

## Article

# Motherhood, Human Trafficking, and Asylum Seeking: The Experiences and Needs of Survivor Mothers in Birthing and Postnatal Care

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**Abstract:** This article aims to illuminate the little-studied phenomenon of asylum-seeking child-bearing women in the UK, survivors of violence and human trafficking. This is a significant issue in terms of the proportion of women affected and the paucity of care and support currently available to them as mother survivors. This study looked to examine the frontline support services of one project to survivor mothers through two collaborating organisations, Happy Baby Community and Hestia, and how their services support mothers' experiences of perinatal mental health, infant feeding, and the general experiences of migrant women and trafficking survivors in maternity care in the UK. Using evidence collected from semi-structured service-users' interviews and focus groups, and an anonymous online staff survey, this article shows the types of care and support that are required to address not only the challenges faced by any new mother, but also the additional challenges experienced with trafficking and seeking asylum such as mental health, housing, and legal and access to other support. This article illustrates the many complex and inter-related challenges these women face, and the way the project meets practical, informational, emotional, appraisal, and social needs. It concludes by identifying several implications of the support provided and/or needed, which could be considered by other services or policymakers looking to meet the fundamental needs and rights of this cohort.

**Keywords:** human trafficking; human rights; asylum; refugees; mothers; pregnancy; care; mental health; perinatal support; postnatal support; doula services; inequalities



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## 1. Introduction

The overarching aim of this article is to illuminate a specific under-represented and under-served constituency of need amongst asylum-seeking pregnant and new mothers, survivors of violence and human trafficking.

An average of 4000 females per year were granted asylum or resettlement as refugees between 2011 and 2021, with an estimated 14% percent falling pregnant while seeking asylum [1]. The psychological and financial challenges of their situations are compounded by experiences of facing poorer maternity care, poor health outcomes, and barriers to accessing social services. The appropriate medical, health, and support practices for these women are widely unknown. Between 2019 and 2022, 12,700 females in the UK were referred as victims of slavery to the Home Office's National Referral Mechanism (NRM) [2]. Currently, pregnancy statistics are not captured by the NRM for those exiting slavery, but research suggests that around 30% of trafficking survivors have experienced one or more pregnancies during exploitation [3], making maternity services and wider perinatal care services critical for the identification of and response to needs.

Mothers like those in this study pursuing their right to asylum in the UK were faced with barriers in establishing their families and homes, such as allowances less than half

of the destitution threshold [4], and the poor allocation of food and housing impacting mental and physical health. When outlining the entitlements of basic rights, the United Nations Declaration of Human Rights refers not only to those rights enabling and not undermining life, liberty, or the freedom of exploitation, but also to rights permitting an adequate standard of living including food, housing, social care, and special assistance for motherhood and childhood [5]. Indeed, the UK has ratified conventions including the following: the 1966 International Covenant on Economic, Social and Cultural Rights includes articles related to special protections of mothers before and after childbirth, and the right of everyone to a high standard of physical and mental health [6]; and the 1989 Convention on the Rights of the Child considers the non-discriminatory rights of children, and relatedly, their parents [7].

With solid support, and thoughtful care, the maternity and birthing process can be a pathway to change, even as it is an irrevocable step into motherhood with all the pressures and responsibilities that brings. The women within this study have experienced a perfect storm of health and social barriers to care, and due to their asylum status, experience serious challenges to their ability to build a new life with their children in the UK. This study assessed and evaluated a project that offers an evolving model for change and improvement in the service to this unique constituency of need.

### *1.1. The Perinatal Support Project*

This study followed a collaboration between the voluntary sector organisations Happy Baby Community and Hestia through Starting Well project funding. This project offers support to 200 asylum-seeking mothers per year in London through pregnancy, birth, and early parenthood [8,9]. Women supported by the project include those who have experienced violence, war, persecution, trafficking, or commercial sexual exploitation, who arrive to the service with complex needs. This study focussed on how the project addressed and supported mental health and wellbeing, infant feeding, and peer support, as well as wider needs regarding practical, emotional, social, informational, and appraisal support, all of which were beyond the immediate maternity care provided by the NHS. We look closely at existing experiences of survivor mothers who received support, identified gaps in support, and considered implications for wider audiences who support perinatal or related frontline services for this group.

The project's support services are for mothers who are seeking asylum from the time they are five-months' pregnant, through birth, and up to three months post birth. Once children are 3 months old, families are invited to continue engaging with the wider community activities, through planned activity sessions and other support services offered by the organisations. During the project, Happy Baby Community provided birth and postnatal support through doula services, health and nutrition information classes, peer support, and social opportunities with shared meals. For clients who experienced trafficking and exploitation, casework support was provided by Hestia, helping clients in accessing justice and navigating housing, government benefits, employment, and the wider social support systems. These activities aim to meet the needs of the client group; to enable mothers to become confident, capable, and supported; and to help them care for their children while building safe, stable futures.

Analysis of the identified themes of mothers' responses helped us understand the benefits of the project's activities within the conceptual framework of social support theory ([10], see also Section Theoretical Framework: Social Support Theory). This theory suggests that improvements in circumstances and wellbeing are attained through four to five common modalities of support: instrumental (practical), emotional, social, informational, and appraisal. Support theory has been considered with those experiencing violence, deprivation, rape, domestic violence, conflict, and risk, and has been recognised to have both mental health and physical health implications [11]. The benefits include the direct-effect hypothesis of health and wellbeing, and buffering physiological effects of stress, which is important

both during pregnancy and postnatally, supporting positive health outcomes, reducing anxiety, and building mother–baby attachment [12].

## 1.2. Background

Before undertaking this research, we explored some of the published academic, policy, and civil society literature of three priority research themes for this project using keyword searches on a search engine: 1. perinatal mental health, 2. infant feeding, and 3. the experiences of migrant women and trafficking survivors in maternity care in the UK. This review highlights some experiences, challenges, and barriers experienced by the target group, to better understand the context in which the organisations operate.

### 1.2.1. Perinatal Mental Health

Pregnancy, childbirth, and becoming a mother are periods of enormous significance in a woman's life. There are changes to physical and emotional wellbeing, and pregnancy is considered a period of increased vulnerability for poor mental health; hence, it is a key development area for the national "Better Births" policy [13]. The National Institute for Health and Care Excellence ("NICE") guidance for the care of women with complex social factors acknowledges that additional support is needed for particular groups of women, including care such as specialist trauma services [14]. Lacking social support increases anxiety and depression during pregnancy [15]. Mental health problems during or after pregnancy are distressing for women and have negative implications for a woman's relationship with her baby, attachment, parenting, and the quality of their relationship, as well as physical and cognitive health and development of the child [16–19].

Previous trauma increases the risk of childbirth-related post-traumatic stress disorder (PTSD) [20]. Migrant women experiencing depression can come with feelings of insecurity or failure, which can inhibit them from seeking professional help. Cultural isolation, communication barriers, and a lack of social support undermine their mothering [21]. In a UK study of trafficked women, the majority of interviewees experienced some form of mental health problem [3]. Survivors of modern slavery commonly have a range of mental health needs, and may have pre-existing vulnerabilities for poor mental health due to abuse or interpersonal violence [22,23].

