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A *"better service"* promoting *"better experiences"*: Midwives' experiences working in a caseload service for women of refugee backgrounds

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ABSTRACT

Background: Women of refugee backgrounds living in high-income countries experience health inequities. One contributing factor is maternity services that are unresponsive to their particular needs. In 2016, after a service evaluation identified significant issues, an Australian tertiary hospital redesigned a service for women of refugee backgrounds by incorporating continuity of midwifery carer with 24/7 phone access to midwives and interpreters. Midwives provided group antenatal care at a community venue with an onsite social worker, interpreters, and postnatal care at home. There is a dearth of literature describing midwives' experiences of working in such services.

Aim: To explore and describe midwives' experiences and perceptions of working at a dedicated Refugee Caseload Midwifery Group Practice service (RMGP).

Methods: One focus group and five one-on-one online interviews were conducted between 12 and 30 July 2021 with eight midwives working, or previously working, at the service. Reflexive thematic analysis interpreted midwives' work perspectives and experiences.

Findings: Themes included 1) Accessible and responsive care, 2) Understanding and valuing women's needs, and 3) Strong partnerships. Our findings suggest that the RMGP service promoted equity-oriented care by contextually tailoring care to meet women's cultural and logistical needs. The service components were responsive to women's needs, promoting easier access to care. However, midwives lacked adequate support to provide trauma-informed care.

Conclusion: The RMGP service promotes accessible care and is an excellent example of a service that provides equity-oriented care for women of refugee backgrounds. Effective training in trauma-informed care will enhance midwives' provision of quality care.

1. Introduction

Women of refugee backgrounds residing in high-income countries experience poorer perinatal outcomes when compared with women born in host countries [1,2]. Despite accessing better services in high-income countries, women have a higher risk of stillbirths, low birth weight babies (<2 500 g), maternal deaths, and postpartum haemorrhage [3,4]. The inequitable perinatal outcomes are often associated with women's unmet medical, psychological, and sociocultural needs and access issues. This is likely to be influenced by the intersectionality of complex factors like refugee status, social disadvantage, race, and service organisation favouring dominant norms, resulting in poorer outcomes [5–7]. Women often miss care because services are inaccessible, such as being far from their homes or having rigid appointments and operational times that clash with school drop-off and pick-up [8]. Notably, staff are often unfamiliar with the less common medical [9] and psychological [10] conditions that women present with and have been described as racist, unempathetic, and discriminatory [5], which could deter women from accessing care. Furthermore, communication barriers and staff's unfamiliarity with women's cultural practices [11,12] promote culturally unsafe care, a critical deterrent to women accessing care. Reduced access to care contributes to late detection of pregnancy complications, with consequential poor outcomes.

Inequitable outcomes for women from refugee backgrounds in high-income countries are described as "unjust and avoidable" because they are preventable [13]. Implementing services that promote equity-oriented care is critical for addressing health inequities [2]. Gilboe and colleagues [13], define equity-oriented care as safe and

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respectful health services that tailor care to fit populations' needs, priorities, history, and contexts. Equity-oriented care is a tri-dimensional framework prioritising contextually tailored care, culturally safe care, and trauma-informed care [13]. Therefore, to address inequities experienced by women of refugee backgrounds, respectful and culturally safe services [5,6], incorporating strategies to address women's access to care, communication, social, and cultural needs [6,7,14] are required. Caseload midwifery models, though known to improve health inequities, are rarely framed as equity-oriented care.

In 2016, an Australian tertiary hospital implemented an equity-oriented Refugee Midwifery Group Practice (RMGP) service. This paper reports on the third aspect of a mixed-method study evaluating the service's clinical impact [15], women's [16] and midwives' experiences. The paper reports on midwives' experiences and how they relate to equity-oriented care. Most women of refugee backgrounds in Australia receive standard care in public hospitals, where midwives and doctors work on a regular rotational shift basis. This means that women receive fragmented care because they are supported by different midwives or obstetricians in different areas and, sometimes, in a single episode of care. This contributes to the paucity of research on specialised caseload midwifery models, including their contribution to equity-oriented care.

2. Methodology

2.1. Study setting

We explored the experiences and perceptions of midwives who were working in, or who previously worked in, an RMGP service, operating from a large tertiary maternity hospital in Brisbane, Australia. The service is one of eight midwifery group practices (MGPs), with other specialised MGPs for First Nations women and young women under 25. The service was established using recommendations from an evaluation of a specialised refugee antenatal care service [8,17]. The service provides care to women from about 32 different countries and provides group antenatal care in the following cultural groups: Somali group, Sudanese/Arabic group, Rohingya/Burmese/Tamil/Dari group, Ethiopian/Eritrean group, and Swahili/Kirundi group. There is also a combined group for women with English language proficiency. At the time of data collection, there were four midwives working at the service. Table 1 describes the RMGP and standard care service components.

2.2. Participants

The service midwifery manager purposefully identified all eligible midwives (n = 8) who had worked at the RMGP service for three months or more since inception. Their contact details were shared with MD, who emailed each midwife notifying them about the study (Supplementary File 1) with an attached plain language statement (Supplementary File 2). All midwives agreed to participate and signed a consent form (Supplementary File 3). We excluded midwives who had worked less than three months due to limited exposure to the service.

