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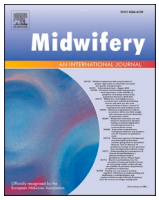

The experiences of pregnancy and NHS maternity care for women who have been trafficked: A qualitative study

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ABSTRACT

Problem: Little is known about the maternity experiences of women who have been trafficked and further investigation is needed to better inform midwifery practice and to ensure that the voices of women are heard when developing guidance.
Background: People who have been trafficked experience a range of health problems that could impact on pregnancy.
Aim: The aim of this study was to explore the experiences of pregnancy and NHS maternity care for women who have been trafficked, as well as increasing understanding of social and health factors that may impact on pregnancy outcomes.
Methods: A qualitative interview study was conducted. Participants (professionals and service users) were recruited using purposive sampling. Data were analysed using thematic analysis.
Findings: Seventeen interviews were conducted (5 service users and 12 professionals). Five themes were identified: 'One Size Fits All', 'Loss of Control', 'Social Complexity', 'Bridging Gaps', and 'Emotional Load'.
Discussion: Our findings identify that women are expected to fit into a standardised model of maternity care that does not always recognise their complex individual physical, emotional or social needs, or provide them with control. Support workers play a vital role in helping women navigate and make sense of their maternity care.
Conclusion: Despite the issues identified, our research highlighted the positive impact of individualised care, particularly when women received continuity of care. A joined-up, trauma-informed approach between midwives and support workers could help improve care for women who have been trafficked.

Introduction

Human trafficking is defined as the recruitment and transfer of people through force or deception, with the aim of exploiting them for profit (UNODC, 2004). Women and girls represent 65 % of all trafficking victims globally (Bahous, 2022), and research suggests that at least 25 % of trafficked women in the UK are pregnant, many as a direct result of rape whilst in the trafficking situation (Bick et al., 2017; ATMG, 2016; Hestia, 2018). The available evidence suggests that women who have been trafficked experience a range of health problems that could impact upon pregnancy, including neurological problems, sexually transmitted infections, weight loss, drug and alcohol use, experiences of violence and mental health problems (Oram et al., 2016; Lederer and Wetzel, 2014; Collins and Skarparis, 2020). Many of these issues are associated with experiences of rape and sexual violence and are likely to be compounded by long periods of transit and poor access to health care (Westwood et al., 2016). Women who experience pregnancy whilst trafficked in the UK do so in the context of a *Hostile Environment,* encouraged by UK government policy since 2012 (Griffiths and Yeo, 2021). This has been further and more recently reinforced with the Nationality and Borders Act (2022) and Illegal Migration Act (2023); both of which have been criticised for failing to protect the rights and welfare of those seeking asylum in the UK (United Nations, 2023).

A recent scoping review concluded that there is very limited peer-reviewed research examining maternity care and pregnancy experiences of women who have been trafficked, and that further research is needed to better inform midwifery practice and to ensure that women's voices are heard when developing guidance (Collins and Skarparis, 2020). This study therefore aimed to generate insight into the experiences of pregnancy and NHS maternity care for women who have been

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trafficked and increase understanding of social and health factors that may impact on pregnancy outcomes.

Participants, ethics and methods

This paper presents findings from a qualitative interview study theoretically informed by social constructivism. It explores the experiences of pregnancy and NHS maternity care for women who have been trafficked. In-depth, semi-structured interviews were conducted with women (service-users) who experienced pregnancy whilst in the trafficking situation and with professionals with expertise in supporting women through the perinatal period. A purposive sampling strategy was used to identify information-rich participants who could provide a detailed understanding of the phenomena under investigation. (Further details of participant characteristics, inclusion and exclusion criteria shown in Table 2, Recruitment and Sampling Strategy shown in Fig. 1). Ethical approval was obtained (*details removed for submission)*.

In-depth, semi-structured interviews were conducted, using a topic guide developed after a thorough review of the literature and discussion with key workers in the field. Open-ended questions were used covering topics regarding access to care, experiences of care, feelings about the pregnancy, health and social considerations. Probes and prompts for each topic question were used to ensure rich descriptions (Saunders et al., 2018).

Interviews were conducted virtually by the first author ($n = 17$) using Microsoft Teams* and digitally audio-recorded. (*Interviews were

