The University Of Sheffield.

South Asian Women's Experiences of Maternal Mental Health

Aditi Sharma

A thesis submitted in partial fulfilment of the requirements for the award of Doctorate in Clinical Psychology (DClinPsy)

Clinical and Applied Psychology Unit

Department of Psychology

The University of Sheffield

May 2023

Declaration

This thesis has been submitted for the award of Doctorate in Clinical Psychology at the University of Sheffield. It has not been submitted to any other institution, or for the purpose of obtaining any other qualifications.

Structure and Word Counts

Literature review

i. Word count excluding references and tables- 7,998

ii. Word count including references and tables- 12,664

Research report

i. Word count excluding references and tables – 7,997

ii. Word count including references and tables – 12,238

Total word count (combining lay summary, literature review and research report)

i. Word count excluding references and tables – 16,493

ii. Word count including references and tables – 25,400

Lay Summary

Literature Review: Maternity services support women and birthing people through pregnancy and childbirth. Research has shown that women from ethnic minority backgrounds are more likely to experience poor maternity care than White women. Also, maternity care researchers tend to group all ethnic minority women together. This means differences between ethnicities may not be considered properly. Therefore, we chose to focus on South Asian women. South Asian women are women from India, Pakistan, Bangladesh, Sri Lanka, Nepal, Bhutan, and the Maldives. Little is known about South Asian women's experiences of maternity care in the United Kingdom. Therefore, we aimed to find all the current research in this area. We found 12 studies. We summarised these 12 studies using a method called 'thematic synthesis' which developed four themes. Firstly, '(in)ability to express maternity needs.' This reflected the difficulties some South Asian women had with communicating and being assertive with maternity healthcare professionals. Secondly, 'uncompassionate relationships with maternity healthcare professionals,' showed how some South Asian women felt neglected and stereotyped. Thirdly, 'integrating maternity care with cultural identity,' described how some South Asian women had difficulties balancing cultural pressures or traditions with maternity advice. Fourthly, 'family being a part of maternity care,' reflected how most South Asian women valued their husband and family's support through pregnancy and childbirth, including attending maternity appointments. From our findings, we have suggested new areas to research and improve its quality. Also, to help maternity healthcare professionals and maternity services improve their care for South Asian women.

Empirical Report: Research has shown that ethnic minority women may be more likely to experience a traumatic birth. Specifically, not enough South Asian women take part in childbirth-related research or use the National Health Service. Therefore, we aimed to explore

how South Asian women make sense of their birth trauma and how they seek support. Our study was advertised through charities, specialist postnatal research groups and social media. Eight South Asian women with experiences of birth trauma took part. They completed an online or telephone interview. We used a method called ‘interpretative phenomenological analysis’ to analyse these interviews, which developed four themes. Firstly, ‘the power of maternity healthcare professionals.’ Most South Asian women felt that maternity healthcare professionals were dominating and powerful. This led to feeling undignified, violated, ignored, and dismissed by professionals and the National Health Service. Secondly, ‘loss of connection’ described how most South Asian women felt disconnected with reality during childbirth. Also, South Asian women experienced a loss of bonding time (time to connect) with their baby and a loss when their partner could not be there during childbirth, causing distress. Thirdly, ‘disentangling discrimination’ reflected how most South Asian women recognised their own experiences of discrimination (sexism and/or racism) during childbirth. Fourthly, ‘pervasive cultural stigma in motherhood,’ captured how most South Asian women felt cultural pressures to cope well. Often, they felt ashamed for needing emotional support. Our findings helped to find ways to improve future research and clinical practice for South Asian women experiencing birth trauma.

Acknowledgements

I would like to dedicate this thesis to my Dadiji and Babaji. Babaji was incredibly proud of my academic achievements.

Firstly, I would like to thank the eight women who took the time to share their experiences so openly and honestly with me. I feel hugely privileged to have heard your stories and how you trusted me with them, they will stay with me for the rest of my career. I hope through this research I have offered you a space for your voices to be truly heard and captured them honourably.

Secondly, thank you to Dr Vyv Huddy for agreeing to take on a project that enabled me to pursue an area I am passionate about. It was important for me that this project was meaningful, so your support has meant a lot to me. Thank you also for being so open, showing genuine interest and guiding me through this research. I have valued our supervision sessions, deep reflections, and expertise along the way.

Dr Emma Williamson, I have valued your compassionate and warm approach through supervision, thank you. Your passion for maternal mental health is so inspiring and an extra thank you for allowing me the privilege to work with you.

I also want to give thanks to some fantastic people I have met along the way when trying to make this research possible. Thank you to Jen, Farah, Priya, Community of Cultures, Support Me CIC, and Make Birth Better for your generosity, warmth, and enthusiasm with recruitment and feedback.

Thank you to Charlotte Merriman, my clinical tutor, you have been so kind and caring through training.

Tansy Warrilow, thank you, you inspired and reminded me that I had the ability to pursue this project and make it work. I am grateful to have had your support through training.

My special trainee friends, Margaret Lyons and Charlotte Grahame thank you for your unwavering support. You are the kindest, strongest, and inspirational women, you have really made my last 3 years and couldn't imagine training without you.

Thank you to all my lovely Bristol friends you kept me going throughout and provided respite when it was all getting too much. I am so excited to move closer to you!

To the Skane-Davis family, thank you for the encouragement, support, and interest throughout the doctorate, I cannot wait to become an 'official' member of the family.

To my dearest family, thank you for your constant support, care and always believing I could do it! A special thank you to Mum and Dad for proofreading my final drafts.

Finally, thank you to Will, I have no doubt I have been the most well-fed trainee ever! You have kept me grounded with your humour, never doubted my ability to get the work done (it turns out I CAN do it) and been my biggest cheerleader. I am incredibly grateful with how much support you have shown me and excited for the next chapter!

Contents

Section 1 Literature Review

South Asian Women's Experiences of Maternity Care in the UK: A Systematic Review and Thematic Synthesis

Abstract

Objectives

Research suggests that many South Asian women underutilise antenatal support offered by maternity services. Additionally, South Asian women are more likely to experience poor maternal outcomes, compared to White women, likely to adversely impact maternal mental health. Therefore, this systematic review aimed to explore South Asian women and birthing people's experiences of maternity care in the United Kingdom.

Methods

Three databases were searched for published peer-reviewed qualitative studies. The Critical Appraisal Skills Programme checklist for qualitative research was used to appraise the quality of included articles.

Results

Twelve articles met the inclusion criteria. Using Thomas and Harden's (2008) approach for thematic synthesis, four themes were developed '(in)ability to express maternity needs,' 'uncompassionate relationships with maternity healthcare professionals,' 'integrating maternity care with cultural identity,' and 'family being a part of maternity care.'

Conclusions

The review highlighted how South Asian women in the UK have varied maternity needs which are often unmet and unexpressed to maternity healthcare professionals. Most South Asian women experienced maternity healthcare professionals as uncompassionate, discriminatory, and with varied sensitivity to their cultural identity and family systems.

Practitioner Points

- Utilise clinical psychologists in maternity services to support maternity healthcare professionals deliver culturally sensitive psychologically informed care

- Increase provision, consistency, and quality of professional interpreters/link workers to improve maternity care interactions
- Maternity healthcare professionals/services to engage with unconscious bias and cultural awareness training
- Maternity policies to be developed reflecting the maternity, emotional, psychological, and cultural needs of South Asian women/birthing people and their collectives

Keywords: Maternity; antenatal; pregnancy; childbirth; South Asian; ethnic minority; thematic synthesis

Introduction

Childbirth is an intense and transformative psychological experience which can be promoted through supporting the woman[1], physically, emotionally, and socially (Olza et al., 2018). Maternity care describes healthcare services providing care through pregnancy to postnatal care. Experiences of maternity care in the United Kingdom (UK) have worsened thus, not meeting the needs of women (Care Quality Commission, 2023; Knight et al., 2022). Subsequently, the National Health Service (NHS) Maternity Transformation Programme has set out clear ambitions to improve maternity care to prevent poor physical health and mental health outcomes, particularly from women from ethnic minority[2] backgrounds (NHS, 2021).

Disparities in Maternity Care

There has been increasing recognition of ethnic maternal health inequalities, with ethnic minority women experiencing a higher risk of dying in pregnancy, stillbirth, and neonatal deaths compared to White women (Knight et al., 2022; Matthews et al., 2022; Mothers and Babies Reducing Risk through Audits and Confidential Enquiries [MBRRACE-UK], 2023). Also, higher mortality rates exist for Black or Asian infants than White infants (MBRRACE-UK, 2021).

---

[1] This current review recognises the importance of gender-inclusive language to represent all maternity service users. However, the research outlined throughout this review represented or assumed participants identified as cisgender women. Therefore, the review uses the term 'women,' as used in the research. The researcher acknowledges that this may exclude other gender identities and gender-additive approaches such as 'women and birthing people' are recommended. Therefore, the researcher uses 'women and birthing people' where possible, namely when discussing wider implications/recommendations for future work (Green & Riddington, 2020).

[2] There is no consensus on the appropriate terms regarding ethnicity and race in research, however, the term 'ethnic minority' is embedded in within the NHS guidance and consistent with the UK government's recommendations therefore this term is used throughout the review (Bhopal, 2004; Government Digital Service, 2023; NHS, 2021)

In light of ethnicity being a risk factor for maternal and perinatal deaths, an NHS maternity provider investigated serious obstetric clinical incidents to explore differences between ethnic minority and White women (Farrant et al., 2022; Knight et al., 2022). There were no significant differences in the proportion of clinical incidents, although there was a trend towards Pakistani, Bangladeshi, Black African and Black Caribbean women being at higher risk (Farrant et al., 2022). This may be due to factors beyond ethnicity such as having a pre-existing medical problem. However, findings suggested that ethnic minority women involved in clinical incidents, had a lower frequency of pre-existing medical problems or obstetric problems than White women. (Farrant et al., 2022). Such maternity care disparities increase the risk of ethnic minority women developing perinatal metal health problems (Watson & Soltani, 2019).

The Importance of Relationships with Maternity Healthcare Professionals

Women place importance on the interpersonal behaviours of maternity healthcare professionals (MHPs) (Downe et al., 2015; McLeish & Redshaw, 2019). A positive birth experience has shown to reflect a sense of empowerment and capability during the transition to motherhood (Karlström et al., 2015; MacLellan et al., 2022). A trusting relationship with midwives throughout pregnancy has shown to instil a sense of ability to cope with the challenges of childbirth (Leap et al., 2010). Consequently, this has been reported to reduce the use of pharmacological pain relief during labour and childbirth (Leap et al., 2010). Additionally, experiences with MHPs have shown to be crucial for reducing feelings of powerlessness and low self-esteem, regardless of pregnancy complications (Lynn et al., 2011; McLeish & Redshaw, 2019).

Ethnic Minority Women's Experiences of Maternity Care

Ethnic minority women were less likely to report positive experiences in maternity care compared to White women (Care Quality Commission, 2023; Henderson et al., 2013). Ethnic minority women reported positive maternity care when MHPs met their medical, emotional, psychological, and social needs (Higginbottom et al., 2019). However, ethnic minority women experiencing negative care was underpinned by experiences of MHPs being perceived as rude, discriminatory, and unmet cultural and/or social needs (Higginbottom et al., 2019).

