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The maternity experiences of women seeking asylum in high-income countries: a meta-ethnography

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ABSTRACT

Problem: The maternity care experiences and perinatal outcomes of women seeking asylum in high-income countries (HICs) are poorer than the general population of pregnant women in that HIC. There is a paucity of literature on the maternity experiences of women seeking asylum in HICs.
Background: There is an increasing number of women seeking asylum in HICs due to escalating violence and human rights abuses. Asylum-seeking women are a distinct group whom are likely to have different needs to refugees or migrants as a result of their undocumented status.
Aim: This literature review aimed to explore the emotional, physical and health information needs of women seeking asylum in the perinatal period in HICs, to provide insights to better address their maternity needs.
Method: A meta-ethnography described by Noblit and Hare, was applied to analyse the studies, to reflect the voices of women seeking asylum, hosted in HICs in their perinatal period.
Findings: Eight studies were included in the review. The overarching theme was 'just having to survive.' Four sub-themes were revealed which highlighted the vulnerability of asylum-seeking women. They included: '*I was never sure if I had understood*', '*feeling ignored and alone*', '*ongoing dislocation and recurrent relocation*' and '*knowing there's someone who cares for you*'.
Discussion: Improved maternity care for women seeking asylum requires culturally appropriate respectful maternity care and supportive strategies such as consistent access to language services.
Conclusion: It is recommended that future research is targeted to explore the maternity experience of women seeking asylum in HICs, such as Australia.

Statement of significance

Problem or issue

There is a growing number of women seeking asylum in the perinatal period, who are an extremely vulnerable group with unique needs. There is a paucity of research regarding their maternity care experiences. An understanding of this is necessary to provide them with tailored respectful maternity care.

What is already known

The health outcomes of women seeking asylum in HICs are poor for both mother and baby.

What this paper adds

This paper adds in-depth insights into the maternity experience and needs of women seeking asylum in HICs. Women seeking asylum require professional interpreters and midwives who are culturally competent. Improvements must be made to maternity care to provide respectful and trauma informed care for asylum-seeking women. In the context of this study, respectful care requires greater accountability in terms of inclusive and culturally safe practices.

1. Introduction

The number of forcibly displaced people worldwide has doubled in the last ten years, due to violence, persecution and conflict. Refugees number more than 26 million globally [1]. In 2019, 4.2 million asylum seekers around the world were waiting for their asylum claim to be processed [1]. There were also ten

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million stateless people who lacked nationality and access to fundamental human rights such as education, health care and employment and a total of 68.5 million globally displaced people [2].

An asylum seeker, according to the definition of the United Nations Educational, Scientific and Cultural Organisation (UNESCO) is,

> '*someone who has applied for protection as a refugee and is awaiting the determination of his or her status* [3].'

In contrast, a refugee is someone who has been awarded refugee status by a host government and therefore has greater access to health and social care.

The legal status of people seeking asylum is complex. Asylum-seeking men and women lack documentation that allows them to reside in the country of arrival. Consequently, people seeking asylum must wait for their claim for refugee status to be processed. The detention of people seeking asylum has long term mental health and social implications that affect access to housing, education, employment and their ability to pursue their refugee claim [4]. Studies show that people seeking asylum may have lived in war-like conditions most of their lives are at higher risk of post-traumatic stress syndrome in comparison to refugees [5].

The World Health Organisation (WHO) report [6] states that asylum seekers have poorer perinatal outcomes than the general population of high-income countries (HICs), including preterm birth, lower birth weight, and higher rates of maternal and infant mortality [7] and congenital malformations. Verschuuren et al.'s [7] recent study in the Netherlands compared women seeking asylum in high-income countries (HICs) [8], as defined by the World Bank, to Dutch women and demonstrated asylum seeking women had poorer perinatal outcomes [7]. Furthermore, women seeking asylum have an increased risk of mental health issues, including postnatal depression, and post-traumatic stress syndrome. For example, the incidence of postnatal depression is 31 % for women seeking asylum in Canada compared to a rate of 8.1 % for Canadian born women [9]. Women seeking asylum attending a genitourinary clinic in the UK, had experienced high rates of sexual violence (76 %) compared to British women (0%). However, these rates cannot be generalised to the context of all HICs [10]. In the UK, reports into maternal deaths state that asylum-seeking women and refugees comprised 12 % of maternal deaths despite representing only 0.3 % of the population [11]. The prolonged stress associated with asylum-seeking can exacerbate health risks [12], that can impact upon the health outcomes of the woman and her unborn child and subsequent bonding with her newborn [13–16]. Pregnant women seeking asylum and their infants face an uncertain future. In Ireland, for example, legislation states that Irish citizenship is not necessarily provided upon birth in the country [17]. Therefore, an infant born to an asylum-seeking mother in Ireland maybe stateless. The fear of an insecure future for their children heightens the extreme vulnerability of these women. Understanding the issues that asylum-seeking women face when accessing maternity care in high-income countries may ultimately lead to improved health outcomes for this vulnerable population.

