



## Navigating new lives: A scoping review and thematic synthesis of forced migrant women's perinatal experiences<sup>☆</sup>

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### ABSTRACT

**Background:** For health systems and maternity services to respond effectively to forced displacement, an understanding of the lived experiences of women seeking protection during childbearing is required. This study aim was to systematically review existing literature on the perinatal experiences of forced migrant women.

**Methods:** We conducted a scoping review including MEDLINE, CINAHL Plus, Web of Science and PsychINFO databases and manual search of references. Included studies were quality-assessed and analysed using inductive thematic synthesis.

**Findings:** In total 39 studies were included, involving 624 forced migrant women in 12 countries. Three inductive themes were: (1) “The nature of being a forced migrant,” describing multiple liminalities experienced by women; (2) support during the perinatal period, showing women's (re)negotiation of shifting kinship and support networks; and (3) interactions with maternity services, revealing variations in maternity care experiences.

**Conclusion:** Findings highlight the systemic power structures forced migrant women must (re)negotiate during the perinatal period and the supportive and empowering role maternity services can play through provision of woman-centred care. Further research is needed to understand the lived perinatal experiences of forced migrant in low-income and transit country contexts.

### Background

Over the past 30 years, interest and literature concerning women and migration has grown. The global movement of women has remained steady since the 1960s, now accounting for 48% of all migrants, with the majority of these women in the childbearing years ([International Organization for Migration, 2020](#)). Women on the move are exposed to particular health-related vulnerabilities including sexual exploitation, violence and reduced access to reproductive health services ([World Health Organization, 2018](#)) but remain under-researched. Pregnancy, childbirth and the six weeks after birth, (hereon in referred to as the perinatal period) continue to be experienced by women who are migrating ([World Health Organization, 2019](#)). Obstetric outcomes for forced migrant women are unclear, largely due to heterogeneity in migrant categories and contexts between studies, rendering evidence synthesis problematic. Nonetheless, there is clear evidence that perinatal mental health is worsened across all groups of migrants, contributing factors of

which are thought to include social isolation, traumatic events before or during migration and stressors related to immigration regulations ([Collins et al., 2011](#); [Fellmeth et al., 2017](#); [Anderson et al., 2017](#)).

This study focuses on the perinatal experiences of women who are forcibly displaced and seeking protection, that is to say, forced migrant women. Whilst recognising the difficulties in defining groups of people whose mobility is complex in motivation and trajectory, the term ‘forced migrant’ has been chosen as a term to encompass people in need of protection for the purposes of this systematic review and literature synthesis. While it is a loosely-defined concept, its use recognises the need to go beyond the precise legal definition of ‘refugee’ as defined by the 1951 Refugee Convention (those who leave their country due to persecution on the grounds of race, religion, nationality, membership of a particular social group or political opinion), to include involuntary mobility for a complexity of man-made or natural reasons ([Zetter, 2014](#)).

Previous reviews have focused on the perinatal experiences of migrants generally ([Pangas et al., 2019](#)) or in specific countries or regions

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(Fair et al., 2020; Schmied et al., 2017; McKnight et al., 2019). The aim of this review was to synthesise the literature pertaining to the experiences of forced migrant women during the perinatal period. Objectives were to: (i) identify the extent and quality of the existing literature; (ii) generate themes and consider their implications; and (iii) highlight gaps and areas for further research

## Methods

### Study design

We conducted a scoping literature review (Arksey and O'Malley, 2005) and thematic synthesis (Thomas and Harden, 2008). Scoping review methods are detailed in Woodward et al. (2014). This enabled aggregation of qualitative data on participants' experiences, from which analytical themes can be developed. It is well suited to a woman-centred approach as it enables understanding of lived experiences from participants' perspectives.

### Search strategy

ES conducted the literature search and selection process followed methods outlined by Arksey and O'Malley in July 2020 with supervision from DD and NH (Arksey and O'Malley, 2005). To answer the question, "What is known from the literature about the perinatal experiences of forced migrant women?", the search included all eligible sources up to 31 July 2020 in four online databases (i.e. MEDLINE, CINAHL Plus, Web of Science and PsychINFO) and further manual and Google Scholar searches to ensure all relevant articles were included. The main search terms were "forced migrant", "perinatal" and "experiences" with keywords related to these search terms used.

### Eligibility and screening

ES screened studies for inclusion with guidance from DD. Inclusion criteria were all peer-reviewed studies published in English, using qualitative methods and including forced migrant women participants. Mixed-method studies were included, but only qualitative results were synthesised. Studies including data from other groups (e.g. health professionals, fathers) or migrant typologies were included if data relating to forced migrant women were identifiable. Studies across a range of countries and contexts were included, to reflect the varying contexts of women's perinatal experiences during migration with study context identified in this synthesis. Studies focussing on internally-displaced women, grey literature, and conference abstracts were excluded. Descriptive pieces, studies focussed exclusively on motherhood (after the 6-week postnatal period), reproductive or neonatal health, or perspectives of fathers and healthcare providers, were excluded.

Initial database and manual searches yielded a total of 2968 records (Fig. 1). Removing duplicates and screening the titles and abstracts resulted in 99 articles for full-text screening, leaving a total of 39 studies for inclusion in the thematic synthesis.

### Quality assessment

We used the Critical Appraisal Skills Programme (2018) tool to assess quality, though this was not used as a filtering tool for exclusion, as even low-quality qualitative studies can yield valuable insights (Hannes, 2011).