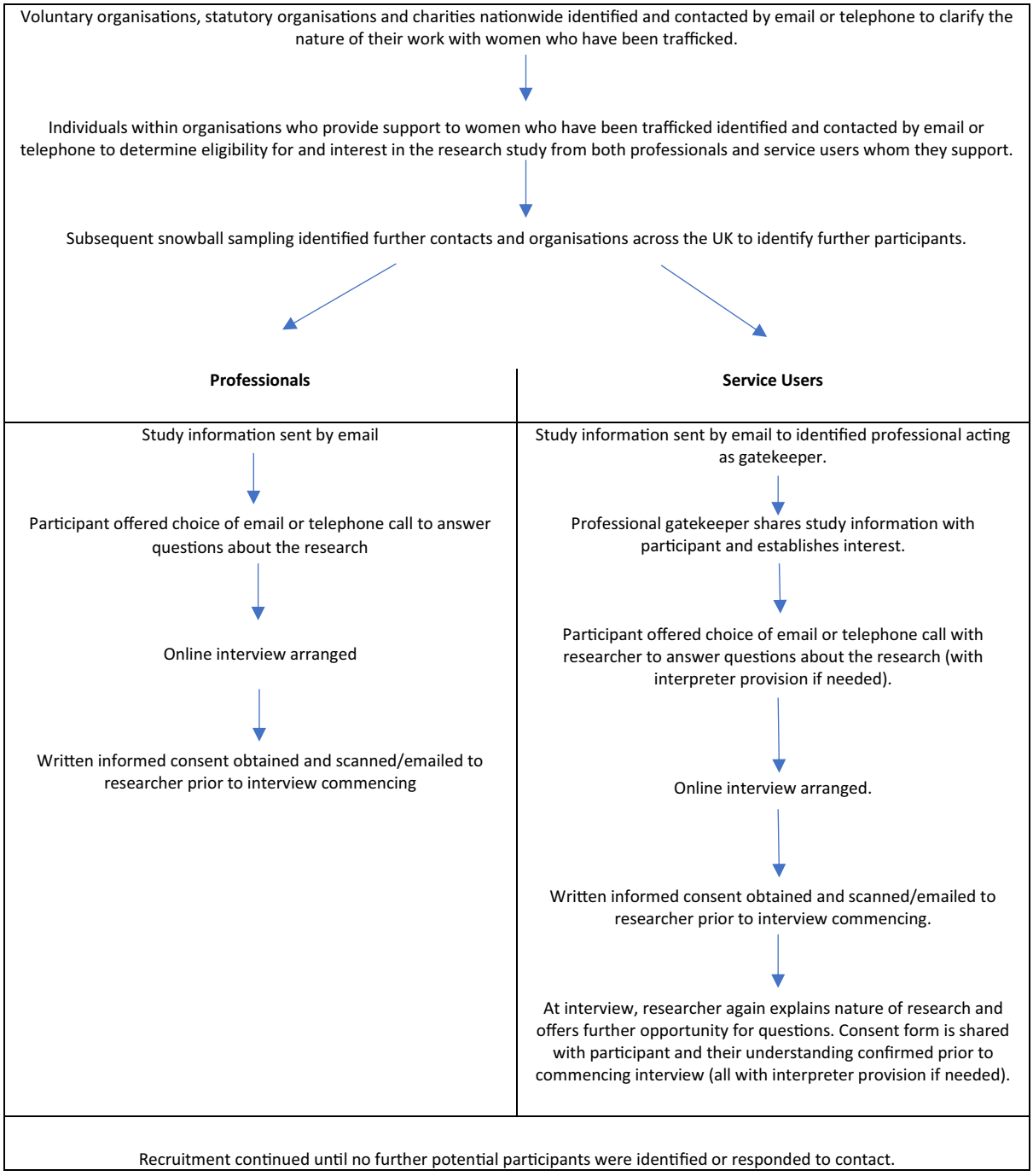

Fig. 1. Sampling and recruitment strategy.

originally planned to be face-to-face but were changed to virtual in light of the Covid pandemic and restrictions on face-to-face contact). Interviews took place between July 2020 and April 2021. During and immediately after each interview, notes and reflections were recorded.

Braun and Clarke's (2019,2021,2022a), six step reflexive thematic analysis approach was used to analyse the data. This method provided a suitable structure to explore and interpret the data with patterns of meaning being identified from the dataset. It was recognised that the authors' experience would influence both questions asked and interpretation of data and therefore researcher reflexivity was important and aided by a reflective journal throughout. As the first author is a white, professional woman – an academic, but also a midwife, this may have affected the perceptions, and potentially the responses, of the participants, particularly if they viewed the first author as an authority figure. Having awareness of this was vital, and as recommended by Bourdieu (1993), although this 'social distance' cannot be removed altogether, the tone and content of questions in the interview were used to demonstrate empathy and legitimate all responses of participants (Bourdieu, 1993: p265).

Both authors used reflexivity to increase validity and transparency of the analysis. As health care professionals whose clinical and academic focus has been in supporting vulnerable groups of women, both authors took care not to influence or pre-judge responses.

After familiarisation with the data, an inductive approach was taken to code interviews. Initial codes were discussed, and the lead author performed an iterative approach to analysis using an agreed structure – however this did not limit the development of new codes. Analysis moved from initial topic summaries towards the generation of themes as interpretive stories (Braun and Clarke, 2022b). Patterns of meaning were discussed, and themes generated, reviewed and refined after discussions between authors.

This study used the Consolidated Criteria for Reporting Qualitative Research checklist to report methods, data analysis and results.

(Table 1: Statement of Significance)

Results

Seventeen interviews were conducted with five service users and 12 professionals. The professionals included seven support workers; one individual who worked in women's advocacy; four doulas and one midwife.

Five themes were identified from the data: 'One Size Fits All', 'Loss of Control', 'Social Complexity', 'Bridging Gaps', and 'Emotional Load'.

One Size Fits All

Interviews with women and support workers described maternity care experiences where women's individual circumstances were not considered, and they were expected to fit into a fixed maternity service structure, without recognition of their often-complex needs:

> "they just treat them as any other mum and baby when they're really not any other mum and baby… they are tremendous people who are unfortunately deeply traumatised and it's horrible…." (P08)

> "there needs to be flexibility to provide the care that these women actually need and that trying to force them into a standard box just isn't going to work… that equality and equity are different and that for somebody with this number of issues, they're going to need more input to achieve the same baseline." (P12)

An example of this includes difficulties in retention of information, and that this was not reflected in their information-giving:

> "A traumatised person might not retain the same level of information as you and I, who are able to cope with the general stresses of life. But they have come out of a situation where they have been trafficked, abused and harmed.. and then the expectation is that they will function like general normal human beings that do not have all of these vulnerabilities and traumas…" (P08)

Routine and repeated questions that were part of standard processes were described as problematic for women who have been trafficked. Questions regarding paternity of the baby, or the woman's background for example, caused unnecessary anxiety:

> "when they asked that… "Where is the baby's dad?" That was the most bad thing that I can be at that moment because I think, when you go into hospital, they already got everything off me. You know, they got who I am and everything. There is a time when they were asking "where do you live?" Or "what date you came to England… You know, asking for my life in a time when I don't think it's the moment…" (SU01)

