Motherhood After Migration

The pregnancy and postpartum experiences of women from Afghanistan, Burma, China, Sudan and Vietnam

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Introduction
Australian society is characterised by ethnic diversity. As well as long history of receiving free settlers, Australia also receives forced international migrants as part of its Humanitarian Program. While the majority of migration to Australia has historically been attributed to immigrants from the United Kingdom, increasing numbers of arrivals come from countries outside of Western Europe. This has seen a corresponding increase in the proportion of the Australian population from culturally and linguistically diverse (CALD) backgrounds. The significant proportion of residents born overseas is reflected in the national birth rate with around a quarter of births in Australia to immigrant women (Laws and Sullivan 2009).

Pregnancy is a time when many immigrant women can feel particularly vulnerable. Foreign-born women, especially those from CALD backgrounds, may be more likely to face problems navigating the local maternity health system, have issues with language and communication, deal with potential conflict between their traditional practices and those of the receiving country, and face social isolation, particularly when separated from extended family members who reside in the natal country or elsewhere.

The following report explores the pregnancy and postpartum related experiences of CALD immigrant women who have given birth in Western Australia (WA) between 2004 and 2009. Information was gathered through focus groups, co-interviews and individual interviews with refugee women from Afghanistan, Burma and Sudan and free settlers from Vietnam and China. The report includes a number of recommendations for the improvement of perinatal care services for women from the targeted groups, as well as women from CALD backgrounds in general.
Background

Australian society is characterised by ethnic diversity, with 21.9% of its population born overseas. This increases to 27.1% for WA, which has the highest proportion of overseas-born residents of any Australian state (ABS 2007). For most of the 20th century Australian immigration guidelines were governed by Eurocentric sentiment. Historically, the majority of immigration to Australia has been from the British Isles. Following the Second World War the Australian government turned to non-English speaking Europeans, particularly those from Southern and Eastern Europe, to populate the country. The declaration of Australia as a multicultural society by the Whitlam government in the 1970s saw an influx of immigrants from countries outside of Europe.

Australia is perceived as an affluent nation with a high standard of living and a long history of attracting foreign-born residents. While the majority of immigrants in Australia have traditionally been from Anglo-Celtic backgrounds, an increasing proportion is from culturally and linguistically diverse CALD backgrounds (ABS 2009). Due to Australia's geographical location in the Asia-Pacific region there has been a marked increase in immigration from Asia in recent decades. Australia is also one of ten countries that resettles international refugees, and is third after the United States and Canada in terms of the total number of people resettled (DIAC 2009). Australia's commitment to the Humanitarian Program has seen an increase in the numbers of international refugees relocated to Australia. At the last national census, Australians reported speaking over 200 different languages and claimed over 270 ancestries. In addition, 22% were born overseas while 16% spoke a language other than English at home (ABS 2008).

Relocating to a new country is a major life event. For many new residents the process of international migration brings with it ongoing stressors: an unfamiliar environment, language difficulties, new cultural norms, and social isolation. For those individuals whose migration is forced, such as those entering Australia as part of the Humanitarian Program, there can be additional risk factors to consider such as limited literacy and employment opportunities, exposure to malnutrition and infectious disease, post-traumatic stress and mental health issues, and separation from family and friends. Women constitute a significant proportion of the foreign-born population in Australia and may be more vulnerable when compared to their male counterparts (Allotey 1998). Female immigrants are less likely to speak English, less likely to be educated, and less likely to be employed outside of the home than male immigrants, placing them at further risk of economic and social isolation.

A significant proportion of foreign-born women in Australia are of childbearing age. Pregnancy and childbirth are important life events that exist within a sociocultural context. As such, the practices and behaviours that surround this stage in life are moulded by beliefs and traditions which exist to support the new mother and her baby. Religion may play a significant role in reproduction with the number, timing or outcomes of pregnancies deemed to be the responsibility of God or good moral practice. All
of these factors influence a woman’s understanding of appropriate maternal behaviour during pregnancy, birth and the postpartum period.

