MARY SEACOLE DEVELOPMENT AWARD

Developing effective maternity services for refugee and asylum seeking women with symptoms of perinatal depression.

Increasing the visibility of an invisible population.

Amanda Firth

Senior Lecturer in Midwifery at University of Huddersfield & PhD Candidate at University of Bradford

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"Do the best you can until you know better. Then when you know better, do better"

Maya Angelou

Amanda Firth, 2021

Project Summary

Background: Perinatal depression is the most frequently diagnosed perinatal mental health condition in the general population, but global research shows that refugee and asylum seeking women are less likely to have their symptoms recognised or appropriately managed by healthcare services. Perinatal mental health is a key public health concern, with new services and models of care currently being commissioned and implemented across the NHS. At a time where finances are being invested and new services commissioned, it is important that ensure that those who are most marginalised are represented. Midwives and women are required to navigate maternity services and it is important that the systems work effectively for those providing the care and those accessing the care. Therefore, the aim of this qualitative research project was to investigate how midwifery services can be developed to support refugee and asylum seeking women with symptoms of perinatal depression.

Methods: 20 refugee or asylum seeking women and 14 midwives were recruited from across England to participate in the project. Semi-structured interviews were conducted by telephone or video-calling software due to the geographical spread of the participants and the impact of the Covid-19 pandemic national lockdowns. Interviews were audio recorded and transcribed verbatim. Reflexive thematic analysis was used to analyse the data.

Findings: Two themes were developed from the data, each with further sub-themes. Theme one exposes systemic inequities experienced by both women and midwives which influenced the ability to support symptoms of perinatal depression. Theme two displays what midwives need to be able to thrive in the role of supporting women's mental health, which is supported by narratives from women.

Recommendations: The participants of this project demonstrate the authentic diversity of the models of maternity care, experiences of women and experiences of midwives in England's maternity services. The report suggests that system level change is necessary but acknowledges that change evolves slowly in healthcare. It proposes that a 'one size fits all' guideline or service would not meet the needs of women accessing services or midwives

providing care, suggesting that incremental change is initiated at the ground level to meet the needs of individual midwives and women who work in geographically and demographically diverse areas. The key recommendation of this report is the development of a national network for midwives who care for refugee and asylum seeking women. The aim of the network would be for midwives to share resources, expand training opportunities and provide peer support so that they can corporately and individually develop the role of the midwife in supporting refugee and asylum seeking women's mental wellbeing.

Key words: Perinatal depression, refugee, asylum seeker, midwife

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Introduction

Perinatal mental health conditions may affect up to 20% of all pregnant and childbearing women in the general population, with the most commonly diagnosed condition being perinatal depression (NICE, 2014). Perinatal depression is defined as depression occurring during pregnancy and up to the end of the first year postpartum. The risk of developing perinatal depression increases if you are part of a minority population; with prevalence suggested to be around 42% for migrant women and higher still for forced migrant women such as refugees and those seeking asylum (Brown-Bowers et al., 2015, Collins et al., 2011).

Prevalence rates, although somewhat helpful, are unreliable because statistics are usually estimated using data from those who come forward for diagnosis and care, with reports suggesting that less than half of all cases of perinatal depression are identified because many women choose not to seek help in formal services (Khan, 2015, NICE, 2014, Knight et al., 2018). Issues such as health literacy, access to services and stigma may influence help seeking behaviours in the general population and this may be intensified for migrant women who might experience language barriers and have a different cultural interpretation of mental health (Fonseca et al., 2015, Jones, 2019, O'Mahony et al., 2013).

Refugee and asylum seeking women have a greater risk of having their perinatal mental health issues remaining unrecognised or supported by health services and they are frequently invisible within research and formal reports (Gagnon et al., 2013). A recent UK based Royal College of Obstetricians and Gynaecologists (RCOG) survey suggests that although 85% of women were asked about their mental health in the perinatal period, only 7% of those who presented with symptoms were referred to any kind of specialist care (Russell et al., 2017). The results may be shocking to health care providers, but starker still, the official report suggests that data on ethnicity, language fluency or migration status was not collected, and it appears that the survey was only available to complete in English. This may suggest that many women, such as forced migrant women and women without fluent English were not represented within the data, rendering their experiences invisible to healthcare providers and commissioners.

Equity of access to perinatal mental health services remains inconsistent for many UK women, despite increased commissioning and investment in service provision (Maternal Mental Health Alliance, 2017). At a time when new services are being commissioned and new roles created it is imperative that the voices of marginalised women and healthcare practitioners are amplified so that services can be effective for the women accessing services and the midwives working within them.

Background

Clarifying migration vocabulary

Migration vocabulary is not universal, which can lead to confusion when reading reports or research. The United Nations (UN) defines migration as a person moving to a country that is different to their country of birth (UN, 2016). Migration may be voluntary, for example relocating for study, work, to be with a partner; or forced for reasons such as escaping war or persecution (Aspinall and Watters, 2010). People may be referred to according to their migration status, defining their legal right to reside in a country. Until the 1990's all forced migrants were described as refugees, with the term 'asylum seeker' introduced by Western countries in an attempt to reduce their obligation to accept the growing number of forced migrants seeking humanitarian protection (Kennedy & Murphy-Lawless, 2003; Tobin et al., 2014). This report is about women who are forced migrants, predominantly women with refugee status or seeking asylum. Table one defines the vocabulary used in this report.

Table one: Migration vocabulary

Term	Definition
Asylum seeker	A person seeking sanctuary from serious harm or persecution in their home country, who on arrival at the host country submits an application for refugee status (IOM, 2016).
Refugee	Refugee status is granted where formal immigration services have recognised and validated that a person's life would be endangered if they returned to their home country (IOM, 2016). This humanitarian protection may be permanent or temporary.

Contextualising UK migration statistics

The UK has a population of almost 67 million, with 9.5 million (14%) of those being migrants, defined in the data as people born outside of the UK (ONS, 2020, Migration Observatory, 2020). Over 93% of all people migrating to the UK, do so for voluntary reasons such as work, study or marriage; with asylum seekers and refugees comprising less than 7% of all migrants entering the UK (ONS, 2019). The majority of people making an asylum application in the UK are male, with only 26% of applicants in 2019 being from women (Refugee Council, 2020).

In the UK refugee and asylum seeking women represent a minority within a minority population demonstrating why they are more susceptible to invisibility within health services in comparison to the general population

Dominant attitudes to migration in the UK

The discourse around migration within the government, media and general public is predominantly negative (Phillimore, 2016). Many people fail to distinguish between voluntary and forced migration, and those who do frequently have inaccurate perceptions about proportionality (Aspinall and Watters, 2010). Public perception of immigration in the UK is significantly influenced by media and political discourse. Derogatory press coverage portrays that migrants take advantage of an overly generous welfare system (Aspinall and Watters, 2010). Investigation of UK press headlines shows that the most common tabloid and broadsheet adjectives used to describe migration are 'mass', 'uncontrolled' and 'illegal'; fuelling the negative rhetoric and hyperbole around UK migration (Allen, 2016). The media alleges that pregnant migrant women in the UK (both forced and voluntary migrants) are overburdening areas not accustomed to caring for this population, yet a report commissioned by the Department of Health states clearly that there is minimal data available on the costs of migrant use of NHS health care (Phillimore, 2016, Creative, 2013).

