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Karla Marleny Escobar

Experiences of Venezuelan refugee mothers during pregnancy and delivery in Trinidad & Tobago: A qualitative study

By

Karla Marleny Escobar
MPH

Hubert Department of Global Health

_____

Reynaldo Martorell, PhD, AB
Committee Chair

_____

Saria Hassan, MD, MPH
Committee Member

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By

Karla Marleny Escobar
Bachelor of Science
Texas A&M University – Corpus Christi
2017

Thesis Committee Chair: Reynaldo Martorell, PhD
Thesis Committee Member: Saria Hassan, MD, MPH

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Abstract

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The worsening humanitarian crisis in Venezuela has forcibly displaced millions of Venezuelans who are mostly settling in other Latin American countries and the Caribbean. There are currently little data on maternity outcomes and contributing factors to maternal morbidity and mortality within this population. This is made more difficult by the number of Venezuelans finding themselves in irregular situations and with undocumented status in host countries. The proximity of Trinidad & Tobago, in addition to the number of Venezuelans it has received compared to the size of its population, makes Trinidad & Tobago a country of interest. For this reason, fourteen qualitative interviews were conducted with Venezuelan refugees who were pregnant or mothers, living in Trinidad & Tobago. Subsequently, a thematic analysis of transcripts was completed to better understand the lived experiences of this population during prenatal care and delivery. There were five main themes developed that included *multi-faceted discrimination*, *normalization of suboptimal care*, *mental health burden*, *significant role of family and friends,* and *significant role of support organizations*. To address the gaps in knowledge that exist for Venezuelan refugees, further research is needed for specific sub-populations that may be facing different challenges to maternity care, including indigenous Venezuelans. More research is also needed to examine the prevalence of maternal morbidity and mortality and how current prenatal care is impacting maternal outcomes.

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Chapter 1 Literature Review

Displaced Populations Globally

By the end of 2020, the United Nations High Commissioner for Refugees (UNHCR) estimated that globally 82.4 million people were forcibly displaced and an estimated 48% of these individuals were female (United Nations High Commissioner for Refugees [UNHCR], 2020). Forced displacement includes individuals driven to leave their homes due to persecution, conflict, violence, or human rights violations. After forced displacement, some individuals will apply for international protection seeking refugee status. Asylum-seekers are those in the process of seeking protection but whose case has not yet been determined (Heslehurst et al., 2018). Refugees are asylum-seekers whose case has been successful and their legally recognized as refugees by governing bodies (Heslehurst et al., 2018). Currently, most governing bodies use the 1951 Geneva Convention to determine the validity of asylum-seeker applications and define a refugee as:

> "…a person who is outside his or her country of nationality or habitual residence; has a well-founded fear of being persecuted because of his or her race, religion, nationality, membership of a particular social group or political opinions; and is unable or unwilling to avail him- or herself of the protection of that country, or to return there for fear of persecution (*Article 1A(2)*)" (UNHCR, 2011).

There are fifteen countries in Latin America that have adopted the 1951 Convention definition and the 1984 Cartagena Declaration definition (Freier et al., 2022). The 1984 Cartagena Declaration expanded the refugee definition in response to the mass displacement from civil

wars and human rights violations across Central America (Freier et al., 2022). This definition includes:

> "…persons who have fled their country because their lives, safety, or freedom have been threatened by generalized violence, foreign aggression, internal conflicts, massive violation of human rights or other circumstances which have seriously disturbed public order" (UNHCR, 1984).

For individuals whose cases are denied, they become stateless persons and lack access to basic rights such as education, health care, employment, and freedom of movement (UNHCR, 2020). Additionally, the term migrant overlaps with asylum-seekers, refugees, stateless persons, and includes individuals who are forcibly displaced, but have not applied for refugee status and includes those who move either temporarily or permanently (immigrants) for other reasons such as work or seeking a better life (e.g., economic migrants) (Heslehurst et al., 2018; Merry et al., 2013). Of all forcibly displaced individuals in 2020, 20.6 million had refugee status, 4.1 million were asylum-seekers, and another 4.1 million were stateless persons (UNCHR, 2020). In 2020, the top five countries where the greatest number of refugees and displaced populations originated included the Syrian Arab Republic (6.7 million), Venezuela (4.0 million), Afghanistan (2.6 million), South Sudan (2.2 million), and Myanmar (1.1 million) (UNHCR, 2020). By the end of 2020, 86% of all refugees and displaced Venezuelans were hosted in developing countries (UNCHR, 2020). As defined by UNHCR, displaced Venezuelans are individuals who need international protection according to the Cartagena Declaration, but have not applied for asylum (UNHCR, 2020).

Venezuelan Crisis and Displacement of Venezuelan Population

The República Bolivariana de Venezuela, hereinafter called Venezuela, is a country in South America with a total area of 916,445 km^2 and a GDP of 44.89 billion in 2022 (McCoy et al., 2022; O'Neill, 2021b). It has an estimated population of 3.2 million in 2021, and its official language is Spanish, but also has official indigenous languages (i.e., Goajiro, Warrau) (McCoy, 2022). The current political, health and economic crisis has led to the largest displacement crisis in Latin American history (Bahamondes et al., 2020; Freirer et al., 2022; Gallo Marin et al., 2021; Teff, 2019). Starting in 2014, the drivers of this humanitarian crisis include severe food and medicine shortages, extreme hunger, and poverty (Labrador & Merrow, 2019; Teff, 2019; UNHCR, 2017). Estimates in 2021 by the *Encuesta Nacional de Condiciones de Vida* (ENCOVI), National Survey of Living Conditions, conducted by researchers at Universidad Católica Andrés Bello, place 94.5% of Venezuelans in poverty and 76.6% in extreme poverty. Furthermore, human rights violations are increasingly common including arrests for arbitrary reasons, torture of incarcerated individuals, persecution of journalists, and increased violence and use of force (Freirer et al., 2022). As of January 2022, an estimated six million Venezuelans have been displaced with five million being hosted in other Latin American and Caribbean countries (Inter-Agency Coordination Platform for Refugees and Migrants from Venezuela [R4V], 2022). While there have been increases in the number of asylum-seekers from individuals originating in Venezuela, most displaced Venezuelans find themselves in irregular situations without any legal protection (UNHCR, 2017). Many Venezuelan refugees primarily leave for Colombia, Peru, and Chili but have settled in many other Latin American countries (Doocy et al., 2019; Freirer et al., 2022; Gallo Marin et al., 2021; UNHCR 2017).

Table 1. Estimated number of Venezuelans in Latin American Countries as of January 2022.

Country	*Population*
Colombia	1,840,000
Peru	1,290,000
Ecuador	508,900
Chile	448,100
Brazil	261,400
Panama	121,600
Mexico	83,000
Costa Rica	29,900
Argentina	173,200
Uruguay	16,600
Bolivia	12,100
Paraguay	5,640
Dominican Republic	115,300
Trinidad & Tobago	28,500
Guyana	24,500
Aruba	17,000
Curacao	14,200
Other countries	1,050,000

Estimates from R4V. Numbers are likely underestimates since they do not include individuals with undocumented or irregular status.

Countries in the Caribbean have received lower numbers of Venezuelans compared to countries such as Colombia (1.3 million). However, the Caribbean as a region has higher proportions of refugees and migrants per capita (R4V, 2022). True estimates of displaced Venezuelans are difficult to assess given the underestimation that results from undocumented individuals leading to large discrepancies in estimates from different sources (Herbert, 2021). For example, R4V estimates that there are 28,500 Venezuelans in Trinidad & Tobago as of 2022. On the other hand, Melanie Teff with Refugees International estimated 40,000 Venezuelans, including undocumented individuals, living in Trinidad & Tobago as of 2019. This is of great significance since this would mean that Trinidad & Tobago has received more Venezuelans, compared to the percentage of its population, than other countries (Labrador & Merrow, 2019; Teff, 2019).

Table 2. Estimated number of refugees and migrants from Venezuela in Trinidad & Tobago

Category	*Population*
Residence permits and regular stay granted[1]	16,500
Pending asylum claims[2]	17,800
Recognized refugees from Venezuela[2]	3,100
Total	**37,400**

Estimates from R4V. This does not include individuals with undocumented or irregular status. [1]Last updated 5 April 2022. [2]Last updated 30 June 2021.

Trinidad & Tobago consists of two main islands and smaller islands in the Caribbean Sea with a total area of 5,130 km^2 (IOM, 2020; Watts et al., 2022). The country has a population of 1.3 million, a GDP of 2.16 billion, and the official language is English (O'Neill, 2021a; Watts et al., 2022). At its nearest point, Trinidad & Tobago is only 12 km from Venezuela across the Caribbean Sea (IOM, 2020). Many Venezuelans cross the dangerous passageway known as *Bocas del Dragón* (Mouth of the Dragon) by boat where they are vulnerable to human trafficking, violence, and shipwrecks (Rodriguez & Collins, 2021). Venezuelan refugees have disappeared, drowned, or been killed crossing into Trinidad & Tobago (Rodriguez & Collins, 2021).

Once in Trinidad & Tobago, many Venezuelan refugees are forced into irregular situations, even those considered asylum seekers or granted refugee status by the UNHCR. Trinidad & Tobago does not provide these individuals with legal access to employment despite their refugee status and they are forced into the same exploitive irregular situations as undocumented Venezuelans to survive and support themselves and their families (Teff, 2019). In 2018, the Minister of National Security explicitly stated that their government still considered refugees and asylum seekers as "illegal immigrants" (Teff, 2019). However, in 2019, the government in Trinidad & Tobago provided a two-week amnesty period where anyone, regardless of legal status, could register for a one-year work permit (Herbert, 2021; IOM, 2021). During this period 16,532 Venezuelans

were registered and in 2021 the government allowed a re-registration process for those who had previously registered allowing them to extend their one-year work permits (Herbert, 2021; IOM, 2021). For those who were not able to register for the permit or for newer arrivals, they are forced to continue in irregular situations that place them at greater risk of violence, exploitation, coercion, sexual abuse, trafficking, and discrimination (UNHCR, 2017).

Although it is difficult to determine the population composition of Venezuelan refugees in Trinidad & Tobago, a 2021 non-probability sample study by the International Organization for Migration (IOM) provides limited information on the demographics of Venezuelan refugees. Between October and November 2021, 1,376 participants participated in a survey carried out by IOM in Trinidad & Tobago. They found that 0.4% did not have any formal schooling, 35% completed secondary school, and 32% completed University education (IOM, 2021). When examining their migration status, 34.7% reported having the Minister's Permit whereas 31.5% were without any migration status (undocumented) (IOM, 2021). Approximately 50% of respondents journeyed to Trinidad & Tobago accompanied and 82% of respondents traveled with their families (IOM, 2021).

