Social support in the perinatal period: a feminist exploration of asylum seeker and refugee women's experiences and suggestions for change

by

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ABSTRACT

Asylum seeking and refugee women in the UK face significant challenges to their perinatal wellbeing, with high levels of maternal mortality and morbidity experiencing multiple disadvantages and inequalities due to their immigration status, gender, migration experience and minoritised ethnic status. These women can lack social support and improving the level of social support available to women who experience multiple disadvantages can be a way of improving their perinatal experiences and wellbeing. There are, however, currently no studies which explore this in the context of asylum seeking and refugee women in the UK.

A feminist-informed study was undertaken aiming to explore asylum seeker and refugee women's experiences of social support in the perinatal period and their suggestions for change. A critical interpretative synthesis was undertaken to explore existing literature on perinatal social support for asylum seeking and refugee women in a European context. From this, two empirical studies, underpinned by feminist social constructionist epistemology were undertaken to explore asylum seeking and refugee women's experiences of perinatal social support in the UK and the ways they felt this support could be improved. Women with lived experience, and staff and volunteers who supported them, were interviewed using feminist semi-structured interviews (n=22), then for study 2, four focus groups, including a member checking group (n=11) were undertaken.

Findings from the studies identified key issues around needing social support to access statutory services and overcome challenges to meet basic needs. The role and nature of networks of support were discussed, getting support right to meet women's needs, and who provides support and how. Midwives were considered central to provide support and knowledge and communication. These results fit with the ethics of care, placing women's experiences within the socio-political context of the immigration system and current healthcare provision, focusing on ideas of the careless state, the voluntary sector and the creation of caring communities, systemic carelessness in maternity care, promiscuous care and gender and care.

The research marks a unique contribution to knowledge being the first study, using a feminist-informed approach, to explore UK based asylum seeking and refugee women's experiences and perceptions of social support and their suggestions for change.

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GLOSSARY OF TERMS AND ABBREVIATIONS

Terms

Asylum seeker

Asylum seekers are individuals whose claims for refugee status have not been definitively decided by the country in which they seek refuge (United Nations, 2014).

Befriender

Befrienders are a form of one-to-one support organised by voluntary agencies, in which the organisations pair women in need with a supporter who provides social support over a period of time.

Continuity of carer

Organisation of care where the same midwife supports the women throughout the maternity journey, this may or may not include the intrapartum period.

Dispersal

The term generally refers to the policy by which asylum seekers who have been provided with accommodation from government approved suppliers, can be moved at short notice, with no choice of geographical location to different accommodation anywhere in the UK. This can be from initial accommodation to longer term accommodation or between long term accommodation.

Detention

The practise of keeping asylum seekers or other migrants in government facilities for administrative purposes, including processing, identification or removing from the UK.

Destitution

The inability of a person to meet their basic needs to stay warm, dry and fed, commonly related to a lack of housing and income.

Deportation

The enforced removal of a person from the UK by the UK government.

Doula

Doulas are trained, lay, birth supporters who support women during part of the perinatal period, usually the period immediately before, during and after birth.

Forced migrant

A person forced to leave their home due to threats to life and livelihood, this can be due to human (e.g., war, persecution) or natural causes (e.g., floods, famine).

Home Office

The UK government department with responsibility for immigration, passports, drugs policy, crime, fire, counter-terrorism and police.

Hostile environment

A term first used by UK Home Secretary, Theresa May, in an interview with The Telegraph May 2012, when she spoke of wanting to create a '*hostile environment for illegal migrants'*.

Illegal Migration Act 2023

The act was designed to ensure that individuals who were deemed to come to the UK illegally, are to be detained and removed to their home or safe third country.

Immigration Act 2014

The act changed the existing removal and appeal system and sought to ensure that those in the UK deemed to be illegal by the government were unable to access public services.

Immigration Act 2016

The act brought in new measures to enforce immigration legislation, place novel sanctions on illegal working and prevent some migrants accessing public services.

Leave to remain

Leave to remain is permission to stay in the UK either temporarily (limited leave to remain) or permanently (indefinite leave to remain).

Multiparous

Having at least one previous birth

National Asylum Support Service (NASS)

A division of the Home Office which has responsibility for accommodating and supporting people claiming asylum while their claims are being processed.

Neo-liberal

A political philosophy which favours the economic, social and political organisation of society in a way which favours free market capitalism, individualism and a reduction of the role of the state.

No recourse to public funds (NRPF)

This term refers to people from abroad who are subject to immigration control and are not entitled to receive benefits or access public housing.

Paraprofessional

Someone who has some training to do a job but not professional qualifications.

Patriarchy

An ideology and social system based upon upholding the systemic dominance of men over women.

Peer support

Assistance offered between individuals or groups, who have some similarities of lived experience.

Perinatal period

The perinatal period is a term which is usually used to refer to the period of pregnancy and up to a year post birth. In the empirical part of this thesis however, I include women who have babies who are up to 2 years old.

Primiparous

First time mothers

Racialisation

Racialisation is the process and intent by which racial identities are constructed in particular social and political contexts, and in which these identities are hierarchically assigned to groups of individuals.

Refugee

Under the United Nations (UN) 1951 Convention Relating to the Status of Refugees, a refugee is a person who:

> ‘owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country … and are seeking in accordance with international conventions refuge in another country’ (United Nations High Commissioner for Refugees (UNHCR), 1952)

Refused asylum seeker

A person whose asylum application has been unsuccessful and who has no other claim for protection awaiting a decision.

SERCO

A company which provides asylum accommodation in the North of England on behalf of the Home Office.

Syrian Vulnerable Persons Resettlement Scheme (VPRS)

A scheme run by the UK Government working with the UN High Commissioner for Refugees (UNHCR) between 2014 and 2021 which offered refuge in the UK to some Syrian refugees considered to be particularly vulnerable or at risk. These refugees are relocated directly to the UK from overseas and have refugee status immediately.

UK Border Agency (UKBA)

The government agency responsible for the borders and controlling migration in the UK.

Undocumented/irregular/illegal migrant

A migrant who does not have permission from the Home Office to be in the UK.

Women and birthing people

The term *asylum seeking and refugee women* is used throughout this thesis for brevity and to reflect those who participated in the empirical studies, but this work acknowledges that there is wider birthing community.

Abbreviations

ESOL	English for speakers of other languages
LGBTQ	Lesbian, Gay, Bi-sexual, Trans & Queer
NASS	National Asylum Support Service
NHS	National Health Service
NICE	National Institute for Clinical Excellence
NRPF	No recourse to public funds
RCM	Royal College of Midwives
RCOG	Royal College of Obstetricians and Gynaecologists
UKBA	United Kingdom Border Agency
UN	United Nations
UNDESA	United Nations Department of Economic and Social Affairs
UNHCR	United Nations High Commission for Refugees
VPRS	Vulnerable Persons Resettlement Scheme
WHO	World Health Organisation

PUBLICATIONS AND PRESENTATIONS FROM THIS THESIS

Peer reviewed article

Balaam, M. C., Kingdon, C., & Haith-Cooper, M. (2021). A Systematic Review of Perinatal Social Support Interventions for Asylum-seeking and Refugee Women Residing in Europe. Journal of Immigrant and Minority Health, 24(3), 741-758. https://doi.org/10.1007/s10903-021-01242-3

Peer reviewed international and national conference presentations

Balaam, M.C. (2019). A review of perinatal social support interventions for asylum seeking and refugee women resident in Europe. International Normal Labour and Birth Conference, Grange over Sands, UK.

Balaam, M. C. (2020). A review of perinatal social support interventions for asylum seeking and refugee women resident in Europe. Virtual day of the Midwife 12th Annual Online Conference, 5th May (https://vidm.org/vidm-2020-midwifery-student-posters/)

Balaam, M.C. (2022) We'll look after you, we'll try to sort this mess out for you': Asylum-seeking and refugee women's experiences of social support during the perinatal period: A qualitative study in the North of England. International Normal Labour and Birth Conference Arhus, Denmark.

Balaam, M.C. (2023) When they listen, they'll be able to help: improving perinatal social support for asylum seeking and refugee women in England. 20th IMISCOE Annual Conference, Migration and Inequalities: In search of answers and solutions, Warsaw, Poland.

Balaam, M. C. (2024) Perinatal social support for asylum seeking & refugee women: what do women want? NHS England National Maternity Research Programme Conference, Birmingham, UK, 2024

Other presentations: invited speaker

Balaam, M.C. (2018) Doing research in maternity care with and for migrant women New to the UK: Midwifery Conference, Oxford Brooks University, UK.

Balaam, M.C. (2023) The perinatal experiences of asylum seeking and refugee women in the UK and the role of social support. MIDEX seminar series, University of Central Lancashire, UK,

Balaam, M.C. (2024) Experts by Experience: Asylum seeking and refugee women and maternity care Why, how and who benefits? Promoting Collaboration and Public Involvement within Health and Care Research, LIFE Institute, UCLan, UK.

CHAPTER 1 INTRODUCTION

1.1 Introduction

This thesis presents the findings from a feminist-informed study of asylum seeker and refugee women's experiences of social support in the perinatal period and their suggestions for change. It is underpinned by a feminist social constructionist epistemology. This introductory chapter will introduce the aims of the study, I will then locate myself in relation to the study, provide the context to the study and finally conclude with details of the organisation of the thesis.

1.2 Aims of the thesis

The aims of the study were (i) to explore asylum seeker and refugee women's experiences of social support in the perinatal period and (ii) to explore their suggestions for ways in which social support could be best provided for asylum seeking and refugee women from their perspective as women with lived experience. These aims were addressed through undertaking a literature review which explored existing literature on perinatal social support for asylum seeking and refugee women in a European context (see chapter three), and by undertaking two empirical studies to explore the following research questions developed from that review.

Study one: What are asylum seeking and refugee women's experiences of social support in the perinatal period in the UK?

Study two: What do women perceive to be the best ways in which asylum seeking and refugee women could be supported in the perinatal period?

1.3 Situating myself in the study

The focus of this study grew out of the research I have undertaken over the last decade of my academic career. This work has explored the perinatal experiences of migrant women in Europe (Balaam et al., 2013; Balaam, Cooper, et al., 2017; Balaam et al., 2021; Pařízková et al., 2024; Viken et al., 2017) as well as of minority ethnic women in the north of England (Thomson et al., 2022) and asylum seeking

and refugee women in the UK (Balaam et al., 2016). The focus of these studies along with research on the perinatal experiences of other margianlised women was the psycho-social and political aspects of maternal health and care exploring how women's embodied experiences are located with the social realm by exploring the role of social support and other psycho-social issues (Balaam & Thomson, 2018; Thomson et al., 2015; Thomson et al., 2017). This along with work that looked at befriending (Balaam, 2015) and other social support in the context of wider forced migrant populations (Balaam et al., 2024; Balaam et al., 2023; Jallow et al., 2022) reinforced my interest in the role of the socio-political context of the perinatal period, as well as the importance of social support or care in terms of a holistic view of perinatal wellbeing, particularly for asylum seeking and refugee women who face the challenges of social, cultural and political marginalisation.

Alongside this work my on-going interactions on a professional and personal level with voluntary groups working with asylum seeking and refugee women has given me insight into issues women who use these groups face and the challenges faced by those who seek to support them. Pursuing a PhD allowed me the space to focus on and explore the role of social support in the perinatal experiences and wellbeing of asylum seeking and refugee women in more depth and to explore with them what their experiences of support were and what they would ideally want support to look like.

In addition to this research work, I bring to this study my previous experiences as a feminist researcher and educator. Since asking as a teenager why the lives of my grandmothers and other working class women like them were not in any of the history I was taught, my interest has been in seeking out the stories of those whose experiences were systemically marginalised. My professional academic life of over 25 years as researcher and educator has been dominated by seeking to find and amplify the stories of, women and other margianlised groups whose voices were absent or diminished within traditional academic locations. My work teaching feminist, African American and oral histories as well as researching women's and community oral histories, AIDS/HIV, women's gender-crossing and menopause sought to do this work. While much has changed in the last 25 years some voices remain marginalised and seldom listened to or regarded.

These experiences are combined with a feminist commitment to social justice and the desire to support change; a commitment which was re-ignited in the context of the perinatal period with the birth of my own children in the early 2000's. This brought me back to a feminist understanding of birth and the perinatal period as being more than a bio-medical phenomena and to the social and political location of women's bodies, health and reproductive experiences within a patriarchal, colonial and hierarchical society which I had explored in my academic life. The personal and political aligned in my understanding now I had children, and while I had experienced amazing perinatal care and social support, I was aware very quickly, partly through my role as a member of the local maternity services liaison committee, that many other women were much less likely to experience such care. After working on aspects of maternal experiences in a voluntary capacity this then became my focus as I re-entered academia.

The combination of these elements led to the topic of this thesis and the approach and theoretical perspectives I have chosen to use. Using a feminist-informed social constructionist approach was a way of ensuring that my research focused on women's views and stories as the centre of the research and allowed me to use the insight offered by a range of feminist writers to support my thinking. The aim of the work has been to amplify the voices of the women who have shared their stories with me as well as ensuing that the work has an applied and practical focus so that it can produce knowledge which can used to support positive change.

1.4 Context of the thesis

The focus of this thesis has become even more pertinent over the seven years it has taken to complete. The international and national situation for asylum seeking and refugee women has become more complex and challenging. Global events including the intensification of the Syrian civil war and its impact on the surrounding countries, the western alliance's withdrawal from Afghanistan, war in Ukraine as well as ongoing conflict other regions including Eritrea, Sudan and Somalia as well as the impact of climate change has seen an increase in the number of international migrants, refugees and those seeking asylum in Europe (European Commission, 2024; United Nations High Commission for Refugees, 2023). In the UK the

increasing politicisation of migration and the implementation of strict immigration legislation, along with austerity and the rising cost of living has created an environment which is increasingly harsh for women living within the immigration system as asylum seekers and refugees (Benchekroun, 2023; Lonergan, 2023).

Alongside this repeated MBRRACE reports (Knight et al., 2023; Knight et al., 2021), the work of the NHS Race and Health Observatory (Esan et al., 2023) and the work of groups like FiveXMore (Five X More, 2024) have highlighted the maternal inequalities faced by asylum seeking and refugee women due to their status and ethnicity. This work has increased knowledge of the nature, extent and impact of these inequalities and fuelled calls for work to bring about significant change to address systemic racism and to challenge persistent health inequality. This research therefore presents a timely addition to this work which seeks to highlight the challenges faced by perinatal women living within the current punitive immigration regime and identify possible ways to address the health inequalities asylum seeking and refugee women continue to face.

1.5 Thesis structure

The thesis consists of ten chapters as detailed below.

Chapter 1: Introduction - This chapter introduces the aims and context of the thesis, as well as my position in relation to it and presents an overview of the structure.

Chapter 2: Background - This chapter provides the background and context for the thesis exploring asylum seeking and refugee women's perinatal experiences in an international and national setting. It explores the role of social support in the perinatal period and provides a definition of social support which underpins the empirical work of the thesis.

Chapter 3: Literature review - Critical Interpretative Synthesis - This chapter presents the findings from this review which explores the impact of existing perinatal social support interventions on asylum seeking and refugee women in a European context and establishes the research questions for the two empirical studies.

Chapter 4: Methodology - This chapter identifies and justifies the choice of methodological approach chosen for the thesis as a feminist-informed qualitative approach and the nature of the relativist feminist social constructionist epistemological underpinning.

Chapter 5: Methods: Study one- This chapter explores the choice and use of feminist qualitative interviews and reflexive thematic analysis as the methods used in Study one to explore the research question, what are asylum seeking and refugee women's experiences of social support in the perinatal period in the UK?

Chapter 6: Findings: Study one- This chapter presents the findings from the interviews with 18 women and four staff and volunteers undertaken in this study. The findings relating to experiences of social support are presented in the form of five key themes. These themes are struggling to ensure that basic needs are met, meeting social needs by creating networks of support, family as a source of psychological safety and social support within the NHS maternity services and the need to ensure effective communication.

Chapter 7: Methods: Study two - This chapter explores the choice and use of focus groups, member checking and reflexive thematic analysis as the methods used in study two to address the question, what do women perceive to be the best ways in which asylum seeking and refugee women could be supported in the perinatal period?

Chapter 8: Findings: Study two - This chapter presents the findings from the focus groups and member checking group used in study two which explored women's views of the best ways in which asylum seeking and refugee women could be supported in the perinatal period. This is provided as four key themes and associated suggestions for ways to improve perinatal social support. These themes are, the need for social support to navigate statutory services, getting social support right to meet women's needs, improving knowledge about what social support is available and enabling midwives to provide social support within and beyond the healthcare setting.

Chapter 9: Discussion - This chapter discusses the implications of the findings from both studies in the context of wider research and using insights from writings on the ethics of care, focusing on exploring ideas of the careless state, the voluntary sector

and the creation of caring communities, systemic carelessness in maternity care, the need for promiscuous care: families, families of choice and wider peer support and gender and care.

Chapter 10: Conclusion - This chapter provides the conclusion to the whole thesis, it also explores the approach to dissemination used in the study, it discusses its original contribution to knowledge, its strengths and weaknesses and finally provides recommendations from practice, policy and research.

1.6 Conclusion

This chapter has presented an introduction and overview of the thesis including the context, aims, theoretical approach and structure of the thesis as well as my location in terms of this work. The next chapter presents the background to the thesis placing asylum seeking and refugee women's perinatal experiences within a global and national context as well as exploring the role of social support in the perinatal period.

CHAPTER 2 BACKGROUND

2.1 Introduction

The previous chapter introduced the study and provided an overview of the structure of the thesis. This chapter provides the background to the thesis placing asylum seeking and refugee women's perinatal social support experiences within a global and national context as well as exploring the role of social support in the perinatal period. The chapter begins by considering the challenges faced by asylum seeking and refugee women in the perinatal period in the context of contemporary migration patterns. It then focuses on asylum seeking and refugee women's perinatal experiences in the UK, identifying the nature of the challenges they face within the UK's current political climate and immigration regime. It then explores ideas of social support and its role in the perinatal period. I argue that improved social support may play a role in addressing some of the challenges faced by asylum seeking and refugee women in the perinatal period and improving their perinatal experiences but that more research is needed to explore this. This exploration will then provide the focus of this thesis. The chapter concludes by providing a discussion and definition of the idea of social support which will be used to underpin the subsequent work of the thesis.

2.2 Contemporary migration

In 2021 the United Nations estimated that there were more than 281 million people living outside their country of origin and that international migrants, a term which includes asylum seekers, refugees and other forced migrants, made up 3.6 % of the world's population (United Nations Department of Economic and Social Affairs, 2020). By 2020 Europe was host to over 87 million international migrants, made up of those moving within the region and those from other regions (United Nations Department of Economic and Social Affairs, 2020). The international migrant population is heterogeneous differing in terms of reasons for migration, region of origin, process of migration, status within reception country and position in relation to national and international law. In recognition of this and to avoid artificial homogenisation it is important to identify, as far as possible, which population of migrants are being discussed when undertaking health research (Balaam, Haith-

Cooper, et al., 2017; Heslehurst, 2018; World Health Organisation, 2020). A lack of differentiation, in addition to the challenges in data collection around migrant health, can at times result in the production of data in which it can be difficult to recognise and understand the heterogeneity of migrant experiences and their impact on health (Bozorgmehr et al., 2023; Hannigan et al., 2016).

This thesis focuses on the experiences of women who are refugees and asylum seekers (see glossary). Asylum seekers and refugees are part of a wider group of people who have been forcibly displaced from their homes due to '*persecution, conflict, violence, human rights violations or events seriously disturbing public order*' (United Nations High Commision for Refugees, 2024). The United Nations High Commission for Refugees (UNHCR) reported that at the end of 2023 there were 117.3 million forcibly displaced people globally, of which 37.6 million were refugees and 6.9 million were asylum seekers with nearly 75% of this population originating from five countries Afghanistan, Syrian Arab Republic, Venezuela, Ukraine, South Sudan (United Nations High Commision for Refugees, 2024). While the UNHCR estimated that 75% of refugees, asylum seekers and other displaced people remained in low and middle income countries (UNHCR, 2024), there has been an increase in the number of displaced people, including refugees and asylum seekers coming to Europe since 2015 with the escalation of the war in Syria and the increased instability in the surrounding countries. The number of refugees in European countries was estimated as 12.4 million by the end of 2022 as millions of people from Ukraine sought refuge in nearby countries (United Nations High Commission for Refugees, 2023) leading to a situation in which Europe went from hosting less than 10% of all refugees to hosting more than 20% by the end of 2022 (European Commission, 2024). In the UK in spring 2023 there were approximately 365,000 refugees and 175,000 asylum seekers (Home Office, 2023) with 75,658 asylum applications in the UK in the year ending June 2024 (Home Office, 2024). Data from the end of 2022 suggested that at that time 4% of the UK's foreign-born population and 0.6% of the UK's total resident population comprised of people who originally came to the UK to seek asylum (The Migration Observatory, 2024).

2.3 Asylum seeking and refugee women in the perinatal period: the global context

The sexual and reproductive health of asylum seeking and refugee, as well as migrant women more generally, has become an area of concern for policy makers at both global and European levels. Some reception countries struggle to provide optimal maternal healthcare for these populations as the numbers of migrants increase and women now make up 50% of this population (European Institute of Women's Health CLG, 2022; Women Political Leaders, 2017; World Health Organisation (WHO), 2018a; (United Nations High Commission for Refugees, 2023). The health and wellbeing of perinatal women is of particular concern because evidence suggests that asylum seeking and refugee women experience significant challenges to their health in this period. In that while many asylum seekers and refugees experience poor physical and mental health, as a result of both their migration journey and the poor economic, social and political conditions many face in their countries of reception (World Health Organisation, 2022; World Health Organisation (WHO), 2018; World Health Organization, 2024), women are particularly vulnerable to challenges to their physical and psychological wellbeing (Mangrio & Sjögren Forss, 2017; United Nations, 2017; World Health Organisation, 2018).

This situation is exacerbated in the perinatal period as a result of the difficulties women face in accessing timely antenatal care, along with the loss of family and social support and the impact of pre-existing health conditions (Fair et al., 2020; Frank et al., 2021; Heslehurst et al., 2018; Liu et al., 2019; Ramadan et al., 2023; Sharma et al., 2020). This has led to a situation in which asylum seeking and refugee women are particularly vulnerable to adverse maternal and infant outcomes and poorer maternity care experiences compared to native born women and other groups of migrant women. This is evident in higher rates of negative perinatal outcomes (Rogers et al., 2020), higher maternal mortality (Eslier et al., 2023; Gieles et al., 2019), maternal morbidity (Bollini, 2009; Gieles et al., 2019; Harakow et al., 2021; Heslehurst et al., 2018; Heslehurst, 2018), poorer mental health (Firth et al., 2022; Heslehurst, 2018; Stevenson et al., 2023) and higher neonatal mortality and higher preterm births (Behboudi-Gandevani et al., 2022; Harakow et al., 2021;

Heslehurst et al., 2018; Heslehurst, 2018). These outcomes represent evidence of significant health inequalities which affect the wellbeing of women, their babies and their families and highlight the need for measures to be taken to address the causes of these inequalities and improve the situation for asylum seeking and refugee women.

2.4 Asylum seeking and refugee women in the perinatal period: navigating a hostile environment in the UK

While there are commonalities in the perinatal experiences of asylum seeking and refugee women globally, as identified above, the specific situation women face within a reception country, in terms of political and ideological situation, numbers of migrants, immigration regime and ability to access health services, have a significant impact on their perinatal experiences (Frank et al., 2021; Pařízková et al., 2024). It is hard to quantify the numbers of asylum seeking and refugee women giving birth in the UK due to the limitations of NHS data collection (McGranahan et al., 2024). However, data published by the Office for National Statistics (ONS) in 2023 showed that in the year previously there were 183,309 babies born to non-UK born women in England and Wales, making up some 30.3% of all live births and that this was part of a longer term growth in the number of babies born to non-UK born mothers. While not all these women would be asylum seeking and refugee women, the data shows this is due to increases in births to non-EU born women (an increase of 7% from 2021), who are more likely to be asylum seekers and refugees than EU women (Office for National Statistics (ONS), 2023). This suggests that more asylum seeking and refugee women are navigating the perinatal period in the UK. The sections below consider the situation for these women as they navigate this period within the contemporary UK and the impact of this context on their perinatal experiences.

Women who come the UK as asylum seekers and refugees face challenges to their physical and psychological wellbeing due to pre-existing health conditions, the impact of the migration process and the migration journey which brings with it increased vulnerability to exploitation and sexual and gender based violence as well as the conditions they face in the UK (Frank et al., 2021; Heslehurst et al., 2018; Sharma et al., 2020; Stevenson et al., 2023). Research has demonstrated the

negative impact on women's physical and mental wellbeing of living under the current UK immigration regime. The regime is one in which women have limited agency, as they cannot work, cannot choose where they live, may be living in temporary accommodation in hotels or hostels and have little money. They live in a liminal situation, particularly with the current delays in processing claims, knowing that their situation may change at any time due to a change in their status or that they may be subject to dispersal (see glossary) or detention (see glossary) which leads to a loss of social connections and lack of continuity of healthcare (Feldman, 2014; McKnight et al., 2019; Rowe et al., 2023; Shortall et al., 2015). The sections below explore the creation of the current UK approach to immigration, which has seen the creation of a *hostile environment* and its detrimental impact on the physical and mental wellbeing of perinatal asylum seeking and refugee women in the UK.

In 2012 the then Home Secretary, Theresa May, declared that the government wanted to create a '*hostile environment for illegal migration'* (Kirkup, 2012). The idea of the hostile environment May desired has become synonymous with the target of reducing migration to the UK, the passing of restrictive immigration acts in 2014 and 2016 as well as the increasingly hostile ideological, political, media and public discourses surrounding migration. The impact of this agenda has gone beyond May's stated aim of making life difficult for 'illegal' migrants. The policies and tenor of the hostile environment has affected the lives of all migrant communities, including current asylum seekers and refugees as well as members of the Windrush generation and their families as well as other ethnically minoritised communities within the UK (Griffiths & Yeo, 2021). The Conservative government's policies however, while more restrictive than some earlier policies, are the continuation of an existing policy trend evident since the late 1990's. International and national events, including the wars in Balkans and the expansion of the European Union, led to increased migration into the UK. The political reaction to this saw the construction of asylum seekers (and non-European migration) as a political problem to be addressed through legislation which sought to prevent, restrict and criminalise those seeking asylum and to make life in the UK difficult (Crawley & Skleparis, 2018; Mulvey, 2010, 2011; Yasmin & Howarth, 2018).

Legislation passed in 2014 and 2016 built on these foundations and aimed to, reduce the number of migrants coming to the UK, to increase efforts to identify those without a legal right to be in the UK and to place additional restrictions on access to services such as education, healthcare and accommodation for those already in the UK (Home Office, 2014, 2016b). It also effectively extended the regulation of immigration from the external borders of the UK into civil society as landlords, employers, educators, civil servants and healthcare professionals were all implicated in the surveillance and management of migrants (Fannin, 2023; Griffiths & Yeo, 2021). This legislation, along with the impact of increasingly slow processing times for those seeking asylum have worsened the situation for asylum seeking and refugee women (Cuibus et al., 2024). Additionally, the continued politicisation and racialisation of immigration through such legislation and governmental rhetoric has created and perpetuated negative media and public discourses around asylum seekers and refugees, evident in concern over a range of emblematic issues including 'small boats', 'illegal' migrants, health tourists, Albanian gangs and other constructed moral panics (Abraham-Hamanoiel, 2021; Cooper et al., 2020; Griffiths & Yeo, 2021; Shenton, 2020). Global and national events, such as the escalation of the war in Syria, Brexit, the rise of nationalism, austerity, the western coalition's withdrawal from Afghanistan and the Russian invasion of Ukraine have been used to create a sense of crisis around migration and fuel further restrictive practices most recently the Nationality and Borders Act, 2022 and the Illegal Migration Act 2023 (Mulvey, 2010). This legislation which aims to deter people from seeking asylum in the UK, increase the removal of those currently in the UK and penalise those who arrive outside what are called *safe and legal* routes, continues the politicisation of asylum and intensifies the restrictions faced by those seeking asylum (Burns et al., 2022; Griffiths & Yeo, 2021) to the extent that it has been condemned by the UN as failing to respect the legal conventions around asylum (United Nations High Commision for Refugees, 2021).

The implications of this legislation and the hostile public and political climate have a negative impact on the physical and mental wellbeing of asylum seeking and refugee women in the perinatal period. Current immigration legislation regulating the employment, education, housing and financial situation of asylum seekers and refugees has led to women facing multiple economic and social disadvantages.

These include poor housing, poverty, homelessness, destitution and discrimination, all of which negatively affect their physical and mental wellbeing and are particularly challenging for women who are asylum seekers or who have more precarious status within the immigration system (Adil et al., 2022; Asif, 2022; Dudhia, 2020; Ellul et al., 2020; Maternity Action, 2022). Additionally, many women experience social isolation as they have no or limited family in the UK. This isolation and limited social support, both of which are detrimental to women's wellbeing, are exacerbated by language barriers, dispersal policies and challenges in travelling to access support (Arrowsmith et al., 2022; Heslehurst et al., 2018; McKnight et al., 2019; Obionu et al., 2023; Rowe et al., 2023).

In addition to these challenging conditions, many asylum seeking and refugee women in the UK struggle to access appropriate and timely maternity care. This can be the result of the challenges of having to travel to attend care on a very restricted income (Higginbottom et al., 2019) as well as a lack of knowledge of how the NHS works and how to access it, as this may be very different to healthcare systems in home countries (Higginbottom et al., 2019; Rowe et al., 2023; Royal College of Midwives, 2022a). This situation can be exacerbated further by language barriers (Higginbottom et al., 2019; McKnight et al., 2019; Rowe et al., 2023) and by a lack of culturally appropriate information and care (Higginbottom et al., 2019; Sudbury & Robinson, 2016).

These challenges to accessing care are exacerbated by legislation linked to the hostile environment. The 2016 Immigration Act and subsequent legislation sought to strengthen connections between the Home Office and the NHS in terms of tightening regulations on charging for maternity care and data sharing (Weller et al., 2019). While the provisions on data sharing have been scaled back (Bowcott, 2018) some of the concerns around the connections between the NHS and the Home Office remain. This has led to a situation where some women, particularly those with irregular status, fear that if they access care they could be reported to the Home Office putting them at risk of detention and deportation (Adil et al., 2022; Doctors of the World, 2022). While most asylum seekers and refugee women do not have to pay for NHS maternity care some, predominantly those with irregular immigration status, do have to pay for care. Fear of being charged for care, whether founded or

unfounded has led to some women avoiding timely maternity care (Coddington, 2021; Feldman, 2020; Maternity Action, 2019b, 2022). Concern over the extent and detrimental impact of this legislation has led to the Royal College of Midwives (RCM) and the Royal College of Obstetrics and Gynaecology (RCOG) calling for the ending of charging vulnerable migrant women for NHS maternity care (Royal College of Midwives, 2020; Royal College of Obstetrics & Gyneacology, 2022).

This combination of factors means that many asylum seeking and refugee women access care late in the antenatal period well after the 10 weeks recommended by the NHS and so receive less than the recommended amount of ante-natal care, a situation which is associated with negative maternal health outcomes (Doctors of the World, 2022; Higginbottom et al., 2019; McGranahan et al., 2024; Sturrock et al., 2021). When women do access maternal healthcare they often face challenges in receiving optimal care due to poor communication and lack of interpretation facilities (Higginbottom et al., 2019; Lephard & Haith-Cooper, 2016; McKnight et al., 2019), lack of knowledge amongst staff about the cultural and practical needs of asylum seeking and refugee women and/or a lack of specialist care (Sharma et al., 2020). They also can be subject to prejudicial, and discriminatory attitudes or treatment from some staff reflecting the impact of the hostile environment (Birthrights, 2022; Evans, 2022; Haith-Cooper & Bradshaw, 2013; Higginbottom et al., 2019; Kapadia et al., 2022 ; McKnight et al., 2019).

This has led to a situation where asylum seeking and refugee women experience significantly worse maternal outcomes than women born in the UK, including maternal mortality and severe or multiple morbidity with refugee and asylum seeker status and/or recent arrival in the UK being significant risk factors in this (Asif et al., 2015; Feldman, 2014a; Puthussery, 2016; Sturrock et al., 2021; Walker & Farrington, 2021). Recent data suggests that women born outside the UK represented nearly a quarter of maternal deaths in the UK and a disproportionate number of these were asylum seekers or refugees (Knight et al., 2021; Walker & Farrington, 2021). In addition to these poor physical outcomes, asylum seeking and refugee women experience extremely high rates of perinatal mental ill health (Doctors of the World, 2022; Firth & Haith-Cooper, 2018; Firth et al., 2022; Giscombe et al., 2020; Moore et al., 2019).

Asylum seeking and refugee women's experiences of the perinatal period and of maternal health care in the UK are a product of complex and intersecting structural, cultural and organisational issues. They are affected by their gender, their immigration status, the restrictions of the immigration regime, the organisation of maternal health care and their socio-economic status as well as their ethnicity (Asif, 2022; Benchekroun, 2023; Dodsworth, 2023; Isaacs et al., 2022; Lonergan, 2024; Talks et al., 2024; Willey et al., 2022). It can be argued that to address these issues there needs to be an ideological and practical commitment to systemic change in immigration and health policies (Mahase, 2023) however, and while not reducing the need to call for and bring about such systemic change, there remains a question of what can be done to address the inequalities in perinatal health that asylum seeking and refugee women experience in the present.

2.5 Social support

One approach could be, while not denying the structural inequalities and systemic challenges women face and continuing to highlight these, to work with women, health professionals, statutory and voluntary agencies to find ways in which the situation currently faced by asylum seeking and refugee women can be ameliorated (Taylor, 2009). One possible avenue for doing this could be to develop targeted interventions to improve the level of social support available to asylum seeking and refugee women, as existing research suggests that increasing the social support available to women who are marginalised or face multiple disadvantage and commonly have low levels of social support can improve their psycho-social wellbeing and outcomes (East et al., 2019; McLeish & Redshaw, 2021). Indeed both the World Health Organisation (WHO) and the National Institute for Clinical Excellence (NICE), recommend that all perinatal women are provided with psychological and emotional support as well as medical care (Leahy-Warren et al., 2018).

Social support has been conceptualised at its most basic as the process by which social relationships promote health and wellbeing (Leahy-Warren et al., 2018) and as an '*exchange of resources between at least two persons, perceived by the provider*

or the recipient to be intended to enhance the well-being of the recipient' (Shumaker & Brownell, 1984, p. 11). However, since its emergence as a part of discussions around the relationship between the social and the biomedical aspects of health and wellbeing in the 1970s and1980s (Goldsmith & Albrecht, 2011; Williams et al., 2004) there has been ambiguity around its conceptualisation (Gale et al., 2018; Wachter et al., 2022; Williams et al., 2004), around ideas of the mechanisms by which it acts to improve wellbeing (Ahmadi, 2015; Battuluga et al., 2021; Cohen et al., 2000; Williams et al., 2004) and about how it should be evaluated (Hogan 2020). Despite these differences, there is agreement over certain key aspects of social support, these include recognition of the role of social relationships and interactions, in human wellbeing (Ahmadi, 2015), the understanding that social support has two key elements, the structure of relationships and networks which provide the sources of support and the content, nature and function of the support provided. Support can also include aspects that are informal, part of existing networks, and/or more formalised or 'synthetic' (Gale, 2018) taking the form of interventions designed explicitly to provide improved levels of social support for those involved (Gale et al., 2018; Leahy-Warren et al., 2018).

Over the last several decades, a considerable body of research has established the negative effects of a lack of social support on individual wellbeing and has explored the ways in which the presence of social support can positively impact psycho-social and physiological health (Gale et al., 2018; Hogan et al., 2002; Umberson & Montez, 2010; Wachter et al., 2022). In relation to mental health, social support is now widely considered to be a significant protective factor for a number of aspects of mental health (Doma et al., 2022) as well as reducing incidents of depression (Gariépy et al., 2016), supporting recovery from mental ill health (Bjørlykhaug et al., 2022), reducing stress (Acoba, 2024) and reducing isolation and loneliness, particularly amongst older people (Gable & Bedrov, 2022; Zhang & Dong, 2022). Other research has highlighted the physiological impact of social support in promoting physical wellbeing (Reblin & Uchino, 2008; Uchino et al., 2018) as well as its role in improving heath promoting behaviours and in reducing chronic pain (Gong et al., 2024). Of particular relevance to this study is research exploring social support and migrant populations including asylum seekers and refugees. This research has demonstrated how migration leads to the loss of social support and the negative

impact this has on the health and wellbeing of people who have recently migrated, and conversely, the positive impact of access to social support in the wellbeing of newly arrived populations (Doma et al., 2022; Wachter et al., 2022). Studies have suggested that higher levels of social support are associated with improved mental health for humanitarian migrants in their reception countries (Doma et al., 2022), that social support may act as a protective factor for Post-traumatic stress disorder (PTSD) (Gottvall et al., 2019) and can mitigate the effect of the poor social conditions and stresses experienced in reception countries (Sengoelge et al., 2020; Wells & Seage, 2022). Other studies noted the benefits of a range of interventions undertaken with migrant youth (Heyeres et al., 2021) as well as the positive impact of social support interventions and of informal social support networks in increasing a sense of wellbeing during resettlement (Song et al., 2024) .

2.6 Perinatal social support

Interest in the role of social support within the perinatal context emerged as part of the work of feminist academics and birth activists whose work challenged traditional ideas around motherhood and maternity. They sought to re-conceptualise birth as a biopsychosocial phenomenon rather than a purely medical one and to explore the impact of social, cultural and environmental factors on birth and women's experiences of the perinatal period, as well as challenging wider issues of medicalisation within maternity care and conceptions of motherhood (Kitzinger, 1992; Oakley, 1992; Roberts, 1981). The foundational work in this area was Oakley's work on social support and maternal outcomes (Oakley, 1985, 1988; Oakley & Rajan, 1991). In her 1988 review of social support and maternal health which considered both existing social support and support provided by targeted interventions, Oakley found that mothers with social support had improved pregnancy outcomes (Oakley, 1988). Following this review, Oakley published *Social Support and Motherhood: The natural history of a research project* which explored the interaction of the social and biological in the context of the maternal experience looking at the impact of social support provided by specific midwives on the physiological process of birth and outcomes (Oakley, 1992). These midwives provided a *'non-judgemental listening ear'* as well as discussing with women their '*their pregnancy needs … giving information when asked to and carrying out*

referrals when appropriate to other health and welfare professionals and voluntary and statutory agencies' (Oakley, 1992, p. 144). This work again suggested that women who received additional social support from these designated midwives had better psycho-social and physical health and increased use of health services than those who did not and that women were positive about having social support, particularly in terms of feeling listened to.

In the decades since Oakley's work the importance of social support in the perinatal period has been established, with social support being seen as a crucial element in maternal wellbeing (M. Al-Mutawtah et al., 2023; Battulga et al., 2021; Bedaso et al., 2021; Leahy-Warren et al., 2018). Research has explored many aspects of perinatal social support including the role and impact of women's personal and preexisting social support (Battulga et al., 2021; Bedaso et al., 2021), as well as the impact of interventions specifically designed to increase social support. The later have included interventions for example, offered by health professionals (Evans et al., 2020; Reyes et al., 2021) as well as those offered by lay, volunteer and peer supporters (Gale et al., 2018; Kenyon et al., 2016; Small et al., 2011). Research has also considered the role of social support for certain groups of women for example; LGBTQ parents (Kerppola et al., 2019; Leal et al., 2021), adolescent mothers (Huang et al., 2014), women with high risk pregnancies (Hinton et al., 2023) and first time mothers (De Sousa Machado et al., 2020; Ginja et al., 2018; Leahy-Warren et al., 2012). There has also been research into the role of social support in relation to specific areas of the perinatal period, for example antenatal care (Evans et al., 2020), breastfeeding (Chambers et al., 2023; Fallon et al., 2019; Lyons et al., 2023) and health promoting behaviours (Fathnezhad-Kazemi, 2021; Rashan et al., 2021). A lack of social support has been associated with a higher risk of poor maternal and infant health outcomes and higher levels of perinatal mental ill health (Elsenbruch et al., 2007; Paredes Mondragón et al., 2019). Conversely higher levels of social support, whether due to existing social support or the impact of interventions to increase support, have been associated with increased maternal wellbeing and improved maternal and infant outcomes (M. Al-Mutawtah et al., 2023; Battulga et al., 2021; Bedaso et al., 2021; Leahy-Warren et al., 2018). Social support has been proved to act as a protective factor in perinatal mental ill-health by reducing isolation, increasing social connection and reducing incidences of depression and anxiety and

stress thereby improving the overall psycho-social wellbeing of women, supporting their physical health and that of their infants (M. Al-Mutawtah et al., 2023; Bedaso et al., 2021; Kay et al., 2024; Sufredini et al., 2022).

A number of papers have reported on interventions designed to increase the social support available to socially and economically marginalised women who lack existing social support and were at increased risk of poor psychosocial wellbeing and maternal outcomes. The results of these studies suggest that increased social support in the form of lay pregnancy outreach workers (Gale et al., 2018; Kenyon et al., 2016), volunteer trained peer supporters (McLeish & Redshaw, 2015; McLeish & Redshaw, 2017; McLeish & Redshaw, 2021) and specialist midwives and volunteer support (Balaam & Thomson, 2018; Thomson et al., 2017), improved perinatal wellbeing. The research suggested that this support helped women overcome some of the challenges they face, increase health promoting behaviours and support access to care by making them feel emotionally supported and less isolated, increasing their confidence and self-efficacy (Balaam & Thomson, 2018; Gale et al., 2018; Kenyon et al., 2016; McLeish & Redshaw, 2015; McLeish & Redshaw, 2017; McLeish & Redshaw, 2021; Thomson et al., 2017).

While evidence suggests that increased perinatal social support is beneficial for marginalised women who may experience low levels of social support, there has been little work which focuses specifically on social support for asylum seeking and refugee women and its potential to improve their wellbeing and maternal outcomes. Several recent studies looking at the wellbeing of refugee and migrant mothers highlighted the range of factors which put their physical and mental wellbeing at risk as well as identifying the reduction of social support which occurred with migration (Abi Zeid Daou, 2022; Hawkins et al., 2021; Stevenson et al., 2024; Vollrath et al., 2021). Recent international reviews identified that there were a limited number of social support interventions tailored to address the specific needs of refugee women, particularly their high risk of poor mental health (Abi Zeid Daou, 2022; Hawkins et al., 2021). The need for increased social support for this group of women was noted and the key aspects of support which were useful in this context were identified. These included free access to maternity care for migrant women, the creation of safe spaces for women to meet and access support, addressing the need for linguistic

support, the support and promotion of effective liaison between women and agencies, the provision of advocacy and the facilitation of community building to support the creation of informal sources of support. It was felt that these aspects of support were important, supporting women to integrate and adapt to life in the reception country, improving wellbeing by acting as protective factors in women's mental health, reducing social isolation and increasing access to healthcare (Abi Zeid Daou, 2022; Hawkins et al., 2021; Stevenson et al., 2024; Vollrath et al., 2021). It was also noted that the quality of research evidence in this field was limited, and further evaluation of interventions and more research was needed, particularly work which sought to locate migrant women at the centre of evaluations and intervention design (Stevenson et al., 2024).

In the UK, while research has identified the negative impact of limited social support on asylum seeking and refugee women's perinatal wellbeing (Arrowsmith et al., 2022; McKnight et al., 2019; Rowe et al., 2023) and the benefit of social support for other marginalised women (McLeish & Redshaw, 2021; Thomson et al., 2017) there has been limited work considering this area in depth. Work that has been published reports on relatively small scale, local, social support interventions which provide for example, befriending (McCarthy & Haith-Cooper, 2013), a specialist midwifery service (Filby, 2020) and a community based mental health group intervention (O'Shaughnessy et al., 2012). All of these studies found that increased social support was beneficial to women's perinatal wellbeing in terms of improving knowledge about and access to healthcare provision and other sources of support, reducing social isolation and increasing a sense of social connection, improved knowledge about mothering, improved mother-baby relationship and increased self-confidence (Filby, 2020; McCarthy & Haith-Cooper, 2013; O'Shaughnessy et al., 2012). This suggests that increasing the social support available to asylum seeking and refugee women may be a way of addressing some of the challenges they face in the perinatal period, however it also shows the lack of detailed work on this area. It is this gap in knowledge that is the focus of this study.

2.7 Conceptualising social support for this research

In the light of the various definitions of social support available to researchers, it was important for me to think about how I wanted to conceptualise the idea within this study in a way which would maximise my opportunity to explore asylum seeking and refugee women's experiences of social support from their perspective. I wanted to think about social support in the widest sense both in terms of the nature of the support, as well as the relationships which provide the support, while keeping women's experiences at the centre of the research.

As alluded to earlier it is helpful to think about social support in this context as being made up of two related aspects, structural and functional (Gale et al., 2018). The structural aspect is linked to the extent and nature of people and relationships that make up an individual's social networks and by exploring this it is possible to see who provides support and in what context. In this study I wanted to explore this aspect of social support in the broadest sense. I wanted to include personal, informal and ad hoc sources of support and relationships women may have with family members, volunteers, individuals from different communities and peers, in addition to the support offered within more professional or formal settings by HCPs and trained volunteers.

The other aspect of support considered is the nature or content of the support provided within relationships of support, what is commonly called the functional aspect of support, whether within formalised interventions or more personal or informal situations. This aspect of social support has been seen as taking various forms, and is commonly characterised as emotional, appraisal, instrumental and informational support (Gale et al., 2018; House, 1981; Langford et al., 1997) (Table 2.1). This characterisation can provide a way of exploring this functional aspect of social support to see what specific elements of support are available, valued and useful and so these ideas have been used to inform aspects of this study.

Emotional support	The provision of support as care, being cared for, receiving or feeling love, trust and empathy for example attentive listening, being responsive

Appraisal support	Communication about self-evaluation, giving feedback, encouragement and support to bolster confidence and self-esteem
Instrumental support	The provision of practical and tangible support including finance and material goods as well as practical support such as letter writing, form filling, researching
Informational support	The provision of information about services, rights including signposting to sources of help, help navigating systems and providing direct information about relevant issues

Table 2.1 Characteristics of social support

My exploration of the perinatal social support experiences of asylum seeking and refugee women follows the qualitative contextual approach advocated by Williams et al. (2004) by seeking to understand social support as being located within the context of a particular population and for a particular individual. In this sense social support is what the individual within their own context and cultural location perceives to be support (Wachter et al., 2022; Williams et al., 2004). This fits with the idea that social support is culturally and contextually specific and needs to be understood in its context by those involved as it relates to their understanding of support and their perceptions of their needs (Döring, 2019; Kim, 2008; Wachter et al., 2022). This approach also reflects my feminist-informed social constructionist approach by seeing knowledge as socially constructed from the perspective of those experiencing a phenomena and by locating women's knowledge and perceptions as a source of authoritative knowledge. I am more interested in asylum seeking and refugee women's perceptions and experiences of support, than in an evaluation of the amount or nature of support provided.

Using this approach allows me to explore in more depth the way in which those receiving support perceive it on a personal level, in the sense of how individuals internalise or feel the sense of support or care resulting from the provision of social support, described by Cobb as a ' *belief that one is loved, valued and cared for as a member of a network of mutual obligations'* (Cobb, 1976 p. 300). Using this approach allows me to explore with the women who participated what they considered to be social support and what they perceive to be valuable to them from their specific location and their understanding of their needs and experiences.

2.8 Conclusion

This chapter has provided the background to and context for the thesis and provided evidence of the need for this research by exploring the nature of the challenges faced by perinatal asylum seeking and refugee women within the global and UK context. It has provided a rationale for the thesis's focus on social support as a way of addressing some of the challenges experienced by asylum seeking and refugee women and outlined the ideas of social support which underpin the thesis. This chapter has suggested that social support may be a way of addressing some of the challenges asylum seeking and refugee women currently face in the perinatal period, while also identifying the lack of detailed work on this area. To explore this issue further the next chapter provides a literature review in the form of a critical interpretative synthesis which considers the existing research on social support interventions offered to asylum seeking and refugee women in a European context and the impact of these on their perinatal experiences and wellbeing.

CHAPTER 3 LITERATURE REVIEW

3.1 Introduction

In the previous chapter I detailed the background to and context for the thesis and provided evidence of the need for this research by exploring the nature of the challenges faced by perinatal asylum seeking and refugee women within the global and UK context. I concluded the chapter by suggesting that increasing social support available to asylum seeking and refugee women may be a way of addressing some of the challenges they currently face in the perinatal period. I also identified a lack of research in this area. This chapter presents a literature review exploring the research on social support interventions offered to asylum seeking and refugee women in a European context and the impact of these on their perinatal experiences and wellbeing. The chapter details the choice of method used and the process of undertaking the review. It then presents an interpretation of the findings and concludes by identifying my research questions for the empirical part of the thesis.

