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Refugee women's experiences negotiating motherhood and maternity care in a new country: A meta-ethnographic review

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ABSTRACT

Objectives: The aim of this meta-ethnographic review was to examine refugee women's experiences negotiating motherhood and maternity services in a new country with a view to identifying the specific needs of refugee women accessing maternity care in high income countries.
Design: A meta-ethnographic synthesis of qualitative research.
Data sources: Five databases were searched for papers published in English between January 2000 and January 2017.
Review methods: The synthesis process was guided by the seven steps of meta-ethnography. The quality of included studies was assessed using the COREQ tool.
Results: One overarching theme and three major themes emerged from the synthesis. The overarching theme "Living between two cultures" conveyed women's experience of feeling "in between" cultures and described refugee women's experience of striving to maintain a strong cultural identity from their country of origin while simultaneously adapting to their new context and country. This theme permeated the following three major themes: 1) "Constructing maternal identity across cultures" which discusses the cultural conflict experienced by refugees accessing maternity services in their host country; 2) "Understanding in practice" which describes reciprocal issues in communication between women and health professionals; and 3) "Negotiating care" which illustrates a mix of coping mechanisms which refugee women utilise to navigate health services in the context of high income countries.
Conclusion: Liminality is a ubiquitous experience for refugee women seeking maternity care in high income countries. It impacts feelings of belonging and connection to services and society. It is often a challenging experience for many women and a time in which they reformulate their identity as a citizen and a mother. This review found that the experience of liminality could be perpetuated by social factors, and inequality of healthcare provision, where communication and cultural barriers prevented women accessing care that was equal, accessible, and meaningful. Findings revealed both positive and negative experiences with maternity care. Continuity, culturally appropriate care, and healthcare relationships played an important role in the positive experiences of women. The review also revealed the damaging effects of disparities in care experienced by refugee women.

What is already known about the topic?

- Women who have migrated for humanitarian reasons have poorer pregnancy and birth outcomes including higher rates of pregnancy complications, maternal and neonatal mortality and morbidity, and postnatal depression than economic migrants and non-immigrant groups.

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- Most studies do not separate migrant groups, and less is known about the specific experiences of refugee women and how their experiences may differ from economic migrants.

What this paper adds

- Contributes one of the few meta-ethnographies focusing specifically on the experiences of refugee women.
- Contributes to the explication of liminality, or the sense of living "in between" and not belonging, that may be experienced by refugee women when accessing maternity care in high income countries.
- Reveals the potential for re-traumatisation when refugee women access maternity care in high income countries and discusses the need for trauma informed care.
- Identifies specific coping mechanisms and strengths employed by refugee women accessing maternity care in high income countries and how a strengths-based approach can guide service design and care provided.

1. Introduction

Unprecedented global displacement over the last two decades means that increasing numbers of refugee women are accessing maternity care in receiving countries, including high income countries (HIC). The status, experiences, and circumstances that forced refugee women to leave their country of origin render them more likely to have poorer health, and for those of childbearing age, poorer pregnancy and birth outcomes than economic migrants (Bradby et al., 2015; Heslehurst et al., 2018; Keygnaert et al., 2016). However, at present there are significant gaps in service provision that affect the successful integration and service utilisation of refugee families, and evidence from studies in superdiverse areas indicates that health and welfare providers in HIC are struggling to understand and meet new migrant needs (Phillimore, 2014). This meta-ethnography presents findings from a review of 25 papers reporting on the experiences of refugee women undertaking motherhood and accessing maternity care in HIC. There are a limited number of meta-ethnographies exploring the experiences of migrant women accessing health services and commonly the literature groups refugee women with other immigrant populations. None focus specifically on the in-depth experiences of refugee women accessing maternity services in HIC. By excluding the literature on women who are economic migrants and focusing on refugee women, this review will contribute to our understanding of refugee women's experiences of maternity services.

2. Background

At the end of 2017 there were over 68.5 million people forcibly displaced as a result of conflict, persecution or generalised violence; the largest number of displaced persons recorded in two decades (United Nations High Commissioner for Refugees (UNHCR), 2017). The health of these large displaced groups is an important global, humanitarian and economic concern and the number of refugee and asylum seekers currently far exceeds resettlement or repatriation solutions, requiring HIC to take a greater role in the resettlement of refugees (United Nations High Commissioner for Refugees (UNHCR), 2017). The experiences of forced migration, trauma, detention, and resettlement render refugees more vulnerable to serious health concerns (Roberts et al., 2016). Common health problems include accidental injuries, hypothermia, burns, gastrointestinal illness, cardiovascular events, diabetes, hypertension, and pregnancy and delivery-related complications (World Health Organistion (WHO), 2018). Refugees are more likely to arrive at host countries with a pre-existing condition or disability (Asif et al., 2015; Chaves et al., 2016). Interruption to, and loss of access to healthcare plays a major role in complicating pre-existing non-communicable diseases, and the experience of poverty and overcrowding while migrating or encamped renders refugees vulnerable to communicable diseases (World Health Organistion (WHO), 2018).

Refugees are also more likely to suffer mental health issues than economic migrants and those born in HIC. The distress and trauma associated with forced migration can also have long lasting psychological repercussions for refugee people. Common risk factors for trauma at different stages of migration are often multiple and include fear, risk of physical harm, separation, uncertainty of situation, detention, discrimination, and reduced social integration (Collins et al., 2011; Frankova, 2017). A meta-analysis conducted by Lindert et al. (2009), found that the rate of mental illness suffered by refugee and asylum seekers is double that of economic migrants. Recent Swedish research also revealed that refugees have a threefold higher incidence of schizophrenia and other psychotic disorders compared to the Swedish born population (Hollander et al., 2016), supporting previous literature demonstrating increased diagnosis of psychiatric disorders among migrants (Cantor-Graae, 2007; Coid et al., 2008; Frankova, 2017). Extended displacement and asylum procedures are also associated with psychiatric disorders, and this increases with the length of detention, particularly where there is a threat of deportation and confinement (Bradby et al., 2015).

Upon arrival in resettlement countries refugees commonly experience social disadvantage, and this can result in differential access to care (Bradby et al., 2015; Keygnaert et al., 2016; Sundquist, 2001). Common barriers to health care include language literacy, access issues (including difficulty accessing service locations and navigating healthcare pathways), the provision of culturally inappropriate care, and experiences of discrimination and racism (All Party Parliamentary Group on Refugees, 2017; Joshi et al., 2013; Small et al., 2014). Diagnoses of health issues are often delayed by dispersal policies, lack of accessible services, and issues which complicate disclosure including fear and personal shame (Asif et al., 2015; Bhatia and Wallace, 2007).

2.1. The health of refugee women

Approximately half of displaced persons are women and girls and, with many of reproductive age, increasing numbers of women will be accessing maternal and reproductive health care in HIC (United Nations High Commissioner for Refugees (UNHCR), 2017). A substantial body of literature has demonstrated that migrant women, both economic migrants (those migrating voluntarily for economic reasons) and humanitarian migrants (those with refugee status and those seeking asylum), have poorer maternal health outcomes. These include higher rates of pregnancy complications, maternal morbidity, and neonatal mortality and morbidity than the general population (Almeida et al., 2013; Gissler et al., 2009; Heslehurst et al., 2018). However, refugee and migrant women are not homogeneous populations. Studies that have examined health outcomes among resettled refugee women in countries such as Australia, Canada, and Sweden report significant disparities in maternal and perinatal outcomes when compared to other migrant groups and the mainstream population. These disparities include higher rates of preterm birth, low birth-weight infants, stillbirths, and maternal mortality (Gagnon et al., 2002,2013; Heslehurst et al., 2018). A recent study conducted by Gibson-Helm et al. (2015) in Australia compared the health of migrant women born in humanitarian (HSC) and non-humanitarian source countries

(NHSC), to examine the health of recent migrants from probable refugee and non-refugee backgrounds. They demonstrated that health risk profiles vary between migrant categories and found that pregnant women from HSC were statistically more likely to be teenagers, multiparous, have anaemia, tuberculosis, syphilis, and a BMI of 25 or higher (Gibson-Helm et al., 2015). During migration refugee women are also more commonly exposed to sexual and gender-based violence, sexual assault, sexual exploitation, and transactional sex (Hersh and Obser, 2016; Refugee Council, 2009; UNHCR, United Nations Population Fund, and Women's Refugee Commission, 2015).