The WHO report states there are significant unmet needs for this population [6] and asserts that all women including those seeking asylum have a right to non-discriminatory, available, accessible, acceptable and quality health services [18]. Women seeking asylum have been found to engage in antenatal care later in the pregnancy [15], and attend fewer antenatal visits than women who were born in the HICs [19]. Government policies affect the quality of maternity care provided to women seeking asylum. In the UK, the policy of dispersement means pregnant women seeking asylum are moved from one accommodation service to another and are required to register with a new general practitioner and recommence their antenatal care in a different hospital [13].

Access to health services for people seeking asylum may be affected by discrimination and social exclusion [20]. People seeking asylum may be reticent to seek care due to the perceived negative attitudes of health professionals, language barriers and poor health professional knowledge concerning their health care entitlements [21]. Research from the UK has shown that midwifery students assumed asylum seekers were criminals, demonstrating their poor understanding of this population [22]. Consequently, the negative attitude of midwives may mean that women seeking asylum are reluctant to attend maternity appointments [23,24].

There is limited research on the maternity experiences of women seeking asylum in HICs, whose country of origin is low to middle income countries (LMIC). This literature review sought to synthesise current knowledge of the maternity experiences of women seeking asylum to understand how health care and outcomes may be improved.

2. Methods

A qualitative synthesis of the literature was conducted, using the meta-ethnography approach of Noblit and Hare [25], to examine the availability, accessibility, acceptability and quality of maternity care of women seeking asylum in HICs [8]. According to this method, authors' interpretations of primary research studies are treated as data and are translated across several studies to produce a synthesis which is interpretive rather than aggregative [26].

2.1. Data sources and search strategy

Our initial literature search in 2018, sought studies published from 2010 to 2018. However, we identified only five studies, and as a result we increased the years for the search from 2010 to 2000. We conducted the literature search in February 2020. We limited the literature search to papers published from January 2000 due to the complex and frequently changing political and legal context of seeking asylum in HIC.

Thus, we sought up to date research that is relevant to the current political climate in HICs [8]. Peer-reviewed literature published in English, between 1st January 2000 and 7th February 2020 was sought. The aim was to identify studies that provided qualitative data from women seeking asylum who had experienced maternity care in high-income countries. Medline, EMBASE, PsycINFO, CINAHL and Maternity and the Infant Care databases were searched, using the following search terms: 'perinatal', 'antenatal', 'postnatal', 'postpartum', 'prenatal', 'pregnancy', 'maternity', 'expectant mothers', 'obstetric patients', 'asylum seeker', 'illegal migrants', 'irregular migrants', 'undocumented migrants', 'refugee', 'undocumented aliens' or 'illegal aliens'. These search terms ensured no studies were missed as there is inconsistent use of definitions. Subsequently, they were screened to exclude refugees or migrants.

2.2. Criteria for inclusion

Studies that reported qualitative findings specific to the experience of asylum-seeking women in their perinatal period in HICs [8] that were published in English were included.

2.3. Criteria for exclusion

The terms 'asylum seeker' and 'refugee' are often used interchangeably, which is problematic as they are not a

homogenous group. After examining the abstracts, studies were excluded if they combined data concerning the experiences of women seeking asylum and the experiences of migrants and refugees as the data could not be disaggregated. However, if data on asylum seekers was able to be disaggregated, the sections of the paper relevant to asylum seekers were included. Furthermore, studies were excluded if they were conducted in low or middle-income countries. The focus was on the perspectives of asylum-seeking women and studies that reported only on the perspectives of health professionals were excluded.

