

Irish midwives' experiences of providing maternity care to non-Irish women seeking asylum

Carolyn L Tobin¹
Jo Murphy-Lawless²

¹Department of Nursing, College of Health and Human Services, University of New Hampshire, Durham, NH, USA; ²School of Nursing and Midwifery, Trinity College, Dublin, Ireland

Background: Immigration and asylum seeking has been an important social and political phenomenon in Ireland since the mid 1990s. Inward migration to Ireland was seen in unprecedented numbers from 1995 onward, peaking in 2002 with 11,634 applications for refugee status. Asylum and immigration is an issue of national and international relevance as the numbers of displaced people worldwide continues to grow, reaching the highest level in 20 years at 45.2 million in 2012. Midwives provide the majority of care to childbearing women around the world, whether working as autonomous practitioners or under the direction of an obstetrician. Limited data currently exist on the perspectives of midwives who provide care to childbearing women while they are in the process of seeking asylum. Such data are important to midwifery leaders, educators, and policy-makers. The aims of this study were to explore midwives' perceptions and experiences of providing care to women in the asylum process and to gain insight into how midwives can be equipped and supported to provide more effective care to this group in the future.

Methods: Data were collected via indepth unstructured interviews with a purposive sample of ten midwives from two sites, one a large urban inner city hospital, and the second, a smaller more rural maternity hospital. The interviews were audio-recorded and transcribed verbatim. The data were analyzed using content analysis.

Results: Five themes emerged from the data, barriers to communication, understanding cultural difference, challenges of caring for women who were unbooked, the emotional cost of caring, and structural barriers to effective care.

Conclusion: Findings highlight a need to focus on support and education for midwives, improved maternity services for immigrant women, and urgent policy revision.

Keywords: midwives, maternity care provision, Ireland, refugees, asylum process

Introduction

This paper reports the findings of a qualitative study exploring Irish midwives' experiences of providing maternity care to women seeking asylum in Ireland. The data are a subset from a larger study that explored women's experiences of childbirth in Ireland while in the asylum process, the findings of which are published elsewhere.¹ Immigration and asylum seeking have been important social phenomena in Ireland since the mid 1990s. Prior to this, Ireland was a relatively homogenous nation with a poor history related to the treatment of immigrants,²⁻⁴ and has subsequently struggled to adapt to its new multicultural reality. Inward migration to Ireland was seen in unprecedented numbers from 1995 onward, peaking in 2002 with 11,634 applications for refugee status; figures have fallen steadily since then to 956 in 2012.⁵ However, asylum and immigration continue to be an issue of national and international relevance

Correspondence: Carolyn L Tobin
Department of Nursing, College of Health and Human Services, University of New Hampshire, 4 Library Way, Durham, NH 03824, USA
Tel +160 3862 4715
Email carolyn.tobin@unh.edu

as the numbers of displaced people worldwide continue to grow, reaching the highest level in 20 years at 45.2 million in 2012.⁶ Midwives provide the majority of care to childbearing women around the world, whether working as autonomous practitioners or under the direction of an obstetrician. Few data currently exist on the perspectives of midwives who provide care to childbearing women while they are in the process of seeking asylum. These data are important to midwifery leaders, educators, and policy makers as they provide insight into the specific needs of midwives and how they can be better equipped to provide effective care to this group of women. The purpose of this study was to explore midwives' perceptions and experiences of providing care to women in the asylum process, in order to gain insight into how midwives can be equipped and supported to provide more effective care to this group of women in the future.

The birth rate in Ireland recently reached its highest in over a decade with the total number of births in 2011 recorded as 74,377, which represents a 22% increase in that time.⁷ This increase has put persistent pressure on a maternity system that has been suffering from years of underfunding and inadequate staffing levels.^{8–10} Maternity care in Ireland is dominated by the medical model of care that results in a predominantly obstetrician-led, hospital-based model of care. However, midwives provide the majority of prenatal, intrapartum, and postnatal care to women under the obstetrician, who is the lead professional and assumes ultimate responsibility. While data on the number of births assisted by midwives in Ireland are not collated, it is common practice for the midwife to assist women with spontaneous vaginal births.

