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The perceptions and practices of Thai health professionals providing maternity care for migrant Burmese women: An ethnographic study

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ABSTRACT

Background: Across the globe, many women including economic and humanitarian migrants receive inadequate antenatal care. Understanding the difficulties that migrant women encounter when accessing maternity care, including the approach of health professionals, is necessary because inadequate care is associated with increasing rates of morbidity and mortality. There are very few studies of migrant women's access to and experience of maternity services when they have migrated from a low- to a middle-income country.
Aim: To examine the perceptions and practices of Thai health professionals providing maternity care for migrant Burmese women, and to describe women's experiences of their encounters with health professionals providing maternity care in Ranong Province in southern Thailand.
Methods: Ethnography informed the study design. Individual interviews were conducted with 13 healthcare professionals and 10 Burmese women before and after birth. Observations of interactions (130 h) between health care providers and Burmese women were also conducted. Data were analysed using thematic analysis.
Findings: The healthcare professionals' practices differed between the antenatal clinics and the postnatal ward. Numerous barriers to accessing culturally appropriate antenatal care were evident. In contrast, the care provided in the postnatal ward was woman and family centered and culturally sensitive. One overarching theme, "The system is in control' was identified, and comprised three sub-themes (1) 'Being processed' (2) 'Insensitivity to cultural practices' and, (3) 'The space to care'.
Discussion and conclusions: The health system and healthcare professionals controlled the way antenatal care was provided to Burmese migrant women. This bureaucratic and culturally insensitive approach to antenatal care impacted on some women's decision to engage in antenatal care. Conversely, the more positive examples of woman-centered care evident after birth in the postnatal ward, can inform service delivery.

Statement of significance

Problem
A lack of culturally appropriate maternity care means that some migrant women do not engage with the maternity services they need.
What is already known?
Migrant women have worse pregnancy and birth outcomes than non-immigrant women, with higher rates at complications in pregnancy, more birth intervention in some groups and higher rates of postnatal depression.
What this paper adds?
This study provides insights into how Thai healthcare professionals interact with migrant Burmese women when providing antenatal care and women's experiences of that care. There are many opportunities for improvements to be made to enhance health service engagement.

1. Introduction

Studies of migrant women now living in high-income countries (HIC) report a higher risk of health complications in pregnancy and

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childbirth, and a higher risk of maternal and infant death [1]. Globally, many pregnant women, in particular women who are economic or humanitarian migrants, receive inadequate antenatal and postnatal care resulting in poorer outcomes for mothers and babies [2–4]. Attendance at antenatal care is hindered by poor health literacy, limited financial resources, cost of services, lack of transport and difficult or dangerous travel over long distances to reach facilities [4]. For migrant women, limited language proficiency is a significant barrier to care [5]. Additionally, services may be culturally inappropriate or differ from women's previous experiences or cultural beliefs [2]. Following birth, a higher proportion of migrant women experience depressive symptoms [6]. In a recent meta-synthesis of migrant women's experiences of postnatal depression, many women reported that care in hospital after birth did not address their support needs or recognise cultural practices important to women [6]. These experiences influence women's decisions to access maternity care in the next pregnancy [4,7].

Most research on migrant women's encounters with maternity services has been conducted among those living in HIC, with few studies of women who begin their lives as mothers having migrated from a low-income country (LIC) to another LIC or middle-income country (MIC). Recently, there has been a sharp increase in the number of workers migrating from Myanmar to Thailand; and over time, many become parents. However, little is known about the maternity care experiences of these migrant women.

The majority of migrants to Thailand come from Myanmar. There are over 135 ethnic groups in Myanmar, each with its own culture and customs, two thirds identify as belonging to the Bamar or Burman ethnic group, and the majority of the remaining one third belong to one of eight major ethnic minority groups – the Shan, the Karen, the Mon, the Kachin, the Chin, the Arakanese, the Rohingyas and Karenni. The primary reasons for migrating to Thailand are to improve quality of life, for economic reasons, such as earning an income, or more prosperous employment opportunities, personal reasons, such as the desire to follow family or friends, or for personal experience, and for security [8]. There are also many migrants from Myanmar to Thailand who are refugees or displaced people and have been living in the Thai-Burma border camps since 1984 [9]. The majority of these refugees are Karen people. In contrast in southern Thailand, where this study was conducted, the majority of people from Myanmar are economic migrants and identify as Bamar or Burman people [10]. Many of these migrants continue to experience difficulties related to living and working conditions, even in situations in which they are legal immigrants [11]. In addition, many of these migrant women are of child-bearing age and will have their first or subsequent children in Thailand [12]. This poses challenges for women in terms of pregnancy and infant care, fulfilling domestic responsibilities and responsibility for maternal, newborn and child health [13].

The universal health coverage, known as the '30-Baht scheme', is available for all Thai people and migrants who have legal worker status in Thailand. This scheme provides maternity services in public health facilities, including at least four antenatal visits and postnatal care in hospital and in the community, and immunisations for babies [14]. In addition to the universal coverage, some migrant women can access the Medical Welfare Scheme, provided by their employers through the Social Security Scheme in the same way as Thai workers [15]. To be eligible, migrant women must pay five per cent of their wage to gain access to health care [11]. Without the health insurance card, women have to pay the full cost of attending antenatal care.

Although Burmese women have the right to access Thai maternity care services, many do not access routine antenatal care [16]. Belton and Whittaker [17] found Burmese women workers living in Thailand feared that pregnancy would make it more difficult for them to retain work and this resulted in increased numbers of unsafe abortions. In their study of refugee Karen women in northern Thailand, Wichaidit et al. [18] reported that women attended less than the recommended four antenatal visits and many gave birth to low birth weight infants.

In Ranong Province, in southern Thailand, there is an increasing number of migrant women from Myanmar seeking maternity care [19]. Understanding the difficulties that migrant women encounter when accessing adequate and appropriate maternity care is necessary because receiving inadequate care is linked to increasing rates of morbidity and mortality [18]. It is also important to understand the perceptions and practices of health professionals and how these may impact on women's decisions to access services. All the study participants came from the ethnic majority group in Myanmar, that is the Burman, and wanted to be referred to as Burmese. Thus, in this study, the name Burma is used rather than the Union of Myanmar to maintain consistency with participants' descriptions.

The aim of this paper is to: 1) examine the perceptions and practices of Thai health professionals, providing maternity care for migrant women, and 2) describe Burmese women's experiences of healthcare encounters in Ranong Province in southern Thailand.

2. Methods

Ethnography informed the design of this study. An ethnographic approach is suited for use in maternal and child health as it provides in-depth detail of participants and gives insight into participants' experiences in maternal settings [20]. Ethnography allows the researcher to examine interactions in specific contexts and to explore people's perceptions, and their behaviours in context [21]. Data were collected through observations of the interactions between the women and healthcare providers as well as interviews with Thai nurse-midwives, Burmese interpreters, and Burmese women accessing the services. Ethnographic research includes documenting individual interactions as well as the settings, the decor, the symbols, and the broader social and political culture [21]. The authors have previously published two papers reporting Burmese women's experiences of pregnancy [19] and motherhood [22]. In this paper, we report on the analysis of the observations of the encounters between Thai healthcare providers and Burmese women during antenatal care in the community-based clinic, or hospital, and postnatal care in the hospital. We describe healthcare providers and Burmese women's experiences of these interactions.