Existing literature indicates that pregnancy and birth outcomes in immigrant women often differ from those of local-born women. Perinatal studies in other Western countries have noted significant variation in pregnancy complications, birth outcomes and general perinatal health for local-born and immigrant women and their infants (Gagnon et al. 2009). In certain instances international migration has been shown to have negative associations with maternal mortality (Schuitemaker et al. 1998), perinatal mortality (Burton and Lancaster 1999, Essen et al. 2002), fetal growth (Dejin-Karlsson and Ostergren 2004, Diani et al. 2003), gestational diabetes (Kieffer et al. 1999, Weijers 1998), antepartum haemorrhage (Forna et al. 2003), and obstetric interventions (Ibison 2004).

Existing literature also indicates that antenatal and postpartum care can be difficult to navigate for foreign-born women. While access to care during the perinatal period for foreign-born women in western countries is generally good (Malin and Gissler 2009, Small et al. 2002) it is often impeded by unsympathetic services, prejudice and racial stereotyping. Immigrant women in Australia have reported feeling that they required more support than they received after giving birth in hospital (Yelland et al. 1998). The cultural context of childbirth is important, particularly for women who have relocated to a new country and therefore lack their traditional support networks. Refugee women are particularly susceptible in this regard.

Immigrant populations are highly vulnerable and deserving of equitable and culturally appropriate health care. The pregnancy and childbirth related needs and wants of foreign-born women from CALD backgrounds are not well understood, particularly in an Australian context. Therefore this exploratory study aimed to report on the experiences of foreign-born women from Afghanistan, Burma, China, Sudan and Vietnam. With increasing numbers of women from CALD backgrounds birthing in WA, this study sought to identify areas of antenatal and postpartum care that could be improved for foreign-born women.
Methodology
A qualitative method was deemed most appropriate for this study. There are numerous research paradigms available for qualitative work, but in attempting to provide insight into how immigrant women perceive the perinatal period in general, as well as how they experienced it as individuals, it is important that representations are structured by the participant and not the researcher. Working with vulnerable populations, such as immigrant and refugee women, requires a certain level of flexibility. In order to accommodate the participants and maintain high levels of integrity, focus groups, co-interviews and individual interviews were used to collect data, depending on the circumstances of the participants in question.

Participants
Women from several CALD groups were targeted for participation because of a combination of factors, including general patterns of immigration to WA from the country of origin, numbers of women from each country giving birth in WA, variation in migration experiences, cultural and linguistic distinctness, and the likelihood of being able to access women from these backgrounds for the purposes of the study.

Chinese, Vietnamese, Burmese, Sudanese and Afghan immigration into Western Australia increased noticeably between the 1996 and 2006 censuses. While Vietnamese migration to WA has significantly slowed in recent years, Vietnamese mothers still account for the largest proportion of babies born to non-English speaking CALD immigrant women in WA. Chinese migration to WA is steadily increasing, particularly for women seeking a tertiary education or accompanying their husbands to Australia for business or employment opportunities. Afghanistan, Burma and Sudan are currently three of the top four countries of origin for refugee and humanitarian entrants into Australia (DIAC 2009).

In order to minimise issues of recall bias and to keep the qualitative data relevant to recent experiences of the health system, participation in the study was limited to women who had given birth during the previous five years.

