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RESEARCH ARTICLE OPEN ACCESS

# Migrant Mums and Maternity Care: A Qualitative Participatory Health Research Study

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**Keywords:** arts-based methods | health inequities | maternal health | migrant health | participatory health research | qualitative research

## ABSTRACT

**Objective:** To explore the expectations and experiences of migrant women, including international students, in using maternity care services and describe factors affecting their access and use of these services.

**Design:** This is a qualitative participatory research study.

**Methods:** Data were collected through 12 photo-elicitation workshops and 20 semi-structured in-depth interviews. We conducted inductive reflexive thematic analysis in a collaborative process with participants, community partners and academic researchers.

**Setting:** Melbourne, Australia.

**Sample:** Twenty-one migrant women who had been pregnant or given birth since 2021 and were either international students, and/or born in Vietnam or Indonesia.

**Results:** Key challenges migrant women faced accessing and navigating Australian maternity care included costly services, inadequate language services, limited continuity of care and limited health information sharing from health workers. Lack of culturally and linguistically appropriate care hindered women's ability to transition from passive to active participants in decision-making. When provided, social and community support, along with respectful care from health workers, improved access and experiences. Practical enablers included accessible transportation, health insurance information sessions, waivers for insurance waiting periods for maternity coverage and language-concordant care.

**Conclusion:** Migrant women showed pragmatism when navigating maternity care challenges but faced structural barriers that limited their decision-making and access to healthcare. Strengthening shared decision-making and woman-centred care is essential for addressing health system inequities.

## 1 | Introduction

One-third of births in Australia each year are to migrant women [1]. Migrant women in Australia face structural and racial inequities accessing and receiving maternity care [2, 3]. These include transport and economic barriers to accessing health services, clashes between their cultural expectations of maternity care and the Australian health system, discrimination from health workers and critical limitations in interpreter services [2]. They are also less likely to attend antenatal care in the first trimester [4]. Moreover, migrant women on temporary visas (e.g., international students) are ineligible for universal health insurance (Medicare) and face 12-month waiting periods for pregnancy coverage under costly private insurance [3]. Consequently, migrant women from non-English speaking backgrounds experience higher risks of adverse maternal and newborn health outcomes than Australian-born women, including stillbirth, neonatal death and small-for-gestational age babies [4–6].

Addressing the inequities migrant women face in maternity care is necessary to improve their health outcomes, well-being and experiences of care. Implementing models of care that prioritise shared decision-making and woman-centred approaches is critical for achieving this, as outlined in national clinical standards [7, 8]. Shared decision-making in maternity care is a collaborative process between health workers and women, whereby care options are explored to align with women's needs [9, 10]. Woman-centred maternity care aims to reframe the medicalisation of childbirth into a 'normal' physiological event, which empowers women through personalised, holistic approaches, without sacrificing evidence-based, high-quality care [8, 11]. It includes continuity of care and carer, effective communication, pain relief, birth companionship, mobility throughout labour, choice of birth position and culturally responsive care [8, 11–13]. This framework provides a foundation for equitable, respectful care that addresses the diverse needs of migrant women.

Existing research describing migrant women's maternal health in Australia has typically used deficit-based approaches, mirroring socio-economic and political structures that marginalise this community [14–16]. Our study counteracted deficit-based approaches by using participatory health research methodologies to centre the knowledge and expertise of migrant women [17]. Participatory health research is a paradigm in which communities intended to benefit from the research are actively engaged through the research process [18, 19]. This study explored the expectations and experiences of migrant women and international students using maternity care services in Melbourne, Australia, and factors enabling them to access and use these services.

## 2 | Methods

We conducted a phenomenological qualitative study using a participatory research approach, and applied an intersectional feminist lens [18, 20, 21]. Feminist research is 'collaborative, non-hierarchal and reflexive' and grounded on equity and social justice [22]. The 'Giving migrant mums a fair go' study was conducted in partnership with the Multicultural Centre for Women's Health (MCWH), a community-based, not-for-profit organisation led by, for and with women from migrant and refugee backgrounds [23]. Following principles of participatory research, the research objectives, participants, sample size, recruitment approaches, methods, analysis and writing were determined by MCWH and academic researchers collaboratively [18]. We report according to the consolidated criteria for reporting qualitative research checklist (Table S1) [24].

