NEST: Not even a safe territory: The maternity experiences of women seeking asylum in Australia

by Glenys Dale Frank

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the degree of

Doctor of Philosophy (Public Health)

under the supervision of Associate Professor Deborah Fox
and Adjunct Professor Nicky Leap

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Certificate of original authorship

I, Glenys Dale Frank, declare that this thesis is submitted in fulfilment of the requirements for the award of Doctor of Philosophy, in the School of Public Health in the Faculty of Health at the University of Technology Sydney.

This thesis is wholly my own work unless otherwise referenced or acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

This document has not been submitted for qualifications at any other academic institution. This research is supported by the Australian Government Research Training Program.

Signature: *Glenys Frank*

Date: 9th October 2023

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I acknowledge that I have written this thesis on the lands of the Wurundjeri people of the Kulin nation and pay respects to their elders, past, present and emerging. I also acknowledge the land upon which the University of Technology, Sydney (UTS*)* stands and pay respect to the custodians of knowledge for this land, the Gadigal people of the Eora nation.

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I am indebted to my family and friends for their genuine support and interest throughout the journey. Paolo Canale, my partner, who provided mountains of encouragement and editing to complete my thesis. My parents, Jeanette and Ken, who sadly have passed away but would have been proud to see the completion of my thesis. My sisters, Robyn and Alison, and brother, Ian, and their families for their encouragement over many years. And my wonderful sons, Martin and William, who I hope will be inspired in their own journeys of lifelong learning. Your love and support has carried me through this journey.

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> *Life wasn't meant to be easy, my child, but take courage:*
> *it can sometimes be delightful!*
> George Bernard Shaw

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Format of thesis

This thesis is structured in the format of a conventional thesis. It contains the standard thesis chapters and one published paper with permission of the publisher (see Appendix 1). The published paper has been placed in the literature review chapter without changes. A list of the published papers and conferences are listed in the following pages.

Statement of jointly authored works contained in thesis

As the author of this thesis and candidate for the award I am the primary author of these publications. I have been principally responsible for preparing these publications, for conducting the analysis, and for determining the research questions and direction of the manuscripts. I have been supported in these undertakings by Associate Professor Deborah Fox, Adjunct Professor Nicky Leap, Professor Angela Dawson and Dr Caroline Njue.

Publications arising from this research

Paper 1	
Title:	The maternity experiences of women seeking asylum in high-income countries (HICs): a meta-ethnography
Authors:	Frank, G. D., Fox, D., Njue, C. & Dawson, A.
Journal:	*Women and Birth* 36(6)
Status of publication:	Accepted 19 December 2020, published 2021.
Unique contribution to knowledge	This paper adds in-depth insights into the literature on the maternity experiences 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. This article appears in its published form in Chapter 2, the Literature Review.

Paper 2	
Title:	The maternity experiences of women seeking asylum, in Australia
Authors:	Frank, G., Fox, D. & Leap N.
Journal:	University of Hamburg. (2023). The Migration Conference 2023 programme, Germany.
Status of publication:	Accepted August 2023, Abstract of conference presentation, not published in this thesis.
Unique contribution to knowledge	Women seeking asylum must be identified in order to understand the issues they experience during their maternity care and to provide appropriate support.

Paper 3	
Title:	Life without a Medicare card: The maternity experience of women seeking asylum in Australia
Authors:	Frank, M. G., Njue, C., & Fox, D.
Journal:	*Women and Birth, 35*(54), p.38 https://doi.org/https://doi.org/10.1016/j.wombi.2022.07.153
Status of publication:	Accepted September 2022, not published in this thesis.
Unique contribution to knowledge	No Medicare, no family support and desperate financial situations increase the numerous obstacles to accessing care for marginalised women.
Other comments:	Abstract of conference presentation, Australian College of Midwives (ACM Conference), Cairns, Australia.

Paper 4	
Title:	Experiences of midwives and doulas who care for women seeking asylum in Australia
Authors:	Frank, G., Njue, C., & Fox, D.
Journal:	*Journal of Paediatrics and Child Health*, 58(S2), 60–156. https://doi.org/10.1111/jpc.15946
Status of publication:	Accepted May 2022, not published in this thesis, Abstract from Perinatal Society of Australia and New Zealand (PSANZ) Conference, Adelaide, Australia.
Unique contribution to knowledge	Models of continuity of midwifery care may help to address the inequity for women seeking asylum and undocumented migrants in Australia.

Paper 5	
Title:	Book of Abstracts: Midwives providing sanctuary care for asylum seekers
Authors:	Janssen-Frank, G., Fox, D., Njue C., & Dawson, A.
Journal:	32nd ICM Virtual Triennial Congress, International Confederation of Midwives
Status of publication:	Accepted June 2021, not published in this thesis.
Unique contribution to knowledge	International literature demonstrates that asylum seekers in high-income countries often express distress regarding the discrimination they experience with health professionals providing maternity care. The Sanctuary 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 promotes safety and respect of individuals who have experienced trauma.

Paper 6	
Title:	NEST- not even a safe territory
Authors:	Janssen-Frank, G., Fox, D., Njue, C., & Dawson, A.
Journal:	*Women and Birth*, 32, S33. https://doi.org/10.1016/j.wombi.2019.07.245
Status of publication:	Accepted September 2019, not published in this thesis.
Unique contribution to knowledge	Appropriate professional development regarding the complex clinical, cultural and social issues of women seeking asylum is necessary to assist midwives to meet their professional standards.
Other comments:	Australian College of Midwives Conference Abstract.

Dissemination

Conference presentations

Frank, G. (August 2023) *The maternity experiences of women seeking asylum, in Australia.* Migration Conference, Hamburg, Germany, Live Zoom Presentation. https://www.researchgate.net/publication/373113939

Frank, G. (August 2023) *The maternity experiences of women seeking asylum, in Australia.* Twilight Seminar, University of Technology, Sydney (UTS), Collective of Midwifery, Child and Family Health, Sydney, Australia (pre-recorded).

Frank, G. (November 2022*) Sisterhood: How can we improve maternity care of women seeking asylum, in Australia.* 5-minute thesis at UTS Faculty of Health Higher Degree Research Student Forum, Sydney, Australia.

Frank, G. (September 2022) *Life without a Medicare card: The maternity experience of women seeking asylum in Australia* (Poster Presentation). Australian College of Midwives National Conference, Cairns, Australia.

Frank, G. (June 2022) *The maternity experiences of women seeking asylum and the midwives and doulas caring for them.* 5-minute thesis at UTS Faculty of Health Higher Degree Research Student Forum, Sydney, Australia.

Frank, G. (May 2022) The experiences of midwives and doulas who care for women seeking asylum, in Australia. Poster Presentation via Zoom, Perinatal Society of Australia and New Zealand (PSANZ) congress, Adelaide, Australia.

Frank, G. (April 2022) *Adapting care for culturally diverse women*. Australian College of Midwives (ACM) webinar panel discussion relating to Indigenous women and women from culturally diverse backgrounds. The recording is available for professional development for ACM members, on the ACM website https://www.midwives.org.au

Frank, G. (March 2022) *How can we improve the Australian maternity experience of women seeking asylum?* Presentation at Australian Doula Conference, Melbourne, Australia.

Frank, G. (November 2021) *She wanted to be invisible: Midwives experiences of caring for women seeking asylum in Australia.* 3-minute thesis presentation (category winner) at UTS Faculty of Health Higher Degree Research Student Forum, Sydney, Australia.

Frank, G. (June 2021) *Respectful maternity care for women seeking asylum.* 3-minute thesis presentation at UTS Faculty of Health Higher Degree Research Student Forum, Sydney, Australia.

Janssen-Frank, G. (June 2021) *Midwives providing sanctuary care for asylum seekers*. International Confederation of Midwives 32nd Triennial Virtual Congress, 3-minute thesis presentation via Zoom. (Frank et al., 2021)

Janssen-Frank, G. (March 2020) *Not even a safe territory (NEST): Human rights for pregnant women seeking asylum,* Australian Doula Conference, Presentation and panel discussion (online).

Janssen-Frank, G. (September 2019) *NEST: Not even a safe territory.* Australian College of Midwives National Conference, Canberra, Australia.

Janssen-Frank, G. (12–14 June 2019) *Improving perinatal health outcomes for asylum seekers.* Public Health Australia Conference, Melbourne, Australia.

Preface

Researcher statement and personal reflections

Professor Albert Moore studied phenomenology in Germany in the 1950s and was a founding member of the School of Phenomenology at Otago University in New Zealand. Attending my Uncle Albert Moore's guest lectures at a Sydney university began my early interest in phenomenology. At the time, I didn't understand his academic lectures, but his fascination and curiosity for other people's 'life worlds' made a lasting impression. His manner of relating to people was with curiosity and he was genuinely interested in what people had to say. Being in his company was an immersive phenomenological experience, and it was delightful. The last time I met him he was visiting academics in Melbourne, and he impressed on me the importance of building bridges with other cultures, particularly with the Muslim community.

My interest in this research topic was further stimulated by my role as a midwife working in Melbourne, Australia, which involved caring for many Muslim families. During my research towards my Master of Public Health, in 2008, I developed an appreciation of global perspectives on public health and midwifery. I had the opportunity to establish a new state-funded Victorian Government program, *Healthy Mothers Healthy Babies (HMHB)*, in a disadvantaged area in Melbourne, which focused on supporting women who were marginalised, such as refugees or people seeking asylum. The program supported asylum-seeking women and their families who were distressed by the insecurity of their ongoing visa situation. Some were imprisoned in a detention centre nearby, and others in an offshore place of detention in Nauru. Women detained in Nauru were flown to mainland Australia for the last weeks of their pregnancy, where they waited in the detention centre to give birth at a local Melbourne hospital. Many women seeking asylum were allowed to live in community detention and were often referred to the *HMHB* program for additional support. Thus, in my role at the program I met many families who had fled to Australia, via a perilous boat journey, and then applied for asylum.

One family I visited had arrived by boat. On their journey from Indonesia to Australia, they were intercepted by the Australian Navy. In the night, and in high seas, this family

and the other people seeking asylum on board were transferred from their vessel to a navy ship. The mother held her child in her arms, but in the chaos her daughter slipped from her grasp and drowned at sea. In her dreams, the mother was haunted by her daughter calling for her. Her distress was profoundly consuming. Her poor mental and emotional health meant she could not engage with her current pregnancy.

After six years working in the *HMHB* program, I moved on to work with *Birth for Humankind (BfH),* which is a non-government organisation which supports disadvantaged families, such as women seeking asylum, during their pregnancy, labour and birth, and postnatal period. *BfH* provides support for women during labour with a volunteer doula or a midwifery student. In my role as their volunteer coordinator, I met many families seeking asylum and my work included attending visits at the Melbourne detention centre. I heard their stories and was motivated to begin research into the topic of supporting marginalised women in pregnancy, by commencing my PhD study in Public Health.

I was particularly drawn to the unique challenges experienced by people seeking asylum, and noticed there were key differences from those experienced by migrants and refugees. For example, after the birth of their baby, one family I supported was threatened with the possibility of being removed from their home in community detention at any time. They told me the Border Force Officer had come to their home and informed them that they would be removed with their baby and returned to the Nauru detention centre. Their older daughter was at school in Melbourne and was old enough to make some sense of the situation. She didn't want to make friends because they were going back to Nauru. I visited them with a pro bono lawyer, who later told me there was nothing that she or her colleagues could do for this family.

During my PhD I have reflected on my identity as a midwife, doula, woman, and mother, which are key social categories in empathising with the research participants. I felt shame, guilt, sadness, and sometimes joy, during my PhD journey. Shame, that as an Australian who stayed silent on the human rights abuses inflicted in Australia to people seeking asylum meant in a small way, I condoned it. Guilt, at my blindness of my white unearned privilege. The power imbalance was striking in my research, as an educated white, Australian citizen conducting research with women seeking asylum in Australia. I experienced sadness and vicarious trauma when hearing their stories. At times my heart

sang with the passion and hope of making a difference in improving maternity care for women seeking asylum. The resilience of these families with the hope a new baby often brings, gave me joy. My reflexivity allowed me to be sensitive to these issues when conducting interviews.

Further details of the processes of my reflexivity are in Chapter 3.

Fernanda Perez Trevino is a bicultural doula and artist. Her painting below (image 1) speaks of the loneliness, isolation and unspoken grief of many of the women interviewed in this study.

Image 1: *La Catrina, self-portrait* by Fernanda Perez Trevino (used with permission).

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Definitions

Asylum seeker: 'someone who has applied for protection as a refugee and is awaiting the determination of his or her status' (United Nations Educational, Scientific and Cultural Organization [UNESCO], 2015, p. 1).

Caseload model: 'A midwife is a named lead professional in the planning, organisation and delivery of care to a woman from the initial booking to the postnatal period' (Rayment-Jones et al. 2015, p. 410).

Caseworker: 'is usually someone who was a refugee who is employed by a local settlement agency … due to their shared language and culture … to be an advocate between the refugee community and the new community' (Wilson & Rodriguez, 2018, p. 382).

Child Protection: 'The Victorian Child Protection Service is specifically targeted to support those children and young people at risk of harm or where families are unable to protect them' (Victorian State Government, 2022, p. 1).

Doula: 'a professional who provides continuous physical, emotional and informational support to their client before, during and shortly after childbirth' (DONA, 2018, para. 3).

FGM: 'Female genital mutilation comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons' (World Health Organization [WHO] 2008, p. 1).

FGC: 'Female genital cutting is the preferred term rather than female genital mutilation in reflecting non-judgmental terminology' (WHO 2008, p. 3).

Forcibly displaced people: 'encompasses refugees, asylum seekers, internally displaced people and Venezuelans displaced abroad' (United Nations High Commissioner for Refugees [UNHCR] 2022, p. 4).

Medicare: 'Australia's health care system which covers partially or fully public medical expenses such as visiting a General Practitioner (GP), pathology, hospital admission and ultrasound' (Australian Government 2022b, pp. 1–2).

Midwife continuity of care models: ‘a known and trusted midwife or a small team of trusted midwives supports a woman throughout the antenatal, intrapartum and post-partum period to facilitate healthy pregnancy and childbirth. It is usually aimed at providing care for low-risk women’ (WHO 2016, p. xv.).

Post-traumatic stress disorder (PTSD): ‘exposure to a traumatic event … that is outside the range of normal human experience and would be markedly distressing to almost anyone … involving serious threat to life or physical integrity … where the prominent symptom is reliving the event’ (North et al. 2016, p. 200).

Racism: ‘the relegation of people of colour to inferior status and treatment based on unfounded beliefs of innate inferiority, as well as the oppression and unjust treatment of people of colour, whether intended or not’ (Braveman et al., 2022, p. 171).

Refugee: ‘someone who is unable or unwilling to return to their country of origin based on a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion a person applies for refugee status in the host country’ (UNHCR 1969, p. 14).

Shoulder dystocia: ‘Failure of the shoulders to spontaneously traverse the pelvis after birth of the fetal head’ (Marshall & Raynor 2014, p. 737).

Stateless people: ‘are not recognised by any country, thus they have no nationality’ (UNHCR 2022, p. 42).

Undocumented migrant: ‘a person who enters or stays in a country without the appropriate documentation’(International Organization for Migration [IOM] 2019, p. 235).

Vicarious trauma: ‘experiencing in the trauma worker of symptoms similar to those seen in people with posttraumatic stress disorder’ (Cohen & Collens 2013, p. 570).

Woman centred care: ‘is a concept. It implies that midwifery:

- Focuses on the woman’s individual needs, aspirations and expectations, rather than the needs of the institution or professionals.

- Recognises the need for women to have choice, control and continuity from a known caregiver or caregivers.
- Encompasses the needs of the baby, the woman's family and other people important to the woman, as defined and negotiated by the woman herself.
- Follows the woman across the interface of community and acute settings.
- Addresses social, emotional, physical, psychological, spiritual and cultural needs and expectations.
- Recognises the woman's expertise in decision making (Leap 2009, p. 12).

Abbreviations and acronyms

ACM	Australian College of Midwives
ACMHN	Australian College of Mental Health Nurses
ACN	Australian College of Nurses
ACSQHC	Australian Commission on Safety and Quality in Health Care
AHRC	Australian Human Rights Commission
AIHW	The Australian Institute of Health and Welfare
AMA	Australian Medical Association
ANMF	Australian Nurses and Midwives Federation
ASRC	Asylum Seeker Resource Centre
BAME	Black, Asian and minority ethnic communities
BfH	Birth for Humankind
CALD	Culturally and linguistically diverse
EMA	European Midwives Association
FIGO	Federation of International Gynaecology and Obstetrics
GANC	Group Antenatal Care
GP	General practitioner
HICs	High-income countries
ICM	International Confederation of Midwives
ICN	International College of Nurses
IHMS	International Health and Medical Services
IOM	International Organization of Migration
NGO	non-government organisation
PHAA	Public Health Association of Australia
PTSD	post-traumatic stress disorder
RACP	Royal Australasian College of Physicians
RANZCOG	Royal Australian and New Zealand College of Obstetrician and Gynaecologists
RCA	Refugee Council of Australia
RCM	Royal College of Midwives
SANDS	Miscarriage, Stillbirth and Newborn Death Support
SHEV	Safe Haven Enterprise Visa
SIDS	Sudden infant death syndrome

STARTTS	Service for the treatment and rehabilitation of torture and trauma survivors
TPV	Temporary Protection Visa
UN	United Nations
UNAA	United Nations Association of Australia
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization
WONCA	World Family Doctors Caring for People, Europe

Abstract

Background

In the context of the global refugee crisis, this research focuses on the experiences of women seeking asylum in their pregnancy, labour and birth, and postnatal period. Asylum seekers are a distinct group with different needs than refugees or migrants. Perinatal outcomes are significantly poorer for women who seek asylum, than women who birth in their high-income country of origin. There is limited research examining the maternity experiences of asylum seekers in high-income countries and there are no studies from Australia.

Aim

To explore the maternity care experiences of asylum seekers, and the midwives and doulas who care for them, in Australia.

Method

Qualitative research was conducted, using a phenomenological approach to understand the maternity care experiences of women seeking asylum, and the midwives and doulas who care for them. Data was collected via in-depth semi-structured interviews.

Findings

There were four overarching themes expressed by the women, midwives and doulas. The themes were:

- *Living with uncertainty*
- *Sisterhood: the care provided by midwives and doulas*
- *The care provided by midwives and doulas*
- *The importance of midwifery continuity of care*

Discussion

Midwives frequently did not identify women seeking asylum and thus were unable to offer appropriate support to women who remained unidentified. In order to increase

midwives and doulas confidence in caring for and identifying women seeking asylum training is necessary in trauma-informed, culturally safe care. Organisational and systemic changes are needed to address the challenges to identifying women seeking asylum, and improve access to maternity care for these disadvantaged women. Women expressed their loneliness and lack of support during their maternity experience, but appreciated the kindness of midwives and doulas.

Conclusion

This research, by closely examining the maternity experiences of women seeking asylum in Australia, shines a light on this under-researched issue. This study provides some important insights into the challenges faced by women seeking asylum and the midwives and doulas caring for them. Further research is necessary to design and implement changes to current maternity models.

Keywords: asylum seeker, high-income countries, maternity, midwifery, refugee

Chapter 1: Introduction

> *And so, we lift our gazes, not to what stands between us*
> *but what stands before us …*
> *for there is always light, if only we're brave enough to see it.*
>
> (Gorman, 2021, p. 1 & 3)

This thesis presents a study that explored the maternity experiences of asylum-seeking women and undocumented migrants in Australia. In order to provide background context, this chapter will discuss the political, legal and human rights issues faced by people who seek asylum internationally and in Australia, and the potential impact on maternal and newborn health. A definition of key terms will identify the challenges where interchangeable and fluid terms and definitions are used in data and research relating to people seeking asylum. International human rights laws aim to inform policies and protect people seeking asylum. In recent years professional health organisations' position statements have adopted a human rights approach in recommendations for the maternity care of women seeking asylum, which will be summarised in this chapter. Finally, an overview of the issues facing people seeking asylum in Australia will provide background information to the research question, and the aims and objectives of this research.

Background

The number of people fleeing their homes and country internationally has increased in recent decades due to persecution and conflict, with the number of refugees worldwide reaching more than 27.1 million (UNHCR, 2018, 2020, 2022). Globally, in 2021, 4.6 million asylum seekers were waiting for their refugee claim to be approved, and the population of displaced people reached 89.3 million (UNHCR, 2022). There were also 4.3 million stateless people who lacked a nationality and access to education, health care, and employment (UNHCR, 2022).

Pregnant women seeking asylum are a disadvantaged population who face barriers to accessing health care in their host country (Australian Human Rights Commission, 2014), placing them at risk of poor maternal and newborn outcomes (WHO, 2018). Systematic reviews of quantitative research in high-income countries, such as the United Kingdom

(UK), indicate that the perinatal outcomes of women seeking asylum are poorer than those birthing in their country of origin (WHO, 2018). This includes a higher incidence of preterm birth, low birth weight, perinatal mortality, and congenital malformations (Bozorgmehr et al., 2018; Bradby et al., 2015; Tankink et al., 2021). Barriers to accessing maternity care may also lead to higher rates of maternal mortality (Heslehurst et al., 2018) and mental health problems such as anxiety, depression, and post-traumatic stress disorder (Patanè et al., 2022; WHO, 2018).

In the past few years, COVID-19-related restrictions have had an impact on people seeking asylum, due to border closures and travel restrictions (UNHCR, 2022). This situation has human rights ramifications for powerless groups such as pregnant women seeking asylum who, as mentioned above, have poorer obstetric outcomes than women born in the host country (Brown-Bowers et al., 2015; Patanè et al., 2022; Pfortmueller et al., 2016). The USA received the highest number of applications for asylum in 2022, and the majority of applicants were people seeking asylum from Afghanistan (UNHCR, 2022). Accurate data on asylum applications is dependent on processes in each individual country, and not all countries report this information (UNHCR, 2018). People seeking asylum are predominantly an under-researched group with very few systematic reviews looking exclusively at the maternity experiences of asylum seekers in high-income countries (Balaam et al., 2021; McKnight, 2019).

Definitions

There is confusion between the terms *asylum seeker* and *refugee*. Asylum seekers lack visas that allows them to live in the country of arrival, which differs from the situation facing refugees. An asylum seeker must wait for their refugee application to be processed, which in some countries, such as Australia, can involve temporary detention in a specific centre (Kaplan, 1998). The *United Nations Educational, Scientific and Cultural Organization's* (UNESCO) definition is: '*an asylum seeker is someone who has applied for protection as a refugee and is awaiting the determination of his or her status'* (UNESCO, 2015, p. 1). A refugee is defined by the *United Nations High Commissioner for Refugees (UNHCR)* Convention as:

> [someone who] owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political

> opinion is outside the country of [their] nationality and is unable or, owing to such fear, is unwilling to avail [themselves] of the protection of that country; or who, not having a nationality and being outside [their] former habitual residence, is unable or, owing to such fear, is unwilling to return to it. (UNHCR, 1969, p. 14)

A group who experiences similar protracted periods of visa uncertainty are undocumented migrants. *The International Organization for Migration (IOM)* defines an undocumented migrant as *'a person who enters or stays in a country without the appropriate documentation'* (IOM, 2019, p. 235). This can include those who have had their application for asylum rejected, those who have violated the terms of their visa, those whose visas have expired, or those who have no visa in the country where they seek asylum (Cuadra, 2012). The term *undocumented migrant* is frequently used interchangeably with the term *people seeking asylum* in research (Barkensjo et al., 2018).

Undocumented migrants face similar challenges as those faced by people seeking asylum. In Germany, for example, the stress of living in fear and the uncertainty, anxiety and depression resulting from their undocumented status has led to what is described as *illegal syndrome* — a name given to the generalised stress and anxiety that affects the health of undocumented migrants (Castaneda, 2009). Similarly, research into the experiences of pregnant undocumented migrants in the UK concluded that they faced intersecting stressors of powerlessness, precarious legal and economic status, and barriers to accessing health care (Nellums et al., 2021). Willen described the life of being an undocumented migrant as:

> Life as an illegal foreign resident is really like living underground.
> You're anonymous, without a name, without an identity, without an address.
> (Willen, 2007, p. 9)

There is a degree of uncertainty in the literature around the terms used to describe people seeking asylum and undocumented migrants, these include: *irregular migrants* (WHO, 2018), *illegal migrants* (Aspinall, 2010), *failed asylum seekers* (Phillimore, 2016), *temporary residents* (Steel, 2006), *transients* (Yelland et al., 2018), *unauthorised plane arrivals* and *illegal maritime arrivals* (Australian Government, 2021). The term *failed asylum seekers* is used to refer to asylum seekers whose refugee claim has been denied

but who remain in the host country where they live as unrecognised refugees (Ghio & Blangiardo, 2019). Some of these terms — *irregular migrants*, *failed asylum seekers*, *illegal migrants* and *illegal maritime arrivals* — are derogatory. In this study I will use neutral terms such as *woman seeking asylum* or *asylum-seeking woman*. Use of the term *woman/women seeking asylum* in this thesis is inclusive of *undocumented migrant/s* throughout the thesis. However, the term *undocumented migrant* is used to refer to any discussion of issues that are specifically relating to this cohort.

Rates of poor perinatal outcomes, including perinatal mortality rates, are similar for women seeking asylum as they are for undocumented migrants (Bradby et al., 2015). Since people seeking asylum and undocumented migrants face similar issues, both were included in this research (Barkensjo et al., 2018; Funge et al., 2020). As migrants and refugees have secure immigration status and may receive more support, they were excluded from this research. This exclusion has enabled a focus on the specific experiences of women seeking asylum during their maternity care experience.

Maternity care for women seeking asylum: A human rights issue

The *United Nations (UN)* Universal Declaration of Human Rights was adopted by the *UN General Assembly* in 1948 and set out, for the first time, fundamental rights that should be protected universally. The Declaration became the basis for human rights law. Article 14 states*: 'Everyone has the right to seek and to enjoy in other countries asylum from persecution'* (United Nations, [UN] 1954, p. 4). In 2016, the *UN General Assembly* unanimously adopted the New York Declaration for Refugees and Migrants, which aims to allow stronger collaboration between countries to protect the rights of people seeking asylum and refugees (UN, 2019). The right to health is a fundamental human right identified in both these *UN* documents, and was defined as a standard of living that is adequate for wellbeing. This was further elaborated on in relation to reducing maternal mortality and morbidity in the annual report of the *UN* in 2012 (UN High Commissioner, 2012).

Despite these *UN* declarations, there are significant barriers to accessing maternity care for pregnant women seeking asylum (Ellul, 2020; Feldman, 2014; Phillimore, 2016). These barriers are complex and may include firstly, a lack of interpreters, which

exacerbates communication challenges (Lephard & Haith-Cooper, 2016). Secondly, the cost of accessing health care services is a major barrier as people seeking asylum typically have limited access to finances, and may experience confusion regarding their entitlements. Thirdly, transport may also be a barrier due to costs and feelings of uncertainty when travelling to an unfamiliar health care service. Furthermore, specialist services, such as complex pregnancy care, may not be available or readily accessible (Saunders et al., 2022; UN, 2018). Thus, there are complex intersecting barriers to accessing health care that are related to the challenges of seeking asylum, which will be examined further in the following sections.

Maternity care for women seeking asylum: Guidelines and position statements

Health professional organisations play a vital role in the ongoing education and training of their members, as well as providing clinical guidance to ensure best practice standard of care. There are no systematic reviews of current care guidelines that have been developed to respond to the particular needs of asylum-seeking pregnant women in high-income countries (HICs). I reviewed the position statements of professional midwifery, nursing, and medical bodies in HICs to examine what advice was provided concerning the care and treatment of pregnant women seeking asylum, and to explore the advocacy platforms of these organisations.

Organisations in the UK, Australia and Europe — such as the *Royal College of Midwives (RCM)*, the *Royal Australasian College of Physicians (RACP)* and the *European College of Midwives (ECM)* — identified the challenges to overcoming barriers to access health services for people seeking asylum in high-income countries (AkiDwA, 2010; Department of Health, 2014; International Council of Nurses [ICN] 2018; Kennedy, 2003; McLeish, 2002). These organisations recommend that health professionals advocate on behalf of people seeking asylum to persuade governments and legislative bodies of the need to address their rights and health care needs.

In the UK, the detention of people seeking asylum impacts on the availability of health care. The *Royal College of Midwives (RCM)* argued that detention is harmful for pregnant women, citing the stress it imposes on them, and the lack of access to appropriate maternity care (RCM, 2022). Similarly, the *Royal College of Obstetricians and*

Gynaecologists (RCOG) stated that government-provided detention settings are inappropriate accommodation for pregnant women (RCOG, n.d.).

Barriers to accessing health services for people seeking asylum occur in many European high-income countries for reasons such as cost, lack of interpreter support, and difficulty navigating the health systems of host countries (Abubakar et al., 2018). As identified by the *RCOG* (n.d.), a significant issue for pregnant women who seek asylum is access to professional interpreters when required. The *RCOG* advocated for the use of professional interpreters, stating that, without this service, informed consent and education is often not possible (RCOG, n.d.). Interpreters enable a positive experience of maternity care, which in turn promotes confidence in attending future appointments (Correa-Velez & Ryan, 2012).

In many countries, full charges for health care can be incurred by people seeking asylum whose claim for asylum has been rejected. Confusion about eligibility for free maternity services often exists, due to the complexity of funding arrangements and discrimination. *The Australian Medical Association (AMA)* stated that people seeking asylum should have universal access to basic health care, counselling and educational opportunities, independent of their visa status (AMA, 2015). Other organisations such as the *European Midwives Association* (EMA 2015), the *International Confederation of Midwives* (ICM, 2017) and the *Australian Nurses and Midwives Federation* (ANMF, 2020) argued that women should have free access to midwifery care during their pregnancy, birth and postnatal journey, including breastfeeding support.

The Royal College of Midwives (RCM) in the UK acknowledged that addressing the power differentiation between midwives and the women they care for has relevance for improving the maternity experiences of women seeking asylum. In particular, the *RCM* suggested that cultural sensitivity and cultural awareness training may improve the understanding of midwives regarding the issues faced by women seeking asylum, such as the implications of their uncertain visa status (RCM, 2017; RCM, 2022). Furthermore, the *International Council of Nurses* (ICN, 2018) called on nursing organisations, clinicians, and researchers to develop and improve their cultural competence, and to develop initiatives that aim to incorporate cultural competence into service delivery for all people in their care.

The *ANMF* (2020) also recommended that all health professionals must be supported through education to provide high calibre, culturally appropriate care. The *ANMF* (2020) argued that education should promote awareness of health issues that are common in people seeking asylum, such as the physical and mental effects of torture, and the prevalence of illnesses that are often not seen in Australia. Midwives require training to understand the complex health issues of people seeking asylum, including the need for psychological support and health literacy.

A recent report into the Australian migration system identified that a lack of good data impedes policy improvements (Parkinson et al., 2023). Similarly in the UK, the *Royal College of Obstetricians and Gynaecologists (RCOG)* highlighted the importance of promoting appropriate research, so that reliable data can enable understanding of the issues that must be addressed to improve health outcomes for asylum-seeking and undocumented migrant women (Royal College of Obstetricians and Gynaecologists [RCOG], n.d.). The *ICN* encourages nurses to engage in research to improve the quality of care for people seeking asylum (ICN, 2018).

In response to the growing number of refugees and people seeking asylum worldwide, the *WHO* developed a global health plan known as 'No Public Health without Refugee and Migrant Health' (WHO, 2018). This plan advocated for a focus on addressing the social determinants of health of refugees and migrants, including 'forced migrants' who may be seeking asylum. Social determinants include poverty, poor living conditions and unemployment, which are potentially avoidable risk factors in poor maternal health (WHO, 2018). The *WHO* report, No Public Health without Refugee and Migrant Health, (WHO, 2018) concluded many refugees and people seeking asylum do not have access to quality health care services, which can be addressed by improving education, socioeconomic status, and strong interpretation policies in the host country.

Human rights issues faced by people seeking asylum in Australia

The mandatory detention of asylum-seeking people who arrive by sea, presumably for health and safety checks, commenced in Australia in 1992 (Philips, 2013). In Australia, people who arrive by boat without a visa are imprisoned in mandatory detention in remote

offshore centres, such as Christmas Island or in other nations including Nauru and Papua New Guinea, or metropolitan centres, for an unlimited period (Kaplan, 2020).

The organisation *Doctors for Refugees* criticised the Australian Government for failing to provide appropriate medical attention for pregnant women detained in Nauru, an island over 3000 kilometres from Australia (Doctors for Refugees, 2016). The harsh policy maintained by the Australian Government, of intercepting boats at sea and sending those seeking asylum to remote islands (Kaplan, 2020), has been criticised by many health professional organisations. For example, the *Australian Medical Association (AMA*) asserted:

> Prolonged, indeterminate detention of people seeking asylum in immigration detention centres violates basic human rights and contributes adversely to their health. The longer a person is in detention, the higher their risk of mental illness. (AMA, 2015, p. 2)

Limited data is available from the Australian Government, however, agencies such as the *Asylum Seeker Resource Centre* and the *Victorian Refugee Health Network* have compiled annual data reports by using the Freedom of Information laws to obtain data. It is unknown how many pregnant women are in detention in Australia. The *Refugee Council of Australia* reported in March 2022 that the average length of stay in detention was over 700 days (Refugee Council of Australia [RCA], 2022).

Policy changes in 2013 allowed more people in detention to live in the community on Temporary Protection or Safe Haven Enterprise visas. However, family separation has been used as a deterrent for people seeking asylum, with policies removing the right for family reunification to those seeking asylum (Human Rights Law Centre, 2021). The impact of these policies may remain a continuing emotional and psychological issue for people many years beyond their detention (Royal Australasian College of Physicians [RACP], 2015). Table 1.1 is compiled from Australian Government statistics identifying the number of people seeking asylum in Australia according to their visa status in 2021 and 2022.

Table 1.1

Number of people seeking asylum in Australia according to visa status in 2021 and 2022

Australian Government visas relating to people seeking asylum	Number of people seeking asylum
Temporary Protection Visas (TPV) or Safe Haven Enterprise Visas (SHEV) (Australian Government, 2020)	19,000 people seeking asylum (Australian Government, 2022a)
No visa (People in immigration detention or alternative places of detention) (2022a)	1079 people seeking asylum 1353 including community detention (Australian Government, 2023)
Living in community on Bridging Visa E (Australian Government, 2020)	10,708 people seeking asylum (Australian Government, 2023)

Source: Australian Government. (2020). (2022a). (2023). *Immigration detention statistics and community statistics summary*.

The *International Health and Medical Services (IHMS)* is an organisation that provides primary and mental health care services within the Australian immigration detention network to people seeking asylum in on and offshore detention centres and in the community, under a contract with the Australian Government (Buckmaster & Guppy, 2014). The *IHMS* also provides health care for people seeking asylum without a visa or with an expired visa. The quality of the services provided in detention centres is questionable according to reports of people who have worked in these centres. Natasha Bulcher was employed as a senior case worker at the Nauru detention centre and later became an advocacy officer at the *Darwin Asylum Seeker Support and Advocacy Centre*. She described the plight of people detained in Nauru:

> I have worked as a senior case worker on Nauru … providing support to people seeking asylum … And those of us who wrote those reports are well aware that what you have seen is not the half of it. Behind every objective description of complete loss of hope, the desire to die, or the sexual and physical abuses inflicted on people – there is a person. There is a person who came to Australia fleeing persecution, with great hope (Brodie, 2016, p. 1).

The law and entitlements of people seeking asylum in Australia

The Australian Human Rights Commission criticised the Australian Government's policy of enforcing the indefinite mandatory detention of people seeking asylum, often for over one year, because it contravenes Australia's international obligations (Australian Human Rights Commission, 2014). The *United Nations Association of Australia* (UNAA, 2019) urged the Australian Government to support the human rights of people seeking asylum and refugees with compassion, as stated in the 1951 *UNHCR* Convention related to the status of refugees (UNHCR, 1969, p. 2).

In disregard of the fact that Australia is a signatory of the *UN* Human Rights Charter, people seeking asylum arriving by boat were still processed in offshore detention centres, usually on Christmas Island (Asylum Seeker Resource Centre [ASRC], 2019). Furthermore, recent changes to Australian law state that people seeking asylum who arrive by boat cannot ever settle in Australia (Philips, 2013). Instead, if they are recognised as a refugee, they are sent to a third country, such as the USA, for settlement (ASRC, 2018). Infants born to women seeking asylum in Australia become stateless, rather than Australian citizens (Department of Home Affairs, 2019b); this breaches the human right to nationality and protection convention (Australian Human Rights Commission, 2014).

