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**Pregnancy in a new home:
Refugee mothers in New Zealand.**

A thesis
submitted in partial fulfilment
of the requirements for the degree
of
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by

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THE UNIVERSITY OF
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Abstract

Purpose: Pregnancy signifies a delicate phase for women and is associated with potential adverse negative outcomes. Refugee women are more at risk of experiencing heightened stress and negative pregnancy outcomes. As the population of refugee women in New Zealand continues to grow, it becomes imperative to comprehend their unique challenges, needs, and available supports during their pregnancy in New Zealand. Despite this, no research on this topic has been conducted in New Zealand. Therefore, the current research aims to explore what are the needs and challenges of former refugee women in New Zealand during their pregnancy and how are they being supported?

Methods: A thematic analysis was conducted on eight semi-structured interviews to understand the experiences of former refugee mothers. Participants consisted of four former refugee mothers who had recently given birth in the last three years in New Zealand and four service providers who had supported refugee mothers during their pregnancy.

Results: The study identified six key themes critical to supporting pregnant refugee women in New Zealand. These encompassed the need for language assistance, guidance in navigating available systems, fostering relationships, cultural awareness within services, and recognizing the interconnected nature of their challenges, which often resulted in inadequate support for some pregnant refugee women. Additionally, the research highlighted a sense of appreciation among refugee mothers for the services provided by New Zealand.

Conclusion: This study highlights the need for a holistic approach when supporting pregnant refugee women and the significance of developing tailored community programs to educate and provide opportunity for socialisation.

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I would like to express my gratitude towards the refugee woman and service providers that took part in this study. Without your support and openness to talk about your experiences, writing this thesis would have not been possible. Thank you for taking the time to allow anyone that reads this to learn on how to best support other refugee women in New Zealand. It has been an amazing experience and learning opportunity to learn from your experiences.

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Introduction

Pregnancy represents a significant phase in the lives of women and their families, encompassing profound preparations for the impending arrival of a new child (Hagemann et al., 2021). However, it is crucial to acknowledge that this period may also introduce heightened levels of stress, which, regrettably, can yield adverse consequences for both the expectant mother and the developing fetus. Therefore, recognising and mitigating adverse pregnancy outcomes hold paramount significance. There is evidence that various factors present in the prenatal and early life environment can have long-term effects on health and wellbeing (Hagemann et al., 2021). As such, an understanding of these factors is imperative to promote healthier outcomes for both the mother and the child. For instance, research has highlighted undernutrition during pregnancy as one such factor, leading to low birth weight, which, in turn, has been associated with an elevated risk of obesity, diabetes, higher blood pressure, schizophrenia, anxiety disorders, learning difficulties, and cardiovascular health issues in adulthood (Antonelli, et al., 2017; Harris & Seckl, 2011; Heindel et al., 2015; Li, et al., 2012). Moreover, prior large-scale research has shed light on the increased risk of adverse pregnancy outcomes among refugee pregnant women, in comparison to the host countries' citizens (Harakow et al., 2020; Liu, et al., 2019; Persson & Persson, 2020; Turkay et al., 2018; Turkay et al., 2020; Vural et al., 2021). These outcomes include gestational diabetes, hypertension, obesity, anxiety, stress, depression, preterm birth, low birth weight, higher rates of caesarean deliveries and obstetric complications, fetal mortality, and infections (Harakow et al., 2020; Persson & Persson, 2020; Turkay et al., 2018; Turkay et al., 2020; Vural et al., 2021). These findings emphasises the significance of comprehensively understanding factors influencing pregnancy outcomes for refugee woman, to inform targeted intervention and support systems, ultimately striving for better maternal and child health. However, limited research has been conducted with refugee women and their experience of pregnancy.

The 1951 refugee convention legal document by United Nations High Commissioner for Refugees (UNHCR) defines ‘refugee’ as someone who is unable or unwilling to return to their country of origin due to fear of being persecuted because of being from a particular race, nationality, religion, social group or political opinion (United Nations High Commissioner for Refugees (UNHCR), 2010). Ellu, et al. (2021), suggest that refugees are forced migrants, who had to leave their home country for safety purposes such as a threat to life or livelihood, war, conflict, or natural disaster. Therefore, many pregnant refugee women have experienced extremely stressful and traumatic events and environments with access to limited resources (Collins, et al., 2011; Tobin et al., 2015; Turkay, et al., 2020; Vural, et al., 2021). Refugee women face a compounding level of stress starting from the challenges in their home countries, exacerbated during the resettlement process (Collins, et al., 2011; Kingsbury & Chatfield, 2019; Tobin et al., 2015; Turkay, et al., 2020; Vural, et al., 2021). This stress is further intensified by feelings of isolation, loneliness, and limited access to family, social, and cultural support in the host country, increasing their vulnerability to postpartum stress disorder (PPD) (Collins, et al., 2011; Kingsbury & Chatfield, 2019; Tobin et al., 2015; Turkay, et al., 2020; Vural, et al., 2021).

Migrants who register as refugees in New Zealand are legally entitled to access health care, including public maternity care services, although this is far from straightforward. This is because refugees gain entry to New Zealand through various programs, which influence their resettlement process and effect their awareness of available resources. Under the refugee quota program, refugees from large international crisis situations have been allocated a place to be resettled in New Zealand (New Zealand immigration, 2023). Quota refugee’s usually go through the resettlement program through Mangere Refugee Health Service (MRHS) to ensure they receive the adequate support to resettle into New Zealand (Te Whatu Ora Health New Zealand Counties Manukau, n.d.). Afghan evacuees, who have been given a set number

of places to be resettled in New Zealand (New Zealand immigration, 2023), were supported by different organisations with little information about the approach taken (Wood, 2021). However, with Asylum seekers and sponsorship program, refugees do not go through the same introductions to services as the previous mentioned programs (Priebe, et al., 2016; New Zealand immigration, 2023). For example, refugee that come under the sponsorship program are dependent on family to settlement and their understanding of their rights or services are dependent on how well the family can navigate the resources. According to Boor and White (2020), depending on migration status and the term they are identified by can limit entitlements, the number of services the pregnant women have access to, and increase barriers such as misinformation about service coverage, difficult administrative procedures, and delays in waiting time due to law and policies of services. As a result, it is very important to understand the needs, support and barriers available to refugee women during pregnancy in New Zealand, to ensure that mothers have sufficient access to support.

Enhancing positive mental and physical health outcomes among displaced populations, especially refugee pregnant women, requires the implementation of diverse and thoughtful strategies. The growing number of global displacements necessitates inclusive policies, programs, and approaches to cater to the needs of this highly diverse population (Kingsbury & Chatfield, 2019). According to the United Nations High Commissioner for Refugees (UNHCR), in 2017, approximately 25.4 million people were registered as refugees worldwide, and by 2019, an estimated 79.5 million individuals were displaced due to conflict and human rights violations (UNHCR, 2022; Hassan & Blackwood, 2021). The end of 2020 saw a staggering 82.9 million people forcibly displaced due to various reasons such as persecution, conflict, violence, human rights violation, or events disturbing public order (UNHCR, 2022). Even in countries like New Zealand, which welcomed around 46,100 migrants in March 2022, addressing the needs of refugees had increased the refugee and family reunification quotas

from 1,300 to 2,100 (Abbas, et al., 2022). UNHCR statistics revealed that the refugee community is characterised by diversity, with significant proportions hailing from countries such as the Syrian Arab Republic (27%), Myanmar (5%), South Sudan (9%), Venezuela (16%), and Afghanistan (11%) (UNHCR: the UN Refugee Agency, 2021). This rich cultural diversity highlights the importance of achieving a harmonious balance between their culture and that of New Zealand. Within this context, pregnancy and childbirth emerge as critical areas to focus on constantly improving approaches to ensure the well-being of refugee pregnant women. It is estimated that 44 percent of refugees in each region are females, with 24 percent falling within the age range of 18-59 and 6 percent aged 12-17 (UNHCR: the UN Refugee Agency, 2021). Given the large number of refugees women being at a childbearing age, it is imperative to conduct research and adapt service practices to meet the unique needs of refugee pregnant women. By doing so, it is possible to enhance preventive measures and reduce vulnerability and adverse pregnancy outcomes for those from refugee backgrounds in New Zealand (Abbas, et al., 2022; Kingsbury & Chatfield, 2019). Despite the significance of this issue, the experiences of refugee pregnant women within New Zealand remain relatively unexplored in the existing literature. Understanding and addressing their specific needs, supports and challenges are crucial steps in providing comprehensive and effective support for this vulnerable population. Consequently, this research aims to explore the experiences of former refugee pregnant women in New Zealand to inform and improve service provision and healthcare practices for this marginalized group.

Review of international literature about refugee health and wellbeing

Since no research is available within New Zealand about refugee background woman during pregnancy, the current study used international literature on migrant and refugee health and wellbeing during pregnancy. The literature (Ellul, et al., 2020; Kingsbury & Chatfield, 2019; Willey et al., 2020) identifies the following factors that need to be considered when providing support for pregnant refugee women: cultural, stress, financial, and mental health factors. Countering these hardships experienced during the refugee journey or resettlement require providers and agencies to employ multiple strategies that reduce challenges or needs, and increase supports to reduce physical and mental long-term negative effects on former refugee pregnant women (Kingsbury & Chatfield, 2019).

Mental Health factors and refugee women during pregnancy

Refugee women face a critical need for mental health support during their pregnancy. Research indicates that refugee pregnant women are particularly susceptible to mental health disorders (Iliadou et al., 2019). Perinatal depression and anxiety affect approximately 20% of all women globally, with refugee women facing an elevated risk (Willey et al., 2020). Additionally previous literature has reported higher rates of post-traumatic stress disorders in refugees and asylum seekers than in the local populations (Priebe, et al., 2016). Priebe, et al. (2016) reported prevalence of post-traumatic stress disorder (PTSD) and depression is higher than the host country's population. The prevalence of PTSD is higher in refugees (9%) and asylum seekers (17%) than the host country population. Similarly, 40% of refugees have been reported to have PTSD and depression (Priebe, et al., 2016). Furthermore, refugee women are more susceptible to experiencing postpartum depression (PPD) (Correa-Velez & Ryan, 2012). In the United States, approximately 19% of women suffer from PPD at some point following pregnancy, whereas the percentage may rise to as high as 42% for refugee women (Tobin, et al., 2015).

This heightened vulnerability stems from their previous experiences of conflict in their home countries, challenges encountered during the refugee journey, and difficulties in the resettlement process (Ellus et al., 2020; Willey et al., 2020). Factors such as violence in their country of origin, loss of family or support networks, and the hostility of the environment contribute to adverse pregnancy outcomes (Ellus et al., 2020; Willey et al., 2020). Consequently, prioritizing mental health support for refugee pregnant women is crucial to address their unique needs and mitigate the potential negative impacts on their well-being during this sensitive period. By doing so, it allows for earlier identification and management of mental health conditions, which can significantly enhance maternal and neonatal outcomes, considering that up to half of postnatal depression cases can originate during pregnancy (Willey et al., 2020).

The challenges faced by refugee and asylum background women in accessing mental health care were identified by the World Health Organization (Priebe, et al., 2016) and include a lack of knowledge about healthcare entitlements and systems in the host country, language barriers, and a lack of trust in professionals (Priebe, et al., 2016). Similar findings were reported by a study in Australia that evaluated the experiences of refugee background women using a mobile perinatal mental health screening program (Willey et al., 2020). The study reported that while most women were open to discussing their emotional well-being by themselves and the screening program facilitated conversations with their midwives, some encountered barriers such as stigma, lack of knowledge, humiliation, and shame in accepting mental health support. Therefore, ensuring privacy and confidentiality in the mental health sector is crucial. In addition, the study reported that the use of consistent interpreters, who the women had prior experience trusting, contributed to their comfort during interactions (Willey et al., 2020). However, the interpreter's skill is vital in building a cultural bridge and trust between health professionals and the women to ensure access to mental health support of

high quality (Hassan & Blackwood, 2021; Willey et al., 2020). While interpreters can help understand cultural and language differences, limited referral options and longer appointments due to the translation process may bring challenges (Hassan & Blackwood, 2021; Willey et al., 2020). Additionally, using interpreters brings complexities such as the magnification of stigma and trauma, the triadic relationship between interpreter, client, and clinician, interpreters' need for support to avoid triggering their own traumas, potential loss of information through translation, the importance of a healthy clinician-interpreter collaboration to achieve client goals, and difficulties in maintaining professional boundaries (Hassan & Blackwood, 2021). Willey et al. (2020) also reported that some women were unable to effectively describe emotional pain, indicating that emotional expression was not common due to the hostile environments they had experienced, resulting in keeping quiet and not sharing their issues. These factors point to the need for specialized and sensitive approaches when providing mental health support for refugee and asylum background women, considering the potential time-consuming and financial implications for the sector (Willey et al., 2020).

Stress factors for refugee women during pregnancy

Refugee women face heightened risks of adverse maternal health outcomes such as preterm birth, low birthweight, stillbirth, and maternal mortality after resettlement (Malebranche, et al., 2017). One contributing factor maybe the amount of vulnerability to experiencing stress. Refugee women encounter a cumulative stress burden starting with hardships in their countries of origin, compounded by resettlement stress, and further exacerbated by potential feelings of isolation and loneliness in the host country (Collins, et al., 2011; Kingsbury & Chatfield, 2019; Tobin et al., 2015; Turkay, et al., 2020; Vural, et al., 2021). Previous research conducted on effects of stress on woman, have indicated that stress during pregnancy is a risk factor in affecting babies' mental health (Babenko, et al., 2015; Davis, et

al., 2020; Entringer, et al., 2015; Hobel & Culhane, 2003). Proper attention and support are essential to address the unique challenges they face during the perinatal period to improve maternal and mental health outcomes. When the mother experiences stress and mental health issues during pregnancy, she is likely to put herself and the baby at risk of negative pregnancy outcomes (Iliadou, et al., 2019). Some examples include decreased postnatal adjustments psychologically, compromised infant bonding with fetus and newborn, psychological consequences, intrauterine growth restriction, low birth weight, preterm birth and negative consequences that involve family and society (Iliadou, et al., 2019). As mentioned in previous research early life experiences can influence vulnerability in the later life of the baby (Hagemann et al., 2021). Maternity care providers should approach all recent immigrants as being at a heightened risk of mental health issues and provide increased monitoring and support as needed (Collins, et al., 2011). Hence, the stress from current challenges and any need for support for refugee background pregnant women in New Zealand would need to be explored.

Financial factors

Refugee women often experienced significant financial stress, which frequently influenced their decisions regarding seeking care, taking into consideration factors such as the location and cost of healthcare. A study conducted in UK (Ellus, et al., 2020) reported that poverty is an important stress factor for refugee woman that contributes to the poor mental and physical disparities and lead to adverse pregnancy outcomes. The study aimed to explore vulnerable forced migrant women's pregnancy experiences and to enable midwives to better address the needs of forced migrant pregnant women. Over the course of one year, six interviews were conducted with forced migrant pregnant women who were destitute. The study reported the volunteer organisations had gone above and beyond their role to support in providing access for food, clothes and toiletries. Hunger was another challenge for forced migrant women because the limited amount of money would not be sufficient for daily

expenditure and the pregnant women were dependent on donations for resources. Often, the donated food sources were inadequate in nutrition value, or the women would lack access to a kitchen facility to cook the food (Ellus, et al., 2020). As supported by previous research, undernutrition during pregnancy could result in negative pregnancy outcomes such as problems with fetus development, gestational diabetes and preterm birth (Ellus, et al., 2020; Harris & Seckl, 2011; Heindel, et al., 2015). Poor living conditions and housing are another challenge that was reported by the study that could contribute to the negative outcomes for forced migrant pregnant women (Ellus, et al., 2020). The unsafe accommodation lacks the support for healthy pregnancy because of the increased stress and reduce quality of sleep. The uncertainty or unsafe accommodation can contribute to the social isolation and mental health issues of the forced migrant pregnant women (Ellus, et al., 2020).

Cultural factors

Roughly 16% of refugees worldwide relocate to high-income countries that significantly differ from their home nations in terms of culture (Haque & Malebranche, 2020). This might be the case for New Zealand, considering the diverse range of refugees in New Zealand with different cultures. Consequently, this migration poses cross-cultural difficulties when attempting to access healthcare services. Failure to consider cultural backgrounds can result in inadequate evaluations, diagnoses and treatments (Haque & Malebranche, 2020). Kingsbury and Chatfield (2019) conducted a qualitative metasynthesis focusing on the experiences of refugee women during pregnancy following resettlement in countries with different cultures. Among the themes identified, one prominent aspect highlighted the challenges refugee mothers encounter while navigating unfamiliar language and cultural processes (Kingsbury & Chatfield). During the immigration experience, individuals often encounter the necessity of acquiring or improving their skills in a nonnative language. This adaptation process also involves becoming familiar with a new cultural.

Research has shown that healthcare workers may lack understanding due to their unfamiliarity with immigrant cultural norms (Kingsbury & Chatfield, 2019; Iliadi, 2008). For example, the lack of language competence hindered immigrants' access to information (Riggs et al., 2012; Iliadi, 2008;), while a lack of awareness about health systems in the host country limited immigrants' access to proper healthcare (Iliadi, 2008; Kim et al., 2017; Merry et al., 2011). Furthermore, Kingsbury and Chatfield (2019) identified that refugee women could regret their care preferences due to being unable to communicate effectively. This resulted from women feeling uncomfortable with asking for language support to understand care alternatives (Kingsbury & Chatfield, 2019).

Haque and Malebranche (2020) conducted a systematic review of literature across six data bases to address impacts of culture on the conceptualisation and experience of postpartum depression among refugee and asylum-seeking women resettled in high income countries. The study reported only 8 articles meet the criteria of focusing on refugee women being pregnant during their resettlement and focused on impacts of culture on women's experience of PPD. The analysis of the literature derived four key themes associated with impacts of culture and mental health (Haque & Malebranche, 2020). The study reported that refugees had diverse conceptualisations, perceptions and experiences of postpartum depression. In addition, stigma surrounding mental health had significant influence on how refugee women perceived and coped with postpartum depression, which affected help seeking behaviour. Lastly the study had reported cultural traditions and strong social support played protective roles in promoting well-being among refugee women (Haque & Malebranche, 2020).