Being a pregnant refugee or asylum seeking woman in the UK

Most forced migrant women enter the UK as asylum seekers and are held in a detention centre or placed in an Initial Accommodation centre whilst their application for humanitarian protection is processed into the system, including their entitlement to Section 95 financial support (Refugee Council, 2019). Section 95 aid entitles an asylum seeking woman to accommodation and financial support of £39.60 per week, which is sometimes distributed via a cashless card, restricting where the money can be spent.

Accommodation is allocated on a 'no choice basis' within the UK, in a process known as dispersal. A woman may be dispersed multiple times with little to no notice during her

asylum application (Feldman, 2013). Although UK policy states that pregnant women should not be held in detention centres, should only be dispersed once during pregnancy and not during the protected period six weeks before and up to six weeks after the birth, research demonstrates that women are frequently detained and then moved multiple times during this period with a detrimental effect on their mental health (UKBA, 2019, Feldman, 2013).

Women who are granted refugee status are entitled to financial aid via the UK welfare system but are no longer eligible for Section 95 support. New welfare applications can be long and complex, often resulting in gaps in funding which may lead to periods of destitution (Aspinall and Watters, 2010). A select minority of women and families enter the UK as refugees through government schemes such as the Vulnerable Persons Resettlement Scheme, the Gateway Protection Scheme and most recently, the UK Resettlement Scheme (Walsh, 2021). These women will have a more structured support package in place in comparison to other refugee and asylum seeking women.

Housing for refugees and asylum seekers is generally of low quality and located in deprived areas (UNHCR, 2019). Asylum seekers are not permitted to work in the UK and therefore have no way of supplementing their income, leading to poverty and possibly destitution (UNHCR, 2019). Racial discrimination is common, with communities showing hostility towards those dispersed to the area (Merry et al., 2017).

Unfamiliarity with complex welfare systems, language difficulties, poverty, difficulty integrating within new communities, experiences of racial discrimination and social isolation all increase refugee and asylum seeking women's susceptibility to mental health issues such as depression (Benza and Liamputtong, 2014, Merry et al., 2017, Goodman et al., 2017).

Perinatal depression in the general population

Perinatal depression in the general population is characterised by symptoms which include persistent low mood, apathy, lethargy, change in appetite, withdrawal from social situations, feelings of inadequacy, shame, guilt and hopelessness (NICE, 2014). However

women from non-Western cultures or different ethnicities may express somatic symptoms such as aches, pains or lethargy and this is an issue that current NICE guidance does not acknowledge (Parvin et al., 2004, NICE, 2014). There is no difference in the clinical diagnostic criteria between generalised depression and perinatal depression, but there are characteristics linked to the perinatal phase which increase the susceptibility to depressive symptoms, including increased responsibility, loss of an old life and adaptation to the role of a parent (Highet et al., 2014). Socio-economic and demographic factors also influence depression; with women experiencing poverty, social isolation, unplanned pregnancies, unsupportive relationships or without a partner having a higher risk of developing perinatal depression (Hickey et al., 2005, Beck, 2008, Lancaster et al., 2010). Ethnicity is an further risk factor, with a systematic review suggesting that depression in the postnatal period is higher in women from ethnic minority groups (Gavin et al., 2005).

Additional risk factors for perinatal depression in refugee and asylum seeking women

Refugee and asylum seeking women may experience additional risk factors which are specifically pre or post migratory in origin (Brown-Bowers et al., 2015). Women may have experienced ethnic or religious persecution, war, sexual violence and slavery, occurring in their home country and during a dangerous migration journey to the host country (Zimmerman et al., 2009, Correa-Velez and Ryan, 2012). Imprisonment and kidnapping are common, with some women witnessing the death of other people in the group and subject to dangerous transportation by human traffickers (Feldman, 2013, Korukcu et al., 2017). For some, these experiences trigger flashbacks and traumatic memories which impede their ability to sleep or function in the new country (Korukcu et al., 2017).

Post-migration risk factors include a lack of protection from government agencies when arriving in the host country, with asylum seeking women describing being detained like prisoners by UK border agencies; treated like criminals and questioned by immigration workers who appear to disbelieve their reasons for forced migration (McLeish, 2002, Feldman, 2013). Refugee and asylum seeking women also have a distinct multi-dimensional experience of social isolation which may increase depressive symptoms (Tobin et al., 2015).

Women who feel forced to leave behind family members in dangerous situations are more likely to worry for their safety and fear never seeing them again (Shishehgar et al., 2017, Tobin et al., 2017). Furthermore, women may feel guilt, shame and fear at leaving some or all of their children behind in conflict filled countries (Miranda et al., 2005, Brown-Bowers et al., 2015). Isolated women may miss matriarchal support structures, female kinship and being surrounded by a large family (O'Mahony and Donnelly, 2012, Ahmed et al., 2017).

Asylum seeking women who are dispersed during the perinatal period are at an even greater risk of developing symptoms of depression. They face additional barriers to accessing care and increased risk of poor health due to multiple forced dispersal episodes during pregnancy and the immediate postnatal period, meaning that they cannot access familiar health systems, build relationships with service providers or maintain established social support (Reynolds, 2010, Bryant, 2011).

Considering these unique risk factors, it is important that midwives and maternity services can effectively recognise and respond to symptoms of depression in refugee and asylum seeking women.

The midwife's role in screening for perinatal depression

All women in the England are cared for by a midwife during their pregnancy and in the immediate postnatal period, with screening for perinatal depression being a fundamental part of this role (NICE, 2014). Screening is usually completed using one or more validated depression screening tools, with no consensus of the most suitable tool to use (NICE, 2014). It is argued that depression screening tools are biased towards Western symptoms of depression and that although they are validated for use in different languages, they have not been psychometrically tested for use with migrant women who are assimilating their experiences with life in a different country and culture (Tobin et al., 2015, Zubaran et al., 2010). It is also argued that depression screening tools are designed for self-completion, with the reliability and validity of the data decreasing when translated through an interpreter, who may struggle with cultural equivalence or vocabulary (Hayden et al., 2013).

When screening identifies that a woman is symptomatic for depression, a midwife will refer to a doctor or mental health professional for further assessment and diagnosis. Treatment for perinatal depression in the UK consists of the possible use of antidepressant medication and referral to talking therapies (Dennis and Hodnett, 2007, NICE, 2014).