The increase in the birth rate, coupled with the new experience of catering to a larger immigrant population and new multicultural society has exposed the inadequacies of the current organization of maternity service. Ireland lags behind the rest of Europe in offering women choice in childbirth, and while change is slowly taking place with the introduction of community-based midwifery-led care, it is sporadic and inadequate to meet the demand for change.¹¹ Women coming from other countries to seek asylum in Ireland have a particular set of individualized needs requiring a maternity service that offers an approach to women that is caring, competent, individualized, and culturally sensitive.¹² However, this kind of service remains extremely limited in the current system.

Pre and post migratory stressors add to the challenges of providing effective care to this group of women, as their needs are complex and multifaceted.^{13,14} Childbirth can be a physically and emotionally challenging journey for many

women; for women who are pregnant and give birth while seeking asylum, these challenges can be complicated by psychological, social, and/or physical trauma.

The asylum process is lengthy and can take 2–7 years to complete.¹⁵ In Ireland, those seeking asylum are housed in government-funded accommodation centers. These centers are often geographically removed from the wider community, a situation that exacerbates social isolation and marginalization. While basic needs for food and shelter are provided and a weekly community welfare payment (of €19.10 per adult and €9.60 per child) is made, people in the asylum process are barred from paid employment and higher-level education, and this leads to increased frustration, isolation, and poverty. Pregnant women have free access to maternity care while in the asylum process and are usually referred to the nearest maternity hospital for antenatal and intrapartum care. Postnatal care is very limited in Ireland and is the remit of public health nurses, usually consisting of one or two postnatal visits.

The term “asylum seeker” is used to describe an individual who has entered a country to seek refugee status, and came into common use in the mid 1990s; however, it is a somewhat contested term.¹² This term carries with it connotations of the need to prove oneself a true refugee, which impacts negatively on society's view of those in the asylum process, and also on the perceptions of midwives and other providers who care for them.^{16,17} This has a detrimental effect on women's experiences, increasing stigma, fear, and marginalization.^{1,18}

Several studies have been undertaken related to the specific maternity care needs of refugee and asylum-seeking women in Ireland, and their findings have highlighted the lack of culturally sensitive care, poor communication, barriers to access to care, loneliness, isolation, and detrimental effects of living in direct provision on psychological well-being.^{1,12,13} These findings were also consistent with those of international studies.^{19–22}

An Irish study undertaken by Lyons et al¹³ used a grounded theory approach to explore “the experiences, understanding and perspectives of maternity service providers when working with ethnic minority women in the Dublin maternity services during 2002 and 2003”. The sample group included a variety of providers, including obstetricians, midwives, and nurse aides, and data were collected using a combination of 15 semistructured interviews and five focus groups. Four themes emerged from the study, ie, communication difficulties, knowledge and use of services, cultural differences, and “them and us”. These encompassed a

variety of issues, including inadequacy of interpreter services, childcare issues, coping with labor, identification as different, and racism. Lyons et al¹³ also found that ethnic minority women are expected to adapt to the system rather than the maternity services being responsive or adapting to the new multicultural population. These findings are supported by international literature highlighting the complexity of challenges for providers caring for immigrant women.

Of particular interest, O'Mahony and Donnelly^{23,24} found that the relationship women have with providers profoundly affects whether or not immigrant women seek help for mental health issues. This finding is relevant to the Irish context, given the barriers to midwife/client relationships that exist within a model that currently does not provide for any level of continuity of care.

Degni et al¹⁶ undertook a combination of individual interviews and focus groups with a total of 25 providers, including nurses, midwives, and obstetricians to explore communication and cultural issues in providing reproductive care to immigrant Somali women living in Finland. Degni et al explored the complex nature of communication and cultural problems, and found that cultural awareness and effective communication were enhanced with nurse midwives who engaged in interpersonal contacts and partnership building with Somali women in their care.

The current study contributes to the international discussion in highlighting the continued difficulties midwives experience in achieving effective communication, understanding difference, and coping with the emotional cost of caring within a hospital-based technological model of maternity care that militates against a quality maternity service based on partnership and continuity of care.