3.2 Critical Interpretive Synthesis (CIS)

This review of literature took the form of a Critical Interpretive Synthesis (CIS), a systematic method for reviewing literature developed by Dixon-Woods et al. (2006). While having commonalities with, and building upon aspects of, existing review designs (systematic review and meta-ethnography) (Depraetere et al., 2021), CIS has some distinctive features which make it particularly suited for use in this study. A CIS approach supports the inclusion of a broad range of literature including qualitative and quantitative studies, peer reviewed and grey literature and literature from different methodological and disciplinary perspectives (Depraetere et al., 2021; Dixon-Woods et al., 2006; Salmon et al., 2017; Wilson et al., 2014). This was important in this study as literature relating to social support interventions for asylum seekers and refugees encompasses a range of methodological approaches and disciplinary areas for example, midwifery and public health, and previous knowledge suggested that relevant material was likely to be found in grey literature in addition to peer reviewed publications. A CIS acknowledges the complex, interpretative and iterative nature of research. Starting with a relatively broad review focus or

questions, which can be adapted as the review progresses if necessary, it supports a process which is organic and reflexive, allowing the reviewer to be responsive to the material found which again is appropriate when exploring material from a range of contexts and sources (Dixon-Woods 2006).

CIS has a '*critical orientation*' (Depraetere et al., 2021, p. 670) which is applied throughout all aspects of the review. This approach encourages the reviewer to critique the literature under review, making the literature itself an '*object of scrutiny'* (Dixon-Wood 2006 p 2) by looking at it within the context of its production and location within the wider field of research. This critical approach is valuable in the context of this study, as an understanding of the context, temporal, ideological and disciplinary, in which knowledge about such a politicised topic as migration is produced is crucial to allow a fuller understanding of the issues explored. Linked to this critical and interpretative orientation, reflexivity is identified as another important aspect of a CIS, which differs to some other review designs. CIS sees reflexivity as integral to the process of review supporting the researcher to explore their relationship to their research content and process (Salmon et al. 2017). There is an explicit acknowledgement of, the partiality of any account of evidence, the role of the author in the review and the importance of intuition and tacit knowledge within the review process (Chalmiers et al., 2022; Dixon-Woods, 2012). In this review I was aware that I brought existing knowledge of the subject to the review and sought to explore the possible impact of this, through personal reflection and in discussion with my supervisory team.

Differing from some other review approaches, quality appraisal within CIS is based on the content of the paper and its relevance to the review rather than formal methodological quality (Depraetere et al., 2021; Dixon-Woods, 2012; Dixon-Woods et al., 2006; Salmon et al., 2017). This principle guided the quality appraisal in this review (see quality appraisal section) This method was particularly appropriate for this study as a number of included studies took the form of grey literature, where the format of reporting is not always aligned to quality appraisal tools used in the appraisal of peer reviewed literature. In this review, while focusing on relevance I still wanted to have some appraisal of the rigour and quality of the literature used, not to exclude any studies but to help me consider the strengths and weaknesses of the literature both individually and overall.

A CIS goes beyond the aggregation of data from existent studies to allow the development of concepts and theory generation. It aims to produce, through the integration and synthesis of evidence from a wide range of sources and a critical consideration of the literature, a coherent theoretical framework and new understandings of the phenomena under consideration (Dixon-Woods, 2012; Wilson et al., 2014). Drawing on the principles developed to support researchers undertaking CIS reviews (Depraetere et al., 2021; Dixon-Woods, 2012; Dixon-Woods et al., 2006), I followed the key aspects of the CIS method they identify. These were: formulating the review question(s), undertaking the search, sampling, determination of quality, data extraction and analysis and reflexivity and are explored below.

3.3 Methods

3.3.1 Formulate the research questions

Following the findings of the background chapter suggesting that increasing the social support available to asylum seeking and refugee women may be a way of addressing some of the challenges they face in the perinatal period, the questions to guide this review were developed. The focus on Europe was chosen to reflect a similarity of previous colonial histories, recent experiences of migration and similar approaches to health and social care services which would allow a consideration of a range of interventions, beyond the UK, while still allowing for some degree of similarity in context. The review question relating to the social context of the interventions was included to help me locate social support and health and social care with its wider societal context. The questions were as follows:

- What social support interventions have been or are currently offered to asylum seeking and refugee women in Europe in the perinatal period?
- How are these interventions located within the wider socio-cultural-political position of asylum seekers and refugees in these countries and their maternity care settings?
- What is the impact of these interventions on the wellbeing of asylum seeking and refugee women?

3.3.2 Literature searches

In a CIS review the search strategy characteristically has two stages; a systematic review of literature and a more purposive and focused search as the review progresses (Salmon et al., 2017). Following this approach, I found that in this review most of the studies were found in the first phase, with the more focused search used to confirm the findings and allow further clarification. The search strategy used for this study included a systematic literature search of electronic databases (set to include both peer and grey literature) and then a more specific grey literature search. Grey literature was included in this review as it is a valuable source of information on issues related to public health and because many reports related to this area of study will not be included in peer reviewed bibliographic databases as they have been produced as evaluation of specific small scale interventions rather than as published research studies (Adams et al., 2016; Godin et al., 2015; Paez, 2017).

1. A Systematic literature search of electronic databases

Eight electronic bibliographic health and social science databases were searched in May 2018, this search was then updated in October 2020. The databases included in the search were: EMBASE, Public Health Database, Social Science Citation Index, Social work Abstracts, Maternal and Infant Health, Academic Search Complete, CINHAL, Medline. These were chosen as they provided access to a broad range of health and social science literature, allowing me to take an inclusive approach to possible literature. In my previous research I identified that the terminology around migrant women within healthcare literature can be imprecise and that a range of generalised terms are used which can include women in a range of migrant situations, including those who are refugees or seeking asylum (Balaam et al., 2017). To address this, in addition to the key terms, asylum seeking and refugee, the search terms for this review also included: migrant, immigrant, undocumented, irregular migrants, asylum seekers, transient, refugee, foreign, illegal, alien (Table 3.1). As part of the screening process any literature recovered was then screened to ascertain if asylum seeking and refugee women were included within these broader terms, studies were excluded if they were not. In addition to electronic searches other searching techniques were employed, including hand searching techniques (i.e., reference mining -searching the reference lists of articles) and back and forward citation searches.

Search terms				
Migrant OR immigrant OR undocumented OR irregular OR asylum seekers OR transient OR refugee OR foreign OR alien, emigrant OR illegal OR ethnic minority OR BME OR trafficked OR incomer OR stateless OR newcomer	AND	Social support OR social support intervention OR psychosocial support OR peer support OR befriending OR doula OR emotional support OR informational support OR practical support OR telephone support OR social networks OR social connection OR additional support	AND	Woman OR Perinatal OR Antepartum OR antenatal OR prenatal OR Postpartum OR postnatal OR Pregnancy OR expectant mothers OR maternal and child health OR childbirth OR labour

Table 3.1 Search terms

2. Grey literature search

The definition of grey literature used in this study was from the Prague definition of 2010 (Schöpfel, 2010). The search excluded ‘grey data ‘or ‘grey information’ (Adams et al., 2016) and followed the approach used by Higginbottom et al. (2017) to identify the most relevant types of grey literature to include. The search was initially undertaken in spring 2018 and then updated in October 2020. The grey literature search strategy included four elements commonly recommend when using grey literature (Adams et al., 2016). These were a search of specific grey literature databases, a search of the websites of relevant organisations, a Google search and contacts with relevant experts asking them for any relevant studies.

a) Grey literature databases

Following consultation with an information specialist five specific grey literature databases were selected as the most appropriate for the topic area, these included, OpenGrey, BASE-Open access resources, the North Grey Literature Collection, Social Care Online and Ethos. These generally had a much lower level of functionality than more standard electronic bibliographic databases, so the search strategy was adapted and simplified to maximise consistency as far as possible

while responding to the individual nature and functionality of the different resources (Stansfield et al., 2016), as identified in Table 3.2 below.

Grey literature data base	Search	Search terms used
OpenGrey	Very simple search, no advanced search possible all you can do is combine key words in one search window, cannot show search history. Chose to combine broad key terms with OR & AND to include largest possible range of documents.	key words used – identified as words which would catch a wide range of results (umbrella terms) Migrant OR asylum OR refugee OR ethnic minority AND social support OR intervention OR psychosocial or peer support AND maternity OR pregnancy OR perinatal
BASE-Open access resources	Basic search, called advanced but doesn't let you have different rows for the search, just one row. You can save searches, but you cannot combine them in a more sophisticated way. Used combination of key words using OR & AND. Limited only for language.	Migrant OR asylum OR refugee OR ethnic minority AND social support or intervention OR psychosocial OR peer support AND maternity OR pregnancy OR perinatal
The North Grey Literature Collection	Very simple search only, no advanced search, no search history. Only possible to search by keyword, subject or title, therefore combined the key terms with OR & AND.	Migrant OR asylum OR refugee OR ethnic minority AND social support OR intervention OR psychosocial OR peer support AND maternity OR pregnancy OR perinatal
Social care online	The system allows an advanced search & combining search facility – therefore followed same approach as other academic data bases 'all fields search '– no limiters possible/applied	Followed procedure used in academic databases

Ethos	The system allows an 'Advanced search', but this only allows combining key terms not combining searches.	Migrant or asylum or refugee or ethnic minority AND social support or intervention or psychosocial or peer support AND maternity or pregnancy or perinatal

Table 3.2 Grey literature database search

b) Websites of relevant organisations

A focused internet search of websites of relevant organisations supporting or working with migrant women in the context of maternity was undertaken following the approach used by other researchers using grey literature (Godin et al., 2015). This was done to ascertain if there was relevant material which was published on the websites of key organisations who work with this population which was not available from other sources. The websites were identified through my prior knowledge of the area, expert recommendations, and references in searched literature (Table 3.3).

NCT	https://www.nct.org.uk/
Refugee Council	https://www.refugeecouncil.org.uk/
City of Sanctuary	https://cityofsanctuary.org/
Maternity Action	https://www.maternityaction.org.uk/
Birth Companions	https://www.birthcompanions.org.uk/
ORAMMA	https://oramma.eu/
Resources for professionals who support AS&R online hub	https://www.ljmu.ac.uk/microsites/resources-for-professionals-who-support-asylum-seekers-and-refugees
Gynécologie Sans Frontières	https://gynsf.org/
Infant feeding support for refugee children	http://safelyfed.org/home/

Table 3.3 Website Search

c) Google/Web search

An internet search, using Google search, was undertaken as this was likely to provide information on smaller and more localised initiatives. The search was undertaken in the Google search advanced search setting on 06/04/2018 and updated on 14/10/2000 using the following terms: Migrant OR asylum OR refugee OR ethnic minority AND social support OR intervention OR psychosocial OR peer support AND maternity OR pregnancy OR perinatal in the 'all of these words' setting and limiting only to English language. The results were followed up for 20 pages by which time there were no new responses. The results of the search took the form of either (1) references to websites relevant to the topic, these were then explored to see if they had relevant papers or references to further sites of relevance or (2) documents of relevance to the search question, these were recorded and downloaded for screening.

d) Contacts with experts

At the outset of the review, I used contacts from an existing international network of maternal health researchers with nearly 200 members (COST Association, 2024) and a post on JISC mail to gain information relevant to my research questions. All responses were followed up, but these did not provide any material that met my grey literature criteria (Appendix 1).

3.3.3 Sampling

In line with a CIS approach, the inclusion and exclusion criteria used in the review were purposefully wide to support the inclusion of a wide range of experiences and phenomena (Entwistle et al., 2012). This approach therefore supported the inclusion of papers which presented primary research (qualitative, quantitative or mixed method) and focused on social support interventions for asylum seeking and/or refugee women based in Europe. Papers could be peer reviewed or grey literature, and no time limitation was used to allow for the widest possible range of papers. Papers had to be written in English however due to limitations with translation opportunities. Papers were excluded if they did not present primary research, were not focused on perinatal social support interventions, did not include the experiences of asylum seeking and refugee women, were not based in Europe and were not written in English (Table 3.4 Inclusion and exclusion criteria).

Inclusion	Exclusion
Research on women who are part of the immigration system as asylum seeking and refugee women (see background chapter). However, to access papers which evaluate interventions which include asylum seeking and refugee women the search initially used a range of terms to identify possibly relevant papers. These papers were then reviewed to determine if they included women who could be identified in some way as being asylum seekers or refugees.	Do not include any asylum seeking or refugee women
Focusing on perinatal social support interventions for asylum seeking and refugee women.	Social support interventions offered but not in the perinatal period and/or did not include some asylum seeking and refugee women.
European, defined as the WHO European region (53 countries http://www.euro.who.int/en/about-us)	Not in the WHO European region
Published in English	Not in English
Primary research including qualitative, quantitative & mixed methods approaches	Protocols, reviews or reports with no empirical or evaluation data
Peer reviewed academic literature and grey literature which meets to criteria identified above	Grey literature that does not meet the criteria identified above
Any date of publication to allow broadest scope and to allow a sense of historical development over time	None

Table 3.4 Inclusion & Exclusion criteria

3.3.4 Summary of included studies

Sixteen studies, seven qualitative, six mixed method and three quantitative were included in total. 14 from the initial search and two additional studies from the updated search. In total nine were identified from the electronic bibliographic database searches, one from reference mining, six from the grey literature searches (three grey database, two Google search and one website search) for more detail see the PRISMA diagram below (Figure 3.1).

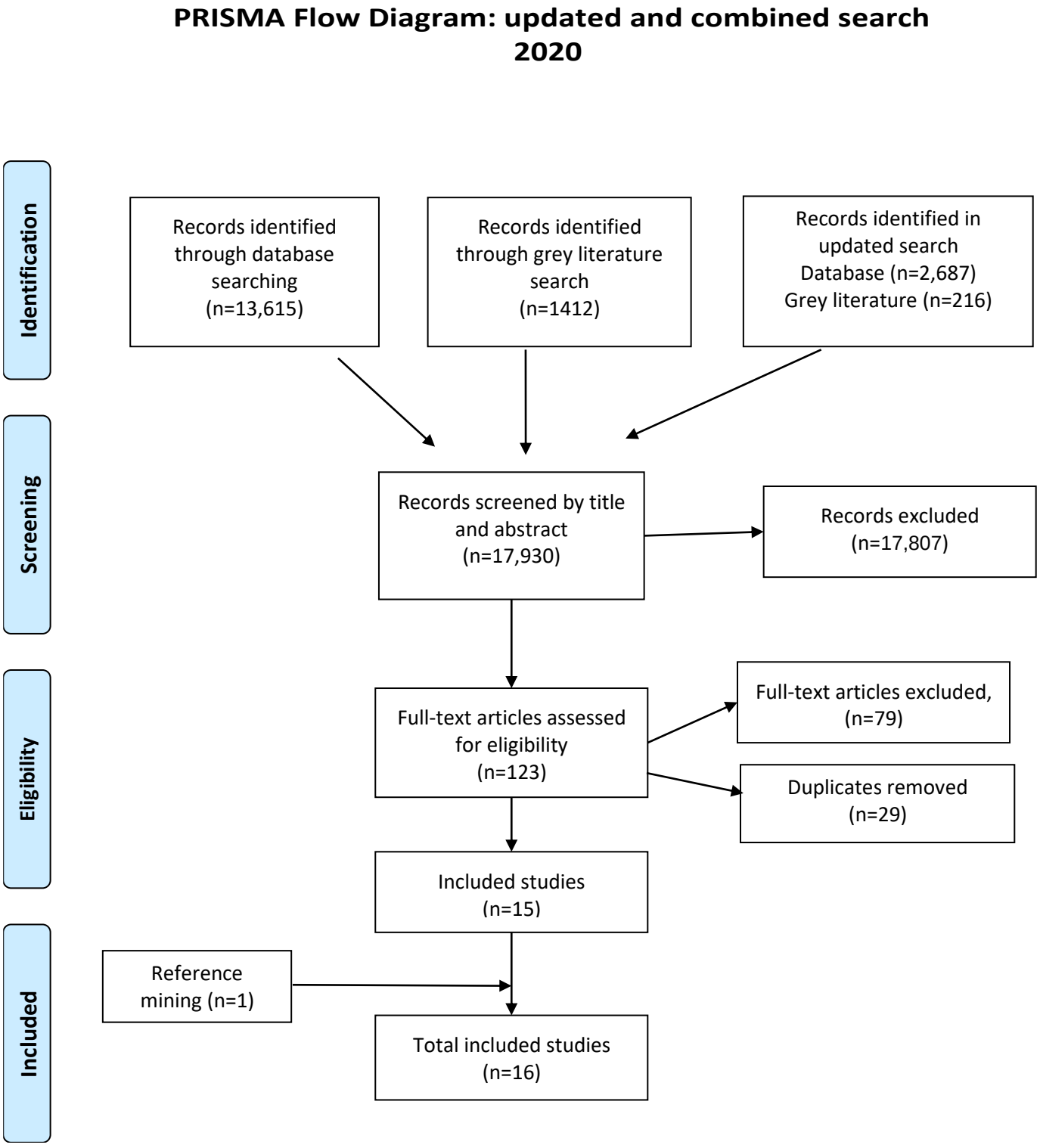

Figure 3.1 PRISMA diagram

3.3.5 Quality assessment

To undertake quality assessment I employed the quality appraisal scale proposed by Salmon et al. (2017) as this scale has been designed to be used in a CIS review. It supports the evaluation of key areas including sampling, data collection and analysis

and can be applied to qualitative, quantitative, and grey literature. This meant that I could use a single tool to appraise all the literature rather than multiple tools, reducing the need for later integration or comparison. All selected literature was reviewed using this scale and given a grade from 0-10 (Table 3.5).

Article	1 Question	2 Theoretical perspective:	3 Study design	4 Context	sampling	data collection	data analysis	reflexivity	generalisability	ethics	numerical score
	Is the research question clear?	Is the theoretical perspective of the author explicit & has this influenced the study design, methods or research findings	Is the study design appropriate to answer the question?	Is the context or setting adequately described?	Is the sample adequate to explore the range of subjects and settings & has it been drawn from an appropriate population? (Quantitative) Is the sample size adequate for the analysis used & has it been drawn from an appropriate population?	Was the data collection adequately described & rigorously conducted to ensure confidence in the findings?	Was there evidence that the data analysis was rigorously conducted to ensure confidence in the findings?	Are the findings substantiated by the data & has consideration been given to any limitations of the methods or data that may have affected the results?	Do any claims to generalisability follow logically, theoretically & statistically from the data?	Have ethical issues been addressed and confidentiality respected?	
Essential or Desirable	E	D	E	E	E	E	D	D	D	D	
Parsons & Day, 1992	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	9
Rocheron, 1990	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	8
Ahmed, 2006	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	9
Karl-Trummer, 2006	No	No	Yes	Yes	No	No	No	No	Yes	No	3
Lederer, 2009	Yes	No	Yes	Yes	Yes	Yes	No	No	No	No	5
Akhavan & Lundgren, 2011	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	9
Hesselink, 2011	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	8
Akhavan & Edge, 2012	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	9

Hesselink, 2012	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	9
O'Shaughnessy, 2012	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	10
McCarthy & Haith-Cooper, 2013	Yes	No	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	8
Bhavnani & Newburn, 2014	Yes	No	Yes	yes	Yes	Yes	No	Yes	Yes	No	7
Brookes & Coster, 2015	Yes	No	Yes	Yes	Yes	No	No	Yes	Yes	Yes	7
Peters, 2017	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	yes	Yes	9
Sioti et al., 2019	Yes	No	Yes	Yes	Yes	Yes	No	No	Yes	Yes	7
Haugaard, Tvedte, Severinsen & Henriksen, 2020	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	9

Table 3.5 Quality assessment

3.3.6 Data extraction

To facilitate data management and data extraction an Excel workbook was used following a version developed by Kingdon et al. (2018). This was to allow me to efficiently manage the data and to increase the transparency of the process for myself and to support my discussion of the process and my thinking with my supervisors. This format was piloted on a small number of studies to ensure that the format was appropriate for this study. The selected studies were read in depth and data extracted from them and recorded in the workbook. This included details on the nature of the intervention, the rationale behind the intervention, the target population, who did the intervention, who funded it, the reported outcomes and key aspects of the studies identified. This process was discussed with and checked by my supervisors at each of these stages to support rigor and to mitigate against potential biases and pre-existing assumptions that I brought into the analysis.

3.3.7 Data analysis

The interventions detailed in the selected studies were analysed to address the three key research questions detailed earlier: to identify the type of support offered in the perinatal period and the context in which it was offered and to identify the impact of the interventions on women's experiences. Analysis of the qualitative data involved a detailed reading of all included studies to allow for familiarisation and identification of themes. A process of constant comparison and an on-going exploration of constructs developed from original ideas in the papers as well as new synthetic constructs was used. Codes were developed and then refined and revisited in an iterative process, these were then applied to the data to identify patterns within the studies and explore commonalities and differences. These codes were then developed into themes to make sense of the data (Table 3.7). Quantitative data were summarised in a descriptive narrative way by summarising and interpreting numerical data to reveal patterns and insight into characteristics of the studies There are no clear or widely used quantitative outcomes routinely measured in terms of measuring the impact of

social support in this area so there are no common or directly comparable outcome data. Along with an ongoing critique of the nature of the literature as well as its content, new themes and original constructions in the papers were integrated into a theoretical framework bringing in wider literature and theories relevant to the topic to support the interpretative synthesis. All stages of this process were discussed with supervisors to support rigor and transparency.

Codes	Themes
Confidentiality	*It's only in this group you can ask*: Safety & Trust
Feeling of safety	
Safe spaces	
Trust	
Trusting relationships	
Who provides care	
Role or status of supporter (professional or peer)	
Personal qualities of supporter	
Supporters own experience	
Gained new knowledge/information about maternity issues	Practical knowledge and Learning
Practical help with daily needs	
Gained knowledge of support and other services	
Knowledge of cultural differences in childcare/ relationships/practises	
Mutual learning	
Knowledge of nature of women's needs and need to change & tailor interventions	
Learning that women's basic needs were not currently met	
Feeling *'Gharib'* - alone, a stranger, outsider	*Gharib:* Alleviation of being alone
Social isolation/loneliness	
Fear/anxiety/worry/stress	
Communication challenges	
Shared experiences	
Together not alone - group relationships	
Shared culture	
Impact of acculturation/time in country	
Lack of knowledge about country	
Someone to talk to	Being cared for and emotional support

Feeling cared for	
Being listened to	
Reassurance	
Being understood	
Expressing their feelings	
Continuity	
Ability to speak out in some settings	*I can do anything now*: increased confidence in and beyond the intervention
Increased confidence in own ability (as parent) as individual	
Motivation/empowerment	
Self-esteem	
Relationship between mother & baby	
Positive impact on volunteers	
Links with the wider community	
Clients become befrienders	

Table 3.6 Themes and associated codes

3.4 Review findings

The selected studies were published between 1992 and 2020 in the UK (n=8), Italy/Austria (n=1), Netherlands (n=3), Norway (n=1), Sweden (n=2) and one multi-site intervention (UK, Netherlands, Greece) (n=1) and included both peer reviewed and grey literature. The selected studies seven qualitative studies (Akhavan & Edge, 2012; Akhavan & Lundgren, 2011; Brookes & Coster, 2015; Haugaard et al., 2020; Hesselink & Harting, 2011; Karl-Trummer et al., 2006; McCarthy & Haith-Cooper, 2013), six were mixed methods studies (Ahmed. S et al., 2006; Bhavnani & Newburn, 2014; Lederer, 2009; O'Shaughnessy et al., 2012; Rocheron & Dickinson, 1990; Sioti et al., 2019) and three quantitative studies (Hesselink et al., 2012; Parsons & Day, 1992; Peters et al., 2017). The studies took place at various times in the perinatal period. Six interventions took place only in the antenatal period and two only in the postnatal period. Five interventions offered support both antenatally and postnatally but not during the intrapartum period and three interventions offered support throughout the whole perinatal period including intrapartum. The study populations ranged in size from 10 to 4000 participants. Table 3.7 below provides a summary of included study characteristics and quality assessment.

Author and date	Country	Period	Characteristics of participants	Number in intervention	Number in study	Method	Quality Assessment (1-10)
Rocheron Y, Dickinson R, 1990	UK	Antenatal	Asian women	16 District health authorities (DHA)	Women in 3 DHAs who had/had not had link workers total =100	Mixed methods	8
Parsons L, Day S, 1992	UK	Antenatal	Non-English-speaking women	Total 4000, 1000 in intervention, 3000 in 3 control groups	Total 4000, 1000 in intervention, 3000 in 3 control groups	Quantitative; Retrospective study	9
Ahmed S et al., 2006	UK	Postnatal	Women with English as second language (Bangladeshi women)	194 supported in total, 80 by support worker alone	15 women	Mixed methods; questionnaires and interviews	9
Karl-Trummer U et al., 2006	Italy & Austria	Antenatal	Migrant/ethnic minority; Turkish, Indian & Pakistani women	Women 29 Austria, 12 Italy	Women 29 Austria, 12 Italy Staff 27 Italy, 5 Austria	Qualitative Interviews	3
Lederer J, 2009	UK	Antenatal, Postnatal	Socially excluded women - including asylum-seeking & refugee	46 women, 19 befrienders	15 women, 11 befrienders	Mixed methods; questionnaires, surveys & interviews	5
Akhavan S, Lundgren L, 2011	Sweden	Antenatal, Intrapartum, Postnatal	Immigrant women	25 midwives	10 midwives	Qualitative; semi structured interviews	9
Hesselink A E, Harting J, 2011	Netherlands	Antenatal	1st & 2nd generation Turkish women	119 women	119 women	Qualitative; process evaluation	9
Akhavan S, Edge D, 2012	Sweden	Antenatal, Intrapartum, Postnatal	Foreign born Non-European women	32 women	10 women	Qualitative; semi structured interviews	9
Hesselink A E, et al., 2012	Netherlands	Antenatal	1st & 2nd generation Turkish women	119 in intervention, 120 in control	119 in intervention, 120 in control	Quantitative; non-randomised trail	8
O'Shaughnessy R, et al., 2012	UK	Postnatal	West African refugee & asylum-seeking women	unclear	57 women	Mixed methods; Participatory Action research	10
McCarthy R, Haith-Cooper M, 2013	UK	Antenatal, Postnatal	Asylum-seeking & refugee women	51 befrienders, 83 clients	51 befrienders, 83 clients	Qualitative; questionnaires, focus groups and interviews	8
Bhavnani V, Newburn M, 2014	UK	Antenatal, Postnatal	4 groups of women considered vulnerable/excluded communities, one of these groups was asylum-seeking & refugee women	Total volunteers = 299 volunteers in asylum-seeking & refugee groups= 65 Total women supported = 364 Asylum seeking & refugee women supported= 73	Total of 120 stakeholders in study Asylum-seeking & refugee women in study: 10 pre intervention questionnaire, 4 post intervention questionnaire, 5 interviews	Mixed methods; questionnaires, focus groups & interviews	7

Brookes H, Coster D, 2015	UK	Antenatal, Postnatal	Disadvantaged minority ethnic women including refugee and asylum-seeking women	Not given	14 parents (11 mums, 3 dads)	Qualitative: Semi-structured face-to-face interviews	7
Peters I A, et al., 2017	Netherlands	Antenatal	Turkish & Moroccan women	262 women in control & 117 in intervention group	262 women in control & 117 in intervention group	Quantitative	9
Sioti E et al., 2019	Greece, UK, Netherlands	Antenatal, Postnatal	Migrant, Asylum-seeking and Refugee women (MAR)	Greece: Healthcare professionals (HCP)= 8, Maternity Peer support (MPS)=6, women=13 UK: HCP=12, MPS=14, MAR=7, Netherlands: HCP=5, MPS=10, MAR=12	Greece: Healthcare professionals (HCP)= 8, Maternity Peer support (MPS)=4, MAR=13 UK: HCP=12, MPS=14, MAR=7, Netherlands: HCP=5, MPS=10, MAR=12	Mixed methods; demographic & outcome data, Qualitative semi structured interviews & focus groups	7
Haugaard A. et al., 2020	Norway	Antenatal, Intrapartum, Postnatal	Newly arrived non-western migrant women	11 multicultural doulas	9 multicultural doulas	Qualitative; semi structured interviews	9

Table 3.7 Summary of included study characteristics and quality assessment

The findings related to the first two review questions relating to the type of support offered and its context is discussed first in the section, type, timing and context of social support in the perinatal period. The findings relating to the final review question addressing the impact of interventions on the wellbeing of asylum seeking and refugee women are then presented.

3.4.1 Type, timing and context of social support in the perinatal period

The use of a CIS approach allowed the identification of similarities in the type of social support offered by the interventions and in the underlying rationale and thinking behind this support. This led to the categorisation of the interventions into four categories; (1) educational, (2) community befriending/ peer support, (3) community doula and (4) paraprofessional support. Table 3.8 provides a summary of all the included interventions, grouped according to these four categories. These are described in more depth below.

1. Educational interventions

Four of the interventions, reported in five papers (Brookes & Coster, 2015; Hesselink & Harting, 2011; Hesselink et al., 2012; Karl-Trummer et al., 2006; Peters et al., 2017), were characterised as educational as they all provided different forms of educational interventions in the perinatal period. One intervention, based in the Netherlands (Peters et al., 2017), developed culturally appropriate educational films to address concerns about poor uptake of prenatal screening. This intervention effectively increased the knowledge and uptake of screening amongst women within the intervention. Two other interventions, presented in three papers (Hesselink & Harting, 2011; Hesselink et al., 2012; Karl-Trummer et al., 2006), provided antenatal education targeted at specific groups of women. These groups were identified as being at risk of not accessing prenatal care (Karl-Trummer et al., 2006) or of engaging in unhealthy lifestyle or parenting behaviours (Hesse-Bibber & Piatelli, 2012; Hesselink & Harting, 2011; Hesselink et al., 2012). These interventions were identified as effectively providing culturally appropriate educational programmes, although Karl-Trummer reported there were still low levels of attendance. The fourth

intervention, the UK based Baby Steps programme (Brookes & Coster, 2015), provided perinatal education for parents from '*particularly disadvantaged or isolated minority ethnic communities including those who are recent migrants, asylum seekers or refugees'* (Brookes & Coster, 2015, p. 10). It sought to promote good parenting and was framed in positive terms of providing support and building capacity and resilience. It identified parents as '*disadvantaged*' or '*vulnerable*' but did not, in contrast to the other approaches, discuss issues of risk, or potential or actual poor outcomes. It was based on the idea of capacity building to support parents to manage a potentially challenging time in contrast to the other interventions which sought to promote specific behavioural changes to address behaviours deemed to be negative. The study reported that the intervention effectively provided relevant and useful information about maternity care, parenting practices and relationships to the groups targeted.

2. Community befriending/peer support

Four interventions (Bhavnani & Newburn, 2014; Lederer, 2009; McCarthy & Haith-Cooper, 2013; O'Shaughnessy et al., 2012) provided support that was categorised as community-based befriending/peer support. Based in specific locations in the UK these interventions addressed the needs of local communities using resources located within those communities. Developed and run by non-statutory or voluntary agencies, they relied on trained local community-based volunteers who commonly shared a background with the women they supported. In these interventions befrienders worked with women who were refugees or seeking asylum in community settings and/or in their homes on a one to one basis supporting them to deal with some of the challenges they face in the perinatal period. One intervention, located at sites in three countries (UK, Greece, Netherlands), provided volunteer maternity peer supporters from within the migrant communities they served as part of a wider multidisciplinary project (Sioti et al., 2019). One intervention Sweet Mother (O'Shaughnessy et al., 2012), included some professional psychological support along with the befriending/peer support model.

3. Community doula support

Two interventions, detailed in three papers (Akhavan & Edge, 2012; Akhavan & Lundgren, 2011; Haugaard et al., 2020), can be characterised as community doula support. These interventions, one based in Sweden (Akhavan & Edge, 2012;

Akhavan & Lundgren, 2011) and one based in Norway (Haugaard et al., 2020), like the befriending and peer support initiatives detailed above, were located in the communities they serve but differed from them in the specific aspects of the support offered. Rather than more generalised support offered by befrienders, these interventions, trained foreign-born women from local communities to provide doula support to newly arrived women. The doulas were themselves migrant women, who spoke both the language of their country of origin and Norwegian or Swedish. The interventions are based on the idea that the continuous support provided by a doula may be beneficial to foreign-born women's maternity care experience and help address the inequity in care experienced by migrant women. The interventions provided support to women throughout the perinatal period. The studies by Akhavan and Lundgren (2011) and Akhavan and Edge (2012) do not specify the level of support provided, whereas Haugaard et al. (2020) stated women were supported several times before and after birth and during childbirth. The intervention evaluated by Akhavan and Lundgren (2011) and Akhavan and Edge (2012) was positively evaluated by the midwives and women involved. Both women and midwives reported that doula's provided support and reassurance in the perinatal period leading to women having better care. However, midwives did express concern over whether doulas should be used to compensate for deficiencies in the system or whether policies should be developed to address these deficiencies (Akhavan & Edge, 2012; Akhavan & Lundgren, 2011). In the study by Haugaard et al. (2020) it was the doulas who were asked to evaluate the intervention, they assessed the impact of the intervention as successfully providing support for newly-arrived women and so improving their access to care as well as acting as 'cultural bridge' between maternity care and migrant women (Haugaard et al., 2020).

4. Paraprofessional

Three interventions based in the UK (Ahmed et al., 2006; Parsons & Day, 1992; Rocheron & Dickinson, 1990) provided a form of social support based on the use of trained paraprofessionals, individuals who were trained to take on specific health based roles but did not have professional qualifications. These individuals acted to provide social support to perinatal women by working with social or healthcare professionals and included the provision of link workers, breastfeeding supporters and health advocates. In these interventions these individuals provided support and

advocacy for women accessing maternal health care in order to, address lack of cultural competence within the healthcare system, facilitate better communication with healthcare professionals (Parsons & Day, 1992), act as advocates, translators and cultural mediators (Rocheron & Dickinson, 1990) or provide specialist bi-lingual breastfeeding support (Ahmed et al., 2006). All the interventions were reported as having a positive impact on the women who accessed them. In Rocheron and Dickinson (1990) women supported by link workers reported an improvement in their experiences of care. In the Ahmed (2006) study, participants reported that the support workers provided a useful source of support and in Parsons and Day (1992) women who gave birth in the hospital having been supported by health advocates had improved maternal outcomes in terms of reduction in length of antenatal stay, lower levels of inductions and lower caesarean section rates.

Author and date	Intervention	Intervention delivered by	Aim of intervention	Reported Findings	Underlying rationale	Category of intervention	Impact/ themes
Rocheron Y, Dickinson R. 1990	health promotion publicity campaign and link workers	Paid link workers	To encourage early 'diagnosis' of pregnancy, awareness and uptake of maternity care services and aid communication between professionals and Asian communities.	Publicity campaign had limited success as failed to fully address the heterogeneity of the population. Link workers scheme improved women's experiences.	Deficiency/lack of cultural competence/communication	Paraprofessional	Gharib, Safety & Trust; being cared for.
Parsons L, Day S 1992	health advocacy	health advocates	To improve & facilitate communication between staff & local ethnic minority women, and to influence hospital policy & practise. The project grew from concerns over the quality of maternity care local women who did not speak English were receiving & the poor obstetric outcomes for women Asian backgrounds more generally.	Improved outcomes amongst women who received support compared to control groups, including; reduction in length of antenatal stay, lower level of induction of labour & lower CS rates.	Deficiency/lack of cultural competence/communication	Paraprofessional	Quantitative
Ahmed S et al. 2006	Bilingual peer support for breastfeeding	Bangladeshi support worker	To increase the uptake and duration of breastfeeding amongst Bangladeshi women through the employment of a bilingual support worker provide extra breastfeeding support and education.	The current system did not effectively support Bangladeshi women to breastfeed. The majority of women found support workers the most useful source of support for breastfeeding.	Deficiency/lack of cultural competence/communication	Paraprofessional	Gharib, Safety & Trust; being cared for
Karl-Trummer U et al. 2006	Prenatal courses for ethnic minority women	Health professionals	Health promotion intervention which emerged from the European Migrant friendly hospital initiative and the WHO 'Making pregnancy safe initiative' (2000) which identified poor outcomes amongst some migrant women.	High efforts and good results, but low attendance.	Clinical need/risk	Education	Gharib, Safety & Trust
Lederer J.2009	Perinatal support project	Community volunteer befrienders	To improve the mental health of specific groups of women (one of these being AS&R women) considered to be vulnerable during pregnancy, to support increase maternal and child wellbeing.	The intervention is reaching its target group, Users demonstrate reduced depression & anxiety, better social support & feel more confident as parents. Befrienders gained in confidence.	Structural challenges	Community Befriending/peer support	Practical Learning and knowing about; I can do anything; Gharib, Safety & Trust; being cared for
Hesselink AE, Harting J. 2011	Antenatal education programme on smoking, infant care & psychosocial health for ethnic Turkish women.	Turkish community health workers (CHW)	To provide antenatal education programme to prevent 'unhealthy lifestyles, poor maternal infant care practises and poor psychosocial health in EM women. Specifically, Turkish women as identified as having an accumulation of identified risk factors e.g., smoking behaviour, depression, smothering, shaking and slapping	The intervention was effective in reaching a hard to reach population. The need crucial role of the community health workers and the need to integrate them into practises was noted. The intervention was, popular with mothers but had a mixed reception from staff.	Clinical need/risk	Education	Gharib, Safety & Trust
Akhavan S, Lundgren I 2011	Doula support for immigrant women	Voluntary community-based doula	To improve the quality of maternal health care for foreign born women, based upon the idea that the continuous support provided by a doula may reduce negative outcomes and allow foreign born women to receive the same level of care as non-foreign born women.	Midwives described their experience of working with the doulas positively, but issues were raised about whether doulas should be used to compensate for deficiencies in the system or whether policies should be developed to address these deficiencies.	Inequality /structural challenges	Community Doula	Gharib, Safety & Trust; being cared for.
Akhavan S, Edge D. 2012	Community-Based Doulas for Foreign-Born Women's	Voluntary community-based doula	To improve the quality of maternal health care for foreign born women, based upon the idea that the continuous support provided by a doula may reduce negative outcomes and allow foreign born women to receive the same level of care as non-foreign-born women.	Doulas can provide support & reassurance in the perinatal period & mean women have better care	Inequality/structural challenges	Community doula	Gharib, Safety & Trust, being cared for
Hesselink A E, et al. 2012	Happy Mother, Happy Baby (HMHB) antenatal education programme on smoking, infant care & psychosocial health for ethnic Turkish women.	Turkish community health workers (CHW)	To provide antenatal education programme to prevent 'unhealthy lifestyles, poor maternal infant care practises and poor psychosocial health in EM women. Specifically, Turkish women as identified as having an accumulation of identified risk factors e.g. smoking behaviour, depression, smothering, shaking and slapping	Improved knowledge about smoking, intention to engage in SIDS prevention & short-term SIDS prevention behaviour, no effect on smoking in pregnancy, long term SIDS prevention, soothing behaviour, serious depressive symptoms &parent- child attachment.	Clinical need/risk	Education	Quantitative

O'Shaughnessy R. et al. 2012	Mental health service for asylum-seeking mothers and babies	Home Start volunteers & psychologists	To provide an early intervention mental health service focussing on supporting positive mother- baby relationships by delivering social & practical support as well as specialist therapeutic support.	Women positively evaluated the intervention and there was an improvement in attachment relationships between mothers & their babies.	Structural challenges	Community befriending/peer support	Practical Learning and knowing about; I can do anything; Gharib, Safety & Trust, being cared for
McCarthy R, Haith-Cooper M 2013	Befriending for pregnant asylum-seeking and refugee women	Community Volunteer befrienders usually AS&R	To train volunteers to support pregnant AS&R women so they can understand and access timely maternity care & help them to connect with the local community & experience less social isolation.	The project was beneficial to the women involved & had potential benefits to midwives and wider healthcare system. Befriending may help to meet the currently unmet needs of AS&R women	Structural challenges	Community befriending/peer support	Practical Learning and knowing about; I can do anything; Gharib, Safety & Trust; being cared for
Bhavnani, V, Newburn M 2014	Community perinatal support – community based outreach & 1 to 1 support for women in their homes or community venues	Community volunteer befrienders	To provide perinatal support & information to women and their partners who had been identified as vulnerable or from socially excluded communities	The intervention successfully reached the groups they had been aiming to reach. Demonstrated benefits for the parents and volunteers, provided lots of learning about working with diverse communities and about how their needs differ. Notes that AS&R women valued much more practical and informational/educational input as opposed to emotional support.	Structural challenges	Community befriending/peer support	Practical Learning and knowing about; I can do anything; Gharib, Safety & Trust; being cared for
Brookes H, Coster D. 2015	Parental education programme for parents from a minority ethnic background	NSPCC staff	To support vulnerable parents in the transition to parenthood, focusing on the relationship between partners, the development of a positive parent-infant relationship and creating a social support network to help to develop inner resilience.	The intervention provided relevant and useful information to the group targeted about maternity care, parenting practises and relationships.	Structural challenges	Educational	Gharib, Safety & Trust
Peters I A, et al. 2017	Use of culturally competent educational films about prenatal screening to increase knowledge amongst Fb women	prenatal screening counsellors	To address research findings which identified low levels of IDM and low knowledge about PS amongst women from a non- western background.	Intervention increased knowledge of and IDM around FS for foreign born women	Clinical need/risk	Education	Quantitative
Haugaard A, Tvedte SL, Severinsen MS, Henriksen L. 2020	Multicultural doula support for newly arrived non-western migrant women	Multicultural volunteer doula	The main purpose of the project was to strengthen, and ensure equitable access to, maternity care for migrant women through multicultural doulas.	Multicultural doulas were an important resource during pregnancy and birth, for women & midwives. Their presence can strengthen maternity care for migrant women by providing information, ensuring continuity & building a cultural bridge between the migrant women and maternity care in Norway	Inequality/structural challenges	Community doula	Gharib, Safety & Trust, being cared for, Practical Learning and knowing about
Sioti E et al. 2019	An integrated, woman centred, culturally sensitive, and evidence-based approach to perinatal health care for migrant, asylum seeking or refugee (MAR) women	Multidisciplinary team of HCPs and volunteer community-based maternity peer supporters	To ensure a safe journey to motherhood, improve access and delivery of maternal healthcare for refugee and migrant women, and to improve maternal health equality within the European Union.	The project was effective in providing access for MAR women to the usually hard-to-reach maternity health care services. This success can be attributed specifically to the involvement of the MPSs, who shared language and cultural background with the MAR mothers.	Structural challenges	Community befriending/peer support	Gharib, Practical knowledge and learning, I can do anything, being cared for

Table 3.8 Summary of interventions

3.4.2 The impact of social support interventions

In this section, I discuss the final review question which considers the impact of the social support interventions reported in the included studies. I first present the findings from the quantitative studies and then the present the key themes which were developed from the qualitative data from the qualitative and mixed methods studies.

The findings from the three quantative studies are presented below. The quantative data included in the mixed methods studies was reported in a way in which it was not possible to differentiate between women who were or were not asylum seekers or refugees, so this data was excluded from the analysis.

Two of the quantitative studies (Hesselink et al., 2012; Peters et al., 2017) reported that their educational interventions did increase knowledge and/or support behaviour change amongst participants. Peters et al. (2017) reported that their prenatal educational intervention had led to an 11% increase in informed decision making about intentional participation in screening and a 12% decline in non-informed decision making around participation in screening among the targeted non-western women in their study. Hesselink et al. (2012) evaluation of the perinatal Happy Mother, Happy Baby intervention found improvements in knowledge about smoking, intention to engage in Sudden Infant Death Syndrome (SIDS) prevention and short term SIDS prevention behaviour. However, the intervention had no effect on other behaviours or conditions including smoking in pregnancy, long term SIDS prevention, soothing behaviour, serious depressive symptoms, and parent-child attachment. Parsons and Day (1992) in their retrospective study reported that the involvement of paraprofessional health advocates had a positive impact on three aspects of clinical maternal outcomes. These outcomes were, reduced antenatal hospital stay (from an average of 8.6 days to 5.7 days), a lower level of induction of labour (9% compared to 16.1% at non-intervention site), and a reduction in caesarean section, both over time at the intervention site (10% to 8.5 %) and in comparison to the control hospital in which rates rose (11% to 17%).

Five key aspects of support emerged from the analysis of the qualitative data, (1) Gharib: alleviation of being alone (2) ‘it’s only in this group you can ask’: safety and trust (3) Practical knowledge and learning (4) Being cared for and emotional support and (5) ‘I can do anything now’: increased confidence in and beyond the intervention. These key aspects of support were then mapped to see how they related to the four types of intervention previously identified to see which interventions had which impact on women (Table 3.8).

1. Gharib: Alleviation of being alone

The first aspect is captured in an Arabic/Persian term used by Akhavan and Lundgren (2011) *Gharib*. They translate this as *‘a feeling that one is alone, a stranger, and an outsider who cannot understand the languages, rules, laws and traditions in this new society'* (Akhavan & Lundgren, 2011, p. 840). Community befriending/peer support and community doula type interventions all identified and sought to address this sense of loneliness and isolation described by one woman as making her feel ‘*really sad and hopeless’* (Brookes & Coster, 2015, p. 18). These feelings were commonly linked to issues of poor communication and language difficulties and to a lack of understanding of how the new society functions.

A number of studies described how women faced challenges communicating as they were unable to speak the language of the reception country (Ahmed et al., 2006; Akhavan & Edge, 2012; Akhavan & Lundgren, 2011; Brookes & Coster, 2015; Haugaard et al., 2020; McCarthy & Haith-Cooper, 2013). This led to, in the most extreme case, a woman who was unable to speak the language of the country and had no translator, giving birth alone (McCarthy & Haith-Cooper, 2013). Interventions which provided befrienders or doulas who shared a common language allowed women to communicate more effectively, reducing their sense of loneliness and isolation. One woman described how her befriender was the only person she had spoken to in her native tongue (Arabic) since arriving in the UK and how she ‘*took me out of my loneliness corner’* (McCarthy & Haith-Cooper, 2013, p. 407).

Several community befriending interventions reduced the sense of isolation felt by women through supporting them to access groups and group activities. Bhavnani and Newburn (2014), Brookes and Coster (2015) and O'Shaughnessy et al. (2012)

all noted how accessing groups, spending time with other women and sharing experiences made women feel less alone and reduced their sense of isolation. One woman noted that:

> *It's a good thing to talk about. Because like when you are at home . . . I am alone with my baby . . . and when you see that letter . . . you are afraid. So if I come out of the house and meet people to talk about that. When I leave I will be a little bit better. So for stress, it's good . . . it's good to talk about that* (O'Shaughnessy et al., 2012, p. 100).

Women faced challenges in understanding and accessing maternity care as some could not *'speak the language, have been traumatised, isolated and are unaccustomed to the system* (Akhavan & Edge, 2012, p. 82). Several interventions, which provided doula or befriending support, were described by participants as acting as '*a bridge'* from one culture to another, helping them to move towards understanding new ideas and unfamiliar situations (Akhavan & Edge, 2012; Akhavan & Lundgren, 2011; Brookes & Coster, 2015; Haugaard et al., 2020). Akhavan and Lundgren (2011) explained that the doulas in their intervention had a shared cultural background with the women they supported and this allowed them to '*understand the women's perception of life based experiences and, her customs and practises'* (Akhavan & Lundgren, 2011, p. 82) and support them as they sought to navigate an unfamiliar system. In Haugaard et al. (2020) the doulas felt their shared migrant background allowed them to have extra empathy with their clients, noting that:

> *The midwives don't have the same understanding as us. When we talk with the women, it is heart communication* (Haugaard et al., 2020, p. 4).

2. 'It's only in this group you can ask': Safety and Trust

A second aspect evident in all four types of interventions, although most clearly in community based interventions, related to women's need for psychological safety and the role of trustful relationships in helping women feel safe. Several studies (Akhavan & Edge, 2012; Brookes & Coster, 2015; McCarthy & Haith-Cooper, 2013) documented how interventions created situations where women were able to

develop relationships of trust with those who supported them. This could be though the one to one relationships they developed or by creating safe spaces in which women could express themselves and feel secure. This in turn enabled women to receive social support and services that they needed but previously may have not been able to access. This was, for some women, a contrast to earlier experiences where they had not felt they were safe to trust individuals, particularly those with a professional role.

Akhavan and Lundgren (2011) linked the ideas of trust to feelings of safety, they commented on the significance of doula support for women:

> *'to have someone with her who she trusts and can communicate with …is incredibly important and makes her feel safe'* (Akhavan & Lundgren, 2011, p. 82).

Haugaard et al. (2020) similarly noted how the continuity provided to women by doulas through their ongoing relationships allowed them to feel safe. One doula noted:

> *when I arrived and spoke the same language as her and told her that I would be with her throughout the period—during childbirth and at the maternity ward—she felt safe. It was very important for her* (Haugaard et al., 2020, p. 4).

Brookes and Coster (2015) commented that supporters who were '*friendly, caring approachable responsive and knowledgeable*' allowed women to '*forge strong relationships… and to build a high level of trust*' (Brookes & Coster, 2015, p. 21). In Hesselink et al. (2012) the presence of community health workers and their ability to build trusting relationships through shared language and culture, overcame the '*lack of interest and trust'* that had previously characterised relationships with health professionals and allowed a more positive engagement with services. This is echoed in the work of McCarthy and Haith-Cooper (2013) who described the situation of an HIV positive woman who was unwilling to take the advice of a consultant about her condition. However, when this advice was reinforced by her befriender (who was also HIV positive) she accepted this advice as she trusted the befriender. In other situations, they noted that trusting relationships allowed women to disclose issues such as domestic abuse which meant befrienders could then support them to access appropriate support.

The value of the nonprofessional status of supporters was evident in several interventions. Lederer asserted that it was evident that '*having a non-professional befriender was key'* (Lederer, 2009, p.14). Women felt that the befrienders were more available and less official than paid staff and that their relationship with them was '*different from a midwife or health visitor more like a friend'* (Lederer, 2009, p.15). Some women's trust and confidence in the supporters was also enhanced if the person supporting them had similar experiences to them as they felt that they were then better placed to understand their situation (Bhavnani & Newburn, 2014; Lederer, 2009).

