Being There is the Most Important Thing

Supporting Refugee and Migrant Women in the Perinatal Period – the Experiences of the Polish Migration Forum Foundation

FUNDACJA Polskie Forum Migracyjne

care

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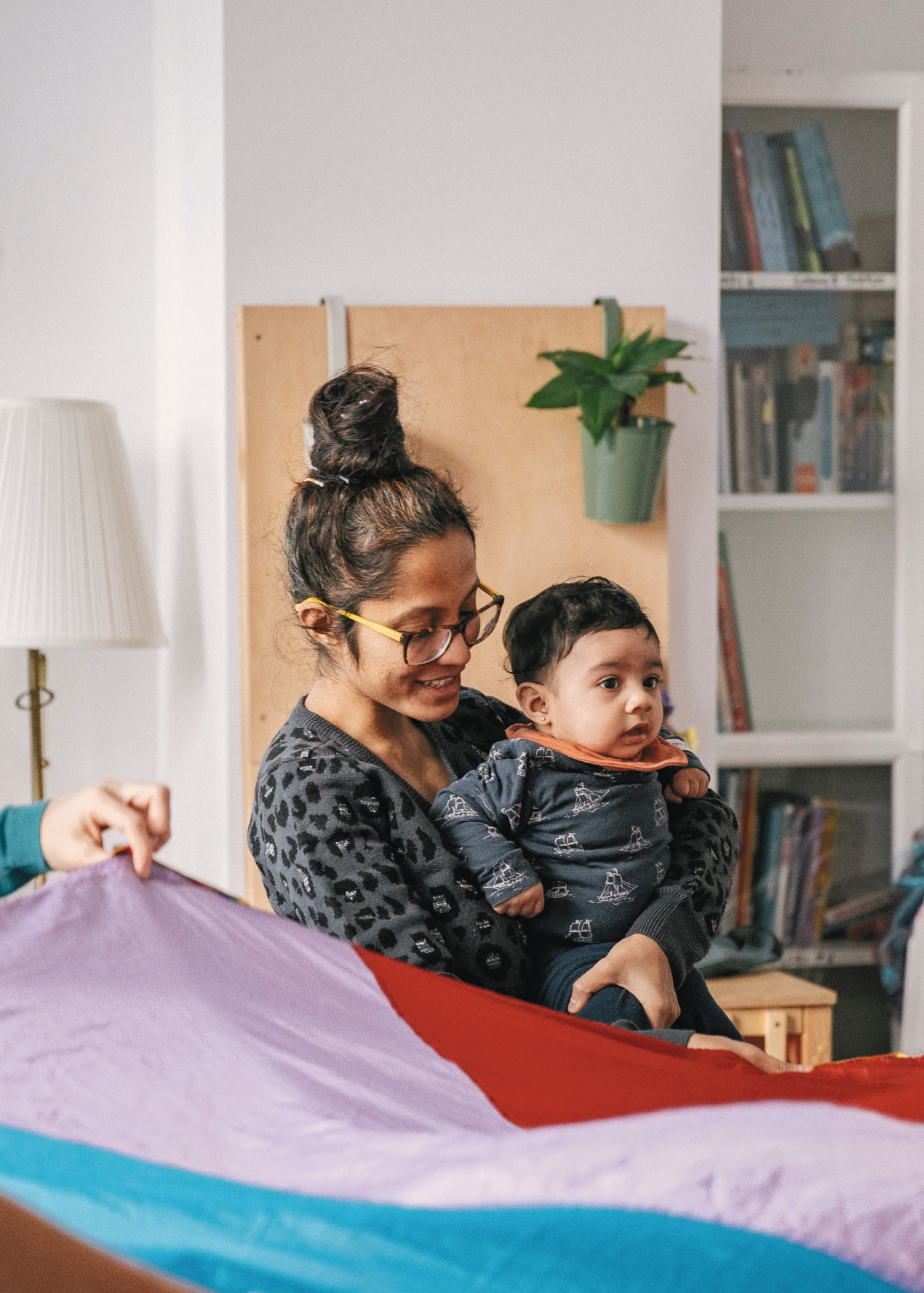
Between 2022-2023, activities for pregnant women, young mothers and children with refugee and migration experiences were implemented by the Polish Migration Forum Foundation with the support of Care International in Poland.

Warsaw, 2024



Introduction

2024 marks ten years since the Polish Migration Forum Foundation started its perinatal support programme for migrant and refugee women.

This programme is unique on the national scale. Foreign women, whose pregnancy, birth, postpartum and entry into motherhood take place hundreds or thousands of miles away from their homes and loved ones, find themselves in a peculiar situation. Loneliness, fear, redefining one's own identity – these emotions and processes can accompany both migration and early motherhood. It would not be difficult to imagine how strongly they are experienced when they reinforce each other.

We never had any doubt that refugee and migrant mums should be provided with special protection and support. We know this from numerous studies: the risk of perinatal depression in refugee women is significantly higher, and their children encounter more risks too. Their protection was our focus when we started this project.

Moreover, in the project participants we saw a community building a women's support network for each other, celebrating their successes together, but also sharing the longing for loved ones, experiencing good and bad times associated with adaptation both to a new country and to motherhood. We were guided by the idea that "it takes a whole village to raise a child" – and we set ourselves the goal of building a social space for such "villages".

When full-scale war broke out in Ukraine in 2022, it became clear how badly needed this kind of support for refugee and migrant women in Poland really was. At the time of writing this brochure, there are 1.8 million foreign men and women in Poland, including almost 1 million refugees from Ukraine under temporary protection. Poland is changing before our eyes into a multicultural, multiethnic and multilingual country, facing huge integration challenges. The pilot "perinatal" project proved to be a valuable resource of knowledge and competences, as recognised by our partner CARE International in Poland, which has supported us in scaling up.

Our aim was for the project to combine various tasks and areas into a coherent whole, as we know that holistically designed social initiatives bring about real change. We introduced support activities: birthing schools and reproductive health education classes, we also offered physiotherapeutic and psychological assistance to participants. We also implemented integration activities: helping include project participants in the life of local communities and promoting the formation of self-help mechanisms among refugee and migrant women. Finally, we started to advocate for systemic change, because we believe that the needs of refugee and migrant women in the perinatal care system are not sufficiently recognised by politicians, officials and medical staff. We conducted trainings and webinars, educating about the psychological effects of migration and the particular situation of refugee mums, and supported the development of intercultural competences of medical staff. We have further goals to pursue: to advocate for free perinatal care for all women staying in Poland, regardless of their residence status; to include content related to community-based support for refugee and migrant women in the training curriculum for nurses and midwives.

We view this publication as part of our work with the whole community, including hospitals, clinics, city and municipality authorities shaping local healthcare policies and finally the Ministry of Health. An important aspect is also our environment, i.e. NGOs, both those supporting refugees and migrants and those focusing on the protection of reproductive rights or preventive healthcare. We believe that the conversations and stories featured in this publication will become a source of inspiration for other organisations and institutions. The topic is and will remain relevant, and we declare our openness to share the experiences we have gathered over the last ten years.

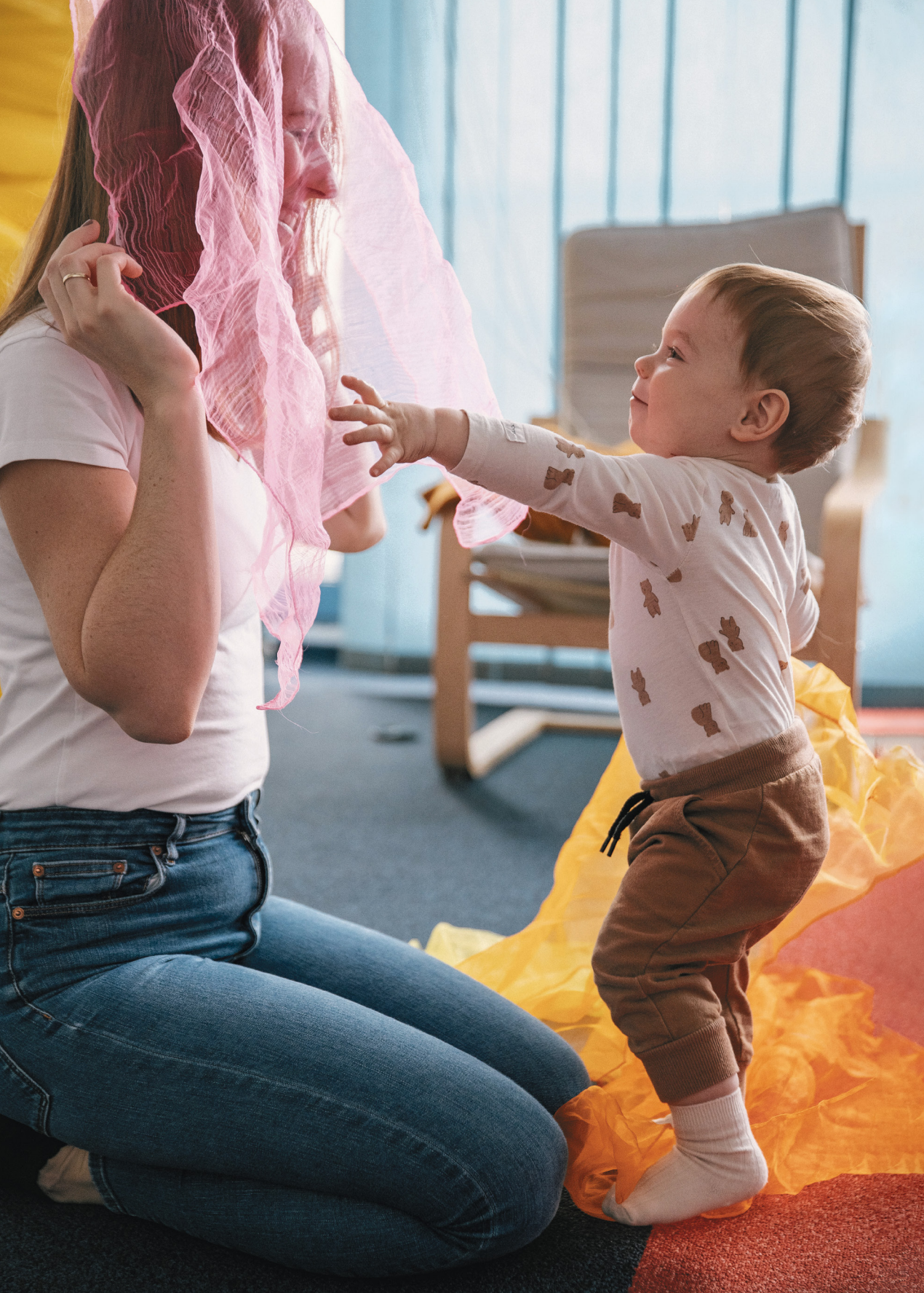
This project could not have happened without the Foundation's extraordinary team: Marta Piegat-Kaczmarczyk, intercultural psychologist, who has developed, co-created and acted as the godmother of the project since its very beginning; Hanna Kamińska, Inna Padshakh, Małgorzata Skalska – our brilliant midwives, who have shared their knowledge and attention with hundreds of future mums; Weronika Brączek, project coordinator, who spectacularly scaled up the project, adapting it to the new context after 2022 while at the same time paying attention to the individual needs of its participants. Thanks also go to Anfisa Yakovina, Marharyta Olshanska, Larisa Sugay and the rest of the PMF Team.

We would also like to thank experts Anna Bajkowska and Wioletta Rębecka-Davie, who contributed added knowledge to our publication

We would like to thank CARE International in Poland for sharing this journey with us and for professionally supporting our organisation.

And above all – we are grateful to the project participants, who placed their trust in us. It was an honour to accompany you!

Karolina Czerwińska,
Programme Director of the Polish Migration Forum Foundation
(first coordinator of the perinatal support programme at the PMF)



Above all: wellbeing

Kinga Gałuszka talks to **Agnieszka Kosowicz** and **Weronika Brączek** about the perinatal care system and the Polish Migration Forum Foundation's training for midwives

In November 2023, you invited midwives from all over Poland to Warsaw to talk about how to help migrant women in Poland – who often carry a baggage of difficult experiences and don't know Polish – to give birth comfortably and safely.

W.B.: The training was attended by midwives from Rzeszów, Bielsko, Bydgoszcz and Toruń. They showed a lot of determination, wanting to spend those two days with us. Some of them are only at the beginning of their professional careers, while others have over 30 years' experience. They all feel the need for change in their hospitals, to simply make it easier for migrant women to give birth.

But I also feel that this training – perhaps even more than a lesson in intercultural communication – was a workshop on wellbeing, which we were able to offer them over these two days. Without it, it would simply not have been possible to go even one step further. We also gave the ladies space to feel angry and to talk about the difficulties they face. Several such voices could indeed be heard.

Our maternity wards – as has become particularly evident after the outbreak of full-scale war in Ukraine – are and will increasingly become a multicultural environment. Migrant women give birth, refugee women from all over the world give birth, and these births are accompanied by experiences and emotions that even the most excellent and experienced midwives may not be prepared for.

W.B.: The PMF team have been training midwifery students at the Silesian Medical University in Katowice in multiculturalism since 2023: the girls can talk directly about the challenges they encounter and learn some practical solutions. But not all midwives, including most of the specialists who attended the training, have ever had such an opportunity. Nobody ever told them: "listen, the anger and frustration of patients, including migrant women, does not mean that they are angry at you. It just means that this person comes to you with a burden of experiences, most often difficult ones, or with buried dreams about what this birth and the first months of the baby's life were supposed to look like".

The difficult situation of midwives resonated strongly in the context of the hierarchical hospital setting and the dominant role of the doctor – a person endowed with respect granted from above, by virtue of authority. There was also discussion about the system in which they work, which usually does not provide midwives with what it should provide, such as an interpreter to help understand the pregnant patient and to make their work easier. Not to mention a psychologist or a lawyer…

What did the first training for midwives organised by the PMF look like?

A.K.: Our programme to support migrant women in the perinatal period has been in operation since 2009, in various forms. In 2014, we started working with the Rodzić po Ludzku Foundation, which at the time was much more advanced than we were in thinking about the system, and had managed to expand its contact network and cooperation with midwives. We had one or two groups of around 20 people recruit -ed by the Rodzić po Ludzku Foundation and we organised the train- ing for them. Two participants started working with the PMF over time and have now been training others for years. This year we also had two or three participants who attended that very first training and wanted to come along again.

There was also a midwife with experience of working in The Hague. From her I learnt that the specific nature of working as a midwife deal- ing with women from other cultures is not just a matter of a different language or customs. She also talked about the fact that maternity wards see women who had undergone female genital mutilation, which carries physiological consequences for the course of child- birth. If the medical staff are not prepared for this, difficulties will occur during the birth. The testimony of this one person with inter- national experience showed us the multiplicity of aspects we have to consider.

A lot has changed in public awareness since then, we all understand the challenges and experiences of migration a bit better now. You also know much more about the needs of pregnant migrant women these days.

A.K.: This is certainly the result of the work done by Weronika and the whole team over the years – it has taken our services to a new level. But also the system itself has grown up enough to talk to us. It took us a lot of time and effort to get the doors to open at all, so that we could convince the system and healthcare institutions just how important this topic really was. I must admit that this surprised me, as I had thought that our proposal responded to a real need and would be welcomed with open arms. We already have experience of working with both midwives and other professional groups and have heard the accounts of migrant men and women who find themselves in a system that is unprepared to function in a diverse world. We can offer a lot to the system, and our knowledge and experiences are simply useful.

The competence of our team working with migrant women today is incomparably greater than what we started with – which was a general reflection that migrant women had no knowledge of the healthcare system. We now know much better what they do not understand, or what the system does not understand, and where migrant women's needs are not met by our services.

From the perspective of this change, how do you see the healthcare system in which migrant women give birth today?