2.3. Data collection

We initially aimed to collect all data using one-to-one face-to-face interviews. However, we modified our data collection method to include face-to-face focus group discussions and one-to-one online interviews due to COVID-19 restrictions. This necessary adaptation, which was endorsed by the service manager enabled researchers living in a different region to complete data collection. We conducted one face-to-face focus group discussion, but subsequently, COVID-19 boarder restrictions came into place, which required the remaining data to be collected using one-to-one online interviews. MD collected the data between 12 and 30 July 2021. An Interview Guide (Supplementary File 4) was used to explore access, continuity of care, education, social support, quality of interpreter services, cultural appropriateness, and

Table 1
Components of refugee midwifery group practice and standard care services.

Midwifery Group Practice service	Standard care services
Antenatal care	
Women are allocated by the liaison midwife at the tertiary hospital or self-refer to the RMGP. Midwives from the RMGP service then contact women by phone to explain the service, and this may require interpreter services. The primary midwife conducts the first face-to-face appointment at women's homes, meeting the women and their families. Subsequent antenatal care is received from a community-based location or, rarely, sometimes at home, depending on the woman's situation. Women receive group antenatal care, and midwives assess women who need one-to-one care or assessments in a separate room. Midwives are employed on an annualised salary and work in a group of 4 (Full-Time Equivalent) to support approximately 160 women annually. Each midwife is allocated four women per month (adjusted for part-time). If the woman's primary midwife is on annual or sick leave, has more than one woman in labour, or is scheduled off call, the backup midwife, whom the woman will know from group sessions, will be available. Women receive continuity of antenatal care and have 24/7 phone access to a known midwife available with interpreter services. Antenatal care and education are provided every two weeks in six different language-based groups, which are: Somali group, Sudanese Arabic group, Rohingya/Burmese/Tamil/Dari group, Ethiopian/Eritrean group, Swahili/Kirundi group, and English group. Groups usually comprise between four and ten women of different gestations, and sessions are scheduled for 90 minutes. All midwives participate in group sessions except when they are on leave, scheduled off call or are supporting labouring women.	Antenatal care may be received from a General Practitioner, hospital-based midwives or doctors, or the refugee antenatal clinic. Staff are paid based on shifts worked and rotate throughout the service on rosters, except in the refugee antenatal clinic, where there is a designated midwife. There is no formal continuity of antenatal care except in the refugee antenatal clinic. Women receive care from a rostered care provider and have no 24/7 phone access to a known care provider. Women receive one-to-one antenatal care with interpreters as required and education according to primary carer or hospital guidelines.
Labor and birth care	
Midwives provide birth care in birthing rooms at the hospital (no home or birth centre service is available). Women call their midwife when in early labour or during an emergency, then seek their own transport to the hospital, i.e., by ambulance or private vehicle. The woman's primary midwife, or backup if the primary midwife is unavailable, provides labour, birthing and early postnatal support.	Birth care is provided in a birthing room at the hospital (no home or birth centre service). Women call the hospital birthing suite in early labour, or during an emergency, then seek transport to the hospital, i.e., by ambulance or private transport. Birthing support is provided by a large roster of midwives and is likely to be by a midwife the woman has never met.
Postnatal care	
Postnatal care is provided in the woman's home by her primary midwife or backup (if the primary midwife is unavailable) for up to six weeks after birth as required. Women with booked social work appointments or those who have relocated to zones outside the service's catchment area receive postnatal care at the community location. There are no established postnatal groups at the service.	Postnatal visits or phone calls from a rostered community midwife are available for women who discharge before 48 h after vaginal birth and 72 h after caesarean section, usually for < 2 weeks.
Interpreting services	

(continued on next page)

Table 1 (*continued*)

Midwifery Group Practice service	Standard care services
Antenatal care	
Dedicated onsite trained interpreters work with midwives and women during group care and education sessions. All face-to-face interpreters who support midwives during group care are women. Face-face or phone interpreters are also accessed via the National Interpreting Services as needed. Three-way conversations between the woman, her midwife, and an interpreter are available 24/7 during the antenatal, intrapartum, and postnatal periods, including when care is provided in the women's homes. Often, there is a continuity of interpreters.	Face-face or phone interpreters are accessed via the National Interpreting Services as needed.
Cultural safety framework	
There are no specific formal cultural training sessions. The RMGP staff's ethos is openness to cross-cultural learning. Midwives seek cultural knowledge from the women and share the knowledge with each other. A senior midwife has been working in the RMGP since its inception and, before that, worked in the Refugee Antenatal Clinic. She provides support and mentoring to the other midwives and has extensive knowledge and experience working in this setting. The hospital offers general cultural education and training on how to work with interpreters, but the training is optional. Different organisations in Brisbane sometimes run cultural education sessions, but the training is optional.	There are no specific formal cultural training sessions specific to women from a refugee background. Frontline staff may seek out their own cultural training or clinical supervision. There are no cultural mentors for staff. The hospital offers general cultural education and training on how to work with interpreters. Different organisations in Brisbane sometimes run culturally appropriate education sessions but the training is not mandatory.
Holistic wrap-around services	
The group education aims to facilitate peer support for women from similar language groups with the aid of an interpreter. There is a female social worker onsite during antenatal group sessions. She is the main point of referral for any social/emotional support (e.g., family violence support, mental health support, English language support, settlement services, housing support services, and child health). There was continuity of social workers during the establishment of the service, but continuity has since declined. Other support services (e.g., psychologists) are accessible via the hospital referral system. A physiotherapist from the hospital visits the community venue every three months.	Women may be referred to allied health services (e.g., psychologist, social worker, diabetic educator) via the hospital or their General Practitioner. A social worker services the refugee antenatal clinic and is the main point of referral for any social/emotional supports, referring as required.
Coordinated care integrating primary health network with tertiary services	
An MGP Manager oversees the services' resource requirements, including eight other MGP services. Midwives share accountability and responsibility, and the team meets weekly to discuss coordination and day-to-day successes and challenges experienced by each midwife. The RMGP midwives often troubleshoot with each other, the manager, and a specialist in obstetrics and gynaecologists at the hospital. Referrals are sent to community support agencies as required (e.g., family violence support, mental health support, English language support, settlement services, housing support services, and child health). Midwives refer women with complex medical conditions to doctors with consultations undertaken via telehealth or sometimes face-to-face at the tertiary hospital. Midwives are always present during women's consultations.	Electronic or postal referrals and discharge summaries are the main sources of communication between maternity carers and other support services (hospital, General Practitioners, and Child Health. Referrals to community support agencies as required.