Several interventions provided or facilitated access to shared spaces in which women felt safe. One described the local Children's Centre as a place where she felt safe and that her befrienders support had allowed her to access this, saying:

> *having someone to talk to at a children's centre where I felt safe made all the difference, she saved me* (McCarthy & Haith-Cooper, 2013, p. 407).

For some women the sense of safety in a group or with an individual was enabled by the work supporters did to ensure that women perceived them to be trustworthy and able to '*keep confidence'.* This meant women felt safe to talk openly and ask questions in a way that they did not in other settings or with professional services. They explained how it was *'ok to say it here'* and that *'it's only in this group you can ask'* (O'Shaughnessy et al., 2012, p. 220). Other interventions acknowledged the importance of confidentiality in creating a safe and trusting environment for women but also highlighted some difficulties over the ways in which women understood ideas of more formal confidentially and information sharing (Brookes & Coster, 2015; Hesselink & Harting, 2011).

3. Practical knowledge and Learning

A third aspect related to learning and new knowledge. This opportunity for learning and the acquisition of new knowledge was primarily identified in community based interventions and some educational ones. It included women gaining new information on medical issues related to pregnancy, birth, and on parenting including topics such as infant development, infant communication and discipline (Akhavan &

Edge, 2012; Brookes & Coster, 2015; Haugaard et al., 2020; Sioti et al., 2019). Some women described how they valued the opportunities for learning that came from the intervention and the kind of practical advice and knowledge they gained *'I love her so, so, sooooo much! She give me lots of advice, lots of, every week when she comes,'* another that they learned '*how to do baby massage …* [and where*] learning lots of useful things'* (O'Shaughnessy et al., 2012. p.220).

Lederer (2009) and Bhavnani and Newburn (2014) noted that the information about maternity care and support provided by their community based interventions meant that more women knew about what support was available to them. At the beginning of the intervention Lederer noted that half of the women did not know where they could access support but after three months all of the women knew where and how to access support. Bhavnani and Newburn (2014) reported a similar increase in knowledge and both studies reported an increase in women accessing support and community activities such as those located in Children's Centres. These and other studies linked the new knowledge women gained to improvements in the perinatal experiences of the women, families and babies in different ways (Akhavan & Edge, 2012; Brookes & Coster, 2015; Karl-Trummer et al., 2006; McCarthy & Haith-Cooper, 2013; Rocheron & Dickinson, 1990).

The studies by Brookes and Coster (2015), O'Shaughnessy et al. (2012) and Haugaard et al. (2020) described how some of the parents they supported were unfamiliar with reception countries' cultural practices relating to birth and parenting, e.g., fathers being present at birth, feeding, sleeping and disciplining practises and with legislation on children's rights, particularly relating to physical chastisement and Female Genital Mutilation (FGM). One participant noted that:

> *we don't know anything about this county or its laws, we don't know how to look after a child here because it is all totally different to where we lived before* (Brookes & Coster, 2015, p. 18).

For some participants, particularly those recently arrived in reception countries, interventions led to changes in opinions and behaviours. One woman described how one of the interventions had affected her, *'so you said that and it's changed an idea*

or opinion' (O'Shaughnessy et al., 2012, p. 220). Changes in opinions and behaviours where primarily related to parenting practices, however they also effected attitudes towards the practise of FGM and gender roles within relationships (Brookes & Coster, 2015; O'Shaughnessy et al., 2012).

In some of the interventions, gaining knowledge took the form of a mutually beneficial knowledge exchange. Midwives in Sweden explained how '*we learned from each other'* (Akhavan & Lundgren, 2011, p. 82) and the organisers of the Birth and Beyond intervention in the UK noted how those involved in providing the intervention *'learned a lot about working with marginalised and disadvantaged groups'* from the women they worked with (Bhavnani & Newburn, 2014, p. 6).

However, there was a more profound learning experience for many of those involved in providing the interventions. This was an understanding of the challenges faced by asylum seeking and refugee women in terms of the level of unmet basic needs such as housing and material goods women faced. This new knowledge meant that interventions had to be adapted both in terms of the type of support offered and who provided the support. Brookes and Coster (2015) noted how the *'complex problems'* and additional challenges faced by asylum seeking and refugee women in the perinatal period, including inadequate housing, insecure immigration status, relocation and severe financial hardship, made it harder for them to take part in the intervention. It also meant that in some cases the '*support provided by the practitioners was in fact far broader than the actual remit of Baby Steps'* (Brookes & Coster, 2015, p. 18) and that '*a degree of tailoring was necessary in order to respond to these parents additional needs*' (Brookes & Coster, 2015, p. 23). They learned that in addition to the work that was part of the planned intervention they also needed to act as advocates, to write letters to the Home Office and solicitors, liaise with other agencies, visit those who had been relocated and to provide nappies and supplies for those in need, services that one woman described as *'a lifeline'* (Brookes & Coster, 2015).

Interventions found that they needed to refocus or adapt their interventions based on what they had learned which led to support for families often taking a *'more practical form'* (Bhavnani & Newburn, 2014, p. 15) in that:

> *practical support and practical activities, were more useful and culturally more understood and accepted among asylum seekers and refugees, compared with contact for no purpose beyond talking listening and emotional support* (Bhavnani & Newburn, 2014, p. 24).

This practical support included accompanying mothers to appointments, helping with shopping, cooking and caring for children (Bhavnani & Newburn, 2014) and helping with bills and grants (Lederer, 2009) reflecting the more basic and practical needs of many women. Bhavnani and Newburn (2014) noted the project changed its recruitment policy to include women from different communities who they felt were likely to be '*more emotionally and practically resourceful*' than asylum seeking and refugee women who they had initially aimed to recruit as volunteers, but who they now realised were *'often highly pressured by having to deal with their own asylum issues'* (Bhavnani & Newburn, 2014, p. 18).

4. Being cared for and emotional support

The role played by the interventions in providing care and emotional support to address the high levels of stress, anxiety and depression experienced by many asylum seeking and refugee women is highlighted in a number of studies (Akhavan & Lundgren, 2011; Bhavnani & Newburn, 2014; Brookes & Coster, 2015; Haugaard et al., 2020; Lederer, 2009; Sioti et al., 2019). This support is particularly evident in the interventions characterised as community befriending/peer support, community doula and paraprofessional.

The women in these studies speak of experiencing' *depression'*, '*stress',* '*anxiety',' anger'* and of '*feeling scared'* as they face pregnancy, birth and new parenthood in challenging situations (Akhavan & Edge, 2012; Bhavnani & Newburn, 2014; Brookes & Coster, 2015; Lederer, 2009). Rocheron and Dickinson (1990) asserted that *'mothers who had support from link workers enjoyed greater continuity of care, emotional support, less stress'* (Rocheron & Dickinson, 1990, p. 131) and that the emotional support and care received seemed to reduce fears of hospital, labour and birth. One woman who had support from the link workers explained that, *'if they weren't around I would have felt scared… they were very helpful and comforting'*

(Rocheron & Dickinson, 1990, p. 132). Other women involved in the Newpin project, evaluated by Lederer, described how they received emotional as well as practical support from the project:

> *The project gives me support with my feelings as well as helping with the baby … support with my feelings as well as with the baby's crying* (Lederer, 2009, p. 16).

Women spoke of the importance of having somewhere to express their concerns and having someone to listen to them. Some women felt:

> *reassured by spending time and sharing experiences with other parents-to-be and having a forum for them to raise their concerns and worries* (Brookes & Coster, 2015, p. 15).

The importance of talking and being listened to was crucial, one woman described how her befrienders was *'all ears wide'* and that '*she understands me'* (Bhavnani & Newburn, 2014). Another that having a befriender meant *'I am able to talk about my worries'* and that *'I feel I have known her for 5 years,* [and that] *she understands me'* (Lederer, 2009, p. 15).

Another important aspect of this emotional support was the sense of being cared for. Brookes and Coster (2015), Bhavnani and Newburn (2014) and Akhavan and Edge (2012) all shared that women valued the sense of being cared for by supporters and doulas. One woman explained that the support they received '*made me feel like somebody actually wanted to help, somebody actually cared…'* (Brookes & Coster, 2015, p. 18) another who took part in the NCT intervention stated that *'I find it really good because you feel you are cared for'* (Bhavnani & Newburn, 2014, p. 31).

5. *'I can do anything now'*: increased confidence in and beyond the intervention

The final aspect of support, evident in community befriending/peer support interventions was the positive impact of the interventions on the confidence of women both during and after the intervention. This theme also included an acknowledgement of the positive impact of the intervention on the community befrienders or peer supporters, many of whom were facing similar challenges to the

women they supported. In this way some interventions had an impact well beyond their remit of supporting specific women in the perinatal period.

A number of studies note how the interventions increased women's confidence in their '*ability to speak out in some contexts*' (McCarthy & Haith-Cooper, 2013, p. 407). For other women the increased confidence related to their ability to overcome challenges related to birth and parenting. One woman noted that support helped her overcome her fears and give birth to a 10lb cephalic presented baby and that following that she felt *'I can do anything now'* (McCarthy & Haith-Cooper, 2013, p. 407). Other women reported the interventions had increased their confidence in their ability to parent and to communicate with and care for their babies (Brookes & Coster, 2015; Lederer, 2009; O'Shaughnessy et al., 2012). Other women felt more able to access services and sources of support they had previously been unable to (Bhavnani & Newburn, 2014; Lederer, 2009). Beyond this confidence in their daily lives some women went on to take on new roles, for example, some women involved in the ORAMMA project went on to act as:

> *'propagating keys', by providing advice on maternity related issues, access to healthcare services and spreading health messages to their social circle* (Sioti et al., 2019, p. 57).

Lederer noted that many women generally felt '*more confident and are motivated and empowered to take control of their lives'* (Lederer, 2009, p. 15). Brookes & Coster study reported that for some the intervention was *'transformative',* changing their lives and relationships (Brookes & Coster, 2015, p. 23). Interventions also helped some women move forward with their lives, for some this involved moving from being supported to being supporters, while others looked towards taking courses at college (McCarthy & Haith-Cooper, 2013).

Studies noted the positive impact on the self-esteem and self-confidence of volunteers working on the projects, some of whom where asylum seekers and refugees themselves (Bhavnani & Newburn, 2014; Lederer, 2009; McCarthy & Haith-Cooper, 2013). One woman noted that '*It has made me aware of skills that I never thought I had. I feel strong'* (Lederer, 2009, p. 26) another that:

> *I used to think I was nothing now I think I'm something and when I wear my refugee council badge I feel like a professional* (McCarthy & Haith-Cooper, 2013, p. 408).

For some volunteers the projects provided an opportunity for progression into other voluntary roles or paid work and Bhavnani and Newburn (2014) argue that the community based nature of the project benefits social engagement for these volunteers as well as a wider sense of community connectedness and awareness.

3.5 Discussion

This review identified four main types of intervention in the selected studies; educational, community befriending/peer support, community doula and paraprofessional. Looking critically at the studies and at the nature of the social support offered within the interventions described, offers an insight into the differing rationales underpinning the interventions and the different ways in which asylum seeking and refugee women are constructed within public health and maternal health contexts.

Educational interventions were delivered to women by paid health professionals and were based on clinical priorities and health professional's perceptions of need, risk or perceived deficiencies in asylum seeking and refugee women's health seeking and promoting behaviour. Seeking to promote individual behaviour change, they generally did not explicitly locate women within the social, political or cultural context of their country of residence or identify structural or social issues which may contextualise some of these behaviours. The rationale behind the paraprofessional interventions were also based on clinical perceptions of need and were developed to address what were perceived to be deficiencies in effective communication and culturally competent care within existing maternity services provision. However, some of the work done by paraprofessionals comes within the scope of midwifery practise as defined in The Lancet midwifery series (Renfrew et al., 2014) and subsequently included in the UK regulations for midwifery practice (Nursing and Midwifery Council, 2019) which raises the issue of whether these interventions should be seen as an integral part of midwifery practice. Both approaches tended to remove asylum seeking and refugee women from the social context of their

experiences and were focused on professional or professionalised ideas of what asylum seeking and refugee women needed within a clinical perspective.

A contrast to these approaches was evident in the interventions identified as community befriending/peer support. These interventions were located within the communities in which women lived, underpinned by a belief in the efficacy of peer support and volunteering in improving experiences of care and in addressing some aspects of health inequalities. In these interventions asylum seeking and refugee women were seen as being socially located and having to operate within challenging legal, economic, social and gender structures in their reception countries. The purpose of the interventions was to support women as they faced these societal, systemic and organisational challenges or barriers to optimal care and wellbeing. These interventions focused on the impact of these structural forces on women's experiences rather than using ideas of risk or individual deficiencies in women or their behaviours. Community doula type interventions similarly located women within the communities and situations in which they were living. These interventions were based on concerns that structural inequalities meant that immigrant women do not receive the same level and quality of maternity care as women born in reception countries. These interventions sought to address this inequality and to improve the quality of maternal health care for foreign born women by using resources from the communities in which the women are located to address these challenges.

All the interventions in the selected studies had an impact on some aspects of asylum seeking and refugee women's experience of the perinatal period, however as presented in Table 9 this review suggests that it was those based within the community, i.e., community befriending/peer support and the community doula models that had the most impact in terms of the aspects of support provided and in the timing of support offered.

Interventions	Areas of impact	Timing of support
Community befriending/peer support	Alleviation of being alone, Safety & Trust, Practical knowledge and Learning, Being cared for and emotional support, confidence in and beyond the intervention	Provided antenatal & postnatal

Community doula	Alleviation of being alone, Safety & Trust, Being cared for and emotional support	Provided antenatal, intrapartum and postnatal
Para-professional	Alleviation of being alone, Safety & Trust, Being cared for and emotional support	Provided antenatal or postnatal
Educational	Gharib – Alleviation of being alone, Practical knowledge and Learning	Four antenatal only, one antenatal & postnatal

Table 3.9 Mapping interventions and impacts

3.5.1 Impact of the interventions: mapping the findings against the hierarchy of birth needs

To explore to what extent and how these interventions were able to provide perinatal social support for asylum seeking and refugee women and what aspects of support they provided, it is helpful to locate them within a sense of what support or conditions women may need to have a good experience of the perinatal period and a positive birth. As a way of conceptualising and exploring the range of women's needs and the capacity of the social support interventions to meet these needs, I have used insights from the Hierarchy of Birth Needs model (Radloff, 2020). This model, developed as part of a way of thinking about the holistic needs of women around birth and the perinatal period, uses insights from Maslow's Hierarchy of Needs model to explore the range of women's needs in this context (Maslow, 1954). The application of insights from Maslow's hierarchy of needs have been used in maternal health research which has been looking at the needs of perinatal women in a holistic perspective in a number of situations, but I have not been able to find literature in which it is used in relation to asylum seeking and refugee women (Anderson et al., 2021; Higgins, 2017; Kornelsen & Grzybowski, 2005). Mapping the perinatal social support interventions detailed within the selected studies and their impact on women's experiences using Radloff's model (Figure 3.2) provides a way of considering which aspects of asylum seeking and refugee women's birth needs are provided by which interventions and to identify gaps and deficiencies in the support provided. It also highlights the unique challenges faced by asylum seeking and refugee women. It facilitates thinking about the perinatal experience in a holistic way, recognising the range of needs which have to be addressed in order for women to

achieve a positive birth, or in Radloff's terms, a birth which can be a self-actualised or transcendent experience. The later concept resonating with both, wider literature on birth as a transformative experience (Kurz et al., 2019, 2022), and with ideas that women in the perinatal period should be supported to thrive not just survive (Every Woman Every Child, 2015).

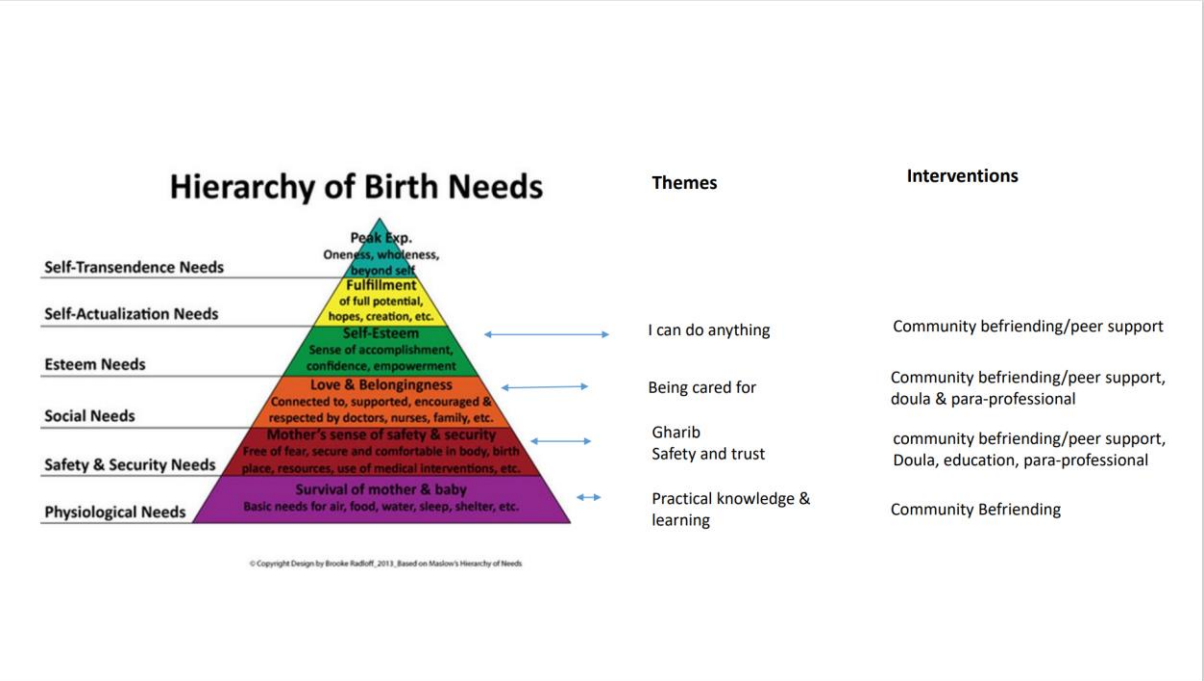

Figure 3.2 Hierarchy of Birth Needs and social support provision for asylum seeking and refugee women

In the theme *Practical knowledge and learning* we see how some community-based interventions sought to address the most basic '*physiological needs'* of women. This theme highlights the ways in which those organisations and individuals providing the interventions, learnt of and sought to address the fact that some asylum seeking and refugee women's basic needs were not being met. These studies illustrate how some women lacked secure housing and sufficient finances: the requisites to ensure the survival and health of mother and baby. In Radloff's terms these women then lacked the basis necessary for women to have a positive perinatal and birth experience, as without this basis and these needs being met, women's ability to have their other needs met cannot be fully realised.

In the two themes *Safety and trust* and *Gharib* (provided by all types of interventions) we see how some interventions allowed women to overcome feelings of mistrust and fear, enabling them to build trusting relationships with those who supported them and

with their peers. Group interventions provided women with psychological safety by creating environments in which they could speak out and share their experiences within a safe and confidential place. Support offered to women also helped them to understand and access care more effectively and thus allowed them a greater sense of security and safety over how and where they would deliver their child and receive care, and the nature of this care. All of these increased participants' ability to achieve a sense of what Radloff characterised as '*psychological safety and security'*.

The theme *being cared for* highlights the ways in which some community-based, and paraprofessional interventions provided women with emotional support. This led to an improvement in mood for many women, reducing anxiety and depression and allowing them to feel cared for by, and connected to, those supporting them. This links to the '*social needs'* element of the model in which women need to feel connected, supported and encouraged by those who support them in this period.

The final theme, *I can do anything now*, *increased confidence in and beyond the intervention,* shows how some community based befriending/peer support interventions enabled women to have increased confidence and to feel motivated and feel empowered. These are outcomes which correspond with the '*self-esteem'* aspect of the model in which women feel a sense of accomplishment and empowerment (and in some cases have experiences that could be deemed to be transformative) in the perinatal period. The findings from the selected studies highlight that only the community based interventions address the majority of women's needs in this period, including some of the key basic physiological needs. While many interventions sought to provide social support which relates to women's psychological, emotional, social or esteem needs in the model, if women do not have their most basic needs addressed, according to the model, they are unlikely to be able to attain the higher levels of experiences of an optimal perinatal and birth experience.

The evidence from this review suggests that community-based befriending/peer support interventions are most successful at addressing many aspects of asylum-seeking and refugee women's needs, suggesting that interventions of this type maybe of most benefit to women due to their holistic approach and underlying rationale. This is congruent with the work of Haith-Cooper and Bradshaw (2013) and

Rogers et al. (2020) whose work suggests the need to view the perinatal health of migrant and refugee women in a socially located and holistic context which acknowledges the global, macro and micro contexts with in which women experience the perinatal period in their new country as well as need for psychosocial and practical support for women to help them access health systems.

3.6 Summary

The review findings demonstrate that perinatal social support interventions take four approaches: educational, community befriending/peer support, community doula and paraprofessional. These have variously physical, practical, behavioural and psychological impacts on women, as illustrated in the five themes identified in the qualitative data: *Gharib, safety and trust, practical learning and knowing about, being cared for* and '*I can do anything now': increased confidence in and beyond the intervention*.

However, these interventions which seek to provide social support to asylum seeking and refugee women face a number of challenges. Many of the asylum seeking and refugee women they seek to support cannot meet their basic needs, in terms of secure housing, finance and legal status. These needs are so basic that any other psycho-social needs associated with ensuring a positive perinatal and birth experience cannot be addressed successfully until these most basic needs/conditions have been addressed. The interventions which women experience as having most positive impact are those which are located within the community rather than those which come from a clinical model of need. These interventions, particularly those using a community befriending model, seem to provide support which can address women's needs on a range of levels, suggesting that they are based on a more holistic view of women's needs. However, despite the success of these types of interventions there is still a significant lack of focus on addressing the most basic physiological needs of asylum seeking and refugee women in the perinatal period. While interventions such as these do acknowledge women's basic needs they only address them in a limited and non-systematic way, as a side effect of what they have learned during the intervention rather than as an integral or central part of the intervention.

3.7 Strengths and limitations

The European perspective, the inclusion of grey literature as well as peer reviewed literature and the inclusion of quantitative, qualitative, and mixed method approaches are a strength of the review, allowing the inclusion of a breadth of literature and perspectives to provide examples of different approaches and contexts. A limitation of the review is that only literature in English was reviewed. Another limitation was that there were issues with inconsistent and limited definitions of, and ways of identifying, migrant women and asylum seeking and refugee women within the existing literature. This made data selection challenging as it can be hard to disaggregate data that is reported in the more general categories used, however this difficulty needs to be balanced with the need to look at and ensure the inclusion of a wide range of data to inform future research.

3.8 Research gaps

Thus far I have argued that community based, and more specifically community befriending/peer support interventions seem to have the most positive impact on the wellbeing of asylum seeking and refugee women in the perinatal period. However, the lack of a holistic and contextualised view of the needs of asylum seeking and refugee women in the design and provision of many social support interventions suggested by the review is a concern. This could be addressed by talking to the women whom the social support interventions are aimed at as this will provide a way to ensure that interventions are more likely to address their needs. Within the selected studies there was little evidence that asylum seeking and refugee women had either, been consulted over what social support they would find useful, or had input into the nature of the interventions rather they have been asked in some settings to evaluate the impact of pre-existing or pre-designed interventions.

Personal experience, prior knowledge and the research linked to this study demonstrates that there are localised social support interventions being undertaken to support asylum seeking and refugee women across Europe. However, there is a lack of evidence of their work as few projects undertake rigorous evaluations (understandably as these are largely charitable and voluntary agencies with limited finances). However, this lack of evaluation of interventions and the limited

dissemination of outcomes mean that it is challenging to find evidence of their work to use to provide substantive data to inform evidence based practise and support demands for change. To gain a better insight into the ways in which social support can meet the perinatal needs of asylum seeking and refugee women the empirical part of this thesis will work with women to understand their experiences of perinatal social support and to find out from them what forms of support they feel would best meet their needs. This will be done by looking at the specific needs and experiences of asylum seeking and refugee women currently living in the north of England.

3.9 Research questions

As a result of the work in this chapter, the following research questions have been designed and will direct the focus of empirical work. These questions are:

Study one: What are asylum seeking and refugee women's experiences of social support in the perinatal period in the UK?

Study two: What do women perceive to be the best ways in which asylum seeking and refugee women could be supported in the perinatal period?

3.10 Conclusion

This chapter has provided a review of existing literature on the provision, nature and impact of social support interventions on the wellbeing of asylum seeking and refugee women in the perinatal period across Europe. It has identified the strengths and limitations of the review, noted the gaps in research gaps and identified research questions for the empirical part of the thesis. In the next chapter, I outline the methodological and the theoretical underpinning of the empirical aspects of my thesis as I explore the research questions identified above.

CHAPTER 4 METHODOLOGY

4.1 Introduction

In the last chapter I presented the results of the literature review which suggested that many social support interventions failed to take a holistic approach to meeting the perinatal support needs of asylum seeking and refugee women. The review suggested that to improve social support and to ensure it addressed asylum seeking and refugee women's needs, it was necessary to work with them directly to explore their experiences of social support and what they felt were the best ways of providing support which meet their needs. Two research questions were identified to direct the empirical aspect of the thesis:

1. *What are asylum seeking and refugee women's experiences of social support in the perinatal period?*
2. *What do asylum seeking and refugee women perceive to be the best ways in which asylum seeking and refugee women could be supported in the perinatal period?*

This thesis uses what has been characterised by Ackerly and True (2020) as a feminist-informed approach to research. This approach provided the basis for both the *'knowing and doing'* (Letherby, 2003, p. 3) aspects of this research. In terms of '*knowing*' it guided my thinking about what can be known, how can it be known and what sort of things we should strive to know. It also provided the guiding principles for *'doing'* the research in terms of the practical and ethical ways in which the research should be conducted. A feminist-informed approach in this sense is therefore:

> *self-reflective, political, and versed in multiple theoretical frameworks in order to enable the researcher to 'see' those people and processes lost in gaps, silences, margins and peripheries* [drawing on] *theoretical, methodological, and empirical insights from a diverse body of feminist theories and feminist research* (Ackerly & True, 2020, p. 20)

and as such a feminist perspective is evident in the discussions in this chapter and throughout the thesis. The chapter begins by exploring what a feminist-informed approach to research means for this thesis and the research questions it explores, it

then considers some aspects of reflexivity. Next it discusses the feminist and social constructionist epistemological perspective which, building on a relativist ontology, provides the philosophical underpinning of the thesis. The chapter concludes by exploring the rationale for using a qualitative research design, the practical application of which is explored further in chapters five and seven.

4.2 A feminist-informed approach to research

At the heart of this thesis are the voices of the asylum seeking and refugee women currently resident in the UK who have shared their experiences of, and thoughts about, social support in the perinatal period. Using a feminist-informed approach to research, as conceptualised by Ackerly and True (2020), has allowed me to draw on aspects of several feminist methodological and theoretical perspectives and helped me to ensure the centrality of asylum seeking and refugee women's voices to the research. The possibility of using insights from a range of feminist thinkers from different traditions has been identified as a potentially fruitful approach to research. It has been suggested that acknowledging and working within the plurality of contemporary feminist approaches and valuing aspects of modernist and postmodernist traditions, as well as insights from post-colonial and other critical perspectives, can be a useful way to approach complex issues in research (Ackerly & True, 2020; Letherby, 2003; Olesen, 2018; Zalewski, 2000). A feminist-informed approach fits with both my intellectual autobiography, identified in chapter one (Stanley, 1993) and provides me as a white academic researcher with the most appropriate way to research with, and think about, the perspectives and experiences of asylum and refugee seeking women in the perinatal context. The section below explores why this feminist-informed approach is best suited to this study.

A commitment to a feminist-informed approach to research begins with the choice of topic to be researched, in that the act of choosing a research area and research question is not a neutral act but a political one; what we research is a choice which relates to our ideas of what it is important to know. Feminist research involves at some level a commitment to social justice, an interest in bringing about change or a desire to improve the situation for women in some sense as well as an approach which recognises the relationship of the research to the topic and participants

(Ackerly & True, 2020; Flores Golfín et al., 2022; Kemp & Squires, 1997; Letherby, 2003; Ramazanoglu. C & Holland. J, 2002). The choice to research with asylum seeking and refugee women and look at their experiences around social support in the perinatal period is linked to an acknowledgement of the inequity and disadvantages faced by women in this period, a commitment to highlight this issue and to seek knowledge that can be used to change this situation.

My work draws on the rich tradition of feminist researchers who have sought, in both historical and contemporary settings, to move the lived experiences and views of those who have been marginalised and silenced to the centre, allowing their voices, concerns, and perspectives to be heard and to be seen as valid, important and worthy of study (hooks, 1987; Roberts, 1984). This study seeks to learn about the perinatal social support experiences of asylum seeking and refugee women by listening to their experiences and by acknowledging and valuing their perspectives as legitimate forms of knowledge. Placing women at the centre of the work as experts in their own lives helps to address the current situation in which the authenticity of narratives of women within the immigration system are consistently challenged as part of the '*culture of disbelief*' inherent in that system (Hynes, 2003). This focus also seeks to address the way in which the voices of asylum seeking and refugee women are seldom heard within research settings or other public contexts (Fedyuk & Zentai, 2018; Goedhart et al., 2021a; Smith, 2008; Thummapol et al., 2019). In health settings, as in wider public discourses, asylum seeking and refugee women are commonly spoken about or for; they are, 'the hard to reach', 'the vulnerable', 'victims' or 'health tourists', but their own voices and ideas are rarely evident or given authority (De Souza, 2004; Lonergan, 2023; Ryan & Tonkiss, 2022; Seu, 2003; Shobiye & Parker, 2023). By centring women's voices and asking women what social support they think could help address the challenges they face in the perinatal period, this research aims to counter established constructions of knowledge about asylum seeking and refugee women in which they are spoken of and for, locating them as experts in their own experiences.

A desire to amplify the voices of women has been at the centre of feminist work. However, the issue of how this should be done, and the challenges feminist researchers face when writing or speaking about, or for, other individuals or groups

has been an area of concern (Alcoff, 1991; Wilkinson, 1996). This situation has been identified by Black, post-structuralist and post-colonial feminists as being particularly problematic in the case of white, academic researchers, in the global north (re)presenting the voices of women whose identity they do not share and those whose identity means they have been traditionally marginalised or seldom heard (Alcoff, 1991; Hill Collins, 1990; Schmidt et al., 2023; Spivak, 2015). As a white academic researcher working with asylum seeking and refugee women who are marginalised within contemporary UK society and who have life experiences which are very different from my own, the issue of how I (re)present the voices and views of these women in an appropriate, ethical and useful way has been an important consideration. To address some of these issues I draw on the work of Alcoff (1991) and the interrogatory practises she suggests as a way of working to ensure that the research I do acts to amplify the voices of asylum seeking and refugee women rather than speaking about them in a way which could solidify or perpetuate established oppressions. These practices are reflected in several aspects of the research process, particularly at the inception of the research project and in establishing the need for this research to be done. I have also considered why I am doing this research (rather than women with lived experience) and the issues of the representation of minoritised groups in academic research and wider issues of epistemic injustice explored below. The research has been designed to allow me to listen to women's voices throughout the research including asking them to reflect on my interpretation of their narratives and suggestions (see section 7.6 Phase 2: member checking focus group). The opportunity to be accountable for my work and to engage with critiques of it has been facilitated by presenting aspects of the work in different settings, providing me with the opportunity to hear and learn from critical voices. The research produces recommendations for practice and policy to promote impact beyond the academic realm and on completion the work will be presented to the organisations and women who have been involved in the project (see section 10.6 Dissemination strategy).

My approach to researching the perinatal period draws upon the traditions of feminist researchers and birth activists who challenged the patriarchal, bio-medical model of birth and the androcentric bias of health research into birth and women's health. These researchers and activists sought to produce work that valued and explored

the experiences of women as experts in their own experiences (Kitzinger, 1992; Oakley, 1985; Roberts, 1981). Challenging patriarchal and colonial traditions and hierarchies of knowledge production, which valorised androcentric and westernised ideas about women's bodies, maternity and maternity care (Lokugamage et al., 2022), these researchers have sought to challenge and expand ways of knowing about maternal health, exploring the wider socio-cultural context of maternity care and motherhood (Davis-Floyd, 2018; De Souza, 2004; Newnham & Rothman, 2022; Rothman, 1982). In addition to feminist insights into the way in which we conceptualise and know about the perinatal period, a feminist-informed approach in which gender is foregrounded, is also valuable when looking at asylum seeking and refugee women's interaction with maternal health and social care as organisations. The maternity services, as well as the other sources of social support women commonly access, are overwhelmingly used by and staffed by women but are systems which reproduce patriarchal and racialised structures and configurations of power (Pendleton, 2019; Walsh, 2016), for example in the ways in which women's health and the health of minority ethnic populations are neglected and under-resourced (Devlin, 2024; Kapadia et al., 2022). Similarly, the areas of social care, the concept of caring and the activities of the voluntary sector who provide much of the support for asylum seeking and refugee women are heavily gendered and as a result consistently undervalued, underpaid, and underfunded (Kings Fund, 2023; Tronto, 1993).

As identified above, a feminist-informed approach can provide guidance on the '*doing*' aspects of research, the practice of undertaking research, in that feminist research is concerned with the process of research as much as the product of research (Letherby, 2003). The work of feminist researchers has sought not only to challenge established, androcentric ways of knowing about and understanding the world but also to explore what feminist research practice should look like and how feminists should act as researchers (Ackerly & True, 2020; Harding, 1988; Oakley, 1981; Stanley & Wise, 1983; Stanley & Wise, 1993). A feminist-informed approach to research is one in which researchers are encouraged to critically interrogate their research practise in order to ensure that their work is done in a way which is congruent with feminist ethical principles (Ackerly & True, 2020; Hesse-Bibber & Leavy, 2005; Olesen, 2018; Sprague, 2005) and as such is an approach which is

particularly appropriate when working with marginalised or vulnerable groups, such as asylum seeking and refugee women (Liamputtong, 2007; Mauthner et al., 2002; Sprague, 2005). Part of this doing research in a feminist-informed way also involves thinking about ethics both in terms of doing and in a philosophical sense in a way which aligns to feminist principles.

4.3 Ethics of care

My understanding of the wider social and political location of the perinatal social support experiences of asylum seeking and refugee women within the UK has been influenced by writing on the ethics of care. This work has built on the ideas of feminist ethics developed in the 1980s by Gilligan (1982) and Noddings (1984). Their work critiqued traditional Enlightenment ideas of ethics and morality, which emphasised concepts of justice and rights, valorising autonomy, independence, and self-sufficiency by showing the gendered and partial nature of these ideas. They suggested an alternative way of thinking about ethics and morality which privileges values such as care, the self in relation to others, interdependence and nurture, ideas traditionally omitted from philosophical discussion due to their association with femininity and the private sphere (Loughnane, 2022; Newnham & Kirkham, 2019; Thompson, 2020). Coming from this exploration of feminist ethics and particularly useful in my understanding of the nature and function of social support in the perinatal experiences of asylum seeking and refugee women, has been the work of Tronto (1993) and Chatzidakis et al. (2020) and their perceptions of the centrality of care, support and relationships in human wellbeing. This understanding of the role of relationships in human wellbeing resonated for me with Cobb's explanation of the personal experience of social support as being in part a '*belief that one is loved, valued and cared for as a member of a network of mutual obligations,'* (Cobb, 1976, p. 300) and in doing so highlighted to me the commonalities of the ideas of social support with their ideas of care and the need to locate social support and care within wider social, philosophical and ethical settings.

The writings of Tronto and other recent writing on the ethics of care have explored the value and centrality of relationships, interdependence and care as '*a central concern of human life'* (Tronto, 1993, p. 180) and have considered the role of

nurture, and care in a societal sense in a range of settings (Held, 2006; Kittay, 2020; Kittay, 2002; Sevenhuijsen, 2003). Underlying these discussions has commonly been the insight offered by Tronto and Fisher (1990) and Tronto (1993) who sought to explore the ideas of care and its societal meaning in more depth by identifying the concept of care as having four essential aspects; ca*ring about, taking care of, care giving* and *care receiving* and four associated care ethics; *attentiveness, responsibility, competence*, and *responsiveness* (Tronto, 1993, p. 127) (Table 4.1).

Caring about- recognising the need for care and that this need should be met	Attentiveness - the ability to recognise the needs of others by looking beyond our individualised needs
Taking care of – assuming some responsibility for the provision of care to address need	Responsibility - is an acknowledgement that humans have an obligation to care for each other and that this care be at both individual and collective levels.
Care giving – the acts or work of giving care	Competence - in this sense, is an obligation on those who provide care to ensure it is effective and appropriate and
Care receiving- the response of that which is cared for to the care received	Responsiveness - is related to the impact of care, whether person who receives care feels they have experienced care and the carers process of reflection on that

Table 4.1 Tronto and Fisher's four elements and aspects of care

Discussions of the ethics of care have considered how the ideas of care extend beyond the personal into a way of thinking about issues of care at the wider social and political level (Darling, 2011; Newnham & Kirkham, 2019; O'Riordan et al., 2023; Sevenhuijsen, 2003; Thomson et al., 2022). These writers have argued that care is culturally and social situated and that by looking at how current society values and does care, we can get an insight into how key aspects of social relations are currently structured and for whose benefit (Chatzidakis et al., 2020; O'Riordan et al., 2023; Sevenhuijsen, 2003). They use the idea of care as a way of exploring the relationship between the state and the individual looking at how care is politically and ideologically used, exploring ideas of the state's responsibility or lack of in terms of ideas of care and carelessness (Chatzidakis et al., 2020; Edwards et al., 2023; O'Riordan et al., 2023) (see chapter nine).This approach can therefore provide a way of exploring intersectional power, privilege, and inequity in society by looking at

how care is viewed and enacted and by whom (Lopez, 2019; Tronto, 1993) and provides a way to think about attitudes towards and the nature and provision of care in terms of the social support available to asylum seeking and refugee women. This understanding of the situated and culturally located nature of care, in this case as social support, and the ways in which it is conceptualised, understood and enacted is congruent with the feminist social constructionist underpinning of this thesis detailed below. Contemporary discussions of the ethics of care critically interrogate ideas of care within contemporary society as part of a critique of contemporary social attitudes and ethics, with the intention to influence change towards social justice (Newnham & Kirkham, 2019; Thompson, 2020) and so are congruent with a feminist-informed approach which seeks to critique the established and unequal social world.

4.4 Reflexivity

Reflexivity, '*the process of reflecting critically on the self as researcher*' (Guba & Lincoln, 2005, p. 192), is a key aspect of a feminist-informed approach to research. It forms a crucial part of feminist critiques of androcentric and positivist research and is a vital part of the goal of feminist research work which seeks to produce socially situated knowledge (Ackerly & True, 2020; Hesse-Biber & Piatelli, 2012). Reflexivity provides a way of acknowledging the role the researcher plays in research and the production of knowledge, allowing researchers to think about the epistemological and practical impact of our positions and lived experiences (Kingdon, 2005). Researcher reflexivity has been conceptualised as having several aspects (Kingdon, 2005; Olmos-Vega et al., 2023). In this study, two key aspects are explicitly addressed and integrated into the research and the writing of the thesis: personal reflexivity and communal or interpersonal reflexivity (Hesse-Bibber & Piatelli, 2012; Olmos-Vega et al., 2023). Personal reflexivity supports the researcher to explore their own biography, life experiences and position(s) in relation to the research, based on the assumption that we as researchers cannot take ourselves out of the process of knowing and so researching. The second, communal or interpersonal sense of reflexivity, supports the researcher to consider the social, the structural, political and cultural context in which the research takes place and in which the researcher and participant are located and how these affect the research process

and product (Hesse-Bibber & Piatelli, 2012) producing what Stanley has described as ‘accountable knowledge’ (Stanley & Wise, 2006).

In a feminist-informed approach, aspects of personal reflexivity need to be addressed throughout the research process from the inception of the research project to the final writing for submission. This was done through conversations with my supervisors and academic colleagues, through the process of reflexive writing and through presenting within academic settings. It was also addressed through reflection, conversations and writing within a more personal space in which I could explore and acknowledge my own life experiences and intellectual biography (as identified in chapter one) and how these affect the research process and the knowledge produced. These reflections have been integrated throughout the thesis as feminist reflexivity demands a constant and on-going process and is involved in and affects every aspect of the research process (Mauthner & Doucet, 2003) As part of this I have explored how my ideas about, and prior knowledge of, issues around motherhood, social support and migration may have effected nature of the research and considered the multiple, intersecting and shifting positions I hold within the research process and the possible tensions in these positions (Adams, 2021; Ryan, 2015). One of these tensions, identified by a number of feminist researchers, is between the desire to find commonalities in experiences, in this case as a woman and mother, of which I am both and approached participants from this perspective, while being mindful of the differences in experiences and avoiding universalist assumptions, as I am a white, non-migrant woman which makes my position and experience of these aspects of my identity very different to those of the women (Archer, 2004; Letherby, 2003).

The communal or interpersonal aspect of reflexivity mentioned above, has also been important in the research process and in thinking about my relationships with the women I have worked with who experience a marginalised location within UK society and whose situations are different to my own. When reflecting on my position as a white, non-migrant female researcher working within an academic tradition, with all the privileges inherent in that situation, the work of black feminists are helpful (Hill Collins, 1989; Hill Collins, 1990; hooks, 1984; hooks, 1987; Lorde, 1984). Their work provides a way for me to interrogate how I might undertake this work and produce

useful and valuable knowledge about lives of women whose experiences and identities are very different to mine in a way which does not perpetuate or reproduce dominant and oppressive tropes or forms of knowledge (Schmidt, 2023). Insights from these and other feminist thinkers supported the ways in which I have been able to reflect on the implications of differences in power within our relationships in all aspects of the research process. I did this within my field notes and in discussions with supervisors, colleagues working in the field, colleagues working with asylum seeking and refugee women and women with lived experience of the immigration system. This in turn has allowed me to try to address some of these issues in my research practice for example in the ways I recruited women, the data collection methods I chose and the ways in which I practically undertook the research with women; this aspect is explored further in chapters five and seven.

4.5 Ontological and epistemological position

Having undertaken to use a feminist-informed approach to doing research, it is important that the ontological and epistemological underpinning of the work are congruent with this. Consequently, this thesis takes a relativist ontological and feminist social constructionist epistemological philosophical position, to address the research questions chosen which explore asylum seeking and refugee women's perspectives on and experiences of perinatal social support. Traditionally, what has been valued as knowledge within maternal healthcare has been produced from within a realist and positivist bio-medical paradigm, which itself has been located within wider patriarchal, and colonial systems of knowledge (Lokugamage et al., 2022). Within this setting what has been seen to be known about women and maternity has been presented as measurable, replicable and universal and authoritative (Pendleton, 2019). This is an approach to knowledge which is based on assumptions about reality which are that it is stable and that there is a knowable reality or truth which exists outside, or independent of, human practices (Braun & Clarke, 2021). In contrast to this, a relativist and feminist approach as used in this research, is one which asserts that there is no single observable truth or reality waiting to be discovered that can be applied universally and has ahistorical authority (Braun & Clarke, 2021) and that what we think of as realty is unequal and hierarchical not universal and objective. In this understanding of the world and truth,

what is seen as real, or what we think of as true, is contingent, multiple and dependent on the historical and cultural context in which it (the phenomena) and we (the knower) are located (Braun & Clarke, 2021; Lincoln et al., 2013; Moon, 2014). It is this relativist approach which provides the most useful way to conceptualise and seek to understand the complex nature of asylum seeking and refugee women's experiences in the perinatal period.

The relativist ontological and feminist social constructionist epistemological approach was chosen as it is best placed to consider the complexity of asylum seeking and refugee women's experiences in the perinatal period. This approach provided me with a way of thinking about the nature of knowledge, what I can know and the ways in which knowledge is produced by, with and about asylum seeking women as I work with women to explore their experiences of the perinatal period (Braun & Clarke, 2021). While definitions of social constructionism vary (Burr, 2003; Crotty, 2012) Crotty defines it as being an approach in which:

> *all knowledge and therefore all meaningful reality as such, is contingent upon human practices being constructed in and out of interaction between human beings and their world and developed and transmitted within an essentially social context* (Crotty, 2012, p. 42).

This way of thinking about what we know and how we communicate that knowledge, helped me think about how asylum seeking and refugee women's knowledge and experiences of being an asylum seeker or refugee, becoming a mother and receiving social support, are produced, understood, and communicated. A feminist social constructionist perspective provided a way of thinking about how the experiences, ideas and perceptions asylum seeking and refugee women shared with me are constructed by and located in relation to their gender, immigration status, ethnicity, racialised identity, socio-economic location, previous experiences and the cultural resources they have access to (Ryan & Tonkiss, 2022).

Asylum seeking and refugee women experience these multiple and intersecting social positions or locations in their daily lives in the UK and as they interact with health and social care structures (De Souza, 2004; Lonergan, 2023; Rayment-Jones et al., 2019; Seu, 2003; Shobiye & Parker, 2023). The material and ideological consequences of these multiple and interacting constructions, are evident in asylum

seeking and refugee women's interactions with systems of power and authority such as the immigration, health and social care systems as well as wider social locations (De Souza, 2004; Rayment-Jones et al., 2019). It is within this context, that insights from feminist intersectionality helped me to think about the complexity of asylum seeking and refugee women's experiences and perceptions as well as my understanding of these issues. Drawing on the work of Black feminists and feminists of colour working in the 1980s and 1990s, feminist intersectionality was brought into public consciousness through the work of Crenshaw (1989) and Hill Collins (1990). While definitions of intersectionality vary, Hill Collins and Bilge (2016) suggest that it can provide:

> *A way of understanding and analysing the complexity in the world, in people and in human experiences. The events and conditions of social and political life and the self can seldom be understood as shaped by one factor. They are generally shaped by many factors in diverse and mutually influencing ways. When it comes to social inequity, people's lives and the organisation of power in a given society are better understood as being shaped not by a single axis of social division be it race or gender or class, but by many axes that work together and influence each other* (Hill Collins & Bilge, 2016, p. 2).

Insights from this approach helped me to think critically about the complexity of the multiple positions inhabited by asylum seeking and refugee women and how these are part of wider relationships and manifestations of power which shape the material experiences and perceptions of asylum seeking and refugee women.

A feminist social constructionist approach provided the most appropriate way for me to address the research questions identified for this research and to increase knowledge of the experiences and perceptions of asylum seeking and refugee women about social support in the perinatal period. This approach provided me with a way to think critically about categories or accepted 'truths' about ideas such as gender, race, migration, asylum seekers, refused asylum seekers and refugees, how they are constructed and the power of these constructions. It facilitates an understanding of how these taken for granted ideas or dominant understandings of phenomena are not natural or inevitable but have been produced, sustained, and reproduced by the interaction of people within specific historical and cultural settings

(Burr & Dick, 2017). It crucially illuminates the ways in which there can be multiple understandings and knowledges which exist at the same time, for example, there are different understandings of what it means to be an asylum seeker, a refugee, a woman, and a mother which depend upon the location of those who produce the knowledge. Asylum seeking and refugee women's experiences of and ways of understanding and thinking about the perinatal period are culturally and historically specific and are part of the wider social context in which they take place (De Souza, 2004; Floyd & Sakellariou, 2017), they are formed within their position as women, as migrants, as people of colour or as women who are ethnically marginalised in a particular geographical, historical and social context. Using a feminist social constructionist approach in this context provides a way of acknowledging and exploring how asylum seeking and refugee women's views and perspectives on social support and the perinatal period are produced through their location within patriarchal structures as women and as women of reproductive age, they are also linked to their past experiences in home countries, their migration experiences and by their interaction with dominant legal, health, policy discourses as well as those produced in the media or public settings (Seu, 2003).

However, some constructions, social classifications and categorisations, for example those relating to gender or migration, gain greater societal authority due to their relations to structures of power (Crotty, 2003; Lynn & Lea, 2003). For instance, in terms of the multiple constructions of knowledges about asylum seekers and refugee women, it is those from the media, legal or policy settings which have greater social power than those produced by asylum seeking or refugee women themselves. It is these overwhelmingly negative narratives which are produced and reproduced by more dominant groups, that have power to decide and enforce what can be seen as legitimate knowledge or the truth (Burr & Dick, 2017; Lonergan, 2023; Shobiye & Parker, 2023). In this context asylum seeking and refugee women's knowledge can be understood as a subjugated knowledge, one which differs from and has less power than the knowledges constructed by those with more access to power (Foucault, 1980). Seeking to explore and foreground women's understandings and knowledge of their own situation and to see this as legitimate and authoritative in this setting acts as a way of contesting the dominant narratives.