> "it's just being really mindful of, you know, those general questions… that they're not invasive… there's a lot of the time that we go to the GP and they'll say "oh [name], that's a lovely name… And where are you from? Albania? Oh I'd love to go to Albania, what's it like..? And 'not great, because we were trafficked in Albania' and her family's under threat… those things are really triggering.." (P06)

Several professionals described difficulties caused when maternity staff asked repeated or intrusive questions when taking a history, without reading notes first:

> "most of them are suffering post-traumatic stress. It brings back flashbacks all the time. And all this is in the notes… Now they should have sat there and read their notes, they should know that going back through the terrible things that have happened to them… is going to bring back memories…" (P04)

A repeated example of providing 'One Size Fits All' care was in relation to interpreters. Every participant described problems with interpreter use and availability:

> "they should have provided an interpreter, but they didn't and they were still trying to explain to me, knowing the fact that I can't speak English and I felt really bad because I would just nod or try my hardest to just understand. But I couldn't… I didn't understand." (SU02)

> "the receptionist will be like 'how come you haven't brought your translator?' There's this thing about 'your translator', who carries a translator around, it's very odd, erm some appointments are being done by Google translate, which is very dangerous." (P11)

Table 1
Statement of significance.

Problem
Women who have been trafficked in the UK commonly come into contact with maternity services. Little is known about their experiences.
What is Already Known
People who have been trafficked experience health and social problems that could impact upon pregnancy.
What this Paper Adds
Women who have been trafficked experience emotional and social concerns that may impact on their pregnancy; and their complex needs are not always recognised by a standardised model of maternity care that does not prioritise communication and control for women. Greater collaboration with trafficking support services could enhance women's experiences of care.

Table 2
Inclusion and exclusion criteria.

Service Users	
Inclusion Criteria	Justification / Further information
Participant is willing and able to give freely informed consent for participation in the study.	Participant happy to take part, has read and understands the information about the research study.
Aged 18 years and above.	Ethical approval given for adults only to participate in the research.
Have been trafficked into forced sex work or other forms of forced labour and been identified as a victim of trafficking by statutory or voluntary agencies, using operationalised criteria.	Participant recognises themselves as someone who has experienced trafficking, and this has also been recognised by the agency providing them with support, whether that be a statutory or voluntary organisation. The UN definition of human trafficking (UNODC, 2022) is difficult to operationalise for research purposes, due to ambiguity in how key concepts should be understood (eg. exploitation, consent and coercion). This could impact on deciding who should or should not be included in the research. In this study, initial assessments of whether or not people have been trafficked was made by statutory and/or voluntary agencies (eg. post-trafficking support agencies, social workers, police and immigration officials).
Have either previously received or be currently receiving assistance and/or support from one or more statutory or voluntary agencies (eg. post-trafficking support providers, social workers, and police and immigration officials).	In order to protect participants, it is important that they are already in receipt of support whilst participating in the research. This is in line with the WHO guidance for interviewing trafficked women that was followed when conducting this research (WHO, 2003).
Have been trafficked internally (ie. domestically) or internationally.	No restrictions were placed on the geographical nature of the trafficking experienced, in order to avoid excluding participants with valuable experiences to share.
Have experienced a pregnancy or birth whilst in the trafficking situation.	In order to ensure broadly comparable experiences, participants experienced a pregnancy or birth whilst in the trafficking situation, rather than at a later date.
If participant, does not speak English, must be willing to conduct interview through interpreter.	No participant excluded due to language difficulties. Only recommended, female interpreters used by statutory and voluntary support agency currently supporting the participant were used, in order to ensure they were familiar and skilled at interpreting for individuals who have experienced trauma. Interpreters joined online interview in person and were briefed beforehand on the study aims and ethical obligations such as confidentiality and participants' right to refuse to answer questions. Decision around need for an interpreter initially taken by professional 'gatekeeper'. Need for interpreter further assessed at interview and interview stopped and rearranged with an interpreter if researcher felt level of English was not sufficient to proceed.
Exclusion criteria	**Justification**
Currently in the trafficking situation – ie. if they are in the setting in which they are being exploited for forced sex work or other forms of forced labour.	As recommended by WHO guidance for interviewing trafficked women (2003), conducting interviews in the settings in which people are currently being exploited may pose serious risks to both participants and researcher.
Considered by their support worker or the researcher to be too unwell or distressed to participate in the study.	As recommended by WHO guidance for interviewing trafficked women (2003), participants could easily be traumatised by answering questions related to the trafficking experiences, and so only those women deemed mentally and emotionally able to participate by those who know and support them, were approached to participate in the research.
Unable to give informed consent to participate in the study.	Any lack of understanding about the nature of the research would mean truly informed consent could not be taken.
Professionals	
Inclusion Criteria	**Justification / Further Information**
Participant is willing and able to give freely informed consent for participation in the study.	Participant happy to take part, has read and understands the information about the research study.
Aged 18 years and above.	Ethical approval given for adults only to participate in the research.
Self-disclosure of relevant experience: have supported trafficked women through the perinatal period.	Professional participants could include support workers, case workers, midwives, doulas, workers from women's advocacy organisations. The nature of trafficking support in the UK is varied and diverse according to area and so it was important not to exclude people with relevant experience who worked for different types of organisation. Therefore, all participants were included on the basis of personal experience. They were asked if they had experience of supporting trafficked women through the perinatal period and as such, can be considered experts in these experiences.
Exclusion Criteria	**Justification / Further Information**
Unable to give informed consent to participate in the study.	Any lack of understanding about the nature of the research would mean truly informed consent could not be taken.