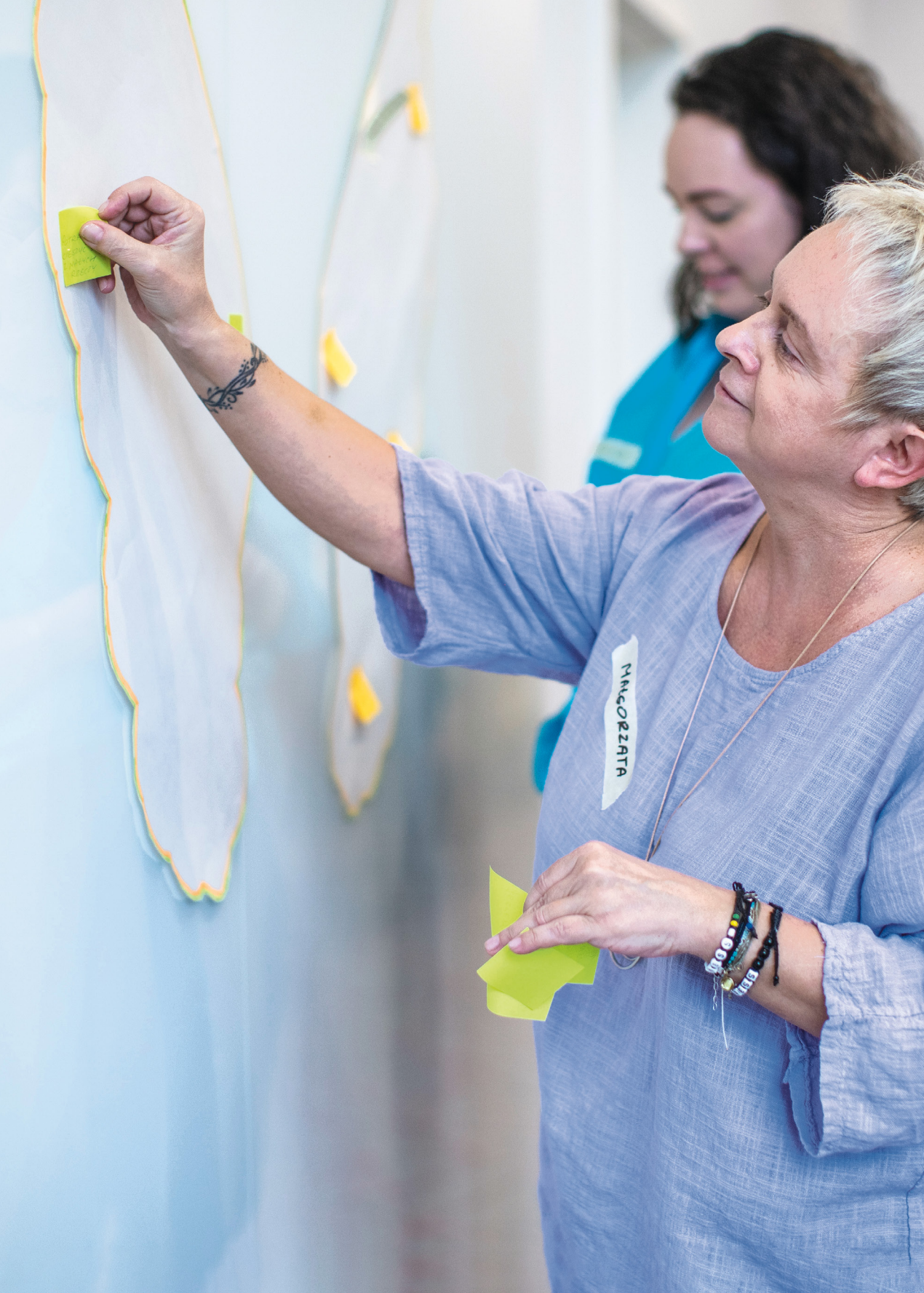
A.K.: The arrival in Poland of masses of people from Ukraine fleeing the war has had an unexpected effect: it would not be difficult to demonstrate now that Poland is no longer a homogeneous country. It is a nationwide and at the same time a personal experience: people see migrants on the streets; they know they have problems too. Doctors and medical staff see them too. Yet only a few years ago people thought that the presence of migrants in Poland was an imaginary issue.

But the fundamental thing has not changed: the state's way of thinking about who we are as a society. So, both at the level of lawmaking and the operation of hospitals, the situation has not evolved enough to take into account the needs of such a diverse community.

Why is that?

A.K.: For the past eight years of government (2015–2023 - ed.), the attention of the people in power was not focused on solving the real problems of those perceived as minorities. They did not look at what kind of country we were, how society was changing. The main focus was on Polishness – no consideration was given to the needs of a growing population that is not indigenously Polish, does not speak Polish, is not white, is not Catholic, and which, for example, may be circumcised or mutilated. And which simply originates from other contexts.

We need to see what the society we make up is really like. It is diverse, comprised of many groups that are different and that are not small or marginal. For example, Poles with black skin colour: it seems there are maybe just a few such people, or none. And yet these people exist, they have their associations. Or people who have Asian features, but their last relatives who spoke Vietnamese lived two generations ago. Such people are also here. Poland has become a much more diverse country over the past decades. It is high time to acknowledge this. Czas to przyjąć do wiadomości.


MAŁGORZATA

The midwife training programme focuses on issues related to intercultural communication and the wellbeing of midwives working in difficult settings – at almost every level. It seems that what you are proposing can be used more widely not just for inter-cultural initiatives.

W.B.: On the one hand, the training programme covers topics related to intercultural education; on the other, we simply talk about relationships and communication. For instance, we pose the question of whether midwives in general feel needed and valued in their workplace. And the situation is mostly bad right now.

A.K.: This broader perspective of our activities can also be seen, for example, in education. Teachers tell us that quite often our practices dedicated to the inclusion of children with migratory experiences translate into the inclusion of children who have been victims of bullying or who, for whatever reason, stand out from the "national average". Our main challenge is precisely to integrate otherness into the way we think. But also, just talking about otherness assumes that there is a norm, which sadly has a very narrow definition. What we need, also in midwifery, is to recognise the diversity of personal circumstances and to help people who are different find their place in the system.

What was the preparation for the training like two years after the escalation of the war in Ukraine and the consequential mass migration to Poland? How did you reach the participants that time?

W.B.: That time it was easier – the topic of migrants was being discussed everywhere, also at maternity wards. Plus, many midwives got very involved: they travelled to the Ukrainian and Belarusian borders. They felt a responsibility and a personal need to support women. But many of them were acting alone – which prompted the need for systemic work. The scale became enormous. Suffice to say that from the end of February 2022 we have been organising one or two antenatal classes per month, instead of one per quarter as before; we are also being approached by maternity hospitals referring their patients to us or ordering our publication: *I Am a Mom in Poland*.

Does this mean that you see a readiness for change?

W.B.: At some point – at the suggestion of our partner Care International in Poland – I contacted the Supreme Chamber of Nurses and Midwives. The discussions stretched over six months. It started innocently enough: we sent leaflets to the Chamber, then there was an interview

with Marta Piegat-Kaczmarczyk in the *Nurse and Midwife Journal* [*Magazyn Pielęgniarki i Położnej*], which the Chamber publishes and sends out to hospitals all over Poland. This meant that the conversation with our psychologist reached six thousand medical facilities in the country! I thought to myself: maybe one hundredth of the staff will read it, but at least the article will stay out there. So let's scale up and send out information about the midwife training through the Chamber. It is an ideal partner to bring about change – with an outreach incomparable to ours. Today as we speak, the first webinar on the Chamber's website is launching. More than five hundred people have signed up. Dozens have applied for the webinars announced on our website.

Our collaboration with the Rodzić po Ludzku Foundation was also highly valuable. Together we relaunched the aforementioned publication, *I Am a Mom in Poland*. It is dedicated to people who have come to Poland from other countries and are now expecting the birth of their child. We want to make this time more comfortable for mums-to-be, so that they can feel more confident and know what to expect from the Polish healthcare system. On the occasion of the Refugee Day, we also organised a joint webinar with the Foundation, which allowed us to discuss, among other things, the legal aspects of supporting migrant women in hospitals in the perinatal period.

I heard a lot of words of support during the training, but it is also clear that new knowledge and the need to learn new things can also meet with resistance from the participants, resulting from feeling overworked or burnt out.

W.B.: This is why we started our training by asking the ladies what they were good at, what they were happy with and what worked well for them. They talked about a lot of the great things they do. It was moving to hear them talk about it amongst themselves, and at the same time very empowering for them.

The evaluation after the training also showed some change in expectations. At the enrolment stage, the midwives wrote that the 'hard' competence areas were key for them, i.e. understanding the legal aspects or cultural differences. But afterwards, they turned their attention to 'soft' skills, i.e. how to simply be present and accompany the patient. At the very end of the training, Hania Kamińska, co-hosting the event, handed out tiny envelopes to each participant with hand-written quotes from her patients, whom she had visited at home as a midwife after the birth of their children. There were words of gratitude – not for access to inter-

preters in the delivery rooms or to lawyers, but for the midwife holding their hand or saying their name. These were the moments that made their memory of childbirth beautiful.

How was the training programme developed?

W.B.: We relied on the PMF's extensive experience and the solid competences of the people delivering the programme. They are midwives familiar with the legal basis for supporting migrant women and psychologists with experience of intercultural work. There was also a physiotherapist and also a crisis interventionist, writing a thesis on the topic of migration in the context of anthropology. They are all great experts. In addition, we also sent out a questionnaire to midwives asking what they had been doing so far and in which area they would like to receive further training. We tailored the programme to meet these needs, but we also took care to include key themes, such as an introduction to the topic of migration.

What issues not yet addressed could be discussed in the future?

W.B.: We think a lot about the topic of wartime rape and the transgenerational trauma associated with it, as well as what is said in the context of perinatal loss. All of this represents not only a vast area of knowledge, but also extensive potential cooperation with various stakeholders. So far, we have started with the Blue Line, we can already complement each other's knowledge. But surely anything related to the welfare of midwives should still be at the forefront of the training.

Let's stop for a moment at the real problems experienced by people – those very difficult ones – in the context of perinatal care.

W.B.: They are, for example, a lack of insurance or a failure (for various reasons) to legalise the residence of migrant women. Such people follow a completely different route into the healthcare system – they don't have access to free care – despite the fact that, after all, a miracle is about to happen: a human being will be born. There is also abuse that happens in refugee centres, e.g. a woman who is nine months pregnant and has been there since the start of her pregnancy has not undergone any examinations, although she had reported that she would like to have it done. How is this possible when these facilities have a duty to protect the baby, which also means examining the mother? She should have the same rights as any other woman. Or another situation: a pregnant woman is seen by a doctor who neither speaks any language she knows

nor uses an interpreter. And when the woman tells him that she is in pain and in labour, he recommends a painkiller.

There is no clarity on the medical service package available to the patient at the centre. By design, this is intended to be basic care. However, for pregnant women, it is debatable what this means exactly. Patients do not know what they can expect.

What could be considered an example of good practice or beneficial change moving towards the goal of safe and comfortable births for migrant women today, at the present stage?

W.B.: Certainly the cooperation between hospitals and organisations dedicated to supporting migrants. When a doctor or midwife does not have enough resources or knowledge on how to support people with a migration experience legally or psychologically, they can refer their patients to such organisations. It is also the previously mentioned training of midwifery students and cooperation with the Supreme Chamber. Many heads of maternity units from all over Poland, whom I met recently at a conference at the Chamber, told me: come to us.

And for the future?

A.K.: I think perhaps it is also our role to ensure that midwives stay in regular contact, if only online. So that they can feel that they are not alone and are able to discuss various challenges or simply vent.

W.B.: We would like to continue to train and educate others, and we would also like to see antenatal classes like ours organised in other cities to reduce the queues. It is also important to push for the inclusion of migrant women in the system of free antenatal classes, available to all people who pay taxes. I think we can do a lot at provincial level or in cooperation with city mayors. My dream is to provide midwives with access to interpreters.

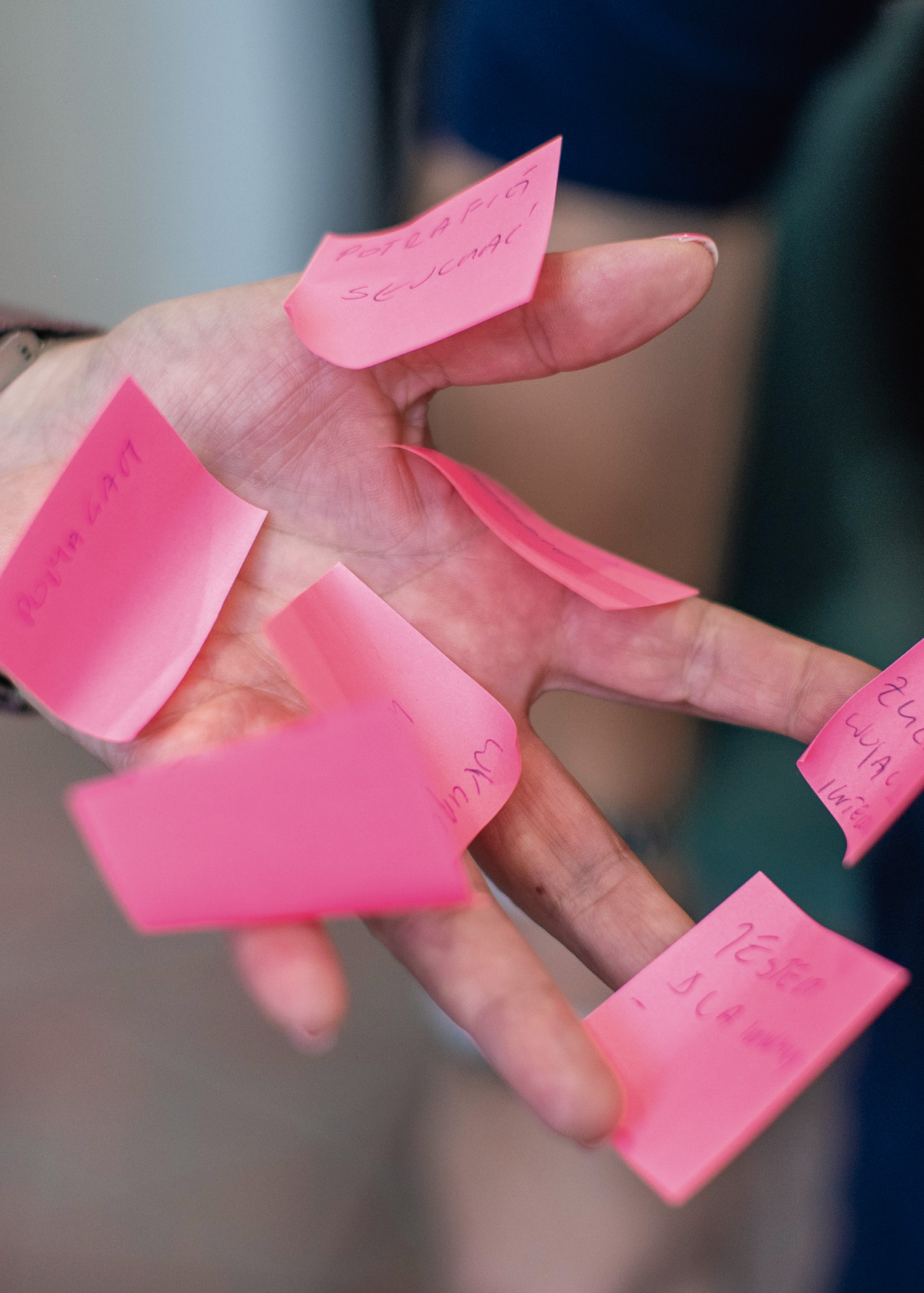
What doors do you need to knock on to effectively advocate for better standards of perinatal care for migrant women?

A.K.: We intend to approach the parliament and government, mainly the Ministry of Health, but also our donors, who on the one hand have the money and on the other hand sometimes have the capacity to engage in high-level discussions on issues that are important to us.

At the Foundation we often discuss what our role should be: whether we should focus more on helping people or rather advocate for systemic change. I believe we need to do both, because it is only this combination that makes a real impact. When I give talks at peri-governmental level, people listen to me when I cite specific examples and practices, when I am able to point out what does not work or which regulations are dead and why. Abstract talk about theory does not have the desired effect. Only knowing the real problems of real people makes it possible to seek systemic change.

Agnieszka Kosowicz –President and Founder of the Polish Migration Forum Foundation. She has been advocating for refugees and asylum-seekers since 2000. Initiator of various activities for refugees and migrants in Poland, author and co-author of publications on refugees, migrants and integration.

Weronika Brączek – Coordinator of the programme dedicated to women in the perinatal period at the Polish Migration Forum Foundation. Since 2009, she has been initiating activities aimed at people with migration experience in Poland and at Poles abroad.



Sitora Yusupova

After arriving in Poland, my husband and I got very lucky because I came across a wonderful Polish family who took care of us. I don't even know what would have happened without their help. But even this support did not protect me from bad experiences linked to gynaecological care and childbirth in Poland.

I can't afford private care, I always have to make appointments with the National Health Fund. When we applied for international protection, we had to use Petra Medica care. Later, once we have been granted protection, I always used the district clinic. I have never encountered a good gynaecologist through this route. Whenever I call to make an appointment and give my name, I am assigned doctors, almost always men, whom other women do not want to see. They always have a lot of available appointments, and I have no choice, even though I ask them not to make appointments for me with male doctors. The same happens when I help, for instance, the Afghan women I support through the Polish Migration Forum – it is also difficult to find a female rather than a male doctor for them. My impression is that this is due to ill will, there is no habit at the clinics to take care of such patients, and a request for a female gynaecologist is seen as unreasonable. I was very stressed during my pregnancy, we were still going through the refugee procedure at the time – at nine months' pregnant I had to attend a police interview, the police would come to the house where we lived unannounced. At times like this I was very scared, and the appointments with the doctors added to this stress every time.