The different refugee communities not being familiar with mental illness symptoms, cultural differences associated with interpretation of symptoms and traditional beliefs can impact help seeking. However, some cultural and traditional practices had been described as

important coping mechanism in helping with mental health such as herbal remedies or praying (Boor & White, 2020). Hence, perinatal services in New Zealand should consider culturally appropriate care to improve the quality of services and better support refugee women in dealing with mental health and pregnancy challenges by developing trusting relationships (Iliadi, 2008; Iliadou, et al., 2019).

Complex interconnection between factors

The inter-relatedness of these factors makes it difficult to distinguish exactly which services or support, need and challenge would be experienced by refugee woman in New Zealand during their pregnancy. For instance, Iliadou, et al., (2019) reported that factors such as lack of social support, lack of access to resources, time in host country, socioeconomic difficulties such as money and housing, other mental health or stress, unemployment and legal status are correlated with risks of postnatal depression. Similarly cultural and language challenges such as being unable to seek help or having no awareness of services available for pregnant women would add to the mental strain on the pregnant migrant women (Iliadou, et al., 2019). Mental health issues can increase social isolation due to the stigma present and social isolation can increase the effects of mental health issues (Iliadou, et al., 2019). Based on international research, the challenges faced by pregnant refugee women are complex and multidimensional, often contingent upon the country in which the women have resettled. Consequently, conducting research in New Zealand is essential to comprehend the unique barriers, needs, and support systems for pregnant refugee women in this specific context. Since no research has been conducted in New Zealand, it would be beneficial to gain a generalised understanding of all the supports, challenges, and needs of pregnant women from refugee backgrounds has experienced in New Zealand during their pregnancy.

This study adopts the UNHCR definition of refugee (UNHCR, 2010), identifying New Zealand citizens or permanent residents from diverse backgrounds who have undergone

the refugee journey and resettled in the country. The program used to enter New Zealand is not within the scope of this research, the focus is on their rights to qualify for services. This distinction is vital as it can significantly impact the support, challenges, and needs of refugees based on the program they were in during their pregnancy in New Zealand. Unlike previous research, this study acknowledges the importance of defining the refugee participants and understanding their access to services during their refugee journey or resettlement process, providing an analysis of the needs, supports, and challenges faced by former refugees in New Zealand.

Current Research:

The purpose of this qualitative study is to identify, investigate and understand the support, needs, and challenges faced by former refugee women during their pregnancy in New Zealand. Drawing upon the experiences of former refugee mothers and individuals who have supported refugee pregnant women in the country, the research aims to offer valuable insights to service providers, professionals, and other stakeholders. The findings will inform the development of effective planning and improvement of programs, policies, and interventions, aimed at enhancing the pregnancy experience and outcomes for this marginalized group. Therefore, this study seeks to provide better support for refugee women in New Zealand during their pregnancy.

Research Question:

What are the needs and challenges of former refugee women in New Zealand during their pregnancy and how are they being supported to meet these needs?

Methodology

Research Question:

What are the needs and challenges of former refugee women in New Zealand during their pregnancy and how are they being supported to meet the needs?

Study Design:

The current research aims to explore and investigate former refugee women's needs, struggles and support systems during their pregnancy in New Zealand. A qualitative approach was utilised to understand the needs and challenges former refugee pregnant women may face in New Zealand during their pregnancy; also, to explore how pregnant refugee women are supported in New Zealand to meet their needs. Barun and Clarke (2013) define qualitative research as the process of collecting written and spoken language, or words, as data to analyse, interpret and comprehend the meaning and context of a particular topic. Therefore, this approach would allow an in depth and complex understanding of the participants experiences (Barun & Clarke, 2013). This form of research is ideal for the current study because we do not have a comprehensive understanding of the challenges, needs and supports of refugee mothers within New Zealand. Similarly, semi-structured interviews were conducted because of its unique flexible characteristic which allows exploring specific factors of this research and provides space for new meaning to be explored (Galletta, 2013). As a result, this method of interviewing creates opportunity to explore participants narrative, while also informing questions by previous research (Galletta, 2013).

The target groups for this study were former refugee pregnant women and professionals who had experience supporting pregnant refugee women through their pregnancy journey in New Zealand. Professional participants were required to have experience in assisting pregnant mothers from refugee backgrounds. Pregnant women who

met the eligibility requirements had their recent birth within 2020-2022 in New Zealand and have a history of forced migration or identified themselves as a refugee.

About the Researcher

I am an Afghan woman who arrived in New Zealand when she was young. I have faced many challenges and have grown as an individual within the refugee community. The refugee communities are connected by their journey of leaving their home behind, but each have their unique experiences to share. When working with Red Cross, parent would share their struggles and want a place of belonging, so I was always interested in improving my understanding of challenges, needs and supports of refugee communities experience at different ages, ethnicities and journeys in life. Being a single woman, I did not have adequate understanding of pregnancy experiences but had seen mothers go through this process without any complaint. During this research and supporting my sister-in-law through her pregnancy, it became clear that there are gaps within systems in New Zealand to be addressed so that refugee mothers are supported during their pregnancy. My passion for ensuring that refugee mothers are supported because they are the most vulnerable within our communities and are our pillars in bringing the next generations. With the love and respect, I feel towards my mother, I hope the current research can help with meeting refugee mother's unmet needs and informing others on how to better support them in New Zealand.

According to Braun and Clarke (2013), the analysis can be influenced by the researcher's standpoint, knowledge, and epistemology. Hence, my experience of being a former refugee and working with refugees, allowed for some themes to be identified very easily. Some of the themes were very evident during the transcription process and did guide the interview process by allowing the interviewer to explore and get a better understanding when mentioned by participants. Hence, words such as "would you be able to explain" or "what

do you mean” were used to get a better understanding of concepts, instead of assuming the interview understands.

Ethical considerations:

The Code of ethics for NZ Psychologists: principles and values of the code of ethics regarding New Zealand cultural diversity and the importance of the Treaty of Waitangi was followed to ensure the safety and wellbeing of individuals and communities during research practice. The University of Waikato Human Research Ethics committee provided the ethical approval and oversight for this research project (HREC (Health)2021#92) on 7th March 2022. After the ethics approval, participant recruitment, interviews and transcription could begin. Key information to ensure participant safety are followed within the current study, an outline was provided to get an understanding of important considerations for ethical reasons:

Informed consent

Ethical research requires participants to be informed and no deception to be present in the study. Therefore, informed consent was obtained from anyone involved in the study to meet the code of ethics approval for psychologist and research student in New Zealand. The current study created an informed consent that was easy to understand and overcome the English barrier that some participants might be experiencing. Consent forms were signed by all participants (Appendix C) and providing language support (Appendix D).

Confidentiality and anonymity

Maintaining confidentiality and anonymity is important in general within research to allow participants to feel comfortable in sharing their experiences and not have negative consequences because of participating within the research. It is essential for confidentiality and anonymity to be strictly followed when working with refugee community to ensure safety from potential threat from their refugee journey does not follow. To ensure this, stored data and

report participants has been given pseudonym. When writing the thesis identifying information was removed. In addition, access to transcripts is only available to me and my supervisor. In addition, the cross-cultural worker signed a confidentiality form to ensure the content of the interview was private (Appendix D).

Participant distress

The experience of participants experiencing any form of harm was very unlikely, however measure was taken in participants experience distress. The interviews were conducted in the participants preferred place to ensure they are comfortable. In addition, the participants could have a support person with them during the interview. Working with Youthline, allowed me to handle situations that can be challenging in a sensitive manner and if the participants were to be extremely distress, I have been trained in de-escalating situations. I was aware of visual and verbal cues that the participants might be displaying to identify distress. If the participant was distress, we would take a break or stop the interview. In addition, to ensure that the participants have support to lean on in case distress arises after the interview, contact information of services had been provided at the end of the interview (Appendix G).

Cultural sensitivity

Being from a diverse background and through work with Red Cross, I was understood a lot of the cultural competencies to practice during the interview. Adequate time was taken to build rapport before starting the interview and starting the interview with small details of their experiences. In addition, the interviews did not take place in front of men or children and the mother had a safe place to share. The process of the interview was place, food and beverages were provided to ensure the mother is not busy with being hospitable. When providing the Koha, understanding that refugee mothers are very shy in accepting gifts. Other small cultural practices such as taking shoes off inside their home, sitting on the same level as the participant and eating anything food they provided.

Participant Recruitment:

Participants were recruited through organisations, communities, and personal relationships such as family, friends, and colleagues. The most effective recruitment process was approaching community members, family and friends to spread among their networks by word of mouth. I also posted the research poster (Appendix E) on my Facebook and Instagram and requested my followers to share the details. In addition, I had emailed (Appendix A) organisations such as Red Cross, Refugees as Survivors New Zealand (RASNZ), UMMAR Trust, Asylum Seekers Trust, and Aotearoa Resettled Community Coalition (ARCC) requesting to share among their networks and anyone who would be interested in participating in the study, with the participant information sheets (Appendix B). Cross-cultural workers were recruited through community connections and Red Cross before the research to gain access to language support. As interpreters would be more difficult to access and were extremely expensive, cross-cultural workers were used when language support was required. Cross-cultural workers are individuals in the community who know English and another language for linguistic and cultural support. However, it should be noted that Cross-cultural workers do not have an interpreting qualification and do not interpret verbatim, so some information may be lost in the translation process.

Participants voluntarily self-referred themselves to be part of the current research. Due to the recruitment occurring through word of mouth, the participants who had limited English would communicate their interests through their connections who informed them. Language support would be arranged if participants were unable to communicate in English.

The interviewer contacted participants to introduce herself, discuss this research further, send the poster with the participant information sheet and answer any enquires. If participants were interested, arrangements for the interview time, date, cross-cultural or support person and any other requirements for an interview. Prior to the interview,

participants were notified about the cross-cultural workers used for their interview. The poster and information were written in Persian (Afghanistan language also known as Dari), Arabic and English (Appendix E).

Interview:

Overall, eight interviews were conducted between May 2022 until January 2023. Semi-structured interviews of four former refugee mothers who were pregnant or gave birth in the last 3 years in New Zealand and four professionals that have experience supporting former refugee mothers during their pregnancy in New Zealand. Within this research, one interview required using a cross-cultural worker, while three mothers had grown up in New Zealand, so they were able to speak English fluently. Refugee pregnant woman that shared from their experiences were Afghan, Burmese and Palestinian. The diversity of service providers consisted of social workers, midwives, and interpreters. Some the service providers had been in multiple industries while supporting refugee woman. The service providers were also from a diverse community such as Burmese, Afghan, Columbian, kiwi and Assyrian. One of the participants fit in both the groups.

The interviews were conducted at participants' homes or in private rooms in public areas such as coffee shops. Refreshment or food was provided to ensure participants were comfortable and allowed for culturally appropriate practices to be followed. Before initiating the interview, participants were briefed about the research to refresh their memories, and consent forms were signed before the recording began (Appendix C and D).

The interview started with broad questions to build relationships, put participants at ease, and slowly progressed to more difficult questions. All the interview questions were open ended and broad to ensure participants are not constricted or limited in what they share. The study wanted to get as much information as possible. In addition to that interview

questions (Appendix F) were aimed to have basic sentence structure and wording to ensure that participants can easily understand.

After the interview was completed, the participants were again notified that if they wanted to withdraw from the research, they would be given two weeks deadline because once the information is transcribed and analysed it would be difficult to pinpoint their contribution. Participants also received a koha of \$20 and a list of services and their contact information for them to use (Appendix G) in case they had any issues arise after the interview. One interview was conducted each month to ensure that there was sufficient time for transcription.

Transcription:

Each interview was transcribed after the two-week notice period was over. The transcription process consisted of manually typing the interview exactly as it was being spoken in the interview, while pausing in between sentences to type. Once the transcript was typed, it was revised multiple times to ensure it is an exact replica of the original interview. Hence, the interview transcriptions were full verbatim to ensure that a lot of information is not lost during the transcription process. For the mother that used language support, translation occurred in English. Therefore, the cross-cultural workers words were translated verbatim. Since I could also speak the language, any parts of the participants experience that was missing, I transcribed it during the transcription process because I had access to the audio to ensure majority of information is not missing. This allowed as clear as possible for the mother's experiences to be shared.

During the transcription, places, names, and aspects that could potentially identify the participants were altered to ensure they remained anonymous. Since participants had indicated no interest of receiving transcription of their interview in their consent form, such steps were skipped. While some patterns were noticed during the transcription process,

themes were not concluded until all the interviews were conducted. This was to ensure that my existing knowledge does not influence the interview or information sharing. However, when similar concepts were shared by participants, it was explored to ensure as much information is given during the interview so that the analysis phase occurs effectively.

Thematic Analysis:

The current study utilised thematic analysis to understand, investigate and report on the finding of the information in the interviews. Thematic analysis is an approach that identifies patterns and themes of meaning across data depending on the research question (Braun & Clarke, 2006). Using this form of qualitative analysis was important within this study because of its flexibility to accommodate to different qualitative research. The analysis allowed critical, constructive and detailed descriptive accounts of the needs, supports and challenges of refugee mothers and identifying the meaning within the data (Braun & Clarke, 2006).

Since previous qualitative information could not fully inform the different themes to explore, the current study used an inductive or bottom-up approach. This means that the data was used to guide development of themes.

Coding:

The analysis was initiated once the transcription of all the interview were completed. The initial phase of thematic analysis consisted of listening to the interviews and reviewing the transcripts multiple times to become familiar with the data. Once familiarised with the data, initial thoughts and notes were made on the side of the printed transcript to be reviewed again. The initial codes were systematically identified based on points within the transcript that seemed interesting or important, repetitive constructs or wording and any indication of the information being related to a need, challenge or support. The initial codes were written

in pencil to allow alteration or change to the code name to give a closer description. The codes were clustered to form twelve themes. The themes were initially confusing and complex, due to the interconnection between the different themes. Hence each of these themes were reviewed and similarities and difference between the themes were identified. Some of the themes were reconstructed to have subthemes. To ensure the inter-connection, similarity and differences of the themes was understood, a small description of each theme was written on a separate paper. Each theme was colour coded in the printed transcript to ensure a clear identification between the themes and which participant it belong to. Overall, six themes were identified. The themes were explained and discussed with the supervisor and themes were revised based on this.

Sorting and comparing

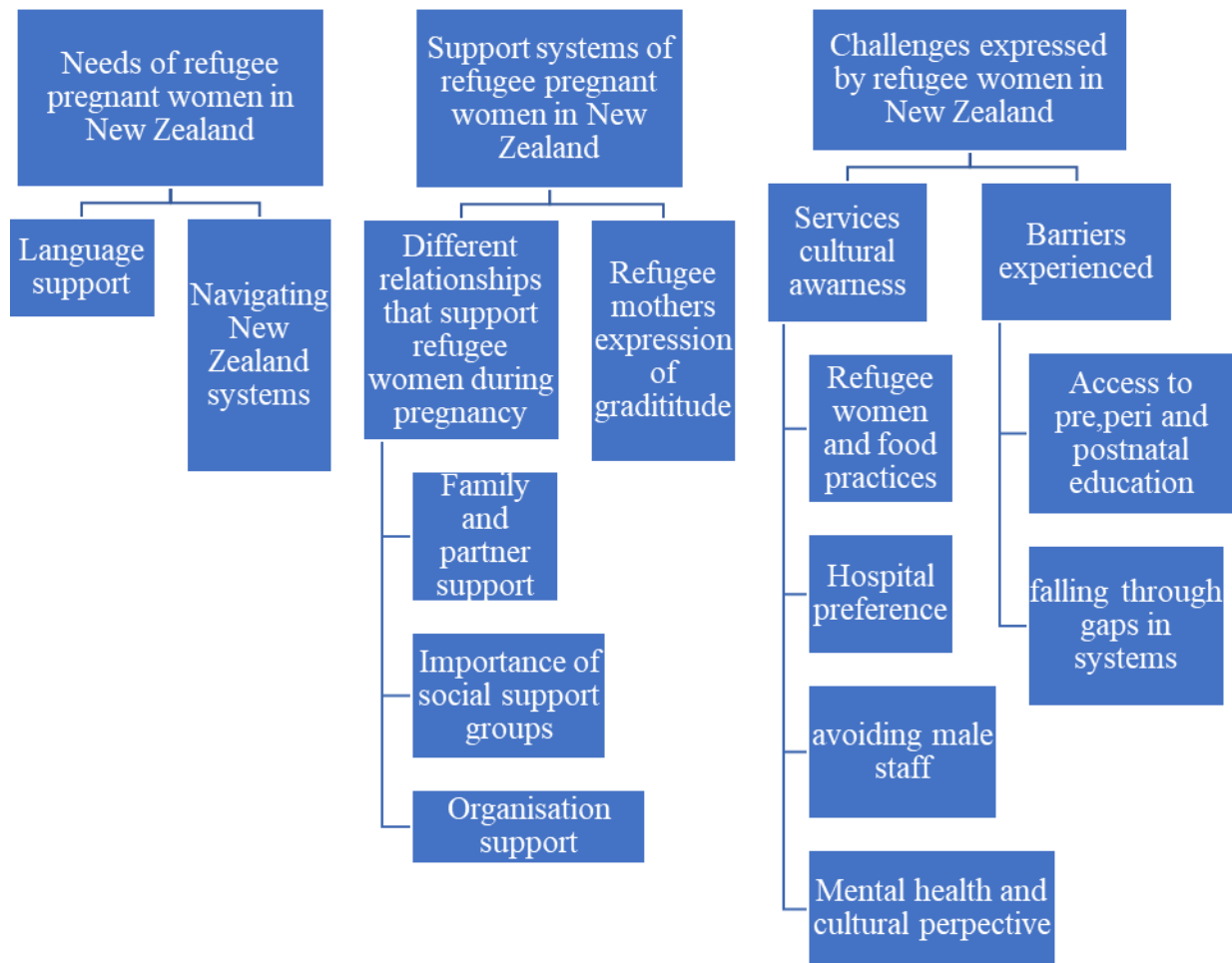
Once the themes were finalised, they were all transferred to a word document with all the examples of quotes of participants associated with each theme. Themes and subthemes were sorted to convey the message of the participants clearly and notes were made to assist with writing the results and naming the theme. This allowed the theme to be reviewed again and ensure the themes are grouped appropriately. Both the supervisor and I reviewed the information about the themes and created a thematic map to understand the connection between themes and give readers a visual understanding.

