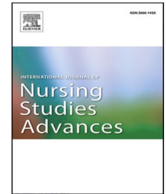
International Journal of Nursing Studies Advances 5 (2023) 100139

Contents lists available at ScienceDirect

International Journal of Nursing Studies Advances

journal homepage: www.sciencedirect.com/journal/international-journal-of-nursing-studies-advances



Care and support during maternity for mothers affected by modern slavery: A scoping review

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ARTICLE INFO

Keywords:
Maternity care
Modern slavery
Human trafficking
Survivor
Mothers
Healthcare professionals
Non-statutory services
Scoping review

ABSTRACT

Background: Modern slavery is a largely hidden crime disproportionately affecting women and girls, with 71% of the world's enslaved people being female and approximately one third estimated to be pregnant. Healthcare professionals experience difficulties in caring for mothers affected by modern slavery, including asking appropriate questions and initiating discussions, making safe referrals, being uncertain about entitlements, and facing obstacles in accessing language support and specialist mental health services. Despite the expectation of cohesive and consistent services, which avoid the recounting of experiences that may re-traumatise, interdisciplinary collaborations between maternity services and non-statutory agencies remain unclear.
Objective: To map the available evidence and resources on maternity care provision and non-statutory support to pregnant women and mothers affected by modern slavery.
Design: A scoping review was conducted following the JBI methodology for scoping reviews.
Methods: Five databases (Applied Social Sciences Index & Abstracts, Cumulated Index to Nursing and Allied Health Literature, Dissertations & Thesis A&I, Embase, Scopus) were searched. Inclusion criteria: English language; published between 2012 and May 2022; related to both maternity care provision and modern slavery; cross-sectional perspectives, including survivor mothers, healthcare professionals, midwives, and non-statutory service staff; any methodology. Exclusion criteria: general healthcare or not maternity related; opinion pieces, letters, book reviews, commentaries. Grey literature was searched using relevant websites reporting theses, blogs, policies, guidelines, and resources.
Results: Twelve articles reporting 11 studies and 29 grey literature reports were retained for the scoping review. Three key themes were identified from research studies: **a)** women's perspectives on barriers to access and engagement with maternity services; **b)** challenges and needs identified by healthcare professionals; and **c)** the impact of human trafficking on maternal and neonatal outcomes. The grey literature resources comprised mainly blogs, information sheets, leaflets or webpages, and research or consultation reports. Maternity was being experienced by survivor mothers with the following: unfamiliarity with and lack of access to systems and information across all sectors, barriers to care and entitlements, contemporary threats of violence from partners/traffickers, restricted ability to move freely, issues related to traumatisation, dispersal policies, and dealing with multiple new systems.

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https://doi.org/10.1016/j.ijnsa.2023.100139
Received 2 February 2023; Received in revised form 12 June 2023; Accepted 16 June 2023
Available online 29 June 2023
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Conclusions: Although several sources indicate principles that should be adopted, the detail of *how* optimal care and support during maternity should be provided by healthcare professionals and non-statutory service staff is lacking. Further research is required, from which recommendations for good maternity practice and the effective intersection between statutory and non-statutory services can be derived and subsequently mobilised across different systems and settings.

What is already known about the topic?

Modern slavery is a largely hidden crime disproportionately affecting women and girls, with 71% of the world's enslaved people being female and approximately one third estimated to be pregnant.

- Healthcare professionals experience difficulties in caring for mothers affected by modern slavery.
- Interdisciplinary collaborations between maternity services and non-statutory agencies are unclear.

What this paper adds

- Maternity was being experienced by survivor mothers with the following: unfamiliarity with and lack of access to systems and information across all sectors, barriers to care and entitlements, contemporary threats of violence from partners/traffickers, restricted ability to move freely, issues related to traumatisation, dispersal, and dealing with multiple new systems.
- Although several sources indicate principles that should be adopted, the detail of *how* optimal care and support during maternity should be provided by healthcare professionals and non-statutory service staff is lacking.
- Literature gaps have been identified, and further research is required from which recommendations for good maternity practice and effective intersection between statutory and non-statutory services can be derived and subsequently mobilised across different systems and settings.