Childbirth was a terrible experience for me. I got pains in the evening, went to the hospital with my husband and my Polish mother, who had taken us in with her family. I had not yet been granted protection at that time, I did not have a passport, and only had the referral to hospital on me. I had previously been told that this was enough to get me admitted to the ward. The woman at reception yelled at me. First, she didn't want to admit me, then she said I would have to pay PLN 3,500 for the birth. I was terrified that something bad would happen to the baby or that I would have to give birth at home. In the end, I was admitted, but I had the impression that they were doing everything to get me out of there as quickly as possible. I also understood little of what was being said

around me – back at the reception and later, during the birth and during my hospital stay.

I was given an IV, probably to induce contractions, and then I was being rushed the whole time. I didn't feel I was ready to give birth, I was eight centimetres dilated and I felt that it wasn't time yet, I remember someone pressing down on my abdomen, my perineum tore. It was stitched up after the birth, but it hurt terribly, the stitches came apart, they had to correct the stitching and they did it without anaesthetic.

Even if you don't understand the language, you can sense when someone says bad things to you. And that is how I felt at the hospital. Nobody explained anything to me. I had no strength and the doctor told me I had to leave the hospital the next day. I didn't agree, the baby was OK, but I was sore, I couldn't imagine leaving in such a state. The doctor said: in our country women leave the hospital after a few hours! I stayed for four days. When my husband had to leave me alone with my daughter, a Polish woman helped me, who was staying in the same postnatal room with me. It was already her second child and she knew that my daughter was crying because she needed her nappy changed. I was in such a state that I didn't realise it. She also helped me change her for the first time and offered to help me bathe her.

After giving birth, I started having very serious gynaecological problems, suffering from endometriosis, and I also had postpartum depression for a year and a half. I didn't even want to think about having more children. I was told by doctors that my very painful periods, which I never had before the birth, were normal, just like pain during intercourse, which also only started after the birth of my daughter. "So don't have intercourse if it hurts" – one doctor told me. I had severe back pain, my physiotherapist told me it was a consequence of giving birth. To this day, when I pass that hospital, my whole body hurts.

To get out of my depression, I went to see a psychiatrist, took medication and also started working with a psychologist. She told me to write down all the dreams and goals I had. It was a list of about 60 items. The most important thing for me was that I wanted to work with women. A few months later, I started working for the Polish Migration Forum. I love what I do, I get amazing support here, the supervisions I have twice a month help me a lot. I am learning how to better help women. In the beginning I made myself available to them at all times, ready to help with anything. I have learnt to set boundaries. I know women who

have lived here for almost ten years, who have several children who were born here, and yet they do not even speak Polish. I have to admit that this makes me angry. I explain to them that they need to learn the language, that their children cannot be their interpreters, that they have been here three times longer than me and yet they cannot take care of the simplest things themselves. Aid can be addictive. I once heard an official say about some woman: "Why does she need another child if she can't even handle this one". Without language skills, they cannot get a better job either. I promised myself I wouldn't be like that. It even came to the point where we would not speak Tajik to our daughter. She came back from kindergarten one day and complained that the children were saying she was not Polish. I then came to a class with her group, talked about Tajikistan, told the children that my daughter, like me, is both Tajik and Polish. We wore traditional costumes and taught the children dances and Tajik. I was surprised that my daughter knew so many words. At home, she did not want me and my husband to speak Tajik, and she often corrected our Polish. The psychologist advised us to start teaching her our mother tongue, to use relational words in Tajik: "I love you", "I missed you". She really likes it now. I already know that she will not lose the ability to speak Polish, she will probably speak in Polish to her brother or sister.

I didn't plan the second pregnancy; I was sure I would have difficulties getting pregnant at all. When we found out we were expecting another child, I was very scared.

My daughter is very much looking forward to having a sibling and I am now looking forward to it too. I see my daughter kissing my belly and I feel the maternal instinct awaken inside me again. I am still very scared about the future and whether we'll manage financially, whether I'll be able to look after them on my own while my husband is at work. We have a wonderful paediatrician, a friend of the family, who we came across after arriving in Warsaw. When I tell her about it, she laughs and replies: "Sitora, it will be just like it is now, only instead of one child, you will visit me with two". It helps, chases away the dark thoughts. I am also getting ready to give birth. I already speak much better Polish, I will understand what they're saying to me, I am planning to visit a few hospitals beforehand to try to talk to the doctors and midwives. I also have a special notebook – I write down important information, legislation. If someone treats me badly again, I will say loudly in Polish: I know my rights, I pay taxes here, I do not agree. So they see that I am a human being.

Sitora Yusupova: a journalist from Tajikistan, came to Poland with her husband in April 2018. They had to flee because of the threats they were receiving (Sitora refused to cooperate with the pro-Russian authorities). When they left their country, she was four months pregnant. They spent six weeks trying to cross the border at the Brest-Terespol crossing. Despite declaring that they had applied for international protection, Polish border guards repeatedly refused them entry to Poland. Finally, they succeeded. After crossing the border, Sitora and her husband spent a few more weeks in a centre for foreigners in Biała Podlaska. From there they made their way to Warsaw, where they were hosted by a Polish family. This is where their daughter was born. Since 2022, Sitora has been working with the Polish Migration Forum as an intercultural assistant at a school.

Małgorzata Skalska

Every birth is part of a primordial experience, which involves fears shared by all women. Regardless of whether it is a migrant woman or a Polish woman giving birth. Although culture imposes different patterns of behaviour and expectations in relation to this event, we all feel the same. However, we as midwives need to always be aware of what a life-changing experience it is to give birth on foreign soil.

We all label others based on nationality or skin colour, we rely on stereotypes which, on the one hand, make it easier for us to function, but, on the other hand, often do not allow us to see the real problems faced by a specific person. I, too, can fall into this trap, for instance when I unconsciously attribute a certain way of reacting to childbirth to a migrant attending antenatal classes. It is, after all, a very human thing to do. So whenever I feel I'm falling into a routine in conducting my classes, I always ask myself how I would feel if I were forced to give birth in a foreign language or without understanding at all what the midwife or doctor was saying to me.

Together with Marharyta Olshanska we run antenatal classes for Ukrainian groups at the PMF. It is often said that Poland and Ukraine are close in terms of culture. But actually, in every class I learn something new about how the girls perceive childbirth, what their fears are. Sometimes this is strongly linked to cultural elements, but it usually relates to that primary sphere I was talking about.

Sometimes the unfamiliar causes fear among staff and a withdrawal reaction, which is bad for the care provided afterwards. But the most important thing is what I always try to communicate in my classes: at the key moment of childbirth, words are not needed, except for: we can do it. Touch, facial expressions, smiles are important. I believe that when we give birth, everything happens at that basic level and if the midwife is experienced, we can give birth in any language.

The problem is the issue of continuity of perinatal care. We always emphasise the importance of the role of the community midwife – the person who cares for the baby and the mother in the period just after the birth. She is the one who will come to the new parents' home, identify any problems and refer them further. But here is where the language

barrier sadly comes into play and then the migrant woman is often left alone. This is a systemic problem. Our communication with the patient determines whether she will leave the hospital knowing how to feed and care for her baby. And this is already an arduous process.

In the work of the midwife, as well as in the work of any healthcare professional in general, observation and attentiveness should always come first. Empathy and experience are the foundations of our work. I know that a good rapport can be developed by spending time with the patient. But undoubtedly, as midwives we need training and preparation in intercultural communication. It is important, because a solid knowledge of a given culture influences how we perceive the patient's behaviour or what questions we ask when discussing the birth plan. So then, as in the case of Afghan patients, for example, we will not have to wait for the couple to tell us that they do not wish male staff to be present during the birth. There is a wealth of material on intercultural education available online, which is easily accessible, but it certainly does not replace training, which is lacking.

The midwife, like the nurse, is the first point of contact and the first observer. Credit is due to those doctors who are willing to listen to us, because communication in the medical team is very important, and we all know that doctors are overworked and there is often not enough time to talk to the patient. The women we meet in the delivery room are all very different, whether they are migrants or born here. Sometimes it is difficult to work with a Polish woman who speaks the same language and yet does not establish a dialogue with the midwife, does not want to talk, does not respond to messages, questions or suggestions.

We ourselves also perceive different patients very differently; in this respect we are just like everyone else. If one were to listen to all the staff who had to deal with a particular patient, very often it would seem as if everyone was talking about a different person. The face of a woman at the pregnancy pathology ward is different from the face of the same woman later at the obstetrics ward. The experience of pregnancy, childbirth and postpartum changes us – it is simply a different state of consciousness. I myself sometimes find it difficult to recognise the patient, because she behaves differently at each stage, interacts differently. To one midwife she can be a difficult case in terms of communication. Another does not see any problem; they understand each other very well. This is just how it is.

We certainly lack evaluation tools and surveys in hospitals, because after all it would be beneficial to receive some feedback. Now we don't know: perhaps the patient who we thought didn't get everything she needed from us, was actually delighted? She just didn't show it the way we think she should have.

The main issues I find difficult in our work right now – and there will probably be more and more of them – concern cultural relativism. I think it is difficult for us as Polish women to assist at births where the man plays an important role. There are communities or nationalities accustomed to the father being present in the delivery room and him making all decisions, including whether the woman will get anaesthesia. It is a very paternalistic arrangement. Plus, in our system, the subject of care is the woman, not the accompanying person.

There are also these challenging situations when a woman who does not know even basic English is giving birth, and the man is not present at the birth due to his culture or religion. So then, and I've had such experiences, we're on the phone with him the entire time. It would be beneficial to have an opportunity to meet with such a couple beforehand to discuss how they see it, as there is no time for this during the birth. These are very sensitive issues, I find them difficult.

I would also like us to be aware of the fact that there are different migrants and different needs. A completely unique group were refugee women from Ukraine who arrived just after the outbreak of war and had to give birth in Poland. There were very many preterm births at that time, and there were also very many losses. These women were in total shock. The problem with communication did not result from a language barrier, but from their mental state. A completely different case is couples who know they will be here for a while, they know the Polish medical system, attend classes and learn.

I have never had a negative reaction to the fact that we had to set a boundary for migrant patients and their families due to our organisational system. For example, that the whole family cannot stay in the hospital corridor or enter the delivery room. We clearly communicate that we need to look after the safety of other patients. I think it is our duty to be aware of cultural relativism and to learn about other cultures, but this has to go hand in hand with respect for the rules that are in place here.

Written down by **Dorota Borodaj**

Małgorzata Skalska – midwife and doula specialising in perinatal education. Since 2017, she has been running classes to prepare women for childbirth. Since 2022, working with the Polish Migration Forum Foundation. She works at one of Warsaw's teaching hospitals, looking after parturients, as well as new mums and newborns.

The most important thing is one you cannot see

Kinga Gałuszka talks about antenatal classes for foreign women with **Marta Piegat-Kaczmarczyk**, **Inna Padshakh** and **Hanna Kamińska**

It all pretty much started in the delivery room…

M.P.-K.: When I gave birth to my first child and was already at the maternity ward, during the rounds the doctors would ask us all: "How are you feeling? Are you breastfeeding? Is everything OK?". In the bed next to me was a Vietnamese woman, who nodded at every question. But I could see that she was suffering. She tried expressing her milk with a breast pump – standing up and even on all fours, kneeling. To no avail. She cried. Whenever the doctor came, she nodded to say that everything was fine. One time I stopped him and told him that this lady was having a hard time feeding and that she was not fine at all. I did it without consulting her, but I felt there was no other option. They actually helped her: the baby learned to feed from the breast and all went well. It was only later that I explained to her that I had spoken to the doctors. She was very grateful.

This gave me food for thought. If I, a 29-year-old mother, well adjusted in life, am in total stress and panic at the hospital, what must a Vietnamese woman who can't communicate with the staff feel? Imagine this: having a baby among people who don't understand you and you don't understand them. How stressful! We started exploring the topic at the Foundation and found that there was a gap in the system. This is how we came up with antenatal classes, or birthing schools, for migrant women – the first project of its kind in Poland.

The first classes launched five years later…

M.P.-K.: It took so much planning, researching, checking, analysing various studies. We also travelled to conferences and talked about the project. We felt a bit like a circus. I'm joking, of course, but that's more or less how we were perceived when we said we were doing classes for foreign women giving birth. "Foreigners? Well, yes, indeed they are here, and they give birth, too" – we heard. In 2014, we brought the project to life. This time I was giving birth to my second child. While I was lying in the antenatal room, I got a call from Agnieszka Kosowicz saying that we had signed the contract and we were going ahead.

From the beginning you also assumed that the programme would be based on the idea of continued support after the birth.

M.P.-K.: This was due to the specific circumstances of migrant women, with their lives being cut into different stages. So continuity of support in their case

is vital. Sometimes the girls would meet a midwife at the antenatal classes who then assisted them during the birth, and after the birth they would come to me for the support group. This was the thing we wanted most – for the meetings to be held in a language they could understand and for them to be uninterrupted. From the moment a pregnant woman comes to us, we cater for her parenting needs and this continues up to the nursery or pre-school stage. During this time, other topics come up: more children, divorce, all the things that life brings with it.

What was the timetable for these activities in the early years?

M.P.-K.: We run one birthing school per quarter. Immediately after the classes we would start support groups. Then, when the groups wanted to work with us for over six months, we merged them into one larger group.

Who took part in your classes?

M.P.-K.: These were truly beautiful groups. Ukrainian women, Belarusian women, Russian women came – they were all together. There were also Indonesian or Tajik women. We did a split between English and Russian, although this did not always work. For several years, classes in these two groups ran in parallel. The girls came with older and older children and then with more children, supporting each other.

Over the period of nearly 10 years since the first birthing school, the migrant reality in Poland has changed a lot, especially of course since 2022, when the war in Ukraine escalated…

M.P.-K.: The type of problems has not changed, only their intensity. There are simply many more women who are in need. Added to this was a group of independent mums – but that was only at the very beginning of the war. In the first few months, women came alone, in advanced pregnancy. They were fleeing the war – without their husbands, and they did not know if they would see them again, if the father would meet the child, if the child would meet the father. It was a distinctive group of very lonely and very terrified girls, to whom it all happened suddenly. Things are different now.

Hania, you are one of the midwives who have been working with the PMF almost since the beginning of the project.

H.K.: I was a volunteer with the Rodzić po Ludzku Foundation. There I met Marta, who was running a training for midwives – she taught us what

the cultural differences were and why a Vietnamese woman nods to say yes but thinks the opposite. At the time, I was working at an ordinary district hospital in Piaseczno, where a lot of Vietnamese and Chechen women were giving birth. We were unable to establish a real connection with them. So for me as a midwife that training was groundbreaking and much needed.

I came to the PMF in 2015. Previously, birthing schools were run on the obstetric side by Martyna Grygiel-Kaczmarek, who handed over the job to me as she decided to focus on her work at the hospital.

M.P.-K.: I remember that in 2015 the government froze funding for NGOs, so our financial situation was also tragic. We waited for the money awarded to us in international competitions, which never came. We were only able to do four birthing schools per year, with no possibility of giving postnatal consultations. All our activities were trimmed to the bare minimum.

In 2022 the project kicked off anew…

H.K.: First, in addition to the standard antenatal classes, we included individual consultations for pregnant women. In the middle of the year, we also started postnatal consultations and that was also a hit. We knew the girls needed them. I am very happy that we are able to do this, because we always wanted it.

Hania, you run English language groups...

H.K.: I work together with psychologist Anfisa Yakovina. Our classes are generally attended by open-minded people, who are also very keen on postnatal consultations. According to my calculations, since April, so over nine months, I have held 56 consultations for women of different nationalities from 15 countries. I am not counting the men who sometimes come from some other places. Most girls need a lactation consultation, because breastfeeding is the main problem. Sometimes there are also some nursing issues, and sometimes they just want to make sure they are doing everything right. We often have a postpartum contraceptive consultation.

In total, we provided over 300 individual consultations in 2023. And each of them, at least the at-home ones, lasts two hours.

What do migrant women fear before giving birth?

H.K.: Apart from focusing on what all other pregnant women think about, i.e. to get everything ready and to buy the necessary items, they also experience the added stress connected to the registering: registering the children. There is also a lot of anxiety about whether they will find their way around the healthcare system. I always advise them not to call the clinic, but to go there in person or to send their partner there, as it is often difficult to communicate in English over the phone.