Typically, women who worried less about labour and birth were more likely to report no problems and feeling 'very well' in themselves (Henderson et al., 2013). However, there have been differing experiences between women, with ethnic minority women being more likely to worry during labour and birth, compared to White women (Henderson et al., 2013; Redshaw & Heikkilä, 2011). Ethnic minority women were less likely to report compassionate treatment, feel sufficiently involved in decisions and trust healthcare professionals in their antenatal care (Henderson & Redshaw, 2013). However, other ethnic minority women have perceived that their ethnic background did not matter in relation to the maternity care received, representative of equitable care (Puthussery et al., 2010).

Experiences from Maternity Healthcare Professionals

Research has consistently reported that MHPs experience challenges when meeting the needs of ethnic minority women, despite striving to provide equitable maternity care (Aquino et al., 2015; Bowler, 1993; Chitongo et al., 2022; Lyons et al., 2008). Although, some MHPs show some understanding and consideration for religious and cultural practices (Hassan et al., 2020). Often MHPs have perceived working with ethnic minority women as an increased demand to workload and held negative views towards these women, especially

when women's cultural and religious practices conflicted with their clinical practices (Aquino et al., 2015; Bowler, 1993; Chitongo et al., 2022; Lyons et al., 2008). Mostly, MHPs found it easier to meet the needs of ethnic minority women when they were UK-born because they perceived that their needs were like White women (Puthussery et al., 2008). These experiences have considered to be underpinned by unconscious bias and racism (Aquino et al., 2015; Bowler, 1993; Chitongo et al., 2022; Lyons et al., 2008; Puthussery et al., 2008). Unconscious bias describes associations that reflexively change perceptions, thus influence behaviour, interactions and decision making (Fitzgerald & Hurst, 2017).

Previous Systematic Reviews

A recent systematic review explored ethnic minority women's experiences of maternity care (Toh & Shorey, 2023). This further indicated the struggles and fears for ethnic minority women. Negative experiences represented ineffective communication, cultural and religious sensitivity, and disregard for women's needs (Toh & Shorey, 2023). Whilst this review highlighted the importance of enhancing understanding of ethnic minority women, the systematic review included women from different countries (Toh & Shorey, 2023). Therefore, reflected a wide range of different maternity care systems and its underpinning organisational and financial structures.

Ethnic minority women's experiences of maternity services, specifically, in the UK, have also been systematically reviewed and synthesised (MacLellan et al., 2022). Findings suggested that ethnic minority women experienced mistreatment, communication failures and poor maternity care due to a technocratic system (MacLellan et al., 2022). Additionally, positive maternity care was described as atypical, whilst being valued by ethnic minority women. Although the review highlighted systemic influences and positioned from a midwifery perspective, specific clinical and research implications to improve maternity care for ethnic minority women were lacking. For instance, with regards to addressing the

emotional and psychological needs, which advocates for research conducted from a psychological perspective.

Both these systematic reviews utilised the term ‘ethnic minority’ which assumed homogeneity of women from different ethnic minority groups and disregards differences with, and between, ethnic minority groups (MacLellan et al., 2022; Toh & Shorey, 2023). For instance, a secondary analysis of survey data recognised differences in maternity care experiences within, and between, Black women and South Asian (SA) women (Henderson et al., 2013). It is recommended to focus on ethnicity specific groups where possible (Barnett et al., 2019; Commission on Race and Ethnic Disparities, 2021).

Policies and Clinical Guidance

The NHS Long Term Plan (2019) has committed to improve maternal outcomes and continuity of care antenatally and postnatally. Also, it advocates for the needs of ethnic minority women to be identified which can be incorporated into their reproductive and pregnancy healthcare provision (MBRRACE-UK, 2021). The clinical guidance recommends that antenatal women are offered regular check-ups, information, and support (National Institute for Health and Care Excellence [NICE], 2021). This includes meeting the clinical, psychological, and emotional needs of antenatal women (NICE, 2021). Especially, when mental health difficulties are common during pregnancies and exacerbated when pregnancy complications arise, threatening women’s psychological wellbeing (The British Psychological Society [BPS], 2016).

Clinical Psychologists in Maternity Services

The NHS Maternity Transformation Programme has recommended clinical psychologists to be embedded within maternity services (BPS, 2016; NHS, 2021). Clinical psychologists support with the stepped care approach of women’s diverse individual needs

such as medical, social, and psychological needs in maternity services (Ickovic et al., 2019; BPS, 2016). The stepped care approach includes advising, supervising, and training other MHPs to support women with psychological needs (BPS, 2016). This may significantly improve psychological support for MHPs in relation to providing psychologically informed care plans to prevent or limit women's experiences of distress (BPS, 2016; NHS, 2021).

Rationale

Maternity and perinatal research often group ethnic minority women as a homogenous group (MacLellan et al., 2022; Toh & Shorey, 2023; Watson et al., 2019). Whilst similarities may present within women from different ethnic minorities, this excludes the unique historical, cultural, general health status, genetics, and differences in service use (Ekezie et al., 2021). The largest ethnic minority group in England and Wales represents South Asian ethnicity, which includes people from India, Pakistan, Bangladesh, Sri Lanka, Nepal, Bhutan, and the Maldives (Minority Rights Group International, 2022; Office for National Statistics, 2022). Specifically, SA traditional practices may include, following specific diets, activities, Ayurvedic (traditional medicine) during pregnancy and childbirth (George et al., 2022). SA women in the United States and Canada have perceived positive experiences with maternity services when MHPs were open to their cultural practices (George et al., 2022; Grewal et al., 2008). However, some SA women felt the medical advice did not suit their cultural beliefs or assumed the MHP would not understand their culture (George et al., 2022).

SA women often utilise healthcare services when requiring urgent care or during significant life course events such as pregnancy and childbirth (Pallegadda et al., 2014). However, during pregnancy and childbirth SA women do not seem to utilise all the antenatal support offered by maternity services, for instance have lower attendance rates for antenatal

classes, which poses a negative impact on the women, infant, and the wider family (Bauer et al., 2016; Grewal et al., 2008). Specifically, SA women are at increased risk of adverse pregnancy outcomes in relation to weight management during pregnancy, gestational diabetes, and preterm labour (Delanerolle et al., 2021; Sheikh et al., 2022; Slack et al., 2018). Consequently, this increases the likelihood of experiencing high-risk pregnancy and mental health difficulties such as antenatal/postnatal depression, antenatal/postnatal anxiety, and post-traumatic stress disorder (Delanerolle et al., 2021; Isaacs & Andipatin, 2020; Sheikh et al., 2022).

Systematic reviews are considered the gold standard for informing clinical decision making, policy and practice whilst evaluating the quality of the evidence available (Chai et al., 2021; Pussegoda et al., 2017). The saturation of maternity-related systematic reviews has been acknowledged however, there is a need to review and synthesise findings from SA women to advance current knowledge, as little is known (Smith et al., 2011). Exploring the experiences of SA women can help to identify how to provide more sensitive and better-quality maternity care. This review supports the NHS plans to tackle maternal health disparities (NHS, 2021; The NHS Long Term Plan, 2019).

Review Aims

The review question is ‘what are South Asian women/birthing people’s experiences of maternity care in the UK?’ The review aims to systematically explore and synthesise SA women/birthing people’s experiences of maternity care in the UK.

Method

The review question was developed using the SPICE framework which refers to setting, perspective, intervention/interest of phenomenon, comparison, and evaluation, suited to qualitative research (Booth, 2006). SPICE enabled the Researcher (AS) to define the setting and perspective to limit results applicable to SA women/birthing people in the UK.

Scoping searches relevant to the research question were performed using Google Scholar in January 2023. The review was registered on PROSPERO on 8th February 2023 (CRD42023396945).

Search Strategy

A comprehensive search from three databases: Scopus (version 1970-present), MEDLINE via Web of Science (version 1950-present) and PsycInfo via Ovid (version 1806-present) were conducted to identify literature published until 12th April 2023. The databases were searched from inception because this review has not been conducted before, thus aimed to capture and form a comprehensive meta-synthesis of available qualitative evidence.

The grey literature facilitates increasing the scope to access more studies however, this was not consulted to limit the literature search, as sufficient papers were identified (Mahood et al., 2014). Additionally, there is limited guidance on how to systematically search the grey literature, thus restricted to academic peer-reviewed studies (Mahood et al., 2014).

The search terms are presented in Table 1, guided by the SPICE framework, and used Boolean terms (Appendix A). The search terms were refined in consultation with a specialist librarian. To supplement the systematic searches, forward citation searching using Google Scholar and manual backward citation searching was conducted on all included studies, and

relevant systematic reviews identified during the searches, to locate additional studies (Haddaway et al., 2022).

Table 1

The Search Syntax Corresponding to the SPICE Framework

SPICE	Search Terms
Setting	NHS OR "National Health Service" OR UK OR "United Kingdom" OR GB OR "Great Britain" OR Britain OR England OR Wales OR Scotland OR Ireland OR British OR English OR Welsh OR Irish OR Scottish
Perspective	"South Asia*" OR India* OR Pakistan* OR Bangladesh* OR Bhutan* OR Nepal* OR Maldives OR "Sri Lanka*" OR "ethnic minorit*" OR migrant*
Intervention	"Maternity service" OR "maternity care" OR antenatal OR pregnanc* OR postnatal OR perinatal OR childbirth OR childbear*
Comparison	-
Evaluation	Experience* OR Perception* OR View* OR Attitude* OR Perspective* OR Qualitative

Data Management and Screening

All literature were exported from each database and managed using EndNote 20.5 (Lorenzetti & Ghali, 2013). Records were organised alphabetically, and duplicates were removed manually and double-checked using Microsoft Excel. Titles and abstracts were screened for inclusion by the Researcher (AS) using a predefined inclusion criteria. Subsequently, relevant full-text papers of titles and abstracts were obtained. The relevance of each study was assessed according to the inclusion criteria.

Inclusion Criteria

The inclusion criteria were developed and guided by the SPICE framework and Polanin et al., (2019)'s recommendations, shown in Table 2. The inclusion criteria were consulted with a Specialist Clinical Psychologist (EW) which resulted in clarifying the boundaries of standard maternity care in the UK (Appendix B). The inclusion criteria were piloted on 30 articles prior to screening all titles and abstracts, with no subsequent amendments (Polanin et al., 2019). To increase the review rigour, an independent reviewer (CG) randomly checked 50% of the included articles against the inclusion criteria to ensure transparency and reproducibility (Porritt et al., 2014).

Table 2

Inclusion Criteria

	Inclusion	Exclusion
Setting	UK	Non-UK
Perspective	SA women/birthing people	Asylum seekers, refugees, undocumented UK status and impact of COVID-19 because these represent unique experiences
Intervention	Maternity care (antenatal to postnatal care)	Postnatal care after >8 weeks after childbirth which is in accordance with NHS maternity care remit. Specialist services, for example, neonatal intensive care unit, termination of pregnancy and in-vitro fertilisation
Comparison	-	-
Evaluation	Experiences	Standardised measures
Study design	Qualitative Mixed-methods studies containing relevant data	Quantitative, systematic reviews, literature reviews, conference posters, notes, opinion/letter pieces

Data Extraction

Data extraction was performed in two stages. Firstly, extracting publication and study characteristics and secondly, extracting the results/findings. The results/findings included verbatim and non-verbatim statements relating to SA women's experiences of maternity care. A second Researcher and Research Supervisor (VH) checked the received data, and a third Researcher (EW) was available to consult and resolve any discrepancies prior to meta-synthesis.

Thematic Synthesis

This review utilised thematic synthesis, considered useful for policymakers and practitioners (Booth et al., 2016). The thematic synthesis aimed to integrate the findings of studies exploring the lived experiences of SA women/birthing people's maternity care in the UK. A guide of 8-12 papers was set a priori, despite no rules for what is considered a suitable number of studies or adequate data for a meta-synthesis (Booth et al., 2016; Lewin et al., 2015).