Maternal Morbidity, Mortality & Humanitarian Crisis

In a humanitarian crisis, refugees are at greater risk of worsened maternal and pregnancy outcomes. The World Health Organization (WHO) defines maternal health as the "health of women during pregnancy, childbirth, and the postnatal period" (World Health Organization [WHO], n.d.). Maternal morbidity includes any health condition (e.g., diabetes, depression, cardiovascular disease) that negatively impacts a woman's health during these periods (Office of the United Nations High Commissioner for Human Rights [OHCHR], 2009; National Institute of Child health and Human Development [NICHD], 2020). When these events are life-threatening

and require specialized care at a hospital, they are considered severe maternal morbidity and can include organ system failure, massive hemorrhage, cardiac arrest, stroke, heart failure, eclampsia, sepsis, peripartum hysterectomy, and uterine rupture (van den Akker & van Roosmalen, 2016; NICHD, 2020). Maternal mortality results when these maternal morbidity events result in the death of the mother during pregnancy or within six weeks after the pregnancy ends, not including accidental deaths of a woman who is pregnant (NICHD, 2020; OHCHR, 2009). According to WHO, the most common causes of maternal mortality include unsafe abortions, labor and delivery complications, severe hemorrhage, infections/sepsis, pre-eclampsia and eclampsia, and disorders of blood pressure (OCHR, 2009; NICHD, 2020). Maternal mortality is often used to monitor pregnancy outcomes across the world (van den Akker & van Roosmalen, 2016; NICHD, 2021). Despite the standardized definition of maternal mortality, in practice, it is difficult to measure because it can be challenging to identify maternal deaths because a woman's pregnancy status may be unknown or, in some countries, causes of death and medical certification are not reported (OHCHR, 2009).

Most maternal deaths are preventable and often result from delays when deciding to first seek care (e.g., financial considerations), reaching care (e.g., transportation, location of health facilities), and in receiving care (e.g., poor referral system, lack of trained providers) (van den Akker & van Roosmalen, 2016; Hynes et al., 2012). In 2017, WHO estimated that every day 810 women died from complications related to their pregnancy and they report that these deaths were preventable. Maternal mortality and morbidity could be reduced with timely access to care for obstetric emergencies, access to adequate prenatal care (four or more visits), and having skilled and trained assistance during delivery at a hospital (Geltore & Anore, 2021; Hynes et al., 2012).

Refugees are at an increased risk of adverse outcomes during pregnancy due to sporadic access to sexual and reproductive health services (SRH) (e.g., perinatal care), lack of health infrastructure and social networks, inadequate SRH services, unplanned pregnancies, unsafe abortions, increased sexual and gender-based violence, high-risk sexual behavior, and increased sexually transmitted infections (van den Akker & van Roosmalen, 2016; Endler et al., 2020; Fair et al., 2020; Hynes et al., 2012). Other social determinants of health, such as social-economic status, increased stress during migration and settlement, barriers to healthcare, history of trauma for refugees and migrants, and existing health conditions from lived experiences in the home country (e.g., malnutrition) can all significantly impact the health of the mother (Merry et al., 2013). In high-income countries, literature exploring maternal morbidity and mortality among refugees documents higher rates of induced labor, elective and emergency cesarean delivery, pre-term births, infants with low birth weights, and increased risk for excessive bleeding, infections, and post-partum depression (Mosely et al., 2021). Contributing to these worsened health outcomes is suboptimal and inadequate care during the perinatal period indicating that many of the maternal deaths in this population are preventable (Villadsen et al., 2016; Leppälä, 2019). In Norway and Sweden, studies exploring maternal death among immigrants reported that two out of three maternal deaths were linked to suboptimal care during both pregnancy and childbirth (Villadsen et al., 2016; Leppälä, 2019). In Canada, it was found that over 20% of immigrant mothers new to Canada received inadequate care and the mother's ethnicity was a significant risk factor (Khanlou et al., 2017). Those considered undocumented or in irregular situations, are at greater risk for worsened maternal and pregnancy outcomes and often face higher stress and anxiety due to fear of deportation, less social support networks, and fewer resources to access adequate and timely healthcare (van den Akker & van Roosmalen, 2016). In addition, the

underreporting of undocumented individuals and asylum-seekers may lead to an underestimation of the true prevalence of maternity outcomes within this population (van den Akker & van Roosmalen, 2016).

Interestingly, there have been studies that reveal migrant populations, specifically refugees, may have better maternal and pregnancy outcomes than local populations. A study examining maternal deaths in ten UNHCR-funded refugee camps across Africa and Asia found that refugee mothers had better outcomes and fewer maternal deaths due to the resources and support provided by UNHCR and local organizations (Hynes et al., 2012). Reasons for this included better access to care since services provided were free for refugees, transportation was provided for referral hospitals that could perform specialized procedures (e.g., cesarean sections), and transportation was provided to facilities with adequate equipment, supplies, and trained health personnel in emergency obstetric care (Hynes et al., 2012). On the other hand, other studies have shown that even when resources are comparable for refugees and local populations, refugees often perceive worse care. This is the case of a study examining refugees from South Sudan in Northern Uganda, despite the availability of obstetric services to both populations, refugees accessed prenatal services less frequently, were less satisfied with their received care and were more likely to feel discriminated during their prenatal visits (Rustad et al., 2021).

Maternal Morbidity and Mortality Among Venezuelan Displaced Populations

Currently, there is limited published information examining the prevalence of maternal mortality, morbidity, and SRH in general among Venezuelan displaced populations. Most of the literature on Venezuelan migrant health has focused on infectious diseases such as Zika, Chikungunya, Chagas, measles, and diphtheria (Gallo Marin et al., 2021). There is less literature focused on

migrant women and their maternity care, and this literature is focused on South America, specifically Brazil and Colombia (Makuch et al., 2021; Gallo Marin et al., 2021).

In Venezuela itself, the Ministry of Health reported an increase of 65.8% in maternal mortality from 2015 to 2016 (UNFPA, 2021). In 2019, there were 352 maternal deaths reported by the Ministry of Health in Venezuela (98,87 deaths per 100,000 live births) which was a decrease of 17% from the previous year (UNFPA, 2021). The 2021 ENCOVI survey found that among Venezuelan participants who had a child in the past five years, 97% had at least one prenatal visit, 23% started prenatal visits at four months (adolescents started later), 14% had four or fewer prenatal visits, 75% had eight or fewer prenatal visits, and 73% accessed prenatal services in public facilities (Universidad Católica Andrés Bello, 2021). In studies with Venezuelan refugees, it has also been documented that the search for accessible and quality maternal services along with economic opportunity and food security are drivers of migration for pregnant women (Doocy et al., 2019; Giraldo et al., 2021; Makuch et al., 2021).

For Venezuelan refugees in other Latin American countries, there have been documented increases in low birth weights and peri- and neonatal mortality, maternal morbidity, and mortality (Doocy et al., 2019). The Colombian Government reported that in 2018, more than 8,000 pregnant Venezuelans entered the country and the majority had not received any type of prenatal care (Government of Colombia, 2019). Of concern, is that 673 Venezuelan pregnancies in Colombia belonged to girls and adolescents aged 13-17 and 57 belonged to girls and adolescents from indigenous groups (Government of Colombia, 2018). In 2019, the Colombian Ministry of Health (MoH) reported an increase in the number of births to Venezuelan mothers from 5,561 in 2017 to 52,635 in 2019 (Gallo Marin et al., 2021). In one Brazilian hospital, there was an increase in the proportion of pregnancy deliveries belonging to Venezuelan refugees from

3.4% in 2016 to 26.1% in 2019 (Bahamondes et al., 2020). The rising number of pregnant Venezuelans delivering in these two countries highlights a need for maternity service accessibility. Furthermore, when comparing the period from 2017 to 2019 in Colombia, the number of reported severe maternal morbidity cases increased from 26 to 617 and maternal mortality cases increased from 5 to 19 (UNFPA, 2020). In this same period, the number of newborns with low-birth-weight increased from 7 to 105 (Ministerio de Salud Colombia, 2019). Despite these statistics reflecting an increase in the number of adverse maternal and neonatal outcomes from 2017 to 2019, it is unclear if these numbers reflect worsening health or the overall increase in the number of Venezuelan refugees.

When it comes to the extent of the mental health burden of pregnant Venezuelan refugees, there are little available data. A study exploring mental health and migration among Venezuelans in Peru found that of their participants (n=799), 19% were determined to have depression (PHQ9 $\geq$ 10), and 23% were determined to have anxiety (GAD $\geq$ 10) (Carroll et al., 2020). For pregnant women in this study (n=394, 7%), the odds ratio of depression was 4.15 times higher than non-pregnant participants (significant) and the odds ratio of anxiety was 1.59 times higher than non-pregnant participants (not significant) (Carroll et al., 2020). Another study of Venezuelan migrants in Colombia (n=520) found that 32.1% of pregnant women in irregular situations had depression (CESD-D $\geq$ 12) in Barranquilla and Riohacha, Colombia (Fernández-Niño et al., 2019).

In Trinidad & Tobago, there is scant published information regarding maternal mortality and morbidity for Venezuelan refugees. The study by IOM (mentioned earlier) reports that among their Venezuelan participants in Trinidad & Tobago for 2021, 46% of pregnant women reported not accessing prenatal services (IOM, 2021). No access to prenatal care has been linked to

worsened maternity outcomes among migrant populations. With few data available, it is difficult to determine the prevalence of maternal mortality and morbidity for Venezuelan refugees in Trinidad & Tobago and the factors contributing to worsening maternity outcomes.

Barriers & Facilitators to Healthcare Access

For the displaced Venezuelan population, there are few studies exploring barriers and facilitators specific to perinatal care. However, consistent with findings among other migrant groups (Khanlou et al., 2017; Leppälä et al., 2020; Villadsen et al., 2016), language barriers for Spanish-speaking Venezuelans have been identified as a barrier to healthcare access among refugees hosted in non-Spanish speaking countries such as Brazil (Gallo Marin et al., 2021). Language barriers contribute to inadequate maternity care since women are unable to express their concerns or needs to health staff (Khanlou et al., 2017). Contributing to decreased patient-provider communication is the consistent lack and underutilization of quality interpreter services in healthcare for migrant women (Villadsen et al., 2016).

The legal status of undocumented Venezuelans has been identified as another significant barrier to maternity care (Girlado et al., 2021). This is due to increased challenges in accessing healthcare (e.g., required identification/registration), less knowledge of the health system, increased risk of job insecurity, and no access to social protection systems (Giraldo et al., 2020). Undocumented refugees in irregular situations often do not have healthcare coverage or any other resources for help. Some countries (e.g., Colombia) have policies in place that undocumented individuals who are pregnant can access perinatal services (Giraldo et al., 2021). However, there remain many countries that do not have these types of policies in place (e.g., Canada, Finland) that prevent vulnerable populations from accessing critical maternity services (Khanlou et al., 2017). For undocumented Venezuelans, pregnancy itself can become a barrier

since it can become difficult to find or hold a job once a woman becomes pregnant (Giraldo et al., 2021). With no access to health insurance and limited access to public services, women's only options are expensive private services. However, with little or no income, these private services are often not an option leading to the underutilization of maternity services by undocumented Venezuelan refugees (Giraldo et al., 2021). This increases the risk of adverse maternity outcomes in a population that is already vulnerable.