Some exceptions to the 'One Size Fits All' theme include positive experiences linked to the provision of more individualised care within a continuity model:

> " I think having the same midwife in the community I think was really nice for them because, erm, especially the lady who had suddenly lots of professionals working with her, at least she had the same midwife." (P02)

Specialised services or midwifery models that were set up specifically to cater for the needs of asylum seekers or people who had been trafficked were described more positively than standard NHS services:

> "those GP surgeries, especially for asylum seekers and refugees, they know how to handle a situation like that." (P04)

Loss of control

Interview data reveals examples of women lacking control over their lives, bodies or social circumstances. Within the maternity care system, this included denial of choice. A woman who had booked late (due to the trafficking situation) was told without discussion that she needed to be induced because she hadn't had early scans and didn't know her dates. Another example was given of a woman who was denied the request to have no male practitioners or students be involved in her care:

> "the midwife's response to that was… 'this is a teaching hospital, you will have to have students'." (P09)

Participants described a maternity care system that left women feeling overwhelmed and out of control:

"I don't know whether the actual environment, the space, the way it's clinical… what they wire you up to, what they're putting inside of you, like all of those things… I found that even if the services were trying to be gentle, erm, there's a lot of unknown and that's quite overwhelming." (P07)

Some participants described feeling rushed:

"kind of… "Let's hurry up; let's get this out of the way" in a way. So that's how I felt. Like just a number." (SU02)

Vaginal examinations (VEs) were discussed in relation to a loss of control. Professionals described a lack of trauma-informed care around VEs which could lead to re-traumatisation and flashbacks for women:

"She was in such a state; she was locking herself in the bathroom; she was pulling out drips and things like that… And what they didn't realise and what they didn't understand is: every time they went to see whether she was two centimetres or three centimetres… she thought that was the traffickers." (P04)

"I've seen examples of them not asking, not even asking…" (P11)

Women described feeling out of control and fearful during labour:

"I felt so lonely and so petrified. I didn't know what to expect… throughout the labour, I panicked a bit and I kept holding my friend's hand saying 'I think I'm going to die…It was a petrifying experience' (SU02)

"… it was too many things in my brain, so I thought: hold on now. I don't understand nothing what is going on." (SU04)

A lack of control was also described in relation to the asylum system, including access to food, living conditions and dispersal across the UK which disrupted care and support networks:

"Because sometimes we didn't have fruit for three or four days at all…. You're not allowed to eat as much as you want; it's just two slices of bread for the day and then the lunch and the dinner" (SU04)

"at any time, they can just move the women into different areas, into different houses, so there's lots of disruption there as well, of women getting settled and understanding her area and then being moved for sometimes no particular reasons, just to like the other side of the country." (P06)

Social complexity

Women's social circumstances were described as challenging and complex. This related to trafficking experiences, loneliness, accommodation, food, money, and the stress of navigating the asylum system.

Participants described violence and forced drug or alcohol use in the trafficking situation, leading some women to be dependent on substances:

"Enforced use of prescription drugs is a really common like, form of abuse against women." (P01)

"there's sometimes issues with the baby, which is down to the trafficking, especially if they've been beaten quite heavily or… they've got internal injuries as a result of kind of being abused by the traffickers." (P06).

Loneliness and isolation were mentioned in all interviews:

"if you are alone, it can feel difficult but if you stay somewhere where you are safe, you can feel good and have the baby. But you're still by yourself. You don't have no one to help you." (SU05)

"I didn't have no visitors for two weeks. All of this was really hard for my emotional feelings." (SU04)

Housing for women who had been trafficked was described as unsafe, small and overcrowded; unsuitable for pregnant women or those with babies:

"Really bad houses with damp, dead bugs, rats, erm… Just not adequate furniture.." (P06)

Hostel accommodation was described as particularly problematic – mixed-gender and large, with two to three women potentially housed in one room. In hostel accommodation, women are provided with three meals a day but not given any choice and the food was described as poor quality:

"the food that they get in the accommodation is absolutely diabolical, I mean it's so, it's so poor and they have no choice, and you know culturally it could be nothing like what they're used to, erm, so nutritionally I think health-wise they're definitely suffering." (P09)

Although one woman who lived in a safehouse described her money as adequate due to receiving clothes and food donations, several participants described financial difficulties that impacted their care, and for women not in receipt of support from the National Referral Mechanism* (NRM) (*a government framework for identifying and referring potential victims of modern slavery which aims to ensure they receive the appropriate support) poverty was described as a huge issue.

"While I was pregnant, I was receiving £40 per week, so it was quite difficult because I had to go to all of these appointments and I had to take the bus or the taxi sometimes.." (SU03)

Dealing with the asylum system added to the complexity and stress of women's lives:

"the Home Office will be sending them letters saying that their support has finished, or… their application for such and such has been denied; they haven't got their NRM, which is so vital for them… So the Home Office is just sending these things without any thought about how that pregnant woman is feeling or her mental health…" (P05)

One woman described how she needed more therapy after her interview with the Home Office:

"So I needed another two or three months with a therapist just to explain how I felt with this interview." (SU04)

Some professionals described how dealing with such multifaceted social issues meant that pregnancy was not prioritised by women:

"I think the pregnancy would be very low down on her priority list. And I've certainly seen this with other people that are struggling with these issues or asylum issues. The pregnancy is way down on their priority list." (P12)

Bridging gaps

Interview data suggests that support workers from trafficking support organisations help to bridge gaps that exist in standard maternity care, such as accessing care and appointments, fighting incorrect charges, interpreter provision, understanding the maternity system, and emotional support and reassurance.