safety. Participants chose interview dates and times and the focus group location. Online interviews were conducted and digitally recorded using Microsoft Teams and lasted 60 −75 minutes. The focus group discussion was audio-recorded and lasted 120 minutes. All data were de-identified during transcription and stored in password-protected files accessible only to the research team to protect participants' privacy and confidentiality.

2.4. Data analysis

We used reflexive thematic analysis to interpret midwives' experiences [18,19]. Constructionism, which aligns with reflexive thematic analysis and our belief that as researchers, we actively participate in knowledge generation [18–20], underpinned our analysis. We constructed latent themes using predominantly inductive data coding [19]. MD reiteratively read transcripts, performed coding, and generated initial themes. AB and SI read the transcripts and reviewed and refined themes to enhance richer meanings [21,22]. We continuously evaluated our values, assumptions, and beliefs and engaged in team-based reflections and writing to develop nuanced interpretations and findings [23].

2.5. Reflexivity

All members of the research team are experienced midwives except YG, who has a clinician obstetrician background. SK, SI, and AB are experienced qualitative midwifery researchers. MD is a migrant and bilingual African research student, and midwifery academic. SK led the previous evaluation of the Refugee Antenatal Service and was involved in the planning and implementation of the RMGP service and this evaluation. YG is an Asian medical professional and quantitative researcher. Our combined midwifery care and research expertise, alongside our knowledge of the service, likely promoted meaningful interpretations of midwives' experiences related to midwifery practice.

3. Findings

We interviewed a total of eight midwives: one-to-one (n = 5) and focus group discussion (n = 3). The midwives included one midwifery manager, four current employees, and three previous employees (two terminated work due to contract expiration and one to set up a new caseload service). Table 2 summarises participant details.

We generated three themes: 1) Understanding and valuing women's needs, 2) Accessible and responsive care, and 3) Strong partnerships (Fig. 1). Pseudonyms are used but not linked to Table 2 to ensure participants' privacy and confidentiality protection.

3.1. Theme 1. Accessible and responsive care

All midwives described the RMGP service as a responsive service compared to standard care because it promoted easy access to care and midwives adapted care to meet women's needs.

Table 2
Participant details.

Midwife	Number of years worked as a midwife	Number of years worked at RMGP	Working at RMGP at the time of interviews	Experience working in other MGP services
1	3.5 years	2.5 years	No	No
2	1.5 years	0.5 years	Yes	No
3	13 years	5.0 years	No	Yes (4 years)
4	6.5 years	2.5 years	Yes	Yes (3 years)
5	38 years	5.5 years	Yes	Yes (9 years)
6	4 years	2.5 years	Yes	No
7	31 years	5.5 years	Yes	No
8	2 years	2.0 years	No	Yes (4 months)

3.2. Accessible care

Rather than a hospital setting, antenatal care was provided primarily at a community location with on-site access to a social worker and 24/7 phone access to midwives and interpreters. Midwives perceived this as improving women's access to care and reducing women's healthcare-related costs when compared to receiving care at the hospital. One midwife explained:

> Transport and car park costs can be prohibitive… a lot of our women live at least forty minutes bus ride away from the hospital, it's eighteen or twenty-five dollars for the parking. The fact that we're in their community and have free parking is a really good benefit (Jane).

The service had an onsite social worker present during scheduled group antenatal care sessions. Midwives perceived the easy accessibility of social workers as facilitating quicker resolution of women's social issues:

> On clinic days, she [social worker] might see sort of three or four women. Sometimes, she'll also invite women to the clinic who don't have a midwifery appointment but do need to be seen by a social worker. Many women who have needed social work help have accessed it because it's convenient (Sally).

Implementing 24-hour mobile phone midwifery access for women of refugee backgrounds can be challenging due to their limited English proficiency. However, midwives described successfully using mobile phones with women and interpreters to ensure effective cross-cultural communication. They valued mobile phone use for improving women's access to midwives:

> If they've [women] got issues… It's easy to just pick up the phone and call your midwife (Sally).