Ethics approval for the study was sought and obtained from the Human Research Ethics Committee of Western Sydney University (HREC No), and formal approval was provided by the Ranong Hospital and Ranong Provincial Public Health Office in Thailand.

2.1. Study setting

The research was undertaken at two antenatal care clinics in Ranong, the main urban area of Ranong Province. One clinic was located in the main public hospital, and the other was a community-based clinic close to where the majority of the Burmese community lived. Ranong province is located on the Thai–Burma border in southern Thailand and has the second-largest Burmese community in Thailand. It reports one of the highest numbers of both legal and undocumented Burmese workers living in the country. According to a survey of migrants in Ranong province, many lack the means to access medical care particularly because of language barriers and lack of knowledge about where to obtain information about health and other services. Although migrants have registered work permits with health insurance cards, they continue to face difficulties in accessing health care services [8]. More recently, there has been an increase in the number of Burmese people who remain living in

Myanmar but travel daily by boat to Ranong province for work [8]. Many of these women are undocumented workers. With these recent migration and employment patterns, there has been an increase in the number of Burmese women working in Ranong province who are pregnant, seeking Thai medical care and want to birth in a Thai hospital [23].

2.2. Participants and recruitments

2.2.1. Burmese women

We recruited 10 Burmese women (5 in hospital clinic and 5 in the community-based clinic) as key informants for the study. The women had to meet the following criteria:

- be receiving their maternity care at one of the two sites,
- be willing to have author 1 observe one of their antenatal appointments with the healthcare professionals, and if possible, to observe interactions on the postnatal ward,
- agree to participate in an interview with the researcher – one in the antenatal period and one following birth and to have the interaction voice-recorded during interviews,
- agree to provide their contact details, such as telephone numbers and home address to enable contact for data collection.

Women were excluded from the study if they or their babies experienced antenatal health complications or post-childbirth complications. However, women were given the opportunity to remain in the study if that was their wish. None of the women or their babies experienced any complications; thus, they all remained in the study. Recruitment occurred consecutively until 10 women were recruited to participate in both the observations and interviews across pregnancy and the postnatal period. During recruitment, Author 1, a Thai-speaking nurse-midwife was accompanied by one of two experienced Burmese interpreters. Initial contact was made with women in the antenatal clinics by the interpreter, who invited the women to participate in the study. The women were provided with an information flyer written in Burmese. If women were interested and agreed to participate, the Burmese interpreter introduced and helped the researcher communicate with the Burmese women and to offer the information and consent forms in Burmese. Women were given the opportunity to ask as many questions as necessary before being asked to sign the consent form, indicating that they understood the information provided and agreed to participate.

Participation in this study was voluntary. All participants were informed that they could withdraw at any time without providing a reason. An information sheet and a consent form were provided in Burmese for the potential participants. If the woman could not read in her own language, the interpreter read the information sheet to the woman. Women were given the opportunity to ask as many questions as necessary before signing the consent form, indicating that they understood the information provided and agreed to participate.

As part of the ethnographic research, on each visit to the antenatal clinics, around 50–60 non-consenting women were observed in the clinic reception area and waiting areas. This was necessary to observe the work of nurse-midwives and other health staff in both antenatal settings. Similarly, during participant observations on the postnatal ward. Approximately 40–50 people including Burmese women, their family and the health staff were present on any one day of observation.

2.3. Healthcare professionals

There were 25 staff members in the maternity service including the community-based clinic, and all staff were invited to participate. They were provided with the participant information statement and given the opportunity to ask questions before agreeing to participate. Nine of the 25 health professionals, including nurse-midwives, obstetricians, and public health officers, agreed to participate in a face-to-face interview. All staff working at the time of observations of interactions with Burmese women agreed to be observed in either the antenatal clinics or the postpartum ward. The managers of the health service also approved the observation of general activities and interactions in the antenatal clinics and postnatal wards. All 25 staff participated in the study either in interviews and or the observations.

In addition, four Burmese interpreters (*lam*) employed to work in the hospital clinic, the PHC clinic or the postpartum ward were invited to participate. Two interpreters worked in the PHC clinic and two worked in the hospital (one in the antenatal clinic and one in the postpartum ward). The *lam* were asked to participate in an interview about their experiences of interpretation and working with Thai health professionals. They were also asked permission to observe interactions with Burmese women and Thai health staff (e.g., in an antenatal appointment or in the postpartum ward). The interpreters had worked in the hospital and PHC sites for a minimum of one year and were fluent in Burmese and Thai.

2.4. Data collection

Data collection was conducted during May to December 2015. Data were collected in three ways: 1) Interviews with 10 Burmese women conducted in pregnancy and one 4–8 weeks following birth; 2) Interviews with healthcare providers, and 3) Observations of interactions between health providers and Burmese women. The first author conducted all the observations and face-to-face or phone interviews with women and staff. Each interview was digitally recorded. The interviews with health professionals were held in a private room in the hospital or clinic and with the women were either in the clinic or at their homes. Each healthcare provider was interviewed once only about their perceptions and experiences of providing care for the women. Interview questions for health staff included: 1. Please, tell me about your experience of working with/caring for Burmese women in maternity services? 2. What are the barriers that Burmese women experience in accessing maternity care? 3. What would help Burmese women access antenatal care? 4. How are Burmese women supported to practice their cultural traditions? The women were interviewed before and after birth; open-ended questions were used to elicit to their perceptions about access to maternity services. For this paper, the relevant interview questions/prompts that were analysed were: 1. What is your perception/experience of the care you have received at the clinic or hospital? 2. How do you feel about the interactions with health providers?

A total of 130 h of observation were undertaken. This comprised on average four hours per week in each antenatal clinic for a 12 week period and included approximately three hours spent observing individual interactions between the ten participating women and health providers. In the second stage, observations occurred in the postnatal ward and comprised 45 h of observation) over eight weeks. The focus of the observations was guided by the work of Spradley [24], detailing the style and content of the interactions. Observations included: staff actions and interactions with women, women's responses to staff, the non-verbal styles used, tone of voice, facial expressions and positioning during interactions as well as their activities at work. The observations were recorded in the field notes. Participant observations were recorded by a note-taking technique soon after the event. In order to reduce the bias that the first author, who is a Thai researcher, may mis-interpret the reactions of the Burmese women when

interacted with Thai health care providers, she worked closely with the interpreters who offered interpretations of cultural use of body language and this documented in field notes where relevant.

2.5. Data analysis

2.5.1. Transcription and translation

The interactions between health professionals and Burmese women were all conducted with the assistance of an interpreter or *lam* and were conducted in Thai and Burmese, thus the recordings of the interactions comprised both Burmese and Thai language. Only the Thai language spoken by the nurse-midwife, the interpreter and at times the Burmese woman in each interview was transcribed. Similarly, the interviews that author 1 conducted with the Burmese women were conducted in Burmese and supported by a Thai-and Burmese-speaking interpreter. In accordance with this position, when author 1 interviewed the women, the questions were in Thai and the interpreter translated the questions to Burmese. The woman responded and answered in Burmese; their meanings were then interpreted in Thai by the interpreter. All this interaction was captured in the recording but only the Thai language was transcribed. The first author had a second bilingual interpreter listen to the recordings to check that all information had been precisely interpreted.