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines [27] informed the process of reporting the search strategy. Fig. 1 describes the search strategy using the PRISMA diagram. The initial database search revealed 434 hits. Fifty-five studies were excluded because data from women seeking asylum could not be disaggregated from those of refugee participants. A further fifty-four studies were excluded because they were not explicitly related to maternity care. A further three hundred and sixty-nine quantitative studies were excluded because they were conducted in low or low to middle-income countries, or because they were based on the experiences of care providers. After abstract and full-text review, ten eligible studies remained. The study quality was assessed by two authors, using the Critical Appraisal Skills Program (CASP) checklists [28]. Eight studies were retained after quality appraisal.

2.4. Data synthesis

Data were extracted from the reported results section of the included studies and examined using Noblit and Hare's [25] seven steps of meta-ethnography. The eight studies were repeatedly re-read to enable immersion in the content and developed the clarity of the concepts and themes in each study. Two authors compared and contrasted the studies using a mapping exercise to develop the relationship between the studies.

3. Findings

This study focuses on women seeking asylum in HIC and whose country of origin is a low or lower middle income countries such as Afghanistan, Somali, Eastern Europe and other African countries, countries as defined by the World Bank [8]. Eight studies met the eligibility criteria, which comprised of data from a total of 116 women seeking asylum. It was significant that one study each was conducted in Germany [29] and Sweden [30] and Ireland [31] and five originated from the United Kingdom [31–36] and identifies

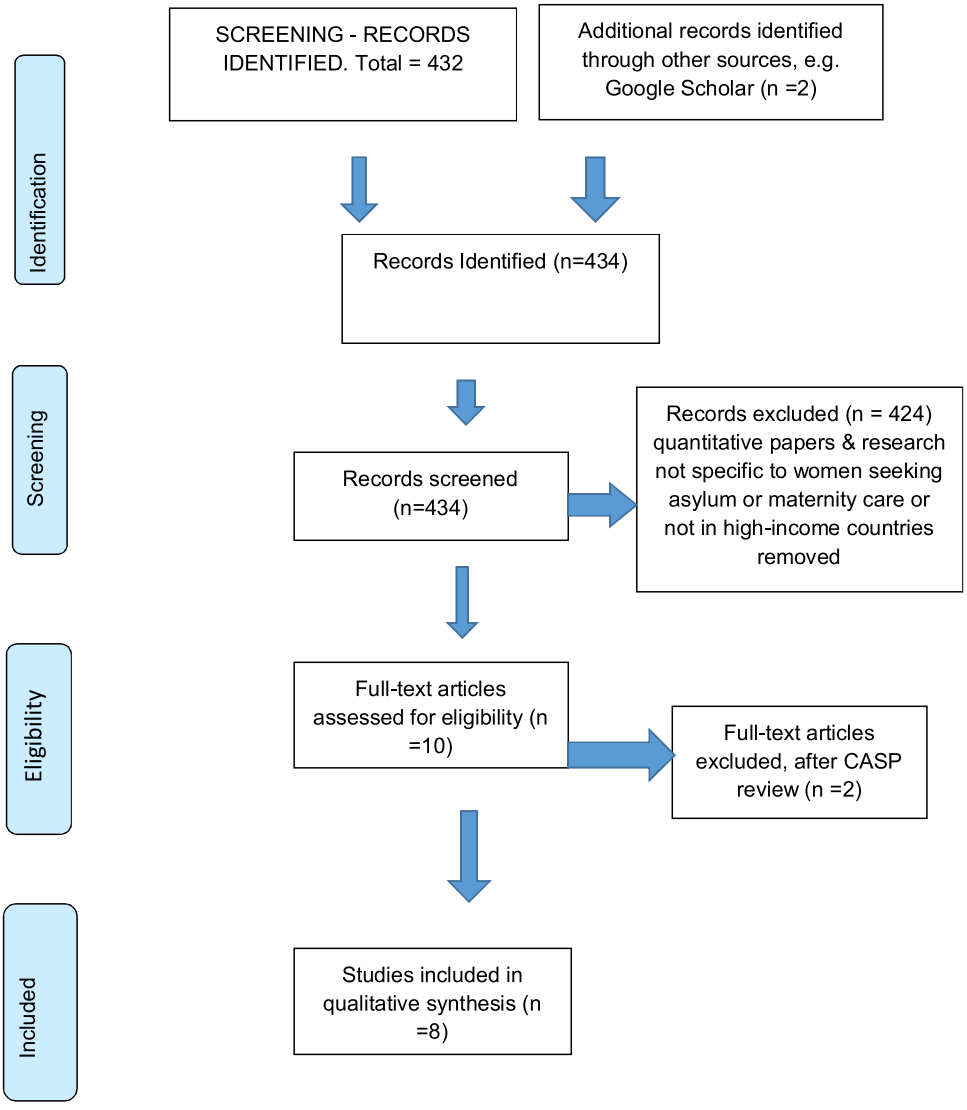

Fig. 1. PRISMA 2009 flow diagram [1].