They are anxious that they will not understand the doctor; sometimes they write to me to make sure they have understood correctly, or send images from their appointments. Of course, Polish women are also stressed, because every paediatrician is different. I hear stories about young mums feeling terrible after an appointment because the doctor criticised everything they do. This is already a systemic issue. It can also be stressful to deal with a midwife, although it is not so bad because there are midwives who are not afraid to communicate in English.

What do migrant women tell us about their births?

H.K.: They have good memories. However, let's remember that I only have accounts from Warsaw, where there is a choice of facilities and where, already at the antenatal classes, we advise which hospital to choose depending on the needs of the individual woman.

The ladies are grateful that they had care, that their perineum was not incised or that they were able to give birth in water or in the position of their choice, that they could cuddle the baby before the umbilical cord was cut. We take it for granted.

Sometimes postnatal care has its problems, but I am a midwife myself and I know that one midwife can have up to 20 women who have just given birth under her care. It is not possible to dedicate a lot of time to each of them.

Let's go back to Vietnamese women for a moment, who sort of started it all. What is your experience with this large and still poorly integrated community in Poland?

M.P.-L.: Vietnamese families do not report to birthing schools. And we know from the Vietnamese women we meet in various places that they lack both knowledge and support. A few years ago, we put together a programme

designed for them – there was a need on their part and a willingness on ours. But a barrier arose: the fact that we held the classes at our premises proved too time-consuming for couples, especially when they were supposed to come together, dedicate the whole weekend to it and not work during that time. It is a community that works a lot, and pregnant women often don't take sick leave.

So when a couple of years ago we went with an interpreter to Wólka Kosowska, the closest place to where they work all day, we found that the ladies were very interested. They were grateful for all the information we gave them. They asked a lot of very interesting questions, such as how to go straight from hospital back to work with a baby. They were pleased to learn that they could carry the baby in a sling and that the baby did not have to sleep on a pile of jeans in the hall at all. So even if a woman needs to go back to work, at the same time she can fulfil herself as a good, caring mum who is close to her child…

Sadly, we have not managed to transfer these activities back to our premises. And a mobile school in the long term is a highly challenging task. But if every other class was dedicated to the Vietnamese community, we would certainly have full attendance.

What is it like working with Russian- and Ukrainian-speaking groups?

I.P.: Those first classes just after the outbreak of war, as mentioned earlier by Marta, were only for mums who had just come here, experiencing a lot of fear, without any support around them. It was very difficult. Most of all, we tried to build a community and, in the beginning, not so much to impart a lot of medical knowledge as to give psychological support. They really needed it a lot. Only later did we get into the subject of childbirth. We explained how the healthcare system in Poland works, so that they would know what they could expect and what they were not necessarily used to.

I know that girls from Ukraine are terrified to learn that an ambulance will not take them to hospital to give birth in Poland…

I.P.: In Poland, we try to stay in the home environment for as long as possible, in comfortable conditions. In Ukraine it is different – women in labour prefer to go to hospital earlier to stay under observation until the birth itself. Polish women wait until the last minute and go on their own.

Inna, from the perspective of your Ukrainian midwifery experience, how do you perceive the standards of perinatal care in Poland and Ukraine?

I.P.: In Ukraine, it is the norm for the doctor who looked after the pregnancy to be present at the birth. In Poland it is completely different: not only is there little chance of the same gynaecologist attending the birth, but in Poland in general a doctor is rarely present at the birth. Especially if everything runs smoothly and the mother and the baby feel well. Everything depends on the midwives, who are very professional.

I hear from girls that they expect the doctor looking after their pregnancy to prescribe some medication or supplements. Meanwhile, if everything is OK and test results are good, the doctor in Poland does not prescribe anything, whereas in Ukraine you always leave the doctor's office with a prescription. This makes them feel that the doctor over here is not paying enough attention to them.

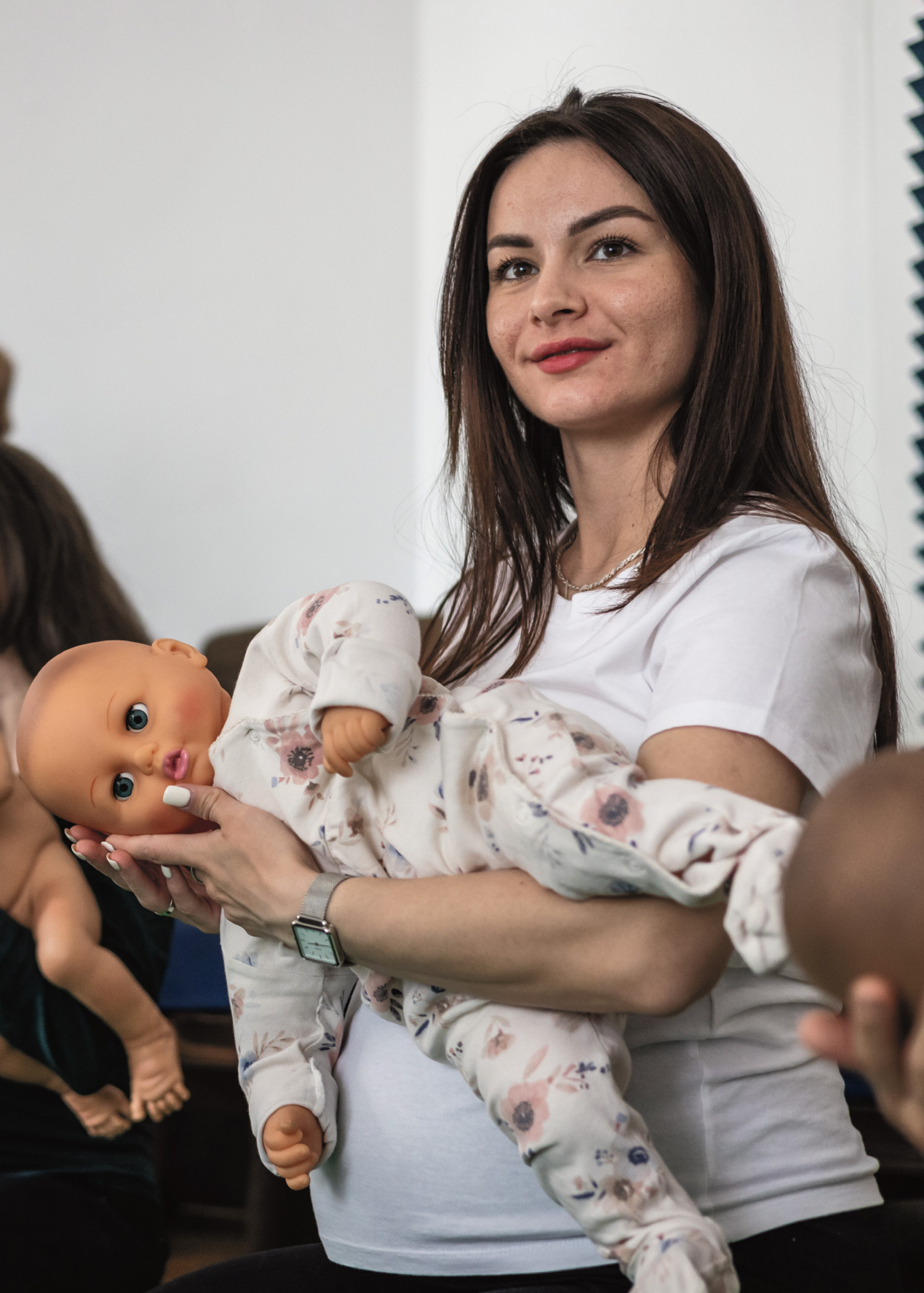
And any positive surprises?

I.P.: In Ukraine if a woman has made arrangements with a doctor at the hospital, she will receive care and be treated well. But you have to pay a lot for everything. So they are surprised that in Poland you can get the same care for free – from a midwife, who just works at the ward and is on call. All the standards in place here, like Hania said, are a pleasant surprise. This is nice, and it was especially important for the women who came to give birth here at the beginning of the war and were in a very difficult situation.

The war has been going on for so long now, so your groups must have changed too?

I.P.: Now women come to classes with their partners. They are much calmer. They ask specific questions about hospitals where they can give birth, as well as types of delivery. They are more aware. They have lived here for some time now and have become accustomed to the system.

The programme of your birthing school is divided into several modules. The first deals with formal-legal issues, the second with the psychological wellbeing of women in the postpartum period and the supportive role of the partner during this period, the next with purely obstetric issues and finally with issues related to taking care of the newborn. From the perspective of your experience so far, are there any areas you would like to add to the programme?



M.P.-K.: The answer to this question is complex, as we assume a great deal of flexibility each time, as each group is different. When the ladies showed up just after 24 February 2022, we knew that with them we had to work mainly on their resources, on community building. Whereas we certainly couldn't start the subject of the relationship with the partner after the birth. We knew it was a very painful topic.

With each group, we explore their expectations. And although the framework programme of the classes is always the same, we try to manoeuvre with perinatal, psychological, educational and migration topics. Multidisciplinarity is key in this work.

There are some topics that we would not have thought of and could not have planned for, such as what to do when registering a child if the father is not the husband of the child's mother and he is not here, or what should the mother do if she gives the father's name, which could result in his deportation?

Let us pause finally on the subject of mental wellbeing. During the antenatal classes you devote a lot of time to this subject, you do it in a very specific way – talking directly about, among other things, postnatal depression. You say: there is such a disease and it can also be part of the experience.

M.P.-K: We observe that many of the girls we know from the schools or support groups reach out for psychological and psychiatric help, which we familiarise them with a little bit during the antenatal classes. They often say that they would never have gone to a psychologist before because they thought that a psychologist, and even more so a psychiatrist, was a last resort.

Meanwhile, all studies show that women with migration experience have a much higher risk of postnatal depression. This is linked to high levels of anxiety and uncertainty about the future and often also to previous traumatic experiences.

I believe, from the point of view of a psychologist working with childhood trauma, that the most important thing about antenatal classes is something that is not visible. Working with women in the perinatal period is the key element in protecting children from possible later harm and trauma. Because if the parents or the woman herself, if she is an independent mum, gets support,

understanding and acceptance of her different and difficult emotions during this very sensitive time, she will be a safer person for her child. These first patterns of attachment are of key importance for our whole lives.

Hanna Kamińska – midwife, been working with the Polish Migration Forum Foundation since 2015. As part of the "I Am a Mom in Poland" project and at her own birthing school, she educates and supports young parents of different nationalities living in Poland. She gained experience at St. Anne's Hospital in Piaseczno and St. Sophia's Hospital in Warsaw. Advocate of home births.

Inna Padshakh – midwife and doula, been working with the Polish Migration Forum Foundation as an educator in the women's programme since 2022. She supports migrant women in the perinatal period in the scope of issues related to being a parent in Poland, preparing for childbirth in Polish hospitals and the healthcare system in Poland. She cares for pregnant women and women with young children in long-term accommodation and crisis centres.

Marta Piegat-Kaczmarczyk – intercultural psychologist, certified TSR therapist. She runs therapy for children and adolescents with refugee, trauma, violence or discrimination experiences. She supports migrant and refugee women in perinatal crises, conducts intercultural birthing schools, support groups and workshops for parents as well as postgraduate classes at the University of Warsaw.

Marianna Guzar

It was 2015 and the second year of antenatal classes led by Marta Piegat-Kaczmarczyk and Hanna Kamińska. The classes were held in Polish with an interpreter translating into Russian. Language was not a problem for me because I had studied in Poland and knew Polish well. However, I was very stressed at the time because of my situation. I had just lost my job and had to quickly legalise my stay in Poland and apply for a new permit. On top of that there was a lot of fear, as there probably is for most mothers-to-be: will we be able to cope, what lies ahead? How will the birth go?

The classes lasted two days, they were intense but not tiring. I remember well that we all left feeling calm at the end. We left all worries behind the door. I felt like I already knew everything, including the details: what bathing products are good for the baby, what creams to choose and so on.

I was about to give birth to my first child and everything I learnt during the antenatal classes was completely new and very interesting. I found out how to prepare for childbirth, how to choose the best hospital for me, when to report to the admissions unit.

I think if I had been in Ukraine, my home country, I wouldn't have had a clue beforehand what it was like either. It seems to me that there are no huge differences between us when it comes to perinatal care. Indeed, in Ukraine it is possible to make an appointment to give birth with the doctor who is looking after the pregnancy. But it costs money – in state hospitals this is a verbal contract – you pay unofficially and then you can be sure that the doctor will actually be present with the patient in the delivery room.

At the birthing school we were in a group of people from Belarus, Ukraine and Russia. In our classes, not many people knew Polish. At that time, I befriended a girl who spoke very good English, she told me that she had communicated with the midwife in that language without any problems before the birth. But she was still really afraid that she wouldn't remember the right words or that the midwife or doctor present at the birth wouldn't speak English. And when women in labour don't speak any language that is understood here, the fear is even greater.

I also remember that my husband was impressed when during the class Marta talked about the father's role in caring for the baby after leaving the hospital: what to do and how to do it, how to support and relieve the wife. He was amazed that the father could do all this. We were given a task to write down our expectations and commitments regarding the division of responsibilities. I still have these sheets of paper! And when sometimes he complained that he was tired or sleep-deprived, I would show him these sheets: look, here I have your declaration in writing. We laughed, of course, but I think it was a great idea. My husband had already told me before that he wanted to be involved so that we would be partners, but after the birthing school he was completely up for it.

I was supposed to give birth naturally and when the contractions became frequent, we went to the hospital, which I also knew a lot about and felt safe with, but the baby was positioned wrong and we ended up having a caesarean section. I found out at the admissions unit that there wasn't an operating theatre available, but luckily, I came across a very good doctor who organised everything. I have good memories.

After the birth, almost all of us started coming to the support group for migrant mothers led by Marta Piega-Kaczmarczyk. It was supposed to last a year, but stretched over three years. And if we could, we would have liked to keep meeting even longer. It was fantastic support for us and our children.

Written down by **Kinga Gałuszka**

Mariana Guzar – consultant, translator, author of informational materials for foreigners in Poland. Works at the Info/Protection team of the PMF. She provides consultations and information to foreigners on their rights and obligations in Poland, legalisation of stay, employment and integration.

Lali Tvalchrelidze

When I came to the PMF birthing school, I had already lived in Poland for 10 years. This school suited me best because the classes were held at weekends and not on weekday afternoons or evenings like in other places. It was important to me because of my partner's work – I wanted us to go together.

The breakthrough for me in these classes was the topic of postpartum. In fact, this is my biggest discovery in my whole perinatal history. You think that once you have given birth, you will feel good, it is all over. My mother wanted to come from Georgia to support me. This was the case with most of my foreign friends – after the birth, the mother or the sister would come over. Whereas I thought that since there was nothing wrong with me, it would be better if it was just the three of us, we would settle into our lives with the baby. If my mum was going to do everything for my partner, it would be very difficult for me to get him to take care of his duties afterwards. Unfortunately, the birth ended in a caesarean, there were complications and of course I felt poorly. I was really regretting the thing with my mum. But in my part of the world – and not only there – the fact that the postpartum period is difficult is not discussed at all.

Menstruation is also not talked about in Georgian culture. You can't even say that you are on your period. When a woman gives birth, she stays at the family home for 40 days after the birth. I thought it was just to make it easier in caring for the newborn. But then I read that, among others, in African cultures, the woman is sent away for the period of bleeding in the postpartum period as she is considered unclean. I think that is what it is about in Georgia too.

I remember when I came to study in Poland in 2001, a friend of mine was giving birth in Georgia. She said that she got yelled at in the hospital because she had soiled her sheets with blood. Today, the delivery rooms there are already of a high standard. But birthing schools are still not popular. You have to really try hard to find one. There is no awareness at all of what childbirth is. This is a culture where you simply have to give birth. When you give birth to your first, they ask when you're going to have the second, if it's your second, they ask when the third is coming. You can have five professor degrees in Georgia, but you are not an adult woman until you give birth. But no one cares about women's wellbeing, just – as in

any more traditional culture – about meeting social expectations. It frustrates me that no one tells women that just having a baby is not all.

Every piece of information I heard at the birthing school was important. I was preparing to give birth to my first child, so I didn't know what it would look like. I already spoke good Polish, but I can imagine how hard it must be for a person who knows neither the language, nor the rules of hospital operation, nor their rights. After all, some come from remote, backward regions, where 10 women give birth in one room, not knowing that there are standards, for example concerning perineal incisions or anaesthesia. There are different customs in different countries. While giving birth with your husband or partner is a perfectly normal thing here, in Georgia if I said I wanted to give birth with my partner they would say I was crazy. A man shouldn't have to see "that sort of thing".