The next step in preparation for analysis involved translating the Thai language to English. This was necessary because authors 3 and 4 only speak English and these data were to be used in a doctoral thesis that also had to be written in English. The translations from Thai to English were also checked by a bilingual expert.

All English language data were analysed using thematic analysis. An iterative process based on the steps of Braun and Clarke [25] was employed to identify the themes. Thematic analysis is an iterative process used to code concepts and identify categories or themes from the data [25]. The process of analysis included several steps. First, following preparation of all datasets, author 1 read and re-read all transcribed interview and observation data to become familiar with or immersed in the data to generate initial insights. This, together with the translation and transcription process, assisted in identifying meanings, patterns and issues that were of most interest to the study aims. It also helped to formulate ideas for preliminary themes. Following this, all data were coded first within each individual dataset, using key words and phrases from the participants, as appropriate, to label codes or subthemes. Codes were then collated into potential themes, gathering all data relevant to each essential theme. During the ongoing analysis process, author 1 constantly asked questions of the data: 'What is this piece of data referring to?'; 'What is this woman thinking while she is waiting to see the midwife at the primary health care clinic?'; and 'What does this say about barriers to accessing maternity care?'. Data were then compared and contrasted across the three datasets using the preliminary subthemes or broader themes to identify linkages and relationships between the themes and subthemes (see Table 1). Subsequently, the constructed themes were examined and discussed with the research team (authors 2, 3 and 4) and relationships were examined. Finally, the key themes and sub-themes were summarised, compared, and contrasted to each other both within and across datasets. We used a pseudonym name to refer to the women in the findings in order to protect their true identity.

2.6. Reflexivity

The term 'rigour' refers to the quality of qualitative enquiry since it can be 'trusted' as the passage of evaluating the findings or insights of the qualitative data [26,27]. The term trustworthiness has to be used to guarantee that the successive steps in a research project have been conducted with scrupulous attention to detail [27]. In qualitative research, numerous approaches are used to ensure trustworthiness of the findings. In this study, triangulation of data sources (participant observation, interviews and field notes) and prolonged engagement during fieldwork [26] enhanced rigour.

In collecting these data, the first author drew on her previous experiences as a Thai nurse-midwife and nursing educator. She has worked in Thailand providing antenatal and postnatal care for women for the past seven years and taught maternal and child health nursing at the university. She has two children both born by caesarean section in a Thai hospital. Her position as a nurse-midwife, an educator, and a mother, may have influenced the data collected, including what was considered important to record in the field notes and how the data were interpreted. Her experiences as a nurse-midwife may have enabled her to develop rapport with women and health care staff in maternity care. While data collecting, she deliberately did not wear a uniform as a uniform can be a symbol of power [28]. She approached the collection of this data with sensitivity bearing in mind the needs of women. The other authors do not live in Thailand, although author 2 is Thai. Authors 3 and 4 are both midwives.

3. Findings

The ten Burmese women who participated as key informants, aged 23–32 years, had migrated to Thailand as legal migrant

Table 1
Exemplar of data analysis across themes.

Theme	Sub theme	Interview data from women	Interview data from health providers	Field notes
Insensitivity to cultural practices	It's time you were sterilised	The nurse handed me the letter of consent to sign. I told her that my mum did not want me to do it since she still wanted one more grandchild. But she was angry and said, 'It is you who will die, not your mother. You are the one who get pregnant, not your mother? What is with her?' I was so terrified. Did she have to say so? Why did she have to be that harsh? I was in tears. She insisted that I had to sign the consent. (The Burmese women)	You know what I am talking about? We suggested that since they are too old and have many children; getting pregnant is dangerous for both mother and child. Unfortunately, they kept denying taking sterilisation and she had got pregnant again shortly afterwards. (The nurse-midwife)	Another occasion today when I heard a nurse-midwife telling a Burmese mother that she should be sterilised after this baby because they should not have any more than two children. The woman looked stunned that the nurse-midwife would say this to her; she did not say anything and had no further eye contact with the staff member, but she looked upset.
		Sterilization is the only point I want them to understand us Burmese.	She said she didn't want to be sterilized since she was afraid it will be painful and cost a lot of money. She said if she had been sterilized, it would make her weak and she wouldn't be able to work well.	

labourers and were Buddhist. Two women had completed secondary school; seven had two to four years of primary education; and one had no formal education. The main language spoken at home was Burmese, but six women could speak a little Thai. None of the women were able to read Thai. Two women were born in Thailand but had spent their childhood in Burma (see Table 2 for demographic characteristics of Burmese women).

The healthcare participants were all female except for one and ranged in age from 23 to 50 years and had been working in the maternity settings for a range of two to twenty-eight years. They were all employed full-time, currently working in either the PHC or in the Hospital (see Table 3 for demographic characteristics).

The overarching theme identified in this study was '*the system is in contro*l'. We found that healthcare professional practices varied depending on whether they were working in the time-pressured antenatal clinic and its associated rules, or what appeared to be the more relaxed environment of the postnatal ward. These practices impacted on Burmese women's experiences. The analysis of the observation data suggested that antenatal care in both the PHC clinic and the hospital was akin to a production line, demonstrating that it was the system that was 'in control' and was relatively inflexible in its approach and processes. At times, there was also less tolerance of certain cultural practices or beliefs. Lack of familiarity with the health system and other government organisations as well as miscommunication between health professionals and women, meant that Burmese women either complied with health professionals or ignored their directions, partly because they could not understand them. In contrast, the environment in the postnatal was more relaxed, and the staff appeared compassionate and caring. Three main themes emerged in the analysis: 'Being processed'; 'Insensitivity to cultural practices' and 'The space to care' (see Table 4)

4. Being processed

There appeared to be strict rules governing Burmese women's attendance for antenatal care, including which clinic they could access, how care was organised and how long women spent waiting for care. Overall, it appeared that in the antenatal clinics, women were treated as a number, something, or someone to be processed rather than treated as a woman becoming a mother. Three sub themes comprised the theme 'Being processed' – 'They have to go to the PHC service'; 'They must wait' and 'Directing patient flow'.

4.1. You must go to the PHC service

In Ranong, women were directed to use the antenatal care services at the community-based PHC clinic and were only referred to the hospital clinic if they have risk factors. Penjai, one of the nurse-midwives explained the policy:

> The ANC in the hospital provides care for women who live in the area, except for cases with risk in which the women need assessments and treatments at the hospital. Otherwise they have to go to the PHC near their house instead.

Penjai went on to say that they have difficulty explaining this restriction to the women:

> Some of them keep coming to the hospital. I always send them to the PHC anyway. I have to make them understand that they will receive the same service.

However, from the women's perspective, these rules were 'too strict' and five of the women argued they had worthy reasons to attend the hospital rather than the PHC clinic. Neeza indicated she was able to get to the hospital clinic by herself, 'the hospital is closer. I can come here myself'. Yusoo was determined to go to the hospital for antenatal care as she had family responsibilities and she knew that the hospital might deny her, stating, 'the service system is good. I lied to the staff that my place was in the market nearby, so she allowed me to have antenatal care here'.