### 2.1 | Study Site and Participants

The study setting was Melbourne, Australia, where people from more than 200 countries live [25]. Participants were migrant women ≥ 18 years old who were currently pregnant or had been pregnant or given birth up to 2 years prior to data collection and were either 1) student visa holders during pregnancy, who face unique visa precarity and health insurance challenges; 2) of Vietnamese background, among the largest migrant groups from non-English speaking countries in Melbourne; or 3) of Indonesian background, a rapidly growing migrant group. This participant range allowed us to explore factors affecting healthcare experiences for women across diverse migration experiences.

Recruitment used posters in English, Vietnamese and Bahasa Indonesia featuring a QR code linked to an online expression of interest form, shared via MCWH social media accounts, online motherhood groups, paid Facebook ads, public spaces and Melbourne educational institutions. Potential participants completing the expression of interest were telephoned by MVC, AH or JC to explain research procedures. Participants were purposively sampled based on eligibility criteria and availability. Out of 23 selected participants, two withdrew for personal reasons before or at the start of data collection. We formed three groups: international students, Vietnamese women and Indonesian women.

### 2.2 | Data Collection and Management

Data were collected between August and November 2023 through photo-elicitation workshops and semi-structured in-depth interviews. Photo-elicitation is an arts-based method of data collection that enables participants to describe their experiences in their own terms and can bridge cultural differences during the research process and dissemination of findings [26, 27]. A pragmatic sampling approach was used and initial recruitment was deemed sufficient to capture rich data from diverse participant perspectives [28]. We conducted four workshops with each participant group (12 workshops total), each lasting 2 h. Participants provided written informed consent. Workshops were facilitated in English (MVC), Vietnamese (JC), or *Bahasa Indonesia* (AH). MVC, AH and JC are women and early career researchers who shared cultural and linguistic backgrounds with the women in the groups they facilitated. They were experienced workshop facilitators and received training on research methods and procedures prior to data collection. In the first workshop, participants were requested to take photographs to describe their experiences of maternity care and write accompanying descriptions. The 101 participant-generated

photographs and descriptions served as discussion prompts in subsequent workshops. Workshops were conducted in a private room at the University of Melbourne or a public library meeting room. Participants received on-site childcare, AUD$100 gift cards per workshop attended and reimbursement for parking or public transportation fees.

Workshop participants were invited to participate in an additional hour-long in-depth interview to further discuss their photographs and experiences. Twenty interviews were conducted in English, Spanish, Vietnamese and *Bahasa Indonesia* by MVC, AH and JC, either in person at a public place or through video call, based on participant preferences. Interview participants received a $50 AUD gift card.

Workshop and interview guides are available in File S1. Workshops and interviews were audio recorded, and field notes were taken during data collection. MVC, AH and JC held debriefing sessions after each workshop and interview. Verbatim transcription was done using Otter.ai [29], Cockatoo [30] or Microsoft Word Dictate [31], and manual transcription by native speakers. Transcripts were checked, cleaned and translated into English by MVC, AH and JC. Participant-chosen pseudonyms were used to protect privacy. Electronic data were stored online in password-protected cloud storage. Paper-based forms were stored in a locked cabinet in a restricted-access office.

### 2.3 | Data Analysis

We triangulated data across workshops, interviews, photograph captions and different participant groups. We used a reflexive thematic analysis approach [32], in a tailored six-phase collaborative process between participants, community partners and academic researchers. During the workshops, participants identified key messages in their photo narratives and discussions, and summarised them into initial codes. Participant-identified codes were then merged based on shared meaning by MVC, AH and JC. These codes were applied to all photo captions and transcripts, using NVivo [33]. During this process, new codes were identified and previous codes refined, resulting in 21 conceptual categories (File S2). These conceptual categories were discussed and interpreted within health equity and intersectionality frameworks (DA, GT, MVC, AH and JC). Finally, MVC mapped concepts, sorted and interpreted categories into themes and drafted initial findings. Researcher reflexivity is reported in File S3.

## 3 | Results

Twenty-one women participated (Table 1). Most (71.4%) had their first pregnancy in Australia. All women had a bachelor's degree (or higher) and four international students were pursuing a doctoral degree.