Materials and methods

A purposive sample of ten midwives was drawn from two sites, five from a large urban inner city hospital, and five from a smaller more rural maternity hospital, both on the east coast of Ireland. A purposive sample ensures participants have experience of providing care to women

in the asylum process, in order to provide insights into this experience. The two sites provided opportunity to gain insight into a wider variety of midwives' experiences as these sites catered for different groups of women in the asylum process. The urban site dealt more often with women who had just arrived and could be seen by midwives within hours or days of arrival, and the rural site was located near a well established accommodation center so women accessing care had been in the country longer, possibly for years, as they awaited a decision on their case. Both sites are teaching hospitals with similar birth rates in excess of 9,000 per year.

The sample was accessed in a variety of ways. Information packs describing the study were distributed by researchers to the two sites; the researchers then followed up with visits to the sites to hold information sessions about the study and to answer questions. Participants' years of experience ranged from one year (two interviews) to four midwives with more than 15 years of experience (Table 1).

Midwives' experience and expertise working with women in the asylum process varied. The number of years' experience as a midwife did not equate with experience in caring for non-Irish women or women in the asylum process because some midwives with many years' experience had little prior exposure to working with women from diverse cultures. Four had worked in other countries as midwives. Seven midwives had no knowledge of the difference between asylum seeker and refugee status. Six midwives had received no training in caring for women from different cultures. All of the participants were Caucasian, and nine of the ten were of Irish nationality (Table 1).

The majority of participants believed it would be very helpful to have continued training in how to care for women from different countries and cultures. All of the midwives said that they appreciated the opportunity to work with this group of women, and felt their professional and personal lives were enhanced by the experience. However, this may serve to highlight a lack of self-awareness and reflexivity on the part of some of the participants, given the level of difficulty

Table 1 Demographic characteristics of participants

Number of participants	1	2	3	4	5	6	7	8	9	10
Years licensed (n)	6–10	0–5	11–15	>16						
Had training in cultural awareness				4						
Had work experience in other countries				4						
Understood difference between asylum and refugee status			3							
Midwife ethnicity, White/Irish									9	
Midwife ethnicity, nonWhite/non-Irish	1									

they experienced in providing empathic care to these women as evidenced in their narratives. It may also be worth noting that this view might not hold true in a larger sample that is not self-selecting.

Data collection

Data were collected via indepth unstructured interviews; one open-ended question “Can you describe your experience of providing care to women who were in the asylum process?” was used to begin the interview. Interviews were audio-recorded with permission, and later transcribed verbatim. Interviews were held at a place convenient to participants, usually their home or in a private office provided at the hospital site. Time of interview ranged from 26 to 70 minutes. Informed consent was obtained from participants and participation was entirely voluntary. Ethical approval was granted from the relevant institutions. Informed consent, voluntary participation, and assurance of confidentiality were made explicit.

Data analysis

Data were analyzed using content analysis.²⁵ Content analysis is the analysis of narrative data to identify prominent themes and patterns of themes as they emerge from the data.²⁶ The analysis was undertaken by hand, and involved several readings of transcripts, followed by coding of data and grouping coded material based on shared content or concepts to identify common themes.

Limitations and trustworthiness of data

The findings of this small-scale, qualitative study cannot be generalized to the entire population; however they provide a valuable insight into midwives’ experiences and perceptions of their role in the provision of safe and effective care. Issues concerning trustworthiness of the data were ensured in several ways. Extensive field notes and reflective journals were kept, that provide an audit trail of decision-making and an aid for the qualitative researcher to deepen awareness of their own bias, reactions, and emotions to the data as they emerge. Clinical and peer supervision was used throughout the data collection process. Transcripts were also read in their entirety by a second researcher to confirm the themes that were identified and add to the validity of the findings.

Results

Five major themes emerged from the data. These were barriers to communication, understanding cultural difference, the challenges of caring for women who were unbooked, the

emotional cost of caring, and structural barriers to effective care. A schematic of emerging themes is provided in Figure 1.

Barriers to communication

Consistent with previous national and international studies, communication difficulties were viewed as a major barrier to effective care and a source of increased stress for midwives. Subthemes included language barriers, lack of access to trained interpreters, and gaining informed consent.