UK clinical guidance for supporting refugee and asylum seeking women's mental health in the perinatal period

Maternity care in the UK is supported by clinical guidance from the National Institute for Health and Care Excellence (NICE). This clinical guidance acknowledges refugee and asylum seeking women as service users with complex social needs, recommending that they are cared for consistently by a named midwife who has undertaken additional training to care for this client group (NICE, 2010). The guideline suggests that a midwife's training includes UK migration policy, entitlement to NHS care, physical health needs such as FGM and HIV and an awareness of the social, religious and psychological needs of this population, failing to acknowledge the increased perinatal mental health risks to women and the increased skill-set needed by midwives support women's mental health.

UK health services and government bodies acknowledge that current perinatal mental health provision is insufficient and recognise that there is a need to improve public access and engagement with mental health services (NHS England, 2016, Maternal Mental Health Alliance, 2017, Russell et al., 2017). Yet disappointingly, this is not represented in clinical guidance which merely reports that the development of services for refugee and asylum seeking women is impeded by a lack of robust evidence to support how to care for this population effectively (NICE, 2010).

Summary

The context provided above displays that refugee and asylum seeking women are clinically vulnerable in the perinatal period. They are a very small and invisible sector of the whole population who have a higher estimated prevalence of perinatal depression, but who are also less likely to have this recognised by healthcare professionals.

Although it is positive that new perinatal mental health services are being developed; stakeholders, commissioners and clinicians need to recognise that there are women who are more likely to experience barriers accessing services or fall through gaps within services. These include women with complex social needs, those from an ethnic minority and forced migrant women who have multiple increased risks of being invisible to services (Khan, 2015, Dennis and Chung-Lee, 2006, Phillimore, 2016). Further work needs to be undertaken to establish how refugee and asylum seeking women can more effectively have their perinatal mental health needs supported by maternity services.

Project overview

Interviews were undertaken with 14 midwives and 20 refugee and asylum seeking women across England to address the following aim and objectives:

Aim

To investigate how midwifery practice can be developed to support refugee and asylum seeking women with symptoms of perinatal depression.

Objectives

1. Explore how refugee and asylum seeking women think midwives in England can better identify, understand and respond to symptoms of perinatal depression
2. Identify the barriers and facilitators that midwives in England experience working within the NHS system to help refugee and asylum seeking women with symptoms of perinatal depression

Underpinning project philosophy

All research is influenced by the researcher's own perspectives and credibility is increased when these are reflexively acknowledged in the project design and analysis of the resulting data (Rees, 2011). This project is influenced by social constructionism and post-colonial feminism.

It is argued that the Western concept of mental illness reduces mental health to a prescribed set of symptoms to be cured (Engel, 1977). In contrast, social constructionism asserts that knowledge and concepts of mental health are socially constructed according to contextual realities, directly opposing the medical model's reductionist view of mental illness (Burr, 2015, Morgan et al., 2007). If mental health is socially constructed, then this is also influenced by power differences and social position, with factors such as gender, social class and ethnicity influencing social inclusion and exclusion (Burr, 2015, Crotty, 1998). It is argued that the mental health of marginalised populations is affected by their exclusion at both a community and institutional level (Morgan et al., 2007).

Feminists suggest that research methodology has been masculinized to oppress women, with a bias towards quantitative research which seeks to reduce issues faced by women to statistics, rendering their experiences and concerns invisible (Oakley, 1998, Clarke, 1983). It is also proposed that research is prone to colonial arrogance, taking a Western stance on the phenomena being researched and alluding that migrant women are uneducated or in need of emancipation (Castro Varela and Dhawan, 2015, Spivak and Riach, 2016).

UK clinical guidance for the clinical management of perinatal mental health states that care should be culturally sensitive but also recommends the use of Western diagnostic criteria for depression and screening tools which have been designed for a Western population (NICE, 2014). Post-colonial feminism dismisses that mental illness can be attributed to one factor, instead considering the intersectionality of issues such as gender, ethnicity, social class or politics and their influence on women's health and construct of reality (Anderson, 2002, O'Mahony and Donnelly, 2010). One of the central aims of post-colonial feminism is to reveal systemic practices which oppress marginalised groups and consequently, social justice and transformative action are two of the key requisites for post-colonial themed research (O'Mahony and Donnelly, 2010).

Project design

Sampling and recruitment

Midwives were intentionally recruited from outside of the NHS systems, using a research poster disseminated via social media, prominent national midwifery networks, national midwifery journals and snowballing, meaning that participating midwives were invited to share details of the study with others in their network (Mason, 2018). The rationale for this is that there is no NHS register of specialist midwives or services, and it was important that midwives were able to self-identify as eligible based on their own experiences of caring for women. Research suggests that participation in research may be influenced by gatekeepers in official systems such as the NHS (Block et al., 2013). Such gatekeeping may lead to

managers only sharing my study information with selected midwives or choosing not to share the information at all. Midwives were recruited according to the eligibility criteria in table two.

Table two: Eligibility criteria for midwives

Inclusion criteria	Exclusion criteria
Midwives who: - Are currently working within the NHS in England - Identify as providing care for refugee and asylum seeking women in their role as a midwife	Midwives who are: - Not currently working within the NHS in England - Working with refugee and asylum seeking women in a purely voluntary rather than professional capacity

Refugee and asylum seeking women were recruited through their participation in groups or services run by voluntary agencies. Recruiting women attending third sector services was appropriate because they frequently do not seek or receive help through official health systems. Recruitment through official health systems also risks the trustworthiness of the data as participants may feel obliged to answer in a way, which falsely legitimises ineffective systems (Zion et al., 2010). Women did not need a diagnosis of perinatal depression to participate because many women do not perceive themselves as depressed according to Western diagnostic criteria and forced migrant women are also far less likely to have been formally diagnosed or treated by the NHS. Women were recruited according to the eligibility criteria in table three.

Table three: Eligibility criteria for refugee and asylum seeking women

Inclusion criteria	Exclusion criteria
Women who: • are forced migrants who have/had a refugee or asylum seeker migration status in the perinatal period (including women whose migration status changed during the perinatal period) • are pregnant or have given birth in the last two years • have accessed NHS maternity care with a midwife in England • are members of an established voluntary community group	Women who: • are not forced migrants • are not pregnant or had a baby within the last two years • did not access NHS maternity care in England

Sample size

This project interviewed 14 midwives working across England and 20 women from different forced migrant backgrounds who had used NHS maternity care in the last two years. Qualitative research perceived as 'gold standard' frequently claims to aim to attain data saturation, a point where no new information is gained from data collection or no new themes emerge from analysis and is frequently used as justification for a sample size or the cessation of data collection (Lincoln and Guba, 1985). Yet this is in conflict with the nature of qualitative research with humans, who are heterogenous by nature (Braun and Clarke, 2021b). It is argued that the notion of data saturation is a positivist quality assurance mechanism, incongruent with qualitative methods and used as arbitrary justification by gatekeepers of knowledge. In reflexive thematic analysis, codes continue to evolve after data collection, moving from a surface level interpretation to analysis that is more nuanced

and implicit therefore there is no objective way of measuring data saturation (Braun and Clarke, 2021b). This project does not claim to achieve data saturation as the rich interpretation of the data alludes that new author interpretations are always possible, instead it uses what Low (2019) describes as 'theoretical' or 'pragmatic' saturation, an interpretive judgment of enough new knowledge to answer the research objectives set. Pragmatic research decisions are also influenced by the timescale and funding available for a project (Mason, 2018).