### 3.1 | Navigating Health Insurance Complexities

Participants found the Australian health system's blended public-private funding complex, with unexpected gap payments

**TABLE 1** | Participant characteristics.

| Participant characteristics | Women ($n = 21$) |
|---|---|
| **Country of birth** | |
| Indonesia | 10 (47.6%) |
| Vietnam | 3 (14.3%) |
| **International students** | |
| Sri Lanka | 1 (4.8%) |
| Afghanistan | 1 (4.8%) |
| Brazil | 1 (4.8%) |
| China | 1 (4.8%) |
| Colombia | 4 (19.0%) |
| **Age (years)** | |
| 29–33 | 9 (42.9%) |
| 34–38 | 12 (57.1%) |
| **Years in Australia** | |
| > 1 | 1 (4.8%) |
| 1–5 | 11 (52.4%) |
| 6–10 | 7 (33.3%) |
| 11–15 | 2 (9.5%) |
| **Pregnancies in Australia** | |
| 1 | 15 (71.4%) |
| 2 | 5 (23.8%) |
| 3 | 1 (4.8%) |
| **Pregnancies before migration** | |
| 0 | 15 (71.4%) |
| 1 | 3 (14.3%) |
| 2 | 2 (9.5%) |
| Preferred not to answer | 1 (4.8%) |
| **Year of last childbirth in Melbourne** | |
| 2021 | 5 (23.8%) |
| 2022 | 5 (23.8%) |
| 2023 | 8 (38.1%) |
| Non applicable[a] | 3 (14.3%) |
| **Health insurance during pregnancy** | |
| Public[b] | 5 (23.8%) |
| Private | 13 (61.9%) |
| Public and private | 3 (14.3%) |
| **Last attained educational level** | |
| Bachelor's degree | 12 (57.1%) |
| Post-graduate | 9 (42.9%) |

[a]Three of the four pregnant women who were present during data collection had not given birth in Melbourne yet.
[b]Public health insurance is not available for international students and other people on temporary visas.

between provider charges and insurance coverage. Lack of clarity about gap payment calculations left migrant women facing unpredictable costs (Figure 1a,b). Women on temporary visas were at heightened financial risk; burdened by the required upfront costs of private health insurance for visa approval. Some women and their partners had a limited number of permitted work hours due to their temporary visas, restricting their income. These financial factors affected women's abilities to access costly healthcare services, causing substantial stress, anxiety and fear. All participants described financial concerns as the most challenging aspect of accessing and navigating maternity care: 'The issues with costs were the most stressful. I didn't know the medical terms in English for maternity related things, so I couldn't fully figure out what was covered' (Mar, international student).