Studies exploring barriers to healthcare among Venezuelan refugees were conducted in Colombia and Brazil. In Colombia specifically, the cost of services and transportation, the distance of health facilities, and the lack of health insurance were all identified as barriers to healthcare (Doocy et al., 2019). In Colombia, the government provides emergency care for all but denies preventative care to Venezuelan refugees except for free perinatal services offered to pregnant Venezuelans regardless of legal status (Giraldo et al., 2021). Although providing access to perinatal care for pregnant women, the inefficiency of the health system from its policies prevents many women from receiving timely perinatal care. Pregnant women are required to receive prior authorization for accessing prenatal care and for every medical procedure at the City Hall (Giraldo et al., 2021). When the program first began, City Hall only issued 25 authorizations daily and some Venezuelans reported spending the night near City Hall and still not being able to obtain authorizations for care (Girlado et al., 2021). In response, the government created telephone lines for appointments, but the limited allocations leave many women with the inability to access timely prenatal care (Giraldo et al., 2021).

In contrast to Colombia, Brazil offers its population universal healthcare including foreign-born individuals (Doocy et al., 2019). Refugees are still required to hold a national health card to access care. Although migrants with refugee status or residency are eligible, they often identify

language and discrimination as barriers to receiving these cards and accessing care (Doocy et al., 2019). Similarly, to Colombia, Venezuelans with no legal status have fewer options of care and worse maternity outcomes. Additionally, in a qualitative study with Venezuelan migrants living in shelters in Brazil, some participants described delayed and insufficient number of visits for prenatal care that resulted from difficulty accessing the first consultation (Makuch et al., 2021).

Though studies have mainly identified barriers to care for pregnant Venezuelan women, there are also facilitators that have been identified for this population. Personal support systems that consist of partners, family, friends, and community organizations have been found to facilitate access to medical care services (Giraldo et al., 2021). For Venezuelan women in UNHCR shelters in Brazil, UNHCR facilitated transportation to and from health facilities when they needed certain exams or treatments, especially for pregnancies considered high risk (Makuch et al., 2021). In Colombia, Venezuelan refugees used informal and formal networks to receive information related to their pregnancy and maternity services (Giraldo et al., 2021). These informal networks included friends that would provide information and instructions based on their own experiences, such as informing the participants of where to go and what to do after accessing maternity services (Giraldo et al., 2021). Formal networks include social workers and other health staff that refugees can ask for advice and information related to health (Giraldo et al., 2021). These support systems were identified by Venezuelan women as aiding their access to healthcare and navigation of the country's health system.

The limited amount of information available regarding Venezuelans in Trinidad & Tobago, the proximity of Venezuela to Trinidad & Tobago, and the estimated high proportion of Venezuelans to the total population in Trinidad & Tobago indicate a clear need to better understand the context, experiences, and needs of the Venezuelan population who are pregnant or mothers in

Trinidad & Tobago. This knowledge can then be used to inform future interventions aimed at improving maternal and pregnancy outcomes among this population and contribute to literature for migrant women in the Caribbean and at large. To that end, this qualitative study focused on the following research question:

What are the healthcare experiences of displaced Venezuelan women during prenatal care and delivery in Trinidad & Tobago?

Chapter 2 Methods

Study Design

This is a cross-sectional study design of qualitative semi-structured in-depth interviews. The principal investigator (PI) is Saria Hassan, MD, MPH. The study was originally funded by The Downs International Health Student Travel Fellowship. Thematic analysis was completed on transcripts that were collected as part of an ongoing mixed-methods study started in May 2021 in Trinidad & Tobago with Venezuelan refugees of reproductive age. This ongoing study is a collaboration between Emory University and the local faith-based organization Living Water Community (LWC). The original research is seeking to understand the lived healthcare experiences of Venezuelan migrant women in Trinidad & Tobago while simultaneously examining healthcare access, perceived discrimination, anxiety, and depression. The research protocol was approved by Emory's Institutional Review Board (IRB) and Trinidad & Tobago's Ministry of Health IRB Committee; the author (KE) is listed as an investigator in IRB documents.

Participants

The study population included pregnant Venezuelan women or non-pregnant Venezuelan women with children two years old or younger currently living in various cities in Trinidad & Tobago including Princes Town, San Fernando, Chaguanas, Arima, Arouca, and Tacarigua. Participants were all older than 18 years. Participants had gained refugee status or were in the process of acquiring refugee status; hereinafter, all will be referred to as refugees. The recruitment process was completed in collaboration with LWC. LWC is partnered with the United Nations High Commissioner for Refugees (UNHCR) in Trinidad & Tobago and closely works with Venezuelan refugees in a variety of services that include facilitating registration for asylum-

seekers, case management, and helps with housing, health, education, documentation, and other key services (Teff, 2019). As a trusted member of the Venezuelan migrant community, LWC recruited participants for interviews through purposive sampling. They contacted women in their listserv of pregnant Venezuelan women or non-pregnant Venezuelan mothers to ask if they were interested in participating in this study. If women expressed interest, the contact information was sent to me. Of the twenty-eight women that I contacted for possible participation in the qualitative study, fourteen agreed and consented to interviews. The remaining women did not respond to initial contact efforts and the reasons for non-participation are unknown.

Procedures

After the interview guide was developed by-(PI), interview guide with piloted with Spanish-speaking LWC caseworkers who were themselves, immigrants and refugees. This was done to ensure questions were culturally appropriate and tailored to our target population. Adjustments and changes in the phrasing of questions were made for clarity based on the recommendations of the caseworkers. After LWC recruited the Venezuelan women, interviews were scheduled at a convenient time for the participants. Participants were informed of study background, objectives, and associated risks prior to interview. Participants were notified that participation was voluntary and they could end interview at any time. Written consent was obtained prior to interview. Verbal permission was obtained from participant interview using Zoom. Interviews were conducted through various media platforms including, Zoom, WhatsApp, and Rebtel for international phone calls depending on the participant's request. Confidentiality was maintained by assigning numbers to participants. Audio recordings and transcript data were securely stored in password protected OneBox Drive.

Student Contribution: KE piloted the interview guide, coordinated interviews with participants, conducted interviews, assessed data quality and accuracy

Data Analysis

A qualitative thematic analysis was completed for this thesis. Interviews were professionally transcribed using Landmark Associates, Inc. Recordings and transcriptions provided by Landmark Associates, Inc. were reviewed to ensure data accuracy from recordings to transcription. Codes were developed through an inductive and deductive process. Common themes were identified through the literature review of qualitative studies with Venezuelans and other refugees to develop deductive codes (e.g., language barriers, discrimination). After transcription, codes were added to the codebook (e.g., migrating for healthcare) through an inductive process when reviewing transcript data. Participant transcripts were first printed to manually memo and develop initial codes for re-occurring themes, ideas, experiences, attitudes, and concerns. Next, transcripts were added to the software package MAXQDA 2020 to organize data and continue data analysis through an iterative process of refining codes/themes. Common themes were discussed with PI before finalizing major themes.

Chapter 3 Results

Semi-structured in-depth interviews were completed with fourteen Venezuelan migrant women living in Trinidad & Tobago. Characteristics of the participants are found in *Table 2.* Only three of the participants were pregnant at the time of the interview. After a thematic data analysis of transcripts, five major themes emerged: *Multi-faceted discrimination, Normalization of suboptimal care, Mental health burden, Significant role of family and friends,* and *Significant role of support organizations.*

Table 2. Characteristics of the women who participated in semi-in-depth interviews (n=14)

Participant Characteristics	*n*
Pregnant	3
Children under two	13
Living with partner	10
Working	0
Delivery at hospital	13
Migrated while pregnant	1

Table 3. Themes & Subthemes developed from qualitative interviews.

Themes	Subthemes	Description
Multi-faceted Discrimination	Legal Status	Challenges accessing care due to lack of proper documentation, experiences of denied care and threats
	Language Barriers	Challenges communicating with providers due to language barriers (Spanish-speaking participants vs English-speaking providers), refused care without in-person translator
	Racism	Being treated differently for being Venezuelan and Spanish-speaking; discriminatory behaviors and attitudes of providers and staff
	Health Risk	Implications of discriminatory behavior during delivery for health of mother and newborn

Normalization of Suboptimal Care	Acceptance of status quo	Satisfaction of care described in context of substandard care
	Lack of agency	Feelings of being unable to speak up and advocate for themselves in healthcare setting
Mental Health Burden	Feelings of worthlessness	Response to being ignored or having medical concerns not taken serious
	Depression	Response to negative treatment received by providers
	Isolation	Feelings of isolation expressed during delivery when participant was alone
	Stress/Anxiety	From non-medical stressors such as financial concerns
Significant Role of Family and Friends	Emotional Support	Support at home and validation
	Logistical Support	Facilitating access to healthcare by providing serving as in-formal translator and recommending places/doctors
Significant Role of Support Organizations	Financial Support	Providing financial assistance for food, rent, and other needs
	Logistical Support	Facilitating access to healthcare by aiding in the registration process
	Emotional Support	Feeling supported by community organizations

Multi-faceted Discrimination

Participants described discriminatory behaviors by health providers when first accessing pregnancy services and throughout their prenatal and delivery experiences based on their nationality, legal status, and language. Some of the participants noted that when they first attempted to access prenatal care they were turned away because of their undocumented status. Most participants using public facilities stated they were able to access care after registering with UNHCR. While Trinidad health policies require women to present their legal documentation, the behavior of health staff extended beyond their normal enforcement of policies and became discriminatory when they threatened to call authorities.

> *"…I was six months pregnant, and I went to the hospital. They did not want to provide care because I did not have my registration. They told me that it was a problem because I*

was here illegally, that they could call the police and they did not provide any services." (P 1)

"Y aquí ya tenía yo ya seis meses de embarazo y fui al hospital, no me quisieron atender porque no tenía registro, me dijeron que era un problema porque yo estaba ilegal, podían llamar a la policía y no me atendieron." (P 1)

In addition to the difficulties in first accessing care due to legal status, a few of the participants also reported difficulties due to language barriers from their own experience or what they had heard from others. Many of the health facilities in Trinidad required Venezuelans to bring someone to translate in-person, and very few accepted the use of a telephone to translate. When speaking about this language barrier between providers and Venezuelan patients, participants stressed the lack of flexibility health staff demonstrated by refusing to allow phone translators. For some participants, this caused a further delay in receiving timely prenatal care since they were turned away and denied care.