their tenuous visa situation, isolation, racism, and discrimination concerns as barriers preventing attendance in maternity care. The UK studies focused on the government policy of dispersement. Women in the study were moved from one accommodation setting to another up to six times in their pregnancy, leaving them alone and separated from their supported networks [34]. The Swedish study argues that women seeking asylum are reluctant to seek care due to fear of being deported and financial concerns as their right to have access to health care was frequently disputed [30]. The German study describes the overcrowded shared institutional accommodation, catering and basic monthly allowance as having a negative health impact [29]. In Germany, Sweden, and the UK, the state covers health care costs; however, cost has been a barrier when women seeking asylum access health care [37]. Table 1 summarises the eight studies, all of which are part of the European Union at the time of this literature review, and demonstrates the translations and emerging themes. Tobin's study explored women seeking asylum in Ireland where the care is described as a medically dominated hospital-based service [31]. The majority of women in Tobin's study were from Nigeria [31]. Briscoe's study in the UK describes the maternity care of three women from Afghanistan, Congo, and Rwanda seeking asylum was disrupted by dispersement and therefore left the women feeling powerless [36]. Nabb's study interviewed women seeking asylum in the UK, from African countries and Iraq, with a mix of GP, hospital and community midwifery care [33]. Lephard's research of six women, four from Sub-Sahara Africa and two from Eastern Europe, also describes care as interrupted due to the UK policy of dispersement [32]. However, the papers do not offer sufficient detail to provide an in-depth insight into the context of midwifery care in specific countries.

Using Noblit and Hare's seven steps of meta-ethnography, data were extracted and examined [25]. The seven steps are: getting started, deciding what is relevant to the initial interest, reading the studies, determining how the studies are related, translating the studies into one another, synthesizing translations and expressing

Table 1
Summary of central characteristics of included studies (n = 8).