Results

The present chapter provides a comprehensive and detailed exploration of the overarching themes and corresponding subthemes that emerged through the thematic analysis of the conducted interviews. Within the scope of this study, a total of six themes were identified, each encompassing varying numbers of sub-themes. These themes were thoughtfully classified into three overarching categories, namely "need," "support," and "challenge," aiming to enhance clarity and facilitate comprehension. It is important to note that the categorization of themes into these distinct categories was contingent upon the available resources accessible to the mothers involved. To illustrate, if a mother possessed strong language skills, the corresponding theme could be categorized as "support." A thematic map was created (Figure 1) by the researcher and supervisor to get a visual representation. This visual aid was strategically designed to provide readers with a tangible and intuitive depiction of the interconnections between themes and subthemes, subsequently aiding in the comprehension of the intricate relationships. In the segment dedicated to the presentation of results, the exposition is enriched through the inclusion of direct quotations extracted from interviews with both refugee mothers and service providers. These extracts serve as tangible evidence that supports the identified themes. However, it is important to highlight that measures have been taken to ensure the privacy and confidentiality of all participants. Pseudonyms have been attributed to participants, and any quotes utilised have been carefully edited to eliminate potentially any identification of individuals involved. This conscientious approach maintains the ethical integrity of the research while still effectively conveying the essence of the themes as illustrated by the participants' narratives.

Figure 1

Thematic map of the themes and subthemes driven from the thematic analysis conducted on the interviews of refugee mothers and service providers experiences in New Zealand.



Importance of language during pregnancy

One of the reoccurring themes reported by all participants was the importance of language when accessing services and the quality of care they receive. Participants who identified themselves as service providers reported that “most of the women don’t know English” (Behishta), and language is a major challenge for some pregnant refugee women. Diana went on to express that “only two out of thirty” refugee mothers she has cared for as a midwife could speak English. Knowing and understanding the language is important because many refugee mothers require health education and conversations about medication, bodily autonomy and information related to different aspects of pregnancy. However, these conversations would require having access to interpreters or the client speaking English. Hence, mothers who were unable to speak English would struggle to communicate their

needs, problems, thoughts or how to seek support, as well as struggle with basic communication with their midwives, general practitioners, hospitals and other services.

Diana: A lot of them are uneducated and so when you're having conversation, you're also teaching them about bodily autonomy and what things actually are and teaching about how to use drugs to take away pain.

Behishta: The first support they're doing with refugee woman it is language support because most of them they don't know the language. When they are coming here, they're struggling ... because they don't know how to express their thoughts, they don't know how to ask for support so most of the time they are stuck.

Lena shared an example from her experience of using hospital services during childbirth and struggling with language barriers. She indicated that due to her lack of English, she was unable to communicate her discomfort and unable to ask whether she could wear her head scarf or if someone could assist in covering her legs.

Lena: The time I was in the hospital, I wasn't allowed to wear my scarf and my legs were showing. The problem was my lack of language because I don't know how to explain to them that I can't walk like this... also, I can't tell the doctor what I want to because I can't explain everything.

Mothers that spoke English appeared to utilise already existing services within New Zealand effectively to meet their needs. On the other hand, mothers that had limited English required additional assistance or struggled to get their needs met. Thus, several of the mothers who spoke English during their pregnancy could communicate their needs, better resolve their issues and in turn, would benefit from services available for pregnant women within New Zealand. For example, Aryana, could understand the information provided, ask questions and understand her medication. In addition, she could attend education sessions to get a better

understanding of the services available, the changes her body undergoes and the birthing process. As a result, Aryana could describe the pain she experienced during her pregnancy and understood the treatment being provided. Therefore, she could mentally and physically prepare for a baby and have an assisted understanding of what to expect after childbirth.

Aryana: The doctors and the nurses don't use big medical terms and they do ask at the end do you understand, do you have any questions, is there anything that's not clear.... midwife suggested antenatal classes that ... help you through preparing your body, your mind for birth and also telling you how to look after a baby ... some education about woman's body, what they go through while they're pregnant and what happens at birth, different stages of labour ... being able to tell my midwife and the doctors the pain that I'm going through and what to expect so that was helpful. If my midwife didn't tell me about those classes, I wouldn't have known what to expect from labour and wouldn't have understood what's needed while I'm giving birth and what the doctors are kind of really doing. I would have just gone there blindfolded ... it requires a lot of communication with the patient who is delivering the baby and the doctor and the midwife so that was good to understand.

As mentioned previously by Aryana, the pregnancy procedures require a lot of communication between patient, doctor, and midwife. However, if the mother spoke limited English, she required additional assistance when having conversations to benefit from these services. Hence, simple tasks, such as communicating with the hospital and follow up about issues related to pregnancy, would be difficult for mothers with limited English. Behishta shared her experience of supporting a mother who struggled with communication or being able to access educational classes during their pregnancy due to the language barrier, suggesting a need for services to accommodate some pregnant refugee women's lack of English to ensure they receive support during their pregnancy.

Behishta: One of the women ... she asked me if there is some classes or some people to go to talk to about how should I change the clothes... she doesn't know how to feed her, how to give her the medication, how to bath her. She doesn't know how to do basic stuff because it was her first baby and she had no one here to support her ... she didn't know the language... I have written, I need support on how to give bath to my baby, change the clothes, feed her like sometimes they're feeling pain when they feed the baby.... The midwife supported her and she was so happy.

Some organisations provided some language support through staff members that can speak the same or similar language and telephone interpreting services, but due to it being limited, it was not available for all. For example, Lena, who did not speak English, was able to communicate with her Iranian midwife due to previously living in Iran and her native language being similar. She could communicate with Red Cross, who was supporting her during her settlement period, because they provided a caseworker or cross-cultural worker who spoke her native language.

Lena: with the midwife she had bought an Iranian person and then with Redcross they bring with them the cross-cultural worker or case worker who spoke my language.

Behishta indicated that the majority of the midwives did not speak the refugee mothers' native language. Hence, access to midwives that spoke the mothers' native language is limited. As a result, phone interpreting services are used to communicate with clients.

Behishta: Most of the midwives they are speaking English and just when they go, they weigh the baby you know just like they write down you know the stuff some of them they use the language line.

Communicating over the phone can be limiting as important visual cues are missed, resulting in misunderstanding important information. For example, Diana described an experience

from the maternal health service where she works, which has a maternal mental health care component. While she was supporting a refugee mother experiencing a psychotic episode, some key information was omitted due to only having access to a phone interpreter. In addition, information can be lost and missed due to the message interpreted being from the patient to the interpreter and from the interpreter to the doctor. This issue became understood later during a face-to-face consultation by a midwife who spoke the mother's native language and understood that she required mental health services.

Diana: The challenge there is we don't speak Pashto or Dari or any of their languages and there's not many at going around in those fields and so what happens is this woman have to then talk to an interpreter that then has to talk with the doctors and things can often get missed. I had a woman that had a psychotic episode at the hospital ... there was someone translating on the phone ... talking about these people that were coming to kill her or take her away and the translation wasn't coming back that this was an ongoing issue ...it wasn't until we got a midwife that speaks Dari to come in and ask her these things and then get true explanation of it that we were able to then help her because it made all the difference having spoken in their native tongue. They were ready to keep her in the hospital for a long time that she was scared, she was away from her family, she was in a big hospital where no one spoke her language.

Myat suggested that difficulty accessing interpreters from some refugee backgrounds could be a limitation to services. Diana acknowledged that organisations and services have limited funding and providing qualified interpreters can be financially challenging. Hence not all services provided interpreters to pregnant refugee women with limited English. As a result, some mothers are unable to utilise some services. For instance, Gemma shared her experience as a case-worker supporting a pregnant refugee woman. Due to not having interpreters, she

struggled to communicate with her midwife and doctor about issues she was encountering with her partner. Gemma made a referral to an organisation associated with family violence; they were unable to provide interpreters to help with language support. When advocating had failed, Gemma could only provide recommendations.

Gemma: I was so sad because I found her, she was in her maybe six nearly seven months of pregnancy and she was so skinny and she told me that she was not eating because one the issues with the husband was increasing.... family violence organisation was happy to help him but the problem was they didn't provide interpreters. So as a social worker, I was not able to provide a family violence support apart from the recommendations, I give advice and you know I went to talk to them and everything, they couldn't help.

When language support was not available, mothers tended to use informal method of communication. Hence to benefit from services available, mothers reported using community members to act as informal interpreters. An example was the incident described above, where Behishta wrote a note for a mother to help her to get information from the midwife. Similarly, Myat voluntarily provided language support to a mother within her community who wanted to get closure with the hospital about her stillbirth. After hearing about the mother's misunderstanding of what had happened, Myat facilitated effective communication because of the limited available interpreters in their specific language and as a midwife she was familiar with medical terminology. The mother and the hospital had different understandings of what had occurred during the stillbirth. Hence, Myat acted as a mediator to ensure both the hospital and the mother had the same understanding of what occurred.

Myat: A lady in our community who lost a baby ...and that lady had to wait three or four months to get proper professional appointment with these specialists to

understand what had happened ... I thought they would have the support that they needed ... but couple of weeks later there were rumors around the community how the baby died, ... and I'm like this is not good you know misinformation, it's gonna scare other people in the community... maybe it'll be good for her to sit down with somebody and to clear up so that she can understand ... I was there myself personally to help her with the communication.

A limitation of using community members to interpret is that it is dependent on community members' availability and whether the mother has a connection within the community. Since many community members work, they have limited time to spare. Some community members described doing interpreting after their own work hours on a volunteer basis.

Behishta: Most of the time I gave my free time to the like woman they need you know the needy woman so like I give my time to them and just like the time when I had no job or for instance I'm working like for instance from nine to three and after three I was free you know just I gave my time to them to like go and ask and like I find out just like which kind of support they need.

For mothers who are unable to access community members for informal interpreting, family members were used as an alternative measure to cope with service's lack of language support. Therefore, the refugee women's children were used to communicate their needs and interpret medical information for important health services. Behishta indicated that some mothers go to doctor appointments with their children and are forced to use them as a form of language support for fear of being denied treatment when the doctor cannot provide an interpreter. Behishta described that when listening to the mother's conversations, the children start to disrespect them due to the "responsibility" on young children to constantly provide support. Hence using children as the interpreter is deemed problematic because family

dynamics change due to the responsibility on children to provide language support, causing conflict within families.

Behishta: Majority of the office like work and income, GP like majority places when they are going they need interpreter, they refused to provide interpreter for them...they are feeling scared, ... They said if I say I don't wanna use my daughter or my son, maybe they refuse to treat me... Their English is good but the medical terminology is different from English so they can't tell the doctor what's going on so this is huge challenges for the mom ... because the family members said all the time I'm the one to take all the responsibility and it start to find some conflict between the family member because they start disrespecting.

Diana explained that while working with Afghan mothers, there is a cultural practice of some ethnicities being “conservative” and not being comfortable with sharing some information with children. This means that mothers would not have the appropriate space to share or ask questions, limiting their ability to explore and get a better understanding.

Diana: Culturally getting to know what Afghanis do in their postpartum and what's appropriate, like talking about contraception in front of other people, some ethnicity and groups I would openly talk about it in front of the male or in front of the children but they're far more conservative about that and so making sure that you have better space to do those things. just little things like that.

Lena illustrated the problem of using children as interpreters, describing how her teenage daughter was called on to interpret during her labour. Lena indicated this was inappropriate and appeared uncomfortable with the interviewer when sharing that the hospital was explaining the mother's labour process to her teenage daughter. Lena further explained that her daughter was struggling with understanding some words and could not comprehend the

explanation provided by the hospital. Hence, the daughter would ask for assistance from the mother who had very limited English. As a result, the mother stayed hungry for three nights.

Lena: I was in the hospital for 3 nights and there was no interpreter. My language is no good.... on the phone they called my oldest daughter which was not good or appropriate to talk to my daughter because she was a teenager and then they explained everything, we going to do this to your mum and that to your mum. It wasn't good. Some of the words were not easy to understand for my daughter and then she would call me to say mum they told me this one and I don't know what does this mean and I would be like ohh this is what they mean. Then I was the one to explain. For 3 nights I had nothing to eat. There was nothing halal.

Alternative measures of communication such as family and community are unreliable, and errors can occur when interpreting information between languages. Hence there is a higher risk of information not being translated or interpreted accurately, which can lead to negative consequences. Medical services have specialised terminology that can be difficult for some community members and children to understand and interpret. Therefore, misinformation can occur due to informal interpreters not being equipped with adequate skills to serve as mediators between the medical professional and the pregnant mother. The misinformation can create complications, which could result in mothers becoming reluctant to communicate their problems to health services. Behishta shared an example through an experience a pregnant woman shared with her about a doctor misdiagnosing her due to miscommunication. The mother struggled with communicating her stomach pain, and had used the wrong description (diarrhea), therefore the doctor prescribed the wrong medication resulting in the mother experiencing constipation.

Behishta: For instance, I know one family because she said I was pregnant and like I want to tell that I have lower tummy pain ... I'm like I have diarrhea and I just like they gave them some pills to use and then she says when I use that I become constipated and then since that I never want to say something if I feel pain

Participants recommended that quality language support should be provided by services. For example, Diana describes an incident where when she was supporting a mother who wanted access to a pregnancy termination, and the interpreter was laughing during the conversation. Therefore, Diana's recommendation was access to adequate and trained health interpreters would be essential to reduce inappropriate or unprofessional behaviour.

Diana: I think that better access to interpreters and adequate health interpreters; you know I had an example where I was talking an Afghani woman and she didn't wanna keep her pregnancy she wanted access to termination services and the interpreter that was interpreting for me was laughing which is quite a kind of a strange thing to be laughing during the conversation and we don't know if it was appropriate and they were having a conversation that was the most uncomfortable thing or not making sure you know that you have adequate health interpreters that's really important. training them

Behishta suggested that if services are unable to provide in-person interpreting, they should at least provide over-the-phone interpreters when providing care. As mentioned previously, phone interpretation is not ideal, but would be better than no language support services.

Behishta: The doctor it is their job ... to provide interpreter if they can't face to face at least on the phone you know, they have to provide some you know interpret.

Fara recommended having very important or quite frequently used information related to pregnancy in a pamphlet format translated into the most common languages that the majority

of the refugee women speak. This ensures that the information is present for the mother to refer to at any given time when the interpreter is not present. If further clarification is needed, they can book a session with the general practitioner or organization with available interpreting services. This ensures that interpreters are used when necessary and allows the mother, interpreter and medical professional to discuss. It also provided resources for the community to refer to.

Fara: the translation for community is essential so they can have the hardcopy at their home because the interpreter is not, the professional is not there so the hardcopy is there in their own language they can refer it to it.

The common thread in this theme is that language is very important during pregnancy for refugee mothers in New Zealand. Mothers with limited English will struggle to meet their needs and are highly dependent on services to provide interpreters. However, services are not always able to provide interpreters due to limited funding and access to interpreters from specific languages. As a result, community members are used as informal interpreters. The disadvantage with using community members as volunteers are refugee mothers are not always able to find someone within the community to interpret. Hence as a last strategy to get language supports, family members such as children are used to provide interpreting. These informal strategies used by mothers are highly risky as misinformation or misunderstanding can occur which could have extremely negative consequences. Participants recommended that in order to provide quality of care to refugee mothers, it is essential to have access to trained language support with health experience and would be ideal to have information interpreted in pamphlets in common refugee languages.

Refugee mothers struggle with navigating systems in New Zealand

Challenges with understanding and navigating systems was another reoccurring theme that was reported by seven participants. Service providers indicated that due to refugees being introduced into a new environment, they are often unaware of all their rights within New Zealand, services available to them and how to utilise and seek help from systems available to solve their problems. Behishta emphasised that some mothers struggled with finding a doctor and midwife or how to use public transport to get to appointments. If someone is unable to guide the mothers to the location, they are likely to have delayed medical care.

Behishta: They don't know where they can go and seek support for midwife or to see the GP... Some of them are not familiar with the area, they are new to the country or city... If you go to the doctor you have the right to have an interpreter.... It is not about gaining trust; it's about using the system... how to use the system how to solve their problem...Some of them they don't know how to use the bus... Sometimes they say it is overdue, the vaccination but no one was there to support us... Most of them don't know about RASNZ (Refugees As Survivors New Zealand) Most of them don't have the idea to go to RASNZ, some of them they don't have the number, some don't know the address.

Lena shared her experience with such struggles when asked how she would have liked to be supported by the psychologist. Lena suggested talk therapy was not helpful and expressed interest in having support in navigating systems, information, or referrals with issues such as housing, bringing her family members and support for her children. While these issues were not related to pregnancy, it does depict that mothers in similar situation as Elena would also struggle with these.

Lena: If the person could have done what I had requested. For example, when I asked about the house, he said it's not in my hand. I asked him how do I bring my family member into New Zealand or anything else, that person would be like I don't know how to do that. At least they can inform me about something or refer me to some place but the psychologist would be like I am here to help you with talk therapy. I would request if they can introduce me to some organisation with enrolling my children to some program or some places as I can't afford it. But they said I am not familiar with that. If you can introduce me to receive support for some problem I have or some need then they say no.

Myat expressed that her experience of navigating the hospital system to get clarity for her birthing procedure would have been very difficult to maneuver even by long-term New Zealanders. She was able to get the help needed through work contacts. Hence, refugee mothers with limited language and understanding of systems will have difficulty navigating the system without assistance.

Myat: I don't think the process that I went through I don't think even a regular New Zealander would know, reason is because they wouldn't have connection with these people. The reason why I got to the top straight away is because I had some contacts through work, and I knew who to contact directly. Most people had no idea how to go on about the way I did and if they did, apparently there's like this it's not easy...I know of a lady in our community who lost a baby....and that Lady had to wait three or four months to get proper professional appointment with these specialists to understand what had happened.

Finding a midwife was reported as extremely difficult to navigate by the refugee mothers. Refugee mothers who are new to the country or have been in New Zealand for a short time may have limited understanding of the process of finding a midwife. Therefore, mothers are likely to delay the process and depend on doctors as a last resort.

Myat: oh God, you have to find your own midwife, I really struggled initially so I ended up calling the hospital that I couldn't find a midwife and they helped me find it. Somebody coming new to the country or even being in the country for couple of years, they struggle. They don't know so they go without midwife for first some month just to avoid that hassle, when things get quite serious and then they approached their GPs It becomes extra job for the GPs.

Aryana shared her difficult experience of finding a midwife through a website that was intended to help with this process. She contacted midwives to see if they could support her during her pregnancy. However, she had limited options in choosing a midwife because this was her first pregnancy, while others rejected her because she wanted a hospital birth. The delay in finding a midwife made her feel nervous and recommended that there should be an easier way to find a midwife.