On the day, Tata attended the hospital clinic however she was less fortunate. The nurse-midwife she encountered in the clinic was strict about the rules telling her that she could not attend the hospital clinic and that she had to go to the PHC. This resulted in Tata missing two antenatal visits because she did not feel confident in meeting another group of unknown staff:

> My first ANC was in the hospital but a midwife did not permit me to continue accessing ANC in the hospital. However, although the ANC in the PHC is located near my house, I was afraid to attend the PHC. I just worry about communication so that I came to the PHC for ANC clinic a bit late.

Table 2
Demographic data of the Burmese women participants (n = 10).

Burmese women		Tata	Ning	Meena	Neenee	Neeza	Mint	Teena	May	Yunin	Yusoo
Age		26	26	29	32	23	24	27	31	25	23
Work prior to pregnancy	Frozen food	X								X	
	Factory worker									X	
	Waitress	X	X			X					
	Fishery worker	X		X			X				X
	Fish processing							X			
	Cleaner				X						
	Coal factory worker								X		
Currently employment status	Unemployed	X		X	X		X	X		X	X
	Temporary employed										
	Casual employed		X			X			X		
Monthly incomes/a couple (in Thai baht)	2000–4500								X		
	2000–5000			X	X						
	2000–6000	X								X	X
	3000–6000		X				X	X			
	4000–6000					X					
Level highest education	No education								X		
	Some primary			X		X	X			X	X
	Completed primary				X			X			
	Secondary	X	X								

*All names mentioned are pseudonyms.
All the 10 Burmese women are Buddhist, and their ethnicity is Burman.

Table 3
Demographics of 13 health staff.

Health staff		Veena	Maloo	Sudjai	Penjai	BuaAe	Pimpa	NeeMoe	Jasmine	Sopa	Chaiyut	Soraya	Patumtip	IngDao
Age		35	38	36	44	37	46	29	38	44	41	40	50	23
Gender		F	F	F	F	F	F	F	F	F	M	F	F	F
Position	Public health official	X												
	Interpreter		X			X		X						X
	Nurse-midwife			X	X		X			X		X	X	
	Obstetrician								X		X			
Currently working in	[a]Local clinic (PHC)	X	X	X				X						
	ANC in the hospital				X	X	X		X		X			
	Postnatal ward in the hospital								X	X	X	X	X	X
Length of health working	Currently working (years)	4	4	2	18	5	20	4	10	22	5	13	28	2
	Previous work in other PHC or hospitals	8	16	11	5	8	5	0	0	0	8	0	0	0
Level highest education	Primary		X					X						
	Secondary					X								X
	Health science	X												
	Nursing and Midwifery			X	X (Master)		X			X		X	X	
	Obstetrics and Gynecology								X		X			

ANC: antenatal care clinic; PHC: primary health care clinic.
[a] All names mentioned are pseudonyms.

Table 4
Themes – the system is in control.

Themes – the system is in control	Interviews with women	Interviews with staff	Observations
Being processed			
You must go to the PHC service	x	x	
You must wait	x	x	x
Directing patient flow		x	x
Insensitivity to cultural practices			
They keep doing what they want	x	x	x
Use only one name	x	x	x
Wash off the powder		x	x
It's about time you were sterilized	x	x	x
The space to care	x	x	x

4.2. You must wait

During the observations, it was not uncommon to see 30–40 women waiting in the hospital antenatal clinic or sitting outside the PHC clinic, or on the veranda, or on the floor of the PHC clinic. This was captured in the field notes (8 June 2015):

> Two women have been waiting since the early morning, but had not received ANC yet. At 1.20 pm the nurse-midwife asked the women, 'what are you were waiting for?' One of the women could understand some Thai and replied. 'We come for antenatal care. We do not know why the health staff kept us waiting. I do not know what we are waiting for, but the person in pink (the interpreter) told us to wait'. It appeared that the two women had come in the morning for their first antenatal appointment but were told they had to wait for the afternoon session. Eventually, the nurse-midwife called the women who could speak a little Thai because the interpreter had not returned from lunch.

This situation was common. Women came in the morning and had to wait their turn. Language barriers, particularly when there was no interpreter present, meant they often had to wait even though they had come in early. At times women decided to leave the clinic without having their appointment. Meena for example, missed an antenatal appointment because the day she came, there were less staff working:

> I missed an antenatal appointment last time because I came to the PHC and there were a lot of women waiting there, but on that day the clinic had only two staff and one interpreter. I could not wait so that I decided to go back home.

4.3. Directing patient flow

In Thailand, the Ministry of Public Health provides guidelines on the services that must be offered antenatally. However, the organisation of the service, including staffing and processes, is determined at the local level by each hospital or PHC clinic. These decisions are dependent on the resources available, including the number of nurse-midwives, availability of interpreters, and space, rooms and equipment (e.g., sphygmomanometers) available. In Ranong, it was evident that the Thai health service managers had thought about how to direct the patient flow in the clinics. The waiting room both inside and outside the main building were quite small and so the managers appeared to have thought about how to move women from one care provider and care station to the next. This approach had the effect of fragmenting care, that is different tasks were completed by different health professionals.

On visits to the Pak-Klong PHC clinic and hospital, the way antenatal care was organised was mapped by Author 1. Fig. 1 demonstrates how the woman navigated the antenatal clinic on a visit to Ranong Hospital (i.e., A ➡ B1 ➡ C ➡ D ➡ B2).

Clinic care is provided by two nurse-midwives and one Burmese interpreter. When women first arrive at the hospital clinic, they wait outside the building to be called by one of the staff (zone A in Fig. 1). On average, women wait for 15 min in zone A.