### Data synthesis

Data were synthesised by ES, with checks by DD and NH. First, all text in the findings section of papers was included in analysis, using NVivo v12 (QSR International 2020). Only data directly relating to forced migrant women's experiences was inductively coded, including

primary quotations and author's text. Second, codes were grouped into descriptive themes. During coding, a pattern fitting the Ecological Model (Bronfenbrenner, 1979) was noted, so this model was used to provide *a priori* descriptive themes of five symbiotic systems; individual, interpersonal, organisational (relating to health or maternity services), political and cultural (relating to the host country). Third, by looking at patterns and relationships across the descriptive themes and codes, as well as looking back at the primary data fragments, analytical themes and sub-themes were developed.

## Findings

### Study characteristics

Table 1 summarises the 39 studies included. In total, 33 studies were conducted in high-income countries (i.e. Australia, Canada, Germany, Ireland, Sweden, USA, UK) and 6 in low/middle-income countries (i.e. Kenya, South Africa, Sudan, Thailand, Turkey) with 3 of these in neighbouring country refugee camps. In total, 624 forced migrant women participated. A diversity of perinatal experiences were explored, allowing for wide-ranging experiences to be synthesised.

### Quality assessment

Table 2 shows results of study assessment using the CASP (Critical Appraisal Skills Programme 2018) tool, which revealed mixed quality of included studies. The common study weaknesses were failing to address issues of reflexivity and the way in which the role of researchers or research assistants may have influenced the study. This is particularly pertinent when bicultural or community research assistants were used (Riggs et al., 2016; Riggs et al., 2017; Nithianandan et al., 2016; Russo et al., 2015), as participants may have been concerned about revealing or discussing sensitive issues with other community 'insiders'. Ethical issues were another common study weakness – discussions about the impact of the study on participants was often not addressed. In both of these cases, it is possible that the word count of papers limited the amount of discussion that was possible.

### Thematic analysis

The overarching themes are: (1) the nature of being a forced migrant; (2) support during the perinatal period; and (3) interactions with maternity services. Although findings are described as discrete themes and sub-themes, in reality, they are synergistic and overlapping, demonstrating the complex lived experiences of forced migrant women during the perinatal period.

### The nature of being a forced migrant

*Liminality.* The transition from one state of being to another or being 'betwixt and between', was experienced by forced migrant women around the childbearing time repeatedly; socio-culturally, economically, legally, physiologically and spatio-temporally. Separation from home country socio-cultural structures, coupled with the loss of rituals associated with rites of passage from pregnancy to motherhood, often resulted in feelings of loss and grief [22–3118–26]. An Afghan refugee woman who delivered in Australia captured this:

"Having a child was such an important time. It was a time when we ate the best food, we get massages every day and were treated with the best of everything. Here we are left to look after ourselves..." (Russo et al., 2015).

Liminal citizenship status was experienced not only as a source of stress in itself, but also imposed protracted insecure living arrangements, lack of hygiene and cleanliness, overcrowding and with the stress of possibly being re-housed (Hufton and Raven, 2016;