Participants described support workers helping women to access the care they required, helping women to make appointments, and assisting with the logistics of getting to appointments or to the hospital:

"I was able to support them a lot, you know I could ring the GP for them, get them referred in. I could help in that I was there navigating them through it." (P02)

"showing them how to get to the GP, where the midwife was. Practically with maps showing the bus routes and things like that." (P02)

Some participants described spending large amounts of time supporting women to fight incorrect NHS charges:

"We've had quite a few issues with that, actually. Particularly around women being given these astronomical bills for giving birth when they're going through the asylum process and the NRM process, so they shouldn't be charged…" (P06)

Support workers helped women to better understand their care, through provision of interpreters or additional explanations:

"they'll say 'I've attended an appointment, but I don't understand what it was about… with their consent then I do a bit of phone calling…" (P09)

"My caseworker used to re-explain things that I may not have understood and I got support from this organisation." (SU03)

Support workers also provided emotional support and reassurance (particularly postnatally) that family or a midwife might provide to a woman in different circumstances:

"You know, all the time, going to staff 'my baby's got that; do you think that's a worry, or…' And the other times, if they see me sad and stuff, they say 'come and talk to us.'" (SU01)

Emotional load

Interview data revealed that women deal with a burden of emotions resulting from their background, trafficking experiences, and experiences of maternity care. One dominant emotion was fear, which for some, prevented them from accessing care in the first place. Many described living in a state of fear:

"Erm, I was frightened at all times… But prior to having the baby, it was like living with fear and having flashbacks of the past" (SU02)

Fear was described by professionals as impacting women's ability to communicate:

" when she got really fearful, she went mute and it was really like having to interpret what was going on in her eyes… " (P07)

"So you have a whole lot of people who become paranoid. People who are so just completely scarred; people who have PTSD, they can't even interact with particular individuals… You have individuals who are scared of men so much, such a distrust…"(P08)

Some women were fearful of the 'authority' of maternity care professionals:

"women feel very threatened by anybody in authority… whether it's a midwife, or someone from the Home Office, they all merge into the same figure of really in our society of somebody that can make decisions that affect you, for you, about you…" (P07)

Participants described feeling judged, and experiencing shame or discomfort during maternity care encounters:

"they would ask me my address, where am I staying? Then I would tell them that where I am staying.. And you could tell by their reaction, but I just didn't explain myself fully; why am I staying there; it's a safe house; you know… It's just a different reaction. Like, you could see their faces… I was [thinking] that if I have to come back and see this nurse again, they know where I live now and am I going to expect the same reaction? Would they judge me? Would they think I'm homeless? I've nowhere to live and I'm living in this safe house? So I would feel low. You know? I would feel like I don't belong anywhere." (SU02)

The emotional load included mental health concerns for women (including stress, anxiety, depression and PTSD). These were repeatedly mentioned in the data and related to the impact of the trauma of trafficking. It was described as rare for women not to be on anti-depressant medication.

"I think certainly mentally erm, that's where we see an awful lot more, so particularly around anxiety, erm and you know the impact that having been trafficked, the trauma has had on them mentally, erm, I think probably every single woman is suffering with that." (P09)

"They talk a lot about anxiety, they have a lot of anxiety… I mentioned the sleeplessness… Probably 90 % of them talk to us about their inability to sleep." (P11)

Increased anxiety around the pregnancy or the baby was noted from women and professionals:

"I was being all the time very anxious of that, because I don't know if I will be alive, both of us; I didn't know if the baby was okay.." (SU01)

One professional highlighted that women generally do not like to be labelled as having mental health problems as it is often used as a form of control during the trafficking situation:

"Especially when there's a transnational dimension, the abuser will often be grooming the family – you know, telling the family "oh you know, she's not well; her mental health's not right" etc., which is part of the process of control. So women will be very fearful about being seen to have mental health issues, while of course, the trauma has brought on a lot of mental health issues in relation to depression, anxiety and stuff like that.." (P01)

It was noted that women's anxiety, trauma and stress could present as physical symptoms:

"they've got headaches, they've got stomach aches and some of it may be down to pregnancy but I think a lot of it is down to stress and anxiety." (P03)

"they have pain. Everywhere. But that's emotional pain. So… And they don't understand why doctors can't cure their emotional pains." (P04)

However, data also revealed examples of kindness that eased women's emotional burden and gratitude that the care received was free:

"you get a lot of support here; that it's definitely not like Africa, where you get very little support and I would say that I'm very grateful for the support I received here." (SU03)

"It was amazing because back home, we pay for everything. Like even if you need a paracetamol, you have to pay… And to think that you can have that for free, it's really a relief from your mind." (SU04)

Moreover, the arrival of the baby was seen as a positive moment in women's lives:

"So I feel like this is when my baby was born, I was born a second time." (SU01)

"I felt like it was a really, really positive thing in their lives that really provided them with hope and meaning." (P02)

Discussion

Our research builds on that of Bick et al. (2017), highlighting some similar themes and providing greater insight into, and examples of, women's experiences. Like Bick et al. (2017), our findings suggest there was often limited continuity of care for women who have been

trafficked. Individualised care was not the norm (particularly within the hospital setting), and women are expected to fit into established systems without consideration of additional needs. Positive experiences were more likely to be expressed where relationships could be developed with midwives and other caregivers. This reinforces research findings about the value of continuity of care, particularly for women with social complexities (McRae et al., 2016; Rayment-Jones et al., 2020; Homer et al. 2017).

Mirroring the findings of research into asylum-seeking women, poor communication was highlighted (Beecher-Bryant, 2011; McKnight et al., 2019). Repeated, intrusive questions cause unnecessary anxiety and trauma for women. Women who have experienced trauma may find it more difficult to absorb and retain information (Smith et al., 2012), highlighting the importance of tailored information-giving. Problems described with interpreting services echoes previous research with asylum-seeking and refugee women (McKnight et al., 2019 Williamson et al., 2020), and does not follow NICE or NHS England guidance (NICE, 2010; NHSE, 2018). If women do not understand what professionals are saying to them, then it is impossible to provide safe, individualised care as recommended by Better Births (NHSE, 2016).