Aryana: Finding a midwife was hard for me. There's a website that pregnant women need to go on to find a midwife and there's information about the midwives... you go in, read and contact them... because it was my first baby most of the midwives were not willing to take me on board. I contacted about a handful of midwives and they were like sorry I can't take you on board because you require a lot more support than if it was your second or third baby... For about two months I was without midwife, I was quite nervous that I was not going to find a midwife. Also some of the midwives that I contacted they were like if you're giving birth in the hospital, I won't be able to

take you on board because I want my clients to give birth either at home or at birth center ... Easier way to find a good one because I feel like there was not enough midwives available for me to choose from.

Participants recommended that the process of health care selection would be easier if refugee mothers had recommendations of good doctors and midwives that are from different ethnicities. This would allow practitioner by being able to do the referrals, follow-ups, keep track of the mother's needs, resources and ask questions. Depending on the mother's needs, some participants indicated a need for a support person who would introduce the mother to their community, different organisations that can help with clothes or resources, information or other needs. The support person would go beyond to advocate for the mother's need, for example when the mother requires language support, for the support person to talk to the doctor so that adequate language support is provided.

Noor: I think it would be important to have a few really good recommended doctors for them to go see rather than just find their own doctors cause it's very difficult to find a good doctor that will do the referrals that will keep chasing up on these little things so I think it would be helpful to recommend a few specialised doctors with different ethnicities so that they can or if they have language barriers as well get translators.

To summarise, the participants found navigating systems within New Zealand challenging. One of the systems was selecting a midwife that would be best suited to support the refugee pregnant women. Hence it was recommended that support is provided by having recommendations of good ethnic midwives and doctors that refugees can use.

Different relationships that support refugee woman

This theme describes the importance of different relationships as a support system for mothers. Participants highlighted the significance and limitations of family and organisational support. They also recommended establishing social groups to better support refugee mothers.

Family and partner

Participants shared that their family and partner was a major support to them during their pregnancy. Some supports that were reported by participants were helping with cooking, taking care of their other children, doing household chores, going to appointments with them, provide emotional support, socializing, sharing experiences, assisting with navigating systems and providing resources the mother might need. Behishta shared that in their home country during pregnancy when the mother is in their “one week or 40 days” of pregnancy, families would meet “at least once a week” to spend time and talk to each other. Hence such practices would allow the mother to be able to express herself in her own language. Aryana shared examples of how her family and spouse supported her during her pregnancy.

Aryana: My mom made the baby's bedding, blanket, mattress pillows, clothes, swaddles, bath towels, washcloths, shampoos, and nappies... When I came home, I forgot how to breast feed... my mom and mother-in-law was helping try different positions that they had learned and experienced.... Eventually I was able to understand when my baby is hungry, and I was able to hold my baby again and properly breast feed the baby with their help.... My family help a lot emotionally, by looking after my baby and making sure I get my me time and relax ... I don't think I slept for a week or two, until my husband took the baby away from me to make sure I sleep... because I was using a breast pump, I had milk available for anyone to feed my baby at night and I was able to rest but I was refusing. I was like it's my baby, I'll

feed my baby, you guys stay away but that was not good for me. I was getting down, grumpy, you could see dark circles, I was tired, sleep deprived, I couldn't eat and when you don't eat, you don't have enough breast milk to give to your baby... My family looked after me and the baby to make sure we are both healthy and I'm not emotionally down.....so I use my family instead using those other services that are available in New Zealand... when I was feeling down my family would take me out for a walk, change the environment, watch a movie or something to make sure I'm more social and not feeling down or emotionally stressed.

An issue recognised by participants was that not all refugee mothers have access to their families and partners. Diana indicated that some mothers do not have their families and spouse in New Zealand. Arranging for their family to be in New Zealand can be difficult as it requires a lot of money, and the processes can be challenging. Behishta shared that some families live far from the pregnant mother and would struggle with transport to support the mother; she also suggested that not all partners are helpful in providing support because they might not be equipped with the skills, busy with work related issues or not be considerate of the mother's needs and struggles. An example is Lena not having her family during her recent pregnancy.

Lena: Sometimes I would be in pain, but I need to take care of the children to cook for them because my husband was depressed and stressed, and he had to take some stress medication. I had to take care of them. It was very difficult. After having the baby, I had reached the point that I had to take medication for my depression.... The biggest challenge for me, my family was not with me. My husband was alone, it felt very lonely, missed my family because I didn't have my family to support me and raising 5 other children was difficult.... So, during pregnancy, looking back at my previous pregnancies. What great days it used to be. As you know during pregnancy you need

someone to be with you, to help you, and support you. My mum was around me, she supported me, she would take my children to look after them, she cooks for me but here I had no one to support me.

Social support groups

Three participants recommended developing a social group specific to refugee pregnant women as a form of support. This was deemed important because it would allow refugee mothers who do not have the necessary resources such as the connections to form relationships or the language to connect with Kiwi culture. This would provide a way that they could socialise, have people they can ask assistance from, share experiences or struggles and have space to relax and enjoy connecting with others from similar ethnicity, cultures, or backgrounds. It would also provide some time for the mother to be away from house chores, attending to the baby and would provide a change of environment. Hence it could be beneficial in helping the mother to reduce feeling depressed or anxious by providing people they can talk to. An example of a social group being created was provided by Diana, where in the hotel that refugee evacuees were being supported, mothers were given space to socialise. Diana suggested that antenatal classes are available for Kiwi mothers, where they can learn and socialise. However, such connections are missing for refugee mothers in the community because they are unable to communicate. It also makes forming such a group difficult as they are in different areas and transport can be difficult. To overcome this issue, it was recommended by Noor that someone create social groups consisting of both wider communities and local areas where refugee mothers who are recently pregnant can join. Diana recommended training some mothers to run the antenatal class for specific groups in their native language. Hence, they can create their own groups if they are resourced.

Diana: At the hotel we have mothers' group and every Tuesday they all get together.

We said you can be here in this room; we can get you some tea and just enjoy it for an

hour or two and they all really loved it. They were able to sit there, breast feed, have their other children, interact, and talk about what they normally would talk about being back home. I think antenatal classes, Kiwi woman, they go to antenatal group, and they get to know other mamas and spend time and that connection is a good support network and they always meet up afterwards and so the refugees Afghanis are missing out on that. There's a real big disconnect there and we're trying but they're all getting moved everywhere...I've seen for Indian speaking woman, and they have someone set them up recently for women to meet each other and have education in their native tongue. so being able to maybe educate some of the moms that already come through and helping them given the education give them the space and bring in those Mamas... so I think there are pockets of the areas that you could set things up then people would then through word of mouth would start to attend and go to these things.

Organisations mothers mentioned that supported during their pregnancy.

Organisations were another support system for some mothers during their pregnancy. The organisations mentioned were Red Cross, Plunket, birthing center, and midwives. Many organisations resourced the mother with assistance such as donations of clothes, toys, and blankets, doing referrals to other services or providing information. Aryana mentioned various aspects of midwife support during her pregnancy and postpartum period. The midwife provided essential information about vaccination, health requirements and dietary advice tailored to her cultural background. The midwife also recommended antenatal classes to educate Aryana about pregnancy, childbirth, and postpartum care. The birthing center assisted regarding breastfeeding, baby care and maternal wellbeing. Plunket was supportive as it monitors the wellbeing of the mother, baby and family and provided guidance on various aspects of infant care and ensured essential supplies are available.

Aryana: The midwife provide a lot of information... she was explaining what vaccinations I need and she helped me a lot with my diet... she knew my background so she explained that she had other pregnant women from Asia that later in their pregnancy developed diabetes and so she notified me at the beginning to be aware.... The midwife suggested antenatal classes that was very helpful for ... preparing you for birth and telling you the first few weeks of how to look after a baby.... I went to the birth center... they help you breastfeed, how to hold your baby, change nappies, how to put the baby to sleep and how to basically look after their new mum.... Plunket... every time I go, they ask me how's my mental health, how how's my sleep is there any issues at home that that they could help me with... they make sure that everything we've got at home for the baby is sufficient, for example a bed, enough milk, if I'm formula feeding, and they provide guidance with immunization and having the right car seat or giving car seats for hire if you don't have the right one and making sure you're babies well and making sure you have got everything to bring up a baby.

Since some mothers do not have adequate support, they become reliant on organisations and disconnecting can be difficult. Diana, a midwife who works with many refugee women, commented:

Diana: I think one of the biggest challenges was letting go of me because I was their person in New Zealand and I was there all the time, they were familiar with me, I saw during pregnancy, I saw them weekly. so, they got really connected with me and so they would text me all the time, call me all the time, they asked me when I'm coming to their house all the time and so trying to create that boundary between health professional and friendship is challenging.... their longing for that connection to someone and midwifery is sort of a health professional but you're also there for a lot of social support and so yeah trying to get that disconnect has been challenging.

However, participants highlighted a lack of available organisations dedicated to supporting refugee pregnant mothers, emphasising the limited extent of assistance provided to them. For instance, Behishta mentioned that some organisations supported specific forms of refugees such as quota refugees to resettle into New Zealand. Hence, they would be only supporting pregnant refugee women that were in their care during this period. While Myat suggests that Plunket “fades away” after a few months. Similarly, Lena expressed her struggles with the limits in support by some organisations. She expressed that when asking her psychologist about referrals or support due to her limited understanding, she was not directed. Hence, she had to rely on her own efforts to gather information from searching through different sources.

Lena: I would request if they can introduce me to some organisation with enrolling my children to some program or some playground... But they said I am not familiar with that. Or they said if you can introduce me to receive support for some problem I have or some need then they say no. Things for us were very different for us I was in Auckland for 4 months; I didn't know anything. I asked Red Cross staff, the case officer who answered and showed me the way and asked questions from my psychologist.

Participants expressed a need for more specialised services tailored to the needs of refugee mothers. Multiple participants recommended that it is important for services to build a strong trusting relationship with the mother. The interaction should feel more like a “human” connection rather than “robotic” or “check the boxes” (Myat). To achieve this, participants suggested that service spend time with the mother to build rapport, connection and understanding between each other. Hence, being “compassionate”, “acknowledging” the issues and supports that the mother might be missing, listening to them and taking time to explore what the mother wants or needs by asking question (Myat). As a result, a holistic

approach of care should be considered when designing supports that are specific to the need of each mother.

Lena: They could ask questions about the pregnant women who do you have? who you don't have, do you need some support person at home and if they don't to provide that support person to support them at home. Sometimes some people have more problems... It depends on the person and their situation.... Because they look at everyone with the same eye, they don't know. They think that all refugees are the same, but no they are not.

Other participants indicated that control of power within the relationship should be shared between service providers and the mother. Hence, it is important to get an idea of the type of support the mother wants and how she would like her birthing process rather than the midwife or doctor making all the decisions. However, this may prove to be difficult to regulate with mothers with limited language. Therefore, services are more likely to have more “power over the clients” because some services are in control to “manage a lot of things” (Gemma).

Myat: Ask the woman how do you want your birth...The midwife, the doctors flow with the woman supposed to be the other way around but because the woman don't have this understanding so you just give them the authority about how they want things to be done you just do it their way, rather than having the power in your hand the whole time, not giving any autonomy to the woman ... they know what they want, you just ask them.

The recommendations focus on allowing the mother to have an open communication with services about her needs, problems and ask for help when needed. This is because the service provider does not feel like a stranger and a trusting relationship has been formed. Therefore,

allowing the mother to be engaged in her own birthing process. Myat shared that the above recommendations would have been helpful as during her pregnancy she felt uncomfortable and unsupported by the mental health practitioner and midwife when she was having antenatal depression.

Myat: I never really built anything with them, so I never really felt comfortable...I didn't feel that confident in sharing so much about me. I don't think they knew what I wanted. They just did things from the clinical side... it was super inappropriate.... I felt that it was so insensitive.... so, I just told him that I'm fine I don't need anything, and I close myself and I wish they understood more or how to deal with it...I feel that they do this only to check the boxes that's about it, that's not really coming from them that they really care.... In general, I had this understanding that when you see midwife you be like oh hello how are you, how was your day... but mines were more let me check your blood pressure, let me feel your tummy, you've got another coming on this day.... I think that pregnancy is such an intimate time and me having to share so much about myself, I didn't know anything about them.

In summary the current theme emphasises the importance of relationships as support for pregnant refugee mothers. Family and partner played a significant role, providing practical assistance, emotional support and sharing experiences. However, not all mothers had access to their families or supportive partners, highlighting the need for additional support system. Participants recommended the establishment of social groups specifically for refugee pregnant women, where they could connect with others, receive assistance, and find a sense of belonging. Organisations such as Red Cross, Plunket, birthing centers and midwives also provided support, but participants described a lack of dedicated services for refugee mothers. They emphasized the importance of building trusting relationships with service providers, allowing mothers to have a say in their birthing process and tailoring support to

their specific needs. Improved communication, understanding and compassionate care were suggested to enhance support for refugee mothers during their pregnancy.

Refugee mothers' expression of gratitude in New Zealand

One of the recurring themes for the four participants who were refugee mothers in this study indicated a sense of gratitude for the facilities, resources and systems available to them during their pregnancies in New Zealand. While the resources are a standard practice within New Zealand, the mother's awareness of other countries' treatments during pregnancy not being as supportive made them appreciate New Zealand systems. Noor and Aryana emphasised that public systems in New Zealand are more efficient. They described how in their home countries, the majority of the births are done at home and once the baby is born, the mothers are learning without nurses, midwives or doctors to assist them. Therefore, participants said that mothers in these other countries are more likely to neglect their own health and concentrate on learning to meet the needs of the new-born infant at home in Afghanistan. The disparity between facilities in different countries that the refugee women have access to during their pregnancies was portrayed by Lena's experience. Elena came to New Zealand via a refugee camp in Indonesia; her experience in her home country was one of violence and danger but with medical care available. Lena was grateful for the safety or peace within New Zealand. While, when describing her birthing experience in Indonesia, she found very little compassionate support, contrasting it with the help she received from nurses during her labour and birth experience in New Zealand.

Lena: In there is no peace or safety. If you are out, you don't know if someone will attack you or not... The rest of the things are the same. The hardest place and time was Indonesia. When I had received my baby in Indonesia, they never helped me, and they put my clothes in front of me because I couldn't bend my knees and stuff and they

said ohh its up to you. No one supported me, no one helped me. At least here the nurses help you.

In addition, the mothers showed gratitude for the New Zealand health systems' responsiveness of services being easy and quick to meet their health needs during their pregnancies. Both Noor and Myat indicated that when they faced complications or were worried about the baby's safety, the hospital quickly acted to do a check-up and referral when needed. This provided the mothers an assurance of their baby being safe and reduced feelings of worry.

Myat: One thing that I really liked I had couple of complications along like there were two occasions where I was worried about the baby's movement when I communicated this to the hospital, they were quick to act so they did what I needed to do, it was almost immediate they took no chance. So that was good because it gave me assurance that my baby is safe... both times they're like just come to the hospital straightaway there was no delaying in anything.

One system that was very appreciated was the financial support provided by New Zealand system to ensure mothers are financially supported during their pregnancy. For instance, women that have been in New Zealand for long period of time and have established their career were very appreciative of not being required to working during pregnancy due to paid parental leave. For instance, Aryana shared that she felt lucky for being able to be paid and have time off to attend pregnancy related appointments. In addition to that, the paid parental leave being six months was helpful as it meant that mothers are financially supported even after childbirth. Similarly, Lena was very appreciative of the financial support provided by the government of New Zealand because it allowed her partner to not be busy. This meant that he could keep her company and support with taking care of their children.

Aryana: I was in one of the luckiest companies while I got pregnant, they had very good support available to pregnant woman and they provide time off to go and see your midwives and have your appointments. Those time offs are actually paid you get three paid days to do your appointments... they're very supportive when you're pregnant they help you sort out your leave as well and another great thing we have in New Zealand is parental leave just recently extended to six months, it's paid leave.

Lena: As you know the government provided benefit for my husband and it was good because he didn't have to go look for work and since I had no one around, at least my husband used to look after the children.

The current theme showed that participants displayed gratitude for the services available. Participants were grateful for the way services were compassionate and quickly responded to their needs during pregnancy. Access to the benefit and parental paid leave was much appreciated by mothers because it meant in New Zealand they were financially supported.

Cultural awareness for refugee women in New Zealand during pregnancy.

All participants highlighted the importance of cultural practices and awareness in effectively communicating and providing comprehensive support for the needs of expectant mothers. Fara proposed that certain cultural practices have significant health implications that can also be medically explained. One illustrative example shared was the tradition within her culture where postpartum women are not left alone for a period of time, which can be medically linked to the vulnerability experienced after childbirth. Nevertheless, it is essential to educate families and mothers in certain cultures regarding specific issues such as postnatal depression or parenting concerns.

Fara: they (cultural practices) will be different the way that pregnant women will be looked after and in many cultures they've got their own ritual way to look after the woman.... There's a lot of education needs not only for the pregnant person but for the whole family to accept that this (postnatal depression) can happen to any woman during pregnancy that it's not them, it's their hormones will play up. If they go through cesarean sections so they can be really exposed to postnatally because the body is not changing slowly from being pregnant to not. The hormone will be unbalanced for a while and there's a lot of drug in their body. So, I think families, husbands, everyone needs to be aware and they need to be really looked after and accompanied and in my background a woman should not be left alone until 40 days after pregnancy and in New Zealand they say 40 days after giving birth, they can have infection. so, it's the same but here we're talking the facts in the health and facts in cultural. This is how it is culturally but realistically there is a health risk behind it that's why.

Furthermore, it was emphasized that services should facilitate the process of “adapt the family to this new environment” and successfully maintaining a blend of "kiwi culture" and the native culture for the well-being of the baby, as pointed out by Gemma. Therefore, to provide effective support for pregnant refugee mothers, it is crucial for services to have a comprehensive understanding of and respect for the cultural practices specific to each mother. Participants mentioned the following topics in relation to culture: preference of hospital birth over home, female staffing, mental health, stigma, and food cultural awareness.

Gemma: Give the opportunity to the pregnant women to freely express their cultural needs and for the organisations to cover these needs in a cultural way not just imposing the Kiwi culture, respect what their culture is.

Preference of hospital birth over home delivery.

Participants expressed that a diverse range of cultures that refugee mothers belong to prefer giving birth at the hospital rather than at home. Aryana shared her experience that midwives declined taking her in because she wanted hospital birth over home birth. In addition to that some midwives advocated for home birth by indicating natural deliver's benefits and avoiding drugs that could affect the baby. She described this experience as "weird" and was shocked by the "kiwi midwife" suggesting homebirth. She described a sense of distrust toward the midwife and a sense of security towards hospitals.