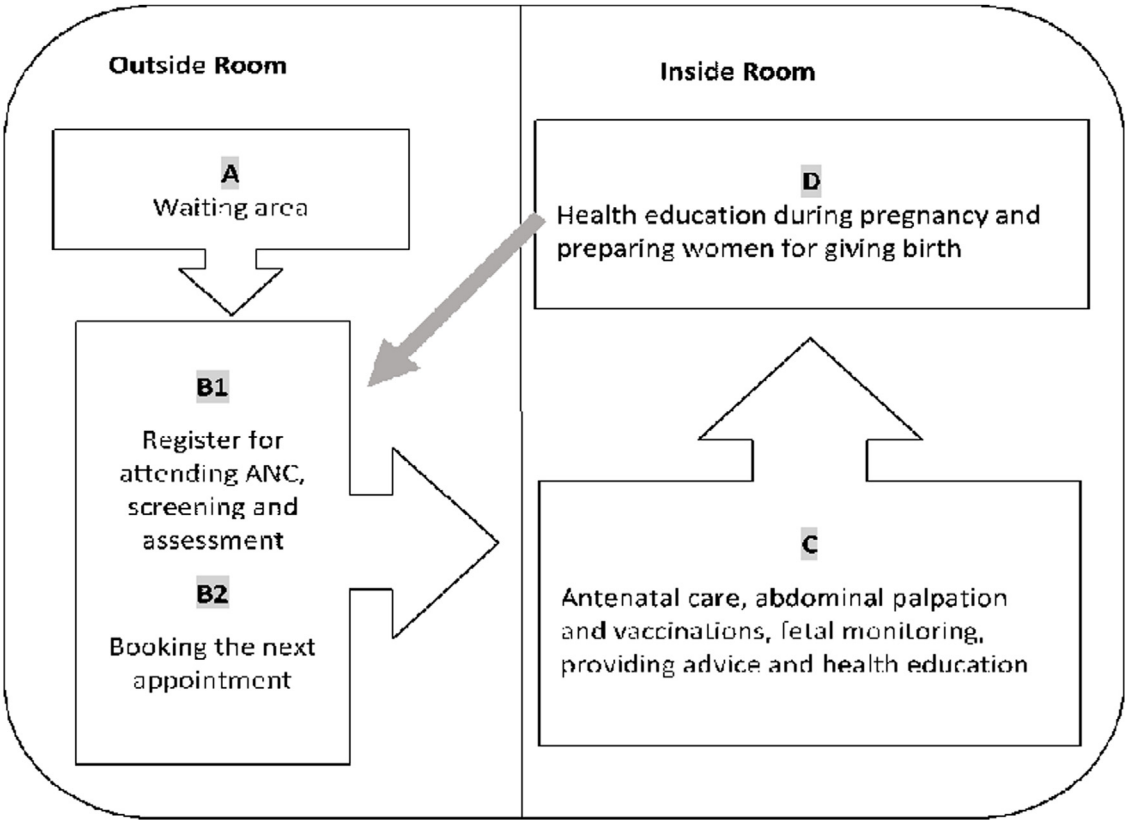

Fig. 1. The process and patient flow in the antenatal clinic at the hospital.

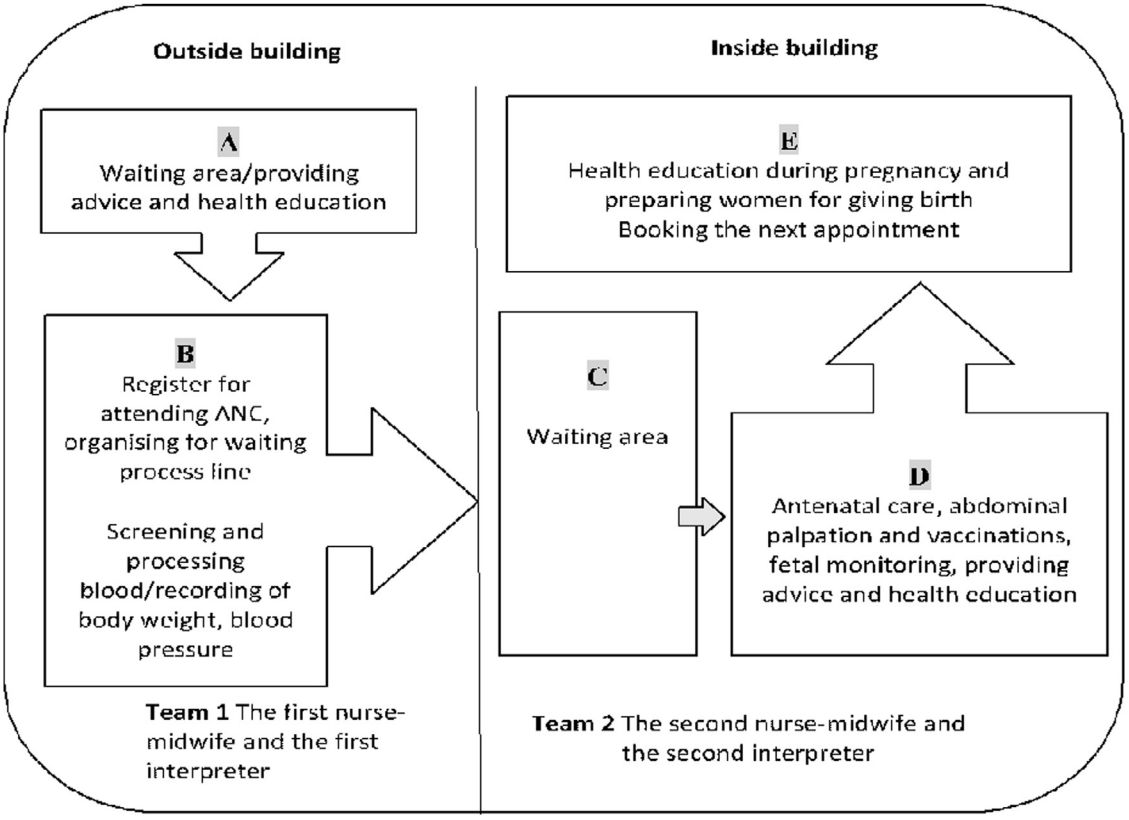

Fig. 2. The process and patient flow in the antenatal clinic in the PHC.

When it is their turn, a nurse-midwife or interpreter will call their name. The woman then follows the staff member and interpreter into zone B1, where they will register the woman and ask basic administrative questions, such as their name, their address and if they have previous children. The nurse-midwife consulting with the woman will also conduct assessment and screening tasks, such as taking her blood pressure.

The woman is then directed to move inside the hospital ANC, where the same nurse-midwife will conduct the second part of her antenatal check-up (zone C). In zone C, the nurse-midwife listens to the fetal heart, but this is typically done without the interpreter, as the interpreter continues to work with the nurse-midwife in zone B1. The second stage takes about four to five minutes. If the woman did not speak Thai, it was noticed that the nurse-midwife used non-verbal communication, such as signs to indicate all was well with the baby.

The last part of the process occurred inside the hospital building (zone D), where women received information and health education from the same nurse-midwife. The education focused on the need to take the prescribed iron medication, the hazards of sugary drinks and the need to rest and reduce the amount of paid work in the last month of pregnancy. The interpreters assisted with this, but were often engaged with other women in zone B. Therefore, the nurse-midwife managed this with the use of health information pamphlets translated in Burmese. The education session was short, lasting around to two to three minutes. When this was complete, the women returned to zone B2 to book the next appointment.

A similar process was used in the community clinic in Fig. 2. What was most interesting in the community clinic was the opportunity that staff created for 'communal' education or education by chance. The nurse-midwife and interpreter in Team 1 provided information and education to the woman while registering her and taking her blood pressure. After they are finished in zone B, the woman is then directed inside the building to another waiting area (zone C), where the nurse-midwife and interpreter from Team 2 conduct the antenatal check-up. The final part if the process is in zone E, where the woman receives health information and education from the nurse-midwife and interpreter in Team 2. However, this was done in a way that was also directed at all other Burmese women waiting for their appointment in zone A and E. For example (Field notes: 10 June 2015), on several occasions a nurse-midwife was observed telling a woman that her blood pressure was high and then turning to the group of waiting women and saying:

> This is not good; your blood pressure is too high . . . [turning to other women] . . . do you know why your blood pressure is high? [The woman just smiled] . . . it is high because you are eating too much salty fish and you put too much salt in your cooking.