Language barriers

Language barriers were identified by all of the participants as a significant challenge to providing effective care. Only one of the midwives in the participant group was fluent in a language other than English. In the following excerpt, one midwife explained how she tried to communicate with a young woman who was in labor:

“It’s just, you try to do it visually, you know smile and reassure them, rub them, things like that, you know try to make them at ease, show them how to breathe, things like that ... she had no English at all and she was on her own, very young, 17 year old girl ... she didn’t know what was going on, you know and she was in pain, you know she did okay, we got through it and that but I just remember thinking oh this is just horrible”.

Language barriers were a cause of concern to participants for a variety of reasons. Some participants were concerned about the impact of language barriers on gaining informed consent and felt it was more difficult to make emotional connections with the women or to build relationships and trust when spoken communication was difficult. Other participants focused more on the impact of language barriers on themselves, expressing frustration at the increased time and perceived extra workload this caused them.

Access to interpreters

Language barriers have been cited in numerous studies as a barrier to effective care; however, despite existing evidence, lack of access to trained interpreters continues to be a problem. Participants expressed frustration and concern at not having 24-hour access to translators or interpreters because these were an expensive resource. Hospital translators were often difficult to access in person or by phone, especially out of normal working hours. The difficulties accessing translators resulted in midwives using the woman’s husband,

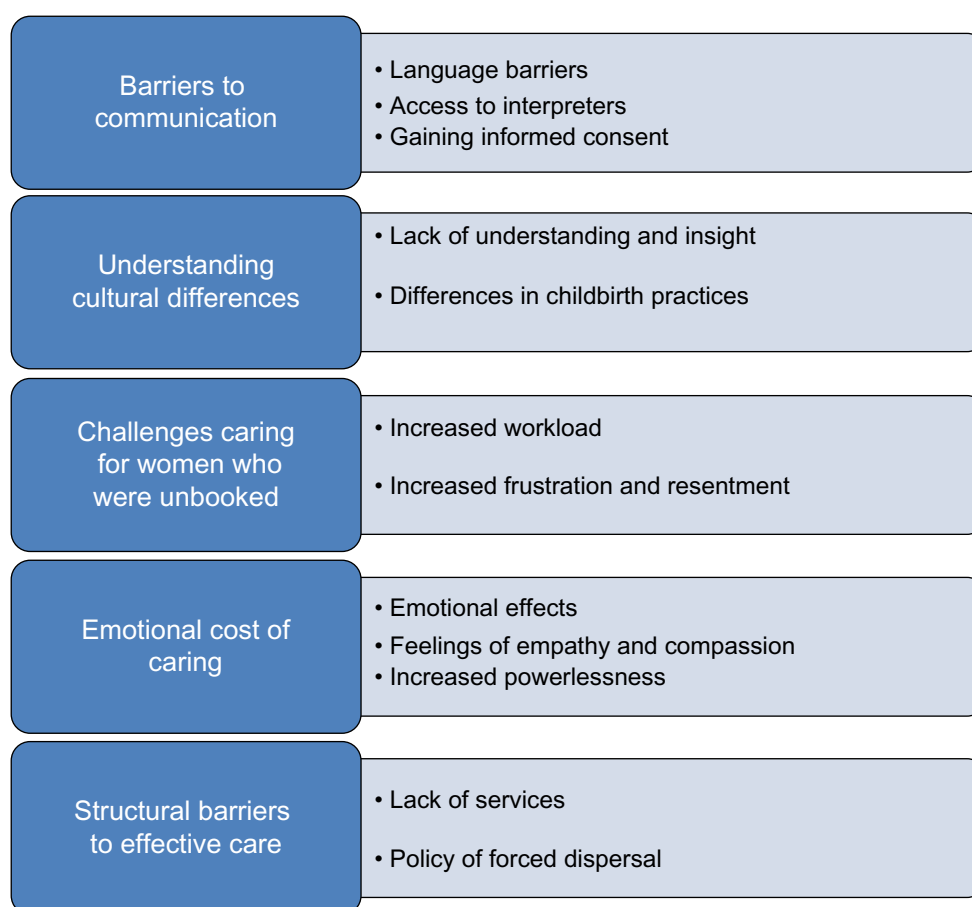


Figure 1 Schematic of emerging themes.

friend, or child to translate, a practice that has been criticized in the existing literature as being detrimental to maintaining confidentiality and the woman's safety.^{13,21,27}