Recruitment
Ishar Multicultural Women’s Health Centre Inc., more commonly known as Ishar, was opened in Western Australia in 1992 to serve the needs of women from CALD backgrounds who may not have otherwise been able to access suitable healthcare. Since then Ishar has continued to provide culturally appropriate and sensitive care to a diverse client base. As recent arrivals from Afghanistan, Burma and Sudan are almost always in Australia as refugees, Ishar often runs activities targeted at including women from these backgrounds in the wider community. As a result women from these backgrounds are often aware of Ishar and attend Ishar for primary health care, referral services and community support programs run at the centre. It was decided, in consultation with staff at Ishar, that the most appropriate method of recruitment of participants would be to send a Burmese, Sudanese
and Afghan bicultural worker out into the community to talk to women about participating in the study. The bicultural workers were all female, had entered Australia as refugees themselves, and were competent in both English and their native language. These same bicultural workers also attended the focus groups and co-interviews with the women they recruited and assisted with translation. They were also able to assist participants in filling out a short survey.

Focus groups followed by co-interviews with a smaller subset of focus group participants were deemed the most appropriate way to collect information from Afghan, Burmese and Sudanese women. Participants from these groups came together at Ishar for a discussion ‘workshop’ with other women from their native country, the bicultural worker and two researchers. As all attendants were female the participants were given a safe space to talk about their experiences of pregnancy and childbirth in their home country, in a refugee camp, and in Australia. Participants who shared experiences or opinions of particular interest to the study were then invited back for a co-interview. Individual interviews were not conducted with any refugee women as it was not considered to be appropriate to isolate or single-out individual women. Co-interviews were conducted with two or three women, the bicultural worker and a researcher.

Vietnamese and Chinese immigrants typically have a different migration experience to Burmese, Sudanese and Afghan immigrants. As a result Vietnamese and Chinese women were recruited through the social networks of the researchers. Women were invited to participate in an individual semi-structured interview with a researcher and a translator (if required). Snowball sampling, whereby participants with who contact had already been made use their social networks to refer other potential participants, was used to identify Chinese and Vietnamese mothers.

Individual semi-structured interviews were conducted with Chinese and Vietnamese participants. A translator was required in only three interviews with Chinese women. The interviews used the same question guide as the discussion ‘workshops’ and similarly provided room for interviewees to direct the conversation. Individual interviews took place at a time and location preferable to the participant, including at their home, at their workplace, at their place of study, and one interview at a public library close to childcare services.

Data gathering methods were adapted to the needs and preferences of each group. As a result participants engaged in a one-on-one interview (8 Chinese and 6 Vietnamese mothers) or a focus group followed by a co-interview (8 Afghan, 7 Burmese and 10 Sudanese mothers). The focus groups and co-interviews took place between October and November 2009. The individual interviews took place between October 2009 and April 2010.
Mothers’ Survey
The focus groups and individual interviews were either preceded or followed by a short survey. This was designed to elicit information specific to individual participants in order to provide a context to the views, ideas, opinions and experiences discussed. Questions pertaining to general demographics (e.g. age, ethnicity, education) were supplemented with questions about migration, children and proficiency in reading, writing and speaking English (see Appendix).

Data analysis
Present at each of the discussion groups, individual interviews and co-interviews were two digital audio recording devices which recorded the conversation from two different positions in the room to ensure every voice could be detected and recorded audibly for later transcription. Also present at the discussion groups with Afghan, Burmese and Sudanese mothers was at least one other researcher who was able to take notes while the discussion progressed. These notes helped to provide context to the interviews. Once data collection had been completed, the English portions of the digital recordings were manually transcribed and then analysed for thematic content.

Thematic analysis aims to identify themes within the data. Each theme is determined by emergent categories. Categories consist of significant phrases, sentences and paragraphs that contribute to a particular concept. The technique of analysis followed a common pattern. Each group of transcripts was initially analysed as a block: Afghan mothers; Burmese mothers; Sudanese mothers; Chinese mothers; Vietnamese mothers; and midwives. As transcription continued key ideas that were expressed or returned to in each transcript were noted, as were themes which occurred across multiple transcripts. Tables were constructed for information either related to direct questions that were asked (e.g. whether or not they had experiences a caesarean delivery) or to themes that emerged from the discussion/interview (e.g. experiences of perinatal depression). Each participant expressing that theme was noted in the table. Inclusion was based not only on shared language but also shared meaning, for example women may not have openly named their experience as ‘depression’ but openly expressed feelings of extreme sadness, detachment and confusion at becoming a mother.