The law concerning the entitlements of those seeking asylum in Australia is complicated. Immigration law frequently changes in Australia in order to defend government policies from accusations regarding the treatment of people seeking asylum and their obligations under international human rights law (Karlsen, 2010). Such changes to the law have often further decreased entitlements of people seeking asylum (Department of Health, 2014). While living in the community waiting for the outcome of their visa claims, persons seeking asylum may be eligible to receive a Status Resolution Support Services payment from *Centrelink*, the Australian Government social service, payments and general health care service (Australian Government, 2021b). In 2012, for example, changes to the law meant that people seeking asylum could apply for a Temporary Protection Visa (TPV) or a Safe Haven Enterprise Visa (SHEV) in certain circumstances (Department of Home Affairs, 2019a). These visas are both time-limited and are not a pathway to permanent residency or family reunification in Australia.

Table 1.2 describes the health care, work, study, and *Centrelink* benefits that people may be eligible for, according to the different types of humanitarian visas in Australia. The global special humanitarian visa is for refugees and allows the same rights to health care, employment, and welfare benefits as permanent Australian residents. The other categories listed in the table are entitlements, according to visa types, that those seeking asylum may or may not have.

Table 1.2

Summary of entitlements according to visa status in Australia 2020

VISA Type	Medicare Eligible	International Medical & Health Services (IMHS)	Eligible to Work or study	Centrelink
Global Special Humanitarian Visa	Yes – permanent resident. (can apply to become an Australian Citizen)	No	Yes	Yes
Resolution of Status Visa (February 2023)	Yes – can apply for permanent residency	No	Yes	Yes
Temporary Protection Visa (TPV)	Yes – for 3 years.	No	Yes – for 3 years	Yes – for 3 years
Safe Haven Enterprise Visa (SHEV)	Yes – for 5 years	No	Yes – for 5 years	No
No Visa	No	Yes – while residing in detention centre or community detention.	No	No
Declined Visa	No	No	No	No

Sources: Immigration and Citizenship visa list (Australian Government, 2020) and Healthcare and Medicare (Australian Government, 2022).

An overview of services for pregnant women seeking asylum in Australia

There are no current national guidelines for public hospitals in Australia relating to payment for health services, however, some organisations may waive fees for the provision of maternity care for asylum-seeking women and refugees (The Royal Women's Hospital [RWH], 2019). In Australia, non-government services, such as the *Asylum Seeker Resource Centre (ASRC)* provide primary health care, legal advice, and material aid for people seeking asylum who do not have access to Medicare (ASRC, 2022). Medicare is the public health care system in Australia that partially or fully covers public medical expenses, such as visiting a general practitioner (GP), pathology, hospital admission, and ultrasound (Australian Government, 2022b).

There is no coordinated policy in Australia to support the complex needs of women seeking asylum and no national database that identifies projects that provide such services. There are, however, a number of non-government organisations (NGOs) that specialise in supporting people seeking asylum. *Foundation House* in Victoria, and *Service for the treatment and rehabilitation of torture and trauma survivors (STARTTS)* in New South Wales are examples of not-for-profit organisations providing services for refugees and asylum-seeking people who have experienced torture and trauma. The services offered at *Foundation House* include medical, psychological, and social work (Kaplan, 1998).

In Victoria, another non-government service, *BfH* provides volunteer doula support for marginalised women, including women seeking asylum, during pregnancy, labour and birth, and the postnatal period (Birth for Humankind [BfH], 2019).

Table 1.3 provides an overview of the services that were contacted during the recruitment stage of this research, or services that were referred to by midwives who were interviewed.

Table 1.3: Services referred to by participants in this study

Service name	Location	Services available
Centrelink (Australian Government)	Australia	Eligible for partial payment if on temporary protection visas (Australian Government, 2021)
Medicare (Australian Government)	Australia	Australia's public health care system (Australian Government, 2022b)
Red Cross, a non-government organisation (NGO)	International	Humanitarian support, advocacy and community connection for people seeking asylum informed by the lived experience of their clients, volunteers and staff (Australian Red Cross, 2020)
The Salvation Army (NGO)	International	Care includes access to affordable food items, conversational English classes, referral for financial counselling and pastoral care (The Salvation Army, Australia, n.d.)
Save the Children Fund (NGO)	International	Programs focus on health, education and protecting children (Button & Lamoin, 2016)
Asylum seekers centre(NGO)	Sydney	Practical and personal support such as English classes, accommodation, and employment assistance for people seeking asylum (Asylum seekers centre 2019)
House of Welcome (NGO) part of St Francis Social Services	Sydney	English classes, employment assistance and case work (St Francis Social Services, 2020)
Muslim Women Australia (NGO)	Sydney	Supports victims of family violence and provides advocacy in response to Islamophobia (Muslim Women Australia, 2020)
STARTTS (NGO)	Sydney	Provides assessment and trauma treatment for refugees and people seeking asylum (STARTTS, n.d.)
Asylum seeker resource centre (NGO)	Melbourne	Primary health care, legal advice and material aid for people seeking asylum who do not have access to Medicare (ASRC, 2022)
Cabrini Asylum seeker and refugee health hub (NGO)	Melbourne	Provides access to a range of health services for people seeking asylum (Cabrini Health Service, n.d.)
Birth for Humankind (NGO)	Melbourne	Volunteer doula support for disadvantaged women in the perinatal period, including women seeking asylum (BfH, 2019)
Foundation House (NGO)	Melbourne	Services for asylum-seeking people who have experienced torture and trauma. The services offered include medical, psychological and social work. (Foundation House, 2017)
St Kilda Mums, (NGO)	Melbourne	Material aid in the form of nursery equipment and baby items, for marginalised new mothers in Victoria (St Kilda Mums, 2020)
Victorian Arabic Social Services (NGO)	Melbourne	Counselling, case work, advocacy, social, cultural and linguistic support to people of Arabic-speaking background (Victorian Arabic Social Services [VASS], 2022).
Romero Centre (NGO)	Brisbane	Provides a warm welcome and practical support for people seeking asylum (Romero Centre, 2023)

Gaps in existing knowledge of women's needs when seeking asylum in Australia

There is a dearth of research in Australia focusing explicitly on the experiences of pregnant women seeking asylum. The majority of related research combines people seeking asylum and refugees as if they were a homogenous group. This is problematic because asylum-seeking persons face unique challenges that are not faced by refugees, such as the experience of imprisonment in the Australian detention system, having no access to Medicare, living in Australia with temporary visa status, and having uncertainty about their future visa status.

Women's health data is not reported for several population groups, including refugees and women seeking asylum (Australian Institute of Health and Welfare [AIHW], 2019). Research regarding women seeking asylum in the perinatal period in Australia often combines migrants, refugees, and people seeking asylum in the same cohort, even though they are a diverse group (Hach, 2012).

Although the maternity experiences of asylum-seeking women have been studied in Sweden (Barkensjo et al., 2018), UK (Briscoe & Lavender, 2009; Feldman, 2014; Lephard & Haith-Cooper, 2016; McLeish, 2005; Nabb, 2006; Tobin et al., 2014b; Ellul et al., 2020; Nellums et al., 2021), Germany (Gewalt et al., 2019), and Denmark (Funge et al., 2020), this is the first study to explore the experiences of asylum-seeking women in Australia. The research question, aims and objectives of the study are as follows:

Research aims

To explore the maternity care experiences of women seeking asylum and undocumented migrants in Australia, and the experiences of the midwives and doulas who care for them.

Research questions

- What are the experiences of maternity care and relative needs of women who seek asylum in Australia?
- What are the barriers to accessing maternity care for women seeking asylum in Australia?

- How do midwives and doulas identify and care for pregnant women who seek asylum in Australia?

The impact of COVID-19 on this research

Initially, it was envisioned that research participants for this project would be recruited through the hospital sector and that the research would be conducted in person, in hospital settings. In March 2020, however, due to the COVID-19 pandemic and to decrease the risk of COVID-19 transmission, research was interrupted at hospitals in Melbourne. The research plan changed to recruitment through community organisations and interviews via phone and via an online platform. Midwives interviewed all noted that provision of care was more difficult due to COVID-19. For example, interpreters play a key role facilitating the interactions between the midwife and woman seeking asylum. However, during COVID-19, interpreters could only be accessed over the phone, not in person. Being unable to have face-to-face contact with women made it more difficult to build rapport with them. These issues will be discussed in more detail in Chapter 3: Methods.

Thesis structure

Chapter 2 contains a published review of the existing literature on the maternity experiences of women seeking asylum in high-income countries, followed by an updated review of the literature published up until August 2023. A second literature search included the experiences of midwives and midwifery students caring for women seeking asylum. The third literature review focused on the experiences of doulas and volunteers caring for asylum-seeking women and refugees. The citation for the published literature review is:

> Frank, G., Fox, D., Njue, C., & Dawson, A. (2021). The maternity experiences of women seeking asylum in high-income countries: a meta-ethnography. *Women and Birth*, *34*(6), 531–539. https://doi.org/10.1016/j.wombi.2020.12.012

Chapter 3 explains the methodology, theoretical perspectives, and methods employed in this research, including ethical considerations.

Chapter 4 introduces the three findings chapters and the demographics of the research participants.

Chapters 5, 6 and 7 present the detailed findings of the research, identifying themes and subthemes.

Chapter 8 discusses the implications of the findings drawing on relevant literature.

Chapter 9 is the concluding chapter. Study limitations and strengths, and the implications for practice and future research also are discussed.

The Epilogue describes how Priya and Nades Nadesalingam and Behrouz Boochani have raised public awareness of the treatment of people seeking asylum in Australia, and increased community support and political awareness of the human stories of people seeking asylum.

Language considerations in this thesis

Whilst recognising the importance of using gender inclusive language, in this thesis I have used the terms *woman* and *women* in consideration that all of the participants identified as women. I have also decided to continue to refer to *woman-centred* rather

than *person-centred* care. At the time of writing the use of non-gendered language was starting to be addressed in maternity care and areas of public health. I do not intend to offend anyone who is pregnant and who does not identify as a woman or those who are advocating for non-binary inclusive language.

Chapter 2: Literature review

> *Individuals in detention are not defined only by the experience. Even when restricted in their freedom of movement, people must be given the resources to keep living with dignity and respect.*
>
> (Tran et al., 2018, p. 4)

Introduction

To understand the existing literature regarding the maternity experience of women seeking asylum, I conducted a literature review which was published in the peer-reviewed Q1 journal, *Women and Birth*. The article is inserted in this chapter in its published form and was titled, 'The maternity experiences of women seeking asylum in high-income countries, a meta-ethnography'. The methodological approach to this meta-ethnography is described within the publication.

Following the published manuscript is a review of research papers published from February 2020 to August 2023, regarding the maternity experiences of women seeking asylum in high-income countries. In addition, a review was conducted of the experiences of midwives and midwifery students in caring for women seeking asylum. Finally, a review of the literature on doulas and volunteers was undertaken, however, no studies were found that were specifically related to caring for women seeking asylum and undocumented migrants. Overall, very few studies on this topic from high-income countries have been found.

Publication reference:

> Frank, G. D., Fox, D., Njue, C., & Dawson, A. (2021). The maternity experiences of women seeking asylum in high-income countries: a meta-ethnography. *Women and Birth, 34*(6), 531–539. https://doi.org/https://doi.org/10.1016/j.wombi.2020.12.012

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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

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for their asylum claim to be processed [1]. There were also ten 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].

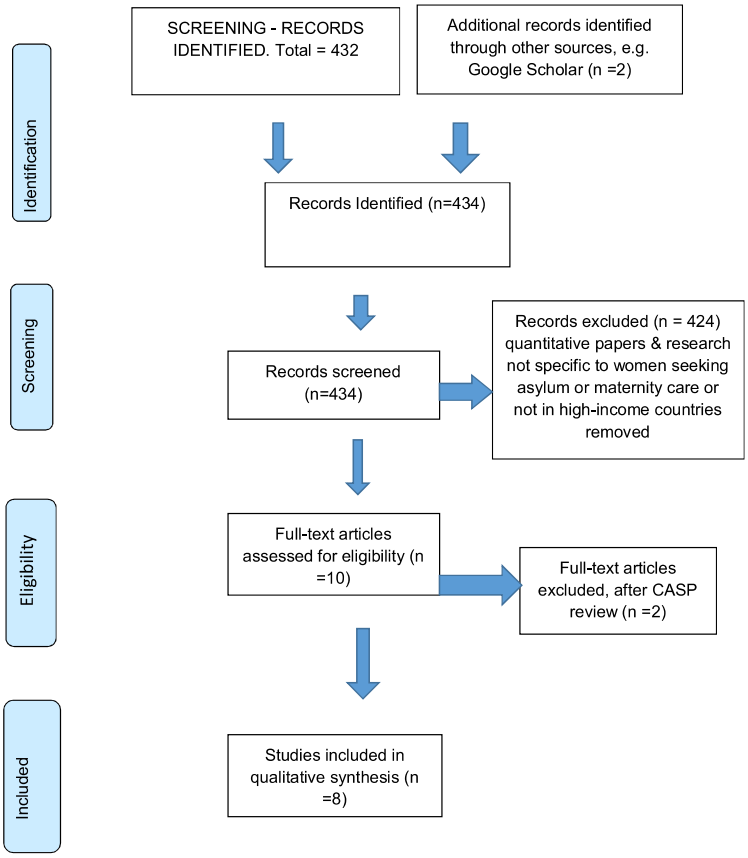

Fig. 1. PRISMA 2009 flow diagram [1].

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 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.

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 [38]	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.

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 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,

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.

'*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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Updated literature review on women's experiences

The literature search was re-run in August 2023, to include all studies published from February 2020 to August 2023 inclusive, using the same search terms and databases as in the publication. I limited the search to peer-reviewed qualitative research in English, that was conducted in high-income countries. A search was conducted of Medline, EMBASE, PsycINFO, CINAHL, and the Maternity and the Infant Care database, using the 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*. Research papers frequently use the terms *asylum seeker* and *refugee interchangeably*, and so both terms were used to include all relevant papers. Three studies were found to supplement the eight in the published article, two were published in the UK and one in Denmark. Refer to the table below (Table 2:1) which lists the studies included in the updated review of the literature on the maternity experiences of women seeking asylum in high income countries.

The impact of destitution on pregnancy for women seeking asylum, such as homelessness and insufficient food, was reported (Ellul, 2020). None of the literature included in the published meta-ethnography explored this issue in as much depth, except for one study in Germany (Gewalt et al., 2019), which examined the impact of the social determinants of health upon pregnancy. For example, not having enough money for food and being homeless impacted women's experience of pregnancy and led to poor mental and physical health. Furthermore, the worry of having to pay for maternity care was a concern for women who were destitute (Funge et al., 2020).

The isolation experienced by women seeking asylum is a key finding of my published literature review on this topic (Frank et al., 2021). Women talked about being isolated, afraid and feeling anxious (Ellul, 2020). The lack of support women have during pregnancy and labour magnifies their experience of isolation (Lephard & Haith-Cooper, 2016). The feeling of isolation when pregnant and seeking asylum was an underlying issue across many studies in the literature review (Tobin et al., 2014b).

Delays in seeking maternity care occurred due to the challenge of negotiating fees, fear of incurring costs and, for undocumented migrants, a fear of being deported (Funge et al.,

2020). Being deported was a major concern for women, who feared that by attending antenatal appointments, they may be identified by the health system and subsequently, by government authorities. This fear often resulted in women delaying their pregnancy care and labour support (Funge et al., 2020), which is a significant problem that leads to poorer perinatal outcomes (Nellums et al., 2021). This finding was consistent with findings from past studies by Barkensjo (2018) and Feldman (2014), as discussed in the published literature review (Frank et al., 2021).

Women experienced positive maternity care experiences when they felt safe with services that provided free maternity care and would not report them to authorities (Funge et al., 2020). For other women seeking asylum, a positive maternity experience was felt when there was a safe and trusting relationship with their midwife (Barkensjo et al., 2018). Midwives providing empathic care in the context of a trusting relationship with women seeking asylum was consistent with the findings of the published literature review (Frank et al., 2021).

Table 2.1: Updated review of literature on maternity experiences of women seeking asylum: List of included papers

Author, date, country	Aims	Methods	Cohort	Themes	Subthemes
Ellul et al., 2020, UK	Exploring forced migrants' experiences of being pregnant and destitute.	Hermeneutic phenomenological study: semi-structured interviews.	Forced migrants include asylum seekers, refugees and people who have been trafficked.	Having nothing, A place to call home Suffering physical and mental health Searching for support	
Funge et al., 2020, Denmark	Exploring undocumented migrants experiences of access to maternity care	Qualitative: semi-structured interviews.	21 undocumented migrants	Access to public versus private maternity services Perceptions of care entitlement Feeling dependent	Fear of deportation, Uncertainty about payment Wishing for fair treatment Support and dependency on Red Cross
Nellums et al., 2021, UK	To investigate the experiences of undocumented migrants and their access to health care.	Qualitative: in -depth semi-structured interviews.	20 undocumented migrants	Powerlessness and lack of control of access to care, Interconnected stressors The ongoing cycle of insecurity	

Review of the literature on experiences of midwives and midwifery students caring for women seeking asylum

A literature review to explore the experiences of midwives and midwifery students was conducted in August 2023. It included qualitative research published from February 2000 to August 2023, in high-income countries. The literature search included studies using the following search terms: *midwife*, *midwifery student*, *asylum seeker*, *refugee* or *undocumented migrant*, and was limited to peer-reviewed research in English. The search was conducted in the following databases: Medline, EMBASE, PsycINFO, CINAHL, and Maternity and Infant Care. Six studies were identified, as per Table 2.2 that lists the studies included in the review of the literature relating to the midwives and midwifery students' experiences of caring for women seeking asylum.

Language barriers were a common theme in research about providing maternity care for women seeking asylum (Letley, 2022), an issue that led to inadequacies in seeking informed consent and difficulty in providing education (Kurth, 2010). Some midwives spoke of using hand signals in labour to indicate instructions, and the difficulties of knowing if the woman understood what was being communicated (Tobin & Murphy-Lawless, 2014a). Despite the efforts of the health professionals, it was frustrating when an interpreter was unavailable due to costs or lack of time to organise the service (Tobin & Murphy-Lawless, 2014a). Thus, it was challenging to connect with a woman without the assistance of an interpreter (Leppala et al., 2020), leading further to her marginalisation (Letley, 2022).

The discriminatory attitudes of midwives caring for disadvantaged women (Letley, 2022) was identified in the literature. Furthermore, the impact of UK government policy and media bias discouraged empathy with people seeking asylum (Haith-Cooper & Bradshaw, 2013). The 'othering' language used by midwives resulted from a lack of knowledge about people seeking asylum, that described them as separate, leading to discrimination, and the antithesis of woman-centred care (Tobin & Murphy-Lawless, 2014a). For example, midwifery students wrongly thought people seeking asylum were of criminal persuasion (Haith-Cooper & Bradshaw, 2013, part 1). One student suggested that people seeking asylum lied to stay in the UK for purely economic reasons (Haith-Cooper & Bradshaw, 2013, part 1). Furthermore, discriminatory attitudes were reflected in the

attitudes and discourse of the managerial model in which the midwifery students undertook clinical placements (Haith-Cooper & Bradshaw, 2013, part 2).

Midwives felt they needed more training to be confident in supporting women seeking asylum who had complex social needs (Tobin and Murphy-Lawless, 2014a; Cross-Sudworth, 2015). Some midwives lacked awareness of the supports available for these women (Cross-Sudworth, 2015; Voldner et al., 2023). Irish midwives felt unprepared for dealing with the complex needs of loss and loneliness experienced by women seeking asylum (Tobin & Murphy-Lawless, 2014a). The paper by Tobin & Murphy-Lawless (2014a) suggested that understanding the complexity of the social, emotional and psychological issues facing asylum-seeking women may change attitudes of midwives from discriminatory to empathic.

The emotional cost of caring for women seeking asylum was significant for midwives, who at times felt a sense of sadness and powerlessness. The emotional cost of caring was a consequence of their compassion and empathy for the situation and of hearing the stories of these disadvantaged women (Voldner et al., 2023). Poor organisational support and a lack of debriefing also contributed to the sense of powerlessness for the midwives (Tobin & Murphy-Lawless, 2014a).

These six studies highlighted the experiences of midwives and midwifery students in the UK and Europe. Communication difficulties were common, due to difficulties engaging interpreters. A confronting theme was the discrimination and racism, from midwifery students and midwives, towards people seeking asylum. Midwives acknowledged they needed training to confidently address social issues for women seeking asylum and refer them to appropriate services. To my knowledge, no such research regarding the experiences of midwives or midwifery students caring for women seeking asylum has been conducted in Australia.

Table 2.2: Review of the literature on midwives' experiences of caring for women seeking asylum: List of included studies

Author, date and country	Aims	Methods	Cohort	Themes	Subthemes
Cross-Sudworth et al., 2015, UK	To investigate community midwives supporting women with complex social needs	Qualitative: questionnaires	213 community midwives	Routine midwifery care Social care Attitudes towards social care	Advocate: going the extra mile Unwanted time-consuming additional role Intentionally ignoring
Haith-Cooper & Bradshaw, 2013, part 1, UK	To identify dominant discourses that influence midwifery students' attitudes to people seeking asylum	Qualitative: focus groups	30 midwifery students	The asylum seeker as different Asylum seeker as criminal Questioning dominant discourses	N/A
Haith-Cooper & Bradshaw, 2013, part 2, UK	To explore how midwifery students approach care to women seeking asylum	Qualitative: focus groups	11 midwifery students (from part 1 of the study above)	Medical discourse Managerial discourse Midwifery discourse The context of care	N/A
Kurth et al., 2010, Switzerland	To investigate health care for asylum seekers by health professionals	Mixed methods	3 midwives	Language barriers Conflicting roles Coping with tragic stories	
Tobin & Murphy-Lawless, 2014, UK	To explore midwives' experiences of caring for women seeking asylum	Qualitative: group and individual interviews	10 midwives	Barriers to communication Knowledge of services Understanding cultural differences Emotional cost of caring	Lack of interpreters and services Lack of informed consent Increased workload Frustration Feelings of empathy, concern and powerlessness
Voldner et al., 2023, Norway	To explore community midwives' experiences of caring for undocumented migrants	Qualitative: semi-structured individual interviews	10 community midwives	Finding strategies to support undocumented migrants Lack of continuity of care Lack of trust Having to pay	

Review of the literature on the experiences of doulas and volunteers caring for women seeking asylum

A review of the literature related to the experiences of doulas and volunteers providing care to women seeking asylum in high-income countries was conducted in August 2023. The literature search included studies published from January 2000 to August 2023. The following search terms were used: *doula*, *birth attendant*, *volunteer*, *asylum seeker*, *refugee* or *undocumented migrant*. I limited the search to qualitative peer-reviewed research in English, from high-income countries. The search was conducted in the following databases: Medline, EMBASE, PsycINFO, CINAHL and Maternity and Infant Care. No studies were identified specifically focusing on doulas supporting women seeking asylum in HICs. Studies combined migrants, refugees, and people seeking asylum as one group that could not be disaggregated. Studies referred to doulas or cultural volunteer maternity guides in the health system. These studies were excluded as they combined refugees and women seeking asylum in the one cohort, making it impossible to synthesise findings on women seeking asylum.

My research will include data from interviews with volunteer doulas from *BfH* in Australia, and will be described in the methods and findings chapters. As far as I am aware, no research has been conducted into the maternity experiences of women seeking asylum, (as distinct from migrants and refugees), who received doula support in Australia.

Conclusion

This chapter reviews the existing literature on the experiences of women seeking asylum, and the experiences of the midwives and doulas and volunteers who cared for them. The published meta-ethnography included in the chapter provides a synthesis of the literature on women's experiences up until 2019, which informed the development of the research question. This chapter forms a background to the findings by synthesising research from high-income countries of the experiences of women seeking asylum, and the midwives and doulas caring for them. The next chapter will explain the methodology, theoretical perspectives, and methods employed in this research, including the ethical considerations.

Chapter 3: Methods

> *Stooped and suffering, bearing children, scant belongings, or unimaginable emotional loads, she has trodden an unending path across our screens and pages.*
>
> (Ball, 2021. p. 3).

Introduction

Through my research, I aimed to gain a better understanding of the experiences of women who were seeking asylum in Australia whilst pregnant, giving birth and in their postnatal period. In this chapter, I will discuss the epistemology, the theoretical perspectives, methodology, and methods that have framed my research. This will include identifying the theoretical underpinning of the research in Section A, and the methods I employed, including ethical considerations, in Section B.

Research questions

I sought to explore the following questions:

- What are the experiences of maternity care and the relative needs of women who seek asylum in Australia?
- What are the barriers to accessing maternity care for women who seek asylum in Australia?
- How do midwives and doulas identify and care for pregnant women who seek asylum in Australia?

Section A: Epistemology

Epistemology has been described as a way of understanding and explaining what we comprehend and the significance we associate with that information (Crotty, 1998a). In order to meet this definition in terms of exploring the maternity care experiences of women seeking asylum in Australia, I used a constructivist approach to address the research questions. Constructivism explores individual meaning within the relevant social context as well as 'the meaning we place on that knowledge' (Kelly et al., 2018, p. 11). In essence, constructivism tries to understand the meaning that participants ascribe to their thoughts, feelings, and perceptions (Durham et al., 2015). Hence, constructivism is

aligned with the research questions of this study, including my intention to explore the depth of human experience, and the complex perspectives of the women seeking asylum, and those of the doulas and midwives supporting and caring for them.

Theoretical perspectives

I have been mindful of feminist perspectives in order to theoretically ground the methodology of this research (Pernecky, 2016). Whilst a constructivist approach addresses social, cultural, and historical meanings in order to understand the human experience (Kim, 2014), I am aware that knowledge also needs to be informed by an understanding of gendered forms of social and political oppression (Pitts, 2018). The patriarchal world oppresses women through cultural, social, and political institutions as highlighted by Kelly and Gurr (2020), who proposed that a feminist approach to social constructivism involves emphasising that gender categories and expectations are created by society and vary over time and place. Feminist theoretical perspectives enabled me to consider the inequalities in health care experienced by women seeking asylum (Kelly & Gurr, 2020), whilst attempting to understand the invisibility and distortion of the female experience (Ogle, 2004). This is particularly important when understanding the experiences of women seeking asylum. Women's voices have often been excluded in gender-neutral refugee research, which assumes the homogeneity of the asylum seeker experience, rather than experiences of women (Kalt et al., 2013).

In my research, I have documented asylum-seeking women's experiences of maternity care using their own words, in an attempt to bring to life a sense of their resilience and strength, as well as to identify the challenges they have faced. Whilst the maternity experiences of women seeking asylum have been explored in the UK using phenomenology (Lephard & Haith Cooper, 2016), and in Denmark (Funge et al., 2020) and Ireland using narrative analysis of childbirth narratives (Tobin et al., 2014b), as far as I am aware, this is the first time that research, in Australia, has allowed the stories of pregnancy, birth, and the postnatal period to be told by women seeking asylum.

In a feminist approach, social researchers have a role in highlighting the potential ways in which gender and power imbalances can affect the relationship between the researcher and research participants (Kelly & Gurr, 2020). I have therefore practised reflexivity, both personally and in discussions with my supervisors, in an attempt to understand how my

own identity and experiences may have shaped the research, including how participants may have been affected by a perceived position of my power as a researcher (Kelly & Gurr, 2020).

My research can be seen as inevitably gendered because I engaged with it, at each stage, through a feminist lens. This was informed by my identified commitment to promoting social justice for marginalised women (Oakley, 2015) in the work I have been engaged in throughout my midwifery career. My own journey in the feminist profession of midwifery (Leap, 2009) has focused my interest on the stories of mothers, with their struggles and resilience (Oakley, 2015). Through critical self-reflection, I have been able to explore the impact of how I identify as a midwife, woman, and mother, which has enabled my understanding of key social categories related to feminism and patriarchal power dynamics. This process has also promoted my empathising with the research participants, all of whom were women and the majority of whom were mothers (Vogl et al., 2019).

Methodology

Refugee research crosses many disciplines — such as public health, nursing and midwifery, medicine, law, and media — which provides richness but also complexity when choosing the methodological approach of the research (Gifford et al., 2007). I was aware of the need to employ a methodology that would allow me to understand the barriers that women seeking asylum face in accessing maternity care, while at the same time reveal the complexity and heterogeneity of their experiences, through listening to and analysing their stories in a way that is not defined by stereotypical homogenous life experiences (Lennette, 2019). Furthermore, it was necessary to draw on feminist understandings of 'the lived experiences' of my participants. With these considerations in mind, I decided that a phenomenological approach suited the study questions, due to its potential to highlight the meaning and patterns of the lived experiences of women through the study of their conscious interpretations and reflections (Van Manen, 2017).

Phenomenology was initially a philosophical approach that was developed into a research methodology by Husserl, and later by Heidegger (Holloway & Wheeler, 2016). According to the theories of Husserl, upon which phenomenology is based, the perspective of the researcher should be set aside, allowing the research question to be understood without assumptions (Thomson et al., 2011). Rather than this initial approach of Husserl, I decided

to use Heidegger's understanding of phenomenology which aims to 'bridle' rather than 'bracket' the researcher's perspectives, encouraging a respectful approach that does not dominate the research process (Dowling, 2011). Heidegger described his philosophy of phenomenology poetically as an unfolding or unveiling of the multi-layered lived experience (Crotty, 1998b).

Significantly, the lived experience of participants and the meanings ascribed to those experiences are specific to time, place, and context and may change, based on the characteristics of the researcher and participants (McConnell-Henry et al., 2011). Hermeneutic phenomenology allows for these considerations to be studied, including how experiences, traditions and culture can shape the individual meaning participants ascribe to their unique life stories. This adds an interpretive element to the research and an opportunity to explain the richness of the lived experience of participants (Ajjawi & Higgs, 2007).

Phenomenology can play an important role when attempting to enable alternative voices to be heard (Ball, 2022), a concept referred to by Nelms (2014) as breaking the silence of the forgotten. This is significant in efforts to enable the voices of marginalised women to be heard and their essential meaning to be understood (Ball, 2022; Kleiman, 2015; Turkmani, 2020). The marginalised women in this study were asylum-seeking women. I used a phenomenological approach with a view to enable their voices to be heard and to bring to light their experiences of engaging with maternity services in Australia, something that has been missing in Australian research.

I have used the first person in this thesis in order to bring my voice to the research (Braun & Clarke, 2021) and to show how I have situated myself within the research, including personal reflections on my values, attitudes, and opinions (Webb, 1992). I recognise that reflexivity is an essential task of the researcher in order to hear the stories of participants without preconceptions, whilst recognising how our own experiences will affect the way we engage with the research process at every turn. The stories of participants can be heard in an attitude of 'experiencing wonder' by giving full attention to and being open to the existence of numerous options (Kleiman, 2015, p. 12). This attitude of giving participants full attention can enlarge and deepen the research experience, enabling the researcher to connect with neglected or unspoken aspects of the lived individual experience (Nelms, 2014). Reflexivity also demands that the researcher explores their own perspectives as

well as those of the participants and is aware of the complex interplay between them (Rossman, 2017). With this in mind, I consciously attempted to be sensitive to the multiple perspectives of participants during interviews and in my analysis of the data, whilst identifying how my own perspectives, beliefs, and values might help or hinder that process.

Thoughtful discussion with the supervision team allowed me to explore these issues and unpack the layering and context of the lived experience of each participant, whilst being aware of the intersections with my own lived experiences when carrying out the research. This included discussing the social interaction I had with participants, which felt emotionally heavy at times. In addition to reflecting on this with my supervisory team and through journaling and taking field notes, I participated in art therapy, which often uncovered new insights by exploring a creative experience. Often reflecting on the journey with my friends and colleagues provided immense support and encouragement.

The following sections will outline the methods I employed in this research and the ethical considerations that played an important role at every stage.

Section B: Methods

My research explored the maternity experiences of women seeking asylum and undocumented migrants, and the experiences of midwives and doulas caring for them, using individual in-depth interviews. Table 3.1 provides an outline of the methods used in each stage of the research process, which will be described fully below.

Table 3.1: Outline of methods

1.	Following ethics approval, recruitment of participants took place using snowball sampling.
2.	Individual interviews were audio-recorded, and extensive notes written.
3.	Demographics were entered in an Excel spreadsheet and de-identified.
4.	Interviews were transcribed from audio to notes using Otter.ai (an online transcribing artificial intelligence program). Errors in transcription were corrected and data was checked to ensure de-identification. (Steps 1–4 were repeated where participants were interviewed twice.)
5.	Interview transcriptions were entered into the NVivo 12 software program to highlight repeated points, and to code and map findings.
6.	Codes and findings were discussed with the research team, and linkages and connections between codes enabled themes and subthemes to be developed.

Ethics approvals

An initial ethics application was approved by the Medical Research Ethics Committee at the University of Technology Sydney, in August 2020. Amendments were made to this application on two occasions. Due to difficulties recruiting participants during the COVID-19 pandemic restrictions, midwifery students who volunteered at *BfH* and midwives who were currently caring for women seeking asylum, or who had done so in the past five years, were added to the inclusion criteria.

In February 2021, an approved application for amendment allowed in-person interviews to be added to telephone interviews or interviews via an online platform, such as Zoom. I applied for this amendment at a time when the COVID-19 lockdown restrictions in Melbourne had temporarily eased. The amendment enabled me to conduct some interviews in person, which enabled a deeper level of trust and engagement during the interviews. In July 2021, a second ethics amendment added undocumented migrants to the inclusion criteria. I was experiencing difficulties recruiting a sufficient number of women seeking asylum when a midwife working in a rural health service provided me with an opportunity to invite pregnant undocumented migrants to participate in this study. The midwife referred to the women as ‘asylum seekers’ because they were either in the process of applying for asylum or planning to do so, even though technically they were undocumented migrants.

All of these ethics amendments were significant in enabling recruitment. Ethics approval letters are found in Appendices 2,3 and 4 .

Recruitment

Recruitment for this study was undertaken by inviting participation through relevant agencies, contacts and social media, followed by snowball sampling. Snowball sampling is a process that occurs when the researcher accesses participants through contacts from other participants, and then repeats the process to access more people (Noy, 2008).

Recruitment of midwives and doulas

The difficulties I experienced in recruitment due to the impact of COVID-19 have been discussed in Chapter 1. When planning this research, it was envisaged that midwives working in hospital settings would recruit women seeking asylum by giving them information about the research. However, due to the COVID-19 pandemic restrictions and resultant lockdowns in 2020–2021, all research was discontinued by Melbourne hospitals. Restrictions limited the number of people allowed to enter the hospital to engage in research activity, and thus recruitment of women seeking asylum mainly occurred through midwives and doulas in community settings and through key informants in the community agencies supporting asylum-seeking women. Flyers explaining the research were placed in these agencies and shared by staff with potential participants in their first language.

Midwives, midwifery students, and doulas were invited to participate in this study. The inclusion criteria were that they were a midwife, midwifery student, or doula, and that they were caring for women seeking asylum or undocumented migrants during pregnancy, labour, or the postnatal period, or that they had been doing so in the past five years.

Initially, I promoted my research through contacts in my own midwifery social media groups, and through emailing and telephoning services providing health care for women seeking asylum. These contacts were asked to suggest others who might be willing to engage with my research, as were participants. An advertisement was placed in the social media pages and newsletter of the Australian College of Midwives. Information about the

study and an invitation to participate were also emailed to all members of the College (refer to Appendix 5).

The recruitment of the majority of doulas was through *BfH* staff, who emailed the study information to their volunteer team. *BfH* is a non-government organisation in Melbourne that provides volunteer doula support for disadvantaged women during pregnancy, birth, and the postnatal journey. The plan was to use snowball sampling so that *BfH* doula participants would invite other doulas or women seeking asylum who they were supporting, or had supported, to participate in the study. However, due to COVID-19 restrictions, the doulas' support was limited to telephone calls with women and this made it very difficult for them to build a trusting relationship and to invite women to participate in the research.

I was known to the organisation *BfH* as I had previously worked as their volunteer coordinator in Melbourne. Following initial emails and phone conversations, I wrote to the board of *BfH* and received permission to recruit doulas who were interested in the research. Following each interview, the doulas were asked if they knew of any women seeking asylum who might be interested in participating in the research.

Gag order

The *Australian Border Force Act 2015* threatened health professionals with two years' incarceration for speaking about their work in Australian detention centres. The High Court Challenge (2016) to the Border Force Act, led by Doctors for Refugees, was successful, allowing health professionals to speak of concerns regarding health care of their patients in detention centres. However, the sense of threat remained for many midwives, who were reluctant to speak about their work in Australian detention centres, due to their uncertainty of the legal situation and fear of imprisonment. This proposed a challenge for me as a researcher, as midwives who had cared for women seeking asylum in Nauru declined to be interviewed due to fear of legal ramifications known as the *chilling effect*. The chilling effect is defined as when a law discourages discussion or limits freedom (Turner, 2006).

