Introduction

There is copious evidence regarding the experiences of asylum-seeking women accessing maternity care in the UK (McKnight et al 2019, Briscoe and Lavender 2009, Feldman 2013, Lephard and Haith-Cooper 2016, Phillimore et al 2010) but less evidence regarding the experiences of midwives themselves. This systematic review aims to consider the experiences of midwives providing care to asylum-seeking women, in order to reflect upon why outcomes are poor and how care can be improved.

In the year ending September 2020 the UK received 31,752 asylum applications (Home Office 2020). Compared to other European countries this is a relatively small amount, however the UK media and political discourse often present the volume of asylum-seekers as a 'crisis' or 'threat' (Hill 2022) which can negatively alter the public perception of this demographic.

Midwives are in many ways, practicing in a time of 'crisis' themselves. For every 30 newly qualified midwives, 29 are leaving (Royal College of Midwives (RCM) 2018), management systems are reported to be bullying and hierarchical (Royal College of Obstetricians and Gynaecologists (RCOG) 2018), midwives are burnt out and unsatisfied with the quality of care they are able to deliver (RCM 2021). With a welcome interest in policy development to reduce maternal inequalities in outcomes (RCOG Race Equality Taskforce, RCM Race Matters Campaign), this systematic review adds an insight into the practical and emotional challenges midwives are facing when caring for this demographic.

Background

Asylum seeking women in the UK

Asylum-seekers often describe feeling that they occupy liminal spaces, in between being fully 'here' having recently left 'there' (Pangas et al 2018). Current legislation perpetuates an economic, social and cultural marginalisation of asylum-seekers (Balaam et al 2016).

In a maternity setting, women experience multiple barriers to care where translation services are poorly utilised (Haith-Cooper and McCarthy 2015, Frank et al 2021) and often face dispersal mid-pregnancy (McKnight et al 2019, Puthussery 2016). The literature highlights how asylum-seeking women are already psychologically vulnerable often due to history of sexual violence or post-traumatic stress disorder (Phillimore 2015, Feldman 2013). The dispersal system arguably exploits this psychological vulnerability even further.

Some literature reports that midwives are perceived positively by women seeking asylum (McLeish 2005, McKnight et al 2019, Frank et al 2021). Conversely, some womens' experiences were of stereotyping, hostility, explicit racial abuse and indifference (Asif et al 2015, McKnight et al 2019, Balaam et al 2016, Phillimore 2015).

Dehumanisation of black women's bodies

It is important to recognise the intersectional discrimination asylum-seeking women's racialisation will exacerbate. The top countries of nationality for asylum applications in the UK are Iran, Albania, Iraq and Eritrea (UNHCR 2020). The ethnic groups most highly represented in these countries are Persian, Azerbaijani, Albanian, Arab, Tigrinya and Tigre. Some of these ethnic identities would be classified by many in the UK as 'BAME'.

In the UK being BAME is an additional risk factor for poor outcomes in pregnancy including maternal and neonatal death (Knight et al 2019). Of the 217 women who died between 2016-18 from causes associated with their pregnancy, 5 were asylum-seekers or refugees

(ibid.). This equates to 2.3%. In the UK, asylum-seekers and refugees make up only 0.26% of the population (UNHCR 2020). Therefore it is clear that asylum-seeking women are at a higher risk of maternal death than women who hold UK citizenship.

The historical treatment of Black women contextualises what is a legacy of inequality and exploitation, particularly in regards to obstetrics and gynaecology (Horn 2020, Owens and Fett 2019). Our history of racial relations influences how we engage with care today. The colonial concept that Black people do not feel pain (Owens and Fett 2019) may subconsciously impact how a midwife assesses pain in a woman from a diverse ethnic background. Following the 2020 BLM movement the conversation about inequalities in maternal mortality for systematic racist reasons are arguably only now occurring in a meaningful way.

Methods

Search terms:

I mainly used the University of East Anglia online library database for my electronic search. Further articles were sourced via JSTOR, Scopus and Google for unpublished studies. The search terms used were, “Asylum-seekers OR refugees AND midwives experiences OR attitudes OR feelings AND UK or United Kingdom”.

Exclusion criteria:

All studies were screened for exclusion. Any articles which were not discussing a research project (descriptive, informational articles) and papers not explicitly focused on asylum-seekers or healthcare professionals perspectives in providing maternity care.

Selection of literature:

The Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) flow diagram was used to structure the process of literature screening and the Critical Appraisal Skills Programme (CASP) qualitative article checklist was used to assess the quality of articles included in the review. Both tools have their limitations, however as a novice qualitative researcher I felt comfortable using both tools to assist me in quality appraisal.