Studies examining the mental health of refugee and asylum-seeker women demonstrate that they generally have a higher risk of poor mental health, including perinatal depression and post-traumatic stress disorder, than both economic migrants and women born in many HIC countries (Collins et al., 2011; Kirmayer et al., 2011; Lindert et al., 2009). This finding was supported by Dennis et al. (2017), who compared rates of postnatal depression among immigrant and non-immigrant populations in Canada. They found asylum seeking women had the highest rate of postnatal depression (14.3%), followed by refugee women (11.5%), and non-immigrant women (5.1%).

Specific barriers to accessing optimal maternity care for refugee women have also been documented. Low language literacy, low socio-economic status, and social disadvantage contribute to differential access to health and maternity care. These issues often result in the delayed initial presentation of pregnant refugee women at services and fewer visits in the pre- and post-natal periods (Kentoffio et al., 2016).

The provision of optimal reproductive and maternal healthcare is critical for ensuring the health and wellbeing of refugee women and their families. For refugee women, access to maternity care influences more than their immediate and long-term health; it also impacts upon integration, attitudes to health and health seeking behaviour, and has ramifications for inter-generational health (Hollander et al., 2016; Khawaja et al., 2017; Nelson-Peterman et al., 2015). However, providing maternity care for culturally, ethnically, and linguistically diverse (CALD) groups is complex and can be challenging for health services (Foster et al., 2017; Newall et al., 2012; Vertovec, 2007). Furthermore, identifying the unique needs of this vulnerable population can be difficult. There is currently no universal definition of migrant and the term can be used to describe a variety of immigrant populations (Keygnaert et al., 2016). In HIC, legal status is often the most important factor in determining access to healthcare and yet health literature commonly conflates migrants, refugees, and asylum seekers (Bradby et al., 2015). This results in literature that obscures the perinatal health experiences and outcomes for these vulnerable groups. By excluding the literature on women who are economic migrants and focusing on refugee women, this review will contribute to enabling health services to tailor service design and delivery to the meet specific needs of refugee women.

3. Method

Meta-ethnography is a systematic approach to synthesising the findings from qualitative studies with the aim of gaining an in-depth understanding and new interpretation of the investigated phenomenon. This study is informed by the seven phases of synthesis outlined by Noblit and Hare (1988) on meta-ethnography.

3.1. Data generation

This research utilised the United Nations definition of refugee (United Nations High Commissioner for Refugees (UNHCR), 2010, p.3). A literature search of academic papers reporting qualitative data, published in English, from 2000 to January 2017 was conducted using the MEDLINE, PubMed, CINAHL, SocINDEX and Scopus databases. Search terms and Medical Subject Headings included: "refugee", "asylum seeker", "displaced person", "pregnancy", "reproductive health", and "maternal health". The term "migrant" was excluded from the search to capture papers with refugee populations. Papers that primarily focused on adolescent health or one aspect of reproductive health were excluded. Mixed methods studies were included if they had a substantive qualitative component. The papers were evaluated for quality using the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (Tong et al., 2007). Two researchers individually assessed each paper, with team discussion to resolve any discrepancies.

3.2. Data extraction and synthesis

Data extraction and synthesis was led by JP. Papers were read individually by all authors to identify preliminary themes, ideas, and concepts which were then discussed with the research team. Key concepts and themes along with study aim, participants, methodology, methods, and key findings were extracted into a table. It was determined that the studies met the criteria for reciprocal translation and an iterative process was undertaken systematically comparing the key themes and concepts across studies (Noblit and Hare, 1988). We then followed idiomatic rather than word-for-word translation to determine the relationships of the key concepts across studies (Noblit and Hare, 1988). Despite this, it was determined to maintain two original themes found during the translation process as they most accurately captured particular phenomena. These were developed conceptually, and new themes and subthemes were added as necessary. Final themes were reviewed JP, VS, OO, RE and discussed with the research team. No computer software was used to assist analysis (Table 1).

4. Results

A total of 2927 papers were retrieved, and 1858 duplicates removed. After initial evaluation, 1069 titles and abstracts were reviewed with 798 excluded. Following this, 271 abstracts were examined more closely and 200 were excluded. Seventy-one papers were read in full and screened using the inclusion criteria. 46 papers were excluded. The remaining 25 papers were subjected to critical appraisal and all were selected to be a part of the synthesis. The search process and outcomes are outlined in (Fig. 1). Two papers that examined both refugee men and women's experiences related to maternity care were included, however, only the women's perspectives were extracted, and the men's perspectives informed context. Some papers that did not meet all the COREQ quality criteria were included in the synthesis. However, all papers were included as they were deemed conceptually rich and provided data that contributed to interpretation.

A total of 22 qualitative studies and 3 mixed methods studies were included. These studies were conducted in eight different HIC including the United Kingdom, Australia, Sweden, Canada, and the United States of America, and included a total of 607 participants who were either refugees or asylum seekers (see Table 2).

One overarching theme and three major themes emerged from the data (Fig. 2). The overarching theme "Living between two cultures" conveys women's experience of feeling "in between" cultures and describes their experience of striving to maintain a strong cultural identity from their country of origin while simultaneously adapting to their new context and country. This theme permeates the three major themes: 1) "Constructing maternal identity across cultures" which discusses the cultural

Table 1
Consolidated criteria for reporting qualitative research (COREQ) (Tong et al., 2007).

✓ = Yes X = No - = Not indicated	Baird & Boyle (2012)	Briscoe & Lavender (2009)	Brown, et al. (2010)	Bulman & McCourt (2010)	Carolan & Cassar (2008)	Gurnah et al., (2011)	Herrel et al., (2004)	Higginbottom et al., (2013)	Hill et al., (2012)	Illadi (2008)	Kennedy & Murphy-Lawless (2003)	Lillrank (2015)	McLeish (2005)	Murray et al., (2010)	Niner et al., (2014)	Niner et al., (2013)	Owens et al., (2015)	Russo et al., (2015)	Shafiei et al., (2012)	Stapleton et al., (2013)	Stewart et al., (2015)	Straus et al., (2007)	Tobin et al., (2013)	Wiklund et al., (2000)	Wojnar, et al., (2015)
1. Interviewer/facilitator	✓	✓	✓	✓	-	✓	-	✓	✓	-	-	✓	✓	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
2. Credentials	✓	-	✓	-	✓	✓	✓	✓	✓	✓	-	✓	✓	-	✓	✓	-	-	✓	-	-	✓	✓	✓	✓
3. Occupation	✓	✓	✓	-	-	✓	✓	✓	✓	✓	✓	✓	✓	-	✓	-	-	-	-	-	✓	✓	✓	✓	✓
4. Gender	✓	-	✓	✓	✓	-	-	✓	X	-	✓	✓	✓	-	-	-	✓	✓	-	-	-	-	✓	-	-
5. Experience and training	✓	-	-	-	-	-	✓	-	✓	-	-	✓	-	-	✓	-	-	✓	-	✓	-	-	-	✓	-
6. Relationship established	✓	-	-	✓	-	-	-	-	X	-	-	-	-	-	-	-	-	✓	-	-	-	-	✓	-	-
7. Participant knowledge of the interviewer	✓	-	-	✓	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	✓	-	-
8. Interviewer characteristics	✓	-	-	-	-	-	-	-	X	-	✓	✓	-	-	✓	-	-	✓	-	✓	-	-	-	✓	✓
9. Methodological orientation and Theory	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	✓	✓	✓	✓	✓	-	-	✓	✓	✓	✓	✓
10. Sampling	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
11. Method of approach	✓	✓	✓	✓	✓	✓	-	✓	✓	✓	✓	✓	-	✓	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓
12. Sample size	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
13. Non-participation	-	✓	✓	-	-	-	-	-	-	-	-	✓	-	✓	-	-	✓	-	✓	-	-	-	-	✓	✓
14. Setting of data collection	✓	✓	✓	-	✓	-	✓	✓	✓	-	✓	✓	✓	✓	✓	-	✓	✓	✓	✓	✓	✓	-	✓	✓
15. Presence of non-participants	✓	-	✓	✓	✓	✓	✓	✓	X	-	-	✓	✓	✓	-	-	✓	-	-	-	-	-	✓	✓	✓
16. Description of sample	✓	-	✓	-	✓	✓	✓	X	✓	✓	✓	-	-	✓	✓	✓	✓	✓	✓	✓	-	✓	✓	✓	✓
17. Interview guide	✓	-	-	✓	✓	✓	✓	✓	-	-	-	✓	-	-	X	-	✓	✓	✓	-	✓	✓	-	✓	✓
18. Repeat interviews	X	-	-	-	-	-	-	X	X	X	✓	✓	-	-	-	-	-	-	-	-	-	-	-	-	✓
19. Audio/visual recording	✓	-	✓	-	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	✓	✓
20. Field notes	✓	✓	-	-	✓	✓	-	-	-	-	✓	✓	-	X	-	-	✓	✓	-	-	-	-	✓	✓	✓
21. Duration	-	-	-	-	✓	-	-	-	-	-	-	✓	-	-	-	-	✓	✓	-	-	-	✓	-	✓	-
22. Data saturation	X	-	-	-	✓	✓	-	-	-	-	-	✓	-	-	-	-	-	✓	-	-	-	-	-	✓	-
23. Transcripts returned	✓	-	✓	✓	-	-	-	-	-	X	-	✓	-	-	-	-	-	-	-	-	-	-	-	✓	-
24. Number of data coders	-	✓	✓	-	✓	✓	-	-	✓	-	-	✓	-	-	-	-	✓	✓	-	✓	✓	-	✓	✓	✓
25. Description of the coding tree	✓	✓	✓	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	✓	-	-
26. Derivation of themes	✓	✓	✓	✓	-	✓	✓	-	✓	✓	✓	✓	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
27. Software	-	-	-	✓	-	-	-	✓	X	-	-	-	-	-	-	-	-	✓	-	✓	✓	-	-	-	-
28. Participant checking	✓	✓	✓	-	-	-	-	-	✓	-	X	-	-	-	-	X	✓	✓	-	-	-	✓	-	✓	✓
29. Quotations presented	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
30. Data and findings consistent	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
31. Clarity of major themes	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
32. Clarity of minor themes	X	-	-	✓	-	✓	-	✓	✓	✓	✓	-	-	-	✓	✓	✓	✓	-	-	✓	X	X	✓	✓