These concerns about power in relation to the (re)production of knowledge have been explored in feminist critiques of established ideas about knowledge production and the inequalities inherent in, and reproduced by, established academic practices (Harding, 1988; Hill Collins, 1990; Stanley & Wise, 1993). Concerned with issues of how we know, who knows and whose knowledge is valued, feminist approaches have sought to move towards a more collaborative and participatory approach to knowledge production, in order to challenge traditional androcentric and colonial approaches to knowledge production and the valorisation of certain knowledges (Hesse-Bibber & Piatelli, 2012; Hill Collins, 1990; Thwaites, 2017). This concern with epistemic injustice and the inequalities inherent in traditional ways of knowing and producing knowledge is particularly important for my study as the views, knowledges, and ways of knowing of asylum seeking and refugee women are likely to have been silenced and marginalised. This is due to traditional approaches to research and knowledge production which valorise certain views and ways of knowing belonging to those with traditional positions of power within the mechanisms of knowledge production and which exclude the less powerful (Bhakuni & Abimbola, 2021; Sik Ying Ho & Jackson, 2021; Spivak, 2015). This lack of epistemic power is a product of the ways in which asylum seeking and refugee women are marginalised as women and as ethnically minoritised women within patriarchal and colonial/racialised structures. It is also a production of their location as migrants within the global and local immigration system and how the knowledge claims of those positioned with these systems are seen as less valid than those who are not within the system who occupy more privileged and powerful positions (Davies et al., 2023). Using a feminist-informed approach to research and using insights from feminist thinkers have provided me with a way to remain aware of these issues of power and knowledge production and to address issues of power within all aspects of the research and knowledge production process (Ackerly & True, 2020; Duncombe & Jessop, 2012; Oakley, 1981).

4.6 Qualitative research design

This research uses a qualitative research design to explore the perinatal social support experiences of asylum seeking and refugee women, as this is an approach which is the most appropriate to the research questions posed. It is also an approach

to research which aligns with the relativist, social constructionist, and feminist underpinning of this thesis. Qualitative research acknowledges the situated, relativist informed and socially constructed nature of knowledge and experience (Ackerly & True, 2010; De Vaults & Gross, 2012). It seeks to understand particular social phenomena, in this case the perinatal social support experiences of asylum seeking and refugee women, within rather than separate to, the context of the phenomena, through exploring the perceptions and lived experience of individuals and social groups as they themselves experience and express these (Braun & Clarke, 2021; Lincoln et al., 2013). By using a qualitative research design, I have been able to acknowledge that, and explore the ways in which, asylum seeking and refugee women's experiences of social support are socially constructed. This approach also enables me to acknowledge the constructive and interpretative nature of the research process and the location of myself as a researcher within that process, being cognizant of the way in which I am an actor in the (co)construction of knowledge which is congruent with the relativist underpinning of the research (Burr & Dick, 2017; Hesse-Bibber & Piatelli, 2012; Lincoln et al., 2013).

In contrast to a quantitative approach, the purpose of qualitative research is not to quantify or measure. This approach is one which seeks to explore, understand and gain knowledge about social phenomena from the perspective of those involved, thereby gaining insight into the subjective perceptions, views and beliefs of individuals and groups. It seeks to use methods which can provide thick or rich experiential data to develop knowledge about the depth and complexity of experiences and as such fits with a understanding of the complexity of asylum seeking and refugee women's lived experience (Bearman, 2019). It aims to produce detailed insight through interaction with a limited number of participants rather than the production of uncontextualized and more surface data with a larger number of participants. There are a number of methods of data collection that can be used within a qualitative research design, both direct and indirect, the most common are interviews and focus groups, and these are the ones which have been chosen as the most appropriate ones for this thesis as they align with the feminist-informed research approach and the nature of the topic. As the purpose of the research is to explore women's personal experiences and views of social support from their perspective, this use of personal narratives enable connections to be made with the

social and historic context they are narrated within (Plummer, 1994). They allowed a personal and direct interaction between myself and the women I work with, allowing them to express themselves in their own words and for me to be responsive to their narratives and detailing of their views and experiences. The rationale behind the choice of these methods and their use within the empirical studies are explored in more depth in chapters five and seven.

4.7 Concluding paragraph

This chapter has established the methodological and theoretical underpinning of the thesis. It has explored my rationale for using a feminist-informed approach to research and what that means in the context of this work. I have detailed my relativist ontological and feminist social constructionist epistemological perspectives and their relationship to the research to be undertaken. Finally, I have explained my choice of a qualitative research design as the most appropriate design for this thesis. The next chapter will detail the rationale for and use of feminist semi-structured interviews in the first empirical study of the thesis.

CHAPTER FIVE METHODS - STUDY ONE

5. 1Introduction to the chapter

The previous chapter detailed the methodological approach and the theoretical underpinnings of this thesis. This chapter details the methods chosen for study one, in which feminist semi-structured interviews and reflexive thematic analysis were selected to address the research question *what are asylum seeking and refugee women's experiences of social support in the perinatal period?* The chapter explores the rationale behind these choices and demonstrates how they align with the methodological and theoretical underpinning of the thesis, as well as their practical application in the conducting of study one. It explores issues of recruitment, sampling, and ethical considerations as well as exploring the practicalities of undertaking the interviews with women, staff and volunteers. It concludes with an account of the application of reflexive thematic analysis to the data collected. As identified in the previous chapter, researcher reflexivity is an intrinsic part of doing feminist-informed research and was an important part of all aspects of the research process (Braun & Clarke, 2021; Hesse-Biber & Piatelli, 2012; Olmos-Vega et al., 2022), reflexive observations are therefore integrated though out this chapter.

5. 2 Method of data collection: Feminist semi-structured interviews

Research methods are defined by Harding as '*a technique for (or way of proceeding in) gathering evidence'* (Harding, 1988, p. 2) and as such are the specific tools, techniques and practices used to undertake research and address a specific research question, in this study, what are asylum seeking and refugee women's experiences of social support in the perinatal period? There have been debates over what methods should be used to undertake feminist research and the idea of specific feminist methods (Ackerly & True, 2020; Harding, 1988; Letherby, 2003; Oakley, 1981; Stanley & Wise, 1993). Drawing on these debates, my conceptualisation of feminist research methods is that methods in themselves are not feminist or non-feminist and that in feminist research the methods chosen for a study need to fit the research question and be located within a wider feminist-informed approach to research. As Sharp asserts:

> *It is not just the processes through which data are collected that make it feminist, but also the way in which projects are conceptualized and how we as researchers act as people (ethically, politically, emotionally) while engaged in the process* (Sharp, 2005, p. 305).

This chapter will demonstrate how a feminist-informed approach influenced all the practical aspects of the research process, from the process of recruitment, the consideration of the location and timing of the interviews, to the ways the interviews were conducted and my interactions with all those involved in the study (Oakley, 2018; Sprague, 2005).

As identified in the previous chapter, there are several possible methods of data collection which can be used in qualitative research. However, for study one, feminist semi-structured interviews were chosen as the most appropriate method for working with asylum seeking and refugee women, and the volunteers and staff who support them. As a white, non-migrant woman with an academic position doing research with asylum seeking and refugee women from marginalised and racialised backgrounds, it was important for me to think about my position(s) in relation to those I was interviewing, potential power imbalances and the impact of this on the way research was undertaken and knowledge produced (Edwards, 1990; Herron, 2022). This need to address issues of power within the research process has been identified as a crucial aspect of doing research work with asylum seeking and refugee populations (Dempsey, 2018; Fedyuk & Zentai, 2018; Liamputtong, 2007; Merry et al., 2016; Thummapol et al., 2019). A feminist approach to interviewing, and insights from the theoretical underpinnings of this approach, developed as part of feminist critiques of androcentric research methods (DeVault & Gross, 2012; Gluck & Patai, 1991; Herron, 2022; Letherby, 2003) allowed me to explore and seek to address these issues of power and knowledge production. This approach also allowed me to consider issues around the ideas of voice, difference, and research relationships, as these are all key aspects of a feminist approach to interviews (DeVault & Gross, 2012; J. Duncombe & J. Jessop, 2012; Oakley, 1981; Oakley, 2016; Thwaites, 2017).

At this stage of the research, I wanted to work with participants in a one-to-one setting to hear their experiences of perinatal social support and to locate these

experiences at the centre of the research. Feminist semi-structured interviews are a method which produce rich data and as such provided an opportunity to explore in depth the lived experiences and perspectives of the asylum seeking and refugee women, volunteers and staff who participated in the study (Hesse-Bibber & Leavy, 2005; Mason, 2011). While unstructured interviews provide the greatest opportunity for participant involvement in knowledge production and are frequently used in feminist research, when there are specific issues which need be addressed semi-structured interviews are more appropriate. Using a semi-structured approach allowed interviews to be more exploratory and cooperative in terms of knowledge production than structured interviews would have been, by creating space for the emergence of issues identified by participants from their lived experiences, while still allowing for a focused exploration of key research areas (DeVault & Gross, 2012; Fedyuk & Zentai, 2018; Hesse-Bibber & Leavy, 2005). This approach fitted with my social constructionist epistemology as it acknowledges the idea that knowledge produced during an interview is socially constructed, that it is subjective, situated and co-constructed in the interaction between participants during the interview (De Vault & Gross, 2014; Herron, 2023; Mason, 2011).

Using feminist semi-structured interviews thus provided me with a method which fitted with my qualitative interpretative research design, as well as aligning with my feminist-informed approach and the underlying feminist and social constructionist epistemology. Following a feminist approach to interviewing meant that a key concern within the research was keeping the needs of all the women I spoke to at the centre of the process in all aspects of the research and acknowledging the complexities of the daily lives of asylum seeking and refugee mothers (Merry et al., 2016; Thummapol et al., 2019).

5. 3 Interviews with Asylum seeking and refugee women

5.3.1 Constructing the interview schedule

A broad semi-structured interview schedule was developed, drawing on the results of the Critical Interpretative synthesis and insights from Birth Hierarchy model (Radloff, 2020) as presented in chapter three. Questions were developed using the elements of the model as a way of thinking about different aspects of women's perinatal

experiences and needs to get a holistic view of women's social support experiences in the perinatal period. The schedule was designed to explore with asylum seeking and refugee women their experiences of social support in relation to their physiological needs, their feelings of safety and security to give birth, their social needs and issues of self-esteem; all areas linked to the model. While I had areas I hoped to address with women in the interview schedule, I sought to ensure that there were opportunities for women to raise issues that I had not thought of and for other issues to emerge.

In addition to questions about women's experiences, basic demographic questions were included to provide context including country of origin, status within the immigration system, length of time in the UK, number of children and age of youngest child. These ideas were then discussed with supervisors and in initial informal conversations with voluntary workers and staff.

The impact of social support during the perinatal period on the wellbeing of asylum seeking and refugee women

Participant interviews: topic guide

Preamble

Introduce the research and the purpose of this interview

Opportunity to ask questions

Explain confidentiality and data protection

Discuss and take verbal consent

General questions guide

What was your experience of being pregnant, having a baby and being a new mother in the UK?
Did you have people who supported you during this time?
If so, how did they support you?
What was the most important thing people did to help you at this time?
Did women have their needs (as identified below) met and how was this done?

Did people help them with these, if so how helped and how?

Themes to explore linked to the birth needs hierarchy model:

Physiological needs: explore issues related to women's physiological needs. These include housing, destitution, dispersal, food, money, immigration status, having requisites for baby and self.

Safety and security needs: explore issues which relate to feelings of safety and security during the perinatal period. These include knowledge of and access to services, place of birth, communication around birth and any medical procedures, access to birth supporters, concern over possible payment or dispersal.

Social needs: explore issues including respectful care, did they feel cared for, did they feel encouraged and supported, who supported them in this period and what was the impact of this support (or lack of).

Self-esteem: explore issues related to if they encouraged, praised or made to feel valued as a birthing woman and new mum, did they feel confidence/pride in their achievement, if they received support who did they receive this from.

Self-actualisation: how did they feel during and after the birth – evaluate the experience overall.

5.3.2 Sampling and recruitment

There are several sampling strategies which can be used as part of a qualitative research design - purposive, convenience, snowball and theoretical - for this study a purposive sampling strategy was chosen. This strategy was chosen as it is a way of selecting participants who are most likely to have appropriate knowledge and experience of the phenomena (Campbell et al., 2020) and are best placed to answer the research question (Mason, 2011). In this study it allowed me to recruit women within the UK immigration system who had recent experience of having a baby in the UK. In a qualitive study, as opposed to a quantitative one, a small number of purposively selected participants may be used, as the focus of the research is to support an in-depth understanding of an issue amongst those with specific experiences (Campbell et al., 2020). The issue of sample size or number of interviews needed in qualitative research is identified by Baker and Edwards (2012)

as an area of considerable debate. They suggest that within qualitative research, sample size, in this case how many interviews were needed, should depend on the nature of the project, its aims and epistemological underpinning as well as practical considerations, and that these considerations should determine the number of participants. Following this approach, I decided that for this study to reflect the heterogeneity of asylum seeking and refugee experience, I wanted to ensure that I had a sample which represented a range of different aspects of the perinatal experience of asylum seeking and refugee women. This was reflected in the inclusion and exclusion criteria identified below. I had aimed to recruit 20 women to achieve this diversity, however recruitment concluded at 18 women, as I felt I had achieved a diverse group of participants who represented a range of experiences. This was also balanced with the practicalities of limited research resources.

To acknowledge the heterogeneity of asylum seeking and refugee women's backgrounds and the impact of this heterogeneity on women's perinatal experiences (Balaam, Haith-Cooper, et al., 2017; Fair et al., 2020), the inclusion and exclusion criteria for the study were designed to ensure that women recruited came from a range of countries worldwide, had a range of different legal statuses within the UK and had been in the UK for differing amounts of time. To gain insight into the perinatal experience in the UK, women were recruited who had a child two years old or under who had been born in the UK. This was to ensure that women's experiences of perinatal social support were recent and so were more likely to reflect current experiences of the immigration regime and the social support currently on offer. Additionally, and pragmatically, women with children of this age are still accessing mother and baby groups which provided an important location to recruit women.

In this study no specific geographical locations, organisations or women are identified. This is for safeguarding reasons to ensure the anonymity and so the safety of all those involved. This is particularly the case in terms of naming the voluntary organisations involved. While other services were available for asylum seeking and refugee populations more generally, depending on the size of the town or city, the organisations I worked with were all small organisations but were at that time the primary source of support specifically for perinatal women in these locations and as such were potentially identifiable.

This study focused on and recruited women from a number of locations within the north of England. These locations included towns and cities which represented a range of areas within the wider region and included locations with different size populations, ethnic demographics and histories of immigration. While these differences may affect aspects of the women's experiences and the level of support they received, there are key commonalities within the region which affect all women's experiences compared to other regions and so present a common regional experience. The north of England is a region which has experienced significant de-industrialisation and under-investment since the 1980s, leading to high levels of deprivation, under-employment and poor population health outcomes (McKee et al., 2021; Munford, 2023). A recent report has highlighted the particular challenges faced by women in the region who experience some of the worse health outcomes in the UK, including maternal and perinatal health and where the experiences for minoritised and marginalised women are particularly poor (Bambra et al., 2024). Additionally, the north of England is an area which houses a high number of asylum seekers and refugees per head of population, including both newly arrived populations as well as large numbers of asylum seekers dispersed from their initial locations in line with governmental policies following the 1999 Asylum and Immigration Act (Halliday et al., 2021; Migration Observatory, 2022a). However, despite this there is a limited amount of research on the experiences of asylum seeking and refugee women in this region.

Women were eligible to take part in the study, if they could speak English or if it was possible to access interpretation for them. I wanted to access as many women as possible but as there was no funding for interpreters, interpretation was only possible using local informal sources of interpretation (see section on language and interpretation below). This approach was used to reach as many women as possible and to not further marginalise women with limited English fluency. Women who are not fluent in the language of the reception country can be additionally marginalised (Floyd & Sakellariou, 2017) and lack of language proficiency provides an additional challenge to accessing care and support in the perinatal period (Cull et al., 2022). Being able to access these women allowed a wider range of women and experiences to be included in the study. If women did not speak English and it was not possible to secure interpretation for them, they could not be interviewed. This

was a challenging aspect of the study and is explored further in the section on language and interpretation below.

Inclusion	Exclusion
Women who are currently resident in the North of England	Women who were resident elsewhere in the UK
Women whose youngest child is 2 years old or under	Women whose youngest child is over 2 years old
Women who have given birth in the UK	Women whose youngest child was born outside of the UK
Women who are within the UK Immigration system including those who are asylum seekers, refused asylum seekers, were appealing against their refusal or had no recourse to public funds, refugees, part of the Syrian resettlement or Gateway protection scheme	Women who are not within the UK immigration system, UK residents or EU/other migrants
Sufficient fluency in English or have someone who can interpret for them	Non-English speaker without possibility of interpretation
Women who have come to the UK from any country	Women who were born in the UK

Table 5.1 Inclusion and exclusion criteria

To recruit women to the project I worked with community organisations who support asylum seeking and refugee women. This provided me with a pragmatic way to reach women and is a way which can address some of the challenges associated with recruiting individuals from marginalised communities, as it means that the researcher is associated with trusted organisations with which potential participants already have relationships (Block et al., 2012; Bonevski et al., 2014; Ellard-Gray et al., 2015; Rockliffe et al., 2018). Working in this way can build relationships which may reduce mistrust of researchers and support a more collaborative sense of research with participants who otherwise may be reluctant to become involved in research (Bonevski et al., 2014; Ellard-Gray et al., 2015; Thummapol et al., 2019).

To begin the process of recruitment I contacted a number of charities, community groups and individuals in the North of England who work with asylum seeking and

refugee women and families. The project was discussed with these contacts to see if they, and the women they supported, would be interested in being involved. All contacts were sent information about the project in the form of an information sheet and details of the consent procedure (Appendix 2 and 3). Several groups declined to be involved as they had no women who fitted the inclusion criteria, they did not want to be involved in research or they felt the women they supported were too vulnerable to be involved. In the end participants were recruited from four local community groups as well as in collaboration with two individuals, one who worked for a local council and another who was part of a church organisation. I was not working with any of the organisations or groups approached at the time of recruitment and data collection.

It has been noted that in some situations leaders of organisations can act as gatekeepers, limiting and controlling access to individuals within those organisations (Hynes, 2003; Rockliffe et al., 2018). I did experience this in one situation where I was unable to gain access to a mother and baby group despite several people referring me to it. However, after several attempts to follow up initial contacts with the group leader I was unable to access the group. This situation limited the participants I could recruit from one city and meant the data I had from this location came from one participant. However, in all other settings, contacts and group leaders welcomed me and the research I was doing, seeing it as a positive and empowering opportunity for women to speak out and to have their voices heard and seeing involvement in research as beneficial to the women they supported.

As identified in the methodology chapter, a feminist-informed approach to research necessitates attention to relationships within all aspects of the research process. Developing a trustful relationship is important in all research settings but is particularly so when working with asylum seeking and refugee women in the UK whose daily life experiences are located within an immigration system which is predicated on and perpetuates a '*a culture of disbelief*' (Anderson et al., 2014, p. 4). This can create a lack of trust in, or fear of, those who are perceived to be in a position of authority including those undertaking research (Anderson et al., 2014; Hynes, 2003). It was therefore important that I worked with staff and volunteers who were part of organisations with whom the women already had a positive relationship. It seemed that if these individuals were happy for me to work with them, I was seen

as someone who was, due to this association, more trustworthy to potential participants.

I made an initial visit to the groups to meet the women, staff and volunteers. I explained the nature of the project to the volunteers, staff and women who were present as well as providing information sheets (Appendix 2). Informal translation was undertaken by staff or women in the group where necessary to ensure that all women were clear about the nature of the project (for a fuller discussion around using interpreters see section language and interpretation below). Women were individually asked if they would be interested in taking part in the study and/or volunteers or staff suggested women they thought would be happy to talk about their experiences. If women were interested in taking part, I arranged to come back to the group at the usual time and location to meet them to undertake the interview which would be audio-recorded. 13 out of the total of 18 women who participated in the study were recruited in this way.

It had been initially envisaged that all participants would be contacted in this way. However, it became apparent that there were some women who were part of the organisations and groups, and who my contacts felt would be interested in the project, but who did not always physically attend the groups. To address this the volunteers from the organisations and a contact from a local church organisation, reached out to these women to discuss the project. If they were interested, the volunteers and myself discussed the project with them, giving them the participant information details. If the women were interested, the contact arranged a time that was convenient, for them, for us to meet. Five participants were recruited in this way. This need for this flexibility was part of my commitment to a feminist-informed approach which sought to respond to the daily lives and needs of women, to ensure that I could work with a wide range of women and to ensure that they remained at the centre of the research.

5. 4 Including volunteers and staff in the study

The initial project plan had included only interviewing refugee and asylum seeking women, however my contact with the staff and volunteers made me realise the insights they could offer would be beneficial to the research. One example of this was when I became aware from talking to staff that there were sources of support

available in the local area that the women I had spoken to had not mentioned as they personally had not used and were unaware of. Talking to the staff and volunteers would help me have a fuller picture of the support available for women locally. Volunteers and staff could provide information about the nature and context of the social support offered by each organisation in the local area, as well as about their experiences of providing this support.

5.4.1 Constructing the interview schedule

After completing the interviews with women, a broad semi-structured interview schedule was developed for the interviews with volunteers and staff. This was based on the key themes from the women's interview schedule, which was then amended and adapted following reflections on the interviews undertaken with women, as well as discussions with staff as the project developed. The schedule was developed to ask staff about what they felt were the most important aspects of social support for women at this time, the nature of social support their organisations offered and details of other local sources of support that were available.

The impact of social support during the perinatal period on the wellbeing of asylum seeking and refugee women

Participant interviews: volunteers/workers: topic guide

Preamble

Introduce the research and the purpose of this interview

Opportunity to ask questions

Explain confidentiality and data protection

Discuss and take verbal consent

General questions guide

What support is provided by your organisation for refugee and asylum seeking women during pregnancy, birth and new motherhood?
How is support provided and by whom?
What is your experience of supporting women in this period?

Are you aware of other sources of support in the area from other groups or statutory services?
What do you think are the biggest challenges and most important aspects of support for women at this time?

Themes to explore linked to the birth needs hierarchy model and the provision of services that might support the following issues:

Physiological needs: explore issues related to women's physiological needs. These include provision of housing, destitution, dispersal, food, money, immigration status, having requisites for baby and self.

Safety and security needs: explore issues which relate to feelings of safety and security during the perinatal period. These include: knowledge of and access to services, place of birth, communication around birth and any medical procedures, access to birth supporters, concern over possible payment or dispersal.

Social needs: explore issues including: respectful care, care, encouragement and support for women, who supported them and how.

Self-esteem: were/how were women encouraged, praised or made to feel valued as a birthing woman and new mum, did they feel women had confidence/pride in their achievement.

5.4.2 Sampling and recruitment

Purposive sampling was again chosen as the most appropriate method of sampling for the research with staff and volunteers (Campbell et al., 2020). I wanted to talk to key individuals involved in providing services for asylum seeking and refugee women with whom I had contact in the five locations in this part of the study. This was to provide me with background information about local services available support asylum seeking and refugee women. The only inclusion criteria were that the individual worked with the organisations and/or in the localities in which support was offered and that they had knowledge of the services offered to women. I approached staff and volunteers who were local contacts and/or worked with the groups I had been in contact with to see if they were willing to be interviewed. They already understood the nature of my research and were familiar with myself through our

initial discussions about the project and recruitment of women participants to the study. I provided them with specific information relating to their involvement as interview participants (Appendix 4) and discussed this with them. All other issues related to ethics, data protection and research processes were the same as those undertaken with women participants.

I recruited four staff and volunteers, these included representatives from three of the four key organisations that I worked with and one member of staff who worked for a local authority. I was unable to interview a representative from the fourth key organisation due initially to a lack of availability and then recruitment had to stop due to the start of the COVID-19 pandemic. Following the principles used above in terms of the numbers of participants needed for a study being that which fitted the specific project, and in light of the onset of COVID-19, I stopped recruitment at this point. I felt that having these participants, who were key informants about these issues within their locality and linked to the organisations which supported the women, provided me with knowledge about social support in different settings and geographical locations and as such were a sufficient sample for the specific needs of this element of the study.

5.5 Conducting the interviews

5.5.1 Reflexivity

As discussed in the previous chapter, reflexivity is a crucial part of a feminist-informed and qualitive research. As part of the process of data collection, I kept fieldnotes to support the reflexive aspect of my research practice (Olmos-Vega et al., 2023; Phillippi & Lauderdale, 2018). These notes served several key functions in this stage of the research process. Firstly, they allowed me to think about practical and methodological issues related to data collection as I undertook the interviews. For example, they helped me to reflect on the process of interviewing, the content and nature of the interviews and helped me to think about my approach to subsequent interviews to incorporate any learning and insights gained as the research progressed. Secondly, the notes provided me with the opportunity to think about my personal location within the interviews as well as my relationship to the participants and interview process. They provided me with an opportunity to explore my feelings about the content and nature of the interviews and the stories women had shared with me. They allowed me a space to try to process the issues raised in the

interviews which could often be challenging and upsetting before I reverted into my daily life. Insights from these notes are integrated in the sections below.

5.5.2 Location

All interviews were undertaken in locations within the community where women felt comfortable, in a local community venue or in their home. The choice of the location of an interview is an important consideration. Undertaking interviews in a location in which a participant does not feel comfortable or confident will affect the nature of the interview and can increase power imbalances within the research relationship (Edwards & Holland, 2013; Elwood & Martin, 2000) and does not fit with a commitment to creating a positive relationship with participants, a less hierarchical setting and supporting participant wellbeing; all important aspects of a feminist-informed interviews (Oakley, 1981).

13 interviews with asylum seeking and refugee women were undertaken at the location of the mother and baby groups where recruitment had taken place. This location was familiar to participants and meant that participants did not incur any travel expenses as the groups reimbursed their travel costs. The interviews were undertaken in separate rooms from group activities where possible, or else in a quiet corner of the room where other people couldn't overhear the interview to ensure privacy and confidentiality. The location of the interviews within community settings when other activities were going on, particularly mother and baby groups, meant that interviews were commonly done in situations which were noisy and with women talking to me while managing their children and/or waiting to speak to support workers, or take part in other activities:

> *It was a very busy drop in day …. not a formal mum and baby group but a space in larger hall with toys out and some chairs for mums, many people were there to access other services, so not necessarily just for mum and baby groups- kind of passing through.* (Extract from field notes)

Women's babies and often other children were present at the interviews adding an extra dimension to interviewing, particularly the need for flexibility and empathy as the participant, the volunteer if present, and myself acted to engage with the children while I undertook the interview:

Both women had children and small babies with them who were very unsettled throughout the whole interview, so it was very hard to hear them at times as they had to get up/settle or feed children. I also tried to play with the children while they were talking – drawing with them. (Extract from field notes)

Figure 5.1 Drawing done with toddler while interviewing

Interviews took place at times when older children would be at school or when other members of the group could look after additional children, if appropriate, to address issues of childcare. However, there was a need to fit into women's timetables and to adapt to situations. In several situations the times women had indicated as being convenient for them were close to the end of school or time for older children's meals, so this meant that I had to be mindful that women had to leave to pick up children or were thinking about feeding their children:

> *We had to curtail interview as [interviewee] had to go to collect older children from school. (*Extract from field notes)

In these situations, interviews may not conform to the traditional ideas of the ideal or good interview, as one that is uninterrupted and in a quiet space (Edwards & Holland, 2013). However, this idea of the perfect interview setting is not a realistic ideal if research is to be done with women and families (MacDonald & Greggans, 2008) and adhering to this ideal would exclude much research with women and families and would not reflect the real lives of women. It is in these settings, which can feel challenging and chaotic, that researchers need to be flexible and adapt to fit the situation and keep the needs and comfort of the participant in mind.

Five interviews took place in women's homes; in this setting the issue of researcher safety was considered (Kenyon & Hawker, 1999) and UCLan safe lone working procedures were followed. When interviews were undertaken in women's homes I was often given refreshments, commonly dishes from women's home countries that they were keen for me to try and indeed often gave me extra to take home for my children. I was aware that when I was in women's home there was a different dynamic and power relationship, with women having a more powerful position as I was a guest rather than us meeting in a common space. In all but one of these interviews participants chose to have other people they trusted with them, in one case a female friend, in several others a trusted female volunteer and in one case a grown-up daughter who interpreted for her. While the presence of other people in the interviews affects the dynamics, and content of the interview, to ensure that women felt comfortable and psychologically safe and were willing to take part in the research, it was important to be flexible and support women's choices to have

people they trusted present. The impact of other people in the interview setting was something that I reflected on in my field notes and in my understanding of the construction of women's narratives. In no situation did the presence of others feel inhibitory; it seemed to allow women to feel comfortable within the interview. The interviews in these settings were generally more relaxed and quieter than those held in community venues outside of the home.

Interviews with women, in both settings, varied in length, with recordings lasting between 20 and 50 minutes, reflecting the extra time needed for interviews which included interpretation, as well as women's confidence in speaking, and interruptions and external issues which limited women's time.

Interviews with staff and volunteers were undertaken at a time and a place convenient to participants, including their work setting, at a community venue and in their home according to their preference. Safe lone working procedure was followed when interviewing in a home setting. The interview recordings lasted between 25 and 40 minutes. These interviews were largely undertaken in a quieter setting than those with the women, though there were time constraints related to the participants' availability as there had been with the women's interviews:

> *In retrospect felt she was very busy, and this was a bit rushed/not an ideal time for her the interview ended abruptly as her husband needed her.* (Extract from field notes)

Field notes were written up after each interview.

5.5.3 Language and interpretation

Women who were confident speaking English were interviewed in English. For five women who were not confident speaking English but who wanted to be involved in the project informal interpretation was used. As identified above, this was a pragmatic choice as this was an unfunded project with no budget to pay for formal interpretation. This approach followed the precedent of other research projects with marginalised women where informal or peer interpretation has been used to support the participation of participants from underrepresented communities (Iqbal et al., 2023; Montague & Haith-Cooper, 2022).

Research on the use of informal interpreters in medical settings has, while acknowledging their widespread use, identified ethical and practical concerns over their use in patient-professional interactions (MacFarlane et al., 2009; Zendedel et al., 2018), with more formalised or professional interpreters being seen as a more appropriate option in these settings (Cull et al., 2022; Flores, 2005; Keller & Carrascoza-Bolanos, 2023; Zendedel et al., 2018). From a migrant participant perspective, the research is less clear; several studies suggest that some people prefer informal interpretation as they have more trust in peer interpreters who they feel will understand their situation, while others express concern about a lack of confidentiality and privacy (Keller & Carrascoza-Bolanos, 2023; MacFarlane et al., 2009; Zendedel et al., 2018). While acknowledging that the interviews undertaken for this study are different to medical interactions, it is useful to reflect on these issues and the issues involved in using interpretation of any kind when undertaking interviews and to take steps to mitigate where possible any issues of concern.

It was important to acknowledge that using an interpreter during an interview has an impact on the process and content of the interview (Suurmond et al., 2016; Wechsler, 2016). However, as I could not speak any of the native languages of my participants this was a necessary situation if I wanted to have them participate. Interpreters affect the interaction between the interviewer and participant bringing with them new relational and power dynamics, they can also affect the content of the interview, what is said and how it is said by changing, omitting or adding information (Suurmond et al., 2016; Wechsler, 2016).

Attempts were made to address some of these issues within the study. The use of an interpreter was discussed and agreed with all participants prior to the interview and all women were happy with the person who was interpreting for them. Those who interpreted for women included an older daughter, a friend and other women who were present at the mother and baby groups. All interpreters were female and had an understanding of issues related to asylum seeking and refugee women through personal and/or professional experience and so understood the sensitivity involved. The aims and nature of the project were discussed with all interpreters as was the need for confidentiality and privacy. During the interview additional time was made to ensure that interpretation could take place as interviews with interpretation commonly take longer. During the interviews any uncertainty or lack of clarity was

addressed by asking follow-up questions to ensure that I understood what a women was trying to say. Reflexive notes were made after the interviews which included reflection on aspects of the nature and possible impact of interpretation within the interview setting.

Interpretation was not needed for any volunteer and staff interviews as all participants were English native speakers or were fluent in English.

5.5.4 Relationships/positionality

A key area of concern in feminist interviews, as it is in wider feminist-informed research, is the nature of the relationship between the participant and interviewer. In a rejection of traditional approaches to interviewer – interviewee relationships which stressed detachment and objectivity, early feminist approaches sought to develop a more equal and a friendly relationship, one in which the interviewer shared her experiences with the women they interviewed and in which a commonality between women, due to gender oppression, was assumed (Oakley, 1981). More recent work has problematised this approach and its underlying assumptions, seeking to explore the complexity and shifting nature of the relationship between the researcher and participant, the challenges of seeking commonality and the idea that a researcher can hold multiple positions simultaneously (Jean Duncombe & Julie Jessop, 2012; Herron, 2022; Lokot, 2019; Oakley, 2016; Ryan, 2015; Thummapol et al., 2019; Thwaites, 2017). Influenced by insights from feminist work and from researchers working with asylum seekers and refugees, I sought to create the conditions in which women felt comfortable to talk to me, while thinking about my position within the interview and the power dynamics present in the context of the interviews.

All interview sessions began with introductions, or re-introductions and an informal chat as a way of trying to make women feel comfortable with the situation and with myself. To establish some sense of connection and reciprocity, and to make women feel comfortable before we undertook the interview, we commonly spoke about their children, who were usually present, and their daily lives, and they often asked me about my children and my work (Oakley, 2016; Thwaites, 2017). I shared some details with them about being a mother and the nature of my work and interests. In these conversations I was very aware of both the commonalities we had as women and mothers, our common concerns about the wellbeing of our children and our

experiences of birth, while also being keenly aware of the differences in all other aspects of our lived experiences. I found that the reconsideration of the ideas of interview relationships which explore the ideas of intersecting and multiple positionalities helpful. This idea of multiple positionalities, which questions the simpler idea an insider/outsider dichotomy and allows that researchers can be both insider and outsider, privileged and oppressed, simultaneously, helped me think through these issues (Edwards, 1990; Herron, 2022; Iqbal et al., 2023; Joseph et al., 2021) .

The relationship dynamics within the interviews with staff were different than in those with asylum seeking and refugee women. There were more commonalities in status and backgrounds between these women and me, as they were all British or European heritage women who were UK citizens or had formal legal status within the UK. Three of them were mothers, two were also grandmothers and all had a commitment to working with and supporting women's wellbeing on a voluntary or professional level. There was a level of familiarity and trust with these staff and volunteers already built up though our earlier and on-going contacts as I worked with them to recruit women to the study. The content and tenor of the interviews differed as well, as these interviews were less focused on very intimate personal experiences and more focused on providing support for women, than on reflecting on supporting women on the issues faced and the support services available in the local area. As with the interviews with women, field notes were taken to support these interviews.

5.6 Ethical considerations

Researchers have discussed practical and ethical challenges related to doing research with what are seen to be vulnerable, marginalised or disadvantaged populations (Bonevski et al., 2014; Ellard-Gray et al., 2015; Liamputtong, 2010; Smith, 2008), including migrant populations (Block et al., 2012; Goedhart et al., 2021b; Halilovich, 2013; Matos et al., 2023; Merry et al., 2016; Rockliffe et al., 2018; van den Muijsenbergh et al., 2016). These challenges have previously led to situations in which marginalised groups have been excluded from research, being seen as too difficult to reach or as too vulnerable to include (Goedhart et al., 2021b; Smith, 2008; Thummapol et al., 2019). However, it can be argued that it is unethical to exclude populations from research from which they may benefit, particularly within health research where a lack of relevant research exacerbates health inequities and

where it can be argued that it is an ethical necessity that researchers seek to engage with such populations (Floyd & Sakellariou, 2017; Matos et al., 2023; Merry et al., 2016; Smith, 2008). To do this in an ethical way researchers need to respect the agency of individuals and groups who experience social, cultural and economic marginalisation and facilitate their participation in research whilst also ensuring that they are not exploited or further marginalised by the research (Block et al., 2012; Liamputtong, 2007, 2018; Merry et al., 2016). Areas of particular concern have been identified as consent, privacy, power and the need to balance benefits and potential harms of involvement (Fox, 2020; Liamputtong, 2011; Matos et al., 2023; Merry et al., 2016; Smith, 2008). It was therefore important to think about ways in which I could address these issues in my research to ensure that my research was undertaken in an ethical and sensitive way. Particular attention was paid to informed consent, confidentiality and addressing the wellbeing of participants throughout all aspects of the research; these are explored below.

5.6.1 Informed consent

The principle of informed consent is crucial in all research with human participants. However, gaining fully informed consent when undertaking research with vulnerable or marginalised communities may be more challenging (Liamputtong, 2011; van den Muijsenbergh et al., 2016). As informed consent is based upon participants clearly understanding what they are consenting to (Miller & Bell, 2002) it was important to ensure that women understood the nature of the research and their involvement in it. Information about the project in the form of participant information sheets given to organisations and shared with participants were written in plain English. Women were encouraged to read this if they could and/or to share this with friends, family or volunteers. As all women approached or recruited to the project had English as an additional language, information about the project was also discussed verbally in English, or where needed informal interpretation was used. Following a practice used and recommended by researchers working in this field, verbal rather than written consent was taken from participants at the start of the interview. Verbal consent is recommended as a way of overcoming issues relating to literacy as well as to avoid a situation where some women from migrant backgrounds maybe reticent to sign documentation (Haith-Cooper et al., 2020). After the initial chat at the beginning of all interview sessions, consent was discussed to ensure participants

were happy to take part in the study and to be audio-recorded. Verbal consent was then taken before the interview began and then was reviewed at the end of the interview to ensure participants were still happy with having shared their stories.

Imbalances in power and status may affect the ability to gain fully informed consent. This can be the case particularly when participants are recruited, as mine were, through organisations offering them support. Some participants may feel coerced or obligated into taking part in research or find it challenging to say that they do not want to participate (Merry et al., 2016; Mkandawire-Valhmu, 2009). To address this possibility, care was taken to reassure women that participation in the study was entirely voluntary. Participants were informed that the researcher was not linked to the organisation or to any official body relating to immigration. It was also stressed that choosing not to participate would not negatively affect the support women received from the organisations and would not affect their asylum claim. It was explained to the participants that they could withdraw from the study up to the point at which data analysis was undertaken and any information they had given would be deleted.

5.6.2 Confidentiality and anonymity

Issues of confidentiality**,** anonymity, the use of information and data sharing are particularly salient when working with women within the immigration system (Ellard-Gray et al., 2015; Merry et al., 2011; van den Muijsenbergh et al., 2016). To address these concerns, steps were taken to ensure their anonymity and the safety of their data by complying with data protection regulations. Participants were reassured that only the researcher would know their identity and be able to link it to their data and that their identity would be protected as any contributions would be anonymised. They were further assured that none of the information they provided would be shared with any statutory authorities (e.g., the Home Office). The only time any information would be shared with any authorities would be in relation to the safeguarding of participants or their children, as it is a statutory obligation to report safeguarding concerns, and this was explained to the participants during initial discussions. To conform with GDPR and University data protection procedures all electronic data was stored securely on the university password protected system with demographic or identifiable data stored separately to interview data. Following data protection regulations all identifiable data will be destroyed after seven years.

5.6.3 Wellbeing of participants

Concern with the wellbeing of all participants was paramount and steps were taken to ensure that all participants were happy with the research process and knew how to access support if they needed it. However, the difference between the situation for the asylum seeking and refugee women and that of the staff was acknowledged. While asylum seeking and refugee women were discussing personal experiences, staff were interviewed in a more professional and less personal capacity about the nature of social support their organisations offered and details of other local sources of support that were available.

As identified in 5.3.1 (constructing the interview schedule), the interviews undertaken with asylum seeking and refugee women focused on women's perinatal experiences in the UK and did not seek to explore wider issues relating to migration or experiences outside the perinatal period. This was done to focus on the specific period which the research question addressed to explore this in depth. It also reflected ideas from sensitive and trauma informed practice to try to reduce the chance of re-traumatisation of women I spoke to, if they had experienced trauma, and to acknowledge that participants may have had traumatic experiences as part of their migration journey, including gender-based violence. The ideas underpinning trauma-informed care (Law et al., 2021) and insights from researchers working with migrant populations (Healy, 2021; Lokot, 2019; Tomren & Opaas, 2024) suggest that repeated recounting of traumatic events can re-traumatise individuals, therefore it was important not to ask the women to recount the story of their migration experiences, which they will already have had to tell others, e.g. immigration officials, many times as this could increase the risk of distress. I tried to ensure that interviews were undertaken in a sensitive way, being aware of the impact of possible previous trauma when talking to women and asking them about their experiences. I ensured that women understood the subjects we were going to talk about and tried to ensure that women felt they had control over the progress of the interview by being able to stop it at any time, all of which are good practice in undertaking trauma informed work. I also ensured that interviews took place where women felt comfortable. During the interviews I took care follow women's lead, avoided intrusive questioning and ensured that I listened if women did offer details of wider aspects of their lives (Edelman, 2023; Tomren & Opaas, 2024)

At the end of the interviews, I chatted with participants to provide an informal debrief and to make sure that they were happy with the interview and to see if they had any questions, concerns or if there was anything else they wanted to talk about. I thanked them for their time and explained what would happen next in the project and with their data. To ensure that women were not still thinking about the issues that we had been talking about, bring them back to the present and ensure that they were ready to continue with their day, I then spent some time chatting with them generally about everyday things.

In addition to taking care in the ways in which the interviews were conducted, attempts to safeguard the wellbeing of the participants was also addressed by working closely with staff and volunteers from the local groups. I was guided by the staff and volunteers' knowledge of the women and their situations and asked them to introduce me to women they felt were in a psychologically safe situation and who they felt it would be appropriate for me to talk to. This allowed us to work together to approach women for whom an interview would be a positive experience and not one that may make them feel vulnerable or cause distress. This relates to feminist researchers' concerns over the need for research to be non-exploitative and mutually beneficial and the idea that listening to women's stories is an important and valuable activity (Herron, 2022; Oakley, 1981). The insight and support from the staff and volunteers was invaluable in helping me to reduce the possibility of any participants being distressed by the research. All participants were provided, on the participant information sheet and verbally, with details of sources of support they could access if they experienced any distress relating to any aspect of the project (Appendix 2).

For some women the perinatal period had been a challenging one and while most women felt able to talk about this without being upset one woman did become distressed during the interview. I asked her if she wanted to stop the interview, but she refused the offer and insisted on continuing the interview and telling her story. I felt that she was composed enough to continue the interview and made sure that at the conclusion of the interview we spent some time chatting generally to allow her time to recover her composure and come back to the present. She was calm when we ended the session and re-joined the group for the rest of the social session. I mentioned her distress to the group leader to ensure that she would check in with her and direct her to any further support she might need.

Formal ethical approval was secured from the UCLan Science, Technology, Engineering, Medicine and Health (STEMH) committee (STEMH 1026) July 2019 with an amendment submitted and accepted in November 2019 to allow volunteers and staff who supported women to be interviewed. A minor amendment was submitted and secured for the use of SONIX transcription software in November 2020 (see Appendix 5-7).

5.7 Data analysis

The approach to data analysis in a research project needs to be compatible with the methodological approach and theoretical underpinnings of the research and with the nature of the research question. While there are a range of approaches that can be used for qualitative data analysis, I chose to use reflexive thematic analysis. This method was chosen as the most appropriate method for this project as it fits with my study's qualitative research design and the data set produced. Reflexive thematic analysis, an approach developed by Braun and Clarke from their earlier work on thematic analysis, was selected as a method of analysis as it is an approach which explicitly acknowledges the role of reflexivity in the process of analysis (Braun & Clarke, 2006; Braun & Clarke, 2021; Braun & Clarke, 2023). This approach sees analysis as a productive rather than descriptive process with knowledge being produced by interaction with the researcher with the data and as such acknowledges the role and position of the researcher in the process. This aligns with my study's feminist and social constructionist approach and the need to situate the researcher in the data. Reflective thematic analysis provides a way of working with qualitative data in order to address a research question by analysing and interpreting patterns within the data and developing themes which provide information about and relate to the defined research question (Byrne, 2022). It asks the researcher to engage with and interpret the data and develop insights from it which are a product of the connections within the dataset and to locate this within the wider social and theoretical contexts, in which the research and analysis happens (Braun & Clarke, 2021). In this case the way in which the data on women's lived experiences is articulated and the ways in which I as researcher interact, interpret and try to understand and make sense of women' experiences included in the data. It provides a rigorous and systematic way of working with qualitative data following a set of steps moving from familiarisation with the data to coding sections of the data to developing interpretative or

explanatory themes. These steps can be followed and evidenced to support rigor and transparency.

5.7.1 Reflexivity

To support researcher reflexivity and to inform data analysis, I kept notes and memos throughout the process of familiarisation, coding and theme development (Birks et al., 2008; Braun & Clarke, 2021). These notes served two important functions, one was that they provided a way of attempting to manage the messiness of data analysis (Sakata et al., 2019) as I moved through the analysis process from the initial stages to the final write up. Their second function was to allow me to reflect on the nature of the data and my developing interpretations of it. This allowed me to think about the impact I had on the analysis in terms of my pre-existing beliefs about the research topic as well as the judgments and choices I was making as I undertook coding, theme development and presentation of the data. I was particularly conscious of this in the development of themes from the data. This happened during early attempts at coding and in initial theme development in which I kept focusing on aspects of the data which dealt with women's experiences within the healthcare episode of the perinatal period, rather than focusing on the wider social support aspects of care. This was because most established literature focuses on this period, so I was used to looking at this perspective, I therefore had to ensure that I reframed my focus to expand into social support rather than aspects of medical care. I also found that I had pre-existing ideas about gender roles with respect to migrant families in terms of expectations of male heads of families having traditional patriarchal roles and that this might negatively affect women's agency and decision making in the perinatal period. These assumptions were not reflected in the data and this dissonance highlighted the assumptions I had made, supporting me to examine and re-consider the basis of my pre-existing assumptions in more depth in the light of my findings. In addition to these notes, the reflexive aspect of data analysis was supported by ongoing discussions with my supervisors, as well as by presenting my work in various fora and the critiques I received on these presentations, all of which supported me to think in further depth about the analysis.

5.7.2 Undertaking the analysis

Braun and Clarke (2021) describe six stages in reflexive thematic analysis. These are (1) familiarisation with the data set (2) coding (3) generating initial themes (4)

developing and reviewing themes (5) refining, defining, and naming themes and (6) writing up. However, they note that while these are sequential the process of analysis is not a simple linear one.

To begin the data analysis audio recordings from the interviews were downloaded to a folder on the password protected UCLan system and erased from the audio recorder. Anonymised files were then uploaded to SONIX (https://sonix.ai) an automated transcription software approved by the university as compliant with GDPR requirements. They were then transcribed and saved as word documents which were stored on the university password protected system. Once transcribed the audio files were deleted from SONIX.

Following Braun and Clarke's model, stage one of the analysis began by working on these interview transcriptions. While the interviews had been transcribed using the SONIX software, these initial transcriptions needed to be checked against the original recordings as accented English is not always accurately translated by the software and other nuances can be missed, particularly if audio quality is not perfect (Bokhove & Downey, 2018). Transcription is a subjective process (McMullin, 2023) and once any inaccuracies were addressed, the transcripts were not corrected in terms of grammar or expression and were kept verbatim to remain as close to the recording as possible. This process allowed me to immerse myself in the interviews and re-familiarise myself with the data as it necessitated close and repeated listening. I made notes during this process and reviewed my field notes. The field notes were used throughout the analysis process to provide further context for the interviews. Listening to the interviews and re-visiting my notes helped me to ensure that I kept my participants' voices at the centre of research, remembering the wider context of the interviews and the women, volunteers and staff who shared their experiences with me, so they were not just uncontextualized voices. The completed and checked transcripts where then imported into NVivo 12 to aid data management.

Next, line by line coding, stage two in the model, was undertaken; this included both deductive and inductive elements. Both the data from the women's interviews and that from the volunteer and staff interviews were analysed together, as I was addressing the same research questions incorporating the two perspectives. The ability to use aspects of both deductive and inductive approaches is one of the

benefits of the flexibility afforded by reflexive thematic analysis. This meant that in this analysis the coding reflected both pre-existing concepts/ categories from the Birth Hierarchy model (see Chapter three) which had informed the interview schedule as well as phenomena arising from the interview data. I made notes and reflections on the process of coding as well as any ideas and observations which came up. These ideas and the preliminary coding structure were then discussed with my supervisors to ensure rigour and coherence. Once the initial coding was completed in NVivo the data were exported to Excel, as I found this an easier way for me to work when trying to view, generate and then work with the codes for the next stages of the analysis.

The next part of the analysis involved developing themes from the coded data (described by Braun and Clark as stages three, four and five), generating initial themes, developing and reviewing themes and finally refining, defining and naming themes. Braun and Clarke (2021) stress the messiness of this process and the need to be open to changing and revisiting ideas and the process was indeed messy and iterative, moving between the individual transcripts and trying to identify patterns within the wider data set. Initial or candidate themes were identified from the codes as ways of identifying patterns across the data set and making meaning from the data. These themes were reviewed by myself and in discussion with my supervisors and further revisions made as I revisited the data and my research question. The repeated movement between the coded data and possible themes allowed me to think through the ways in which the patterns within the data could be best understood. Care was taken to avoid taking quotations and statements out of context by carefully looking at the place they had within the interview narratives and locating them within the larger research picture. Reflexive notes and discussions with supervisors (as mentioned above) were used to ensure that I interrogated and acknowledged the active role my positionality played as a researcher in the analysis with the pre-existing ideas and perspectives on the topic which I brought with me to the analysis process (Braun & Clarke, 2023). As part of the process some initial themes were maintained, others were revised, and some initial themes were rejected being replaced by new themes which were developed as my thinking evolved. Eventually I refined the themes into their final forms, choosing theme names that I felt came closest to capturing the essence of those themes (Braun & Clarke, 2021).