5. Insensitivity to cultural practices

Generally, the Thai health professionals spoke positively about the Burmese women they cared for, emphasising that they aimed to provide the same level of care to all women and their babies. This view is illustrated in quotations from Soraya, a nurse-midwife working in the maternity services, and Veena, a nurse-midwife in the postnatal ward:

> Burmese women have the same equal rights to receive medical care as the Thais. The medicines and the treatments are the same. They are treated under the same standards with the Thais. (Veena)

However, some individual health professional participants demonstrated an insensitivity to the cultural practices and beliefs of the Burmese women concluding that the women did not always comply with their advices or directions. This insensitivity is captured in several sub themes; *'They keep doing what they want'; 'Use only one name'; 'Wash off the powder'*, and *'It's about time you were sterilised'*.

5.1. They keep doing what they want

Some health professionals indicated that the Burmese women did not always comply with their advice or directions. For example, in the health education sessions, the nurse-midwives and interpreters encouraged the women to eat well and advised them against sweet and fatty foods. During fieldwork, I observed Pimpa, a nurse-midwife, advising a woman, 'You should not eat so much oil and sweet things because you have gained too much weight and you could get diabetes. It is dangerous for you and the baby'. She then handed the women information in Burmese. The woman just nodded and turned away to put the brochure in her pocket (Field notes: 11 May 2015).

Pimpa repeated to author 1 that some Burmese women ignore what they are told to do in relation to antenatal care education:

> Regarding taking prenatal education, Burmese women seem to only take the information they want and they ignore the rest. They sometimes took only a few bits of the information we gave them. In fact, in general they keep doing what they want and ignore what they were told to do.

Nee Moe, an interpreter stated that the Burmese women did not always understand the health information they were given, despite the interpreter's many explanations and clarifications:

> I clearly explained it, wrote it in Burmese, and the midwife told them everything, but they just did not follow the guidelines and suggestions. Some women did not know how to take the medicine (folic acid and iron). Some say they just do not want to take it.

Although in both clinics the interpreters were employed to assist the communication, some of the women were embarrassed to ask questions and most were not confident in talking with the health staff even if via an interpreter. Maloo, an interpreter explained that she has seen Thai staff become upset with Burmese women if they could not understand what the staff asked them:

> Sometimes the staff ask women questions but the women could not understand. Sometimes the staff were a bit upset. That was why some women do not have the courage to ask. They would prefer to have the interpreter speak for them.

Teena stated that she would often say 'Yes' to someone, despite not having understood the question. 'I could not remember how many times I used to say "Yes". I did not know what the health providers were talking about, I did not understand'. This challenge in communicating was made more difficult when women experienced staff who were strict, and inflexible.

5.2. Use only one name

Due to their circumstances, some Burmese women used different names in different contexts, which caused difficulty in the antenatal clinic in recording their profiles. Often, the name of their health record did not match the name on their passport. This meant that the Burmese women could not access antenatal care services. Health professionals expressed frustration at the use of multiple names, as it was too difficult to 'process' the women. This was demonstrated in a conversation documented in the field notes (8 June 2015):

Nurse-midwife: 'Why did you change your name?' (looking serious and maintaining a long period of eye contact with the pregnant woman).

Nurse-midwife (shaking head): 'Choose just one name, the one according to your passport'.

Yunin stated via the interpreter): 'I cannot remember my name. Sometimes my employer calls me this and I am called a different name at home. The name in the passport is so long that when I came into register, I could not remember it'. In response the nurse-midwife says the following with serious expression and hint of anger:

> That is why you have so many patient cards, too many names for one person. Okay! I will not ask anymore. Next time use only one name. Got it! I do not want to give you another card. You never understand and never fix it'.

5.3. Wash off the powder

Some Burmese women choose to apply thickly coated powder (known as *Thanakha* in Burmese) on their skin to prevent dry skin. This is believed to have both therapeutic and beauty benefits. During observations of the interactions in the hospital it was noted that the Thai nurse-midwives disapproved of this practice. They understood that this was a traditional Burmese practice but dismissed it because they could not see any benefits. Penjai, a nurse-midwife explained: 'I will not do anything if they do not wash off Burmese powder but the powder will bed up'. Pimpa, another nurse-midwife added: *'The injection cannot be done since the whole body is covered with powder'.*

Conversely, in the PHC clinic, the staff did not complain about the use of the powder:

> That is okay because we understand their culture. If they required an injection that day, it was only wiped the area needed. The instruments are then cleaned after use so any powder is removed. (Sudjai, a nurse-midwife)

Some women appeared distressed because they were told to wash off the powder, Mint said that "*I am worried about how she would be treated in labour and birth because of wearing the powder*".

5.4. It's about time you were sterilised

Staff appeared to be of the view that once a woman had two children or was 30 years of age or older, she should not have any more children, and pressure was put on the women to agree to sterilisation. For example, in this encounter below, the nurse-midwife seemed irritated that the woman was pregnant. She took the woman's blood pressure and said:

> Where do you live? Next time, go to the PHC clinic. Today, I will get your blood tested and you will have to come and get the result on the 2nd of June, got it?

The woman did not answer, she listened to the interpreter, who explained in Burmese and nodded. It was noted that she looked worried. At this point, the nurse-midwife turned to talk with the author 1:

> The situation is worse with older pregnant women. When it is suggested to get sterilised, almost all of them decline. They said they could not make the decision themselves, so they needed to talk with their husband. They did not know contraception. I had seen all kinds of Burmese women, they cooperated and were willing, but once it came to sterilisation, there was hardly any positive response.

Teena, one of the Burmese women, described how fearful she was when the nurse-midwife raised the issue of sterilisation:

> The midwife asked me how many children I have got. I told her I have already had one. She said to me, 'Then let's have you sterilised after this delivery'. I told her I did not want it because I have just had two children. When I said so, she looked angry. I was terrified. I do not understand why she had to be angry and annoyed with me. Then, the midwife said angrily to me, 'What! You have two children already and you are almost 30 years old. It is about time you were sterilised. Why are the Burmese so stubborn? Do it, have the sterilisation. Sign! sign the consent now . . . .'. . . . Anyway, luck was on my side. Now I had already given birth safely, I will definitely not have the sterilisation . . . .

One of the nurse-midwives explained the reasons for having sterilisation that focused on the mother and baby's health:

> They are old. They might not have knowledge or ideas about contraception. Some of them have been pregnant many times and they are quite old having underlying disease; however, they deny taking sterilisation. (Pimpa, a nurse-midwife).

6. Theme 3: the space to care

In contrast to the situations in the antenatal clinics, it appeared that the atmosphere and the interactions in the postnatal ward were more supportive of women's needs, and the nursing staff were more flexible in their approach to care. In the postnatal ward, the Burmese women looked happier. The following field note captures this atmosphere:

> The healthcare providers interacted with the postnatal women in soft tones as they informed the women about what they were doing. The nurse-midwives were friendly, smiling as they provided care to women and demonstrated techniques such as bathing the newborn and cleaning the umbilical cord and eyes. The women responded positively to these interactions. They appeared to be pleased that the staff were happy to advise them even though they could not speak Thai and had to use the Burmese interpreter. They appeared to listen intently to the nurses, nodding their head and holding eye contact with the staff.