conflict experienced by refugees accessing maternity services in their host country; 2) "Understanding in practice" which describes reciprocal issues in communication between women and health professionals that perpetuate the experience of "Living between two cultures"; and 3) "Negotiating care" which illustrates a mix of responses that refugee women had when navigating health services in the context of maternity care in HIC.

4.1. Living between two cultures

"Living between two cultures" illustrates refugee women's experiences negotiating the landscape "in between" the culture and society of their country of origin and the culture and society of their host country. It incorporates the concepts of belonging and identity. This theme was adapted from Baird and Boyle (2012) and is associated with being in a "liminal or "in-between" state, both physically and psychologically (Baird and Boyle, 2012; Owens et al., 2016; Russo et al., 2015; Wojnar, 2015).

Refugee women living in a new country bring with them a strong identity from their country of origin and are conscious of differences between their culture and the culture of their host country (Baird and Boyle, 2012; Carolan and Cassar, 2010; McLeish, 2005; Wojnar, 2015). Women's narratives described feelings of being displaced (Niner et al., 2013), different (Carolan and Cassar, 2010; Murray et al., 2010), like outsiders (Kennedy and Murphy-Lawless, 2003; Niner et al., 2013), isolated and marginalised (Carolan and Cassar, 2010; Kennedy and Murphy-Lawless, 2003; Murray et al., 2010; Niner et al., 2013, 2014). The dichotomy of living between two cultures is described by a Sudanese refugee:

> *. . . It's hard because Sudanese woman — now they are in the middle between; they not in the American culture, and they not in Sudanese culture. They just in the middle from nowhere. (Sudanese woman)* (Baird and Boyle, 2012, p. 17)

The unique experiences of forced migration and subsequent resettlement contributes to the experience of "Living between two cultures" for refugee mothers. Women are required to negotiate significant life transitions and challenges whilst also adapting to the unfamiliar context of their host country. During this time they evaluate, balance, and assimilate their beliefs with new societal values. This experience can result in a climate of uncertainty for refugee women (Baird and Boyle, 2012; Carolan and Cassar, 2010; Kennedy and Murphy-Lawless, 2003; Lillrank, 2015; Niner et al., 2013; Owens et al., 2016; Russo et al., 2015; Wojnar, 2015). As described by one woman:

> *. . . How are we going to apply these cultures? We need these two cultures, we cannot lose our cultures. We need our cultures and we need Canadian culture. We need to bring these two cultures together. (Sudanese female)* (Stewart et al., 2015, p.1150)

This cultural conflict contributes to a re-evaluation and redefinition of cultural beliefs leading to a reformulation of identity as a citizen and a mother (Baird and Boyle, 2012; Briscoe and Lavender, 2009; Carolan and Cassar, 2010; Higginbottom et al., 2013; Kennedy and Murphy-Lawless, 2003; McLeish, 2005; Murray et al., 2010; Stewart et al., 2015; Straus et al., 2007).

> *I don't pray for anyone, the way we have it. You lose whole country, whole identity collapses and then you come someplace to a country, it's something very, very hard. (Somali woman)* (Straus et al., 2007, p. 184)

Numerous factors contribute to the experience of "living between two cultures" for refugee women accessing maternity care in a new country. These include trauma and loss (Kennedy and Murphy-Lawless, 2003; Murray et al., 2010; Owens et al., 2016; Stewart et al., 2015), loneliness and isolation (Kennedy and Murphy-Lawless, 2003; Owens et al., 2016; Panagiota, 2008; Stewart et al., 2015; Straus et al., 2007), social and economic disadvantage (Briscoe and Lavender, 2009; Bulman and McCourt,

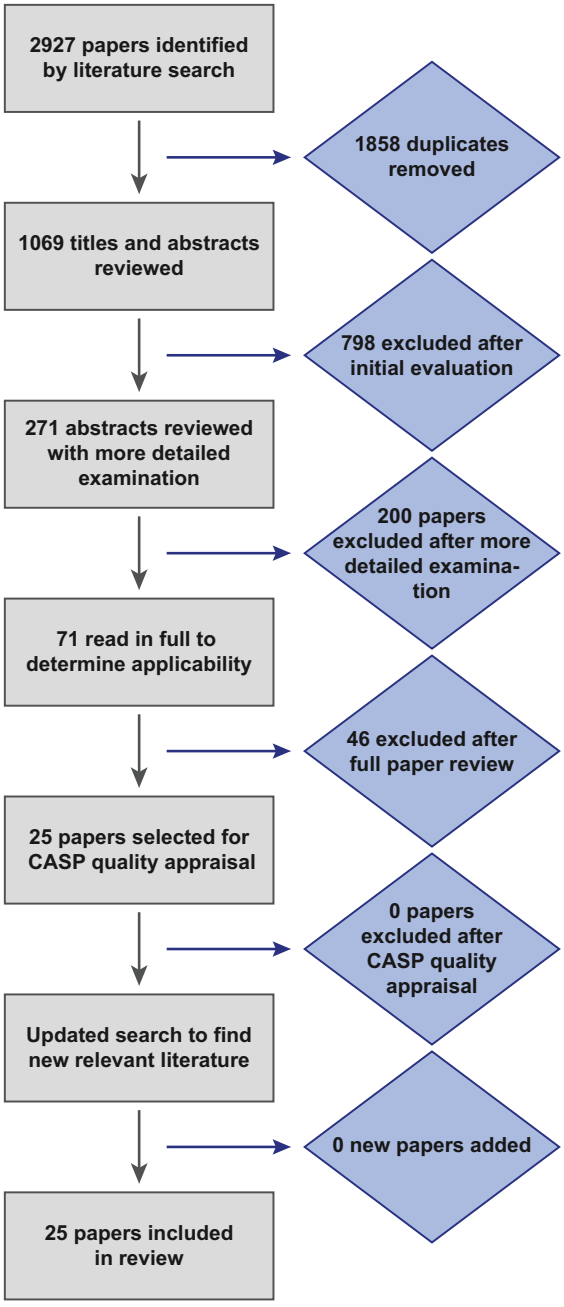

Fig. 1. Search process.