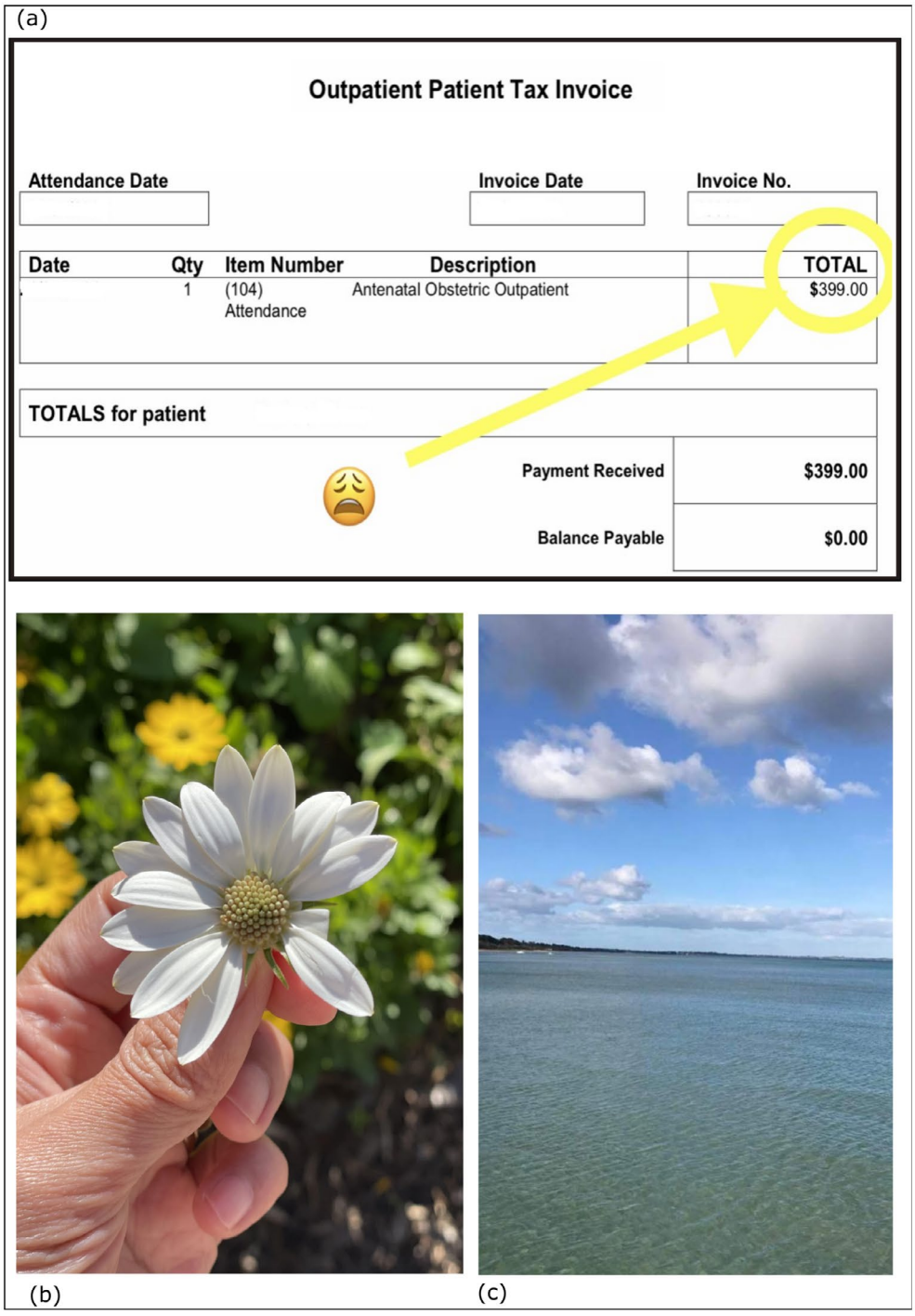


**FIGURE 1** | Participant photos and abridged captions. (a) 'Expensive fees to access services made me feel worried and stressed out' (Mar, International student). (b) 'My maternity care experience in Melbourne was perfectly imperfect, just like this flower, beautiful but not complete. My main issue was obstetrician and hospital charges despite having private health insurance which covered pregnancy...the most memorable thing was the kind nurse ...who said hold my hands if you are stressed...' (Azzy, International student). (c) 'I felt the maternity care in Melbourne is like an ocean. Beautiful, but unexpected. People and huge resources were there, but it did not match what people promise to deliver...' (Hiyen, Vietnamese woman).

The complexity of the healthcare system presented persistent barriers to accessing services, even following previous pregnancies in Australia. Most women reported receiving no advice from their health workers on accessing services with small or no payment gaps (bulk-billing), which exacerbated financial challenges. Health workers typically did not offer alternative options for maternity care referrals, leaving women uncertain about attending more affordable practices not listed in their referral letters: 'I did not know I could find a provider without a gap payment (for ultrasounds), I wasn't informed by my doctor' (Apple, Indonesian woman).

Despite these difficulties, women prioritised attending antenatal care over other healthcare and pregnancy services, to monitor pregnancy and ensure fetal health. Women described love for their babies as motivation to prioritise these appointments. Women reported that health workers suggested certain services were optional, including genetic testing, physiotherapy, childbirth education classes, or lactation support. As a result, some women skipped these costly services: '*the birthing class costs $170 AUD, that's why I didn't take it'* (Apple, Indonesian woman). In retrospect, women felt skipping services negatively affected their childbirth and postpartum experience, and wished health workers had emphasised their importance.

### 3.2 | Unclear Health Information and Poor Guidance

Participants described their unmet needs for health information as diminishing shared decision-making throughout maternity care. All women expected clear information, personalised recommendations and direct guidance from their health workers. However, most had their questions unanswered, and their concerns dismissed: '*I wish* [health workers] *listened to you. Because sometimes you say that this is a problem. They just don't believe you'* (Kate, international student).

Women described how they wanted help from health workers to understand pregnancy and be prepared for childbirth. The abundance of information online made credible sources hard to identify '*I'm not sure if it's the right information or the wrong information'* (Hien, Vietnamese women). Therefore, obtaining reliable health information was a strong motivation for attending maternity care.