"It was here at the health center… [that] it was a problem. They did not want to accept my telephone, like always. I had to bring someone to translate. I would say that I didn't have anyone, that is why I had my phone… [they would say] no to the telephone. That if I came here to do nothing, that I should leave. With their hand, they would gesture for me to leave, and I would leave from there. I would leave or they would scold me…" (P 2)

"Fue aquí, en el centro clínico… fue un problema. No me querían aceptar cómo siempre el teléfono. Tenía que llevar alguien que tradujera. Yo decía que yo no tenía, por eso llevaba el teléfono..que el teléfono no, que si yo no iba a hacer nada ahí, que me fuera.

Me hacían con la mano que me fuera y yo me salía de ahí. Me salía o me regañaban…" (P 2)

Of note regarding the use of phones as translators, one participant linked the acceptance of telephones for translation in healthcare as an acceptance of Venezuelans by providers in that area.

"But now, Venezuelans, in some parts, have been accepted… [and health staff] accept the telephone, using the telephone." (P 12)

"…ya los venezolanos, en algunas partes, han sido aceptados…[y los proveedores] aceptan el teléfono; el uso del teléfono." (P 12)

Also, a few of the participants directly linked their negative healthcare experiences to racism and discrimination. In these cases, participants mentioned occasions of being denied care, being treated last despite arriving at the center early and being ignored or not taken seriously by health staff.

"Very few times is the treatment good, but more often it is with racism. They leave us talking to ourselves, they ignore us, we are the last ones to get seen. I lived those experiences throughout my appointments towards the end of my pregnancy…" (P 7)

"Muy pocas veces es bueno el trato, pero más es con racismo. Nos dejan hablando solos, nos ignoran, somos los últimos a quien atienden. Eso lo pasé conforme a las citas, a lo último de mi embarazo…" (P 7)

Participants were aware of the differences in treatment for pregnant Venezuelans and Trinidadians even if they did not encounter it themselves. These differences were experienced

throughout the entirety of their pregnancy to delivery. During prenatal consultations, participants described experiencing denial of care for arbitrary reasons (e.g., wearing a dress), delayed care, enduring medical staff yelling, or demeaning commentary. Participants stated that priority of services was given to non-Venezuelans, and they would often arrive early but were the last patients to leave. These experiences were specifically connected to nationality, being Venezuelan, and their spoken language, Spanish.

> *"In some cases, it has not been easy. Because, for the fact of being Venezuelan, they tell you that there is no care for Venezuelans. For the Hispanics, as they call them, Spanish." (P 12)*

> *"En algunos casos, no ha sido fácil. Porque, por el hecho de ser venezolana, te dicen que no hay atención para los venezolanos. Para los Hispanics, le dicen ellos. Spanish." (P 12)*

> *"…it was what they wanted. If they wanted to treat you it was when they felt like it when they chose to. But no, with the women in the area, the treatment was different…" (P 1)*

> *"… era lo que ellos quisieran, si te querían atender era cuando les diera la gana, cuando se les antojara en cambio no, con mujeres en el área el trato era diferente…" (P 1)*

During delivery, participants shared experiences that ranged from discriminatory behaviors with less severe consequences (e.g., being reprimanded by staff) to experiences that put the mother or newborn's life at risk (e.g., providers ignoring medical concerns). For those behaviors with less severe consequences, participants described similar discriminatory events or behaviors to those experienced during their prenatal consultations (e.g., reprimanded, yelled at, ignored).

> *"… and when they saw that we were there like helping each other, they separated us. They sent her to one side and sent me to the other. They reprimanded us. I already had very strong pains and when I told them I wanted to go to the restroom, they did not accompany me. The Venezuelan accompanied me, she helped me go to the restroom and to them, all of that bothered them. They yelled at us." (P 9)*

> *"y ellas como vieron que nosotros estábamos ahí como ayudándonos nos separaron. A ella la mandaron por otro lado, a mí por otro y nos regañaban, ya yo tenía los dolores muy fuertes entonces yo pues ya le decía que yo quería ir al baño y demás y ellas no me acompañaban y la venezolana me acompañaba, me ayudaba a ir al baño y a ellas todo eso les molestaba, nos gritaban pues." (P 9)*

For two participants, discriminatory attitudes of indifference and disregard directly placed their life and their newborn's life at great risk. These experiences resulted from language barriers where health staff ignored efforts by participants to share their medical concerns. One participant described her attempt to inform her doctor of her symptoms (i.e., numbness and bleeding) immediately after giving birth using the phone translator. However, the doctor told her to put the phone away and did not attempt to communicate with the participant in any way. Another participant shared her experience with a nurse who refused to aid her suffocating baby.

> *"When they took me to the observation room, my baby was suffocating… So I called a nurse, [told her] my baby was suffocating and the nurse told me she didn't – 'Don't speak Spanish,' and she treated me badly. She did not want to see my baby… A Trinitarian, a young woman, got up and helped my baby. My baby was purple… well, they left me in pain because of racism." (P 7)*

"Cuando me llevaron a la sala de observación, mi bebé se estaba ahogando... Entonces yo llamé a una enfermera, que mi bebé se estaba ahogando y la enfermera me dijo que ella no— "No habla Spanish", y me trató mal, y no quiso ver a mi bebe… una trinitaria, una muchacha. Se levantó, me auxilió a mi bebé, mi bebé estaba moradita… Bueno, así me dejaron con dolor, por racismo." (P 7)

In the hospital after delivery, the discriminatory treatment by healthcare staff was often extended to their children. A few women stated that after giving birth, the nurses refused to touch them or their children because they were Venezuelan.

"And they had me in the observation room and there the nurses help us. Well, yes, help [lay the baby] down so we could breastfeed, and like that. But no, they never touched my baby because I was Venezuelan. That is, they saw her, like with disgust. They didn't even touch her." (P 7)

"A mí me tienen en una sala de observación y ahí las enfermeras nos ayudan, pues, que, si con el bebé acostándolo para que uno le dé el pecho, y eso. No, a mi bebé ni la tocaban por ser venezolana. O sea, la veían, así, como con asco. Ni la tocaban." (P 7)

Another layer of discrimination after delivery was highlighted by one participant's experience when providers did not meet the hospital's normal standard of care. As explained by the participant, hospitals routinely provide antibiotics to patients after delivery to prevent infections. However, in this case, the participant was refused antibiotics she was entitled to as routine hospital care.

"…they had not given me any antibiotics. They had not given me anything and well they told me to leave, to buy the antibiotics… The Trinidadian man who was with my partner told them that the hospital has the [antibiotics], that they give them, and that they should give them to me because those pills were expensive. They told me no, that I should figure it out, that it was not their problem, to buy them. And well, I left like that." (P 9)

"… a mí no me habían puesto antibiótico, ellas no me habían puesto nada y bueno, y me dijeron que me fuera, que comprara unos antibióticos… El trinitario que andaba con mi pareja le dijo que eso tiene el hospital, lo daban pues que me lo dieran porque esas pastillas eran costosas y ellas me decían que no, que viera cómo hiciera, que ese no era su problema, que las comprara. Y bueno, y me fui así." (P 9)

Normalization of Suboptimal Care

Two women stated they received good and excellent medical care and the rest of participants described both positive and negative experiences during their pregnancy and delivery. These experiences varied by medical facilities for those using private vs public facilities or after being transferred to other facilities throughout care, as well as within the same facility by different health staff. Even for participants who received "good" care, they recognized that many other pregnant Venezuelan women received "terrible" care that included medical negligence and in the worst cases, took the life of the mother or the child. Some participants described this suboptimal care as "normal" for Venezuelans.

"Well, thinking about my own experiences, I think that [health staff] have treated me like a Venezuelan. They will never treat us as, even if we know English, they will not treat us as if we are from here, because they will always treat us differently." (P 8)

"*Bueno, yo pensando en mis experiencias propias, creo que me han tratado como venezolana [laughs]. Nunca nos van a tratar como que por más que tengamos el inglés, no nos van a tratar como si somos de aquí, porque es que ellos siempre nos van a tratar diferente."* (P 8)

This new suboptimal standard of care for Venezuelans was used by some of the participants to describe their satisfaction with the care they received during pregnancy and delivery. Many of the participants stated that care was deemed "good" if they received all their exams during prenatal consultations.

"Then I went there, and I had my consultation. They did all of the exams, everything, everything was there. It was at least good, in other words, not too bad for being Venezuelan and enduring mean facial expressions, all of that." (P 1)

"Luego ya fui ahí y me pusieron en consulta, me hicieron todos los exámenes, todo, todo estuvo ahí, por lo menos bien, o sea, no tan mal por ser venezolana ni pasando malas caras, todo eso." (P 1)

Critical to the normalization of negative care was the creation of an expectation of negative healthcare experiences during the rest of their pregnancy. This normalization process and creation of expectations led to an acceptance of subquality of care. Important to this expressed acceptance by participants was the lack of agency to speak up and advocate for themselves.

"…it was always the same doctor, and she had no empathy… She did not appear to be professional. I would explain my problem, that I had severe headaches that lasted five to seven days. She would say that is normal and I would tell her 'how is that normal?' but she would respond it is normal. I insisted and asked, 'what if something happens to me

because of the pain in my head?' and she would insist that it was normal… so I accepted it." (P 4)

"...siempre la misma doctora, y le faltaba empatía… Ella no parecía profesional. Yo le explicaba cuál era mi problema: que tenía fuertes dolores de cabeza que duraban cinco o seis días, y ella solo decía que eso era normal. Y yo le decía, "¿cómo puede ser esto normal?" y me respondía que era normal, y yo insistía, "¿y si me pasa algo por este dolor de cabeza?", y me volvía a insistir que es era normal…Entonces, lo aceptaba." (P 4)

"Well, I felt uncomfortable.... But since we are in a different country, we cannot complain, we can't do anything, just be grateful for the care we receive." (P 11)

"Bueno, me sentía incómoda… pero como estamos en un país diferente, no podemos reclamar, no podemos nada, solo agradecida por la atención que nos dan." (P 11)

Mental Health Burden

Participants described strong emotional reactions to their negative medical experiences in Trinidad & Tobago. These feelings were present throughout both their prenatal and delivery experiences. Participants commonly expressed feelings of being undervalued or rejected by medical staff from Trinidad or other Spanish-speaking countries because they were refugees and Venezuelans.

"There are also people who work at the health center who are Venezuelans or Cubans, and they think they are like them, like the women who are from Trinidad. They treat you like a migrant and to them, you are worthless." (P 13)

"Cómo también hay personas que trabajan en el módulo que son venezolanas, cubanas, se creen que son ellas; son ellas aquí en Trinidad y te tratan así, como migrante y cómo que tú para ellos, no vales nada." (P 13)

When describing negative medical experiences, experiences were shared that elicited strong emotional responses to the discriminatory treatment received by health staff. Participants described feelings of isolation, anger, sadness, suffering, and feeling worthless. These feelings were a reaction to providers' lack of empathy, purposely ignoring or not taking concerns seriously, and discriminatory attitudes.