Participants sometimes questioned the medical knowledge of the translator and therefore the accuracy and completeness of the information received. Participants were also aware that the interpreter service was expensive and appeared consequently to ration the service. They were also aware of the inadequacies of the service and the possible ethical implications of using family members to translate:

"Our [translation] service is a phone call, a three-way phone call which we do at the desk and that is €50 or €60 a call so it's quite expensive and we find it's not really worth it. So sometimes what we were doing was say your husband spoke English, well we'd ask him to help us ... then we were kind of finding some of the things were a bit personal and it really wasn't that suitable and ... we were kind of a bit dubious then thinking maybe that really isn't very ethical, you know to go that route."

However, it was common practice to use whomever could be found. On more than one occasion, midwives from one site spoke of using a hospital porter to translate.

Informed consent

Participants expressed concern over the impact of language barriers on gaining informed consent and on teaching and education. It appeared common practice for midwives to use hand signals for demonstrating postpartum and newborn care, making it difficult to establish how much the women understood and impossible to evaluate the effectiveness of their teaching. Leaflets were sometimes available; however, they were also suboptimal because they were not available in every language and some woman may have experienced literacy issues.

Understanding cultural difference

The concept of "cultural difference" emerged as a strong theme in the midwives' experience, and appeared to cluster around three subthemes. These were lack of understanding

and insight, differences in childbirth practices, and caring for women who were unbooked.

Lack of understanding and insight

The provision of culturally competent care is a multifaceted concept that encompasses not just factual knowledge of the customs, language and social norms of another culture, but also a level of reflection, self-awareness, and cultural humility on the part of the provider. Cultural competence education that does not incorporate these essential elements has been criticized in the literature as perpetuating cultural stereotypes.^{28–30} Four of the participants had varying levels of training and six midwives had no education or training in providing culturally competent care. While the women in their care came from a number of different countries, including Nigeria, Cameroon, Burundi, South Africa, Sierra Leone, Zimbabwe, Iran, and Iraq, it appeared that they were viewed by some midwives as a homogenous group with the same needs. Lack of understanding and insight resulted in objectification of the women as “other” or different to themselves, and this led in some instances to ignorance, bigotry, and stigmatization of the women in their care. The following example illustrates how one midwife conceptualized difference:

“[They are] you know very different and their cultures were very different than ours. Some cultures, lazy we would have found, they thought we were nearly like maids”.

The following excerpt illustrates another midwife’s deep level of ignorance and lack of insight into the lives of women seeking asylum. This was apparent in the expectation that a woman newly arrived and seeking asylum should understand the system as well as any Irish woman:

“But you might kind of say well why didn’t you go to a doctor, you kind of question them, you know what I mean, but no more than if it was an Irish woman, I’d say well do you not realize the importance of antenatal care, I would be the same, I would get a bit annoyed but I would be the same if there was an Irish woman, you know, because like you just don’t know, if they’re high risk and they are HIV-positive ... and I suppose I’m being a little bit racist or whatever”.

Differences in childbirth practices

Many of the women coming to Ireland were unfamiliar with the medicalized model of childbirth that predominates in Ireland, choosing instead to be much more active in labor and preferring little intervention. The fact that the women

labored differently was a source of intrigue, particularly for those midwives who had no prior experience working in nonmedicalized environments. Women who resisted medical interventions and chose to give birth naturally without pain medication caused varying reactions among the midwives. One midwife recalled:

“Yeah I mean these women were not going to stay in the bed, they were going to get off the bed and they were going to take off their monitors, and for a lot of people that was hard to take, but in the end it became the norm. And they would walk around the labor ward, that was the other thing too, you’d be walking around during the labor, and they wanted you to walk with them. They very much benefit from it, they showed very clearly how important being with the woman is, do you know what I mean?”.

Breast-feeding was another significant issue for the midwives in this study. There appeared to be a predisposition towards considering African women as “wonderful breast feeders”, which had a detrimental impact on African women who have difficulty and needed breast-feeding support.³¹ They were also disapproving if women chose to mix feed. However, one midwife suggested that Ireland is not a breast-feeding friendly nation, nor is there social support for breast-feeding mothers, making bottle-feeding a difficult option to resist.