Positive experiences result from providers' welcoming and supportive approaches, acknowledgement of the woman's individual preferences, and the enabling of informed decision making [24]. Negative interactions with maternity providers are known to be a risk factor for PTSD [25]. Trauma-informed care has the potential to decrease the risk of re-traumatisation and post-traumatic stress disorder. The systematic review by Singla (et al.) found that interventions provided by non-specialist care providers (nurses, lay counsellors, etc.) could be effective for both preventing and treating depression and anxiety symptoms, much like the support of doulas [26].

### 1.2.2. Infant Feeding

Breastfeeding is highly recommended for all infants worldwide, such as UNICEF's Baby Friendly Initiative [27], but the process of beginning breastfeeding is not always easy for a new mother. Women are encouraged to initiate breastfeeding "as soon as possible after birth, within the first hour" [28]. Short- and long-term benefits accrue from breastfeeding: (1) it enables the regulation of newborns' body temperature; (2) it enables the acquisition of beneficial bacteria from their mother; (3) it lowers risks of infections [28]; and (4) it reduces future risk of obesity [29]. Several studies show benefits for the mother's health in the short and longer term: (1) decreasing women's risk of breast and ovarian cancer, (2) reducing the risk of type 2 diabetes mellitus and postnatal depression, and (3) lowering rates of overweight and obesity [30,31].

Nevertheless, there is evidence that some women might be hindered—especially those from vulnerable backgrounds—from starting or sustaining breastfeeding. Acknowledging this reality, the Royal College of Midwives emphasises the significance of proper guidance

encompassing adequate advice, support, and information on alternative responsive methods of feeding (e.g., safe preparation of bottles for formula milk) [32]. This support should ideally be provided not only by the midwives but also by family and friends [32].

Acculturation within breastfeeding practices can occur: women that are familiar with breastfeeding, when moving to a new country with low breastfeeding levels, are likely to be influenced by the host country and decrease their rates [33]. This is likely to be observed among migrants in the UK, given that the UK has one of the lowest breastfeeding rates in the world [34].

### 1.2.3. Experiences of Migrant Women and Trafficking Survivors in Maternity Care

Women from migrant and refugee backgrounds have perinatal healthcare needs that are understood internationally as a public health priority [35]. Access to healthcare systems can be difficult for some women, including those who are immigrants, due to unfamiliarity with NHS maternity care [36]. Barriers to receiving proper care include language and cultural challenges, insufficient support to access services, and limited health literacy [35]. Fear of being reported to the authorities also prevents women from accessing healthcare, as well as concerns about paying for care [37]. Some women are controlled by their traffickers, who either prevent them from accessing healthcare services or are threatened about revealing their situations. Traffickers will sometimes accompany mothers to the follow-up appointments [3,37].

Maternity services offer an important contact point for identification and care yet need to be prepared for the impacts of violence, sexual abuse, and exploitation on women when providing perinatal care [3]. Interviews with survivors of human trafficking in 2017 found a third diagnosed with a sexually transmitted infection, and over 42% had undergone one or more pregnancies, including terminations, during the period of their trafficking and exploitation [3]. Survivors also described inappropriate service charges, fears about confidentiality, and negative attitudes from staff among the challenges they faced while accessing NHS maternity care [3]. At the same time, maternity and mental health services admit feeling overwhelmed by the complex needs of asylum seekers and trafficked women [38]. There is a growing recognition among healthcare professionals of the need for specialist roles and competency training when it comes to supporting mothers with traumatic histories.

Many healthcare workers, however, have no formal trauma-informed training [38], and few report receiving formal training about human trafficking [39], so healthcare professionals face difficulties when it comes to providing care. This encompasses struggles from direct contact with the person (such as asking appropriate questions, initiating discussions, or accessing language support) to a lack of expertise when dealing with mental health issues or a lack of knowledge regarding referrals and entitlements [40]. The availability of specialised support for groups varies between geographical areas, even within London [41]. Thus, research suggests that there is “an absence in the detail of *how* optimal care and support during maternity should be provided by healthcare professionals and non-statutory services” [40].

In the UK, non-white mothers face higher mortality rates [42] in childbirth, and those facing multiple disadvantages experience poorer maternity care [43]. For instance, late access to maternity services is found among women who experience trafficking [37] and is recognised as a risk factor for maternal morbidity and mortality [44]. An enquiry into racial disparities in maternity care found that refugee, asylum-seeking, and migrant women, from a range of ethnic communities, claimed their antenatal care was negatively impacted by fear linked to their immigration status. They confronted “intrusive questions about their immigration status during maternity appointments,” as well as a failure to provide adequate interpreting services that exacerbate these barriers [37,45].

Understanding important ethnic and cultural issues faced by non-UK nationals is broader than language barriers, however [46], but offering “cultural mediation” can facilitate a mutual understanding of critical information, overcome cultural barriers while

providing verbal translation [47], and avoid unnecessary suffering [48]. Cultural competence, for instance, through cultural interpreter doulas is identified as of utmost importance to promote inclusive and equal healthcare among all women, such as promoting positive pregnancy experiences [49]. Moreover, cultural competency has been claimed to be a priority for meeting the maternal outcome elements of the Sustainable Development Goals 2030 [50].

Maternity Action's investigation into "hostile" charges for healthcare services found them to cause high levels of stress and anxiety due to aggressive debt collecting and fears about implications on immigration applications [51,52]. NHS staff may not always know about cost exemptions for refugees, asylum seekers, and victims of modern slavery. This bureaucratic stress, added to experiences of destitution, homelessness, deportation, dispersal [53], the subsequent financial hardship experienced by asylum seekers [1], and additional health problems, is recognised as having an adverse effect on immediate pregnancy outcomes such as pre-term birth and low birth weight [54]. Mothers facing multiple disadvantages also reported continuity of care as a key theme to reduce fear. Continuous carers would reduce the need for mothers to review the same challenging questions and histories multiple times [38], while providing trusted support through challenging births such as that provided through birth companionship.

## 2. Materials and Methods

### 2.1. Study Design

We invited mothers with a lived-experience of violence and trafficking to share their thoughts and opinions of the services they received through the project's participating organisations before, during, and after birth. We aimed to ascertain the impacts of the programme in supporting health outcomes for 0–2-year-olds through improvements in perinatal mental health and access to evidence-based information regarding feeding, as well as to understand the overall experience of women supported through the programme. We also sought to measure adherence to the programme principles in practice, in order to understand the effect of key service and community partnerships.