"[I felt] very bad. I cried a lot because that was the first time that I was treated that way… I was sick, in pain, and they did not pay me any attention. I told them I was in pain, and they would only give me a pill, like if I were an animal." (P 7)

"Muy mal. Yo lloré demasiado porque es la primera vez que yo tengo un trato así. Me dieron un trato conmigo y yo así enferma, adolorida, no me prestaban atención, y o decía que tenía dolor y solo me daban una pastilla, así como si uno fuera un animal." (P 7)

"Because I don't have anyone who can translate for me. I don't speak the language, English, either. I do not want to endure another rejection, another scolding, I don't want any of that. In truth, it makes me feel very bad. I am a human being." (P 2)

"Porque no tengo quien me traduzca, no hablo el idioma inglés tampoco, no quiero tampoco aguantar otro rechazo, un regaño, no quiero nada de eso. En verdad, eso me hace sentir muy mal. Yo soy ser humano." (P 2)

These same feelings were expressed when witnessing the quality care staff was capable of providing but did not practice with them, the Venezuelans. This further exacerbated the feelings mentioned previously, especially isolation and suffering.

> *"I felt very bad, I mean I felt more alone than ever. More alone than ever... [because] the Trinidadians had their husbands. Clearly, they could not pass into the room, but they were just outside. But no, we couldn't even leave them outside. We had to be alone…" (P 9)*

> *"Me sentí muy mal, yo o sea, me sentía más sola que nunca. Más sola que nunca… [porque] las Trinitarias tenían sus esposos. Claro, no podían pasar hacia adentro, pero estaban ahí afuera. Pero no, nosotras no podíamos ni siquiera dejarlo ahí afuera. Nosotros teníamos que quedar solas…" (P 9)*

Also, when describing the impact on mental health resulting from the harmful treatment by providers, the descriptions of participants provide some insight and context to the level of suffering they experienced. One participant compared their stay at the hospital to hell and states she would have preferred to stay at home dying from the pain when reflecting on the care she received at the hospital,

> *"They arrived with great care; they treated their patients. They gave them injections and I was there suffering with that pain, but well, hoping that the time would pass to return home quickly where I could feel better. It was like hell." (P 7)*

"con delicadeza, atendían a sus pacientes, le ponían sus inyecciones y uno ahí sufriendo con ese dolor, pero bueno, esperando que pasara el tiempo rápido para llegar a casa y uno sentirse mejor. Era como un infierno." (P 7

Of importance, one participant expressed a desire for empathy and acknowledgement of the hardships Venezuelans endure in their country. The lack of empathy by providers and their discriminatory behaviors, further burdens individuals who may have experienced difficulties in Venezuela.

"Why am I treated like this… There must be a consideration for the need one has to force them to come here, for the things that we went through in Venezuela. In Venezuela we endured some things, we endured some things until we arrived here." (P 2)

"por qué me tratan así… hay que considerar la necesidad que uno logró aquí llegar. Por las cosas que pasamos en Venezuela. En Venezuela pasamos unas cosas, pasamos unas cosas, y hasta que llegamos aquí." (P 2)

For a few participants, their experiences of negative healthcare and stories they heard from other Venezuelans, contributed to constant worry throughout their pregnancy. One participant mentioned she heard stories of denied medical procedures during pregnancy emergencies. This led her to constantly worry about complications that may arise during her pregnancy and their outcomes.

"I think that it can become difficult for me because, if I were to have a complication when I go to give birth if there is a complication and they do not treat me, I don't know. Because here I have heard that for Venezuelan women, foreign women, they don't

operate on them, they don't do a cesarean, they don't do [tubal] ligation, none of that. Sometimes, it gets stuck in my head, I think that, so there will be no complications, I don't know." (P 13)

"Yo pienso que se me puede hacer difícil porque, al tener alguna complicación al yo ir a dar a luz, si hay una complicación y que no me atiendan, no sé. Porque he escuchado aquí qué a las venezolanas, las extranjeras, no las operan, no les hacen cesárea. Ni las ligan, nada de eso. A veces, se me mete en la cabeza, que pienso que, para que no haya complicación; no sé." (P 13)

Participants also described non-medical stressors that impacted their mental health. These stressors mostly centered on financial concerns for necessities (e.g., rent, food) and materials directly related to the pregnancy and home preparation for the child (e.g., diapers).

"A woman who... has a baby, has given me clothes for newborns. That is all I have, for the rest, I have nothing. That is my worry. When I go to give birth, since I don't have anything, and I go to the hospital, they ask me for things. And I don't have clothes for the baby or something to place the baby in. I have nothing. I don't have diapers, I have nothing" (P 13)

"Una señora que… tiene un bebé, y me ha obsequiado ropa de recién nacido. Lo único que tengo; lo demás, no tengo nada. Esa es mi preocupación, cuando yo vaya a parir, como no tengo nada, y me vaya del hospital, me pidan cosas, y no, ropa para el bebé, o qué colocarle al bebé, no tengo nada. No tengo pañal, no tengo nada." (P 13)

A few participants also described a consistent fear throughout the initial period of their pregnancy-related to their legal status. Specifically, they feared deportation from the country.

“In the beginning, I felt fear. I was scared because I was told that the police could catch you and they could send you back.” (P 12)

"Al principio sentí miedo, porque sentía miedo de que me decían que los policías te podían agarrar y te podían devolver." (P 12)

Significant Role of Family and Friends

Participants stated that their family and friends were important to support systems throughout their pregnancy as sources of knowledge for health navigation and emotional support. Often families or friends were facilitators of healthcare in Trinidad by helping navigate the health system through recommendations of clinics or providers.

“The friend I mentioned, she told me ‘You are going to the hospital in [City] this day and you are going to take this with you.” And I went as she told me one Friday. That Friday I was seen; they did the exams and all that. And they scheduled monthly appointments for me.” (P 4)

"La amiga que le comenté ella me dijo: “vas a ir aquí al hospital de [ciudad] en tal día y vas a llevar esto” y yo fui como ella me dijo, un viernes. Ese viernes me atendieron, me hicieron exámenes y todo eso y me empezaron a citar los lunes mensualmente." (P 4)

Alongside the referrals and recommendations to specific healthcare centers, some friends and family with proficient English would sometimes accompany participants to their medical visits and help with translations. In these cases, the friends were addressing the language barriers by enabling communication between providers and the participants.

“And after I received the registration, I went to a health center, but I wasn’t seen because I needed a person who spoke English. I spoke with a sister-in-law, my husband’s sister, and she spoke some English. She helped me.” (P 12)

"Y después que conseguí el carnet, fue que fui a un health center, no me atendieron porque necesitaba una persona que hablara inglés. Hablé con una cuñada, hermana de mi esposo, ella medio hablaba el inglés. Ella me ayudó." (P 12)

Furthermore, participants described support from families and friends when they facilitated their connection to community resources that could help them get access to care. At times, this help was indirect and involved friends referring participants to organizations, such as LWC, that helped them register with the UNHCR and first access prenatal care. In other cases, they advocated for the participants to receive medical services directly in the medical facilities.

“Yes, I went alone and they did not want to see me. I had to ask a neighbor for help… and he offered transportation and spoke for me, that is why I was seen. He spoke, the man posed as my husband so that they would see me. He spoke with the secretary and that was why they accepted my papers.” (P 7)

"Sí, fui yo sola y no me querían atender. Le tuve que pedir ayuda a un vecino… y se ofreció a hacernos el transporte y hablar por mí, por eso me atendieron. Habló, el señor se hizo pasar como mi esposo para que me pudieran atender. Él habló con la secretaria, y fue que me recibieron los papeles." (P 7)

Equally as important as the role of support systems in accessing and navigating health systems, was the validation of negative experiences. For family members, there was a sense of understanding and empathy from the experiences participants faced when visiting health centers.

Participants also expressed feeling support when they shared their experiences with other Venezuelan friends who had endured similar negative experiences throughout their pregnancy journey.

> *"Yes, they spoke to me so that I would stay calm. The young woman also went through the same thing as me, because I also had a baby here. She told me to stay calm…" (P 4)*

> *"Sí, ellos hablaban conmigo para que me quedara tranquila. La muchacha también pasó por la misma que yo, porque yo también tuve un bebé aquí me dijo que estuviera tranquila…"* (P 4)

For other participants, their partner was their only support system throughout their pregnancy. This support was mainly displayed at home in the form of doing house chores, helping take care of other children, and spending time with the participant.

> *"[He] was the only person because no one, well no one else supported me. Sometimes I was in so much pain that I didn't eat anything. He was the only person that was here with me." (P 5)*

> *"Fue la única persona porque nadie pues nadie me apoyaba. A veces tenía demasiados dolores, no comía nada y él era el único que estaba aquí conmigo."* (P 5)

Significant Role of Support Organizations

During the interviews, participants raised the importance of organizational support throughout their pregnancy in the form of financial assistance and help with accessing healthcare. There were three types of organizations identified by participants that included hospitals, NGOs, and churches. When mentioning hospitals, participants were specifically referring to public medical facilities that offered free prenatal services for pregnant women in regulation with Trinidadian

policies, compared to participants who accessed private healthcare services and paid out of pocket. For women who did use private facilities for their prenatal consultation, they were referred to public hospitals for delivery because the cost of the private delivery services was too great. Women using public facilities felt supported by these hospitals since they did not have to concern themselves with medical costs.

> *"In the hospital, I had that support because, thank God, I did not have to pay for any exam. I did not have to pay for any medications I needed… since my husband does not have a stable job, I did not have any problems and did not have to pay anything in payments… that was all the support that I had." (P 2)*

> *"En el hospital, tuve el apoyo de eso porque gracias a Dios, no tuve que pagar ningún examen, no tuve que pagar medicamento para yo tomar… como mi esposo no tiene un trabajo fijo, entonces no tuve problemas para hacerme nada a pagos; ni compramos medicamentos a pagos. Ese era el apoyo que yo tenía." (P 2)*

When participants mentioned being supported by NGOs, they identified LWC as playing an important role. Other community organizations mentioned by participants were local churches. Participants shared they received financial assistance for rent, and food, and in some cases, were offered limited financial support for medical exams and services. These few participants receiving this type of financial support were forced to seek care with expensive private facilities since they were unable to apply for asylum and did not have the necessary paperwork to access free public services. Participants expressed feeling supported by the help the community organizations provided.

"…people in the church who provide aid… so I write to them. I tell them my situation that I am without a job, I have my baby, I am pregnant. And automatically, they help me with food." (P 13).

"… personas de la iglesia que dan ayuda…. entonces, yo les escribo, les cuento mi situación, que yo estoy sin trabajo, tengo a mi bebé, estoy embarazada. Y, automáticamente, ellos me ayudan con comida." (P 13)

"Well, the experiences I have lived here in Trinidad, that I think are good, are the aids of the churches, UNHCR and thank God they have been attentive. It seems to me they are very wonderful people…" (P 13)

"Bueno, la experiencia que he vivido, aquí, en Trinidad, que me parece muy buena, son las ayudas de la iglesia, la ayuda de ACNUR, que, gracias a Dios, han estado pendientes. Eso me parece, unas personas muy maravillosas…" (P 13)

Additionally, participants first accessed the Trinidad healthcare system when they became pregnant and sought prenatal consultations. Unfamiliar with the system and not knowing what documents was required when accessing care, participants shared experiences of being turned away since they did not have the necessary legal documentation. Participants stated that LWC helped them register as asylum-seekers with the UNHCR. Once they were registered and with proof of application submission, women were able to see a provider and access testing services to assess the condition of their pregnancy.