2002; Carolan and Cassar, 2010; Kennedy and Murphy-Lawless, 2003; McLeish, 2005; Niner et al., 2014), communication and cultural challenges (Briscoe and Lavender, 2009; Bulman & McCourt, 2010; Gurnah et al., 2011; Herrel et al., 2004; Iliadi,2008; Niner et al., 2013; Stapleton et al.,2013; Stewart et al.,2015), change in relationship and gender dynamics (Baird and Boyle, 2012; Higginbottom et al., 2013; Niner et al., 2014; Stewart et al., 2015; Straus et al., 2007) and being challenged by foreign notions of motherhood and parenting (Baird and Boyle, 2012; Kennedy and Murphy-Lawless, 2003; Stewart et al., 2015). During forced migration, women are exposed to the trauma, persecution, fear, and loss associated with war and conflict. Many have experienced violence, separation from loved ones, displacement, poverty, and suffered human rights violations (Kennedy and Murphy-Lawless, 2003; Murray et al., 2010; Owens et al., 2016; Stewart et al., 2015).

> *I couldn't sleep at night, thinking about the children. I never knew, maybe they are dead, maybe they are alive, maybe something else happened to them, because in Freetown, when the rebels took it, they just cut off the hands of kids . . .* McLeish (2005, p. 785)

Women also suffered from a separation and loss from core aspects of their former lives (McLeish, 2005). They often described a deep sadness and isolation due to loss of family, community, status, livelihood, homeland, and culture (Carolan and Cassar, 2010; McLeish, 2005; Owens et al., 2016; Wojnar, 2015).

> *I miss my family and I miss the crowds and the neighbourhoods. In Afghanistan, your child is looked after by the entire neighbourhood . . . (Laila, Afghani woman)* (Russo et al., 2015, p.7)

Despite being removed from the immediate threat, the suffering and trauma women experienced can have long lasting physical and psychological ramifications, including mental health issues, such as depression and Post Traumatic Stress Disorder (Carolan and Cassar, 2010; Hill et al., 2012; Kennedy and Murphy-Lawless, 2003; Niner et al., 2013, 2014; Russo et al., 2015). This is illustrated by a participant in McLeish's (2005) study:

> *"I am rubbish. I haven't got anything left. I have no value. I pretend too much to be happy but inside me I am dead." (Participant 6, Asylum seeker)* (McLeish, 2005, p.7)

During resettlement, refugee women reported that while their basic needs were met they were still disadvantaged due to barriers such as low socio-economic status, potential further displacement, and poor social policy and support (Briscoe and Lavender, 2009; Carolan and Cassar, 2010; Kennedy and Murphy-Lawless, 2003; McLeish, 2005; Niner et al., 2014). Difficulties transitioning into society were also reported due to a lack of access to healthcare, employment, and limited language skills (Carolan and Cassar, 2010; Niner et al., 2014).

> *I'm worried about taking care of myself and my baby. I think about that all the time. Where will they move me? If they don't put you in good accommodation, how can you do your best? (Asylum seeker)* (Kennedy and Murphy-Lawless, 2003, p.50)

The resettlement period also challenged refugee women's relationships and changed previously defined gender roles. Accounts vary from couples having stronger relationships to those of experiencing increased marital strain and greater numbers of separation or divorce (Baird and Boyle, 2012; Higginbottom et al., 2013; Stewart et al., 2015; Straus et al., 2007).

> *We were going through so much individually, so that was also putting pressure on our relationship. Whereas in a normal day, that shouldn't have been, but you have frustrations with the language barrier and culture shock contributed.* (Stewart et al., 2015, p.1156)

4.1.1. Constructing maternal identity across cultures

"Living between two cultures" has a profound impact on women who are trying to maintain culturally significant constructs of mothering while simultaneously striving to provide the best for their children. Many women had clear ideas about mothering and patterns of parenting which were learnt from family networks, the wider community, and witnessing birth practices from an early age (Briscoe and Lavender, 2009; Higginbottom et al., 2013; Hill et al., 2012; Kennedy and Murphy-Lawless, 2003; Niner et al., 2013; Russo et al., 2015). They valued their cultural heritage and often felt responsible for carrying on the beliefs of their homeland (Baird and Boyle, 2012; Carolan and Cassar, 2010).

> *There is a lot of pressure on women that come here. You are carrying so much. You are carrying the culture of Sudan.* (Dinka Refugee) (Baird and Boyle, 2012, p.17)

Table 2
Studies included in the meta-ethnography.

	Author	Aim	Country	Method/Design	Participants	Key concepts and themes	Findings
1.	Baird and Boyle (2012)	The purpose of this study was to understand the health and well-being of Sudanese refugee women who were resettled with their children to the United States	United States	Interpretive ethnography Interviews and participant observation	10 refugee women from the Dinka tribe of southern Sudan	Liminality—Living between two cultures; Self-support—standing on our own two legs; and Hope for the future	Liminality Constructing maternal identity across cultures Negotiating care
2.	Briscoe and Lavender (2009)	The aim of this study was to explore the experience of maternity care by three asylum seekers and one refugee	United Kingdom	Longitudinal exploratory multiple case study In-depth interviews	4 asylum seeker or refugee women	The perception of 'self'; Understanding in practice; and The influence of social policy	Liminality Constructing maternal identity across cultures Understanding in practice
3.	Brown et al. (2010)	The authors explore sources of resistance to common prenatal and obstetric interventions	United States	Qualitative Individual interviews and focus groups	34 Somali women	African birth experience and lay medical knowledge; U.S. obstetrical experience; Fears about caesarean section; Female circumcision; and other birth experiences	Understanding in practice Negotiating care
4.	Bulman and McCourt (2002)	The aim of this small study was to develop an understanding of the reality faced by Somali women in their contacts with the maternity services in the UK	United Kingdom	Qualitative Semi-structured interviews and focus groups	12 Somali refugee women	Local provision of language services; Women's experiences of language services, Women's experiences of using informal interpreters; Implications of the language barrier; Pain control; Female genital mutilation; Implications of continuity versus non-continuity of care; Quality and sensitivity of care; Health professionals' knowledge of interpreting services and Health professionals' awareness of the language barrier	Liminality Understanding in practice Negotiating care
5.	Carolan and Cassar (2010)	To explore the experiences and concerns of an African-born sample of pregnant women receiving antenatal care in Melbourne, Australia	Australia	Qualitative Interviews	18 pregnant African women	Pregnancy is not special; Resettlement is a priority; Childbearing is a normal process; Coming to value continuous pregnancy care and Cultural sensitivity is important	Liminality Understanding in practice Constructing maternal identity across cultures Negotiating care
6.	Gurnah et al. (2011)	The objective of this study was to explore the reproductive health experiences of Somali Bantu women in Connecticut	United States	Qualitative Interviews, focus group session, and a semi-structured survey	39 Somali Bantu women	Ethnic distinction/language barriers; Passive acceptance of incorrect care; Cultural discordance in family planning services; Patient-provider sex discordance, and Desired but limited scope for decision making	Understanding in practice Constructing maternal identity across cultures Negotiating care
7.	Herrel et al. (2004)	To obtain information to develop culturally sensitive health education materials	United States	Qualitative Focus groups	14 Somali refugee women	Childbirth experiences; Issues of labour and delivery; Childbirth education needs; Sources of information; Decision making; Use of interpreters; Prenatal visits and Formats for health education	Understanding in practice Negotiating care
8.	Higginbottom et al. (2013)	The aim of this paper was to report on findings specific to the experiences of immigrant Sudanese women throughout the prenatal period and to explore the disparities, based on their ethnocultural beliefs, they may have experienced while receiving maternity care services in Alberta	Canada	Mixed-methods Focus group interviews	12 immigrant Sudanese women	Personal agency and Resistance to health practices. Sub themes: Hidden contraception; Resistance to patriarchy; Strength and knowledge in pain relief; Fear of caesarean sections and Resistance to other practices – delivery positions and relief for swelling	Constructing maternal identity across cultures Understanding in practice Negotiating care
9.	Hill et al. (2012)	The purpose of this study was to describe and better understand Somali immigrant women's healthcare experiences and beliefs regarding pregnancy and birth in the United States	United States	Qualitative Focus group interviews	18 Somali women	Pregnancy as a natural experience for women; Value and relevance of prenatal care; Lack of control and familiarity with delivery in the United States; Balancing the desire to breastfeed with practical concerns and barriers; Discomfort with mental health issues and Challenges in the healthcare system	Constructing maternal identity across cultures Understanding in practice Negotiating care

Table 2 (*Continued*)