We took a mixed-methods approach and collected data in two main parts:

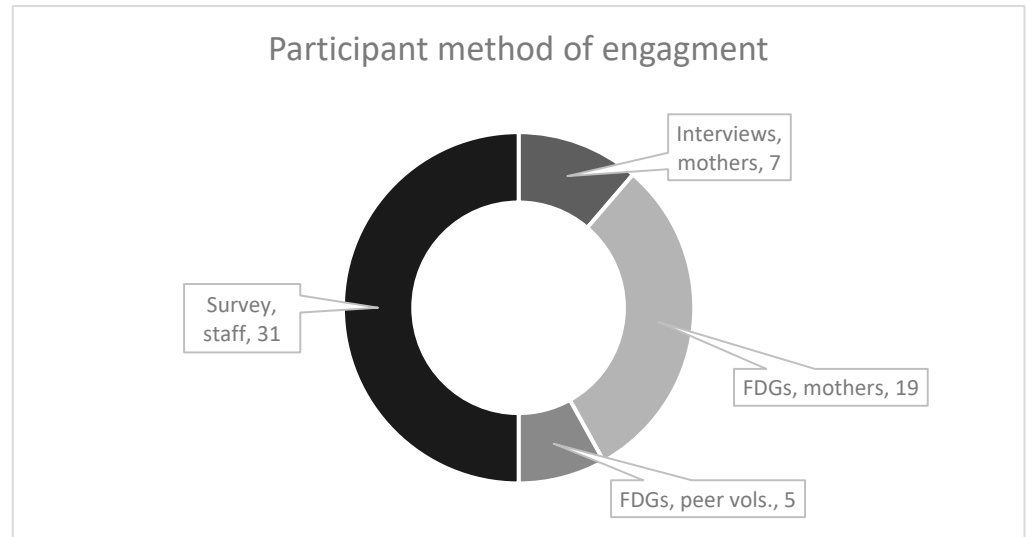
- Semi-structured discussions with client mothers to illuminate the experiences and opinions of the services they received. The sample ( $n = 31$ ) included current or recent recipients of the project's services, and peer volunteers<sup>1</sup> who had previously received Happy Baby Community's perinatal support (Figure 1). These were undertaken both through focus group discussions (FDGs) and one-to-one discussions, with the same topic format followed in both modes. These data were collected between December 2022 and January 2023.
- An online, anonymous survey for any staff and volunteers from both Happy Baby Community and Hestia who work with mothers through the project. We received responses from 31 participants, 6 of whom were through Hestia which represents a similar proportion to the mother participants. These data were collected in February 2023.

### 2.2. Language, Recruitment, and Setting

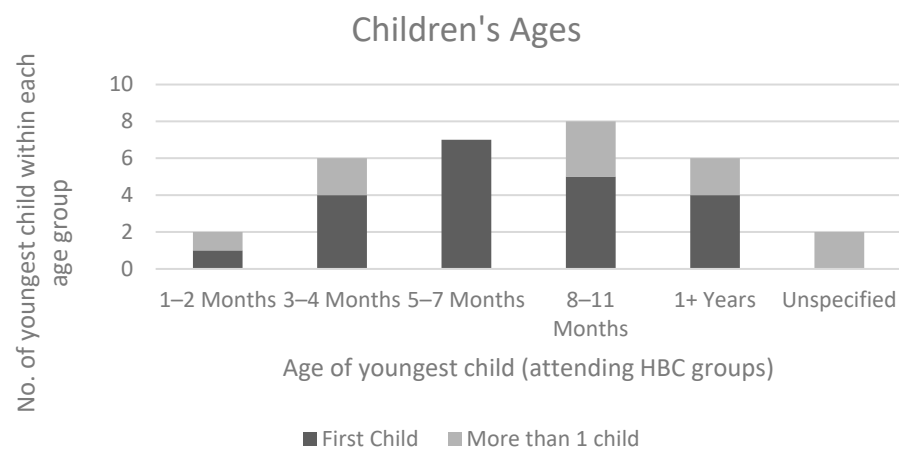
Participants spoke English, Albanian, Arabic, Amharic, and Spanish. We selected these languages as they represented large groups of mothers within the project and facilitated focus group discussions. Clear Voice, a translation service already used by the partners and endorsed by Migrant Help, provided the translation of information and consent forms prior to data collection, the interpretation of discussions during sessions including summarised back-translation for the researcher to facilitate conversation, and straight-to-English transcription services following sessions for the purposes of analysis.

Happy Baby Community and Hestia supported the participant recruitment by inviting relevant language speakers to attend groups, which reduced the need to share personal information with the research team, but also due to the existing trusted relationship and regular points of communication with the mothers. They approached 88 mothers across

selected language groups using a convenience sampling approach, all of whom had given birth in the previous year (2021–2022, See Figure 2 for ages). Where interest exceeded spaces available, mothers joined based on availability on the given date.

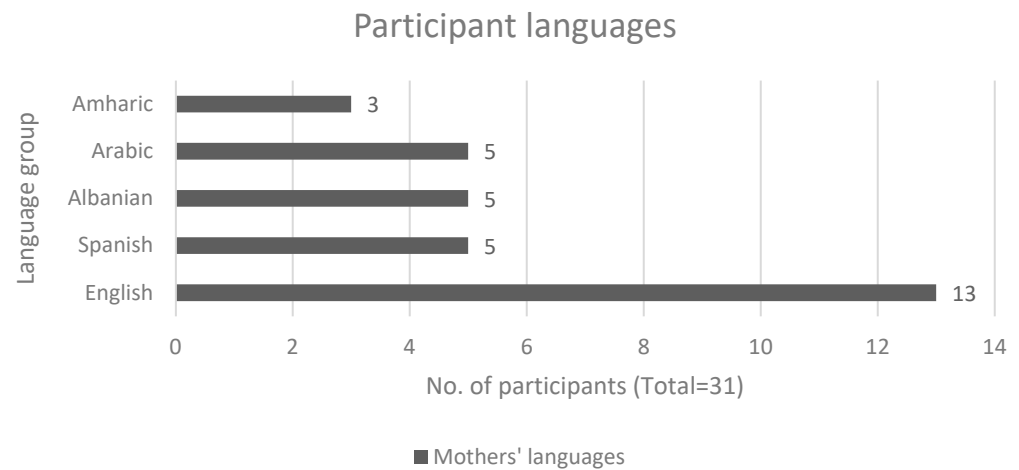


**Figure 1.** Numbers of participants engaged in each data collection approach, across mothers, peer volunteers, and staff.



**Figure 2.** Children’s age distribution. (Mothers across service users and peer volunteers reported their first or most recent baby’s age, as relevant to their engagement with Happy Baby Community services at the time of data collection).

Mothers who fell into any of the 5 language categories who had given birth during the project were eligible to join (Figure 3). Our main exclusion criteria were declining participation, and the limits on the study around the size of the group and languages included. Thirty-one mothers participated, all of whom were seeking asylum and received perinatal support through Happy Baby Community, and around 20% of whom had also experienced a form of trafficking or exploitation and therefore also received support through Hestia (n = 6/31).



**Figure 3.** Participant languages (the number of English speakers includes both mothers and peer volunteers).

In the case of the small cohort of the peer volunteer group, conducted in English, all were invited. These were mothers who had been service recipients of Happy Baby Community usually more than 18 months prior (e.g., 2020–2021) or were second-time mothers and were now volunteers for the service so could speak as both recipients and contributors of the services at Happy Baby Community.

The focus group and interview discussions were facilitated by University of Nottingham researchers, independent of the project staff. The organisations' staff forwarded participant information and consent forms translated into their relevant language during invitation stages, and a further question-and-answer document was provided to support the staff with any additional questions which may have arisen. Mothers were offered high-street vouchers as an acknowledgement for their time and contribution. Happy Baby Community distributed these to the mothers following confirmation of attendance.

Following consideration with the services about safety, comfort, childcare, independence from the service, project-supported access, and familiarity with technology, discussions took place online via Zoom, which enabled mothers from across the project to join from their homes. They were able to attend to their children's needs during the call when necessary, and interviews and focus groups were held at a time that did not conflict with usual project services.