The analyses used in the qualitative study were based on verbal communication. Formal analysis of body language was not undertaken beyond aspects included in the notes provided by the other researcher/s who attended the group discussions. However, when strong emotions were displayed, either through facial expression or changes in voice, they did contribute to the interpretation of that individual’s words.
Results
A total of 39 women participated in the study (see Appendix). All participants had experienced between one and seven pregnancies, not all occurring in Western Australia. Time since arrival in Australia varied from 8 months to 16 years. All of the women from Afghanistan, Burma and Sudan had arrived as part of the federal government’s Humanitarian Program. All of the women from China and Vietnam, except one, had entered on a student or skilled worker visa. One Vietnamese woman had entered on a family reunion visa, 10 years after two of her older siblings had entered Australia as refugees. In general, the women from China and Vietnam were highly educated. By comparison the refugee women had limited literacy in both English and their native language/s. There were high levels of fertility among both the Sudanese and Afghan women, especially noting that several of the participants were still of reproductive age and did not consider their childbearing to be over. Religious backgrounds varied with participants reporting to be Christian, Buddhist, Muslim or to have no religious affiliation.

Themes
There were five main themes which emerged concerning the well-being and pregnancy-related care of women from CALD backgrounds. The first three themes relate directly to the provision of culturally appropriate health care: (1) barriers to accessing and providing adequate care; (2) the sociocultural consequences of interventions, including caesarean section; and (3) perinatal depression. Two themes relate indirectly to the well-being of CALD mothers: (4) the maintenance of traditional birth practices; and (5) co-sleeping.

Barriers to care
Foreign-born women in Western Australia experience several barriers to care during pregnancy and postpartum, the first and foremost being language. Proficiency in English was greater for those women who had entered Australia for educational purposes and those who had been in the country for longer. Not being able to understand English or express themselves sufficiently in English was considered the most significant barrier, not just in pregnancy-related care, but in life in general. “To not speak English is the hardest thing about living here” (Sudanese Mother 1)
Some spoke with interpreters via phone at their antenatal appointments but not all had been able to do so. Women often compromised by using spouses or older children to interpret for them. Of all the women who had used an interpreter during their pregnancy care, none had been provided an interpreter during labour and delivery, even when undergoing major obstetric interventions.

Transport was another significant barrier for the women. Many did not have a driver’s licence or own a car and were often dependent on friends or family members to drive them to appointments. Unreliable public transport and expensive taxi services were cited as common reasons for non attendance at antenatal appointments, especially among refugee women.
“It’s very hard when you have to catch a bus because sometimes you miss appointment” (Burmese Mother 3)

Transport issues were also problematic for women attending follow-up care. The one woman in the study who had gestational diabetes (Vietnamese Mother 5) did not attend her 6 week postpartum screening test because she did not have a driver’s licence and her husband was working away at the time.

**Medical interventions**

The most common medical interventions experienced by the participants were induction of labour and caesarean section. These interventions were more acceptable among those women who were highly educated and women who had been resident in Australia for a longer period of time. Ultimately they were happy to defer to the opinion of their attending doctors. For other women childbirth was considered a completely normal process that did not require interference. Several participants had had babies in their homeland and/or in a refugee camp and had received minimal antenatal care. Most babies were born at home and women were often assisted by female relatives or friends, or occasionally a doctor or midwife. Interventions are often viewed as unwanted. This was particularly the case among Sudanese women.

“**If you have a caesarean it means you are sick.**” (Sudanese Mother 6)

Cultural connotations accompany interventions. If birth is a normal process then intervention is abnormal and therefore implies that there is something abnormal about the mother. Two of the Sudanese participants were the only participants to experience a vaginal birth after caesarean (VBAC).