Thematic synthesis was guided by Thomas & Harden's (2008) three-stage iterative process: coding of text 'line-by-line,' developing 'descriptive themes' and generating 'analytical themes.' The extracted results/findings of the included studies were entered into NVivo. The Researcher (AS) independently coded each line of text according to its meaning and content (Thomas & Harden, 2008). The codes were 'free' codes without a hierarchical structure and the use of line-by-line coding aimed to translate concepts between studies and categorise using codes (Appendix C). The dataset was checked for consistency of interpretation and new codes were generated. The Researcher (AS) checked for similarities and differences between the codes to organise them into descriptive themes (Appendix D for

an example). This produced a meta-synthesis close to the original findings of the included studies.

To ensure applicability to the review question and go beyond the studies' findings, the descriptive themes developed from the inductive analysis of study findings were scrutinised. One-by-one, the descriptive themes were critiqued in relation to the review question. This iterative process was repeated until no new analytical themes sufficiently captured the descriptive themes. Two supervisory team members (EW and VH) checked the themes.

Quality Assessment

Quality assessments were completed to appraise the methodological quality of the included studies, establish research rigour, and inform research recommendations (Ryan et al., 2013). There is a lack of consensus around what constitutes quality qualitative research (Sandelowski & Barroso, 2002). Therefore, quality assessments did not inform whether studies were removed, establishing all relevant studies was deemed to contribute to a balanced summary (Gopalakrishnan & Ganeshkumar, 2013; Soilemezi & Linceviciute, 2018). Removing studies based on the quality score could risk erroneous conclusions as scores may be influenced by the selection bias of the quality assessment tool itself (Møller & Myles, 2016).

Currently, there is an absence of guidance on how to select an appraisal tool for meta-synthesis (Soilemezi & Linceviciute, 2018). Considering the aims and priorities of the review, the commonly utilised Critical Appraisal Skills Programme (CASP) qualitative tool was chosen because it is advocated by the Cochrane Qualitative and Implementation Methods Group, recognised as contributing to high-quality evidence-based healthcare (CASP, 2018; Long et al., 2020; Majid & Vanstone, 2018) (Appendix E).

The CASP tool consisted of ten items with ‘yes’ responses scored as 1-point, ‘can’t tell’ scored as 0.5-points and ‘no’ scored as 0-points (Butler et al., 2016; CASP, 2018; Finazzi & MacBeth, 2022). The CASP tool for all studies was completed by the researcher (AS) and an independent reviewer (CG), with four discrepancies resolved through discussion.

A scoring system for the CASP tool was developed to indicate low quality or bias (Soilemezi & Linceviciute, 2018). Informed by existing systematic reviews and literature, the following criterion was developed, scores of 9-10 on the CASP indicated ‘high’ quality, scores of 7.5-9 indicated ‘moderate’ quality and scores <7.5 indicated ‘low’ quality (Butler et al., 2016; Finazzi & MacBeth, 2022). Although scores <6 are recommended to be excluded, reflecting poor quality, this review did not exclude studies based on these scores (Butler et al., 2016; Finazzi & MacBeth, 2022).

Sensitivity analysis can assess the impact of including lower quality studies and weigh in favour of findings from higher quality studies in a meta-synthesis (Boeije et al., 2011; Carroll et al., 2012). However, integrating sensitivity analysis may not meaningfully impact meta-synthesis findings and can reduce transferability (Long et al., 2020). Additionally, lower quality studies can contribute novel insights not provided by adequate studies, thus sensitivity analysis was not completed (Dixon-Woods et al., 2006; Long et al., 2020).

To support the transparency in reporting, the ‘preferred reporting items for systematic reviews and meta-analyses’ (PRISMA) 2020 Checklist supplemented with the ‘enhancing transparency in reporting the synthesis of qualitative research’ (ENTREQ) checklist, were completed by an independent reviewer (CG) (Page et al., 2021; Tong et al., 2012) (Appendices F-G).

Reflexivity

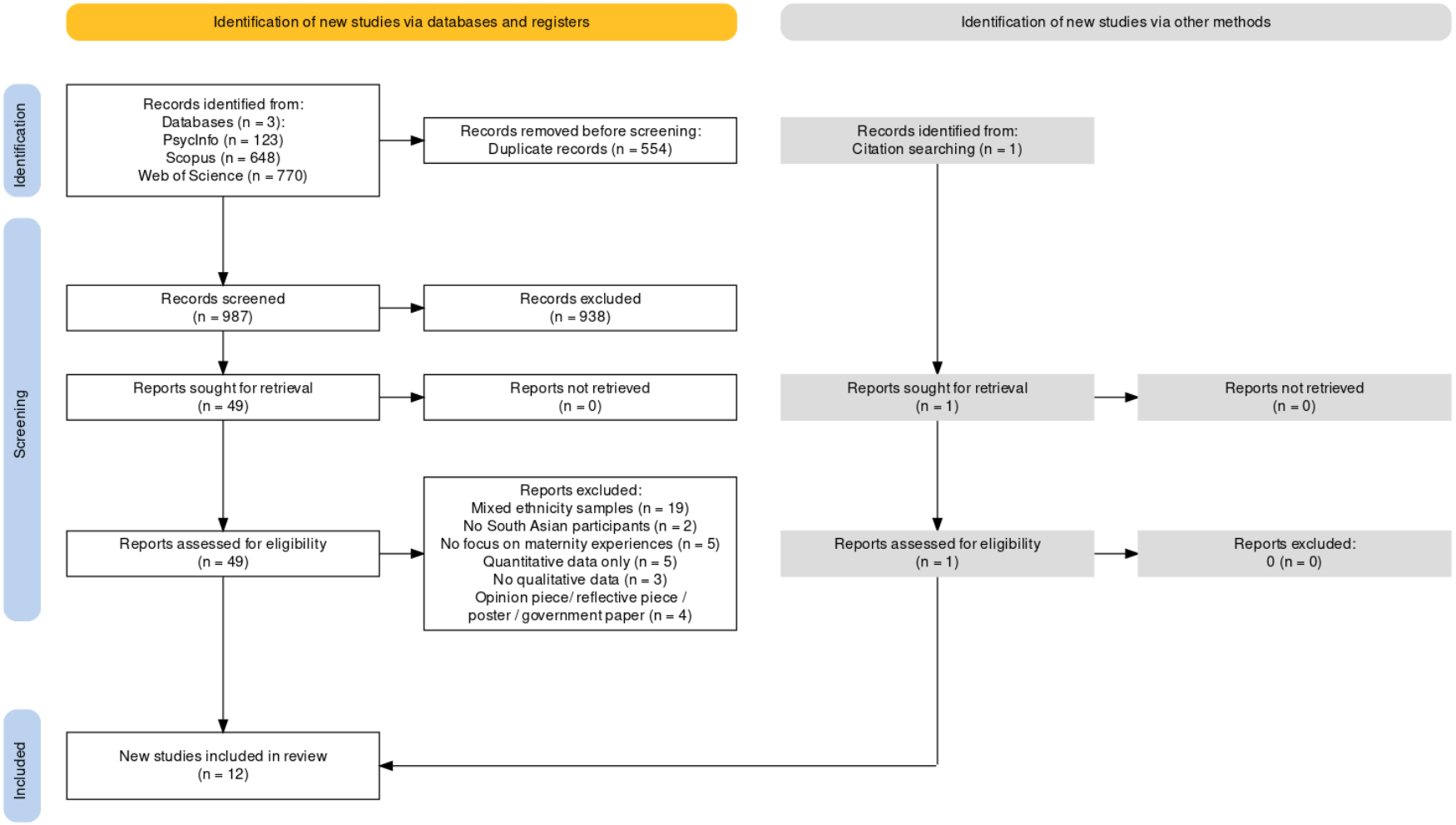
Reflexivity is crucial for high quality qualitative research and recommended throughout the research process (Barrett et al., 2020; Tong et al., 2007). The Researcher (AS) was a Trainee Clinical Psychologist, working in a specialist NHS maternity service (a multidisciplinary team consisting of psychologists and specialist midwives). AS identified as a cisgender woman, with British Indian ethnicity, thus shared some cultural experiences with participants. However, AS did not have experience of childbirth. To manage these influences, a reflexive log was completed throughout the research process and discussed in supervision with the supervisory team (EW and VH).

Results

The finalised literature search comprised of 12 articles published between 1990 and 2020, summarised in Figure 1. The study characteristics are presented in Table 3. A total of 244 SA women were represented, with no representation of birthing people. Two studies comprised of healthcare professionals' views however, data was easily separated and excluded in the analysis (Goodwin et al., 2018; McFadden et al., 2012). One study contained a distinct non-SA sample which was also excluded from the analysis (Woollett et al., 1995).

Figure 1

PRISMA Flow Diagram



Quality Assessment

The CASP appraisals are summarised in Table 3 (Appendix H for detailed CASP scores). Overall, three articles were considered high quality, one article moderate quality and eight articles low quality. Eleven articles included a clear research aim, with all studies suitable for qualitative methodology. Although, three articles did not clearly justify the research design. Nine articles clearly reported appropriate recruitment strategy. Nine articles collected data that clearly addressed the research issue, for three articles, this was unclear. Nine articles did not adequately discuss the relationship between the researcher and the participants. Seven articles did not sufficiently discuss or report ethical approval or considerations which were mostly represented by studies conducted in the 90s. Eight studies did not clearly report or justify the processes for the data analysis. All studies reported a clear statement of findings and represented valuable research.

Table 3

Summary of the Study Characteristics

Participant Characteristics				Methodology				
Authors (year)	Participants	Stage of maternity care	Parity	Data collection	Sample methods	Analysis	Themes/ Key Findings	Quality Appraisal
Bowes & Domokos (1996)	20 women (19 Pakistani Muslim and 1 Libyan woman[3]) in Glasgow	Antenatal and postnatal	Not reported	Semi-structured interviews (Punjabi interpreter available)	Purposive sampling	Ethnographic study	Experiences of maternity care were varied between being satisfied and unsatisfied.	Low
Cross-Sudworth et al. (2011)	15 first and second generation Pakistani women in the West Midlands	Postnatal (3-18 months)	Not reported	Semi-structured interviews Focus groups (Urdu interpreter available)	Purposive sampling	Q-methodology	6 factors: (1) Empowerment and high confidence (2) Isolation and need of professional support (3) Poor maternity care (4) Caring maternity services and cultural traditions (5) Information and	High

[3] Included because majority of participants were SA

Participant Characteristics				Methodology				
Authors (year)	Participants	Stage of maternity care	Parity	Data collection	Sample methods	Analysis	Themes/ Key Findings	Quality Appraisal
							support (6) Importance of midwifery care	
Garcia et al. (2020)	6 women (3 Pakistani, 1 Bangladeshi and 2 White British women*) in Luton	Postnatal (6-24 months)	0-1	Semi-structured interviews	Retrospective and purposive sampling	Framework analysis	3 themes: (1) Knowledge and information of pregnancy and perinatal mortality (2) Attitudes and perceptions to pregnancy and perinatal mortality (3) Mothers' experiences with maternity services	Moderate
Goodwin et al. (2018)	9 Pakistani migrants (7 women; 1 mother of a participant; 1 interpreter) and 11 midwives in South Wales	Antenatal	Not reported	Interviews at 2 time points (after first antenatal appointment and after second/ third antenatal appointment)	Purposive sampling	Thematic analysis	3 themes: (1) Family relationships (2) Culture and religion (3) Understanding different healthcare systems	High