Ethics

Ethical approval was granted by the University of Bradford, with approved amendments to enable video and telephone interviews for women during the Covid-19 pandemic. All midwives and women gave informed consent to participate in the study, with women providing recorded verbal consent rather than written consent. Verbal consent widens participation for marginalised groups who do not read or write English, is preferable to asking a woman to sign official looking forms which can trigger negative migration-related memories, reduces power differentials between the participant and interviewer, and enables consent to be an ongoing process throughout the interview (Block et al., 2013, Mackenzie et al., 2007).

Questions used in the semi-structured interviews were co-designed with midwives and forced migrant women to ensure that they were sensitive, relevant and used appropriate vocabulary. All participants were anonymised and interviews were audio recorded and transcribed verbatim, with recordings destroyed after transcription. All midwives had access to internet connections to participate in interviews, but women were interviewed during the Covid-19 national lockdowns and were provided with a £10 voucher to cover the costs of mobile/ internet data associated with participation. Women were offered the use of an interpreter for the interview and all participants were provided with details of support networks should they require any support following the interview.

Data collection

Semi-structured interviews were conducted via telephone or video call, depending on the participant's preference. Traditionalist researchers assert that interviews should be conducted face-to-face to aid rapport-building and so that non-verbal communication can be captured to contextualise interview responses (Gillham, 2005). This was not possible due to the geographical spread of participants and the impact of the Covid-19 national lockdown. Additionally, telephone based interviews also provided anonymity for the participant to answer honestly, more evenly distributing power in the researcher/ participant relationship (Holt, 2010, Vogl, 2013).

Data analysis

Braun and Clarke's Reflexive Thematic Analysis was used, acknowledging the influence of social constructionism and post-colonial feminist perspectives on the interpretation of data (Braun et al., 2018). Braun and Clarke (2021a) argue that all knowledge generation is subjective and underpinned by theoretical assumptions or philosophical influences, stating that acknowledging this is a central principle of reflexive thematic analysis, something to be proclaimed rather than refuted. Data from midwives and women were analysed collectively rather than separately, fitting with the post-colonial feminist perspective of demolishing power hierarchies, and not pitting women's experiences against midwives' but searching for collective nuances within the narratives.

Braun and Clarke's (2020) six steps were used to structure the data analysis as documented in figure one. In reflexive thematic analysis, although the steps are sequential, there is movement back and forth between the steps until the themes are finalised.

Figure one: 6 phases of reflexive thematic analysis (reproduced from Braun & Clarke 2020)

Findings

14 midwives from 13 cities/ towns/ boroughs serving 13 different NHS Trusts participated in telephone-based interviews. Their demographics can be viewed in table four. There are a limited number of midwives in specialist roles within England therefore only geographic regions are reported here to protect their anonymity. The demographics demonstrate that the midwifery roles assigned by NHS Trusts are heterogenous across the UK, with specialist midwife roles differing between regions and Trusts. In addition, some midwives were able to caseload women's antenatal and postnatal care (none providing intrapartum care), whereas other specialist midwives had a helicopter view over the maternity care provided to women but did not caseload women's care themselves. The data shows that there is no consistency in the role of specialist midwives who are allocated to care for refugee and asylum seeking women within England.

Table four: Demographics of midwife participants

Identifier	Location	Role
Midwife 1	North West	Community midwife - general case loading (no specialist midwife in the Trust)
Midwife 2	London	Community midwife (plans for a specialist team being formed)
Midwife 3	North East & Yorkshire	Specialist midwife - case loading (women with complex social factors)
Midwife 4	North East & Yorkshire	Specialist midwife - case loading (women with complex social factors)
Midwife 5	London	Hospital based antenatal care midwife (reports to specialist vulnerable families team)
Midwife 6	London	Specialist midwife - case loading (vulnerable women)
Midwife 7	North East and Yorkshire	Specialist midwife - case loading (vulnerable women)
Midwife 8	North East and Yorkshire	Specialist midwife - case loading (vulnerable women)
Midwife 9	Midlands	Specialist midwife – not case loading (migrant and homeless women)
Midwife 10	London	Specialist midwife – case loading (vulnerable women)
Midwife 11	North East and Yorkshire	Specialist midwife – case loading (women with complex social factors)
Midwife 12	South West	Specialist midwife – not case loading (women with complex social factors)
Midwife 13	North West	Specialist midwife – not case loading (women with complex social factors)
Midwife 14	North West	Specialist midwife – case loading (non-English speaking women)

Table five describes the diverse sample of 20 women who accessed care in eight different NHS Trusts (predominantly in the North of England) who participated in interviews by either telephone or video call. All women were offered the use of an interpreter, with nine women choosing to use an interpreter and 11 who declined because they were fluent in English or felt confident enough in their language ability to participate. 11 women were asylum

seekers during their maternity care and nine women were refugees. The five Syrian women interviewed had all entered the UK as part of the government Syrian Vulnerable Persons Resettlement Scheme.

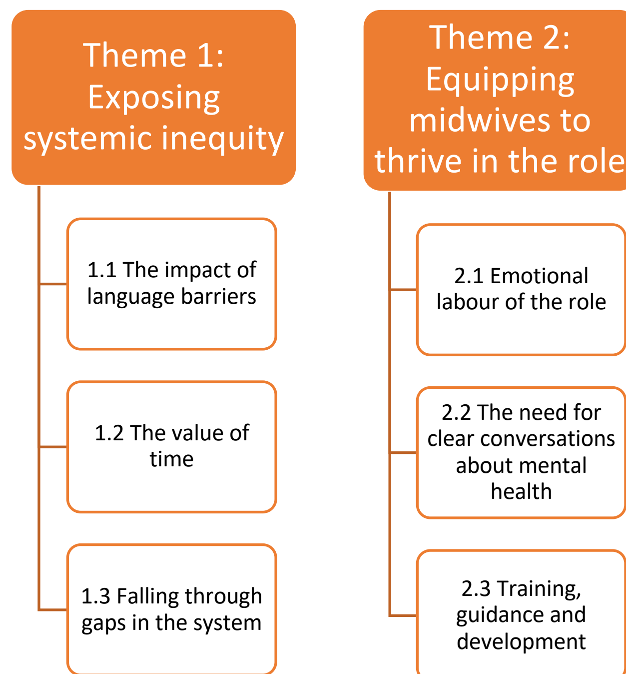
Table five: Demographics of women participants