Aryana: Some of the midwives in New Zealand that I contacted they were like if you're giving birth in the hospital, I won't be able to take you.... She was telling me New Zealand is wanting to introduce home delivery and having the birth of a baby more natural instead of more medical. She was telling me that a lot of people who go to the hospital, they take drugs and stuff for pain and that could affect the baby in one way or another and it's better to bear the pain... I found it weird because I thought we were stepping away from home deliveries and making sure we get the right medical attention in the hospital.... I'm not from a village to give birth at home. I have the right medical care for myself and my baby. So I would like to go to the hospital to make sure I'm in the right place. I'm gonna be safe, if I'm in the hospital and that was a shock for me, coming from a Kiwi midwife telling me do a home birth and I'm like I don't trust you.

Myat advocates that midwives encouraging home birth might be beneficial, it is culturally inappropriate. Participants mentioned that in their home countries, women give birth at home due to the lack of hospital services and this results in higher rates of infant and mother mortality. In addition to that in some countries, experienced individuals without formal health training act as midwives and the lack of a formal midwifery system in their home country

results in higher risks during home deliveries. Hence the traumas of the past incidents, experiences and beliefs that only doctors can provide efficient care, lead community to be in favour of hospital birth.

Myat: It's good that they want to encourage home birth but culturally it's not. It's not even appropriate to consider, even if the woman can be good... Back home you don't have the luxury of giving birth in the hospital setting and so women are giving birth in their homes and if there's any complications almost all the time the woman never survives, well complicated cases the baby don't survive as well. So there's that trauma... For example, it may not be that woman but their whole generations been giving birth at home but they have seen many deaths with this incident it's basically like why cause more problem.

Ensuring Female Staffing Only

Participants highlighted that presence of female staff members in maternity settings were crucial for comfort, cultural and religious considerations of the pregnant mothers. Back in their home countries, maternity wards commonly had all female staff. This practice aligned with the cultural norms and made the women feel more at ease during their pregnancy journey. However, in New Zealand, male doctors, nurses, interpreters and other staff are present and cause discomfort for the women especially during sensitive procedures such as pregnancy scans and childbirth that require undressing, exposing skin or any forms of touching.

Aryana: Back home the doctors were all female in the maternity ward and we're not that comfortable about male being around. The nurses, doctors and people who does their radiology scans in New Zealand sometimes they could be male and if I remember booking my scan appointments, making sure that the radiologist was a

female because they can't kind of have to undress for it so having a male is uncomfortable. Touching you or explaining to you hey put your leg up. So having a female in the maternity ward or not having male available kind of makes the journey a lot easier. I'm not sure how much control we would be able to have with that or not but just making sure that being aware of cultural differences between western and eastern countries are different.

Participants raised the issue that some women may struggle to expressing their concerns or voicing discomfort openly. Myat and Noor shared their experience of not being able to address their concern of covering and female staffing due to the amount of pain, exhaustion and not being in the right mindset to advocate for themselves during their birthing experience. Myat expressed feeling of powerlessness, while Noor describes her experience as “good” due to her midwife having cultural awareness and taking extra care to cover her when male staff were around.

Myat: when I was giving birth half of it was males and half of the time they could have avoided that but because I wasn't competent enough to communicate because I was so exhausted after 23 hour plus, I just I had no power to say don't touch me down there, I want to have a female and it wasn't my choice I wish I had the you know the ability to say no but I was so powerless at that time I was exhausted I was tired I didn't know who was coming in and out.

Noor: I think when you are giving birth during that a lot of the time you're not wearing any clothes, in my case it was really good because my midwife would cover me up, every time a male doctor would come in, so she was aware but usually when you're in that much pain, you pay you don't even think about how you look like... it's just good for midwives and doctors to be aware

Aryana and Behishta mention that in their culture women feel discomfort in asking due to social norms and politeness. Other factors such as limited English, feeling shy or not having “trust” further hinder the process of making such request. Aryana suggests that while indirect approaches can be taken to understand whether the health practitioner in charge of a procedure is a woman, it is important for healthcare providers to foster an environment where women feel comfortable raising their voice to request female staff without fear of offense or disrespect.

Aryana: you might not feel right raising your voice... but you were very uncomfortable. I think they should be enough understanding of our culture and religion in New Zealand as well so that we are comfortable to say hey I'm not comfortable, is there a female doctor or even asking for it. Sometimes when I was booking my appointment, I would be like oh should I be asking or is it OK, sometimes I would just ask what's the doctor's name to make sure if it's a male or a female doctor and instead of asking for a female doctor because I don't want to offend them. Having the option available there that there is a female one as well or not feeling offended or disrespected saying that hey I want a female doctor.

Participants do acknowledge that controlling presence of male staff may not be easy due to funding and female staff availability. Nevertheless, participants urged the healthcare providers to be understanding and accommodating to these cultural and religious differences. Having female staff and for them to be aware is crucial for providing culturally sensitive, comfortable and respectful care for the pregnant women. This would significantly enhance the overall pregnancy experience.

Aryana: Having a female in the maternity ward or not having male available kind of makes the journey a lot easier.... I'm not sure how much control we would be able to

have with that or not but just making sure that being aware of cultural differences between western and eastern countries are different and being a Muslim woman religious practiced they need to kind of be aware that it could not be comfortable for us.

Mental health, cultural beliefs and stigmas

Three out of the four mothers that were interviewed had reported experiencing emotional and mental distress during and after pregnancy. Some stressors that mothers reported was existing traumas getting retriggered, not having stable accommodations, struggling with socialising and not having family support to deal with tasks such as taking care of their other children, breastfeeding or baby care and being isolated. Language barriers and a new environment were additional stressors.

Lena: We used to be in another City and there was a lot of earthquakes. So, the doctor told me it was not good cause I had fear... I used to take some medication cause when I was back home, they destroyed my house, bombing and rocket, cause of that I had bad experience and I can't manage.... they told us that this is temporary house.... I faced depression and it wasn't easy... Going from your country to another country, you would be a little better but by the time you come here, you would be different and not well.... I can't tell the doctor what I want to tell cause because of the language barrier, I can't explain everything.

Mothers may not rely on professional services to deal with distress because they utilise their relationships to emotionally support such as family, friends or community.

Aryana: I didn't feel like I needed to use all of that because I did have the family support with me.... we rely more on our family then on our community or helplines or services available from the government because we are more connected to our family.

However, some mothers require additional support to deal with emotional stress such as loneliness or isolation due to supports were not available to them. While mental health services exist, a lot of cultural groups are not as keen to utilise.

Two of the mothers sought professional help for their mental health concerns during pregnancy. However, they expressed dissatisfaction with the services received. The refugee communities, as reported by services and mothers, demonstrated limited understanding of mental health, perpetuating stigmatizing beliefs such as labelling people as “crazy”, “being possessed by demons” or “unappreciative of what they had” (Behishta, Fara and Myat). These cultural stigmas hinder the acknowledge and acceptance of mental health issue, leading to “brush it off” or “everyone avoid talking” about it”, which hinders assistance seeking behavior (Diana, Fara). This avoidance behavior negatively impacts the help seeking process, as individuals are reluctant to see assistance due to cultural perception. The unsatisfactory outcomes and avoidance of using mental health services can be attributed to the stigmatisation with different cultural and community beliefs, significantly impacting their understanding of mental health.

Fara: I really emphasize mental health, postnatal and antenatal depression that people go through. I've seen people who suffered from it. People don't know they just go oh this mother in the olden days went crazy after giving birth that's why they've never been treated and she stayed that way... everyone avoid talking about it.

Behishta shed light on challenges within her culture, where mental health issues are not shared. Therefore, participants recommended education to normalise experience of mental health issues and using services.

Behishta: during the pregnancy some are feeling stressed, anxious and depressed but they never want to share it. Firstly, they don't know how to share, secondly, they

scared it cause more problem and thirdly, they think maybe my husband or my family are not happy if I share with stranger so they keep it with themselves.... back home they think if we talk to counselor or psychologist, they think I'm mental, I'm not OK, I'm crazy.... People, they're kind of like it is rubbish, you don't need it, what's the point of talking to someone, you can talk to me.... We have to educate people and tell them you're not crazy and when they are not feeling OK, you can talk to someone.

Myat emphasises the significance of education in her understanding of mental health and her decision to seek help. Reflecting on her personal journey, she underscores the limitation of remote consultations and highlights the importance of face-to-face interaction. She highlights that patients' backgrounds should be considered while discussing sensitive mental health issues. She shares her frustration regarding the immediate focus on suicide risk during conversations, stressing the importance of a more considerate approach. Myat further emphasizes the cultural context, noting that mental health issues are often overlooked or misinterpreted within her culture, leading to a lack of understanding and recognition of the need for assistance.

Myat: I am a bit shy to say but they diagnose that I was having mental health issue during pregnancy, which they referred me but I didn't find the specialist helpful. So, I closed myself... talking about mental health, it's a huge thing and doing it over the phone is another... It's appropriate to have somebody real in front of you, so you can see the person, not the words, it's the expression, how you present yourself matters. These are sensitive issues to talk about in general so be more considerate about where the patient is coming from. Not getting straight into do you want to kill yourself? They were asking 2 seconds into the conversation. I was shocked and offended even if I wanted to kill myself, I wasn't gonna say it. I was so annoyed. Also, going through something, you try to rationalize, I wish I could get better and I didn't

know what was wrong with me, I wish I wasn't feeling the way I was feeling. Culturally mental health is not regarded as an issue so there's no understanding, no definition and if anyone presenting with mental health we looked at them like somebody who's unappreciative of what they had and being possessed by demons, rather than looking at it as an issue that the person needs help.... but I had pretty good understanding about mental health and I was able to actually identify when things were going out of control and I was the one who opened up about it in my pregnancy, the person that got back to me was the one who didn't know how to handle me.

Food related cultural awareness:

Participants expressed the importance of understanding and respecting individuals' religious and cultural backgrounds, in relation to food practices during pregnancy and childbirth. Myat shared that lack of awareness or sensitivity to these practices creates challenges and feelings of intimidation. This highlights the need for healthcare professionals to recognise and accommodate different religious practices without judgment or misunderstanding.

Myat: I think just understand or respecting other people's religious background or demands that they had say. For example, sikh background when the baby is born they have to have a prayer before the baby is fed.... some midwives would be triggered by it... Having understanding that people needs are different depending on their religious background. We feed a bit of sweet when the baby is born, not everybody understand it. We recite call of prayer and you wanna feel comfortable doing that. I remember we were in a shared room the baby needed to have that azan and we were so intimidated by the fact that we were not allowed to do it because there's someone else there and they might hear and be triggered.

The availability of “halal” food was also mentioned as a necessary consideration to accommodate Muslim patients’ dietary requirements.

Lena: The time they keep the patient there you know the mother there specially the Muslim people, if they can provide some halal food cause they are not allowing the family to drop off some food or some people don't have family. But still they should provide some halal food.

Due to the diversity of the groups, Noor proposed that inclusion of cultural competency courses for healthcare professionals to familiarise themselves with the customs and practices of various ethnicities and religions, ensuring a more inclusive approach to care.

Noor: when you do your CPD, courses when you're working, you do you do these courses that kind of keep you up to date with everything. In those courses, you have one for Maori and their practises. It will be helpful to have it for other different ethnicities, like for Chinese or Asians in general, Middle Eastern or different religions they should have a few a little bit on other cultures as well, so that a lot of the health care providers are aware of other cultural practises.

The current theme emphasis the critical importance of cultural awareness and sensitivity in providing comprehensive support for mothers. Cultural practices, such as postnatal care rituals and dietary preferences were mentioned, emphasizing the need for professionals to understand and respect these practices. The significance of providing culturally appropriate food options such as halal food, was also raised. The presence of female staffing members in maternity setting was considered essential to accommodate cultural and religious considerations. Many mothers prefer hospital rather than home birth due to the perceived safety and medical attention provided. Cultural beliefs, previous traumas, and lack of formal midwifery system in their home countries contribute to this

preference. Participants shared mental health challenges during and after pregnancy, highlighting the stigmas and lack of understanding surrounding mental health within their cultures. Hence education and normalization of mental health issues were emphasised as crucial factor in help-seeking behavior. Participants recommended inclusion of cultural competency courses for professionals to enhance their understand of diverse cultural practice.

Gaps within systems in New Zealand

Importance of Education and associated barriers

During the interviews, one prominent theme emphasized by 5 participants was the significance of education and the obstacles hindering its accessibility. In terms of content, the participants expressed the belief that mothers would greatly benefit from receiving free education on various topics. These included vaccinations, dietary requirements, and the potential consequences of specific foods during pregnancy, as well as insights into the pre and antenatal process, mental health, different referral for healthcare and social services, approaches to parenting, and the rights mothers possess within the context of New Zealand. Additionally, knowledge pertaining to baby care and handling was also identified as crucial. Despite the existence of educational initiatives facilitated by midwives or free community classes, it was mentioned that these resources do not adequately address the specific limitations faced by refugee mothers, such as limited English proficiency or lack of transportation.

Diana: Language... and a lot of them are uneducated and so when you're having conversation you're also teaching them about bodily autonomy and what things actually are and teaching about how to use drugs to take away pain and then it's OK to do that so those are probably the two biggest challenges.....having access to antenatal classes that are in their language that are run by people within their community. Because antenatal care and education is key to having a successful birth

and having a birth that woman can reflect on proud or positivity about. Also around breastfeeding because a lot of my refugees don't talk about issues, they brush it off that it's nothingI think kiwi woman go to antenatal group..... they (refugee mothers) likely won't engage in an antenatal group, Because it's in English.....so being able to maybe educate some of the moms that already coming through and if they wanna become antenatal educators, helping them comes through given them education and space.

Refugee mothers falling through cracks and having inadequate support:

The second sub theme that was highlighted revolved around the various difficulties encountered by refugee mothers, pointing to existing gaps within their support systems. Consequently, these gaps can lead to inadequate support for refugee mothers during their pregnancy. For example, mothers with limited English proficiency face challenges in effectively communicating and accessing necessary resources and support services. Furthermore, the scarcity of available services combined with the diverse struggles stemming from refugee ethnicity and culture exacerbate the existing gap. Refugee mothers' lack of transportation and knowledge create barriers to being independent. In addition, the limited relationships and connections such as family, community or organisation, result in having limited resources that the mother can depend on. The interconnection between the gaps can lead to mothers falling through gaps within systems and not having sufficient support. An example is portrayed by Gemma's experience when closing a case of a pregnant mother who was facing issues and did not have adequate support to deal with the situation.

Gemma: I had the opportunity to work with one pregnant woman... she already had two kids and she was having a lot of issues with her husband.... Husband was not very helpful; he was going out a lot and she lacked English. She didn't have opportunity to study because she was looking after the other two kids, and he really

didn't want her to go study. He wanted her to stay home and do it from home. She was having home tutor, but she couldn't improve her English a lot. ... The volunteer start helping her finding the midwife. I'm coming back to the problem of language or English barrier for this woman. When she was attending the midwife appointments to get an interpreter because anytime she was going the midwife didn't have the interpreter, so this was difficult... when I come back to my last visit with her, she was in her nearly seven months of pregnancy and she was so skinny. She told me that she was not eating because the issues with the husband were increasing and she was not feeling physically strong enough, she was depressed and she was not receiving a mental health support, so this means a lack of support around this lady and around family in general. Even though the volunteer was doing her best, was so difficult to find counselling or the psychologist for her... I saw her very tired, very bad. She was having the same problems every time she went to the midwife or doctor didn't have a good support with the interpreted. I contact the family violence organisation... but the problem was they didn't provide interpreters I give advice and you know I went to talk to them and everything, they couldn't help.

Discussion

The global increase in registered refugees, with approximately 44% being women and nearly 50% in the childbearing age group, emphasizes the necessity for a comprehensive understanding of the needs, supports and challenges of pregnant refugee women in New Zealand (Abbas, et al., 2022; UNHCR, 2022). A better understanding is crucial for providing effective support and addressing their distinct challenges, particularly considering the absence of prior research in New Zealand. Thus, this study's objective was to investigate the specific needs and challenges encountered by former refugee women during pregnancy in New Zealand, as well as the existing support mechanisms in place.

The following discussion section delves into an analysis of the needs, supports and challenges of refugee mothers in New Zealand. These findings are then contextualized within the scope of relevant existing research. The study's findings revealed six primary themes that emerged from the interviews, encompassing aspects that either provided support, posed challenges, or represented needs: 1) Language, 2) Navigating complex systems, 3) Gratitude, 4) Relationships, 5) Culture, and 6) Overcoming barriers.

Importance of language

In line with prior research, language has been identified as a significant barrier for refugee mothers during pregnancy (Iliadia, 2008; Kim et al., 2017; Merry et al., 2011; Kingsbury & Chatfield, 2019; Boor, C. & White, 2020; Ellul et al. 2021; Sozbir et al. 2021; Griffin et al., 2022). Notably, Ellul et al. (2021) emphasized the need to amplify the voices of marginalized groups facing language barriers, highlighting that more than fifty percent of women in their study required interpreters. In our study, one of the four mothers' required interpreting services. This variance might be attributed to the absence of a specific time frame for resettlement in New Zealand in our recruitment criteria and participants volunteering to participate in this study. To ensure that refugee woman with limited language had the

opportunity to participate in our study, we had translated the participant information sheet (Appendix B) and poster (Appendix E) in two main languages which were Arabic and Persian (Dari). In addition, the participant information sheet (Appendix B) mentioned that we can provide language support, which one participant had used this opportunity. However, majority of our respondents were well-settled refugee mothers. Service providers typically assisted mothers with limited English proficiency, with one provider mentioning that merely two out of thirty women she supported could communicate in English. Our study therefore shed light on a variety of language experiences, demonstrating that mothers proficient in English could autonomously address their basic needs, while those with limited English struggled to articulate their requirements, issues, and reach out for assistance from services in the absence of interpreters. This proficiency in communication is crucial given that general practitioners constitute the primary source of contact and information for the refugee community, making effective communication essential (Griffin et al., 2022).