Once I had reached what seemed to be the final themes I began the last part of the analysis, stage 6, writing up, as within reflexive thematic analysis the final writing up phase is a crucial part of the analytic process and is not just a description of the already finalised findings. In this approach the researcher continues the process of producing data during the final write up (Braun & Clarke, 2021). I found this to be the case with this research which was at times frustrating and messy but did allow a constant refinement and reflection on the interpretation of the data and the presentation of it in a meaningful form. The final themes and their relation to the codes are detailed below in Table 5.2.

Codes	Sub themes	Final Themes
Housing security/insecurity	Housing	*I sleep in the spare room, because I don't have a house*: struggling to ensure that basic needs are met
Quality of housing		
Impact of housing on wellbeing		
Homelessness		
Navigating the system		
Support with housing-statutory, voluntary & others		
Lack of food/ food banks	Money, food and basic needs	
Lack of clothes & baby necessaries		
Role of voluntary agencies in providing basic provisions		
(The limits of) benefits		
Feel alone	Lack of social support	*They know each other because they used to go in the same classes*: meeting social needs by creating networks of support
No one to support us		
Alone with other children		
Doing it ourselves		
Lack of trust		
Church	Peers as sources of support	
Peer networks		
VPRS connections		
Immigration journey		
Language/country		
Disruption to support through immigration policies		
Support networks through contacts with voluntary groups	Voluntary and community groups as crucial networks and sources of support	
Role of specialist mother & baby groups		
Emotional support from groups		
Friendship & belonging		

English classes		
Informal support from UK residents	Local informal networks	
Neighbourhood & School connections		
Educational opportunity/achievement	Increased self-confidence through social support	
Voluntary activity		
Business activity		
Lack of family support	Family support	*It's like I'm with my family:* Family as a source of psychological safety and support
Support of family if in UK		
Loss of female familial support		
Different to birth at home		
Families of choice	Importance of families of choice	
Husbands support	Gendered roles in familial support	
Role of husband - beyond birth		
Different to home/ birth culture		
Importance of sensitive care	Social support throughout the perinatal journey	*It's OK don't worry it's going to be fine:* social support within the NHS maternity services
Continuity/companionship		
midwives make women feel supported		
Discrimination		
Reassurance		
Safety		
Impact of speaking English or not		*I don't want any lady to be … isolated so people will speak about her health and she [will have] have no idea about it:* the need to ensure effective communication
Lack of communication		
Happenstance of interpretation		
Types of interpretation		
Lack of knowledge of system		

Table 5.2 Final themes and associated codes

5.8 Conclusion

This chapter has described the use of feminist qualitative interviews and reflexive thematic analysis as the method of data collection and analysis for study one of this thesis. It has presented the rationale for the choice of these methods and demonstrated how they align with the methodological and theoretical underpinning of the thesis. It has discussed aspects of the practice of undertaking data collection and analysis including recruitment, sampling, ethical considerations, and the practical aspects of collecting and analysing data using these methods. The next chapter will present the findings from study one.

CHAPTER 6 FINDINGS – STUDY ONE

6.1Introduction to chapter

In the last chapter I reported on the methods used to undertake study one; feminist qualitative interviews and reflective thematic data analysis. Building on the exploration of Radloff's model in chapter three and following my conceptualisation of social support, defined in chapter two, this chapter presents the findings from study one, addressing the question what are asylum seeking and refugee women's experiences of social support in the perinatal period? The chapter begins by presenting the participant characteristics. It then presents the findings in five main themes.

6.2 Participant characteristics

6.2.1 Women

18 women were interviewed for the study. They had come to the UK from ten different countries and were currently living in five different towns and cities in the north of England. They had a range of immigration statuses and included women who had arrived as part of the Vulnerable Persons Resettlement Scheme (VPRS) (see glossary), women currently seeking asylum, those with refugee status, refused asylum seekers with no recourse to public funds (NRPF) and those who were or had irregular migration status. Their ages ranged from 21 to 42 and they had between one and five children with all having at least one child under two who was born in the UK. They had been living in the UK between eight months and seven years. For more information see table 6.1 below where participant demographics are detailed using the following identifier for participants (woman=W and participant number) and the number 1 to 5 for the town/city where the women currently reside.

Participant ID	Town/City	Status	Time in UK at interview	County of origin	Age	Parity
W_1	1	No Recourse to Public Funds	1 year 6 months	Pakistan	25	2, 1 born in UK
W_2	1	Refugee	2 years	Sudan	29	Twins born in UK
W_3	1	Asylum seeker	5 years	Albania	31	3, 1 born in UK
W_4	1	Asylum seeker	4 years	Afghanistan	36	5, 1 born in UK
W_5	2	Vulnerable Persons Resettlement Scheme	1 year	Syria	21	2, 1 born in UK
W_6	2	Vulnerable Persons Resettlement Scheme	2 years	Syria	25	3, 1 born in UK
W_7	2	Asylum seeker at birth of last child (undocumented for previous children)	7 years	Zimbabwe	37	3, all born in UK
W_8	3	Vulnerable Persons Resettlement Scheme	2 years & 3 months	Syria	34	4, 1 born in UK
W_9	3	Asylum seeker	1 year 7 months	Georgia	42	3, 1 born in UK
W_10	3	Asylum seeker	2 years	Albania	28	3, 1 born in UK
W_11	3	Asylum seeker	Less than 2 years	Eritrea	29	1 born in UK
W_12	4	Vulnerable Persons Resettlement Scheme	3 years	Syria	26	2, 1 born in UK
W_13	5	No recourse to public funds, overstayed visa	8 months	Nigeria	29	1, born in UK
W_14	5	Refugee	7 years	Nigeria	35	2, both in UK
W_15	5	Refugee	5 years	Syria	41	4, 1 born in UK
W_16	5	Refugee	3 years	Eritrea	30	2, 1 born in UK
W_17	5	Leave to remain granted (asylum seeker while pregnant)	Left Eritrea 4 years ago, unclear when arrived in UK	Eritrea	32	1, born in UK

W_18	5	Leave to remain in 2015, previously No Recourse to Public Funds	14 years	Ghana	33	3, all born in UK, currently pregnant

Table 6.1 Participant demographics - women

6.2.2 Staff and volunteers

Four staff and volunteers were interviewed, they were from four of the five towns and cities in which the women lived, and all worked with women who were asylum seekers and refugees. Three women worked in a voluntary capacity providing leadership and support within local voluntary organisations. They worked with women in groups and provided one to one support. One participant was a paid worker who worked in a local government setting, organising aspects of support for local asylum seekers and refugees. For more information see table 6.2 below where participant demographics are detailed using the following identifier (staff/volunteer =S/V and participant number).

Participant ID	Location	Role	Gender	Background
S/V_1	1	Volunteer at organisation	F	British
S/V_2	2	Volunteer and group lead	F	British
S/V_3	3	Volunteer at organisation	F	British
S/V_4	4	Staff at local authority	F	European/British

Table 6.2 Participant demographics - staff and volunteers

6.3 Findings overview

The five key themes from the analysis of the interviews with women and staff are reported below, *Struggling for support to ensure that basic/ physiological needs are met, meeting social support needs through creating networks of support, Family as a source of psychological safety and support, social support within the NHS maternity services, Facilitating effective communication.*

6.4 *I sleep in the spare room, because I don't have a house:* struggling for support to ensure that basic/ physiological needs are met

Women commonly spoke about the challenges they faced meeting their basic or physiological needs, as defined in Radloff's Birth Hierarchy model (Radloff, 2020) (see chapter three), in terms of having adequate housing, food and money. Some women, primarily those who had come to the UK as part of the Vulnerable Persons Resettlement Scheme (VPRS), described how the social support they received as part of the scheme enabled them to meet their basic needs, however women who were not part of this scheme faced significant challenges in doing so. Many women relied on voluntary agencies to provide this support, without which they struggled to access adequate housing in appropriate areas, and to secure sufficient money to buy food and the other basic things they needed for themselves and their babies. It is in this area that the impact of women's different positions within the immigration system was particularly evident, as was the failure of statutory provision to adequately support some women, and the crucial role played by voluntary agencies in providing social support.

6.4.1 Housing

There were significant disparities in the type and availability of instrumental social support women could access to help them meet their housing needs. This disparity primarily related to women's status within the immigration system and/or the way in which they came to the UK, both of which affected the support they could access. Women who came to the UK as part of the VPRS received higher levels of instrumental support from statutory agencies than women who came to the UK in other ways. In terms of housing, one woman who had arrived with her family as part of the VPRS scheme described the level of support they had received, which included housing secured before arrival and a designated case worker allocated to them:

> *When you came here, the house was ready, our ID was ready …after one week just, yes everything was ready we had supporter you know, we had everything.* (W_12)

The case workers provided ongoing instrumental and informational support, helping with the day-to-day challenges and complexities of setting up home in a new country. One described how their case worker:

> *She helped me …. With the bills the electricity and gas and the Internet, everything ...you know everything we need we was just given, we was giving her a call, come on we need this she was giving us appointment once a week.* (W_12)

This level of support contrasted with the experiences of other women who had arrived in the UK outside of such schemes and had different immigration status. This contrast was particularly stark in the case of women whose status was more insecure, such as those who were asylum seekers or had no recourse to public funds. These women lacked this level of social support to help them secure appropriate housing. This led to a situation where several women spoke of facing homelessness or experiencing inadequate housing as without social support, they were unable to effectively navigate complex bureaucratic statutory systems to gain adequate housing. One woman described the situation she faced during her pregnancy and early motherhood:

> *When I was pregnant [I was] sharing the house and then when I am six months pregnant, I had homeless … until he is five months [old].* (W_16)

Others who had been able to secure statutorily provided housing described their experiences of poor physical conditions and unsafe shared housing:

> *The temporary house … is very bad house it is upstairs no lift and make my pram up down, up down.* (W_17)

> *I am living with SERCO, sharing a house there are two people, three people with me, Albania and Irani people, sometimes it is good and sometimes not good, fighting .... when baby is born and pregnant my friends they are coming to help me but the lady said she didn't like that.* (W_17)

The struggle to navigate complex statutory systems without social support was mentioned by volunteers who also noted that in some cases even when social support was provided, the statutory systems were very difficult to navigate for many women and families. It was explained that:

> *If you have come in as a refugee under the refugee programme you come into housing found for you and [get] help to register for Universal Credit and all the rest of it. If you are an asylum seeker moving from asylum accommodation, you have four weeks; that's your decision to move out of the house and get everything done and just find somewhere else to live and fully furnished it …. It's impossible to do and we have a family living at the moment in a temporary sort of bed and breakfast accommodation which is fairly appalling while they try and get somewhere to live.* (S/V_2)

A woman with refugee status, living with three children and a newborn in poor housing, with very limited social support, described how she had nearly missed the opportunity to access better housing as she had been unaware of how the council housing system worked. She noted that it was only by luck that she found out she had been offered council housing to replace her temporary housing:

> *I was in temporary house it has damp, a lot of damp, cold …during the pregnancy but once I born, my baby was born then one month and a half I discover by chance the offer cause I was just calling [name of agency], by chance yeah I was calling to update my circumstance I have now four children this is the rule and they told me ah you have offered, you have been offered a house from 31st of January. I told them, wow, nobody contacts me nobody and by chance I get council house, it's good now.* (W_15)

Several women spoke of how the informational and instrumental social support offered to them by local voluntary agencies enabled them to better access the statutory services, including the housing, they needed. One woman explained how supporters had helped her to navigate the complicated bureaucratic procedures surrounding housing provision:

> *They teach a lot, they explain a lot of things, where to find help and what to do if … you don't know. They will tell you if you need this help, like even if you*

need help in anything, they will direct you. This is where to go. Oh, this is the number to call. They show you all those ways. (W_17)

Others explained how informational and instrumental support from volunteer agencies helped them address the specific challenges they faced with their housing. One woman explained how a voluntary agency had provided her with vital support when she faced eviction:

So at that time the landlord was on my neck that I have to go, most of they [statutory agencies] say that I am not qualified for any service and they say so they can't do anything for me. So I have to go back to the [voluntary agency] so they ... they call the social worker and say that she needs to do something because of the children that she should do something, then they said OK she is getting in touch. (W_7)

Several volunteers explained how they provided support to women to access services. One volunteer described how she was supporting a new mum, currently living with a newborn in inappropriate multiple occupancy accommodation, to approach the housing provider (SERCO) to secure more appropriate housing for her and her newborn:

The doctor thinks that it would be better if you didn't share a house with other people … we've been, you've been talking to SERCO. (W_11)

A volunteer at another organisation explained how they supported women to navigate the housing system as they moved from asylum to refugee status:

if it's an asylum seeker who's got leave to remain, they have a choice to stay in [town] or to move and we would get them to the housing department, we might do the online application. (S/V_2)

6.4.2 Money, food and basic needs

Women who were entitled to statutory benefits generally received regular financial support, either through the standard UK benefit system, if they had refugee status, or though asylum support payments. A number commented on the challenges they

faced due to the low level of this support which was inadequate to meet their basic needs. This was particularly the case for those women who were seeking asylum (or refused asylum seekers with children), as they were only eligible for asylum support payments which are designed to be lower than standard state benefits.

Voluntary agencies and local groups played a significant role in providing instrumental support for women supplying them with, or signposting them to, sources of food and basic items for themselves and their infants. This was particularly the case for women on asylum support or those who could not access statutory benefits. Some women explained how they lacked the most basic things, one explained that:

> *I was just coming from the [name of organisation] because every Friday I have no money for food [so I come] to get a food parcel.* (W_7)

Others provided insight into the importance and extent of the instrumental support offered by voluntary agencies:

> *When I came to [organisation] they gave me food, they give me bread, they give me a lot of things, clothes, even these clothes I wear now they are from [organisation] so they give me clothes … they give toys and even some food now in my hostel.* (W_13)

> *When we give birth to the baby they (organisation) [came] round to our house, they support us with a lot of stuff for us you know because they know we have little money so they bring stuff for us, most of the stuff for baby they are bring so that baby has…helped a lot cause we have most of the things to care of the baby*. (W_7)

Some women who were eligible for benefits found applying for these confusing and needed support to be able to do this effectively. A volunteer explained how they helped women by:

> *Filling in the child benefit form online because so many of the forms, the applications are online and they don't have access to that kind of, you know,*

and rather than them going to the library or whatever, they just come and then somebody will sit and go through it with them. (S/V_2)

A lack of this kind of support could mean that women struggled to navigate the complexity of the system. For one woman a lack of support meant that she faced a delay in receiving the money she needed:

Because [daughters name] is five years I'm supposed to change to Universal Credit ... it was a bit complicated and confusing. I was like, I don't I don't get hold of this money, I don't know how you do it … it took like three to four months. (W_14)

6.5 *They know each other because they used to go in the same classes:* meeting social support needs through creating networks of support

The levels of social and emotional support women felt they had access to when navigating the perinatal period in the UK varied. While some women faced the period with no support, others were able to create or access networks of social support, either informally from individuals within local neighbourhoods, or more formally through asylum seeker and refugee focused mother and baby groups. These networks of contacts allowed them to make connections, have some sense of belonging and enabled them to give and receive emotional and other forms of support enabling them to navigate the demands of this period.

6.5.1 A lack of social support

Some women spoke about their experiences of having no sources of social support in the UK and the negative impact this had on their wellbeing. These were primarily those who had no family or wider networks in the UK and who had not at that time accessed support from voluntary agencies; they explained how this lack of support left them feeling isolated, alone, and sad. As one participant explained:

I had another child and I was living alone with her. No family, no brother, no sister no mother, so it was really really hard. (W_14)

I am not having anybody to help me, I am on my own. (W_3)

One participant expressed the distress she felt as a single mother with no partner or family in the UK when she compared her life with the situation with the lives of the women she saw around her:

> *My experience is very hard … I feel so sad everybody is living with husband, with children, with house You know, here in this country, everybody is work, going to work …. because I wish this.* (W_1)

Another participant's negative experience within the immigration system had led to her finding it hard to trust people or seek support:

> *You don't want to talk to people because you don't know who they are so you don't know maybe some of them believe your story talking and using your story to talk against you so yes you don't want to, you don't want trust people much*. (W_7)

6.5.2 Peers as sources of support

Many of the women who felt that they had social support were those who had a positive relationship or a connection with others through the construction of networks of support amongst their peers. This included connections with people with whom they shared a language and/or country of origin and/or status as displaced people. These connections allowed them to feel part of a community and receive and give each other emotional, instrumental and informational support. Women, from Sudan, Albania and Eritrea, commented on how they had made friends with other women from their home countries who they had met in the UK during their journey through the immigration process.

Several women who were part of the VPRS spoke of networks of social support they established with other Syrian women who were also part of the scheme:

> *All of these they came with her like in the same resettlement program. So they know each other because they used to go in the same classes, English classes …so it's like this and maybe they are not very close to her but … when they have someone at the hospital alone, they used to visit her*. (W_8)

There were other networks of support women accessed; for one woman support and a sense of belonging came through involvement in a local Eritrean church where she connected with others who shared her language and faith.

The connections and networks of support women developed with their peers were, however, vulnerable to the effect of immigration policies. Women could be moved by the Home Office to new areas losing the sources of social support they had established or struggling to maintain them. One woman described how she had to move away from her friends who had provided crucial support for her through having no choice in the location of the accommodation she was moved to:

> *You know, I wanted [to be] near to a friend's house but [I was moved] even far from town, one hour without a car.* (W_16)

This left her feeling isolated as well as increasing her travel costs when she had to report to the local Home Office reporting centre, attend medical appointments or try to maintain social connections. She described having to travel for over an hour to continue to attend the mother and baby group that had provided her with vital instrumental and emotional social support.

6.5.3 Voluntary and community groups as crucial networks and sources of support

Many women found support networks, connections and a sense of belonging through local voluntary organisations who worked with refugees and asylum seekers. Indeed, one member of staff from a voluntary group saw network building as an important part of the work of their group:

> *We signpost people to services, we organize um activities to do and introduce them to other women try to build a social network around them and that kind of thing.* (S/V_2)

Mother and baby groups for refugee and asylum seeking women played a significant role in reducing women's sense that they were alone and unsupported by providing informational, instrumental and emotional support. In these groups women connected with other women with whom they had shared experiences. One woman had attended a local mother and baby group but had struggled to make connections

and had not felt welcome, however in a group run specifically for asylum seeking and refugee women she felt more at ease:

> *There are refugee and asylum seekers from all countries not just Arabic, from Nigeria, Ethiopia, too many countries… so that [is] better, I am happy there.* (W_12)

Several women described the positive impact of the emotional support these groups offered. One woman, who had recently been dispersed to a city in which she had no connections, explained how after joining the group:

> *I have friends, I am happy but I don't know [anyone] outside these ladies…when I come [name of women's group] I am happy because [name of group] gave me friends.* (W_16)

For another woman the group provided a place in which she could enjoy time with her baby and with other women and which she felt was beneficial for her own wellbeing and that of her child:

> *I like [name of group], when I come here to [name of group], I make [good] memory[s] and my baby, my baby he see[s] another child and another people.* (W_17)

One participant described the importance to her emotional wellbeing of going to the group and connecting with other women she explained:

> *You have a chat with them, you laugh with them, and then after, when you are there you don't even think of anything [so you are not] in the house of thinking [negative thoughts] and all that*. (W_18)

In addition to providing a place for connection and emotional support, voluntary agencies provided instrumental and informational support through the English classes they provided. These classes could take the form of classes at home as one staff member explained how they offered:

An English teaching at home service, particularly to the women who have childcare responsibilities and find it more difficult to go out of the house. So one volunteer would be attached to a couple of clients teaching English to be a mentor and a friend so they can discuss any little problems that arise at around that, maybe school admission, school issue things like that. (S/V_2)

However, most women received support at classes outside of their home. These classes provided women with opportunities to develop the language skills they needed to help them in their daily lives. They also provided another opportunity for women to meet and develop further networks of social support amongst their peers:

All the Syrian ladies have like ESOL class learning English together so from there they will find out about this group and like word of mouth, so everyone told others. (W_6)

6.5.4 Local informal networks

Some women received social support through informal links made within the communities and neighbourhoods in which they lived. This could be through connections with neighbours or with other families at the schools their older children attended. Several women noted the instrumental support they had received through these connections:

So they [are] saying are you OK, I can come and help you I don't know them ….it was people who see me around [name of daughter] school sometimes. (W_14)

So is this like because we go [to the hospital in labour] in the morning you will leave the kids with my neighbour… because [they] also have a child the same age like my children. So we just leave the kids with them and we take them to school. So after like in the afternoon, their dad will come home and then look after them and then he will come back again to visit me at the hospital. (W_18)

One woman received valuable support from local Arabic speaking women. She described how she had become a member of a What's App group set up to connect

local and newly arrived Arabic speaking women and how this had provided her with a source of both emotional and instrumental support in the perinatal period:

> *She is from Arab country and we would put her in What's App and if anyone needs help or support, we will help each other, so by this, What's App? they know A....and they visit her also when she discharged that so that she know most of them*. (W_8)

Shared language and culture also fostered a connection between a very vulnerable woman with an older local couple who spoke her language and shared her region of origin. This couple provided her with support when they found her abandoned and completely alone on her arrival in the UK. They provided her with crucial and on-going instrumental and emotional support:

> *She didn't have the language, she was scared, she was vulnerable. She was at the airport, she didn't know what to do. So they were from [her home country] and they obviously took pity on her and wanted to help her. So they brought her back to [town], they said, look, come with us. We'll look after you we'll try to sort this mess out for you So because she had nobody, nobody*. (W_1)

6.5.5 Increased self-confidence through social support

In addition to the practical benefits to their daily lives, the sense of psychological and emotional wellbeing which came from interaction with peers and voluntary agencies some women also commented on the ways in which receiving social support had increased their sense of self-confidence and self-esteem.

Some women whose English language skills had improved through attending English classes and other groups described how they were increasingly able to speak English in their daily lives in different settings. Their success at learning and being able to use English gave them a sense of achievement and increased self-esteem:

> *[when I] first came here I need interpreter to be informed about even one year after I told my doctor I don't need more interpreter I can speak to you. I am OK now in English. One year I took my English classes here …after one year, so I*

didn't have interpreter I speak to the doctors, teachers, schoolteachers and every. (W_4**)**

One woman who had received limited education in her home country and had come to the UK with no English, spoke of how she was proud to be studying English and how she was now starting her own business:

She's doing well with English now, she progressed well and she's now starting get make like her business, she is cooking and yes selling her food. (W_8)

Women who had received support from voluntary agencies gave examples of how this had a positive impact on their confidence and self-agency as they undertook new challenges and took up new opportunities. One woman described how the support she had received from volunteers meant that she gradually felt more able to address some of the issues she faced more independently:

I know this from [volunteer] she'll always whatever you say to her she straightaway she'll call like to ask for advice for you and then she will go, oh, this is what she has to do. This is where you have to go. And then sometimes she'll book an appointment for you, you can go here, this is what you have to do, this is what you are supposed to do and then gradually gradually you will get used to it, you know what to do, you know what you are. (W_13)

Other women who had received support were now volunteering themselves or looking for opportunities to do so. One woman who had previously received support explained who she now wanted to:

Help, volunteer or give something to the community as well. They have given to me. I appreciate them, you know. (W_14)

Another woman who had also received support was now volunteering to support other women at a local church:

[I am] going there voluntary, every second Friday in the month. (W_10)

6.6 *It's like I'm with my family:* Family as a source of psychological safety and support

The role of family as a source of social support in the perinatal period was an issue raised by all the women interviewed and was also raised by staff and volunteers. Women now living in the UK felt the absence of family members and the loss of familial and maternal support being separated from their birth families who were in their home or other countries. However, some women were able to create and feel supported by, new family or family-like relationships in the UK as they constructed families of choice. This familial support, whether through birth families or families of choice, played a huge role in providing women with the psychological safety and security, and feelings of connection they needed in the perinatal period. Women who did not have this support were keenly aware of its absence. Some women also discussed changes in family and gender dynamics they experienced as they negotiated the perinatal period in the UK.

6.6.1 Family support

Many women had no family with them in the UK other than in some cases their dependent children. This lack of any family support left some women feeling alone and without sources of social support in this challenging period. However, four women did have other family members with them; these were women who had come to the UK as part of the VPRS and one who had sought asylum as a family group. This provided them with a level of emotional and instrumental support throughout the perinatal period that other women lacked:

> *She has a brother-in-law, which is a brother, but the husband's brother, his wife also from the Syrian community, his wife she used to look after the daughter while she is in the hospital.* (W_6)

Many women commented on the challenges and distress they faced at the loss of female social support. For many, the perinatal period is a culturally and traditionally gendered period, in which the role of mothers, sisters and other female relations is crucial. This was an area in which the location of women within the immigration system did not affect their experiences, the distress at the loss of female support was common amongst the participants even amongst those who had some family

support in the UK. This was felt in terms of a loss of emotional support and instrumental support.

One woman spoke of how difficult emotionally it was for her without her extended family, particularly her mother and sisters and was distressed that her mother hadn't seen her new daughter:

> *She missed her family so much until now and even her mum she wants to see [name of daughter] and ... this is difficult things for her*. (W_8)

Women compared their experiences of birth back home, where they had the instrumental and emotional support of their mothers, female relatives and wider family, with their more recent births in the UK where they lacked this support. They reflected on the loss of important and valued traditional and cultural practices, which had provided them with support during earlier births but were not available to them in the UK. One woman who had several previous births noted that:

> *It's very difficult for her she said because … when she had the baby before her mum, she used to stay with her and all the time, we usually in Arab culture the mum, she would stay with her like one month, maybe the month, and she miss that.* (W_8)

Another woman explained how:

> *Back home you stay indoors for like 40 days, so everything is someone will do for you. The only thing you will do is just to go and bath … they cook your food for you. They did everything for you and ... by six o' clock you are in bed. So you got a good enough relax till you get to the forty days and then you can go out even though you have the baby, the only time you see the baby just to breastfeed the baby. Always the family members look after the kids, so you always feel happy.* (W_18)

She compared this to the challenges she faced in the UK where, with no social support from her family and birthing within an individualised and neoliberal UK maternity system, she was expected to care for her new baby and older child alone:

> *So you have to do everything by yourself, like you need to do school, school runs and all that no one will do for you. So you need to pull yourself together and do everything. That's what I've seen in this country. Everything is just you.* (W_18)

Another participant who was without any familial support in the UK found the experience of pregnancy and birth in the UK '*very difficult* and *confusing'* and felt overwhelmed in that she had to take on a '*big responsibility'* for her child alone, a responsibility which would have been shared by her family at home.

6.6.2 The importance of families of choice

Many of the women who had no or very limited family to provide social support in the UK, primarily those seeking asylum or with precarious immigration status, spoke of the importance of people who they identified as being family. These people provided them with emotional and instrumental support by making them feel cared for and helping them to feel more safe and secure as they approached birth and new motherhood. They describe how women they had met either from voluntary organisations or other asylum seekers and refugees had taken on the role of trusted, older female relatives, as aunties, mothers and grandmas or in one case as an uncle.

Some women created relationships with fellow asylum seekers they met in the UK who they explained '*treat us just like a family'* (W_10). Other women made family-like connections with individuals from local communities. For one particularly isolated woman, who had no support in the UK, a local couple became her uncle and aunty, integrating her into their extended family and supporting her practically and emotionally. She explained how her aunty was '*very caring and lovin*g' and how this couple:

> *Took her in and they put her in one of their flats. They look after her. They really do look after her... they got make sure that she was registered the GP.* (W_1)

One participant explained the significance of the support of her family of choice, in this case women she met at the local voluntary organisation, on her wellbeing and sense of belonging:

> *Since I've been here [organisation], it's like I'm with my family. I don't feel like I don't even feel like I don't have family. I don't think that I have and well maybe I don't have brother, I don't have sister I don't have mum, [volunteer] is like a mother to me and does everything and people around here we talk like a family as well.* (W_13)

This idea of the importance of families of choice was also identified by volunteers. One explained how they acted as:

> *Grandparents, aunties, extended family when someone is pregnant sharing in the general excitement … sharing the news.* (S/V_2)

Another volunteer described how she was like a grandma to one of the women's children and another, how she had been '*birth partner, mum-like person'* (S/V_1) to a woman without family support.

6.6.3 Gendered roles in familial support

Several women raised issues related to gender, culture and gendered roles as they talked about experiences of social support in the perinatal period in the UK. Women who had husbands with them found that, in contrast to their experiences at home, their husbands were now their primary source of support in the perinatal period. Several Syrian and Afghan women noted that this reliance on their husband for support was an unusual or novel experience for them and one which differed from the gendered norms around birth they identified as usual in their home countries or within their culture:

> *She said her husband, he was very support[ive] and also the care that how the hospital and the nursing, because this is very new for us as Arabic.* (W_8)

This new role of the male partner being the primary source of support could feel strange for some women and their husbands. One Syrian woman explained how:

> *I was frightened, so I asked him, please, it is not normal she said, but I asked him to come because I was very scared and I want him to be with me …. my husband was scared, and he didn't want to come in, but he had no other options, so he came with me [during labour and birth].* (W_5)

An Afghan woman explained how she was pleased to have her husband supporting her at this birth even though he had not been at her previous births:

> *So with me good for with me I have … I have a feeling that I have a helper with me*. (W_4)

This change in traditional gender roles extended in some cases beyond the role of the husband providing emotional support during labour. Some women explained that in the UK their husbands provided instrumental support for them in wider aspects of domestic life in the perinatal period that they would not have done in their home countries. They explained how this instrumental support would have traditionally come from their female family members:

> *[It is] totally different her husband support her more now because we are here, yeah this the same as mine, yeah because you now, they're Arabic men. They are really not like English men. They're not used to help a woman at home or maybe they can take care of the kids. Yeah, but you're not clean or cook or all this stuff. But here because she's alone and that they have around her English people and so men feel shy, (Arabic) even feel shy if you didn't help her, you know and so. Yeah, and in our country men they used to depend on woman and her mum and her sister and so here she don't have anyone, only her husband, you know.* (W_8)

> *But here maybe because I am here alone with my husband and he was with me he was preparing the food for me he was washing the dishes he was doing everything (laughs) yes he was very kind* (W_12).

6.7 *It's OK don't worry it's going to be fine:* social support within the NHS maternity services

Women spoke of the support they received from NHS services; they placed great value on the care and social support they received from healthcare professionals. This was evident for all women who participated irrespective of their immigration status and levels of familial or other support. The social support provided by healthcare professionals alongside medical care gave women a sense of psychological safety and security throughout the perinatal period and particularly during labour and birth.

6.7.1 Social support throughout the perinatal journey

Women described receiving supportive antenatal care from midwives. One woman who was alone in the UK, described the positive impact of the emotional and instrumental support her midwife provided:

> *So when I start seeing the midwife I was feeling relief … happy they say are you OK, you sure you are OK tell me what happened, do you need any help? they are so lovely people, even when I don't even need the help, when I hear that from them, I'm so happy like really I can't [believe] that someone cares about me in this country.* (W_13)

Another described the reassurance and emotional support she received from her midwife:

> *I am pregnant, they are, my midwife something don't be stress[ed], that's OK, everything is going to be alright, like that so it's going, now I am so happy, I am going to settle now*. (W_17)

Facing labour and birth in a new and unfamiliar setting, women described situations in which they felt *'afraid', 'worried, 'frightened'* and *'scared'* however, a number spoke of the positive impact of the emotional support they received from their health care professionals. One woman described how support from healthcare staff reassured her during a long labour when she was scared, and was worried her labour wasn't progressing, she described how they were:

> *Very good people, they are very smiley they are very helpful, very friendly, yes it's good.* (W_3)

For another participant reassurance from staff provided her with emotional support which helped reduce her fears of having a caesarean section:

> *We don't know section, cause in my country … section is very big problem, we think that because more times we make to babies born in normally, c-section is very big… so I want to be normal but my baby he can't push, so the doctors say operation, I am so afraid …. but the nurse and midwives, it's OK it's normal.* (W_17)

Having continuity of carer during birth was seen to increase the level of emotional support women felt they had. The continuity they experienced made them feel cared for, supported and safe. One woman noted, again referring to the importance of a maternal figure as identified above, how her midwife was *'like a mother'* and was '*there throughout the whole birth'* (W_17). Another participant compared her experiences in the UK favourably to her previous birth in Lebanon and to that of her sister in Germany, explaining how the midwife:

> *Was very kind she didn't move for hours from nine she was staying with me all the time, she was very kind …. the midwife stayed with me the whole, the whole time.* (W_12)

Women also spoke of the positive impact of the instrumental and emotional support they received in the postnatal period from midwives and other healthcare professionals as they dealt with the challenges of new motherhood:

> *I stay in the hospital, they come to check baby and they come to help me if my baby is crying in some midwife is here and they tell me you sleep and I see your baby, yeah its very nice.* (W_5)

> *This is very nice, very good people very smiling, helpful and calm every two weeks come my home or make appointment up with the caller to see my baby, taking blood pressures anything, yes.* (W_5)

While most women spoke of the positive support they had received from their midwives, one woman spoke of the discriminatory and unkind treatment she had faced:

My experience with midwife, it wasn't good not enough she didn't reassure me I told her I am refugee here she told me you will go back to your home to born baby, I told her I am refugee everything is destroyed there …. and she didn't express, how to say, didn't express empathy ……yes even just even how to say like act, like even just act as at that time I need something need reassurance. (W_15)

6.8 *I don't want any lady to be … isolated so people will speak about her health and she [will have] have no idea about it*: Facilitating effective communication

Some women faced language barriers when navigating the perinatal period as English was not their primary language and as such, they needed to rely on social support from others to be able to effectively communicate their needs and access care. The ability to access this social support, whether in terms of being assisted to access formal interpretation or accessing support from individuals or organisations who could help with informal interpretation, varied. In some cases, the provision of interpretation also was a source of emotional support for women in that it acted to reduce their anxiety. The ability to access support to communicate had a significant impact on women's experiences, in that a lack of support meant that women struggled to access and receive care they needed.

Several participants did not need support to communicate effectively:

There was no issue with English because she was actually, she went to an English speaking school … she knew English right from the start. (S/V_1)

Yeah, I'm going [to have] my baby I'm alone I haven't an interpreter. I told them I don't need more interpreter I'm ok. (W_4)

However, for other women communicating in English without support was more challenging:

I understand everything. I understand but speak English not very well. (W_2)

In some situations, despite women speaking some English, support was still needed to access and understand their care:

Say I don't understand this word because I was speaking English with them they were saying you are speaking English very good you don't need to a translator, but if don't understand ... anyway they was just writing … or translating. (W_12)

Most women needed interpretation to enable them to access care and to express their needs in the perinatal period. However, the availably of instrumental support to help them access formal interpretation varied significantly. Women who had arrived through the VPRS were provided with a case worker who would help them in their interactions with the healthcare system. One woman explained how:

Because I am quite new in the country, not one year yet [the case worker] helped me a lot like booking my appointment guide me where to go and where to start. (W_5)

However, having a case worker assigned to them to support them did not always guarantee that interpreters would be provided. One woman who had this support still did not receive the interpretation she needed:

So when he book an appointment for me at the hospital the issues start here and he make sure that he book an interpreter but unfortunately when I go there they said we didn't find an interpreter free sometimes. (W_5)

In the absence of the statutory provision of interpretation by the NHS or other agencies women had to rely on support from their partners, if they had one, or volunteers or friends. One woman who had no support and did not speak English explained how they had needed support to access healthcare:

[My] English friends is help me because they understand. (W_10)

Another woman who was in the UK as part of the VPRS still faced with birth without an interpreter, she explained how:

They didn't provide any interpreter, but her friend [name] was with her [and she explained that she understood as] … she can explain well with her briefly and then [it was] OK. (W_8)

Where women did receive support to communicate effectively, they felt more confident about their care encounters in this period:

> *Everything is clear, if they wanted to do any examination they ask me before and I say yes then they carry on.* (W_5)

Several women explained how a lack of support with communication had meant they had been unable to understand what was happening to them and communicate their needs during a perinatal healthcare appointment leaving them feeling '*worried'* and '*scared'.* One woman explained how:

> *When I go to my appointment, I can't speak enough English and I don't know what to do ... I can't express myself*. (W_6)

For another women the failure to support her to access interpretation led to her giving birth without understanding what was happening, causing her distress:

> *They say they will book a translator, interpreter for the surgery because it was planned but she said when I went … I asked them is the interpreter ready and they said unfortunately there is no interpreter and …. I don't understand most of the things the vocabulary and medical terminology, so I was frightened, and I was scared but I had my baby without interpreter*. (W_6)

6.9 Conclusion

In this chapter I have presented the findings from study one which explored the research question *what are asylum seeking and refugee women's experiences of social support in the perinatal period?* through interviews with women and staff and volunteers based on the understanding of social support identified in chapter two. Five key themes were developed which were: the challenges women faced in meeting their basic needs due to the limits of statutory support and the challenges of accessing it, how women sought to meet their needs for support by utilising existing and creating new networks of support. The findings also identified the importance of the role of family, both traditional and chosen, as a source of psychological safety and social support as well as the role of the maternity services in providing social support. Finally, the need to ensure effective communication to allow women to have social support and a positive perinatal experience was identified. The implications of

these findings, along with those from study two, will be placed in the context of existing literature and discussed in depth in the discussion chapter. The next chapter will give a rationale for, and provide an account of, the use of focus groups as the method used in study two.

CHAPTER 7 METHODS - STUDY TWO

7.1 Introduction

The previous chapter detailed the findings from study one, which explored the perinatal social support experiences of asylum seeking and refugee women in the north of England. Study two used the findings from study one as the basis of the work undertaken in this study. Figure 7.1 presents the relationship between the two studies in diagrammatic form. Study one explored the personal experiences of perinatal social support with individual asylum seeking and refugee women through interviews. Study two built on these insights to explore with groups of asylum seeking and refugee women practical suggestions for ways in which social support can be improved for all asylum seeking and refugee women. While the women in study two reflect on their personal experiences, the focus is not on the individual. in the same way. The focus here was on wider experiences and ideas for change that can support the development of recommendations for change to existing social support available to asylum seeking and refugee women.

This chapter provides an overview of the methods used in study two, which were online focus groups, reflexive thematic analysis and member checking. These methods were chosen as the most appropriate to the address the research question, *What do women perceive to be the best ways in which asylum seeking and refugee women could be supported in the perinatal period?* The study was made up of two sequential phases; phase one consisted of three online focus groups, following on from this, phase two was an online focus group used to facilitate member checking. This chapter explores the rationale behind the choice of methods, the practical issues involved in using these methods and how they align with the feminist-informed research approach and feminist social constructionist underpinning of the study explored in chapter four. As identified in that chapter, a feminist-informed approach to research directed both the practical undertaking of the research and the methodological and theoretical approach to the research topic. As in study one, fieldnotes were used to support the reflexive aspect of my research practise. These allowed me to think about practical and methodological issues related to data collection and analysis and to think about my role in the research process. As

previously, reflexive insights are integrated throughout the chapter where appropriate.

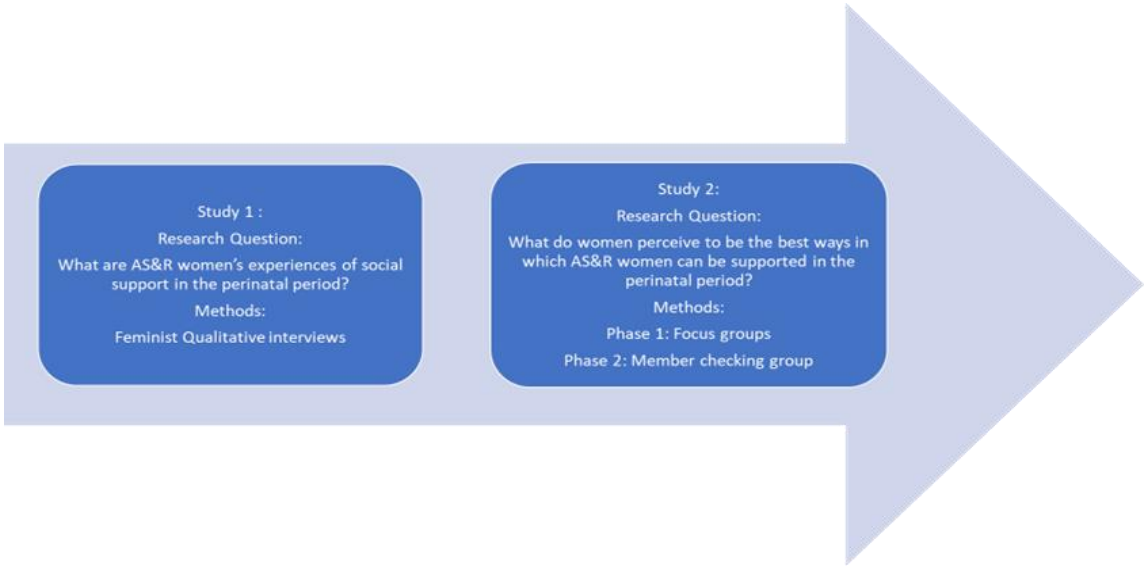

Figure 7.1 Overview of research questions and methods in empirical studies

7.2 Data collection method: Online focus groups

Online focus groups were chosen for both phases of this study as a way of working with asylum seeking and refugee women to explore their perceptions and ideas of what were the best ways in which social support could be provided in the perinatal period. To explore this question, the phase one online focus groups took as their starting point the findings from study one presented in the previous chapter. Following initial analysis of the data produced in phase one of this study, in phase two a member checking focus group was undertaken. In this group women were invited to reflect upon the issues raised, and suggestions made, by women in the initial analysis of phase one focus group data, to see if they felt these resonated with their experiences and answered the research question, *what are the best ways in which asylum seeking and refugee women could be supported in the perinatal period?* They were also able to identify any additional issues or suggestions they felt were not included.

Focus groups are a well-established, widely used method of qualitative data collection in which informal discussion is used to produce data around a particular

subject from a group of individuals, who have some shared interests or characteristics (Liamputtong, 2011; Moore, 2015; Wilkinson, 2004). Focus group methods are located within a qualitative approach to knowledge production, and so align with my qualitative research design, Liamputtong describes their primary aim as being *'to describe and understand meanings and interpretations'* around an issue from the perspective of those involved (Liamputtong, 2011, p. 4). Focus groups are a method in which insights and new knowledge are produced through the interaction of group members. They can bring an understanding of a phenomenon from multiple perspectives, and knowledge is produced through the collective experience and interaction of individuals in a particular and unique setting; because of this it may produce insights not anticipated by researchers (Dos Santos Marques et al., 2021; Kamberelis, 2014; Rose & Phil, 2001). This collective and collaborative approach was particularly appropriate for this study as, while the research questions did ask participants to draw upon their own personal experiences, its focus was a consideration of what would work for asylum seeking and refugee women as a group rather than an in-depth exploration of individual participant experiences.

It has been suggested that the use of focus groups is a particularly useful method for researchers using a feminist-informed approach to research and as such align with my methodological approach. Focus groups are a method which can address some key feminist research concerns including issues relating to relationships, power and knowledge production, all of which need to be thought about in this study (Eklöf et al., 2017; Kitzinger, 1995; Kook, 2019; Liamputtong, 2011; Madriz, 2003; Munday, 2014; Rose & Phil, 2001). For example, compared to more individualised approaches to research, such as one-to-one interviews, the collective nature of focus groups may act to reduce researcher-participant power inequality by de-centring the researcher and reducing their directive power and as such go some way to address some of the power inequalities in research practise. This is particularly important in research such as that undertaken in this study, where academic researchers work with communities who are currently marginalised (Sprague, 2005; Wilkinson, 1999).

The choice to use focus groups also aligns with this study's feminist and social constructionist epistemology in that they are a method of research which makes explicit the social context and situated nature of knowledge production, as within a group setting knowledge is co-created through the interaction of different participants

in a particular setting with the researcher as an integral part of the research process (Bosco & Herman, 2010; Kitzinger, 1995; Kook, 2019; Munday, 2014; Wilkinson, 1999). In this way focus groups can provide an opportunity for a more collective, participatory, and democratic approach to knowledge production which aligns with the feminist-informed approach to this research (Kook, 2019; Madriz, 2003; Munday, 2014; Rose & Phil, 2001).

For Kitzinger and other feminist researchers, focus groups have a value beyond their utility as a method which supports a collective and more participatory approach to knowledge production. They suggest that sharing lived experiences in a collective setting can provide women with an opportunity to talk about and acknowledge possible common experiences, which in turn provides validation for those experiences and can support the development of a collective consciousness (Kitzinger, 1995; Kook, 2019; Madriz, 2003; Wilkinson, 1999). They suggest that this can lead to a situation which allows some women:

> *A realisation that their experiences and opinions are tangible and legitimate and to raise women's consciousness that their problematic experiences are not individual but structural, and that they are also shared by many others*. (Liamputtong, 2011, p. 19)

Online focus groups, as opposed to in-person groups, were chosen for this study as a response to the impact of the COVID-19 pandemic. By late 2021 and Spring 2022 when data collection for this part of the study was initially being designed, the situation with COVID-19 remained uncertain, with the UK Government *Plan B*, designed to address the Omicron variant, being launched in December 2021 (Institute for Government Analysis, 2021). While in February 2022 the *Living with COVID* strategy was released, removing restrictions within England (Sherrington, 2022), there remained a concern amongst researchers and participants about travel and group meetings. As a result, it was decided that the recruitment and data collection for study two would be undertaken online.

In the last decade online focus groups have been established as a useful and effective way of collecting qualitative data within health and social sciences research (Dos Santos Marques et al., 2021; Forrestal, 2015), with the COVID-19 pandemic leading to an increase in their popularity (Lathen, 2021; Lupton, 2021). It has been

suggested that undertaking focus groups online can be time and cost-efficient, may reduce geographical and access barriers and that some participants may feel more relaxed attending groups virtually rather than in-person (Dos Santos Marques et al., 2021; Forrestal, 2015; Lupton, 2021; Moore, 2015). However, while online focus groups can be a valuable method for working with groups who may face barriers to accessing in-person research settings, there are challenges in using this method. These challenges include a lack of familiarity with, and limited access to, technology which can be particularly significant when working with marginalised communities including asylum seeking and refugee women (Lathen, 2021; Sim, 2019). In this study, meeting virtually was a familiar and convenient format for participants, reducing the need for physical travel and, in light of concerns around COVID-19 transmission, personal interaction. All the women in the study were familiar with the software used for video communication as they used this to keep in touch with family and friends outside the UK. In addition, during the COIVD-19 pandemic, participants had both accessed a range of services and met socially online. Consideration was given to which software should be used to ensure that this was secure, easy to use and familiar to participants. Zoom was chosen as all participants had previously used this software and were confident in using it.

7.3 Participants, sampling and recruitment

As in study one, a purposive approach to sampling was used, for both phases of this study, as a way of recruiting participants who had lived experience of being a refugee or asylum seeker in the perinatal period and who could therefore speak directly to the research question (Campbell et al., 2020).

The same inclusion and exclusion criteria were used for both phases of this study as those used in in study one (chapter five), with three exceptions highlighted in blue below in Table 7.1 below. Firstly, I extended the maximum age of the participants' youngest child to four years. Previously I had required women to have a child of two or under to increase the chance of accessing women in mother and baby groups and to ensure recent experience of maternity care. Based on learning from study one, in this study, I extended the age criteria to include pre-school children. This meant that some of these children could be in nursery which would make it easier for women to take part in a focus group, whilst at the same time the children were young enough for their mothers' perinatal experiences to have taken place within the current

maternity care system. Secondly, for financial and pragmatic reasons I was unable to offer interpretation for this study. This meant that women had to be able to speak English to participate as the groups were conducted in English. While acknowledging that this may have limited the range of participants I could access, I still was able to recruit women with a range of experiences. The third additional criteria was that women needed to be able to access the internet, or have sufficient data on a mobile device, to join an online group. This proved to be a challenging aspect of the research, particularly for one woman who joined a group late as she had struggled to access the internet. One participant noted that some of the locations in which women were housed had poor internet access. Most women joined the sessions on their phones which affected the sound quality and the visual aspect of the group, others kept their cameras off due to poor bandwidth. This meant at times it was more difficult to identify who was talking within the group, to hear women clearly and to appreciate non-verbal responses. But as identified in the previous methods chapter (chapter five), undertaking research with marginalised groups means that researchers need to be flexible and adapt to the real life situations in which the research takes place to ensure that the voices of these groups are heard. I was also concerned that some women may have to use their mobile data to join the sessions which could have financial implications for them as I was not able to provide funding for data, this could potentially have limited access to the research for some women.

Inclusion	Exclusion
Women whose youngest child is four years old or under who was born in the UK.	Women whose youngest child is over four years old
Sufficient fluency in English to take part in focus group	In sufficient English to take part in group
Access to the internet/data on a mobile device	Lack of access to the internet/data
Women who have given birth in the UK	Women whose youngest child was born outside of the UK
Women who are within the UK Immigration system as asylum seekers, refused asylum seekers, were appealing against their refusal or had no recourse to public funds, refugees,	Women who are not within the UK immigration system, UK residents or EU/other migrants

Syrian, Afghan or Sudanese gateway protection or resettlement programmes	
From any country or region of origin	None
Any length of time in the UK	None

Table 7.1 Inclusion and exclusion criteria (additional/changes to criteria highlighted in blue)

As in study one and discussed in the previous methods chapter (chapter five), sample size was based on the specific needs of the research as well as practical issues related to the method chosen - in this case online focus groups. Following this approach, in this study, the sample size was determined by the need to include participants who represented a range of perinatal experiences while also considering the optimal size and make up of online focus groups when working with participants with English as an additional language (Baker & Edwards, 2012; Munday, 2014).