In the postnatal ward, we observed that women were able to have their husbands, family and friends with them for lengthy periods and a female relative was able to stay overnight with the woman. Meena said to me "*I am happy that my family can stay, they help me a lot and I feel safe*." We also noted that the Thai staff spoke in the local dialect (southern Thai dialect). This is a more informal Thai language than the Central Thai language and it appeared that some of the Burmese women were able to understand this dialect. Sopa, a nurse-midwife, explained:

> If we talk with them using the southern Thai dialect, rather than using the Central Thai language, the women are happier because the local dialect is more informal, as though we are talking with close friends or our family. If the Burmese women have been living here a long time they know some of the local dialect, and this makes them feel more comfortable with us.

In interviews, the nurse-midwives and other health providers working in the postnatal ward, spoke in a compassionate and respectful way about the Burmese women. Soraya, a nurse-midwife stated:

> We take care of them the same way we take care of the Thais. I do not feel we are different at all. I used to hire a Burmese woman to be a nanny for my daughter. I do not have any problems providing the services for Burmese women.

Some staff indicated that their perceptions of working with Burmese women had changed over time and they were happy to

support Burmese women and believed that the maternity service should address their needs. Sopa, a nurse-midwife explained:

> When I first came here, I did not want to talk to them (Burmese women) because we could not communicate. Recently, I have more empathy. The longer I work, the more I want to help them. I want to be kind to them and take care of them like the other women. I listen to them more. Our job is to provide maternal and child care services. We have to do it with our hearts.

The following field note also demonstrates the way nurse-midwives provided care for women in the postnatal ward. In this observation, one Burmese mother asked Sopa, 'I am worried I have no milk and my baby will be hungry'. The mother looked worried. Sopa responded, coming closer and explained through an interpreter:

> Please, do not worry because it is a common for a new mother in the first day after delivery, the milk may not come yet. However, breastmilk may take a few days to come in. What you should do, you just take care of yourself by drinking water, consuming healthy foods, and please do not stress. Just breastfeed every two or three hours even though no milk yet, but it will be coming soon. Please, trust me.

It was also evident in the postnatal ward, that the staff were not concerned about the Burmese women using powder on themselves or their babies. For example, in one observation, the grandmother put Burmese powder on the baby's body. Soraya, a nurse-midwife, smiled at the grandmother and said, 'It is alright to apply the powder but just be careful to avoid applying on the umbilical cord or the baby's eyes, but for other areas that would be okay'. When the baby cried loudly, this grandmother held and rocked the baby and sang softly to her. Soon the baby fell asleep. The nurse-midwife observed this and said to the grandmother, 'You are a good mother and a good grandmother as well'.

It also appeared that staff in the postnatal ward did not have the same concerns about family size and the need for sterilisation. One doctor in the postpartum unit demonstrated her empathy and caring regarding the women's decision about sterilisation:

> From my experiences talking with Burmese women, many women believe that there are going to be many problems following the sterilisation. They are afraid that they would get weak and would not be able to work hard, have less sexual needs and have family problems. They deny the sterilisation because of these reasons. (Jasmine)

7. Discussion

This paper has explored the health professionals' experiences of providing maternity services and care for Burmese women and women's experience of that care. Our overarching finding demonstrated that the 'system was in control', antenatal services were restrictive, bureaucratic, and culturally insensitive towards Burmese women. This meant women often had to forgo other priorities such as their work or family commitments to attend clinics, without a scheduled appointment time, and to wait for long periods of time. Burmese women were not confident to speak up, and some women were coerced into procedures they did not want, such as removing the powder on their skin. There were some situations in which the insensitivity to cultural needs and poor communication between women and health professionals led to confusion and refusal to follow advice. It was also evident that some staff held strong views about Burmese women as mothers and were critical of their desire to have more than two children. In contrast, the care in the postnatal ward appeared to be more compassionate and supportive.

In a previous paper, we reported that some Burmese women were comfortable and keen to attend Thai antenatal services in pregnancy and were satisfied with the service [19]. Health professionals reported however, that other Burmese women, both migrants and refugees [11,17] do not attend Thai antenatal services. In the findings presented here, it was clear that Burmese women preferred to attend the antenatal clinic that was closest to where they lived as this reduced transportation costs and enabled a speedier return to their workplace after waiting at the clinic. Similarly, Veerman and Reid [16] reported that Burmese migrants in Phang-Nga Province in Thailand also had to wait a long time for appointments and this may discourage them from returning antenatal appointments.

Existing literature has pointed to the language barriers that migrant women experience when accessing maternity services in HIC [29,30]. Murray et al. [29] and Riggs et al. [30] also found many migrant women often said 'Yes' to health providers even if they did not understand what they were asked. It is known that women in LMIC with a higher level of formal education are significantly more likely to use health services [31]. A study by Carrara et al. [32] among refugee and migrant pregnant women living along the Thai-Burma border, reported challenges associated with low literacy levels among Burmese women and when women did not receive adequate antenatal care, this was associated with a higher rate of premature births and neonatal death. Recent data suggests that, even when services are more accessible and affordable, women do not always use them, especially if they are members of marginalised population groups [3].

To address language barriers, the Ranong health service employed interpreters [31], however, as has been reported by other researchers [33], there were times that the interpreters were not available, or the staff did not call the interpreter into the clinic room or the interpreter did not meet women's needs. This meant that sometimes women were unable to clarify the reason for the prolonged wait or to interpret the information about registration or care offered.

7.1. The system is in control – antenatal care as a production line

Despite the commitment by the Ranong health services, to providing a specific antenatal clinic for Burmese women with interpreters, antenatal care was bureaucratic and represented a 'production line'. Women did not receive care individualised to their needs but instead were offered the same care, that resembled a list of tasks to be done to the woman. It appeared the needs of the system were prioritized over those of the woman. Other studies have reported that high ratios of women to health providers is a major barrier to high quality antenatal care. Women often feel they are rushed through the appointments and health professionals report they have little opportunity for health education [34]. In addition, the lack of comfortable seating cleanliness, aesthetics, and privacy, impact on women's decision to access services [34,35]. A recent study of the interactions between Jordanian women and nurses providing antenatal care found that the task-oriented approach dominated service delivery at the expense of a woman centered care [36]. The organisation of antenatal care in the two Thai clinics resembled a production line, where women had to wait for lengthy periods and then when it was their turn they were moved through the different parts of the 'production process'. Dykes [37] used the term 'the production line' to describe hospital based postnatal care in the UK. This analogy to factory work implies that women are processed like a mechanical object, with busy staff giving little time to women's individual needs, offering a one-size-fits-all approach to care, with no opportunity for relational care [37].

At times, health staff were strict and seemed unpleasant in their interactions with the Burmese women. Studies in both HIC and LMIC indicate that disrespectful care disempowers women [4]. The growing recognition of the degree to which women are subject to disrespect and abuse by caregivers in formal maternity care systems, also explains why women may not attend antenatal care or why they may attend once, and then not again [38]. An ethnographic study of women who lived in a rural Hmong village in Thailand reported that those women who experienced previous negative encounters with antenatal care were less likely to attend for care and some preferred to birth at home for subsequent children [7].