Nevertheless, when faced with challenges in expressing themselves and when appropriate interpretation measures were lacking, the quality of care could be compromised (Griffin et al., 2022). The use of interpreters introduces confidentiality concerns such as the interpreter's role within the family or community, potential omissions or inaccuracies in translation, disruption of interpersonal dynamics, and the potential for judgment or bias (Boor and White, 2020). The shortage of competent interpreters, particularly for less commonly spoken languages, often forces providers to resort to informal mediation methods (Boor and White, 2020). Consistent with earlier findings, our study found that staff members sharing the same or similar language as the mother, community members, or family members often assumed the role of informal interpreters (Boor and White, 2020; Iliadia, 2008). This reliance on informal interpreters can affect interpretation quality due to potential biases, reduced relationship-building or empathetic responses, decreased willingness of mothers to share with

providers, compromised user satisfaction, and increased likelihood of medical errors (Boor & White, 2020). The utilisation of family members as informal interpreters can be considered inappropriate due to cultural taboos among refugees, which cause embarrassment and discomfort when sharing or posing questions in the presence of family members, husbands, or men (Iliadia, 2008). Our study further underscored the practice of mothers enlisting their children for language support, prompting concerns about the cultural appropriateness of this approach and the implications for service quality.

Limitations in language support can result in delays in receiving antenatal care or receiving such care with limited or inaccurate perinatal information (Iliadia, 2008). According to Boor and White (2020) language barriers and the absence of interpreters contributed to anxieties of uncertain outcomes stemming from an inability to communicate effectively with service providers. Kingsbury and Chatfield (2019) found that mothers could experience regrets due to their incapacity to articulate their care preferences. This arises from their uncomfortableness and diminished confidence in acknowledging their inadequate language support, as well as their lack of awareness of their authority to question provider recommendations (Kingsbury & Chatfield, 2019). In our study, feelings of shyness, fear, discomfort, and adherence to cultural norms appeared to impede communication regarding the need for an interpreter or the quality of interpretation received. Sozbir, et al. (2021) reported that mothers were more inclined to accept and consent to monitoring, care procedures, and treatments without a full comprehension of their care, leading to a sense of loss of control over their pregnancy experiences.

Need with navigating systems

The refugee journey often entails exposure to new environments and cultures (Kingsbury and Chatfield, 2019). However, having the ability to effectively navigate unfamiliar systems can present significant challenges, acting as a barrier (Boor & White,

2020; Griffin, et al., 2022). Mery, et al. (2011) and Kim, et al. (2017) reported that refugee mothers often faced obstacles such as confusion about health program coverage and fear of jeopardizing their legal status, hindering their willingness to seek service assistance. Other areas that were identified was the location of medical centres, understanding of available services and limited knowledge about the process of obtaining entitled care (Boor & White, 2020). Our study, building on prior research, also identifies additional facets of the challenge. Refugee mothers face the need to familiarise themselves with using public transportation to reach appointments, secure support for their other children, seek information or referrals within healthcare facilities, and finding a suitable midwife that can best support their needs. Notably, the complexity of system navigation tends to be more acute for recent arrivals compared to those further along in the resettlement process (Iliadia, 2008; Kim et al. (2017). Consequently, acquiring proficiency in navigate systems is time consuming (Iliadia, 2008; Boor & White, 2020), with potential consequences including delayed access to essential medical care (Iliadia, 2008). Our study also sheds light on challenges that persist regardless of temporal considerations, such as the difficulty in locating a suitable midwife. In spite of the time that the participants in our study had been in New Zealand, they still found some of these barriers challenging.

Importance of relationships

Refugee mothers navigate pregnancy and motherhood in an unfamiliar resettled environment that differs extremely to their country of origin by relying on family or social supports (Kingsbury & Chatfield, 2019; Kingsbury, et al., 2019). Consistent with previous research (Kingsbury, et al., 2018; Kingsbury & Chatfield, 2019; Boor, C. & White, 2020; Iliadia, 2008), our study concludes that refugee mothers in New Zealand rely on pre-existing relationships encompassing family, community and organisations to help navigate the struggles of pregnancy and motherhood. Family provided emotional and practical support by

assisting with childcare and completing household tasks, chatting with mothers and attending appointments, which is also supported by previous findings (Iliadia, 2008; Giscombe, et al., 2020). In addition to previous findings, our study indicated families also helped with navigating unfamiliar systems, sharing experiences and any essential resources the mother needs. Unlike our study, Denzongpa and Nichols (2022) mentioned that families also made decisions associated with family-planning and health decisions for the mother.

In alignment with previous research (Ellul et al., 2021), the volunteer sector has proven helpful in offering essential support, encompassing supports with clothing, toys, referrals, and information access. Our study further reveals the role of Plunket in post-birth monitoring of maternal and child well-being, coupled with the provision of essential supplies that the family may need after birth. Midwives emerge as an important source of assistance, offering insights into vaccines, health, dietary needs, and antenatal education. However, Ellul, et al. (2021) scope of support, while caring and knowledgeable, does exhibit limitations. Our study highlights organisational limitations in assisting refugee mothers, with constrained offerings and support extents. For example, some organisations work with specific type of refugee for a specific time limit, while others are not able to assist with specific tasks such as navigating the systems or providing transport and language support. Ellul et al. (2021) characterize social services as inflexible, which occasionally renders them unhelpful. Iliadia (2008) states that social services often lack awareness of women's experiences, and hospital social workers primarily engage during financial hardships experienced by refugees.

In our research, mothers did not explicitly reference community support, yet service providers highlighted instances where the community played a crucial role when organisations faced limitations. Examples include aiding with transportation, translating, and advocating on behalf of mothers. Griffin et al. (2022) highlighted the fundamental nature of

community support for refugee women. Notably, community leaders, family members, and peers facilitated access to health information, introduced services, translated content, and can offer practical assistance like transportation (Griffin et al., 2022). As women grow more confident and knowledgeable about obtaining, comprehending, navigating, and translating health information, they could reciprocate support within the community (Griffin et al., 2022). Regrettably, in New Zealand, language barriers and a lack of dedicated community spaces for refugee mothers often hinder their opportunities to socialise during pregnancy. Refugee mothers could encounter challenges in forming connections beyond their own cultural boundaries due to language barriers and a lack of shared understanding (Kingsbury, et al., 2018). Within our study, an organization managed to create a space, allowing supported refugee mothers to engage socially between each other. This is significant as it offered a platform for sharing experiences, alleviating stress, and fostering connections among women from similar backgrounds.

Nonetheless, certain mothers do not have an effective social network to rely on for support and can experience feelings of isolation and loneliness (Collins & Zimmerman, 2011). Being displaced distant from their families, mothers could feel an extreme gap within their support networks (Giscombe, et al., 2020). Iliadia (2008) describes that many refugee mothers have no one with whom to discuss their struggles during perinatal period, because most feel uncomfortable sharing female related issues with men and their husbands. Usually, other women in the family would provide such support; however, with no family and social support, women experience feelings of hopelessness and loneliness (Iliadia, 2008; Collins & Zimmerman, 2011). Kim, et al. (2017), reinforces findings of refugee mothers having weak social support, which leaves the mothers vulnerable to experiencing extreme emotional and physical challenges. This highlights the significance of fostering social networks over time

and enabling mothers to access assistance with resettlement process and navigating healthcare utilisation (Kim, et al., 2017).

Important cultural competences

Cultural comprehension significantly influences the discourse surrounding challenges and assistance required by pregnant refugee mothers. According to Boor and White (2020) culturally competent care utilises individuals' experiences and their process of meaning to equip practitioners with insights into potential and actual factors that impact the mothers' quality of care receive from service providers. To effectively comprehend, address, and bridge cultural, traditional, and religious needs of refugee mothers, it is imperative for service providers to undergo comprehensive training (Kingsbury & Chatfield, 2019). Consequently, an enhanced comprehension of cultural competencies within the literature is crucial to facilitate the development of efficacious programs (Kingsbury & Chatfield, 2019). While prior research often concentrated on mental health and cultural aspects (Boor & White, 2020; Giscombe, Hui & Stickley, 2020; Tobin, et al., 2017), the present study adopted a more expansive cultural approach. In addition to mental health, the analysis revealed that refugee mothers exhibit a preference for hospital childbirth, a desire to exclude male personnel during labour, and distinct food-related practices linked to pregnancy.

Muslim mothers have specific cultural and religious requirements, including the need for access to Halal food and practices such as involving newborns in the call of prayer and introducing a taste of sweetness. Ellul, et al. (2021) concentrated on the financial situations of refugee mothers, their undernutrition and access to adequate food. The areas of dietary needs and cultural practices remain relatively underexplored. This highlights a heightened responsibility for service providers to be attuned to these essential aspects, particularly given that language barriers may hinder effective communication of these needs by some refugee mothers. A notable example from this study which highlights the ramifications of such

oversights was a mother who was unable to convey her requirement for Halal food, and due to the hospital's lack of awareness, she experienced hunger during her hospital stay after birth. This instance emphasises the necessity of addressing these cultural and religious requirements to ensure the provision of appropriate and sensitive care for refugee mothers.

Refugee mothers in New Zealand exhibit a distinct preference for hospital-based birthing experiences over home births. This preference aligns with findings from a study conducted in the United States (Denzongpa & Nichols, 2022), which also observed disparities in childbirth practices among Nepalese women based on their home country and resettled nation. In their home country, the women adhered to traditional childbirth practices, resulting in potential implications for maternal health. Conversely, those who gave birth after resettlement opted for hospital births (Denzongpa & Nichols, 2022). Denzongpa and Nichols (2022) attributed these distinctions to maternal age, education, and the influence of familial pressures on decision-making. In contrast, our current study found that refugee mothers' preference for hospital births may be rooted in traumatic experiences associated with childbirth in their country of origin. Limited access to hospital facilities and adequately trained midwives in their home country led to heightened perception of risks and accounts of challenging deliveries. Consequently, the availability of hospital resources within New Zealand appeals to refugee mothers in utilising this opportunity to enhance their birthing experiences. This engenders a sense of comfort, trust, and security rooted in the belief that safe care is provided within hospitals settings and with medical experts. Although this realm of inquiry lacks exhaustive exploration, it underscores a heightened responsibility for healthcare professionals in New Zealand to exhibit cultural competence while delivering healthcare services. This necessitates a deeper understanding of the unique needs, preferences, and experiences of refugee mothers to ensure that quality healthcare is provided in a manner that aligns with their cultural and personal backgrounds.

When providing culturally sensitive care, it's crucial to address the preference of refugee women for female staff rather than male. During the childbirth process, situations arise where male staff and shared multi-patient rooms are involved. This often can result in discomfort and dissatisfaction among refugee mothers regarding the quality of service they receive (Sozbir et al., 2021). This discomfort can stem from the fact that mothers are in a particularly vulnerable state during labor, and certain religious beliefs forbid male staff from witnessing exposed female bodies (Sozbir et al., 2021). Our study highlighted the need to extend this cultural competency not just within hospital environments but also to other contexts requiring sensitive interactions, such as interpreter services. Within the framework of New Zealand's code of health and disability service consumers' rights, the first right highlights an individual's entitlement to respectful treatment and protection of their privacy (Health & Disability Commissioner, n.d.). The responsibility falls upon healthcare practitioners to uphold these practices, primarily due to the limitations faced by refugee mothers – which include language barriers, cultural norms that discourage open expression of discomfort, and mothers not being in a state to communicate that need during labour. While organisations might encounter constraints such as a shortage of female staff or specialized experts, alternative measures can be implemented to ensure the respect and comfort of refugee mothers. For example, informing mothers about the potential presence of male staff and providing suitable coverings if significant skin exposure is expected can mitigate these concerns.

In our study, three out of four mothers reported experiencing mental and emotional distress. This aligns with existing literature which highlights the heightened vulnerability of refugee mothers to mental health issues (Boor & White, 2020; Ellul et al., 2021; Haque & Malebranche, 2020; Kingsbury & Chatfield, 2019; Priebe et al., 2016; Tobin et al., 2017; Willey et al., 2020). Prior research (Tobin, et al., 2017; Boor & White, 2020; Ellul, et al.,

2021) has explored the cause of mental health issues through the interplay between stressors such as lack of social support, financial constraints, existing traumas, language barriers and limited awareness. However, our study focused on the cultural perspectives of refugees about mental health. Consistent with previous findings (Giscombe, et al., 2020), the mothers in our study conveyed that their community attaches stigmas to mental health issues. Notably, Boor and White (2020) observed that refugees possess limited familiarity with mental illness symptoms and seriousness of the issue. This was also depicted within our study by diverse responses among mothers in dealing with distress. One mother sought support from her family, while another expressed a need for practical assistance, such as navigating systems, when discussing her preferred approach to psychologist support. Conversely, a mother who had utilised phone-based mental health services described her interaction as detached and overly directive, emphasizing a lack of rapport. In addition, Boor and White (2020) indicated that the refugee community often attributes symptoms to supernatural causes, such as malevolent spirits, curses, witchcraft, or destiny. Our study also revealed that both service providers and mothers articulated community perceptions that label mental health as "craziness," being "possessed by demons," or "a failure to appreciate one's circumstances". Previous research (Kingsbury & Chatfield, 2019; Haque & Malebranche, 2020; Patricia et al., 2015; Shannon, et al., 2014; Tobin et al., 2017), indicates that these perceptions, coupled with fears of societal judgment, social isolation, hospitalization, child separation, and a dearth of accessible treatment, collectively serve as barriers when discussing mental health among refugees. Additionally, other barriers were that individuals from refugee backgrounds had difficulty describing emotional pain and avoid talking about it, which is consistent with finding of Willey, et. al. (2020). Haque and Malebranche, (2020) highlighted the role of stigma acting as a barrier to help seeking behaviours, while social support plays a protective role in postpartum mental health wellbeing. Considering these insights, it becomes imperative

for the community to gain a comprehensive understanding of mental health and its influences on maternal well-being, thereby enabling families to provide effective support during this critical phase. Furthermore, health practitioners should undergo training that equips them to navigate scenarios when mothers seek assistance, considering the unique cultural and psychological aspects of the refugee experience.

Gratitude towards New Zealand systems

According to Rash et al. (2011), gratitude is characterized as a positive and communal emotion evoked by an unearned act of kindness or generosity from another individual, without any associated costs. Within the scope of this study, mothers expressed a profound sense of gratitude toward the resources and facilities available in New Zealand to aid pregnant women. This sentiment aligns with the findings of Kingsbury and Chatfield (2019), who suggest that refugees, often originating from lower-income countries, are more likely to resettle in higher-income nations. Therefore, these mothers place considerable emphasis on the value of accessible pre- and postnatal care in their new environments, given the relatively limited availability of such resources and opportunities in their countries of origin prior to resettlement (Kingsbury & Chartfield, 2019). Furthermore, our study advances this understanding by highlighting mothers' appreciation for various resources, including easy access to midwives or nurses, facilitating their adaptation to the changes brought about by pregnancy. The efficiency and promptness of services catering to pregnant mothers, along with New Zealand's comprehensive system of financial support like paid parental leave and benefits, were also noted as sources of gratitude. However, Ellul et al. (2021) present a contrasting perspective, where participants living in United Kingdom (UK) reported instances of resource scarcity, including the lack of financial support from local authorities, experiences of hunger due to inadequate income for purchasing food, and substandard living conditions. Discrepancies between these studies might be attributed to country-specific

disparities or the current study's inclusion of refugee mothers who had sufficient time to establish themselves and their careers in New Zealand. Moreover, Ellul et al. (2021) encompassed asylum seekers within their participant pool, a demographic not represented in the present study. Denzongpa and Nichols (2022) reported that refugee women's perception and expectation of quality care was described based on their awareness of their home countries' care. This implies that any improvement over prior experiences may be construed as a favourable quality of care (Denzongpa & Nichols, 2022). Consequently, the current study refrains from drawing conclusions about whether former refugee mothers encounter financial challenges in New Zealand; instead, it underscores the prevailing sense of gratitude exhibited by the community for the services and support extended during pregnancy in New Zealand.

Overcoming barriers

Pregnancy is an effective time for psychosocial intervention because the mother is receptive to learning to care for herself and the arriving newborn and the community is more willing to contribute resources to the pregnant women (Akesson, 2008). Due to pregnancy being a stressful experience, any program to reduce the stress has the potential to be helpful for the mother and child (Akesson, 2008). Both, prior studies (Boor & White, 2020; Griffin et al., 2022; Price, et al., 2020) and the current research highlighted the crucial requirement for refugee mothers to receive comprehensive and cost-free education spanning a range of pertinent topics. Boor and White (2020) highlighted the prevalent learning pattern among individuals, often characterized by a trial-and-error approach. This could lead to adverse outcomes, particularly in the context of pregnancy. For example, the limited reproductive health knowledge within refugee communities in Jordan resulted in long-term health and financial situations (Price et.al., 2020). Consequently, facilitating access to sexual and reproductive education could be profoundly beneficial for refugee populations (Price et.al.,

2020). Griffin et al, (2022) also indicated a need for education on antenatal care, identifying complications and accessing care when required. Akesson (2008) suggested education about psychosocial challenges and their effects on the mother, fetus and infant. Building upon these insights, the present study emphasised the imperative for comprehensive pre-, peri-, and postnatal healthcare education for refugee mothers. This study identified additional educational domains, including vaccination protocols, the consequences of dietary choices during pregnancy, mental health awareness, navigation of health and social service referrals, effective parenting strategies, infant care, and mothers' legal entitlements within the New Zealand context. Patricia et al. (2015) indicated the necessity for refugees to be educated about mental health systems and governmental legislation affording them rights to treatment during pregnancy. Although New Zealand offers certain antenatal educational opportunities to the general public (Ministry of Health, 2021), these do not account for the unique struggles and requirements of the refugee population. The absence of tailor-made educational program inclusive of refugee mothers needs leads to missed opportunities. For instance, Denzongpa and Nichols (2022), indicated that education would be beneficial in the familial decision making to support pregnant refugee women during pregnancy. Consequently, families without formal education often overlooked maternal well-being, while those with formal education exhibited heightened awareness of women's health (Denzongpa & Nichols, 2022).

Previous studies highlight the interplay between the different challenges refugee mothers experience by stating multiple factors (Kim, et al., 2017; Boor & White, 2020; Ellul, et al., 2021; Griffin et al., 2022). In addition to previous findings, our study highlights the consequences of interplay between challenges by providing an example of where a mother slip through the gaps in the system, due to encountering multiple difficulties and limited support. Refugee mothers with limited English proficiency encounter obstacles in articulating their needs and accessing crucial information. Moreover, some mothers lack familial,

communal, or organizational networks to rely upon for guidance or problem-solving. Drawing from the insights of Kingsbury and Chatfield (2019), it is evident that refugee mothers heavily depend on their interpersonal relationships to navigate the realms of motherhood, pregnancy, and acclimation to a new environment. Additional challenges tied to transportation, cultural dissonance between the mothers' home countries and their resettled location, limited knowledge, and a scarcity of supportive refugee-focused organisations, collectively amplifying the likelihood of mothers having to stay in unpleasant situations.