	Author	Aim	Country	Method/Design	Participants	Key concepts and themes	Findings
10.	Iliadi (2008)	The aim of the present study was to examine whether refugee women, resettled in Greece, receive antenatal care and to explore possible factors that may influence their attitude towards maternal care	Greece	Qualitative Semi-structured interviews	26 refugee women from five non-governmental organizations for refugees	Language barrier; Financial factor; Familiarity with the health system; Continuity of care; Support, Wellbeing of mother and child; The man's role in pregnancy and The vaginal examination	Liminality Understanding in practice Constructing maternal identity across cultures
11.	Kennedy and Murphy-Lawless (2003)	The objective of the research was to collect baseline data on asylum-seeking and refugee women's experiences, and their expressed needs and perspectives of the existing care services in order to inform the development of relevant maternity care policies for this group	Ireland	Qualitative Interviews	61 women asylum seekers from Nigeria, Romania, Kosovo, Cameroon, Ghana, Ukraine, Algeria, Bosnia, Iraq, Poland, Russia and Sierra Leone	Direct provision and accommodation; Antenatal care; Experiencing birth; Breastfeeding; Coping without the extended family; Programme refugee women's experiences; Racism and The future for women asylum seekers	Liminality Understanding in practice Negotiating care
12.	Lillrank (2015)	The aim of this paper was to explore how refugee women experience pregnancy and childbirth in interaction with the Finnish maternity care professionals	Finland	Narrative analysis Semi-structured interviews	10 refugee women (6 Somali, 3 Russian/ Chechen, 1 Iranian and 1 Afghan)	Women who were satisfied with the maternity care experience; Accounts of faltering recognition of needs and Tragic accounts of neglect and lacking recognition	Living between two cultures Understanding in practice Negotiating care
13.	McLeish (2005)	To describe the maternity experiences of thirty-three asylum seekers who were either pregnant or had a young baby	United Kingdom	Qualitative Semi-structured interviews	33 asylum seeker women from 19 different countries	Accessing care; Information needs; Experiences with midwives; Communication; Informed consent, Postnatal support and Women's emotions	Liminality Constructing maternal identity across cultures Understanding in practice
14.	Murray et al. (2010)	To uncover first-person descriptions of the birth experiences of African refugee women in Brisbane, Australia, and to explore the common themes that emerged from their experiences	Australia	Descriptive phenomenology Semi-structured interviews	10 African refugee women	You don't know, you feel alone, and You feel different; They are very kind nurses, but still they don't have much time and We are used to a natural type of giving birth	Liminality Constructing maternal identity across cultures Understanding in practice Negotiating care
15.	Niner et al. (2014)	To explore the ways in which displaced Karen mothers expressed emotions in narrative accounts of motherhood and displacement	Australia	Ethnography Interviews	15 Karen women who had been displaced due to forced migration	"I wanted my heart to stay very tight"; The unstable heart: embodiment of emotion; "Here nobody holds your heart"; Life after resettlement and "How we survived": self-reliance	Liminality Constructing maternal identity across cultures Negotiating care
16.	Niner et al. (2013)	The study examined the effects of displacement on the lives of a group of ethnic minority Karen women from Burma-Myanmar through a focus on perinatal health	Australia	Ethnography Interviews	15 Karen women who had been displaced due to forced migration	Birth experiences in Burma and during displacement; Birth experiences in Australia: Narratives of gratitude, acceptance, confusion, and complaint; Normalizing distress: Self-reliance,"gracious" acceptance" and complaint; and Discrimination, and entitlement	Constructing maternal identity across cultures Understanding in practice Negotiating care
17.	Owens et al. (2016)	To explore the perceptions of care experienced by refugees and migrant women of culturally and linguistically diverse backgrounds who had participated in a community-based antenatal programme specialising in maternity care of multicultural women	Australia	Phenomenology Semi- structured interviews	12 refugee and migrant women	Social support; Gaining of knowledge; A holistic service and New opportunities	Liminality Constructing maternal identity across cultures Understanding in practice
18.	Russo et al. (2015)	To explore the experiences of Afghan women living in Melbourne throughout pregnancy, birth, and early motherhood, and gain insight into the aspects of their experiences that they perceive as positively and negatively impacting their emotional wellbeing	Australia	Qualitative Focus groups and in-depth interviews	38 Afghanistan-born women from a refugee background	Experiences within formal maternity care settings and Experiences within the context of relationships, home, and community	Liminality Constructing maternal identity across cultures Understanding in practice
19.	Shafiei et al. (2012).	To explore immigrant Afghan women's views and experiences of maternity care in Melbourne, Australia	Australia	Mixed methods Interviews	40 Afghan women	Interactions with caregivers; The organisation of care and the hospital environment, and Reflections on care at home in Afghanistan	Understanding in practice

Table 2 (*Continued*)

	Author	Aim	Country	Method/Design	Participants	Key concepts and themes	Findings
20.	Stapleton et al. (2013)	To examine if maternity care experiences for women from refugee backgrounds, attending a specialist antenatal clinic in a tertiary Australian public hospital, be improved?	Australia	Mixed methods	202 participants. 42 refugee women, 147 hospital staff, 3 clinic staff, 3 hospital managers, 2 interpreting co-ordinators and 5 key community-based stakeholders	Service provision: models of care, access, and appointments and Socio-cultural and medical norms: differences between home and host country	Liminality Constructing maternal identity across cultures Understanding in practice Negotiating care
21.	Stewart et al. (2015)	To examine the challenges faced by refugee new parents from Africa in Canada	Canada	Mixed methods	72 refugee mothers and fathers	Loneliness; Trauma and stress; Marital conflicts; Gender role conflicts; Insufficient time for family; Cultural conflicts in parenting; Lack of culturally appropriate services; Child care and child rearing costs; Inability to perform cultural traditions; Language barriers; Discrimination; Prolonged immigration processes and Educational barriers and employment Barriers	Liminality Constructing maternal identity across cultures Understanding in practice
22.	Straus et al. (2007)	To conduct a qualitative study of perceptions of experiences of childbirth from Somali health workers in the UK	United Kingdom	Ethnography In- depth interviews	8 Somali women	Circumcision; Cultural aspects of care and Pressures arising from migration experience	Liminality Understanding in practice Constructing maternal identity across cultures
23.	Tobin et al. (2013)	The purpose of this study was to gain insight into women's experiences of childbirth in Ireland while in the process of seeking asylum	Ireland	Narrative analysis In-depth unstructured interviews	22 asylum seeker women	Scene/Agent and Act/Agency imbalance in the women's experiences, highlighting lack of communication, connection and culturally competent care evident in their experiences and how this impacted the care they received	Liminality Understanding in practice
24.	Wiklund et al. (2000)	The aim of this study was to study the childbirth experiences of Somali women and men in Sweden	Sweden	Qualitative Semi- structured interviews	9 Somali women and 7 Somali men	Similarities of experiences in childbirth between Somali women and men in Sweden; Meeting the Swedish antenatal and delivery care; Childbirth in Sweden becoming a deviant to culture and gender-specific norms; Somali family structure in transition; From norm regulated to individualistic decisions in parenthood; Different experiences in childbirth between Somali women and men in Sweden; Skills in childbirth; Female and male pioneering in childbirth in Sweden; Changes in gender spheres after delivery and Somali couple's dual vulnerability in childbirth in Sweden	Liminality Understanding in practice Negotiating care
25.	Wojnar (2015)	To explore the perspectives of Somali couples on care and support received during the perinatal period in the United States	United States	Descriptive phenomenology Semi-structured interviews	48 immigrant women and men from Somalia, including refugees	Navigating through the conflicting values, beliefs, understandings and expectations	Liminality Understanding in practice Constructing maternal identity across cultures Negotiating care

While women valued access to contemporary biomedical care when accessing maternity services, often their constructs of what constituted an appropriate mother could also be undervalued, contradicted, and challenged. Women were regularly offered care which contrasted with their culturally embedded notions of motherhood or did not accommodate their cultural beliefs (McLeish, 2005; Niner et al., 2014; Russo et al., 2015; Stewart et al., 2015).