> We often tell the mother to just call us. If they want to, they can just simply say interpreter, and we will understand and call them back with an interpreter (Julie).

3.3. Adapting care to meet women's needs

Midwives described different ways they used to adapt care to meet women's needs rather than *'women fitting into organisational requirements.'* Care adaptation included providing care for late attendees, home-based antenatal care for women who could not attend the community clinic and adjusting antenatal and postnatal care schedules when necessary. The service also had an early discharge from the hospital (four hours after birth) preference for healthy women (and babies) who opted to return home to care for their other children. As these midwives explained:

> Even if they [women] came late, we could still have that consult and time with them… because the concept of time, I feel, is more of a Western way…, whereas women of a refugee background maybe are not so specific in keeping time (Jas).

> Adapting that care to suit individuals… If mums are struggling to attend the clinic… it might be that you need to do a home visit… so that's really around working with women's needs (Suzie).

> We can discharge at four if they're very autonomous (Julie).

3.4. Theme 2. Understanding and valuing women's needs

All midwives demonstrated familiarity with the women they cared for. They adeptly described women's complex situations and strengths. However, many midwives suggested further training could improve their responsiveness to women. Overall, they unanimously felt that they understood and supported women better than hospital staff:

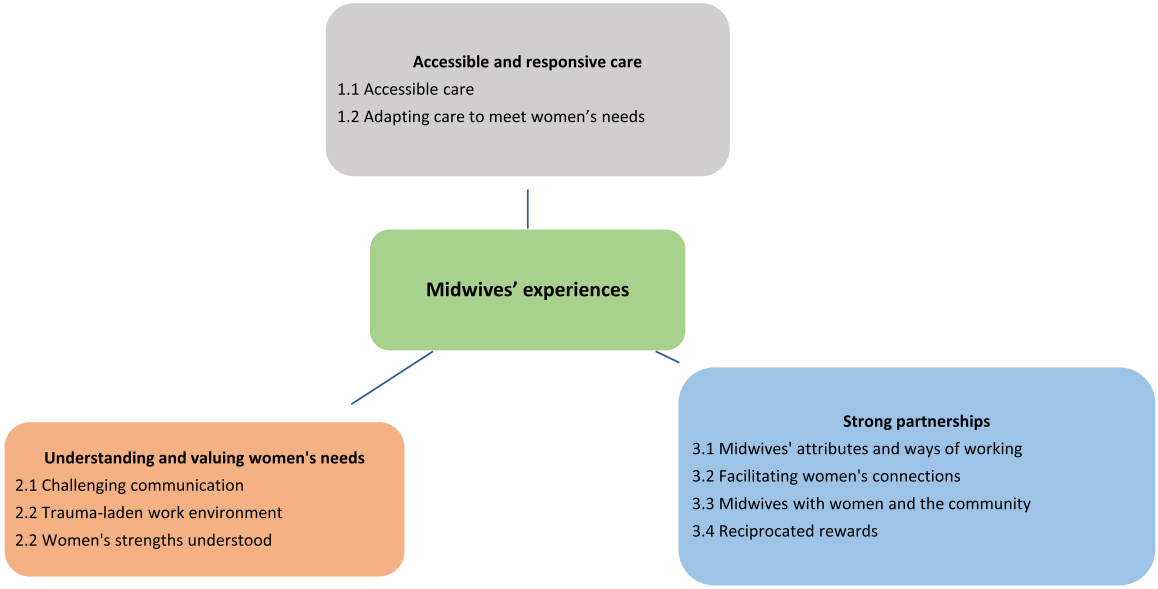


Fig. 1. Theme summary.

Having midwives with a deeper understanding of women's issues has helped women to get better support (Suzie).

When women have RMGP care [they] are receiving care from midwives who are aware and prepared to support them in their unique way, whereas, when they're going through the hospital system, midwives don't understand (Jane).

3.5. Challenging communication

All the midwives interviewed described women as often presenting with *'unique challenges'* or *'complexities.'* In the context of providing midwifery care, they described communication as a *'big thing'* due to language differences. Midwives explained numerous strategies they use to promote effective communication such as avoiding medical jargon, modifying speech tone and speed, and simplifying information. They explained these strategies were used to try and facilitate respectful communication and ensure women's understanding of information:

Speaking slowly; well-constructed sentences that use good English and no jargon… because their health literacy is low… We need to speak in such a way that it sounds like it's a normal tone, and not broken English, or pidgin English, or loudly – because they are not deaf (Julie).

Midwives understood the increased risk of miscommunication when working with women who were not fluent in English. They assessed each woman's English language proficiency at initial contact to ensure that they arranged interpreters as necessary:

We would go through the referrals and I would engage by calling the women up, and when I'd call them, I would ask, "Do you need an interpreter?" (Sally).

They valued interpreters for promoting and facilitating improved communication, and many saw this as also important to developing therapeutic connections with women. These midwives had normalised working with interpreters in their practice but described it as adding complexity because they could not verify the accuracy of intercultural communication. They expressed mixed feelings about different interpreters, categorising them as either *'good'* or *'not so good.' 'Good'* interpreters facilitated '*culturally safe'* communication, while the *'not so good'* interpreters were perceived to alter the information by *'adding their spin.*'

Sometimes, we get interpreters; for example, we might have another family member sitting in the same area, and they have a decent grasp of English. After the end of the visit, they turn around and say what that interpreter was saying was not correct. By the same token, we also have some fantastic interpreters, and as soon as I hear their voice, I go, "Oh, thank goodness". I know that I'm going to be able to have a culturally safe conversation (Jane).