The Expert Advisory Group<sup>2</sup> advised on appropriate language for certain key themes which would be addressed including mental health, particularly in the case of interpreted groups, but also the sensitivity required for mothers to feel safe about sharing their experiences and feelings in order to prepare appropriately across the cultural mix of participants.

### 2.3. Data Collection

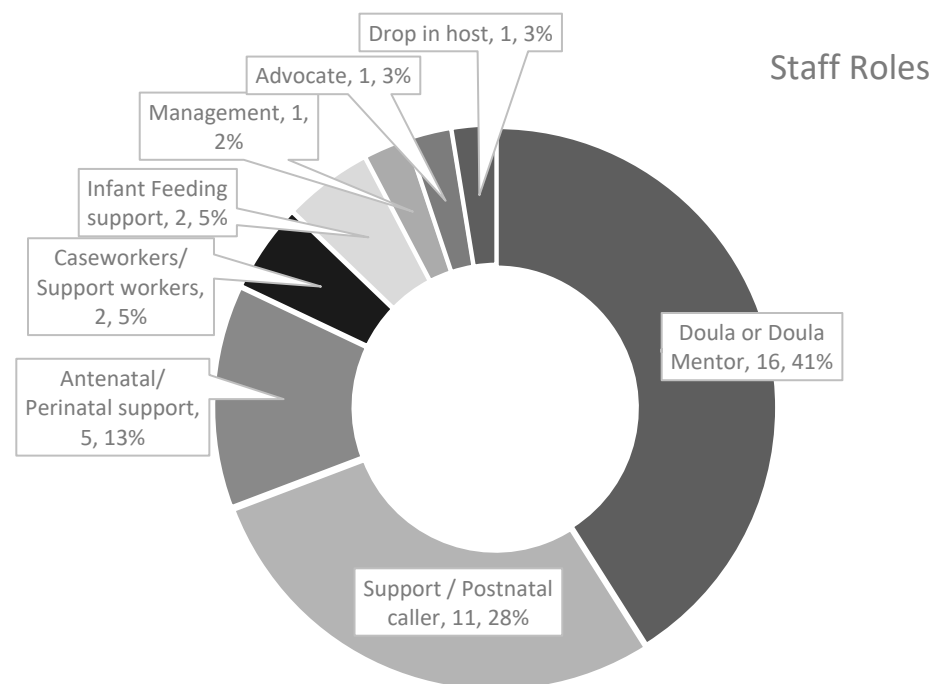
We undertook five focus groups across four key languages, and a focus group in English for peer volunteers. We also ran five "one-to-one" interviews in one further key language as recommended by the EAG (a mother, a researcher, and an interpreter present). Focus groups typically included up to six mothers, two researchers, and an interpreter for non-English groups. While groups ran up to 90 min, taking into account the time it took to interpret and gather consent from the mothers, one-to-one interviews ran up to 60 min. Individual interviews and focus group discussions were recorded and transcribed verbatim.

Focus group discussions provided a pragmatic approach in terms of efficiency in data collection but more importantly to enable the use of existing group dynamics. The EAG (professional and lived-experience leaders) [8] supported this approach as they recognised that, with most of the women, there was already a familiarity and comfort with sharing through Happy Baby Community group sessions, but they also advised that one specific

cultural group be invited to join one-to-one discussions rather than groups. For most of that cultural group, a higher number of experiences of trafficking brought additional vulnerabilities. There was also a suggestion from the EAG that the culture tended towards feeling less comfortable to share in a group, with fears of rumours and suspicion or consequences from what they shared about their personal experiences. We were advised that cultural needs in those cases would be best met through individual interviews rather than FDGs, so both approaches were used within the participant group.

Questions were posed in chronological order of the women's experiences of the services: the immediate practical needs and the emotional experiences during early pregnancy; birth, whether with or without birth companionship; feeding and support needed in the early weeks of the newborn's life; broader project activities and services; informational support around weaning and parenting; and finally thinking and preparing for the future.

We also carried out a short, online, anonymous survey of staff and volunteers. This included doulas and breastfeeding counsellors with role-specific training, as well as peer volunteers who have been trained through Happy Baby Community's perinatal programme (Figure 4). Here, we were able to capture additional insight or experiences related to the way the project interfaced with external services. We captured opinions on the extent of achievement of the project's priority principles through scoring 5 questions (quantitative approach, results not reported in this paper). We complemented these responses with free-text responses to capture additional experiences, contextual information, or feedback that respondents felt was helpful for the research team to understand alongside the mother's responses (qualitative approach, some quotes are reported in the following findings section). We received responses from 31 participants, 6 of whom were through Hestia which represents a similar proportion to the mother participants.



**Figure 4.** Participant staff roles. (Some of the respondents undertook several roles. Total roles reported = 39, total participants = 31).

#### 2.4. Ethics and Rigour

Ethical approval was given through the University of Nottingham's School of Politics' committee prior to recruitment and data collection.

Sessions were audio-recorded, transcribed, and stored securely. Consent was collected verbally, due to mixed literacy abilities and the online setting. The participants received



copies of both the participant information and consent form in advance in their language to have time to reflect, and had it read to them on the day with time for queries. Consent records were kept separately from transcriptions, and mothers were allocated a code for analysis to maintain anonymity. The codes are included within the findings and contain a simple corresponding group letter and a participant's number within that group, e.g., A1.

### 2.5. Data Analysis

Transcripts were read and re-read in full by the lead researcher to achieve immersion in the data, in an active process [55]. The lead researcher analysed transcripts thematically, with coding samples verified by coinvestigators. We took a descriptive approach to thematic analysis of the data [56], aiming to “give voice to participants” [55] to identify categories of shared experiences by the mothers [57]. Through analysis, the themes identified in the data aligned with the framework of social support theory.

After reviewing the mothers' transcripts, the numeric and narrative responses of the staff and volunteers through the survey were collected and analysed. As the focus of this study was on the experience of the perinatal project services, we did not enquire specifically into the past experiences prior to pregnancy, including those of the terms of their asylum, or for the 20% who also had experiences of trafficking or exploitation. We therefore did not specifically analyse the difference between those in that 20% and the majority in terms of service delivery. The mother's experiences were viewed as a whole, and there were no notable differences in the experiences of any one language group. The only differences were noted in those who had previous children, and those for whom it was their first child in terms of confidence and need for information.

#### Theoretical Framework: Social Support Theory

Our research methodology is guided by social support theory, informing both variable formulation and measures of outcomes. Social support is a complex and multidimensional concept, and it can be defined as the assistance provided by a person's social network involving emotional and physical support [58]. Improvements in circumstances and well-being are experienced through four to five common components: instrumental (practical); emotional; social; informational; and appraisal support [10]. This theory has been explored in other contexts of those experiencing violence, deprivation, rape, domestic violence, conflict, and risk, and has been recognised to have both mental health and physical health implications [11].