> *I felt like I was judged by my doctor . . . I wanted to do things according to my tradition but I was expected to do things differently. (Refugee woman.)* (Russo et al., 2015, p. 6)

Most women tended to adopt the recommended maternal practices of their host country (Carolan and Cassar, 2010; Hill et al., 2012; Owens et al., 2016), but differing views of motherhood could create uncertainty for refugee women who felt conflicted about

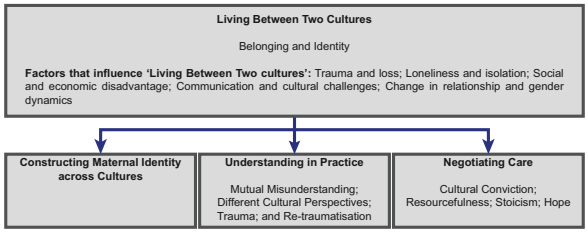

Fig. 2. Diagram illustrating themes.

what constituted the best possible care. This often required women to compromise, re-evaluate or assimilate their beliefs (Carolan and Cassar, 2010; Lillrank, 2015; Russo et al., 2015; Wojnar, 2015), resulting in the adoption of new values of motherhood and influencing their maternal identity (Hill et al., 2012; Russo et al., 2015).

> *. . . and I was thinking, should I listen to my mum, or to my doctor? I think, my mum is uneducated, doctor is educated, what should I do? First time I was like, sometimes listening to mum, sometimes listening to doctor. The second time all I did [was] . . . listen to my doctor . . . And I did and I find it really good . . . (Shabnam, Refugee woman)* (Russo et al., 2015, p. 7)

4.1.2. Understanding in practice

Despite a large proportion of refugee women reporting positive experiences with health services, challenges associated with "Understanding in practice" perpetuated the experience of "Living between two cultures" for refugee women and represented a major issue for women seeking to utilise maternity care in HIC. "Understanding in practice" was adapted from Briscoe and Lavender (2009) and refers to reciprocal issues with understanding between refugee women and health practitioners. This was perpetuated by organisational barriers, language barriers, different cultural perspectives, and lack of cultural sensitivity. These issues contributed to differential access to health care, uninformed decision making, disempowerment, re-traumatisation, and played a role in the marginalisation of refugee women, rendering the experience of "Living between two cultures" more difficult.

4.1.2.1. Mutual misunderstanding. Organisational barriers and unfamiliarity with services prevented women from gaining the necessary knowledge and confidence to enact personal agency and negotiate care (Gurnah et al., 2011; Herrel et al., 2004; Iliadi, 2008; McLeish, 2005; Murray et al., 2010). Often women felt marginalised by services which focused on efficiency and throughput and inadequate resourcing and information rendered women vulnerable to misunderstanding, particularly if they had low literacy levels or lacked the language proficiency to negotiate care (Bulman and McCourt, 2002; Kennedy and Murphy-Lawless, 2003; Murray et al., 2010; Panagiota, 2008; Shafiei et al., 2012; Stapleton et al., 2013). Women described being unsure of decisions they made or whether they were understood, and they detailed encounters with health professionals who made assumptions about their understanding (Bulman and McCourt, 2002; Gurnah et al., 2011; Herrel et al., 2004; McLeish, 2005; Murray et al., 2010; Wojnar, 2015).

> *They were putting all those funny cords around me . . . which were so tight, so irritating, I didn't know what those were, I never had seen them before. It's like going to another planet and you are seeing all these things which are happening to you and you can't ask anything. Because you don't know how people are going to relate to you. I was the only black there, so I was so scared I didn't want to make them, to put them off.* (Tobin et al., 2013, p.836)

Language barriers represented a significant obstacle to understanding. A lack of available and adequate interpreting services was commonly reported (Bulman and McCourt, 2002; Gurnah et al., 2011; Herrel et al., 2004; McLeish, 2005; Murray et al., 2010; Niner et al., 2013; Stewart et al., 2015; Straus et al., 2007). This hampered disclosure, contributed to fear, anxiety, and uninformed decision making, and resulted in misdiagnosis or unnecessary medical treatment (Bulman and McCourt, 2002; Gurnah et al., 2011; Herrel et al., 2004; McLeish, 2005; Straus et al., 2007). Women often relied on their husbands, support networks, or paid interpreters for assistance communicating, and this contributed to gender and cultural barriers when accessing care.

> *He [the interpreter] was a man and he was not my brother or my husband, and when they were checking me I asked him to go out, but I really needed to understand everything because I was really scared. I had already had two miscarriages, and I was scared to have another. (Somali refugee)* (Bulman and McCourt, 2002, p.370)

4.1.2.2. Different cultural perspectives. Cultural sensitivity played an integral role in refugee women's experience of care. A lack of cultural awareness on the part of health services or professionals prevented cultural beliefs and practices being recognised as legitimate and significant (Russo et al., 2015; Shafiei et al., 2012; Wojnar, 2015). This deprived women of the opportunity to carry out important cultural traditions they deemed necessary to the health and legacy of their cultures (Russo et al., 2015; Shafiei et al., 2012; Wojnar, 2015) and reinforced a disconnect between women and health professionals, with women reporting feeling marginalised by unfriendly treatment, discrimination, and stereotyping (Bulman and McCourt, 2002; Carolan and Cassar, 2010; Herrel et al., 2004; Kennedy and Murphy-Lawless, 2003; McLeish, 2005; Niner et al., 2013; Russo et al., 2015; Shafiei et al., 2012; Straus et al., 2007).

> *Because of the cultural restrictions that I had, I asked to be seen by a female doctor at my antenatal appointments, but the staff got very angry at me and once I had to wait 4 [hours] before I was seen by a female doctor and when I asked them, they said I was being fussy . . . (Feroza, Afghani woman, Living in Australia for 2 years)* (Russo et al., 2015, pg. 6)

Refugee women's perspectives of pregnancy, labour and birthing could differ to those of contemporary biomedical care. Many women perceived medical interventions including caesarean sections, inductions, and use of technology negatively, as they were unfamiliar, unnecessary or contravened their traditional beliefs (Brown et al., 2010; Bulman and McCourt, 2002; Carolan and Cassar, 2010; Herrel et al., 2004; Higginbottom et al., 2013; Hill et al., 2012; Murray et al., 2010; Stapleton et al., 2013; Straus et al., 2007).

> *I don't see the point to look inside with the machine [ultrasound]. Maybe it will kill the child.* (W1, African woman) (Carolan and Cassar, 2010; pg. 194)

Many women described loneliness from being isolated in a new country and were lacking family, community, and social support in the perinatal period (Carolan and Cassar, 2010; Kennedy and Murphy-Lawless, 2003; McLeish, 2005; Murray et al.,2010; Niner et al., 2014; Niner et al., 2013; Straus et al., 2007). Often health services provided an important opportunity for refugee women to develop connections, with women seeking to utilise health professionals as sources of information and emotional support (Briscoe and Lavender, 2009; Owens et al., 2016; Russo et al., 2015). Often women recognised that they were different (Baird and Boyle, 2012; Carolan and Cassar, 2010; McLeish, 2005; Wojnar, 2015) and

if they perceived they were treated unkindly, or their cultural beliefs were devalued, the feeling of being "in between" cultures was reinforced. As outlined by a Rwandan woman:

If the nursing staff see you are foreign or of a different colour, they treat you badly. (Somalian woman) (Herrel et al., 2004 pg. 347)

Continuity and connection with health professionals promoted trust, facilitated communication, and rendered women more likely to reveal sensitive information and adopt different models of care (Bulman and McCourt, 2002; Carolan and Cassar, 2010; Hill et al., 2012; Iliadi, 2008; Owens et al., 2016; Russo et al.,2015; Stapleton et al., 2013). When women felt respected and had an established relationship with a health professional they were more likely to ask questions, attend appointments, and recommend services to others (Carolan and Cassar, 2010; Hill et al., 2012; Owens et al., 2016).