Participant Characteristics				Methodology				
Authors (year)	Participants	Stage of maternity care	Parity	Data collection	Sample methods	Analysis	Themes/ Key Findings	Quality Appraisal
				(Urdu interpreter available)				
Griffith (2010)	2 Bangladeshi women in East London	Postnatal (23 months -5 years)	1-2	Interviews	Purposive sampling (2 case studies)	Narrative analysis	N/A	Low
Jayaweera et al. (2005)	9 low-income Bangladeshi women in Leeds	Antenatal-1 year postnatal	0-unknown	Semi-structured interviews (6 interviews completed in Sylheti)	Purposive sampling	Not reported	Maternity benefits; Access to shops and services; Social support; Antenatal and postnatal care; Health and wellbeing	Low
McFadden et al. (2012)	23 Bangladeshi women, 4 health service managers and 28 health practitioners in West Yorkshire and	Postnatal (3 weeks-6 years)	1-6	In-depth interviews (10 interviews completed in Sylheti) Focus groups	Purposive sampling	Not reported	Ethnic identities; Breast-feeding support in the early postnatal period; Community support; Home context of breast-feeding	High

Participant Characteristics				Methodology				
Authors (year)	Participants	Stage of maternity care	Parity	Data collection	Sample methods	Analysis	Themes/ Key Findings	Quality Appraisal
	Northeast England							
Miller, (1995)	5 Bangladeshi Muslim women in Britain	Postnatal	Not reported	In-depth interviews (2 women) Group interview with Bengali interpreter (3 women)	Snowball sampling	Not reported	Practice of the Muslim religion; Attendance to antenatal clinics; Language difficulties and use of antenatal services; The influence of the Imam; The take up of parentcraft classes	Low
Parvin et al. (2004)	25 first generation Bangladeshi and British-Bangladeshi women in Tower Hamlets, East London	Postnatal	Mean= 3.9	3 focus groups (Sylheti interpreter used for all groups)	Purposive sampling	Thematic content analysis	4 themes: (1) Bangladeshi women's experiences of giving birth in the UK (2) Family circumstances after birth – problems within the home and support from the family (3) Responses to emotional distress	Low

Participant Characteristics				Methodology				
Authors (year)	Participants	Stage of maternity care	Parity	Data collection	Sample methods	Analysis	Themes/ Key Findings	Quality Appraisal
							and problems within the family (4) Experiences of primary care services in the postnatal period	
Woollett & Dosanjh (1995)	100 SA women and 43 non-Asian in Newham, East London	Postnatal	1-unknown	Structured interview	Purposive sampling	Qualitative analysis	Pregnancy and antenatal care; Childbirth; Experiences of postnatal care	Low
Woollett & Dosanjh-Matwala, (1990a)	32 SA women, East London	Postnatal	1-4	Semi-structured interview (Punjabi, Hindi and Urdu interpreters available)	Purposive and snowball sampling	Content analysis	Feeding; Rest and recovery; Bonding and the mother-child relationship; Relations with staff; Language difficulties	Low
Woollett & Dosanjh-	32 SA women, East London	Postnatal	1-4	Semi-structured interview (Punjabi, Hindi and Urdu	Purposive and snowball sampling	Not reported	Reactions to pregnancy; Changes during pregnancy: nausea and changes in eating; Other changes in	Low

Participant Characteristics				Methodology				
Authors (year)	Participants	Stage of maternity care	Parity	Data collection	Sample methods	Analysis	Themes/ Key Findings	Quality Appraisal
Matwala, (1990b)[4]				interpreters available)			pregnancy; Sex of child; Antenatal clinics; Sources of information and support about pregnancy and birth; Leaflets, books and videos; Antenatal classes; Support from other people; Experiences of women who spoke very little English	

[4] Same participants as Woollett & Dosanjh (1990a)

Thematic Synthesis

Thematic synthesis developed four themes, presented in Table 4. Table 5 demonstrates the representation of themes within and between studies.

Table 4

Summary of Themes

Themes	Sub-themes
(In)ability to express maternity needs	Degrees of passivity
	Speaking English unlocks better care
Uncompassionate relationships with maternity	Neglecting needs
healthcare professionals	Subject to stereotyping
Integrating maternity care with cultural identity	-
Family being a part of maternity care	Significance of female relationships
	Husbands are an advocate

Table 5

The Representation of Themes

	Bowes & Domokos (1996)	Cross-Sudworth et al. (2011)	Garcia et al. (2020)	Goodwin et al. (2018)	Griffith (2010)	Jayaweera et al. (2005)	McFadden et al. (2012)	Miller, (1995)	Parvin et al. (2004)	Woollett & Dosanjh (1995)	Woollett & Dosanjh-Matwala, (1990a)	Woollett & Dosanjh-Matwala, (1990b)
(In)ability to express maternity needs	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓
Degrees of passivity	✓	✓	✓		✓		✓	✓		✓		✓
Speaking English unlocks better care		✓			✓	✓		✓	✓	✓	✓	
Uncompassionate relationships with MHPs	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	
Neglecting needs		✓	✓		✓		✓		✓	✓	✓	
Subject to stereotyping	✓	✓	✓		✓	✓		✓				

	Bowes & Domokos (1996)	Cross-Sudworth et al. (2011)	Garcia et al. (2020)	Goodwin et al. (2018)	Griffith (2010)	Jayaweera et al. (2005)	McFadden et al. (2012)	Miller, (1995)	Parvin et al. (2004)	Woollett & Dosanjh (1995)	Woollett & Dosanjh-Matwala, (1990a)	Woollett & Dosanjh-Matwala, (1990b)
Integrating maternity care with cultural identity		✓	✓	✓			✓	✓		✓		
Family being a part of maternity care	✓	✓	✓	✓	✓	✓		✓	✓	✓		✓
Significance of female relationships	✓	✓	✓	✓		✓		✓		✓		✓
Husbands are an advocate				✓	✓			✓	✓	✓		✓

(In)ability to Express Maternity Needs

The following sub-themes captured the internal processes for expressing maternity needs. These represented SA women's process of speaking up and asserting themselves with associated facilitators and barriers.

Degrees of Passivity

The degree of passivity varied between SA women. Some SA women appeared to choose passivity and complied with MHPs' instructions because of how they perceived the seniority of professionals (Miller, 1995). SA women were also satisfied with surrendering decision-making and prepared for MHPs to take the responsibility to make decisions (Woollett et al., 1995). Sometimes passivity was self-identified by participants, as a cultural weakness whilst others recognised the value of being assertive and defended against being passive (Woollett & Dosanjh-Matwala, 1990b). "They could tell you rather than wait for you to ask because some Asians there they don't know how to speak and they won't push for anything" (SA woman, postnatal, English speaking) (Woollett & Dosanjh-Matwala, 1990b, p.70). For other SA women, compliance did not feel like a choice and instead felt a pressure to comply with MHPs (Bowes & Domokos, 1996; Miller, 1995). "It's difficult to be assertive even when you have the language, I feel I was bossed around and I feel quite resentful about that" (Bangladeshi woman, postnatal, English speaking) (Miller, 1995, p.306).

SA women withheld their assertiveness which presented as being appreciative of maternity care however, SA women seemed unable to express their preferences for care, despite wanting more midwifery support (Bowes & Domokos, 1996; Goodwin et al., 2018; McFadden et al., 2012; Woollett et al., 1995). This coincided with a fear of being judged (Bowes & Domokos, 1996; Garcia et al., 2020). However, assertiveness was developed when SA women had experienced a previous childbirth (Cross-Sudworth et al., 2011). "It's easier

this time around. I've been quite confident. Personally, I feel I'm quite a strong person. If I had any problem, you know, I would just ask" (Pakistani woman, postnatal, English speaking) (Cross-Sudworth et al., 2011, p.463).

Speaking English Unlocks Better Care

SA women recognised that their ability to speak English influenced their maternity care and building relationships with the midwife (Cross-Sudworth et al., 2011; Griffith, 2010; Jayaweera et al., 2005; Parvin et al., 2004; Woollett & Dosanjh-Matwala, 1990a). SA women experienced that speaking English would attract the care and attention of the midwife to meet their needs, however if they were unable to speak English, their needs would remain unmet (Griffith, 2010; Jayaweera et al., 2005; Woollett & Dosanjh-Matwala, 1990a). "They're quite good you see, the midwives, if you know English – they'll come and see you" (Bangladeshi woman, antenatal, English speaking) (Jayaweera et al., 2005, p.92).

English speaking SA women expressed concerns that non-English speaking SA women were unable to express their needs if MHPs were not receptive to their lack of English ability (Griffith, 2010; Woollett & Dosanjh-Matwala, 1990a). They perceived MHPs as ignoring their maternity needs, withholding flexibility of care that may be offered to other women and providing insufficient effort to communicate with SA women (Cross-Sudworth et al., 2011; Jayaweera et al., 2005; Parvin et al., 2004; Woollett & Dosanjh-Matwala, 1990a). However, some SA women were empathetic to MHPs and recognised their challenges of providing care to SA women unable to speak English (Cross-Sudworth et al., 2011; Woollett & Dosanjh-Matwala, 1990a). "They don't give enough attention if you can't speak English. But I don't know whether to blame the midwife because if they say something and the patient ignores it then it's like talking to a brick wall." (SA woman, postnatal, English speaking) (Woollett & Dosanjh-Matwala, 1990a, p.183).

The availability of interpreters was variable and recognised as a valuable resource to aid communication between SA women and MHPs (Jayaweera et al., 2005; Miller, 1995; Parvin et al., 2004; Woollett et al., 1995). When SA women experienced easy access and reliable interpreter support, they found this helpful and contributed to their satisfaction with care (Jayaweera et al., 2005). “Brought an interpreter with them and explained everything clearly” (Bangladeshi woman, postnatal, non-English speaking) (Jayaweera et al., 2005, p. 92). However, when interpreters were unavailable, this was problematic as they missed out on support (Miller, 1995; Parvin et al., 2004). “Sometimes when you have a baby, a woman comes from the hospital. Bengali girls don’t come with the midwife, we don’t understand what they say, we just sit there staring at their faces.” (Bangladeshi woman, postnatal, Sylheti speaking) (Parvin et al., 2004, p.256). SA women also positively experienced link workers as an important source of information and support (Woollett et al., 1995).

Uncompassionate Relationships with MHPs

Two sub-themes reflected the impact and dynamic of interactions with MHPs. Interpersonal aspects of maternity care were important to SA women, with trust being highly valued (Cross-Sudworth et al., 2011; Woollett et al., 1995). SA women experienced hostility from MHPs with some feeling punished during labour or when actively asking for help (Bowes & Domokos, 1996; Cross-Sudworth et al., 2011; McFadden et al., 2012; Woollett & Dosanjh-Matwala, 1990a). “When this one was born if I asked them to help me they would get angry with me, making an angry face” (Bangladeshi woman, postnatal, Sylheti speaking) (McFadden et al., 2012, p.e128). Sometimes these experiences developed a fear of interacting with staff (Woollett & Dosanjh-Matwala, 1990a).

Neglecting Needs

SA women regularly experienced being dismissed and overlooked by midwives and nurses whilst recovering postnatally (Cross-Sudworth et al., 2011; Garcia et al., 2020; Griffith, 2010; McFadden et al., 2012; Woollett & Dosanjh-Matwala, 1990a).

> They [the midwives] didn't [come], I was in hospital for a week and my actual midwives didn't even know that I was there, didn't bother coming to see me until day five when they came to see somebody else from the ward (Bangladeshi woman, postnatal, English speaking) (Griffith, 2010, p.294).