As well as the cultural consequences of caesarean section there were also physical consequences. These were often related to limitations on movement and mobility as a result of surgery and were seen as an imposition, especially as many women did not have extended family in Australia. They therefore lacked sources of help during their recovery, and clearly defined gender roles often meant husbands were either not willing or not able to help out with childcare and housework.

“Women do a lot of work, they do everything so if you have a caesarean you can’t do what you need to do.” (Sudanese Mother 2)

**Perinatal depression**

The risk factors for perinatal depression among immigrant women were very similar to those for women in general. Unplanned pregnancy and lack of social support were key factors in women using depressive language in reference to their pregnancies.

“I was very, very sick and I had perinatal depression, and we didn’t plan the baby, me and husband were really happy just the two of us.” (Chinese Mother 2)
In this sense immigrant women are not dissimilar to Australian-born women. What is different is that the likelihood of experiencing known risk factors for perinatal depression.

Experience of insufficient social support and social isolation are more likely among these women, particularly refugees. Most women immigrated with spouses and existing children and have extended family who still reside in their home country, or in refugee camps. Traditional cultural practices dictate that women should be assisted after birth, predominantly by female relatives. However, being in Australia often isolated them from their female relatives who would have provided postpartum care and support.

“Actually in China there is always family... If you compare, then it (having children) is harder here.”

(Chinese Mother 1)

As a result several of the Chinese and Vietnamese women either returned home to visit family with their infants shortly after the birth or had family arrive in Perth to live with them and assist them in their homes. This was not possible for the majority of Afghan, Burmese and Sudanese women. Two of the Vietnamese mothers and one of the Chinese mothers were happy to forgo direct support from extended family as they viewed this akin to interference. However, all three reported having very supportive husbands.

**Traditional practices**

All groups of women, except the Burmese, acknowledged a traditional postpartum confinement period. The Chinese and Vietnamese mother’s talked about the confinement being one month in duration while the Afghan and Sudanese women referred to a 40 day confinement period. Although the Burmese women were unfamiliar with an explicit confinement period they still discussed the importance of providing assistance to new mothers and special food that should be eaten following birth to aid recovery and assist lactation. Refugees have been crossing the borders out of Burma for approximately half a century. This extensive history of forced migration may account for the lack of a defined confinement as expressed by a Burmese participant.

“If they have the baby it could be only five or ten minutes later that they’ve got to run. There’s no time to rest. You can’t rest for a month!” (Burmese Mother 1)

The confinement period was defined for all women as a time to rest and recover from the process of childbirth. Traditional practices during this time included food restrictions (e.g. avoiding raw and uncooked foods for Chinese and Vietnamese women), food preferences (e.g. eating hot soups for Burmese, Sudanese, Chinese and Vietnamese women), behavioural restrictions (e.g. not bathing for Afghan, Chinese and Vietnamese women) and behavioural preferences (e.g. sitting by a fire for Afghan and Sudanese women). For some women, predominantly the Chinese, Vietnamese and Burmese, postpartum assistance was offered by husbands or other family members who were willing to help with cooking, cleaning or childcare while the mother recuperated. Sudanese and Afghan women were more reliant on friends and neighbours for postpartum support. However, if husbands,
friends or neighbours were not available or willing to help, women had to forgo a confinement period and return to cooking, cleaning and childcare duties as soon as they returned home from hospital. Even when husbands offered support, there was often conflict between what they could do (as men) and the expectations of traditionally female support.

“My husband he gave me... some salad, you know raw tomato, lettuce, raw cucumber (my mother) got angry. She said to my husband ‘Do you want to kill your wife?’” (Vietnamese Mother 6)

**Co-sleeping**

Co-sleeping with their infant in their own bed was commonly practiced by participants. In fact only one mother reported not co-sleeping with her infant. When asked if there was anything she would do differently in a subsequent pregnancy she said she would co-sleep. “So that’s the only thing, maybe with the next baby I’ll put her or him into bed with me.” (Vietnamese Mother 6)

Proximity to their infant, ease of breastfeeding and improved sleep for both mother and child were cited as benefits to co-sleeping.