Identifier	Originally from	Migration status during perinatal period	Interpreter used
Woman 1	Zimbabwe	Asylum seeker	No
Woman 2	Iraq	Asylum seeker	No
Woman 3	El Salvador	Asylum seeker	Yes
Woman 4	Sri Lanka	Asylum seeker	No
Woman 5	Pakistan	Refugee	No
Woman 6	Sri Lanka	Asylum seeker	No
Woman 7	Ethiopia	Asylum seeker granted refugee status in perinatal period	No
Woman 8	Eritrea	Asylum seeker granted refugee status in perinatal period	No
Woman 9	Zimbabwe	Asylum seeker	No
Woman 10	Syria	Refugee	Yes
Woman 11	Syria	Refugee	Yes
Woman 12	Syria	Refugee	Yes
Woman 13	Syria	Refugee	Yes
Woman 14	Iraq	Refugee	Yes
Woman 15	Syria	Refugee	Yes
Woman 16	Angola	Asylum seeker	Yes
Woman 17	Albania	Asylum seeker	Yes
Woman 18	Yemen	Asylum seeker granted refugee status in perinatal period	No
Woman 19	Botswana	Refugee	No
Woman 20	Zimbabwe	Asylum seeker	No

Themes

Two themes were generated from the combined data, each with subthemes as seen in figure two.

Figure two: Themes



Theme 1: Exposing systemic inequities

Midwives and women describe navigating a system that treats them the same as any other midwife or woman in the maternity care system, not recognising that effectively supporting refugee and asylum seeking women's mental health requires additional resources. This led to a decrease in women's likelihood of disclosing or being able to effectively discuss their mood.

1.1 The impact of language barriers

Language barriers were cited by all 34 participants as the biggest factor effecting whether a woman was able to disclose concerns about her mood. Midwives spoke about the

complexities of interpreter use and how this influenced the conversations they had with women about maternal mood. A minority of midwives worked in well-developed services with good levels of resources, but most midwives discussed the difficulty in having consistent access to effective interpreter services.

"if I can get a face-to-face interpreter brilliant, otherwise it's telephone interpreter, you just hope to God that you can get a signal in their house, because it doesn't always work like that… and again, you do what you've got to do, and if you need to do a bit of Google Translate then that's what, that's what you need to be doing as well you know"
Midwife 7

Midwives described needing to support the interpreter's wellbeing as well as the woman's and they sometimes doubted that interpreters were accurately conveying messages about mental health.

"and I then had a very poor phone line, and then the interpreter on the other end who absolutely couldn't cope and was in floods of tears, because of what this woman was telling her. And then because of the poor phone line I was only getting half a story, and I just thought, this is shocking, this is the worst experience of my life because I cannot, I can't support the telephone interpreter, I can't support the woman properly"
Midwife 9

"you have a gut feeling that the question you have asked hasn't actually been asked in the same way, you just, and I know that's not evidence based, but that's just, just I'm going to ask that in a different way again because I'm not sure you've got what I was saying"
Midwife 12

Women who had an interpreter during their maternity care were generally able to speak freely about their mental health, but those who didn't have an interpreter frequently felt disadvantaged and silenced. Some women perceived midwives to be gatekeepers to interpreters, with midwives choosing to access an interpreter to have their own questions answered rather than to meet a woman's needs.

"She got stuck with me in the middle of the pregnancy, and she told me she cannot understand me, and that she needed an interpreter"
Woman 12 (had an interpreter once during her maternity care)

Women reported that this impeded their communication with midwives, particularly in discussions around mental health and wellbeing.

"My midwife didn't ask if I wanted an interpreter. It would have been good honestly. I understand mostly but I cannot always explain it in words... I think it would be helping because maybe I can express my feelings talking in my language better"
Woman 20

1.2 The value of time

A lack of time impeded both midwives and women's discussions around mood and mental health. A minority of midwives worked in areas with manageable caseloads, had autonomy over their schedule and recognised how fortunate they were in comparison to other colleagues. Almost all specialist midwives had a broad role of caring for a range of marginalised women and many struggled to juggle the diverse workload in the time they had, impacting on the time that they could spend with refugee and asylum seeking women and supporting their mental well-being.

"I'm only part-time, only work three days to cover, well my role's expanded so it kind of also covers trafficked women and homelessness which is massive in [city], so trying to then, you know, cover all those specialities on three days and that is quite tricky"

Midwife 9

Midwives disclosed making adaptations to their role to manage their workload, acknowledging that the adaptations were necessary but did not benefit women.

"So it used to be that [colleague] and I would caseload women and certainly women with particular mental health, you know, really severe issues or any severe safeguarding issues we would caseload them but actually because of the huge volume of work and the fact that we're only a job-share we've had to let that go. So we would have kind of a helicopter view of the woman's care instead"

Midwife 10

"So I went to more telephone appointments, and then using our telephone interpreter system to try and ring women to start off with, to find out what the issues were, and then arrange more home visits for some ladies who were really in need"

Midwife 9

Midwives also described feeling the need to work beyond their contracted hours to be able to support women and their mental wellbeing

"if you really want to get the best support for a woman you have to do it on your own time, even with things like, you know, ringing the Home Office at stupid times of the night"

Midwife 3

Women were perceptive of midwives' time constraints, and this affected whether they felt able to discuss their mood. Some women did not want to be a burden to busy midwives or take time away from other women.

"She's busy she doesn't have much time, so they have come, listened to baby movement and she said, "How are you feeling?" Just say, "Good" so they can go to the next person. Yeah, so if I say "good" no-one can know what's inside unless you say it. Let them go see the next woman who is pregnant. They are very busy"

Woman 1

One quarter of the women interviewed felt that the busyness of the midwife had a negative impact on their relationship, reducing the likelihood of the woman discussing her mental wellbeing.

"My midwife she wasn't interested in me, always telling me she is busy or didn't have much time. She wasn't caring like other peoples' midwives"

Woman 17

Women and midwives felt that the ability to provide additional time would encourage women to discuss their mood with midwives.

"So I think if they can talk a little bit longer with us, because I know they are busy and they are doing a lot, but yeah, if they can ask little more and then that, you know, start to ask questions, and yeah, we will answer"

Woman 4

"If you are able to spend a lot of time with someone and really talk, you can pick up most things can't you?"

Midwife 12

1.3 Falling through gaps in the system

Midwives were frustrated that women frequently fell through gaps within systems or were passed between systems. Women did not comment on this within the data, suggesting that they had a reduced knowledge of healthcare systems and that midwives absorbed more of this burden in their attempts to help women access support and treatment for depressive symptoms.