However, the behaviour of nurse-midwives is often the result of working in pressured environments with high workloads with procedures and guidelines that must be followed and reported on Ref. [39]. In their systematic review, Murray and colleagues reported that most health providers wished to provide quality care focused on women's wellbeing and satisfaction. However, as Murray et al. [29] found, while most midwives are kind, reassuring, and helpful, they do not have enough time to meet women's needs. Interestingly, in this study, the production line dominated the antenatal clinic services and not the postnatal ward.

7.2. Insensitivity to cultural needs

It was also evident that some nurse-midwives in the antenatal clinics were insensitive to the cultural needs of the Burmese women for example, restricting the use of body powder and their preference not to be offered sterilisation while other staff, including those in the postnatal ward, supported these traditional practices. The capacity to participate in, or adhere to, certain cultural practices is important to many migrant women. These practices can ensure women's emotional and physical safety during pregnancy and childbirth, and when supported, builds trust with health providers [3,4]. Lack of cultural sensitivity by health providers or services [40] can hinder women attending health care services [7]. However, there is variability reported in the support women receive to engage in traditional practices during pregnancy or the postnatal period [7,41]. For example, in a previous paper, we reported that Thai nurse-midwives supported Burmese women's use of herbal tonics and other food practices both before and after birth [19]. Kaewsarn et al. [41] also reported that Thai women in north-eastern Thai hospitals were supported to follow traditional practices such as lying close to the fire and placing heated lamps close to the perineum to aid in recovery [41] and this coexisted with western medicine [42]. In contrast, Culhane-Pera et al. [7] found that when Hmong women living in Thailand were not supported in their traditional practices, they did not use antenatal care and often decided to give birth at home for subsequent children.

Some Thai health providers in our study advised Burmese women to be sterilised after birth. They implied this would be safer for women and better for their health. However, the Burmese women were against sterilisation as having a big family was important to them (author) and they believed that sterilisation might affect their health. Other studies of Burmese Women in northern Thailand, Belton and Whittaker [17] and Whittaker [43], have reported that Burmese women lacked knowledge about fertility, menstruation, and using birth control and did not know how to plan for having a baby [43]. It has been reported, in the United States, that some Burmese women agree to have a tubal ligation, and some considered sterilisation, but these women did not fully understand alternative birth control options [44]. Fear of coerced sterilisation may impede some Burmese women from seeking antenatal care.

7.3. The space to care

In general, studies of postnatal care demonstrate that postnatal wards are extremely busy places where nurse-midwives are not able to provide individualised care and communicate information effectively to women because their time is so limited [45]. We found in contrast that staff in this Thai postnatal ward were caring towards the Burmese women and appeared to have the time to spend with women to guide and explain infant care in the postnatal care environment.

This may have been facilitated by the fact that women were able to have support people with them much of the time including their partners, as well as a female relative staying overnight with the woman. Social support provided by partners, family, female relatives, and friends is necessary for both physical and psychological health of women after birth [46]. Many migrant women however, are separated from their families when giving birth in a new country. Hence, their needs must be met in some way by caregivers and services [6]. Schmied et al. [6] found that many migrant women were distressed that they were alone in the postnatal ward after birth, particularly if they could not speak the language of the care providers. Having family members present, enables women to celebrate the birth of their baby as well as to have additional support in terms of infant care and also someone who may speak the language of the care providers, as was the case in this study.

What was interesting in the postnatal ward was the use of the more informal Thai language and many of the Burmese women had some understanding of that. This contrasted with the more formal Thai language (Central Thai) used in the antenatal clinic setting. The official language of Thailand is Central Thai or Standard Thai and this is the language used by government, education, and in formal communications with strangers [47]. In contrast, the southern Thai dialect is more informal and is used generally when speaking with family or friends or people who they are familiar with [47]. Some Burmese women or their relatives spoke or understood this more informal Thai language and thus there was a more comfortable conversation flow, even if the interpreter was not available.

The care provided appeared to reflect what was described in a meta-synthesis of studies examining the support needed by women in HIC for breastfeeding. Care characterised by kindness, positive appraisal, reassurance, shared experiences and realistic and credible advice and information, resulted in positive breastfeeding outcomes [48]. Furthermore, a study by Smythe et al. [49] in New Zealand describe positive outcomes from postnatal environments where women felt relaxed, replenished and nourished. While this postnatal ward environment was a shared space, having one's family members present may have helped to create a relaxing environment.

8. Implications for clinical practice

The findings of this study provide new insights into the experiences of Burmese migrant women seeking maternity care in Thailand and healthcare providers perceptions of providing maternity care for this group of women. Most importantly, the findings illustrate how the interactions between Burmese migrant women and Thai healthcare providers are impacted by the prioritization of service system needs and not those of women. These findings offer insights for practice and service improvements. Burmese migrant women often waited many hours for their antenatal appointments, particularly in the PHC clinic. This was very stressful, as women had to take time away from paid employment or their children. The health service should consider offering women appointments at the clinic which is closest to their

home. It is also noted that women were more comfortable when the informal Thai language was used in the postnatal ward and this could be encouraged across services.

There is an opportunity to rethink how antenatal care is provided. One option may be to introduce a group-based antenatal care model, such as the model developed by Sharon Schindler Rising in the US: Centering Pregnancy [50]. Group-based antenatal care involves exchanging the individual examination room for a group setting, which includes self-monitoring and extended time with the provider. Centering Pregnancy incorporates the three components of ANC—education, risk assessment and supportive care—into one entity, and encourages women to take responsibility for their own health.

There has been one Thai study [28] that developed a model of group-based antenatal care facilitated by nurse-midwives. Wisanskoonwong [28] reported that group-based care could improve safety of women and their babies, and their satisfaction with care. If initiated in Ranong, this model could provide Burmese migrant women with additional social support from nurse-midwives, interpreters and other women in the group.

There were many examples in which Thai staff were unkind or judgemental towards the Burmese women. Training in cultural competency would give staff a greater awareness of the needs of these women and enable them to provide compassionate care.

9. Limitations of the study

This is a small ethnographic study conducted in two sites in Ranong province in Thailand and the findings may not reflect care provided to migrant and refugee women in other parts of Thailand. The ten women who participated all held legal status and they had the right to access health care. Women without a legal status in Thailand may not have participated in the study for fear that their status would be exposed. It is also possible that important information has not been captured or appropriately translated. As described, the process of translation and back translation from Burmese to Thai (via interpreters in the interviews and health professional consultations) and then the translation and transcription from Thai to English was complex and may have impacted the quality of the data.

10. Conclusion

In general, all the health providers held mainly positive views about their experiences of interacting with Burmese women. However, in many cases, the interactions between the women and health staff reflect that some women may have faced barriers accessing antenatal services, and when they did, the feeling of 'being processed' and lack of recognition of cultural values may have impacted ongoing engagement. On the other hand, health professionals in this service, and more globally, can learn from the more positive outcomes when relational, person-centered and family-inclusive care, evident in the postnatal ward, was adopted.

Conflicts of interest

There are no conflicts of interest to declare.

Ethical statement

The study was approved by the Human Research Ethics Committee (HREC) of Western Sydney University. Registration number: H11099; date: 4th May 2015. The study was also granted approval letter by the Ranong Hospital Committee and Provincial Public Health Office; date: 6th May 2015. Written informed consent for participation in the study was obtained from the Burmese migrant women and the health staff.

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