Conflicting information was found, it was unclear whether, as the researcher, I may risk legal action for interviewing midwives about their role in detention centres. The *ANMF* lawyers were approached who stated that they could not provide me with any advice, and

neither could they advise any midwives who were to be interviewed. After several enquiries I discussed the issue with a lawyer who was involved in the *Doctors for refugees* case (Kaldor Centre for Refugee Law, 2018). They advised me that speaking to midwives about their experience caring for women in detention centres in the context of academic research was not high risk.

The purpose of the legal investigation was to enable me to interview midwives who had previously worked in detention centres. They justifiably needed reassurance that they were allowed to speak about their experience without threat of incarceration. This enquiry took a considerable amount of time and delayed the recruitment of midwives in my research. Furthermore, I was gravely concerned that these midwives may be traumatised by their experience, and that they may fear speaking about it. Their stories should be told, and not shielded in secrecy by government attempts to hide the outrageous breaches of human rights occurring in Australia.

Recruitment of asylum-seeking women

Women who identified as currently seeking asylum or who were undocumented migrants were included in the study if they were pregnant or had had a baby in the past 12 months in Australia. Cultural background, country of origin, or English as a second language, were not a basis for exclusion from the study. There was uncertainty regarding the legal status of some women who were referred by agencies and midwives. Consequently, several women who were referred as potential participants were excluded because it became apparent that they were refugees or international students when a phone or an in-person discussion occurred, prior to the interview.

I contacted *Cabrini Asylum Seeker and Refugee Health Hub*, in Melbourne and met with the clinic nurse, who subsequently recruited a number of women, by verbally reading the information sheet to the women. Two community health services in Victoria and New South Wales, where I interviewed midwives, referred women seeking asylum. In addition, midwives referred women through a community health service supporting asylum seekers in Melbourne.

Snowball sampling was also used in my attempts to recruit women seeking asylum. Initially, midwives who were participating in the research were asked to invite women seeking asylum if they would like to participate in the interviews. If a woman seeking

asylum was interviewed, she was invited to recruit a friend to the study, if it was appropriate in their situation.

In an attempt to ensure women would be comfortable with the research, I employed a bicultural doula to assist me with the challenges of recruitment, and to work with me during telephone interviews with women. The bicultural doula enabled the recruitment of four women and developed a positive rapport with the women who were interviewed over the telephone. However, due to the increased demand in her regular employment during the COVID-19 pandemic, she was only available for a few months. Following this, I attempted to recruit another bicultural doula, but none were available. Hence the recruitment slowed again, however snowball sampling ensured that there was some ongoing recruitment, due to the efforts of case managers and refugee health nurses in community agencies.

Based on the ethical considerations of privacy and confidentiality, specifically for undocumented migrants who may technically be working illegally in Australia, I requested verbal consent rather than written consent from women for the interviews. To ensure the information already given to them was understood, I gave potential research participants a verbal explanation and a Participant Information Sheet, in the form of a plain language written statement to describe the purpose of the research. A consent form was developed in uncomplicated English, translated into eight different languages, and interpreted where required to ensure informed consent (see Appendices 6 and 7).

During the process of obtaining verbal consent, I stated clearly that participants could withdraw from the interview at any time and that participation or withdrawal would not affect their visa application (Tobin et al., 2014b). In addition, I stated that I would have no influence on the visa determination of the participants, as previous studies have noted that this is important to ensure transparency and reduce any false expectations (Feldman, 2014).

Data Collection

Target numbers for this research were difficult to predetermine because, in qualitative research, recruitment usually continues until data saturation occurs (Nelms, 2014). Based on similar phenomenological research (Lephard & Haith-Cooper, 2016), the goal was to interview 9–20 women who were seeking asylum or undocumented migrants, and 15–20

midwives and doulas. I discussed data saturation with my supervisory team and based on the quality of the data I had obtained through interviewing women, we decided that saturation had been reached at 13 interviews.

In similar studies in the UK, participants were interviewed on a number of occasions to facilitate the building of trust and enhance further discussion (Briscoe & Lavender, 2009; Goodwin et al., 2018). Due to the time limitations of my research, a decision was made to carry out two interviews with each participant who was a woman seeking asylum or undocumented migrant: one during pregnancy and one in the first year after their baby was born. This would allow them to add to the initial interview about their experiences during pregnancy, with reflections on their labour, birth, and postnatal journey up to 12 months after their baby was born.

Prior to the commencement of the interviews, all participants were asked if they had read the information sheet and whether they would like to ask any questions. I read the information sheet and consent form to the participant when this was necessary. The majority of midwives and doulas provided verbal consent, and a few provided written consent. No interviews were conducted without consent. A recording of the verbal consent was taken and transcribed with each of the interviews.

I interviewed nine of the 13 women participants on two occasions: once during pregnancy and once after the birth. This allowed them to add to their interviews based on their experience during the pregnancy and again up to 12 months after their baby was born. Three women were unable to be contacted for a second interview, and it was not appropriate to ask one woman because her baby was stillborn.

Interviews were conducted in the homes of asylum-seeking women or in community venues, based on the preference of each participant, over a period of 14 months between October 2020 and December 2021. Initially, I planned interviews to be conducted in the participants' homes when the partner might also want to participate in the interview. The second interview was intended to be over the telephone or an online platform, such as Zoom, if the participant preferred. However, none of the participants seeking asylum could access an online meeting platform and subsequently most interviews involved a three-way conversation over the telephone with an interpreter. Quality recording of phone interviews was poor for a few interviews and therefore my extensive handwritten notes

were used to supplement the poor transcriptions. On one occasion, an interpreter was unavailable in the preferred language, and so the interview was rescheduled.

Seventeen midwives and nine doulas were interviewed, each on one occasion. After discussion with my supervisory team and based on the quality of the interviews, it was decided that data saturation was reached after 24 interviews. Two more interviews were conducted with midwives and doulas to confirm data saturation.

Interviews with midwives and doulas were primarily conducted on online meeting platforms, with a few conducted by phone or face-to-face in their homes. I interviewed four midwife participants from NSW and Queensland via the online Zoom platform, which provided the option to audio record interviews with consent. Two doulas were also interviewed in person in their own home.

Three women seeking asylum were interviewed from New South Wales. Whilst most interviews with women seeking asylum and undocumented migrants were conducted via telephone between the COVID-19 lockdowns, a number of in-person interviews were conducted in rural Victoria. I was able to interview four of the women seeking asylum in their homes and one at her local shopping centre, and three undocumented migrants at their local health service.

Table 3.2 details the number of women seeking asylum and undocumented migrants interviewed, whether an interpreter was used and the location of the interviews. Table 3.3 details the location of the interviews with midwives and doulas and whether they were in person or online.

Table 3.2

Interview details: Women seeking asylum and undocumented migrants

Interview details	Women seeking asylum (n=10)	Undocumented migrants (n=3)
In-person interviews	5	3
Telephone interviews	5	0
Interpreter required	7	3
Professional interpreter used	7	1
Location	3 family home 1 home of the doula 1 shopping centre 5 telephone	3 community health service

Table 3.3

Interview details: Midwives and doulas

Details of interviews	Midwives	Doulas
Number	17	9
Location	10 Melbourne 3 Regional or Rural Victoria 3 Sydney, NSW 1 Brisbane, Queensland	9 Melbourne
In-person, telephone or online interview	Online or telephone: 16 In person: 1	Online or telephone: 7 In person: 2

Interviews with asylum-seeking women

People who seek asylum are considered a disadvantaged population whose human rights have been infringed and denied. I was aware that it might be challenging for participants to provide informed consent and to discuss their experiences for a number of reasons, including fear of deportation and the potential risks of engaging with bureaucracies.

Many women seeking asylum have experienced gendered violence in their country of origin, in their migration journey, or in detention centres in their host country (Kalt et al., 2013). Furthermore, violence that targets women, such as female genital cutting (FGC)

(Turkmani et al., 2018) or rape, can be the impetus for women to flee their country (Ball, 2022). As a result of such experiences, asylum-seeking women may have post-traumatic stress disorder (PTSD) and be at risk of further traumatisation when being asked to discuss their experiences (Zion et al., 2010). I considered it unethical to ask participants about their history of trauma or gendered violence due to the potential harm it might cause them in retelling their stories. With that in mind, I attempted to create a safety net, allowing women to choose what information they disclosed.

As a midwife with experience of working with refugees and asylum-seeking women, I was careful not to ask questions that might trigger past trauma. For example, I did not ask questions regarding the reason for leaving their country, or details about their family in their country of origin, or their experiences of gender-based violence (Kaplan, 1998). I made sure participants were aware that they did not have to disclose any personal information they felt uncomfortable with sharing, nor did they need to explain why they preferred not to impart this information. Furthermore, I developed distress protocols (see Appendices 14, 15 and 16), a disclosure of illegal activity and victimisation protocol (see Appendix 17), and a COVID-19 safe risk assessment (not included in the appendices).

I asked demographic questions such as the number of years women had been in Australia (see Appendix 10). To ensure confidentiality and privacy, consideration was made of potential identifiers — such as names, demographics and hospital names —which were all deleted from the transcriptions. The demographic details of the participants are documented in the following chapter. As required by UTS research protocols, the interview transcripts were kept in a secure online cloud-based data file. I changed the names of all participants; this will be discussed in Introduction to the Findings in Chapter 4.

A plan was in place so that if an interviewee became distressed, I would stop the interview and ask her if she wished to terminate the interview or be referred to a support service. This process is detailed further in the 'Distress protocol: Women seeking asylum during the perinatal period' in Appendix 14. If the woman had been recruited through a community agency, she would be referred to *Foundation House* (Foundation House, 2017), in Melbourne, or *Service for the treatment and rehabilitation of torture and trauma survivors*, (STARTTS, n.d.) in Sydney. Both of these organisations provide counselling

and support for victims of torture and trauma. No interviews were terminated as a result of participant distress and no referrals were required.

The services of a female interpreter or a bicultural worker were offered to women who agreed to participate in interviews, with respect and regard for their potential cultural preferences. The bicultural worker was also bound by confidentiality and signed a position description detailing the privacy expectations. I used a number of prompts to facilitate the interviews (see Appendices 10 and 11).

I planned to engage in in-depth, semi-structured interviews with women in an attempt to allow them to speak without limitations about their experiences. Women who had English as a second language were offered an interpreter with the hope that this might enable them to participate meaningfully in the research. Some women sent photographs of their baby and others allowed me to take a photograph of their baby after their second in-person interview. The photograph was used to initiate the conversation in their second interview and convey warmth. All photographs taken of the babies were only used in the context of the interview and were deleted later to respect privacy and confidentiality.

I offered prompts to facilitate a more conversational style during the interviews. The participants appeared to enjoy my warmth and interest in their baby, which helped me to build rapport and facilitated me asking questions. Based on my years of midwifery experience, I have learnt that an openness to discussing experiences, an interest in the lives of the participants, and responsiveness to their stories are all conducive to building trust and rapport. This approach is supported in the literature by Oakley (2015).

During the interview, a gift card of $25 was offered to the women as a small gesture to thank participants for their time. This was funded through the Epworth Centenary Scholarship which was awarded and administered by the *Australian Nurses Memorial Fund*. In addition, I contacted *St Kilda Mums*, in Melbourne, which is a non-government organisation which provided items such as toiletries, baby clothes and nappies (St Kilda Mums, 2020). *Thornbury Church of Christ Foodbank* provided food boxes for participants experiencing financial difficulty who were interviewed in person. The toiletries, baby clothes, nappies and food boxes were given to participants during the in-person interviews as a small gesture of thanks to the women seeking asylum.

Challenges encountered when interviewing women seeking asylum

I encountered various challenges when interviewing women seeking asylum. A variation in interpreter quality was one of these, with some interpreters providing responses to questions that were significantly briefer than the participant's response. It was sometimes necessary to clarify the purpose of the interview. A few women participants requested a family member or friend to interpret, and several participants were fluent in English as a second language. Thus, there were numerous challenges involved when attempting to tread a path that would gently provide a safe space to develop rapport and encourage participants to share their lived experiences.

Due to the COVID-19 lockdown restrictions, nearly all the interviews took place via telephone. Also, during the pandemic, the interpreters' services changed from face-to-face to only being available over the telephone. These restrictions made it difficult to build trust and rapport during the interviews. Three initial interviews with women seeking asylum were conducted over the telephone, and as a result, I found it difficult to build a connection as the researcher. Thus, I decided to delay the interviews with women seeking asylum until face-to-face interviews were possible after the lockdown restrictions eased.

I am aware that a challenge of conducting in-depth interviews in qualitative research is to engage fully while maintaining an emotional distance between myself as the researcher and the participant (Sandelowski, 1986). Individual experiences of the women were often emotionally heavy and at times tragic; and on reflection, at times I felt sadness when hearing of the treatment the women received in Australia and shameful about being an Australian. The strength and resilience of the women was, however, my focus, rather than dwelling on their vulnerability and ongoing challenges. Throughout, I attempted to listen attentively and hear the experiences of the women seeking asylum without preconceived ideas or responses that were based on my own experiences or emotional responses (Chan, 2010).

Interviews with midwives and doulas

Nine doulas and 17 midwives were interviewed over a 13-month period from August 2020 to September 2021. The time for each interview session ranged from 60–70 minutes. The interviews were mostly via an online platform such as Zoom, which was recorded as

audio only, to protect the privacy of participants. I asked demographic questions (Appendix 11)., such as age, and years working in the role; factors that will be presented in Chapter 4. The interview questions included prompts relating to midwives' and doulas' experiences of working with women seeking asylum (refer to Appendix 12). After the interview I offered a transcript of the interview to each midwife and doula so they could clarify any unclear statements, but only two midwives accepted this suggestion. I emailed the interview transcript to them and neither of them asked for any changes to be made.

Data analysis

The interviews with women seeking asylum were challenging to transcribe, due to the interpreter speaking with an accent or in a language other than English. The Otter.ai program also had limitations in transcribing interviews involving the use of an interpreter, which required manual editing of the transcription based on extensive notes. When I could not record a few of the telephone interviews because of a technical issue, the transcription was based on my notes taken during and immediately after the interview. Interviews with midwives were transcribed verbatim, and then checked and edited with the interview recording.

I used reflexive thematic analysis to analyse the data, based on the approach of Braun and Clarke (2021). I checked and corrected the field notes and transcriptions as soon as practical after each interview to maximise accuracy. Firstly, each recording was uploaded into an artificial intelligence transcription program, Otter.ai, which converted the recordings into text. Secondly, I corrected errors by repeated listening to interviews to check the accuracy of the transcription. This helped me to familiarise myself with the data. Thirdly, I used the NVivo 12 software program to allow me to code and map interviews efficiently. There were several steps in understanding the phenomenon of interest, where initially interviews were read as a whole and then divided into units of meaning as described in the quotations of the participants (Kleiman, 2015).

Codes were developed based on the frequency and emphasis placed on a particular issue. Then I created mind maps on notepaper which were placed on the floor and moved around to visualise the connection between codes. Thirdly, themes were generated to understand patterns of meaning (Braun & Clarke, 2021). The coding and potential theme were discussed at length with the research team, and as a result, themes and subthemes emerged

from the data. These themes were reviewed and refined until the narrative was woven together (Clarke & Braun, 2016).

In this chapter I have discussed the constructivist epistemology, feminist theoretical perspectives, phenomenological methodology, and methods I used in this research. In addition, I have detailed the study setting, recruitment, sampling, inclusion and exclusion criteria, and ethical issues and processes that I considered. I have explored the fieldwork challenges of conducting research during the COVID-19 pandemic, and shared my own reflections on the challenges I encountered when engaging with participants during interviews.

The following chapters will present the findings of the research interviews.

- Chapter 4 introduces the findings chapters and the demographics of the participants.
- Chapter 5 details the challenges of accessing maternity care for women seeking asylum.
- Chapter 6 highlights the care the midwives and doulas provided despite the challenges.
- Chapter 7 presents the recommendations made by doulas and midwives to improve maternity care for women seeking asylum.

Chapter 4: Introduction to Findings

The following three chapters present the findings of this research which explored the maternity care experiences of women seeking asylum in Australia. As identified in the previous chapter, 13 women who were seeking asylum or were undocumented migrants participated in in-depth interviews during their pregnancy. Nine women were interviewed again after giving birth. Interviews were also conducted with doulas and midwives, who had experienced working with women seeking asylum or women who were undocumented migrants.

Demographics of women participants

Thirteen women were interviewed — including ten women seeking asylum and three women who were undocumented migrants — over a period of 14 months between October 2020 and December 2021. Table 4.1 summarises the demographics of women who participated. Most of the 13 women had other children, however, for four women it was their first pregnancy. The age of the women ranged from 20–41 years, with an average age of 30. The countries of origin of the participating women seeking asylum included Iran, Pakistan, and Asia. Most of the women who were undocumented migrants were originally from the Pacific Islands. Amongst the women participants, education levels ranged from no school attendance to completion of high school. Four women had their visa applications rejected, four had expired visas, four had temporary visas, and one was in community detention with no visa.

The majority of women who were interviewed required an interpreter and, in all instances, a professional interpreter was used over the telephone. Using professional telephone interpreters was recommended by Sioti (2017) in the *Operation Refugee and Migrant Maternal Approach (ORAMMA)* Practice Guide for perinatal health care of migrant, asylum-seeking and refugee women, to ensure clear communication in a clinical setting. In instances where participants declined a professional interpreter for in-person interviews, informal interpreters, usually a family member or friend, were used. Nine of the women were interviewed on two occasions, once during their pregnancy and once after their birth. Three women were unable to be contacted for the second interview.

Some potential participants could not be recruited, as referrers who were assisting with recruitment thought it might cause women to be retraumatised or triggered by retelling the ordeals they experienced during detention. One woman was not included in a second interview, after her pregnancy was discontinued as her baby had a condition which was incompatible with life. The demographics of the women interviewed are summarised in Table 4.1.

Table 4.1

Demographics of women seeking asylum and undocumented migrants

Attribute	Women seeking asylum (n=10)	Undocumented migrants (n=3)
Age of participant	25–30 years: 6 31–35 years: 2 36–41 years: 2	25–30 years: 2 36–41 years: 1
Number of children (Including current pregnancy)	1 child: 3 2 children: 3 3 children: 3 4 children: 1	1 child: 1 2 children: 1 5 children: 1
Years in Australia (Including time spent in detention centres)	0–2 years: 3 2–3 years: 1 4–5 years: 3 8–9 years: 3	2 years: 1 3 years: 1 4 years: 1
Visa type	Rejected visa: 4 Bridging visa: 4 Community detention: 1 Expired visa: 1	Expired visa: 3
Education level	No education: 2 1–6 years school: 4 Finished high school: 4	Finished high school: 3

Demographics of the midwives and doulas

Nine doulas and 17 midwives were interviewed over a 13-month period from August 2020 to September 2021. Four participants were no longer working as midwives, preferring to work as doulas. These participants were coded in the midwife demographics because their field of expertise and perspectives were informed by their previous midwifery roles. Therefore, they will be quoted as midwives in the findings chapters

unless they are specifically referring to an experience while working as a doula. The majority of midwives were employed in the hospital setting (n=9), with six employed in a community health setting. All midwives provided antenatal care, most also provided postnatal care (n=15) and approximately half provided care in labour and birth (n=9). The average age of the midwives was 48 years and they had, on average, 17.5 years of experience in the role. Ten midwives interviewed were based in Melbourne and three in rural and regional areas across Victoria, three midwives were based in Sydney, and one midwife worked in Brisbane.

All of the doulas worked as volunteers through *BfH*, a non-government organisation in Melbourne, Australia, that supports disadvantaged women during their pregnancy, labour and birth, and postnatal journey. All doulas provided antenatal and postnatal support, and the majority also provided non-clinical assistance during labour (n=7). All the doulas interviewed were based in Melbourne and three doulas were volunteering as bicultural doulas, due to their culturally and linguistically diverse backgrounds. The average age of the doulas was 46 years, and they had an average length of experience of four years, which was significantly less than the years of experience of the midwives interviewed.

As a result of the COVID-19 pandemic lockdowns in Melbourne, the majority of interviews were conducted over an online video platform or by telephone. For privacy reasons, cameras were switched off and only audio data was recorded.

The midwives and doulas were each interviewed on one occasion. Twenty-six interviews were conducted. Data saturation was suspected after 24 interviews, and then two more interviews were conducted with midwives to confirm saturation of data. The demographics of the midwives and doulas interviewed are summarised in Table 4.2.

Table 4.2

Demographics of the midwives and doulas

Demographics	Midwives	Doulas
Number	17	9
Work environment	Hospital setting: 9 Community setting: 8 Currently work as doulas: 4	Community setting: 9
Context of caring for women seeking asylum	Antenatal care: 17 Labour and birth: 10 Postnatal: 16	Antenatal: 9 Labour and birth: 7 Postnatal: 9
Age range	20–30 years: 1 31–40 years: 3 41–50 years: 6 51+ years: 7	20–30 years: 2 31–40 years: 2 41–50 years: 1 51+ years: 4
Average years working in the role	17.5 years	4 years
Location	10 Melbourne 3 regional or rural Victoria 3 Sydney, NSW 1 Brisbane, Queensland	9 Melbourne

Table 4.3 demonstrates the contexts in which the midwives and doulas cared for women seeking asylum.

Table 4.3: Midwives and doulas context of caring for women seeking asylum

Context	Role	Continuity of care	Number
Midwife working in a single episode of care model across antenatal, labour and birth, and postnatal	Tertiary hospital – city	No	4
Midwife working in a single episode of care model	Regional hospital	No	2
Community health centre, continuity across pregnancies and between pregnancies supporting the woman's family e.g. refugee health nurse midwives	Refugee health nurse midwives – city	Yes	3
Midwife working in continuity of care model e.g. caseloading or group antenatal care	Tertiary hospital – city	Yes	2
Midwife working in a community health centre -– caring for mothers and babies in the antenatal and postnatal period	Child and family health nurse midwives – city	Yes	1
Midwife working in community health service providing antenatal, postnatal, childbirth education, and women's health clinics	Midwife and women's health nurse – rural area	Yes	1
Midwives and midwifery students who chose to work as doulas	Doulas – city	Yes	4
Doulas working in the community through *Birth for Humankind*, an organisation supporting marginalised women during their maternity journey, in a city	Doulas – city	Yes	8

The structure of the findings

Four overarching themes were constructed from the data, and these will be presented in the following three findings chapters:

Chapter 5: *Living with uncertainty*

Chapter 6: *Sisterhood: the care and support provided by midwives and doulas*

Chapter 7: *The challenges for midwives working in fragmented models of care and The importance of midwifery continuity of care*

The theme of *Living with uncertainty* is described in Chapter 5 in seven subthemes*:*

1. *Living with visa uncertainty*
2. *The impact of detention*
3. *Being unable to pay*
4. *Having no family and friends to provide support*
5. *The impact of sexual violence*
6. *Racism and disrespectful care*
7. *The challenges of ensuring clear communication with interpreters*

The first three subthemes were specific to women seeking asylum and the next four subthemes may also apply to other groups of marginalised women.

Chapter 6 will provide an overview of the theme of *Sisterhood: the care and support provided by midwives and doulas,* addressed in the following five subthemes:

1. *The doula and midwife support was like family*
2. *Midwives who chose to work as doulas*
3. *Helping women to feel safe and informed*
4. *Practical assistance: housing support and addressing transport challenges*
5. *Carrying vicarious trauma home*

Chapter 7 will introduce the findings relating to two themes:

- *The challenges for midwives working in fragmented models of care*
- *The importance of midwifery continuity of care*

The chapter provides an overview of: *The challenges for midwives working in fragmented model of care,* in the subthemes:

- *Difficulties identifying women seeking asylum*
- *Ticking every box*

The importance of midwifery continuity of care is presented in the subthemes:

- *Caseloading continuity of care in the hospital context*
- *Group antenatal care*
- *Community-based continuity with midwives*

To ensure confidentiality and privacy, I changed the names of all the participants using pseudonyms. Naming the participants was important to me, in response to the depersonalising nature of the Australian legal asylum-seeking process which identified people as a number rather than a name. In the Australian detention centres, many people seeking asylum were addressed by their boat number. It was more respectful to allocate names to the participants, to strengthen their voices in the narrative.

Table 4.4 summarises the themes and subthemes of the three findings chapters.

Table 4.4

Themes and subthemes

Chapter: Themes	Subthemes
Chapter 5 *Living with uncertainty*	*Living with visa uncertainty* *The impact of detention* *Being unable to pay* *Having no family and friends to provide support* *The impact of sexual violence* *Racism and disrespectful care* *The challenges of ensuring clear communication with interpreters* *The challenges of needing an interpreter* *Family interpreting* *Poor interpreting* *Confidentiality concerns*
Chapter 6 *Sisterhood: the care and support provided by midwives and doulas*	*The doula and midwife support was like family* *Midwives who chose to work as doulas* *'Helping women to feel safe and informed'* *Practical assistance: housing support and addressing transport challenges.* *Carrying vicarious trauma home*
Chapter 7 *The challenges for midwives working in fragmented models of care*	*Difficulties identifying women seeking asylum.* *Ticking every box*
The importance of midwifery continuity of care	*Caseloading continuity of care in the hospital context* *Group antenatal care* *Community-based continuity with midwives*

Chapter 5: Findings: Living with uncertainty

> *What is needed for a life of thinking is hope.*
> *Hope of knowing more, understanding more, being more that we currently are.*
> *We have good cause for hope.*
>
> (Jacobs, A., 2017, p. 151)

Living with visa uncertainty for an indefinite period overshadowed the lives of women seeking asylum in Australia. The average time that women in my study lived on temporary, rejected or expired visas in Australia was five years. The disempowerment of women, who have lived with visa uncertainty for years, underpinned the testimony of all participants.

Uncertainty for women seeking asylum is a thread that is woven throughout this research. Uncertainty existed regarding their financial situation. Uncertainty existed regarding their Medicare status. Uncertainty existed about their health care rights. Uncertainty existed foremost about the future of their family.

This chapter presents the first theme of the findings: *Living with uncertainty.* This theme encompasses a series of interconnected issues related to the barriers to accessing maternity care for women. Being held in detention centres or living in the community with temporary visas, without access to free health care, was associated with destitution, isolation, domestic violence, and racism. The subthemes of *Living with uncertainty* are:

- *Living with visa uncertainty*
- *The impact of detention*
- *Being unable to pay*
- *Having no family and friends to provide support*
- *The impact of sexual violence*
- *Racism and disrespectful care*
- *The challenges of ensuring clear communication with interpreters*

The challenges of ensuring clear communication with interpreters refers to the uncertainty for health care providers as to whether an interpreter will be provided at maternity care appointments, and if they will respect the women's privacy and speak the right dialect. There is uncertainty around whether family members will interpret, and whether they will understand the health care provider.

Living with visa uncertainty

The sense of uncertainty about their future that stemmed from their asylum-seeking status had a profound impact upon women and their families. Midwives and doulas reflected on the situations faced by these families, highlighting how the ongoing effects of detention, powerlessness, and visa uncertainty affected pregnant asylum-seeking women in Australia. Lack of access to Medicare, which is the public health care system in Australia that covers the cost of medical expenses, was an acute problem for women seeking asylum, one that stemmed directly from their visa uncertainty. Midwives and doulas described the protracted uncertainty, powerlessness, and financial hardship, which impacted on their access to appropriate housing, that they observed when providing continuity of care to a woman and her family:

> She has no rights; she has no power. She's currently not pregnant, but she and I have been through four or five pregnancies … All of that time she's been on a bridging visa. She's had a Medicare card but still it's been seven years, and she's still waiting to hear a judgement on her claim for asylum (Melissa, midwife).

> So much uncertainty about everything, not just the uncertainty of having a baby in that situation but, of their life [which was] very difficult (Cat, doula).

> A woman who is pregnant, no money … they had no work rights, either … They might have had their visa declined … I think they were eligible for … 64% of the normal Newstart allowance [government support]. But that's all and it wasn't even enough to live … She had to live in shared accommodation (Penny, doula).

The positionality and powerlessness of families seeking asylum meant that they were vulnerable to exploitation. The story of Eliz illustrates an example of such exploitation. Eliz and her partner, who both spoke English, arrived in Australia on a short-term working

visa to do farm work. At the time of my first interview with Eliz, her baby was only a few weeks old, her temporary visa had expired.

> My visa expired because of my agent. We gave him the money and he ran away (Eliz, woman seeking asylum).

After the agent stole her money, she could not afford to apply for a temporary visa and so was living as an undocumented migrant. Not only was Eliz left in a desperate financial position, but she was also in a tenuous legal situation. When the second interview was arranged, six months later, she had a temporary visa, which recognised her as seeking asylum. Her partner was working as a fruit picker and with access to a temporary Medicare card, they were provided with some relief from the financial pressure of medical expenses. The migration laws changed in 2023, so that some undocumented migrants who do farm work may apply for a permanent visa, however, she believed she was ineligible because she was already on a temporary visa. Although Eliz was feeling relieved by having less financial pressure, she was frustrated that she was unable to apply for a permanent visa due to the changes in immigration law in Australia that occurred at the time.

The impact of detention

The distressing impact of time spent in detention centres led to ongoing poor mental health, for many women seeking asylum. Mental health problems included depression, anxiety, and post-traumatic stress disorder. As discussed in the previous chapter, midwives and doulas, who helped recruit women for this study, thought that some women who may have been potential participants should not be interviewed. Midwives and doulas felt that disadvantaged women retelling their ordeal experienced during their journey to Australia and in detention might cause them to be retraumatised.

Midwives and doulas described women, who were in the Australian detention system, as being treated like prisoners when they were in the hospital setting, with guards accompanying them to the maternity unit.

> The mum was on her own and had two guards outside her door (Robyn, midwife).

Guards were a disturbing presence that made women seeking asylum immediately identifiable to all hospital staff. A few midwives and doulas described the presence of

guards in the birth unit and postnatal wards as an enigma. Midwife Robyn described her experience with guards:

> She had her twin babies, I think a week before arriving, yet they weren't with her. They stayed in … detention with their father and other siblings … I didn't understand why there were guards there … I think it was just protocol. In case she tried to escape, perhaps, she didn't understand any English, so it was it was difficult to communicate …. However, we realised upon walking into the room, that she didn't have anything but a small plastic bag. She didn't even have [a chair]. The guards had removed the chairs from her room …. (Robyn, midwife).

One midwife described a situation where the guards were present in the birth room, explaining that:

> They're not allowed to stand in the corridor because it's got to be accessed in case there's an emergency (Abbey, midwife).

The lack of freedom and deprivation of human rights for women in the Australian detention system created a significant barrier to accessing respectful maternity care.

Following many years in detention centres, some families seeking asylum were living in community detention, on temporary visas. Midwives spoke of the serious effects of detention on the lives of these women as lasting beyond the years they had spent incarcerated. The conditions around community detention continued to have negative effects on the mental, social, and emotional wellbeing of families. For example, Jana described the challenge of the rejected appeal for her family to be permitted to live near their friends in Australia. She was distressed that her family in community detention lacked the freedom to reside in their chosen location, due to the controls of the Australian Government Department of Immigration:

> The Immigration Department … they are responsible … We are miserable. By keeping us where we have no one to talk to … My daughter … has nobody to play with … Come … and visit … our family … we have been deprived. Very sad … Overall, not only physical, it is [also] mental. It is very, very frustrating (Jana, woman seeking asylum).

Being unable to pay

Medicare is the public health care system in Australia that partially or fully covers the cost of medical expenses, such as visiting an endorsed midwife or general practitioner (GP), receiving pathology and ultrasound tests, and being admitted to hospital (Australian Government, 2022). The high cost of maternity care without access to Medicare cover creates another stressor for asylum-seeking families, many of whom may be surviving on casual employment or little to no income. A midwife who had worked as a refugee health nurse midwife, explained that most pregnant women in her care who are seeking asylum have no access to Medicare cover:

> I work in a … [clinical] service who whose main clients … include asylum-seekers … The clients that we typically see, well I'd say 99.9% are asylum seekers without Medicare access (Rachel, midwife).

Katrina would facilitate access to free pathology tests for pregnant women who had no Medicare cover, saying:

> They can't access any pathology through the hospital service. So, they do need to go out into the community, and find the … pathology [service], that provides pro bono blood testing (Katrina, midwife).

Women without a Medicare card included those who had expired visas, or whose visa applications had been rejected by the Australian Government, and were therefore classified as undocumented migrants. Without access to Medicare the cost of maternity care in Australia was prohibitive, as one woman explained:

> It costs $16,000 to have a baby without Medicare (Freda, undocumented migrant).

Midwives wrote advocacy letters to hospitals for women without Medicare cover, explaining the woman's legal situation as an asylum seeker, and requesting that the costs of admission and treatment be waived, based on their human right to access urgent medical care. Midwife Rachel described how this was a regular part of her role as a refugee health nurse midwife:

> My role … is advocacy around health access (Rachel, midwife).

One woman expressed her appreciation of the reduced cost that resulted, saying:

> With the payment plan and reduced cost, it is much more manageable. (Freda, undocumented migrant)

Due to concerns about poor attendance in antenatal care, one community midwife negotiated discounted fees for ultrasound and pathology, and payment plans for inpatient admissions. Women described the advocacy role provided by community midwives as invaluable. When the midwives organised for them to access pathology tests, however, some still faced ongoing problems. Problems included being questioned about why they didn't have a Medicare card and whether they had private medical insurance. Women found this questioning intimidating, and they described this as a negative encounter with hospital staff. Letters of demand for payment of the hospital fees were often received by the women. Ayesha explained that she could not speak to her lawyer until she had paid the outstanding legal fee. Her two older children remained in her country of origin with a family member, which added to her distress:

> Because I don't have a Medicare card, they [the community midwife] gave me a letter. They [the clerical staff] asked me a lot of questions and I felt bad about that … for one night the room [cost] about $653 (Ayesha, seeking asylum).

Midwives were aware that financial stress caused some women to delay seeking maternity care, saying for example:

> They presented late because, [they] thought it would cost more if they went earlier for antenatal clinics (Rachel, midwife).

Midwives repeatedly emphasised the destitution of families seeking asylum and undocumented migrants when they have no visa and no access to Medicare cover. One community midwife described an incident in which she realised that family members were sharing a Medicare card:

> One of the first things that happened to make me aware [of the financial consequences for these women] was a client started using her sister-in-law's Medicare [card] (Beth, midwife).

Beth's concerns were that when women are sharing a Medicare card they may be wrongly identified and therefore not be provided with the appropriate clinical care or support. Using her sister's Medicare card could result in life threatening consequences for a woman if, for example, she has a different blood group from her sister and was given a blood transfusion.

Another woman, who was without access to Medicare cover, felt that her distress over the burden of debt was exacerbated by unhelpful advice and not being made aware of her rights. Her midwife described the situation where the woman had significant debts from her first pregnancy, due to poor advice from a GP that she should access private obstetric care:

> She was told by [her] GP when she was pregnant, to go through the private system, because she didn't have Medicare. She … borrowed a lot of money (Grace, midwife).

Midwife Grace explained how this woman was assisted by a multidisciplinary team in her subsequent pregnancy where her care was coordinated by the community midwife:

> She came to us … with a subsequent pregnancy … We were able to tell [her] her rights as an asylum seeker and advocate for her to have … care coordination with her mental health team, psychiatry team and counsellor and with a GP (Grace, midwife).

Midwives, who worked in midwifery group practices, providing continuity of care through a caseload model, knew each woman's personal situation well. They were keenly aware of the hardships for women who did not have access to Medicare cover and described being proactive about ensuring support for these women. Katrina was a midwife who had worked with women seeking asylum for many years, including providing midwifery continuity of care for the past nine years in an 'all-risk' caseload model (caring for women with low- and high-risk pregnancies). She described how she would try to allocate herself to the care of women seeking asylum:

> I would … ask the ANUM (Associate Nurse Unit Manager) if there was anyone who didn't have a Medicare card and sift through those to work out which ones were overseas students or asylum seekers (Katrina, midwife).

Women spoke of the practical support they received from midwives, which enabled them to navigate the Australian health care system, secure housing, and manage the costs of maternity care without access to Medicare cover. Mel came to Australia on a short-term visa to work on a farm picking fruit, with the goal of funding her older child's education in her country of origin. Her visa expired during the COVID-19 lockdown and therefore, she lost her access to Medicare cover. She was pregnant for the second time during our first interview. Mel was accompanied by a friend, who acted as an informal interpreter. She recalled:

> We did a payment plan … and when I had the baby … we paid off the rest … from the money that Red Cross offers (Mel, undocumented migrant).