Women were disappointed and frustrated at general practitioners looking up pregnancy symptoms online, seeing it as a sign of inadequate knowledge. They preferred one-on-one guidance, rather than referral to generic hospital websites or social media. Women described receiving written information—typically only in English—about health and care issues, instead of face-to-face explanations. They lamented that these practices lacked follow-up discussion or understanding of how general recommendations applied to them personally: '*We got a bit scared because English is my second language...They said, "Here's all the information. Just go home and read"'* (Hien, Vietnamese woman).

Women reported receiving ineffective guidance on important topics, including breastfeeding, exercise, nutrition and pain management. Insufficient guidance made women disillusioned with the health system (Figure 1c). Women also described an information void on postpartum care, which they felt led directly to poor health outcomes, including prolonged pain, inadequate wound care and deteriorating mental health: '*after I gave birth, I had no clue at all what normal symptoms of recovering from a caesarean section were'* (Naya, Indonesian woman).

### 3.3 | Structural Factors Restricting Health Knowledge

Structural factors affecting women's health knowledge throughout maternity care included the following: inadequate language services, short consultation times and limited continuity of care. These structural barriers reduced migrant women's power during maternity care and constrained their autonomy over health decisions.

Inadequate language services included long wait times for interpreters during antenatal care appointments and delays that made scheduled interpretation unfeasible despite pre-booking. Women who experienced these difficulties were discouraged from re-requesting these services and risked receiving antenatal care in a language they did not understand.

Some women feared discrimination for using interpreting services: '*I was worried they* [health workers] *would treat me differently'* (Gloria, international student). Women then relied on their partners (if they spoke English) or waited to see a different health worker to ask for simpler explanations: 'I did not understand what the doctor said...so I just followed the midwives' (Naya, Indonesian woman). Lack of adequate language services prevented some women from following healthcare recommendations and communicating their needs during childbirth: 'The only word I knew in English was "help". I was in excruciating pain, begging' (Quyen, Vietnamese woman).

Brief antenatal consultation times also precluded comprehensive explanations of medical information by health workers. This limited women's capacity to ask questions, adhere to medical indications, or understand their importance: 'I didn't know why I had to take it, so I didn't pick up the prescription' (Amira, Indonesian woman). Women receiving maternity care through the public health system reported longer initial antenatal consultations with their general practitioners. However, subsequent appointments were restricted to under 15 min (Figure 2a), which 'just isn't enough for them to explain things to you' (Eli, international student).

No continuity in care and carers undermined trust between women and health workers: '...if it was the same person, then I think it could be better because the person knows about the patient...' (Ish, international student). Women described how different health workers provided conflicting information: 'midwives say different things that you should do' (Kate, international student). These difficulties prevented women from raising health concerns during consultations, and made them anxious about making mistakes during pregnancy and postpartum. For example, some women reported they '*didn't know what to eat'* to improve glucose levels when diagnosed with gestational diabetes.