SA women felt MHPs were unwilling to listen and did not respond to support (Cross-Sudworth et al., 2011; Garcia et al., 2020; Woollett & Dosanjh-Matwala, 1990a). "When I had my first baby, I really wanted help with bathing the baby; I asked a couple of times, but she never came" (Pakistani woman, postnatal, Urdu speaking) (Cross-Sudworth et al., 2011, p.464). The MHPs' interactions were perceived as neglectful which influenced unrealistic expectations for SA women to care for themselves and their baby, contributing to distress (McFadden et al., 2012; Parvin et al., 2004; Woollett & Dosanjh-Matwala, 1990a). "The nurse is there to help but they say 'you do it yourself'" (Bangladeshi woman, postnatal, Sylheti speaking) (Parvin et al., 2004, p.255).

However, there were infrequent exceptions whereby SA women received good maternity care and experienced opportunities for sufficient postnatal recovery and emotional support (Cross-Sudworth et al., 2011; Woollett et al., 1995; Woollett & Dosanjh-Matwala, 1990a). "I had two midwives; one was a student, and one was the regular there. The regular lady she was so generally, like, caring and she actually put – like she put a smile on my face" (Bangladeshi woman, postnatal, English speaking) (Garcia et al., 2020, p.5).

Subjected to Stereotyping

Experiencing negative and cultural stereotyping hindered SA women's ability to express their needs, although not experienced by all women. SA women self-identified negative stereotyping when they felt MHPs made assumptions about them (Bowes & Domokos, 1996; Miller, 1995). "I will wear these clothes and open my mouth later on to shock people you know, shock white people, because they think this is an idiot sitting there wearing these clothes" (Pakistani woman, postnatal, English speaking) (Bowes & Domokos, 1996, p.58).

Experiences of racism were identified in the company of White women through noticing differences in care (Bowes & Domokos, 1996). Sometimes this resolved as the SA women developed a relationship with the MHP however, for others discrimination was questioned (Bowes & Domokos, 1996; Griffith, 2010; Miller, 1995). "Is it me, the people that they like that they select', which I know isn't true. At the time I was saying to my husband, it's just the English babies that are getting that [care]" (Bangladeshi woman, postnatal, English speaking) (Griffith, 2010, p.294).

SA women described positive experiences of maternity care when they recognised they were not being treated differently due to ethnicity (Bowes et al., 1996; Garcia et al., 2020; Jayaweera et al., 2005). "They're angels over here, and they don't consider if you're a black or a white person" (Pakistani woman, postnatal, English speaking) (Bowes & Domokos, 1996, p.58).

Integrating Maternity Care Advice with Cultural Identity

This theme represented the cultural pressures, dilemmas, and impact on religious practices for SA women within maternity care. SA women attempted to balance the cultural traditions and midwives' clinical advice. "I would listen to the midwife. Cos she's obviously

the person who's more experienced in that. But then it's tradition….and you kind of respect tradition as well. I don't know – it's a bit difficult" (Pakistani woman, antenatal, unknown if English speaking) (Goodwin et al., 2018, p.351). For some SA women, the community attitudes were more influential, particularly advice from older family members, than MHPs (Goodwin et al., 2018; Miller, 1995). "Whatever [midwives] say, [Pakistani women] won't follow you. They will say "ok yes we will do" in front of you…but when they go back home, they won't follow you! They will follow whatever the elders say" (Pakistani woman, antenatal, unknown if English speaking) (Goodwin et al., 2018, p.352). There was pressure to conform to cultural norms, however, this did not always impact the experience of maternity care when good care was perceived (Cross-Sudworth et al., 2011).

Some SA women were Muslim and prioritised religious beliefs, which led to fasting through Ramadan during pregnancy and declining post-mortems following baby loss (Garcia et al., 2020; Miller, 1995). Some SA women sought advice from religious figures alongside MHPs (Miller, 1995). Breastfeeding in the presence of other people was stigmatised and SA women valued their privacy during breastfeeding and internal examinations, with a preference for female doctors (McFadden et al., 2012; Miller, 1995). "[it is] totally against our religion you see and that's why we do prefer a lady doctor…I feel shame actually" (Bangladeshi woman, postnatal, English speaking) (Miller, 1995, p.306). However, SA women who were distanced from the SA culture embraced deviating from cultural traditions, prioritising professional maternity care (Cross-Sudworth et al., 2011; Woollett et al., 1995).

Family Being a Part of Maternity Care

Two sub-themes represented the value of family support, particularly husbands and extended families, throughout the antenatal and postnatal period (Goodwin et al., 2018; Jayaweera et al., 2005; Woollett & Dosanjh-Matwala, 1990b).

Significance of Female Relationships

Female relatives were a salient source of support for SA women, particularly mothers and/or mothers-in-law (Cross-Sudworth et al., 2011; Garcia et al., 2020; Goodwin et al., 2018; Jayaweera et al., 2005; Miller, 1995; Woollett et al., 1995; Woollett & Dosanjh-Matwala, 1990b). “I was 5 months pregnant so my mum said that there is enough space anyway so move in, so I moved in, into the house, and in that 5 month I didn’t do no cooking, no shopping, no anything” (Bangladeshi woman, postnatal, unknown if English speaking) (Jayaweera et al., 2005, p.91).

SA women perceived that older female relatives were more experienced with talking to midwives and valued them speaking on their behalf (Goodwin et al., 2018). “I’d rather have [my mum] talk, she’s more experienced with talking to midwives and doctors. And she knows the whole process, I think I’d rather have her talk, than me” (Pakistani woman, antenatal, unknown if English speaking) (Goodwin et al., 2018, p.352). Sometimes, maternal figures offered emotional, practical, and financial support through pregnancy, and the postnatal period (Cross-Sudworth et al., 2011; Jayaweera et al., 2005; Miller, 1995; Woollett et al., 1995).

> My mother-in-law told me everything the first time she told me about the pains and where the baby was going to be delivered from. My mother-in-law told me I should breathe down and not up every time I had the pains (SA woman, postnatal, Punjabi speaking) (Woollett & Dosanjh-Matwala, 1990b, p.73).

Mothers-in-law provided educational information on childbirth to the SA woman, although some SA women found their support unhelpful and inadequate (Garcia et al., 2020; Miller, 1995; Woollett et al., 1995; Woollett & Dosanjh-Matwala, 1990b). However, female relatives carried ‘authoritative knowledge’ which was not always beneficial, for example, if

antenatal services were not deemed important, they tended not to support the SA woman attending (Miller, 1995). Subsequently, feelings of regret during labour manifested when realising the benefits of antenatal classes and the realities of childbirth were not realised until after the birth (Bowes & Domokos, 1996; Woollett et al., 1995).

Husbands are an Advocate

SA women reported that husbands were a source of moral support and found their presence at antenatal services through to delivery helpful (Griffith, 2010; Miller, 1995; Woollett et al., 1995). “I went to the antenatal services and I was talking to people and having your partners there makes such a difference” (Bangladeshi woman, postnatal, English speaking) (Griffith, 2010, p.294). Partners frequently adopted the advocate role and SA women were accepting of them speaking on their behalf or translating information (Goodwin et al., 2018; Woollett & Dosanjh-Matwala, 1990b). “Think it’s a caring thing. Because they care about their wives and their children. That’s why they [speak] for their wives or girlfriends…he speaks for me and he cares about me so I’m happy about it” (Pakistani woman, antenatal, unknown if English speaking) (Goodwin et al., 2018, p.352).

However, for other SA women, including the husband in their maternity care was at their discretion and created a sense of shame if the wider community knew about their involvement (Miller, 1995; Parvin et al., 2004). “Some people they don’t understand and said “oh, it’s shame for boy to go.” (Bangladeshi woman, postnatal, English speaking) (Miller, 1995, p.305).

Discussion

Four themes represented SA women's experiences of maternity care in the UK. Most SA women perceived difficulties with expressing maternity needs, underpinned by internal and external influences. However, some SA women successfully navigated their maternity care and were assertive in their care. Relational experiences in maternity care for SA women were perceived as neglectful, uncompassionate with some experiences of stereotyping. Although, there were some positive experiences of maternity care, these experiences were less salient. SA women's experiences encompassed challenges and issues navigating professional maternity care advice, alongside cultural traditions, and practices. SA women widely viewed their professional maternity care to incorporate family, particularly valuing husbands, and female familial relationships.

Linking Findings with Previous Research

(In)ability to Express Maternity Needs

Findings indicated that SA women perceived difficulties with communication, especially around obtaining sufficient information about childbirth, birth choices, and language barriers. These were recurrent themes experienced by ethnic minority women in the UK (Khan, 2021; MacLellan et al., 2022). Findings also highlighted that SA women were not reliably accessing an interpreter independent of the woman, contrasting clinical guidance (NICE, 2021). Subsequently, interpreters have shown to support discussions of sensitive topics, ultimately leading to non-English speaking women experiencing better maternity care (Rayment-Jones et al., 2021).

The findings detailed unique differences with some SA women experiencing difficulties with being assertive and sometimes self-identifying as passive. A study focusing on Asian American women experiences of racialised sexism, described perceptions of being

'submissive and passive' directed at them (Mukkamala & Suyemoto, 2018). Subsequently, Asian American women made attempts to dismiss the salient characterisation of presenting as passive (Mukkamala & Suyemoto, 2018). Linking this to the review findings may suggest that experiences of racialised sexism may be internalised for some participants.

Uncompassionate Relationships with MHPs

Salient experiences of poor relationships with MHPs have been reinforced within recent systematic reviews, exploring more broadly, ethnic minority women's experiences, therefore will not be detailed here (Fair et al., 2020; Higginbottom et al., 2019; MacLellan et al., 2022). Furthermore, review findings reinforced findings from an independent review of NHS maternity services, which represented women's negative experience with MHPs, more generally (Ockendon, 2022). Thus, indicating transferability and reinforcing the need for action to improve all women/birthing people's maternity experiences in the UK.

Findings reflected that SA women experienced stereotyping by MHPs, supported by research focusing on exploring midwives' stereotypes of ethnic minority women (Bowler, 1993; Crowe, 2022). Midwives have shown to use stereotypes to support them to identify the differing needs of women however, tended to be held negatively (Bowler, 1993; Puthussery et al., 2008). Midwives may apply stereotypes based on women's physical appearance which hinders the ability to meet the woman's individualised maternity care needs (Bowler, 1993). Midwives have perceived incongruent expectations with ethnic minority women in their maternity care (Crowe, 2022). Also, some midwives have assumed ethnic minority women disregarded their own health, were unlikely to make wise clinical decisions and were disempowered by men from their cultural background (Crowe, 2022). The current review findings mirrored midwives' attitudes as SA women felt aware and recognised when they were being stereotyped (Crowe, 2022). Experiencing stereotyping has been linked with

feeling misunderstood, the delivery of inequitable maternity care and poorer perinatal outcomes (Thomson et al., 2022).

Integrating Maternity Care Advice with Cultural Identity

Findings highlighted some dilemmas SA women experience when engaging with maternity services and desires to follow SA traditions. SA women often experienced feeling misunderstood by MHPs, particularly with context to traditional customs. These experiences have been emphasised by Fair et al., (2020) which highlighted migrant women's struggles and feelings of insecurity when deciding what actions to take between medical, cultural, and family advice, leaving women feeling misunderstood by MHPs.

In terms of religiosity, the most salient religion in the current review was Islam. These perspectives from the review complemented perspectives from Muslim women more generally (Firdous et al., 2020). For instance, Muslim women experienced anticipating misperceptions, or misunderstandings from MHPs, therefore withheld expressing religious practices (Firdous et al., 2020).