1. Background

International law defines slavery as 'the status or condition of a person over whom any or all of the powers attaching to the right of ownership are exercised' (Office of the United Nations High Commissioner for Human Rights, 1926: 1). Modern slavery is a largely hidden crime that may take several forms, including human trafficking, sexual exploitation, forced labour, debt bondage, child slavery, forced and early marriage, and domestic servitude (Anti-Slavery, 2022). According to the latest Global Estimates of Modern Slavery report (International Labour Organization, 2022), 50 million people lived in modern slavery in 2021, with figures showing a significant rise of 10 million compared to 2016 global statistics (International Labour Organization, 2017). Women and girls remain disproportionately vulnerable, with an estimated 71% of the world's enslaved people being female (International Labour Organization, 2017; Such et al., 2020; Cameron et al., 2021) and approximately one third anticipated to be pregnant (Bick et al., 2017).

Women survivors of modern slavery are affected by an intersection of multiple disadvantages, such as economic burden, lack of close family or friend support, and mental ill-health due to trauma and abuse. Additional maternity-specific vulnerabilities for modern slavery survivors include previous physical or psychological childbirth-related trauma, poor nutrition, previous or ongoing interpersonal violence (Human Trafficking Foundation, 2018), increased risk of sexually transmitted infections (Bick et al., 2017), suboptimal home conditions, a lack of safety and safeguarding concerns for the woman and her baby (Collins and Skarparis, 2020), changes of location delaying and limiting access, and a lack of continuity and follow-up by maternity services (Nightingale et al., 2020). Although there are no specific maternity outcome data for this group, these characteristics, together with delayed access to and poor engagement with maternity services, reflect those of disadvantaged childbearing women, identified as more likely to experience poor birth outcomes and increased mortality (MBRRACE-UK, 2020; Nair et al., 2016). In addition to the increased risk of poorer physical outcomes, a synthesis of vulnerable women's maternity care experiences revealed stigma, judgemental attitudes, insensitivity, and negative care interactions that increase insecurities and diminish self-esteem. Positive experiences reflected providers' acknowledgement of the woman's individual needs and preferences (Heys et al., 2021). Care that includes negative interactions with maternity providers and previous trauma are risk factors for post-traumatic stress disorder (Dikmen-Yildiz et al., 2018; Czarnocka and Slade, 2000).

All women should receive maternity care that is safe, personalised, respectful, supports perinatal mental health, utilises rights-based approaches, and does not cause or exacerbate trauma (Renfrew et al., 2014; White Ribbon Alliance, 2011; World Health Organization, 2018). However, information and training resources for maternity care providers appear to be limited, with better guidance required for healthcare professionals to identify modern slavery survivors and meet their needs (Such et al., 2020; Ross et al., 2015). In particular, healthcare professionals experience difficulties in caring for mothers affected by modern slavery, including asking appropriate questions and initiating discussions, making safe referrals, being uncertain about entitlements, and facing obstacles in accessing language support and specialist mental health services (Ross et al., 2015; Williamson et al., 2020). Despite the expectation of cohesive and consistent services, which avoid the recounting of experiences that may re-traumatise (Human Trafficking Foundation, 2018), links and interdisciplinary collaborations between maternity care providers and non-statutory agencies (Balaam et al., 2016) remain unclear.

The aim of this scoping review was to map the available evidence and resources on maternity care provision and non-statutory support to pregnant women and mothers affected by modern slavery. A scoping review was deemed to be the best approach to determine the scope and breadth of literature and give an overview of studies and resources available on the topic (Munn et al., 2018).

2. Methods

The scoping review was conducted in accordance with the JBI methodology for scoping reviews (Peters et al., 2021). The review protocol has been registered on Open Science Framework Registries (web link: https://osf.io/hd4b8).