None of the mother’s reported co-slept with their infants in hospital and reported that that bed sharing was not encouraged by midwifery staff. However, this did not prevent them from co-sleeping at home. Conflict between the lack of support for bed sharing by hospital staff and bed sharing as a cultural norm for these women was particularly evident during the co-interview with two recently arrived Afghan women:

Interviewer: “When you took your babies home, where did they sleep?”

Mother 1: “In the cot.”

Interviewer: “Did they baby sleep with you in the bed?”

-- Silence --

Mothers 1 and 2: “Yes. Yeah.” (nervous laughter)

A disservice is done to both mothers and practitioners when mothers feel that their behaviour is so undervalued that it is better to give the ‘correct’ answer than it is to give the honest answer.
Recommendations
In light of the findings of this study there are several changes to antenatal and postpartum care which could assist in improving the pregnancy and childbirth experiences of foreign-born women in Western Australia.

1. Language
The lack of English proficiency among immigrant women from CALD backgrounds is the biggest barrier they experience in participating in the Western Australian health system. It affects both how they are able to understand their caregivers and how they are able to express themselves. Therefore, support in the form of adequate and appropriate use of interpreter services must be promoted within those institutions providing care to CALD women. The use of audiovisual aids such as videos or audio CDs to provide information in the native language may overcome some of the issues associated with poor literacy, particularly in refugee groups. In an obstetric setting, lack of English proficiency has ongoing consequences for issues of informed consent and perinatal education.

2. Transport
The location of antenatal clinics that provide care to CALD women needs to take into account their lack of mobility. If care can be provided closer to home either through General Practices or community-based clinics rather than hospital-based clinics issues of non-attendance may improve. Similarly comprehensive appointments which address multiple topics and thereby decrease the total number of antenatal visits required may also be beneficial. Also, all of the women in the study who received their postpartum care through home visits from midwifery staff were very happy with this arrangement and the quality of care which was provided them.

3. Obstetric Interventions
For the majority of women who participated in the study childbirth is a normal part of a woman’s life that is governed predominantly by God and/or nature. The sociocultural consequences of obstetric interventions, particularly caesarean section are real. Therefore intervention should be viewed as a last resort, to be used only when completely necessary. Women need to be fully informed of why they are having an intervention and what the side effects and consequences of that intervention may be. This information needs to be delivered to them in a language that they can understand so that they are fully informed, can ask sufficient questions and can provide informed consent. If an intervention is necessary, agreed to, but still ultimately unwanted they should be given adequate support to enable them to cope with the reality of having the intervention. Also, normal birth following an intervention, in particular vaginal birth after caesarean section should be supported wherever possible. This will assist women in achieving their goal of a normal delivery following what is often viewed as a highly abnormal one.
4. Perinatal Depression
CALD women may be at increased risk of perinatal depression when compared to mainstream women due to social isolation resulting from language difficulties, family commitments, differing cultural norms and the stress of migration. This may result in an increased risk of depression in general, as well as perinatal depression. However, the perinatal period provides a unique opportunity to educate women and provide relevant services as pregnancy guarantees interaction with the health system for the majority of CALD women in WA. Activities which encourage social interaction such as antenatal classes with other women from similar backgrounds may help in reducing experiences of social isolation and increase the social networks of CALD women.