We find that sometimes, 'cause the husband, or someone in the room that we can't use, speaks English, and they will say – "They haven't said what you said" (Judy).

Although, for the most part, interpreters promoted effective communication, a few of the midwives interviewed described some negative impacts of working with Interpreters. This included needing to limit the volume of information shared and feeling distanced from the women, impacting their ability to develop therapeutic rapport.

Using an interpreter makes it difficult for me to build rapport … makes it difficult to get to know somebody beyond basic discussion (Sally).

3.6. Trauma-laden work environment

Midwives described caring for women experiencing trauma as common. Trauma experiences ranged from past war atrocities to sexual abuse, family violence, and mental health conditions. Though commonly experienced, midwives perceived these topics as taboo, which made discussions with women difficult and challenging. Midwife Julie articulated the sensitivity of discussing these issues, being a '*minefield*'. However, midwives felt that continuity of carer facilitated them to build trusting relationships, which promoted women's disclosure of sensitive information.

'I'm still blown away by the way women will open up… it's what happens when you have relational care, isn't it? It [relational care] helps develop a deeper trust and engagement with the midwife (Jas).

Supporting women through trauma impacted midwives. They unanimously perceived their work as complex and at times mentally and emotionally draining:

You have conversations in your head like, "Wow! This really happened today!" We have had complex – quite emotionally draining ones (Judy).

Midwives described feeling emotionally distressed by listening to women's traumatic stories and sometimes these involved women sharing stories of cultural practices such as female genital cutting:

Some days like, "S***! I've just heard about how someone remembers being held down and had her labia removed. Somebody's had their ribs broken by a man… War stories." You come home and go, " Okay, it's never going to be ordinary" (Julie).

Most midwives perceived the caseload of 40 women annually as manageable except for Judy, who perceived the caseload was heavy due to many women presenting with complex issues, suggesting a reduced caseload:

I found the caseload quite straightforward to run, and there's certainly times where you've got people with higher needs that you really are putting a lot more effort into their management, but then that is sort of counter-balanced by people that really have very low needs (Jas).

I think I can manage the caseload okay. Sometimes you feel a little bit tired, but those feelings don't often last for long (Jane).

Should we have the reduced load? In my experience, yes, because I do end up with many complex women – it's exhausting (Judy).

Despite working with women with complex needs, all midwives disclosed not receiving specific training to prepare them for working with women of refugee backgrounds. Rather, they self-sourced information from books, documentaries, online or face-to-face courses, and each other:

No training – no… I did a bit of my own research into the different groups that I'd be caring for and what some of their main issues were (Jane).

I don't feel like we specifically had training in how to work with women from a refugee background, it's more like on the job (Jas).

Midwives suggested professional and women-led education would better support them in their clinical practice. They recommended initial orientation and then ongoing professional development training. Worthy topics for education included women's cultural practices, trauma-informed care, recognising and talking about medical and mental health conditions, and domestic and family violence.

> Information about the unique health complications that women have would be helpful (Sally).

> It probably would be a good idea to do more formal training recognising domestic violence in linguistically and multi-culturally diverse settings (Jane).

3.7. Women's strengths understood

Midwives' practice was underpinned by a strengths-based approach. Midwives were eloquent in describing women's strengths which were evident in comments such as women *'trusted their bodies to birth*', had '*strong spiritual faith*,' '*intrinsic parenting knowledge,'* and *'community support.'*

Midwives viewed these factors as reducing their workload. For example, Jas described providing postnatal care in a *'superfluous'* way because most women possessed good parenting knowledge and skills and were well supported by their community. Midwives also valued the community for providing emotional support to women:

> …she's sitting back like a princess on her bed with her baby beside her. All the women are fawning over her and feeding her dates. Then it's time for the baby to breastfeed; somebody came and opened her dress and put the baby to her breast. It's like – Wow! The community is providing a lot of the emotional support that we may otherwise be providing… that load is lifted by the community stepping in (Judy).

Women's spirituality and trust in physiological birth were viewed as beneficial for reducing obstetric interventions:

> Many of these women have good faith in their bodies and a lot of women would choose not to have interventions (Suzie).

However, midwives explained how women's strengths often led to distress for hospital staff unfamiliar with the confidence shown by this group of women who had believed and trusted in their ability to give birth without interventions:

> This mum wants to just not be induced. She's happy to go two weeks over her due date and believes in her own body that everything is good… a lot of healthcare professionals get pretty freaked about that (Jas).

Midwives described how they advocated for women's wishes and spoke of respecting women's preferences even in situations perceived to be outside of hospital guidelines. Julie explained how she *'actively shut down judgmental conversations,'* advocating for a woman who declined a caesarean section for religious reasons:

> She had clearly explained what was important to her in her world. I said, "Actually, she's told us". This is not a frame of reference we can understand (Julie).