Cultural practices in childbirth exist beyond religious beliefs with most Asian traditional beliefs and practices considered unharmful to women and underpin successful pregnancy and birth experiences (Withers et al., 2018). Thus, such knowledge should be integrated within maternity care practices.

Family Being a Part of Maternity Care

Collectivist cultural processes may contextualise the current findings, around SA women experiencing family and husbands as salient sources of support in maternity care (Chadda & Deb, 2013; Karasz et al., 2019). In South Asia, this was reinforced by women's experiences of family members supporting with confidence and comfort through pregnancy and childbirth (Kaphle et al., 2022). However, SA women in collectivist families may be

suppressed by older female relatives and reluctantly conform to avoid fear of negative consequences (Karasz et al., 2019; Withers et al., 2018). These experiences were reinforced by the current findings which may help MHPs better understand the needs of SA women/birthing people.

Male partners in the UK have shown to be supportive for women and positively influence engagement in maternity care (Draper & Ives, 2013; Suandi et al., 2020). In SA countries, some husbands have shown to hold a dominant role in deciding the SA woman's antenatal attendance and determining place of delivery (Rahman et al., 2021). This may support how some SA women found it helpful for their partners to dominate maternity appointments.

Midwives recognise that family plays a significant role in maternity care for SA women (Goodwin et al., 2018). However, midwives have perceived the woman's family involvement as negatively influencing the midwife-woman relationship (Goodwin et al., 2018). Midwives have described female elders as 'dominating' and struggle with women declining clinical advice (Goodwin et al., 2018). This mismatch of experiences from the MHPs and SA women may explain the lack of attunement when perceiving poor quality maternity care.

Strengths, Limitations and Research Implications

This was an original review using a comprehensive search strategy with transparent reporting that explored maternity experiences exclusively to SA women in the UK (Tong et al., 2012). The review represented SA women who were English and non-English speaking, thus covered a breadth of experiences. However, there was diversity within the SA samples, with varying levels of religiosity, English language ability and acculturation which may influence maternity care experiences and limit transferability. Also, SA birthing people's

experiences were not explicitly reported. Thus, some experiences or issues may be more salient according to such diversity, which may not be apparent within this meta-synthesis.

Review findings may be limited by the included studies representing a period whereby the NHS context was outdated and not reflective of the current context. However, similar narratives identified across studies suggested that experiences had not changed over time.

A strength of the review was the use of quality assessments with a second independent reviewer to increase reliability of appraisals. However, the robustness of the thematic synthesis was limited by the poor-quality reporting of the included studies. Whilst the quality of reporting in qualitative studies have improved in recent years, older studies may be more likely to be reported as poorer, which was reflected in this review (Soilemezi & Linceviciute, 2018).

Although the CASP tool can assess the procedural aspects of the study, it has limited sensitivity to interpretative, evaluative, and theoretical validity when compared to other qualitative quality assessment tools, which may have impacted quality assessments (Hannes et al., 2010). For instance, one study rated as high-quality did not explicitly report methodological orientation, despite this underpinning quality qualitative research (McFadden et al., 2012; Tong et al., 2007). Thus, may have biased the meta-synthesis if sensitivity analysis was conducted, although would introduce complexity due to the frequency of low-quality papers.

Furthermore, it was concerning that most studies insufficiently addressed ethical considerations, which may explain why ethnic minority women experience distrust and hesitance to participate in maternity research (Lovell et al., 2023). Three included studies considered reflexivity however, omitted sufficient detail (Olmos-Vega et al., 2023). Reflexivity should be embedded in all aspects of the study processes and within the context

of SA women, intersectional reflexivity should be considered in future research (Olmos-Vega et al., 2023; Rodriguez & Ridgway, 2023).

The researcher belongs to the ingroup and held important perspectives as a SA cisgender woman (Harrison & Michelson, 2022). This may have introduced bias through the review process. However, this was considered and managed by a supervisory team who were outgroup members. Variations in positionality were considered to enable different insights and knowledge generation (Harrison & Michelson, 2022).

Overall, this review highlighted the lack of rigorous research in SA women's experiences of maternity care, due to the lack of dependability of the included studies inadequately reporting study processes. Subsequently, this may question the credibility of the review findings. As a priority, research implications include increasing the quality of in-depth and ethical qualitative research focusing on SA women/birthing people to contribute to the maternity care evidence-base (Tong et al., 2007).

Clinical Implications

Findings highlighted that maternity services are inconsistent in their provision of culturally sensitive care to SA women. It is crucial that SA women feel understood and are supported to express their maternity needs. Therefore, they should be offered opportunities to build compassionate relationships and discuss culture and religion more openly, without the fear of judgement. Also, MHPs should consider engaging with the wider family and increasing the provision of professional interpreters/link workers.

Due to varied difficulties with integrating maternity clinical advice with cultural identity, MHPs should be perceptive to the woman/birthing person's needs by offering support to collaboratively resolve cultural dilemmas that may arise between medical advice and tradition or religion. Also, to respect women/birthing people's wishes if they refuse or decline aspects of maternity care, which has been implicated with difficult MHPs interactions

and create internal conflict for MHPs (Jenkinson et al., 2017; Niles et al., 2021). Clinical psychologists embedded in maternity services can support MHPs by offering reflective spaces, for example, if MHPs feel distressed or disempowered if SA women/birthing people decline their advice. Alternatively, clinical psychologists can offer clinical supervision and consultation. For example, to support with resolving dilemmas within maternity teams and provide psychologically informed care plans.

Findings indicated that SA women experienced difficulties in maternity care, which may increase the risk of perinatal mood difficulties (Delanerolle et al., 2021; Isaacs & Andipatin, 2020; Sheikh et al., 2022). Therefore, clinical psychologists are recommended to provide timely access to reduce antenatal and postnatal distress (BPS, 2016). For instance, detecting vulnerable antenatal women/birthing people, supporting with birth preparation alongside specialist midwives, and detecting antenatal anxiety, in addition to providing postnatal psychological intervention for women distressed by birth experiences (BPS, 2016).

It is recommended that MHPs complete unconscious bias and cultural awareness training, a widely reported clinical recommendation (Aquino et al., 2015; Bowler, 1993; Chitongo et al., 2022; Lyons et al., 2008). Particularly if unconscious bias adversely impacts MHPs adherence to provide quality maternity care, as represented by SA women. The reinforcement for unconscious bias and cultural awareness training with limited implementation-based research, suggests that research and services should focus on how this can be integrated within clinical practice (Gopal et al., 2021). This inclusive work should be viewed as an integration to MHPs' roles and the maternity system rather than an additional demand, whilst offering culturally sensitive, psychologically informed training to improve SA women/birthing people's experiences (Puthussery et al., 2008).

Future policies should meet the needs of SA women/birthing people and their collectives, alongside supporting the maternity care system. Additionally, to consider the co-production with SA service users, or utilise the Maternity and Neonatal Voices Partnership (ensuring SA representation), an NHS working group to improve and develop maternity care services (Lovell et al., 2023; National Maternity Review, 2016). This aligns with NHS priorities (NHS, 2023; Ockendon, 2022; The NHS Long Term Plan, 2019).

Conclusion

This review highlighted the lack of in-depth rigorous qualitative research exploring SA women/birthing people's experiences of maternity care in the UK. Findings represented unmet and unexpressed maternity needs, challenging SA women. As a priority, MHPs and maternity services need to improve the relational experience with SA women/birthing people and their collectives, whilst offering culturally sensitive and compassionate care. The review findings informed recommendations for prospective research and clinical practice.

References

Aquino, M. R. J., Edge, D., & Smith, D. M. (2015). Pregnancy as an ideal time for intervention to address the complex needs of black and minority ethnic women: Views of British midwives. *Midwifery, 31*(3), 373–379. https://doi.org/10.1016/j.midw.2014.11.006

Barnett, P., Mackay, E., Matthews, H., Gate, R., Greenwood, H., Ariyo, K., Bhui, K., Halvorsrud, K., Pilling, S., & Smith, S. (2019). Ethnic variations in compulsory detention under the Mental Health Act: A systematic review and meta-analysis of international data. *The Lancet Psychiatry, 6*(4), 305–317. https://doi.org/10.1016/S2215-0366(19)30027-6

Barrett, A., Kajamaa, A., & Johnston, J. (2020). How to … be reflexive when conducting qualitative research. *The Clinical Teacher, 17*(1), 9–12. https://doi.org/10.1111/tct.13133

Bauer, A., Knapp, M., & Parsonage, M. (2016). Lifetime costs of perinatal anxiety and depression. *Journal of Affective Disorders, 192*, 83–90. https://doi.org/10.1016/J.JAD.2015.12.005

Baxter, C. (1997). The case for bilingual workers within the maternity services. *British Journal of Midwifery, 5*(9), 568–572. https://doi.org/10.12968/bjom.1997.5.9.568

Bhopal, R. (2004). Glossary of terms relating to ethnicity and race: For reflection and debate. *Journal of Epidemiology & Community Health, 58*(6), 441–445. https://doi.org/10.1136/jech.2003.013466

Boeije, H. R., van Wesel, F., & Alisic, E. (2011). Making a difference: Towards a method for weighing the evidence in a qualitative synthesis. *Journal of Evaluation in Clinical Practice, 17*(4), 657–663. https://doi.org/10.1111/J.1365-2753.2011.01674.X

Booth, A. (2006). Clear and present questions: Formulating questions for evidence based practice. *Library Hi Tech*, *24*(3), 355–368. https://doi.org/10.1108/07378830610692127

Booth, A., Noyes, J., Flemming, K., Gerhardus, A., Wahlster, P., van der Wilt, G. J., Mozygemba, K., Refolo, P., Sacchini, D., & Rehfuess, E. (2016). *Guidance on choosing qualitative evidence synthesis methods for use in health technology assessments of complex interventions*. Integrated Health Technology Assessment for Evaluating Complex Technologies (INTEGRATE-HTA). http://esquiresheffield.pbworks.com/w/file/fetch/111070576/Guidance-on-choosing-qualitative-evidence-synthesis-methods-for-use-in-HTA-of-complex-interventi.pdf

Bowes, A. M., & Domokos, T. M. (1996). Pakistani women and maternity care: Raising muted voices. *Sociology of Health & Illness*, *18*(1), 45–65. https://doi.org/10.1111/1467-9566.ep10934412

Bowler, I. M. (1993). Stereotypes of women of Asian descent in midwifery: Some evidence. *Midwifery*, *9*(1), 7-16. https://doi.org/10.1016/0266-6138(93)90037-s

Butler, A., Hall, H., & Copnell, B. (2016). A guide to writing a qualitative systematic review protocol to enhance evidence-based practice in nursing and health care. *Worldviews on Evidence-Based Nursing*, *13*(3), 241–249. https://doi.org/10.1111/wvn.12134

Care Quality Commission. (2023, January 11). *Maternity survey 2022*. https://www.cqc.org.uk/publication/surveys/maternity-survey-2022

Carroll, C., Booth, A., & Lloyd-Jones, M. (2012). Should we exclude inadequately reported studies from qualitative systematic reviews? An evaluation of sensitivity analyses in two case study reviews. *Qualitative Health Research*, *22*(10), 1425–1434. https://doi.org/10.1177/1049732312452937

Chadda, R. K., & Deb, K. S. (2013). Indian family systems, collectivistic society and psychotherapy. *Indian Journal of Psychiatry, 55*(Suppl 2), 299-309. https://doi.org/10.4103/0019-5545.105555