Thematic Analysis:

All eight studies were analysed for thematic similarities. Common attitudinal and practical themes were grouped into three sections: Structural difficulties, Systematic problems, and Racism and Resentment. These were then considered alongside the outcomes which arose as a direct consequence of midwives perceptions: lack of holistic insight and perceiving the asylum-seeker as a passive recipient of care.

Quality Appraisal

The CASP checklist highlighted that literature in this area is low-quality. However, by synthesising all available data on this topic some important themes were identified.

Setting:

Two papers are not set in the UK, one in Ireland (7) and one in Switzerland (3). Although this review is focused on the experiences of NHS staff in the UK, these papers have been included due to their specific study design which so accurately fits the inclusion criteria. Due to a general lack of data these papers were deemed valuable.

Relationship between researcher and participant

The racial dynamics and consequential relationships between researcher and participant were often not considered (2, 3, 4, 5, 6, 7, 8). Some papers reference the racial identity of the participants, but none reference the racial identity of the researcher. Where a white midwife is being interviewed by a BAME professional on issues surrounding asylum-seeking women, she may not be as forthcoming regarding her true experiences for fear of being judged as racist. However, a white midwife being interviewed by a white researcher may have been more inclined to use language referencing ‘us’ and ‘them’ which may have led to interesting analysis.

Dynamics within a focus group

Studies which utilised focus group discussions did not consider the interpersonal dynamics between participants. The papers under-appreciated how focus groups themselves constitute a unique social context (Kitzinger 1994). Of studies which used focus groups of midwives (2, 8) no consideration is given to the seniority amongst midwives in the group and how this may direct the discussion. This could lead to reticence to share and self-censoring (Carey and Asbury 2012, Bloor et al 2001).

Participant demographics:

5 papers were focused exclusively on the experiences of health professionals (1, 4, 5, 6, 7) and 3 also considered broader debates regarding the experiences of asylum-seeking women themselves (2, 3, 8). Papers including analysis on asylum-seekers had a different conceptual focus to investigating more on the holistic experience of the asylum-seeking woman, than that of the health professional.

The number of health professionals interviewed in each study varied greatly. Most studies (3, 4, 5, 6, 7) interviewed between 10-11 health professionals. In one study (2) it is

unknown how many were interviewed and where focus groups were used it is also not clear (2, 8). The study with the largest population analysed survey responses from 213 midwives (1). There is a total of approximately 303 midwives and student midwives views represented by this systematic review.

Results and discussion

I have structured the analysis of results into three sections. By categorising the thematic narratives from the studies in this way I can analyse the results alongside the current realities of working in the NHS. The four sections are 1) Racism and Resentment 2) Structural difficulties and 3) Systematic failings.

1) Racism and Resentment

Resentment

> *the combined impact of ignorance, fear and increased workload sometimes resulted in frustration and resentment"* (7:164).

Some midwives reported feeling, *"concern and frustration in trying to do 'the right' thing for women"* (1:19). As a consequence, frustration then led to resentment being projected on to the individual,

> *"the women often perceived the frustration and resentment … this compromised the midwife s ability to develop a relationship with them"* (7:165).

Some midwives were described by researchers as having a "*frank expression of hostility*" (8:23), here mirroring current UK Home Office policy. Student midwives also showed explicit resentment towards this demographic and were quoted saying:

> "*we re only a small island, so there s got to be rules and there s got to be cut offs as to who can come … there isn t an infinite amount of housing for everybody to go round*" (5:1010).

The UK media commonly presents an image of the country as a container, fit to burst with the pressure of housing asylum-seeking families (Pruitt 2019) and this is reflected here. These are clear examples of how attitudes can be shaped by emotive media discourse and political policy.

Dishonesty

Asylum-seekers were perceived as liars, "(asylum-seeking women) *made up a reason so that they can stay in this country because there are you know, more employment prospects*" (5:1010). The women were also perceived to be "*not truthful about their age*" (8:24).

Women were not believed when they said they were unable to understand English, "*they claim they do not speak English*" with some midwives trying to prove their dishonesty, *"I test them by saying something inflammatory just to see if they understand"* (8:27).

Midwives did not always treat asylum-seeking women with compassion, and there was a lack of patience for asylum-seeking women who did not understand the system:

"I d say well do you not realise the importance of antenatal care, I would be the same, I would get a bit annoyed, but I would be the same if there was an Irish woman, you know, because like you just don t know, if they re high risk and they are HIV positive … and I suppose I m being a little bit racist or whatever" (7:164).

The asylum-seeker as criminal

It is also suggested that media discourse which conflates asylum-seekers with criminal activity (O'Regan and Riordan 2018, Tong and Zuo 2019) may have influenced the opinions of midwives.