Our findings reveal that women who have been trafficked experience a lack of control over many aspects of their lives, mirroring a lack of control experienced during the trafficking situation. Conversely, control rests with the systems they are accessing, whether that be maternity care, housing or the asylum system. A lack of control over women's place of residence, living conditions or food amplifies the importance of having control over their bodies and maternity care decisions. However, our findings suggest that this is not the norm. A fundamental principle of the 'Better Births' report was the importance of enabling women to make choices about and be in control of their care (NHSE, 2016). Previous research suggests that socially disadvantaged women want to engage with their care, but do not feel safe to do so, instead feeling like an outsider to the maternity care culture and decision-making process, and delegating decision making to midwives (Ebert et al., 2014). Our findings would support this. A sense of control is particularly important during labour where women who have been trafficked and experienced sexual abuse can be re-traumatised by care in labour, particularly VEs (Hansard, 2020).

Our findings support those of the wider literature on asylum seeking women and social complexity, suggesting that women's vulnerability is compounded by complex life factors (Heys et al., 2021). Loneliness and isolation are commonplace (Hestia, 2018; McKnight et al., 2019), and many women have nobody to support them, answer their questions or reassure them about worries or fears. Isolation is compounded when women are moved to different areas as a result of dispersal. In addition to its social impact, dispersal risks interrupting care provision and could lead to unidentified risks because of a lack of co-ordinated care and follow-up (Feldman, 2014; Reynolds and White, 2010).

Our research supports previous findings around health issues for trafficked people (Oram et al., 2016), and additionally highlights factors that may increase risks for women and babies. Sleeplessness may impact on memory loss, mood and cognitive functioning (Ellis et al., 2023). Drug and alcohol use in pregnancy, and experiences of violence are associated with a range of potential complications including preterm birth, growth restriction, low birth weight, abruption, physical and cognitive impairments in the neonate, fetal alcohol syndrome, placental damage and genitourinary infections (Pinto et al., 2010; Easey et al., 2019; Hill et al., 2016).

Inappropriate accommodation, also highlighted in other studies (McKnight et al., 2019), may impact a woman's pregnancy experience or life with a new baby, due to shared rooms, a lack of privacy or sub-standard conditions. Women's nutritional health may be adversely affected by restricted or poor-quality food. A low body mass index and insufficient gestational weight gain are associated with poor perinatal outcomes, and poor maternal nutritional status is causally associated with both FGR and LBW (Marshall et al., 2022). Limited financial resources, highlighted in the wider literature on asylum-seeking women (McKnight et al., 2019), may mean that women cannot travel to all antenatal or postnatal appointments, and this may therefore impact their access to care.

Women with social risk factors and those with multiple disadvantage are over 50 % more likely to experience stillbirth or neonatal death, as well as an increased risk of premature birth and maternal death (Knight et al., 2023; Rayment-Jones et al., 2019). MBRRACE-UK state that "In considering how to act to improve outcomes, these complexities must be better recognised. Blunt or generalised responses to complex situations, such as using standard rules in place of proper resourcing to enable personalised care, may result in unintended consequences" (MBRRACE-UK, 2023, p4). Our findings suggest that unfortunately, blunt or generalised responses are what women who have been trafficked often experience.

Our research underlines the vital role played by support workers in the maternity care of women who have been trafficked, supporting the findings of Balaam et al. (2016). They provide emotional and practical support to women, helping them to navigate the maternity system, make sense of their care, and advocating to ensure women's voices were heard. In alignment with the objectives of the NHS Long Term Plan to provide genuinely integrated care outside of traditional boundaries, more joined-up care between midwives and support workers could help improve care for women who have been trafficked (NHSE, 2019).

The results from this study highlight that women who have been trafficked experience a range of emotional and mental health issues including fear, anxiety, distress, shame and stress. This emotional load may impact their behaviour, responses and needs. Women may initially view midwives as figures of authority rather than support, and therefore building trust with women, a key component of the midwife-mother relationship, is vital (Lundgren and Berg, 2007). Unmet information needs may cause fear and a perceived loss of control for women, which may affect their input into decision-making (Fenwick et al., 2015). Our findings suggest that women did not always understand the care they were receiving yet felt unable to question decisions, thereby adding to the emotional load they were experiencing.

Women's descriptions of the impact of basic kindness are notable, and maternity staff should demonstrate compassion, and avoid stereotyping and judgement in all interactions. This mirrors findings from other research that highlight the importance of kindness, respect and dignity from midwives when caring for mothers with multiple disadvantages (McLeish and Redshaw, 2019).

Recommendations are shown in Table 3.

Strengths and limitations

To our knowledge this is the first study to collect primary data to exclusively explore pregnancy and maternity experiences of women who have been trafficked in the UK. The inclusion of the professional voice adds a novel dimension to the understanding of women's experiences. The paper presents vital new knowledge that increases awareness for maternity practitioners.

One limitation is the experiences of women discussed in this paper only relate to those in receipt of support via the NRM. Ethical and safety concerns in accessing participants not in receipt of support, or in an active trafficking situation, mean that the findings presented here may not be representative of all trafficked women, many of whom will not receive the levels of support discussed in this paper. It is recognised that this is a hard-to-reach group and therefore the smaller proportion of service users interviewed (compared to professionals) may have influenced the findings of this research.

Conclusion

Women who have been trafficked are often expected to fit into a standardised model of maternity care that does not always recognise

Table 3
Recommendations for practice and research.