"I had to ask for help with Living [Water Community] with the registration and with that, I was able to go [and access prenatal services]" (P 1).

“Tuve que pedir ayuda a una Living [Water Community] con lo del registro y fue que pude ir [y acceder a los servicios prenatales]”(P 1)

Chapter 4: Discussion

The findings of this study contribute to the literature by providing insight into the lived experiences of the target population, Venezuelan pregnant women and mother refugees living in Trinidad & Tobago. In this study, participants described experiences of *multi-faceted discrimination* and the *normalization of suboptimal care* throughout their prenatal and healthcare experiences that involved negative interactions with healthcare staff. These negative experiences and interactions resulted in high levels of stress and anxiety that created a significant *mental health burden* for pregnant women and mothers. There was also a *significant role of family and friends* and a *significant role of support organizations* in the context of providing support to participants throughout their pregnancy while also facilitating access and navigation to the healthcare systems in Trinidad & Tobago.

One of the main drivers of displacement within the study population was the lack of financial opportunities in Venezuela. Some participants recounted experiences of food insecurity and hardships because of the lack of money. For this reason, economic opportunity was a factor that drew participants specifically to Trinidad & Tobago. These factors were consistent with reasons for migration among other Venezuelan refugees in Colombia and Brazil (Doocy et al., 2019; Giraldo et al., 2021; Makuch et al., 2020). Another factor forcing displacement that is unique to Venezuela, is the migration of pregnant Venezuelans in search of maternity services (Doocy et al., 2019; Giraldo et al., 2021; Mkuch et al., 2020). This was the case for one participant in the study who migrated while pregnant. She explicitly stated that she moved to Trinidad & Tobago for access to maternity services. Participants with previous pregnancies in Venezuela shared that they were required to buy all supplies necessary for their pregnancy (e.g., sutures, gauze, injections) which was difficult because of the country's shortages and the cost. This is consistent

with previous studies and reports that have described the Venezuelan healthcare crisis resulting in shortages of medications, rising costs of health products, and lack of clean water at health centers (Page et al., 2020).

After arriving in Trinidad & Tobago, when participants sought maternity services after becoming pregnant, they described difficulties in navigating and accessing health in an unfamiliar system. This is consistent with findings from studies with other refugees who often describe difficulties in navigating health systems that are drastically separate from those in their home country (Fair et al., 2020; Khanlou et al., 2017). For participants in Trinidad & Tobago, friends, family, and partners were important sources of logistical support in recommending clinics with maternity services or accompanying participants as translators during their healthcare visits. On the other hand, organizations provided logistical support in legal help by helping participants acquire necessary documentation (e.g., asylum-registration) to receive prenatal consultations. Similarly, Venezuelan refugees in Colombia also described the important role support networks had in their navigation to the Colombian healthcare system (Giraldo et al., 2021). In the Colombian context, friends, families, and partners were support systems of Venezuelan refugees that facilitated access to care and medication. However, in contrast to the role organizations played in Trinidad & Tobago, as viewed by the participants, organizations in Colombia played a larger role in advocacy by organizing the community to influence decisionmakers (Giraldo et al., 2021). In a study of Venezuelan migrants in Peru, social networks and organizations intersected in virtual social networks using social media platforms where people could pose health related questions and receive responses with non-government and governmental organizations (Zambrano-Barragán et al., 2021).

In addition to the unfamiliar health system in Trinidad & Tobago, Venezuelans had difficulties when first seeking prenatal services because of their legal status. This was a significant factor for experiencing discrimination, especially when health staff would deny care to participants when they first attempted to access prenatal services. Denied medical care because of "migrant" status has also been documented for Venezuelans in Colombia (Giraldo et al., 2021) and among other refugee groups in Nordic countries (Leppälä et al., 2020). Denied care, especially for undocumented refugees, can lead to women not receiving any prenatal services (Tasa et al., 2021; Khanlou et al., 2017), delayed critical screening due to late-term access, and increased risk of neonatal morbidity and mortality (Carvalho et al., 2020). In Trinidad & Tobago specifically, the government does not have a formal process for asylum-seekers and instead relies on LWC partnered with UNHCR to register Venezuelans (Teff, 2019). Since the Trinidad & Tobago government considers those granted refugee status or in the process of seeking asylum as undocumented individuals, this greatly reduce the Venezuelan refugees' legal protection and rights when seeking healthcare (Teff, 2019). Equally as important is the fear of deportation that is associated with legal status (Fair et al., 2020). For pregnant Venezuelans, this caused additional stress and anxiety throughout the pregnancy.

When discussing factors contributing to discrimination, in addition to legal status, language was also identified by the study population. The finding of discrimination based on language barriers is consistent with studies of Venezuelan refugees in Brazil whose national language is Portuguese (Makuch et al., 2021) and refugees from other countries settling in non-Latin American countries (Fair et al., 2020; Villadsen et al., 2016). Language barriers in medical settings have significant healthcare implications. They impede effective communication for migrant women who do not speak the host country's language (Dopfer et al., 2018; Khanlou et

al., 2017; Leppälä et al., 2020; Gallo Marin et al., 2021; Merry et al, 2013). Associated with the language barriers is often the inflexibility of the system to address these communication issues. While this may take the form of refugees being forced to place phone calls for appointments with no alternative options despite language barriers (Leppälä et al., 2020), for participants in Trinidad & Tobago, it was the unwillingness of some providers to accept phone translators. These communication barriers often result in inadequate medical care for refugee populations (Fair et al., 2020; Makuch et al., 2021; Villadsen et al., 2016).

Discriminatory attitudes and behaviors are often cited as barriers to quality care, factors for unsatisfactory care, and reasons for poor provider-patient relationship (Fair et al., 2020; Leppälä et al., 2020). Participants in Trinidad & Tobago identified these same factors which included unfriendly & disrespectful attitudes, providers ignoring them, or not taking their concerns seriously, and denial of care. In qualitative studies with Venezuelan refugees, discrimination has been identified in healthcare (Giraldo et al., 2020; Makuch et al., 2020; Zambrano-Barragán et al., 2021). As stated previously, Venezuelan refugees in Colombia identified discrimination in the form of denied services when seeking prenatal care due to their "migrant" status or being forced to remain at the hospital until fees for services rendered are made (Giraldo et al., 2020; Zambrano-Barragán et al., 2021). In Brazil, language was identified as a factor for discrimination when accessing or seeking healthcare (Makuch et al., 2021). In Peru, Venezuelans described experiences of discriminatory attitudes from medical providers during their care (Zambrano-Barragán et al., 2021). In this study with refugees in Trinidad & Tobago, a few participants described how the provider's behavior and attitude led to great health risks for the mother and newborn. This was also true for Venezuelan refugees in Peru. One participant in their study stated that *"… the physician did not like me because I was Venezuelan, and she made that very*

clear to all of the doctors in the operating room. I was between life and death…" (Zambrano-Barragán et al., 2021). Discrimination during delivery and obstetric emergencies has significant implications for maternity outcomes.

Also noteworthy, Venezuelan refugees in Brazil reported good care despite having a different but related language, Portuguese (Makuch et al., 2020). Venezuelans were in UNHCR shelters along the Brazil border and all accessed care at one hospital. Women stated they were treated well by providers, they were thoroughly examined and received all their medications (Makuch et al., 2020). With participants in this study living in a country that also speaks a different language, English, participants who stated they received good care identified the same reasons. They stated they received all their exams and medications and described providers as attentive. However, for participants in Trinidad & Tobago, there was another distinction to satisfaction of care that came from an acceptance of substandard care and treatment by providers. For Venezuelan refugees, there was an expectation of subpar treatment in the context of behaviors and attitudes of health staff and providers, and women were satisfied if they were provided the minimum services that included receiving all exams and medications.

With discrimination and acceptance of substandard care for Venezuelan refugees in Trinidad & Tobago, participants also raised the issue of the lack of agency that contributed to these negative healthcare experiences. Participants often felt ignored by providers who made no effort to understand or communicate, but they did not feel empowered to speak up. This is consistent with findings from Leppälä et al. (2020) where migrants had "diminished negotiation power" during their interactions with providers because of health literacy gaps, lack of health system knowledge, and the disinterest of providers to recognize patients' needs. All factors lead to

reduced quality of care and contributed to feelings of worthlessness and the mental health burden of not having questions and concerns addressed.

Refugees are often at risk for trauma, exploitation, and sexual violence leading to an increased risk of mental health burdens and depression due to social isolation, poverty, and language barriers (Anderson et al., 2017; Calderón-Jaramillo., 2020; Endler et al., 2020). In a study among pregnant Venezuelans in the Colombian Caribbean, 32.1% were discovered to have depression (Fernández-Niño & Rojas-Botero, 2019). In Canada, migrants were more likely to suffer from prenatal and postpartum depression (Khanlou et al., 2017). Mental health services are critical for pregnant refugees who may suffer traumatic experiences in their home countries, on their journeys, and in the host country. Findings in this study were consistent since participants raised similar issues and feelings of isolation, worthlessness, and depression. There were high levels of mental health burden and at least one participant had access to mental health services after a referral from LWC.

Intensifying these negative experiences were financial concerns. There is documented stress associated with basic living costs (e.g., rent and food), medical costs, and the lack of work (Fair et al., 2020) among refugee populations. Participants in Trinidad & Tobago specifically identified infant supplies (e.g., diapers) as stressors and medical costs were only a concern for participants seeking private care. Additionally, many of the mothers with children under two did describe their inability to work as a stressor since they did not have the funds to pay for a babysitter. This was consistent with findings among Venezuelan refugees in Colombia who expressed stress from the inability to work and the resulting financial challenges from the lack of work (Giraldo et al., 2020). These financial stressors compound or exacerbate the feelings of loneliness, worthlessness, and depression that participants are already experiencing.

Strengths & Limitations

A strength of this study is that it provides novel data in an area where there is limited literature. It provides context and understanding to the lived experiences of Venezuelan refugees currently living in Trinidad & Tobago. However, one limitation is that perspectives of refugees not associated with LWC were likely missed since participants were recruited by LWC. Other limitations include the non-random sample selection of participants, the small sample size (*n=14*), and the high refusal participation rate *(50%).* This is a vulnerable population with many needs, stressors, and fears that should be taken into consideration.

Another significant limitation is that data analysis was conducted by a single user resulting in a lack of intercoder agreement. To address this limitation and ensure that themes were reflective of issues found in transcripts, these themes were discussed and finalized with the PI. Furthermore, all themes were developed from direct participant quotes and checked to ensure that selected major themes included issues raised by multiple participants.