Mel expressed her gratitude for the education and assistance she received in navigating the health service, from her midwife and a health promotion officer. When her extended family disowned Mel, based on their cultural expectations that pregnancy is only acceptable in the context of marriage, the health promotion officer offered to interpret for her. From this they developed a friendship and the health promotion officer organised accommodation and provided practical assistance and navigation through the health care system. The support that Mel received contrasted with that of her own family, who refused to bless Mel when she chose to continue her relationship with the father of her baby. Mel was crying when she described the support she received from the midwife, who had organised ambulance cover, negotiated payment plans for the hospital, and ensured discount rates for pathology and ultrasounds.

> I found the health promotion officer and the midwife [very helpful]. I would encourage people … to … seek for help and make sure they go to midwives. And … when [my] daughter will grow up [she will] understand ….all those people who have helped (Mel, undocumented migrant).

Prior to the introduction of payment plans in one area, more than 60 women per year arrived in labour at the local hospital. They then needed to be transferred to another hospital, because the local hospital had no maternity unit. The nearest maternity hospital was approximately a one-hour drive away. Due to the women having received no antenatal care, the maternity hospital had no medical records on which to base their care:

> They're having about 60 babies born at the hospital a year with no antenatal care and they just rock up here and give birth here. No [antenatal] care at all (Beth, midwife).

In contrast, after payment plans were organised, all women who gave birth in the maternity hospital had received antenatal care, making a positive difference to the safety of these women and their babies.

The community midwife helped marginalised women manage expenses, such as ambulance costs, by facilitating her clients to organise ambulance insurance, and negotiating discounted fees for pathology tests:

> To get them on the system here you have to ask [for] their Medicare number … With the pathology I have an arrangement with our local provider … we give them a rebate amount. [My motto is] 'leave no stone unturned' (Beth, Midwife).

The community midwife, Beth, provided holistic support, incorporating into her care aspects of public health initiatives, such as housing, financial support, and education in understanding the health system. Rachel, who works as a refugee health nurse midwife, explained the impact of the cost upon women's attendance for antenatal care:

> [They are] quite destitute … when someone's pregnant and having a baby … and with kids it can … impact their experience and the welfare of that family unit … [they ask me] 'Is this going to cost me any money, because we haven't got any money' (Rachel, midwife).

Doula Penny, whose background was in social work, explained the situation further:

> They're not allowed to have an income, which means that there's no regular income coming in, even though they are working for cash to survive (Penny, doula).

The impact of destitution impacted heavily on the experiences of maternity care for women seeking asylum, as they may not attend health care services when they have no access to Medicare, and they cannot afford to pay for their care.

Having no family or friends to provide support

Some women spoke about their feelings of loneliness in Australia, due to the absence of friends and family, even though they valued the support they received from midwives and doulas. They talked about the cultural norm that family, and particularly female family members, would stand beside them to provide support and celebrate the rite of passage of motherhood. One woman despaired about the lack of nurturing she received, when reflecting on her cultural expectation that family should surround her at the time of the birth:

> The nurse [midwife] came to my house to check on the babies. But there's no-one here [all the time] to help me (Jana, woman seeking asylum).

Jana's feelings of isolation and loneliness were palpable when she spoke. Jana had been incarcerated in an Australian detention centre for more than five years after arriving by boat, which may have led to a negative impact on her mental health:

> My first baby was born in Nauru [a remote island in the Pacific Ocean that houses an Australian offshore detention centre], but my mental health was not good, so I don't remember. I was transferred to Australia because my mental health was so bad. My second baby was a bit different. My mental health was good. I was in Australia. It was hard for me. We are only two people, no-one was around me, I had to go by myself to the hospital in a taxi. My husband was looking after the baby (Jana, woman seeking asylum).

Women who had arrived by plane, and hence avoided incarceration in the Australian detention centres, also felt isolated and lonely when they had no social support. Helen arrived in Australia by plane on a short-term visa without her partner, who later applied for asylum after her arrival. She emphasised:

> I don't have friends … I don't want women to go through what I went through … I want [every] woman to have lots of support and access [to services] when she's about to give birth (Helen, woman seeking asylum).

The impact of sexual violence

The distress that asylum-seeking women experienced in relation to their temporary visa status was exacerbated when they were living with domestic violence. Doulas and midwives spoke of the layers of vulnerability women experienced when they were impacted by domestic violence. They expressed concern about women remaining in violent relationships because they feared that their visa was linked to their husband, without which they might be deported. Midwife Jane described how, during a routine antenatal risk screening process for family violence, she met a woman who feared that she would have her visa cancelled if she separated from her partner. The scenario poignantly demonstrates the powerlessness the woman faced when fearing for her safety:

> I knew she was seeking asylum because she revealed … that she thought she was in danger, and then described what was going on … I thought this woman sitting before me [is] actually going to be murdered … it's been an arranged marriage … her partner is harming animals, like putting kittens in boxes and kicking them around … threatening to take the baby, threatening to kill her. And she has no idea how to resolve that situation (Jane, midwife).

Jane described how the woman was terrified of the domestic violence she suffered from her husband. She had few opportunities to leave, and Jane felt there would be limited occasions to encourage her to do so. Jane spoke about how concerning it was for her not knowing beyond this one occasion if the woman was safe or what had happened to her. In contrast, she preferred the ongoing relationships enabled by her present role as a volunteer doula, where she provided support for a woman over the course of many years and several pregnancies:

> The most amazing continuities [continuity] … after the birth of that first child with all of that situation, she got pregnant again. And she said, 'Yeah, I need Jane'. And then I rang her … And she said, 'Jane, I need you'. It was so beautiful. It shows what the doula can do (Jane, midwife, speaking about her work as a doula).

Doula, Penny, who provided continuity of support throughout the maternity journey, described how she nurtured a woman who had experienced trauma and did not want to disclose anything about herself, or to engage with social services. Penny stated:

> They don't want to put themselves at risk of having their visas declined … it was on a three-monthly basis … she was in a really fragile, vulnerable, frightened situation when I had her as my client (Penny, doula).

The following vignette demonstrates the extreme vulnerability women seeking asylum may face. As a consequence of the trauma of being pregnant as a result of rape, the woman Penny cared for wanted to be 'quiet and invisible':

> She was gang raped. And so, being pregnant, she had her own issues with what was coming up … the birth … on top of that, she was dealing with her visa … She just wanted to be quiet. She didn't want to be exposed. She didn't want anyone knowing … she wanted to be invisible (Penny, doula).

Pregnancy may be the result of sexual violence and therefore, in such cases, women are at risk of retraumatisation. The care they are provided with may influence whether or not this occurs. The following vignette demonstrates how the doula was able to support trauma-informed care:

> We're constantly trying to not have people be retraumatised especially … leading up to the birth … The client that … was gang raped, just a horrible experience for her. And so, she didn't want to talk about the vagina. She didn't want men coming in the room … And she had no idea that she could say, 'No, I don't want a vaginal examination.' No, I don't … she had to keep saying it. … At the antenatal visits … I was able to have that on her file: 'History of trauma. Please don't retraumatise her by asking her things, you must ask her for consent for everything'… That's just [a] duty of care. All that trauma-informed kind of stuff. Retraumatisation is a huge thing to try and prevent (Pauline, doula).

Racism and disrespectful care

Women seeking asylum, doulas, and midwives all shared their numerous experiences of witnessing racism and disrespectful care during hospital appointments or on the maternity wards. They spoke of comments made by hospital staff that demonstrated a culture of systemic racism. Hannah spoke of experiencing racism when attending her antenatal appointment. Hannah had fled Somalia and spent years incarcerated in an Australian offshore detention centre. When her visa expired, she applied for another one, but whilst

waiting, she temporarily had no access to Medicare. Her grandmother had died recently, and she said she was feeling very sad when she went to the hospital for an antenatal appointment. Upon arrival, she was met with xenophobic responses from an administrative staff member:

> She said to me, 'If you don't understand English just go'
> (Hannah, woman seeking asylum).

The racism and disrespectful care extended beyond the hospital services to community housing services. Doula Gill described the way in which a housing worker spoke about a woman seeking asylum who needed accommodation:

> That will encourage her to continue to ask for handouts. That's just their attitude, from that area, and you don't want to give her any more help, because she'll just keep taking those sorts of things (Gill, doula).

In the following vignette, Tabitha, a doula, described the disrespectful treatment of a woman in her care who was pregnant while in the detention prison. Compounding her PTSD was the disrespectful treatment she received, without consideration to her complex mental and emotional health issues:

> It was complete stranger care, but when the doctor did come in, she got the courage up to just say quite clearly that she wanted to book her induction in that day. And his response was, I wouldn't say ridiculing, but it … [was] very much minimising and … disrespectful … 'Well, why would you want that … there's nothing wrong with you. We don't do those sorts of things unless there's a need.' I remember feeling as a doula … really uncomfortable …. We're very powerful advocates for our clients. … His snapping at her just caused her to retreat, instantaneously … this is classic PTSD behaviour. I felt really compelled in that moment to speak out … I remember saying something like, 'Look, I'd really urge you to take a few minutes, please, to read her file. This woman is currently living in a detention centre has a very complex history, and some really specific family needs.' At that point, to his credit, he kind of just stopped in his tracks, and I could see that he had been forced to go from his autopilot kind of approach, which is seeing women like … tick, click, click, click all day (Tabitha, doula).

Racist comments made by hospital staff frequently appeared to be left unchallenged. One midwife described comments made by doctors and midwives about women who are seeking asylum as, *'Here's someone else that wants something from us'* (Katrina, midwife). Katrina described racism not only as an individual problem but as an organisational problem, due to a lack of awareness and education that allows racism to continue unchallenged. Furthermore, poor communication can exacerbate disrespectful attitudes. The next subtheme, *Ensuring clear communication with interpreters* addresses how communication issues contributed to the challenges faced by women seeking asylum.

Ensuring clear communication with interpreters

The importance of ensuring clear communication with interpreters was expressed by midwives and doulas. They described a spectrum of circumstances ranging from women whose family members interpreted, to situations where professional interpreters were engaged in person or over the telephone. The issue of the quality of interpreters was significant to midwives and doulas, but appeared to be less of a concern for the women. For example, Ayesha, a woman seeking asylum who had a rejected visa, expected her husband to interpret, saying, *No, I didn't have an interpreter because my husband was with me. My husband explained it to me.* In contrast, most midwives and doulas spoke of the difficulties they faced when family members interpreted. These difficulties included family members having limited English or interpreting with poor detail. These challenges arose from a systemic lack of adequate use of professional interpreters in both hospitals and community settings.

The challenges of needing an interpreter

All midwives and doulas agreed on the importance of women having someone to interpret as they negotiate maternity services. Midwife Grace identified the difficulties women face when they cannot speak the language of their maternity care providers. Grace had an ongoing relationship with the women she cared for, and she knew their stories and the restrictions they were experiencing. She despaired:

> I just see only barriers … I think ultimately a fragmented system makes things really difficult for marginalised women, especially if they don't speak the [English] language (Grace, midwife).

Language limitations were a barrier to accessing maternity care, both in hospitals and with general practitioners (GP). Jana, a woman who had fled her home country, described her Australian maternity journey as a difficult, lonely, and challenging time, saying:

> The midwife was good. But there was no-one to talk to in my language (Jana, woman seeking asylum).

Community midwives also reflected on the difficulties of working with women when there was no interpreter present. Midwife Anne, who worked as an infant welfare nurse midwife, expressed her frustration about a GP providing antenatal care who had stated it was too time-consuming to use an interpreter:

> He's saying that he's not using an interpreter because it takes too long for him to connect up (Anne, midwife).

She explained that her parents were *UNHCR* refugees from Vietnam. Their life story inspired her passion for improving care for refugees and women with rejected or temporary visas. Her words speak powerfully of the impact of her own journey as a child of refugee parents:

> My mother always said to me … you can't effect change when you need an interpreter or you have an accent, but you can effect change because you were born here (Anne, midwife).

Lack of access to a professional interpreter impeded women's capacity to give informed consent. Women were sometimes not offered an interpreter, even when the need was obvious, for example, if they wanted to ask a question or needed to fully understand the information regarding their care. Nat (a woman seeking asylum) described her ability to speak English as a benefit in her labour but empathised with her friend, for whom no interpreter was available:

> We need support because we don't have our families here. My friend could not even ask for a glass of water when she was in labour, because they refused to get her an interpreter.

Nat described how, due to language difficulties, she felt her friend did not have her basic needs met, and her voice would not have been heard if not for Nat relaying her story.

The time taken to organise and use an interpreter was a barrier for many health professionals, and this issue was raised repeatedly by doulas and midwives. Bicultural doula, Emma, described an experience where she was supporting a woman in labour:

> I say to the midwife … 'No, listen, bring the interpreter. She must understand what's going on with her body, with the baby, and for her safety' … and she [the midwife] says, 'There's no time for that' (Emma, bicultural doula).

Emma witnessed the midwife declining a request for an interpreter because of the time it takes to organise, which denied the woman her right to safe care and to fully understand the care she was given during her labour.

Cat, who had been a doula for over 10 years, described resistance from hospital staff when advocating for an interpreter for a woman in her care, explaining:

> I said to the midwife, out of a duty of care to this woman, she needs to be able to ask questions in her language …. And then, half an hour later [the midwife] came back with a phone interpreter (Cat, doula).

Another doula described a situation where a woman might have been further traumatised if an interpreter had not been there to explain the emergency procedure of managing a shoulder dystocia during the birth:

> I pressed for an interpreter to come … and the midwife declined, saying it wasn't necessary … And I needed to stress that it was necessary because the woman was in distress … And, that midwife … was surprised to find out that there actually was an interpreter on duty on staff that she could call on. A female interpreter was able to come … just in time, as the shoulder dystocia was diagnosed, to … explain to the woman … what was going on in the emergency procedure (Karen, doula).

Fortunately, the timely arrival of the interpreter enabled the woman to hear a clear explanation of the emergency procedures, and she could respond to requests to change position to help release the shoulders and enable the birth of the baby. This is significant as, without the doula advocating for an interpreter, the outcome may have led to significant psychological and emotional trauma for the mother and a poor outcome for the baby.

Most midwives and doulas requested a female interpreter, explaining that women preferred a woman interpreter for cultural reasons. Anne said:

> It's women's business, basically. And women generally feel, especially from CALD [culturally and linguistically diverse] backgrounds, safer with other women … you understand what they go through … it's just the case because women identify more with women (Anne, midwife).

Midwives and doulas cared for women from many different cultures, often advocating for women requesting a female interpreter. Penny explained:

> She was Tamil, and she was very specific, to have [ask for] a female Tamil interpreter, due to her history of trauma (Penny, doula).

There were occasions where male interpreters were used if no female interpreter was available. Midwives and doulas explained that it is a hospital-dependent organisational issue whether male interpreters were routinely used with women during their maternity care. Kathy relayed her understanding that:

> In one hospital that I went to, and this isn't uncommon across the board … it's impossible to get female interpreters for the appointments. And yes, that's a systemic problem (Kathy, doula).

Midwife Beth explained that for some women, the interpreter provided a sense of continuity during appointments:

> I will tend to get the same interpreter, and we … know each other on a first-name basis (Beth, midwife).

The interpreter service was provided over the telephone, but the midwife described how the familiarity of the voice of the interpreter provided reassurance to the woman and the midwife.

Family interpreting

Midwives and doulas identified that women seeking asylum often preferred to use their partner, family member, or friend to interpret. Women appeared to be more comfortable with a family member interpreting, often due to confidentiality concerns, where the

professional interpreter may be part of the small community of their language group. Ruth explained the importance of using a professional interpreter and discussed the challenges of providing care without one:

> People don't … call an interpreter [and] often use a partner, in an emergency situation … They should be on the phone regularly, at all the … key times when things are changing, especially because people are in a state of stress … Their ability to take on … and retain information is reduced. Even if they've had reasonably proficient English prior, in a … stressful situation … there might be more need to use an interpreter … to talk and ask questions in their first language (Ruth, midwife).

According to most of the midwives and doulas interviewed, having family members interpret was common during labour and in emergencies. A doula described a serendipitous scenario, where a doctor spoke the first language of the woman and was able to reassure her in Arabic. Lucy said:

> The daughter was always the interpreter until they found the obstetrician, who was also an Arabic speaker. And then they just spoke in their own language (Lucy, doula).

It was clear the woman did not expect a professional interpreter and was reassured by the doctor speaking directly to her in Arabic. Up until this point the daughter, who was under the age of 18, was expected to interpret for her mother, throughout all the complex medical discussions in the labour. Midwives and doulas expressed concern that interpreting by family members and children could lead to serious errors, particularly if medical terminology is unfamiliar to the family member, or if they interpret selectively rather than accurately.

In contrast, undocumented migrants spoke about their preference to have family members interpreting rather than a professional interpreter. For example, Freda declined a professional interpreter and requested her sister interpret for the research interview. Freda arrived at the interview without her two-week-old baby and when I enquired about using the phone interpreter, Freda declined. She stated her sister was looking after the baby and would be arriving shortly to interpret. When her sister arrived with the baby, I offered the interpreter again. She (the sister) began to interpret and stated:

> I'm always with her, so she doesn't need an interpreter (family member and interpreter for Freda, undocumented migrant).

It was the fifth baby for Freda, but her first pregnancy in Australia. Her older children were in her country of origin, cared for by her parents. Freda had travelled to Australia to work to financially support her young children. She appeared fearful of having an interpreter involved, which may be due to her undocumented status, and the concern for the cost of interpreters or the risk of being deported.

Poor interpreting

Midwives and doulas described situations where there appeared to be no accountability for inadequate or disrespectful interpreting. Gill (midwife) expressed concern about this and described her issue of using interpreters as:

> I'll say a whole sentence … and then they'll relay [it] in one word.

Midwife and doula participants described the potentially serious consequences that could arise from inadequate interpreting. One example was when social workers made assumptions that a baby was not safe in their mother's care, because an interpreter had not been used to clearly communicate the nature of the emotional stress of the woman. Bea (a doula) explained that she spoke with the social workers and was able to explain properly that, due to a lack of adequate interpretation, and the limited English vocabulary of the woman, they had misunderstood the circumstances. Bea shared that:

> She … nearly lost the baby to Child Protection [Victorian Government services to support children at risk of harm] simply because she didn't know the correct words for saying, 'I feel like I'm not coping.' She didn't have the language. That's what she was trying to say (Bea, doula).

Bea described the occasion of caring for a woman whose baby had died in-utero, and the appalling lack of care on behalf of the interpreter:

> When the doctor said the words out loud and clear to the interpreter that this was a dead baby, the interpreter says, 'I have to go now. I'm only booked for 15 minutes' (Bea, doula).

The interpreter demonstrated no accountability or empathy of the woman's situation. Repeatedly, doulas and midwives illustrated the point of poor interpreting or a lack of access to interpreters, with concerns about the potentially dire consequences to the health and wellbeing of women and their babies.

Confidentiality concerns

There were many accounts from doulas and midwives reflecting women's concerns about privacy and confidentiality. Doula Penny was a valuable source of information about this, as she had a background as a social worker with a long history of caring for victims of torture and trauma and disadvantaged women. She gave an example of where she organised a phone interpreter:

> I was visiting her at home. I organised a face-to-face interpreter, but she declined because the community is so small. So, we organised a phone interpreter and that worked very well (Penny, doula).

Penny explained that this woman's traumatic personal story resulted in her living in fear, as she and her husband had tried to seek asylum after arriving by boat to Australia. Due to the small size of the community to which she belonged, she was fearful about confidentiality and, 'wanted to be anonymous' (Penny, doula). Incarcerated in the Australian detention system, the woman had suffered sexual assault and abuse, and was therefore distrustful of in-person interpreters.

There were several illustrations of women seeking asylum who wanted the anonymity that was offered by a phone interpreter. Women identified that this allowed a more open conversation with their midwife, doula, or counsellor. Ayesha described how her need for confidentiality was fulfilled by using the phone interpreter, rather than an in-person interpreter:

> I do have counselling. [I have an interpreter] over the phone. I'm really happy, because we met one [with] face-to-face counselling, I wasn't able to tell her some things, but over the phone [with this one] … I'm able to tell her everything [and it] makes me feel more relieved (Ayesha, woman seeking asylum).

In contrast, in one community health setting there was an organisational expectation that interpreters would always be used, which demonstrates that it is possible to consistently use interpreters.

> We have to use interpreters, no matter what, and we always do [and] have (Anne, midwife).

This finding shows that, despite the barriers experienced in organising appropriate interpreting services, it is possible and plausible to provide consistent interpreting services.

The positive impact of having an interpreter who is known to the woman and the midwife is demonstrated in the following vignette. Melissa, a midwife, described a situation in which the woman had been informed her baby would not survive, and spoke of the empathic communication that ensued:

> They found it [at] a 22-week morphology … But because of her belief, she carried the baby, and we knew it wouldn't survive very long if it survived the labour and after the birth … she was telling me she knew when the baby died because it stopped moving … and I'm using the interpreter … an interpreter known to both of us … And I'm bawling my eyes out. And she's got her hijab and she's wrapped me up in it, and she's wiping my tears and then the interpreter and she's crying and, then she said, 'Can I just talk to her myself?' And I said, 'Yeah sure', and so they had a bit of a chat … more tears but so dignified and so resilient and so strong. I can't imagine what they've been through to get to that point (Melissa, midwife).

Having written resources in appropriate languages was recommended by participants as a way to reinforce the information shared verbally. Katie, a doula, described the value of having educational resources for pregnant women that were translated into Arabic:

> Just having some resources in their language [was beneficial] an English component … as well as Arabic. And I think … knowing that they understand that communication is really important. Instead of them just agreeing and saying, 'Yes' (Katie, doula).

Conclusion

This chapter synthesised the findings of interviews with women seeking asylum and the midwives and doulas caring for them in Australia, in relation to the theme of *Living with uncertainty.* There were multiple layers of challenges to accessing maternity care for these marginalised women, but the fundamental issue was *Living with visa uncertainty.* The trauma women experienced as a result of *the impact of detention* severely affected their experience of care. In the most extreme situations, women were accompanied by guards to the hospital and during their hospital stay. Furthermore, women felt *the impact of sexual violence*, where they felt they depended on their partner for a visa, which was a barrier to disclosing and may lead to difficulty accessing the appropriate care they need. For example, when their partner was interpreting, they were potentially disadvantaged further. Women may be fearful of what they can safely disclose.

The impact of *being unable to pay*, having limited income and no access to Medicare cover, led to women delaying their treatment due to a fear of the expense involved. The destitution of having little or no income added pressure to their daily needs of living, particularly regarding housing. Another layer was the isolation of the women, who had *no family or friends to provide support*, which added the challenges of attending appointments alone, having no-one accompany them in labour, and caring for a newborn without extended family support.

A further barrier to accessing maternity care was that women were faced with *racism and disrespectful care*, which was reported by women, doulas and midwives. The final layer was *the challenges of ensuring clear communication with interpreters* and the issues raised when using family members to interpret. For cultural reasons, female interpreters were often needed and at times the issue of confidentiality led to the women preferring a phone interpreter or declining professional interpreters. Without professional interpreters, women faced the challenges of not being able to communicate their needs or understand the information given to enable informed consent. Thus, there were many complex layers of barriers that challenged women in accessing quality maternity care.

The thread of uncertainty will be further explored in the following two findings chapters that present the themes:

- *Sisterhood: the care and support provided by midwives and doulas*

- *The challenges for midwives in providing good care*
- *The importance of midwifery continuity of carer*

Chapter 6: Findings: Sisterhood–The care and support provided by midwives and doulas

> *Doulas offer an opportunity to build a trusting relationship with women and their chosen birth companions and guarantee to offer support during labour … Ample time is spent during pregnancy exploring the woman's hopes.*
>
> (Leap & Hunter, 2022, p. 6).

Introduction

The previous chapter of findings related to the experiences of women living with uncertainty and their challenges engaging with maternity services when they had temporary, expired, or rejected visas. The descriptions of the experiences of women painted a concerning picture of the challenges of isolation and destitution, being unable to pay for hospital expenses, and having limited access to interpreters. This chapter presents the findings in relation to the theme of *Sisterhood: the care and support provided by midwives and doulas*. The theme is comprised of five subthemes:

1. *The doula and midwife support was like family*
2. *Midwives who chose to work as doulas*
3. *'Helping women to feel safe and informed'*
4. *Practical assistance: housing support, addressing transport challenges*
5. *Carrying vicarious trauma home*

The doula and midwife support was like family

Sisterhood was the word that midwife Avril used to describe her relationship with asylum-seeking women. She could relate to their experiences because her own family of origin immigrated to Australia after World War II. Reflecting on her vast midwifery experience after decades of working in maternity care gave her insight into her own culture and motivation as a midwife:

> It's sort of almost like a sisterhood. You feel this … incredible empathy towards them … It might come from a background of my family … who migrated here after World War II [to] escape persecution (Avril, midwife).

The doulas who were interviewed all worked in a voluntary capacity to befriend and support disadvantaged women through a non-government organisation called *BfH*, in Melbourne, Australia. Doulas provided continuity of support throughout the journey of pregnancy, labour and birth, and in the postnatal period; a model they described as enabling them to provide woman-centred care.

> I've always asked them, is there something … important to you, that's cultural, that you would like to incorporate with my support? (Katie, doula)

Doulas provided continuity of support for women across pregnancy, labour and birth, and the early postnatal period, guiding them through the maternity system.

Three bicultural doulas who were interviewed provided unique perspectives from their own lived experiences, concerning the power dynamics that may exist between the woman and health care providers. Emma, a bicultural doula, understood the power imbalance between the dominant white culture among care providers and the woman, who may be unsure of the health system:

> Many women … once you … fully inform [them] … they [are] … coping [better] … Information is power. And when you have power, you have control of your own body (Emma, bicultural doula).

Respectful support for women, who are unfamiliar with the Australian maternity culture and may feel overwhelmed, was seen as crucial, as midwife Hannah explained:

> When there's questions coming at you, you want somebody there … whether it's your doula … [or] somebody there [who] knows your story and what your preferences are (Hannah, midwife).

Hannah, who had trained as a midwife, was working as an academic and a doula. She discussed her role as an advocate and health system navigator for women during their appointments:

> This is her birth, and this is … her space, and she's safe … and we're all here to help her have the best experience possible … I saw my role as advocate … I think helping a woman feel a bit confident, because of course, there is a big power dynamic, always … I think … that navigation of the health system is a really big one and being present for the woman as an advocate [are] the two big things (Hannah, midwife).

Penny, who was a doula and a social worker, spoke of the issue of transport to antenatal appointments:

> I was able to take her on … [in my role] as a Healthy Mothers Healthy Babies worker … I had the funding to transport her to her antenatal visits, etcetera. But at the same time, I was also a doula for her … on top of [the] social worker [role] (Penny, doula).

A trusting relationship with a midwife or doula appeared to ease the sense of isolation and loneliness expressed by women seeking asylum. Hannah simply and eloquently described the emotional support she felt all women needed, although were not always afforded, when she said:

> Every human deserves to have somebody hold their hand through that journey (Hannah, midwife).

The doula can explain to women in lay terms how the maternity care model works, which is particularly useful when women have limited support and English proficiency. Midwives described how a doula can help women to navigate the health system during the pregnancy, labour and birth and postnatal journey:

> Pregnancy support … even a volunteer … a doula … someone … able to be present, and … give their time to be an extra support person and advocate, someone … confident with interpreters, confident with the system and [able to] help women to navigate those areas (Ruth, midwife).

Midwives and doulas and expressed the belief that continuity of care facilitated engagement with maternity care, through a trusting relationship with the woman. Eliz suggested that the doula as a female support person may be more culturally acceptable for some women than support from a male partner:

> For women from different culture[s], this is women's business (Eliz, doula).

Doulas saw their positionality as outside observers of maternity care. For example, doula Katie felt that because she was not employed by or accountable to any maternity hospital, she remained independent of the dominant culture. She often witnessed what she perceived as suboptimal treatment of women seeking asylum, feeling that midwives who are part of the staff of the hospital may be culturalised to the behaviours, asserting:

> The coercion was just so black and white, and the treatment of her was so bad. That whole birth … The lack of humanness that we [see with] these women … is just appalling (Katie, doula).

In the previous quote, Katie gave voice to the voiceless, by telling the story of a woman who may not have been able to advocate for herself or speak up about the treatment she received during her birth.

Whether it was their first or subsequent pregnancy, women seeking asylum described the relationship with their doula like a nurturing relationship between a mother and her daughter. One woman emphasised how the support from her doula was emotionally and practically supportive.

> [The] doula helped a lot. She went to my appointments. [The] doula looked after me like my mother (Helen, woman seeking asylum).

The image of a mother-daughter relationship invokes a sense of the strong bond that was developed, perhaps beyond the professional boundaries of a continuity of care relationship. Midwife Lisa echoed this view:

> You sort of get this motherly thing; you just want to look after them a little bit more (Lisa, midwife).

Many doulas and midwives reflected on the importance of their role and of the personal satisfaction they experienced, feeling that their support helped to fill the vacuum left when the extended family of the woman could not be present.

Midwives who chose to work as doulas

Four of the midwives interviewed preferred to work outside the constraints of the hospital system, as independent doulas. Interestingly, none of these midwives reflected on the option of working in a model of continuity of midwifery care within the hospital. Working as doulas outside the hospital system gave these four midwives the opportunity to accompany women across the continuum of pregnancy, birthing, and the postnatal journey.

> (Working as a doula) gave me an opportunity to use my skills, having been a midwife for many years, without … the pressure of what midwives have to deal with (Hannah, midwife).

The midwives working as doulas were dissatisfied with the constraints of the midwifery role because they felt they were unable to provide continuity or develop a sense of trust with marginalised women.

> I work with women closely and provide support probably better than I would have been able to as [a] midwife (Gill, midwife).

Gill expressed her satisfaction of using her midwifery experience outside of the hospital system where she was independent of the time restraints imposed by the organisation. Midwives working as doulas provided unique reflections into the experiences of caring for marginalised women. Jane, a midwife, described how working as a doula enabled her to provide continuity of support for disadvantaged women.

> The doula … fills the continuity of care gap. She's filling that space, which midwives would love to do … That's the gold standard of care. And that's how you get good outcomes (Jane, midwife).

One midwife described how a woman with complex trauma benefited from continuity of care with a midwife, alongside doula support. Gill explained that, although it was rare for women to be given this level of support, it was an:

> Amazing birth … with somebody very traumatised, who was an immigrant … She somehow got into the continuity of care … a known midwife and known doula … known caregivers during the birth just changed everything (Gill, midwife).

To be cared for during the labour and birth by a midwife and doula, who both had a trusting relationship with the woman, was an unusual scenario. Most of the midwives acknowledged the benefits of women receiving ongoing emotional support from a known midwife and doula.

Several participants described how a doula may encourage the woman to ask questions, help her to understand the recommendations of the midwife or doctor and take the time to ensure informed consent.

> I saw my role as … just making sure that it was truly informed consent … [that] there was understanding of what the other options were (Hannah, doula).

The doula may take the time to explore with the woman her choices regarding pregnancy, labour and birth, and to clarify options that may have not been communicated clearly by her midwife or doctor.

'Helping women to feel safe and informed'

Women seeking asylum spoke a lot about the relationships they shared with their midwives and doulas. They were less aware of the different models of maternity care that existed, so were unable to comment on specific models of care. The relational care they enjoyed was important to them.

Midwives and doulas comforted and nurtured women and described that it was important for them to feel, 'safe and informed' (Grace, midwife). Accounts of the care and support women received demonstrated how such nurturing built their strength and resilience, in the face of challenging circumstances. One woman described the support during her birth experience as follows:

> They took care of me very well. They were so kind and so understanding. I gave them a lot of trouble, but they were very patient and very kind. The nurse [midwife] was really wonderful (Ayesha, woman seeking asylum).

A relationship of reciprocal trust with the woman provided doulas and midwives with encouragement in their work, saying, for example:

> It was very grounding and really reminded me that the essence of being a doula is … just being there … It's support for that woman (Tabitha, doula).

Most midwives described the benefits they received from the reciprocal relationship they experienced when working in a continuity of care role. Despite the challenges women faced, their resilience motivated and inspired the midwives:

> [They are] so resilient and so strong. I can't imagine what they've been through to get to that point or whether it's simply such a strong belief system that keeps them going. But … they're amazing and I take my strength from them (Melissa, midwife).

The doulas and midwives providing continuity of care were dedicated to nurturing a relationship with women that enabled them to facilitate trauma-informed care that was empowering, rather than traumatising:

> Their experience is leaning more towards being empowering, they're feeling safe and understood (Karen, doula).

Doulas had the skills, time, and space to provide trauma-informed support that addressed the needs of women seeking asylum.

> I was able to work with more cultural awareness and trauma-informed care than the rest of the team (Karen, doula).

Advocating for the women to have support around them was key:

> It's a really hopeful … time, and as a midwife … I want … them to feel safe and informed and to have the best experience possible, and advocate for them to have people around them that are… committed to the well-being of the woman and the baby (Grace, midwife).

Developing a clear management plan for marginalised women aimed to ensure they felt emotionally secure during their labour and birth. Midwife Katrina, working in a continuity of care model, described how she would share this plan to inform other staff members of the need to provide trauma-sensitive care:

> Make it a gentle, positive experience. I hope to keep a nice dark, quiet, calm space [and] minimise interruptions. I usually also have like a very clear management plan in place. So, that other staff members… are aware of the story [of] the woman (Katrina, midwife).

The need for cultural awareness and trauma sensitivity training

Different terms were used by participants to describe the skills and attributes that provided midwives and doulas with the awareness needed to care for women seeking asylum, including *cultural competency*, *cultural awareness* and *trauma sensitivity*. Most midwives interviewed had actively sought and participated in trauma-informed cultural competency or cultural awareness training on their own initiative, but participation appeared to be ad hoc:

> I've done a lot of cultural competency training in my other roles … and that was done not as a mandatory thing but done as more voluntary thing and I've always … kept up to date with… Aboriginal cultural awareness training (Anne, midwife).

Indigenous cultural competency training was considered to be an accessible program for professionals that was offered regularly: *'I've done cultural competency training with Indigenous women'* (Mary, midwife). Developing an understanding of unconscious biases and privilege, such as is included in Indigenous cultural competency education in New Zealand, was raised as an example of training that would be relevant to the education and professional development of midwives in Australia:

> [Australians could benefit from] looking at that whole New Zealand model of cultural competency and understanding power dynamics … so that you're aware of your glaring white privilege and education and assumption of authority and … your unconscious bias (Jane, midwife).

Cultural awareness training that is specific to working with refugees and people seeking asylum was seen to be less accessible than training targeted towards caring for Indigenous people. Community organisations such as *Foundation House* (2017), *STARTTS* (n.d.) and *BfH* (2019) provide cultural training for their team and health professionals from elsewhere.

> There is a lot of ongoing training that is around … Cultural competency, advocacy, understanding the really complex needs of these women which have been very diverse, depending on their background (Tabitha, doula).

Midwife Lisa expressed her views about why cultural awareness training is necessary:

> People are very inflexible [and say], 'this is the way we've always done it'… Like on the postnatal ward … the women that don't shower … for five days … That's the culture, that's fine. But a lot of people [midwives] will try and get them up, and … hand over, 'She won't even move … [out of] … bed'… We're not going to change … centuries of culture in [a] 24–48 hour stay … No, I don't think there's enough basic cultural training at all (Lisa, midwife).

Professional training in cultural competency, awareness or sensitivity was seen as both an individual and an organisational responsibility. It was felt that organisational training would facilitate strategies and policies to protect women seeking asylum from suffering further trauma in their interactions with the hospital maternity care. Karen, a doula, expressed her concerns around the lack of professional training:

> One area where asylum seekers have really been let down [is] … the lack of training around cultural awareness and sensitivity [to] trauma … unfortunately, compounding people's trauma even further (Karen, doula).

Despite the many challenges, some women felt positively about their experiences of maternity care, expressing that the care and kindness of the midwives and doulas was greatly appreciated. Maxi, who had her fourth child, her second child born in Australia, expressed her perception of the kindness of the midwives:

> What more could the midwives do? … They did so well (Maxi, woman seeking asylum).

Many women explained the care as being beyond their expectations, especially when comparing it with experiences of giving birth to their older children in their country of origin. Some women expressed their appreciation for the midwives who provided them with information and the opportunity to make informed decisions. This often contrasted with their previous experiences in their country of origin, where informed decision-making and consent had not been part of their maternity care experience.

> It was a great experience in Australia. They support you a lot. They discuss everything with you. Nothing could be improved (Sahar, woman seeking asylum).

Some participants felt that their lack of family support needed to be acknowledged and addressed by health professionals during their maternity care. Nat and her family, after nine years in Australia and two rejected visa applications, were still waiting for a federal court decision. With numerous health issues complicating her pregnancy, such as carpal tunnel syndrome resulting in numbness and weakness in her hands, Nat explained:

> We need support because we don't have our families here (Nat, woman seeking asylum).

Nat emphasised that the support was vital, as she struggled with daily tasks due to her health problems.