3.8. Theme 3. Strong partnerships

Midwives fostered and valued partnerships that promoted better care for women. They described having strong relationships with each other, the women, and the communities they served through community engagement. They also described how women connected and supported each other.

3.9. Midwives' attributes and ways of working

There was consensus across all interviews that working successfully in the RMGP required the *'right person'* and good teamwork. Midwives identified personal attributes that supported effective and sustainable work in this setting. This included *'passion,' 'open-mindedness,' 'compassion,' 'respect,' 'flexibility,' 'good communication,' 'strong,' 'commitment,' responsiveness*,' and *'advocacy'*.

Midwives who had worked in other caseload teams described the RMGP team as the '*most functional*' they had experienced due to the match of work ethics and commitment to teamwork. Midwives fostered collegiality and supportive partnerships by connecting and sharing information during group antenatal care sessions and weekly meetings. Online group chatting provided an additional platform for frequent team communication. Less experienced midwives reported feeling supported by experienced colleagues who provided mentorship, cultural knowledge, and guidance:

> … it was quite a jump for me working in a MGP Team… the team is very approachable, encouraging, enthusiastic and willing to help… we have a WhatsApp discussion group. So, we're always in contact with each other (Jane).

Midwives also valued each other's support after experiencing challenging experiences like poor perinatal outcomes:

> I want to pay credit to the team because someone will always say, "How you going? That must have been horrendous" (Mary).

3.10. Facilitating women's connections

Midwives valued and perceived group care as important for promoting connections, addressing women's isolation by providing space for women to share and foster a sense of belonging:

> Women get a sense of community and comradeship through coming together and getting to know each other. Especially the younger women, sort of being initiated into the group of women who have had babies before, which is really great (Judy).

Midwives acknowledged and described how many of their clients were also receiving support from other women of refugee backgrounds who were midwives in their country of origin. While these skilled women were not recognised or registered as midwives in Australia, their care was recognised by the families, and their support was evident to the RMGP midwives who described how many women independently sought labour home care by their "own" midwives and only presented to the hospital for imminent birth.

> She came at nine centimetres and pushed out the baby. When I asked her what was going on, she said, "Oh, Mum checked me and said, "Yeah, you're eight centimetres. You can go now" (Julie).

3.11. Midwives with women and the community

Midwives mostly worked *'in the community'* conducting postnatal and sometimes antenatal visits. They perceived they *'had become part of the communities*,' who *'had taken them in.'* Midwives described building strong connections with women, attributing the strong connections to continuity of carer. Connections were further enhanced when women returned for care during subsequent pregnancies, including midwives providing care for women's extended families:

> I became the midwife for all of her family. The daughters, the daughters-in-law, and their midwife for their next births. It was lovely (Jas).

Across all interviews, midwives described how accepting cultural foods and invitations to community events, including learning and using women's basic languages helped to build connections with women and their communities:

> You sit down, and you have to have three coffees or you're not a friend for life (Suzie).

It was a Somali group, and [midwife's name] said, "I'm [midwife's name], Umuliso, which is Somali for 'midwife.' Little things like that brought such warmth. Women loved that we used their words (Julie).

Lastly, midwives acknowledged cultural safety as '*an essential aspect*' for promoting solid connections with women. They sought women's individual cultural preferences and continuously reflected on how their culture and power could create prejudices that could hinder forming strong connections with women:

It was always through asking, "Is this okay?" Isn't that whole basis of cultural awareness that you reflect on what your prejudices might be, based on your position in culture? I'm very aware that we're the dominant white, educated women (Mary).

3.12. Reciprocated rewards

All midwives felt that working with women promoted reciprocal rewards:

They [women] made such an impact on me, and I know I did on them (Suzie).

Midwives expressed heartfelt affection for working with women, describing their experience as *'fabulous,' 'enjoyable,' 'fascinating,' and 'lovable.'* They also perceived their work as greatly rewarding despite experiencing complex situations:

The challenges are so minor in the scheme of things, and the rewards are great (Sally).

Importantly, midwives described working with women of refugee background as *'never boring*' because of interacting with women from different countries. Sally equated her experience working with women from different ethnicities to '*travelling to Somalia, Sudan, and Ethiopia in a day,' 'colourful and interesting,'* helping her to experience different ways of knowing, being, and doing:

'We can have the same antenatal conversation with a Congolese woman, a Somali woman, an Ethiopian woman, and a Liberian woman. It's always going to be a different conversation because of the way they drive it. It's diversity in its best sense (Sally).

Working with women of refugee backgrounds broadened midwives' perspectives on the importance of family and helped them gain new parenting skills. Judy described her experience as:

…having a curtain pulled back on a new world. It's only made me a better person, opening my eyes to different views of the world and ways of making family work (Judy).

Importantly, midwives described feeling recognised, understood, and valued by women, which was deeply satisfying:

Our women value a midwife. They want a midwife. It's wonderful to work with a community of women who deeply value midwifery care. It's wonderful for us as professionals to be valued in that way (Sally).

Midwives described the RMGP as a *'better service'* promoting *'better experiences'* for women. They perceived women who received RMGP care as receiving better care, being involved in decision-making, and being effectively advocated for, and protected from *'harsh elements,' 'judgement,' 'racism,'* and *'unconscious bias'* from hospital staff than those receiving standard care.