The two main theoretical mechanisms of this framework are the direct promotion of health and well-being, and the buffering of stress, including reducing the physiological effect of stressors [12]. Social support is distinguished by the extent to which social networks and relationships fill individuals' specific needs, and the degree of social integration [59]. It is also defined as the “individual's perception and actuality that one is cared for and has available assistance from others, and that an individual is part of a supportive social network” [60]. Emotional support refers to manifestations of love, trust, empathy, and caring that can be provided through gestures of affection. Informational support involves the provision of advice, suggestions, and information to assist the individual in solving problems. Instrumental support is “tangible assistance” which can mean financial support, a type of service or practical items. Appraisal is the assessment and constructive feedback of the situation provided to an individual for encouragement, self-evaluation, and affirmation [60]. Social integration into a network of meaningful relationships enables the sense of belonging and value and contributes to thriving long-term, both in personal and relational outcomes [61]. As we explored and analysed the experiences of the mothers, we found each one of these support mechanisms evident in some form in various stages of their perinatal care.

Such support is important both during pregnancy, with an impact on positive health outcomes, and postnatally, including helping reduce anxiety and build mother–baby attachment [12]. For this, understanding women's lived experiences and perceptions of

social support during pregnancy becomes imperative to better support women [58]. Social support effectiveness has been used as a tool to *assess* the quality and quantity of social support women receive, such as the support received from their partners and the extent to which it meets their needs [62], as well as to examine the association of family social support vs. non-family support and antepartum depression in early pregnancy [63].

Research demonstrates that social support can improve an individual's positive interactions, reducing the risk for depression, anxiety, and stress [10,59,64]. In general, it is perceived that higher social support is connected to lower risk for depressive and anxiety symptoms for mothers; however, there is a gap in research regarding the role of individual perceptions of types of social support during pregnancy [64]. Most studies have primarily employed quantitative approaches, being unable to capture wider contextual factors which may also shape women's experiences [58]. While this was not intentionally built into the design of the services or this study, using it to analyse our findings helped us understand the strengths and impacts of the services on the mothers and their families.

### 3. Findings

In this section, we present the findings of our data collection, from both mothers (prioritised) and our staff survey. The findings are presented following the chronology of the women's experiences of the service. After contextualising why women have joined the service, it reflects aspects of social support: (i) meeting women's immediate needs reflecting practical, instrumental support; (ii) informational support and guidance, (iii) birth preparation and doula's role offering all forms of support, (iv) breastfeeding support, (v) mental health and well-being reflecting emotional and appraisal support, and (vi) building relationships through social support. Finally, it provides gaps in the service provision perceived by participants.

Woven into the mother's responses (prioritised) are some anecdotes and experiences of staff and volunteers who submitted to the online survey. Here, some responses echo the mothers, and others bring additional insight from the perspective of those who have worked with a number of clients in different circumstances including language groups who did not participate in this study, and those with external perspectives. This is also beneficial when considering the project's working relationship with other services, as the mothers may not always see some of these "behind the scenes" collaborations.

#### 3.1. Why Are Women Joining the Service?

The project supports and attends to immigrant women who are pregnant or have already had their babies, and who face broad challenges. Many women attending the service have arrived in the United Kingdom with few social networks, family, or friends; "for me, it was very difficult because I have no one here, no family either" (D3); "I was alone at home with no one to help me to take care of the baby" (A2). Women are alone and lack any sort of social support; "At the beginning, I was really scared I would be alone in this whole thing" (G1), "I don't have any family here" (G5). Moreover, they usually face language barriers and are unfamiliar with the healthcare system. These factors caused the mothers high levels of stress, and sometimes depression, which they shared with this study.

Women often accepted help because they wanted someone to accompany them during their labour, or because their only relatives or friends were not available to accompany them. A common sentiment expressed was: "You need someone to talk to, to ask for help" (G2). Asylum-seeking mothers were often placed in hotels and lacked any clothes or basic material provisions for their babies. Normally, they do not hold the paperwork needed for legal residence, exacerbating their insecure situation; "I'm still an asylum seeker with no papers or residence or anything" (D2). For instance, one woman (G4) was found on the street after seeking help from the UK Home Office on a Saturday, when it was closed. After being attended by an ambulance, a midwife referred her to the Happy Baby Community.

### 3.2. Meeting Women's Immediate Needs

Those interviewed identified an urgent need for basic items for themselves and their babies, with this lack of provision being a source of distress. When the project was able to provide the needed items, distress was relieved, and respondents expressed gratitude. Some women literally did not have anything for their babies or the means to get what they needed. One woman explained that she did not even have a t-shirt for her baby (F1), and others admitted feeling desperate. Women often mentioned receiving clothes for their babies, maternity bags (including everything they need for the hospital), toys, shampoo, bathrobes, nappies, cots, soap for babies, milk bottles, and breast pumps. In addition to these, some were given vouchers for food or transport costs, helping them to attend project activities.

A small number of women also received larger items such as a phone, a pram, or a bed, which were highly valued. A Hestia caseworker highlighted that “an anxiety that a lot of mothers seem to face is the issue of material supplies” (Staff n°30) since, financially, this can be difficult; she confirmed that both Happy Baby Community and Hestia assist with referrals or grants to cover costs of nappies, cots, and clothing. Beyond material needs, a Happy Baby Community 24 h helpline is available to ask for support. Some women have been assisted in moving out of hotels and finding more secure accommodation in London with urgency before birth. Women also appreciated the extra help and support received by the Happy Baby Community during the COVID-19 pandemic such as groceries, pointing out how hard it is for “immigrant mothers to arrive to a new country where there is lockdown.” (C3). In general, women's immediate material needs appear to be met through the project, providing instrumental and practical support which was greatly appreciated.

### 3.3. The Need for Information and Guidance

Upon arrival in the United Kingdom, women recounted feelings of loneliness, worry, and fear. Often, they did not know where to ask for help, or what steps they would need to follow regarding their pregnancy. Informational support and guidance are crucial here, and a woman found this to be “the most important thing for new mothers that come along to the UK” (C4). Women often felt unaware of how to navigate the NHS, GPs, schools, councils, and nurseries, and they were very pleased with the help and guidance: “I really needed someone to tell me how to act and where to go” (C4).

Beyond practicalities, women felt relieved and assured knowing that they will receive the necessary support within their pregnancy, labour, and for their child. A single pregnant mother stated she was “a bit, well not a bit, a big worried” (B1) and felt that 50% of her stress was gone after talking with the staff and acknowledging that she could count on a doula to assist her. In the case of C2, HBC started supporting her in her second pregnancy, and she highlighted: “I wished I had met them before because during my first pregnancy, I was so stressed” (C2).

Women were reassured by the help provided in their first contact with the services, a contact that helped them to recover their hope. For G3, it was “the only door that was opened to me in England” (G3). They felt welcomed, embraced, and calm since they knew that they were going to receive appropriate support and help for themselves and their children. As several women highlighted, “Women that work there are very nice, I feel very welcome there” (G2); “She embraced me as if we were family” (A1); “I really need that kind of support, someone that just calm me and ask how I am doing” (B4). Some were encouraged by the opportunities available to them like language classes, through the organisations' wider services, which helped them feel hopeful about the future, be excited to learn, and be able to secure work and provide for their families.

### 3.4. Birth Preparation and the Doula's Role

The role of the doula enables various parts of “social support” with a focus on the birthing period itself, with some preparation and immediate aftercare to complement this birth support function: beginning with informational support; practical support to meet

physical needs during birth; emotional and appraisal support to help see mothers through; and an important point of social contact and practical and informational support again for immediate aftercare and in the early weeks of recovery post birth before other service roles step in. Of mothers interviewed, 24 out of 31 received doula support, which is offered to all upon joining the project.