Throughout the interviews with midwives, they often associated asylum-seekers with criminal behaviour: *she was from Zimbabwe or one of those places … obviously here illegally … it creates more work"* (8:22). The paper on student midwives highlighted the same issue, "*go to court…question illegal immigrants and asylum seekers. And there's a judge there and they have a barrister … put the case against them"* (5:1011).

Media discourse is capable of effectively shaping the views of a society (Machin and Myr 2012; O'Regan and Riordan 2018). Individuals within the systematic review may have adopted these ideological beliefs in order to satisfy their psychological needs: in the justification of inequality, conservative beliefs and avoidance of change (Van de Vyver et al 2016).

Stereotyping and racism

The healthcare system does not give adequate consideration to the historical context within which care is provided. It can be emotionally jarring to consider the UK'scolonial and

racial past, but it is pertinent to understanding the discrimination women from minority ethnic groups face.

The Needs Assessment Report (8) was focused on a maternity unit very close to Heathrow airport. The researcher reported a noticeable tension with, "*the issue of people's immigration status and the need to work with them regardless"* (8:29) which was compounded with broad assumptions regarding individuals rights to be in the UK - "*we get all these illegals from Heathrow"* (8:22). This highlights the troubling notion of current 'citizen-on-citizen' immigration checks as enforced by Immigration Acts of 2014 and 2016, with midwives now having to explicitly ask women about their immigration status. This midwife's need to "*work with them regardless"* (8:29) indicates that she may feel unwilling to care for someone with unstable immigration status. This highlights some troubling preconceptions this midwife may hold regarding who is, or is not deserving of NHS care. Hence it is clear that asylum-seeking women on the receiving end of this 'caring relationship' could face multiple disadvantage in regards to relational care.

Stereotypes perpetuate all of our actions, judgements and behaviour even if we do not consciously agree with them (Christian 2019). Individuals who are sensitive to differences in status between groups may try to sustain positive in-group identity. Out-group members (those who are different) may pose a threat to this position of power, be it a cultural or economic threat (Abrams 2010). Some scholars consider that people who have a high need for 'closure' - i.e to reach decisions quickly and finally without ambiguity are more likely to show prejudice towards out-groups.

Time pressure and noisy environments, such as that on a maternity ward, increase this need for 'closure' (Good and Kruglanski 1995, Kruglanski 2006). When individuals are

stressed they are more likely to rely upon subconscious beliefs than their conscious minds when making decisions. Therefore it is plausible that the intense pressures on midwives could lead to an exacerbation of subconscious discriminatory attitudes.

The formation of stereotypes

It is critical to consider how stereotypes are created. Midwives are subject to the same media and political news discourse as anyone else. Media discourse often utilises collective pronouns such as 'us' and 'them' - fuelling the public perception of asylum-seekers as 'other' and 'underserving' (Kirkwood et al 2013). An example of the medias alienation of asylum-seeking populations is the use of water-based metaphors. Describing the *"first wave"* (Drury 2015) of people, a *"flood"* (Brown 2015) or *"surge"* (Drury 2016) of migrants. This encourages the reader to see asylum-seekers not as people, but as objects of force which discourages empathy and understanding towards them (Pruitt 2019).

Amongst academic papers, statements such as: "*the child in utero of an immigrant is a future UK citizen and optimising maternity care is a dimension of securing the future health of the nation"* (Higginbottom et al 2019:20) perpetuate this idea that care is only important and valid when it is given to one of 'us'. The woman is not given any value in this statement, and a justification to provide care is for the good of a future member of 'us' - the fetus. These perceptions of asylum-seeking individuals as 'other' will undoubtedly impact how professionals care for these women, even at a very subconscious level.

The UK's political stance towards asylum-seekers can directly impact peoples perceptions. The Home Office is currently enforcing a 'hostile environment' policy to discourage people from entering the UK, to prevent people overstaying and to stop irregular migrants from accessing the essentials of an ordinary life (Yeo 2018). Where midwives in the NHS are

unhappy and are looking for someone to ‘blame’ for their poor pay, being overworked and generally despondent - it is understandable that they may align their beliefs with that of the UK popular press. Even more so, when political parties falsely claim that addressing immigration issues would secure millions of pounds worth more funding for the NHS (Reid 2019).

2) Structural difficulties

The systematic review illustrates how midwives as carers themselves are under resourced, under-staffed and face increasing pressures at work (1, 4, 7, 8). This negatively impacted on their ability to provide adequate care.

Translation services

The language barrier was commented upon in the majority of papers as a significant barrier to providing adequate care (1, 2, 3, 4, 7, 8). However, on deeper analysis it was not the actual language barrier which was the problem, rather the ability to utilise translation services. The impact of the language barrier on the professional was given great emphasis with midwives expressing *“frustration at the increased time and perceived extra workload this caused them”* (7:162).