When using focus groups as a method, it is important to consider the composition and size of the groups. In terms of composition, groups with a large degree of homogeneity may produce a smaller variety of opinions but facilitate more in-depth conversations and provide a safer space for discussion, whereas more heterogeneous groups may provide a wider range of views but may be more challenging for some participants (Kitzinger, 1995). In this study a balance was struck between the two, with women having some areas of commonality in terms of being asylum seekers or refugees in the UK in the perinatal period, while also demonstrating heterogeneity in terms of country of origin, immigration status, length of stay.

In terms of group size, Munday (2014) has suggested that this should be determined by the context and specific needs of the research and that smaller groups provide effective opportunities for data collection, allowing attention to be paid to the process as well as the content of a session. In this study I chose to use smaller groups for several reasons. Firstly, as these groups were online it is generally recommended that online groups should have a smaller number of participants than in-person groups as this allows for a more effective interaction in a virtual setting (Jovanovski, 2023; Lathen, 2021; Moore, 2015). Secondly, as all the participants had English as

an additional language, I felt that smaller groups would be more appropriate. Smaller groups would give women more time to think and formulate answers in a language which is not their native tongue, and some women may feel more comfortable speaking in a smaller group. In line with these considerations, in phase one, three focus groups were undertaken which consisted of two groups with three women each and one group with five women, a total of eleven women. In phase two, one member checking focus group was undertaken which consisted of five women who had taken part in the previous focus groups. Recruitment was concluded here as it was felt that the women recruited provided a range of experiences of perinatal social support and came from a range of countries of origin, status, time in the UK and experiences of maternity.

Recruitment for the online focus groups used in study two was done through pre-existing contacts with individuals from two voluntary organisations working to support asylum seeking and refugee women in the north of England. These organisations were different to the ones I had worked with in study one and the women who participated in study two were different to those involved in study one. This was as a response to COVID-19 regulations which meant that during the pandemic the mother and baby groups, through which women had been recruited for study one, did not meet due to the restrictions associated with the pandemic and so I could not recruit women through these groups. Additionally, some of the women who were involved in the interviews in 2019 had moved to new areas by the time the focus groups were undertaken in 2022. In light of the changed situation brought about by doing research during COVID-19 and its immediate aftermath, women were recruited through two different organisations. These two organisations were chosen as they had online women's groups which had been meeting virtually during the COVID-19 pandemic. This meant that contacts in these groups could support me with online recruitment and that women in these groups were experienced in participating in online groups. An additional benefit of recruiting through these groups is that I was able to gain the perspectives and hear the voices of more women, as these groups reached out to women who had not been involved in the first study allowing me to work with a wider range of women with differing experiences. I was not working with either of these groups at the time of the research.

Contacts from these groups were approached by email and telephone to discuss the nature of the project and recruitment. These contacts were happy to support me with recruitment and felt that online groups would be an effective and acceptable way to work with women. They were sent written information about the project including details of the consent procedure and participant information sheets to share with their groups verbally and to send out electronically. This allowed them to discuss these with the women in their groups and address any questions women had about the research (Appendices 8 and 9). Contacts from both groups invited me to join online Zoom meetings with possible participants so that I could introduce myself and the project. In this session, information about the project and the nature of the consent process were discussed, with women having opportunities to ask questions. At the end of this meeting any women who were interested in participating and who met the inclusion criteria, detailed above, provided their contact and basic demographic details through a Microsoft form that either they or the group lead completed. This provided me with their contact details, allowed me to collate demographic information and thus ensure that potential participants met the inclusion criteria. Using this information, I was then able to arrange convenient dates for the focus groups with participants in both phases of the study.

The inclusion of participants already known to each other in focus groups has been seen as problematic by some researchers, in terms of the impact on group dynamics, issues of artificial consensus and/or issues of disclosure and confidentiality (Krueger, 2000; Rose & Phil, 2001). However, Munday (2014), while acknowledging the need to be cognisant of these challenges, argues that often pragmatically to maximise recruitment of certain populations, researchers need to recruit participants who are part of pre-existing groups and so are known to each other. She also notes that participants who know each other may feel more relaxed and at ease in what could otherwise be a challenging and unfamiliar situation and so may be more likely to contribute to the conversation. These two issues, along with the fact that concern for and attention to the wellbeing of participants was congruent with my feminist-informed approach to research, resonated with my work, and I chose to include women who knew each other in the groups for these reasons. I did, however, use my fieldnotes to reflect on how this could affect the group dynamics:

This group was comprised of women from both organisations, three women in total. The two women, from organisation one already knew each other and were part of a group of women training to be peer researchers. The third woman, from organisation two, did not know the other participants however a rapport between the women was established very quickly. All the women spoke English confidently and were confident in their opinions, keen to share them with me, keen to relate to each other and to share their ideas to improve conditions for women. (Extract from fieldnotes from focus group one)

7.4 Ethical considerations

Chapter five explored many of the ethical issues involved in undertaking research with asylum seeking and refugee women as a marginalised group. The section below considers the additional ethical issues considered when undertaking focus groups and online methods. An addition to the existing ethical approval for the thesis to undertake online focus groups was granted by the UCLan ethics committee (STEMH 1026 Stage 2) April 2022 (Appendix 10).

7.4.1 Informed consent

As in study one, all participants were provided with details about the project and the consent procedure verbally and in written form. Written information was provided in plain English as all women had English as an additional language. These details were discussed with participants at the beginning of each group to ensure that women were happy to provide consent to take part in the research and had had the opportunity to ask questions and for me to address any concerns they had. Additional issues relating to research being undertaken in a group and online setting were discussed as part of this process. Women were informed that an audio and visual recording of the focus group was being made. I reminded them that involvement in the project was voluntary, and that they could withdraw from the study at any time during the group but that after the group ended they would not be able to withdraw their data. I explained that not participating or choosing to leave the sessions would not affect the support they could receive from the organisations they had been recruited through. As in study one, consent was taken verbally, with women taking it in turns to speak to record their consent. In two cases women

joined one of the groups late, after initial consent had been taken, at this point the session was stopped, and verbal discussion of the information sheet and the consent procedure was undertaken with the women who had come into the session late.

7.4.2 Confidentiality and anonymity

Confidentiality and anonymity have been identified as issues which need to be considered when using focus groups on and offline (Forrestal, 2015; Lathen, 2021; Sim, 2019). In a group setting, as opposed to a one-to-one interview situation, the participants are visible and present with each other and so cannot be anonymous within the group. Indeed, in this research as I recruited participants from established groups, most participants already knew each other prior to the focus groups. All women were aware of this, and all agreed to take part in the research knowing this. Participants were assured verbally and in the information sheets that they would not be identifiable in the research outputs which came from these focus groups. The issues of confidentiality within the group and ensuring that personal data was not shared outside the group was discussed with participants as this is an area which has been highlighted as being a challenging aspect of focus groups (Munday, 2014). Participants were reminded that they should ensure that the sessions were not observed or overheard by others, to protect the confidentiality of the group discussions and so were encouraged to undertake the groups in a private location if this was possible for them.

To ensure high levels of data security I obtained an institutional Zoom account owned by UCLan. Zoom meetings were set up following the advice provided by UCLan LIS/ JISC's CSIRT team (https://cybersecurity.jiscinvolve.org/wp/2020/04/23/tips-on-zoom-safety/). Following the completion of the session, and in line with data protection requirements, the audio-visual recordings of the sessions were uploaded to the secure university password protected system and deleted from Zoom. The audio aspects of the recordings were then uploaded to and transcribed using Sonix; once completed the transcriptions were saved onto the university system and the recordings were deleted from Sonix. All other aspects of data storage and management followed the principles used for study one as detailed in chapter five.

7.4.3 Wellbeing of participants

As in study one, consideration was given to the wellbeing of those involved in the groups and the same procedures to support participant wellbeing were followed (see chapter five). In contrast to study one, in which women were asked to explore their lived experience of the perinatal period, in this study participants were being asked to comment on the best ways in which women could be supported. The focus of the groups in this study were less sensitive, and while some participants shared personal experiences, the discussions were less personal and so the chance of women experiencing distress was less. Where possible women were encouraged to keep their cameras on as that gave me to opportunity to assess visually if any participants seemed distressed. However, as identified above, some women were unable to keep their cameras on. To address this, I verbally checked in with women to ensure they were happy to continue with the discussions within the sessions.

7.5 Phase 1 Focus groups

7.5.1 Focus group schedule

The schedule for the three phase one online focus groups was structured around the five themes developed in the analysis of the participant interviews in study one, presented in chapter six. These were:

1. Struggling to ensure that basic needs are met
2. Meeting social needs by creating networks of support
3. Family as a source of psychological safety and support
4. Social support within the NHS maternity services
5. The need to ensure effective communication

These five themes represented the participants' experiences of perinatal social support and explored the support they felt they had been able to access, where they lacked support and what support had been useful to them. These themes were used as the starting point for the focus group discussions as they allowed me to keep the views and voices of asylum seeking and refugee women at the centre of the research. It also meant that the focus group discussions were building on the perceptions and experiences of women who had lived experiences of being asylum

seeking or refugee women in the perinatal period, rather ideas drawn from previous academic research.

At the start of the online groups, I shared a PowerPoint slide which had bullet points with the five themes from study one to provide an overview of the issues which would form the basis of the session (Figure 7.1). As all women had English as a second language, the slide was written in plain English and the contents were read out to ensure that any women who were not confident reading English could access the information.

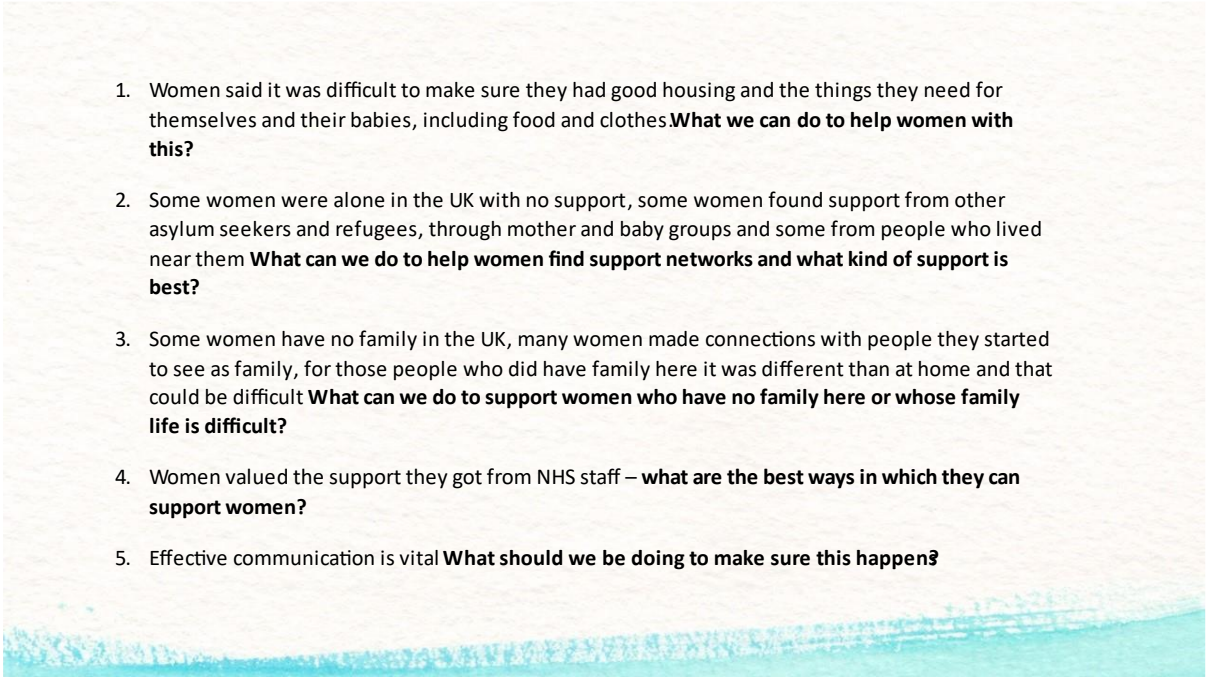

Figure 7.1 Slide from phase one focus group

7.5.2 Undertaking the focus groups

Three focus groups were held over Zoom with 11 women during the summer of 2022. The groups lasted between 45 and 70 minutes.

In online, as with in-person. groups the researcher acts as group facilitator. This involves addressing practical issues such as establishing the focus of the discussions and recording the sessions. It also involves establishing a respectful and inclusive environment to ensure that all participants feel comfortable to speak and freely express their views and that they feel the groups are a safe, non-judgemental space (Eklöf et al., 2017; Munday, 2014).

To develop some connection with and between the participants and following on from our initial online meetings, I spent some time chatting to participants and the women spoke to each other at the beginning of the sessions. I took care to ensure that women felt the groups were a space in which they were all able to speak, making sure no individual dominated a group by encouraging all participants to take part and ensuring they had time to formulate and express their ideas (Munday, 2014). I tried to be particularly aware of those who were less confident in expressing themselves in English as they were less vocal compared to those who were more fluent. Some women were also more confident in expressing their views and so care was taken to gently encourage all women to express themselves. As identified previously, most women knew each other and met together in group settings outside of the research sessions and so there was a familiarity which allowed them to feel comfortable with each other. In the one case where a woman did not know the others in the focus group, rapport was established very quickly between her and the other participants as they shared experiences, resulting in by the end of the group women calling each other 'sister' and planning to remain in contact after the group ended.

Where possible women were encouraged to leave their cameras on to encourage fuller interaction, but this depended on the preference of the participants, their location and their internet connection, with some women joining with audio and video while others just used audio or switched between the two. Few women had childcare which meant that they had to try to ensure their children were napping or had to amuse them during the sessions. This meant that several children were present during the sessions which could be challenging both for the women and for recording the sessions, with periods in which it could be hard to hear participants over their children:

> *Some women had their children with them as they were too small for nursery or were not in nursery so you could hear children and sometimes discussions were disrupted by the children. All women kept muted when not speaking the limit noise from children etc. The fact they had children there who were being noisy was likely to have limited women's participation as they may not have felt they could unmute if they had children making a noise* (Extract from reflexive notes).

I saw my role once the session began as introducing the themes, providing prompts where needed and encouraging all participants to be involved in the discussions. I tried to speak as little as I could to allow space for women to talk with each other. I found that some women, particularly in two of the focus groups, were very confident in their opinions and were keen to explore them within the group with other participants. They were also happy to correct some of my assumptions and challenge my ideas, expressing their own views to correct mine. Other less confident women were often backed up and supported when they expressed ideas, with participants referring to each other's ideas and taking these forward. In this sense it could be argued that the collective nature of the focus group did, as some feminist researchers have suggested, reduce some of the power imbalance between myself as the researcher and the participants (Kitzinger, 1995; Munday, 2014). However, at times I needed to take a more directive role and asked additional questions to facilitate discussions (Munday, 2014). This was particularly the case in the third focus group where women were less confident in speaking English and more hesitant in expressing their ideas. In this session I became more aware of the differences in our ability to express ourselves confidently in English and how the implications of this difference affected the session and the balance of power within it. In contrast to the earlier groups, in this third group women were less confident in expressing their views, so I had to ask more questions and use more prompts and as such had more power in determining the direction of the session and its content than I had in the earlier sessions where the women had expressed themselves more confidently and directed the flow of the session more. In addition to the awareness of this increased power difference between myself and the women in the group and its potential effect, I was aware that the limitations women were experiencing, in understanding the questions and expressing themselves in English, would also have an impact on the nature and depth of their responses, which in turn may have an impact upon the depth of insight into the topic. To address some of these issues I tried to support those who were less confident in speaking English by encouraging them to speak, ensuring that there was plenty of time for them to think about the questions and formulate a response to the points made. I tried to make sure I was expressing myself clearly and using appropriate and accessible language.

7.5.3 Analysis of data from phase one focus groups

An analysis of the data from phase one focus groups was undertaken using as in study one, reflective thematic analysis (Braun & Clarke, 2021). This was chosen as it is compatible with the methodological approach and theoretical underpinnings of the research and with the nature of the research question addressed in this study (for more detail of the rationale for this choice see chapter five).

As in study one, analysis followed the six steps of reflexive thematic analysis (described in detail in chapter five). As previously, interview transcripts were transcribed using SONIX software, the transcripts were then reviewed and corrected for any inaccuracies in the transcription. This process supported familiarisation with the data and it's context, as did reviewing my field notes. Line by line coding was undertaken using both pre-existing ideas which had guided the focus group schedule, and ideas which arose from the data. Following coding themes were then developed from the data. This was an iterative process which included, generating initial themes, developing, reviewing and refining themes until final themes were arrived at (Braun & Clarke, 2021). Throughout this process notes were kept which were discussed with my supervisors to support the analysis, increase rigour and address personal bias, which I would bring to the analysis (for more detail on reflective thematic analysis see chapter five).

The data from the three phase one focus groups produced four main themes, which represented the participants' discussions of, and suggestions related to, the best ways they felt asylum seeking and refugee women could be supported in the perinatal period. These themes are presented in Table 7.2 below. These findings provided the basis for the member checking group, as the purpose and focus of this group was an exploration and evaluation of my interpretation of the data from phase one focus groups.

7.6 Phase 2: Member checking focus group

Following on from the three phase one focus groups, in phase two, a member checking online focus group was undertaken. This was held on Zoom with five asylum seeking and refugee women in December 2022 and lasted 50 minutes. As the rationale for the use of focus groups and the practical issues related to using them, as well as the sampling, recruitment, ethical and wellbeing issues common to

both phases of this study has been explored above, the section below provides the specific rationale for the use of member checking and the key issues related to undertaking this group.

Member checking or member reflection is a technique used by researchers to invite participants to reflect on, evaluate and explore further, aspects of their research. Some researchers using a qualitative and/or social constructionist approach, have expressed concern with the positivistic overtones associated with the idea that such research can or should be externally validated, an approach at odds with their epistemological approach. However, others have suggested that this process can be a valuable way of asking participants to engage with the interpretation of data produced by the researcher (Braun & Clarke, 2023; Olmos-Vega et al., 2023). It has been suggested that this approach provides researchers, particularly those without lived experience of a phenomena, with a way of exploring if their interpretation provides an acceptable representation of the ideas expressed by participants with that experience (Brear, 2019; López-Zerón et al., 2021) and as such is particularly relevant for this research with asylum seeking and refugee women. As a method, it algins with a feminist-informed approach to research as it seeks to challenge traditional hierarchies within knowledge production and to encourage participants to be more actively involved in research practises (Caretta, 2016). In research which has sought to be sensitive to issues of '*speaking for others'* (for more detail see chapter four), holding a member checking group provided me with an opportunity to try to ensure that the views and voices of my participants remained central to the understanding and representation of the research. It provided me with a way of balancing my own understanding and interpretations of what women told me about their experiences with those of women with lived experience, acknowledging the different perspectives from which we approach the issues (Braun & Clarke, 2023). It allowed me to ensure that women's voices remained present though out the interpretation and presentation of the findings. Using member checking in this way recognises the social and collective construction of knowledge and the partial nature of analysis (Brear, 2019; Caretta, 2016; Olmos-Vega et al., 2023) and therefore aligns with the underlying feminist social constructionist epistemological and methodological approach of this study.

7.6.1 Recruitment

Purposing sampling was used again for this phase of the study, following the principles described in the section on recruitment and sampling above. Women from the two organisations, who had been recruited as part of phase one of this study, and so had shared their contact details, were contacted to see if they were interested in taking part in this final aspect of the study. The information sheet and details of the consent procedure were re-distributed to remind them about the study and to make sure that they were still happy to take part. Following this contact, five women agreed to participate and so, as previously, a mutually convenient time was established for us to meet on Zoom and details of the meeting sent to all participants.

7.6.2 Constructing the focus group schedule

The schedule for the member checking group was structured around a discussion and evaluation of the voracity of the four themes and suggestions for improvement which had been developed from the analysis of the data from the phase one focus groups. These were presented to the group as relating to:

1. the need for support to access statutory services
2. the provision of support that met women's needs
3. the need for information
4. the role of midwives as sources of support

The purpose of this group was to invite participants to reflect on these findings and to see, if they felt that these themes, and the associated suggestions for improvement addressed the question*, what are the best ways in which asylum seeking and refugee women could be supported in the perinatal period*, if they resonated with their experiences, and if they represented the spirit of the earlier discussions. The group, in-line with a member checking approach, also provided an opportunity for women to raise any additional issues or suggestions which they felt were important but were not included.

7.6.3 Undertaking the member checking group

I began the session by reminding participants about the project and explaining its purpose and format. As previously identified, participant consent was taken verbally following a discussion of the participant information and consent procedure at the start of the session. My role in the session was to introduce the key themes and suggestions developed from phase one and ask them to reflect on these in the light of their own experiences. As in the phase one focus groups, attention was paid to the management of the group and the dynamics within it. The participants in the session already knew each other prior to the group as they all were recruited from the same organisation. All women were active in the discussions, although their level of input varied. Two of the women in the group were more confident in English and one of these was involved in voluntary work within her community; these women were most confident in the discussions and tended to explore the issues in greater depth and to offer additional ideas and/or suggestions. However, care was taken to ensure that the other, less confident, women were encouraged to speak and given time to formulate and express their ideas to ensure that all women's voices were heard, and all inputs valued. As after other focus groups field notes were made:

> *In the member checking group women responded very positively to the initial findings and suggestions presented to them and felt that these resonated with their experiences and that these were key issues which need to be addressed to improve social support. In the discussions they explained why they thought the suggestions and ideas were appropriate and, in some cases, gave more detail or examples from their experiences and/or made further suggestions* (Extract from reflective field notes).

At the end of the session, as previously described, recordings were downloaded from Zoom, audio recordings uploaded to Sonix to be transcribed and then recordings were deleted from both systems.

7.6.4 Analysis of data for study two

As previously, recorded data were transcribed and where appropriate corrected (for more detail see above and chapter five). The data from phase two, the member

checking group, was coded, then compared with and added to, existing data from the phase one focus groups to see if additional codes, themes or suggestions were evident. While several new codes were identified, no new themes were developed but the data from the member checking group helped to substantiate and add depth to the existing themes and produced several additional suggestions for improvement within the existing themes. Following the combination of the data from both phases the final theme titles, themes and suggestions were decided on and these are presented in Table 7.2 below.

Codes	Sub themes	Themes including suggestions for improvement
Agencies to provide basic needs	Role of statutory agencies	***The Home Office didn't respond*: the need for social support to navigate statutory services** There should be people who can help women to deal with housing, benefit and the Home office These agencies need to be better at dealing with asylum seeking & refugee
The role of statutory agencies		
Need for systemic change		
Housing		
Access to support	Support to access agencies	
Who gets support, support varies		
Encouraging	Qualities of supporters	***Because if I'm not comfortable with you, I'm not going to tell you anything*: getting social support right to meet women's needs** Supporters need to be kind, non-judgemental, friendly, good at listening as these key attributes & skills will allow them to effectively support women All asylum seeking & refugee women should be able to access to doulas &/or befriending support Mother & baby groups should be provided for all asylum seeking & refugee women Where groups currently exist, they should be promoted & women encouraged to attend them Think about who is best to support women, people from our communities or people from outside There should be childcare for women who have no support to allow them respite and to go to appointments
Nonjudgmental		
Friendly & welcoming		
Friendly communication		
Understanding		
Patient		
Listen to us/let us talk		
Make us comfortable & then we can trust		
Other asylum seeking & refugee women provide support	Who is best to provide support	
Peers as understand & don't have to explain		
Help can come from anywhere		
Value of a befriender	Forms of support	
Value of doulas		
Voluntary organisations & activities		

Women's groups - role and importance		
Role of vol agencies		
Family & impact of lack of		
Chosen family		
Need for day-to-day support with children	Post-natal childcare	
Agency - do it ourselves		
Information on our rights & available support	More effective dissemination about sources of support	***Information, information, information*: improve knowledge about what social support is available** Women need to know about & be told about local sources of support available to them Any information about how to access social support &/or services that are aimed at asylum seeking & refugee women should be provided in forms which are accessible to as many women as possible. This should be done by Using a range of locations and ways of doing this Using a range of formats including, verbal, pamphlets & other written forms including posters in different languages Anyone working with asylum seeking & refugee women should know about national & local sources of social support so they could signpost women to them.
Help is available if you know where to find it		
Importance of signposting	Signposting	
Knowledge of how to help		
Sources of information	Providing information effectively	
Dissemination of information, verbally, pamphlets, other written formats – posters and in other languages		
Importance of continuity of carer/known midwife	Organisation of care	***I think, you know when you plant a tree yeah, without the roots, the tree will not blossom…the midwives are actually the roots*: enabling midwives to provide social support within and beyond the healthcare setting** All women should have the same midwife or a midwife they know for all their care All midwives should be trained to provide care & support to asylum seeking & refugee women & understand their experiences in the UK not just specialist midwives
Specialist midwives		
All midwives need to be able to support all women		
Longer appointments		
Role & importance of the midwife		

Qualities of good care – trust, confidence		All midwives should receive training to ensure that they have a greater understanding of the experiences of asylum seeking & refugee women and their cultural needs All midwives should be trained to know about asylum seeking & refugee women's mental health Provide longer appointments for asylum seeking & refugee women, particularly for women who do not speak, or are not confident in speaking English Provide access to interpretation services for all women whenever they need it, ideally in person, if not virtually Think about who provides interpretation – ideally it would be provided by women who know about the experiences of asylum seeking & refugee women & are mothers themselves Provide specialist antenatal education for asylum seeking & women Midwives need to have the information to signpost women to local & national services (e.g., Maternity City of Sanctuary)
Need for training for midwives	Awareness of the perinatal needs & experiences of asylum seeking and refugee women	
Culture and communication		
Specialist knowledge		
Mental health support		
Need for antenatal education & knowledge		
Source of information	Knowledge to refer women to support	
Midwives - initial & ongoing contact		
Role in signposting		
Speaking English or not	Communication	
Discrimination - poor treatment		
More time in appointments		
Someone to explain/interpret		
Qualities of interpretation		
Mothers and peers as interpreters		

NB: novel additions from the member checking group identified in blue text.

Table 7.2 Final themes and suggestions following combination of data from phase one and two, study two

7.7 Conclusion

This chapter has presented the methods used in study two. It has explored the rationale behind the use of focus groups for data collection and member checking. It has explored the practical issues involved in undertaking data collection and data analysis in this. The next chapter will present the findings from both phases of this study to explore the research question, *what do women perceive are the best ways in which asylum seeking and refugee women could be supported in the perinatal period*?

CHAPTER EIGHT FINDINGS - STUDY TWO

8.1 Introduction

The previous chapter provided an overview of the rationale for, and methods used to undertake, study two. This included, in phase one three online focus groups and in phase two an online member checking focus group. In this chapter I present the findings from both phases of this study which explore the research question, *what are asylum seeking and refugee women's perceptions of the best ways in which they can be supported in the perinatal period?* I begin by providing the demographics of the women who participated in this study. This is followed by an exploration of the four themes and associated suggestions for improvement developed from the analysis of the data from the phase one focus groups, combined with insights from the member checking group. The four themes identified are:

1. *The Home Office didn't respond*: the need for social support to navigate statutory services
2. *Because if I'm not comfortable with you, I'm not going to tell you anything*: getting social support right to meet women's needs,
3. *Information, information, information*: improve knowledge about what social support is available
4. *I think, you know when you plant a tree yeah, without the roots, the tree will not blossom…the midwives are actually the roots:* enabling midwives to provide social support within and beyond the healthcare setting.

8.2 Participant characteristics

A total of 11 women participated in study two. In phase one, three focus groups were held in July and August 2022 (identified as groups one, two and three in the table below), these consisted of three women in focus group one, four women in focus group two and five women in focus group three. In phase two, a member checking group (identified as group four below) was held in December 2022 with five women. Five women attended one of the phase one

focus groups and the member checking group, and one woman attended two focus groups and the member checking group. Participants were aged between 22 and 43 and each had between one and eight children. They came from eight different countries and had been in the UK between 10 months and 11 years. They held a range of different immigration statuses including asylum seeker, refugee and refused asylum seeker.

Participant	Age of youngest child	Number of children	Time in UK	Home country	Immigration status	Age	Focus groups attended
1	18 months	1	2 years	Namibia	Asylum seeker	28	1
2	18 months	1	2 years	Nigeria	Asylum seeker	37	1
3	1 year	4	7 years	Ghana	Limited leave to remain	32	1
4	18 months	8	3 years	Malaysia	Asylum seeker	43	2 & 4
5	3 years	1	11 years	Senegal	Refugee	35	2
6	4 years	1	8 years	Eritrea	Refugee	37	2
7	10 months	2	2 years	Nigeria	Asylum seeker	27	2, 3 & 4
8	6 months	2	10 months	Afghanistan	Refugee	22	3 & 4
9	4 months	2	5 years	Zimbabwe	Refused asylum seeker	31	3
10	2 years	3	3 years	Nigeria	Asylum seeker	38	3 & 4
11	2 years	1	4 years	Nigeria	Asylum Seeker	27	3 & 4

Table 8.1 Focus group participant demographics

8.3 Findings overview

The four key themes from the analysis of the focus groups are reported below, *The Home Office didn't respond*: the need for social support to navigate statutory services, *Because if I'm not comfortable with you, I'm not going to tell you anything:* getting social support right to meet women's needs,

Information, information, information: Improve knowledge about what support is available, *When you plant a tree yeah, without the roots, the tree will not blossom…the midwives are actually the roots:* enabling midwives to provide social support within and beyond the healthcare setting.

8.4 *The Home Office didn't respond*: the need for social support to navigate statutory services

8.4.1 Role of statutory agencies

Statutory agencies, which were identified as including the Home Office, SERCO, local government, the National Asylum Support Service (NASS) and the NHS, were seen as playing an important role in the lives of asylum seeking and refugee women. They were seen as being responsible for enabling perinatal asylum seeking and refugee women to access housing, financial support, and the material goods they needed for themselves and their babies. One woman asserted that because women were newly arrived in the UK these services must:

> *Do the things for ladies [so] that they [have] … what they need for their babies… it's very important…* (FG3)

However, others noted that access to this much needed support was piecemeal and that some women were not able to access what they needed from these statutory agencies, despite their legal responsibilities to provide it. One noted that:

> *I have a lot of things for my baby, but I think that it's not good that one lady have a lot of things but one other lady that I know she didn't have any things for her baby.* (FG3)

8.4.2 Support to access statutory agencies

This inequity in the ability to access the statutory services women needed and identified as being so important was frequently related to women receiving

instrumental or informational social support from voluntary agencies to do so. One woman, who was confident speaking English, felt she had been able to access the services she needed partly because she spoke English but mainly because she had support from a case worker:

> *I can share my problems with my council worker and I can say that which things I need for my baby.* (FG3)

However, it was noted that this support was not available to all the women who needed it:

> *Not everyone have that luck to have those kind of people around them,* (FG2)

and that this lack of support affected women's ability to access services. One participant gave an example of how a lack of support meant she had been unable to challenge the poor-quality housing she had been allocated. She noted that:

> *If you can't find it* [support], *they will just give you whatever they have, they gave me a house, which was very damp. My child was always poorly, and I have to go through the council for months and months before they take me out of that place*. (FG2)

She felt that this support was necessary as:

> *when you're an immigrant, I feel like you're not taken [seriously] … people not just taking you as if you are someone who was born here.* (FG2)

Participants suggested that in order to ensure all women could access the services they needed and were able to effectively interact with statutory agencies, there needed to be more widespread provision of instrumental and

informational social support from voluntary or non-statutory agencies than is currently the case:

> *So yeah, we need maybe more of the referral to be accessible to people because if you are not in an organisation, it's not everyone knows about [voluntary agency] and anyone that can help.* (FG2)

and that:

> *maybe what we can do will be like finding there is organisation … who are here to help support talking to the council …we need … more support from maybe people who are from here trying to help those immigrant women to go through the council easily. I think that's that is something that we really need.* (FG2)

The need for social support from voluntary agencies to help asylum seeking and refugee women access statutory services was re-iterated by women in the member checking group. One woman explained how:

> *I think sometimes, yeah, if women like women of colour are talking to them [housing services] directly, they don't really care,* (FG4)

but noted that when someone from a voluntary agency with knowledge of the system and women's rights within it acted to support them, they were able to get the services they needed:

> *if somebody [from a voluntary agency] that they know that knows the law and knows the rules and know everything is talking and talking to them they will do it [help women resolve housing issues].* (FG4)

However, within this group it was also acknowledged that while this kind of instrumental support to access statutory services was crucial, it could be difficult for women to access:

I think it's quite it's quite difficult to make sure I mean to make sure that everyone gets the help, it's really good if everyone can get some help, but in practical wise. I think it's quite difficult to make sure that everyone. (FG4)

Women acknowledged however, that sometimes even with this support women were still not able to access statutory services. One woman, who had been seeking asylum during her pregnancy, explained how she had been housed in unsuitable accommodation and that despite instrumental support from her midwife, the Home Office had failed to address the situation:

I remember in my case, my midwife had to write a letter to the Home Office saying that the house that I was in wasn't suitable for a pregnant woman, a woman that was in my condition, so but and then on the other hand, the Home Office didn't respond to it. So when you were talking, I'm like thinking to myself, the midwife can just do as to a certain stage, but from there it's up to the Home Office. She was trying to her core, but it was just the home office that was not responding. She tried all possible means, it was just up to the Home Office that they didn't respond or didn't do anything about it. (FG1)

In light of the challenges women faced accessing services, it was suggested that in addition to the provision of social support from voluntary agencies and individuals, statutory services themselves needed to change to be more accessible. Further, to improve the availability and responsiveness of current services, there should be individuals within the services who could provide instrumental and informational support for asylum seeking and refugee women. One woman noted that:

probably we have like in SERCO we have people that can … play a role as well in accommodation and stuff. So yeah, I think those are the, the key people that can really maybe make it better for mother and baby and in that situation. (FG1)

> *I think in my own opinion, I think they should have more, more, like more, I don't know how to put it, but like more people to talk to, like, in terms of housing. Like, like [name of participant] she had issues with housing, although now it's sorted out, but it was really terrible for her at first.* (FG2)

Women in the member checking group agreed with these suggestions that there needed to be better support from within agencies, while also noting the need for wider systemic change:

> *But the system like that system is like that. So that's why I was like it's a whole big picture of make a change to all this not only one way of channelling the specific person but the whole big organisations, everybody have to put effort or put the contributions on each way, on each angle.* (FG4)

8.5 *Because if I'm not comfortable with you, I'm not going to tell you anything*: getting social support right to meet women's needs

Participants in all the focus groups noted the limited social support many asylum seeking and refugee women experienced in the perinatal period. They discussed the nature of social support currently available in terms of what they felt worked well, in addition to what needed to be done to improve the levels of support available and the quality of that support. They discussed the need to ensure that supporters had the right qualities and skills, who might be best placed to provide that support and the best ways in which support could be provided in the perinatal period.

8.5.1 Qualities of supporters

To improve the nature of social support for asylum seeking and refugee women, focus group participants highlighted a range of attributes they felt supporters needed to have to provide the best support. One attribute, '*patience'* was repeatedly identified as being crucial in those providing support:

They need to have people that are, that will be patient with them. (FG1)

Participants identified that if supporters were patient, women would feel more at ease and be able to fully express themselves and articulate their needs, this was seen to be particularly important for women with limited English:

I think that patience is really needed, well for non-speaking English people to be comfortable and be able to express or manage to tell them what the problem is. (FG3)

Whereas, if supporters were not patient, women would be less likely to engage with services and access the help they needed. For example, one participant explained how a lack of patience within, in this instance, a healthcare setting, could mean that women chose not to continue to engage with maternity services:

You need to be patient enough because just imagine, you can't [speak English], this is a foreign language, and then someone who was trying to help you is not patient enough. You are pregnant, you get frustrated, it's like, oh, I don't need this midwife she can just go. (FG3)

Women explained that supporters needed to be open and welcoming as asylum seeking and refugee women faced significant challenges in their daily lives within the immigration system:

Try by your level best to communicate in a friendliest way, because that's all sometimes we need as women that are in the system. It's just someone to understand, to be patient with us, to be welcoming. To be welcoming because we are already going through a lot. So we need that welcoming, welcoming person to just, you know, take care of you. (FG1)

Supporters also needed to be '*friendly'* and '*kind'* in order to provide the best social support as this put women at their ease, creating situations in which they feel '*comfortable'*, '*confident'* and so could then '*trust'* those offering them support. One woman explained that:

> *If they make me comfortable, I am welcomed, I think. Then I can tell you what my problem is for you to give me help. Because if I'm not comfortable with you, I'm not going to tell you anything, okay? I'm not going to tell you. Oh, this is my problem, or this is what I need. I need to be comfortable with you first, so you need to show me like show me that. Yes, you care You can help me. For me to be able to tell you, oh, yes, I'm in need. I need help. And this is what I need helping.* (FG2)

> *You know, if you are friendly, you are kind to someone … you know, like they'll be easy to open up and do you [will be able to] … make their lives easier.* (FG3)

Women explained how it was crucial that supporters had, '*listening ears'* and really listened to them, as this would allow them to provide support that aligned with women's self-identified needs:

> *because when they listen, they'll be able to help … when they listen to my problems, what I need, they'll be able to help … they will know what I need … because they've listened to me … yes, and then they will guide me where to go.* (FG2)

It was further suggested that for women to be able to explain the support they needed they must feel able to direct the conversations:

> *Keep quiet or you never have chance to listen to what the person is saying. So please, they should give us a chance to have confidence in them so that we can voice out. Because sometimes there's some things in our mind if we get somebody to explain, it will not lead us to*

some mistakes that they will say, oh, you did this too, but we didn't get a chance to explain to somebody…. We need encouragement. (FG1)

Participants from the member checking group agreed that listening to women was crucial as they felt that when supporters really listened:

They are they are really showing that …they're really interested, they really care. (FG4)

In order to improve the quality of support it was important that supporters were able to '*listen without judging'*. Several women spoke of how they had been negatively affected by judgemental attitudes from supporters. One woman explained how judgement about her pregnancy led her to contemplate self harm:

Oh, somebody would say that. Okay, you know your situation. Why are you still giving birth? I'm woman … A woman. I'm just a woman. [they would say] You know that you don't have enough space. You don't. You know you don't have enough money. You know you don't have enough support. Why are you giving birth with somebody who doesn't want to support, I am woman …so, if you give me that that harsh feedback or that attitude, I was thinking, Oh, I've made a mistake. Or maybe I feel so ashamed for similar reasons. Why shouldn't we end our life? So the impression they give is make us react. (FG1)

8.5.2 Who is best placed to provide support?

There was some discussion of who was best placed to provide support to women within community settings. For several participants, who provided the support was not important as long as those providing the support had the attributes that made them good supporters. However, several other participants felt that it was important that those providing support were peers, in the sense that they had lived experience of the immigration system and so could understand that:

we go through a lot as women in the system. (FG1)

It was felt that by having similar experiences those offering support would have a better understanding of women's situations and needs:

> *the lived experience women, they can relate … in so many things, so many things… it is a different kind of support than having my neighbour who is English. I may be getting a thousand pounds from the English. I may be getting nothing from these women with lived experience, but I would rather relate to that [more] than the one who is giving me the £1,000. Because in my case, yeah, it did happen to me I did have fabulous English people willing to help me, but it took me a while to trust them. But with these other women, with lived experience it was relatable, and it was easier.* (FG1)

However, other participants suggested that this could be problematic, and that care needed to be taken if support was provided by peers, particularly if this was by someone from the same community or country of origin, as this could pose challenges in terms of confidentiality or possible stigma within that community:

> *I can trust someone more than someone who's not from my country because you say, okay, if I tell my problem to someone who's my from my country, that person might know someone that I know and tell that problem my person. But if you're saying someone who's from here who doesn't know your background, who doesn't know anybody, even if they say, say someone who doesn't know your problem, you don't feel a shame that you know you're not in your little community and people know what your issue is, does mean help can come anywhere.* (FG2)

8.5.3 Forms of support

Participants acknowledged that asylum seeking and refugee women needed extra social support in the perinatal period to allow them to receive optimal perinatal care and support. Several participants suggested that one way of improving levels of social support would be for women to be given access to community-based doulas. One woman explained the importance of the support provided by her doula, describing the relationship in familial terms. This speaks to the lack of familial support many women faced. Supportive individuals became valued as part of a 'family of choice', providing crucial informational and emotional support.

> *I had a doula. I had it after birth doula because I had a C-section and [there is] just [me and] my baby. So like, even though when …. Like the six week that she's supposed to help me with is over, she kept in touch. She kept showing me places that I could get help, where I could take the children out to … she's lovely woman and she's like a mother to me and my daughter calls her nana. Wherever she sees her, she runs like, nana, nana, nana.* (FG2)

Other participants who did not have personal experience of having support from a doula recognised their importance and suggested that this service should be offered to all asylum seeking and refugee women, particularly those who were in the UK alone. One woman explained how:

> *I don't have anybody …but I notice of these supports now, but I just got to know, is it called … doula … so if I could introduce them for us to the period … of when especially for those that that don't have people around those … I learned from them that they are helpful to step beside someone.* (FG3)

> *If they could provide those people [doulas] like that, it would be much better because it's not everybody that has friends here. It's not everybody that has family, like me I don't have anybody. But it was during my period when I gave birth. It was painful, far back at home*

when I was in my country there were people around that could help me, but I'm left alone, so if they could provide doula's for people that would be helpful. (FG3)

The provision of community-based befrienders for asylum seeking and refugee women was seen as another way to improve social support in this period. This was again seen to be of particular value to women who had no family or other sources of social support in the UK:

I think we need a good person around me, a good befriender. That's what we need, this befriending thing I'll take them very serious because I have a very great experience about it and I think we all can benefit from it. That's a very good help, I think from a start if we don't have anybody here. The next day I gave birth. She was the first one, a hospital to see if I need something. (FG2)

I don't have a family yeah, but you know, when [name] was talking about it like a befriender …. Yeah, yeah. I think that would also be nice. I know there are other things to make someone that doesn't have family feel, feel welcome and have as if they have family, but I think a befriender should be one of them would be one of them (FG3)

Participants in the member checking group agreed with the suggestion that doulas and/or befrienders should be made available for asylum seeking and refugee women, particularly for those women who had no friends or family to support them. One participant explained that she felt that they were:

very, very important, because some people, they don't have friends… [or] any relatives around them, because it happens to me when I give back to my baby. I was alone and I didn't see anyone so if there is a doula or befriender that would be helpful. (FG4)

In addition to the value placed on one-to-one services such as doulas and befrienders, mother and baby groups established for asylum seeking and refugee women were also seen as being an important location in which social support could be provided. Participants suggested that these groups should be made available to all women, and if they were already available in the local area, should be widely promoted, and women encouraged to attend:

> *I think all pregnant women should be referred to a [name of group], because if they are referred to a [group], they can get most of the help …because I was referred … I got to know X, I got to know so many people that really helped me.* (FG2)

Women noted how these groups were crucial as they provided women with emotional, instrumental and informational support through creating relationships, providing contacts and organising activities.

> *You can ask if I don't know anything, They would say, okay, I will go find it and next week I will let you know which is really good, you know, it's really important and for the emotional help, you can get the practical help as well, because from there you can find where to buy shoes or where the baby banks are, where to get this and that.* (FG2)

> *You just get the information that there's a baby and mother group or something like that … try and attend … because from there that's where you can make friends. You can because sometimes if you think someone from my country will just come from nowhere, you'll be stuck in that house and you do not know, but you just go out. It's good for you as well.* (FG3)

Participants in the member checking focus group agreed with the suggestions from phase one focus groups, that mother and baby groups should be

available for all women as they provided an effective source of social support for those who attended:

> *Yeah, because like most women just go to a baby group, maybe they don't have any help or support around them, but the staff in the baby groups because [they can] easily talk to moms and like most times they can easily sense when something is not really right, or something is going wrong with mum. And they can easily ask Mum, oh, Mum, what's going on…. What do you need? Like, so, like, e.g., like do you need this or do you need something like that.* (FG4)

8.5.4 The need for provision of postnatal childcare

Women in one of the focus groups identified the need for support with childcare for women who were in the UK alone. They suggested there should be some form of childcare provided by the voluntary sector to allow women to leave their children safely to attend appointments or to just have some time away from their children. It was noted that while there were:

> *organizations for food, clothes, even money. What we don't have [is] nannies, like free volunteering nannies yeah, we don't have them … we don't have NGOs where people can volunteer to take care of these babies for like an hour or two*. (FG1)

to address this deficit, it was felt that there should be:

> *some organization or something like that who can step in for us who don't have any family in case of going for medication, treatment or something like that …* [where you could] *leave your baby for 2 hours just to relax and just have you time and they will just take care of your child, you can come and get your child after an hour or two*. … *You won't be having depression, you won't be having like funny sicknesses*

that that comes with not having time on your own your own as a mother. (FG1)

8.6 Information, information, information: Improve knowledge about what support is available

Participants discussed the challenges faced by asylum seeking and refugee women in knowing what social support and other services were available to them and how to access these. They suggested that women would be better supported if there was more effective dissemination of this information. They also felt that all those who worked with asylum seeking and refugee women should know about local and national sources of social support so they could signpost women to them.

8.6.1 More effective dissemination about sources of support

Participants noted that while there were sources of social support available within their local communities, many women were not aware of these and so could not access the support they offered:

So, I do believe there are so many help in the UK, there are so many help, but how to get or how do you know that place that can help you, right? (FG2)

To be fair with the community, there are all sorts of groups willing to help you. But is somebody willing to point you in the right direction? (FG1)

One participant felt that if women were provided with information about the support available to them, including what support and services they were entitled to, they would be better able to deal with the day to day challenges they faced. Reflecting on her experience of facing discrimination in housing one woman explained how she felt that:

I think if we would get access to information, to knowing the rights, like our rights and everything, I think it would help with the housing as well. (FG3)

8.6.2 Signposting

Participants discussed how they felt it was important that people who worked with asylum seeking and refugee women should know about sources of support and be able to direct women to:

> *not only to the maternity stream, but all the groups they think that can help the women who are migrant women pregnant because they are the first point of contact we have.* (FG2)

They explained how when those providing support had this knowledge, they were then able to signpost them to these crucial sources of support which they otherwise might not have accessed:

> *So that one now referred me to [name of charity] so that is where I got a lot of good for my baby, including food for my baby, this was they call the baby food, the formula that is where they could provide that.* (FG3)

8.6.3 Providing information effectively

Women in the phase one focus groups felt that any information provided to women about services and sources of support should be available at a range of locations. This included health and social care settings such as GPs and clinics, which were seen as useful locations for the provision of information:

> *If you go there [GP's surgery], they give you all the leaflets and all the information.* (FG2)

It also included less formal settings such as mother and baby groups, informal social settings or though *'word of mouth'*. These suggestions for the use of a

variety of locations were reinforced by participants in the member checking group who suggested that it was important to:

> *make sure lots of different people have this information because we might get this information in different places. So we might get it from the midwife, but we might also get it from the library or from a mum and baby group.* (FG4)

Participants from the phase one focus groups and the member checking group also suggested that information needed to be provided in a range of formats, both verbal and written, to maximise dissemination. Written information, in a range of languages in the form of both pamphlets and posters was needed and useful, however it was suggested that written information alone may not be enough because '*they can't explain everything in [a] pamphlet'* and so written information needed, where possible, to be combined with verbal information as:

> *some people might not be able to read it, but if they tell you the information of the support [they will understand]* (FG2)

8.7 *When you plant a tree yeah, without the roots, the tree will not blossom…the midwives are actually the roots*: enabling midwives to provide social support within and beyond the healthcare setting.

Midwives were identified as playing a central role in providing social support to asylum seeking and refugee women both within a maternity care setting and in wider aspects of their lives in the perinatal period. This included providing information about services, instrumental support including advocacy and emotional support. The midwife was often the first person the woman had contact with and the person with whom they had most connection. This was particularly the case for women who had few or no other sources of social support. Participants discussed current good practice as well as making suggestions about the ways in which social support provided by midwives

could be improved. Participants considered the optimal organisation of maternity care and the need for training to support midwives in providing social support which met women's needs. They also discussed the need for midwives to have knowledge of the challenges faced by asylum seeking and refugee women, have links to other agencies to facilitate support, as well as the need for more effective communication to ensure the accessibility of support.