Challenges of caring for unbooked women

Caring for women who were unbooked, ie, women who presented for emergency care without prior registration at the hospital, was something every participant referred to. Women who presented in labor or with complications and were not registered for care at the hospital were a particular source of concern and frustration. The subthemes that emerged related to this included increased workload and increased frustration and resentment.

Increased workload

Participants reported that not having access to any medical or obstetric history for the women resulted in the midwife spending more time trying to locate interpreters, taking bloods and waiting for results, and taking the woman’s history. Some midwives expressed fear of cross-infection because the women had not yet had blood screening. The combined impact of ignorance, fear and increased workload sometimes resulted in frustration and resentment.

Increased frustration and resentment

Some participants expressed feelings of frustration and resentment toward these women because of the added burden they perceived them to be. Some participants also appeared to have insight into the detrimental impact of this on how the women related to them. They described how the women often perceived the frustration and resentment they felt, and this compromised the midwife's ability to develop a relationship with them. Midwives also referred to witnessing racism among other staff, but only acknowledged feelings of racism in themselves in more oblique ways, for example, noticing tension or exasperation when women did not come for antenatal care, or were unbooked. The following excerpt is an example of how one participant referred to racism and demonstrates a level of ambivalence in how she both recognized and minimized the issue:

"I think you get, that's where you get a little bit of your racism sort of coming in then, and you know just not even racism, but just what are they doing here. And that's why I feel if there was some sort of study day, just to fill people in, we've had asylum seekers in who have had horrific things done to them, you know in their own home countries and we can physically see that."

Midwives who coped better with the additional pressures appeared to be those with a special interest in working with women from other cultures, those who had more experience in caring for women in the asylum process, and those with a greater understanding of the difficult and dehumanizing circumstances such women dealt with and endured.

Emotional cost of caring

The extent of the trauma that the women had experienced, along with physical evidence of abuse, appeared to affect midwives in a variety of ways, evoking three main responses. These can be described as the emotional effects of working with traumatized women, feelings of empathy and compassion, and feelings of powerlessness. While Irish midwives had experience in caring for indigenous Irish women with traumatic histories or lack of social support, the multiplicity of the trauma that these new immigrants had experienced and were still experiencing within the asylum process appeared to impact the midwives who cared for them. Their lack of experience in caring for women with such complex needs including multiple layers of loss, loneliness, and isolation, their lack of training in the specific needs of childbearing women in the asylum process, and the apparent

lack of institutional support all contributed to varying feelings of powerlessness on the part of the midwives themselves.

Emotional effects

The emotional effects ranged from feelings of sadness for specific women to worry and concern for these women long after the midwives' working hours had ended. Midwives spoke of the emotional impact of working with women with trauma histories:

"How does it affect me, you just feel sad you know, but you just do the best that you can and that's all you can do".

Many were unprepared for the impact that working with traumatized women would have on them, as this became part of their daily scope of practice. The trauma that women in their care had experienced ranged from pregnancy resulting from rape, witnessing the slaughter of their parents, husband, or child, the experience and consequences of female genital mutilation, and physical abuse.

Feelings of empathy and compassion

The emotional impact the midwives experienced also led in some instances to an increase in empathy and compassion for the women as they began to hear individual women's stories. Some participants formed friendships with these women, and remained in contact with them after discharge. While the stories were overwhelming for some, it was the power of the women's stories that helped midwives to see the women as real people with real lives, and as women just like them.

"I said, my God, she went from a proper life, like we all have".

Perhaps a positive aspect of the emotional impact of caring for traumatized women was that the participants in our study expressed compassion for women in these situations and felt that they could communicate compassion and empathy regardless of language and cultural barriers.

Increased powerlessness

Participants also spoke of feelings of powerlessness in the face of the multiple needs of women who had been uprooted from their lives at a time when they most needed the support of close family and friends. While some were overwhelmed by the stories of suffering, it appeared that the midwives did not have anywhere to take their pain. Others simply tried to avoid hearing traumatic stories when

they were unsure how to cope, either for themselves or the women in their care.

“Sometimes, not always, you wouldn’t look for it too much either because, I don’t know, but if you try to talk to them about that you have to be able to offer them counseling or something like ...”