Author	Aim	Methods	Cohort	Themes	Sub-themes
Barkensjo, Sweden [30]	To describe women's experiences during pregnancy and childbirth when living as undocumented migrants.	Qualitative methods (unstructured interviews) Interpreters were offered but used in only 1 case.	13 asylum seekers with rejected or expired visas from 10 different countries (i.e., Macedonia, Romania, Bosnia, Albania, Somalia, Afghanistan, Serbia, Chechnya, Morocco, and Kosovo).	• Experiencing anxiety when suffering neglectful encounters. • Feeling empowered through positive clinical encounters.	Women's hopes were suspended while waiting for approval of their asylum claims. Women delayed or did not attend antenatal care due to fears of deportation.
Briscoe, United Kingdom [36]	To explore the experience of maternity care by women seeking asylum and refugees.	A qualitative method using in-depth interviews. A longitudinal approach to case study, including interviews, field notes, and photographs taken by the women.	3 asylum-seeking women from Afghanistan, Congo, and Rwanda were interviewed at 5 points in the pregnancy or postnatal period.	• The perception of self • Understanding in practise • Influence of moving during pregnancy called 'dispersement' by the government.	The need for cultural competence by maternity carers.
Feldman, United Kingdom [34]	To explore the impact of dispersal of women seeking asylum during pregnancy.	Qualitative research.	19 women were seeking asylum from 14 different countries.	• Experiences of dispersal stressful and destabilising during pregnancy.	Some women were moved several times during their pregnancy, away from their partner and social support, which disrupted their established maternity care.
Gewalt, Germany [29]	To understand the experiences and of women seeking asylum during pregnancy.	A qualitative approach using an explorative case study design, with semi-structured interviews during pregnancy and up to 6 weeks post-partum.	21 women seeking asylum were interviewed with 9 women from West Africa, East Europe, West Asia, and South Asia.	• Material circumstances, e.g., neighbourhood and housing quality and poor diet. • Behavioural factors.	'You just have to survive,' in state-run accommodation for people seeking asylum in Southern Germany
Lephard, United Kingdom [32]	To explore the experience of women seeking asylum in pregnancy.	A qualitative interpretive approach, a hermeneutic phenomenology study Semi-structured interviews, with no formal interpreter.	6 women (4 from Sub-Saharan Africa, 2 from Eastern Europe), were interviewed.	• Pre-booking challenges • 'Inappropriate accommodation • Being pregnant and dispersed • Being alone and pregnant • Not being asked or listened to	Women seeking asylum in the UK have poor maternal and perinatal outcomes. Midwives need to undertake training to understand the specific needs of women seeking asylum in pregnancy.
McLeish United Kingdom [35]	A qualitative study of the maternity experiences of thirty-three women seeking asylum.	Qualitative methods-interviews where recorded but limited information is available regarding the type of interviews conducted.	33 women through convenience and snowball sampling, at stages of pregnancy and early motherhood, and stages of the asylum process were interviewed.	• Accessing the maternity services and obtaining interpreting support. • Having the right to make choices about their care	There needs to be improvements to meet women seeking asylum need for information, interpreting, and support.
Nabb, United Kingdom [33]	The perceptions of pregnant women seeking asylum concerning the provision of maternity care.	Qualitative methods (Unstructured interviews with health professionals and semi-structured interviews with women seeking asylum).	10 women seeking asylum from Algeria, Congo, Angola, Somalia, Nigeria, and Iraq were interviewed.	Provision of maternity care is viewed favorably by the women seeking asylum. They appeared to be recipients of care rather than partners in planning care.	Women seeking asylum rmay be moved during pregnancy, which interrupts continuity of care with a mix of GP, hospital, and community midwifery care.
Tobin [31] Ireland	To gain insight into the women's experience of childbirth in Ireland while seeking asylum.	A qualitative methodology narrative analysis.	22 women seeking asylum, the majority from Nigeria, were interviewed. Care is medically dominated and hospital based.	Communication barriers impacted on maternity care and exacerbated by a lack of cultural competency and insight into the needs of women seeking asylum.	Women seeking asylum living in inadequate accommodation in Ireland. There is a need for the availability of trained interpreters.

Table 2
The process of using Noblit and Hare's (1988) seven-step method of meta-ethnography to analyse findings.

Noblit and Hare's [25] seven steps of Meta-ethnography	Details
Getting started	Preliminary reading on the experience of women seeking asylum in the perinatal period.
Deciding what is relevant to the initial interest	Abstracts and full texts were read and reread to identify inclusion criteria. The CASP (2018) 10 step qualitative checklist was used to guide quality appraisal of the studies.
Reading the studies	Repeated reading of the studies developed the clarity of the concepts and themes in each study.
Determining how the studies are related	Using a mapping exercise, an understanding of the relationship between the studies was developed. Two researchers compared and contrasted the studies and reached a consensus by discussing their understanding of the themes.
Translating the studies into one another	Re-reading the studies and reviewing themes, two researchers agreed on the analysis framework. Tables were developed summarising the studies and emerging themes.
Synthesizing translations	Reflecting on how themes were similar or contrasting in different papers led to a synthesis of the papers.
Expressing the synthesis	The findings were written up, using the women's voices to express their views and experiences.

the synthesis, as illustrated in Table 2 [25]. Based on Noblit and Hare's seven-steps of meta-ethnography [25], the overarching theme and four sub-themes of emerged from the literature. The overarching theme taken from Gewalt's study is 'Just having to survive, [29]' emphasises the lack of acknowledgement of emotional needs and the distress of the women. The meta-theme 'you just have to survive [29]' describes the conditions reported by one pregnant woman of the state-run accommodation for people seeking asylum in Southern Germany. Furthermore, Tobin's research indicates the maternity care is re-traumatising for women who have survived torture and contemplate returning to their home country rather than being alone. For example, the following quote echoes the lack of care received by women who seek asylum despite the different models of care, LMICs of origin and host HICs.

'*I was wishing to go back and face whatever I'm going to face at least if I face it with people, I know it's better than to face this with strangers*' [31].