Recommendations for New Zealand

The current study emphasises the importance of adopting a multi-faceted approach to support refugee mothers in New Zealand, drawing upon insights from existing literature as well as our own research findings. Boor and White (2020) advocate for the implementation of a holistic framework that acknowledges the uniqueness of each individual, steering away from a one-size-fits-all approach. Piacentini et al. (2019) advocate for a holistic approach that comprehends the complex interplay of diverse social identities and multidimensional markers in interpreter-mediated healthcare interactions with migrants. These encompass language, culture, ethnicity, age, gender, and immigration status (Piacentini et al., 2019). Moreover, program design should be a collaborative effort, incorporating input from various professionals, academics, and refugee communities to effectively address the multifaceted challenges faced by refugee mothers in New Zealand (Boor & White, 2020). Ellul et al. (2021) advocate for a patient-centric approach, considering the local, macro, and global holistic needs of the mother. Our study recommends the mothers should be communicated with and involved within their own holistic care and not pushed to the side, where professionals are only checking boxes.

Our recommendation for service providers that are involved in the care of refugee mothers is to implement multiple approaches that address the different challenges

encountered by refugees. To overcome language barriers in service delivery towards refugee women, a multifaceted approach needs to be implemented. Our study recommends access to multilingual pamphlets or booklets containing important and accurate information for health professionals to provide to pregnant mothers (Kim, et al.,2017). Services need access to interpreters and translators with comprehensive knowledge of medical terminology (Sozbir, et al., 2021). In addition, to address concerns about navigating systems, participants propose recommendations that resonate with practicality and inclusion. Specifically, participants advocate for the recruitment of medical professionals, particularly midwives, who share the same or similar ethnic backgrounds as the refugee mothers. This measure serves to mitigate language barriers and provides mothers with valuable assistance in navigating unfamiliar systems. Furthermore, our research highlights the need to simplify the midwife selection process in New Zealand (Kim et al., 2017). For mothers lacking a robust support network, the introduction of a support worker could prove fundamental in empowering and guiding them through the intricacies of the New Zealand systems. For services to provide quality care, a need to engage refugees in a collaborative approach that foster relationships to allow the mothers to obtain better autonomy, trust and support when using services (Patricia, et al., 2015; Tobin, et al., 2017; Iliadou, et al., 2019).

Similar to previous studies, the current study urges providers to be trained to better understand culture and the unique care needed when dealing with supporting refugee mothers (Tobin, et al., 2017; Iliadou, et al., 2019). Clinicians need to be systematically trained in efficient use of cultural brokers and interpreters and improve their cross-cultural communication skills (Boor & White, 2020; Griffin, et al., 2020). Additional training needs to be provided to services by cultural brokers about cultural appropriateness (Griffin et al., 2022). Im and Swan (2022) implemented and evaluated a practice training program that provided culturally responsive trauma informed training for mental health professionals co-

designed by leaders within refugee background. The study facilitated intercultural learning and relationships between community and leaders. Hence, the training can improve understanding of mental health within community, while also support health professionals' cross cultural communication skills (Griffin et al., 2022; Im & Swan 2022). A similar training would be beneficial for the care of refugee mothers in New Zealand. Our study adds the need for cultural brokers and interpreters to be trained about cultural and professional service delivery in New Zealand work environment. Training needs to prepare interpreters and clinicians on the challenging consultations to best support refugee mothers (Boor & White, 2020). However, for these trainings to occur effectively, a better understanding of different cultural practices associated with refugee mothers is needed to advise such trainings. While this research does provide some understanding about cultural practices services need to be aware of in New Zealand when providing care for refugee women during pregnancy, further research needs to be conducted. Interventions in New Zealand that provide education should be evaluated to provide the best practice and guide. This can ensure others are able to replicate these practices.

A recommendation to reduce barriers and enable support for refugee mothers would be the successful implementations of community health and psychoeducation in New Zealand. A community based, specifically tailored antenatal class catered to refugee needs can assist with reducing some barriers for mothers (Tobin et al., 2017; Patricia et al., 2015; Iliadou et al., 2019). A community-based psychoeducation for family, partners and wider community about perinatal and general mental health can assist with destigmatisation and a reduce fear of isolation, treatments ineffectiveness and hospitalisation (Patricia, et.al., 2015; Tobin et.al. 2017). In addition, for women who do not have their family or social supports, community-based psychoeducation intervention is valued as a form of being empowered to better care for themselves and the baby and also act as a networking opportunity to build

support and provide therapeutic benefits (Tobin, et al., 2017). Svensson et al. (2017) implemented a sexual and reproductive health education program for refugee women in Sweden. The study trained peer health educators to deliver culturally sensitive health information in the women's native language. The study reported women felt better informed, more confident, motivated to increase their knowledge, and relayed their learning to their peers outside of the training program (Svensson et al., 2017). Similar findings are reported by Frost et al. (2018), which evaluated a co-facilitated community education program in the United States with refugee women about general health information to access and navigate health assistance. This study also reported successful intervention because community members were encouraged to engage in the development and implementation of the intervention, provided a social space for refugee women and enhanced community health knowledge (Frost, et al., 2018). Hence, it is highly important to create similar community programs for refugee mothers within New Zealand.

Implications of our study

Through a comprehensive analysis of the experiences of former refugee mothers and service providers in New Zealand, this study explores the needs, supports, and challenges pregnant refugee women undergo. Despite the limited number of participants, the research offers a generalized understanding of diverse factors impacting refugee mothers' experiences. Aligning with prior research, a complex interplay emerges, involving language barriers, navigational hurdles, cultural competencies, relational gaps, and health knowledge limitations. The study's recommendations hold the potential to guide academics and professionals towards more effective methods of supporting refugee mothers, thereby enhancing the quality of care. Moreover, it directs organisational attention to system gaps within maternity care for refugee mothers in New Zealand, advocating for quality improvements. Additionally, the study raises awareness about pertinent issues regarding the

rights to informed consent and privacy, calling for their resolution within the New Zealand code of health and disability services consumers.

Limitations of our study

In analysing the outcomes of this study, it's imperative to acknowledge the researcher's unique background as a refugee and their extensive engagement with diverse refugee populations. This factor presented notable advantages, as participants could feel comfortable and a connection with the interviewer, encouraging sharing, and enabling the research to take cultural competencies into account effectively. However, this perspective also introduced certain limitations to the interview process. Instances arose where cultural practices were disclosed, but the interviewer failed to explore deeper into these aspects. This was because of participants and the interview being from refugee background with similar cultural backgrounds. Hence, some cultural practices that were similar were not explored and was assumed to be the same concept. Therefore, it was not elaborated. An example that portrays this was when a mother discussed her interactions with a psychologist, and the opportunity to explore her understanding of what a psychologist is and how they support was not elaborated. This is significantly because the interviewer had assumed that their understanding of a psychologist is the same as in New Zealand. Whereas this may not be the case considering the study uncovered that refugees often regard midwives in their homeland as individuals with experience but lacking medical training. Similarly, participants' cultural viewpoints regarding hesitations to speak up about things they were not comfortable with could have been explored further. Especially, considering the limited research on this issue. Hence, we also did not get an in depth understanding. Additionally, the interviewing process encountered constraints due to participants assuming a mutual understanding of struggles and issues owing to shared backgrounds. This was evident through recurrent phrases like "you

know" during sharing. To mitigate this, participants were explicitly encouraged to assume the interviewer had limited awareness of their unique challenges and experiences.

Another noteworthy limitation pertains to the study's geographic concentration, with most participants living in Auckland and just one from Hamilton. Support systems and resources for refugees can vary across different New Zealand regions. Consequently, future research should encompass a broader geographical spectrum to account for potential regional disparities in challenges, support networks, and needs of refugee mothers. Moreover, the study's strength is its incorporation of a diverse array of experiences from refugee mothers, encompassing Afghan, Burmese, and Palestinian backgrounds. This inclusivity facilitated a generalised understanding of challenges, needs and supports some refugee mother's encounter. Nevertheless, achieving a comprehensive representation of each community's distinct needs necessitates further investigations dedicated to specific groups. For instance, within our study, a Burmese mother highlighted the predicament of securing interpreters proficient in her language, whereas Afghan participants found it comparably easier to access Iranian and Dari interpreters. This divergence underscores the significance of conducting focused studies to acquire nuanced insights into each community's unique demands. The current research acknowledges that this research a very small number of mothers and providers. Recruitment was affected by COVID and by the crisis in Afghanistan during this study.

The Future Studies

The present study highlights the necessity for an enhanced comprehension of how refugee mothers experience gratitude and the potential efficacy of tailored interventions in enhancing the quality of life for pregnant refugee mothers. This recommendation stems from prior research indicating connections between gratitude and overall well-being (Rash et al., 2011). A body of literature has highlighted a positive correlation between gratitude and

favourable aspects of life, including satisfaction, optimism, positive emotions, and happiness (McCullough et al., 2002; Watkins et al., 2003). Additionally, these studies have revealed gratitude being negatively correlated with depression and negative affect (McCullough et al., 2002; Watkins et al., 2003). Of particular significance is Rash et al.'s (2011) observation that participants subjected to gratitude interventions exhibited positive physiological responses, as evidenced by balanced heart rates and enhanced physiological coherence. Furthermore, the same study documented the salutary effects of gratitude interventions, including stress reduction and improved overall well-being. Caputo (2015) reported a negative relationship between gratitude and loneliness. Hence, gratitude was reported to be a significant moderator of feelings of loneliness and supporting social bonds (Caputo, 2015). Remarkably, while existing research has extensively explored gratitude's multifaceted impacts, a noteworthy void exists in its application to the refugee community, particularly among pregnant refugee mothers. Specially, considering the current study found that refugee mothers focus on express gratitude during pregnancy. Therefore, exploring gratitude association to cultural or religious learning and build on such learning to broaden understanding for practitioners to assist mothers in different situations.

Additional research is necessary to comprehensively investigate the challenges that service providers encounter while assisting refugee mothers throughout their pregnancies in New Zealand. Furthermore, research can focus on what are the existing resources, program and services that are tailor to refugee mothers in New Zealand, who possess limited proficiency in English. Within the scope of spoken language limitations and the intricate process of resettlement, it is important to acknowledge that the current study's participant group comprised individuals who had already established themselves to some extent. Therefore, it might be beneficial to explore how distinct refugee status (asylum seeker, family

reunification or quota refugee), limited language and time they resettled in New Zealand could have an impact on the challenges and support of refugee mothers in New Zealand.

Conclusion

Refugee women are at an increased risk of experiencing negative pregnancy outcomes. With the growing numbers of refugees resettling in New Zealand, it is important that services understand the needs, challenges and supports of refugee women during pregnancy. Due to no research being conducted in New Zealand, the current research provides a generalised understanding that services could consider ensuring refugee mothers are better supported during pregnancy. This study found that refugee mothers need support with language and navigating different systems in New Zealand, fostering relationships, access to culturally competent care and access to education about different topics. Due to the challenges being inter-connected, some mothers may experience extreme difficulties and not have access to adequate support during their pregnancy in New Zealand. Therefore, the current study recommended that services use a holistic approach to support refugee women. In addition, different community psychoeducation programs to be implemented for refugee women to support each other and empowered to deal with their situation. It is important for services to follow basic ethical standards of informed consent and privacy when supporting refugee mothers and provide culturally appropriate care to the mothers in New Zealand.

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Appendices

Appendix A: Email to service providers

Kia Ora everyone,

I am currently doing my masters research in Psychology and I am interested in hearing stories of refugee mothers who have had a baby in New Zealand in the last three years. I am hoping to help us to provide better support for refugee families. The study will be exploring the needs and challenges of refugee women in New Zealand during pregnancy. I am hoping to interview refugee women in New Zealand who have been pregnant in New Zealand during the last 3 years, as well as service providers who work with refugee families. Participants will receive a \$20 voucher as Koha for their participation in the study. If language support is required, please let me know and I will arrange for a cross-cultural worker to be present during the interview and get in contact with the individual for further enquiries and arrangement detail.

If you or any women that you support would be interested in participating, please see the attached poster and information sheet for more information. We are looking for 6 to 10 refugee mothers who have had their most recent pregnancy in New Zealand during the last 3 years and 3 to 5 staff members from organisations that have supported refugee women during their pregnancy.

If interested please contact Shabana Sharifi at SS523@students.waikato.ac.nz or phone 0220908403. I appreciate your contribution and support for this study and look forward to hearing from you.

Sincerely,

Shabana Sharifi

Appendix B: Information for participants

Information for participants

School of Psychology
The University of Waikato
Private Bag 3105
Hamilton, New Zealand

Telephone 64-7-856 2889
Facsimile 64-7-858 5132



Former refugee women's needs and challenges in New Zealand: Perspective of mothers and service providers within New Zealand.

Thank you for your interest in participating in our study. This study aims to interview former refugee women in New Zealand who have been pregnant in New Zealand during the last 3 years, as well as service providers who work with refugee families, to identify the needs and challenges of pregnant refugee women in New Zealand. This study is a Master's thesis by Shabana Sharifi, a Master's student in psychology at the University of Waikato.

Pregnancy is an important period in life where women experience multiple changes and share resources so that they can bring another life into this world. However, this process can be stressful, perhaps especially for refugee women, who are far from home and their familiar support systems. This study aims to interview women and those who support them to contribute to improving services.

Study Procedures:

If you choose to participate in the study, you will be contacted by Shabana (the researcher) and, if language support is required, a cross-cultural worker to arrange a time, place or other support you may require for the interview. If you wish, you can have a support person during the interview to ensure you are comfortable. The interview is expected to take approximately 1 hour. The interview questions focus on your experience, needs and challenges of pregnancy or supporting refugee women through their pregnancy (service providers) in New Zealand as a refugee. The interview will be recorded, transcribed, and thematic analysis will be used to report the findings.

All information you provide in the study will be kept confidential; your name will not be stored with any of the data collected. The only exception to confidentiality would be if we were concerned for your immediate health or safety. In this case, we would encourage you to talk with your health care provider. However, in an emergency, we might need to contact them directly. Data will be kept in a password-protected computer in the University of Waikato for at least five years after the completion of the study. Findings from the study may be published in a journal article and/or professional conference presentation. We will also produce a summary of findings in English, which we can send to you if you wish. You will not be identifiable in any report or presentation connected with the study.

You are always free to withdraw from the study at any time up to 3 weeks after your participation in the interview, and you can decline any questions you do not wish to answer. Your participation is much appreciated and will not influence any service you may be receiving from any organisation. We hope that participating in the study will be helpful to you in terms of being able to share your experience and recommendation that in the future services can implement. However, we cannot know for sure whether you will benefit from participation. If you have any questions about this research, please feel free to contact Shabana Sharifi at SS523@students.waikato.ac.nz; 0220908403, or Carrie Barber at carrie.barber@waikato.ac.nz, or 078379221.

This research project has been approved by the Human Research ethics committee (health) of the University of Waikato under HREC (health)2021#. Any questions about the ethical conduct of this research may be addressed to the Secretary of the Committee, email humanethics@waikato.ac.nz, postal address, University of Waikato, Te Whare Wananga O Waikato, Private bag 3105, Hamilton 3240.



Persian Translation

اطلاعات برای شرکت کنندگان

نیاز ها و مشکلات یا چالش زنان پناهنده در نیوزیلند:

دیدگاه یا نظریات مادران و سرویس های خدماتی در داخل نیوزیلند:

از علاقه مندی شما در شرکت با مطالعات یا بررسی ما متشکریم.

هدف این بررسی یا مطالعه مصاحبه با زنان پناهنده در نیوزیلند میباشد که در طول سه سال گذشته حامله یا باردار بوده اند و همچنان مصاحبه ب

حاملگی یا بارداری یک دوره مهم از زندگی است که در این دوره یا زمان زنان تغییرات متعددی را تجربه میکنند و آن ها منابع را به اشتراک ،

کسانی که از خانه و خانواده هایشان و همچنان دور از سیستم های حمایتی می باشند. هدف این مطالعه و بررسی قسمیکه قبلا توزیع دادیم **مصاحبه با این زنان و کسانی که این زنان را بخاطر بهبود خدماتی کمک و حمایت می کند میباشد. روش مطالعه یا بررسی:**

اگر تصمیم اشتراک در مطالعه یا بررسی دارید شبانه (پژوهشگر یا محقق) با شما تماس خواهد گرفت و اگر شما نیاز به کمک بخاطر زبان داشته باشید یعنی زبان انگلیسی شما خوب نباشد و ضرورت به کمک داشته باشید ممکن است برای مصاحبه با شما از کارمند فرهنگی یا کراس و تعیین مکان و زمان مصاحبه همراه شما که از کمپوزیسیون کلان شواهد سوسو تخطی را بصورت می توانید در زمان مصاحبه یک شخص حمایتی یا پشتیبان داشته باشید تا اطمینان حاصل نماید که شما راحت هستید. امکان دارد این مصاحبه یک ساعت طول بکشد و سوالات مصاحبه مبنی بر تجربه و چالش یا مشکلات در مورد حاملگی و حمایت از زنان حامله در طول زمان بارداری یا حاملگی آن ها (ارایه دهنده خدمات) در نیوزیلند میباشد

مصاحبه شما ضبط یا ثبت و رونویس میشود و از تحلیل موضوع شما برای گزارش های استفاده میشود که این برنامه را کمک میکند تمام معلوم

شما را تشویق میکنیم که با مسئولین تامین کننده مراقبت های بهداشتی یا امورات صحتی خود صحبت نمایید، در حالات اضطراری امکان دارد که

اطلاعات شما در کامپیوتر های رمز دار برای پنج سال بعد از تکمیل بررسی یا مطالعه در دانشگاه وایکاتو محافظه میشود. یافته های این مطالعه

بدسترس شما قرار دهیم. و شما در هیچ یک از راپورت ها و یا سخنرانی که ارتباط به این مطالعه داشته باشد شناسایی نخواهد شد یعنی اسم شما یاد و یا واضح نخواهد شد.

شما همیشه حق دارید که در حد اکثر سه هفته پس از مشارکت در مصاحبه در هر زمان از مصاحبه خارج شده و رد کنید که جواب ندهید و یا اگر کدام سوال را نمی خواهید جواب دهید اجازه دارید که جواب ندهید.