4. Discussion

Our study successfully explored the experiences of midwives who worked at an RMGP service and gained insights into what works, why and how [24]. Our findings suggest that the RMGP is an excellent example of a service that provides equity-oriented care. We will further explore this using Ford-Gilboe and colleagues' dimensions of equity-oriented care [13] to better understand how the service achieved contextually tailored and culturally safe practice, despite shortcomings in promoting trauma-informed care.

4.1. Contextually tailored care

Reduced care access contributes to inequitable perinatal outcomes for women of refugee backgrounds. Tailoring care likely improves women's engagement [5–7] and promotes equity-oriented care [13]. The RMGP service addressed commonly reported barriers to care [5–7] by incorporating community-based group antenatal care, home-based postnatal care, onsite social work support, continuity of midwifery carer with 24-hour access to midwives and interpreters. Implementing the service using recommendations from women and staff from a previous evaluation [8] was critical for implementing a responsive service, proving that specialist services are superior [6,8,25] to standard care. We previously reported on the service's improved outcomes [15] and women's satisfaction with care [16]. The midwives' perception that community-based antenatal care and home-based postnatal care promoted easier access to care by reducing travel and parking are congruent with what women who used the RMGP service reported [16], and aligns with research recommendations to re-design services using women and care provider feedback [6,25,26].

Despite different stakeholders perceiving 24-hour access to midwives as difficult for women with limited English language proficiency, mobile phone communication between women and midwives was successfully integrated according to both the women [16] and midwives. The successful implementation was aided by integrating all-day access to phone interpreters as needed. Our study is the first to report successful implementation of mobile phone service in this population. Interpreters were also integrated into group antenatal care, which was made easier by delivering this service by language group. While midwives provide best practice insights into working with interpreters, including characteristics of *"good interpreters,"* they highlighted concerns regarding inconsistent messaging when working with interpreters. We suggest that the midwife-interpreter working relationship is a worthy area for further research.

The RMGP incorporates onsite social work services during group antenatal care and this is a useful strategy for addressing women's social issues in a timely manner [6]. Midwives' appreciation of onsite social workers complements service users' reports [16]. These positive experiences are contrary to the negative experiences reported by caseload midwives working with socially disadvantaged women without the support of onsite social workers [27]. This suggests that onsite social services can support midwives working with women of refugee backgrounds and contribute to job satisfaction.

In the previous evaluation of the service, lack of continuity of carer during labour, birth, and the postnatal period was identified as a significant cause of women's dissatisfaction with care [8]. Continuity of carer promoted midwives' understanding and advocacy for women's needs [28]. Choosing to return to the service for care in subsequent pregnancies was reported by both midwives and women themselves, which is suggestive of care satisfaction. Repeat attendance may also account for the high proportion of 81 % multiparous women in the service (n = 625) [15]. The increased proportion of multiparous women and community support possibly explain the surprising finding that a higher caseload of 40 women was described as manageable by most midwives. The hospital found that the caseload for MGPs for First Nations women needed to be reduced to 28–32 due to the complexity of the service [29] and this was also seen in the Young Women's MGP [30].

Lastly, rigid appointments are problematic for women of refugee background because they have other competing social responsibilities that prevent care attendance [6,31]. Group antenatal care, home-based care, and early postnatal discharge of healthy women and babies from

the hospital promoted the adaptation of care to meet women's needs, demonstrating equity-oriented care [13]. Notably, group antenatal care sessions were conveniently scheduled to afford women time to drop off and pick up their school-going children. Although not reported by participants in this evaluation, we suggest that convenient antenatal care scheduling likely ameliorated women's fears of breaching child protection rules, a concern that contributed to women's missed care in the previous evaluation [8]. Furthermore, midwives' perception that group care fostered social networks and peer learning was similarly reflected in views reported by women who attended the RMGP [16], and supported by another qualitative refugee group antenatal service study [25]. Migration causes women to lose family and social networks resulting in isolation [25] and related mental health conditions. We, therefore support Riggs and colleagues [25] in recommending group care as beneficial for protecting and promoting women's mental and emotional well-being.

4.2. Culturally safe care

Cultural safety will be strengthened when healthcare providers prioritise empowering individual or community cultural identities and well-being. To achieve cultural safety, health providers should critically reflect on their practice behaviours, attitudes, and power differentials to promote the provision of accessible, responsive, and safe care free of racism [32]. Care recipients are the only ones who can determine cultural safety [32]. RMGP service users reported feeling culturally safe, saying they felt "valued without discrimination" [16]. Midwives' determination to provide respectful, dignified, woman-centred care and prevent unconscious bias, discrimination, and racism demonstrates staff aiming to achieve equity-oriented practice [33].