I believe that every woman should be aware of what is going to happen to her before she goes into delivery. Knowledge is a fundamental force that helps. Sometimes the legal aspects are also important, so is telling women and their husbands what documents they need to have or that it is compulsory to register the pregnancy and have it monitored by a doctor. Some get to the seventh month without a single blood test or ultrasound scan. Or they think that if they are here and pregnant, they should give birth free of charge. What they call a six-month visa is usually just a work permit, and the husbands often do not even report their wives for insurance purposes. And then, when they want to register them, it turns out that the husband is not a husband at all, but a partner – because they have come from a country where a couple who start living together are treated as married.

At these meetings there were girls from India, the Philippines, Central Asia, Armenia, Georgia, Azerbaijan, Belarus, Ukraine and Russia. What did we have in common? The fact that each was most concerned about the safety and health of the baby. And the subject of grandmothers. All the girls – regardless of age, country or culture – talked about their mothers knowing best that you are not supposed to apply drugstore oil on your baby, but boil canola oil and tap it onto your baby's skin, and then not to use powder, but something completely different. After all, they have raised a generation and know best. And that in general your way of doing things is wrong.

When my baby was already three months old, I started attending a support group for migrant mothers led by Marta Piegat-Kaczmarczyk. I think

it changed my motherhood and helped me endure a lot of hardships, overcome big problems. I was able to meet other mums and understand that it was not just my baby that cried a lot. Each meeting was dedicated to a specific topic, e.g. if your baby isn't sleeping well, how can you deal with that. The support group also gave me a sense of empowerment in trying to do something to help myself.

Written down by **Kinga Gałuszka**

Lali Tvalchrelidze – has been working on projects addressed at foreigners living in Poland for years. At the PMF, she acts as a service specialist for female and male beneficiaries.

Listen, support, accompany

Dorota Borodaj talks to psychologist **Agnieszka Carrasco-Żylicz** about her work with refugee women from the Polish-Belarusian border

You are a psychologist, you work with refugee women who have crossed the Polish--Belarusian border. How did this chapter of your professional life begin?

I started working with the Polish Migration Forum Foundation even before the border crisis. I joined a project dedicated to standards for diagnosing children and families. I am a systemic therapist and have had experience of working with blended families, but previously they were expats, not refugees. When the crisis at the border started, I joined a group of volunteer psychologists. I was on call, offering psychological support to activists providing humanitarian aid in the forest.

When I started working at the PMF, the organisation had a dozen people. Then the war in Ukraine broke out and actually before my eyes more assignments started to appear, more people came in. I experienced the outbreak of this war with them. I started working with women at the Reception Centre for Foreigners in Dębak in January 2022. I am also in contact with those who have already left the centres. The refugee women mainly come from Cameroon, Nigeria, Democratic Republic of Congo, Côte d'Ivoire and even Tanzania. The majority of these people are victims of persecution, violence, torture or human trafficking. They belong to the so-called vulnerable group. They arrived in Poland via the migration route, across the Polish-Belarusian border. Most of them had experienced push-backs and then spent many weeks in guarded centres for foreigners all over Poland.

Did you find these new tasks challenging?

They were something I was ready for, I had wanted to work with people with refugee experience for a long time. I have a piece of such history in my immediate family. My father's family comes from Chile. After Pinochet's coup, his father's sister had 48 hours to escape. She had to leave all her belongings and flee with her four children. They reached Europe via the Red Cross humanitarian corridor. They got to Antwerp, where a foreign family helped them for six months – thanks to these people my aunt and her children managed to survive. She was able to become independent, my cousins got educated in Europe. The topics and emotions connected to adaptation, integration and the mental crisis that often accompanies this were well known to me from observing and accompanying my loved ones. My father emigrated to Prague to study, over there he met my mother. So in my immediate family I have both typical refugee experience and typical migration experience, which is not linked to such trauma.

It is important to clarify what these different experiences are – refugee experience and migration experience understood as a non-coercive choice.

Indeed, but in both cases there is a lot of work to be done to settle into this new reality. This also means psychological work, which helps connect the present with the past and imagine the future. It also helps accept uprooting. This work concerns not only those who have left their country of origin, but also the next generation. I also observe this among my relatives. My cousins, who were already brought up in Belgium or France, don't feel that they would find their place back in South America, but they are also not completely rooted in Europe. They are somewhere in the middle. I didn't have this problem; instead, my father's roots creat some kind of extra resource for me. I have been around migrant communities all my life. When I started working with the Polish Migration Forum, my contacts with people from other cultural backgrounds were already established. Whereas in terms of working with women with refugee trauma, I was breaking new ground.

What was new about it?

In classic, office-based work, the therapist agrees with patients on specific terms of work. When I started working with women who had crossed the Polish-Belarusian border, I quickly realised that I had to depart from my previous methods. I work here mainly with women from West Africa and I have noticed that it is difficult for them to ask for help, they need time before they open up. They do this when some kind of relationship is formed between us in which they feel safe. These are also often women in survival mode. They don't want to get attached or open up because it seems dangerous to them. On top of this, if we are talking about women who are pregnant or have just given birth, there is the issue of the body and psyche going through a revolutionary moment. This can sometimes be difficult to bear even without all the refugee trauma. The classic approach to helping is simply inviable from the outset. I start by accompanying them and gaining their trust.

And then?

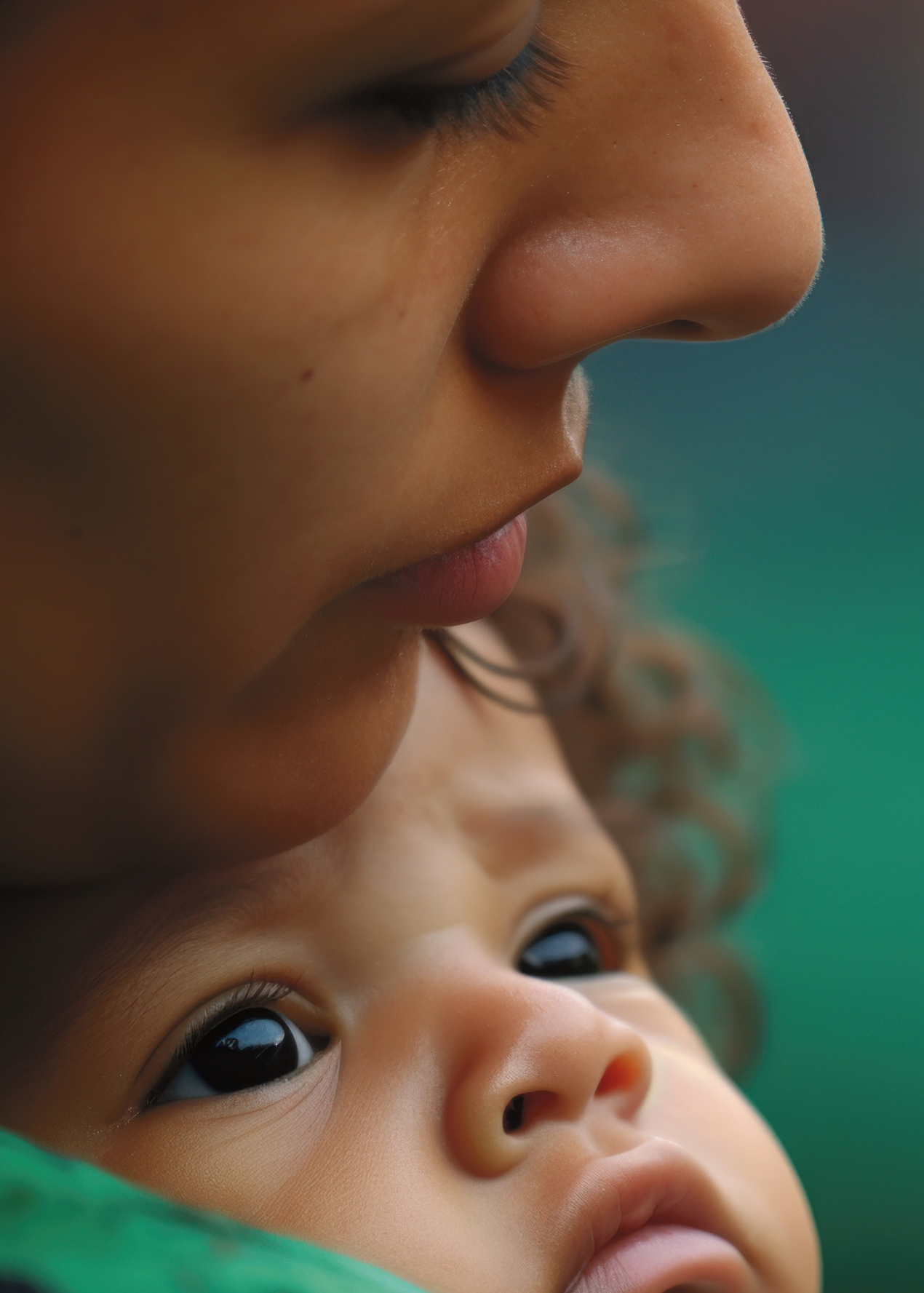
I follow them, respond to their needs, support them in their daily lives. I cannot assume any scenarios. I have to be attentive, follow their pace, not take away their sense of empowerment, because they have lost a lot of it already. I try to show admiration for their strength, their will to fight against adversity, try to discover and show the countless resources they carry within them.

What are they running away from?

In Poland and more widely in Europe, we focus on economic migration, climate migration, we talk about wars. Whereas women often treat migration as an act of fighting for the future of their children. They want to protect them, to give them a dignified life, on this journey they reach the limits of their own dignity, sometimes even the limits of survival, but they still run. Sometimes they take their child with them on this road or leave the child with relatives and then, when they manage to get a job, they put every penny aside to bring that child over to be with them. Sometimes a woman has a supportive, loving family that helps put money together for this journey of hers. I have read reports of gang rapes in the Congo and met women whose relatives see the only hope for their daughter's safety in sending her to Europe. Among these stories of the women I work with, there are also stories of economic and physical abuse they experience from men, there is a story of a mother who has experienced persecution for giving birth to a child with albinism and was brutally expelled from the community. These are the moments when I feel great 8r+ebellion and disagreement, I reject arguments about cultural differences, I lose objectivity. I have met women from communities where the parents choose the girl's husband as soon as she is born. And this wedding takes place when the girl is 16 years old and her husband is often much older than her, he sometimes already has other wives. Contraception is out of the question, so she starts having children immediately after the wedding. This is her role, the goal that society sets for her. And we look at this woman, completely deprived of her rights and ability to decide for herself, with our Western European disapproval. And for her, this escape is often an act of heroism, of some incredible courage.

Where do they get it from?

The ones I have met – certainly from the love for their children. Those yet to be born, those they take with them on their travels and those they have to leave behind with their loved ones. My patients come from places where they often lived in great poverty and had a difficult childhood. They often come from large families, they had to look after younger siblings, take care of the house and work hard physically since childhood. So even if they give birth to their first child in Poland, they already know how to care for a newborn. They also have experience of caring for a woman in the postpartum period, as they helped their own mother this way. Often they had no other choice, but without idealising the experience, I see that they can draw on it here in Poland, when their mother or sisters are not around to help.



And what about other women, other refugees? A centre for foreigners is not a place where anyone should stay for long, but we know that the reality is different. Do they have an opportunity to form bonds there that can replace family bonds?

Let's start by saying that there are no ideas for how to support women there in the perinatal period. This is largely done for the state by NGOs, including ours. People are placed in centres at random, no one checks if a woman is pregnant, no one considers how she will need to take care of her needs, including psychological ones. Although they are officially provided with medical care, being in an open centre it is not easy for them to ask for support when, for example, the doctor on duty treats them unkindly or even with contempt. They do not know the language, plus he is a man and they have a history of rape and assault in their country of origin. It is also difficult for them to ask for psychological support, as the psychologist's office is located next to the office of the head of the centre. It is a deterrent, it is discouraging. The centres are not conducive to establishing intercultural friendships; people from different countries, different nationalities are mixed there, and even if you find people from a similar cultural background, there may be some regional antagonisms at play. And another thing not conducive to building a support network there is the traumas these women come to the centre with. The perinatal care provided to such a woman is a big separate topic. They are at much greater risk of miscarriage, premature birth, breastfeeding problems or postnatal depression from the start. And the system is callous towards them. The public can also be heartless, asking: "why did she choose such a dangerous journey", "why did she endanger the child", "why did she leave the child and run away herself", "why did she set off if she was pregnant" and so on.

I don't ask. I don't interrogate them the way officials do. I look forward to what they themselves are willing to tell me and entrust me with in confidence…

Once they open up, what do they say?

One woman told me that she was walking through the forest and carrying her twins – one tied in a headscarf on her stomach and the other on her back. She spoke of how she focused all her attention on not tripping and falling on one of these children. But she arrived in Poland with only one child. She told me that the other baby had died on the road, taken ill, and her companions helped bury him in the forest. I don't know which side of the border it was, I don't know which day on the road, perhaps

this woman would not be able to tell herself today. Her head was set on surviving, getting out of that forest. She had one more child to save. Another recounted that she had a miscarriage while being detained by the services. She told the guard about it and the guard gave her a tampon. Now imagine the trauma she experienced: she loses a pregnancy and at this very difficult moment for her, she does not receive the necessary support or help.

The guard might not have understood her?

The problem lies deeper. Nobody believes these women. Is she saying she's pregnant? Probably pretending so that she doesn't end up back on the Belarusian side. Is she talking about a child she had and now he is nowhere to be seen? She is making it up. Bleeding? It's probably menstruation. I know many such examples.

Meanwhile, such a woman goes into survival mode with her whole might. This causes a lot of things to blur together later on when the traumatic events are recalled. Memory becomes fragmented, some of the memories repressed, because the mind is in this survival mode the whole time. This is why people may confuse the chronology, tell you they walked for a month, while they actually spent a week or two in the forest. Such a tangled tale is easily undermined. The trauma they have experienced works against them.

You believe them.

I am tasked with listening when the person is ready to talk. And this happens when she feels safe again. A traumatised person needs to tell their story, express their feelings, describe painful events. I accompany the women, I give them time, I let them reveal their story piece by piece, as much as they want. From these snippets of stories, a fuller picture slowly emerges of what happened to them and what we have to work on. It is a job that teaches me humility and flexibility.

What does it involve?

In the case of women with refugee experience, it is not possible to agree on specific rules or set goals at the beginning of the therapeutic work. This is due to various reasons – first of all, the trauma I mentioned before. Secondly, cultural differences. Thirdly, the mode the woman is operating in when we meet. Does she feel safe already or is she still "running away"?

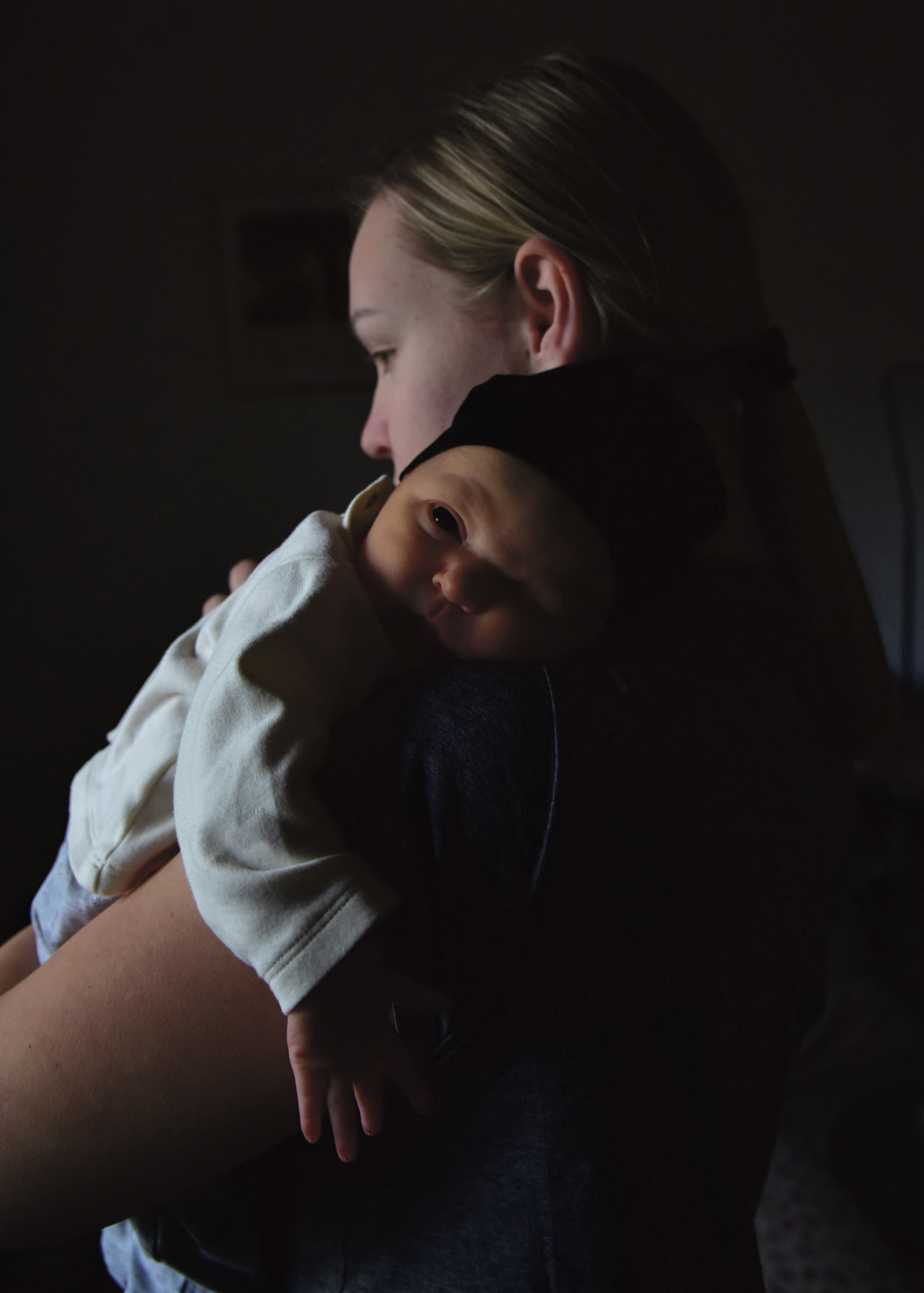
This woman, who told me about the death of one of her children, put all her strength into caring for the other. She talked a lot about his future, about wanting him to go to school, to get educated. She was worried that her son spoke little, that he had no contact with other children who spoke French. She told the story of what she experienced along the way slowly, in single sentences, somehow "by the way". I had to put together some kind of a fuller picture myself. This is a common experience in this work, with these particular women.