2.1. Information sources and search

The search strategy developed by the research team aimed to locate both published and unpublished literature. Five databases (Applied Social Sciences Index & Abstracts, Cumulated Index to Nursing and Allied Health Literature, Dissertations & Thesis A&I, Embase, and Scopus) were searched to identify articles (see Supplementary Material 1 for the electronic search strategy for each database). Inclusion criteria were articles published in English between 2012 and May 2022; related to both maternity care provision and modern slavery; cross-sectional perspectives, including mothers who are survivors of modern slavery, healthcare professionals, midwives, and non-statutory service staff; primary or secondary research; and qualitative or quantitative methodologies. Exclusion criteria were articles published in languages other than English or before 2012; studies reporting topics other than maternity care provision and modern slavery or focussing on only one of the two; population groups other than survivor mothers (e.g. asylum seekers and refugees without specifically stated modern slavery experience) or statutory and non-statutory professionals providing care and support to survivor mothers; general healthcare or not maternity related; and opinion pieces, letters, book reviews, or commentaries. Both Medical Subject Headings and free-text terms for "modern slavery" were combined with "maternity health care" or "pregnancy" terms. The search strategy was adapted for each included database. Searching grey literature is common practice in scoping reviews, and limits to the types of evidence selected are often not applied (Pham et al., 2014). Unpublished sources were included, as information relating to the scoping review aim may be predominantly held in grey literature. Evidence synthesis on the explored topic needed therefore to embrace grey information (Adams et al., 2016; Enticott et al., 2018). Sources of unpublished studies and grey literature were searched using relevant websites reporting theses, blogs, policies, guidelines, and resources. A total of 64 grey literature sources were searched in June 2022: 47 maternal/pregnancy websites in the United Kingdom (UK), 14 modern slavery websites, and three general national and international websites (see Supplementary Material 2 for list of sources and terms). The reference lists of all included sources of evidence were screened for additional studies.

2.2. Selection of sources of evidence

Following the search, all identified citations were collated and uploaded into Endnote and duplicates removed. All citations were entered into an Excel worksheet for review based on the inclusion and exclusion criteria. Following a pilot test of 200 papers screened by three reviewers, titles and abstracts were then screened by one reviewer for assessment against the inclusion criteria for the review. Potentially relevant sources were retrieved in full. The full-text papers of selected citations were assessed in detail against the inclusion criteria by one reviewer. All the full texts included at this stage were screened by a second reviewer, with the consultation of a third reviewer in case of disagreement or doubts. Reasons for exclusion of sources of evidence at the full-text stage that did not meet the inclusion criteria were recorded and reported. Grey literature was screened against the inclusion and exclusion criteria by one reviewer, with two additional researchers reviewing the initially selected sources and achieving agreement on the final included reports. Any doubt arising at each stage of the selection process was resolved through discussion with the research team or with additional reviewers. According to the JBI methodology for scoping reviews (Peters et al., 2021), critical appraisal of sources of evidence is not required.

2.3. Data extraction

The draft data extraction tools were piloted, modified, and revised as necessary during the process of extracting data from each included evidence source. Research studies and grey literature reports that met the inclusion criteria were subjected to data extraction by two reviewers using two separate data extraction tools developed by the research team. Any disagreements arising were resolved through discussion with a third reviewer. The data extracted from research studies included specific details about the full reference, year, country, setting, participants, modern slavery aspect, stage of maternity care, methods, and key findings relevant to the review question (Supplementary Material 3). The data extracted from grey literature included information about the link to the resource, organisation, year, title, type of resource, and summary of content (Supplementary Material 4).

2.4. Data analysis

Descriptive statistics were used to analyse the type, quantity and characteristics of evidence, guidance, and resources available on the topic of interest. As recommended by the JBI scoping review guidance (Peters et al., 2021), a basic qualitative content analysis was undertaken to analyse both qualitative and quantitative data, mapping key topic areas respectively covered by research evidence findings and grey literature. An inductive approach was favoured, as it is in line with the scoping review aim and appropriate where

there is a dearth of evidence on the topic (Elo and Kyngäs, 2008). Data analysis included three phases: preparation, organisation of concepts or characteristics into overall topic categories, and reporting (Elo and Kyngäs, 2008; Peters et al., 2021). A narrative summary of findings presented the data in tabulated form. Due to the different natures of the sources, research studies and grey literature were analysed and presented independently.

3. Results

Overall, the search strategy identified 5390 records on electronic databases. After duplicates were removed, 3902 records and 26 additional records were screened by title and abstract according to the set inclusion and exclusion criteria. A total of 120 full-text articles of potential relevance were sought for retrieval, with nine reports not retrieved and 111 assessed for eligibility. Ninety-nine articles were subsequently excluded for irrelevant topic (n = 84) or non-eligible methodology (n = 15). Twelve articles reporting 11 studies were retained for the scoping review. Regarding the grey literature search, 1084 records were identified, including 173 from maternity websites, 83 from modern slavery websites, 822 from other websites, and six additional records. One report could not be retrieved, and the remaining 1083 sources were assessed for eligibility. After 1054 reports were excluded for irrelevancy, 29 reports from the grey literature were included in the scoping review. The PRISMA flow diagram (Page et al., 2021) is reported in Fig. 1.