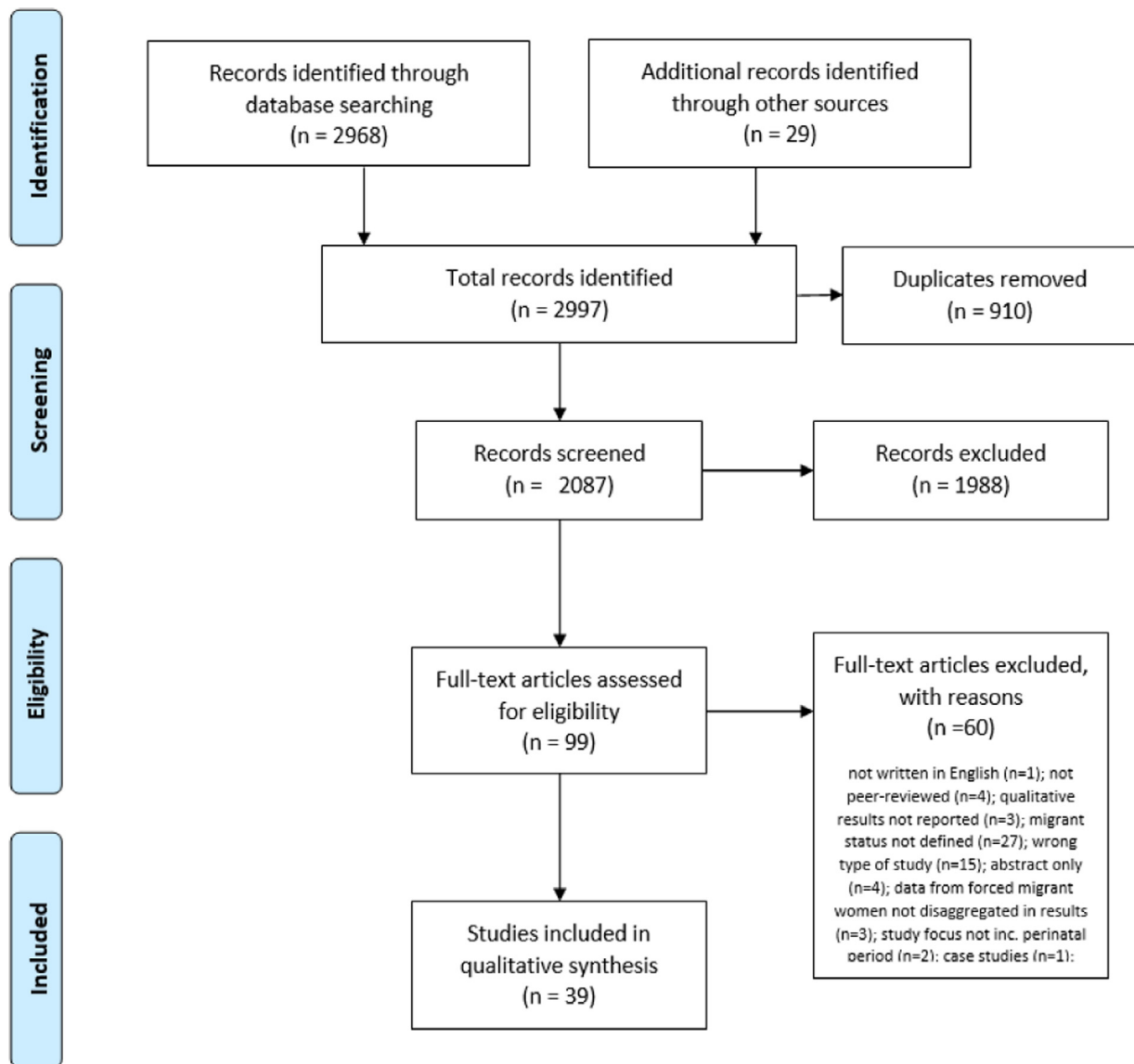


Fig. 1. Flow diagram of literature search and screen.

McLeish, 2005; Lephard and Haith-Cooper, 2016; Briscoe and Lavender, 2009; Gewalt et al., 2018; Nabb, 2006; Korukcu et al., 2018). As an asylum seeker in the UK described:

“I stayed in the hotel for 2 months— eating sandwiches and I was on crutches. I can’t go downstairs ’cause I was on top [floor]. There were scary people. Men smoking, hanging round. So I can’t go in dining room.” (Lephard and Haith-Cooper, 2016).

Across contexts, these everyday insecurities were frequently expressed by many women as powerlessness and loss of control, preventing them from participating in host country life (Hufton and Raven, 2016; Korukcu et al., 2018; Gewalt et al., 2018; Lalla et al., 2020). For some, religious beliefs provided hope and comfort in adversity (Riggs et al., 2017; Chulach et al., 2016; Niner et al., 2013).

Transitioning to motherhood after birth (whether for the first or subsequent time), represented for many, movement towards a redefined identity and reconnection to themselves, thus bringing to conclusion the liminal state of pregnancy (Riggs et al., 2017; Chulach et al., 2016; Korukcu et al., 2018; Ngum Chi Watts et al., 2015; Byrskog et al., 2016). Children provided a *raison d’être*;

“We cling to our children to survive hard times. They make us forget the pain of war.” (Korukcu et al., 2018).

Less frequently, divergent perspectives indicated the burden of having a newborn (Korukcu et al., 2018; Ngum Chi Watts et al., 2015).

**Trauma.** Previous pregnancy or birth-related trauma was described by women. In one study, the ongoing trauma experienced by a woman who was forced to give birth in the open after her refugee camp was destroyed was described (Niner et al., 2013). Other participants spoke of trauma caused by witnessing or being victims of rape (Tobin et al., 2014; Briscoe and Lavender, 2009; Lalla et al., 2020), or labouring during bombing and shootings (Henry et al., 2020).

“Even during that time people were raped things like that. So I ended up becoming pregnant ... but just now and then I keep thinking about it [said in almost a whisper]. It hurts.” (Briscoe and Lavender, 2009).

Trauma could be reactivated during birth in a host country. A refugee woman described feeling that she was “in a place where people are slaughtered” (Niner et al., 2013) during her birth in Australia, which resulted in postnatal anxiety and hallucinations. In the same study, another woman described how her “heart was shaking” (Niner et al., 2013) when some difficult news was communicated to her in labour.

**Table 1**  
Summary study characteristics.

First author (publication year)	Study aim	Study setting	Data collection	Analysis	Participants
Agbemenu (2019)	To explore mechanisms of avoidance of obstetric interventions	USA	Interviews, focus groups (FGDs)	Thematic analysis	Somali refugee women ( $n = 40$ )
Ahmed (2017)	To explore women's experiences of expecting or having a baby after resettlement from a mental health perspective.	Canada	Questionnaire, FGD	Thematic analysis of FGDs; SPSS for questionnaire	Pregnant or postnatal Syrian refugee women ( $n = 12$ )
Asnong (2018)	To develop a better understanding of adolescent pregnancy, including sexual and reproductive health knowledge and family and community support structures.	Refugee camps in Thailand	In-depth interviews (IDI)	Thematic analysis	Pregnant Myanmar adolescents ( $n = 20$ )
Bader (2020)	To examine African origin mothers' infant care values and practices related to feeding, carrying, and daily activities following resettlement.	USA	Semi-structured interviews (SSI)	Open coding to develop themes, axial coding of relationship between themes	Refugee mothers (with infants <24m-old) from DRC and Burundi ( $n = 10$ )
Briscoe (2009)	To explore the experience of maternity care by refugee and asylum seekers.	UK	Collective case study design using IDI	Decontextualization, display, data compilation	Refugee and asylum-seeking women ( $n = 4$ )
Bulman (2002)	To understand the reality faced by women in their contacts with maternity services.	UK	SSI, FGDs	Unclear	Somali refugee women receiving caseload midwifery care ( $n = 12$ ); midwives ( $n=NA$ )
Byrskog (2016)	To explore how women understand and relate to violence and wellbeing during their migration transition and their views on being approached with questions about violence in antenatal care.	Sweden	SSI	Thematic analysis	Somali refugee women who delivered in Somalia or Sweden ( $n = 17$ )
Carolan (2007)	To explore factors that facilitate or impede the uptake of antenatal care.	African Women's Clinic, Australia	Observations, SSI	Generation of categories and themes, coding data, offering interpretation and alternative explanations	African refugee women ( $n = 10$ ); clinic staff ( $n=NA$ )
Chulach (2016)	To explore the experience of pregnancy from the perspective of HIV-positive refugee women.	Canada	SSI	Interpretive phenomenological analysis	HIV-positive refugees who experienced pregnancy in Canada in past 5yrs ( $n = 4$ )
Correa-Velez (2012)	To report the findings of a model of maternity care for women from refugee backgrounds,	Maternity Hospital, Australia	Surveys with open-ended questions (by peer interviewers); maternity records audit	Quantitative data - SPSS; qualitative data -thematic analysis	African-born refugee-background women ( $n = 23$ ); hospital staff ( $n = 168$ ); maternity records ( $n = 83$ )
Furuta (2008)	To understand factors leading to risk behaviours.	Eritrean refugee camp in Sudan	IDI	Unclear	Eritrean women who delivered within 2 years ( $n = 10$ )
Gallegos (2015)	To explore the experience of breastfeeding.	Australia	SSI, FGDs	Thematic analysis	Women from Burundi, DRC, Liberia, Sierra Leone, who delivered in home country or Australia ( $n = 31$ )

