built.[5] A bridge

cannot be built in a day and understanding cannot be reached in one patient visit. Scheduling appointments with the same provider throughout a perinatal period is extremely beneficial for the provider and for patients experiencing liminality.[5]

The importance of building rapport and relationship cannot be underestimated. A review of 607 refugees in the perinatal period revealed that patient's level of comfort in communicating and revealing sensitive information increases the more they know their provider.[5] In fact, studies show that when women have an established relationship with a health professional they were more likely to ask questions, attend appointments and recommend services to others.[5] Through thematic analysis of twenty-two qualitative studies and three mixed method studies, it can be concluded that continuity of care helps ease the mutual misunderstanding that occurs as refugee women seek to live in between two cultures and negotiate their healthcare experience.[5]

Quality Interpreters

Interpreters that share the beliefs and culture of the refugee mother can be a major component of increasing satisfaction for patients and providers.[6] Refugee women typically prefer a same-gendered interpreter who is also of childbearing age or older. This is a fairly specific requirement but understandable given the nature of maternity care. The importance of quality interpreters goes beyond preference. An interpreter can completely change an experience and influence an outcome, "Some women reported negative experiences due to age and gender of the interpreters provided during appointments. Some of these experiences seriously impacted women's well-being and had enduring negative impact on their capacity to trust the hospital."[1]

Conversely, an interpreter who does their job well becomes a life line for the patient and providers alike. They become an advocate not just for the patient's health but for their cultural convictions to be understood, respected and honored. The Obstetrician & Gynaecologist, a

British journal, underscored the importance of interpreters with this statement, "The use of professional interpreters has been shown to improve patient care, satisfaction and lower healthcare costs due to less hospitalization and emergency care use. Studies have also shown that women view professional interpreters as advocates in addition to their translation role."[3]

Clinics and hospitals can work with local interpreting services to find and establish connections that benefit both the staff and the patients. Implementation of quality interpreters is imperative in a best practice model of care as it relates to the refugee experience.

Cultural Competence

Cultural competency is more than a nice idea, it is an important part of a best practice care model to ensure positive outcomes. Data analysis from the interviews of forty-eight Somali patients in the perinatal period revealed an overarching theme of breakdown of communication. Participants believed that well-meaning but uneducated providers contributed to undue pain and prolonged healing. These situations could have been avoided by proper education and training.[6]

Refugee patients want kind, respectful care and do not want to be discriminated against for cultural beliefs.[6] If consistent issues of misunderstanding arise repeatedly, cultural competency training for maternity services staff can be a solution.[3] Another solution can be to employee bicultural workers who have specific training and ease of communication with both the refugee culture and the culture in the country of resettlement. A qualitative study in Australia showed that having a bicultural worker as part of the care team greatly increased refugee women's feelings of satisfaction and cultural safety.[9]

Mental Health Screening

Refugee women are four times more likely than the general population to develop depression in the perinatal period.[2] Mental health screening needs to be included in a best care

practice model for refugee women. Innovative tools to screen refugees for mental health problems are on the rise. Bicultural workers, iPads using native language and increased use of interpreters have all contributed to identifying maternal distress more reliably.[3]

Once maternal distress is recognized, it can be treated accordingly. A study of sixty-two participants in a refugee antenatal clinic in Australia showed that perinatal mental health screening programs lead to higher satisfaction levels for patients.[3] Providers would be hard pressed to learn the cultural idioms of mental health distress for every group of refugees that they encounter. However, as mental health screening research emerges, incorporating evidence-based findings into individual clinic or hospital's best practice model of care would greatly benefit the health and wellness of their refugee populations.[3]

Conclusion

Research shows that developing a best care model for incoming refugees provides an overall better experience for staff and patients. Refugees are living in between cultures and the way in which care is provided must be approached differently. When staff and patients have a shared understanding of how to provide and receive medical care, the incidence of miscommunication greatly decreases. Misunderstandings comprise much of the root cause of refusal of care, failure to comply with instructions or dissatisfaction with the final medical outcome. In this context, it is apparent that shared set of expectations is needed.

Establishing a best practice model of care has been proven to provide greater satisfaction for refugee mothers and their providers. When continuity of care, quality interpreters, cultural competence and mental health screening are implemented, the strains imposed by the experience of liminality can be eased. These elements combine to form a safe place for refugee women to negotiate care for themselves and their families.

References:

1. Correa-Velez I, Ryan J. Developing a best practice model of refugee maternity care. *Women and Birth.* 2012;25(1):13-22.

2. Asif S, Baugh A, Jones N. The obstetric care of asylum seekers and refugee women in the UK. *The Obstetrician & Gynaecologist*. 2015;17(4):223-23.

3. Willey SM, Gibson-Helm ME, Finch TL, et al. Implementing innovative evidence-based perinatal mental health screening for women of refugee background. *Women and Birth.* 2019;34(976):1871-5192.

4. Russo A, Lewis B, Joyce A, Crockett B, Luchters S. A qualitative exploration of the emotional wellbeing and support needs of new mothers from afghanistan living in melbourne, australia. *BMC Pregnancy and Childbirth.* 2015;15(197)1-13.

5. Pangas J, Ogunsiji O, Elmir R, et al. Refugee women's experiences negotiating motherhood and maternity care in a new country: A meta-ethnographic review. *International Journal of Nursing Studies.* 2019;90:31-45.

6. Wojnar DM. Perinatal experiences of somali couples in the united states. *Journal of Obstetric, Gynecologic & Neonatal Nursing.* 2015;44(3):358-369.