3.1. Characteristics of research studies

The included studies were published between 2014 and 2022. Only three studies were published in the last two years, from the United States of America (USA), Spain, and Haiti. Four studies were conducted in the UK, whilst others were undertaken in a range of high and low-income countries, including Brazil, Tanzania, Canada, the USA, South Africa, Spain, and Haiti. Studies used predominantly qualitative methodologies (n = 6), in addition to a small number of articles reporting quantitative research (n = 2), mixed methods (n = 2), and scoping or systematic reviews (n = 2). Regarding modern slavery, most studies focussed on sexual exploitation (n = 9) or human trafficking (n = 5), with two studies exploring domestic servitude, and one considering labour exploitation. Pertaining to the stage of maternity care, seven articles reported care throughout the maternity continuum, and five focussed specifically on antenatal care. No studies were identified concerning intrapartum or postnatal care provision. Study populations included mainly women (n = 11), with fewer involving healthcare professionals (n = 5), midwives (n = 4), non-statutory service staff (n = 2), and entertainment venue managers (n = 1). The characteristics of included studies are reported in Table 1.

3.2. Key themes from research evidence findings

Three key themes were identified as recurrent within the included research studies' findings: a) women's perspectives on barriers to access and engagement with maternity services; b) challenges and needs identified by healthcare professionals; and c) the impact of human trafficking on maternal and neonatal outcomes.

3.2.1. Women's perspectives on barriers to access and engagement with maternity services

Women survivors of or affected by modern slavery reported unfamiliarity with maternity care systems, lack of knowledge on how to

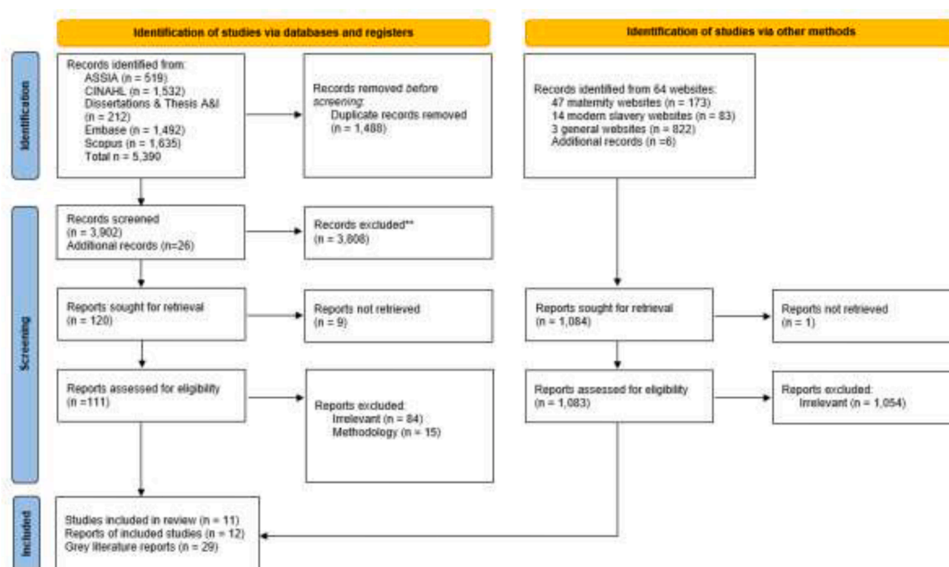

Fig. 1. PRISMA flow diagram, adapted from Page et al. (2021).

Table 1
Characteristics of research studies.