For women held in Australian detention centres during their pregnancy, volunteer visitors provided much needed support and companionship. Sam, a woman seeking asylum, reflected upon the comfort she felt with a volunteer visitor at the Australian detention centre, where she was detained during her previous pregnancy:

> I was a very nervous person, and then … [during] the birth time, one of the lady [ladies] helped me (Sam, woman seeking asylum).

Sam's companion was a known and trusted visitor at the detention centre who was familiar with the Australian health care system, and whose support, knowledge and understanding was valuable to Sam. In her subsequent pregnancy, Sam had a companion worker from the local church, whose role was to assist families seeking asylum. Sam had faced stress and uncertainty regarding her temporary visa and fear of being deported over many years. Coupled with her dire financial situation, this created significant stress during her second pregnancy. In the context of the trusting relationship Sam had with her companion worker, midwives were informed of Sam's complex social, emotional and trauma history. This background information facilitated midwives to provide care that attempted to avoid further emotional and psychological trauma.

The relationship and trust Sam felt with her companion worker was such that she asked her to be with her during the labour, to provide support alongside her partner. Sadly, in the final weeks of the pregnancy, tests revealed that a stillbirth was inevitable. Sam's

companion worker asked for my professional advice and expertise as a midwife. After discussion with my academic supervisors, I stepped aside from the researcher role and provided comfort and my expertise as a midwife in a visit alongside the companion worker. I provided information to the companion worker regarding access to support from organisations such as *Sudden Infant Death Syndrome (SIDS), Miscarriage, Stillbirth and Newborn Death Support (SANDs),* and *Angel babies*. I provided sensitive and respectful support with a visit and phone calls. Only the first interview with this woman, conducted before the diagnosis of the fetal condition, was included in the data for the research. Sam said, *'You have made us happy by visiting us'*, and appeared grateful that someone cared about her situation**.**

Midwives and doulas frequently talked about how their empathy for marginalised women became a key motivator. They saw how empathic listening catalysed positive change for families in their care and wanted to provide support beyond the expectations of their professional role:

> With vulnerable people, it feels heavy for me… I just want to love them. I want to bring them home. I want to give them a nice comfy bed and good food (Katie, doula).

> You want them to go forward and… have a better life, so it's really important that in that [antenatal] interview they feel supported, and they feel cared for (Avril, midwife).

> Part of delivering a service that effects change, in a positive way, is listening to them, and empathising with them. Doing the best, you can for them, and their family. … I go out with an interpreter, and I go out with hoping to address whatever needs that she wants me to help her. I let her identify the needs. I let her lead the way, in terms of …what information she needs me to give her and let her take ownership of the area that she wished me to focus on in her life (Anne, midwife).

Practical assistance

The practical assistance provided by community midwives often came as a surprise to women, who highlighted its value in the context of the monetary stress their families experienced:

> The nurse [midwife in the community] gave me the clothes, the pram and the crib. They were very helpful. Because we didn't have money because of the Corona thing [COVID-19 pandemic). It was a big surprise when she came to my house (Ayesha, woman seeking asylum).

Many families who were seeking asylum lost their only source of income when their casual employment ceased, during the COVID-19 pandemic lockdowns. Ayesha described how grateful she felt when the community midwife, who was able to arrange home visits, provided practical nursery items for the baby. Attempts by midwives to alleviate the financial hardships of the women included providing practical assistance, such as baby items; these efforts were beyond what was expected of a clinical role.

Midwives and doulas were aware of the impact of the social determinants of health upon women seeking asylum and their families, including crucial factors such as finances, housing, transport, and employment. They described how their care was underpinned by a social model of maternity care in terms of addressing the issues of food, housing, employment, and practical material support:

> It's …[the] social determinants of health. If you don't address those issues, you'll never get to support the wellbeing of the mum and baby (Rachel, midwife).

> With the surplus budget we … rush [and] buy things like food, blankets, the heater, for a family sometimes in dire need of these things. [For example] one mother being left homeless because her husband gambled away their things (Anne, midwife).

Alongside the antenatal community program, social workers were linked in to assist these women with visa applications and material aid, such as clothing. Women spoke positively about the antenatal community experience, despite the support not continuing during labour and birth in this model. Co-located in one of the health services was a maternal and child health service, which facilitated collaboration to scaffold marginalised women

in the postnatal period. The postnatal support was part of the continuity model, which enabled a trusting relationship to develop, and ensured the woman did not have to repeat her story to strangers.

> We've got a GP here. We've got speech [a speech therapist] here, we've got physio [a physiotherapist], all the services … So, being co-located … I saw a woman yesterday; she's seeing her [the physiotherapist] today. … We've sorted [it] out. We don't want to clash with appointments, so we make sure we have different times…. The woman gets the best sort of deal … Usually, the social workers do that linking …. and … Red Cross certainly have been very supportive to asylum seekers in general (Beth, midwife).

Bicultural doula, Emma, whose own background was from South America, described providing financial support for a young mother from Colombia. Emma's kindness went beyond what is expected by the women she supported, by providing material aid, such as baby items:

> In the last three months of her pregnancy, [her] visa was finished. She couldn't renew the visa because it was a second time applying for extending of visa. So, she had to go back to Colombia … I … [gave her] money from my own pocket, because she was needing a lot of things (Emma, bicultural doula).

Housing support

Midwives and doulas believed that emergency housing was a crucial issue for many women seeking asylum, arguing that without stable housing women were unable to focus on their pregnancy and upcoming birth:

> She [the woman seeking asylum] said, 'Look, to be honest, all I need right now [is a] safe house. I can't even begin to think about baby or birth … until I have a house to stay in' … then I took her straight to social work (Emma, midwife).

Midwives explained that social workers play an important role in linking women into housing services. Liaising with community workers and social workers to find secure accommodation for women and their families was often needed. Doula, Penny, who was also a qualified social worker, had unique insights into the underlying social issues

asylum-seeking women face, such as housing, poverty, and having no access to Medicare. Penny understood her role as advocating for her clients, particularly regarding housing.

> Housing is number one, I … do a lot of advocacy for housing … because of the asylum-seeker experience (Penny, doula).

Addressing transport challenges

Midwives, doulas, and women spoke about how attending appointments was challenging for women who are new to Australia and unfamiliar with public transport services. Anne (midwife) spoke from the experience of her parents, years ago, when they were newly arrived refugees:

> You don't think twice if you were born here or can read English. But for a newly arrived person who doesn't speak English it's a huge barrier … getting on a train, buying the ticket … That's what happened to my parents, in the past (Anne, midwife).

She described how lack of access to public transport can be a barrier that prevents women from attending their antenatal appointments. Anne described setting up a volunteer transport service as a creative model to provide women with access to antenatal care:

> We've identified [an] area of need … [and] got this program up and running. We got these volunteers from universities who are quite generous with their time, and with their travel expenses … They take them [the pregnant women] to their appointments. Sometimes it's about also navigating, such a simple thing, like how do you get from A to B (Anne, midwife).

Carrying vicarious trauma home

Every doula and midwife caring for women in a continuity of care role learned about their terrifying journeys and shared the stories of what women seeking asylum had experienced. Doulas and midwives acknowledged the emotional impact of hearing such stories on their own emotional and mental health. The traumatic experiences of women seeking asylum included fleeing their country, escaping to Australia, being held in prison-like conditions in detention, or being treated disrespectfully during labour and birth. One family had experienced the tragedy of losing a child at sea in their attempt to seek asylum,

arriving in Australia by boat. Their adversity made the parents feel that the next pregnancy was extra special:

> She was having her fourth child, one of her children had died coming over here, had drowned. And … that was their baby. So, this next child was a really special child, and her partner was able to be at the birth for the first time (Kathy, doula).

Gill, a midwife, described a distressing experience on her first day on placement in the birth suite, as a midwifery student. Gill was looking after a woman in detention and was confronted by the disrespectful treatment she observed; she was profoundly distressed by this experience. This incident describes the complete lack of kindness, humanity and respect for the human rights of the woman, and the failure of the midwife to seek informed consent:

> We were caring for a labouring woman who spoke no English, and who had been transferred in from the detention centre nearby … She had guards stationed outside the door … She couldn't have her husband come with her to provide support, because nobody could watch the other children … The midwife who I was working with … was … dismissive, didn't even try to make a connection … or get a translator … they didn't even try to gain any consent … It was basically just like … she was a vagina with legs, like the top half didn't really matter. Like nobody in the room, even looked at her … And she just was like looking at me … She was just absolutely terrified (Gill, describing her experience as a midwifery student).

No interpreter was arranged, and no companion person was available to support and advocate for the woman. Gill empathised with the powerlessness the woman experienced. Guards outside the door were a physical reminder that the woman had no power or privacy, compounded by the disrespect shown by the midwives and medical team. Furthermore, there was no debriefing or acknowledgement of the distress of the woman and the impact it might have had on Gill as a midwifery student:

> I left that day, and I rang my mum. And I was crying … my mum … [said], 'What's wrong?' … I … [told her] … 'There was this woman and … they basically assaulted her, and I never want to go back'… I didn't think I was going to go back (Gill, midwife describing an experience as a midwifery student).

Gill's story was one example of the way that carers experience vicarious trauma. Gill expressed the painful decision to walk away from the midwifery profession, as she felt the emotional pain of caring had affected her life outside work.

For midwives who are not working in continuity of care models, there appeared to be no system enabling them to follow up with the social worker to ask if the woman had found stable housing, which they found distressing.

> I would look up women in this system and try and see what happened to them … and [wondering] did this default on this referral go through? … I'd be thinking about them [and] worrying about them (Gill, midwife).

Rather than work in a continuity of midwifery care model, Gill chose to accompany women in a non-clinical doula role. She spoke about her decision as follows:

> I felt I either had to choose to continue being emotionally involved in caring, but then it really affected me outside of work, or disassociate completely and not caring for the women, which wasn't a choice for me … I just had to leave (Gill, midwife).

Midwives and doulas from a variety of roles and contexts in hospitals and the community described how they were affected by vicarious trauma. They spoke of the emotional burden of hearing the stories of the women in their care and processing what that meant to them, as in the following examples:

> Listening to some big horrendous stories that we were not fully equipped to receive or even just going through that journey, walking alongside the woman… I feel the injustice (Karen, doula).

> You feel that emotional burden [of hearing women's distressing stories] (Anne, midwife).

> I would carry that [trauma] home with me (Gill, midwife).

Reflecting on their practice was an important coping strategy that enabled midwives and doulas to continue providing woman-centred care and advocacy for marginalised women. Reflection was most often an individual experience or an ad hoc debriefing opportunity.

Midwives spoke of the support strategies they used, such as clinical supervision, or ad hoc or regular debriefing with a friend or manager:

> [We have a] really supportive team and that really helps because we kind of, just banter off each other … We do that a lot, 'Oh my goodness, what will I do about this?' And … that's really good. We have regular … monthly supervision and that's really helpful (Rachel, midwife).

> We're extremely fortunate to have an amazing array of experienced health professionals in all sorts of different areas … Often you can just walk into a room and chat to one of the nurse practitioners, doctors or someone and have a really good debrief (Mary, midwife).

> In terms of my own self-care, [with] a colleague … we provide external supervision to each other … debrief and work through any issues that are coming up for me. [It] is really important … and part of self-care as a midwife and part of that reflective practice I recognise that I can care for these women, but I can't change their lived experience and I can't change their story and I can't change their lives (Katrina, midwife).

Midwives and doulas suggested that training in trauma-informed care may assist midwives and doulas in developing self-care strategies. Lucy (doula) spoke of how training in understanding trauma and providing trauma-informed care offered by the *Blue Knot Foundation* (Blue Knot Foundation, 2023) had enabled her to develop some personal strategies to minimise vicarious trauma:

> Blue Knot Foundation [training] it was specifically tailored … some of it was quite generic trauma-informed care information and then some of it was more specifically tailored to … working in the birth space (Lucy, doula).

Some doulas emphasised the necessity of ensuring other services were in place to assist women seeking asylum after the midwife or doula relationship ends. For example, Penny, a doula, had developed a strategy of not accepting a referral to support a pregnant woman unless there was a plan for ongoing support in the postnatal period after the doula completed her care.

> If you're not able to walk away from that client knowing she's got a team of support around her, it affects you, like a vicarious trauma. She doesn't want to let go of you (Penny, doula).

Knowing the woman is not left isolated after discharge was reassuring for Penny. Other midwives and doulas spoke of the struggle of completing their care of women and then wondering about their welfare in the future:

> I know … that you can't continue your relationship with women, but with women who I … have invested interest in, and I'm genuinely concerned, it's really hard to end that relationship (Robyn, midwifery student).

> You don't walk away from it. One lass who I looked after, who lost a … limb in a landmine explosion when she was a child and so she's here on her own [with] no family, with … missing one arm. And [later] she became at risk of homelessness and rang me and said, 'My landlady is about to throw me out' (Jane, midwife).

Midwives and doulas echoed their ongoing concerns for the women they cared for, which some described as 'burnout'. Bea reflected on her doula role and how she had enjoyed accompanying marginalised women, until she became burnt out emotionally and left the role.

> I loved every minute, until the end, when I got burned out and a bit tired (Bea, doula).

Rachel was conscious of the risk of becoming burnt out, saying:

> It gets hard at times. I'm aware of burnout and I'm really aware of trying to nurture myself. I won't go into this chap that's suicided, that really hit me for six (crying) (Rachel, midwife).

Midwives and doulas in this study described the emotional complexity of supporting women seeking asylum during their childbearing journeys. Despite the frequency of traumatic events, debriefing and support for midwives and doulas appeared to be ad hoc, creating the potential to exacerbate the vicarious trauma they experienced. Whilst vicarious trauma was widespread, midwives and doulas appeared to find motivation in feeling they had made a positive impact on women's lives.

Conclusion

Sisterhood: the care and support provided by midwives and doulas demonstrated how women seeking asylum appreciated the care and kindness offered by midwives and doulas. Women expressed the need for extra support because they were unable to have their family beside them, and felt that *the doula and midwife support was like family*. *Midwives who chose to work as doulas* highlighted the benefits some midwives felt when freeing themselves of the constraints of being accountable to a hospital system.

Helping women to feel safe and informed discussed the importance of training for midwives and doulas in cultural safety, cultural awareness, and trauma-informed care. The findings revealed the ad hoc nature of training, and the potential for retraumatising women when there is a lack of reflection and understanding of trauma-informed care. Participants felt it was important to have an organisational approach to support midwives to develop a culture of supporting marginalised women through trauma-informed care and cultural awareness.

Midwives and doulas valued the opportunity to provide *practical assistance: housing support, addressing transport challenges.* They spoke of the value of continuity of care and of the resilience and strength of the women seeking asylum they met and worked with. Midwives working in fragmented models of care, who were not able to provide continuity of care, also strived to provide empathic care, despite caring for women at only one point in their pregnancy.

The findings in this study indicate that midwives and doulas experienced a profound emotional impact as a consequence of working with women seeking asylum. Midwives and doulas spoke of feeling that they were *carrying vicarious trauma home* from hearing the accounts of the lives of the asylum-seeking women. Individual midwives and doulas discussed their own strategies to prevent burnout from vicarious trauma, such as clinical supervision or debriefing.

The next chapter presents findings of the challenges for midwives and doulas of identifying and caring for women seeking asylum during their pregnancy labour, birth, and postnatal journey. Furthermore, Chapter 7 will detail appropriate maternity services that were recommended by midwives and doulas to care for women seeking asylum.

Chapter 7: Findings: Appropriate maternity services for women seeking asylum

> *Hope has two beautiful daughters; their names are Anger and Courage.*
> *Anger at the ways things are and Courage to see they do not remain as they are*
>
> (St Augustine, in McAfee Brown, 1988, p. 136).

Introduction

The previous chapter explored how midwives and doulas provided valued support and maternity care to women seeking asylum, despite numerous challenges. Most of the women interviewed had positive reflections of their maternity care experiences, despite the barriers to accessing services. However, a few women voiced their frustration with their maternity service, and there were accounts from midwives and doulas reinforcing the lack of support and problems such as access to interpreters and the cost of services.

This chapter will explore the findings from this study relating to two themes:

1. *The challenges for midwives working in fragmented models of care*
2. *The importance of midwifery continuity of care*

The first theme contains two subthemes:

- *Difficulties identifying women seeking asylum*
- *Ticking every box*

The second theme contains three subthemes:

- *Caseloading continuity of care in the hospital context*
- *Group antenatal care*
- *Community-based continuity with midwives*

The challenges for midwives working in fragmented models of care

In Australia, only a minority of midwives work in a model that provides an ongoing relationship with pregnant women through to the early postnatal period. Midwives in this study suggested that understanding what was important to individual women was made possible by walking beside them on their journey through the pregnancy, labour and birth, and the postnatal period. Midwives felt that this was less likely to occur when meeting at a crossroad during a single appointment. They spoke of the challenges of providing good care within the time constraints of mainstream clinic antenatal appointments; citing, for example, the extra time required for organising and using an interpreter. As discussed in Chapter 5 and 6, women spoke of the kindness and patience of the midwives and how they provided practical support.

Difficulties identifying women seeking asylum

A serious issue faced by midwives was the difficulty in identifying women seeking asylum and distinguishing them from women who are refugees (as defined in the definitions on pages xx and xxi of this thesis). It appeared that there were no systematic processes in place to assist health care providers in identifying pregnant women seeking asylum. The capacity to identify these women was seen as important to ensure the women were linked with appropriate services and adequately supported during their maternity care:

> At our hospital we don't have any model of care specific to women of these backgrounds, so it can be tricky to … clearly identify those women … [and to identify] … the difference between migrants or those seeking asylum (Ruth, midwife).

> Our routine data collection software program asks [if] the mother or father identify [as] Aboriginal and Torres Strait Islander. And then [it asks about] the country of birth, and then refugee status … [identifying women seeking asylum is] really out of our hands (Lisa, midwife).

Clarifying if a woman was seeking asylum, an overseas student, an undocumented migrant, a refugee, or a migrant was challenging. Midwives and doulas managed this challenge in a variety of ways. Some questioned whether it was acceptable to ask women about their visa status, or if it was more appropriate to ask about what stage they were in the legal process. Robyn (a midwifery student) described her uncertainty by asking, *'Is it appropriate to ask women if they are asylum seekers?'*

Midwives reported that when the asylum-seeking status of women is not documented in hospital maternity records, they may be invoiced inappropriately. The lack of access to Medicare may indicate a woman is seeking asylum, however, overseas students also lack Medicare cover, so this may be unreliable. Ruth, a refugee health nurse midwife said:

> Often it gets flagged if women are paying for appointments because we [are] being conscious of the resources they're… having to pay for (Ruth, midwife).

Nevertheless, flagging this requires the midwife to be confident in understanding the difference between a refugee, migrant, and person seeking asylum, and motivated to explore this issue further.

Midwives who were motivated to ask women questions, to try to identify whether they were seeking asylum, did so despite it not being considered routine practice to investigate the legal status of the women they were caring for. Often, midwives made an 'educated guess', based on the language spoken, country of origin and/or year of arrival:

> I have a personal interest in that area, so I probably pay a little more attention … to be able to identify those women. I start their conversation based around … 'How long have you been here? Where (did) you come from?' And then asking about supports … It is still an educated guess (Ruth, midwife).

> [I ask them] 'Where are you in your legal process? and … [what is your] country of origin?'… or [I ask about their] community support groups (Rachel, midwife).

In stark contrast, some midwives and doulas did not feel it was at all relevant to ask about the woman's legal status. They may be aware of certain vulnerabilities for the woman, such as insecure housing or needing an interpreter, but did not enquire further, as these examples demonstrate:

> I never actually asked anything about their visa status or [had] that conversation (Hannah, midwife).

> It doesn't bother me that she is an asylum seeker. Here is a human being that needs support, regardless of where she came from, regardless of what got her in that situation. She's going through a major life event here, and there's nothing more than birth, that impacts a woman … regardless of their citizenship, or their status in life (Katie, doula).

Agencies who specifically assist families seeking asylum may refer pregnant women to health services or may accompany them to their maternity care appointments. Such agencies may include the *Asylum Seeker Resource Centre,* or refugee health nurse-midwife clinics in community health settings. Midwives would be able to glean from this referral that a woman is seeking asylum.

> The majority of cases, they are linked in with community services … like NGOs [non-government organisations] in the community and they're the organisations that will refer [women seeking asylum] to the hospital (Katrina, midwife).

Alternatively, the referral letter from their general practitioner (GP) may identify a woman as seeking asylum:

> Sometimes it's on the GP notes. They've written it in their background little summary … on the referral (Emma, midwife).

> In our hospital when a GP refers to our system, there is a standardised letter that the GPs … all use and some of the mandatory questions on there [include]: [are they] Aboriginal or Torres Strait Islander background, [or] are they of refugee background? (Melissa, midwife)

Women incarcerated in detention centres in Nauru were transferred to Australia during their pregnancy and cared for by private obstetricians, with no midwifery input:

> A lot of barriers there, because we couldn't identify them … in time to actually provide them with some sort of midwifery care (Melissa, midwife).

Thus, the findings demonstrated that there was no clear pathway to identifying women seeking asylum during their antenatal appointments. Recognition of their visa status relied on information from the referring agency or GP, or depended upon the individual midwife or doula to ask the woman about the context of her situation. Being unable to identify women seeking asylum may result in a lack of appropriate support at a pivotal time in the lives of these women who are facing significant challenges.

Ticking every box

Ticking every box summarises accounts of midwives working under the pressure of a task-oriented culture within the hospital maternity care system. In contrast, midwives who worked in community settings where their time was more flexible; and doulas, who worked independently within community-based organisations, did not raise the issue of 'ticking the box' or focusing on tasks. Doulas, particularly those who had trained as midwives, described observing the acute restraints midwives faced, as the following quote demonstrates:

> [A midwife is] being more like an obstetric nurse, and everybody is so risk averse, they … aren't allowing people time and there's a lot of pressure (Jane, midwife).

Participating midwives and doulas worked in a range of hospitals and community settings (as shown in Table 4.3). Those who worked in hospital settings described a culture that appeared to prioritise medical treatment over the woman's emotional and mental health needs; giving examples of how they saw the structure of mainstream maternity provision in Australia creating barriers for women seeking asylum.

> You've got this crazy hospital that goes like a rocket … and you've got to fit in (Jane, midwife).

Short appointments meant less opportunity to build trusting relationships.

The underlying cause of the difficulties for midwives were not only organisational but professional and personal. Rachel reported that often, hospital staff lacked knowledge regarding how to refer women to appropriate community and social support services.

> I think people sort of get by on minimal knowledge and … there's not really clear avenues for support. I think sometimes we just do the bare minimum (Rachel, midwife).

The fragmented care that was offered to the majority of women was referred to as a 'factory farm' (Katrina, midwife). Midwives expressed their frustration concerning the time limits imposed upon them, expecting them to complete antenatal appointments and postnatal inpatient treatment or home visits in inadequate timeframes:

> You've got this huge … big hospital setting. They have given each woman a number … and color-coded them according to their postcode and then [they are] turning them out … [like] part of a factory farm (Katrina, midwife).

> It takes time: these women need time to build trust in relationships, and when you have a 20-minute midwives' appointment, your time is just gone, so there's no time to ask questions to care for people's mental health, emotional health, ask how they're going, take a little more time, be a little more creative (Ruth, midwife).

Some midwives repeatedly expressed how the pressure of the hospital system restricted their ability to attend to women holistically and respectfully.

> They [health professionals] could say … 'This is a system problem, and this is the best we can do'… I think that can be acknowledged, but with some compassion and sensitivity (Karen, doula).

Despite the systemic issues, midwives described their professional duty to demonstrate compassion and empathy when caring for these marginalised women, even whilst focusing on completing tasks within a specific timeframe (such as physical checks during an antenatal appointment). They were clear, however, that they found time constraints frustrating and spoke of how they were limiting their capacity to provide compassionate care.

The strict time constraints of providing antenatal appointments in fragmented models of care limited the midwives' ability to provide referrals to other support networks:

> We then send off a referral to social work. It … goes to social work, I suppose because they know the pathways and the support network a lot better than we do (Lisa, midwife).

One doula described this model as *'*complete stranger care' (Tabitha, doula). It was difficult for the woman to repeat her story to a new midwife at each antenatal appointment. This was also identified by Jane:

> One … woman said: 'You're going to be there at the birth of my baby? Will I see you next time? Do I have to tell all of this to somebody else? (Jane, midwife)

A woman with a history of trauma may not disclose this when each appointment she attends is with a different midwife who has limited time. The following account describes the potential consequences of how a marginalised woman in labour may experience flashbacks and be further traumatised without a trusting relationship with her care providers:

> She progressed quite quickly like a normal multi [woman having her second or subsequent baby] … and she was pushing … She was having some sort of like flashback … She was just inconsolable … She was screaming … and nothing we did or were say[ing] seemed to calm her down. Her sister was trying as well. We just couldn't seem to connect with her, and she was just having some sort of PTSD … everyone just left that room feeling like it just had gone so badly … I think time restrictions, particularly in antenatal care, [are] very hard. I think lack of continuity of care for these women [is very hard for women in labour too] (Emma, midwife).

In this account, Emma described a woman who may have been suffering from post-traumatic stress disorder (PTSD). She suggested that the woman's distress may have been alleviated if the midwife had known the woman's story and had been able to provide emotional support.

> I think we desperately need a higher risk continuity of care model. I am very keen to work in a continuity of care model … that is willing to work with interpreters … because I feel like these women … often really need that continuity of care.

> And they deserve it and I feel like they've definitely missed [out] (Emma, midwife).

The importance of midwifery continuity of care

Midwives and doulas shared their reflections on a range of maternity models of care that they felt may optimise experiences for women seeking asylum. Midwives expressed different perspectives on the challenges of providing optimal maternity services and midwifery continuity of care models for marginalised women. In particular, they identified continuity of care models that enabled the building of trust between midwives and women seeking asylum, as offering a high quality of care:

> The continuity of care is pivotal for quality care, for everyone. But the more … socially disadvantaged you are, probably the more important it becomes. If you have a strong family, the family can provide some support for your continuity of care. But if you're … isolated … you're relying on the system [and] it's … absolutely vital (Hannah, midwife).

Models of midwifery continuity of care promoted access to maternity services for women seeking asylum and helped them to navigate the complex Australian maternity care system. Midwives and doulas were of the opinion that continuity of care with a health professional enabled the development of a trusting relationship which may profoundly improve the experience for women, as Hannah recommended:

> The option of continuity of care [is important] … particularly women that are new to the country, it's hard enough if you [have] an idea of the system. The system ... can be so frightening (Hannah, midwife).

Models that aimed to optimise opportunities for continuity included: Caseloading continuity of care in the context of hospital models of care, Group antenatal care and Community-based continuity with midwives.

Continuity of care models provided more opportunities for midwives to hear and listen to what was important to the women in their care, in contrast to providing antenatal care to

many women in a single visit under challenging time constraints. Midwives identified that social and emotional encouragement was the cornerstone of respectful care that can develop from the relationships built in continuity of care models:

> To have a friend and a familiar face and just [some] emotional support, helping them to navigate those things would go an enormous way. I think it's actually quite simple things, but I think it's relationship … advocacy and a presence of someone with them that would be the most meaningful (Ruth, midwife).

Midwives who were not working in a model that provided continuity of care clearly understood the benefits of a model that builds trust for women seeking asylum during their pregnancy:

> We should have a refugee health caseload … where there … is a consistent midwife … confident in that … area … [who] could specialise and have some extra resources and continuity of care … I also think there would be capacity for … pregnancy support (Ruth, midwife).

Caseloading continuity of care in the hospital context

In Australia, many continuity of midwifery care models that are hospital-based are only available to women who are considered to be at low risk of complications. Women seeking asylum are often considered high risk and they are therefore excluded from low-risk caseload models. All-risk caseload models — that provide support from a known midwife throughout the pregnancy, labour and birth, and postnatal journey — are more difficult to access for women. One midwife described the continuity model in which she was employed, as a caseloading team within the hospital, that cared for women with both high- and low-risk pregnancies:

> The Midwifery Group Practice … involves four different caseload teams and they're classified according to postcodes, depending on suburbs. We care for women, whether they're primips [women having their first baby] or multis [women having their second or more baby], but also, we care for priority women …. a specific part of our KPIs [key performance indicators] is caring for at least one priority woman per month. And that can be woman from a refugee, asylum

> seeker, young woman, VBAC [vaginal birth after caesarean] or [woman with] mental health issues (Melissa, midwife).

Some midwives suggested that an all-risk caseload model was the obvious choice for women seeking asylum during the perinatal period, as it enabled midwives and women to build a trusting relationship:

> It would be fantastic if they had the one midwife throughout, because then they would feel supported and very relaxed, [such as a] caseload model for asylum seeker women … but [at this hospital, caseload is] … a low-risk model (Alison, midwife).

Midwife Emma explained that women who are considered at high risk for complications, such as women with an asylum seeker background, need to be provided with continuity of care.

> Time restrictions particularly in antenatal care are very hard … [There's] a lack of continuity of care … We desperately need … a higher risk continuity of care model (Emma, midwife).

Emma argued that it was inequitable that marginalised women are often excluded from models that provide emotional and psychological support, as they are only available for women considered to be low risk.

Midwives and doulas discussed how the emotional and psychological impact of seeking asylum can be profound, especially for women who are likely to have a history of trauma. They suggested that continuity of care from a midwife enables them to avoid the distressing experience of repeating their story to numerous practitioners:

> They don't have to share their story with too many people … you can build that relationship of trust … They don't have to constantly repeat their story and they know they've got someone on their side, within the system, which is an incredibly confusing … space (Katrina, midwife).

> Once safety and trust was established … they had someone that … they trusted to be able to go to with questions or concerns (Karen, doula).

Midwives and doulas described the resilience and strength of women seeking asylum and their openness to engagement. Ruth illustrated how the self-sufficiency of these women inspired her.

> These women are often … self-sufficient … strong and very capable … they're not looking for handouts [and]… they're not needy. They're often women that I think go under the radar because they're so good at just getting on (Ruth, midwife).

The view of the midwives and doulas was that their relationships with marginalised women were reciprocal and fulfilling. They admired the women who demonstrated resilience and tenacity. Doulas reflected on the satisfaction they received from the relationship:

> This volunteer work was filling me up … It kept me going for quite a while (Hannah, doula)

> They invited me into their home, and they sat me down and they wanted to cook, and they cooked for me, and they made me eat and … they were just so open to engagement (Katie, doula).

Continuity of carer models appeared to benefit the midwife and doula and women seeking asylum and their family, in a myriad of ways.

Group antenatal care for women seeking asylum

Melissa, a midwife, described her role in developing a group antenatal care (GANC) program, especially for women who were refugees and women seeking asylum. GANC provided midwifery continuity of care in pregnancy in a group setting, which included information sharing and peer support. Antenatal appointments were organised in cultural groups to allow discussion between pregnant women, an interpreter and a midwife. In addition to continuity models with the midwife and interpreter, these isolated, marginalised women were able to enjoy meeting and speaking in their language to other women from their country, developing their own social support network naturally:

> Midwifery Group Practice (MGP) and the antenatal clinic both run in this manner … instead of grouping them by gestation, we group them by language, and we

> will offer an interpreter … We insist that it's a female and she's part of that group discussion: education … Most of the women know her … so that morning all the Syrian women come …. We do [antenatal education] as a group … 80% of our women in the MGP are multigravidas [a woman who has given birth previously] and only 20% are primigravids [a woman is pregnant for the first occasion]. We use the multis (multigravidas) to teach the primigravids and it's more culturally appropriate (Melissa, midwife).

In the model described above, women seeking asylum attended their antenatal appointments on the same morning as other women who spoke their language. The model provided continuity of care during the antenatal and postnatal period, but not when women attended the hospital birth unit for labour and birth. A benefit of the model was that it allowed for semi-structured information sharing facilitated by a midwife, using the same interpreter for each session. Whether they were having their first or subsequent baby, the women participated in discussions about issues such as labour or breastfeeding, whilst developing important social networks that could sustain them in the longer term. In a friendly environment, the women could familiarise themselves with what to expect in hospital before they arrived there in labour.

Community-based continuity with midwives

Community-based continuity with midwives included refugee health nurse midwives and community health service midwives. Refugee health nurse midwives described how they looked after women and their families holistically over one or more pregnancies, allowing them unique insight into their histories of complex trauma. Marginalised families were supported by refugee health nurse midwives over several years, providing advocacy and sharing information.

> Our role is advocacy around health access. It's also trying to educate other health professionals about the issues around asylum seekers (Rachel, midwife).

Being immersed in working with refugee and asylum-seeking families gave refugee health nurse midwives expertise to educate other health professionals and be strong advocates for the rights of these marginalised vulnerable families.

When there was no capacity to provide labour and birth support, an alternative was the continuity of care through pregnancy and the postnatal period from the same midwife, as part of a community health service. Midwives, who worked in these model, embraced the social model of health and provided person-centred care to women seeking asylum and undocumented migrants.

Conclusion

The most significant finding of this chapter, which impacted all aspects of midwives' capacity to care for women seeking asylum, was the *difficulties identifying women seeking asylum*. Negative consequences, such as lack of support during pregnancy, arose when women seeking asylum were not identified. Traumatic birth experiences may result from lack of appropriate support services in the maternity system and when no plan is in place to prevent retraumatisation during labour and birth. In contrast, when these marginalised women were identified, the appropriate support, such as access to a model of continuity of care, enabled them to have more positive maternity experiences.

During their interviews, the midwives and doulas shared the challenges of supporting these disenfranchised, marginalised women, which they attributed to the entrenched inflexible structure of the hospital maternity care system. Midwives felt they were 'ticking every box' due to the time pressures of their role and described the process as a 'factory farm'. As indicated by the findings, this contrasted sharply to the support provided in continuity of care models.

Most women seeking asylum in Australia do not have access to maternity continuity of care models. However, the final thread in this chapter described several models that enabled additional support to be provided to these women. The first was a *caseloading continuity of care in the context of hospital models of care* where women benefitted from a trusting relationship with their midwife, in order to navigate the hospital system and be well supported. Secondly, *group antenatal care* models allowed social support to develop organically amongst peers. Thirdly, *community-based continuity with midwives,* who sometimes may have cared for the whole family for a number of years and more than one pregnancy. These different models provided marginalised women an opportunity to positively engage with the health system with the assistance of a known midwife. However, community midwifery models do not usually include labour and birth care.

Only one midwifery model described in this study provided a caseloading model where continuity included labour and birth care.

The following Discussion chapter will synthesise and align the findings from chapters 5, 6 and 7, with the existing literature.

Chapter 8: Discussion

> *The isolation and loneliness stemmed mainly from being away from their extended families.*
> (Liamputtong, P., 2003, p. 657)

Introduction

Significant barriers to accessing equitable maternity care for women seeking asylum is the clear picture that is drawn from the previous three chapters of findings (chapters 5–7). My thesis builds on the existing international literature exploring the barriers to access, and the maternity experiences of women seeking asylum and the midwives caring for them (Briscoe & Lavender, 2009; Ellul et al., 2020; Feldman, 2014; Funge et al., 2020; Lephard & Haith-Cooper, 2016; McLeish, 2005; Nabb, 2006; Nellums et al., 2021; Tobin et al., 2014b). Previously, research in Australia has combined the experiences of migrants, refugees, and women from a refugee-like background (Billett et al., 2021). My study is unique in that it is focused singularly on the experiences of women seeking asylum. My published literature review (Frank et al. 2021), that appears in Chapter 2, was the first paper to synthesise the qualitative literature on the maternity experiences of women seeking asylum in high-income countries.

The research questions I sought to address in this study were:

- What are the experiences of maternity care and the relative needs of women who seek asylum in Australia?
- What are the barriers to accessing maternity care for women who seek asylum in Australia?
- How do midwives and doulas identify and care for pregnant women who seek asylum in Australia?

This Discussion chapter will focus on aligning the findings with the existing literature. The findings of each issue will be discussed in the light of the current international research, with recommendations for further research, and implications for practice of maternity care (Dube et al., 2022).

Identifying women seeking asylum

In this study, the principal difficulty experienced by midwives who cared for women in a single episode of antenatal care, was identifying women seeking asylum. Experienced midwives spoke about making an educated guess, for example, that there might be clues when women had no access to Medicare or when they were experiencing destitution. This is significant because when it is difficult to identify women seeking asylum, women may not receive appropriate support. They may also experience further trauma if careful plans are not made for their labour and birth. This finding is supported by Swedish research that identified the need for a systematic organisational approach to identifying women seeking asylum, citing the fact that they often seek perinatal care later, have fewer antenatal visits, and spend fewer days at the hospital postpartum when compared to the general pregnant population (Barkensjo et al., 2018). In the Australian context, the National Safety and Quality Health Service Standards (Australian Commission on Safety and Quality in Health Care [ACSQHC], 2021) recommend that health services collect data on migration history, language preference, and country of origin, to improve access to services by migrants and refugees. However, as women are not identified as seeking asylum when accessing maternity care, there is currently no accurate data regarding their perinatal outcomes.