8.7.1 Organisation of care

Continuity of carer was identified by women in both the phase one focus groups and the member checking group, as the most valuable model of care for asylum seeking and refugee women. It was identified as a way of organising midwifery provision which maximized midwives' opportunities to provide the best level of social support. It was felt that this was a model which should be provided to all asylum seeking and refugee women:

> *I think it will be. It will be a great if we can have one midwife.* (FG4)

And that this was a model of care and support which aligned with what they had received or witnessed in their home countries and as such provided a more familiar form of care and support:

> *Like African and Asian, ... we are used to like having one midwife through it all... who look after us though out all our pregnancy and when we give birth but in the UK what they find is that sometimes you get to see this person, the other time you can see this person.* (FG2)

It was suggested that the relationships developed through having continuity of support from a midwife provided women with emotional support, which was hugely valuable, particularly for those with no familial support in the UK. Drawing on their own experiences of this model of care, several women explained what they saw as its importance and why they felt it should be available to all women:

> *I did have a chance, as I was saying, to have a very good midwife who was just like a mum to me. She was always there for me.* (FG2)

> *My midwife, I loved it [her] like my mum. I was always happy to, you know, I anticipated for you to come back. I would love for every woman to have a relationship like that with a midwife, with every midwife or, you know, kind of thing or anyone or GP or anyone in the health centre.* (FG3)

It was suggested that having a known midwife women felt they could trust and rely on gave women emotional support, which in turn reduced their anxieties. Several women explained the importance of this relationship and the emotional support it provided:

> *She does have some things to do, but she will make sure that you're fine, you're comfortable, and all your worries is gone. And she always gives you the number that you can call me, or if you can't just text me and I will get back to you as soon as those kind of things make you feel comfortable* (FG2)

> *She built that relationship with me …. she give me that confidence … when the mind is tired, you can do anything at any time you want, you regret what you have done, but if you have confidence in somebody, you can give a call. Am I talking to [midwife's name] She say yes, [midwife's name] I think I'm tired. I need somebody, otherwise I'm going to do this [self-harm].* (FG1)

They contrasted the positive benefits of a continuity of carer model, with the less positive experiences of those women who did not have this experience. They suggested women who did not experience some form of continuity, found it harder to establish a trustful relationship and feel emotionally supported:

I'm part of [name of group] maternity stream for years now and all the women keep complaining the same thing, oh I don't have this midwife, they change me to the other one, they change to the other one, which is a very big issue and emotional change as well for them. Others might not understand it, but if you trust someone in a way and then change it to another one, it is very hard for them, I guess. (FG2)

Participants in the member checking group agreed with the suggestions around the provision of a continuity of carer midwifery model and felt this was especially important for women who were in the UK alone:

When I was pregnant, my last baby, I experienced a lot, but my midwife was there for me …. she was the one that gave me the right path so that one is the most important thing once your midwife understand both of you, there is a relationship between you guys. (FG4)

Another aspect of the organisation of care which women felt would enable the provision of more effective support was for midwives to have longer appointments with asylum seeking and refugee women, particularly those who could not speak English. A participant suggested that midwives should:

put an extra 30 minutes ... in their schedule …they should know that, OK, I'm going to attend someone who doesn't speak English let me spend more time with them because I need to understand them. (FG3)

It was felt that longer sessions would provide midwives with time to really listen to women and to provide them with the opportunity to explore in more depth the situation and what type of support the women they were working with needed:

just take time when you have an appointment. Just take your time, don't rush like you know, you have to get see another patient ... just take your time, hear me out. Like [name] said, sometimes we just want to talk. We don't even want you to respond to what we are saying. Just

sit there. Listen. That's all that we want. We'll just be nagging and talking and talking and talking and talking and talking after we finished. you can. You can proceed with other patients. Like I think that. Yeah. (FG1)

8.7.2 Awareness of the needs of asylum seeking and refugee women in the perinatal period

Training for midwives about the needs of asylum seeking and refugee women within the perinatal period was one of the main suggestions made by participants, with surprise being expressed that this did not seem to be in place already:

> *By now, these people should have been trained already, like they have been like past years asylum seekers. We are not the first asylum seekers like this should be, this should have been in their curriculum already because UK is a safe country for everyone to come to seek sanctuary. So they should, they should have already included it in their curriculum to teach midwife and stuff like. But yeah, it's just so surprising that it's not yet there*. (FG1)

It was felt that to provide the best support for asylum seeking and refugee women all midwives needed to:

> *have more knowledge about like immigrant women, either refugee, asylum, immigrant women, because leaving a country and coming to another country, there is always differences. It's not always the same, the system is different, so if they have that little bit of knowledge, they can just know how to help that person.* (FG2)

Participants discussed the role of specialist midwives who were trained to work with asylum seeking and refugee women. Those who had received support from specialist midwives felt that this was very valuable and that they had benefited. However, it was noted that many women were not able to access specialist midwives and that other non-specialist midwives may not

have the level of knowledge about the needs of asylum seeking and refugee women to provide optimal support:

> *Not all midwives are [name of specialist midwives] midwife and very well trained about refugees and asylum woman.* (FG2)

and that this lack of knowledge could limit women's opportunity to receive optimal support:

> *you need to understand there just definitely two types of midwives. Those that understand and those are totally ignorant. So in a special way if you have a totally ignorant once it becomes a problem*. (FG1)

This issue was discussed further in the member checking group where it was noted that as not all asylum seeking and refugee women could access specialist midwives, all midwives needed to have knowledge about how to support women in this situation. This would mean that all midwives would be able to provide optimal social support for asylum seeking and refugee women ensuing that women could receive the best possible support even if they did not have a specialist midwife:

> *So, I think the beginning of everything is training the midwife, all of them. So at least we are [we] feel comfortable, we feel okay even though we don't have that particular midwife with us because they are be trained with the same method.* (FG4)

Women felt that a lack of understanding of cultural differences or a '*cultural clash*' negatively affected the ways in which social support was provided to asylum seeking and refugee women. It was felt that this could lead to some women either not receiving support, or experiencing culturally inappropriate support that did not meet their needs. It was suggested that midwives should be trained to have a greater awareness of the backgrounds and experiences of asylum seeking and refugee women and a greater understanding of issues

of culture and cultural differences. Participants suggested that midwives needed to seek to:

> *understand them, understand their feelings as well, their cultural and background…. try to understand people because I feel like most of our communities, like the African communities, feel like their midwives didn't understand them*. (FG2)

The need for training to improve the provision of support was reinforced by participants in the member checking group. In addition to the need for training, identified in the phase one focus groups, participants in the member checking group suggested that all midwives should be trained to support asylum seeking and refugee women's mental health as they felt this was not currently the case:

> *I believe all pregnant women will struggle with the mental health even [if] they have a family who really support her or whatsoever because this mental health is very tricky and hidden*. (FG4)

It was suggested that social support for women would be improved if midwives provided specialist antenatal education, as this would help women access the perinatal care and support they needed within in an unfamiliar location and healthcare system. One woman explained that while for her:

> *I think they did well with me explaining to me and I understood everything that was going on.* (FG2)

it was not like this for many other asylum seeking and refugee women, and so it was important that:

> *before the birth midwives should also like educate them and tell them they might be and might not be.* (FG2)

Participants in the member checking focus group agreed with this suggestion. One woman who had attended specialist antenatal education classes explained:

> *You know, it's amazing … I'm lucky I went to antenatal class with* [name of antenatal teacher]. (FG4)

But also noted that, '*if someone who didn't know about X's antenatal class'* they may not get the antenatal care they needed.

8.7.3 Knowledge to refer women to support

Another suggestion women made was that to enable midwives to provide the most effective support, they needed to have knowledge of national and local sources of support available to asylum seekers and refugees. While it was important that all those working with asylum seeking and refugee women had this knowledge, it was seen to be particularly important for midwives to have as they were often the primary source of social support for some women. One participant explained how:

> *So, the midwife knows the area or something, they should try and make sure they've got that the right things. Like way where can you go or do you require this or this? These are the support group. These are what? Something like that. And then they can link you to a family outreach leader. There's always like a family outreach in every area. So, if they need to link you to that to that family outreach… so she [family outreach worker] she's the one who continue she'll tell you go they go they she even takes you. 'there's baby bank is coming this time go there'. She will check on everything, furniture, she will check that you have good furniture, you know things like that start with the midwife midwives who do that, you know, like the community midwives and then, you know.* (FG3)

Another that her midwife:

told me to go to [name of local charities], so that's why I was able to get like so many support from different organisations. But if there is not that midwife or I would be? lost? so I think the midwives they should have more information. (FG2)

This suggestion was re-iterated by participants in the member checking focus group. One participant asserted that:

The midwives … should have more information like it was through my midwife I get to know some things because through my midwife I go to now, she said, okay, fine. I'm going to add you to this this maternity group, they're very nice and they can help you. It was also through my midwife, I got to know about Home Start. So the midwife, I think. Yeah, actually the roots, because if she doesn't know, she's not going to help. If she knows, she can render you the help that you need. (FG4)

In addition to suggesting that midwives should have knowledge of local and national sources of support, participants felt it was important that midwives knew the statutory rights of asylum seeking and refugee women, as this would enable them to ensure that women received the support and protection they were entitled to. Participants gave examples of the impact of midwives having this knowledge. One woman explained how without support from her midwife she would have been dispersed to a new city at 38 weeks pregnant:

But then [name of midwife] said no when they come, just deny, tell them no, you're not going. So, they sent an email to safeguarding that why do you want to move, transfer a woman who's 38 weeks pregnant. So, they stopped the transfer …, if I didn't if, I didn't know where to get the information or the right people, you know, I could have been living in the [name of city] where I do not know anyone. (FG3)

A participant in the member checking group also supported this idea as she shared her experience of the need for midwives to have this knowledge:

She just sent an email to Home Office because she aware that within 11 days Home Office need to be notified about the birth. If not, we will miss the allowance. So, all this is really important, especially because we don't have any other source. (FG4).

8.7.4 Communication

One area of discussion within the groups related to the need to improve communication between asylum seeking and refugee women and midwives. It was felt that improved communication would mean that midwives would be better able to provide women with the optimal social support and holistic care they needed. Participants suggested that all women who needed it should have access to interpretation as this was currently not the case and had a negative impact of women's perinatal experience. They also discussed what they felt would be the most appropriate form of interpretation in this context.

Participants asserted that midwives needed to ensure asylum seeking and refugee women could access language support to overcome communication barriers as without this midwives would be unable to offer the most effective support. One participant asserted that:

I believe …that [if] you have someone ... beside someone to explain in detail for everyone [it] would be much better. (FG3)

Participants in the member checking group agreed with this assertion that all women should have access to interpretation to facilitate access to social support and care. They also discussed the form of interpretation they believed would be most helpful in the perinatal setting. They suggested it would be preferable to have female interpreters, as it was felt that they were more likely to understand a woman's situation and that female support was more culturally appropriate for many women in this situation:

Interpreters also need to be someone who really [understands] …. pregnancy, who knows how to talk about pregnancy, because

sometimes GP, they just give an interpreter. They just give like a man to interpret on behalf of a woman. (FG4)

Additionally, they suggested that ideally someone who was a peer, in terms of either motherhood and/or immigration status or background, might be best placed to interpret. They suggested that they could provide more nuanced and emotionally attuned interpretation which would support better communication and from that, more effective emotional and informational support:

If we can ask for interpreter who is a mother, because sometimes I did realize of interpreter who never know how pregnant woman experience they are very flat, they directly translate, they didn't translate … with emotions the feeling so the midwife will not really get what they mean… so at least if the interpreter is I have a motherhood or someone who really know to deal in the childcare or someone get involved with this children or baby, it's really important to have empathetic interpreter because the message will be sent because sometimes we got the flat line interpreter who don't feel anything, who just translate as it is. (FG4)

8.8 Conclusion

In this chapter I have explored the findings from study two which explored the research question *what are asylum seeking and refugee women's perceptions of the best ways in which they can be supported in the perinatal period?*, presenting these as four main themes which identify suggestions for ways of improving perinatal social support. The next chapter will discuss the implications of the findings from both studies, locating them within wider literature and the UK context and using insights from writings on the ethics of care.

CHAPTER 9 DISCUSSION

9.1 Introduction to the chapter

The previous chapter presented the findings from study two which explored asylum seeking and refugee women's perceptions of the best ways in which social support could be provided in the perinatal period. This chapter provides a discussion of the implications of the findings from study one and study two, exploring both asylum seeking and refugee women's experiences of perinatal social support and their suggestions for improving the support available to them. The collective findings are summarised and then discussed within the context of the wider literature and using key ideas from writings on the ethics of care in five main aspects: the careless state, caring communities, systemic carelessness, promiscuous care and gender and care.

9.2 Summary of findings from studies one and two

Focusing on asylum seeking and refugee women resident in the north of England, the two studies undertaken for this thesis explored women's experiences of perinatal social support and their suggestions for ways to improve this support. The studies explored both the structural aspects of support and the functional elements of support as perceived and experienced by the women who participated. When they were able to access social support, women who participated identified three aspects of support which have been identified as instrumental, informational, and emotional (discussed in the background chapter). However, participants did not speak about the fourth commonly identified aspect of support, appraisal support, commonly defined as, acts to support self-evaluation, giving feedback, supporting decision making rather than solving problems (Langford et al., 1997) and so the discussion focuses on the first three aspects of support.

The two studies demonstrated that many asylum seeking and refugee women struggled to access social support in this period. This was particularly evident in the experiences of those women who were in the UK as single parents and/or were asylum seekers, refused asylum seekers or undocumented

migrants, and had not come to the UK as part of a refugee resettlement programme. Women who had the least social support, faced challenges in accessing statutory services and securing their basic needs, including housing, food and the things they needed for their babies. These women commonly relied on the support of voluntary agencies to help them meet their basic needs, through support to access services or by donations of food and other material supplies. Voluntary agencies provided vital informational, instrumental, and emotional support through the provision of doulas, befrienders and mother and baby groups, as well as by functioning as a part of wider networks of support. It was suggested that to improve social support these services should be made available to all asylum seeking and refugee women. The key attributes and skills needed by those offering support were identified by participants, these included being friendly, welcoming, kind, non-judgemental and good listeners. The role and value of peers in providing support was also discussed. Family was identified as a crucial source of perinatal social support for all women, with many reflecting on the impact of the lack of familial and particularly female support they had in the UK. Women who did have family in the UK relied on them for support, whereas for other women support came from chosen families created in the UK, or from networks of peers. Some women noted changes in familial or gender dynamics as they negotiated the perinatal period, including male partners taking on new roles around birth and the perinatal period, roles previously undertaken by female family members.

In both studies, midwives were identified as a crucial source of social support, particularly for women who had limited or no other support in the UK. Women valued the support they received from midwives and offered suggestions for the ways in which this support could be further facilitated. These suggestions included a continuity of carer midwifery model, the provision of more training for midwives, better access to interpretation and improved knowledge about what support was available. Some women experienced language barriers and needed social support to be able to effectively communicate and access the support they needed. The availability of this support, whether it was gained through accessing formal interpretation or informal support from individuals or

organisations, varied and had an impact on women's perinatal experiences. Women in both studies felt that the provision of social support was important for asylum seeking and refugee women as a way of improving their perinatal experiences in the UK.

9.3. Exploring the key findings in the context of existing literature through a feminist ethics of care lens

In the sections that follow I explore the key findings from the two studies in the context of wider literature. I use insights from work on the ethics of care (see methodology chapter), to think about asylum seeking and refugee women's experiences of perinatal social support, and the wider organisation, deployment and resourcing of this support or care within the context of the patriarchal and racialised immigration, welfare and healthcare landscape in the UK (Chatzidakis et al., 2020; Colm, 2024; Loughnane, 2022).

9.4 The careless state

9.4.1 Inaccessible and inadequate formal support

Both studies found that many asylum seeking and refugee women struggled to meet their basic needs, in terms of securing adequate and appropriate housing, food and enough money to cover the costs of daily living. The difficulties women faced were related to both their inability to access what Wells and Seage (2023) call formal social support, and the paucity of this support for those who could access it. Formal support in this context means the statutory services governmental agencies are obliged to provide to meet the basic daily needs of perinatal asylum seeking and refugee women and their infants. The findings from my studies show how, without the provision of informational and instrumental social support from voluntary agencies, healthcare professionals, or case workers, women found it very difficult, or failed, to successfully engage with complex bureaucratic statutory systems within the UK. This meant that they often struggled to access the formal support they needed and were entitled to. This need for support to access services, such as housing and financial support, resonates with other research on the experiences of asylum seeker and refugee populations in the

UK. This wider research also identifies challenges in navigating the complex and bureaucratic statutory systems related to immigration, healthcare, housing and finance (Arrowsmith et al., 2022; Benwell et al., 2023; British Red Cross & Refugee Survival Trust, 2021; Dudhia, 2020; Isaacs et al., 2020; Mental Health Foundation, 2024).

In addition to the difficulties women faced in accessing statutory support, the support offered, if women received it, was inadequate to meet their basic needs. This resonates with recent research which has suggested that in 2023 asylum support payments, which those seeking asylum are dependent on, were 29% lower in real terms than they were in 2000 (Walsh & Jorgensen, 2024). The findings demonstrated the impact of this, showing how women faced poverty, homelessness and destitution during the perinatal period and that this had a negative impact on their physical and mental wellbeing. These results are congruent with wider research looking at the lived experiences of asylum seeking and refugee women. This research has demonstrated how the inadequacy of the provision of formal social support under the current restrictive immigration legislation, evident in policies on housing, dispersal, financial support and charging for health care, has led to women facing poverty, destitution, gender-based violence, exploitation and limited access to healthcare, all of which negatively affect their physical and mental health (Adil et al., 2022; Arrowsmith et al., 2022; Benchekroun, 2023; British Red Cross & Refugee Survival Trust, 2021; Canning, 2017; Cassidy et al., 2023; Dudhia, 2020; McIlwaine, 2019). This is a situation which can be exacerbated in the perinatal period, leaving women at even more risk of poor physical and mental health (Adil et al., 2022; Arrowsmith et al., 2022; Feldman, 2014b; Feldman, 2020; Lephard & Haith-Cooper, 2016; Rowe et al., 2023). There is some acknowledgement within the immigration system of the potential vulnerability of women in the perinatal period, in terms of additional financial support and regulations relating to detention and dispersal around the intrapartum period (Home Office, 2016a; Refugee Council, 2021). However, my findings showed that despite these policies, women had been moved within the protected period, had struggled to access additional financial support and had faced poverty and destitution. This resonates with wider research work which

highlights the failures in both the design and implementation of such policies (Arrowsmith et al., 2022; Bragg, 2021; Lonergan, 2024). The impact of these failures means that women remain at risk of harmful practices including dispersal and having to pay for healthcare, as well as facing extremely poor physical conditions, all of which are likely to increase their risk of poor maternal outcomes (as detailed in chapter two).

This failure of formal statutory social support, both in terms of inaccessibility and its inadequacy to effectively address the needs of asylum seeking and refugee women in the perinatal period, can be seen as part of a wider failure of a public ethic of care in contemporary society (Kittay, 1998). It is a failure to, using Tronto's terminology, *care about* or *take care of* asylum seeking and refugee women and is part of a wider lack of *attentiveness* and failure to assume *responsibility* for the wellbeing of, or the need for support or care for, certain groups within society (see methodology chapter for more detail). This has been identified by some writers exploring the societal and organisational aspect of care at state level, as an element of a more general carelessness, emerging from a neo-liberal ideological position pursued by some modern democratic, global-north states (Chatzidakis et al., 2020; Thompson, 2020). They argue that this approach, which they characterise as demonstrating *carelessness*, seeks to reduce state responsibility for welfare or care generally. It does so by encouraging individuals to act as autonomous agents within a market economy, privatising responsibility for care and promoting the marketisation of the provision of care, the implication of which is that care for those who need it is the responsibility of the individual rather than the responsibility of the state (Chatzidakis et al., 2020; Lopez, 2019; Smith, 2023).

In addition to this wider trend towards carelessness, the situation for asylum seeking and refugee women could also be understood to reflect more specific carelessness, enacted through what Lopez (2019) has characterised as *careless legislation*, taking the form in this context, of restrictive legislation directed towards asylum seekers and refugees (Edwards et al., 2023; Lopez, 2019). The failure to provide adequate statutory or formal support, as identified above, is a product of the political and ideological choices of

successive governments and the legislative and administrative practices which come from these. These are both a part of, and a reaction to, the politicisation and racialisation of immigration and the impact of Brexit and austerity (Benwell et al., 2023; Erel et al., 2018; Griffiths & Yeo, 2021; Mulvey, 2010), which have led to the implementation of increasingly restrictive and punitive policies related to dispersal, detention, housing, finance, leave to remain and access healthcare through successive immigration legislation (see background chapter). These policies which began in the 1990's, have intensified more recently with the creation of the 'hostile environment' (Benwell et al., 2023; Ibrahim, 2018), the ongoing 'securitization' of asylum policies (Daley, 2007) and the associated concerns with the enforcement of external borders and the extension of internal bordering practices into wider aspects of public life (Griffiths & Yeo, 2021; Ratzmann & Sahraoui, 2021; Yuval-Davis et al., 2017).

The studies' findings provide evidence of the impact of hard to access and inadequate formal social support on the perinatal experiences of asylum seeking and refugee women. They demonstrate a lack of state care for the needs of asylum seeking and refugee women in this period, despite some acknowledgment that women and their babies in the perinatal period have additional needs. The lack of real concern for, or effective action to address, women's needs in the perinatal period, means that they are vulnerable to the negative health impacts of the psychological challenges caused by restrictive legislation and the hostile environment as well as the impact of poor housing and poor nutrition. These findings suggest the need for consideration of the gendered impact of immigration legislation. They also demonstrate an ongoing situation in which there is an awareness that asylum seeking and refugee women are at disproportionately high risk of poor maternal outcomes, some acknowledgement within legislation that perinatal women have additional support needs and yet there is a continued lack of provision of effective formal social support available to them, the lack of which acts to perpetuate these maternal and infant health inequities. These findings also run contrary to popular, media fuelled, public discourses, such as recent debate around housing asylum seekers in hotels, which portray asylum

seekers and refugees as a drain on the state, living in undeserved luxury, when evidence shows that the conditions experienced by perinatal women fail to meet their basic human needs (Barradale & Atkins, 2024; Xuereb, 2023).

9.4.2 Inequalities of support or care

While many women in the studies struggled with the negative aspects of the inadequacy of formal social support identified above, there was a difference in the experiences of women who had sought asylum once in the UK and those who came to the UK through a resettlement programme, in terms of their ability to access this support. Women who were part of a resettlement programme had housing and UK benefits in place for them as they arrived and were allocated case workers to support them to access the services they needed. None of these women identified access to housing, financial support or material goods as a major challenge; this contrasted with those who had claimed asylum once in the UK. The latter were less able to access adequate statutory support, had lower levels of financial support (if they could access this), and were subsequently more likely to experience poor housing and poverty and rely on voluntary agencies and charities to meet their basic needs. Work undertaken with asylum seeking and refugee populations more generally has highlighted these differential experiences (All Party Parliamentary Group on Refugees, 2017; Burns et al., 2022; Migration Observatory, 2022b). There is also some acknowledgement that precarious immigration status, such as No Recourse to Public Funds (NRPF), places women at greater risk of harms to their wellbeing such as gender-based violence and destitution (Dudhia, 2020; Southall Black Sisters, 2024). However, despite anecdotal and informal evidence about the different experiences of resettlement and non-resettlement status on women's perinatal experiences, as well the understanding that immigration status is a crucial element in understanding the maternal health of migrant women (Balaam, Haith-Cooper, et al., 2017), no literature was identified which considered this issue. This study therefore seems to be the first to highlight the significance of the ways in which women arrive in the UK in terms of

resettlement versus non-resettlement status on women's access to perinatal social support and their perinatal experience.

These differences in access to formal social support reflect contemporary ideological and political priorities which are enacted in immigration legislation, through which some asylum seekers and refugees are given more access to support than others. This differentiation between the level of support offered to different groups based on subjective criteria or ascribed identity, in this case based on how women or families came to the UK, resonates with 19th century ideas of the deserving and undeserving poor. Initially associated with ideas of class, poverty and respectability, the idea of groups with certain characteristics being more or less deserving of support, has been used more recently in analysis of the discourses and practises around migrants' access to welfare (Kootstra, 2016; Ratzmann & Sahraoui, 2021; Sales, 2002). The hierarchical categorisation of populations in this way, with the needs of certain groups of people being less recognised than others, is a product of the ways in which these groups are socially constructed and so located within contemporary discursive regimes and legislative and political systems. It has been suggested that, generally, migrant populations are seen as less deserving of support than non-migrant populations (Mayblin, 2021; Ratzmann & Sahraoui, 2021). However, within migrant populations further hierarchies of deserving or undeservingness and desirability or undesirability are enacted, influenced by a range of political and ideological factors (Burns et al., 2022; Crawley & Skleparis, 2018; Kootstra, 2016; Ratzmann & Sahraoui, 2021; Van Oorschot et al., 2017) in this case ideas of the right or wrong way to seek asylum in the UK and ideas of restricting 'uncontrolled' or irregular immigration (Schultz & Kaytaz, 2021). It is important that midwives and those supporting women understand the inequalities within the support offered to asylum seeking and refugee women and the impact of this on women's wellbeing.

Concern over the possible impact of the differential support offered to some asylum seeking and refugee women, based on the way in which they arrive in the UK, has been expressed by groups which support and advocate for

women particularly in relation to the provisions of the recent Illegal Migration Act (2023) and the ways in which it may be implemented. While there is currently some uncertainty over how this legislation will be deployed under the new administration, it has been argued that this legislation will lead to more women being deemed to be inadmissible to apply for asylum (Refugee Women Connect, 2021). This in turn places them at increased risk of poverty, destitution and gendered violence and makes it harder for them to access healthcare and wider social support (British Red Cross and VOICES Network, 2022; Maternity Action, 2023; Refugee Women Connect, 2021). These organisations assert that this will have a negative impact on the wellbeing of women and their babies, increasing their risk of poor maternal outcomes (Maternity Action, 2023). In light of these heightened concerns, and the lack of substantive research on this area to date, the studies' findings provide an initial step towards a more detailed analysis of the impact of differential access to social support on the experiences of asylum seeking and refugee women. The findings also have implications for midwifery education and practice in that it is important that students, midwives, and other health care professionals are aware of the heterogeneity of asylum seeking and refugee women's experiences to facilitate the provision of personalised care to meet their needs. Additionally, it is important that all midwives are aware of the Nursing and Midwifery Council (NMC) Standards of Proficiency for Midwives (Nursing and Midwifery Council, 2019) which, along with The Lancet Midwifery series (Renfrew et al., 2014) which underpins them, highlight the role of midwives in providing respectful, skilled, personalised, holistic and culturally appropriate care for all women as key to all midwifery practice. It is also important to support the work done by activist groups and others highlighting the need for an ongoing gendered and intersectional analysis of the impact of policies and legislation (European Institute for Gender Equality, 2020).

9.5 The voluntary sector and the creation of caring communities

Many asylum seeking and refugee women, particularly those who were not part of resettlement schemes, were dependent on support from primarily

voluntary agencies, or in some cases healthcare professionals, to help them access statutory support and for the provision of food, money and material necessities. However, the importance of voluntary organisations in terms of their provision of support went beyond instrumental support to address women's basic needs and mitigate the impact of a lack of statutory formal support. The findings demonstrated how women felt voluntary groups provided a range of valuable social support and care, which improved their perinatal experiences. They did this through befriending and doula schemes, by hosting women's and mother and baby groups, by providing networking opportunities and by signposting to other services which could offer further social support.

The importance of the voluntary sector in the perinatal period has been briefly noted in some research on maternity care for asylum seeking and refugee women (Adil et al., 2022; Arrowsmith et al., 2022; Balaam et al., 2016; British Red Cross and VOICES Network, 2022) and there has been some research on specific types of voluntary provision, such as doulas or befriending, as identified below. More generalised research has highlighted the role of the voluntary sector in mitigating the negative effects of the hostile environment on the material conditions and physical and mental wellbeing of asylum seeking and refugee people (Benwell et al., 2023; James, 2021; Käkelä et al., 2023; Mayblin & James, 2019; Wren, 2007). However, the full extent of the role played by the voluntary sector in the perinatal context has not been explored in depth to date.

Looking at specific aspects of support for asylum seeking and refugee women provided by voluntary agencies, doula services (see glossary) specifically for asylum seeking and refugee women are provided in some areas of the UK. However, there are few published evaluations of these services and women's experiences of them (Balaam et al., 2021; McKnight et al., 2019). More general research exploring doula schemes supporting other marginalised women in the UK found that, in line with my findings, these services provided a valuable source of social support (Darwin et al., 2017; McLeish & Redshaw, 2017). My findings also resonate with wider international research which

attests to the positive impact of doulas on migrant women's perinatal experiences and wellbeing (Khaw et al., 2022) and reports that community based doulas were a valuable source of support which provided reassurance, were seen to be caring and understanding, reduced loneliness and increased a sense of being cared for (Erga-Johansen & Bondas, 2023). Other research suggests that giving women access to doulas could be a valuable way of improving the poorer maternal outcomes experienced by marginalised and minority ethnic women (Bohren et al., 2017; Gruber et al., 2013; Sobczak et al., 2023; Thomas et al., 2017). In light of the poorer maternal outcomes of asylum seeking and refugee women in the UK (see background chapter) findings from this thesis, along with the evidence from wider literature, suggest that doula schemes can provide effective social support for asylum seeking and refugee women and thus may improve experiences and outcomes. This would suggest that there is a need for investment in these types of community based doula schemes, as well the need for a clear strategy to evaluate these schemes to provide evidence of efficacy and mechanisms of effect in the UK context to address the current evidence gap.

Along with doula schemes, my findings suggest that befrienders (see glossary) provided a valuable source of social support which improved women's experiences and which women felt should be available to all asylum seeking and refugee women. While there is evidence of befriending schemes for asylum seeking and refugee women in the UK, as with community doula schemes, there have been few published evaluations of such services and there is therefore a lack of evidence on their impact (Balaam et al., 2021). My findings resonate with those from studies of befriending more generally. These studies suggest that there are a range of positive social and psychological outcomes associated with befriending, including reducing loneliness and isolation, increasing a sense of belonging, as well as increased social networks and sense of wellbeing, and some positive impacts on physical health (Balaam, 2015; Fakoya et al., 2021; Siette et al., 2017). Research on befriending in wider migrant settings suggests that it can provide emotional support, increase a sense of belonging (Askins, 2014; Askins, 2015), support integration, promote wellbeing (Behnia, 2007; Haith-Cooper et

al., 2021) and improve access to healthcare services (Jallow et al., 2022). The findings from this thesis, within the context of the wider literature, suggest that befriending by providing social support can improve the perinatal experience of asylum seeking and refugee women. It would suggest that there is a need for increased access to this form of support for asylum seeking and refugee women as it is a form of support which is seen as acceptable and useful. There is also the need to undertake more evaluations of befriending interventions to provide more evidence of their efficacy and identify the characteristics of particularly effective schemes within this context.

In addition to the befriending and doula services offered, mother and baby groups in community spaces provided an important source of informational, instrumental and emotional support. These groups were small, community based, local groups which provided collective spaces where women gave and received support and care and were places of '*quiet care and solidarity*' (Benwell et al., 2023, p. 2). These were spaces in which care and support was central, prioritised and enabled, and in which support was provided and received in a range of ways (Edwards et al., 2023; Schmid, 2019). The importance of the creation of comfortable and safe spaces as places of connection and emotional support, resonates with wider research on the wellbeing of asylum seeking and refugee women in different global settings. This research identifies how the creation of safe spaces allows women to access social support, create networks, learn and gain information and support their mental wellbeing (Abi Zeid Daou, 2022; International Organisation for Migration (IOM), 2018; Konje & Konje, 2021; O'Shaughnessy et al., 2012; United Nations High Commissioner for Refugees (UNHCR), 2014). This is an area which has received little attention in relation to the perinatal period in the UK, yet the amount of support women received from these locations suggests that they should be seen as a crucial location of support, a place where supportive interventions, both formal and informal, take place in a way which is accessible and valued by women. The findings from this thesis provide novel and important insights into the value of these locations which have to date been largely overlooked in analysis of the experiences of asylum seeking and refugee women in the UK.

It could be argued that it is in these spaces of care (mother and baby groups) and relationships of care (doulas and befrienders), that the ideas of care suggested by Tronto and Fisher (1990) are most fully realised, in that all four aspects of care are evident. Support provided acknowledges and is *attentive* to women's needs, *responsibility* for meeting the needs of the asylum seeking and refugee women within their communities is taken and there is the provision of tangible acts of c*are giving*. They are also importantly seen to be engaged with and display a *responsiveness* to providing the care women want and by providing it in a way which encourages reciprocity and acknowledges both women's agency and the interrelated nature of care giver and care receiver. It could be argued it is this full realisation of the elements of care which explains why women find this support so valuable, accessible and why, when suggesting how support can be better offered in the future, it is the work done by these groups which women identify as significant. Therefore, it is important that these groups, and the work they do, is acknowledged and fully funded in an effective and long-term manner, as these organisations play a crucial role in providing social support and improving the physical and mental wellbeing of women and their infants. There is however a challenge to ensure that these organisations are seen as part of a holistic and multi-agency response to the needs of perinatal asylum seeking and refugee women and not just seen as a cheaper replacement for the provision of statutory support as the state seeks to roll back provision of care as part of a wider ideological agenda (Barford & Gray, 2022; Clasen, 2003; Hall, 1983).

9.6 Systemic carelessness in maternity care and the supporting role of individual midwives

Findings from both studies highlighted how midwives played a crucial role in providing social support to asylum seeking and refugee women and that this support extended beyond the healthcare setting into wider aspects of their lives. Good relationships between women and midwives were seen to be key to the provision of optimal social support, allowing women to gain emotional, informational, and instrumental support from the midwives who cared for

them. Aspects of the organisation and delivery of services which facilitated the creation of these positive relationships and so the provision of support were identified and conversely, issues which were seen to limit midwives' capacity to provide support were highlighted.

The findings showed how the creation of positive and trusting relationships improved the perinatal experiences of asylum seeking and refugee by facilitating the provision of social support. This resonates with wider research which has demonstrated the positive impact of relational care on rates of satisfaction and improved maternal outcomes for women generally (Almorbaty et al., 2023; Goodwin et al., 2022) and particularly for women from minority ethnic or other marginalised communities (Chitongo et al., 2022; Goodwin, 2016; Goodwin et al., 2022). While this existing research focused primarily on the healthcare setting, the findings of my studies highlight how relationships were crucial beyond this as part of the wider psycho-social aspects of women's perinatal experiences.

Women felt that the way in which maternity care was organised affected the creation of positive relationships and the effective provision of social support. They felt that the best relationships were most likely to be developed, and so most effective social support provided, where women could access continuity of carer. These findings resonate with wider literature on the value and efficacy of continuity of care for women generally (Sandall et al., 2024; Sandall et al., 2016) and particularly for women facing maternal inequality and disadvantage, including asylum seeking and refugee women (Beake et al., 2013; Billett et al., 2022; Correa-Velez & Ryan, 2012; Khaw et al., 2022; Konje & Konje, 2021; Obionu et al., 2023; Rayment-Jones et al., 2015; Rogers et al., 2020). In the UK, continuity of carer has been a key part of efforts to reduce health inequalities faced by minoritised women (National Health Service England, 2021; National Heath Service, 2019), with targets that 75% of women from minoritised communities and the most deprived areas should receive continuity of carer by 2024 (National Heath Service, 2019). In 2022 the targets for achieving continuity of carer for all women were removed, however, the commitment to providing this form of care for

minoritised women was retained (Royal College of Midwives, 2022b) and the roll out of continuity of care in line with the principles of safe staffing, as set out in September 2022 (National Health Service England, 2022), remains a key part of the Three Year Delivery Plan for Maternity and Neonatal services (National Health Service England, 2023). However, recent figures suggest that this target has not been met, with an average of 17% of women from the most deprived areas and only 22% of minoritised women, seeing the same midwife (Dodsworth, 2023). This resonates with the findings from studies one and two in that women who had experienced continuity of carer found it valuable, but many women, despite wanting to have this form of care and feeling it would be helpful, were not able to access it. It provides further evidence of both the value of continuity of carer for marginalised women and the challenges the current maternity system faces in expanding this approach in light of the current financial and policy constraints and priorities (National Health Service England, 2022). Yet this form of care is known to have positive benefits for maternal outcomes and this research suggests it can also play a crucial role in facilitating better social support for women for asylum seeking and refugee women beyond the immediate intrapartum healthcare setting.

Findings suggested that the development of relationships and so the provision of social support, was improved when midwives had knowledge of the challenges faced by asylum seeking and refugee women living in the UK. It was noted that some women had been supported by specialist midwives, and it was felt that these midwives had this knowledge, but it was stressed that not all women could access this specialist care provision. It was therefore seen as crucial that all midwives should understand the situation faced by perinatal asylum seeking and refugee women in the UK. It was felt that midwives who had this knowledge were better able to provide more effective emotional, instrumental and informational support to meet women's needs. It was also suggested that a broader awareness and understanding of cultural differences, for example around issues of different cultural expressions of perinatal mental health, were an important aspect of enabling the creation of good relationships. This meant that women were more likely to feel listened to, understood, and not judged; all crucial elements of positive relationships.

These findings resonate with other research which has suggested that midwives who had an understanding of the challenges faced by asylum seeking and refugee women were better able to deliver culturally appropriate and sensitive care to them (Olcoń et al., 2023) and that, conversely, midwives lacking knowledge may act as a barrier to women accessing care, make it harder for them to establish trustful relationships and feel comfortable with the midwives and harder for the midwives to provide optimal care (Billett et al., 2022; Higginbottom et al., 2019; Konje & Konje, 2021; Obionu et al., 2023; Rowe et al., 2023). The findings highlighted the need for midwives to be able to access education and training on these issues and for there to be an environment in which they can be enabled to provide this kind of care and support.

The need for effective communication to support the creation of positive relationships and the facilitation of access to social support was highlighted, as was an understanding that a failure to support women to communicate effectively negatively affected their ability to feel supported, to communicate their needs and understand information given to them. This need for support to communicate was identified at a personal level, in terms of the need for midwives to really listen and pay attention to women. However, many issues identified by the women related to systemic or organisational issues which made communication challenging despite NHS England's commitment ensuring personalised care which has at its core the need to listen to women and families as identified in the Three Year Delivery Plan for Maternal and Neonatal services (National Health Service England, 2023). The need for midwives to have longer appointments with women to maximise their communication was identified as an important suggestion to improve current practice. The lack of effective and consistent provision of interpretation within the current organisation of care was identified as making the provision of social support challenging. The need to improve this access to interpretation and to ideally provide more woman-centred specialist provision was seen as important. This centrality of communication in building supportive relationships and enabling support to be accessible has also been identified in research on the significance of effective communication in the provision of care for women

for whom English is an additional language (Cull et al., 2022; McKnight et al., 2019; Rowe et al., 2023). In the findings from my study, the need for effective communication extends beyond its importance within a healthcare or medical setting into the wider context of creating relationships to access emotional, informational, and instrumental support and reinforces the need for effective communication both within and beyond the healthcare setting. In addition, and to ensure that the needs and experiences of asylum seeking and refugee women are effectively communicated to maternity services as a whole, their views should be represented in local Maternity and Neonatal Voice Partnerships (MNVP) and in the work they do in the co-production of maternity services, as identified in the NHSE Three Year Delivery Plan for Maternity and Neonatal services, Theme 1: Listening to and working women and families with compassion (National Health Service England, 2023).

The role of midwives in the maternity care experiences of asylum seeking and refugee women in the UK has been explored in existing research but there has been little focus on the wider provision of social support by midwives (Adil, 2022; Arrowsmith, 2022; Lephard, 2016; Rowe et al., 2023; Sharma et al., 2020). However, some insight can be gained from research which looked at midwives' experiences of caring for asylum seeking and refugee women. These reports show how, in common with some aspects of my findings, midwives provided informational and instrumental social support including providing maternity supplies for women and their babies, addressing issues with transport and benefits, signposting women to other services and acting as advocates (Bennett & Scammell, 2014; Letley, 2022; Maternity Action, 2019a). In 2020 the Royal College of Midwives acknowledged the role midwives play in the provision of wider social support to asylum seeking and refugee women, noting how they were signposting and referring women to '*charities, food banks, children's services, befriending and advocacy services which can offer support and basic resources.*' (Royal College of Midwives, 2020). However, these studies also noted that while the role of the midwife includes both '*managing a safe pregnancy and delivery'* and addressing *'problematic social issues such as domestic violence or child safeguarding',* it was felt that midwives were providing support for asylum seeking and refugee

women which was '*far beyond their immediate professional responsibility'* (Maternity Action, 2019a). They suggested that the support midwives provided was in addition to their existing workloads, not adequately recognised in current organisational structures and that this was causing some midwives to feel that they could not provide the level of care and support they wanted to or felt that the women needed within the current organisation of perinatal care (Arrowsmith et al., 2022; Bennett & Scammell, 2014; Chitongo et al., 2022; Letley, 2022; Maternity Action, 2019a). While my study did not engage with midwives to ascertain their perspectives, the findings resonate with these concerns and demonstrate from the perspective of asylum seeking and refugee women, the structural and organisational challenges they saw midwives facing when providing social support and the need for further research in this area.

Midwives were identified as providing support and care that resonated with several of the elements and aspects of care described by Tronto, in terms of *caring about* and *caring for,* but the findings suggest that there were challenges in terms of the *competence* and *responsiveness* of care in Tronto's terms (see methodology chapter). These were identified to be predominantly due to systemic and organisational factors which impeded midwives' capacity to provide optimal social support. They noted that midwives needed to have time to care, the resources to ensure effective communication, training to have the specific skills and knowledge to care. They also identified that the provision of effective social support was most likely to take place within the context of continuity of carer. Women see midwives as crucial to their perinatal wellbeing through the provision of both social support and healthcare. They highlight the amount of social support they receive from them, while acknowledging that it can be difficult for midwives to provide this support within the current organisation of healthcare. It could be argued that this situation represents the lack of value placed upon, and a failure to care for, asylum seeking and refugee women and represents carelessness at a systemic and organisational level. There is a lack of attention paid to, and responsibility taken for, the needs of asylum seeking and refugee women as they interact with the health and social care system. It may also reflect a

situation in which asylum seeking and refugee women are located within a wider carelessness towards the needs of other minoritised groups within health policies and systems, both in maternity care and more generally (Birthrights, 2022; Kapadia et al., 2022). It also is part of the wider neo-liberal ideological approach to the funding of healthcare in the UK and the impact of austerity which has led to a situation in which chronic underfunding has meant midwifery, and other health and social care services, are understaffed and underfunded, with staff facing significant challenges in the delivery of care (Ham, 2023; Royal College of Midwives, 2024).

The current situation means that midwives' ability to (and the extent to which they can) provide social support to asylum seeking and refugee women varies depending on the geographical location and organisational characteristics of their service, as well the impact of wider systemic issues. Wider research also suggests that there may be negative implications for midwives providing this support if the provision of this support is beyond their workload, or if they face organisational barriers to do so, in addition to working within a system which may be underfunded and understaffed.

9.7 The need for promiscuous care: families, families of choice and wider peer support

Using insights from contemporary discussions of care as well as drawing on learning from LGBTQ communities' traditions of organising care, I will suggest that we need to explore what authors Chatzidakis et al. (2020) and Landa (2022), drawing on the work of Douglas Crimp (1987), have identified as *promiscuous care*. This understanding of care and support is one which supports an exploration and redefinition of ideas of who we have relationships of care with and responsibilities of care towards. It would, if applied in this context, allow us to understand ideas of care in more expansive way, which would in turn could support the provision of more effective support for asylum seeking and refugee women.

Within the private setting, as opposed to the more public, voluntary, statutory or healthcare setting, family was identified as a crucial source of social support in the perinatal period. For many participants, most of whom had no or very limited family in the UK, their experiences related to the loss of family support. They spoke about missing both the support of their female family members and the loss of the female dominated perinatal practices of support available in their home countries. E. Sharma et al. (2020) noted the significance of the loss of support from female extended family in her review of the perinatal experiences of forced migrants. Little other work has explored this area, although Mona Al-Mutawtah et al. (2023) commented on the significance of female networks in perinatal social support more generally. Many women were experiencing the perinatal period alone and did not have partners or husbands with them, for those who did it was these partners who were the primary source of support. This meant that some male partners took on roles they would have not undertaken in their home countries and acted to provide support more usually given by female family members. Participants who mentioned this considered it to be unusual, but positive, for example, a husband's presence at birth or the provision of additional support in the home. This resonates with E. Sharma et al. (2020) who noted increased support from male partners and the subsequent renegotiation of gendered relationships amongst forced migrants. There is however, limited literature on the experiences of asylum seeking and refugee fathers in the perinatal period (Merry et al., 2020; Mprah et al., 2023), or on male gender roles within asylum seeking families in the UK (Habash & Omata, 2023; Nasser-Eddin, 2017). The implications of these changing roles of male partners, and the loss of family members in providing support for perinatal women, needs to be considered by those working with women and families, to understand and work with possible changes in the dynamics within families who are new to the UK. This is an area in which further research is also needed.

In the face of this limited familial support and reflecting the importance of close personal connections in the provision of social support and in women's physical and mental wellbeing in the perinatal period, many women sought support beyond tradition family networks. One example of this was the

creation of chosen families, where local individuals (or other asylum seeking and refugee women) became family to those seeking support, providing personal relationships of social support. In these situations, several women referred to older women as mothers and grandmothers and explained how these women had provided instrumental and emotional care during and after birth as well as help with other children. One woman explained how a local couple, who she called aunty and uncle, supported her with housing and other practical help as well being a source of emotional support and care. The idea of a chosen family is that of kin-like relationships formed with people who are not biologically or legally related to an individual but between whom there is a committed and emotional bond (Weeks et al., 2001). The idea of chosen family was developed within the LGBTQ community, often in response to constrained situations in which there had been a loss of traditional family relationships. This idea of a family of choice challenges the relevance and primacy of dominant constructions of heteronormative ideas of nuclear family connections, suggesting an alternative and more expansive idea of family. The relationships women formed, it could be argued, were also formed because of constrained situations in which there was a loss of traditional biological families. These relationships were significant, reciprocal, and on-going. Chosen families, particularly the relationships constructed as mother, grandmother, aunty and sister, were a source of emotional and instrumental support, improving the perinatal experiences and wellbeing of women and were particularly crucial for women with no biological/legal family in the UK. There has been some writing on the significance of chosen families within research into the experiences of LGBTQ asylum seekers and refugees, but this focuses on discussions of immigration policy and family reunification rather than maternity or parenting (Kim & Feyissa, 2021; Ritholtz & Buxton, 2021). No literature could be found which explores the importance of chosen families within the context of the experiences of asylum seeking and refugee women in the perinatal period, suggesting this is an area in which more research is needed.

Peer networks were also an important source of support for women in this period. These were wider and looser networks of support and connections but

they still provided important and reciprocal sources of emotional, informational and instrumental support. Women made connections with, and drew strength from, networks of female peers, either peers in terms of countries of origin, in terms of a shared migration experience, shared religion or shared motherhood and the experience of mothering in a new country. Some women also found support within local communities and neighbourhoods where their 'peerness' was less, although these sources of support were commonly linked to other children who were at school, and so related to shared parenting roles as well as geographical location. These findings resonate with research looking at the experiences of other forced migrant women which note the importance of the support of peers to women, particularly in the absence of family (Abi Zeid Daou, 2022; Cassidy et al., 2023; Ritholtz & Buxton, 2021; E. Sharma et al., 2020). It also aligns with wider work on the wellbeing of asylum seeking and refugee populations in the UK which highlights the importance of peer based networks for social support, physical and mental wellbeing and integration for asylum seeking and refugee communities (Käkelä et al., 2023; Wachter et al., 2022; Wells & Seage, 2023).

The ways in which asylum seeking and refugee women seek to construct networks and build chosen families to provide social support, has potential implications for the ways in which social support and healthcare provision for these groups is designed and delivered. The findings suggest that women embrace a more expansive sense of personal support networks through creating families of choice and networks of support. In light of this individual practitioners and wider systems need to acknowledge the importance of these extended networks of care, find ways of supporting, expanding and working with them improve support for women.

The findings raise an important question in terms of the practice of care, in that if care in this period is primarily seen as the responsibility of the (female) family members, how is it to be provided if this source of care is not available. While in this context the lack of opportunity for familial care is predominantly due to the dislocation caused by migration, the more general challenges faced by contemporary families in providing care is highlighted in the work of

Chatzidakis et al. (2020). They suggest that to meet the needs of care within contemporary society, when public sources of care have been reduced and the responsibility for care pushed back onto families, who struggle to provide this care for a range of socio-economic reasons, there needs to be an expansion of the idea of family and kinship. They suggest that there is a need to think about family in a way which looks beyond the nuclear, biological and legal model which dominates most global north communities, although extended ideas of family and kin are evident in other communities (Hill Collins, 1990; Tronto, 1993), and widen our ideas of family and of those we care for and receive care from. Research has identified the value to the wellbeing of those involved in these extended networks of care, both as givers and receivers of care, suggesting that there are a number of benefits to this extension of the parameters of care (Grossman et al., 2007; Hafford-Letchfield et al., 2017). It would also, they argue, be a more egalitarian and non-discriminatory way of caring in which we recognise that we all need care, and it is all our responsibilities. The expansion of our caring relationships in this way within society is a way of acknowledging the centrality and social location of care, extending it further into the public and social setting, accepting a wider sense of responsibility for care (Tronto, 1993).

9.8 Gender and the ethics of care

As discussed earlier in the thesis (see methodology chapter), contemporary discussions of the ethics of care emerged from the work of feminist thinkers who explored the gendered nature of care. Despite a broadening of focus in contemporary writing, the centrality of ideas of care as gendered and the implications of these ideas, remain crucial to understanding ideas of care and its practise. In the section below in the light of the findings of the studies, and in the context of my study, I explore how gender functions in the provision and reception of social support or care for asylum seeking and refugee women.

Most of the support offered to, or lost to, women through the process of migration, was provided by other women, whether as female relatives, peers, voluntary workers or midwives. This perhaps reflects the gendered

associations of care where women, within the setting of the family and home, have been seen as the primary sources of care both historically and latterly within neo-liberal regimes where attempts have been made to (re)privatise care, pushing responsibility back into private and family settings (Chatzidakis et al., 2020; Tronto, 1993). It may also reflect the idea of the perinatal period as being a uniquely gendered period where women support other women (Dennis et al., 2007; Raman et al., 2014). However, it could be argued that the gendered ideas and associations which adhere to the idea of care in these private settings can be seen in the attitudes towards care and those caring within the more public and professionalised settings in the studies. In that while this is care outside of the home and immediate kin network, there is a blurring of the boundaries of private and public location and the maintenance of the idea of care, in this period, as having a gendered, female and maternal nature (Thompson, 2020).