7. Baird MB, Domian EW, Mulcahy ER, Mabior R, Jemutai-Tanui G, Filippi MK. Creating a bridge of understanding between two worlds: Community-based collaborative-action research with sudanese refugee women. *Public Health Nursing.* 2015;32(5):388-96.

8. Niner S, Here nobody holds your heart: Metaphoric and embodied emotions of birth and displacement among karen women in australia. *Medical Anthropology Quarterly.* 2014;28(3):362-380.

9. 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(2):145-152.

10. Kibiribiri ET, Moodley D, Groves AK, Sebitloane MH. Exploring disparities in prenatal care between refugees and local south african women. *International Journal of Gynecology & Obstetrics.* 2016;132(2):151-155.

11. Small R, Roth C, Raval M, Shafiei T, Korfker D, Heaman M, McCourt C and Gagnon A. Immigrant and non-immigrant women's experiences of maternity care: A systematic and comparative review of studies in five countries. *BMC Pregnancy and Childbirth.* 2014;14(152):1471-2393.

12. Im H, Ferguson A, Hunter M. Cultural translation of refugee trauma: Cultural idioms of distress among somali refugees in displacement. *Transcultural Psychiatry.* 2017;54(5-6):626-652.

Appendix A:

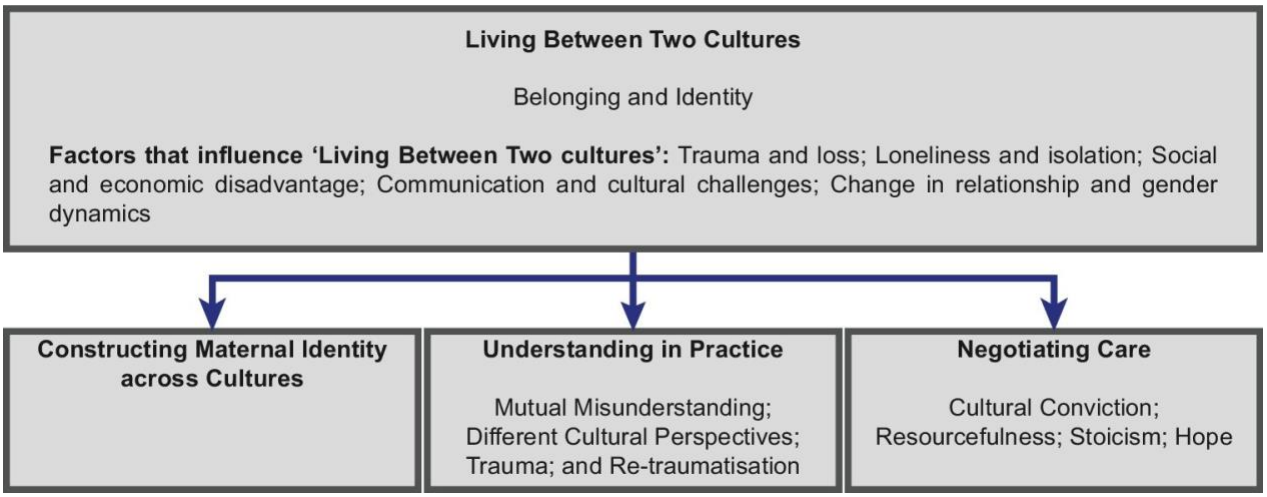

Figure 1: Refugee Mother's Experience of Liminality[5]

AUGSBURG UNIVERSITY

Augsburg University Institutional Repository Deposit Agreement

By depositing this Content ("Content") in the Augsburg University Institutional Repository known as Idun, I agree that I am solely responsible for any consequences of uploading this Content to Idun and making it publicly available, and I represent and warrant that:

- I am *either* the sole creator or the owner of the copyrights in the Content; or, without obtaining another's permission, I have the right to deposit the Content in an archive such as Idun.
- To the extent that any portions of the Content are not my own creation, they are used with the copyright holder's expressed permission or as permitted by law. Additionally, the Content does not infringe the copyrights or other intellectual property rights of another, nor does the Content violate any laws or another's right of privacy or publicity.
- The Content contains no restricted, private, confidential, or otherwise protected data or information that should not be publicly shared.

I understand that Augsburg University will do its best to provide perpetual access to my Content. To support these efforts, I grant the Board of Regents of Augsburg University, through its library, the following non-exclusive, perpetual, royalty free, worldwide rights and licenses:

- To access, reproduce, distribute and publicly display the Content, in whole or in part, to secure, preserve and make it publicly available
- To make derivative works based upon the Content in order to migrate to other media or formats, or to preserve its public access.

These terms do not transfer ownership of the copyright(s) in the Content. These terms only grant to Augsburg University the limited license outlined above.

Initial one:

HE I agree and I wish this Content to be Open Access.

___ I agree, but I wish to restrict access of this Content to the Augsburg University network.

Work (s) to be deposited

Title: An Evaluation of the Refugee Experience of Liminality and the Impact of Best Practice Models of Care

Author(s) of Work(s): Hanna Erickson

Depositor's Name (Please Print): Hanna Erickson

Author's Signature: Hanna Erickson Date: August 16, 2019

If the Deposit Agreement is executed by the Author's Representative, the Representative shall separately execute the Following representation.

I represent that I am authorized by the Author to execute this Deposit Agreement on the behalf of the Author.

Author's Representative Signature: _____ Date: _____