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Table 1 (continued)

First author (publication year)	Study aim	Study setting	Data collection	Analysis	Participants
Gewalt (2018)	To investigate women's experiences and perceived needs whilst living in state-provided accommodation, with a particular focus on psychosocial factors.	Asylum Centres, Germany	Exploratory case study; 21 SSI during pregnancy, 9 follow-up interviews	Thematic analysis	Pregnant asylum-seekers ( $n = 9$ )
Henry (2020)	To explore how perinatal conceptions, premigration experiences, health literacy, and language skills influence women's perceived needs and expectations of care.	Germany	SSI	Content analysis	Asylum-seeking women from Iraq, Syria and Palestine, who were pregnant or delivered in Germany ( $n = 12$ )
Herrell (2004)	To understand women's perinatal experiences, education needs, effective ways to increase attendance at prenatal visits, and appropriate approaches to childbirth education.	USA	FGDs	Unclear	Somali women who delivered in USA ( $n = 14$ )
Hufton (2016)	To explore issues surrounding infant feeding practices and the experiences of health professionals in helping these women to reach the best outcomes for themselves and their infants.	UK	SSI, FGDs	Framework analysis	Refugee women ( $n = 30$ ); maternal health-workers ( $n = 9$ )
Joseph (2019)	To understand how women navigated breastfeeding in face of familial disconnections and the wider healthcare negotiations.	Australia	IDI, participant drawings	Thematic analysis and modified critical visual analytical framework	Vietnamese ( $n = 16$ ) and Myanmar ( $n = 22$ ) refugee mothers with infant <1yr-old, who delivered in Australia or transit countries; Myanmar grandmothers ( $n = 2$ )
Joseph (2020)	To understand how mothers situated their infant feeding perspectives.	Australia	IDI, participant drawings	Thematic analysis and modified critical visual analytical framework	Vietnamese ( $n = 16$ ) and Myanmar ( $n = 22$ ) refugee mothers with infant <1yr-old, who delivered in Australia or transit countries; Myanmar grandmothers ( $n = 2$ )
Kibiribiri (2016)	To examine disparities in the quality of prenatal care received by pregnant refugee women and local pregnant women attending the same primary healthcare facilities.	Primary healthcare facility, South Africa	Cross-sectional mixed-methods using surveys, IDI, maternity records audit	Quantitative data - SPSS; qualitative data - patterns, themes & contradictions	South African or refugee mothers ( $n = 220$ ); refugee mothers with infant <6m-old ( $n = 16$ )
Kingsbury (2018)	To describe personal social network of women who have given birth in the United States.	USA	SSI	Egocentric analysis of personal social network data; qualitative data - descriptive open coding	Nepali-origin Bhutanese refugee women who delivered in USA within last 2yrs ( $n = 45$ )
Koruku (2018)	To determine the birth experiences of women, and their transition to motherhood in Turkey.	Turkey	SSI	Thematic analysis	Syrian refugee women who delivered in Turkey ( $n = 7$ )
Kulig (1990)	To identify the cultural knowledge of women, and how it relates to contraception usage and prenatal care.	Canada	Ethnographic interviews	Unclear	Cambodian refugee women who conceived in Southeast Asia ( $n = 12$ )

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Table 1 (continued)