	Modern slavery aspect				Stage of maternity care				Methodology				Participants					Country
	Domestic servitude	Labour exploitation	Sexual exploitation	Human trafficking	Antenatal	Intrapartum	Postnatal	Overall	Scoping / Systematic review	Quantitative	Qualitative	Mixed methods	Women	Healthcare professionals	Midwives	Third sector	Entertainment venues manager	
Alves de Oliveira et al. (2019)			■		■						■		■					Brazil
Beckham et al. (2013)			■		■						■		■	■		■	■	Tanzania
Beckham et al. (2015)			■		■						■		■					Tanzania
Bick et al. (2017)	■	■	■	■				■				■	■	■	■			United Kingdom
Collins & Skarparis (2020)				■				■	■				■	■	■	■		United Kingdom
Delap (2019)	■			■				■			■		■	■	■			United Kingdom
Duff et al. (2015)			■					■		■			■					Canada
McDow & Dowling Dols (2021)				■	■					■			■	■				United States of America
Nightingale et al. (2020)			■	■				■	■				■					United Kingdom
Parmley et al. (2019)			■		■							■	■					South Africa
Ruiz-Gonzalez et al. (2022)			■					■			■				■			Spain
Vahedi et al. (2022)			■					■			■		■					Haiti
TOTAL	2	1	9	5	5	0	0	7	2	2	6	2	11	5	4	2	1	

access care (Bick et al., 2017; Nightingale et al., 2020; Vahedi et al., 2022), and poor understanding of healthcare entitlements (Bick et al., 2017). Barriers to access and engagement with maternity services included socioeconomic disadvantage (Vahedi et al., 2022) in the form of unstable/inappropriate housing or homelessness (Collins and Skarparis, 2020; Delap, 2019; Duff et al., 2015; Vahedi et al., 2022), lack of financial support (Duff et al., 2015; Vahedi et al., 2022), reduced access to education (Duff et al., 2015), vulnerability to social isolation (Delap, 2019), and poverty (Collins and Skarparis, 2020; Nightingale et al., 2020). Fear of partner's violence (Duff et al., 2015) and restrictions placed on women's movements by traffickers (Bick et al., 2017 Nightingale et al., 2020; Vahedi et al., 2022) were also identified as obstacles. Late pregnancy detection, substance and alcohol use, fear, lack of family and partner support, insufficient resources, and discontent with previous healthcare-related experiences were significant factors specifically impacting antenatal care seeking (Parmley et al., 2019). Denial of care if the woman was attending without her husband and care not being tailored to individual needs were reported in the Tanzanian context (Beckham, 2013; Beckham et al., 2015). When accessing maternity care, women described unsatisfactory information provision and communication, with inadequate choice and consent processes (Delap, 2019), language barriers, and finding terminology difficult to understand (Nightingale et al., 2020). Women often did not feel able to disclose trauma to care providers (Delap, 2019), mainly due to concerns about confidentiality (Bick et al., 2017; Nightingale et al., 2020), re-traumatisation, judgemental attitudes (Nightingale et al., 2020), community stigma, and being afraid of punitive measures regarding their children (Duff et al., 2015). Dispersal policies (Collins and Skarparis, 2020; Nightingale et al., 2020) and navigating multiple systems (Delap, 2019) were considered impediments to accessing and engaging with maternity care pathways.

3.2.2. Challenges and needs identified by healthcare professionals

Healthcare professionals and midwives did not feel adequately prepared to respond to the needs of this vulnerable population (Collins and Skarparis, 2020) due to several factors, including the following: lack of training in how to assist trafficked women, individualized tools, or maternity-specific guidelines or intervention protocols (Collins and Skarparis, 2020; Ruiz-Gonzalez et al., 2022); insufficient knowledge on the human trafficking topic (Ruiz-Gonzalez et al., 2022); difficulty in recognising signs of trafficking (Ruiz-Gonzalez et al., 2022); absence of a clear plan of action to follow, and confusion of roles amongst different healthcare professionals (Ruiz-Gonzalez et al., 2022). Midwives recounted a sense of shame when they needed to ask probing questions (Ruiz-Gonzalez et al., 2022). Communication with victims was often negatively impacted by language barriers, a shortage of adequate interpretation services, and learning difficulties (Delap, 2019; Collins and Skarparis, 2020). Healthcare professionals found feeling responsible for women's concerns and outcomes was exhausing (Delap, 2019). Healthcare barriers and resource constraints (Bick et al., 2017), concerns about charging policies (Delap, 2019), and safeguarding (Nightingale et al., 2020) were also raised as problems. Information-sharing was seen as an obstacle, with confusion about the support services available also reported (Delap, 2019). An evaluation of a USA pregnancy crisis centre was undertaken, including human trafficking training and a screening programme, with the aim of increasing awareness amongst healthcare professionals and facilitating swift victim identification (McDow and Dowling Dols, 2021). Across the included studies, healthcare professionals and midwives identified the following needs within service provision:

- raising awareness of the indicators of trafficking and knowledge of where to signpost victims for help and support (Bick et al., 2017; Nightingale et al., 2020);
- trauma-informed care in recognising trauma and complex needs, with support needed for caregivers when caring is traumatic for them and becomes exhausting (Delap, 2019);
- specialist midwifery and continuity of care/carer (Bick et al., 2017; Delap, 2019);
- effective and appropriate communication, including the use of appropriate language, checking understanding, and face-to-face interpreting services (Nightingale et al., 2020);
- safeguarding support (Nightingale et al., 2020);
- preservation of confidentiality (Ruiz-Gonzalez et al., 2022);
- action protocols clearly defining practical clinical steps to follow with improved coordination amongst professionals, interdisciplinary approaches, and patient follow-up (Ruiz-Gonzalez et al., 2022).

3.2.3. Impact of human trafficking on maternal and neonatal outcomes

Previous research identified that women who have been trafficked are at risk of physical and emotional health issues that may affect maternal and foetal outcomes (Collins and Skarparis, 2020; Ruiz-Gonzalez et al., 2022; Nightingale et al., 2020), including prematurity, low birth weight, increased perinatal mortality (Nightingale et al., 2020; Ruiz-Gonzalez et al., 2022), developmental delays and behavioural and mental health issues, compromised mother-baby bonding (Nightingale et al., 2020), infections, foetal death, and miscarriage (Ruiz-Gonzalez et al., 2022). Late access to maternity care is an additional risk factor for maternal and foetal/neonatal morbidity and mortality (Nightingale et al., 2020). However, systematic and scoping reviews from which the above data have been drawn focussed on broader literature in addition to modern slavery aspects; for example, from migrant, refugee, and imprisoned mothers.

3.3. Characteristics of grey literature

The identified grey literature reports were published between 2015 and 2022, with most reports published in 2018 ($n = 6$) and 2021 ($n = 6$). Six reports were published between 2015 and 2017, one in 2019, one in 2020, and only three in 2022. The reports were released by 15 organisations, including modern slavery or maternity care charities ($n = 7$); human rights and anti-trafficking

organisations/groups ($n = 4$); Medical, Nursing and Midwifery Royal Colleges ($n = 3$); and the Department of Health Policy Research Programme ($n = 1$). The type of resources comprised mainly blogs ($n = 8$); information sheets, leaflets or webpages ($n = 5$); and research or consultation reports ($n = 4$). Other reports were identified as practice guidance ($n = 2$), service offer webpages ($n = 2$), a policy document ($n = 1$), a training offer webpage ($n = 1$), project webpages ($n = 2$), a statement ($n = 1$), an opinion piece ($n = 1$), an update on training delivery ($n = 1$), and a resource pack ($n = 1$). These were variously addressed to survivor mothers, maternity services, and non-statutory agencies.

3.4. Key areas covered by grey literature evidence

Blogs reported two mothers' narratives regarding accessing maternity care whilst being victims of modern slavery (Hestia, accessed 2022) and navigating maternity care in the UK (VITA Network, 2021). Other blogposts focussed on information and knowledge sharing (Snowdrop project, 2017), implications of the National Health Service charging pregnant victims (Royal College of Obstetricians and Gynaecologists, 2021), the lack of protection for trafficking victims with children in the UK (Anti-Slavery International, 2016a), pregnancy being overlooked in the National Referral Mechanism (Anti-Slavery International, 2016b), the importance of midwives and nurses' role in recognising victims (Birthrights, 2019), and doula support (Birthrights, 2021). In one opinion piece, midwives shared their experiences of providing individualised care for pregnant marginalised women, including survivors of modern slavery and human trafficking (Royal College of Midwives, 2018a). The Royal College of Midwives (2021) published a position statement on maternity care provision and ending violence against women, including modern slavery.