Midwives reported that women are sometimes seen as one-dimensional by other professionals, with their status as a migrant woman superseding their mental health needs.

"So when they have really high scores then we can refer them to our mental health team, a perinatal mental health team, however when I did that they were just like "no, you've got to sort of deal with this because she is more of a [migrant team] woman than she is a mental health team woman"

Midwife 3

Almost all midwives reported that refugee and asylum seeking women often did not meet the Western diagnostic criteria used for acceptance into general perinatal mental health services.

"if it's quite severe it's obviously a lot easier, but if they're on like a, they're kind of in a grey area, I find that quite hard because they don't quite meet the criteria but it's too much for just my own care if you will. I find that really challenging because they kind of, they're lost in-between a little gap in the system"

Midwife 1

Midwives felt that they were left with the responsibility of finding a service that would accept a referral for the woman, using their own experiences and networks to decide whether to try other NHS or voluntary services.

"it's generally whichever one's got the shortest waiting list is whichever one we'd refer them to"

Midwife 4

Undocumented migrant women and refused asylum seekers are mentioned by one midwife as the most vulnerable service users due to implications of charging for non-emergency care

"it's getting more and more difficult, because mental health, even sort of like five years ago they weren't so hot on sort of the charging situation, you know, mental health usually is classed as non-urgent so there will be a cost to it"

Midwife 5

Most midwives relied on voluntary agencies to provide talking therapies for women's low mood but describe long waiting lists, very specific referral criteria and the inability to provide an interpreter as barriers to the woman accessing support for her depressive symptoms.

"So you think, oh yeah, that would be perfect for my woman but they're not accepting new referrals at the moment"

Midwife 11

"And they're one of the voluntary agencies that can't pay for interpreters"

Midwife 4

Midwives also recognised the frequent dispersal of asylum seeking women as detrimental to them being able to access timely care for their depressive symptoms.

“The challenges are the Home Office moving them around the country. They might be on a waiting list for one service and then get moved to another area of the country and they start from the bottom of that waiting list, so that’s frustrating”

Midwife 4

Theme 2: Equipping midwives to thrive in the role

Midwives described being unable to thrive in their role, feeling that they needed better preparation for assessing, discussing and supporting symptoms of depression in women. Narratives from women also suggested that midwives would benefit from a greater level of support and training.

2.1 Emotional labour of the role

Many midwives described the negative impact that the emotional labour of supporting women’s mental health had upon them and that this was often invisible to their colleagues or managers.

“I really love this job but I don’t know if it’s good for me… I think we give a lot to this role and we absolutely love what we do but does it help you, is it good for us to be exposed to these stories relentlessly all the time?... But I think in our team it’s almost like an invisible service, I think people don’t always necessarily know what we do, they don’t know the extent of, you know, what we’re exposed to, so I think they kind of take the service for granted and I don’t think that there’s a clear kind of joining up of the dots in other people’s minds and certainly in management’s minds that we’re actually being exposed to bad stuff too”

Midwife 10

Four midwives were cautious about who they sought support or guidance from due to discriminatory attitudes of other staff members. Four midwives reported the loss of statutory midwifery supervision negatively impacting their own support structures at work.

“I think there’s still some midwives that struggle with women having mental health issues, or they’re like, oh, they should be grateful, they should be grateful that they’ve got a roof over their heads and blah, blah, blah, well that’s not, considering we’re a caring profession, that’s not a very caring attitude”
Midwife 9

“We don’t have supervision anymore do we, and that was often a way of getting things off your chest”
Midwife 8

A small number of midwives worked within maternity systems which recognised the complexities of caring for refugee and asylum seeking women’s mental health and the toll that this may have on a midwife’s wellbeing. They described helpful systems of regular supervision or debriefing opportunities.

“so clinical supervision helps my mental wellbeing, that I’m not taking all the load to myself and taking it home”
Midwife 6

Almost all women felt supported by their midwives, but a small number of women felt that their midwives were emotionally unavailable and that this impeded discussions around low mood. These conversations linked closely to the those in sub-theme 1.2, but some women elaborated on how they had felt unsupported by a disinterested or emotionally cold midwife. Woman 17 and woman 18 were both cared for by specialist midwives but felt that the midwives had become uncompassionate or disinterested. The experiences of the women demonstrate the negative influence of not having a midwife who can invest in the emotional labour of supporting refugee and asylum seeking women’s mood and psychological wellbeing.

“I’ve seen midwives and health visitors helping other people you know, even with the conditions they live in or directing them, guiding them, and in my case you know… I’ve seen ladies being supported by midwives immensely but in my case, zero support. I don’t know why”
Woman 17

"They spend their time making reports about me, they make time for that but not to speak with me, to know me. Just to complete their papers"
Woman 18

2.2 The need for clear conversations about mental health

All midwives discussed using depression screening tools and perceived that they had clear conversations with women about their mental health. They didn't always find depression screening tools helpful, but they provided a starting point to discussions around mood.

"I mean, it gives you the opportunity to, as long as you don't kind of just use them, you know, just go on through the questions, ticking the boxes, you know, if you just use them to have a conversation, that they are helpful"
Midwife 3

Midwives felt that most refugee and asylum seeking women presented with mental health concerns in pregnancy.

"It feels like it's rare for them to say they haven't got any mental health issues. The majority seem to say they've got anxiety and depression, at the very least. A lot of them have clearly got trauma"
Midwife 4

In contrast, less than half of the women in this project recognised that they had been clearly asked about their mental health or screened for depression. Many women felt that the midwife prioritised their physical health.

"but my midwife never ask me about my mental health, if always, you know, question around my health, that's all, you know, how's the baby and then, you know, the blood pressure's okay"
Woman 5

Some of women did not understand the concept of depression or certainly hadn't understood it during their pregnancy, only learning about it from their health visitor postnatally.

"some Sri Lankan women, they don't speak because sometimes they don't have idea, they don't have any clear idea do I have any mental health problem or not. They don't have the idea of mental health"
Woman 6

"No, in our country it's like, you know, mental health or how people feel, or how woman feels is not really important to talk about"
Woman 4

Some women did not recognise that it was part of the midwife's role to support their mental health.

"Just I'm thinking she's doing her job, it's for treatment for me and baby, not about depression or mental health – it's different. It's not her job. I'm thinking like that. That's why I didn't ask her. But mental health is very important because for me I worried too much. I have depression still now, so I didn't tell her something"
Woman 8

It seems clear that communication between women and midwives may often be at cross-purposes. There is a need for clearer communication between midwives and women, where concepts of mental health and depression can be discussed more effectively.

2.3 Training, guidance and development

All 14 midwives reported the difficulties in accessing appropriate training or guidance, with some women suggesting that midwives need additional training to be able to effectively support their mental health.