First author (publication year)	Study aim	Study setting	Data collection	Analysis	Participants
Lalla (2020)	To understand women's experiences of insecurity in a refugee camp.	Kenyan refugee camp	Ethnographic SSI	Inductive and deductive coding	Oromo refugee women who delivered in the camp ( $n = 20$ )
LaMancuso (2016)	To study of women's perinatal care.	USA	SSI	Template Style analysis	Karen refugee women who delivered in Thailand, Myanmar or USA within 3yrs ( $n = 14$ ); Karen doulas, community leaders, 6 clinic representatives ( $n = 8$ )
Lephard (2016)	To explore the maternity care experiences of local asylum-seeking women to inform local services.	UK	SSI	Thematic analysis	Asylum-seeking women who delivered in UK within 1 yr ( $n = 6$ )
Lowe (2019)	To explore women's experiences of forced migration, kinship, and reproductive health	Kenya	Ethnographic SSI and observations	Not stated	Somali women and men and healthcare providers ( $n=NA$ )
McLeish (2005)	Describes the maternity experiences of asylum seekers in England.	UK	SSI	Not stated	Asylum-seeking women, pregnant or delivered within 18 m ( $n = 34$ )
Murray (2010)	To explore the experiences of African refugee women who gave birth in Brisbane, Australia.	Australia	SSI	5 step analysis of the essences	African refugee women who gave birth in Brisbane in past 5yrs ( $n = 10$ )
Nabb (2006)	To explore the provision of maternity care while in emergency accommodation in the UK	UK	IDI, SSI	Not stated	Maternity care providers ( $n = 5$ ); pregnant asylum-seekers ( $n = 15$ )
Ngum Chi Watts (2015)	To solicit the lived experiences of young refugee women who have experienced early motherhood in Australia.	Australia	IDI	Thematic analysis	African refugee adolescent mothers ( $n = 16$ )
Niner (2013)	To understand how pregnancy and birth was experienced both before and after resettlement.	Australia	Case studies from narrative ethnographic interviews	Thematic analysis	Karen refugee women who recently gave birth ( $n = 8$ )
Nithianandan (2016)	To investigate barriers and enablers to implementing evidence-based, nationally recommended perinatal mental health screening and inform sustainable implementation of a screening and referral programme, in women of refugee background.	Australia	SSI	Thematic analysis	Health-workers ( $n = 28$ ) and refugees with current/ previous pregnancy ( $n = 29$ )
O'Shaughnessy (2012)	To explore the impact of the intervention on the quality of the mother-infant relationship, foregrounding views of mothers and babies (in the mothers' minds).	UK	Questionnaires, FGDs, videos	Thematic analysis; videos scored by Infant CARE-Index	Asylum-seeking new mothers with infants <1y-old ( $n=NA$ )

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Table 1 (continued)

First author (publication year)	Study aim	Study setting	Data collection	Analysis	Participants
Riggs (2017)	To explore experiences of group pregnancy care.	Australia	FGDs	Thematic analysis	Karen refugee women who had group pregnancy care ( $n = 19$ )
Riggs (2016)	To investigate understandings of maternal oral health, dental priority groups and information provision from women, dental and maternity care providers.	Australia	FGDs	Thematic analysis	Afghan or Sri Lankan refugee women who delivered in past 3yrs ( $n = 24$ ); dental staff ( $n = 19$ ); midwives ( $n = 10$ )
Russo (2017)	To explore women's experiences throughout pregnancy, birth, and into the early stages of motherhood.	Australia	FGDs, SSI	Thematic analysis	Afghan refugee women who gave birth in Australia ( $n = 38$ )
Stapleton (2013)	To identify facilitators and barriers to the delivery and quality of care of a specialist antenatal clinic for refugee-background women.	Australia	Chart and database audit; surveys, SSI, FGDs	Quantitative data - Excel and SPSS; qualitative data - thematic analysis	Records from specialist clinic ( $n = 190$ ); service-users ( $n = 42$ ); staff ( $n = 160$ ); women in 4 FGDs ( $n = 18$ )
Tobin (2014)	To gain insight into women's experiences of childbirth in Ireland while in the process of seeking asylum.	Ireland	IDI	Narrative analysis	Refugee and asylum-seeking women who experienced pregnancy or birth ( $n = 22$ )
Yelland (2014)	To investigate women and men's experience of the way that health professionals approach enquiry about social factors affecting families having a baby in a new country, and investigate how health professionals identify and respond to the settlement experience and social context of families of refugee background.	Australia	SSI, FGDs	Thematic analysis	Afghan refugee men ( $n = 14$ ) and women ( $n = 16$ ) with an infant 4–12 m old; health-workers ( $n = 34$ )

### Support and kinship

*Changing family dynamics.* Women described the shift in family dynamics they experienced as a result of their forced migration, and its implications during the perinatal period. The absence of sharing the joy of pregnancy (Tobin et al., 2014), support in labour (Hufton and Raven, 2016; Lephard and Haith-Cooper, 2016; Henry et al., 2020) or with breastfeeding (Gallegos et al., 2015; Hufton and Raven, 2016; Joseph et al., 2019), and assistance with caring for other children (Gallegos et al., 2015) was noted by participants. In two studies, this was identified as a cause of poor perinatal mental health (Riggs et al., 2017; Henry et al., 2020).

Immigration regulations that kept women and their extended families from being able to visit one another were described by one participant as feeling “like a bird in a cage” (Ahmed et al., 2017). While transnational connections with family, seeking advice and support over the phone was identified in some studies (Chulach et al., 2016; Henry et al., 2020), the extent to which these ties were maintained and the role they played for women during the perinatal period did not appear to be widely explored.

As a result of family separation, a number of studies showed that women had to rely on their partners for support in a manner they would not have expected in their home country (Riggs et al., 2017;

Byrskog et al., 2016; Henry et al., 2020; Herrel et al., 2004), necessitating renegotiation of gender roles, exemplified by a participant as:

“If you were at home would you have your men around at birth? No, No it's just here [in Australia].” (Stapleton et al., 2013).

In the absence of extended family, many women sought support, friendship and advice from those from the same country of origin (Russo et al., 2015; Bader et al., 2020; Kingsbury et al., 2018). However, issues of privacy within communities were often cited as a concern, specifically relating to violence, depression and HIV status (Chulach et al., 2016; Ahmed et al., 2017; Yelland et al., 2014).