- Midwives should be aware that women who have been trafficked may find it difficult to absorb information and their communication should be tailored accordingly, demonstrating patience and giving time to women.
- Midwives should carefully read women's notes before asking any questions and consider whether all questions are necessary before asking.
- Trusts should ensure that high quality, reliable interpretation services are provided, and establish processes to ensure that every woman who needs an interpreter is provided with one at each appointment, and additional time is given to allow for interpretation.
- Trauma-informed care should be given greater focus within midwifery education, and its principles reinforced during regular mandatory training for midwives.
- Midwives caring for women in labour should endeavour to give women control over what happens to their bodies, keep them informed of what is happening at all times, and be aware that women referred to as 'difficult' or 'awkward' may well have experienced and be reacting to a previous trauma.
- Trusts should consider their provision of postnatal care and ensure that women's individual circumstances are considered when asking women to travel to postnatal appointments.
- There should be greater collaboration and joined-up working between midwives and statutory and voluntary sector agencies that provide support to women who have been trafficked.
- Trusts should consider the provision of care by midwifery teams with a specialised remit for women who have been trafficked.
- Further research should evaluate the impact of joined-up working between midwives and voluntary and third sector agencies that provide support to women who have been trafficked.

their complex individual physical, emotional or social needs, or provide them with control. Further collaboration with post-trafficking support agencies could help to ensure a trauma-informed approach that allows women to navigate and make sense of their maternity care.

CRediT authorship contribution statement

Catherine H Collins: Writing – review & editing, Writing – original draft, Methodology, Investigation, Formal analysis, Conceptualization. **Katy Skarparis:** Writing – review & editing.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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References

ATMG, 2016. *Time to deliver. Considering pregnancy and parenthood in the UK's response to human trafficking* Available at: atmg_time_to_deliver_report_for_web_final.pdf (antislavery.org) (accessed 07/03/23).

Bahous, S. 2022. *'Statement: crises drive an increase in human trafficking – here's how we stop it.'* UN Women. Available at: https://www.unwomen.org/en/news-stories/statement/2022/07/statement-crises-drive-an-increase-in-human-trafficking-heres-how-we-stop-it. Accessed 26/01/24.

Balaam, M.-C., Kingdon, C., Thompson, 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, 133–140.

Beecher Bryant, H., 2011. Improving Care for Refugees and Asylum Seekers. The Experience of Midwives. Maternity Action, London. *Available at:*. www.maternityaction.org.uk/sitebuildercontent/sitebuilderfiles/experiencesofmidwivesreport2011.pdf.

Bick, D., Howard, L., Oram, S., Zimmerman, C., 2017. Maternity care for trafficked women: survivor experiences and clinicians' perspectives in the United Kingdom's National Health Service. PLoS One 12 (11).

Bourdieu, P., 1993. Concluding remarks: for a sociogenic understanding of intellectual works. In: Calhoun, C., LiPuma, E., Postone, M. (Eds.), Bourdieu: Critical Perspectives. University of Chicago Press, Chicago.

Braun, V., Clarke, V., 2019. Reflecting on reflexive thematic analysis. Qual. Res. Sport Exerc. Health 11 (4), 589–597.

Braun, V., Clarke, V., 2021. One size fits all? What counts as quality practice in (reflexive) thematic analysis? Qual. Res. Psychol. 18 (3), 328–352.

Braun, V., Clarke, V., 2022a. Thematic Analysis: A Practical Guide. SAGE Publications Ltd, London.

Braun, V., Clarke, V., 2022b. Toward good practice in thematic analysis: avoiding common problems and be(com)ing a knowing researcher. Int. J. Transgend. Health 24 (1), 1–6.

Collins, C., Skarparis, K., 2020. The impact of human trafficking in relation to maternity care: a literature review. Midwifery 83, 102645.

Easey, K., Dyer, M., Timpson, N., Munafò, M., 2019. Prenatal alcohol exposure and offspring mental health: a systematic review. Drug Alcohol Depend. 197, 344–353.

Ebert, L., Bellchambers, H., Ferguson, A., Browne, J., 2014. Socially disadvantaged women's views of barriers to feeling safe to engage in decision-making in maternity care. Women Birth 27 (2), 132–137.

Ellis, J., Ferini-Strambi, L., García-Borreguero, D., Heidbreder, A., O'Regan, D., Parrino, L., Selsick, H., Penzel, T., 2023. Chronic insomnia disorder across Europe: expert opinion on challenges and opportunities to improve care. Healthcare 11, 716.

Feldman, R., 2014. When maternity doesn't matter: dispersing pregnant women seeking asylum. Br. J. Midwifery 22 (1), 23–28.

Fenwick, J., Toohill, J., Creedy, D.K., Smith, J., Gamble, J., 2015. Sources, responses and moderators of childbirth fear in Australian women: a qualitative investigation. Midwifery 31 (1), 239–246.

Griffiths, M., Yeo, C., 2021. The UK's hostile environment: deputising immigration control. Crit. Soc. Policy 41 (4), 521–544. https://doi.org/10.1177/0261018320980653.

Hansard, K., 2020. Supporting Survivors of Sexual Abuse Through Pregnancy and Childbirth. A Guide For Midwives. Doulas and other Healthcare Professionals, Singing Dragon, London.

Hestia, 2018. *Underground lives. Pregnancy & modern slavery* underground lives: modern slavery research report series (hestia.org) Accessed 07/03/23.

Heys, S., Downe, S., Thompson, G., 2021. *'I know my place'*; a meta-ethnographic synthesis of disadvantaged and vulnerable women's negative experiences of maternity care in high-income countries. Midwifery 103, 103123.

Hill, A., Pallitto, C., McCleary-Sills, J., Garcia-Moreno, C., 2016. A systematic review and meta-analysis of intimate partner violence during pregnancy and selected birth outcomes. Int. J. Gynecol. Obstet. 133 (3), 269–276.