Using an interpreter was often a last resort:

> *we look to see whether there is anyone who works in the hospital who knows this particular language”* (3:6)

the interpreting policy is to try and find a member of staff first, this may not be just within maternity services…it could be anyone, someone from the lab for example” (8:26)

“Due to amounts of applications now informed not to book interpreters, too costly for GPs” (1:18)

A reluctance to utilise translation services for asylum-seeking women within maternity services is a very common finding and not isolated to this systematic review (Higgenbottom et al 2020, Feldman 2014, Haith-Cooper and McCarthy 2015, McKnight et al 2019, Fair et al 2020, Asif et al 2015). This is an example of the multiple marginalisations which face women seeking asylum. Interestingly, there is little academic literature regarding the structural reasons that translation services are under-utilised.

The NHS is facing financial difficulty and translation services are costly for local Clinical Commissioning Groups (Robertson et al 2017). In 2012 a Freedom of Information request by 2020 Health described the amount of money spent on translation services as *“truly staggering"* (2020 Health:1) and that “*urgent action must be taken by trusts to stem the flow of translation costs”* (2020 Health:10). The water metaphor used by the media is echoed here in public policy, implying that the system is almost uncontrollably haemorrhaging money on services for those unable to speak English.

Hospitals are under fiscal pressure to limit and carefully prioritise spending on all aspects of care. This instills an attitude of frugality on staff to play their part in saving the NHS money. In reflection upon who decides where money is spent within the NHS, and why translation services are so underfunded - it is critical to reflect on the racial profiles of

those in positions of power. BAME populations are grossly underrepresented in managerial positions within the NHS (NHS England 2020). These populations are more likely to have direct life experience with limited English fluency or to have family whose English fluency is limited (UK Census 2011).

Conversely, some managers without such lived-experience may have less empathetic attitudes. For example, there is a belief amongst some professionals that the ‘right’ to live in the UK is balanced against certain duties. Such as the ‘right’ to receive healthcare being balanced against the duty to learn English (Adams 2007). This perception is under appreciative of the gender dynamics, psychological and structural difficulties influencing individuals ability to learn English (Salvo 2017), as well the dramatic funding cuts for English teaching for asylum-seekers over the last 10 years (Refugee Action 2019). It is interesting to consider the potential implications of NHS managers being predominately white British and the resulting inequality of care provision in regards to budgeting for translation services.

Being overworked

This systematic review highlights that midwives are often overworked and that caring for asylum-seeking women takes up more of a clinicians time (1, 4, 6, 8). Midwives felt “*rushed*” and lacking *“time to deal with complex issues*”. The midwives appreciated the need for more time to “*enable a more thorough and satisfying consultation for woman and midwife”* (1:p17).

> *“(Asylum-seekers) Can double appt time with language problems, but no extra time allocated”* (1:18)

> "*You know that we are going to have to get interpreters and that's going to take a long time and because it does, it doubles the time that you spend with a woman, which I think puts stress on members of staff […] but you know it has to be done, that's the job"* (4:p4)

Midwives were not being given any additional time in order to adequately care for this demographic. This even extended to midwives avoiding seeming 'interested' in care for asylum-seeking populations in case they *"became known as the one who knows and ended up carrying the burden"* (8:p37).

Overall there were frequent mentions of midwives being overworked with "*escalating demand for services in excess of the ability for staff to keep pace"* (8:p20). Midwives were put off from asking about issues such as domestic violence because they would be expected to then "*have the time to listen"* and that they *"may have to do something"* (8:p25).

The findings of this review are supported by vast amounts of literature detailing the extreme pressures which face midwives (Pezaro et al 2016). Maternity services are described as "*running on goodwill"*, reliant on midwives working through their breaks and well beyond their hours to provide safe care for women (Leversidge 2016). Only 21% of midwives take their entitled breaks and 61% delay using the toilet at work because they don't have time (ibid.). The staffing pressures and workload demands facing midwives on a routine shift mean that the additional needs an asylum-seeking woman presents can tip the balance.

"Women who presented in labour or with complications and were not registered for care at the hospital were a particular source of concern and frustration" (7:164)

The social circumstances of asylum-seeking women added to the workload and created logistical problems within the maternity unit such as bed blocking, *"asylum seekers present a particular challenge because they have nowhere to live or clothes for the baby and they effectively block a bed which is costly and a poor use of services"* (8:21). Midwives were *Generally exhausted and frustrated with the role expanding into social care"* (1:18) and felt that this aspect of care was not their role.

The time to negotiate additional social care plans was not able to be a priority: *"A senior midwife explained that there just wasn't time to ring around the community when there were more pressing clinical issues that required attention"* (8:22).