What needs do they have, especially when it comes to refugee women lin the perinatal period?

They need a lot of support at the beginning in finding their way around the healthcare system. They need someone to help them sign up with a clinic, but also rent a flat, to be the kind of guide who will lead them by the hand in the initial stages. And in due course to let go of their hand, because it is not about making these people dependent on aid. A model where Polish families would take refugee individuals or families under their care and become their guides for a while would be useful. To support them in becoming independent and in regaining control over their life.

This happened in a way when the war broke out full-scale in Ukraine. Polish families and whole cities opened their doors.

So it is possible, we can do it, even in a crisis as great as war and the flight of several million people to our country. I think this was also how we dealt with our own fear of this war. We showed that we have this potential with in us, both in society and in the state, to solve such crises. Meanwhile, on the Polish-Belarusian border, we are traumatising these people. I am particularly referring here to the situation of the women I work with. They often broke out of such poverty and violence that it would seem that nothing worse could ever happen to them. Sometimes they leave Poland, even when everything is well on the way to securing their protection. I have met women who were trying to settle here – giving birth to children, or enrolling them in a nursery or kindergarten. What they experienced at the border could not be forgotten, plus, at different facilities, offices, clinics or on the street they were met with unpleasant, sometimes downright racist behaviours. They did not feel safe here, and this safety is what they had been fighting for all along – for themselves and for their children. When I would find out that such a woman had left, I felt the taste of defeat. Not in a personal sense, but as a failure of the system that could have taken better care of them.



How do you understand this failure?

The system works if it can take care of the most vulnerable. And among them are refugee women in the perinatal period. Meanwhile, in Poland, the system does not see them, treats them as anonymous cases. There are those officials on one side and I can even understand that they don't see a specific person in these documents and tables, just case numbers. They do not see the specific needs behind the numbers. A separate topic is the health problems faced by children. A lot of them are premature babies who need constant check-ups, rehabilitation and additional developmental support. If a woman or family manages to bring older children to Poland, they too often require medical care – they have bad teeth or conditions that were not treated well or at all in their country of origin: caries, blood diseases, undiagnosed genetic disorders. Their mothers also receive treatment for the illnesses they came to us with: myomas, complications from malaria, they sometimes have major gynaecological problems, caused, for example, by rapes, previous births, mutilations. Here we have two parallel stories, both true. One is that the Polish system does not have much to offer them. The Office for Foreigners organises tenders and signs a contract with an external company providing medical assistance to foreigners. Unfortunately, doctors are not prepared and sometimes lack the sensitivity needed when working with patients with a huge baggage of trauma. They have special needs in terms of contact, diagnosis and treatment. Especially when it comes to pregnancy or postnatal period. I don't want to generalise, because I have met some very dedicated and helpful doctors, but my general impression is that only the minimum is done. Once a woman is granted international protection and becomes independent, she needs to register with the Social Security Institution. In order to do so, she has to work or register with the employment office. In order to look for work, a person should be in good health, and these women we are talking about often need a lot to improve their health, or are unable to work because of their children. As a result, it is not uncommon for them to end up at Social Welfare Centres, this gives them some minimal insurance. It all shows us what a difficult situation such a woman with a young child finds herself in, in a foreign country, without the support of her relatives, in a system that does not help her to enter the labour market to her full potential and thus to integrate better.

And the other, parallel story?

It is that these women and their children in Poland, even with this minimum, have far better medical care here than in their country of origin. They appreciate this and are grateful for the opportunity to receive

medical attention, diagnosis, tests. I also know beautiful stories from delivery rooms and hospital wards where midwives, especially those of the younger generation, rose to the occasion and took care of their patients with great attentiveness and sensitivity, knowing that they were refugees. They appreciate it very much.

Is there any other knowledge, a lesson particularly important to you, that you get from working with them?

I found that in helping and supporting refugee women, you have to show credibility. To show that these women can count on me, that I am not just saying things, this makes me credible in their eyes. I have to be careful in the sense that I ensure to maintain professional boundaries, but on the other hand, when one of them calls me in the evening because her child has a high fever, I can't tell her to call at 2 PM the next day. Or refuse to help because her child's illness is not my business. At the same time, we always strongly encourage women at the Polish Migration Forum to start learning Polish as soon as possible. I help them when they need me, but I also urge them to increasingly deal with some challenges themselves.

On many occasions I watch with curiosity, but also with admiration and delight, how mothers show tenderness, closeness to their children. In Africa, children accompany their mothers from birth in almost every activity of life. They are constantly carried by their mums in slings or carriers. I really enjoy watching the way the mothers soothe their children, how they play with them, how they sing to them. How they feed and nurture them in a natural, spontaneous way. Sometimes, seeing them, I wonder how much courage, how much determination it takes to give birth to a child in an unknown country, far from loved ones. Without the support and accompaniment of other women. How much strength and acceptance is needed to give birth to a child conceived from rape. We may differ, we may not understand each other's cultures, behaviours, the settings we come from. But what unites us women is the will to live, the need for freedom and the fight for a good life for our children. And that's a lot to start with.

Agnieszka Carrasco-Żylicz – psychologist and psychotherapist. She works as part of the PMF psychology team with adults, adolescents and families with experience of migration. In her private life, she tries to combine her Chilean and Polish roots and two such different cultures.

Marie

I walked to Poland through the forest. I was pushed back to Belarus several times, and I went back over to the Polish side. I was in a larger group, we were hiding between the trees, suddenly we saw the police (Marie uses this term for the uniformed services – it was probably the Border Guard – editor's note). Everyone ran away, I didn't have the strength. I was very weak at the time, I felt that if they threw me out again, I would die in that forest. The police officers approached me. One of them started to calm me down. He told me not to be afraid, that an ambulance was coming to see me. He kept repeating that everything would be fine. And it really was, I was taken to hospital and then I didn't go back to the forest again. I stayed in Poland. This was the first good police officer I met here. From the hospital, I was transferred to the closed camp in Biała Podlaska and there I found out that I was pregnant.

I was very scared because it wasn't a pregnancy I wanted. I went through it terribly, both mentally and physically. I was constantly vomiting, had palpitations, nausea, sometimes I felt like I was suffocating, I couldn't breathe. On top of that, I was worried: what would I say to this child if they ever asked me about their father? I was examined by a good doctor in Biała Podlaska and I could always come to see him when I felt unwell. Then they moved me to Linin, it was no longer a closed camp, but the care standard there was worse, I was given the same pill for everything. From Linin, I ended up in Dębak. I was alone, feeling worse and worse, until I met a girl from Cameroon, she was pregnant too. And this girl settled in Kraków and then invited me to join her. Thanks to her, I met women from the Foundation, also from Kraków, who helped me when I needed to take care of anything, one brought me a bag of things to the hospital. I also met another Polish woman, she worked in the same building where we were renting a flat. She showed me various videos on the Internet about how to prepare for childbirth, she massaged my belly. I also spoke to a friend I live with. She had already had her baby a few months before me, she already knew a lot, which made me feel a little less scared.

Before the birth I still felt terrible and had to have IVs. When I vomited blood, the doctor decided that I needed to be thoroughly examined after the birth and that I would have a caesarean section. I was terrified of this operation. I received very good care at the hospital. On the first day there was a doctor who spoke a little French, and on the next day

another doctor came who spoke excellent French. On the day of the operation, he was not on the ward. The nurses brought a phone into the room and called him. During the caesarean section, he kept talking to me through the speaker on the phone, explaining what was happening, reassuring me. Then, when he came to work, he checked on me straight away. My pregnancy was unwanted and difficult, but thanks to this place, the birth was beautiful.

Written down by **Dorota Borodaj**

Marie is 20 years old. She comes from Cameroon. She worked in an office and discovered some irregularities. When she started to get threats because of this, she decided to flee to Europe. She reached Russia, where the person who was supposed to take care of her, sexually abused her. Marie moved west along the newly opened migration route through Belarus. After several push-backs, she was able to apply for international protection in Poland. She is raising her daughter here and learning Polish. The person's name has been changed.

Survivors

Joanna Mikulska talks to psychotraumatologist **Dr Wioletta Rębecka-Davie** about supporting people who have experienced wartime rape

Since the start of the war in Ukraine, you have been all over the Polish media.

I have been involved in the subject of rape and perinatal violence for 25 years. It may sound awkward what I am about to say, but since the outbreak of the war I have become the "rape expert".

How did you react to that?

I felt it was my responsibility to share what I had. On the other hand, I often felt really angry. You wouldn't want to see me when I was asked by a journalist: "I'm writing a news report, could you give me the contact details of women who have been raped?". I was furious not because I keep my knowledge of the subject to myself or only for a select few, but I am very sensitive to unhealthy excitement, which is traumatising and retraumatising, and to mechanical treatment of this subject.

Where does this excitement come from?

At the beginning of the war, the unprocessed traumas of our grandmothers awakened, and everyone wanted to talk about it. The fear of rape repressed for years suddenly saw the light of day.

Now it's all stopped, as if this topic didn't exist, which is exactly the opposite of what is happening in Ukraine. Of course, I don't want to downgrade the cases from the beginning of the war, because there were also rape survivors among those fleeing Ukraine, but I believe that this initial interest was the result of panic and magical thinking that we could do something to prevent this atrocity.

Why are there more of these cases today?

Because only now are people returning from Russian captivity. We have to remember that when we speak of survivors of war rape, we are thinking of civilians, but also of soldiers. Let us not forget that rape is a strategy for obtaining information. Rape and so-called water boarding are two types of torture used in all corners of the world. Drowning and sexual violence are an almost 100% guaranteed way of getting information.

How do they deal with the topic of trauma in Ukraine?

I am working very intensively with Ukrainians right now and they are really doing a lot and doing well. They are organising training, implementing

techniques and strategies for stabilisation-psychological work, working with global trauma specialists – it is impressive. However, changes are still needed there on a cultural and social level to talk about rape openly as a traumatic consequence of war, rather than hiding it. This is a very big problem in Ukraine, especially in the context of soldiers.

They are often mainly seen as heroes.

And a hero cannot get raped. In any culture based on a monotheistic religion, sexuality has been burdened with shame and guilt, and thus anything involving sexual violence is also burdened with it. Wartime rape is still seen in terms of shame for the victim, not the rapist.

You have travelled around the Earth dozens of times. Where did you encounter good support systems for people who have experienced the trauma of wartime rape?

The complexity of the needs connected to the experience of sexual violence is described by the *war rape survivors syndrome*. We help people with such an experience psychologically, socially, legally and medically. An effective aid system does not neglect any of these areas.

I observed the best way of working with survivors of war rape at the City of Joy centre in the Congo, where survivors of war rape (sometimes of multiple rapes) experiencing social stigma are approached holistically, dealing with the body and emotions.

How was that place created?

In the Congo, near the border with Rwanda, there was already the Panzi Clinic, i.e. a hospital where Dr Denis Mukwege (together with Nadia Murad, he was awarded the Nobel Peace Prize in 2018 "for their efforts to end the use of sexual violence as a weapon of war and armed conflict") worked mainly with survivors: among other things, he performed procedures to remove rectovaginal fistula, an abnormal connection between the rectum and the vagina, which is very often a consequence of violent rape in women. Panzi Clinic has excellent surgical facilities and also manages pregnancies from rape.

But Dr Mukwege saw that the medical care provided to survivors and their several weeks' stay in hospital would not result in them returning fully to being ready to function in the world. Around a dozen years ago, the clinic was visited by Eve Ensler, American playwright and author of *The Vagina Monologues*, who is also an activist in the feminist movement and who

has worked on behalf of rape survivors for decades. Although she had been to the sites of armed conflicts around the world, when visiting the Congo she found that she had not heard such horrific women's stories anywhere else. She campaigned in the States and raised money to buy land adjacent to Panzi Clinic to create a place to support female rape survivors in their return into society.

In fact, if there was a ranking, the Congo would be one of the most cruel places in the world. It is said that the worst thing is to be born a woman in eastern Congo. There is probably nothing worse in terms of the likelihood of getting raped.

Why is that?

In those regions of the Congo, where rare earth minerals are found, influence groups fight among themselves and the so-called militia operate there. Commandos are sent into these areas, occupy the villages, then burn, kill, rape. Women who survive are incorporated into these groups as "wives" or "servants". And they wander with them. Further on, often multiple rapes occur. Women who manage to escape often have to return to their home, to the field, to secure food for themselves and their surviving children, as husbands and sons are most often killed. However, the area is still controlled by these armed groups, so they take the risk: I will have something to eat, but I might get raped. And a stigma comes with it.

What does it involve?

All the horrors happen in front of the whole community, nothing can be hidden. A person who has been raped has to be taken to hospital and has to undergo a series of treatments. It is not possible for it to remain a secret at all, because access to medical help is much more difficult there than in Europe, it cannot be done quietly. Rape really is a social issue in that reality.

A raped child is excluded from the group. Raped young girls become easy prey for subsequent rapists. And this is what they work on at City of Joy, the centre established next to Panzi Clinic.

How does the centre operate?

The staff are women who are rape survivors themselves and who received help at the centre, then trained as social workers or graduated

as nurses and became involved in the work of the centre. City of Joy is an absolutely magical place, even though it is dedicated to people with horrific experiences. It sees raped children with their arms and legs cut off, women who have had a grenade inserted into their vagina. Still, it is one of the most optimistic, positive and good places I have ever been to. It makes use of what has the power of healing in the local culture, such as women's circles.

The women are always doing things together: washing, cooking, sewing, and talking to each other at the same time. This is an enormous value and resource. The circles have a therapeutic dimension, helping regulate emotions, build support, work through the stigma associated with rape. A group of about 60-80 women, often young girls, get together after such an experience, tell their stories and work on it. We need to remember that in many cultures the word 'rape' does not exist: this is the case in Swahili used in East Africa or in the Kinyarwanda language used in Rwanda.

There, one of the official languages is French, and it has the word 'rape'. But if one wanted to talk about this experience in the language of Kinyarwanda, they would use the word 'shake'. In a group of women with similar experiences, calling a spade a spade is much easier.

That is, to call rape – rape, but also to find the language to describe the body that experienced the rape?

A group of ten women meet, sit down and are asked to describe their vagina. Can you imagine what a difficult task this is? Especially with regard to a vagina that has survived rape. For some of these women, this vagina is destroyed, because rape can be terribly cruel. You could say that this is about re-building knowledge and language needed to describe oneself after this traumatic experience. Moreover, I think it comes a lot easier for women in the Congo than it would in Ukraine or Poland. In European culture, bodies do not belong to us, they belong to the fashion industry, BMI (body mass index) calculators, churches. We have done something terrible to our, especially women's, bodies. In the Congo, despite the rape, violence, patriarchy and never-ending wars, women's bodies belong much more to them than ours belong to us. This is a phenomenon.