. . . so by seeing the same midwife and doctor, I am familiar with them and so I am not afraid, not strange for me, so like I can ask questions. (Refugee or migrant woman, via bicultural worker) (Owens et al., 2016, p.132)

4.1.2.3. Trauma and re-traumatisation. Refugee women's narratives described instances which evoked memories of trauma and this could contribute to re-traumatisation. Traumatic memories were awakened when recounting personal health history or if care was inadequate or inappropriate, contributing to further physical and psychological harm. Factors that contributed to re-traumatisation included lack of continuity of care (Bulman and McCourt, 2002; Owens et al., 2016), poor management of birth (Briscoe and Lavender, 2009; Niner et al., 2013; Tobin et al., 2013), and female genital mutilation (Bulman and McCourt, 2002; Murray et al., 2010; Stapleton et al., 2013; Straus et al., 2007; Wojnar, 2015). Re-traumatisation is illustrated by an account from a Karen woman who had a history of trauma and recurrent post-natal depression:

I wanted to move and walk but they didn't allow it. I was annoyed but couldn't do anything and didn't say anything because I knew they couldn't understand me. There was no interpreter. A few minutes later, two nurses came and tied me up and I could not move. I was scared and thought, "something's wrong now," and "that's it." "That's the end of everything." I felt like I was in a place where people are slaughtered. (Niner et al., 2013, p. 544)

4.1.3. Negotiating care

Negotiating care describes a variety of ways in which refugee women responded to both the positive and negative aspects of accessing maternity care in HIC. Women described a range of coping strategies they had developed, and these ranged from a passive acceptance of care to valuing perinatal care. They also demonstrated cultural conviction, stoicism, and resourcefulness. Ultimately, despite the many challenges and barriers that refugee women faced accessing care, many demonstrated resilience by returning and continuing to engage with maternity services (Lillrank, 2015; Owens et al., 2016; Wojnar, 2015).

Refugee women often compared health services in HIC with that of their homeland and most viewed them as superior (Bulman and McCourt, 2002; Gurnah et al., 2011; Kennedy and Murphy-Lawless, 2003; McLeish, 2005; Niner et al., 2013). Many felt gratitude towards the midwives and health professionals they encountered, and this was most positively reported in papers reporting on specialised models of care (McLeish, 2005; Owens et al., 2016; Stapleton et al., 2013). Some women also report feeling indebted towards their host country and therefore approached care with gratitude or implicit trust (Niner et al., 2013). For others, a lack of knowledge and familiarity with services contributed to a power imbalance between health professionals and refugee women which prevented women from speaking up about service issues (McLeish, 2005; Tobin et al., 2013).

4.1.3.1. Cultural conviction. Women judged health information through their individual cultural lens and adopted practices that they deemed beneficial. Many displayed the determination to ensure they had a maternity experience that was meaningful even if this sometimes contravened professional advice and cultural pressure (Baird and Boyle, 2012; Brown et al., 2010; Carolan and Cassar, 2010; Higginbottom et al., 2013):

. . . It's my tradition. I believe in it, you know . . . I have to do what I believe. (Sudanese woman) (Higginbottom et al., 2013, p.7)

At times this resulted in women resisting medical intervention and choosing not to engage with health services (Brown et al., 2010; Bulman and McCourt, 2002; Higginbottom et al., 2013; Hill et al., 2012).

With my last kid I waited at home until I was pretty close to delivery and when I arrived, I think it was too late for any medicines and I had a vaginal birth. Many women I know have done the same. (Wojnar, 2015, p. 363)

4.1.3.2. Resourcefulness. Women also sought ways to empower themselves. They endeavoured to learn the language of their host country, valued the knowledge gained from their healthcare experiences, and established independent sources of information and support. Speaking the language of the host country was empowering as it increased women's confidence to engage in reciprocal relationships with personal agency (Herrel et al., 2004; Murray et al., 2010; Niner et al., 2013, 2014). Women deeply valued information and wanted more education for themselves and their husbands (Herrel et al., 2004; Murray et al., 2010; Shafiei et al., 2012). They embraced opportunities to learn from professionals when they trusted the source of the information (Carolan and Cassar, 2010; Hill et al., 2012; Owens et al., 2016). Refugee women also utilised many sources including health professionals, interpreters, community workers, and social networks to establish community connections and gain advice (Gurnah et al., 2011; Murray et al., 2010; Russo et al., 2015; Stapleton et al., 2013).

I joined a group in my area and within a few months I felt like I was getting better . . . I realised that a lot of women in the group were having the same emotions like me and that I wasn't alone. (Feroza, Afghani woman) (Russo et al., 2015, p.8)

4.1.3.3. Stoicism. Stoicism and self-reliance were common themes and women demonstrated their strength through adversity and adapting to new cultural contexts. Women's accounts revealed stoicism, or, as one Karen woman put it, "controlling your heart" (Niner et al., 2014, p. 368), to get through times of hardship or suffering. It was also reported that their own needs, including those during pregnancy, were secondary to the greater pressures of resettlement (Baird and Boyle, 2012; Carolan and Cassar, 2010; Niner et al., 2014).

We Karen women think that our personal suffering is not important . . . We think that depression cannot kill us and we have to be strong in the face of anything. So women ignore these sorts of feelings and compared to what they have gone through, these feelings are not significant. (Karen woman) (Niner et al., 2014, p. 367)

4.1.3.4. Hope. Hope motivated women to navigate the challenges associated with "Living between two cultures". New possibilities and the desire for a better life provided comfort to some woman who viewed resettlement as an opportunity (Baird and Boyle,

2012; Owens et al., 2016). Connection with family and community also helped perpetuate important cultural traditions necessary for wellbeing (Baird and Boyle, 2012). Coping strategies included relying on religious and spiritual beliefs for comfort and guidance and individual approaches such as walking, debriefing with family, and listening to music (Baird and Boyle, 2012; Hill et al., 2012; Niner et al., 2014; Russo et al., 2015).

5. Discussion

This meta-ethnographic review found that a liminal experience is ubiquitous for refugee women. The theme "Living between two cultures", captures the concept of liminality or that of being "in between" and not belonging. This experience is heightened by trauma, social disadvantage, and isolation and can be perpetuated by health services that do not communicate effectively or offer culturally appropriate care. The liminal experience is often a time of significant uncertainty and identity reformulation, rendering refugee women vulnerable. It is important that health services are aware of the ramifications of this experience has for physical and psychological health, and service utilisation, and continue to address the issues raised in this review.

The experience of liminality for refugee women in this review is congruent with the literature, in which liminality can be conceptual or physical and is associated with transitional states (Burnett, 2013; Stenner, 2018; Turner, 1966). Liminality occurs when an individual is transitioning from one status to another and, while it is complex and challenging, it can also be transformative (Baird and Reed, 2015; Beech, 2011; Simich et al., 2009). The experience of liminality is associated with ambiguity, uncertainty, and powerlessness and it can result in a situation filled with vulnerability, threat, or unease (Dowling and Pontin, 2017; Turner, 1966). This loss of status and notion of not belonging when adapting to a new country has been described as a risk to mental health (Simich et al., 2009) and has implications for identity reformulation (Beech, 2011).

The concept of liminality has been explored previously in refugee and migrant literature and separately in the context of maternal health, however liminality is a relatively new concept in the context of refugee women accessing maternity care in a new country. The women in this meta-ethnography found cultural transitions particularly challenging as the new culture often conflicted with their culturally-embedded traditional belief systems. The studies in this review explored themes associated with liminality (Baird and Boyle, 2012) navigating through conflicting values and beliefs (Wojnar, 2015), adapting to new cultural contexts (Carolan and Cassar, 2010), and finding a balance between two cultures (Owens et al., 2016; Russo et al., 2015; Wiklund et al., 2000). Baird (2012) previously proposed liminality as a middle-range theory of transition explaining experiences of migrants and refugees across three phases - separation, liminality, and integration. Liminality is described as a "profound paradox" offering both negative and positive aspects including loss, detachment, and the opportunity for positive change and transformation.

For refugee women accessing maternity care this can be a time marked by significant life transitions, including displacement, new motherhood, and resettlement. These transitions can be liminal in nature themselves and are known to be disruptive (Bulman and McCourt, 2002; Dowling and Pontin, 2017; Ladge et al., 2012; McGuire and Georges, 2003; Simich et al., 2009). It is within this liminal context that refugee women reconstruct their identity as a citizen and as a mother and this can be a challenging process depending on individual circumstances (Noble and Walker, 1997; Turner, 1966). In HIC, often the dominant culture of health services can dictate the cultural norms of pregnancy and motherhood (Baird, 2012; Banister et al., 2010). Challenging environments such as these can unsettle the fundamental nature of a person's identity (Fearon, 1999) and could be perceived as threatening to refugee women's identity, resulting in an identity shift (Jaspal and Cinnirella, 2012; Timotijevic and Breakwell, 2000).

The length of liminality is dependent on how quickly individuals can reconcile this transition and this is facilitated by contextual factors including employment, social support, societal positioning, and ability to learn a new language (Baird, 2012). This study reveals that it is also influenced by interactions with the service system, in this case, maternity care. For refugee women in this study the key issues when accessing maternity care were accessibility (this includes linguistically appropriate services, economic constraints, and location), continuity of care, and care that is culturally appropriate. A lack of appropriate and available services played a direct role in disconnecting refugee women from healthcare and often indirectly prevented them from seeking assistance with many of the social determinants of health.