Midwives psychosocial wellbeing is suffering (Pezaro et al 2016, Robertson et al 2017). Over one third of midwives have moderate or severe stress, anxiety and depression with personal and work related burnout out scores well above population norms (RCM 2016a).

"Every shift we are short staffed and therefore over worked, don't get breaks and leave late… .It is terrifying sometimes the pressure we have, the fear of litigation, the fear of something awful happening" (ibid:20)

"I don't remember the last time I had any energy and wasn't completely exhausted" (ibid:15)

Physical tiredness contributes to overwhelming levels of compassion fatigue where one is exposed to the suffering of others so much that they develop an inability to empathise or feel compassion for others (Reed 2021).

Burnout is defined as a syndrome of emotional exhaustion, depersonalisation and undermined personal achievement (Maslach and Jackson 1981). Depersonalisation is exhibited through callous attitudes towards clients. Midwives can engender feelings of emotional detachment from women, increases in cynicism and as a result, patient care suffers (Kiman et al 2020).

This emotional detachment and cynicism can be seen in the interviews with midwives included in this systematic review. To conclude that midwives can simply be racist and unkind is reductionist of the broader picture within which a midwife is trying to provide care. Where a midwife is trying to keep all her patients alive on a short staffed unit with little resources - it is easy to see how standards of care can slip. The psychological need to make decisions quickly means midwives may be more likely to rely upon unconscious bias' when making decisions. In addition, patients who do not pose a threat of litigation, such as asylum-seekers, may become less of a priority.

Midwives are known to suffer in silence whilst working in cultures which prioritise outcomes and self-sacrifice above self care (Deery and Kirkham 2006), however clinical outcomes show that poor staff wellbeing can directly relate to poor quality services (Francis Report 2013). For a midwife to adequately support vulnerable women, they themselves are in need of care, *"Midwives are entitled to a psychologically safe professional journey, and caring for them is not an optional issue, it is an ethical one"*

(Pezaro et al 2016:64). Unfortunately this continues to not be made a priority within maternity services (RCM 2016a).

3) Systematic failings

Lack of knowledge

Many midwives lacked knowledge and understanding of how the asylum system worked, were confused by issues of asylum and lacked confidence providing care for these women (3, 4, 5, 6, 7). This review highlights a significant lack of education and training for midwives in caring for asylum-seekers and the related care pathways.

Student midwives had very little knowledge of entitlement to services and were shocked when they learnt how little it was: *How are they supposed to support them, family and a child with that amount of money?"* (5:1011). In addition there was a certain apathetic attitude surrounding knowledge of culture in that it was assumed a midwife could never fully understand all cultural backgrounds with the expectation that one 'learns on the job': "*you can t know the cultures of everybody. She s arrived from Sudan, could be somebody from somewhere completely different. You learn as you go along I think"* (5:1011).

Many midwives, "*expressed need for the wider multi-disciplinary team to have access to training*" (4:5). There was broad uncertainty regarding the asylum trajectory with *people brought in by immigration services from the airport … dismissed as health tourists"* (8:22). A lack of ability to differentiate between immigration categories was not uncommon (5, 6, 8) with multiple examples in the literature of midwives lacking awareness of the reasons for asylum - *"what are they doing here?"* (7:165).

A lack of knowledge led to a lack of confidence amongst midwives: *I am quite overwhelmed at times as to how complex these ladies lives are and how much input they need, and how many different organisations are needed to meet their various needs"* (4:p5). This lack of training and the lack of institutional support contributed to *"varying feelings of powerlessness on the part of the midwives themselves*" (7:165) and relates back to the theme of midwives feeling exploited and overwhelmed. This was exacerbated by hospital trusts which were *"unsupportive and take*(*s) the view of 'just get in and do the job'"* (1:17).

Structurally this is a failing of the education system within which midwives are trained, but also within the mandatory updates midwives receive. Where issues of asylum-seeking and immigration are not valued enough to be within mandatory updates, it is no surprise midwives lack knowledge and understanding. This in turn means asylum-seeking women may face even more disadvantage when they are cared for by professionals with limited knowledge regarding their needs.

The stress of caring

Some health professionals were quite overwhelmed by the complex issues facing asylum-seeking women, *"many were unprepared for the impact that working with traumatised women would have on them*" (7:165). In some regards, this had a positive impact. It increased empathy and compassion for the women and "*helped midwives to see the women as real people with real lives, and as women just like them"* (7:165).

However, for some midwives the emotional challenges were difficult, "*the midwives did not have anywhere to take their pain"* (7:165). This is not an isolated issue to the care of asylum-seeking women. Midwives often suffer vicarious trauma as a result of their

experiences at work and do not have the necessary support systems to debrief and manage these emotional difficulties (RCM 2016). There is a systematic lack of emotional support for health professionals caring for vulnerable women. As a consequence midwives may avoid discussing difficult issues with women who have experienced trauma.