Chai, K. E. K., Lines, R. L. J., Gucciardi, D. F., & Ng, L. (2021). Research Screener: A machine learning tool to semi-automate abstract screening for systematic reviews. *Systematic Reviews, 10*, Article 93. https://doi.org/10.1186/s13643-021-01635-3

Chitongo, S., Pezaro, S., Fyle, J., Suthers, F., & Allan, H. (2022). Midwives' insights in relation to the common barriers in providing effective perinatal care to women from ethnic minority groups with "high risk" pregnancies: A qualitative study. *Women and Birth: Journal of the Australian College of Midwives, 35*(2), 152–159. https://doi.org/10.1016/J.WOMBI.2021.05.005

Commission on Race and Ethnic Disparities. (2021, April 28). *Independent report: Summary of recommendations*. https://www.gov.uk/government/publications/the-report-of-the-commission-on-race-and-ethnic-disparities/summary-of-recommendations

Critical Appraisal Skills Programme. (2018). *CASP Qualitative Checklist* https://casp-uk.net/images/checklist/documents/CASP-Qualitative-Studies-Checklist/CASP-Qualitative-Checklist-2018_fillable_form.pdf

Cross-Sudworth, F., Williams, A., & Herron-Marx, S. (2011). Maternity services in multi-cultural Britain: Using Q methodology to explore the views of first- and second-generation women of Pakistani origin. *Midwifery, 27*(4), 458–468. https://doi.org/10.1016/j.midw.2010.03.001

Crowe, R. (2022). Factors contributing to maternal health inequalities for women who are not white British in the UK. *British Journal of Midwifery, 30*(3), 160–171. https://doi.org/10.12968/bjom.2022.30.3.160

Delanerolle, G., Phiri, P., Zeng, Y., Marston, K., Tempest, N., Busuulwa, P., Shetty, A., Goodison, W., Muniraman, H., Duffy, G., Elliot, K., Maclean, A., Majumder, K., Hirsch, M., Rathod, S., Raymont, V., Shi, J. Q., & Hapangama, D. K. (2021). A systematic review and meta-analysis of gestational diabetes mellitus and mental health among BAME populations. *EclinicalMedicine, 38,* Article 101016. https://doi.org/10.1016/j.eclinm.2021.101016

Dixon-Woods, M., Bonas, S., Booth, A., Jones, D. R., Miller, T., Sutton, A. J., Shaw, R. L., Smith, J. A., & Young, B. (2006). How can systematic reviews incorporate qualitative research? A critical perspective. *Qualitative Research*, *6*(1), 27-44. https://doi.org/10.1177/1468794106058867

Downe, S., Finlayson, K., Tunçalp, & Metin Gülmezoglu, A. (2015). What matters to women: A systematic scoping review to identify the processes and outcomes of antenatal care provision that are important to healthy pregnant women. *BJOG: An International Journal of Obstetrics and Gynaecology*, *123*(4), 529–539. https://doi.org/10.1111/1471-0528.13819

Draper, H., & Ives, J. (2013). Men's involvement in antenatal care and labour: Rethinking a medical model. *Midwifery*, *29*(7), 723–729. https://doi.org/10.1016/J.MIDW.2013.02.007

Ekezie, W., Routen, A., Denegri, S., & Khunti, K. (2021). Patient and public involvement for ethnic minority research: An urgent need for improvement. *Journal of the Royal Society of Medicine, 114*(7), 347–350. https://doi.org/10.1177/0141076821994274

Fair, F., Raben, L., Watson, H., Vivilaki, V., van den Muijsenbergh, M., & Soltani, H. (2020). Migrant women's experiences of pregnancy, childbirth and maternity care in European countries: A systematic review. *PloS ONE*, *15*(2), Article e0228378. https://doi.org/10.1371/journal.pone.0228378

Farrant, K., Faluyi, D., Watson, K., Vause, S., Birds, H., Rowbotham, S., & Heazell, A. E. (2022). Role of ethnicity in high-level obstetric clinical incidents: A review of cases from a large UK NHS maternity unit. *BMJ Open Quality, 11*(4), Article e001862. https://doi.org/10.1136/bmjoq-2022-001862

Finazzi, E., & MacBeth, A. (2022). Service users experience of psychological interventions in primary care settings: A qualitative meta-synthesis. *Clinical Psychology and Psychotherapy, 29*(2), 400–423. https://doi.org/10.1002/cpp.2650

Firdous, T., Darwin, Z., & Hassan, S. M. (2020). Muslim women's experiences of maternity services in the UK: Qualitative systematic review and thematic synthesis. *BMC Pregnancy and Childbirth, 20*, Article 115. https://doi.org/10.1186/s12884-020-2811-8

Fitzgerald, C., & Hurst, S. (2017). Implicit bias in healthcare professionals: A systematic review. *BMC Medical Ethics, 18*, Article 19. https://doi.org/10.1186/s12910-017-0179-8

Garcia, R., Ali, N., Griffiths, M., & Randhawa, G. (2020). A qualitative study exploring the experiences of bereavement after stillbirth in Pakistani, Bangladeshi and white British mothers living in Luton, UK. *Midwifery, 91*, Article 102833. https://doi.org/10.1016/j.midw.2020.102833

George, G. M., Shin, J. Y., & Habermann, B. (2022). Immigrant Asian Indian mothers' experiences with pregnancy, childbirth, and infant care in the United States. *Journal of Transcultural Nursing, 33*(3), 373-380. https://doi.org/10.1177/10436596221075984

Goodwin, L., Hunter, B., & Jones, A. (2018). The midwife–woman relationship in a South Wales community: Experiences of midwives and migrant Pakistani women in early pregnancy. *Health Expectations, 21*(1), 347–357. https://doi.org/10.1111/hex.12629

Gopalakrishnan, S., & Ganeshkumar, P. (2013). Systematic reviews and meta-analysis: Understanding the best evidence in primary healthcare. *Journal of Family Medicine and Primary Care, 2*(1), 9–14. https://doi.org/10.4103/2249-4863.109934

Gopal, D. P., Chetty, U., O'Donnell, P., Gajria, C., & Blackadder-Weinstein, J. (2021). Implicit bias in healthcare: Clinical practice, research and decision making. *Future Healthcare Journal, 8*(1), 40-48. https://doi.org/10.7861/FHJ.2020-0233

Government Digital Service. (2023, February 21). *Style guide*. GOV.UK. https://www.gov.uk/guidance/style-guide/a-to-z-of-gov-uk-style

Green, H., & Riddington, A. (2020). *Gender inclusive language in perinatal services: Mission statement and rationale*. Brighton, England: Brighton and Sussex University Hospitals. https://www.bsuh.nhs.uk/maternity/wp-content/uploads/sites/7/2021/01/Gender-inclusive-language-in-perinatal-services.pdf

Grewal, S. K., Bhagat, R., & Balneaves, L. G. (2008). Perinatal beliefs and practices of immigrant Punjabi women living in Canada. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, *37*(3), 290–300. https://doi.org/10.1111/j.1552-6909.2008.00234.x

Griffith, L. (2010). Motherhood, ethnicity and experience: A narrative analysis of the debates concerning culture in the provision of health services for Bangladeshi mothers in East London. *Anthropology & Medicine*, *17*(3), 289–299. https://doi.org/10.1080/13648470.2010.526698

Haddaway, N. R., Grainger, M. J., & Gray, C. T. (2022). Citationchaser: A tool for transparent and efficient forward and backward citation chasing in systematic searching. *Research Synthesis Methods, 13*(4), 533–545. https://doi.org/10.1002/JRSM.1563

Hannes, K., Lockwood, C., & Pearson, A. (2010). A comparative analysis of three online appraisal instruments' ability to assess validity in qualitative research. *Qualitative Health Research, 20*(12), 1736–1743. https://doi.org/10.1177/1049732310378656

Harrison, B. F., & Michelson, M. R. (2022). LGBTQ scholarship: Researcher identity and ingroup positionality. *PS: Political Science & Politics, 55*(4), 759-763. https://doi.org/10.1017/S1049096522000038

Hassan, S. M., Leavey, C., Rooney, J. S., & Puthussery, S. (2020). A qualitative study of healthcare professionals' experiences of providing maternity care for Muslim women in the UK. *BMC Pregnancy and Childbirth, 20,* Article 400. https://doi.org/10.1186/s12884-020-03096-3

Henderson, J., Gao, H., & Redshaw, M. (2013). Experiencing maternity care: The care received and perceptions of women from different ethnic groups. *BMC Pregnancy and Childbirth, 13,* Article 196. https://doi.org/10.1186/1471-2393-13-196

Higginbottom, G. M. A., Evans, C., Morgan, M., Bharj, K. K., Eldridge, J., & Hussain, B. (2019). Experience of and access to maternity care in the UK by immigrant women: A narrative synthesis systematic review. *BMJ Open, 9*(12), Article e029478. https://doi.org/10.1136/bmjopen-2019-029478

Isaacs, N. Z., & Andipatin, M. G. (2020). A systematic review regarding women's emotional and psychological experiences of high-risk pregnancies. *BMC Psychology, 8,* Article 45. https://doi.org/10.1186/s40359-020-00410-8

Jayaweera, H., D'Souza, L., & Garcia, J. (2005). A local study of childbearing Bangladeshi women in the UK. *Midwifery, 21*(1), 84–95. https://doi.org/10.1016/j.midw.2004.09.003

Jenkinson, B., Kruske, S., & Kildea, S. (2017). The experiences of women, midwives and obstetricians when women decline recommended maternity care: A feminist thematic analysis. *Midwifery, 52*, 1–10. https://doi.org/10.1016/J.MIDW.2017.05.006

Johnstone, L. (2018). Psychological formulation as an alternative to psychiatric diagnosis. *Journal of Humanistic Psychology*, *58*(1), 30–46. https://doi.org/10.1177/0022167817722230

Kaphle, S., Vaughan, G., & Subedi, M. (2022). Respectful maternity care in south Asia: What does the evidence say? Experiences of care and neglect, associated vulnerabilities and social complexities. *International Journal of Women's Health*, *14*, 847–879. https://doi.org/10.2147/IJWH.S341907

Karasz, A., Gany, F., Escobar, J., Flores, C., Prasad, L., Inman, A., Kalasapudi, V., Kosi, R., Murthy, M., Leng, J., & Diwan, S. (2019). Mental health and stress among South Asians. *Journal of Immigrant and Minority Health, 21*(Suppl 1), 7-14. https://doi.org/10.1007/S10903-016-0501-4

Karlström, A., Nystedt, A., & Hildingsson, I. (2015). The meaning of a very positive birth experience: Focus groups discussions with women. *BMC Pregnancy and Childbirth, 15*, Article 251. https://doi.org/10.1186/s12884-015-0683-0

Khan, Z. (2021). Ethnic health inequalities in the UK's maternity services: A systematic literature review. *British Journal of Midwifery*, *29*(2), 100–107. https://doi.org/10.12968/bjom.2021.29.2.100

Knight, M., Bunch, K., Vousden, N., Banerjee, A., Cox, P., Cross-Sudworth, F., Dhanjal, M. K., Douglas, J., Girling, J., Kenyon, S., Kotnis, R., Patel, R., Shakespeare, J., Tuffnell, D., Wilkinson, M., & Kurinczuk, J. J. (2022). A national cohort study and confidential enquiry to investigate ethnic disparities in maternal mortality. *EclinicalMedicine, 43*, Article 101237. https://doi.org/10.1016/J.ECLINM.2021.101237