Structural barriers to effective care

Concordant with the mixed feelings of compassion and resentment that participants expressed was the powerlessness of their position to address the multiple problems the women faced. Two subthemes emerged here, ie, lack of adequate services and the impact of the government policy of forced dispersal.

Lack of adequate services

Some participants were acutely aware of the barriers to effective care that lack of services within the current maternity service had on these deeply vulnerable women. Services such as psychiatric care or counseling were often not available outside the greater Dublin area. Those participants who had extensive experience of caring for women in the asylum process were also aware of lack of access to prenatal care and parenting education as an issue of concern.

Policy of forced dispersal

Due to the government’s policy of forced dispersal, women were often moved to an entirely different part of the country, sometimes in the middle of treatment or within days of being discharged from hospital, losing one of their most important connections at a critical time in their lives. Women received very little notice before being moved, resulting in long delays while they waited for transfer of care to be achieved. One midwife described the impact on the women and the providers:

“Women that were maybe high risk would be transferring to other parts of the country, so when their babies were born there was no neonatal services available to them and they’d have to be transferred back up into Dublin or Cork or wherever the main centers would be so it was absolutely crazy from every perspective”.

Discussion

The findings of this study provide further evidence in a now growing body of Irish and international literature that highlights the complex needs of immigrant women, and in particular vulnerable groups such as those seeking asylum. Specifically, this study explored the experiences of midwives

who provide front-line care to these women during childbirth, and provides some insights into the specific challenges they perceive and how these might be addressed.

Midwives expressed overarching concerns related to the effects of poor communication, including language difficulties, availability and access to appropriate interpreter services, and the detrimental effects these issues have on the health and well-being of women in the asylum process, these findings resonate with previous national and international work.^{12,20,21,32–37}

Good communication is central to the provision of safe and effective maternity care, yet women in nonWhite ethnic minority groups continue to die in greater numbers from childbirth-related conditions. The latest report from the UK Confidential Enquiries into Maternal Deaths²⁷ revealed that 31% of direct and indirect maternal deaths occurred in non-White ethnic minority groups. Lack of access to prenatal care, late booking, and language were key issues in these deaths, and failure to use professional interpreter services was a recurrent theme through every chapter of the report. Recommendations included the provision of appropriate interpreter services given that the use of family members or friends can compromise confidentiality or cover up circumstances of domestic abuse. Access to multiple methods of communication, such as use of posters, leaflets, drawings/diagrams, video clips, DVDs in a variety of languages, as well as access to interpreters was a recommendation of the National Collaborating Centre for Women and Children’s Health³⁸ as a means of improving communication with non-English speaking women.

Late booking was also considered a major factor in poorer birth outcomes for women seeking asylum in the latest Centre for Maternal and Child Enquiries²⁷ report, with exponentially higher rates of late booking (>22 weeks) seen in nonWhite immigrant populations. These findings support work carried out in a North London hospital with a sample of 91 unbooked mothers. Unbooked women were more likely to be young, single, non-English speaking, and more at risk of adverse fetal and maternal outcomes than booked women.³⁹ Several international studies recommend tailored programs for antenatal care and education to increase accessibility of these services for vulnerable populations.^{19,39–41}

The frustrations and concerns described by midwives related to the current provision of services to pregnant women in the asylum process are concerning and identify significant issues of access and continuity of care for this group. Poor organization of referral systems and the government policy of forced dispersal for pregnant women and those who are receiving ongoing care following childbirth are issues of

concern. The policy of forced dispersal whereby a woman can be moved across the country with as little as one day's notice has been shown to have a detrimental effect on the health and well-being of those in the asylum process.

These issues are still a matter of urgent concern for countries like the UK and the USA, which have been dealing with the challenges of integration and provision of culturally competent care for many decades. Countries like Ireland have an opportunity to learn from their mistakes and put adequate services in place as a matter of priority. Examples of good practice include individualized outreach programs and gateway services tailored to increasing access to services, helping new migrants learn how to navigate health services, and providing training in cultural competence for midwives and other health providers.²² However, Ireland has yet to develop a viable community-based maternity service that is crucial to providing continuity of care for childbearing women. For women in the asylum process, having access to dedicated community-based services would begin to address the problems of access, late booking, and development of midwife/client relationships which in turn would help to decrease fear and anxiety for both the women themselves and the midwives who care for them.