Mothers were encouraged to choose how they wanted to give birth through birth plan preparation; “my doula was contacting me through phone about how I want to give birth” (E2). In these sessions, they exercise their own judgement and decide on their birth procedure. As one woman explained (G1), “You sign the birth plan and give it to the midwife, so the doctor prepares the birth according to the plan. If you need anything else, the doula asks for it based on what you have written down.” Respondent G2 learned “a lot of things” as she made plans on how to give birth with her doula. One woman asked explicitly to not have a male doctor because she was not comfortable, and the doula ensured her request was respected (G5). When needed, an interpreter was provided during labour to help with translation.

The aim, as explained by a Happy Baby Community doula, is to “voice their desire to birth in a particular way, for instance in water” (Staff n°5). Such requests are noted on birth preference notes. An antenatal support staff member from the Happy Baby Community highlighted that mothers attending the sessions on birth preparation tended to be more reflective once they had received information (Staff n°15). This allowed them to make choices they had not considered beforehand; for example, some mothers were not aware of the existence of birth centres, the option of birthing their babies in water or a birth pool, or the option of a Caesarean. Once they did learn of these options, they would consider options and raise them with their midwives. Similarly, one Happy Baby Community doula explained that mothers are given information in order to support their choices concerning labour, such as who accompanies them or the extent to which they want to receive postnatal calls (Staff n°31). This doula recounted how a woman she attended to was receiving “constant pressure from midwife and obstetricians to go ahead with induction a week early” (Staff n°31). Through the guidelines received and using birth information, she decided to follow her mother’s intuition and waited.

Companionship, support, and guidance are the core characteristics of a doula’s work, and these factors are often noted as extremely valued and appreciated by women. Respondent F1 described: “She helped me physically, as I was alone, and I was only with her. She wiped my sweat, give me water, tried to distract me. . . and then when my baby born, she helped me to change her clothes.” (F1). Doulas provide emotional and physical support such as calling mothers regularly to check in on how they are feeling prior to labour and whether any issues are arising for them, “she started calling on and off, on and off, calling me, giving me sweet voices” (A1); or accompanying them to the hospital and staying with them to support them during labour and after the baby is born, “I wanted one person to hold my hand firmly, that is how I felt relief, and she stayed there the whole time” (G1); or being available to help them in different aspects of their pregnancy and preparation for birth, infant feeding, and newborn care.

With this support, women feel reassured, comfortable, and safe: “The lady gives everybody hopes!” (A1); “They helped me a lot giving me a lot of instructions and orientation about the pregnancy and delivery (. . .) Beyond being someone to help me, she became a friend (. . .) She helped me a lot, both physically and emotionally, a lot!!!” (F3); “She came the day when I gave birth, and she came, she assisted me, she was more (moooore, she emphasised), I am sorry, more than my mother (B1)”. Similarly, E2 and G3 compared the doula to her mother: “she helped me a lot at the hospital, you can even say like a mother, I am still grateful when I think about her being with me” (E2); “she was like a mother or a sister that I needed at that time” (G3). For C2, being accompanied by a doula during her delivery was a “light” (C2), who was described as “an angel” by C5 (C5).

### 3.5. Breastfeeding Support

Social support has been identified as a predictor of high rates of breastfeeding and self-efficacy [60,65], and other research supports the benefits of breastfeeding, for physical health and development and cost efficiency (using mother's milk rather than the purchase of formula or equipment). In this context, mothers were offered information and support across expression, formula, and breastfeeding methods through antenatal preparation and breastfeeding counselling support available over the phone, through drop-in classes and, where needed, given equipment.

Following birth and discharge from the hospital, women were telephoned to check on how they were and especially to check on their feeding methods. Mothers were asked how they were feeding their children and whether they needed guidance to ease the process of breastfeeding. Staff with breastfeeding counselling experience explained to us that women who have suffered trauma and sexual violence often find breastfeeding challenging, even triggering, and Happy Baby Community doulas and breastfeeding specialists offer trauma-informed breastfeeding support that enables women if they choose to try breastfeeding.

The majority of women, especially those who were first-time mothers when they joined the Happy Baby Community, had no knowledge regarding breastfeeding. The service offered help to women through classes about pregnancy, delivery, and breastfeeding. Respondents were appreciative, recognising that, thanks to the service, they can "breastfeed naturally" and some described breastfeeding as a "beautiful experience" (F1). Many women reported facing challenges in breastfeeding, especially first-time mothers. Mothers mentioned pain, swollen breasts, and a difficulty in stimulating milk: "My breasts were swollen, and he couldn't drink." (G5). Through the help of doulas, project staff, breastfeeding specialists, midwives, or nurses, mothers were able to learn how to position their babies, relieve their pain, and stimulate their breasts to produce milk. One woman who struggled considerably, received guidance on balancing between using a breast pump and breastfeeding, and then only breastfeeding. Another woman was "shocked by the breastfeeding", asserting that it was difficult as she had sore nipples. The help received from her doula enabled her to stop using formula and breastfeed exclusively (G5). Despite the challenges and pains encountered at the beginning of breastfeeding, and thanks to the help and guidance received, some mothers reported that their pain was relieved, and they continued to breastfeed. Some women felt that this led to a special connection with their newborns. When necessary, women need to receive guidance on other options for feeding. For this, the project sought to provide women with advice and information on bottle feeding, formula, and weaning onto solid food. Women also reported joining classes on children's nutrition, as well as health classes about possible infant diseases and how to prevent them.

### 3.6. Mental Health and Wellbeing

Feelings of loneliness, fear, disorientation, and unpreparedness are significant and frequent among participant mothers due to their circumstances and histories. We did not ask about their stories, but many mothers referred to them as they expressed how they felt before entering services. Often, they had arrived in the UK alone, sometimes single or first-time mothers. They often had little or no spoken English, and they lacked access to emotional, social, and/or financial support. This precarious state enhances fear and undermines hope. One woman noted that she was so stressed and depressed that she took an overdose; she stated: "Oh my God, I am pregnant again because I am a victim of violence and abuse (. . .) I don't think I will be able to have it. So, I took an overdose." (A2)

With support from the project, however, the women's mental health and self-efficacy could change considerably; "life became more tender because I was in shock" (A1). With help and guidance, women could meet and understand the challenges of both feeding their babies and looking after their own well-being and health. Beyond the practical help women received, phone call support, one-to-one support, and connections through the group also helped them to deal with whatever stress, depression, and trauma they might

have as they recovered through feelings of calm and the encouragement they received. Emotional support was felt for many from the moment they joined the project; women felt welcomed and embraced. They felt relief when receiving their material support, which also helped them deal with mental health challenges and face the future.