*Role of formal support.* In addition to kinship networks formed among those from the same country of origin, a number of studies found that women also relied on health professionals for support, in the form of practical help, listening, reassurance, empathy and encouragement (Riggs et al., 2017; McLeish, 2005; Joseph et al., 2019; Lephard and Haith-Cooper, 2016; Gewalt et al., 2018; Kingsbury et al., 2018; Yelland et al., 2014)]. This was particularly noticeable among participants who had access either to specialist services or models of care promoting continuity, in which trusting relationships with professionals had been formed. One woman spoke poignantly of this:



**Table 2**  
CASP quality appraisal by source.

First author (publication)	Aims	Methods	Design	Recruitment	Data collection	Reflexivity	Ethics	Analysis	Findings
Agbemenu (2019)	✓	✓	✓	✓	✓	×	✓	✓	✓
Ahmed (2017)	✓	✓	×	✓	✓	✓	✓	✓	✓
Ansong (2018)	✓	✓	✓	✓	✓	×	✓	?	✓
Bader (2020)	✓	✓	✓	✓	✓	×	✓	?	✓
Briscoe (2009)	✓	✓	✓	✓	✓	×	✓	?	✓
Bulman (2002)	✓	✓	✓	✓	?	?	×	?	?
Byrskog (2016)	✓	✓	✓	✓	✓	×	✓	✓	✓
Carolan (2007)	✓	✓	?	?	?	×	×	×	×
Chulach (2016)	✓	✓	✓	?	✓	×	✓	✓	✓
Correa-Velez (2012)	✓	✓	?	×	?	×	?	?	×
Furuta (2008)	✓	✓	×	×	×	×	×	×	×
Gallegos (2015)	✓	✓	✓	?	?	×	×	?	✓
Gewalt (2018)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Henry (2020)	✓	✓	✓	✓	✓	×	✓	✓	✓
Herrell (2004)	×	✓	?	?	?	×	×	×	×
Hufton (2016)	✓	✓	✓	✓	?	×	?	?	✓
Joseph (2019)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Joseph (2020)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Kibiribiri (2019)	✓	✓	✓	✓	?	×	?	×	✓
Kingsbury (2018)	✓	✓	✓	✓	✓	×	?	✓	✓
Koruku (2018)	✓	✓	✓	×	?	×	?	?	✓
Kulig (1990)	✓	✓	?	?	?	×	×	?	✓
Lalla (2020)	✓	✓	✓	✓	✓	✓	✓	✓	✓
LaMancuso (2016)	✓	✓	✓	✓	✓	✓	?	✓	✓
Lephard (2016)	✓	✓	✓	✓	✓	×	?	?	✓
Lowe (2019)	✓	✓	?	?	?	×	×	×	×
McLeish (2005)	×	✓	?	✓	?	×	×	×	×
Murray (2010)	✓	✓	✓	✓	?	×	?	✓	×
Nabb (2006)	✓	✓	?	?	?	×	?	×	×
Ngum Chi Watts (2015)	×	✓	?	✓	?	×	?	✓	×
Niner (2013)	✓	✓	?	✓	?	×	×	×	×
Nithianandan (2016)	✓	✓	✓	✓	?	×	?	✓	✓
O'Shaughnessy (2012)	✓	✓	?	?	?	×	×	×	✓
Riggs (2016)	✓	✓	✓	✓	?	×	?	?	✓
Riggs (2017)	✓	✓	✓	✓	✓	✓	×	?	✓
Russo (2017)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Stapleton (2013)	✓	✓	?	?	?	×	×	✓	✓
Tobin (2014)	✓	✓	✓	✓	✓	×	?	✓	✓
Yelland (2014)	✓	✓	✓	✓	✓	×	?	✓	×

“When I see V [community midwife] [had] come [to] see me, I was like, all my family [has] come to see me!” (Lephard and Haith-Cooper, 2016).

Groups offered a space for forced migrant women to not only gain information and reassurance from professionals, but also locate and build kinship networks (Riggs et al., 2017; Chulach et al., 2016; O'Shaughnessy et al., 2012). These included a mother-infant therapeutic group (O'Shaughnessy et al., 2012) and group antenatal care (Riggs et al., 2016), both facilitated by multi-disciplinary teams with bi-cultural workers, as well as a community support group for HIV-positive women (Chulach et al., 2016).

#### Interactions with maternity services

*Navigating the system.* Women's access to maternity services was marked in studies by having to navigate the system. Barriers to accessing maternity services were numerous. Entitlement to state-provided maternity care (Lephard and Haith-Cooper, 2016) and methods of referral to maternity services (McLeish, 2005; Nabb, 2006; Murray et al., 2010) could be a source of confusion. In a refugee camp, study participants identified financial barriers in the form of maternity care costs or bribery:

“They [nurses and refugee nursing assistants] asked me, ‘Are you Ethiopian or Somali?’ then I had to give them ‘kitu kidogo’ [translated from Swahili as ‘a little something’].” (Lalla et al., 2020).

Location and transportation were a significant barrier to accessing maternity services which in some instances resulted in women being unable to attend antenatal care (Riggs et al., 2017; Chulach et al., 2016; McLeish, 2005; Lephard and Haith-Cooper, 2016; Niner et al., 2013; Carolan and Cassar, 2007; Correa-Velez and Ryan, 2012; LaMancuso et al., 2016; Furuta and Mori, 2008). In refugee camps, the impact of being far away from the nearest hospital with limited access to transport was described by women as being extremely challenging and even fatal (Lalla et al., 2020; Furuta and Mori, 2008).