Conclusion

This systematic review has explored health professionals perceptions and experiences providing maternity care for asylum-seeking women. 8 papers were systematically reviewed and the results thematically analysed into three key groups. This systematic review is the only piece of work addressing this issue.

Although the papers reviewed are generally of limited quality, there are some key messages which can be taken from the findings.

- Midwives lack the time to care appropriately for asylum-seeking women.
- A lack of time and resources may negatively impact upon midwives attitudes towards asylum-seeking women.
- Stereotypical perceptions are held by every individual. In order to be truly self-reflective of our own personal bias, individuals need time and support to critically appraise their own bias.

There is significantly more research to be done in this area. As part of the welcome shift towards a maternity service that is more culturally aware, we must reflect upon the racial and political context within which care is provided.

To conclude, maternity services in the UK are not designed and arranged to provide adequate care for asylum-seeking women. Asylum-seeking women face greater disparities in maternity outcomes. Midwives are grossly overworked and hence unable to provide an adequate standard of care for this demographic. For the system to improve, midwives need to be allocated more time to care for asylum-seeking women, but crucially also so that they can truly reflect upon their own personal bias.

References

Abrams, D., 2010. Processes of prejudice: Theory, evidence and intervention. *Equality and Human Rights Commission.*[Online]. https://www.equalityhumanrights.com/sites/default/files/research-report-56-processes-of-prejudice-theory-evidence-and-intervention.pdf. [accessed 27th July 2021].

Asif, S., Baugh, A., Jones, N., 2015. The obstetric care of asylum seekers and refugee women in the UK., *The Obstetrician and Gynaecologist.* 17, (4). pp. 223-231.

Balaam, M., Kingdon, C., Thomson, G., Finlayson, K., Downe, S., 2016. 'We make them feel special': The experiences of voluntary sector workers supporting asylum seeking and refugee women during pregnancy and early motherhood. *Midwifery*. 34. pp. 133-140.

Bloor, M., Frankland, J., Thomas, M., Robson, K., 2001. Focus Groups in Social Research. Sage: *London.*

Brown, L., 2015. BACK DOOR TO BRITAIN. *The Daily Mail.* 23rd August.

Briscoe, L., Lavender, T., 2009. Exploring maternity care for asylum seekers and refugees. *British Journal of Midwifery.* 17, (1). pp. 17-23.

Carey, M., Asbury, J., 2012. Focus Group Research. Left Coast Press: *Walnut Creek, CA.*

Deery, R., Kirkham, M., 2006. Supporting midwives to support women. In: Page L, McCandish R, editors. The new midwifery: science and sensitivity in practice. London: Churchill-Livingston.

Drury, I., The Daily Mail. Refugees given asylum in UK up 27% in year. 2/21/2016.

Drury, I., The Daily Mail. First of 20,000 Syrian refugees arrive in UK. 9/23/2015.

Fair, F., Raben, L., Watson, H., Vivilaki, V., van den Muijsenbergh, M., Soltani, H., The ORAMMA team. 2020. Migrant women's experiences of pregnancy, childbirth and maternity care in European countries. A systematic review. *PLoS ONE.* 15, (2). pp.1-26.

Feldman, R., 2013. When maternity doesn't matter - dispersing pregnant asylum seekers. Maternity Action. [Online]. Available at: https://www.maternityaction.org.uk/wp-content/uploads/2013/09/When_Maternity_Doesn_t_Matter_-_Ref_Council__Maternity_Action_report_Feb2013.pdf. Last accessed 27th April 2021.

Feldman, R., 2016. *The impact of dispersal on pregnant women seeking asylum. Poster for European Union Public Health Association conference on migration.* [Online]. Available at: https://www.maternityaction.org.uk/wp-content/uploads/EUPHA-A4-colour.pdf. Last accessed 18th August 2021.

Francis, R. Report of the mid Staffordshire NHS Foundation Trust public inquiry executive summary. London: The Stationery Office; 2013.

Frank, G., Fox, D., Njue, C., Dawson, A., 2021. The maternity experiences of women seeking asylum in high-income countries: a meta-ethnography. *Women and Birth.* 30390, (20). pp.1-8.

Haith-Cooper, M., Bradshaw, G., 2013. Meeting the health and social care needs fo pregnant asylum seekers; midwifery students' perspectives Part 3; "The Pregnant woman within the global context": an inclusive model for midwifery education to address the needs of asylum-seeking women in the UK. *Nurse Education Today*. 33, (9). pp.1045-1050.