Could you share any stories?

I was able to witness the work of such a group. One woman recounted her terrible experience and started to cry. She cried and cried. As I would say

it: she entered a state of dissociation. This group was not led by a therapist but by two very experienced women, one of whom was a nurse. The other girls, also survivors, got up, surrounded her, made sort of a cocoon with their own bodies around the one who was crying and started moving with her. She entered a kind of trance. She began to squeal. The women around her began to cry, some began to sing, some joined in the squealing. It all happened in a very natural way. She, at the centre of the group, was in the process of working with her own body and her own trauma, with the solid bodily experience of support from other women. I would love to see body work for rape survivors like this everywhere.

The strength of this centre lies in the grassroots, but also in the fact that survivors work there.

Indeed, when thinking about the work of female rape survivors, it is essential to mention another initiative of Dr Mukwege. In the same year that he received the Nobel Prize, an international organisation was launched called SEMA, which means "tell" in Swahili. It brings together female survivors of rape around the world – the assumption being that survivors will be best understood by other survivors. Your educational background is not important, you don't need to be trained by psychologists, in Ukraine the Head of SEMA is a woman who is a beautician. They organise training, educate themselves, but this is secondary to the willingness and readiness to understand those who have experienced sexual violence. I believe there are no greater heroines than these women. Just imagine: you have survived all these terrible things, and then you go back to your family, your children, your daily chores, you have to work and you still find the strength to tell the world about what happened to you. That is what heroism really is: finding the strength to live well after surviving atrocities.

The social and political aspect is also important in all this. In Kosovo, rape survivors are given war hero or war heroine status.

Kosovo has really developed a whole pioneering area of support for rape survivors. The social revolution took place there and is still ongoing. We are talking about a Muslim country based on patriarchy resulting from male domination and, of course, religion, where women are subordinated. In addition to these changes related to building a new country, coming out of trauma, building an identity, there is a great cultural revolution that women have driven and are driving. Kosovo's President is once again a woman, quite a few NGOs operate there and they have done tremendous work over the years since the end of the war. In Kosovo, people who

have experienced war rape can apply to be recognised and granted – which also involves money – survivor and war hero or war heroine status.

On what basis is this status awarded?

First of all, there is no obligation to find the perpetrator. Sometimes we know who our abuser was, but sometimes we don't know and it is not our fault. Should this rape therefore not be recognised or acknowledged? Kosovo has chosen the approach that you simply have to collect as much material as possible.

That is, survivor stories?

Stories above all. I did some training there, which was mainly to do with how to understand trauma and how to interview survivors: what questions to ask, how to distinguish between truth and lies. For example, why does a survivor today talk about one thing and the next day about something completely different, then another day again about something else? It turns out that this is what dissociation builds on and this is how trauma works. After an experience so terribly overwhelming, I could not sit down opposite you, feeling relaxed, smoking a cigarette, to start telling you, bit by bit, what terrible things someone did to me. The very fragments that do not form a whole, this contradiction, this withdrawal, this deliberation are exactly what constitute the truth of rape trauma.

Your book Rape: a History of Shame Diary of the Survivors is structured in this very way. You give the survivors the floor, they can speak as they wish.

This was very important to me, because I wanted these people to have their narrative, not mine, softened. I was criticised for it, people said these texts were hard to read because they were so naturalistic.

People keep very different evidence of rape, sometimes these are objects. During a workshop in Kosovo, I met a person who had been sleeping on the mattress she had been raped on for 24 years. And she was very unwilling to change that mattress.

I would assume that a survivor would not want to deal with an object related to that experience.

However, from a psychological point of view, if you understand the dynamics of trauma, it is very logical. The place where the crime was

committed, where this person was deprived of her will and ability to decide, started to be under her full control. This mattress allowed her to feel like she had an influence on her life.

Did the mattress become evidence in the case?

This woman also had a child born as a result of that rape, the mattress was an added element to the whole story. We have this socially simplistic thinking, grounded in Roman law, that we must have proof: DNA or some disease: HIV, venereal, or a baby. In Kosovo, fortunately, individuals do not have to have all this evidence to be granted survivor status. Sometimes there are also witnesses. In Rwanda, the first stories of people who were identified as survivors came not directly from them, but from witnesses.

This may sound a bit arrogant, but a well-trained psychotraumatologist with a lot of clinical knowledge will know who is lying and who is not. To date, I have not met a woman who would tell me a false story of sexual violence. Why is that? Because no one wants to be in the position of a rape victim. Rape is always followed by stigma.

You often refer to those who have experienced rape not as victims but as survivors, changing the hierarchy of the situation already at the level of language.

I have been criticised many times for these "survivors". Women have said: "Stop it, I don't feel like a survivor at all today. Today I feel hopeless". Of course, I would like them to feel that they are heroines.But they often do not want to be them, do not want to be locked in some box.. That's the social pressure: I will put you in this box so that you fit in.

What should people who care for women pregnant as a result of rape watch out for?

The topic of maternity care for women after wartime rape is a very broad one, as it covers a wide spectrum of different situations that women face. We never know how a woman will relate to that experience and to that child. There are no ready-made scripts. One option is abortion. I am a feminist, and while I am obviously in favour of the full right to abortion, I would never encourage any woman to do it. There are also those who choose to give birth and this too is understandable. Some want to give these children up for adoption. Sometimes the woman does not want this child but then changes her mind. Or she becomes depressed, i.e. rejects the child, but then returns to that

relationship, tries to build it. Ambivalence can be very complex and last a long time.

In order to understand such a woman well, you need to enter into a deep and long process of accompanying her. This requires commitment from both sides and is not easy.

One of the characters in my book saw her whole family murdered, she was left all alone, pregnant from rape. She was 14 years old and gave birth to a daughter. For her, getting pregnant was a blessing, she built the meaning of her life on that. Not through therapy, just through having a baby. She had an extraordinary bond with this daughter.

Childbirth can be an added trauma for them.

In recovering from war rape, part of the work is to regain a sense of influence over one's body and over one's life. I think that rape survivors find it very important to be able to freely choose the position in which they give birth – for them it is connected to regaining control over their bodies.

The only registered organisation for children born out of war rape is the Forgotten Children of War association operating in Bosnia and Herzegovina.

Two years ago, a legal change was introduced that people had sought for over 20 years. In Bosnia, you couldn't register a child if the father was unknown. Therefore, a child from rape committed on a Bosnian woman did not legally exist. Plus, if the father was absent, it was usually obvious why, and this was associated with social stigma and ostracism.

And what techniques do you use when working on all these consequences?

I use a methodology that I have developed myself, which is called SERS. These are four sequential steps, or phases of work, to recover a sense of self after experiencing the massive trauma of wartime rape. The trauma of rape is paralysing, the survivor descends into a frozen state and does not know what is happening. The first step is stabilization – it allows her to regain contact with her body here and now. The second step, education, is connected to the fact that the survivor needs to be told what war rape is, what she may face as a result of it, what social repression she may deal with, and that it is not her fault. The third step is redirection of thinking, i.e. changing the thinking of both that person and a person who supports

them. The final step is self-regulation, involving permanent work on resources and techniques – giving the survivor awareness of the resources and tools she can use. This is also a language-building exercise: the more and sooner she starts talking openly about her experience, the better.

What if the survivor wants to forget about it?

From a knowledge perspective, trauma cannot be forgotten. It can be denied, it can be dissociated, it can be negated, but it is still there. It is important to show understanding to the person with this experience, not to rush them, but also not to leave them alone. To offer support and an integrated welfare system.

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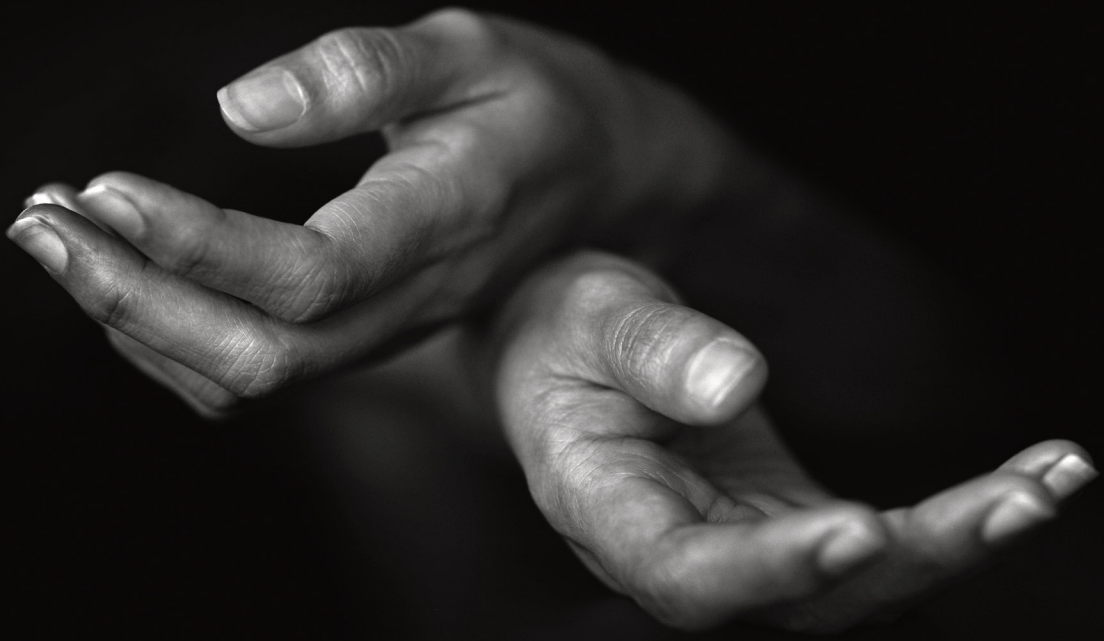
dr Wioletta Rębecka-Davie – psychoanalyst, psychotraumatologist, member of the International Psychoanalytical Association, Women's Therapy Center Institute NYC, Board Member of Women's Chapter International, Vice President of the Polish Center of Torture Survivors, Board Member of the Institute of Humanitarian Conflict Resolution NYC, researcher of *war rape survivors syndrome* at Touro University, Los Angeles, author of *Rape: a History of Shame Diary of the Survivors*.



Nina Ptak

At the “Nomada” Association for Multicultural Society Integration, I lead a team dedicated to supporting migrant and refugee women with experience of violence. Our department was created in response to the needs we began to identify when the Russian invasion of Ukraine escalated. The Ukrainian community living in Wrocław, where “Nomada” operates, was already one of the largest in Poland before the intensification of the war, and after 24 February 2022 it grew significantly with refugees, around 90% of whom were women and children. It was then that we saw a large increase in the level of domestic violence – both among those already living in Wrocław and newcomers.

There are not many organisations in Poland that professionally deal with violence against women, let alone against non-Polish women – there are still none specialising in this issue alone. Our association has dealt with the area of bias-motivated violence for years, so our development towards offering support to people experiencing GBV was a natural response to the growing needs. For the past year we have been focused on development – training ourselves and others, gathering resources and building a coordinated network linking the police, Social Welfare Centres and all those who work in some way to prevent or respond to violence.

Last year I organised a three-day on-site workshop led by Wiola Rębecka-Davie. It was oriented at those working in the area of psychological support, but also at humanitarian or social workers supporting female refugees from Ukraine. It seems that this training was particularly important for people who had not previously dealt with the topic of rape and sexual violence in war, and learned about it during the escalation of the Russian invasion. The very fact that rape is officially recognised by international law as a weapon of war and a crime against humanity was news to some. Thanks to having extensive experience of working with survivors, Wiola is able to explain very well the behaviours and reactions of a person who has experienced complex trauma (CPTSD). Learning about the stages of coping with trauma that a survivor goes through is extremely important in order to be able to create an environment that supports their healing process.

What I think I remember best from the training and what I put a lot of emphasis on in my work is the impact of social perceptions of rape on

the healing of a survivor of sexual violence. Rape is still associated with stigma, yet a person with such an experience should feel support and acceptance from loved ones and those around them, not rejection and stigma. But it is also important that she is not treated as a victim devoid of all agency, who is told how she should behave in the face of this experience.

Specialised and community support measures are strongly linked. I know how difficult environmental support is to build. Raising awareness, breaking down taboos and stereotypes, and tremendous advocacy work require not only effort but also time. And while this aspect was not new to me, it was memorable because in my work I look for trails to blaze, challenges to face and focus on creating solutions for them.

In addition, Wiola's training heavily referred to self-care and the motivations of those working in this area. We discussed how to regulate our own emotions so that we are able to provide support in the long term without falling into secondary trauma. Rarely do people talk about just out how mentally tiring working with survivors is. And yet it is important that you take care of yourself in order to help well and remain professional.

Written down by **Joanna Mikulska**

Nina Ptak – gender-based violence specialist, at the "Nomada" Association for Multicultural Society Integration she leads a team dedicated to supporting migrants and refugees with experience of GBV (gender-based violence) and supports coordination, communication and fundraising.

Break the silence

Margo Sikora-Borecka talks with psychotherapist **Anna Bajkowska** about supporting women after miscarriage and perinatal loss

An important area of your work is perinatal psychotherapy.

Ten years ago I started working as a psychotherapist at the "Nagle Sami" Foundation, which was established to support people with grief experience, people experiencing loss. It was also one of the first places offering help for women and their loved ones facing miscarriage and perinatal loss. There I learnt to accompany and support them during this extremely difficult time. I found out what their needs are, what areas are affected by such a loss, how the environment reacts.

A few years later, I created a training aimed at supporting people with the experience of miscarriage and perinatal loss intended for psychologists, psychotherapists, midwives and other people from the perinatal surroundings. It was at this workshop that I met people from the Polish Migration Forum Foundation.

The PMF participants probably brought in a new perspective.

Their perspective and experiences showed us how many aspects, among other cultural ones, we need to consider in order to consciously and meaningfully support migrants and refugees in this situation. Their experience of miscarriage or perinatal loss is linked to previous losses, to instability, to not having a place or an established social network. We also often do not know what they have experienced before, and these are often very difficult or even traumatic experiences. Plus, there is the language barrier, worry about legal status, insurance issues. As well as cultural differences, to which the people around them – sometimes also medical staff – may react with surprise, reserve or even resentment. When we put it all together, we can see how difficult it is for them to find any framework of security at that time.

What can frontline medical staff do, if they only see their patient for a short time?

Give her the first good experience of supportive contact, of being seen, heard and important in her experience. This is invaluable, as it allows this patient to leave the ward feeling more empowered, with more confidence in herself and others. This may make her more ready to reach out for help later if she needs it. This may also be one of the factors shaping how she will experience the loss or the grieving process. Sometimes a hospital stay brings additional difficult or even traumatic experiences. That is why positive, respectful, empathetic contact is extremely important, and in the context of migrant and refugee women it becomes

even more significant. Studies show that they are up to twice as likely to develop postnatal depression, and that they have significantly higher scores on the anxiety scale in the face of experienced loss.

Is this contact always appropriate?

We have standards of perinatal care in Poland, including in special situations, which define many aspects. We know how important it is to respect the right to intimacy, to dignity, to provide information. But the stories I hear show that their practical execution is still mixed. The rules for dealing with special situations are not set in a protocol or a regulation; rather, they are a certain attitude, mindset and openness.

This applies to women in general, regardless of their personal circumstances?

The way a particular patient reacts is a result of her individual experience, but also her cultural context; but it is important to remember that we are all immersed in a culture that influences our beliefs, although we are not always aware of this. One of the basic tools of working in support professions is self-awareness – what I think, what I feel, what I believe. With this awareness, we can take these beliefs and open up to the other person, to hear what they need.

These are often first of all the things women need at the time of losing pregnancy, regardless of the cultural background they come from.

What the people I meet in my office often remember is the small things, the small gestures of support. Someone brought an extra blanket, someone made sure to close the screen, allowed a loved one to stay longer after visiting hours or brought a glass of tea, held their hand. But also that someone said directly: I'm sorry. And many of these are examples of non-verbal contact, carrying the message of: "I see you, and what happens to you is important to me".

So seeing them and being there for them is important.

Yes, because the absence of another person, which women sometimes experience after a loss, is a kind of additional abandonment. This absence is particularly prevalent in the stories of migrant women. Often because medical staff, not knowing what to say, how to respond, and sometimes encountering a language barrier, simply withdraw. And while we don't know what the patient's future holds or what she will need, it is

something we can certainly give her during this short time of seeing her on the ward. From when we are a baby, from the day we come into this world, we need others to respond to us. This is how we learn about ourselves. This is also how we draw support from those around us and how we draw from relationships. I think it is a universal first step. No matter what happens next, how much time this particular relationship will last.

In Poland, we are starting to talk more and more about grief after perinatal loss.