The findings revealed a haphazard approach to identifying women seeking asylum when they engaged with maternity services, which had the potential to impact the quality of the support required for their complex needs. Midwives in this study suggested that the use of a template for refugee health nurses or general practitioners (GP) making referrals to maternity services would be very helpful to their practice, if the form included a question that asks about the visa status of the woman. This assertion from the findings, that formal identification of women seeking asylum in maternity care services is required, is reinforced by the claims that a unified approach to collecting accurate perinatal data is needed (Parkinson et al., 2023; Public Health Association of Australia [PHAA], 2021) so that women identified as seeking asylum may be offered appropriate support and improved access to services (ACSQHC, 2021).

In response to the research question regarding how midwives identify pregnant women who are seeking asylum, midwives spoke about their uncertainty about the appropriateness of asking women questions about their visa status in Australia. They

suggested that training about the importance of identifying women seeking asylum would increase their confidence in asking identifying questions. The motivation and expertise of the midwife to identify women likely to be seeking asylum was seen to be a determining factor prompting midwives to flag women without Medicare or on short-term visas such as bridging visas. The *Victorian Foundation for Survivors of Torture* recommends health professionals may ask questions such as: "Did you choose to leave your country or were you forced to? What was the journey to Australia like? Have you spent time in a refugee camp?" (Kaplan, 1998, p. 21). None of the midwives interviewed for this study had been advised to ask these questions or had been given any training in a systematic method of identification of people seeking asylum.

As discussed in the background to this research, the varying definitions and interchangeable use of the terms *refugee*, *asylum seeker* and *undocumented migrant* causes confusion (Bradby et al., 2015). Previous research in Australia predominantly discusses women of *refugee background* (Blackmore et al., 2021; Rogers et al., 2020; Stapleton et al., 2013; Yelland et al., 2020) and lacks the critical nuance of identifying that women seeking asylum live with the daily uncertainty of possible deportation and the stateless position of their newborn infants (Australian Human Rights Commission, 2014). My findings highlight the impact that this profound sense of uncertainty has upon women during their pregnancy, labour and birth and postnatal journey. The lack of specific information and direction focused on asylum seekers in research and policy further compounds difficulties in developing a systematic approach to help practitioners in identifying people seeking asylum when they engage with maternity services.

As defined in the Introduction to this thesis, an undocumented migrant is someone who either has no visa or has an expired or rejected visa (IOM, 2019, p. 235). This definition is fluid, as it covers people seeking asylum whose initial claim has been rejected, as well as people whose short-term visa has expired and who become temporarily undocumented migrants (Ghio & Blangiardo, 2019). For example, one undocumented migrant woman I interviewed had received a temporary visa and become an asylum seeker in the six months between her two research interviews, as her application for a temporary visa was processed by the government. Those with an expired visa may include informal workers often working on farms. As in Europe and the UK, undocumented migrants in Australia may have limited access to health care and live in fear of immigration authorities finding and deporting them back to their country of origin (Cuadra, 2012; Nellums et al., 2021;

Stubbe Ostergaard et al., 2017). In these situations, undocumented migrant women may hesitate to seek maternity care due to fear of being deported (Lessard-Phillips et al., 2021).

The impact of destitution on food insecurity and homelessness

Women seeking asylum and undocumented migrants whom I interviewed experienced moderate to severe levels of destitution and homelessness and all of them described their desperate financial situations. People seeking asylum who live in the community in Australia may not be allowed to work and are therefore often forced into destitution and homelessness. During the Covid pandemic, people seeking asylum who already did not have access to social security in Australia became at greater risk of destitution (ASRC, 2021).

Food insecurity during pregnancy, particularly while being held in Australian detention centres, was an issue of concern for women in this study. This finding is aligned with the Forgotten Children Report (Australian Human Rights Commission, 2014) which details the limited autonomy of people seeking asylum regarding food and the prison-like conditions in detention centres. The impact of destitution for pregnant women seeking asylum in Germany was compounded by poor housing in state provided detention centres, where people seeking asylum are housed in a 'camp' and prohibited to cook, limiting their access to healthy and cultural foods (Gewalt et al., 2019). Studies in the UK and Europe have identified similar hardships for women with uncertain visa status (Ellul et al., 2020; Feldman, 2014; Henjum et al. 2019). A quantitative study in Norway found that 93% of people seeking asylum had experienced food insecurity in the previous 12 months, compared to 3% of the local population (Henjum et al., 2019). Not having enough money for food was also a finding of a UK study, which also identified homelessness as an impact of financial destitution for pregnant women seeking asylum (Ellul, 2020). The UK government policy forced women seeking asylum to frequently move during pregnancy from one government provided accommodation to another in regional areas, causing severe disruption to their lives and to their engagement with maternity care (Ellul et al., 2020; Feldman, 2014). Destitution and food insecurity impacted people seeking asylum, both of which are significant health risks for pregnant women and their unborn babies.

Having uncertain visa status and no access to Medicare

For the women seeking asylum in Australia whom I interviewed, having uncertain visa status resulted in a lack of access to free public health care services funded under Medicare. Receiving expensive bills for their maternity care compounded their already desperate financial situations. Midwives and doulas spoke of their advocacy role and efforts to ameliorate this financial stress which included facilitating free or discounted payments for pathology, ultrasound, and/or payment plans for hospital inpatient services. They expressed concerns that asylum-seeking women were delaying or avoiding antenatal care due to the cost, with the potential consequences of a range of poor perinatal outcomes. Similar barriers to accessing maternity care for undocumented migrants have been described in Sweden (Barkensjo et al., 2018) and Denmark (Funge et al., 2020). The potential costs, fear of being reported to authorities, and not understanding the health system all played a role in barriers for asylum-seeking women to access maternity care.

In 2021, the Australian National Safety and Quality Health Service Standards aimed to address barriers faced by migrant and refugee women in navigating and accessing health care (ACSQHC, 2021). These Health Service Standards do not address the specific needs of people seeking asylum, which is problematic, since there is no uniform refugee experience and there are many intersecting complex factors (Blackmore et al., 2020). The complexity of the evolving legal and political situation regarding people seeking asylum in Australia has led to multiple challenges, in particular, access to public health services under Medicare (Hadgkiss & Renzaho, 2014).

Adverse pregnancy outcomes have been linked in the literature to the difficulties faced by refugee and migrant women in accessing appropriate public health services. These challenges expose them to unhealthy lifestyles and psychosocial stressors that accentuate their powerlessness, leading to adverse outcomes (Behboudi-Gandevani et al., 2022a). Behboudi-Gandevani et al. (2022b) asserted that babies born to migrant women from conflict zones are at greater risk of neonatal mortality and morbidity than women birthing in their country of origin. However, this review was not specifically focused on HICs.

Studies specifically comparing outcomes for people seeking asylum with host populations show alarming results. For example, in one study, acute maternal morbidity was four and a half times higher in women seeking asylum than for women born in the Netherlands

(Van den Akker & Van Roosmalen, 2016). The UK Confidential Enquiry into Maternal Deaths (Knight et al., 2022) found black women were 3.7 times more likely to die in childbirth than white women. The researchers drew attention to the fact that most studies do not differentiate between different groups of migrants and that therefore poor perinatal outcomes for asylum seekers may not be properly identified (Knight et al., 2022). A large retrospective study by Bozorgmehr (2018) in Germany comparing differences in maternity outcomes for asylum-seeking women and German women demonstrated that asylum-seeking women experienced a higher incidence of stillbirth and poorer postnatal outcomes, including an increase in mental health issues and postnatal depression. A systematic review specific to undocumented migrants and women seeking asylum showed higher rates of maternal mortality and serious maternal and neonatal morbidity, such as preterm birth and low birth weight, between 2007 and 2017, in Europe (Gieles et al., 2019). The authors suggested that this may be linked to conditions in their country of origin or migration journey and that antenatal care in the host country is vital, to identify and address these risk factors (Gieles et al., 2019).

This thesis proposes that the ongoing uncertainty for the future underpinned the poor mental health status of many women seeking asylum. Evidence demonstrates higher rates of postnatal depression in displaced persons such as refugees, migrants and women seeking asylum (Bozorgmehr 2018; Heslehurst et al., 2018). A higher incidence of adverse outcomes for undocumented migrants has been linked to the issue of reduced access to health facilities (Almeida et al., 2013). Evidence demonstrates that this is directly related to whether they will be granted permanent visas or returned to their country of origin (Funge et al., 2020). A prolonged sense of uncertainty is known to lead to despair, anxiety, and a sense of helplessness (Kaplan1998).

The evidence consistently supports my argument that there is a need for research to be specific to perinatal outcomes for women seeking asylum and undocumented migrants. Strong evidence linking adverse outcomes to the inequities asylum-seeking women face in relation to accessible and affordable health care is needed, in order to influence policy and political decision making. A systematic approach to identifying women seeking asylum in their pregnancy is required in order to conduct research on their perinatal outcomes in Australia.

The deprivation of human rights in detention

The midwives and doulas I interviewed spoke of the appalling treatment in detention of women seeking asylum who were pregnant, giving birth and in their postnatal journey. They described, for example, witnessing prison guards outside the rooms of women seeking asylum in hospital birth suites and postnatal wards. The resulting denial of women's human rights is identified by several human rights organisations, including the *United Nations (UN),* the *ICM* and the *Australian Human Rights Commission (AHRC).* The international treaty, Convention on the Elimination of All Forms of Discrimination against Women (UN, 1979) and The Forgotten Children report into children in detention (Australian Human Rights Commission, 2014). described this practice of women birthing in isolation with guards outside hospital birth rooms as a breach of their human rights. *The Code of Ethics for Midwives* (ICM, 2014) highlights the abuse of the right to privacy for women during their labour and birth.

Women seeking asylum who participated in my research, spoke of their poor mental health during and after their detention in Australia. This aligns with studies that demonstrated how the detrimental mental health impacts of the Australian prison-like detention system are linked to increased anxiety, depression, and post-traumatic stress disorder conditions that are exacerbated in proportion to the length of time spent in detention (Newman et al., 2013; Peterie, 2018).

Pre-existing trauma compounds the severe ongoing mental health impact of the Australian detention system (Hocking et al., 2015). Midwives and doulas in my study spoke of the horrific trauma experienced by the women they supported prior to fleeing their country of origin. Recent research demonstrated that women of refugee background may have experienced rape, torture, imprisonment, or the murder of a family member (Blackmore et al., 2021). In high-income countries, people who seek asylum have 28% higher rates of depression and 31% higher rates of post-traumatic stress disorder than the general population (Blackmore et al., 2020; Patanè et al., 2022).

Proposals by the British government to invoke similar draconian offshore detention systems and to remove people arriving by boat to a third country, such as Rwanda, are raising serious concerns with the *UNHCR* (McDonnell, 2023). In its Statement on the proposed United Kingdom Asylum Bill, the *UNHCR* stated that such measures are

inhumane and a clear breach of the Refugee Convention, which recognises that most people fleeing war and persecution have no safe route of entry and may be compelled to enter a country of asylum irregularly (UNHCR, 2023). Furthermore, such measures discriminate against people who arrive by irregular routes, such as by boat, and denies their right to claim protection under the Refugee Convention (UNHCR, 2023).

Reporting on the clear breach of human rights that the midwives and doulas in this study witnessed is important, as the voices of asylum-seeking women have been systematically silenced (Macken, 2019). The *Human Rights in Childbirth Organisation* states that public bodies must respect human rights when making decisions and that caregivers working in public bodies must respect human rights as they go about their work (Kumar Hazard, 2018). The human rights framework is thus an appropriate lens through which to explore the experiences of detention faced by asylum seekers in Australia, in particular those of women who are pregnant and their families. However, women's reproductive rights remain contentious and vulnerable to male-dominated political institutions (Kumar Hazard, 2018).

The dark thread woven through this thesis is the violence and violations of human rights inflicted on women seeking asylum in the name of maternity care. These women are criminalised by the Australian government and prevented further from exercising autonomy over their bodies and lives by a patriarchal maternity system.

Lack of support and isolation

In Australia, there is a recent history of government policy isolating people seeking asylum in remotely located detention centres (Australian Human Rights Commission, 2014). Asylum-seeking women in this study experienced isolation from friends or family, either in detention centres during a previous pregnancy or in community detention during the current pregnancy. The isolation was deeply felt during pregnancy, when giving birth, and during their life with a new baby, and was exacerbated for those who lacked family, community, and professional support. Midwives and doulas in this study described their concerns for women seeking asylum and the constant challenge of lack of support. This aligns with research literature from both Wales and Canada, where women seeking asylum spoke of their loneliness and sadness (Khanom et al., 2021), and despaired that they had no social support (Merry et al., 2011). The government policy in the UK of

relocating women seeking asylum in pregnancy to accommodation where they have no family connections not only creates uncertainty, as highlighted above, but adds to their sense of isolation (Feldman, 2014). Social, emotional, financial, practical, and language support are primary factors that should be addressed when considering the isolation and distress faced by pregnant asylum seekers held in state-provided accommodation (Gewalt et al., 2019).

The importance of cultural safety training

My findings showed that midwives and doulas actively sought and participated in cultural competency and cultural safety training, often in addition to regular training offered by their workplace. They stated that cultural competency or cultural safety training is important for all practitioners, and especially so for those working with refugees and asylum-seeking women. This aligns with studies from Australia (Olcon et al., 2023) and Ireland (Tobin et al., 2014a), in which midwives spoke of the frustration they felt when they were not supported by their organisation to provide culturally safe care to refugees and migrants. Education and support for midwives is needed to address a range of issues, including the role of interpreters, comprehending cultural safety, the challenges caring for women who have had no antenatal care, and the emotional cost of caring for asylum-seeking women (Tobin & Murphy-Lawless, 2014a). An organisational shift is required to enable training and support if midwives are to provide authentic, culturally responsive care (Olcon et al., 2023).

In discussing the need for education and support when caring for asylum seekers, midwives and doulas in this study mostly used the term *cultural competency* but some also used the term *cultural safety*. Authors of a literature review exploring aspects of cultural safety versus cultural competency training contended that midwives, hospitals, and health systems need to engage in activities that work towards cultural safety, rather than focusing on cultural competence (Curtis et al., 2019). This means practitioners being willing to challenge their own cultural systems and examine how their values and attitudes are influenced by their family and social background, rather than becoming competent in understanding the cultures of others. It involves a complex, ongoing process of reflection and challenge to the personal, organisational and systemic power structures that have the potential to cause harm and increase health disparities for minority ethnic groups (Curtis et al., 2019). Other authors have also stressed the importance of education to address

cultural safety effectively on both an individual and systems level (Gerlach, 2012; McGibbon et al., 2014). Education that encourages personal and professional reflective activities can promote understanding of how privilege and colonisation are complicit with systemic and individual racism and that this has ongoing impact on health inequities.

Addressing disrespectful care and racism

Disrespectful care and racism were witnessed by the doulas and midwives who participated in this study. The findings demonstrate that this was an issue at both an organisational and personal level, with participants giving examples of how a lack of understanding and training allowed a culture of disrespect and racism to continue. They observed doctors, midwives, and support workers ridiculing, minimising and speaking disrespectfully about women seeking asylum. These findings are substantiated by an Australian study looking at racism, health care access and equity for people seeking asylum, which identified that xenophobic and discriminatory attitudes and practices lead to poorer quality health care in their host country, leading to concerning long-term mental and physical outcomes (Willey et al., 2022). Using clinical case studies to raise awareness of the common issues asylum seekers face in health care, the authors gave examples of situations where racism and a lack of trauma-informed care can maintain and perpetuate ongoing health disparities. Willey et al. (2022) asserted that nurses and midwives can play a role in countering racism, including identifying and exposing xenophobia and demonstrating respect and empathy. Recommendations included suggestions for how organisations can make policy changes to support individual staff members to address racism and improve health equity for people seeking asylum (Willey et al., 2022).

Some of the women seeking asylum whom I interviewed gave examples of receiving racist comments from hospital staff about their lack of ability to speak English. Studies of the experiences of pregnant asylum-seeking women in the UK and Ireland have also described disrespectful care; identifying situations where a lack of privacy, dignity and confidentiality were allowed to continue without challenge (Lephard & Haith-Cooper, 2016; McLeish, 2005; Tobin & Murphy-Lawless, 2014b). Tobin and Murphy-Lawless (2014b) found that Irish midwives lacked empathy and reflexivity in caring for women seeking asylum, speaking of them as ‘others’, demonstrating that they perceived stereotypical differences that created an ‘us and them’ attitude.

Attitudes of maternity care providers toward undocumented migrants can sometimes divide women into those who are deserving or undeserving of health care, which creates an 'us and them' status (Sahraoui, 2021). Governments refer to undocumented migrants as 'illegal', with significant consequences for them, such as having no identity and no address (Willen, 2007). The vulnerability this creates means undocumented migrants are open to exploitation, and treated as disposable, particularly regarding employment (Willen, 2007). The concept of 'othering' signifies behaviour where a group of people are treated as though they are different and not part of a group, giving rise to discrimination. According to Grove and Zwi (2006), 'othering' leads to people seeking asylum, refugees, and migrants being situated as separate and disconnected from their host communities. This positioning includes a polarising discourse of 'us and them,' the 'worthy and the undeserving,' 'insiders and outsiders,' and 'the law abiding and the law breaking'. In particular, people seeking asylum are labelled as 'queue jumpers', referring to a fictional administrative queue that those seeking asylum must join (Grove & Zwi, 2006). This 'othering' of people seeking asylum is consistently reinforced by the Australian media where people seeking asylum are framed as possible criminals, thus upholding the government-sanctioned theme of deterrence (Allen & Hoenig, 2018). Grove and Zwi (2006) urged health professionals to challenge the 'othering' discourse. They proposed that health professionals can play a role in reassessing thinking about health treatment and systems to improve health outcomes for people seeking asylum. This includes promoting social and employment inclusion, and a positive narrative that integrates and values the experiences of people seeking asylum.

A culture of negative political discourse about people seeking asylum appears to influence community attitudes, fuelling the type of racist attitudes that were witnessed by the participants I interviewed. Political discourse divides those seeking asylum into those worthy of refugee status versus those perceived as a criminal element, which is inferred by the label of 'illegal immigrant' (Aspinall & Watters, 2010, p. ix). This discourse is prevalent in both Australia and the UK, where research demonstrated racist attitudes of midwifery students who perceived asylum seekers to be of a criminal persuasion (Haith-Cooper & Bradshaw, 2013, part 1).

Midwives and doulas in my study described incidents of women being plagued by disrespectful care as direct examples of racism. They gave examples of women being spoken to directly and indirectly in a demeaning and disrespectful manner, and being

denied appropriate interpreter services. In considering how such behaviours reflect systemic and structural racism as well as racist attitudes of individual health care practitioners, Braveman et al. (2022) offered a definition of racism as:

> The relegation of people of colour to inferior status and treatment based on unfounded beliefs of innate inferiority, as well as the oppression and unjust treatment of people of colour, whether intended or not (p. 171).

As identified in a systematic review of racism and health service utilisation, entrenched systems of privilege contribute to racism, leading to reduced trust in health care professionals, poorer satisfaction with care, delayed care, and poor communication (Zeeb et al., 2017). Likewise, Ziersch et al. (2020) asserted that racism is a fundamental issue that must be addressed to ensure respectful maternity care for women who seek asylum, suggesting that an important first step is acknowledging how systemic and structural racism is embedded in systems, policies, and practices.

The need to address racism is highlighted in recently published practice guidelines for the perinatal care of migrant, asylum-seeking, and refugee women (Vivilaki et al., 2020). Funded by the *Health Programme of the European Union*, the guidelines state that racism has clearly defined effects on the care provided in maternity services and that this is seldom explored. The authors make the point that simply learning about other cultural groups can lead to further dehumanisation, stigmatisation and de-legitimisation, and that health care providers should be encouraged to explore how their own unquestioned beliefs and unconscious bias might contribute to racism.

Fundamental to the issue of racism in Australia is the prevalence of an anti-Muslim, 'queue jumper' and 'illegal immigrant' discourse around people seeking asylum (Refugee Council of Australia, 2022, p. 2). This occurs despite many Australians perceiving cultural differences as a positive aspect of Australian society (Haw, 2022). As I described in the introduction to this thesis, in recent years, those seeking asylum who arrived by boat were processed in offshore prison-like detention centres for an indefinite period. *The Australian Human Rights Law Centre* (2021) is still working to end the Australian Government's punitive policy of offshore detention and the separation of families seeking asylum. *The Refugee Council of Australia* refuted the myth that people arriving in Australia by boat are 'queue jumpers', stating that there is no orderly queue to enter

Australia, and that it is not illegal to seek asylum (Refugee Council of Australia, 2022, p. 2).

Racist attitudes and behaviours, such as those described in my findings, can have a serious effect on the mental wellbeing of people seeking asylum. This was highlighted in a study reporting on refugees and people seeking asylum who had been in Australia for up to seven years. Participants described suffering from mental ill health, due to experiences of discrimination across intersecting characteristics of ethnicity, religion, gender, and visa status. This was associated with a lack of trust, a reduced sense of power, and a loss of confidence. Key settings where discrimination was experienced were public transport, employment, and when accessing health and housing services (Ziersch et al., 2020).

According to the *ICM* (2020), the promotion of respectful care must be addressed at organisational, professional, and personal levels. The international organisation, *Human Rights in Childbirth,* also advocates for respectful maternity care, highlighting examples of racism and the ongoing denial of basic human rights where women face abuse, coercion, and control during childbirth (Kumar Hazard, 2019). In response to such global abuses of human rights, the *White Ribbon Alliance* developed a guide for respectful maternity care (Windau-Melmer, 2013) reinforcing the position that birth is a rite of passage and requires more than physical safety. Ultimately, respectful maternity care includes respecting the woman's autonomy, feelings, preferences, and choices (Windau-Melmer, 2013). In practice, this means that empathy, listening, warmth, and non-judgemental attitudes are key attributes in providing compassionate maternity care for all women (Teskereci et al., 2020). These qualities were highlighted by the midwives and doulas in my findings, when they reflected on what could make a positive difference to promoting respectful care.

Midwifery continuity of care

As described in my findings, midwives and doulas expressed their views that midwifery continuity of care can provide optimal care and promote a sense of safety for women seeking asylum, through the development of a trusting relationship. There is a wealth of evidence supporting the implementation of midwifery continuity of care programs in terms of safety, efficacy, and cost-effectiveness; this has led to policy reform in several countries including Australia, New Zealand and the UK (Homer et al., 2019). A Cochrane

systematic review identified that women who experience midwifery continuity of care are more satisfied with their experience and less likely to have birth interventions. The conclusion of this review was that 'most women should be offered midwife-led continuity models of care' (Sandall et al., 2016, p. 3). Midwives in my study proposed three models involving midwifery continuity of care, all of which they identified as important for promoting safety and wellbeing for asylum-seeking women: midwifery caseload practice, group antenatal care, and community-based antenatal care.

Midwifery caseload practice

My findings support the argument that the development of a trusting relationship between midwives and women through midwifery continuity of care was ideal in assisting asylum-seeking women and undocumented migrants to negotiate the barriers they face in accessing maternity services. Continuity of care with midwives has been shown to lead to improved outcomes for mothers and babies (Sandall et al., 2016) and may be a particularly important public health strategy for women in marginalised groups and those with high socioeconomic disadvantage (Allen, 2019; Homer et al., 2017). Also referred to as *midwifery continuity of carer*, caseload midwifery refers to a model where a primary midwife continues to coordinate and provide ongoing care from pregnancy through to the early weeks after the birth, liaising with other agencies and practitioners as necessary, and with backup from other midwives in a midwifery group practice (AIHW, 2022a; Homer et al., 2019).

The case has been made that midwifery continuity of carer models should be a priority for women with complex social factors (Allen, 2019). Socially disadvantaged women who were able to access a caseload midwifery service in the UK were significantly more likely to be supported with interpreters and mental health, domestic violence, advocacy, and housing services. Improved perinatal outcomes were also demonstrated, including lower rates of caesarean birth, epidural, antenatal, and neonatal admission, and shorter postnatal stays in hospital (Rayment-Jones et al., 2015). Women seeking asylum and undocumented migrants should therefore be among the groups that are prioritised for midwifery continuity of care in maternity service development policy and guidelines.

A study of how women with social risk factors access maternity services in the UK outlined the importance of midwifery continuity of care in facilitating access to services

that provide education, interpreters, and practical support. The possibility of restoring trusting relationships with health care professionals was identified as particularly important for disadvantaged women with a history of trauma (Rayment-Jones et al., 2019). A study of more than 2000 women cared for by the *Albany Midwifery Practice* identified positive outcomes for women in socially disadvantaged and Black and Minority Ethnic (BAME) groups, including those with complex pregnancies and perceived social risk factors (Homer et al., 2017).

In Australia, most midwifery continuity of care models exclude women with complex pregnancies, despite little evidence to justify their exclusion (Fox et al., 2023). The building of a trusting relationship between the midwife and woman promotes emotional safety for women; this may be particularly important where women face pregnancy and new motherhood against a background of uncertainty and vulnerability due to complex pregnancies and social risk factors. Trust and emotional safety have been seen in several studies to benefit low-risk women during their maternity care, and there is a strong case for women with complex pregnancies and social factors to be prioritised where access to midwifery continuity of care is limited (Teate et al., 2011).

Group antenatal care

Group antenatal care (GANC) is a model of care where antenatal care, childbirth education, and social support are combined in a group setting, facilitated by the same health care provider. After their initial antenatal booking, women of a similar gestational age attend all their antenatal appointments together in a group session lasting approximately two hours. Structured group activities promotes information sharing and friendships, as well as continuity of care with a midwife. Originally conceived as *Centering Pregnancy* in the mid-1990s by Sharon Schindler Rising, GANC has been extensively researched and is now operating in many countries. It is identified by the *WHO* as an important health system innovation that may help promote positive experiences of pregnancy for women, while improving continuity and the quality of care (WHO, 2016).

Australian antenatal guidelines have outlined the potential benefits of GANC for women from refugee backgrounds (Australian Health Ministers Advisory Council, 2012). Midwives whom I interviewed in this study were involved in GANC for marginalised

women, and recommended it as an important way of providing antenatal care for women seeking asylum. They described a GANC project that provides weekly group antenatal care in language groups, which serendipitously facilitates social support between the women. The same midwives facilitate the group each week, together with a social worker and an interpreter. A midwife I interviewed who had been instrumental in setting up the program explained that this enabled collaboration to develop across the multidisciplinary team. According to a systematic review of the experiences of midwives facilitating group pregnancy care by Lazar et al. **(**2021), this model may allow midwives to develop relationships with the women seeking asylum and provide opportunities for education.

Group antenatal care for refugees was co-designed by health services in discussion with refugee families in Melbourne (Riggs et al., 2017). In an early evaluation, women reported feeling empowered and confident as a result of their experiences, in particular through the sharing of stories with peers and developing trusting relationships with the GANC facilitators (Riggs et al., 2017). A model of GANC to improve outcomes for women from refugee backgrounds was offered in the evaluation protocol for this project (Riggs et al., 2021), which identified the goals as improved health literacy and trust in health services, healthy birth outcomes, and building social networks (Riggs et al., 2021).

Community-based antenatal and postnatal care

Currently in Australia, only 1% of maternity care systems provide a targeted program to support migrants and refugees (AIHW, 2022a). A model recommended by midwives in my study offered women antenatal and postnatal continuity of care in the community, however this model excluded continuity of carer during labour and birth. They described an example where a woman's primary midwife liaised with other services, such as social work and mental health services, to address issues such as housing, finances, and visa applications. The known midwife was able to provide support in the community after the woman had given birth. In this model midwives working as refugee health nurses or in a community health role provided continuity to women in their care over several pregnancies and supported their whole family.

Studies have identified the benefits of a community health service model in which midwives provide continuity of care, and practise according to a social model of health, supporting women's physical, emotional, psychological, cultural, and spiritual needs

(Gewalt et al., 2019; Iqbal et al., 2021). This model focuses on activating support networks within the woman's community, with opportunities to meet other pregnant women who may provide mutual support in the postnatal journey (Leap, 2010).

As identified by midwives and doulas in my findings, doulas who provide support for women across the interface of hospital and community can act as 'a bridge' in fragmented maternity care systems where midwifery continuity of care and links to community services are lacking (Balaam et al., 2021). An evaluation of a community volunteer support program for disadvantaged women is currently being undertaken in Melbourne, Australia. The research aims to describe how volunteer doulas working in the community support socio-economically disadvantaged women, and the potential impact on care provided by mainstream maternity services (O'Rourke et al., 2020).

The constraints of institutional care

Midwives who participated in my study spoke about finding it challenging to provide the type of care that is needed to support asylum seekers in the context of hospital maternity care, particularly where they are only able to meet women for single episodes of antenatal care and when interpreters are required. A systematic review of interventions to improve care concluded that women who are marginalised and who have complex social needs require extra time to be allocated to appointments (Iqbal et al., 2021). Time restrictions were similarly described by midwives working with asylum-seeking women in the UK, as a consequence of the structural and systematic barriers to accessing hospital care. Letley (2022) proposed that derogatory attitudes towards these marginalised women, were exacerbated by time restrictions, leading to resentment and discrimination.

Fear of disclosing domestic violence

In discussing their experiences of carrying home vicarious trauma, midwives and doulas in my study described being aware of horrendous stories about women experiencing domestic violence feeling trapped and powerless to ask for help. Reasons women may feel trapped included cultural expectations to remain married, and women's experiences with available services, which were identified as barriers to requesting assistance (Afrouz et al., 2021). The Afrouz et al. study investigated Afghan women's experiences of domestic violence after settling in Australia, however, it was unclear what visa type these women held (Afrouz et al., 2021). Whilst all of these factors might apply to pregnant

asylum-seeking women experiencing domestic violence, a concerning finding from this study was the midwives' views that women seeking asylum were not disclosing domestic violence due to concerns that their visas were linked to the visas of their violent partner.

Midwives and doulas identified that women feared deportation if they were to speak out. This was aligned with a scoping review that identified that major barriers to disclosing violence for refugee and asylum-seeking women were fear of deportation, the impacts of relocation, and the risk of losing custody of their children. Factors that were the strongest motivators for disclosure and help-seeking were empathy, trust in health care providers, and concerns about the wellbeing of their children. The review highlighted the imperative for the needs of refugee victim-survivors to be addressed in domestic violence and cultural competence training for all health care professionals (Allen-Leap et al., 2022).

The National Advocacy Group on Women on Temporary Visas Experiencing Violence Report (2019) has been endorsed by 50 organisations across Australia who promote the human rights of women to be safe, regardless of their visa status. In response to identified concerns on the safety of women on temporary visas, this report identified a plan for reform that includes advocating for access to safety, justice, support, free legal services, and changes to Australian migration law. The report drew on a survey which identified more than 300 women on temporary visas who were experiencing domestic violence and accessing social services. Organisations were unable to provide accommodation, which was a priority need, nor could they provide financial assistance. One in four of the women were living in emergency or temporary housing, with one in ten living at home with a violent partner. These findings were identified as a national crisis, requiring immediate law and policy reform (National Advocacy Group on Women on Temporary Visas Experiencing Violence, 2018).

Repeated studies have identified that it is vital to address the issue of domestic violence, due to the recognised potential effects on women's wellbeing, including post-traumatic stress disorder, depression, social isolation, and unwanted pregnancy (Allen-Leap et al., 2022; Feder et al., 2011). Domestic violence leads to increased rates of miscarriage, low birthweight infants, stillbirth, and maternal death (Baird et al., 2013). Pregnancy provides an opportunity for women to disclose domestic violence; and this is significant if pregnancy is the first or only contact a woman has with health professionals (Feder et al., 2011). Midwives therefore play an important role in enquiring about domestic violence,

in order to liaise with other professionals and ensure support systems are in place for the woman (Feder et al., 2011).

In Australia, it is routine practice for midwives to engage in screening for domestic violence, during antenatal care. Standardised questions are asked when the woman is alone (Department of Health, 2020). Screening for domestic violence is therefore not possible if a potential perpetrator, the woman's partner or a family member, is acting as an informal interpreter. My findings demonstrated that women were often not provided a professional interpreter, either due to lack of access or motivation on the part of the health professional, or due to women's concerns about privacy and confidentiality. A synthesis of studies, relating to the opinions of women and midwives on the routine enquiry about previous trauma, emphasised that fear of judgement inhibits disclosure, and that trauma disclosure was more difficult for women who need an interpreter, particularly when their abusive partner acts as an interpreter (Cull et al., 2023). *The Practice Guide for Perinatal Health Care of Migrant, Asylum-seeking and Refugee Women* (Vivilaki et al., 2017) supports the argument that the use of professional interpreters is crucial, emphasising the importance of making sure that health care professionals do not use family members for interpretation in consideration that women may be experiencing domestic violence or controlling relationships from family members or partners.

The resilience of women seeking asylum

Midwives in this study described how women seeking asylum inspired them by the resilience they demonstrated, in spite of their significant trauma histories. *Resilience* is a term used to describe emotional growth and the ability to find meaning after experiencing adversity, such as trauma, loss, disaster, and suffering. It can be a way of dealing with the effects of trauma through self-transformation and human growth (Wilson, 2007). This may be ameliorated by social and emotional support. A study exploring mental health support for people seeking asylum in Australia, applying for and receiving temporary visa outcomes, identified that support helps them to build resilience and which is enhanced by supportive relationships (Procter, 2011).

In discussing their practice, midwives and doulas described drawing on a strength-based approach when framing the experiences of women seeking asylum. A strength-based approach focuses on building rapport, encouraging motivation and mutual goal setting

(Cross & Cheyne, 2018). Using the motivation and the strengths of the woman, the aim of a strength-based approach is to work with women, throughout their maternity care, in a way that imparts a sense of confidence in their abilities (Cross & Cheyne, 2018).

Midwives and doulas participating in my study observed the resilience of the women seeking asylum. They described their relationship when caring for women throughout the pregnancy as reciprocal and in positive terms. This reflects the results of a literature review — aimed at understanding how social support affected the coping resources of immigrant and refugee women with postpartum depression — that explained how resilience in marginalised women can be a strength-based characteristic that focuses on hope (Kassam (2019). Similarly, a synthesis of literature on the parenting experiences of people seeking asylum, refugees, and undocumented migrants described the core of resilience as women's hope for a better life for their children. Other factors that foster resilience included maintaining their language, culture, and religion (Merry et al., 2017). This correlated with the findings of the interviews with the women seeking asylum, who demonstrated their resilience and hope for the future of their family in this research.

Midwives in my study who were employed in a continuity of carer model — such as refugee health nurse midwives and doulas who had specific training — deliberately focused on the strengths-based approach. They adopted the strength-based approach by acknowledging the skills and life experiences of women seeking asylum (Balaam et al., 2017). This approach is the basis of a project that is part of the maternity stream of the *City of Sanctuary project* in the UK. Health befrienders worked alongside women building on existing social and emotional support (Balaam et al., 2017). The aims of the *Maternity City of Sanctuary* are to promote welcome and safety, to involve women seeking asylum in planning maternity services, to overcome barriers to accessing care, and to develop a supportive community. *The Sanctuary Model* builds an organisational trauma-informed culture which promotes resilience in the women seeking asylum and the staff supporting them (Sanctuary Model, n.d.).

Briscoe et al. (2016) developed a concept analysis of women's vulnerability during pregnancy, labour and birth, and the postnatal journey, suggesting that vulnerability can be transformed into resilience with inner strength and external support. Vulnerability was described as a journey, where each day is part of the tapestry, and factors such as bonding with their baby promote resilience (Briscoe et al., 2016). Resilience was boosted by warm

professional relationships, which may be enhanced where women have flexible care (Briscoe et al., 2016). This concept will be further explored in the Implications for Practice section in chapter 9.

Doulas provided valued support

In this study, women seeking asylum appreciated the role of doulas in providing emotional and practical support during their pregnancy, labour and birth, and in their postnatal journey. My research findings suggest that maternity models that include doulas to provide support may assist in overcoming some of the challenges and disparities faced by women seeking asylum in maternity care in Australia. A Cochrane systematic review has focused attention on the benefits of doula support in labour and birth (Bohren et al., 2017) but, to my knowledge, no studies have focused specifically on doula support for women seeking asylum. There is also a dearth of studies asking marginalised women about their experiences of doula support.