Midwives demonstrated a commitment to provide culturally safe care through their openness to learn, respect, and facilitate women's cultural practices. Learning women's languages, participating in cultural or religious ceremonies, and eating cultural foods demonstrate midwives' willingness to respectfully engage with women and communities, which likely promoted therapeutic relationships with women and positively increased their cultural understanding. Having an increased understanding of women's culture possibly enhanced midwives' ability to respect and advocate for women's preferences for physiological birth even in situations contravening hospital guidelines. Home-based care and supporting women's extended families, increased midwives' engagement with communities. We plausibly attribute midwives' respectful attitude to their acceptance and being valued by women and communities. Feeling accepted and valued might be linked to midwives' job satisfaction and passion for their work [34]. The midwives' understanding, appreciation and acknowledgement of community resourcefulness, and the perception that women in the community were contributing to the provision of midwifery care when they supported each other during labour and the postnatal period, is rarely reported. The midwives' perception that women valued receiving labour care from other women in the community suggests a need for recruiting midwives from women's cultural backgrounds. Exploring strategies to identify and integrate women with midwifery qualifications from their countries of origin into the Australian maternity workforce, either as skilled midwives, doulas, or bi-cultural workers, could increase cultural diversity, a workforce that is reflective of the multicultural nature of maternity recipients and possibly improve cultural safety.

4.3. Trauma-informed care

Women of refugee backgrounds often have experienced or witnessed gross human rights violations in their war-torn countries or refugee camps [5–7], increasing their likelihood of experiencing trauma. Issues like unfamiliar health conditions, language barriers, disparate cultural values, and psychosocial conditions that are commonly experienced by women of refugee backgrounds [5–7] can create complex and challenging work environments for midwives. Additionally, care providers who work with populations who have experienced significant trauma can experience vicarious trauma, which is secondary traumatic stress caused by absorbing other people's pain [35,36]. These factors suggest that women from refugee backgrounds need to be supported by staff trained in trauma-informed care [13].

Trauma-informed care is a framework that underscores the need for service providers to fulfil the four "Rs" of trauma-informed care, which are realising that trauma is common, recognising the signs of trauma, responding to trauma using evidence-based strategies, and avoiding re-traumatisation of care recipients [37]. Midwives explicitly recognised that women experienced trauma. However, the lack of training in trauma-informed care disclosed by midwives is a common issue, similarly reported in an integrative literature review of trauma-informed care education for midwives [38], and is worrying. A deficit in trauma-informed care knowledge can affect the midwives' ability to effectively recognise signs of trauma, causing them to respond in ways that re-traumatise women. Midwives' perception that good teamwork, support and collegiality were helpful during difficult experiences and a driver for job satisfaction is common in caseload midwifery models [34]. However, the lack of explicit strategies for supporting midwives needs to be addressed. Like other researchers [35,39], we recommend effectively embedding and teaching trauma-informed care, reflective practice, and clinical supervision in pre- and post-midwifery graduate education to ensure adequate support for midwives working in trauma-prone environments.

5. Strengths and limitations

Our study is the first to explore the experiences of midwives working at a dedicated caseload midwifery service for women of refugee backgrounds. The corroboration of the experiences of the manager and midwives working or previously working at the service and using focus group discussions and one-on-one interviews likely contributed to rich data and stronger conclusions. We are also aware that though we undertook an inductive analysis of the data, our previous experience analysing women's experience of the care they received from the Refugee Midwifery service [16], may have influenced our interpretation of midwives' perceptions. We acknowledge that the relatively small number of participants might have impacted the diversity of views related to the RMGP. However, the participation of all eligible midwives provided valuable insights into the benefits and challenges of providing care at the service.

6. Conclusion

The RMGP service is an excellent example of a service that was redesigned to provide equity-oriented care for women of refugee backgrounds despite shortcomings in trauma-informed care. The service's key elements facilitated tailoring care to meet women's needs. Respecting and facilitating women's safe cultural practices promoted cultural safety. Midwives supporting women of refugee backgrounds require training in trauma-informed care and would benefit from regular reflective clinical supervision.

Statement of significance

Problem: There is a paucity of research on continuity of midwifery carer models and their contribution to health equity-oriented care for women of refugee backgrounds in high-income countries. The experiences of midwives who work in these models need exploring and reporting.

What is already known: Responsive maternity care models inclusive of continuity of midwifery carer are recommended for improving outcomes for women of refugee backgrounds.

What this paper adds: Our paper provides evidence that a maternity service for women from multiple refugee backgrounds, cultures, countries, and language groups was successfully implemented, met women's needs, and was acceptable to midwives. Accessible services and committed service providers are fundamental for promoting equity-oriented care for women of refugee backgrounds.

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Data availability: Primary data access requires approval by the author team, the Human Research Ethics Committee, and the Refugee Midwifery Group Practice service manager.

CRediT authorship contribution statement

MD: Conceptualisation, Methodology, Data collection, Analysis, Writing- Original draft preparation, Writing- Review and editing. SI: Analysis, Writing- Review, editing and supervision. AB: Analysis, Writing- Review, editing and supervision. YG: Writing- Review, editing and supervision. SK: Conceptualisation, Methodology, Data collection, Writing- review and editing, Supervision

Author agreement

We declare that this article is our original work. The manuscript has not received prior publication and is not under consideration for publication in any other journal. All authors have seen and approved the manuscript and we abide by the copyright terms and conditions of Elsevier and the Australian College of Midwives.

Ethical statement

Each participant received information about the study before signing a consent form. To protect midwives' confidentiality, we de-identified all data during transcription and data was stored in password protected computer files accessible only to the researchers. Ethical approval was granted by the hospital's Human Research Ethics Committee and Governance (HREC/MML/46904) and Charles Darwin University Human Research Ethics Committee (H21035).

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Declaration of Competing Interest

All authors declare no conflict of interest.

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Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.wombi.2025.101910.

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