*Using maternity services.* A dichotomy emerged between satisfaction and lived experiences of maternity care. Many women who had migrated to high- or middle-income countries expressed satisfaction with their maternity care overall, but this was usually framed in contrast to their previous maternity experiences in resource-poor settings with higher maternal mortality rates and gratitude for being taken care of within the host country health system (Riggs et al., 2017; Niner et al., 2013; Korukcu et al., 2018; Henry et al., 2020; Bader et al., 2020; LaMancuso et al., 2016). In spite of this satisfaction, women in many studies identified being stigmatised and receiving disrespectful or discriminatory care, due to being foreign, their skin colour, immigration status or being unable to speak the host-country language (Riggs et al., 2017; Chulach et al., 2016; Niner et al., 2013; McLeish, 2005; Lalla et al., 2020; Herrel et al., 2004; Agbemenu et al., 2019). They felt their needs were disregarded, they were treated rudely or as inferior to host-country women and, particularly with reference to female genital mutilation (FGM), put on display and ‘othered’ (Stapleton et al., 2013; Agbemenu et al., 2019).



“I feel like that doctor did not look after me very well... I am not sure if it is because we are refugees that they don't treat us very well. ... I didn't say anything and I have to thank him for helping me give birth... Maybe he looks down on us because we can't speak the language.” (Niner et al., 2013).

Authors of several studies recognised that low expectations of care, cultural understandings of medical paternalism and feelings of beholdness to the host country acted as contributing factors to this dichotomy (Riggs et al., 2017; Niner et al., 2013; LaMancuso et al., 2016). Conversely, specialist and continuity models of maternity care were positively regarded by women (Riggs et al., 2017; Murray et al., 2010; LaMancuso et al., 2016) who placed a high value on the trusting relationships that were formed because, “there's someone there for you... so you don't feel nervous” (Riggs et al., 2017). Women who didn't experience continuity of care found having to explain or express themselves to health professionals “really exhausting telling each one” (Murray et al., 2010).

*Feeling understood.* Women's interactions with maternity services and encounters with health providers were characterised by perceptions of misunderstandings due to health professionals' lack of communication and cultural awareness. Language was significant in women not feeling understood. In a number of studies women did not understand what was happening to them due to language barriers (Riggs et al., 2017; Tobin et al., 2014; Niner et al., 2013; McLeish, 2005; Briscoe and Lavelander, 2009; Henry et al., 2020; Herrel et al., 2004; Kibiribiri et al., 2016) and on some occasions, unfounded assumptions were made about their level of understanding:

“I asked them, “[Can] we cancel the meeting until we get an interpreter... I didn't understand you and you didn't understand me.” She said, “No, it's OK, we can go on—you understand English.”” (Lephard and Haith-Cooper, 2016).

The issue of interpreters was central to women's feelings of being understood, with an emphasis on the suitability of interpreters (Riggs et al., 2016; Herrel et al., 2004; Murray et al., 2010; Correa-Velez and Ryan, 2012; Bulman and McCourt, 2002). For example, when family members were relied upon to interpret, or a male interpreter was provided, women felt uncomfortable or were not able to engage fully.

“I was assisted by a stranger and furthermore he was a man. I had no choice. I was being selective in my responses to the healthcare worker.” (Kibiribiri et al., 2016).

As a result, the disempowerment and disconnectedness of women from decision-making about their care or treatment was evidenced (Tobin et al., 2014; Niner et al., 2013; McLeish, 2005; Lephard and Haith-Cooper, 2016; Herrel et al., 2004; Murray et al., 2010; Correa-Velez and Ryan, 2012; Agbemenu et al., 2019), leading to feelings of loss of control, fear, and for some women, trauma. Women described having procedures without fully understanding what or why these were taking place. For women whose home country understandings of operative birth was associated with maternal mortality or who had experienced past trauma, a lack of shared decision-making in their care could be traumatising, as illustrated here:

“There was no interpreter. A few minutes later, two nurses came and tied me up and I could not move. I was scared and thought, “Something's wrong now,” and “That's it. That's the end of everything.” I felt like I was in a place where people are slaughtered.” (Niner et al., 2013).

Complex and disempowering dynamics with health professionals made it difficult for some women to question their care, due to fear of mistreatment and the verbal and non-verbal disrespect they felt which left women uncomfortable and ashamed (Riggs et al., 2017; Tobin et al., 2014; Murray et al., 2010).

A lack of cultural awareness among health professionals was also seen as a contributor to women not feeling understood in many of the included studies. Attendance by a female doctor (Riggs et al., 2017; Murray et al., 2010) and understanding of FGM (Lephard and Haith-Cooper, 2016; Stapleton et al., 2013; Murray et al., 2010; Bulman and McCourt, 2002) are examples of cultural safety highlighted by study participants. Additionally, there were tensions between women's cultural norms and practices and the biomedical model of maternity care or western cultural norms experienced in high-income countries (Riggs et al., 2017; Gallegos et al., 2015; Niner et al., 2013; Joseph et al., 2019; Stapleton et al., 2013; Bader et al., 2020; Joseph et al., 2020; Kulig, 1990). As one participant said:

“I felt like I was judged by my doctor...I wanted to do things according to my tradition but I was expected to do things differently.” (Riggs et al., 2017).

There were occasional examples of women's strategies of resistance to the biomedical model (Agbemenu et al., 2019; Lowe, 2019), but these were not commonplace in the literature.