Furthermore, it resonates with the four sub-themes. Three of the themes related to the isolation, fear and powerlessness of the women seeking asylum and one which demonstrated the empowering effect of empathetic care. The sub-themes were: *'I was never sure if I had understood,' 'Feeling ignored and alone,' 'On-going dislocation from recurrent relocation'* and *'Knowing there's someone who cares for you.'* These themes are explained below.

3.1. I was never sure if I had understood

The sub-theme, 'I was never sure if I had understood', refers to the significant communication barriers with health professionals that were experienced by asylum-seeking women during their antenatal care. One individual stated,

'they (midwives) communicated in sign language, and I was never sure if I had understood properly' [36].

Problems women faced during interactions with health professionals included inconsistent use of professional interpreters and dismissive attitudes towards the needs of women concerning language, as demonstrated here.

'*I asked them, '(Can) we cancel the meeting until we get an interpreter. I didn't understand you, and you didn't understand me.' She [the midwife] said, 'No, it's okay, we can go on, you understand English*' [32]'.

Many women spoke about how the lack of effective communication exacerbated their experiences of isolation and distress [32]. However, the following comment implies the midwives assumed the women spoke no English and were disrespectful.

'They talked bad, and me, I understand English. If you don't know, it's better' [38].

These comments demonstrated the lack of respect and racism by midwives, who ignored the woman's communication needs.

3.2. Feeling ignored and alone

The second sub-theme, *'Feeling ignored and alone'*, refers to the isolation and loneliness experienced by pregnant women, at a time when traditionally they would be surrounded by family and friends to anticipate and welcome their baby into the world. For example, Zita was so traumatised by this isolating childbirth experience that she never wanted to have another child. An interpreter was used to tell her story.

'[Zita Crying] She went to reception but they could not help her . . . She was just so distressed she just didn't know what to do . . . She went outside and lay on a bench near the hospital, she asked people passing could they help, did they speak any French and nobody could help . . . she stayed there the whole day' [31].

Following this trauma Zita suffered depression [31]. Another woman described similar distress:

'Just crying, just thinking, I have just me, why (is) my mum not here, or my cousin's, or my friends. My sister. Nothing' [32].

Some other women felt ignored because of her status as an asylum seeker and as a result felt unable to access care in a timely manner, for example:

'Sought care for severe pains, I had waited from twelve in the day to twelve at night. We did not receive any examination. We felt ignored and drove home' [30].

The result of poor maternity care experiences women were decisions to delay care or to not attend appointments [31]. These examples demonstrate the emotional impact of disrespectful maternity care.

'*I was worried that something was wrong with the baby which (who) was just screaming and screaming. After a long while, staff entered and said something incomprehensible in Swedish and then just left again. I was hoping that she was going to come back again with an interpreter. That never happened*'. [30]

This quote describes the desperation of the women seeking asylum feeling extremely vulnerable and without access to family or community support.

This experience of isolation may continue into the postnatal period as described here,

'*During the first six days, I just existed, waiting to go home you are alone as if you have been abandoned, all day with nothing to do*' [38].

3.3. Ongoing dislocation from recurrent relocation

Studies conducted in the UK and Germany included descriptions of women's experiences of their 'Ongoing dislocation from recurrent relocation' [33,38] while pregnant, as a result of the

government policy of dispersement. One woman described her situation as:

'*It would have been better if I could have stayed in one place. Moving around made me feel sad, tired and unhappy*' [34].

Women described having to repeat their pregnancy tests and their medical history, every time they were re-located.

'*I have to start again from zero, I was pregnant. And I was sicking [vomiting] all the time. They bring me here. I didn't have nobody here*' [32].

Uncertainty is a constant underlying challenge for people seeking asylum, unlike refugees and migrants who have permanent residency in their host country. The quote discloses the desperation of women birthing alone as a consequence of the dispersement policy in the UK. There is no security and no opportunity to understand the health system or build a trusting relationship with their health care provider. The findings show that moving created challenges for women seeking asylum in securing stable financial and living conditions.

3.4. Knowing there's someone who cares for you

In contrast to the previous sub-themes, 'Knowing there's someone who cares for you' demonstrates the positive influence for women who felt supported by empathetic midwives. Empathetic care meant being able to express themselves and be heard, for example:

'*The best thing the midwife did for me was to sit by my bed, at eye-level, hold my hand and acknowledge me. That was the best in order for me to feel secure as a woman – that I was heard*' [30].