Many women talked about how they were helped to release their stress, to not feel alone, and for some, to deal with their depression. This gave them “hope to enjoy life again,” (B2). The same woman noted that it was a difficult time as she was living in a hotel, and she very much appreciated the advice and receiving “lovely words” (B2). Living in hotels was a cause of distress for eight of the women, partly due to not being able to have a proper diet: “I can’t cook here because the kitchen is far from my room, so it is difficult for me to prepare anything [while caring for my baby]. In my current situation, I could not prepare food for my child, so I buy packet food from the supermarket and give her that. It is difficult for me since she needs a balanced diet, and I cannot give it to her” (E2). Another reported missing meals when they could not provide for her baby’s dietary requirements, and despite self-advocating and a doctor’s letter, was unable to get further support through asylum accommodation provisions: “My daughter is lactose intolerant, she can’t drink milk, which means I have to cut milk from my diet. However, I live in a hotel and, as much as they try, sometimes they serve dinner’s leftovers as lunch and sometimes they would have put milk in the food. This means that, since I am still breastfeeding, I have to skip two meals.” [G4].

Beyond supporting and accompanying women during their pregnancy and birth, doulas helped women in not feeling alone, and at times helped them in dealing with depression: “I didn’t know that pregnancy comes with depression, sometimes you lose hope. So, that person is there to help when I am down” (A2). One woman described the emotional support and encouragement she received from the doula as being “like therapy”, adding “I was completely terrified, very scared, I was weak, I felt it like a very important support” (F3). Similarly, B1 described that she felt very comfortable, “because when they call, you don’t feel alone, you really feel there is someone with you, they make me feel really really comfortable, honestly” (B1).

Another woman stated that while the material support was good, what she appreciated the most was the “love and sympathy”: “it’s the face-to-face contact, the closeness that helps” (D3). Receiving such support, and feeling part of a community, allowed women to feel safe and trust the organisations; “they helped me in the past and it is not forgotten” (B5). Women assert being comfortable as they are constantly checked on and are asked about their feelings and emotions, such as B4: “I really need that kind of support, someone that just calms me and asks how I am doing, you know. . . they make me feel very comfortable.”

### 3.7. Relationships

Due to the closeness of the support received throughout their journeys, strong bonds were seen to develop between mothers and their doulas and other members of staff. Weekly sessions, “mum groups”, and sharing different activities helped women to engage within their community while allowing them to build relationships with each other. There were also “baby groups” where children could interact, play, and have fun. Mothers were able to build appropriately safe and welcoming relationships with doulas and staff. Volunteers called mothers once per week over the first three months, and then rotated to the next cohort of new mothers needing support. Some women reported difficulties and disappointment when this occurred as they did not want such relationships to stop. Though there were open drop-in centre times, these were not always convenient for the mothers. A potential need for ongoing support was noted by one caseworker who highlighted that mothers still needed to receive help “once they have refugee status or when their children are older than one year” (Staff n° 1).

The sense of community built through drop-in services held by Happy Baby Community was highly valued, reducing loneliness and building social confidence. Despite women’s different backgrounds and languages, sharing experiences with other mothers

was “beautiful”, always finding “other ways to communicate” (F1). Hearing from other mothers living in similar situations helped women to “learn more and it helps to heal yourself” (C2). Mothers reported that these drop-in sessions benefitted their children, and they perceived that they found a safe place to play among peers and enjoy themselves.

### 3.8. Perceived Gaps in Service Provision by Participants

Throughout the data collection, in the survey, focus groups, and interviews, we asked participants for perceived gaps in services and opportunities for improvement for the perinatal support service. Their responses suggested the following:

- Funding or signposting options for additional or larger items were desired (i.e., prams, breastfeeding bras, pyjamas, and slippers).
- Further mental health support and counselling services (i.e., greater phone support capacity).
- Further availability when providing birth companionship such as longer postnatal support (i.e., more face-to-face support post birth in the first weeks).
- Strengthening services, offering information on weaning and feeding infants beyond breastmilk.
- Extra help for those women living in asylum accommodations and in hotels since, many times, women are worried about not being able to provide proper food to their children.
- A need for more staff to work within the organisations (a lack of supporters limits the service and causes delays or a shorter amount of post-natal support).
- Increase face-to-face opportunities for women to meet and benefit from the community when sharing ideas, guidance, and information (this provides an additional social opportunity for mothers and supports mothers and children without a nursery place).
- More English class opportunities (including one-to-one English lessons and more class days per week).
- A need for childcare opportunities so the women can access work or study such as engaging better with the service’s activities.

## 4. Discussion

This study revealed the practical, emotional, social, physical, and informational needs of women who entered the UK pregnant or become pregnant shortly after they have entered the country. The five areas of social support theory are reflected in mothers’ accounts of the support they received through the project, helping illuminate the needs of this under-served cohort who have experienced traumatic circumstances, identifying gaps in care as well, and offering insights into the experiences of a model of care beyond that of NHS maternity provision. Practical needs were met through the provision of items needed for the immediate care of their baby; the encouragement of doulas and companionship during labour and support calls received reflected emotional and appraisal support; and interactions with the wider Happy Baby Community group through key workers or community sessions and classes reflected social and informational support that would take them towards their future.

This study benefitted from the existing service’s design, its strong emphasis on listening and developing through the voices of the mothers whom they serve, and the positive trusted relationships of the community through which we could access the testimonies and insights of lived experience and professionals. With additional time and funding, this study would benefit from a wider pool of stories including insights of additional languages and specific cultural experiences. It would be interesting to build a comparison with other services around the country who work with similar cohorts, those who do not have the support of such services but who have similar backgrounds, and to implement further quantitative measures throughout the project to further measure the impact of the services on factors such as breastfeeding rates and wellbeing outcomes.

Pregnancy, childbirth, and becoming a mother bring significant challenges and changes in women's lives, but for survivors of violence and exploitation, this experience is layered with complex mental and physical health needs and the risks of re-traumatisation. The women and infants supported through the project often experienced challenges with health and social barriers to care, impeding their ability to build a new life with their children in the UK.

There are wider discussions as to the context and complexity of being foreigners seeking asylum within a context specifically designed to be a "hostile environment" by the UK Home Office [66], as well as their economic and social prospects. The treatment of women who are the victims of very serious and violent crimes as problematic "migrants" has called into question state duties and obligations under international law, as their physical and mental health often suffers from a lack of decent food, clothing, and appropriate accommodation.

Additional layers of struggle were added for those asylum-seeking mothers, and those who have also survived forms of slavery and trafficking, such as commercial sexual exploitation. Women in this situation are rarely identified as such as their perpetrators seek to conceal such conditions and facts, such as traffickers who speak on women's behalf while paperwork is filed, and women who are constrained from attending appointments or accessing interpreters or are threatened if they reveal their circumstances [37,40]. The non-governmental organisations participating in this study and many others working with those with similar experiences as these mothers work in response to a serious human rights violation within a challenging political context. In 2015, the UK passed the Modern Slavery Act which, among others, extended the National Referral Mechanism (NRM) aiming to provide support for all victims and survivors of modern slavery in England and Wales, and was a move towards fulfilling its obligations under the Council of Europe Convention on Action against Trafficking in Human Beings 2005. During this project's timeline, both the Nationality and Borders Act 2022 [67] and the Illegal Migration Act 2023 [68] were promulgated in the UK, two acts that have considerations for modern slavery, but in doing so, have come under criticism for severely undermining compliance with international rights obligations. Instead of supporting victims of human rights violations with their physical, psychological, and social recovery [69], they provide for detention and deportation [70]. In developing immigration laws through the acts mentioned above, "issues of modern slavery, human trafficking, and immigration have become further conflated and highly distorted" [69]; for example, those whose enter the UK are an element of the criminal offence of trafficking committed against them [70]. For our asylum-seeking mothers who have fled terrible situations to settle their families, they already navigate a complex array of provisions in the UK, but with this changing legal environment, the challenges they described facing in seeking a settled family life are likely to be further exacerbated by these bills.