Doulas provided a unique perspective in this study as they were working outside of the hospital system and were able to provide continuity of support throughout the women's maternity journeys, from early pregnancy to the weeks following birth. In this research, all of the doulas worked in a voluntary role with an organisation called *BfH* when caring for women seeking asylum. The sole focus of their role was focusing on supporting the woman. In contrast, midwives have the dual role of being responsible to the woman and the institution (Bradfield et al., 2019). The Cochrane review of continuous support in labour (Bohren et al., 2017) highlighted the advantages of having support from a person, like a doula, who is solely present to provide support, with no accountability to the maternity care system for providing care. This factor seemed to be linked to improved outcomes, including an increased likelihood of spontaneous vaginal birth, reduced caesarean birth rates, and increased satisfaction for women. A systematic review exploring community-based doula programs for migrant and refugee women included studies from HICs. The conclusion was that a community-based doula, who shares the same cultural and linguistic background as the woman she cares for, may bridge the gap in providing culturally responsive care. Furthermore, bicultural doulas may enhance respectful care and provide culturally safe care in health services that may be difficult to navigate for vulnerable women. There is a need for more research on the wide-reaching

benefits of such programs, including the identification of factors that affect their implementation and sustainability (Khaw et al., 2022).

Doulas, volunteer befrienders, birth companions, and bicultural doulas may all have a positive role to play in providing non-clinical support to marginalised women and their families. Balaam and colleagues (2016) described the ways in which volunteer workers supported women seeking asylum, bridging the gap in the lack of support from maternity services. Their research identified how volunteer workers were able to encourage education, advocacy, and practical support, such as transportation (Balaam et al., 2016). Nursing student doulas in the USA, providing continuity of care as birth companions, were able to advocate for women who were without a labour support person, and improve communication and referral to community services (Van Zandt et al., 2016). However, the retrospective study by Van Zandt et al. (2016) did not interview the women to include their views and experiences of having birth companions.

Two participants in my research worked as bicultural doulas; they spoke English as their second language and were able to provide support drawing on their experiences as migrants. As mentioned above, they worked in, *BfH*, a non-government organisation providing a service for disadvantaged women in Melbourne. Each woman is supported by a volunteer doula throughout pregnancy, labour and birth, and in the postnatal journey. Recent studies have been conducted relating to the *BfH* program (Khaw et al., 2022; O'Rourke et al., 2022; O'Rourke et al., 2020). An assessment of the doula program at *BfH* drew on multiple sources of evidence. The researchers developed theories about how women may have increased their confidence about giving birth and early parenting, as a result of relational continuity of care with the volunteer doulas (O'Rourke et al., 2020). These theories for program evaluation were tested and the researchers were able to identify that the women's confidence in birth and parenting may be influenced by the continuity with her doula, enabling the woman to focus on her own strengths (O'Rourke et al., 2022). Cultural matching was valued by some, but not all, women, and only when the doula was genuinely interested, kind and reliable. These qualities, with or without cultural matching, generated trust between the woman and her doula, enabling the woman to feel confident (O'Rourke et al., 2022).

In another study at *BfH*, midwives and doulas participated in interviews and provided their perspectives on the role of doulas in relation to culturally sensitive care. Findings

demonstrated that the trusting relationship that the *BfH* doulas fostered enabled valuable, trauma-informed support, as well as advocacy in labour (Khaw et al., 2023).

There are parallels between Indigenous doulas and bicultural doulas supporting women seeking asylum, in terms of how their roles provide trauma-informed care. For example, Indigenous doulas may have a role in restoring cultural birth rituals, strengthening connection to community, preventing retraumatisation during birth, and healing trauma. In these ways, Indigenous doula practice shares similarities with programs that encourage intergenerational healing (Ireland et al., 2019). Similar conclusions were reached in research which involved interviewing Indigenous doulas in Canada. The doulas described the value of providing trauma-informed care through developing strong relationships with the women in their care, providing emotional safety and advocacy within a shared understanding of cultural context (Cidro et al., 2021). Another study in Canada, which focused on the Indigenous doula's role, described it as 'heart work [which means] putting relationships at the centre of their work' (Doenmez et al., 2022, p. 12). The findings of these studies were based on the perspectives of the Indigenous doulas who were interviewed, rather than those of the women they cared for; however, a strong case was made for the value of continuity of care by doulas who share a cultural identity and understand trauma-informed approaches to supporting women during pregnancy, labour and birth, and the postnatal journey.

The need to improve interpreter uptake

Midwives and doulas in my study reported that interpreters were frequently not offered when caring for women who required language support, particularly in the labour and birth. This issue has been highlighted in recent research in Australia, which identified the need for systems reform to improve access to antenatal care for women with a refugee background, arguing that there is a significant underestimation of the need for interpreting services due to missing data on pregnancy records (Yelland et al., 2020). Where recommended standards regarding the use of interpreter services are not met, this can pose a threat to the ability of health service employees to work as competent professionals, potentially to the detriment of those in their care (Czapka et al., 2019).

In this study midwives spoke of using sign language rather than interpreters in labour and birth. Research in the UK (Briscoe & Lavender, 2009) and Sweden (Origlia Ikhilor et al.,

2019) highlighted that when midwives used sign language to communicate rather than interpreters, women were left unsure about what the midwives were saying. This level of poor communication can severely compromise maternity care safety and increase inequalities in appropriate referral and care (Rayment-Jones et al., 2021).

Most women in this study preferred having their partner interpret during their maternity care and were satisfied with this option. A study in Sweden also showed that women preferred a family member to a professional interpreter when engaging with maternity services (Barkensjo et al., 2018). Undoubtedly, some women prefer family members as interpreters because they feel they can trust them, as argued by Rayment-Jones et al. (2021) in the UK. This may be a consequence of previous experiences of poor interpreting. Whilst women may prefer to have a choice about whether their interpreter is a family member or a professional, this can promote complex challenges in situations where there is family violence, particularly if a family member interpreting is the perpetrator (Allen-Leap et al., 2022; Rayment-Jones et al., 2021).

In my study, some women preferred telephone to in-person interpreters as they felt it was more private. This preference was identified in a review investigating the experiences of victims of domestic violence when seeking help from health care providers. Specifically, women were especially concerned about their privacy when the interpreter was from their community (Allen-Leap et al., 2022). This issue needs further exploration as practice guidelines highlight the importance of using professional interpreters to ensure clear communication and to provide informed consent, education, and accurate explanation of the health care system (Sioti et al., 2017).

Midwives and doulas reported that a lack of professional interpreters during labour and birth significantly impacted women's access to the right to informed consent, voicing concerns about how well a family member can interpret complex medical information. Incidents of underage children interpreting were also reported by doulas in this study. According to guidelines by the *Australian Migrant and Refugee Women's Health Partnership* (2019), the use of family members and children for interpreting can be problematic due to potentially inaccurate or incomplete interpreting, especially when those acting as informal interpreters are unfamiliar with medical language. A study of people seeking asylum in Wales cited studies showing how weak interpretation services can weaken medical consultations; giving as an example, a situation where a 12-year-old

child gave consent for her operation as the parents did not speak English (Khanom et al., 2021).

Poor quality interpreting

Another finding of this research was concerns of the midwives and doulas about the varying quality of interpretation by professional interpreters. Midwives in Ireland expressed similar concerns when working with asylum-seeking women (Tobin et al., 2014a). The potentially harmful effects of poor quality professional interpreting on the maternity care provided for women seeking asylum and refugees has been discussed in other studies (Nabb, 2006; Origlia Ikhilor et al., 2019; Phillimore, 2015). In a study in the UK, women with language barriers lacked confidence in the ability of the interpreter to relay what they were trying to say to health professionals during appointments. They were uneasy about the level of confidentiality that interpreter services could provide, and this affected their ability to speak openly about their situation and concerns (Rayment-Jones et al., 2021).

Professional development initiatives — such as cultural safety training that explores the issues associated with using interpreters — may increase the understanding of practitioners about the importance of using interpreters. This was demonstrated successfully in an initiative to improve interpreter use in labour in four maternity hospitals in Melbourne, Australia (Yelland et al., 2016). *The Bridging the Gap program* was designed to improve access to interpreters in labour for women of refugee backgrounds through interactive workshops with a team of midwives, managers, and interpreters as participants (Yelland et al., 2017). Multidisciplinary stakeholders in the program supported a policy change to offer an interpreter in early labour, to gently insist if declined, and to offer again later in labour if required (Yelland et al., 2016). This approach will be explored further in the implications for practice section in chapter 9 of this thesis.

Carrying vicarious trauma home

Midwives and doulas participants in my research expressed how feeling empathy for the women they cared for came with an emotional cost. They described the empathy they felt in terms of *sisterhood* and identified that this empathy led to them carrying home personal distress about the situations of the women they cared for. In reflecting on their strategies for dealing with this distress, some midwives stated that it contributed to them deciding

to leave the midwifery profession. Doulas described the distress they felt when they discharged a woman from their care after supporting them through the major life event of birth, having developed a close relationship with the woman and her family. It was difficult to discontinue support where there was no ongoing support from friends, family, or other professionals. In an important Australian study (Peterie, 2018), volunteer visitors also spoke of the emotional impact of witnessing the lives of people seeking asylum, in this case where they had been detained in prison-like detention centres. This emotional impact has been described as vicarious trauma by Jack and Levett-Jones (2022). A definition of vicarious trauma is:

> Personal transformations experienced by trauma workers resulting from a cumulative and empathic engagement with another's traumatic experiences that can lead to long-term changes to an individual's way of experiencing themselves, others, and the world, and symptoms that may parallel those of their client (Cohen & Collens, 2013, p. 570).

Sabin-Farrell and Turpin (2003) explained that the nature of work which involves regularly listening to people in distress can be a risk factor for vicarious trauma, burnout, and compassion fatigue. The terms *vicarious trauma*, *burnout* and *compassion fatigue* are often used interchangeably and are linked to emotional distress and exhaustion in workers, along with a decreased sense of achievement (Sabin-Farrell & Turpin, 2003).

Vicarious trauma was described by befriending volunteers in the UK, who identified with and felt the trauma and grief experienced by the asylum-seeking and refugee families they supported. They described the emotional impact of hearing about experiences that were 'literally through hell and back' (Balaam et al., 2016, p. 133). Through their befriending of these women, the voluntary sector workers had become very aware of the challenges in accessing health care and how this had a deleterious impact on their own lives and mental health (Balaam et al., 2016).

Research exploring Australian midwives' experiences of burnout argued that organisational change was necessary in hospital settings to improve recognition of staff emotional wellbeing. The burnout experienced by midwives was mostly related to working in fragmented models of care, with a lack of continuity of care inhibiting their inability to develop trusting relationships with pregnant women (Jordan et al., 2013).

Another Australian study exploring midwives' wellbeing reached a similar conclusion; midwives working in a continuity of care model experienced lower rates of burnout and depression than midwives working in single episode models of care (Fenwick et al., 2018).

A recent review in the UK explained that midwives caring for women seeking asylum may develop compassion fatigue and decreased empathy as a result of physical exhaustion. Furthermore, midwives may present as emotionally detached because of the increased demands of caring for women with complex social issues (Letley, 2022). In contrast, Australian midwives regarded their stress and burnout as due to the stress of having little or no organisational support, rather than the actual work of midwifery (Geraghty et al., 2019).

A survey in the USA identified vicarious trauma in clinicians involved in conducting asylum evaluations. This highlighted the importance of developing support services and resources to help workers identify and manage symptoms of vicarious trauma. The most important source of support identified in this survey was that of colleagues and peers, followed by professional psychiatric and psychological support and counselling, support groups, and training programs preparing clinicians for the role (Mishori et al., 2014).

In my study, midwives and doulas suggested that support could include debriefing, explaining that often this was initiated by individuals rather than being established as an organisational approach. An editorial by Thapa et al. (2021) addressing burnout, compassion fatigue, and resilience among health professionals stressed the importance of individual practitioners being bolstered by organisational and health system support. The authors suggested that an emphasis on support is necessary at an organisational level to maximise the potential for resilience to counteract burnout. Supportive supervision, effective team coordination, and efforts to improve communication were the main support systems suggested (Thapa et al., 2021).

Clinical supervision is a formally structured reflection session facilitated by a supervisor with one or more supervisees, who are usually peers but can be members of associated disciplines. A joint position statement on clinical supervision for nurses and midwives by the *Australian College of Midwives (ACM)*, the *Australian College of Nursing (ACN)*, and the *Australian College of Mental Health Nurses (ACMHN)* (2019) cites evidence in

stating that clinical supervision can reduce stress and burnout in midwives and nurses by providing a structured, regular opportunity for them to reflect on work issues. This was demonstrated in an Australian study where midwives who participated in a reflective model of clinical supervision felt supported by the organisation and experienced lower levels of burnout (Love et al., 2017). Currently in Australia, a large, randomised controlled trial is evaluating the impact of group supervision on burnout levels in midwives. The study protocol hypothesises that midwives undergoing group supervision will report less burnout and describe positive perceptions of workplace culture than those in the control sites, given previous research results (Catling et al., 2022).

A recent study in the UK explored experiences of nurses and midwives of a peer-group clinical supervision intervention. The sessions were facilitated by supervisors who held appropriate accreditation for this role. The study concluded that this peer-group model allowed supervisees to build rapport and trust with their colleagues, and share challenges and vulnerabilities in a private, time protected space. In spite of their initial concerns, participants valued the sessions and found them to be a safe place to share experiences (McCarthy et al., 2021).

The Sanctuary Model, which began in the USA and is now an international model, focuses on training and skills development to address the issue of vicarious trauma on individual and systemic levels (Esaki, 2013). An organisational change approach, informed by *the Sanctuary Model* training, emphasises the importance of team members supporting each other and understanding the need for self-care.

The Sanctuary Model is a blueprint for clinical and organisational change which, at its core, promotes safety and recovery from adversity through the active creation of a trauma-informed community. A recognition that trauma is pervasive in the experience of human beings forms the basis for *the Sanctuary Model's* focus not only on the people who seek treatment, but equally on the people and systems who provide that treatment (City of Sanctuary, n.d.).

The Maternity stream of the City of Sanctuary UK raises awareness of the specific issues of caring for women seeking asylum, and provides information and strategies for supporting midwives in their role (City of Sanctuary, 2023). With the potential to contribute to the professional development of maternity staff and improve maternity

services for women seeking asylum, consideration should be given to piloting *the Sanctuary Model* in Australia.

Conclusion

This study has illuminated several issues that are unique to pregnant women seeking asylum in Australia, such as the long-term impact of incarceration in the Australian detention system. The legal status of women seeking asylum is complex and uncertain, which underpins their inequity of access to health services. Women seeking asylum spoke of their isolation and need for support.

Midwives were challenged by the difficulty in identifying women seeking asylum during their antenatal care. Current perinatal data collected includes the mother's country of birth, and year of arrival in Australia, but not her visa status (AIHW, 2022a). Health system changes to rectify this situation would require visa status to be included as a compulsory field on the patient registration in the hospital database (AIHW, 2019). Perinatal data could identify the prevalence of mental health issues for women seeking asylum in Australia, providing important data that may enable targeted support programs in the future. A GP referral letter — which required a mandatory field completion that stated whether the woman is a refugee, undocumented migrant, international student, or asylum seeker — would assist with identification. Women seeking asylum would then be followed up regarding provision of continuity of carer, interpreters, social work, mental health, or voluntary support services. The *Bridging the Gap program* in Melbourne, Australia (Yelland et al., 2020) has shown some improvements in identification of women of refugee backgrounds, but not explicitly women seeking asylum. Improvements were achieved by training for health professionals in ascertaining the refugee status of women in maternity care to increase the number of antenatal visits (Yelland et al., 2020).

These findings have several important implications for practice regarding training for midwives and doulas, identifying women in their pregnancy who are seeking asylum, improving support for them during their perinatal journey, and providing professional interpreters. Firstly, midwives need to be able to identify women seeking asylum and benefit from possessing the skills and confidence to ask questions regarding visa status. Professional training for midwives to understand the differences in visa status and the implications of this may motivate midwives to record the visa status clearly on the

antenatal record (Yelland et al., 2020). If midwives were able to identify women seeking asylum, they may refer them to support services, such as social work or mental health services.

Equitable access to health care for women seeking asylum during their pregnancy may be achieved by addressing the complex issues on a personal, professional, and policy level. It is imperative that this research will encourage further research and policy change into the maternity care of women seeking asylum in Australia. This research has brought to light the current barriers and magnitude of inequalities, which breach these women's human rights to health.

Chapter 9: Conclusion

She waits with me, patiently, in a world that doesn't wait,
willingly, in a time that doesn't give, with kindness, in a place that is frightening.
with laughter, that melts away my fear, with strength, that reminds me I am strong.
with song, to welcome my baby today.

(Frank, G., 2018)

This thesis aimed to explore the maternity experiences of women seeking asylum and undocumented migrants in Australia, and the views and experiences of the midwives and doulas who cared for them. Notably, this study explored the complex barriers to accessing maternity care, for asylum-seeking women and undocumented migrants, and the systemic barriers to providing optimal care that were faced by their caregivers. This chapter highlights the significance, strengths, and limitations of the research, recommendations for practice and further research, and draws the thesis to a conclusion.

The original contribution to knowledge made in this thesis is that it is the first study to explore specifically the maternity experiences of women seeking asylum in Australia. To my knowledge the published primary research conducted in the Australian context, combines people seeking asylum with refugees, which does not acknowledge the specific circumstances of women seeking asylum. Furthermore, the majority of previous research does not address the gendered experience of people seeking asylum. The experience of these marginalised women is unique and distinct from refugees and migrants due to the uncertainty of their visa situation, which impacts their journey of pregnancy, labour, birth and early parenting. Uncertainty exists regarding their right to health care and their financial situation. Uncertainty underpins the future of their family, as they may be returned to their country of origin if they are not recognised as refugees. There is a lack of clarity in the research literature regarding definitions of these groups, however, in this thesis an asylum seeker is defined according to *UNESCO* as a person who, *'has applied for protection as a refugee and is awaiting the determination of his or her status'* (UNESCO, 2015, p. 1). An additional challenge in researching this group is the fluidity of the status of people seeking asylum in Australia, as they may, in the future, become

undocumented migrants or occasionally, recognised refugees. This may partly explain why women seeking asylum are an under-researched group.

In Chapter 1 of this thesis, the background elucidated the global trend of increasing forced migration, and defined the different ways in which people may live through the experience, including as refugees, migrants, or people seeking asylum. The Introduction presented the international research that demonstrated poor maternal and neonatal outcomes for women seeking asylum in high-income countries (HICs), compared to women birthing in their home HIC. Specifically, the Introduction chapter explained the complex and changing legal and political situation in Australia, over the past two decades, regarding the status and treatment of people seeking asylum. Australia has excessively harsh policies regarding people seeking asylum who arrive by boat, including the detention in prison-like facilities for an undetermined time.

A human rights approach was used to frame the Introduction, underpinned by international human rights conventions, such as the *Right to Health* (WHO & UNHCR, 2007). Position statements of health professional associations concerning the human rights for people seeking asylum were discussed, including international and Australian medical, midwifery, and nursing organisations. Health professional associations call for equitable access to maternity care for women seeking asylum, including using professional interpreters, when required. These associations advocate for the education of health professionals so that they may provide appropriate quality of care for people seeking asylum. Due to the dearth of research on this topic, these position statements provide an orientation to the potential issues of accessing maternity care for women seeking asylum. In addition, Chapter 1 explained the support services available for people on different visas in Australia.

Chapter 2 of this thesis commenced with my published meta-ethnography on the maternity experiences of women seeking asylum in high income countries (Frank et al., 2021). An updated literature search was conducted which found three further studies published in high-income countries, between 2020 and 2023. No primary research on women's experiences has been conducted, in Australia, prior to this thesis.

A review of the literature on midwives' experiences of caring for women seeking asylum in HICs identified six peer-reviewed published studies, none from Australia. No peer-

reviewed research was identified that explored the experiences of doulas caring for women seeking asylum in HICs. Overall, my literature review demonstrated a gap in the literature that this thesis aims to address.

In Chapter 3 of this thesis, the methodology and methods used in the research were explained in detail, with a discussion of the epistemological approach and theoretical perspectives underpinning the study. A constructivist epistemology, exploring meaning within relevant social contexts, was used to address the research questions. A feminist lens enabled theoretical consideration of the inequalities in health care experienced by women seeking asylum, whilst acknowledging the power imbalances between the researcher and the research participants. Hermeneutic phenomenology was the methodology used as an interpretive element to explain the meaning of the richness of the lived experience of women in this study. An essential aspect of the research was my reflexivity, which involved listening to the stories of the participants without preconceptions, whilst reflecting upon the influence of my own experiences.

There were significant ethical considerations related to the conduct of this research, as outlined in Chapter 3. The primary considerations were ensuring there was informed consent, protecting the privacy and confidentiality of research participants, and not causing any distress or traumatisation during the interviews. Ethical approval was granted through the Health and Medical Research Ethics Committee at UTS, ethics approval number ETH20-5020. Two ethics amendments were submitted and approved, that were related to the challenges of recruitment and data collection during the COVID-19 pandemic and resulting lockdowns in Melbourne, where the majority of the research was conducted.

Chapter 4, the introduction to the findings chapters, details the demographics of the women seeking asylum, midwives and doulas who participated in the research. In chapters 5, 6 and 7, the findings of the research were presented, beginning with the demographic details of the participants. Chapter 5 focused on the maternity experiences of the participating women, including ten women seeking asylum and three undocumented migrants. The theme of *Living with uncertainty* was described in Chapter 5 in seven subthemes: *The impact of detention*, *Living with visa uncertainty, Being unable to pay, Having no family and friends to provide support, The impact of sexual violence, Racism and disrespectful care* and *The challenges of ensuring clear communication with*

interpreters. The first three subthemes were specific to women seeking asylum, and the next four subthemes may also apply to women who are migrants and refugees. The stories and quotes from these marginalised women spoke powerfully of their lived maternity experiences. One alarming finding was that some women who were victims of family violence felt they could not leave the situation as their visa was linked to their spouse.

Chapter 6 focused on the experiences of the 17 midwives and 9 doulas I interviewed. *Sisterhood* described the nature of the support some of the marginalised women felt they received from midwives and doulas. Chapter 6 provided an overview of the theme of *Sisterhood: the care and support provided by midwives and doulas,* addressed in the following subthemes: *The doula and midwife support was like family, Midwives who chose to work as doulas, Helping women to feel safe and informed,* and *Practical assistance: housing support and addressing transport challenges.* This chapter described the practical support offered by midwives and doulas, including housing, transport and baby items, based on their understanding of the social determinants of health.

Chapter 7 portrayed the findings relating to two themes: *The challenges for midwives working in fragmented models of care*, and *The importance of midwifery continuity of care*. The chapter provided an overview of *The challenges for midwives working in fragmented models of care* in the subthemes *Difficulties identifying women seeking asylum*, *Ticking every box*, and *Carrying vicarious trauma home*. *The importance of midwifery continuity of care* is presented in the subthemes: *Caseloading continuity of care in the context of hospital context*, *Group antenatal care*, and *Community-based continuity with midwives*.

Firstly, chapter 7 presented the findings about the difficulties for caregivers in identifying women seeking asylum, and the challenges of providing quality care in a fragmented model of care. The depiction of the challenges of experiencing vicarious trauma for the midwives and doulas who care for women seeking asylum followed, with a portrayal of the ways in which they manage this emotional cost. The chapter also outlined the models of maternity care recommended by participants, that they felt may improve maternity care experiences for women seeking asylum. Antenatal care that provided continuity through a trusting relationship with a midwife — such as a caseloading model or group antenatal care — offered the support women seeking asylum desperately needed. Doulas provided ongoing support and trusting relationships throughout pregnancy, labour and birth, and

the postnatal journey, and an understanding of how to navigate the Australian health care system.

In Chapter 8, the findings and relevant literature are critiqued and synthesised, exploring how this study compared and contrasted with the current body of knowledge. For example, this thesis brings to light a lack of consistency in the use of professional interpreters to ensure that women receive evidence-based information that can enable them to provide informed consent. This thesis adds to a growing body of research emphasising this important issue of using professional interpreters and describing successful small scale organisational models that have been implemented to improve professional interpreter use in maternity care in Australia.

The findings from this thesis enhance our understanding of the uncertainty that women seeking asylum experienced in their daily lives that overshadowed their experiences of maternity care. The first primary finding refers to the challenge of identifying women seeking asylum in order to provide appropriate support in their pregnancy, labour, birth, and postnatal journey. These women were often invisible. Incidents were discussed where women were identified who were victims of domestic violence and because of their fear of losing their visa they felt they could not leave their partner. Most women seeking asylum may not be identified as such unless they are part of a continuity of care program during their maternity care.

The second primary finding of this thesis was that midwives and doulas felt they required more training to be able to identify women seeking asylum and provide them with culturally safe and trauma-informed care. Cultural safety requires reflection to understand health inequities, as determined by the woman rather than the midwife (Gerlach, 2012). The antithesis of culturally safe care is denying women respectful treatment, which must be addressed at an organisational, professional, and personal level (ICM, 2020). Respectful care means acknowledging and addressing the power differentiation between midwives and the women they care for, which requires self-awareness and an understanding of one's own culture and identity (Curtis et al., 2019).

The evidence from this study suggests that continuity of midwifery care, encompassing respectful and trauma-informed care, is a necessary strategy for building trust with disadvantaged women. Respectful care which is trauma-informed acknowledges that

there is a high likelihood of past trauma and torture for women seeking asylum. As the *WHO* guidelines state, women report greater satisfaction with antenatal care in the context of continuity of care and have a lower risk of preterm birth and possibly lower risk of caesarean birth (WHO, 2016). Organisational change is necessary to ensure continuity of midwifery care models are inclusive of women with complex social needs, particularly those with a trauma history. This is foundational in providing a positive maternity experience based on a trusting relationship between the midwife and the woman seeking asylum.

The results from this study found that discrimination and racism were common experiences that created barriers to access in health care settings for disadvantaged women. When a woman-centred approach is at the core of high-quality maternity services, challenges to discrimination and racism in health care may be ameliorated. Furthermore, an organisational commitment to addressing discrimination and racism in maternity care is essential to provide improved access to care for women seeking asylum.

Financial stress occurred for women and families, as a result of costs incurred for hospital admission, when they had no visa and no access to Medicare or public health provisions. In contrast, there were positive examples of community midwives who organised payment plans for pregnancy tests and hospital admission. In summary, this thesis is the first Australian study about the unique challenges faced by women seeking asylum during their maternity care.

There are several implications for training for midwives and doulas to enable them to provide culturally safe, trauma-informed care. Midwives and doulas need to understand the significance of the visa status of women seeking asylum and build their confidence in taking a migration history to ensure it is a routine practice. Furthermore, the findings suggest that midwives and doulas may need training in the importance of engaging interpreter services.

The results revealed that midwives and doulas often experienced vicarious trauma when caring for women seeking asylum. It was found that support such as debriefing or clinical supervision was ad hoc, and debriefing was often initiated by the midwives rather than their manager or employer. If burnout, compassion fatigue and vicarious trauma are

addressed at an organisational and professional level, and not only at an individual level, but the risk of burnout may also be minimised.

Study strengths

To my knowledge, this is the first study conducted in the Australian context to focus specifically on the maternity experiences of women seeking asylum. This is a key strength of the study because asylum-seeking people have specific issues differentiating them from migrants (Liamputtong, 2004) and refugees (Carolan, 2007; Rees et al., 2019; Russo et al., 2015). These are issues that can significantly impact their experiences of pregnancy, birth, and parenting. People seeking asylum experience greater vulnerabilities than refugees, such as prolonged uncertainty regarding their visa status and the financial stress associated with a lack of access to Australian Government support. For example, in Australia, asylum seekers are not eligible for many of the services available to refugees and may delay seeking medical attention due to the cost (Hadgkiss & Renzaho, 2014). This increased vulnerability is due to Australia's harsh policies regarding people seeking asylum (Hocking et al., 2015). Previous research in Australia has combined women of refugee backgrounds (Correa-Velez & Ryan, 2012; Dube et al., 2022; Riggs et al., 2017) and migrants (Mohale et al., 2017; Owens et al., 2016). Authors have identified these cohorts as including asylum-seeking people, based on an assumption about their year of arrival and country of origin.

The uncertainty of their visa situation underpins the reasons why the needs of people seeking asylum are unique. The tenuous visa status granted to people seeking asylum in Australia is often protracted. Women in this study, for example, had lived in Australia for an average of five years on temporary visas. The impact of this is exacerbated by the possible lack of access to public health care benefits, which incurs the significant financial burden of medical expenses for hospital treatment. Furthermore, a lack of government support and secure income can lead to destitution and homelessness.

The experience of detention is the most striking distinction for people seeking asylum in Australia compared to refugees and migrants and compared to people seeking asylum in other HICs. Living in prison-like conditions, for extended periods, contributes to poor mental health that can include post-traumatic stress, anxiety, and depression (Coffey et

al., 2010; Essex, 2014; Peterie, 2018). Thus, it is imperative to understand the experience of women seeking asylum discretely, distinguishing them from refugees or migrants.

This study is unlike the majority of research regarding people from refugee and asylum seeker backgrounds because it is gender specific. A cogent strength of this study is that it focuses on women seeking asylum. Often excluded from research studies because they may require interpreters, women seeking asylum in Australia are an under-researched group. The experience of refugees are often gendered (Lenette, 2019). For example, sexual violence in the asylum-seeking population is predominately targeted at women (Kalt et al, 2013).

Study limitations

The data for this research was collected in Queensland, New South Wales, and mostly in Victoria, reducing the transferability of the findings to other states of Australia. This was in part due to COVID-19 lockdowns and travel restrictions. However, a number of midwives in New South Wales and Queensland were interviewed online over Zoom, and a few women seeking asylum in New South Wales were interviewed over the telephone.

Professional interpreters were used over the telephone for the majority of in-person and telephone interviews. The interviews were influenced by the quality of telephone interpreting and rapport building may well have been more challenging than with in-person interpreting. I was mindful of not triggering further trauma for the woman. I felt I needed to enquire gently and not probe beyond what each woman was comfortable with sharing. Some of the included quotes were brief because of the brevity of the interpreting. Regardless, using professional interpreters for most of the interviews with women was more appropriate than family interpreting, as discussed previously in the Findings (Chapter 5) and Discussion (Chapter 8).

The unique cultural and personal backgrounds of women created heterogeneity in the sample, and hence the transferability of the findings may be limited. Many of the participants were from different countries of origin, which meant that their cultural backgrounds and needs were dissimilar. The women in this study who had arrived in Australia by boat were incarcerated in detention, in contrast to the women who arrived by plane who lived in the community as people seeking asylum. Women interviewed may have had their first pregnancy in Australia or have had previous pregnancies in their

country of origin. Most of the women had support from a partner, however, in contrast several women had no partner to support them. The heterogeneity of the women participants may also be considered a strength, in terms of the way in which it builds understanding of the diversity of perspectives of these women seeking asylum in Australia.

Implications for practice

Women are entitled to respectful maternity care as a fundamental human right. Respectful care includes treatment with dignity, informed consent, privacy, and freedom from racism and discrimination (Windau-Melmer, 2013). Midwives and doulas in this study reflected on the importance of cultural safety. Cultural safety addresses the power imbalances between the midwife and the woman, and the challenges of discrimination and racism in health care (Curtis et al., 2019). The cultural safety model focuses on rights and respect in contrast to cultural risk which leads to demeaning and disempowering care (Gerlach, 2012).

Midwives and doulas who were trained in cultural safety deemed that professional development is key to providing sensitive and appropriate care for women seeking asylum. Hence, a recommendation of this research is that there is an urgent need for training for midwives to enable them to be competent in providing culturally sensitive care for women seeking asylum. Midwives and doulas also expressed the importance of training in trauma-informed care, to develop an understanding of cultural awareness and empathetic, respectful maternity care. An example is the trauma-informed training provided by *City of Sanctuary* (n.d.) that aims to ensure that midwives are aware of possible PTSD trauma triggers that may occur during labour and birth for women seeking asylum. The sensations of labour or a vaginal examination may trigger flashbacks for women with previous experience of sexual violence (City of Sanctuary, n.d.). The *City of Sanctuary* maternity care resource, available at https://maternity.cityofsanctuary.org/resources developed in the UK (City of Sanctuary, n.d.) recommends an organisational approach to cultural safety and awareness training.

The routine provision of professional interpreter services, particularly in the context of labour and birth, may facilitate improved levels of informed decision-making for women. When required, the midwife should offer a professional interpreter and ask the woman if

she prefers a female interpreter, which may be more culturally appropriate. In the context of antenatal appointments, interpreter use necessitates longer appointment times, which needs to be recognised and acknowledged on an organisational level. The consequence of not using professional interpreters imposes an authoritarian approach to health care and a lack of access to education, information, and informed consent (Origlia Ikhilor et al., 2019). Women who are not offered a professional interpreter are denied their right to informed consent, their access to education (Merry, 2011), and their fundamental human right to accessible health care (Yelland et al., 2015).

An example of a successful intervention for people of refugee backgrounds attending a general practitioner (GP) is the *OPTIMISE* trial in Australia (Saito et al., 2021) which facilitated the recording in the electronic medical record of preferred language of the person and interpreter requirements. This model could be adopted in tertiary hospital settings to improve the use of interpreters in all stages of the perinatal experience (Saito et al., 2021). Another example is the *Bridging the Gap* program, which significantly improved the use of interpreters for women in labour at a Melbourne hospital, by training health professionals in interpreter use and engaging interpreters for early labour (Riggs et al., 2016). These examples demonstrate that an organisational commitment to a culture of use of professional interpreters when required, is the basis for an improvement in the routine uptake of interpreters.

Implications for future research

Further research is required into pilot training programs for midwives and doulas to raise awareness of the issues for people seeking asylum. Firstly, future research should pilot and evaluate comprehensive training for health professionals to address interpreter use, trauma-informed care, and cultural safety. Research that is co-designed with women seeking asylum would ensure that the training addresses the barriers to accessing maternity care in Australia. Including the participation of asylum-seeking people in the design of research ensures collaboration and respect (Lenette, 2013).

Secondly, future research is needed to raise awareness of strategies to prevent burnout and vicarious trauma in midwives and doulas. These strategies may include cultural safety and trauma-informed care training, clinical supervision, formal regular debriefing, professional support, or models of care that provide greater personal and professional

satisfaction for midwives. Models of care that improve professional satisfaction for midwives may lead to lower incidence of vicarious trauma. Research by Mishori (2014) encourages a focus on vicarious resilience, reflecting on the powerful resilience of people seeking asylum. Co-design of asylum-seeker identification strategies, and training with experts by experience (that is, in this case, asylum-seeking people) (Kealy-Bateman et al., 2021), may improve accessibility and quality of maternity care.

Thirdly, pilot studies exploring models of care that may improve maternity services for women seeking asylum would provide valuable data on the impact of models of care upon perinatal outcomes. Continuity of midwifery care in pregnancy through group antenatal care, community midwives providing antenatal care, or caseloading models may improve access to care for this group of women. Woman centred care is particularly relevant for women seeking asylum who will inevitably benefit from a trusting relationship with a known midwife. This enhanced support, tailored to individual women's specific needs, also has the potential to prevent or reduce further traumatisation for women during labour and birth, particularly for women who are experiencing PTSD. The *WHO* recommends that providers are involved in planning models of antenatal care to improve the quality of care and ensure women's voices are heard (WHO, 2016).

In this study, midwives and doulas were not confident in asking if the woman in their care was seeking asylum. This contributes to difficulties identifying accurate information about their specific maternity care needs as well as their perinatal health outcomes. The importance of identifying women seeking asylum who access maternity care can, therefore, not be underestimated. Due to the under-researched nature of women who require an interpreter and those who remain invisible to the Australian health system, there are many questions to explore in further research. It is essential to acknowledge the need to improve the maternity experience and perinatal outcomes of these marginalised women. Any further research needs to be co-designed with women seeking asylum to prioritise what is most important in addressing their barriers to accessing maternity care.

Concluding statement

Women seeking asylum face an uncertain future in Australia, distinguishing them from refugees who have permanent visa status. Considering the high prevalence of torture and trauma in people seeking asylum, it is imperative that there is an increase in the current

1% of targeted maternity care for refugees and people seeking asylum in Australia. The challenges of an uncertain future faced by women seeking asylum may be buffered by certainty of respectful, empathic care in the context of a trusting relationship of continuity of midwifery care. Therefore, this thesis recommends asylum-seeking women are identified and supported appropriately with continuity of midwifery care models of care that are culturally safe and trauma informed.

All the midwives interviewed in this study strived to provide quality care for women seeking asylum during their pregnancy, labour and birth, and postnatal journey. Doulas interviewed in this study provided valuable continuity of support through the journey of maternity care for these marginalised women. There were significant barriers for midwives and doulas to provide optimal care for women seeking asylum. This study may enhance our understanding of the experiences of the midwives and doulas caring for women seeking asylum in Australia in a system that largely does not support them to do so.