This finding revealed that despite these women being asylum seekers in Sweden, with rejected or expired visa's, the women delayed or did not attend antenatal care, due to a fear of deportation, midwives were able to ensure they felt safe. However, they reported that, some midwives were able to ensure they felt empowered and acknowledged [30]. One midwife developed strong trusting relationships with a woman, who consequently felt almost as if the midwife became part of her family

'When I see V [community midwife] [had] come [to] see me, I was like, all my family [has] come to see me' [32].

Women seeking asylum appreciated it when a welcoming environment was created by the midwives.

'When I first met the midwife, very kind very nice lady and she bring the Kurdish interpreter' [33].

A simple act of kindness made a valuable difference for these women.

'I know there's someone who's listening and understanding, which makes me feel better' [36].

Therefore, despite the fear and uncertainty of their status, some childbearing women seeking asylum did receive high quality midwifery care. Trust and kindness were identified as key elements of empathetic care.

4. Discussion

This meta-ethnography examined the maternity care experiences of women seeking asylum in high-income countries. The overarching theme of 'just having to survive' [29] highlights the loss of power and hope when treated with disrespectful care, which included experiences of neglectful care [31], racism [38], poor communication [32], and lack of trust and empathy [30]. The sub-themes emphasise the extreme vulnerability of women seeking asylum and the distress women experienced when their trauma was not recognised during interactions with health professionals. However, the women felt empowered when they had positive interactions with health professionals as noted in the English [34–36,39], and Irish [40] studies.

In the context of this study, respectful care requires greater accountability in terms of inclusive and culturally safe practices and increased engagement of professional interpreters and midwives who are culturally competent to provide a safe and caring environment for this cohort. All studies in this review demonstrated disrespectful treatment and discrimination against women seeking asylum, which is disempowering and breaches their human right to health [30]. These experiences are specific to women seeking asylum in the vulnerable position of living in fear of being deported. Stokes [41] argues that trauma is rarely assessed or addressed without an understanding of the principles of safety, collaboration and empowerment [42]. Poor communication is a significant barrier to quality empowering care [36]. The first sub-theme, 'I was never sure if I had understood', demonstrated that women experienced significant difficulties in understanding and being understood. Women who are not fluent in the language of the host country require professional interpreters for effective health communication [43,44]. Furthermore, women who have experienced violence may face difficulties communicating their needs, because of cultural shame, potential retribution, or fear of not being believed [45]. The consequences of not using interpreters include lack of informed consent, confusion and fear of unknown procedures and possible poorer perinatal outcomes. Providing information in a woman's first language could improve health literacy [43]. In addition using a trained interpreter to explain the education provided and re-enforce this with written information in the women's first language, may improve a women's understanding and retention of the relevant information [46]. Efforts to build rapport and health literacy are necessary, especially when medical procedures are unfamiliar to the woman.

In the second sub-theme, 'Feeling ignored and alone', revealed that not only do these women feel alone, and their trauma was unacknowledged, but they are unsure whom they can trust. The women are afraid they could be deported as a result of speaking about their situation. Women seeking asylum in Sweden stated they cancelled or did not attend antenatal appointments as they were fearful of being reported to authorities [30]. In Firth's [47] research, nurses reported that they often found it necessary to emphasise that they had no control over service users' immigration applications. These women were encouraged to speak with confidence about their health issues following reassurance that disclosure would not impact their application for refugee status [47].

The sub-themes 'I was never sure if I understood' and 'Feeling ignored and alone', demonstrate an inability to provide a safe and caring environment and a need for greater accountability of culturally safe practices. A model of identifying, referring, and supporting these distressed women is needed. De Vries et al.'s [48] research reported midwives to have limited knowledge of post-traumatic stress disorder. Sperlich et al. [42] describes a maternity model that understands the impact of trauma, identifies the symptoms, responds by integrating this knowledge into practice and avoids re-traumatization of women in perinatal care. The model may help midwives understand how past trauma impacts on women's childbearing experiences in a way that is cumulative and ongoing. The sanctuary model is an organisational model of trauma-informed care that creates environments that promote psychological and physical safety [49]. There is a risk of re-traumatization in maternity care and therefore enquiry in to trauma history should be in the context of continuity of care and a trusting environment [50]. For example, it is essential to have informed consent prior to examinations in labour that may trigger traumatic memories. Trauma-informed care provides emotional

safety and security for the women and fosters empowerment in trauma survivors [51]. Pregnant women seeking asylum require trauma-informed health care that is emotionally safe and provides specialised psychological support.