Support offered to women from the voluntary sector was provided by mature women who were themselves mothers and grandmothers, caring for younger women and their babies. It was all provided on a voluntarily or low paid basis. The work of voluntary agencies relies on the unpaid labour of mature women who have chosen to be attentive to the needs of asylum seeking and refugee women and to undertake acts of care which others choose not to do or not to see as their responsibility. This, it could be argued, reflects the low value placed upon the provision of care and its continued association with feminised work, as well as the association of voluntary work with women as part of a traditional perception of voluntary work as being women's work, an extension of their caring and private role (Morrison, 2021). Within the healthcare setting, support was also provided by women as midwifery is overwhelmingly a gendered profession, in which a majority female workforce works within a patriarchal organisational setting (methodology chapter). The gendered construction of midwifery as a profession has a long history, with the role and identity of midwives being associated with a range of female tropes (Chenery-Morris & Divers, 2024). The construction of midwifery as a feminised occupation, in terms of both the majority of midwives being women and as a role which is a 'natural' extension of women's reproductive, caring and

nurturing roles, has led to both an undervaluing of this role due to its association with female care as opposed to 'male' medicine, as well it being seen as an extension of a natural female role (Donnison, 1988; Wilson, 1995).

The implications of this, in a wider societal sense, are that the support and care offered to asylum seeking and refugee women is dependent on the low paid or unpaid labour of those in the voluntary and health and social care sectors. Those undertaking this work have chosen to be attentive to the needs of asylum seeking and refugee women, and to undertake acts of care, which others choose not to do, or not to see as their responsibility. This could be understood as part of the traditionally socialised expectation that 'others', those outside of the dominant, white, male group, primarily women, or people of colour, will do the necessary hands-on care work. This assumption allows the perpetuation of that Tronto calls the *privileged irresponsibility* of those with positions of most power in the patriarchal and/or traditionally male public realm. People in these positions feel that care work is not their work to do and do not fully recognise the work or value of those who do it (Tronto, 1993; Zembylas et al., 2014). It has been argued that this extends into the wider social realm where public organisations similarly do not feel responsibility for providing care and support for asylum seeking and refugee women. This can lead to a situation in which some individuals or groups face a situation, characterised by Raghuram (2019), as *the risk of care,* whereby individuals take responsibility for and provide care that is either beyond their formal remit, or beyond their capacity, due to the failure of other individuals and/or systems to undertake this care. The implications of this may be personally negative for these individuals as well as acting to remove the incentive for larger systems to take responsibility for these care needs, perpetuating wider carelessness or irresponsibility.

9.9 Conclusion

In this chapter I have discussed the findings from study one and study two using an ethics of care lens focusing on state carelessness, the voluntary sector and caring communities, systemic carelessness, the need for

promiscuous care and gendered care. The findings demonstrate, for the first time, the significance of the inequalities of access to support perinatal women face dependent on their immigration status, in terms of resettlement or non-resettlement status. They provide evidence of the importance social support provided within the community in the form of doulas, befrienders and mother and baby groups and highlights the need for more investment in these areas as well as more research, particularly into the role of mother and baby groups, to address the current evidence gaps. Highlighting the structural and organisational challenges midwives were perceived to face in supporting women these results suggest the need for research in this area from midwives' perspectives. Changing gender roles in newly arrived families, the impact of the loss of family support as well as the expansion of ideas of networks of familial and peer support to include chosen families and newly built networks were all highlighted as key issues with important implications for those working with and supporting asylum seeking and refugee women. In the next chapter I will draw together the thesis as a whole and offer recommendations for policy, practise, education and research as well as identifying my dissemination strategy and the strengths and limitations of the study.

CHAPTER 10 CONCLUSION

10.1 Introduction

The previous chapter used insights from an ethics of care lens to discuss the findings from the two studies which explored asylum seeking and refugee women's experiences of social support in the perinatal period and their perceptions of the best ways in which support could be offered. This chapter provides a conclusion to the whole thesis. It begins by identifying the original contribution of knowledge made by the study, it then provides an overview of the thesis and how the empirical studies addressed the research questions posed. It then considers the strengths and potential limitations of the thesis, the dissemination strategy, recommendations for practice, policy and further research and concludes with final reflections.

10.2 Original contribution to knowledge

This research provides new insights into the perinatal experiences of asylum seeking and refugee women currently resident in the UK. It focuses on asylum seeking and refugee women's experiences and perceptions of social support within the perinatal period, a phenomenon which is widely accepted to be crucial to women's maternal wellbeing, but which has not been widely considered in the context of the experiences of asylum seeking and refugee women. This study is the first, that has been found, to explore this issue in depth in this context. In-line with a feminist understanding of birth and maternity as more than a bio-medical phenomena and acknowledging its socio-cultural and political context, the research looks at the wider psycho-social aspects of the perinatal period and women's experiences within the contemporary UK immigration system and their interaction with maternal health healthcare.

Using a feminist-informed approach, an interpretation of social support based on women's perceptions and experiences, and member reflection, this work provides a novel approach to exploring social support in this context, keeping women's voices at the centre. This has produced new insights into women's

experiences of social support and their ideas of what would best improve those experiences, which have implications for practice and policy within healthcare, community, and statutory services. Finally, using ideas from feminist theories, discussions of the ethics of care and LGBTQ theories of family and care, it provides a new perspective on social support and care for asylum seeking and refugee women in the perinatal period. The perspectives offered in this context have implications for thinking about support and care for other women in the perinatal period, as well as wider ideas of care and support for refugees or seeking asylum people.

10.3 Thesis overview

The starting point of the thesis was a concern to explore asylum seeking and refugee women's perinatal experiences in the UK and to consider the role played by social support in these experiences. The rationale, and context for the research, was established in the background chapter by locating the experiences of asylum seeking and refugee women in the UK in the context of global migration. The chapter then identified the considerable economic, psycho-social and material challenges faced by asylum seeking and refugee women negotiating the perinatal period within the UK. It highlighted the impact of these challenges on women's perinatal wellbeing, noting the high levels of adverse maternal and infant health outcomes, including high maternal mortality and high levels of perinatal mental ill-health, experienced by asylum seeking and refugee women. It briefly explored ideas and definitions of social support and its role in the promotion of health and wellbeing, particularly in relation to women in the perinatal period. It noted that while the importance of social support in the perinatal period is well established, there is limited research on social support and asylum seeking and refugee women. I concluded by suggesting that the provision of social support may provide a way of addressing some of the challenges faced by asylum seeking and refugee women, identifying the need for more detailed research into this area and suggesting a definition of social support which could be used to facilitate this research.

Following the background chapter, chapter three presented a review of existing literature on perinatal social support for asylum seeking and refugee women across Europe, including the UK, using a Critical Interpretative Synthesis (CIS) methodology. The review explored three questions which considered the nature of social support interventions offered to asylum seeking and refugee women, how these interventions were located within wider socio-cultural-political settings, and their impact on their perinatal experiences and wellbeing. Using a model developed from Radloff's Birth Hierarchy model (Radloff, 2020), aspects of the interventions were mapped against the needs of perinatal asylum seeking and refugee women. This identified that while many interventions sought to provide social support which related to women's needs for safety, security, social connection and self-esteem most did not fully address their most basic physiological needs. The review concluded that, while all the social support interventions in the study had some positive impact on some aspect of women's experiences, community-based interventions seemed to be most effective at providing social support which met more of women's needs. I did however identify that this evidence was limited, from small scale studies and that more research was needed. Additionally, the review identified a gap in the literature around the perceptions, experiences and views of asylum seeking and refugee women, on the nature and value of social support and how they felt it might be best delivered to meet their needs. This review, which provides the first European wide study of perinatal social support interventions for asylum seeking and refugee women, has been published and has been accessed over 3500 times and cited by international peer reviewed publications 11 times to date (Balaam et al., 2021).

The findings from the CIS were then used to develop two research questions to direct the empirical aspects of the research:

(1) What are asylum seeking and refugee women's experiences of social support in the perinatal period in the UK?
(2) What are asylum seeking and refugee women's perceptions of the best ways in which they can be socially supported in the perinatal period?

Having explored the broader European context in the CIS, these research questions allowed me to undertake a more in-depth exploration of the perinatal social support experiences of asylum seeking and refugee women in the UK. In the studies, a wide definition of social support was used (as explored in chapter two). This allowed an exploration of social support which focused on what the women in the studies experienced as support or care and included both formal and informal support as well as functional and structural aspects of support. These studies explored women's perceptions of the level of social support they had experienced, what support had been helpful or not helpful, and what were the types and nature of support which would provide the best social support in this period.

In order to explore these research questions and to ensure that the experiences, perspectives, and voices of asylum seeking and refugee women remained at the centre of the research, a feminist-informed social constructionist methodological approach was used. As detailed in chapter four, this approach used insights from several feminist philosophical traditions and thinkers to direct and support the way in which the research was conducted. Congruent with this methodology and fitting with the research questions, feminist semi-structured interviews (discussed in chapter five), and focus groups and a member checking focus group (discussed in chapter seven), were chosen as the research methods to be used in the two studies. The findings from the two studies are detailed in chapters six (study one) and chapter eight (study two), with chapter nine providing a discussion of the implications of the findings from both studies in the context of an ethics of care lens. The section below provides a summary of the knowledge developed from the studies' findings, and the subsequent discussion chapter, and how this addresses both research questions.

10.4 Addressing the research questions

Women's experiences of social support in the perinatal period varied; some women had experienced very little social support, whereas other women had

been better located to access aspects of social support from a range of formal, informal and personal sources. However, despite these differences, there were commonalities in what women identified in terms of, the need for and value of social support, what the most effective forms of social support were and ideas of how to improve social support for asylum seeking and refugee women.

The research demonstrated the ways in which asylum seeking and refugee women experienced the perinatal period within the context of the current socio-political situation in the UK. Their perinatal experience took place within a 'hostile environment' for migrants, particularly asylum seekers and refugees; an environment which has been created and is perpetuated by the carelessness of the state towards women's need for care and social support. Their experience of, and access to, social support was affected by the restrictive policies and financial limitations imposed by the current immigration regime. These often determined the level of formal social support women could access or receive to meet their basic needs, as well as affecting their access to healthcare and meant that many women were reliant on voluntary organisations for support. This research has highlighted the impact on women's perinatal wellbeing of the differential access to formal support they experienced based on their immigration status, particularly in terms of the different levels of support offered to women on resettlement programmes, compared to those currently seeking asylum and other women with more precarious status.

Women also discussed their experiences of social support and care in the familial, personal or 'private' setting. For most women, discussions of these personal aspects of support focused on an awareness of a lack of support, as they experienced the loss of traditional family support they would have, or had previously experienced, in their home countries. Some women did have their immediate family with them in the UK, and so while missing their extended family, did receive some support in this way. However, for many other women, on their own in the UK, their experience of support came in new ways, from new, and more expansive or 'promiscuous' forms of support, commonly in the

form of chosen families or wider peer networks. This is the first study to explore the role played by chosen families in the context of asylum seeking and refugee women's perinatal experiences in the UK. It highlights the need to think about the importance of chosen family, and more expansive ideas of familial support, and how these relationships of support work in the maternity context. While this research focuses on asylum seeking and refugee women, it could also provide insight into the experiences of other women for whom these are a crucial source of support. It highlights the need to ensure that these forms of support are considered and included in policies and practise, for example, in terms of who can support women in labour.

Women received valued social support outside of their families and close personal networks, and it is in this context that midwives played a crucial role in women's experiences of social support by providing instrumental, emotional and informational support. Women spoke of the value of support they had received from individual midwives, while also noting the challenges midwives faced in providing this within the context of settings which displayed organisational and systemic carelessness towards asylum seeking and refugee women. It was in this context that their suggestions for improving support addressed some organisational aspects of maternity care, including the provision of continuity of carer, longer appointments, effective interpretation, training, and other changes which, they felt, would ensure the prioritisation of the culturally appropriate and relational care they had identified as crucial to their positive experiences of social support.

Alongside the support from midwives, much of the social support women accessed and valued was provided by voluntary organisations. Community-based mother and baby groups, as well as doula and befriending services, provided women with vital instrumental, informational, and emotional support. Voluntary organisations provided a localised 'caring community', which offered a space in which women felt welcome and part of a network of peers. Women experienced these organisations as providing both direct instrumental and emotional support which met their needs and as encouraging and developing reciprocal peer support and networks. Reflecting on these positive

experiences and thinking about the best ways in which support could be provided, women recommended that these forms of support should be available to all asylum seeking and refugee women. This would ensure equality of opportunity for all women, rather than the current piecemeal situation where some women were not able to access this support. While all aspects of this form of support are under-researched, there is a particular gap in knowledge about mother and baby groups, and yet it is these groups which seem to be crucial to women being able to access support.

10.5 Strengths and potential limitations

The study was based in the north of England and so the participants were exploring their experiences of social support from their location within this region. The experiences of asylum seeking and refugee women living in this region may be affected by their location in terms of the nature of communities, histories of migration, the local infrastructure and the services offered. However, there are deeper structural issues, which affect the lives of all asylum seeking and refugee women wherever they are in the UK, for example, the impact of immigration policies and public attitudes to immigration, which are addressed in this research giving the findings resonance beyond the region.

The study included the views and experiences of 29 asylum seeking and refugee women and four staff and volunteers. This was seen as an appropriate number of participants for a qualitive study, as a qualitative approach prioritises the production of rich data from a smaller number of participants than a quantitative approach, which looks for higher numbers of participants (chapter four). The women recruited had a variety of different maternity and immigration experiences. In terms of maternity experiences, the participants included multiparous and primiparous women, women who had only birthed in the UK as well as those who had also birthed in their home countries. Women who participated had been in the UK for different lengths of time, and had various immigration statuses, including asylum seekers, refugees and women who came to the UK through resettlement programmes.

Women were from a range of nationalities, cultures, faiths, and educational backgrounds. The research, therefore, presents data which reflects some of the heterogeneity of women's immigration and perinatal experiences. The number of staff and volunteers (n=4) represented in the project was small, as the focus of the research was the views and perceptions of asylum seeking and refugee women, and the intention was to ensure that their voices remained at the centre of the work. Staff and volunteers were included as they were able to provide details about local support services providing local context for the studies.

One potential limitation of the research has been the challenges I faced in working with women who did not speak English. As my PhD was unfunded, I was unable to pay for professional interpretation services and so relied on interpretation provided by other women at the groups (see chapter five). If I was not able to secure this interpretation, I was not able to conduct an interview. However, I found that the use of this form of interpretation, despite some concerns being expressed about more informal interpretation within research (see chapter five), was welcomed by women and allowed me to access all the women who expressed interest in the project but were not confident in English.

While some researchers have identified working with staff or volunteers from organisations as problematic, seeing them as gatekeepers, limiting and controlling recruitment and access to participants (as discussed in chapter five), my experiences of working with staff and volunteers did not generally reflect this. In the context of my study, working with staff and volunteers was beneficial for my research in terms of recruiting women, developing relationships with women and in ensuring women could access support if they needed to. Staff and volunteers were keen to offer the opportunity of involvement in the project to women, as they felt it was a valuable and confidence-building opportunity for women to articulate their views and to have their perspectives valued.

A strength of the thesis is the use of a feminist-informed approach, which has directed all aspects of the research process, relationships with participants, analysis, and the interpretation of the findings. This approach ensured that women were at the centre of the research, that they felt confident to contribute to the research and that their voices were heard. Keeping women's voices as central was also supported by including an opportunity for member checking within the study. Member checking provided me with a way to try to ensure that the interpretation of the data from the studies was representative of the ideas of the participants. Using this approach of working with participants helped me have more confidence in my analysis and interpretation.

Using a feminist-informed approach has allowed me to explore my positionality in relation to the research topic and to openly address issues of subjectivities and potential biases associated with doing qualitative interpretative research. It provided the opportunity to acknowledge and reflect on my position as a white academic researcher working with minoritised women, and to think more widely about my relationship to the data, the analysis, and the wider context of the research.

A weakness of my study was that due to its unfunded nature, I did not have the resources to undertake consultation work with women at the beginning of the study to help with the study design, which would have been congruent with feminist principles. I would recommend that future work in this area should ensure that there are resources to work with women from the start.

A strength of the research, and congruent with a feminist-informed approach, was evidence that the women felt valued by being involved in the project. As women who are asylum seekers and refugees, as well as women who are ethnically minoritised and experience a range of socio-economic challenges, participants felt that commonly their lived experiences and views were often overlooked and not listened to. They were pleased to be asked for their opinions and ideas and to know that these would be included in a piece of academic research. They expressed hope that their experiences would bring

about change and make things better for other women, with a number saying this was the reason they were taking part in the research.

Women who participated in the focus groups, through their discussions identified common and shared personal experiences, such as having had to leave children behind in home countries, challenges with their mental health and challenges in interactions with statutory services. The sharing of these common experiences seemed to allow women to find support in each other and enabled them to connect their personal experiences to wider societal situations. This was particularly evident in the sessions when women spoke of their challenges in dealing with various authorities. Seeing the similarity of their experiences allowed them to see these individual incidences as relating to structural and organisational issues, such as systemic racism, that went beyond their own personal experiences. This resonates with feminist writing on focus groups which suggests that they can provide a location in which women find a sense of solidarity and a collective consciousness, supporting a wider understanding of their situation (Wilkinson, 1998; Madriz, 2003; Kook et al., 2019 Liamputtong, 2011).

Insights from feminist ethics of care and learning from LGBTQ theories of care and family used in the study, also support a re-consideration of the provision and value of care and social support in the perinatal context more generally, locating it within the wider socio-political context. Applying these insights may allow an exploration of ideas of care and social support, and how they are provided and whether they can be reframed to facilitate a more equitable approach to support and care as well as seeing care as central to society and wellbeing. It can also provide a useful lens by which to explore the wider sense of care and the experiences not only of those who receive care, but also of those, such as midwives and voluntary workers, who offer support and care.

10.6 Dissemination strategy

A range of strategies are being used to disseminate the learning from this thesis. Research which has been undertaken using a feminist-informed approach, where a significant aspect of this approach is to undertake research which moves towards social justice, has an obligation to disseminate research in ways that can support change (International Women's Development Agency, 2022). Dissemination strategies have been designed to share findings with a range of stakeholders, including academics, educators, the third sector and the wider public, including asylum seeking and refugee women.

10.6.1 Education

The findings and approach used in the thesis have been used in teaching on undergraduate and postgraduate midwifery, and health and social care courses. They have been used to support students' learning about issues related to maternity and social support for asylum seeking and refugee women, as well as research practices related to working with seldom heard populations in healthcare research.

10.6.2 Conference presentations

Findings from the research have been presented at a range of national and international conferences. These have included conferences aimed at academics and educators working within migration studies, where health issues are commonly underrepresented, as well as well as conferences for maternal health and midwifery academics, educators, and practitioners, to highlight issues faced by asylum seeking and refugee women (see Publications and presentations from this thesis).

10.6.3 Funding applications

The findings have also acted to inform two UCLan-funded projects. One focusing on including the lived experiences of asylum seeking and refugee women in midwifery education and the second on using material culture as a way of exploring asylum seeking and refugee women's experiences of the

transition to motherhood. Expertise developed from this doctoral work has also led to me reviewing national and international funding bids, peer reviewing for academic journals, preparing aspects of large funding applications, and supporting doctoral students. The findings will also be used as part of future funding applications to: work with practitioners to explore the recommendations for practice, address issues around midwifery education, and to explore the use of alternative and participatory approaches to address the gaps in knowledge and priorities identified in the research. I was also approached by one of the voluntary agencies I worked with during this research for advice on existing research and insights from my research to support a funding bid.

10.6.4 Publications

The findings from the literature review have already been published (Balaam et al., 2021). A publication based on the findings of the studies and their implications for perinatal social support for asylum seeking and refugee women, will be submitted to a high quality open access journal, such as *PLOS One* or *BMC Public Health.* Another publication focusing on recommendations for midwifery practise and education, will be submitted to a publication aimed at midwifery practitioners such as *The Practising Midwife.*

10.6.5 Wider dissemination

Once the thesis has been submitted, I will produce a lay summary for wider dissemination and go back to the groups I worked with, both online and in person, to feedback the findings and discuss next steps for the research. To promote the findings beyond academia, opportunities to speak to professionals and policy makers working in health and social care provision and commissioning, as well as local authority asylum and refugee support provision will be identified through my professional networks. Opportunities for dissemination to a wider audience will be sought through existing contacts in voluntary sector and advocacy organisations including, Inclusive North, Maternity Stream charity and Research Network, and the national City of Sanctuary organisation.

10.7 Recommendations

The following recommendations have been developed from the findings and discussion chapters and build on the suggestions women made about ways in which social support in the perinatal period could be improved. Recommendations are made below for practice and education, policy, and research.

10.7.1 Recommendations for practice

1. Statutory services

- Ensure that statutory services which provide formal social support, such as accommodation services, UKBA and asylum support are more accessible and responsive to asylum seeking and refugee women. To do this ensure that:
    - Staff are trained about how best to support asylum seeking and refugee women to access services. This training could be provided by working with voluntary agencies who support asylum seekers and refugees, such as the Refugee Council or City of Sanctuary groups and should include the views and experiences of those with lived experiences of the immigration system.
    - Ensure there is information about the rights of perinatal asylum seeking and refugee women in a range of formats that women can understand and are accessible to them.

2. Voluntary Sector

- Establish services which can provide community based doulas, befrienders and mother and baby groups for all asylum seeking and refugee women, as these are the sources of support that women see as valuable and effective. Ensure that that these are properly funded so that staff can be paid and that their services have long term sustainability. Evaluate services to establish a fuller evidence base to

secure such funding and lobby for these services to be provided as standard practice for all asylum seeking and women.

- Ensure all services are developed with the women who use the services to ensure they meet their needs in the most appropriate ways.
- Establish services which facilitate appropriate peer support opportunities for asylum seeking and refugee women to support each other and for women from local communities to provide support to encourage the development of relationships within and between communities.
- Offer opportunities for asylum seeking and refugee women to be actively involved in the design, running and development of voluntary organisations and their services. This can provide capacity building and skills development opportunities for future employment for asylum seeking and refugee women, build confidence for those involved and ensure organisations are responsive to women's needs.
- In line with the recommendations above, increase the availability of education, capacity and confidence building opportunities for those with lived experience of the maternity and immigration system to help them take part in providing training for those in the statutory sector, including housing, healthcare, and other services.

3. All sectors

- Ensure more effective dissemination of information about sources of social support available to perinatal asylum seeking and refugee women, both for the women themselves and for those in the voluntary and statutory sectors who work with them, including volunteers, teachers, GP's and social workers. This could increase women's ability to access services independently as well as making signposting to services easier for those supporting them. This information should be provided in a range of formats and languages, for example, posters, online, including Apps and social media, pamphlets and in a range of locations, community centres, places of worship, GPs, clinics, libraries and family hubs.

10.7.2 Midwifery policy, practice and education

- Produce specific guidance on maternity care for asylum seeking, refugee and other forced migrant women, based on what women identify as important to them. Currently there are no specific NICE guidelines on best practice for supporting asylum seeking and refugee women beyond the general guideline, *Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors* [CG110] (National Institute for Health and Care Excellence, 2010), which has a section on supporting *Pregnant women who are recent migrants, asylum seekers or who have difficulty reading or speaking English.* This was reviewed in 2018 but no revisions were made and while the RCM have produced some recommendations for caring for asylum seeking and refugee women (Royal College of Midwives, 2020), this does not hold the status of NICE guidelines within practice.

- The organisation of perinatal care plays a vital role in enabling midwives to provide optimal social support for asylum seeking and refugee women. Key aspects of this include:

    - National Health Service England (NHSE) needs to commit ideologically and financially to the established targets for continuity of carer for marginalised women generally, and act to ensure that within this, all asylum seeking and refugee women have access to continuity of carer.
    - Ensure that asylum seeking and refugee women can access longer midwifery and/or other maternal health appointments, to ensure that midwives have the time to provide the healthcare and social support needed. Ensure that midwives' workloads allow for these longer appointments.

    - Ensure awareness of women's reliance on chosen families, peer support and other wider ideas of social support and care during the perinatal period. Ensure that there is consideration of this when supporting women, in terms of who is 'allowed' to be with women during appointments and other interactions.
    - Ensure that there are NHS professional interpretation services, preferably in person, available for all women who need it, at every appointment with midwifery staff, to facilitate communication and the provision of support.
    - Consider the nature of interpretation offered to asylum seeking and refugee women. While participants stressed that all women must be provided with qualified interpretation at every appointment, they also talked about what they considered to be optimal interpretation. They called for more women-centred, culturally-sensitive interpretation being provided for them for maternity appointments. They suggested that the most helpful interpretation would be provided by women who had experience of being mothers and who came from, or had knowledge of, their experiences or came from their communities, suggesting the need for the training of interpreters with these skills and from these backgrounds.

- Consider the possible impact of the current provision of extended social support offered by midwives on the workload and wellbeing of midwives who deliver this support, as this may be provided in addition to their established responsibilities. There needs to be clarity about the role midwives play in providing social support to asylum seeking and refugee women to ensure that the level of support offered by midwives is acknowledged within workloads and roles.
- Provide training to ensure that all midwives, not just specialist midwives, are confident to support asylum seeking refugee women in the perinatal period. Training about the perinatal needs of asylum seeking and refugee women, the role midwives play in providing social

support and how they can do this should be a requirement in the undergraduate and postgraduate midwifery curriculum. Training should also be provided for all midwives in practice as part of continuing professional development (CPD). This training should always include input from women with lived experiences of accessing maternity services and of the being in the immigration system.

- Ensure midwives have access to information about services and support available to asylum seeking and refugee women in their local area, both in-person and online, so that as part of the social support they offer, they can signpost women to these services, e.g., City of Sanctuary groups, food banks, local drop-in groups.
- Make sure midwives have access to information on asylum seeking and refugee women's legal rights to maternity and other healthcare by accessing the training and services offered by groups like Maternity Action, to support their practice.
- Ensure NHS systems allow the recording of detailed data on the outcomes and experiences of asylum seeking, refugee and other forced migrant women, as current data has insufficient granularity and can lead to over homogeneity of outcome data. This level of data is needed to identify the specific healthcare and social support needs of asylum seeking and refugee women so that care can be better provided.
- Immediately end NHS charging for maternity care, as demanded by professional health bodies including the RCM, BMA and RCOG, as this policy has a detrimental effect on women's perinatal wellbeing as it causes some women to be reluctant to access healthcare and wider social support offered by the NHS.
- Work with groups such as Maternity Action, Women for Refugee Women and Doctors of the world, to continue to lobby for improvements in the level of formal social support available to women through access to statutory support including housing, finance. It has been demonstrated that the current level of provision is inadequate to

support the physical and psychological wellbeing of perinatal women and their infants.

- Local MNVP should ensure that asylum seeking and refugee women are represented within their groups.

10.7.3 Recommendations for social policy

- Prioritise and ensure adequate, long term sustainable funding for voluntary agencies, such as those involved in this research and others working at local and national level who provide social support for asylum seeking and refugee women. This will allow them to provide social support which women have identified as being desirable and effective. Current financial support is short term and piecemeal meaning that future planning is difficult and successful schemes are forced to end as they cannot secure long term funding.
- Establish effective multi-agency working across health, social care, statutory and voluntary sectors which is used in other settings, e.g., domestic violence, safeguarding, to provide a more holistic approach to perinatal wellbeing which establishes links between services and agencies to maximise the availability and efficacy of social support for women.

10.7.4 Recommendations for Research

This research has identified several areas in which work needs to be done to provide evidence to support change in the policies and practices which negatively affect the maternal experiences and outcomes of asylum seeking and refugee women. These include:

- The evaluation of all existing, or newly established, mother and baby groups, befriending and doula services which provide social support, in order that evidence can be gathered to support applications for sustainable funding and to build on good practice.
- Further research to explore the differential perinatal social support experiences of women who have come to the UK as part of re-

settlement schemes compared to those who have entered the UK in different ways and the impact of these differences.

- Research on the importance of families of choice and extended support networks for asylum seeking and refugee women, to understand how this support functions and how these sources of support can be included in the support and care for asylum seeking and refugee women.
- Research which considers the role of gender in the social support experiences of asylum seeking and refugee women, including the role of fathers.
- Research which considers the experiences, education and support needs of midwives and midwifery students who care and provide social support for asylum seeking and refugee women, to support them and to ensure the provision of optimal care for the women they work with.

Research needs to ensure that the experiences, perspective, and ideas of asylum seeking and refugee women, relating to social support and maternity care, are foregrounded in all research. Research must also be undertaken in a woman-centred, sensitive and trauma-informed way. It is therefore recommended that:

- A feminist-informed approach provides a valuable way to locate women at the centre of the research, the principles which underpin this approach should be used in research in this area.
- Recognising the potential sensitivity of this research, researchers should be provided with training on how to work in a woman-centred, culturally-sensitive and trauma-informed way.
- Acknowledging that this can be a challenging area for students to work in, support and/or debriefing should be available to researchers.
- Support should be provided, in terms of funding as well as capacity building, training or other support needed, to ensure that women with lived experiences can be actively involved in research in this area.

10.8 Final reflections

The thesis set out to explore asylum seeking and refugee women's experiences of social support in the perinatal period and to think about ways in which the provision of social support, which met the needs of asylum seeking and refugee women as they defined them, may offer a way to improve their perinatal experiences. Working with women with lived experienced has allowed me to highlight some of the key issues they have identified as being crucial to the provision of social support. These have included the significance of the unequal access to support women face, the structural and organisational challenges facing midwives in supporting asylum seeking and refugee women, as well as the need for new ways to think about familial and peer networks of care. Using a feminist-informed approach, and insights from writing on the ethics of care and LGBTQ ideas of family, the thesis has highlighted the challenges women face in accessing the social support they need, within the context of the current careless legislative regime. It has also suggested practical solutions which can help to improve social support for asylum seeking and refugee women, within these challenging structural and organisational settings. It has stressed the value of expanding the way we think about families, and who cares for whom, as well as the need for caring communities, and support and care which is located within the communities women live in.

Completing this PhD in the past few months as asylum seeking and refugee people in the UK faced increased violence and anti-immigrant rhetoric, following a series of riots directed at those seeking asylum (Boukari & Devakumar, 2024; Reuters, 2024), has made the topic and context of this thesis more relevant than ever. The impact of these events on the lives of asylum seeking and refugee women in the UK, reminds us of the need to place the perinatal care and support of asylum seeking and refugee women, as well as the work of midwives and others who provide this care and support, within the wider socio-political context. It has highlighted the need to take a critical look at the impact of the careless state, and careless legislation, on the wellbeing of asylum seeking and refugee women, but also to take a wider look

at the value placed on ideas of care, community, and interdependence within contemporary society.

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APPENDIX 1 Letter to experts

COST Action request for information on social support interventions for refugee and asylum seeking women in Europe.

Dear colleagues
I am writing to ask you if you have any information on social support interventions designed to support asylum seeking and refugee women in the perinatal period in Europe. My current PhD study is in part to review research on the provision of social support interventions for asylum seeking and refugee women in Europe. Peer reviewed literature on the subject is relatively scarce but I feel there are interventions and projects being undertaken that are not reflected in the peer reviewed/academic literature. I would really appreciate if you know of any such interventions, projects or groups and if you know of literature, either grey or peer reviewed that may document any work that is being undertaken.
Thank you
Marie-Clare

Outline of PhD
The aim of this study is to explore the nature and impact of social support interventions on the perinatal wellbeing of asylum seeking and refugee women currently resident in Europe in order to inform the development of a social support intervention that could more effectively address the needs of asylum seeking and refugee women accessing maternity care in the UK.

Marie-Clare Balaam
Senior Research Assistant, Midwifery
School of Community Health and Midwifery
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https://eubirthresearch.eu/
https://www.facebook.com/iResearch4Birth/

Please note my usual working days are Monday and Tuesday

APPENDIX 2 Participant information sheet interviews-women

Participant Information Sheet: Initial interview

This will be verbally presented to potential participants as well as given in written form to potential participants and voluntary agency workers.

The impact of social support during the perinatal period on the wellbeing of asylum seeking and refugee women

You are being invited to take part in research project. Before you decide it is important for you to understand why the project is being done and what it will involve. Take time to decide whether or not you want to take part and talk to others if you wish. You can also ask me any questions about the project before you agree to be involved.

What is the project about?

This research is part of a larger study which is looking at projects which support asylum seeking and refugee women during pregnancy, birth and as new mothers. It is being done to help find out what women think about these projects and what support they would like to have in this period of their life. The research is being carried out by Marie-Clare Balaam who is a researcher and post graduate student at the University of Central Lancashire in Preston.

Why have I been asked to take part?

You have been invited to take part because you have had a baby in the UK in the last two years and you are currently a refugee or seeking asylum in the UK.

What am I being asked to do?

Taking part would mean that that you have a conversation/interview with Marie-Clare about your experiences of having a baby in the UK and the kind of support you had during your pregnancy, birth and as a new mother. The interview will take place at a time that is convenient for you and will be in a place that you know. You can be interviewed on your own, or with a friend if you prefer. You can have someone with you to help you with your English if you want to. The interview will be recorded on a digital recorder so that we have a record of what you said. If you don't want to be recorded notes of what you said can be taken. The interview will take no longer than 40 minutes. We would also like to ask you some questions about your age, how long you have been in the UK, where you lived before the UK, when your baby was born and how many children you have, so we can make sure we collect information from women with different experiences. If you agree to take part in an interview you will be asked to verbally agree to being involved in the study before we begin the interview.

Do I have to take part?

You do not have to take part if you do not want to. If you do agree to be interviewed you do not have to answer all of the questions and you can stop the interview at any time and we can delete the interview and all the information you have given. If you decide after the interview that you do not want to be involved in the project and do not want me to have your information I can remove your information from the project up to the point that data analysis is undertaken.

What are the possible risks and benefits of taking part?

We don't think there are any direct risks or benefits to taking part. However, your views are very important to help develop services and support for women and their families.

What do I do if I have any concerns or issues about this project?

If you have any worries or questions about the research you can talk to someone you know from this group, or contact the project supervisors, Dr Carol Kingdon (ckingdon@uclan.ac.uk, 01772 893702) or Dr Mel Cooper (mcooper2@bradford.ac.uk, 01274 236440) or the University Officer for Ethics at the University of Central Lancashire at OfficerForEthics@uclan.ac.uk.

What can I do if I feel upset about anything that has come up in the interview?

If you feel upset by anything we have spoken about you can get support from one of the workers in the group. I can help you approach them or you can speak to them directly. They are here to help and support you and you may know some of them already.

What will we do with your information and how will we keep it safe?

The information you give will be confidential and your personal information and will only be seen by Marie-Clare and her supervisors. No personal data or information that can identify you will be shared with any other people or organisations. All the information will be stored on a computer and in files that only Marie-Clare and her supervisors will be able to access (password protected/encrypted computer files). We will keep your information until the end of the project in April 2023 and then destroy it. Some of the information that you give us in your interview will be used in in publications and presentations but it will be done in a way that means you cannot be recognised.

What will happen to the results of the project?

The results will be shared with people and organisations who have been involved in the study. They will be written up to become part of PhD thesis and may be presented at academic conferences, and/or written up for publication academic journals.

Who has reviewed the project?

The project's supervisors Dr Carol Kingdon and Dr Mel Cooper and the STEMH ethics sub-committee at the University of Central Lancashire.

Contact for further information

Marie-Clare Balaam

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School of Community Health and Midwifery
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01772 893885

APPENDIX 3 Consent form interviews

Consent form

The impact of social support interventions during the perinatal period on the wellbeing of asylum seeking and refugee women.

The following statements will be read to the participant who will verbally indicate that they agree. This process will be recorded on a digital audio recorder to provide evidence of verbal consent.

I have understood the information that has been read to me from the information sheet for the project. I have asked questions about what I was told if I was unsure and I am happy with that I have been told.

I understand that I do not have to take part in this study and that I can stop being involved at any time if I want to.

I agree to take part in an interview.

If I take part in an interview, I understand that I do not have to answer all of the questions and may end the interview at any time. If I want to stop being part of the project the recordings will be deleted and any information about me will be destroyed.

I agree to the interview being digitally recorded.

I understand that some of the information I give may be used reports, presentations and publications but that this will be done in a way that means I will not be able to be recognised.

APPENDIX 4 Information sheet volunteers/staff

Participant Information Sheet: volunteer/staff interview

The impact of social support during the perinatal period on the wellbeing of asylum seeking and refugee women

You are being invited to take part in research project. Before you decide it is important for you to understand why the project is being done and what it will involve. Take time to decide whether or not you want to take part and talk to others if you wish. You can also ask me any questions about the project before you agree to be involved.

What is the project about?

This research is part of a larger study which is looking at projects which support asylum seeking and refugee women during pregnancy, birth and as new mothers. It is being done to help find out what women think about these projects and what support they would like to have in this period of their life. The research is being carried out by Marie-Clare Balaam who is a researcher and post graduate student at the University of Central Lancashire in Preston.

Why have I been asked to take part?

You have been invited to take part as you are part of an organisation that provides support to asylum seeking and refugee women.

What am I being asked to do?

Taking part would mean that that you have a conversation/interview with Marie-Clare about your experiences of supporting asylum seeking and refugee women around pregnancy, birth and new motherhood. The interview will take place at a time that is convenient for you and will be in a place that you know. The interview will be recorded on a digital recorder so that we have a record of what you said. If you don't want to be recorded notes of what you said can be taken. The interview will take no longer than 40 minutes. If you agree to take part in an interview you will be asked to verbally agree to being involved in the study before we begin the interview.

Do I have to take part?

You do not have to take part if you do not want to. If you do agree to be interviewed you do not have to answer all of the questions and you can stop the interview at any time and we can delete the interview and all the information you have given. If you decide after the interview that you do not want to be involved in the project and do not want me to have your information I can remove your information from the project up to the point that data analysis is undertaken.

What are the possible risks and benefits of taking part?

We don't think there are any direct risks or benefits to taking part. However, your views are very important to help develop services and support for women and their families.

What do I do if I have any concerns or issues about this project?

If you have any worries or questions about the research you can talk to someone you know from this group, or contact the project supervisors, Dr Carol Kingdon (ckingdon@uclan.ac.uk, 01772 893702) or Dr Mel Cooper (mcooper2@bradford.ac.uk, 01274 236440) or the University Officer for Ethics at the University of Central Lancashire at OfficerForEthics@uclan.ac.uk.

What will we do with your information and how will we keep it safe?

The information you give will be confidential and your personal information and will only be seen by Marie-Clare and her supervisors. No personal data or information that can identify

you will be shared with any other people or organisations. All the information will be stored on a computer and in files that only Marie-Clare and her supervisors will be able to access (password protected/encrypted computer files). We will keep your information until the end of the project in April 2023 and then destroy it. Some of the information that you give us in your interview will be used in in publications and presentations but it will be done in a way that means you cannot be recognised.

What will happen to the results of the project?

The results will be shared with people and organisations who have been involved in the study. They will be written up to become part of PhD thesis and may be presented at academic conferences, and/or written up for publication academic journals.

Who has reviewed the project?

The project's supervisors Dr Carol Kingdon and Dr Mel Cooper and the STEMH ethics sub-committee at the University of Central Lancashire.

Contact for further information

Marie-Clare Balaam

University of Central Lancashire
School of Community Health and Midwifery
Preston PR1 2HE
mbalaam@uclan.ac.uk
01772 893885

APPENDIX 5 Ethics Approval

11 July 2019

Carol Kingdon / Marie-Clare Balaam
School of Community Health and Midwifery
University of Central Lancashire

Dear Carol / Marie-Clare

Re: STEMH Ethics Committee Application
Unique Reference Number: STEMH 1026

The STEMH ethics committee has granted approval of your proposal application 'The impact of social support interventions during the perinatal period on the wellbeing of asylum seeking and refugee women'. Approval is granted up to the end of project date*.

It is your responsibility to ensure that

- the project is carried out in line with the information provided in the forms you have submitted
- you regularly re-consider the ethical issues that may be raised in generating and analysing your data
- any proposed amendments/changes to the project are raised with, and approved, by Committee
- you notify EthicsInfo@uclan.ac.uk if the end date changes or the project does not start
- serious adverse events that occur from the project are reported to Committee
- a closure report is submitted to complete the ethics governance procedures (Existing paperwork can be used for this purposes e.g. funder's end of grant report; abstract for student award or NRES final report. If none of these are available use e-Ethics Closure Report Proforma).

Yours sincerely

Emma Bray
Deputy Vice Chair
STEMH Ethics Committee

* for research degree students this will be the final lapse date

APPENDIX 6 Ethics amendment 1 volunteers/staff

15 November 2019

Carol Kingdon/ Marie-Clare Balaam
School of Community Health and Midwifery
University of Central Lancashire

Dear Carol and Marie-Clare

Re: STEMH Ethics Committee Application
Unique Reference Number: STEMH 1026 _amendment

The STEMH Ethics Committee has approved your proposed amendment to your application 'The impact of social support interventions during the perinatal period on the wellbeing of asylum seeking and refugee women'.

Yours sincerely

Emma Bray
Chair
STEMH Ethics Committee

APPENDIX 7 Ethics amendment 2 SONIX

University of Central Lancashire
UCLan

University of Central Lancashire
Preston PR1 2HE
01772 201201
uclan.ac.uk

21 December 2020

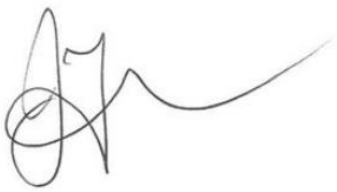
Marie-Clare Balaam / Carol Kingdon
School of Community Health and Midwifery
University of Central Lancashire

Dear Marie-Clare / Carol

Re: Health Ethics Review Panel Application
Unique Reference Number: **STEMH 1026 Amendment14Dec20**

The Health Ethics Review Panel has approved your proposed amendment to your application 'The impact of social support interventions during the perinatal period on the wellbeing of asylum seeking and refugee women'.

Yours sincerely



Jane Fitzgerald
Deputy Vice-Chair
Health Ethics Review Panel

APPENDIX 8 Information sheet focus groups

The impact of social support during the perinatal period on the wellbeing of asylum seeking and refugee women

You are being invited to take part in research project. Before you decide it is important for you to understand why the project is being done and what it will involve. Take time to decide whether or not you want to take part and talk to others if you wish. You can also ask me any questions about the project before you agree to be involved. You do not have to take part in the research.

What is the purpose of the study?

This research is part of a larger study which is looking at projects which support asylum seeking and refugee women during pregnancy, birth and as new mothers. It is being done to help find out what women think about these projects and what support they would like to have in this period of their life. The research is being carried out by Marie-Clare Balaam who is a researcher and post graduate student at the University of Central Lancashire in Preston.

Why have I been invited to take part?

You have been invited to take part because you have had a baby in the UK in the last five years and you are currently a refugee or seeking asylum in the UK.

Do I have to take part?

You do not have to take part if you do not want to. You can leave the focus group at any time if you want to without giving a reason. Once the focus group has been recorded, we cannot remove any information you have given us from the recording.

What will happen if I take part?

Taking part would mean that that you have a conversation with Marie-Clare and the other women in the group about what are the best ways in which women who are asylum seekers and refugees can be supported during pregnancy, birth and as a new mother. The group will take place online using Zoom (audio and video) and will be recorded. If you agree to take part in a focus group, you will be asked to verbally agree to being involved in the study before we begin the group. You will be asked not to talk about any personal issues that other participants might mention in the group with anyone who is not in the group to ensure confidentiality.

We would also like to ask you some questions about your age, how long you have been in the UK, where you lived before the UK, when your baby was born and how many children you have, so we can make sure we collect information from women with different experiences. This information will be taken separately from the Zoom meeting and will not be shared with anyone in the group.

How will my data be used?

Marie-Clare and her supervisors will be able to see the data you share with us in the focus groups. No personal data or information that can identify you will be shared with any other people outside the focus groups unless you share something that suggests that you or family members in the UK are at risk of harm. Any personal data will be kept separate from data from the focus groups. All the information will be stored on a computer in password protected computer files. Some of the information that you give us in your interview will be used in in publications and presentations, but it will be done in a way that means you cannot be recognised.

The University processes personal data as part of its research and teaching activities in accordance with the lawful basis of 'public task', and in accordance with the University's purpose of "advancing education, learning and research for the public benefit". Under UK data protection legislation, the University acts as the Data Controller for personal data collected as part of the University's research. The University privacy notice for research participants can be found on the attached link https://www.uclan.ac.uk/data_protection/privacy-notice-research-participants.php Further information on how your data will be used can be found in the table below.

Are there any risks in taking part?

We don't think there are any direct risks to you taking part. However, if you feel upset by anything we have spoken about you can get support from a volunteer or staff member at your local maternity stream of sanctuary (info@maternity.cityofsanctuary.org), Refugee Women Connect (07538764156 info@refugeewomenconnect.org.uk) or at Maternity Action (0808 800 0041).

Are there any benefits from taking part?

We don't think there are any direct benefits to taking part. However, your views are very important to help develop services and support for women and their families.

Expenses and /or payments

There are no payments or expenses offered for taking part in the focus groups.

What will happen to the results of the study?

I will tell you about the results of the study through contact with the Maternity Stream of Sanctuary or Refugee Women Connect groups by email and/or in an online meeting. The results will also be written up to become part of my PhD thesis and may be presented at academic conferences, and written up for publication academic journals but you will not be identifiable in any of this work.

What will happen if I want to stop taking part?

You do not have to take part if you do not want to. If you want to stop, you can leave the focus group at any time or you can tell Marie-Clare or the person who has helped arranged the group that you want to stop taking part. You can leave at any time if you want to without giving a reason.

Once the focus group has been recorded, we cannot remove any information you have given us from the recording, and this will be included in the study.

What if I am unhappy or if there is a problem?

If you have any worries or questions about the research you can talk to someone you know from this group, or contact the project supervisors: Dr Megan Todd (MTodd2@uclan.ac.uk,01772 892259) or Dr Mel Cooper (mcooper2@bradford.ac.uk, 01274 236440) or the University Officer for Ethics at the University of Central Lancashire at OfficerForEthics@uclan.ac.uk .

The University strives to maintain the highest standards of rigour in the processing of your data. However, if you have any concerns about the way in which the University processes your personal data, it is important that you are aware of your right to lodge a complaint with the Information Commissioner's Office by calling 0303 123 1113

Who can I contact if I have further questions?

Marie-Clare Balaam
University of Central Lancashire
School of Community Health and Midwifery
Preston PR1 2HE
mbalaam@uclan.ac.uk
01772 893885

How will my data be collected?	By taking part in an online focus group.
How will my data be stored?	Any personal data will be kept separate from data from the focus groups. All the information will be stored in password protected/encrypted computer files on the secure university system. Once the focus group has been transcribed, the audio recording will be deleted.
How long will my data be stored for?	Focus group recordings will be deleted once transcribed. In line with UCLan Data Protection guidelines, all other data will be stored for 7 years and then deleted
What measures are in place to protect the security and confidentiality of my data?	All the information will be stored in password protected computer files on the secure university system. The focus group will be transcribed using software and checked by a member of the research team. Information may be used in reports, publications, teaching and presentations, but you will not be identifiable from this information.
Will my data be anonymised?	No one will be able to identify you from the information you give. Your name will not be associated with anything you say.
How will my data be used?	We are collecting your views on the best ways in which women who are asylum seekers and refugees can be supported during pregnancy, birth and as a new mother. This information will help with research into improving the experiences of asylum seeking and refugee women who become mothers in the UK.
Who will have access to my data?	Marie-Clare and her supervisors will be able to see the data you share with us in the focus groups. No personal data or information that can identify you will be shared with any other people outside the focus groups.
Will my data be archived for use in other research projects in the future?	No
How will my data be destroyed?	All data will be deleted from the computer files at the end of my PhD study in October 2023.

APPENDIX 9 Consent form focus groups

University of Central Lancashire
UCLan

Consent form: focus groups

The impact of social support during the perinatal period on the wellbeing of asylum seeking and refugee women.

The following statements will be read to the participant who will be asked to state their name and then verbally indicate that they agree with each statement.

I have understood the information that has been read to me from the information sheet (version 2 27.04.2022) for the project.

I have been able to ask questions about the project if I wanted to and I am happy with what I have been told.

I understand that I do not have to take part in this study and that I can stop being involved at any time if I want to without giving a reason.

I understand that if I leave the study after the focus group has been recorded my data cannot be removed and will still be used.

I understand that some of the information I give may be used in reports, presentations and publications but that this will be done in a way that means I will not be able to be recognised.

I agree to take part in an online focus group where the video and sound will be recorded.

_____ _____

Name of Participant Date

_____ _____

Name of person taking consent Date

APPENDIX 10 Ethics focus groups

University of Central Lancashire
UCLan

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27 April 2022

Megan Todd / Marie-Clare Balaam
School of Community Health and Midwifery
University of Central Lancashire

Dear Megan and Marie-Clare

Re: STEMH Ethics Review Panel Application
Unique Reference Number: STEMH 1026 Stage 2

The STEMH Ethics Review Panel has approved your proposed amendment (by full review) to your application 'The impact of social support interventions during the perinatal period on the wellbeing of asylum seeking and refugee women'.

Yours sincerely

Simon Alford
Deputy Vice-Chair
STEMH Ethics Review Panel