A lack of national level clinical guidance disempowered and frustrated midwives, impeding their ability to effectively support women's mental health through formal care pathways. Some midwives perceived that their roles were invisible or that the needs of women were invisible within guidance.

"So I think in terms of, you know, that kind of the actual official framework that we're given is not really good enough, it doesn't feel current, it's just another factor that feels like this caseload, you know, this group of women are just not important, and that's kind of on a national level isn't it?"
Midwife 10

"the NICE guidance for complex social issues has got some stuff about migrant women, but it's more about the resources that you're giving out, or your auditing that you've got to do, it's not actually about the actual physical practical care, how do you actually look after these women"

Midwife 9

Midwives also discussed the lack of local clinical guidance or needing to write their own guidance.

"there's not a proper pathway that we follow really, other than referring them to the mental health team who then refer them back to us"

Midwife 3

"I've also written the clinical pathways for [city], so we have some pregnancy pathways now in place for [city] hospitals. I've spent two years writing those pathways"

Midwife 8

Midwives were disappointed at the lack of training available on a national and local basis, usually sourcing and financing it themselves.

"I think if I'm honest with you it feels a bit tick box, you know, this is something that we need to be seen to be doing…if it was going to be taken seriously there would be time and money put in to ensure that we were trained"

Midwife 12

"So yeah it was a case of, teach yourself really how to care for these women and I went on a lot of study days in my own time"

Midwife 8

When asked about how services could be improved to support women with symptoms of depression, a number of women suggested increased training for the practical methods of supporting a forced migrant woman, particularly the situational issues such as immigration and finances which presented acute stress in the perinatal period.

"I think some midwives they don't know about immigration stuffs, so they don't know, but if you tell [teach] them at least they will speak with the people and then they try to be helping you better. That would help me"

Woman 7

"I asked her to complete a maternity grant form for asylum seeker women but she didn't know how to complete it. She did it wrong and I didn't get the grant. I had no money. I applied again after the baby was born with the health visitor and it took 6 weeks. That was not helpful to me, it was stressful"
Woman 3

Women also wanted midwives to be able to show increased levels of cultural understanding and competency.

"they have to have more ideas about their culture, their background to their, their ways, and just to talk more and more about that… but not just like oh, she is Muslim, mmm, that means like she hates like white people, she hates this, she hates that, some of them they do have this kind of mentality"
Woman 18

It is clear from the narratives that midwives have a need and desire for greater amounts of training and guidance in their role, with women also suggesting training which would improve midwives ability to recognise and support their mental health needs.

Discussion

This study aimed to explore how NHS midwives can better recognise and support symptoms of perinatal depression in refugee and asylum seeking women. The findings demonstrate a multitude of barriers which contribute to inequitable services for midwives and the refugee and asylum seeking women accessing care. As a project exploring the issues through a lens of post-colonial feminism it was anticipated that the narratives of women would be predominant, but the nuances of the data demonstrate that midwives who care for this population in the NHS system also face relatively hidden inequity which has a detrimental effect on the care provided to women; therefore, the subsequent social action and recommendations must improve the welfare of both women and midwives. Healthcare research frequently places the burden for service improvement on women's own health behaviours but less often looks at the impact of the wider healthcare systems and policies that clinicians and women must navigate (O'Mahony and Donnelly, 2010).

The demographics of the participants demonstrate that the midwives, service provision and women themselves are naturally heterogenous in England. The sample is representative of the diversity of women accessing care, different models of service provision and inconsistent roles of midwives who are assessing and supporting women's mood in the perinatal period. Recognising this diversity at the outset has formed an early project recommendation that a 'one size fits all' approach to developing services will not benefit women or midwives and would risk taking a reductionist view of the issues discussed below.

The impact of language barriers on women's *physical* health is clear to see within research, with women who don't speak English being disproportionately represented in UK morbidity and mortality statistics (Knight et al., 2018). In comparison there is relatively little written on the impact of language barriers on refugee and asylum seeking women's ability to have their *mental* health needs assessed and supported. If black and Asian women are 2-4 times more likely to have their physical health issues missed by service providers, it seems highly likely that their mental health needs will also remain invisible, and research literature discussed at the beginning of this report supports this hypothesis (Knight et al., 2020, Gagnon et al., 2013).

This project reported that midwives found using interpreters complex, mostly for practical reasons such as time and accessibility, but also because there was an emotional aspect of supporting interpreters too. Women in this project felt that they were frequently not offered an interpreter or that midwives were gatekeepers to the service. Although women in this project were mostly able to navigate conversations about physical health, they were often did not have the language ability to discuss the nuances of their mood. A recent small UK study by Bridle et al (2021) confirms that midwives report their reluctance to use professional interpreter services due to a lack of resources and accessibility, acknowledging that this results in inequitable services for women with additional language needs. Other research acknowledges the complex relationship between clinicians, interpreters and refugee and asylum seeking women when discussing perinatal depression, reporting that accuracy can often be lost in translation due to differences in cultural meanings and vocabulary and with women sometimes hesitant to trust interpreters from their own

community (Stapleton et al., 2013). It is clear that the provision of interpreters and the way that midwives work with interpreters requires further training and service development.

The National Maternity Review set the target of all women being able to access continuity of carer (CoC) by 2020-21, recommending that those with complex social needs receive full individual case-loading rather team-based continuity (NHS England, 2016, NHS England, 2017). The findings of this project demonstrate that 3 out of 11 specialist midwives (around a quarter) were not able to caseload and that they had to adapt their practices, diluting the care that they were able to give women. Providing CoC is known to improve outcomes, especially women with social risk factors but it is not a panacea for addressing all health inequalities (Rayment-Jones et al., 2020). Building trusting relationships with women is important, but so is providing a wider infrastructure which provides midwives and multi-disciplinary teams with the skills, training and resources to assess and support women's symptoms of depression.

All midwife and women participants in this project noted the impact of time restraints on their ability to have discussions around mood and mental wellbeing. This is a system level issue and is of concern because the number of midwives in the UK workforce continues to decline (NHS Digital, 2021). An RCOG report recognises that understaffed services affect the time that clinicians have to assess women's mental health and also expresses that women need additional time to disclose their mental health needs and receive individualised care from midwives (Russell et al., 2017). Women and midwives need longer appointments to be able to discuss mental health, but both navigate a system where this is currently not possible or not supported by management structures in individual Trusts.