Three information sheets and webpages were addressed to survivors/victims of trafficking or modern slavery, including guidance about the National Health Service, maternity care entitlement, charging, rights, benefits, and legal support (Maternity Action, 2017, 2018, accessed 2022a). The Project Maternity Actions for Migrant and Asylum-Seekers (Project MAMA 2022a; 2022b; 2022c) webpages offered their services supporting women affected by modern slavery and human trafficking. Two Maternity Stream of Sanctuary (accessed 2022a; accessed 2022b) information leaflets were directed to maternity healthcare professionals, covering terminology, support services, women's needs, and factors affecting maternity care access.

Regarding training available to maternity healthcare professionals, the Royal College of Midwives (2018b) organised a one-day conference on human trafficking; Maternity Action (accessed 2022b) offered education on housing, support options, National Health Service charges, and immigration law implications. One resource pack was identified that aimed to promote a culture of welcome within maternity services for people seeking sanctuary in the UK (Maternity Stream of Sanctuary, accessed 2022c).

A policy document on health and care provision for victims of modern slavery was developed by the Human Trafficking Foundation (2018) for non-statutory services, including guidance to support pregnant women and mothers. Practice guidance for nurses and midwives was published by the Royal College of Nursing (2020) with general information provided on signs of trafficking, health issues, healthcare professional roles, and practical suggestions about safeguarding, safety, support, and referral. The Royal College of Nursing (2018) identified key modern slavery signs during pregnancy.

Research and consultation reports focussed on the impact of pregnancy and parenthood, identification and support within health/maternity care, barriers to accessing care, the role of safeguarding midwives (Anti-Trafficking Monitoring Group, 2016), indicators of trafficking, safeguarding issues, involvement of appropriate agencies, additional care, one-to-one care, consideration of individual needs, flexible timing and duration of contacts, follow-up, respectful care (Department of Health Policy Research Programme, 2015), and gaps in maternity care provision for victims of modern slavery (Hestia, 2018, 2021). One ongoing study is evaluating the Hestia and Happy Baby Community Perinatal Support Programme for pregnant women and mothers with babies who have experienced trafficking, violence, trauma, or abuse, with a focus on how the programme contributes to improved health outcomes for 0–2-year-olds (University of Nottingham Rights Lab, 2021).

4. Discussion

To our knowledge, this is the first scoping review mapping existing evidence on maternity care provision and non-statutory support to mothers affected by modern slavery.

General guidance is available on how to support and provide care to people affected by modern slavery (Hachey and Phillippi, 2017; Gibson, 2018; Oram et al., 2016; Royal College of Nursing, 2022; Such et al., 2020), including research addressing specific health needs and mental health recovery (Wright et al., 2020, 2021). Although key principles in approaching pregnant women, mothers, and their entitlements are available (HTF, 2018), we found a lack of maternity-specific guidance on how to provide optimal care to survivor mothers, as well as a lack of awareness, information, and training, resulting in maternity healthcare professionals not feeling adequately prepared to respond to the needs of survivor mothers (Bick et al., 2017; Collins and Skarparis, 2020; Delap, 2019; Ruiz-Gonzalez et al., 2022). The scoping review suggested that midwives and healthcare professionals require evidence-informed designated pathways and protocols alongside specialised training to ensure the implementation of confidential maternity care tailored to individual needs (Bick et al., 2017; Delap, 2019; Nightingale et al., 2020; Ruiz-Gonzalez et al., 2022).

The identified studies mainly focussed on the barriers, challenges, and uncertainties regarding access and engagement with maternity services. Women experienced barriers to accessing care for a range of personal and organisational factors, found absence of continuity problematic, and were concerned about confidentiality and stigma (Beckham, 2013; Beckham et al., 2015; Bick et al., 2017; Collins and Skarparis, 2020; Delap, 2019; Duff et al., 2015; Nightingale et al., 2020; Parmley et al., 2019; Vahedi et al., 2022). Although Nightingale et al. (2020) presented what women survivors of modern slavery valued when receiving care (feeling safe, the establishment of a trusting relationship, person-centred care, respect of confidentiality, and continuity of carer), no recommendations

were identified on how these requirements can be achieved. It is unclear whether and how differences in jurisdictions, non-statutory service support, and maternity care provision in low, middle, and high-income countries impact pregnant women and mothers' experiences during maternity.