The third sub-theme, 'Ongoing dislocation from recurrent relocation' focused on the impact of government policy that involved moving women to different locations that interrupted their care and existing social support [34]. McKnight examined the specific experiences of women seeking asylum in the UK, and found the lack of interpreters and the dispersal policy to be a major barrier [44]. There is strong evidence that women who receive midwifery continuity of care models are more satisfied with their care [52]. Furthermore, the WHO antenatal care guidelines [53] suggests continuity of midwifery care has the potential to address some of the health inequities for vulnerable women. A volunteer providing social support may ease the challenge of moving in pregnancy, where continuity of carer is not an option [14]. Research involving volunteers supporting pregnant women seeking asylum concluded that when women were able to develop a trusting relationship with their volunteer it helped overcome the feelings of social isolation [54]. Alternatively, continuity may be offered by a volunteer doula from a community organisation, who could accompany the woman to the antenatal appointments [55]. Empowering communication requires professional interpreters and may be facilitated by the continuity of care model. The rapport developed with continuity of care would improve trust and communication and thus acknowledgement of the women's situation [56].

The final sub-theme, *'Knowing there's someone who cares for you'*, further supports the need for empathetic care. A recurrent finding was the isolation experienced by asylum-seeking women. Women were grateful for empathetic midwives, demonstrating the need for respectful maternity care and an opportunity for women to build rapport with midwives [57]. Furthermore, providers who understand the cultural practices of a woman seeking asylum and who demonstrate a positive attitude towards cultural differences, support the women's ability to communicate her needs [58]. Cultural competency training is fundamental to respectful maternity care and to prepare health professionals with the skills necessary to provide excellent care for women seeking asylum [14]. However, health system changes are needed to support culturally competent, and trauma-informed care. For example, extra time must be factored in to allow for the routine use of professional interpreters.

The lived maternity experience, for women seeking asylum, may be different to refugees or migrants and may be contingent on the stage of their visa application process. The studies in the review provided insights from women who were interviewed in different stages of their application for refugee status and different host country contexts such as access to free health care and policies for the maternity care of women seeking asylum [29]. This study adds new understandings of the inability to address specific needs of these women in Germany, Sweden, Ireland and the UK, such as discrimination, isolation concerns and barriers to attending maternity care.

The main limitation of this review is the paucity of evidence on the maternity experience of women seeking asylum. The small body of research identified has predominantly been conducted in the UK, where the experience of women seeking asylum may be unique due to the policy of dispersement. Future research should be conducted in HICs such as Australia, Canada and France to determine the maternity experience of women seeking asylum and to gain an understanding of the specific challenges to accessing equitable maternity care. Further research should involve professional interpreters to ensure the voices the women are heard.

5. Conclusion

There is a growing number of pregnant women seeking asylum, who are an extremely vulnerable group with unique needs. This meta-ethnography focussed on all high income countries and demonstrated that maternity experiences were inadequate in Sweden and Ireland and the UK. In Ireland, women seeking asylum experienced racism rather than empathetic care. In Sweden, women feared being deported, which created extreme anxiety for women who seek asylum.

This review confirmed that women seeking asylum, during their pregnancy, in HIC's, experience breaches in their human reproductive rights due to suboptimal maternity care. Consequently, their pregnancy care may have added to their psychological trauma. Health care providers have the opportunity to engage women and help them better understand the host country health system. The study highlights crucial areas that need improvement to enhance the perinatal experience of these women beyond their feeling that 'you just have to survive'. Interpreters must be used to ensure clear communication, education and informed consent where women are not fluent in the host country language. Improved access to maternity care requires culturally appropriate services with consistent access to language services and information translated in their first language. The key finding is the need for provision of supportive respectful maternity care, which provides asylum-seeking women with trauma informed care, empathy and trust in their midwives. Importantly, changes in policies such as health care and dispersement policy in the UK are recommended to ensure improved social support and better health outcomes for mothers and their babies. Health professionals would benefit from education in cultural competency and trauma-informed care that relates explicitly to the needs of women seeking asylum during their perinatal care.

Author agreement

This article is Glenys Frank's, Angela Dawson's, Deborah Fox's and Carolyne Njue's original work and has not been published previously or under consideration for publication elsewhere.

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None declared.

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