*(Dis)empowerment through information.* Women commonly felt they lacked information (Riggs et al., 2017; Niner et al., 2013; Henry et al., 2020; Stapleton et al., 2013; Herrel et al., 2004), leaving some to rely on family members or home country experiences, resulting in confusion. For example, in one study (Henry et al., 2020), an Iraqi refugee woman describes giving birth alone at home in Germany due to lack of information about who to contact in labour. Conversely, where provided, women in a number of studies in high-income countries articulated the empowering effect that increased education and understanding had for them, saying that it helped them to “feel stronger” (Riggs et al., 2017), with a greater sense of control and self-efficacy as mothers (O'Shaughnessy et al., 2012; Murray et al., 2010).

## Discussion

This review is unique in its examination of the literature specifically pertaining to perinatal experiences of forced migrant women globally. This study has several strengths. Using strict eligibility criteria enabled the lived experiences of forced migrant women specifically to be synthesised, in a range of contexts acknowledging their circumstances as distinct from women migrating voluntarily. Using thematic synthesis allowed us to develop new understandings from qualitative primary data while preserving context (Thomas and Harden, 2008). This method draws on critical realism, accepting objective knowledge while seeking to understand how these interplay with lived experiences, a perspective valuable in seeking to understand maternity experiences and migration (Barnett-Page and Thomas, 2009; Walsh and Evans, 2014; Bakewell, 2010). Our three overarching analytical themes show women negotiating and renegotiating intersecting factors impacting upon their lived experiences in the perinatal period.

*Being a forced migrant* showed the multiple liminal spaces occupied by women simultaneously. Protracted immigration regulations often held women in this ‘in between’ space, reproducing vulnerabilities rather than providing the protection that was being sought. The postnatal reconnection to identity for some women speaks to cultural ideals and expectations of women as mothers as well as the ability to exert agency in mothering in order to carve out new familial identities (Lockwood et al., 2019; Green and Mothering, 2005). The traumas experienced by women are congruent with findings from other studies, which evince the higher risks of psychosocial distress and post-traumatic stress disorder among women who have experienced conflict, FGM, rape or violence (Behrendt and Moritz, 2005; Alsheikh Ali, 2020; Marie et al., 2020). Birth and associated health-related practices have potential to trigger re-traumatisation (Sperlich et al., 2017). However, this review found insufficient consideration of potential traumatisation among maternity providers. While trauma-informed practices are not widely adopted, ensuring that women are equal partners in their care

and that informed consent occurs is a valuable step that clinicians and allied professionals can incorporate into their practice to reduce the risk of re-traumatisation (Sperlich et al., 2017).

*Support and kinship* situated the childbearing time within its social context. The link between social support and psychological wellbeing during the perinatal period is well established (Glazier et al., 2004; Webster et al., 2011; Morikawa et al., 2015) and psychosocial interventions can protect against maternal depression (Morikawa et al., 2015). However, perinatal mental health services are often under-used by migrant women, either due to structural barriers in accessing services or reluctance because of a lack of understanding or stigma surrounding mental health issues (Heslehurst et al., 2018; Giscombe et al., 2020). This highlights the need for greater provision of perinatal mental health services that are accessible and embedded into maternity care provided to forced migrant women.

Female support during labour is the norm in many cultures and associated with fewer interventions (Madi et al., 1999; Hodnett et al., 2013), yet this review showed that female support was lacking and in some instances partners had to take up this previously unfamiliar role. Several studies identified health professionals as being a source of support, which was experienced as compassionate care. Compassionate care is a key constituent of respectful maternity care (Renfrew et al., 2014), which is a right for all women around the childbearing time (White Ribbon Alliance, 2011) but not universally experienced by all forced migrant women in this review.

*Interactions with maternity services*, demonstrated the variations in care women experienced. Maternity care which was disrespectful and racist, failed to account for women's language or cultural needs, or failed to incorporate informed decision-making, produced anxiety and fear. In contrast, trusting relationships with maternity care providers and provision of accessible information to help navigate birth and motherhood gave women greater control and confidence and was a source of support. Woman-centred models of maternity care, in which decisions are made *with not for* women and promote continuity of carers and women's capacities in the perinatal period, have been identified as a framework for providing quality maternity care for all (Renfrew et al., 2014) and therefore must also be provided for forced migrant women. Taking a woman-centred approach involves going beyond biomedical needs to accepting and respecting cultural needs. Women living in refugee camps were shown in this review to experience greater insecurity and further reduced access to maternity services, but further studies are needed to explore the perinatal experiences of women who have been forcibly displaced to neighbouring or transit countries. Using qualitative research methods, including in-depth interviews and observations will provide rich and nuanced perspectives in such contexts. Research focus must shift from being framed by a discourse of victimhood to examining agency and resilience in transient settings. Research that aims to better understand women's resourcefulness in the reproductive sphere will help in developing strengths-based approaches in maternity services.

### Limitations

There are a number of limitations to this study. First, the decision to include studies with small sample sizes (<15 participants, with no justification given for the sample size) and poorer methodological quality may have introduced some bias. However, inclusion of CASP quality assessment helped to mitigate this. Second, the choice of search terms in this review may have excluded studies that identified forced migrants in other ways, although conducting a manual search reduced this possibility. Finally, coding the data and developing themes with a second researcher may have reduced the possibility of bias in synthesising the evidence.

### Conclusion

This thematic synthesis shows the intersecting challenges of being a forced migrant woman during the perinatal period, demonstrates the important role of social support, and considers the potential for maternity services to empower women. Systemic power structures, specifically those relating to immigration regulation but also those at an organisational-level within maternity services, are demonstrated as women navigate a period of liminality, changing kinship networks, and their sense of self.

### Declaration of Competing Interest

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

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