The women's perspectives mainly covered the overall maternity journey (Bick et al., 2017; Collins and Skarparis, 2020; Delap, 2019; Duff et al., 2015; Nightingale et al., 2020; Ruiz-Gonzalez et al., 2022; Vahedi et al., 2022), with no research exploring experiences of intrapartum and postnatal care specifically. Women's experiences of pregnancy were reported in four papers; these focussed on the sexual exploitation of survivors/victims in Tanzanian, Brazilian, and South African settings (Beckham, 2013; Beckham et al., 2015; Alves de Oliveira et al., 2019; Parmley et al., 2019). From a systematic review of qualitative evidence of pregnancy journeys in the context of trafficking and exploitation, Nightingale et al. (2020) suggested that further primary research is required to better understand individual maternity experiences of women victims of human trafficking.

Despite the expectation of cohesive and consistent services (Human Trafficking Foundation, 2018) and the requirement for additional support for women who are not in a position to make full use of antenatal care (National Institute for Health and Care Excellence, 2010), previous research has not addressed cross-sectoral contacts between agencies and maternity providers or how slavery survivors, agencies, and service providers experience these. Non-statutory service staff perspectives regarding support of childbearing women are limited (Beckham, 2013; Collins and Skarparis, 2020) and have not been explored comprehensively in primary research. It is also not possible to discern healthcare professional and non-statutory service staff views within Collins and Skarparis's (2020) scoping review findings. Delap (2019) suggested that further consultation with a wide range of stakeholders reflecting the full spectrum of challenges and services is required, with the aim of providing a better maternity care response to women dealing with severe and multiple disadvantages.

Some inherent limitations to our scoping review exist because the focus was to provide breadth rather than depth of information on the explored topic. Although only one reviewer conducted the screening, a pilot test by three reviewers and team discussion in case of doubts arising were undertaken. We limited the included studies to those available in English. Although international studies and resources were considered, grey literature sources were mainly based in the UK for pragmatic reasons. Whilst critical appraisal of the included studies is optional in a scoping review and not required according to JBI guidance (Peters et al., 2021), it was not undertaken here due to time and resource constraints. JBI scoping review guidance was followed throughout (Peters et al., 2021), and we deemed these methodological choices appropriate, given that our objective was to map the available evidence. We anticipate that our findings will be of interest to a range of stakeholders, including service users; healthcare professionals who provide care during pregnancy, labour, the postpartum stage, and early motherhood; non-statutory service staff who support survivor mothers during maternity; commissioners; and policy-makers and that the results will provide a platform from which future research can develop.

5. Conclusion

The aims of maternity care and non-statutory support should be to achieve optimal health and well-being for each woman and her baby, avoid further traumatisation, facilitate recovery, promote reintegration, and prevent re-exploitation. The present scoping review has identified broad principles that should be followed but highlighted gaps that need to be addressed to ensure that both statutory and non-statutory services provide optimal care and support during pregnancy, labour, and the postpartum period. Further research is required from which guidance and training can be developed, considering that maternity was being experienced by survivor mothers with the following: unfamiliarity with and a lack of access to systems and information across all sectors; barriers to care and entitlements; contemporary threats of violence from partners/traffickers; restricted ability to move freely; issues related to traumatisation; dispersal; and dealing with multiple new systems. Although several sources indicate principles that should be adopted, the details of *how* that should happen are lacking. Further research is urgently needed to provide the evidence base from which recommendations for good maternity practice and an effective intersection between statutory and non-statutory services can be derived and subsequently mobilised across different systems and settings. The investigation of maternal and neonatal outcomes for survivor mothers and their babies is also required.

Funding sources

This work was funded by the University of Nottingham Rights Lab Innovation and Project Development Award 2021/22.

CRediT authorship contribution statement

Sara Borrelli: Conceptualization, Methodology, Software, Validation, Formal analysis, Investigation, Resources, Data curation, Writing – original draft, Visualization, Supervision, Project administration, Funding acquisition. **Renuka Ramasamy:** Formal analysis, Investigation, Data curation, Writing – original draft. **Ruth Wong:** Methodology, Validation, Writing – original draft, Writing – review & editing. **Helen Spiby:** Formal analysis, Investigation, Data curation, Writing – original draft.

Declaration of Competing Interest

None.

Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.ijnsa.2023.100139.

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