We talk about the importance of saying goodbye, we also talk about the rights that the care system provides: to burial, to reduced maternity leave. We have a growing awareness of how important this can be for the patient and her loved ones. We are still developing good practices, and this also applies to situations where the patient comes from a different cultural background. Her way of giving meaning to the experience, her reactions or needs may be different from what we are used to. In many cultures, the loss of a pregnancy, of a child, is a silent loss – often there are no tears, no strong expression of emotion. This may be due to the belief that reserve protects the woman.

The way each patient reacts is a result of her individual experience, but also her cultural context; but it is important to remember that we are all immersed in a culture that influences our beliefs, although we are not always aware of this. One of the basic tools of working in support professions is self-awareness – what I think, what I feel, what I believe. With this awareness, we can take these beliefs and open up to the other person, to hear what they need.

Being attentive and open to what meaning a woman gives to a miscarriage and how she experiences it is fundamental. After all, we can adopt very different attitudes within a single cultural circle because of things like our religion/atheism or the environment we come from. This is why it is so important not to impose your own beliefs on the other woman.

It is not always about imposing beliefs, sometimes it is simply a clear discrepancy or difference between what a woman experiences or needs after a loss and what she gets from those around her. The very way in which we talk about this experience, assign meanings, formulate questions, can be the cause of this discord. It can be difficult for a woman when she hears that the embryo has died or that the pregnancy is abnormal, because it can be impossible for her to connect it with her internal perspective that her baby has died. And the other way round, if she experiences the loss as the loss of pregnancy, and the people around

her or medical staff are urging her to say goodbye, to perform genetic tests or to arrange a burial, she may feel very misunderstood. Occasionally, though thankfully rarely, people also say in this context: "You should do this", "You may regret it later". Such words can have enormous power, quite like spells. They can be memorable and keep coming back for years. This is why it is so important that we take responsibility for the words we say. What matters is how what we say resonates with what language and words our interlocutor uses. Is she talking about the embryo or the baby? Or perhaps about a being? About the end of pregnancy or death?

I believe that words have great power in the sense that they give meaning to our experience. Let us pause for a moment at the word "to miscarry". I miscarried, which means I did it. There is a certain causality, or perhaps maybe a decision, in this word. For some people, it is a very short distance from such a thought to feeling guilty, looking for the causes of what happened in themselves. That is why I often say "you've experienced a miscarriage" and I've been told time and again that this seemingly small change can bring great relief.

One might ask: "How can I help you get through this experience in line with your needs?"

Right. And most likely not everything will be possible, but if we can do something, it is worth doing it in line with those needs. Again, first we need to put aside our surprise that someone reacts differently or that they need something different from what we have been taught.

Is experiencing loss and grief universal?

Yes and no. It is certainly universal that we experience loss in the face of various life events. Loss is a fact, it means that something is no longer there or that we have lost something. Something was there and now it is gone. In terms of the grieving process itself, for me it is one of the ways in which we experience loss. If loss is something that is not here, then grieving is how we experience that absence. It occurs when there was previously emotional commitment, bonding or love.

The grieving process itself, its dynamics and its understanding are highly individual. It is influenced by factors such as the suddenness of the loss, previous experiences, resources and the support networks we have around us. The start of the grieving process can also be influenced by cultural differences, differences related to beliefs, religion, i.e. universal and individual issues at the same time.

It is also worth emphasising here that grieving is a natural, adaptive process. It is a reaction to loss and to its context. It is something we just need to experience.

What makes the grieving process more difficult?

In the context of the experience of miscarriage or perinatal loss, the circumstances in which the loss took place can be extremely difficult. Memories of the hospital, the reactions (or lack thereof) from the medical staff, sometimes a single sentence said carelessly that stays in the memory for a really long time. Sometimes a history of loss and bereavement goes hand in hand with a history of trauma. Often this is the reason why women seek support from a psychotherapist.

What words should not be said?

This is, unfortunately, an endless sea of examples. "What are you crying about? This pregnancy?" plus variations of the following: "At eight weeks it's not a baby yet", "Ma'am, you're not the first, you won't be the last" or, although it sounds hard to imagine: "The first pancake is always spoiled". There are also sentences that are supposed to bring comfort or hope, but are actually extremely difficult and usually only bring a sense of misunderstanding: "Everything will be fine", "You are still young", "Another baby will come soon". I can assume that these are based on good intentions, but they are completely incompatible with what a person might feel after a loss. With her despair, her longing, her helplessness. There is often absolutely no space to think about, plan or hope for what may one day be. And the thought of perhaps having another child does not comfort her at the time when she is mourning the particular one she was carrying inside her, whose movements she may have already felt, whose name she had chosen. These are the kind of sentences that, even if they come from a good place, can be perceived as invalidating the experience and can be hurtful.

So what can be helpful?

First and foremost, saying outright that we are sorry. Noticing the person we are talking to, her feelings, her suffering. It can also be helpful to provide information, to name what might be going on. An element of psycho-education.

You can offer a consultation with a psychologist if one is available on the ward. You can also provide the patient with materials with information on

the available support – support service guides, psychological support content: describing the experience of responding to loss, the grieving process in the context of perinatal loss or the experience of miscarriage, as well as information on her rights and how to exercise them step by step.

Are there words that women with experience of loss would like to hear?

I think this can be something individual and personal for each of them. But I often hear that it is important to simply ask questions: about this experience, about what happened. They need the story to resonate.

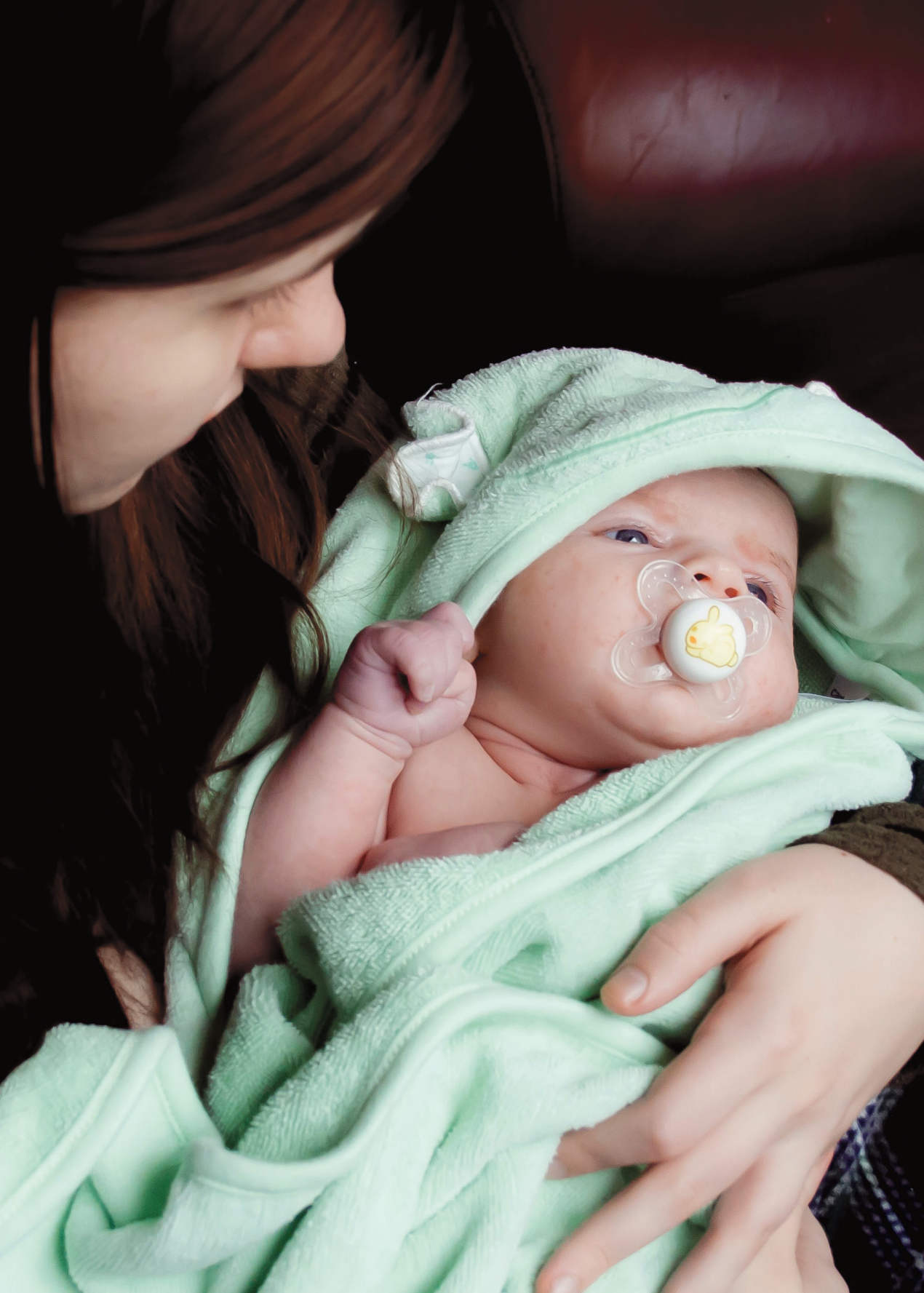
"Do you want to talk to me?", "Do you want to share this with me?" "Is there anything I can do to help?", "And how does it feel now?" – these are the questions that will open up the interaction.

Because there are no words – and we can get rid of this illusion straight away – that will reduce the pain and make the suffering disappear. Nor are there universal words of consolation, making the other person feel relieved. At the same time, when we are open, when we show our willingness to accompany, to listen, we reduce the loneliness in this experience and the sadness can resonate. And this is one of the extremely important tasks in a time of mourning, to make room for the feelings to resound. In different ways, but to experience them and to be able to do that in a relationship as well, because that is what we need as humans.

That is, to listen and to not be afraid to say something?

Right, and this is also often what women talk about after experiencing miscarriage or perinatal loss: "I feel like people are afraid of me", "I have the impression that they are avoiding me, keeping quiet", or: "Suddenly it goes silent or we talk about some very trivial, superficial things", "Nobody asks me about the experience". It is this additional, secondary loneliness. There is a sea of silence in the experience of miscarriage and perinatal loss. This silence is even more profound for women who are experiencing this loss in a foreign country, without the support of loved ones, surrounded by a foreign language. As I mentioned earlier – an important task for us, those around her, is to break this silence.

Anna Bajkowska – Gestalt psychologist and psychotherapist. She specialises in helping people suffering from personal crises and difficulties in close relationships. An important area of her therapeutic practice is perinatal psychotherapy, including support for women and couples with experience of miscarriage and perinatal loss.



I remember...

Midwives who run birthing schools at the PMF visit families in their homes after the birth of their children. During the consultation visits, described by Hanna Kamińska, Inna Padshakh and Marta Piegat-Kaczmarczyk, women also share their experiences of giving birth in Warsaw hospitals.

The accounts collected by Hanna Kamińska are testimony to positive experiences. However, the issue of difficulties and challenges connected to the language and cultural barrier also resonates strongly here. The importance of the so-called soft skills of the medical staff is profound. Thanks to them, the difficulties faced by pregnant women with a migration experience can be minimised to make the birth safer and better – for the mothers and their babies.

I remember the midwife's smile, I felt safe during the birth..

Sunita, Philippines

When I was in labour, the midwife was so patient, like a mother...

Sophie, France

I gave birth to my baby without having a perineal incision! I am so happy!

Teresa, Ukraine

I didn't understand a word of Polish, but the midwife helped me breastfeed my baby with a smile. I nursed for 12 months!

Megi, Georgia

She held my hand in the operating theatre – she was like an angel!

Peris, Kenya

The midwife hugged me and told me I could handle giving birth. I still remember it!

Karima, Afghanistan

The midwife asked if I wanted to be examined by a female doctor instead of a male doctor – I am grateful to her.

Amina, Afghanistan

I was afraid I didn't have milk, but the midwife showed me that the milk was flowing and that there was enough.

Parivinder, India

The midwife wrote me lactation recommendations in English, it was so nice!

Mara, USA

At the hospital everyone was so nice to me, and I speak so little Polish!

Haneen, Jordan

Weigh-ins with the midwife were the best part of the visit to the gynaecologist. She always took the time to answer my questions.

Mara, USA

The midwife spoke to my mother at home, they got along, even though they did not speak each other's language.

Anfisa, Ukraine

What we do in Polish Migration Forum Foundation

- we run antenatal classes for migrant and refugee women,
- we run support groups for women, mothers of babies and young children,
- we conduct workshops to improve parenting/caring skills,
- we provide obstetric consultations, assist with pregnancy care,
- we provide individual consultations for young children with a physiotherapist,
- we train health professionals on perinatal care in a culturally diverse environment,
- we run first aid classes for babies, music and sensory classes and yoga for pregnant women and women with young children,
- we provide financial and material support to pregnant women and women with young children
- we have published a practical guide for young migrant mothers, *I Am a Mom in Poland*, in three language versions,
- we work at permanent accommodation establishments, in surgeries, conduct interventions in homes and over the phone with migrant and refugee women from all over Poland.

Between 2022–2023, our activities were supported by Care International in Poland, an organisation dedicated to providing humanitarian aid and supporting long-term development projects.

Thanks to this collaboration, we helped 1300 women from 56 countries

Tajikistan Ukraine Belarus
Azerbaijan Kyrgyzstan Chechnya
Congo Afghanistan Armenia
Latvia Canada Poland Australia
Iran Russia Albania Pakistan
Brazil Algeria Ireland Kazakhstan
Spain Somalia Rwanda Nepal
Egypt India Kenya Portugal
Italy Romania Bulgaria Moldova
Lithuania Nigeria France
Zimbabwe Bolivia Jordan
Cameroon Iraq UK Vietnam
USA Philippines Germany Mexico
Colombia India Ethiopia
Tanzania Israel Mali Georgia
Sri Lanka

For them, we organised:

28
birthing schools

937
obstetrics consultations

730
consultations with physiotherapists

4
first aid courses for parents of young children

6
Shantala massage courses, lactation counselling sessions

26
Yoga and Support for Pregnant Women" classes

26
"Mama Yoga with Kids" classes

29
music and sensory workshops for young children and their guardians

23
meetings in the series "How to Be a Parent and Not Go Crazy" aimed at parents facing parenting difficulties

11
"MAMY to!" workshops for mums with young children

11
"Your Journey to Self-Compassion" workshops (a support group for women run in English)

ongoing weekly support groups for Ukrainian and Russian-speaking women and consultations with specialists

In 2023, we also provided training for midwives and healthcare professionals:

- a two-day on-site in-depth training for 28 midwives from all over Poland,
- a series of online training courses for 173 midwives and midwifery students,
- a series of webinars in cooperation with the Supreme Chamber of Nurses and Midwives for 1078 people from 16 provinces,
- webinar with the “Rodzić po Ludzku” Foundation, which was seen by 1800 people.

We sent out more than 120 parcels with the *I Am a Mom in Poland* publication to maternity hospitals, health centres, social welfare centres and organisations supporting migrant women throughout Poland.

We made a film called *Lullabies and Stories of Motherhood*, featuring women from different parts of the world: Ukraine, Tajikistan, Venezuela, Jordan, Chechnya, Vietnam, Afghanistan and Mongolia sharing stories of maternity practices in their countries of origin.

Tasks for the future

- training for midwifery students and healthcare professionals on supporting migrant women in the perinatal period and on dealing with children with trauma experiences,
- facilitating better access for hospital midwives and community midwives from outside Poland to practise the profession,
- involvement of interpreters in maternity and paediatric hospitals,
- protection of children after termination of parental rights,
- popularisation of preventive healthcare among migrant women and their children (e.g. vaccination education),
- networking with organisations and institutions supporting women, including women with migration experience.

Polish Migration Forum Foundation
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info@forummigracyjne.org

We offer support (on-site and online):

- psychological support for children and adults
- legal support,
- casework (handling specific matters, e.g. education, health, official matters),
- educational support (we train people working in schools, we specialise in intercultural assistantship)
- career counsellors
- residency legalisation consultant
- business counsellor
- midwives
- other support, especially dedicated to women, people with disabilities, young people, children, seniors, parents and carers, teachers

Our support is available free of charge! We support all male and female migrants and refugees, regardless of their country of origin! We speak Polish, English, Ukrainian, Russian, Spanish, Belarusian, French and other languages.

Join in building an open and diverse society in Poland.
Support the activities of the Polish Migration Forum Foundation!

→ by making a donation via the website (PayU):
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→ by making a donation (one-off or recurring) to our bank account:
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SWIFT: INGBPLPW IBAN: PL79 1050 1025 1000 0023 1482 7813,
→ by donating 1.5% of your tax: our KRS number: 0000272075.

Any form of support is extremely valuable to us and allows us to fulfil our mission