Future health policies, position statements and guidelines that are co-designed with women seeking asylum may improve access to maternity care in Australia for these women. Considerably more work is needed at the professional, organisational and system levels to improve maternity outcomes in the fullest sense for women seeking asylum at the professional, organisational and system level. Improving maternity outcomes requires respectful trauma-informed, culturally safe care, for women seeking asylum in Australia.

Epilogue

My page is blank.
I know what I need to say, but the translation of my thoughts to paper is tangled.
I rewrite, discuss, re-think and wait for the words to flow. The words stop.
I decide to pause and leave my writing.
I leave to catch the sunshine and allow the ideas to reshape.
As I walk, the words fall and resettle.
The ideas float and reform.
The rhythm of my steps allows the thoughts to take shape.
And the words to sing.
And the writing cave to be my sanctuary.
(Frank, G., poem, 2022)

'NEST: Not even a safe territory: The maternity experiences of women seeking asylum in Australia' — the title of this thesis — is based on the words of a young woman I met during her pregnancy many years ago. She was 18 years old. I had invited an art therapist to facilitate a group session for teenage pregnant women, as part of a childbirth education program. The art therapist asked the women to make something that represented their hopes and dreams for their baby. Each woman was given a piece of clay. When this particular young woman fashioned a small pot out of her clay she said:

> I want to build a nest for my baby, somewhere safe that it can fly off but always come back to, something I never had.

When interviewing women seeking asylum for this research, I was reminded of this story as I felt that they were looking for somewhere safe for their new baby, but it was something that they were frequently denied.

The vast majority of stories of people seeking asylum have not been heard by the Australian public. They remain silent, faceless, and nameless. Notable exceptions were the 'Biloela family' and Behrouz Boochani, who captured the hearts of Australians with their stories of resilience, despite immense suffering and breaches of their human rights to seek asylum. The timeline of their stories was close to the timeline of this thesis, which

initiated many conversations with my colleagues who had seen the media stories of the Biloela family and Behrouz Boochani. I decided therefore, that it would be important to pay tribute to those who have provided the connection for many Australians and brought to light the hidden issue of the inhumane treatment of people seeking asylum in Australia.

Image 2: The 'Biloela family', Priya and Nades Nadesalingam,
with their children Tharnicaa and Kopika
(Courtesy of the 'Bring them home campaign')

In contrast to the women I interviewed for this thesis, one family were finally able in 2022 to build their nest, their home, and their future in Australia. The Biloela family, as they became known in the Australian media, are a Tamil family from Sri Lanka. Their plight to flee the conflict in Sri Lanka was made known through the media due to the immense community support of a small town called Biloela, where they lived in central Queensland. Priya and Nades Nadesalingam arrived in Australia separately by boat and attempted to seek asylum. Priya arrived in 2013 and Nades in 2012, it took 10 years before they were finally granted refugee status by the newly elected government in 2022.

In 2018, along with their two Australian-born children, they were removed from their home, by force, at dawn by Border Force officers after their temporary visa expired. At the time, they had been living in Biloela for four years (Doherty, 2018, 12 March). They spent three years imprisoned in a detention centre on Christmas Island with their two children, due to a court injunction preventing the Australian Government from deporting

the family to Sri Lanka. Tharnicaa, aged 5, was transferred to hospital in Perth, Western Australia, due to a medical emergency.

In 2022, the government kept their election promise and the immigration minister granted the family a bridging visa, which allowed them to return to their home in Biloela, in Central Queensland (Gillespie, 2022).

Finally, the government granted permanent residency to the family in 2022, an uncommon outcome for other asylum-seeking families (Booth, 2021, June 21). Their situation is mirrored in the distress experienced by many families seeking asylum in Australia, whose future remains uncertain for not only themselves, but for their children.

Image 3: Behrouz Boochani
Courtesy of www.behrouzboochani.com

Behrouz Boochani is a well-known author and journalist whose journey of asylum seeking was followed closely by the Australian media. His book *No friend but the mountains: Writing from Manus prison* describes his imprisonment on Manus Island; a remote island used by the Australian Government as a detention centre. He wrote this book in Farsi on his mobile phone, his words smuggled out of Manus Island in text messages (Boochani, 2018).

> Boochani's flight to the land of freedom, as he imagines Australia … becomes the land of real imprisonment for him, as he is locked in a cage *indefinitely* without charge (Galip, 2020, p. 727).

Boochani's book won the Victorian Prize for Literature in 2019.

The Government of Papua New Guinea closed the Manus Island detention centre in 2017 and the men were transferred to other accommodation on the island. In 2019 Behrouz was invited to New Zealand, where he was granted refugee status after almost seven years in detention on Manus Island.

He now lives in New Zealand where he holds an academic position and many honorary academic positions internationally. He holds a Master's degree in political science, political geography and geopolitics from Tarbiat Moallem University and Tarbiat Modares University, both in Tehran (Boochani, 2023).

I have chosen a selection of excerpts from Behrouz's book *No friend but the mountain: Writing from Manus prison* (Boochani, 2018) to paint a picture of the potential impact his words had on highlighting the Australian Government's treatment of people who seek asylum after arriving by boat.

After attempting to reach Australia by paying a people smuggler and boarding an overcrowded unseaworthy boat, Behrouz almost drowned. His vessel was intercepted and he was taken to Australia. He described the moments before the rescue:

> *In the depths of darkness, on the verge of losing all hope,*
> *One still maintains a little glimmer of hope, deep down inside,*
> *A tiny light, about the size of a speck, like a distant star,*
> *Is spotted on the horizon this dark night*
> (Boochani, 2018, p. 26).

Behrouz is a Kurdish poet, and in his book he describes his first weeks when he is taken to be imprisoned in the Christmas Island detention centre:

> *A cage -high walls - wire fencing - electronic doors – CCTV cameras*
> *Surveillance cameras gazing at twenty individuals.*
> *Men wearing oversized garments* (Boochani, 2018, p. 81).

Without legal representation, without knowing how long he will be imprisoned, the ordeal continued:

> *I can't believe this is happening to me.*
> *All that hardship.*
> *All that wandering from place to place.*
> *All that starvation I had to endure.*
> *All of it …*
> *So that I could arrive on Australian soil.*
> *I cannot believe I am now being exiled to Manus.*
> *A tiny island out in the middle of the ocean*
> (Boochani, 2018, p. 88).

Behrouz' account has brought a human face to the many nameless and faceless people who have sought asylum in Australia. Not only adults but children were incarcerated in the detention centres:

> *Why does the Australian government have to exile little girls of six or seven years old?*
> *Why does the Australian government have to incarcerate them?*
> *Where in the world do they take children captive and throw them in to a cage?*
> *What crime are those children guilty of?*
> (Boochani, 2018, p. 117).

Campaigns supported by the Australian public protested against the incarceration of children, and finally in 2017 there were no more children in the detention centres. They were removed with their parents to community detention in Australia. Those that remained in detention, however, lost hope:

> *The sound of the deepest kind of affliction.*
> *The sound of hopelessness. A nightmare about the nights.*
> *The sound of moaning floating over the ocean*
> (Boochani, 2018, p. 246).

Despite the utter hopelessness, Behrouz continued to document his experience in the Manus Island detention centre. His resilience and continued fight against the Australian Government's detention centre policy is on behalf of those still imprisoned.

Both the Biloela family and Behrouz Boochani have featured in the Australian press over the past five years, and remain some of the few people who arrived in Australia by boat to be granted refugee status in Australia. There has been a significant change in the Australian Government migration law in 2023, where people on Temporary Protection visas and Safe Haven Enterprise visas may apply for a new Resolution of Status visa, which is a pathway to permanent residency (Asylum Insight, 2023). It is a positive policy change, but it does not apply to people who arrived by boat and had their claims for asylum rejected after 2013 (Kaldor Centre for Refugee Law, 2023).

I would like to give the final 'words' of this thesis to Naser Moradi. Naser is a Hazara man from Afghanistan, who was imprisoned for almost eight years in a detention centre in Australia, after arriving in Darwin by boat. He was finally released in December 2022 on a temporary visa. He is a self-taught artist who painted prolifically during his incarceration to help him cope with the mental and emotional strain. His paintings give a message of hope and compassion.

Image 4: Painting by Naser Moradi
(used with permission).

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Appendices

Appendix 1: Permission to publish article in thesis

Re: Frank, G. D. (2021). The maternity experience [230202-007061]

Permissions Helpdesk Thu 02/02/2023 21:36 To: Glenys Frank

Dear Glenys Janssen-Frank

We hereby grant you permission to reprint the material below at no charge in your thesis subject to the following conditions:

RE: The maternity experiences of women seeking asylum in high-income countries: a meta-ethnography, Women and Birth, Volume 34, Issue 6, November 2021, Pages 531-539, Frank et al.

1. If any part of the material to be used (for example, figures) has appeared in our publication with credit or acknowledgement to another source, permission must also be sought from that source. If such permission is not obtained then that material may not be included in your publication/copies.

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Kind regards,

Roopa Lingayath

Senior Copyrights Coordinator ELSEVIER | HCM - Health Content Management

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Appendix 2: Ethics approval ETH20-5020

From: Research.Ethics@uts.edu.au Sent: Thursday, 6 August 2020 8:43 AM

To: Research Ethics: Angela Dawson, Glenys Janssen-Frank

Subject: HREC Approval Granted - ETH20-5020 Dear Applicant

Re: ETH20-5020 - "NEST: Not even a safe territory: the maternity experiences of women seeking asylum in Australia: a phenomenological research study."

Thank you for your response to the Committee's comments for your project. The Committee agreed that this application now meets the requirements of the National Statement on Ethical Conduct in Human Research (2007) and has been approved on that basis. You are therefore authorised to commence activities as outlined in your application. You are reminded that this letter constitutes ethics approval only.

This research project must also be undertaken in accordance with all UTS policies and guidelines including the Research Management Policy. Your approval number is UTS HREC REF NO. ETH20-5020. Approval will be for a period of five (5) years from the date of this correspondence subject to the submission of annual progress reports.

The following special conditions apply to this approval:

The researchers are requested to remove reference to NEST from the participant consent forms. The following standard conditions apply to your approval: Your approval number must be included in all participant material and advertisements. Any advertisements on Staff Connect without an approval number will be removed.

The Principal Investigator will immediately report anything that might warrant review of ethical approval of the project to the Ethics Secretariat (Research.Ethics@uts.edu.au). The Principal Investigator will notify the UTS HREC of any event that requires a modification to the protocol or other project documents and submit any required amendments prior to implementation. Instructions on how to submit an amendment application can be found here.

The Principal Investigator will promptly report adverse events to the Ethics Secretariat. An adverse event is any event (anticipated or otherwise) that has a negative impact on participants, researchers or the reputation of the University. Adverse events can also include privacy breaches, loss of data and damage to property. The Principal Investigator

will report to the UTS HREC annually and notify the HREC when the project is completed at all sites. The Principal Investigator will notify the UTS HREC of any plan to extend the duration of the project past the approval period listed above through the progress report. The Principal Investigator will obtain any additional approvals or authorisations as required (e.g. from other ethics committees, collaborating institutions, supporting organisations). The Principal Investigator will notify the UTS HREC of his or her inability to continue as Principal Investigator including the name of and contact information for a replacement.

This research must be undertaken in compliance with the Australian Code for the Responsible Conduct of Research and National Statement on Ethical Conduct in Human Research.

You should consider this your official letter of approval. If you require a hardcopy please contact the Ethics Secretariat. If you have any queries about your ethics approval, or require any amendments to your research in the future, please don't hesitate to contact the Ethics Secretariat and quote the ethics application number (e.g. ETH20-xxxx) in all correspondence.

Yours sincerely,

Prof Beata Bajorek

Chairperson UTS Human Research Ethics Committee

C/- Research Office University of Technology Sydney E: Research.Ethics@uts.edu.au Ref: E38 UTS CRICOS Provider Code: 00099F

Appendix 3: Ethics revision UTS HREC Approval - ETH21-5835

Research.Ethics@uts.edu.au Thu 18/02/2021 14:49

To: Research Ethics: Angela Dawson, Glenys Frank

1 attachment (182 KB) Ethics Application.pdf;

Dear Applicant Re: ETH21-5835 - "NEST: Not even a safe territory: the maternity experiences of women seeking asylum in Australia: a phenomenological research study."

The Human Research Ethics Executive Review Committee reviewed your amendment application for your project and agreed that the amendments meet the requirements of the NHMRC National Statement on Ethical Conduct in Human Research (2007).

I am pleased to inform you that the Committee has approved your request to amend the protocol as follows: "In Victoria, the Covid19 pandemic is currently well controlled and therefore face-to face interviews will be offered if the woman seeking asylum participant prefers this to a telephone meeting. The meeting will be taking Covid19 precautions by maintaining a 1.5 metre distance where possible, wearing a mask, using hand sanitiser and meeting outside if practical."

This amendment is subject to the standard conditions outlined in your original letter of approval. You are reminded that this letter constitutes ethics approval only. This research project must also be undertaken in accordance with all UTS policies and guidelines including the Research Management Policy. You should consider this your official letter of approval.

If you require a hardcopy, please contact the Research Ethics Secretariat. To access this application, please click here, a copy of your application has also been attached to this application If you wish to make any further changes to your research, please contact the Research Ethics Secretariat in the Research Office.

In the meantime, I take this opportunity to wish you well with the remainder of your research.

Yours sincerely,

The Research Ethics Secretariat on behalf of the Human Research Ethics Executive Review Committees C/- Research Office University of Technology Sydney T: (02) 9514 2478 Research.Ethics@uts.edu.au | Website PO Box 123 Broadway NSW 2007 Ref: E1

Appendix 4: ETH21-5985 Ethics revision approval

Email received 20.7.21

Dear Applicant,

Re: ETH21-5985 - "The maternity experiences of women seeking asylum and undocumented migrant women in Australia: a phenomenological study."

The UTS Human Research Ethics Executive Review Committee reviewed your amendment application for your project and agreed that the amendments meet the requirements of the NHMRC National Statement on Ethical Conduct In Human Research (2007).

I am pleased to inform you that the Committee has approved your request to amend the protocol as follows: "I propose to interview women who are undocumented migrants in addition to women seeking asylum due to poor recruitment of women seeking asylum. Undocumented migrant women are those who have entered Australia without authority, entered with false documents, overstayed their visas, worked, or studied on a tourist visa or non-immigrant visa waiver. This includes asylum seekers and women who may have been working or studying in Australia.

We originally sought to interview asylum seeking women, but recruitment has been extremely slow and we recently have been presented with the opportunity to interview other types of undocumented migrant women. We believe that the addition of other types of undocumented migrant women will provide more diverse sample and insight into the maternity care experiences of a range of women. The objective is to identify the specific maternity needs of women who seek asylum and undocumented migrant women in Australia, which may be different to refugees and different to those in other high-income countries. Undocumented migrant women are often referred as women seeking asylum and may be women seeking asylum with expired visas. There are similarities between these groups as they may not have access to Medicare or government support and live in fear of being returned to their country of origin.

The risks will probably be less as undocumented migrant women have not fled for their lives and therefore may be less fearful of being interviewed. It demonstrates the heterogeneous nature of this group which increases the richness of the data.

This amendment is subject to the standard conditions outlined in your original letter of approval. You are reminded that this letter constitutes ethics approval only. This research project must also be undertaken in accordance with all UTS policies and guidelines including the Research Management Policy. You should consider this your official letter of approval.

In the meantime I take this opportunity to wish you well with the remainder of your research. Yours sincerely,

The Research Ethics Secretariat on behalf of the Human Research Ethics Executive Review Committees

C/- Research Office University of Technology Sydney

Research.Ethics@uts.edu.au | Website PO Box 123 Broadway NSW 2007 Ref: E4

Appendix 5: Flyer for midwives and doulas

The maternity experiences of women seeking asylum in Australia: a research study.

If you are a midwife (currently or in the last five years), midwifery student (volunteer at Birth for HumanKIND) or doula (volunteer at Birth for HumanKIND) caring for women seeking asylum in Australia we would like you to participate in this study. We would like to interview you to try to improve the care that women seeking asylum receive in Australia.

Image by www.nurtutingthenurturer.com

We will invite you to participate in a phone or ZOOM interview. Participation in this study is voluntary. It is completely up to you whether or not you decide to take part. There may be no direct benefit to you but there may be future benefits to women who seek asylum during their pregnancy.

If you would like to participate in this study text: Yes interview to Glenys Janssen-Frank (Registered nurse and midwife, UTS PhD student) phxxx

Appendix 6: Flyer for women seeking asylum

The maternity experiences of women seeking asylum in Australia: a research study.

If you are over 18 years old, pregnant and seeking asylum in Australia we would like you to participate in this study. We would like to interview you to try to improve the care that women seeking asylum receive in Australia. If you require an interpreter, we will organise an interpreter for the interview. If you are fluent in English, we will offer a bi-cultural researcher to assist you.

We will invite you to participate in two interviews –one during pregnancy and another after your baby is born. Participation in this study is voluntary. It is completely up to you whether or not you decide to take part. There will be no direct benefit to you but there will likely be benefits to other women who seek asylum during their pregnancy. If you would like to participate in this study text: Yes, interview to Glenys Janssen-Frank (Registered nurse and midwife, UTS PhD student) ph xxx

Appendix 7: Participant information sheet for women seeking asylum

The maternity experiences of women seeking asylum and undocumented migrant women in Australia: a phenomenological research study.

UTS HREC APPROVAL NUMBER ETH20-5020.

WHO IS DOING THE RESEARCH?

My name is Glenys Janssen-Frank and I am a PhD student at UTS. My supervisor is Professor Angela Dawson (angela.dawson@uts.edu.au)

WHAT IS THIS RESEARCH ABOUT?

This research is to find out about barriers to accessing maternity care. We would like to interview you to try to improve the care that women seeking asylum receive in Australia. If you require an interpreter, we will ensure an interpreter is available to make sure you understand the research and have your questions answered. If you are fluent in English, we will offer a bi-cultural researcher to assist you in the interview.

The information in this research will be treated confidentially and de-identified in accordance with the university policy. We will not keep any identifying information about you.

FUNDING

Funding for this project has been received from the 2018 Australian Government Research Training Program Stipend, the Epworth HealthCare Centenary Scholarship administered by the Australian Nurses Memorial Centre and the 2018 Australian College of Midwives (Victorian Branch) Scholarship.

WHY HAVE I BEEN ASKED?

You have been invited to participate in this study because you are over 18 years old, pregnant and seeking asylum or in Australia as an undocumented migrant woman. Your contact details were obtained from BirthforHumanKIND or Robinvale District Health Service. We also are inviting midwives to participate to understand their experience of offering maternity care for women seeking asylum and undocumented migrant women. It is important to understand the situation more fully, so we can suggest improvements in maternity care in the future.

IF I SAY YES, WHAT WILL IT INVOLVE?

If you decide to participate, I will invite you to participate in two interviews –one during pregnancy and another after your baby is born. As an additional option, we invite you to take photos on your phone or on a disposable camera. For example, you could take photos of your baby. . The purpose is to make a photo diary to describe your experience and send it to me via a phone message. These photos may be used to talk about your experience of maternity care. These photos may be used with your permission in the research findings but if you prefer, we will not use your photos. You do not have to take photos if you don't want to. The interviews can be over the phone, in -person, or an on-line platform such as ZOOM. Each interview will take approximately 30 -60 minutes.

The interviews will not be recorded, and no-one will be identified by name. I will take hand-written notes during the interview. If you do not want to make a photo diary, we can still interview you about your experience.

The research takes place over three months in total the first interview is during your pregnancy and the second after your baby is born. If you would rather speak in a language other than English an interpreter or bi-cultural researcher can be provided. There will be a few demographic questions such as date of birth, number of pregnancies, country or origin, date of arrival in Australia. This information will be deleted from the interview, so there is no identifying information with the interview notes.

ARE THERE ANY RISKS/INCONVENIENCE?

Yes, there are some risks or inconvenience. In sharing some personal information, you may feel uncomfortable. We will not ask you about the reasons you left your country of origin or your journey to Australia. You don't have to share if you do not want to do so. You do not have to explain why you do not want to share information. If you unexpectedly feel uncomfortable, we can pause or stop the interview. If the interview brings distressing memories, we can refer you to some expert support services or back to the referring agency.

DO I HAVE TO SAY YES?

Participation in this study is voluntary. It is completely up to you whether or not you decide to take part. There will be no direct benefit to you but there will likely be benefits to other women who seek asylum during their pregnancy. For example, improved maternity care may benefit other women in the future.

WHAT WILL HAPPEN IF I SAY NO?

If you decide not to participate, it will not affect your relationship with the researchers or the University of Technology Sydney. If you choose not to participate all the services you receive at hospital or in the community will continue and neither will influence your visa application. If you wish to withdraw from the study once it has started, you can do so at any time without having to give a reason by contacting Glenys Janssen-Frank on xxx.

If you withdraw from the study, your interview transcripts and any associated notes taken will be destroyed.

However, it may not be possible to withdraw your data from the study results as these have already had your identifying details removed. If you choose to stop participating in the research, it will not influence your care at the hospital or your visa application. Any information you shared will be kept confidential unless required to be disclosed by law.

If you decide to leave the research project, we will not collect additional personal information from you, and any personal information already collected will be removed to ensure that results of the research project can be measured properly and to comply with the law. You should be aware that data collected up to the time you withdraw will form part of the research project results. If you do not want them to do this, you must tell the researchers before you join the research project.

CONFIDENTIALITY

By giving verbal or written consent you consent to the research team collecting and using personal information about you for the research project. All this information will be treated confidentially and any identifying information including names will be removed. Phone numbers will be kept separate to interview information and destroyed after data collection is completed.

The researcher will de-identify all personal information when transcribing the interviews. The photo diary will be edited to remove identifying information and will only be used

in the publication of the research with your consent. Photograph diaries and images will only used during the interviews and destroyed once the data collection is complete. Photographs will not be published or used in any way that may identify them.

Your information, such as age, number of children, number of children born in Australia, will only be used for the purpose of this research project and it will only be used in the overall results separate from the interviews, except as required by law. Data will be stored securely and confidentially in accordance with the university data management plan.

We plan to publish the results in a professional journal and give BirthforHumanKIND a copy of the journal article. In any publication, information will be provided in such a way that you cannot be identified.

WHAT IF I HAVE CONCERNS OR A COMPLAINT?

If you have concerns about the research that you think I or my supervisor can help you with, please feel free to contact me on xxx.

You will be given a copy of this form to keep.

NOTE: This study has been approved in line with the University of Technology Sydney Human Research Ethics Committee [UTS HREC] guidelines. If you have any concerns or complaints about any aspect of the conduct of this research, please contact the Ethics Secretariat on ph.: +61 2 9514 2478 or email: Research.Ethics@uts.edu.au], and quote the UTS HREC reference number. Any matter raised will be treated confidentially, investigated and you will be informed of the outcome.

CONSENT FORM The maternity experiences of women seeking asylum and undocumented migrant women in Australia: a phenomenological research study

UTS HREC APPROVAL NUMBER ETH20-5020.

NOTE: Verbal consent is accepted if preferred.

I _____ *[participant's name]* agree to participate in the research project

The maternity experiences of women seeking asylum and undocumented migrant women in Australia: a phenomenological research study,

ETH20-5020.being conducted by Glenys Janssen-Frank (ph. xxx). I understand that funding for this research has been provided by the 2018 Australian Government Research Training Program Stipend and the 2018 Australian College of Midwives (Victorian Branch) Scholarship.

I have read the Participant Information Sheet or someone has read it to me in a language that I understand.

I understand the purposes, procedures and risks of the research as described in the Participant Information Sheet.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described and understand that I am free to withdraw at any time without affecting my relationship with the researchers or the University of Technology Sydney.

I understand that I will be given a signed copy of this document to keep. I understand:

1. An interpreter will be used if required

2. A bi-cultural worker will be used if required

3. Participation in the research is voluntary

I agree to:

☐ Take photos in a photo diary

I agree that the research data gathered from this project may be published in a form that:

☐ Does not identify me in any way

I am aware that I can contact Glenys Janssen-Frank if I have any concerns about the research.

_____	____/____/____
Name and Signature [participant]	Date
_____	____/____/____
Name and Signature [researcher or delegate]	Date

Appendix 8: Participant information sheet for midwives and doulas

The maternity experiences of women seeking asylum in Australia: a phenomenological research study.

UTS HREC APPROVAL NUMBER ETH20-5020.

WHO IS DOING THE RESEARCH?

My name is Glenys Janssen-Frank and I am a PhD student at UTS. My supervisor is Professor Angela Dawson (angela.dawson@uts.edu.au)

WHAT IS THIS RESEARCH ABOUT?

This research is to find out about barriers to accessing maternity care. We would like to interview you to try to improve the care that women seeking asylum receive in Australia. We would like to interview midwives, student midwives and doulas caring for women seeking asylum to understand if they experience barriers in offering excellent maternity care.

FUNDING

Funding for this project has been received from the 2018 Australian Government Research Training Program Stipend and the 2018 Australian College of Midwives (Victorian Branch) Scholarship.

WHY HAVE I BEEN ASKED?

We are inviting midwives to participate to understand their experience of offering maternity care for women seeking asylum. If you are currently (or in the last 5 years) in a role caring for women who seek asylum during pregnancy, we would like to interview you. It is important to understand the experience of midwives, student midwives and doulas caring for women who seek asylum in their perinatal period, so we can suggest improvements in maternity care in the future.

IF I SAY YES, WHAT WILL IT INVOLVE?

If you decide to participate, I will invite you to participate in one interview. The interviews can be over the phone or an on-line platform such as ZOOM. Each interview will take approximately 30 -60 minutes. The interviews will be audio recorded and transcribed and no-one will be identified by name. If you do not want to be recorded, I will take hand written notes in the interview.

The research takes place over three months in total. There will be a few demographic questions such as age bracket, years of practise as a midwife, student midwife or doula, and years of caring for women seeking asylum in their perinatal period. The interview will take approximately 30 -60 minutes.

ARE THERE ANY RISKS/INCONVENIENCE?

Yes, there are some risks/inconveniences. You may feel uncomfortable by sharing some of personal information and exploring your own practise. You don't have to share if you do not want to do so. You do not have to explain why you do not want to share information. If you unexpectedly feel uncomfortable, we can pause or stop the interview. If the interview brings any distress, we can refer you to some expert support services.

DO I HAVE TO SAY YES?

Participation in this study is voluntary. It is completely up to you whether or not you decide to take part. There may be no direct benefit to you but there will likely be benefits to other women who seek asylum during their pregnancy.

WHAT WILL HAPPEN IF I SAY NO?

If you decide not to participate, it will not affect your relationship with the researchers or the University of Technology Sydney. If you wish to withdraw from the study once it has started, you can do so at any time without having to give a reason, by contacting Glenys Janssen-Frank on xxx.

If you withdraw from the study, your interview recording, and transcripts will be destroyed. However, it may not be possible to withdraw your data from the study results if these have already had your identifying details removed.

If you decide to leave the research project, we will not collect additional personal information from you, although personal information already collected will be retained to ensure that the results of the research project can be measured properly and to comply with law. You should be aware that data collected up to the time you withdraw will form part of the research project results. If you do not want them to do this, you must tell the researcher before you join the research project.

CONFIDENTIALITY

By giving verbal consent you consent to the research team collecting and using personal information about you for the research project. All this information will be treated confidentially. The researcher will de-identify all personal information when transcribing the interviews. Your information will only be used for the purpose of this research project, and it will only be disclosed with your permission, except as required by law. We plan to publish the results in a professional journal and give BirthforHumanKIND a copy of the journal article. In any publication, information will be provided in such a way that you cannot be identified.

WHAT IF I HAVE CONCERNS OR A COMPLAINT?

If you have concerns about the research that you think I or my supervisor can help you with, please feel free to contact me on xxx. You will be given a copy of this form to keep.

NOTE: This study has been approved in line with the University of Technology Sydney Human Research Ethics Committee [UTS HREC] guidelines. If you have any concerns or complaints about any aspect of the conduct of this research, please contact the Ethics Secretariat on ph.: +61295142478 or email: Research.Ethics@uts.edu.au], and quote the UTS HREC reference number. Any matter raised will be treated confidentially, investigated and you will be informed of the outcome.

CONSENT FORM

The maternity experiences of women seeking asylum in Australia: a phenomenological research study.

UTS HREC APPROVAL NUMBER ETH20-5020.

I _____ *[participant's name]* agree to participate in the research project

NEST: Not even a safe territory: the maternity experiences of women seeking asylum in Australia: a phenomenological research study,

ETH20-5020. being conducted by Glenys Janssen-Frank (ph xxx). I understand that funding for this research has been provided by from the 2018 Australian Government Research Training Program Stipend and the 2018 Australian College of Midwives (Victorian Branch) Scholarship.

I have read the Participant Information Sheet or someone has read it to me in a language that I understand.

I understand the purposes, procedures and risks of the research as described in the Participant Information Sheet.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described and understand that I am free to withdraw at any time without affecting my relationship with the researchers or the University of Technology Sydney.

I understand that I will be given a signed copy of this document to keep. I understand:

1. An interpreter will be used if required

2. A bi-cultural worker will be used if required

3. Participation in the research is voluntary

I agree to be:

☐ Audio recorded

I agree that the research data gathered from this project may be published in a form that:

☐ Does not identify me in any way

I am aware that I can contact Glenys Janssen-Frank if I have any concerns about the research.

_____ ____/____/____

Name and Signature [participant] Date

_____ ____/____/____

Name and Signature [researcher or delegate] Date

Appendix 9: Verbal consent script

[ETH21-5985] - The maternity experiences of women seeking asylum and undocumented migrant women in Australia: a phenomenological study.

Interview no:	
Date:	
Time:	
Interviewer:	

Thank you for agreeing to speak with me today about *your maternity experience*. This might be a sensitive issue so if you are feeling distressed or need to take a break we can stop at any time. The interview will take approximately *30 -60 minutes*. If you feel that you would rather not go on with the interview that is fine too.

[Wait for participant to confirm they are happy to continue, otherwise thank them for their time.]

Thank you. Now I just need to confirm some information about you, and I'm going to start taking notes. This will help us to accurately record your story, but all this information will remain completely confidential. Is that okay?

First, I need to ask you some questions to confirm that you consent to participating. Remember, even after you've answered these questions, you can withdraw your consent at any time during the interview. However, it may not be possible to withdraw your data from the study results if these have already had your identifying details removed.

The consent questions are:

Question	Yes	No
Have you read the information contained in the participant information sheet or had it read to you in a language that you understand?		
Have you had an opportunity to ask questions and are you satisfied with the answers you have received?		
Do you understand that there may be risks such as feeling uncomfortable sharing your pregnancy, birth and post-natal story?		
Do you understand that the research will produce reports, academic work, articles, and conference presentations.		
Do you freely agree to participate in this activity, with the understanding that you may withdraw at any time?		
Do you understand that phone numbers will be kept separate to interview information and destroyed after data collection is completed?		
Do you understand that photographs will only used during the interviews and destroyed once the data collection is complete and that photographs will not be published or used in any way that may identify you?		

(If answered NO to any of these – clarify and/or discontinue interview)

If you have any concerns about the research, you can contact Glenys Janssen-Frank xxx.

If you would like to talk to someone who is not connected with the research, you may contact the Research Ethics Officer on 02 9514 9772 or Research.ethics@uts.edu.au and quote this number ETH21-5985. [

Appendix 10: Demographic questions for women seeking asylum

Name:

Age: (less than 20, 20- 30, 30-40, 40 +)

Country of origin:

Marital Status: (Single, Partnered, married, divorced).

First Language:

Interpreter required?

Education level: (Primary school, high school, tertiary education).

Length of stay in Australia

Parity (Number of pregnancies)

Is this your first pregnancy in Australia?

Appendix 11:

Demographic questions for midwives and doulas

Name:

Main place of work-

Context of caring for women seeking asylum-

Years as a midwife:

0-5

5-10

10-15

15-20

20+

Years caring for women who seek asylum

Age range:

20-30

30-40

40-50

50+

Appendix 12: Interview guide for midwives and doulas caring for women who are seeking asylum and undocumented migrants

(As per original ethics application)

Tell me about your experience of caring for women who are asylum seekers during their pregnancy, labour and birth and post-natal period?

List of things to cover:
How do you identify women who seek asylum during pregnancy?
The use of interpreters in maternity care of women who seek asylum.
The support available for asylum seekers.
The continuity of care options for asylum seekers.
Cultural competency training available for midwives.
Trauma informed care professional development for midwives.
Advocacy options for supporting women who seek asylum.

Appendix 13: Interview guide questions for women who are seeking asylum and undocumented migrants

(As per original ethics application)

Tell me about your experiences of maternity care in Australia
Interview 1: List of things to cover: The experience of booking into the hospital. The experience of antenatal appointments. The support and continuity of care in your pregnancy. The use of interpreters during antenatal appointments.
Tell me about some of the challenges accessing maternity care in Australia.
Interview 2: The labour and birth story. The experience in hospital after the birth. The experience of the first 6 weeks after the birth.
The use of interpreters during the perinatal experience.
The support and continuity of care in the maternity experience. Could you give me a specific example of that?

Appendix 14 Distress protocol: Women seeking asylum during the perinatal period

NEST: Not even a safe territory: the maternity experiences of women seeking asylum in Australia: a phenomenological research study.

The following protocol will be put into place should a participant become distressed and require on-going support and assistance. A range of options will be put into place depending on her situation. Prior to the commencement of an interview, information will be given regarding counselling services available to actual or potential participants. This information will also be included in the consent form. If a participant becomes distressed during or after the actual interview the information will be given again.

Strategies to assist if participants become distressed during an interview.

The interviewer will suggest it is appropriate for the interview to be terminated.

If the participant agrees the interview will be ceased.

The researcher will spend time with the participant offering appropriate support within their ability, offering time the participant to discuss their concerns and regroup.

The interviewer will recommend the participant speak to a trauma informed counsellor, if appropriate.

If the participant has a case worker or continuity of care midwife, it may be appropriate for the participant to discuss their concerns with her as there is already a trusting relationship. This would be in addition to a counsellor.

The goal of the activation of this protocol is comprehensive assessment and on-going support and counselling.

A follow up phone call will be made by the interviewer the next day to make sure the participant is okay and to determine it is feasible for a future date to reschedule the interview.

Appendix 15: Distress protocol for midwives, midwifery students or doulas

The following protocol will commence if a midwife, midwifery students or doulas, becomes distressed during an interview and should require additional or ongoing support and assistance. A range of services should be offered depending on her circumstance. Prior to the commencement of an interview, the information regarding available counselling services, if required, will be given to prospective and current interviewees. Information regarding counselling services will be attached to the information regarding the study and also to the consent form. Additional information is given if the participant becomes distressed during or after the interview.

Strategies if a midwife, midwifery students or doulas, becomes distressed during the interview.

The interview will suggest it's appropriate to terminate the interview.

If the participant is agreeable the interview will be ceased.

Time will be spent with the participant if appropriate, offering support and discussing their concerns, within the scope of the interviewer's ability.

The interviewer will offer further options for support with professional counselling if required. E.g. EPA

A phone call by the interviewer to the participant will be made the next day to determine the feasibility of completing the interview at another time if feasible.

Conclusion

Although it may be unlikely for the participant becomes distressed, it is a duty of care of the interviewer to provide these options before the interviews commence.

Appendix 16: Distress protocol for the interviewer

The following will be put in place in case the interviewer becomes distressed and require either additional, or on-going support, or assistance. A range of services will be offered depending on her circumstances.

Strategies to assist the interviewer after an interview.

The interviewer will debrief with her supervisor

A recommendation to speak to a counsellor will be made if required.

Supervisors will follow up with the interview to ask if they are okay and if it is feasible to continue the interviews.

Conclusion

Although it is unlikely that these interviews will cause distress it is a duty of care by the supervisors to ensure these measures are put in place, prior to commencing the interviews.

Appendix 17: Disclosure protocol

The maternity experiences of women seeking asylum and undocumented migrant women in Australia: a phenomenological study.

(ETH21- 5985)

Disclosure protocol

Disclosure of Illegal Activity:

The names of all research participants will be changed on all the interview files. We will not record participants' names, location or type of visa that has expired. The researcher will take notes and the interviews will not be recorded. Verbal consent is preferred to written consent. If written consent is given it will be noted and then shredded.

If information is disclosed about illegal activities this will not be recorded in the interviews, but it will be discussed with the referrer.

The researcher will meet participants at the Robinvale District Health service (Victoria) and therefore will not require any identifying information about the participants, except their phone number.

Any request for further information by government agencies will be referred on to Robinvale District Health Service (Victoria).

Research interviews will be stored securely in accordance University of Technology secure data plan. Information will be treated confidentially and any identifying information including names will be removed.

Disclosure of Victimisation:

Any information disclosed that may put participants at risk will be discussed with the referrer, at Robinvale District Health Service (Victoria), to follow up as required.

The information in this research will be treated confidentially and de-identified in accordance with the university policy. We will not keep any identifying information about the research participants.