Homer, C., Leap, N., Edwards, N., Sandall, J., 2017. Midwifery continuity of carer in an area of high socio-economic disadvantage in London: a retrospective analysis of Albany Midwifery Practice outcomes using routine data (1997–2009). Midwifery 48, 1–10.

Knight, M., Bunch, K., Felker, A., Patel, R., Kotnis, R., Kenyon, S., Kurinczuk, J. (Eds.), 2023. Saving Lives, Improving Mothers' Care Lessons Learned to Inform Maternity Care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2019-21. Available at: MBRRACE-UK_Maternal_Compiled_Report_2023.pdf (ox.ac.uk) Accessed 20/10/23.

Lederer, L., Wetzel, C., 2014. The health consequences of sex trafficking and their implications for identifying victims in healthcare facilities. Ann. Health Law 23, 61–228.

Lundgren, I., Berg, M., 2007. Central concepts in the midwife-woman relationship. Scand. J. Caring Sci. 21 (2), 220–228.

MBRRACE-UK (2023) MBRRACE-UK - saving lives, improving mothers' care 2023 - lay summary. Available at: MBRRACE-UK_Maternal_Report_2023_-_Lay_Summary.pdf (ox.ac.uk) Accessed 20/10/23.

Marshall, N.E., Abrams, B., Barbour, L.A., Catalano, P., Christian, P., Friedman, J.E., Hay Jr, W.W., Hernandez, T.L., Krebs, N.F., Oken, E., Purnell, J.Q., 2022. The importance of nutrition in pregnancy and lactation: lifelong consequences. Am. J. Obstet. Gynecol. 226 (5), 607–632.

McKnight, P., Goodwin, L., Kenyon, S., 2019. A Systematic review of asylum-seeking women's views and experiences of UK maternity care. Midwifery 77, 16–23.

McLeish, J., Redshaw, M., 2019. Maternity experiences of mothers with multiple disadvantages in England: a qualitative study. Women Birth 32 (2), 178–184.

McRae, D.N., MN, Stoll, K., Mayhew, M., Vedam, S., Mpofu, D., Janssen, P.A., 2016. Is model of care associated with infant birth outcomes among vulnerable women? A scoping review of midwifery-led versus physician-led care. SSM-Popul. Health 31 (2), 182–193.

NHS England (NHSE), 2016. *BETTER Births – improving outcomes of maternity services in England.* Available at: national-maternity-review-report.pdf (england.nhs.uk) (Accessed 26/04/23).

NHS England (NHSE), 2018. Guidance for commissioners: interpreting and translation services in primary care. Available at: guidance-for-commissioners-interpreting-and-translation-services-in-primary-care.pdf (england.nhs.uk) (Accessed 26/04/23).

NHS England (NHSE), 2019. *The NHS long term plan.* Available at: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf (Accessed 03/05/23).

NICE, 2010. Pregnancy and Complex Social Factors: a Model For Service Provision For Pregnant Women with Complex Social Factors. Clinical Guideline [CG110]. National Institute for Health and Care Excellence.
Oram, S., Abas, M., Bick, D., Boyle, D., French, R., Jakobowitz, S., Khondoker, M., Stanley, N., Trevillion, K., Howards, L., Zimmerman, C., 2016. Human trafficking and health: a survey of male and female survivors in England. Am. J. Public Health 106 (6), 1073–1078.
Pinto, S.M., Dodd, S., Walkinshaw, S.A., Siney, C., Kakkar, P., Mousa, H.A., 2010. Substance abuse during pregnancy: effect on pregnancy outcomes. Eur. J. Obstetr. Gynecol. Reproduct. Biol. 150 (2), 137–141.
Rayment-Jones, H., Harris, J., Harden, A., Khan, Z., Sandall, J., 2019. How do women with social risk factors experience United Kingdom maternity care? A realist synthesis. Birth 46 (3), 461–474.
Rayment-Jones, H., Silverio, S.A., Harris, J., Harden, A., Sandall, J., 2020. Project 20: midwives' insight into continuity of care models for women with social risk factors: what works, for whom, in what circumstances, and how. Midwifery 84, 102654.
Reynolds, B., White, J., 2010. Seeking asylum and motherhood: health and wellbeing needs. Commun. Practition 83 (3), 20–23.
Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., Burroughs, H., Jinks, C., 2018. Saturation in qualitative research: exploring its conceptualization and operationalization. Qual. Quant. 52, 1893–1907.
Smith, H.K., Manjaly, J.G., Yousri, T., Upadhyay, N., Taylor, H., Nicol, S.G., Livingstone, J.A., 2012. Informed consent in trauma: does written information improve patient recall of risks? A prospective randomised study. Injury 43 (9), 1534–1538.
United Nations, 2023. *'Migrants and refugees. Concerns over legislation.'* Available at: https://news.un.org/en/story/2023/07/1138812. Accessed 26/01/24.
United Nations Office on Drugs and Crime (UNODC), 2004. United Nations Conventions Against Transnational Organized Crime and the Protocols Thereto. United Nations, New York. Available at: UNITED NATIONS CONVENTION AGAINST TRANSNATIONAL ORGANIZED CRIME AND THE PROTOCOLS THERETO (unodc.org) (Accessed 26/01/24).
Westwood, J., Howard, L.M., Stanley, N., Zimmerman, C., Gerada, C., Oram, S., 2016. Access to, and experiences of, healthcare services by trafficked people: findings from a mixed-methods study in England. Br. J. Gen. Pract. 66 (652), e794–e801.
Williamson, V., Borschmann, R., Zimmerman, C., Howard, L.M., Stanley, N., Oram, S., 2020. Responding to the health needs of trafficked people: a qualitative study of professionals in England and Scotland. Health Soc. Care Commun. 28 (1), 173–181.