Chapter 5 Public Health Implications and Recommendations

There is scarce literature about the experiences of Venezuelan refugees during their pregnancy and delivery in the Caribbean, especially in Trinidad & Tobago. However, there remains a need to further explore the needs and experiences of refugee Venezuelan women in other countries (Marin et al., 2021) and specific sub-populations that include indigenous Venezuelan refugees (Bahomondes et al., 2020) facing unique challenges to maternity care.

Venezuelan refugees seeking maternity care in Trinidad & Tobago, face many barriers to accessing care in both their home and host countries. The findings of this study can be shared with national and local stakeholders to inform policies, interventions, and next steps critical to addressing the distinctive needs of this population. Recommendations are provided for four stakeholders and decision makers that whose actions have significant health implications for the health of Venezuelan mothers and pregnant women.

Venezuelan Government

Millions of Venezuelans have been forcibly displaced with numbers estimated to continue growing. There are already over 40,000 refugees in Trinidad & Tobago, and the health systems of surrounding countries are being overwhelmed by the influx of Venezuelan refugees and the severity of their healthcare needs (Makuch et al., 2021; Teff, 2019). The Venezuelan government should formally recognize the ongoing humanitarian crisis that is forcing the displacement of its people. In 2016, the Venezuelan government stopped publishing national statistics and health outcomes that included data in maternal mortality and other pregnancy outcomes (Page et al., 2019). The MoH should resume publishing national health statistics that can be used to better understand the health implications of the ongoing crisis. This can provide critical data for relevant information needed to address the needs of pregnant women who are choosing to leave

the country in search of maternity services. Without available data, it is difficult to identify or begin to remedy the root causes forcibly displacing pregnant women.

Furthermore, the Venezuelan government should coordinate and collaborate with international aid organizations to provide essential care and resources for pregnant women and other key vulnerable populations. Since there are documented stockouts of necessary medications and equipment, it is essential for the government to partner with organizations who have these resources and make them available to the Venezuelan people (Page et al., 2019).

Trinidad & Tobago Government

In the latest National Sexual and Reproductive Health Policy Recommendations (NSRHPR) for the Trinidad & Tobago government, the Directorate of Women's Health – Ministry of Health took efforts to assess the national SRH situation that included maternity services. In their report, refugees were identified as one of the many key populations that do not access SRH regularly (Government of the Republic of Trinidad & Tobago–Ministry of Health, 2020). In line with recommendations provided in the NSRHR and the MoH's commitment to deliver timely, cost-effective and high-quality services to those with the greatest need, the MoH should consider implementing and standardizing the use of quality interpretive services throughout all hospital and regional health centers in the country. Currently, health facilities have discretion of which interpretative services to accept. This results in inconsistent experiences between facilities (e.g., acceptance of phone translator vs requiring in-person translator) that translate into delayed prenatal care critical for the wellbeing of the mother and child. MoH should also require regular trainings for health staff and providers on cultural sensitivity (Leppälä et al., 2020), migrant and refugee rights, trauma-informed care (Miller et al., 2019), and respectful care (e.g., Jolivet et al., 2021) that can address the stigmas, identified by the NSRHR, and discriminatory behaviors,

identified by this study, that aim to improve equity in the context of healthcare for Venezuelans who are pregnant and mothers. Along with NSRHR's commitment of evaluating and monitoring implementation of SRH services, systems should be put in place to allow anonymous complaints to an ethics committee that can investigate and hold health staff accountable and enforce consequences for violations of patient rights. Implementing these policies at the national level, would enforce a higher standard of care that would reduce the risk of costly medical emergencies during pregnancy and delivery.

Since pregnant women and the mothers' health was impacted by social factors that extended beyond their direct care, such as their income and financial concerns, it is important to reduce the number of Venezuelan refugees living in irregular circumstances. The government in Trinidad & Tobago should consider providing another amnesty period where Venezuelans, regardless of legal status, are able to register for working permits that provide access to legal work opportunities. They should also consider providing these working permits for a period longer than a year. Additionally, the government should utilize the Cartagena Declaration to assess Venezuelan asylum-seeker applications which Brazil and Mexico are currently using in their policies and practices for Venezuelans seeking refuge in their country (Freier et al., 2022). Changing immigration policies to facilitate access to legal work opportunities would benefit Trinidad & Tobago in the long term by expanding their available workforce. Despite the participants' expressed desire to work, none were working at the time of the interviews, and some called attention to their partner's job insecurity. Venezuelan refugees in Trinidad & Tobago, including mothers after delivery, could be a resource for the Venezuelan government.

United Nations High Commissioner for Refugees

The UNHCR in Trinidad & Tobago currently have three partner organizations in the country which are LWC, Rape Crisis Society, and the Family Planning Association of Trinidad & Tobago. LWC offers a wider range of services for refugees by providing information and assistance with housing, education, and other social services (UNHCR, 2022). It is the only organization aiding refugees in the asylum-seeking process specific to Trinidad & Tobago (Teff, 2019). UNHCR should identify additional local partners that can facilitate the registration process for Venezuelans and provide resources about the asylum and refugee process in language accessible formats.

Living Water Community

At the local level and with available funds, LWC can continue to expand their financial assistance programs. This would help alleviate the stress from financial concerns that further burden mothers and pregnant refugees in Trinidad & Tobago. Since mothers expressed the desire to work but explained their challenges with small children, LWC should consider providing accessible daycare services for mothers who desire to work.

For the challenge of language barriers during healthcare visits, LWC should consider developing and implementing community outreach programs with English classes. Lessons could be tailored to specific subject topics such as medical visits and pregnancy terms that would directly benefit pregnant women and mothers when seeking perinatal care.

To address the feelings of isolation and worthlessness that women expressed, LWC should consider creating social support groups and safe spaces for Venezuelan refugee pregnant women and mothers. As a trusted community organization within this vulnerable population, it is key that LWC take the lead. In the future it may also consider creating care groups that bring

providers and refugees in a collaborative manner for discussions and development of maternity interventions.

References

Anderson, F. M., Hatch, S. L., Comacchio, C., & Howard, L. M. (2017). Prevalence and risk of mental disorders in the perinatal period among migrant women: A systematic review and meta-analysis. *Archives of Women's Mental Health, 20*, 449-462. https://doi.org/10.1007/s00737-017-0723-z

Bahamondes, L., Laporte, M., Margatho, D., de Amorim, H. S. F., Brasil, C., Charles, C. M., Becerra, A., & Hidalgo, M. M. (2020). Maternal health among Venezuelan women migrants at the border of Brazil. *BMC Public Health*

Calderón-Jamarillo, M., Parra-Romero, D., Forero-Martínez, J. L., Royo, M., Rivillas-García, C., J. (2020). Migrant women and sexual and gender-based violence at the Colombia-Venezuela border: A qualitative study. *Journal of Migration and Health, 1*(2020. https://doi.org/10.1016/j.jmh.2020.100003

Carroll, H., Luzes, M., Freier, L. F., & Bird, M. D. (2020). The migration journey and mental health: Evidence from Venezuelan forced migration. *SSM – Population Health, 10*, 100551. https://doi.org/10.1016/j.ssmph.2020.100551

Carvalho, O. M. C., Junior, A. B. V., Augusto, M. C. C., Leite, A. J. M., Nobre, R. A.,, Bessa, O. A. A. C., Monteiro de Castro, E. C., Lopes, F. N. B., & Carvalho, F. H. C. (2020). Delays in obstetric care increase the risk of neonatal near-miss morbidity events and death: A case-control study. *BMC Pregnancy and Childbirth, 20*(437). https://doi.org/10.1186/s12884-020-03128-y

Doocy, S., Page, K. R., de la Hoz, F., Spiegal, P., & Beyrer, C. (2019). Venezuelan migration and the border health crisis in Colombia and Brazil. *Journal on Migration and Human Security, 7*(3), 79-91. https://doi.org/10.1177/2331502419860138

Dopfer, C., Vakilzadeh, A., Happle, C., Kleinert, E., Müller, F., Ernst, D., Schmidt, R. E., Behrens, G. M. N., Merkesdal, S., Wetzke, M., & Jablonka, A. (2018). Pregnancy related health care needs in refugees – A current three center experience in Europe. *International Journal of Environmental Research and Public Health, 15 (1934*). Doi:10.3390/ijerph15091934

Endler, M., Haidari, A. T., Chowdhury, S., Christlaw, J., Kak, E. F., Galimberti, D., Gutierrez, M., Ramriez-negrin, A., Senanayake, H., Sohail, R., Temmerman, M., & Danielsson, G. K. (2020). Sexual and reproductive health and rights of refugee and migrant omen: Gynecologists' and obstetricians' responsibilities. *International Journal of Gynecology & Obstetrics, 149,* 113-119. https://doi.org/10.1002/jigog.13111

Fair, F., Raben., L., Watson, H., Vivilaki, V., van den Muijsenbergh, M., Soltani, H., & ORAMMA team. (2020). Migrant women's experiences of pregnancy, childbirth and maternity care in European countries: A systematic Review. *PLoS One, 15*(2). https://doi.org/10.1371/journal.pone.0228378

Fernández-Niño, J. A., Rojas-Botero, M. L., Bojorquez-Chapela, I., Giraldo-Gartner, V., Sobeczyk, R. A., Acosta-Reyes, J., Flórez-Garcia, V., & Rodriguez, D. A. (2019). Situación de salud de gestantes migrantes venezolanas en el Caribe Colombiano: Primer

reporte para una respuesta rápida en salud pública. *Revista de la Universidad Industrial de Santander Salud, 51*(3), 208-219. https://dx.doi.org/10.18273/revsal.v51n3-2019004

Freier, L. F., Berganza, I., & Blouoin, C. (2022). The Cartagena refugee definition and Venezuelan displacement in Latin America. *International Migration, 60*(1), 18-36. Doi: 10.1111/imig.12791

Gallo Marin, B., Amaya, A., Medina Perez, G., Levine, A. C., Moretti, K., & Garbern, S. C. (2021). A scoping review of non-communicable diseases and maternal and child health needs of Venezuelan migrants in South America. *Journal of Global Health Reports, 5*, e2021045. https://doi.org/10.29392/001c.23621

Geltore, T. E., & Anore, D. L. (2021). The impact of antenatal care in maternal and perinatal health. In (Ed.), Empowering Midwives and Obstetric Nurses. InTechOpen. https://doi.org/10.5772/intechopen.98668

Giraldo, V., Sobczyk, R., Fernández-Niño, J. A., Rojas-Botero, M. L., & Bojorquez, I. (2021). Prenatal care of Venezuelans in Colombia: Migrants navigating the healthcare system. *Revista de Saúde Pública*, *55*, 49. https://doi.org/10.11606/s1518-8787.2021055002999