5. Traditional Practices
Increasing social networks also increases the opportunity for women to be supported in their endeavours to maintain cultural traditions associated with pregnancy and childbirth. The health system could also support women in maintaining some of these traditional practices. The most obvious area is in food preparation and consumption. Most of the women reported food preferences and food taboos that were relatively similar across cultures. These pertained predominantly to avoiding cold, raw and uncooked food and consuming foods that were considered ‘hot' either through cooking or the use of ingredients such as chilli or ginger. Hot tea, soups and porridges were considered nourishing and suitable foods for labouring and postpartum mothers by each of the CALD participant groups. Therefore, offering hot tea or instant soup in the delivery suite instead of cold water or uncooked foods will allow women to adhere to their traditional beliefs concerning food restrictions.

6. Co-sleeping
Co-sleeping was a common practice among all the women interviewed, regardless of their country of origin. Women need to be educated in how to co-sleep safely with their infants as they are likely to do it even when fully aware that it is not considered the norm in Australia. Therefore safe co-sleeping should be broached as part of standard antenatal education. Again, this information needs to be provided in an appropriate language and format so that they are able to digest the information and ask sufficient questions.
Conclusion
Cultural and linguistic diversity is part of modern Australian society. Greater emphasis is currently being placed on providing appropriate and sensitive care for CALD populations. Pregnant women who have migrated to Australia are particularly vulnerable and deserving of equitable and culturally appropriate care. This study helps to highlight several areas where the pregnancy and postpartum experiences of CALD women are often different from the mainstream population. While this report has made recommendations for CALD women in general, it must be acknowledged that CALD groups are not homogeneous. The perinatal experiences of women from the same country of origin are influenced by multiple factors including time since arrival in Australia, education and employment, English language proficiency, economic resources, family structure and acculturation. What have been highlighted here are those areas where practical changes may be instigated by the health care system for the general benefit of immigrant women from CALD backgrounds, using the real life experiences of women from Afghanistan, Burma, China, Vietnam and Sudan as references.
References


Appendix 1
This appendix includes a table of characteristics for each of the mothers that participated in the qualitative study as reported in the survey. If questions were deliberately left unanswered the data has been coded as missing (mis). If participants attempted to answer the question but were not able to do so adequately, data is coded as unknown (unk).

Legend for the table abbreviations
Participant coding includes the country of birth and a participant number
Age 18-4 years inclusive, 25-29 years inclusive, 30-34 years inclusive, 35-39 years inclusive and 40 years and older is based on reported age at the time of the focus group or interview.
Married was recorded as ‘yes’ if the participant was married or in a defacto relationship and ‘no’ if the participant was single or separated/divorced.
Ethnicity included Haz = Hazara, Taj = Tajik, Kar = Karen, Sha = Shan, Chi = Chin, Ara = Arakanese, Chn = Chinese, Din = Dinka, Mad = Madi, Nue = Nuer, Vie = Vietnamese.
Religion included Bud = Buddhist, Chr = Christian, Mus = Muslim, None = No religion.
Citizenship refers to each participants’ citizenship status and covers 1 = Australian citizen, 2 = permanent resident, 3 = student visa
Education none = no formal education, PS = primary school, HS = high school, TAFE = technical and further education, Uni = University
Income sources included 0 = missing, 1 = paid employment, 2 = Centrelink (social security) payments, 3 = Training/educational scholarship, 4 = support from other family members
Arrival was reported as the year of arrival in Australia.
Children included the total number of children born to each participant.
Child ages included the ages of all the participants’ children from oldest to youngest, ‘nb’ denotes a newborn.
Home L. refers to the languages the women used at home and are included in the table in order of preference, 1 = English, 2 = Dari, 3 = Hazara, 4 = Karen, 5 = Shan, 6 = Chin, 7 = Burmese, 8 = Arakanese, 9 = Chinese (Mandarin), 10 = Dinka, 11 = Arabic, 12 = Madi, 13 = Nuer, 14 = Vietnamese, 15 = Cantonese.
Speak, Read and Write refer to the participants self ratings of how well they can speak, read and write English 1 = no, not really, 2 = a little bit, 3 = some, 4 = yes a lot, 5 = fluently.
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<th>Religion</th>
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