Haith-Cooper, M., Bradshaw, G., 2013. Meeting the health and social needs of pregnant asylum seekers, midwifery students' perspectives Part 1; dominant discourses and midwifery students. *Nurse Education Today*. 33, (9). pp.1008-1013.

Haith-Cooper, M., McCarthy, R., 2015. Striving for excellence in maternity care: The Maternity Stream of the City of Sanctuary. *British Journal of Midwifery*. 23, (9). pp.648-652

Higginbottom, G., Evans, C., Morgan, M., Bharj, K., Eldridge, J., Hussain, B. 2019. Experience of and access to maternity care in the UK by immigrant women: a narrative synthesis systematic review. *British Medical Journal Open.* 9, (12). pp.1-23.

Hill, P., The Mirror. Fury over Home Office job advert that calls migrants a 'threat' amid refugee crisis.16/01/2022.

Home Office. 2020. National Statistics. How many people do we grant asylum or protection to? [Online]. Available at: https://www.gov.uk/government/statistics/immigration-statistics-year-ending-june-2020/how-many-people-do-we-grant-asylum-or-protection-to#asylum-applications. Last accessed 27th April 2021.

Horn, A. 2020. Racism matters: 'When people show you who they are, believe them': why Black women mistrust maternity services. *The Practicing Midwife.* 23, (8). (No page number).

Kirkwood, S., Mckinlay, A., Mcvittie, C., 2013. The Mutually Constitutive Relationship between Place and Identity: The Role of Place-Identity in Discourse on Asylum Seekers and Refugees. *Journal of Community and Applied Social Psychology.* 23, (6). pp.453-465.

Kitzinger, J., 1994. The methodology of focus groups: the importance fo interaction between research participants. *Sociology of Health and Illness.* 16, (1). pp.103-121.

Knight, M., Kenyon, S., Brocklehurst, P., Neilson, J., Shakespeare, J., Kurinczuk, J., 2014. Saving Lives, Improving Motehrs' Care - Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-2012. [Online]. Available at: https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/Saving%20Lives%20Improving%20Mothers%20Care%20report%202014%20Full.pdf. Last accessed 24th March 2021.

Machin, D., Mayr. A., 2012. How to Do Critical Discourse Analysis: A Multimodal Introduction. Chapter 4 Representing People: Language and Identity.

Maslach, C., Jackson, S., 1981. The measurement of experienced burnout. *Journal of Occupational Behaviour.* 2, (2)., pp.99–113.

McKnight, P., Goodwin., L., Kenyon, S. 2019. A systematic review of asylum-seeking women's views and experiences of UK maternity care. *Midwifery*. 77, (No issue number). pp.16-23.

NHS England. 2020. *Achieving equitable maternity outcomes.* Available: https://www.england.nhs.uk/mat-transformation/achieving-equitable-maternity-outcomes/. Last accessed 24th March 2021.

O'Regan, V., Riordan, E., 2018. Comparing the representation of refugees, asylum seekers and migrants in the Irish and UK press. *Journal of Language and Politics.* 17, (6). pp. 744-768.

Owens, D., Fett,S., 2019. Black Maternal and Infant Health: Historical Legacies of Slavery. *American Journal of Public Health.* 109, (10). pp.1342-1345.

Pangas, J., Ogunsiji, O., Emir, R., Raman, S., Liamputtong, P., Burns, E., Dahlen, D., Schmied, V., 2018. Refugee women's experiences negotiating motherhood and maternity care in a new country: A meta-ethnographic review. *International Journal of Nursing Studies.* 90. pp.31-45.

Pezaro, S., Clyne, W., Turner, A., Fulton, E., Gerada, C., 2016. 'Midwives Overboard!' Inside their hearts are breaking, their makeup may be flaking but their smile stays on. *Women and Birth*. 29, (3). pp.59-66.

Pruitt, L., 2019. Closed due to 'flooding'? UK media representations of refugees and migrants in 2015-2016 - creating a crisis of borders. *The British Journal of Politics and International Relations*. 21, (2). pp.383-402.

Puthussery, S., 2016. Perinatal outcomes among migrant mothers in the United Kingdom: Is it a matter of biology, behaviour, policy, social determinants or access to health care? *Best Practice and Research Clinical Obstetrics and Gynaecology.* 32. pp.39-49.

Puthussery, S., Twamley, K., Harding, S., Mirsky, J., Baron, M., Macfarlane, A., 2008. 'They're more like ordinary stroppy British women': attitudes and expectations of maternity care professionals to UK-born ethnic minority women. *Journal of Health Services Research and Policy*. 13, (4). pp.195-201.

Reed, A., 2021. Amity Reed reviews the media response to Ockenden's 'emerging findings' report. *Midwifery Matters.* 168, (45). pp.45.