Government of Colombia, National Council of Economic and Social Policy. (2018). *Estrategia para la atención de la migración desde Venezuela*. https://colaboracion.dnp.gov.co/CDT/Conpes/Econ%C3%B3micos/3950.pdf

Government of Colombia, Health Ministry. (2019). *Plan de respuesta del sector salud al fenómeno migratorio*. https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/DE/COM/plan-respuesta-salud-migrantes.pdf

Government of Republic of Trinidad & Tobago – Ministry of Health. (2020). *National Sexual & Reproductive Health Policy.* https://www.health.gov.tt/sites/default/files/womenshealth/National%20Sexual%20and%20Reproductive%20Health%20Policy.pdf

Herbert, C. (2021). More Venezuelans in Trinidad in the 21st century. *International Journal of Anthropology and Ethnology, 5*(15). https://doi.org/10.1186/s41257-021-00056-3

Heslehurst, N., Brown, H., Pemu, A., Coleman, H., & Rankin, J. (2018). Perinatal health outcomes and care among asylum seekers and refugees: A systematic review of systematic reviews. *BMC Medicine, 16*(89). https://doi.org/10.1186/s12916-018-1064-0

Hynes, M., Sakani, O., Spiegal, P., & Cornier, N. (2012). A study of refugee maternal mortality in 10 countries, 2008-2010. *International Perspectives on Sexual and Reproductive Health, 38*(4), 205-213. doi.10.1363/3820512

Inter-Agency Coordination Platform for Refugees and Migrants from Venezuela – R4V. (2022). *RMRP 2022 – Regional refugee and migrant response plan (RMRP).* https://www.r4v.info/en/document/rmrp-2022

Jolivet, R. R., Gausman, J., Kapoor, N., Langer, A., Sharma, J., & Semrau, K. (2021). Operationalizing respectful maternity care at the healthcare provider level: A systematic

scoping review. *Reproductive Health, 18*(1), 194. https://doi.org/10.1186/s12978-021-01241-5

Khanlou, N., Haque, N., Skinner, A., Mantini, A., Kurtz Landy, C. (2017). Scoping review on maternal health among immigrant and refugee women in Canada: Prenatal, intrapartum, and postnatal care. *Journal of Pregnancy, 2017*, 8783294. https://doi.org/10.1155/2017/8783294

Labrador, R. C., & Merrow, W. (2019, July 8). *The Venezuelan exodus*. Council on Foreign Relations. https://www.cfr.org/in-brief/venezuelan-exodus

Leppälä, S., Lamminpää, R., Gissler, M., & Vehviäinen-Julkunen, K. (2020). Humanitarian migrant women's experiences of maternity care in Nordic countries: A systematic integrative review of qualitative research. *Midwifery, 80*, 102572. https://doi.org/10.1016/j.midw.2019.102572

Makuch, M. Y., Osis, M., Brasil, C., de Amorim, H., & Bahamondes, L. (2021). Reproductive health among Venezuelan migrant women at the north western border of Brazil: A qualitative study. *Journal of Migration and Health, 4,* 100060. https://doi.org/10.1016/j.jmh.2021.100060

Martz, J. D., Heckel., H. D., McCoy, J. L., & Lieuwen, E. (2022, April 77). *Venezuela*. Encylopedia Britannica. https://www.britannica.com/place/Venezuela

Miller, K. K., Brown, C. R., Shramko, M., & Svetaz, M. V. (2019). Applying trauma-informed practices to the care of refugees and immigrant youth: 10 clinical pearls. *Children* (*Basel, Switzerland), 6*(8), 94. https://doi.org/10.3390/children6080094

Ministerio de Salud Colombia. (2019). *Ministerio de salud Colombia: Población Venezolana en Colombia* – May 2019 [ES]. https://data2.unhcr.org/en/documents/details/70238

Mosley, E. A., Pratt, M., Besera, G., Clarke, L. S., Miller, H., Noland, T., Whaley, B., Cochran, J., Mack, A., & Higgins, M. (2021). Evaluating birth outcomes from a community-based pregnancy support program for refugee women in Georgia. *Frontier's in Global Women's Health, 2*, 655409. https://doi.org/10.3389/fgwh.2021.655409

National Institute of Child Health and Human Development. (2020, May 14). *What are examples and causes of maternal morbidity and mortality?* https://www.nichd.nih.gov/health/topics/maternal-morbidity-mortality/conditioninfo/causes

National Institute of Child Health and Human Development. (2021, September 6). *Maternal morbidity and mortality.* https://www.nichd.nih.gov/health/topics/maternal-morbidity-mortality#:~:text=Maternal%20morbidity%20describes%20any%20short,weeks%20after%20the%20pregnancy%20ends

Office of the United Nations High Commissioner for Human Rights. (2009). *Preventable maternal mortality and morbidity and human rights*. https://www.ohchr.org/Documents/Issues/Women/WRGS/Health/ReportMaternalMortality.pdf

O'Neill, A. (2021, November 17). *Gross domestic product (GDP) in Trinidad and Tobago 2026*. Statista. https://www.statista.com/statistics/728907/gross-domestic-product-gdp-in-trinidad-and-tobago/

O'Neill, A. (2021, November 23). *Gross domestic product (GDP) in Venezuela 2022.* Statista. https://www.statista.com/statistics/370937/gross-domestic-product-gdp-in-venezuela/

Merry, L,. Small, R,. Blondel, B., & Gagnon, A. J. (2013). International migration and caesarean birth: A systematic review and meta-analysis. *BMC Pregnancy and Childbirth, 13*(27). https://www.biomedcentral.com/1471-2393/13/27

Page, K. R., Doocy, S., Ganteaume, F. R., Castro, J. S., Spiegel, P., & Beyrer, C. (2019). Venezuela's public health crisis: A regional emergency. *The Lancet, 3939*(10177), 1254-1260. https://doi.org/10.1016/S0140-6736(19)30344-7

Rodriguez, N., & Collins, J. (2021, April 28). *As desperation grows, Venezuelans look to a dangerous Caribbean escape route.* The New Humanitarian. https://www.thenewhumanitarian.org/news-feature/2021/4/28/venezuelans-look-to-a-dangerous-caribbean-escape-route

Rustad, S. A., Binningsbø, H. M., Gjerløw, H., Mwesigye, F., Odokonyero, T., & Østby, G. (2021). Maternal health among refugees and host communities in Northern Uganda: Access, quality, and discrimination. *Frontiers in Global Women's Health, 2*(626002). doi: 10.3389/fgwh.2021.626002

Tasa, J., Holmber, V., Sainio, S., Kankkunen, P., & Vehviläinen-Julkunen. (2021). Maternal health care utilization and the obstetric outcomes of undocumented women in Finland – A retrospective register-baesd study. *BMC Pregnancy and Childbrith, 21*(191). https://doi.org/10.1186/s12884-021-03642-7

Teff, M. (2019). *Forced into illegality Venezuelan refugees and migrants in Trinidad and Tobago: field report.* Refugees International. https://www.refugeesinternational.org/reports/2019/1/27/forced-into-illegality-venezuelan-refugees-and-migrants-in-trinidad-and-tobago

The International Organization for Migration. (2020). DTM displacement tracking matrix Trinidad & Tobago. https://reliefweb.int/sites/reliefweb.int/files/resources/DTM%20TRINIDADTOBAGO%20V2.pdf

The International Organization for Migration. (2021). DTM displacement tracking matrix Trinidad & Tobago. https://displacement.iom.int/sites/default/files/public/reports/Trinidad_and_Tobago_round4.pdf

United Nations High Commissioner for Refugees. (1984). *Cartagena Declaration on refugees.* https://www.unhcr.org/en-us/about-us/background/45dc19084/cartagena-declaration-refugees-adopted-colloquium-international-protection.html

United Nations High Commissioner for Refugees. (2011). *The 1951 convention relating to the status of refugees and its 1967 protocol*. https://www.unhcr.org/en-us/about-

us/background/4ec262df9/1951-convention-relating-status-refugees-its-1967-protocol.html

United Nations High Commissioner for Refugees. (2017). *Global Report 2017*. https://www.unhcr.org/en-us/publications/fundraising/5b4c89bf17/unhcr-global-report-2017.html

United Nations High Commissioner for Refugees. (2020). *Global Report 2020*. https://reporting.unhcr.org/sites/default/files/gr2020/pdf/GR2020_English_Full_lowres.pdf#_ga=2.143486967.31605228.1646676438-814650765.1644370950

United Nations High Commissioner for Refugees. (2022). *Help Trinidad & Tobago*. https://help.unhcr.org/trinidadandtobago/where-to-seek-help/unhcr/

United Nations International Organization for Migration (IOM). (2021). *Venezuela regional response – General demographic characteristics of migrant and refugee women in Venezuela*. https://dtm.iom.int/reports/venezuela-regional-response-%E2%80%94-general-demographic-characteristics-migrant-and-refugee-women

United Nations Population Fund, Government of Colombia. (2020). *Colombia: Situación de la salud sexual y reproductive de la población migrante y refugiada de Venezuela.* http://data2.unhcr.org/en/documents/details/75496

United Nations Population Fund. (2021). *2021 UNFPA Humanitarian Response in Venezuela*. https://venezuela.unfpa.org/sites/default/files/pub-pdf/2021_unfpa_humanitarian_plan_in_venezuela_2.pdf

Universidad Católica Andrés Bello. (2021). *Condiciones de vida de los Venezolanos: Entre emergencia humanitarian y pandemia. ENCOVI 2021. https://assets.website-files.com/5d14c6a5c4ad42a4e794d0f7/6153ad6fb92e4428cada4fb7_Presentacion%20ENCOVI%202021%20V1.pdf*

Van den Akker, T., & van Roosmalen, J. (2016). Maternal mortality and severe morbidity in a migration perspective. *Best Practice & Research. Clinical Obstetrics & Gynecology, 32*, 26-38. https://doi.org/10.1016/j.bpobgyn.2015.08.016

Villadsen, S. F., Mortensen, L. H., & Andersen, A. M. (2016). Care during pregnancy and childbirth for migrant women: How do we advance? Development of intervention studies—the case of the MAMAACT intervention in Denmark. *Best Practice & Research. Clinical Obstetrics & Gynaecology, 32*, 100-112. https://doi.org/10.1016/j.bpobgyn.2015.08.013

Watts, D., Brereton, B. M., and Robinson, A. N. R. (2022, April 17). *Trinidad and Tobago*. Encyclopedia Britannica. https://www.britannica.com/place/Trinidad-and-Tobago

World Health Organization. (n.d.). *Maternal health*. https://www.who.int/health-topics/maternal-health#tab=tab_1

Zambrano-Barragán, P., Hernández, S. R., Freier, L. F., Luzes, M., Sobczyk, R., Rodríguez, A., & Beach, C. (2021). The impact of COVID-19 on Venezuelan migrants' Access to health: A qualitative study in Colombian and Peruvian cities. *Journal of Migration and Health, 3*(100029). https://doi.org/10.1016/j.jmh.2020.100029