During this time, the UK also faced extreme pressures in the healthcare system and a cost-of-living crisis, squeezing the already limited financial allowances. The provisions regarding food, allowances, and accommodation are under further threat in the UK, particularly for those who currently qualify for victim care protections under the Modern Slavery Act, and questions are being raised as to whether the policies meet international human rights requirements and expectations, including those which the UK are signatories [71]. The United Nation's OHCHR 'Principles and guidelines on the human rights protection of migrants in vulnerable situations' includes provisions for the right to health, to adequate standard of living, and to access information [72]. As well as expectations for tailored, gender-responsive, and culturally appropriate healthcare and access to health and rights information, Principle 12 specifies guidance for access to adequate mental healthcare which is culturally appropriate and is designed and delivered in cooperation with migrants. This project saw benefits to mental wellbeing as is clear through the participant feedback of finding calm, safety, stress relief, companionship, increased confidence, and the capacity to manage life under difficult circumstances. The project also benefited from co-designing



with service users through feedback, staff, and volunteer inclusion of lived-experience mothers, and the role of the EAG. Happy Baby Community's services were and are delivered with the support of lived-experience staff and volunteers, who are experienced with social services, as well as asylum, motherhood, and shared cultural experiences. Both organisations demonstrate their high value of the lived-experience voice through the engagement of the EAG, which enabled some of these mothers and "graduates" of the services to share improvement, ideas, and solutions which could be further implemented. This study, for example, was guided on which words were appropriate to use in the key languages, and the proper ways to discuss mental wellbeing, before and after receipt of services. This meant opting to use "thoughts and emotions" instead of expressions like "mental health" which are more commonly used among UK nationals. It is important to remember that these two services go beyond the required statutory provision, and therefore it would be expected that many more women in these situations are going without such support [73].

Principle 13 of these OHCHR Guidelines which lays out guidance for standards of living, including clothing, housing, and improved living conditions, demands "*Adequate and safe food sufficient in quantity and quality to satisfy an individual's dietary needs, including the specific dietary needs of pregnant women, nursing mothers and children*" [72]. The fulfilment of this expectation, and the obligations to the attainment of a standard of physical and mental health laid out in the International Covenant on Economic, Social and Cultural Rights [6], is something the mothers in this study report lacking from statutory provisions, a factor which heightens both physical and mental stress for the mother and child. In fact, a weak intersection between statutory and non-statutory services has been identified [40], and this research adds some knowledge about how two non-statutory services are responding to this severe matter. Through hearing the voices of the women affected, such as those struggling to receive sufficient food and housing, it sheds some light for good maternity practices. We recommend that policymakers conduct further research to consider this factor, as this came across as one of the strongest messages from mothers who are struggling to feed themselves and their children under the current provisions for asylum seekers, including those emerging from the National Referral Mechanism.

## 5. Implications and Conclusions

Given the context in which women are being brought to the UK, with some being placed under coercive control, or forced into labour or sexual exploitation, or simply navigating the asylum systems, and the impact on such histories on maternal and neonatal outcomes, it is clear that this cohort of women are regularly not recognised and supported by our stretched national health and social care processes [40]. Because of the invisibility of this cohort of women, when they become pregnant and then give birth, these women and their babies often fail to be provided with sufficient care, support, and protection. There are several dangerous situations and outcomes that follow when a woman is not recognised as the victim of a serious crime by the social and health services, as well as the legal and public order services. In these situations, the mother and child lack fundamental protections, they lack stable housing, and they lack sufficient life support for the mother and child. These linked implications and outcomes can create serious problems and additional risks for mothers and babies, such as missing out on care provisions and, in the worst-case scenarios, risk of further exploitation.

For perinatal and asylum support services, we have noted that the professional, peer, and group support provided by multi-stakeholder collaborations offer a strong social support framework to the meet practical, emotional, social, appraisal, and informational needs of mothers. Without this, it is much more difficult for mothers to cope with managing the health and wellbeing of themselves and their babies, as identified by mothers who described what they felt before entering this project's services. For those who receive settled status, this kind of support can sustain long-term benefits for the mother and baby and for them to be able to contribute to society. We also note that language was identified as one of the main barriers to accessing services outside of this project, and the two organisations

facilitated interpretation where, in some cases such as in hospitals, it was inadequately provided. The facilitation of culturally competent support and interpretation can offer the space for mothers to speak freely, in their own tongue, to not only shape their experience of support but help meet a mother's rights to consent to care. Happy Baby Community has demonstrated that one way to ensure the mother's voice is heard, in addition to the means of available interpretation, is through the means of birth companionship and peer support. Not only is it essential to perinatal mental wellbeing alongside the standard provisions of maternity services, but it also has the potential to reduce the burden on national health services in the long run for mother and child.

Considering other implications of this study for policy and practice in the UK, we note that funding to NGOs for support services contracted by the government, when limited, tends to prioritise immediate material needs and miss meeting the longer-term physical, emotional, and social support needs that can be essential for settlement and integration into society and the reduction in burden on services in the long run. As addressed in the literature, maternity services currently feel challenged in identifying and meeting the needs of mothers with complex histories like asylum and trafficking due to limited resources and issue-specific training. Mothers will continue to find their needs missed without the development of guidance for services. It also appears that pregnancy is currently not identified during asylum and modern slavery case referral through the Home Office, and therefore the full scale and extent of the issue and how and when support is needed are unclear. Mothers reported their struggles in accessing sufficient accommodation and nutrition, appropriate to the needs of the mother and baby, which, even with medical letters of support, was not rectifiable. Should provisions for these continue to be constricted due to emerging legislation for migrants, mothers and children in the asylum system face dire health consequences.

It is a dire and perilous situation, and yet even in the face of criminality, public and cultural ignorance, and a lack of attention by social systems, there have been clear and positive outcomes for those supported by charities such as those participating in this project. Any pregnancy may be challenging but can also be a pathway to recovery and a new orientation to life when given appropriate support, however precarious that may be within the political context. It is also possible to point to key positive experiences that address the special and particular needs of asylum-seeking women and their babies—demonstrating that the two non-governmental organisations studied above have developed compassionate and supportive community-based practices that move women and their families from danger and precarity to stable and beneficial ways of living and being.

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## Notes

- <sup>1</sup> An “Expert Advisory Group” (EAG) was established at the beginning of the project by the two organisations that included mothers and peer volunteers with lived-experience of the asylum system and the services provided by the project, staff, and external professionals, in order to advise on the design, delivery, and ongoing improvements of the project’s services. This group met quarterly and enabled cross-stakeholder collaborations and co-design activities with service users. The EAG also advised on the development of this study and its approach.
- <sup>2</sup> “Peer volunteers” were mothers with experiences of seeking asylum and support through Happy Baby Community services, and whose children were now a little older. These mothers were more established in the UK and chose to support other mothers, especially in those within the same language or cultural group. Peer volunteers offer phone support or leadership in the drop-in sessions. They received training and support through Happy Baby Community staff to deliver these roles.

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