An issue highlighted in the findings of this project is that women are often seen as one dimensional migrants, with service providers not acknowledging the intersectionality of being a woman, forced migrant, pregnant/ new parent and potentially having symptoms of perinatal depression which need further assessment and treatment. Marginalised women falling through gaps in service provision is not a new concept. A report in 2014 noted that migrant women in the UK are a super-diverse population and that there is insufficient service provision to address both practical and cultural barriers to accessing mental health

care (Latif, 2014). There is no evidence that this has yet been effectively addressed and the conscious or subconscious colonial arrogance of services must be acknowledged if inequalities for forced migrant women and their perinatal mental health are going to be authentically addressed. The findings of this project demonstrate that midwives absorb the burden of finding service provision for relatively invisible women. Future service development, if it is to address the colonial inequalities described by women and midwives, must take time to gain the perspectives of what women define as the important issues in their mental health and build formal support structures which are culturally relevant, culturally congruent and accessible (Donnelly et al., 2011). The findings of this project support other research which reports that marginalised women experience unequal shares of the distribution of formal healthcare resources (O'Mahony et al., 2013).

Midwives discuss the emotional labour of hearing narratives that have influenced women's perinatal mental health and they describe working in systems where they feel that both midwives and women are invisible. Only a minority of midwives had good support structures in place which included regular debriefing/ supervision, something which is seen in other careers such as social work and counselling, with those employers recognising the emotional trauma that their employees may experience. There is no consistent or significant recognition that midwives may also be affected in the same way in UK maternity services. Neither NICE (2010) or RCOG (2011) good practice guidance demonstrate any significant recognition of the trauma that women may have experienced or the importance of trauma-informed care. Trauma informed workforces and organisations recognise the impact of trauma on service users and staff, ensuring that it is integrated into policies and practices (Law et al., 2021). Trauma informed care means providing psychological safety for staff as well as women and requires change in culture and practice at individual and system level. It recognises that staff may experience burnout and vicarious trauma and recommends the implementation of training for staff in addition to regular supervision or debriefing. The data in this project supports that guidance should be developed to equip midwives with the tools needed to effectively trauma-informed in their role. This should include more formal support mechanisms for midwives who frequently work with women exposed to trauma, such protected time to access structured supervision or debriefing sessions.

Midwives in this project voiced their frustration at the lack of national guidance and the impact that this had on local guidelines. As already discussed, guidance for the effective care of refugee and asylum seeking women's mental health is mimimal, with NICE suggesting that there is not enough reliable evidence to base service recommendations upon (NICE, 2010, NICE, 2014). Yet in other maternity guidance where there is a lack of conclusive research evidence, expert opinion is used to inform practice guidelines. Refugee and asylum seeking women are a minority within a minority population of migrant women and research project sizes are unlikely to meet those favoured by clinical guideline authors. They are also unlikely to be quantitative in design, which is the positivist methodology preferred by guideline authors.

Training issues were cited by all midwives in this study and are also highlighted by a number of women. There is no national role descriptor for a specialist midwife, which would describe the skill-set needed, but also the minimum level of training, therefore it is difficult for managers to know exactly what training would benefit their staff. Conversely, this also relieves any burden on managers to commit to a minimum level of training and this needs to be addressed. In this data, a lack of direction meant that midwives were tasked with finding their own development opportunities which they accessed mostly in their own time. Future service development must include better access to relevant training for midwives who assess and care for forced migrant women's mental health and it may be valuable to consider a formal job description for specialist midwives which documents the minimum level of training which they should have access to. Good practice guidance suggests that services and training tools are co-produced by women with experience of trauma, to ensure that resources are relevant (Law et al., 2021). This would be an appropriate consideration for midwives who assess and support refugee and asylum seeking women at risk of perinatal depression in England's maternity services.

Conclusion

This study considers how services can be improved so that midwives can better recognise and support refugee and asylum seeking women to discuss perinatal mental health and

symptoms of depression. It highlights systemic inequities for both midwives and women, at a national level with the absence of clear guidance and policy, but crucially, at a local and individual level where many midwives feel unsupported in their role of discussing perinatal depression with women. Managing language barriers, formally acknowledging the emotional labour of caring for this population, improving communication about perinatal mental health with women and developing infrastructures, guidance and training are all important considerations for developing more effective maternity services.

This project suggests that a 'one size fits all' approach to the issues would not adequately support the diversity of women, midwives and the systems that they navigate. It acknowledges that changes and improvement at a national level will be slow to implement and the key recommendation of this report is that incremental change is developed at a ground level with midwives, so that services and care can be improved in local services.

Recommendations

- At a policy level: Clinical guidelines need to be updated to acknowledge the complexities of discussing perinatal mental health and symptoms of depression with women who do not speak English as their primary language and secondly, the impact of potential trauma on the perinatal mental health of women with a complex social history, such as those from a forced migrant background.

- At a service provider level: Updating of clinical guidance and change in NHS systems evolves slowly but it is not acceptable to wait for more effective clinical guidance before implementing change to services, particularly when research continues to demonstrate health inequalities for women.

- At a local level: Incremental change implemented at a local level may have more rapid benefit for both women and midwives. This needs to be evaluated and published more widely so that the body of supporting evidence of how to effectively care for women is developed and acknowledged.

- At a clinician level: The key recommendation of this report is that midwives are empowered to develop their own practise and local services alongside the minimal national guidance which exists. It recommends that midwives (as experts by experience) are supported to develop a national network for midwives who care for refugee and asylum seeking women, facilitating them to share examples of good practice, provide peer support, share resources, collaborative training opportunities and guidance which may be used to influence services within different care models and geographical locations.

- At a service user level: The network should be co-designed to ensure that it maintains relevance to women accessing maternity care. Any service development must encompass listening to women about the services that are relevant to them and their needs.

- Finally, although this project focusses on improving recognition and support for perinatal depression, it also acknowledges the importance of physical health and safety in women's narratives in this project. Therefore, the network, although considering perinatal mental health as a priority, should seek to improve the holistic health of refugee and asylum seeking women and midwives who care for them.

Limitations

This is a small scale project researching a relatively invisible population of refugee and asylum seeking women and the midwives who care them in England. It includes narratives from a very heterogenous population. Some midwives worked in very well-developed services in areas with large numbers of forced migrant women, other midwives worked more rurally caring for smaller numbers of women. Some researchers may deem the diversity of the sample a limitation, but it was important to the author to ensure that the diversity of women's and midwives' voices were amplified, as this is representative of being

a midwife or forced migrant woman in England. In that respect, the heterogeneity of the sample is celebrated as authentic rather than a limitation of the data.

Interviews with women were undertaken during the Covid-19 pandemic and this influenced women's ability to complete interviews due to prolonged national lockdowns. For that reason, online interviews from women in the North of England made up the majority of the sample. Some women moved areas during their pregnancy and also changed migration status, demonstrating that the demographics of the population are not static. If the research was repeated in a non-pandemic environment, face to face interviews or focus groups would have been preferable.

The midwives and women's narratives are entirely separate and describe different experiences of the service as a whole in the UK. Future research may choose to focus on particular service models/ geographical areas by interviewing women and midwives so that specific services could be evaluated.

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