حصه گیری شما قابل تقدیر است و این حصه گیری شما بالای کمک ها که از طرف هر ارگان و یا سازمان باشد تاثیر ندارد. ما امیدواریم که شرکت شما در بررسی و مطالعه برای شما مفید باشد تا بتوانید تجارب خود را به اشتراک بگذارید. شاید از توصیه و تجارب شما در سرویس ها یا کمک های بعدی در آینده استفاده مفید شود و از تجارب و توصیه شما در سرویس ها یا کمک ها میتواند که مورد اجرا قرار گیرد، در حالیکه

شبانه شریفی تماس حاصل نماید

شماره تماس: ۰۲۲۰۹۰۸۴۰۳ یا ایمیل آدرس SS523@students.waikato.ac.nz یا کری باربر تلفون و ایمیل آدرس

Carrie.barber@waikato.ac.nz ۰۷۸۳۷۹۲۲۱

این پروژه تحقیقاتی توسط کمیته اخلاق پژوهشی انسانی (سلامتی) دانشگاه وایکاتو تایید شده است تحت نظر HREC (سلامتی) #۲۰۲۱. هرگونه سوالات در مورد عمل یا روش اخلاقی این تحقیق را میتوان با دبیر کمیته در جریان گذاشت، ایمیل آدرس humanethics@waikato.ac.nz

University of Waikato, Te Whare Wananga O Waikato, Private bag 3105, Hamilton 3240. آدرس پستی،

School of Psychology
The University of Waikato
Private Bag 3105
Hamilton, New Zealand

Telephone 64-7-856 2889
Facsimile 64-7-858 5132



Arabic translation

معلومات للمشاركين

احتياجات و تحديات النساء اللاجئات السابقات في نيوزلندا : انطباع الامهات و مقدمي الخدمة في نيوزلندا

شكرا لك على اهتمامك بالمشاركة في دراستنا. تهدف هذه الدراسة إلى مقابلة اللاجئات السابقات في نيوزيلندا اللواتي كن حوامل في نيوزيلندا خلال السنوات الثلاث الماضية، وكذلك مقدمي الخدمات الذين يعملون مع أسر اللاجئين، لتحديد احتياجات وتحديات اللاجئات الحوامل في نيوزيلندا. هذه الدراسة هي أطروحة الماجستير من قبل شبانا شريفي، طالبة الماجستير في علم النفس في جامعة واكاتو.

الحمل هو فترة مهمة في الحياة حيث تواجه النساء تغييرات متعددة وتبادل الموارد حتى يتمكنوا من جلب حياة أخرى في هذا العالم. ومع ذلك، يمكن أن تكون هذه العملية مرهقة، ربما خاصة بالنسبة للاجئات، البعيدات عن البلد الام وأنظمة الدعم المألوفة لديهن. تهدف هذه الدراسة إلى مقابلة النساء وأولئك الذين يدعمونهم إلى المساهمة في تحسين الخدمات.

إجراءات الدراسة:

إذا اخترت المشاركة في الدراسة ، سيتم الاتصال بك من قبل شبانا (الباحثة) ، وإذا كان الدعم اللغوي مطلوباً ، عامل متعدد الثقافات لترتيب وقت أو مكان أو أي دعم آخر قد تحتاجه للمقابلة. إذا كنت ترغب في ذلك ، يمكن أن يكون لديك شخص داعم أثناء المقابلة للتأكد من أنك مرتاح. من المتوقع أن تستغرق المقابلة حوالي ساعة واحدة. تركز أسئلة المقابلة على تجربتك واحتياجاتك وتحدياتك في الحمل أو دعم اللاجئات من خلال الحمل (مقدمي الخدمات) في نيوزيلندا كلاجئة. سيتم تسجيل المقابلة كتابةً، وسيتم استخدام التحليل المواضيعي للإبلاغ عن النتائج.

سيتم الحفاظ على سرية جميع المعلومات التي تقدمها في الدراسة ؛ لن يتم تخزين اسمك مع أي من البيانات التي تم جمعها. الاستثناء الوحيد للسرية سيكون إذا كنا قلقين على صحتك أو سلامتك الفورية. في هذه الحالة ، فإننا نشجعك على التحدث مع مقدم الرعاية الصحية الخاص بك. ومع ذلك ، في حالات الطوارئ ، قد نحتاج إلى الاتصال بهم مباشرة. سيتم الاحتفاظ بالبيانات في جهاز كمبيوتر محمي بكلمة مرور في جامعة واكاتو لمدة خمس سنوات على الأقل بعد الانتهاء من الدراسة. يمكن نشر نتائج الدراسة في مقال في مجلة و/أو عرض تقديمي للمؤتمرات المهنية. سننتج أيضاً ملخصاً للنتائج باللغة الإنجليزية، والتي يمكننا إرسالها إليك إذا كنت ترغب في ذلك. لن يتم التعرف عليك في أي تقرير أو عرض تقديمي مرتبط بالدراسة.

أنت دائماً حر في الانسحاب من الدراسة في أي وقت حتى 3 أسابيع بعد مشاركتك في المقابلة، ويمكنك رفض أي أسئلة لا ترغبين في الإجابة عليها. إن مشاركتك تحظى بتقدير كبير ولن تؤثر على أي خدمة قد تتلقينها من أي منظمة. نأمل أن تكون المشاركة في الدراسة مفيدة لك من حيث القدرة على مشاركة تجربتك والتوصية التي يمكن أن تنفذها الخدمات المستقبل. ومع ذلك، لا يمكننا أن نعرف على وجه اليقين ما إذا كنت تستفيدين من المشاركة. إذا كان لديك أي أسئلة حول 0220908403 ، أو SS523@students.waikato.ac.nz ، فلا تتردد في الاتصال بشبانا شريفي عليها الب

كاري باربر في carrie.barber@waikato.ac.nz 078379224

Appendix C: Participant consent forms

Consent Form for participants

School of Psychology
The University of Waikato
Private Bag 3105
Hamilton, New Zealand

Telephone 64-7-856 2889
Facsimile 64-7-858 5132



completed copy of this form will be provided to both researcher and participant.

Research Project: What are the needs and challenges of former refugee women in New Zealand during pregnancy and how are they being supported to meet the needs?

Please complete the following checklist. Tick (✓) the appropriate box for each point.	YES	NO
1. I have read, understood and given a copy of the consent form, Participant Information Sheet and referral forms and sufficient time has been given to consider participating in this study		
2. I agree to _____ being present to provide cross-cultural and language support during this interview.		
3. I am satisfied with the answers I have been given regarding this voluntary (my choice) study and I can withdraw from the study until 2 weeks after the interview.		
4. I have the right to decline to participate in any part of the research activity and I know who to contact for more enquiries about the study.		
5. I understand that the interview will be recorded, safely stored and transcribed, and I can request a summary in English.		
8. I understand that the information supplied by me could be used in future academic publications.		
9. I understand that my participation in this study is confidential and that no material, which could identify me personally, will be used in any reports on this study.		
10. I wish to receive a summary of the findings in English.		

Declaration by participant:

I agree to participate in this research project and I understand I have until 2 weeks after the interview to withdraw from the study. If I have any concerns about this project, I may contact the convenor of The Human Ethics Committee, email manethics@waikato.ac.nz, postal address, University of Waikato, Te Whare Wananga o Waikato, Private Bag 3105, Hamilton 3240.

Participant's name: _____ Date: _____ Signature: _____

Declaration by member of research team:

I have given a verbal explanation of the research project to the participant, and have answered the participant's questions. I believe that the participant understands the study and has given informed consent to participate.

Researcher's name: _____ Date: _____ Signature: _____

Appendix D: Cross-cultural confidentiality and consent

Cross-cultural confidentiality form

School of Psychology
The University of Waikato
Private Bag 3105
Hamilton, New Zealand

Telephone 64-7-856 2889
Facsimile 64-7-858 5132



completed copy of this form will be provided to both researcher and participant.

Research Project: What are the needs and challenges of former refugee women in New Zealand during pregnancy and how are they being supported to meet the needs?

Please complete the following checklist. Tick (✓) the appropriate box for each point.	YES	NO
1. I have read, understood and given a copy of the consent form, Participant Information Sheet and referral forms and agree to provide language and cultural support for this study		
2. I have the right to decline to participate in any part of the research activity and I know who to contact for more enquiries about the study.		
3. I understand that the interview will be recorded, safely stored and transcribed, and I can request a summary in English.		
4. I understand that the information supplied by me could be used in future academic publications.		
5. I understand that any information or material shared in this interview will be confidential and private and breaking it can lead to legal action.		
8. I understand that providing Cross-cultural support is volunteer (My choice) and no pressure has been put in place to provide support.		
10. I wish to receive a summary of the findings in English.		

Declaration by participant:

I agree to provide language support and cultural advice in this research project and I understand confidentiality and privacy will be maintained in this project. If I have any concerns about this project, I may contact the convenor of The Human Ethics Committee, email humanethics@waikato.ac.nz, postal address, University of Waikato, Te Whare Wānanga o Waikato, Private Bag 3105, Hamilton 3240.

Participant's name: _____ Date: _____ Signature: _____

Declaration by member of research team:

I have given a verbal explanation of the research project to the participant, and have answered the participant's question about it. I believe that the participant understands the study and has given informed consent to participate.

Researcher's name: _____ Date: _____ Signature: _____

Appendix E: Recruitment poster

Pregnancy in a new home: Refugee mothers in New Zealand

Are you:

- A Refugee women living in New Zealand?
- Pregnant or underwent a pregnancy recently in New Zealand in the last 3 years?



We would like to hear the stories of refugee mothers who are currently pregnant or have had a pregnancy in the last 3 years in New Zealand. We are interested in your needs, challenges and the supports you found helpful. You would be interviewed in a private place of your choosing, with a friend or family member if you wish.

If you are interested or further information, please contact Shabana Sharifi at SS523@students.waikato.ac.nz Or phone 0220908403



This research is being completed for a master's thesis in psychology supervised by Dr Carrie Barber (carrie.barber@waikato.ac.nz) or phone 078379221
Participants will receive a \$20 voucher as Koha
Language support will be provided



This research has been approved by the Human Research Ethics Committee (Health) of the university of Waikato. If require information about this researches ethics please contact humanethics@waikato.ac.nz or 07834166

Persian translation

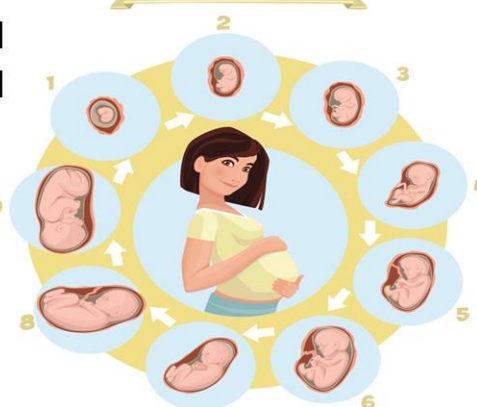
جدید خانه در بارداری یا حاملگی: نیوزیلند در پناهنده مادران

آیا شما؟

- یک زن پناهنده ساکن نیوزیلند؟
- باردار باشید و یا اخیراً در سه سال گذشته حامله شده باشید؟

PREGNANCY

▼ MONTH BY MONTH ▼



ما دوست داریم که داستان های مادران پناهنده را بشنویم که در حال حاضر حامله یا باردار هستند و یا در سه سال گذشته باردار یا حامله بوده باشید. ما به ضرورت ها یا نیاز ها، چالش ها یا مشکلات و حمایت های که برایتان مفید است علاقه مندیم. اگر بخواهید شما در یک مکان خصوصی که به انتخاب خود شما، با موجودیت یکی از دوستان و یا یکی از اعضا خانواده مصاحبه خواهد کرد اگر شما خواهش داشته باشید.



اگر شما علاقمند هستید یا معلومات بیشتر میخواهید لطفاً با این شماره تلفون و ایمیل آدرس به تماس شوید:
شبانه شریفی

SS523@students.waikato.ac.nz

یا ۰۲۲۰۹۰۸۴۰۳

این تحقیق برای پایان نامه کارشناسی ارشد یا نظر داشت ماستری روانشناسی به رهنمائی یا نظارت دکتر کری بلریر در حال تکمیل است
تلفون ۰۷۸۳۷۹۲۲۱

Carrie.barber@waikato.ac.nz

شرکت کننده یک کوپون ۲۰ دلاری به رقم تحفه دریافت نموده و بخاطر زبان هم کمک ارائه خواهد شد



این تحقیق توسط کمیته اخلاق پژوهش انسانی (سلامتی) دانشگاه وایکاتو تایید شده است. در صورت نیاز به اطلاعات در مورد این تحقیقات اخلاقی لطفاً به این شماره و ایمیل آدرس تماس
نماید humanethics@waikato.ac.nz یا ۰۷۸۳۷۹۲۲۱

الحمل في مسكن جديد: الأمهات اللاجئات في نيوزيلندا

هل أنت:

- امرأة لاجئة تعيش في نيوزيلندا؟
 كنت حاملا أو تعرضت للحمل مؤخرا في
 نيوزيلندا في آخر 3 سنوات؟



نود أن نسمع قصص الأمهات اللاجئات الحوامل حاليًا أو حملن في السنوات الثلاث الماضية في نيوزيلندا. نحن مهتمون باحتياجاتك وتحدياتك والدعم الذي وجدته مفيدًا. ستتم مقابلتك في مكان خاص من اختيارك، مع صديق أو أحد من أفراد الأسرة إذا كنت ترغبين في ذلك.



إذا كنت مهتمًا أو تودين بالمزيد من المعلومات،
 يرجى الاتصال في شبانة شريفى
SS523@students.waikato.ac.nz
 أو هاتف 0220908403

يتم الانتهاء من هذا البحث لأطروحة الماجستير في علم النفس
 تحت إشراف الدكتورة كلري بلير
 أو الهاتف 078379221 (carrie.barber@waikato.ac.nz)
 سيحصل المشاركون على قسيمة بقيمة 20 دولارًا كهدية
 سيتم توفيرها عن طريق داعم اللغة



تمت الموافقة على هذا البحث من قبل لجنة أخلاقيات البحث البشري (الصحة) بجامعة وايتاتو.
 إذا كنت بحاجة إلى معلومات حول أخلاقيات هذا البحث، فيرجى الاتصال بـ
humanethics@waikato.ac.nz 07834166 أو

Appendix F: Outline of interview

Interview Question

Research Question: What are the needs and challenges of former refugee women in New Zealand during pregnancy and how are they being supported to meet the needs?

Research and myself introduction to refugee women participant at interview:

- Hi, my name is Shabana and I am originally from Afghanistan. Been in New Zealand for about 18 years and was raised by a single mother.
- I am currently a Master's student at Waikato University who is interested in exploring refugee women's experiences during pregnancy in New Zealand. I will be asking questions about the supportiveness, challenges, what was most helpful during your pregnancy in New Zealand. I am interested in finding out what you need and what would be helpful for New Zealand as a nation and service providers to focus resources on for future former refugee women in similar situations.

Former Refugee Women Participant Research Interview Questions:

General Questions to refugee participants:

1. What country are you originally from?
2. What other countries have you travelled to?
3. How many children do you have?
4. How many family members live in New Zealand?
5. How long have you been in New Zealand?

Interview Questions:

1. When were you pregnant?
 - a. How long have you been in New Zealand at that time of your pregnancy?
2. What stands out in your memory about that pregnancy? (follow-up questions explore)
 - a. What were some moments that were the hardest for you during that time?
 - b. What went well?
 - c. What helped to get you through it?
 - d. Was there anyone you could turn to for help and if so, how did they try to help you?
 - e. How did pregnancy affect you mentally and emotionally and what helped you through it?
 - f. What was your experience of the types of services you received during your pregnancy in New Zealand?
 - i. What went well/ not well with service providers during your pregnancy in New Zealand?
 - ii. How was your experience of different service providers or support systems during your pregnancy?
 1. Midwives
 2. Hospitals
 3. Plunket
 4. Redcross
 5. RASN
 6. Mental health
 7. Community
 8. Family
3. What are some things back in (country of origin) or other countries you have visited that you would consider helpful during pregnancy that would be beneficial to have in New Zealand?
 - a. Why/ how were those things helpful to you during your pregnancy?
4. In a perfect world, what would your perfect support system and different practices look like to make the process of pregnancy a little easier?
5. What would you like New Zealand and services to consider while supporting refugee women during their pregnancy?
 - a. What did you feel you needed most in your pregnancy?
 - b. How do you think could we help to ensure women in the future receive this?
 - c. What different assistance should be available to support them?
 - d. Is there anything else, that you might consider important or helpful for other refugee women in New Zealand?

Service provider Interview Question:

1. What voluntary sector and other services exist in your area to support refugee women needs during their pregnancy?
 - a. What are other services that organisations should be considered while supporting Refugee women during pregnancy to meet their needs?
2. What cultural competencies could organisations consider when supporting pregnant refugee women?
3. What are some major challenges in your practice that should be considered while supporting refugee background pregnant women in New Zealand?
4. What are some strengths or improvements service providers should consider in their practice when supporting refugee women during their pregnancy in New Zealand?
5. Reflecting on a recent experience when you cared for a refugee pregnant woman, what needs did you find most important in working with her?
 - a. Access to what type of resources would make supporting her easier?
6. What are some things you want other service providers to think about while they are supporting Refugee background, pregnant women?

Appendix G: Contact information of service providers

Support contacts

The following service provides mental health and counselling services, in case you require someone to support you. Please find the list below. Your GP and midwife are recommended as the first point of contact if you are struggling. If you feel you are in immediate danger please call 111.

Phone Support:

- Refugee as Survivors New Zealand (RASNZ) – Refugee health and wellbeing RASNZ Mangere (09) 207 0870 or community clinical team (09) 6202252
- Healthline (0800 611 116): A 24-hour telephone health service.
- Lifeline (0800) LIFELINE or (0800 543 354): Free 24-hour confidential support.
- 1737, Need to Talk? Call or text 1737 for free to talk to a trained counsellor.
- Plunket Line (0800 933 922): Call free for 24-hour parenting help and advice.
- Anxiety New Zealand (0800) ANXIETY or (0800 269 4389): Free 24-hour anxiety helpline.
- Crisis Assessment and Treatment Team (0800 50 50 50): Available 24/7 for mental health emergencies.
- [Women's Refuge Crisis Line](#) (0800) REFUGE or (0800 733 843): For women living with violence, or in fear, in their relationship or family.