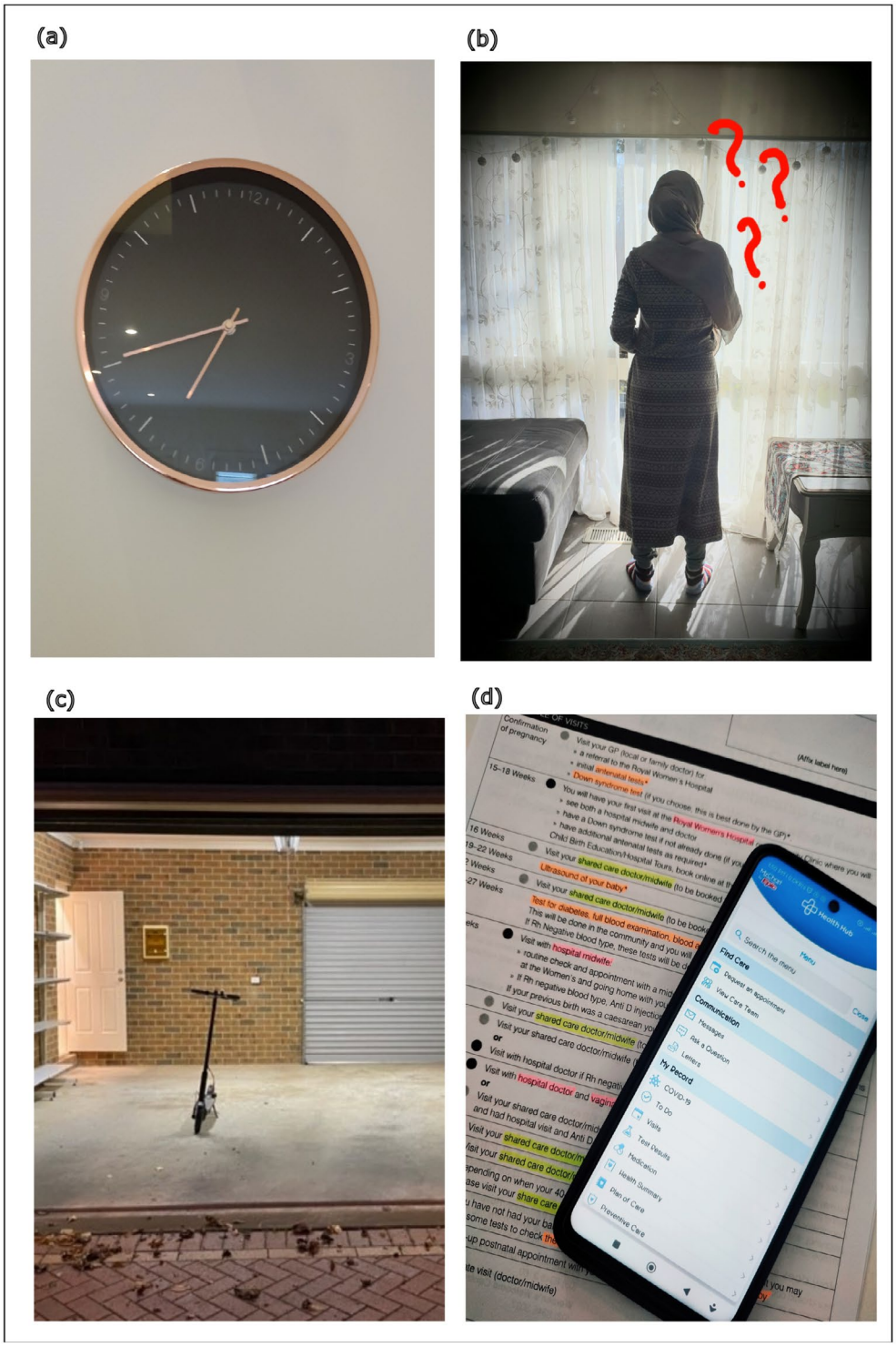


**FIGURE 2** | Participant photos and abridged captions. (a) 'Each examination only lasts about 15 min, if not less... I have to prepare questions and be proactive because midwives won't explain much unless prompted. They often refer to fact sheets available on the website...' (Diane, Indonesian woman). (b) 'We need to be proactive, to ask questions, don't let your different background hold you back ...it's also important for health workers to direct you, let you know the services you can access, to answer your questions patiently and in detail' (Nabilah, Indonesian woman). (c) 'Something that helped us is having our own car. If we need to go to the hospital with public transport, it would be more difficult. We went to our appointments with this scooter for the first 4 months of my pregnancy' (Thùy, Vietnamese woman). (d) 'The smartphone application provided by the hospital is useful ...I don't need to worry about its credibility. It includes features such as appointment schedules, pregnancy progress tracking, lab results, pregnancy education, all accessible at my fingertips...' (Zahra, Indonesian woman).

Other women reported distress due to difficulties breastfeeding, despite repeatedly asking different health workers for advice.

### 3.4 | From Passive to Active Participants

Women discussed being accustomed to and treated as 'passive receivers' of healthcare in their home countries with hierarchical health systems. In Australia, women realised health workers were more '*relaxed*' and expected women to be informed and empowered. Therefore, women felt they needed to be more proactive during healthcare encounters:

> There are different cultural styles here...It's like university...In Vietnam, they tell you and guide you exactly what you'll be learning. Whereas in Australia, they will teach you how to study and then they expect you to go and study yourself. When you go through pregnancy and give birth, the healthcare system [in Australia] is the same (Thùy, Vietnamese woman).