Language barriers and difficulties accessing services identified in this review led to differential access to health care, disempowerment, and prevented the development of therapeutic relationships, reinforcing the feeling of being "outside of" or "between" cultures. Language barriers have been widely recognised in refugee and migrant research as fundamental barriers to accessing healthcare for refugee women (Higginbottom et al., 2014; Jentsch et al., 2007; Yelland et al., 2016). While this is not a new finding, the frequency at which it is reported reveals it is an issue which has not been addressed and reform appears to be slow (Yelland et al., 2016). A recent Australian review in primary healthcare found that those with limited English had only a 1% chance of having a professional interpreter present (Phillips and Travaglia, 2011). This lack of ability to communicate prevents health services meeting not just the immediate, but the broader socio-cultural needs of refugee women. Poor communication prevents outreach, primary healthcare initiatives, and services, contributing to further health disparity. These findings are supported by evidence that refugee women commonly experience psycho-social health needs which are not being addressed (Almeida et al., 2013; Gagnon et al., 2013).

This review found that impaired communication and a lack of mutual understanding contributed to the re-traumatisation of refugee women. For refugee women recounting traumatic health history uninformed decision making and any form of abuse by service providers could lead to re-traumatisation. Re-traumatisation occurs when an individual is exposed repeatedly to multiple traumatic experiences (Leshner et al., 2012). There is little literature exploring re-traumatisation in refugees and migrants (Procter, 2004; Silove et al., 1993). This is surprising given the conflict, persecution, displacement, and detention associated with forced migration, and some of the more salient aspects of resettlement can be causes of trauma for refugee women (Dutton et al., 2010; Refugee Council, 2009; Sinnerbrink et al., 1997). As traumatic events often involve the violation of a person's bodily integrity, refugee women are at an increased risk of re-traumatisation when seeking maternity care, if that care is communicated or undertaken inappropriately, or is culturally unsafe (Raja et al., 2013). Recent research also suggests that trauma and re-traumatisation can affect attachment between mother and baby (Khawaja et al., 2017; O'Shaughnessy et al., 2012; Schmied et al., 2017), and is associated with poor social adjustment and poor mental health (Collins et al., 2011; Fazel et al., 2012; Sweeney et al., 2016). Trauma Informed Care (TIC) therefore is imperative for refugee women seeking maternity services. TIC emphasises physical, psychological, and emotional safety for trauma survivors. It involves early intervention, recognition of trauma, and identifies recovery pathways for survivors. It fosters empowerment and aims to help trauma survivors rebuild a sense of control and avoid

potential re-traumatisation (The National Center for Trauma-Informed Care and Substance Abuse and Mental Health Services Administration (SAMHSA), 2014).

Refugee women also reported many positive aspects of services and care that were supportive and culturally appropriate. Continuity of care is an essential component of effective healthcare for refugee women. It facilitates comfort and confidence with maternity services and is essential to developing rapport and the caring relationships which refugee women revealed is central to their wellbeing. These support networks are often lacking when women arrive in their host country and play a significant role in developing individual strengths and the resilience required to traverse resettlement challenges (Correa-velez et al., 2010; van der Ham et al., 2014). When culturally appropriate care was provided women were more likely to feel respected and trust healthcare practitioners. This facilitated better health outcomes with women who were more receptive to new cultural concepts associated with maternal and infant health. This supports previous reports demonstrating that services that are culturally appropriate are more likely to be utilised and recommended by refugee women (Carolan and Cassar, 2010; Resnicow et al., 1999).

This study supports previous findings that the development of resilience requires internal and external resources and identifies protective factors which can be used to enhance service design and delivery (Babatunde-Sowole et al., 2016; Shishehgar et al., 2017). The refugee women in these studies often responded to stressful situations by employing protective factors and coping mechanisms, some of which fostered resilience. Important changes to the delivery of perinatal healthcare for refugee women is required throughout healthcare systems and much can also be done to aid and empower women during what can be a particularly challenging experience. To foster resilience, authors have argued for the importance of taking strengths-based approaches (Babatunde-Sowole et al., 2016; Hutchinson and Dorsett, 2012; Papadopoulos, 2007). Strengths-based approaches are grounded in the belief that an individual has the inherent abilities and resources to cope with the challenges of living (Brun and Rapp, 2001). In these approaches, the service provider aims to assist individuals to rediscover and/or utilise their personal abilities and available resources, despite how they may have been altered during adversity, to enact self-actualisation and determination (Saleebey, 1996).

6. Limitations

This study was limited to research conducted in English. While we conducted an extensive literature search, it is possible that we did not locate all relevant articles. Some papers in this study included mixed groups of migrants and refugees. Definitional ambiguity surrounding the terms may mean that some populations included in this review were not specifically refugee, rather ethnic minorities or those from CALD backgrounds. In this review there is a dominance of papers surrounding the experiences of African women. This reflected the international patterns of migration during the years from which the studies were selected.

7. Implications

There is no dismissing the significant health and social challenges experienced by refugee women. Major policy shifts are required in many HIC to enable refugee people to resettle and to access universal services. Comprehensively understanding and addressing the psycho-social health needs of refugee women requires policy and service interventions that not only improve access to perinatal healthcare, but also address the social determinants impacting the health of refugee women during resettlement. It is also important that health services and service providers recognise that experience shapes identity both as a mother and as a new citizen. Understanding the extent of refugee women's vulnerability is important for the development and delivery of specialised care. Given the trauma of exposure to sexual and gender-based violence, the risk of re-traumatisation is considerable. The application of TIC to aid refugee trauma is a relatively new paradigm. However, developments in TIC (including the surveillance of trauma, resiliency models, functional capacity, and the health and social adjustment of those who have had adverse childhood experiences) are all highly relevant to the refugee experience and more training for health professionals as well as research on the implementation of TIC for refugee people is required. Strengths-based approaches are recommended and require health professionals and services to hold the belief that women, children, and their families have strengths, resources, and the ability to recover from adversity (as opposed to emphasising problems, vulnerabilities, and deficits). A strength-based paradigm offers a different language to describe women's difficulties and struggles. It allows one to see opportunities, hope, aspirations, and solutions rather than just problems and hopelessness. Further research into the implementation of these approaches for refugee women is required.

The findings suggest that contemporary services in HIC are often not flexible enough to meet the needs of refugee women and the integration of specialised models of care for refugee women within existing maternal health frameworks are required. Beacon services or "one stop shops" could reduce the complexity of healthcare pathways for refugee women. These services provide refugee women with access to many different health professionals and social services in one place (The Royal Australasian College of Physicians (RACP), 2015). Various models of care tailored to refugee women have also been trialled with much success. These models are often based on continuity, culturally appropriate care, and/or bilingual support and have the capacity to provide increased access to refugee women. Models of care which have also been successful include those undertaking co-design (Clifton et al., 2009; O'Shaughnessy et al., 2012; Stapleton et al., 2013), team-based approaches incorporating social workers, midwives, obstetricians and translators (Correa Velez and Ryan, 2012), and those utilising cultural brokers and befriending services (Clifton et al., 2009; McCarthy and Haith-Cooper, 2013; Mead et al., 2010; Paris and Bronson, 2006). Other interventions suggest offering transportation assistance or being more mobile than conventional healthcare services to increase accessibility (Williams and Thompson, 2011).

8. Conclusion

Liminality is a ubiquitous experience for refugee women seeking maternity care in HIC countries. It impacts feelings of belonging and connection to services and society. It is often a challenging experience for many women and a time in which they reformulate their identity as a citizen and as a mother. This review found that the experience of liminality could be perpetuated by social factors and inequality of healthcare provision where communication and cultural barriers prevented women accessing care that was equal, accessible, and meaningful. The findings revealed both positive and negative experiences with maternity care in HIC. Continuity, culturally appropriate care, and healthcare relationships played an important role for women with positive experiences. The review also revealed disempowerment and the potentially damaging effects of disparities in care experienced by refugee women. In some cases, this resulted in re-traumatisation. The inherent resilience of refugee women is an important factor in the negotiation of motherhood and maternity care in HIC and strengths-based approaches should be employed to maintain and build-up resilience in this vulnerable population.

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