Reid, A., 2019. Buses and Breaking Point: Freedom of Expression and the 'Brexit' Campaign. *Ethical Theory and Moral Practice*. 22, (3). pp.623-637.

Refugee Action., 2019. New research shows refugees suffering from lack of english classes, despite strong public support for action by government. *Refugee Action*. [Online]. Available at: https://www.refugee-action.org.uk/new-research-shows-refugees-suffering-from-lack-of-english-classes-despite-strong-public-support-for-action-by-government/. Last accessed 18th August 2021.

Robertson, R., Wenzel, L., Thompson, J., Charles, A., 2017. Understanding NHS financial pressures. *The King's Fun*d. [Online]. Available at https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Understanding%20NHS%20financial%20pressures%20-%20full%20report.pdf. Last accessed 20th May 2021.

Royal College of Obstetricians and Gynaecologists., 2018. Training Data Analysis. [Online]. Available at: https://www.rcog.org.uk/en/careers-training/about-specialty-training-in-og/assessment-and-progression-through-training/training-data-analysis-2018/. Last accessed 30th January 2022.

Royal College of Obstetricians and Gynaecologists. 2020. *RCOG Position Statement on Racial disparities in women's healthcare.* [Online]. Available at: https://www.rcog.org.uk/globalassets/documents/news/position-statements/racial-disparities-womens-healthcare-march-2020.pdf. Last accessed 18th August 2021.

Royal College of Obstetricians and Gynaecologists. 2020. RCOG and Five X More launch joint campaign to tackle racial disparities in maternity care. Available at:https://www.rcog.org.uk/en/news/rcog-and-five-x-more-launch-joint-campaign-to-tackle-racial-disparities-in-maternity-care/. Last accessed 24th March 2021.

Royal College of Midwives 2016a. Work, Health and Emotional Lives of Midwives in the United Kingdom. The UK WHELM study. [Online]. Available at:https://www.rcm.org.uk/media/2924/work-health-and-emotional-lives-of-midwives-in-the-united-kingdom-the-uk-whelm-study.pdf. Last accessed 15th May 2021.

Royal College of Midwives. 2016b. RCM campaign for healthy workplaces delivery high quality care. [Online]. Available at: https://www.rcm.org.uk/media/2898/rcm-campaign-for-healthy-workplaces-delivering-high-quality-care-caring-for-you-survey-results.pdf. Last accessed 14th July 2021.

Royal College of Midwives. 2018. State of Maternity Services Report - England. Online. Available at: https://www.rcm.org.uk/media/2373/state-of-maternity-services-report-2018-england.pdf. Last accessed 30th January 2022.

Royal College of Midwives. 2020a. Fears for maternity as staffing shortages hit safety and moral says RCM. [Online]. Available at: https://www.rcm.org.uk/media-releases/2020/november/fears-for-maternity-as-staffing-shortages-hit-safety-and-morale-says-rcm/. Last accessed 14th July 2021.

Royal College of Midwives. 2020b. *Race matters.* [Online]. Available at: https://www.rcm.org.uk/media/4128/race-matters-a-statement-by-the-rcm.pdf. Last accessed 18th August 2021.

Royal College of Midwives., 2021. RCM warns of midwives mass exodus as maternity staffing crisis grows. [Online]. Available at:https://www.rcm.org.uk/media-releases/2021/september/rcm-warns-of-midwife-exodus-as-maternity-staffing-crisis-grows/. Last accessed 30th January 2022.

Salvo, T., 2017. "If I speak English, what am I? I am full man, me": Emotional impact and barriers for refugees and asylum seekers learning English. *Transcultural Psychiatry.* 54, (5-6). pp.733-755.

Tong, J., Zuo, L., 2019. Othering the European Union through constructing moral panics over 'im/migrant(s)' in the coverage of migration in three British newspapers, 2011-2016. *The International Communication Gazette.* 81, (5). pp.445-469.

UNHCR., 2020. Asylum in the UK. [Online]. Available at: https://www.unhcr.org/uk/asylum-in-the-uk.html. Last accessed 25th June 2021.

UK Census data from 2011. *English language skills.* [Online]. Available at: https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/demographics/english-language-skills/latest#by-ethnicity. Last accessed 14th June 2021.

UK Home Office. 2020., Asylum and resettlement summary tables, year ending September 2020. [Online]. Available at: https://www.gov.uk/government/statistical-data-sets/immigration-statistics-data-tables-year-ending-september-2020#asylum-and-resettlement. Last accessed 14th July 2021.

Yeo, C., 2018., Briefing: what is the hostile environment, where does it come from, who does it affect? *Free movement.* [Online]. Available at: https://www.freemovement.org.uk/briefing-what-is-the-hostile-environment-where-does-it-come-from-who-does-it-affect/. Last accessed 15th May 2021.