Taking an active role during healthcare encounters proved difficult for several reasons. Language barriers impeded women's abilities to speak up. Additionally, women's beliefs in health workers expertise and respect for their knowledge prevented them from challenging advice or decisions, as well as expressing discomfort or refusing procedures. This was particularly true while undergoing procedures in antenatal care and during childbirth: 'they always asked first [before checking for cervical dilation] but I didn't even think of telling them not to, I respect health workers'. (Diana, International student). Women were disempowered from voicing their preferences due to lack of shared decision-making: '*I am not that brave. So, I would just obey. Maybe if they asked me, I could speak out*' (Gloria, International student).

Women understood their shared responsibilities in maternity care, but stated they needed more information and encouragement from health workers to actively participate (Figure 2b). Some women were uncomfortable with the expectation to make quick decisions, especially when overwhelmed, tired, and in pain during childbirth and postpartum: 'I wish doctors would engage more with you, you're under so many hormones, drugs, you cannot decide' (Kate, International student).

### 3.5 | Factors Enabling Maternity Care Access and Use

Migrant women were resourceful and determined to receive appropriate quality maternity and newborn care. They described several practical factors that enabled them to access and use maternity care services; the most valuable and impactful enablers were support from their social networks and receiving woman-centred care. Practical factors included proximity to services and transportation access (Figure 2c). Additionally, women relied on text message reminders or mobile apps from hospitals for appointment management (Figure 2d). Some universities had agreements with health insurance companies to waive waiting times for maternity care services for international students. A few women reported attending informative talks by health insurance providers on pregnancy cover.

Women relied on friends who had given birth in Australia for advice on navigating the system, and for recommendations on health workers. Women also obtained information on maternal health services from social media groups from their cultural communities: '*We had no clue where to go, which doctor to see. The support from the Indonesian community, was amazing. They guided us*'. (Naya, Indonesian woman).

However, partners who advocated for their choices and preferences during antenatal care and childbirth were the main source of support for most women. Partners who attended childbirth education classes were better able to support women during childbirth: 'they can think, they learn what to prepare. When we are in pain from contractions, we cannot think clearly' (Nabilah, Indonesian woman). For single women, or those who could not be accompanied by their partners, friends and midwives provided essential encouragement and support (Figure 3a).

Women valued woman-centred care most during childbirth, and when they received it, felt safe and heard. They deeply appreciated the kindness and understanding of health workers (Figure 3b,c). Women felt empathy for midwives and nurses, who they perceived as overworked. This empathy, however, sometimes prevented women from requesting respect for their cultural needs, which they felt hindered post-birth recovery: 'I didn't want to bother them and ask for hot water' (Gloria, international student). While most women received some level of woman-centred care from midwives and nurses, it was rare during antenatal care with general practitioners, and those who sought it actively looked for language and culture-concordant providers.

### 3.6 | Dissemination of Findings

We shared preliminary findings at an in-person art exhibition in March 2024 and a virtual art exhibition (givingmumsafairgo.com.au) with participants, community partners, and maternal health advocates and researchers.

## 4 | Discussion

### 4.1 | Main Findings

Our study provides critical insights on the diverse challenges migrant women face while navigating maternity care in Australia, and highlights what would help them better access and use maternity care services. High costs, limited tailored health information, inadequate language services, short consultation times and limited continuity of care affected their use of services. Women discussed how health workers expected them to engage in decision-making actively, but they struggled to transition from passive to active participants. Challenges were magnified by scarce information sharing from health workers, exclusion from universal health insurance and limited culturally and linguistically responsive services. Social support from partners and communities, and respectful care from health workers helped


**FIGURE 3** | Participant photos and abridged captions.'This photo is called friendship. Two of my friends were allowed during my labour .... The fact that I felt accompanied helped me in my oxytocin production which triggered a quick labour' (Ellie, International student). (b) 'I feel very satisfied with the maternity care service at this hospital. Especially postpartum maternity care. I was in a large, comfortable room...The doctor and nurse were very kind. After being discharged home, the nurses visited enthusiastically and attentively' (Quyen, Vietnamese woman). (c) 'I have come across many amazing nurses and midwives, taking care of me during my pregnancy, labour, and post labour in the hospital.... who didn't only care for my newborn but also care for me (especially my mental health) ...' (Nabilah, Indonesian woman).

improve healthcare access and use. Practical enablers also included convenient transportation or proximity to health facilities, health insurance information sessions, health insurance waivers for pregnancy waiting periods and language-concordant care.