The impact of increased workload, stress, frustration, resentment, and racism has been studied less, but is supported by the findings of an earlier Irish study by Lyons et al¹³ who undertook focus groups with a variety of maternity care providers in Ireland, including doctors, midwives and nurse aides. Lyons et al found poor communication, lack of access to interpreters, lack of cultural competence, increased stress, and references to racism in their sample of 15 focus groups and five individual interviews. However, work undertaken by O'Mahony et al,^{23,42} Hunter et al,⁴³ and Degni et al¹⁶ suggest that the midwife/mother relationship may be key to addressing levels of stress, frustration, and burnout in midwives and provision of effective care to immigrant women. In a study of health care providers' perspectives of gender influences on immigrant women's mental health care experiences, O'Mahony et al²³ found that one of the key factors in efficacy of care was the quality of the relationship the immigrant women felt they had with providers, where "the relationship with women had profound effects on whether or not immigrant women seek help". Hunter et al⁴³ argue that the quality of relationships midwives have with the women in their care is fundamental to the quality of the maternity care they provide. However, quality relationships cannot be built in where maternity care is organized in an industrialized model with no opportunity for continuity of carers. Within

this model, midwives are themselves marginalized and disempowered because they are unable to meet the complex needs of the women in their care.

While cultural awareness and cultural competence have been part of the Irish midwifery education curriculum since 2005, the quality and content of this education is unknown. It is crucial that cultural competence training is not restricted to knowledge of facts about other cultures that can result in further objectification and stigmatization, but rather that the focus is on developing an understanding of diversity and recognition of the multiplicity of issues that contribute to our understanding of culture. Perhaps when considering how best to educate midwives to provide culturally competent care, the most important focus should be on using what Clark et al³⁰ refer to as a framework of cultural humility. Such training focuses on developing sufficient self-awareness to allow for effective communication where providers are fully attentive to women's beliefs, fears, and goals, and are respectful of these, ie, listening to women rather than telling them what they need.

The impact of working with traumatized women on the midwives who care for them has not been widely studied. However, one study undertaken in Switzerland with staff who provide reproductive health care to women seeking asylum found similar emotional effects of caring for traumatized patients along with subsequent increased stress, that "sometimes resulted in the projection of negative feelings on to asylum seekers".¹⁴ The importance of providing continuing education and support to midwives is central to the provision of effective care. Unlike in the UK and other European countries, hospital-based Irish midwives do not have access to a formal system of clinical supervision. Debriefing and other individual and group supports are at the discretion of the individual institution. There is an urgent need for increased clinical support for midwives who care for traumatized women. Access to continuing education is also essential, along with debriefing and clinical supervision in order to maintain providers' own health and well-being.

Conclusion

This study explored midwives' experiences of providing care to women while in the asylum process. The findings highlight a number of concerns that require urgent consideration at legislative, policy, and practice levels. The current situation of ineffective communication and inadequate 24-hour access to properly trained interpreters is clearly untenable and requires immediate attention, whereby this service becomes embedded within hospital policy as a minimum mandatory requirement. The need for continued high quality in-service education in

cultural competency is also a basic minimum requirement that is essential to the provision of safe and effective care to non-Irish women, particularly women in the asylum process who may have experienced severe pre and post migratory stressors. In order to address access issues concerning antepartum care and the educational needs of non-Irish women in the asylum process, international best practice recommendations support the need for dedicated community-based services that provide the possibility of continuity of care, make access to care easier for women, and provide the possibility of good midwife/client relationships and trust building.

Revision of the government policy of forced dispersal for women in the asylum process who are pregnant or in the early postpartum period is urgently needed. Women who have ongoing health issues or who have infants requiring specialist follow-up should also be exempt from forced dispersal. This inhumane policy has been widely criticized and shown to be costly and detrimental to health and psychological well-being.

Recommendations for future research

The findings of this qualitative study suggest the need for a larger more comprehensive study of midwives' attitudes to the provision of care to non-Irish ethnic minority women in Ireland. Nationwide evaluation of cultural competency education and training in Ireland would provide much needed data on what is currently being offered, both as part of the midwifery education curriculum and in hospital-based in-service training.

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