### 4.2 | Strengths and Limitations

We used a strengths-based approach that centred migrant women to determine priority topics for discussion. Rigour in analysis and

interpretation of findings was enhanced through meaningful collaboration between participants, community partners and academic researchers. Participant-generated photographs and descriptions placed women in control of the shared narratives. Inclusive and equitable measures were taken (e.g., on-site childcare), and women reported feeling safe and comfortable during research participation, fostering rich discussions. Limitations include the focus on Melbourne, which may not reflect experiences of migrant women from regional areas, where remoteness and less cultural diversity present distinct challenges. Women in the study were highly educated, which reflects Australia's strict visa eligibility criteria for the selected groups in the study. We focused on three migrant communities, acknowledging that many migrant communities exist in Victoria, and within each, unique circumstances can shape health system interactions and experiences. This study is intentionally exploratory, and findings are not intended to be generalisable.

### 4.3 | Interpretation

Our findings align with a hospital-based study in Melbourne (not specifically focused on migrant women) that identified the importance of childbirth education classes, timely information sharing, continuity of care and partner support [34]. That study identified societal cultural shifts towards shared decision-making, which contradicts our finding that migrant women experienced difficulties taking active roles during maternity care. Our findings may be explained by intersecting power imbalances between migrant women and health workers caused by language barriers, culturally unresponsive care and compounding effects of interpersonal and structural gendered racism disadvantaging migrant women [9, 35–38].

Intersecting factors such as insurance policies, language services and other structural challenges restricted shared decision-making and negatively impacted migrant women's access to and use of maternity services. Coupled with the exclusion of temporary migrants from Medicare, these are examples of institutional racism resulting in inequitable treatment of migrant women [39] and likely helping to explain limited progress in improving negative maternity care experiences for this group in Australia [40].

Overcoming structural health system barriers is critical to reducing maternal health inequities for migrant women and requires sustained societal and policy commitment. Our study shows that woman-centred maternity care is possible but currently inaccessible for many migrant women. Improvements are needed, including sufficient resources and manageable workloads for health workers to provide better continuity and quality of care. Additionally, capacity building for healthcare workers and interpreters in gendered and cross-cultural awareness, dialogical informational support for migrant women, clear and affordable pricing structures and consistent interpreter services are needed. Screening for existing social support early in antenatal care would help to improve necessary referrals with social workers and patient liaison officers.

## 5 | Conclusion

Migrant women are resourceful, adaptable and pragmatic when navigating maternity care services, but face structural barriers that diminish their decision-making power and abilities to self-advocate. These barriers are a violation of their human right to health and non-discrimination. Structural changes to improve maternal health access and provision are needed to facilitate shared decision-making, culturally responsive and woman-centred care. Our study participants argued that if these structural changes were made, they would feel empowered and safe to make requests that would satisfy their care needs.

We propose three areas for future research. First, health economic evaluations of maternity care for migrant women with varying visa types, to assess how private health insurance policies impact the costs of poor maternal health outcomes in Australia. Second, implementation research to test and evaluate shared-decision making and women-centred care, as outlined in national clinical guidelines. Third, policy research on institutional racism in the Australian health system to identify and address priority areas for the improvement of maternal health for migrant women.

#### Author Contributions

M.A.B. and M.V.C. conceptualised this study. K.B., M.A.B., M.S. and M.V.C. designed the study. M.V.C., A.H. and J.C. collected data. Led by M.V.C.; A.H., J.C., D.A. and G.T. contributed to data analysis. M.V.C. prepared the first draft and subsequent revisions with input from M.A.B. All authors critically reviewed the manuscript, provided feedback and agreed on the final version before journal submission.

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#### Ethics Statement

Ethic approval was obtained from the University of Melbourne Human Research Committee on 22 February 2023 (2023-25868-37109-3).

#### Conflicts of Interest

The authors declare no conflicts of interest.

#### Data Availability Statement

The interviews and workshops transcripts that support the findings of this study are not publicly available due to privacy concerns. Participants did not provide consent for the photographs contained in the manuscript figures to be reproduced by third parties.

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## Supporting Information

Additional supporting information can be found online in the Supporting Information section.