Leap, N., Sandall, J., Buckland, S., & Huber, U. (2010). Journey to confidence: Women's experiences of pain in labour and relational continuity of care. *Journal of Midwifery & Women's Health, 55*(3), 234–242. https://doi.org/10.1016/j.jmwh.2010.02.001

Lewin, S., Glenton, C., Munthe-Kaas, H., Carlsen, B., Colvin, C. J., Gülmezoglu, M., Noyes, J., Booth, A., Garside, R., & Rashidian, A. (2015). Using qualitative evidence in decision making for health and social interventions: An approach to assess confidence in findings from qualitative evidence syntheses (GRADE-CERQual). *PloS Medicine, 12*(10), 1–18. https://doi.org/10.1371/journal.pmed.1001895

Long, H. A., French, D. P., & Brooks, J. M. (2020). Optimising the value of the critical appraisal skills programme (CASP) tool for quality appraisal in qualitative evidence synthesis. *Research Methods in Medicine & Health Sciences, 1*(1), 31–42. https://doi.org/10.1177/2632084320947559

Lorenzetti, D. L., & Ghali, W. A. (2013). Reference management software for systematic reviews and meta-analyses: An exploration of usage and usability. *BMC Medical Research Methodology, 13*, Article 141. https://doi.org/10.1186%2F1471-2288-13-141

Lovell, H., Silverio, S. A., Story, L., Skelton, E., & Matthew, J. (2023). Factors which influence ethnic minority women's participation in maternity research: A systematic review of quantitative and qualitative studies. *PloS ONE, 18*(2), Article e0282088. https://doi.org/10.1371/journal.pone.0282088

Lynn, F. A., Alderdice, F. A., Crealey, G. E., & McElnay, J. C. (2011). Associations between maternal characteristics and pregnancy-related stress among low-risk mothers: An observational cross-sectional study. *International Journal of Nursing Studies, 48*(5), 620–627. https://doi.org/10.1016/J.IJNURSTU.2010.10.002

Lyons, S. M., O'keeffe, F. M., Clarke, A. T., & Staines, A. (2008). Cultural diversity in the Dublin maternity services: The experiences of maternity service providers when caring for ethnic minority women. *Ethnicity & Health, 13*(3), 261-276. https://doi.org/10.1080/13557850801903020

MacLellan, J., Collins, S., Myatt, M., Pope, C., Knighton, W., & Rai, T. (2022). Black, Asian and minority ethnic women's experiences of maternity services in the UK: A qualitative evidence synthesis. *Journal of Advanced Nursing, 78*(7), 2175–2190. https://doi.org/10.1111/jan.15233

Mahood, Q., Van Eerd, D., & Irvin, E. (2014). Searching for grey literature for systematic reviews: Challenges and benefits. *Research Synthesis Methods, 5*(3), 221–234. https://doi.org/10.1002/JRSM.1106

Majid, U., & Vanstone, M. (2018). Appraising qualitative research for evidence syntheses: A compendium of quality appraisal tools. *Qualitative Health Research, 28*(13), 2115–2131. https://doi.org/10.1177/1049732318785358

Matthews, R. J., Draper, E. S., Manktelow, B. N., Kurinczuk, J. J., Fenton, A. C., Dunkley-Bent, J., Gallimore, I., & Smith, L. K. (2022). Understanding ethnic inequalities in stillbirth rates: A UK population-based cohort study on behalf of the MBRRACE-UK Collaboration. *BMJ Open, 12,* Article e057412. https://doi.org/10.1136/bmjopen-2021-057412

McFadden, A., Renfrew, M. J., & Atkin, K. (2012). Does cultural context make a difference to women's experiences of maternity care? A qualitative study comparing the perspectives of breast-feeding women of Bangladeshi origin and health practitioners. *Health Expectations, 16*(4), 124–135. https://doi.org/10.1111/j.1369-7625.2012.00770.x

McLeish, J., & Redshaw, M. (2019). Maternity experiences of mothers with multiple disadvantages in England: A qualitative study. *Women and Birth, 32*(2), 178–184. https://doi.org/10.1016/J.WOMBI.2018.05.009

Miller, T. (1995). Shifting boundaries. Exploring the influence of cultural traditions and religious beliefs of Bangladeshi women on antenatal interactions. *Women's Studies International Forum, 18*(3), 299–309. https://doi.org/10.1016/0277-5395(95)80074-Y

Minority Rights Group International. (2022). *South Asians*. World Directory of Minorities and Indigenous Peoples. https://minorityrights.org/minorities/south-asians/

Møller, A. M., & Myles, P. S. (2016). What makes a good systematic review and meta-analysis? *BJA: British Journal of Anaesthesia, 117*(4), 428-430. https://doi.org/10.1093/bja/aew264

Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK. (2021, November 10). *Saving lives, improving mothers' care: Lessons learned to inform maternity care from the UK and Ireland confidential enquiries into maternal deaths and morbidity 2017-19.* NPEU. https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2021/MBRRACE-UK_Maternal_Report_2021_-_FINAL_-_WEB_VERSION.pdf

Mukkamala, S., & Suyemoto, K. L. (2018). Racialized sexism/sexualized racism: A multimethod study of intersectional experiences of discrimination for Asian American women. *Asian American Journal of Psychology, 9*(1), 32–46. https://doi.org/10.1037/aap0000104

National Health Service. (2021, September 3). *Equity and equality: Guidance for local maternity systems*. https://www.england.nhs.uk/wp-content/uploads/2021/09/C0734-equity-and-equality-guidance-for-local-maternity-systems.pdf

National Health Service. (2023, May 17). *Chief Midwifery Office to England's strategic plan for research*. https://www.england.nhs.uk/long-read/chief-midwifery-officer-for-englands-strategic-plan-for-research/

National Institute for Health and Care Excellence. (2021). *Antenatal care* [NG201]. https://www.nice.org.uk/guidance/ng201

National Institute for Health and Care Excellence. (2012). *Antenatal care* [QS22]. https://www.nice.org.uk/guidance/qs22

National Maternity Review. (2016, February 22). *Better births: Improving outcomes of maternity services in England: A five year forward view for maternity care*. NHS England. https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

Niles, P. M., Stoll, K., Wang, J. J., Black, S., & Vedam, S. (2021). "I fought my entire way": Experiences of declining maternity care services in British Columbia. *PloS ONE*, *16*(6). https://doi.org/10.1371/JOURNAL.PONE.0252645

Ockenden, D. (2002, March 30). *Findings, conclusions and essential actions from the independent review of maternity services at The Shrewsbury and Telford Hospital NHS Trust*. Ockenden Maternity Review. https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERNITY_SERVICES_REPORT.pdf

Office for National Statistics. (2022, November 29). *Ethnic group, England and Wales: Census 2021*.

https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/bulletins/ethnicgroupenglandandwales/census2021

Olmos-Vega, F. M., Stalmeijer, R. E., Varpio, L., Kahlke, R., Ee, R., & Stalmeijer, E. (2023). A practical guide to reflexivity in qualitative research: AMEE Guide No. 149. *Medical Teacher, 45*(3), 241-251. https://doi.org/10.1080/0142159X.2022.2057287

Olza, I., Leahy-Warren, P., Benyamini, Y., Kazmierczak, M., Karlsdottir, S. I., Spyridou, A., Crespo-Mirasol, E., Takács, L., Hall, P. J., Murphy, M., Jonsdottir, S. S., Downe, S., & Nieuwenhuijze, M. J. (2018). Women's psychological experiences of physiological childbirth: A meta-synthesis. *BMJ Open, 8*(10), Article e020347. https://doi.org/10.1136/BMJOPEN-2017-020347

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. E., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M. Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., … & Moher, D. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. *International Journal of Surgery*, *88*, Article 105906. https://doi.org/10.1136/bmj.n71

Pallegadda, R. R., Wang, E. J., Palaniappan, L. P., Gupta, P. K., & Koenig, C. J. (2014). How does culture influence preventive service utilisation among Asian Indians living in the USA? A qualitative study. *International Journal of Qualitative Research in Services, 1*(3), 232-247. https://doi.org/10.1504/ijqrs.2014.060667

Parvin, A., Jones, C. E., & Hull, S. A. (2004). Experiences and understandings of social and emotional distress in the postnatal period among Bangladeshi women living in Tower Hamlets. *Family Practice, 21*(3), 254–260. https://doi.org/10.1093/fampra/cmh307

Polanin, J. R., Pigott, T. D., Espelage, D. L., & Grotpeter, J. K. (2019). Best practice guidelines for abstract screening large-evidence systematic reviews and meta-

analyses. *Research Synthesis Methods, 10*(3), 330–342. https://doi.org/10.1002/JRSM.1354

Porritt, K., Gomersall, J., & Lockwood, C. (2014). JBI's systematic reviews: Study selection and critical appraisal. *The American Journal of Nursing, 114*(6), 47-52. https://doi.org/10.1097/01.naj.0000450430.97383.64

Puthussery, S., Twamley, K., Harding, S., Mirsky, J., Baron, M., & Macfarlane, A. (2008). "They're more like ordinary stroppy British women": Attitudes and expectations of maternity care professionals to UK-born ethnic minority women. *Journal of Health Services Research & Policy, 13*(4), 195–201. https://doi.org/10.1258/jhsrp.2008.007153

Puthussery, S., Twamley, K., Macfarlane, A., Harding, S., & Baron, M. (2010). 'You need that loving tender care': Maternity care experiences and expectations of ethnic minority women born in the United Kingdom. *Journal of Health Services Research & Policy, 15*(3) 156-162. https://doi.org/10.1258/jhsrp.2009.009067

Pussegoda, K., Turner, L., Garritty, C., Mayhew, A., Skidmore, B., Stevens, A., Boutron, I., Sarkis-Onofre, R., Bjerre, L. M., Hróbjartsson, A., Altman, D. G., & Moher, D. (2017). Systematic review adherence to methodological or reporting quality. *Systematic Reviews, 6*, Article 131. https://doi.org/10.1186/s13643-017-0527-2

Rahman, M. A., Rahman, M. A., Rawal, L. B., Paudel, M., Howlader, M. H., Khan, B., Siddiquee, T., Rahman, A., Sarkar, A., Rahman, M. S., Botlero, R., & Islam, S. M. S. (2021). Factors influencing place of delivery: Evidence from three south-Asian countries. *PLOS ONE, 16*(4), Article e0250012. https://doi.org/10.1371/JOURNAL.PONE.0250012

Rayment-Jones, H., Harris, J., Harden, A., Silverio, S. A., Turienzo, C. F., & Sandall, J. (2021). Project20: Interpreter services for pregnant women with social risk factors in

England: What works, for whom, in what circumstances, and how? *International Journal for Equity in Health, 20*, Article 233. https://doi.org/10.1186/s12939-021-01570-8

Redshaw, M., & Heikkilä, K. (2011). Ethnic differences in women's worries about labour and birth. *Ethnicity and Health, 16*(3), 213–223. https://doi.org/10.1080/13557858.2011.561302

Rodriguez, J. K., & Ridgway, M. (2023). Intersectional reflexivity: Fieldwork experiences of ethnic minority women researchers. *Gender, Work & Organization*, 1-23. https://doi.org/10.1111/gwao.12977

Ryan, R., Hill, S., Prictor, M., McKenzie, J. (2013, May 30). *Cochrane Consumers and communication review group: Study Quality guide*. Cochrane. https://cccrg.cochrane.org/sites/cccrg.cochrane.org/files/public/uploads/StudyQualityGuide_May%202013.pdf

Sandelowski, M., & Barroso, J. (2002). Finding the findings in qualitative studies. *Journal of Nursing Scholarship, 34*(3), 213–219. https://doi.org/10.1111/j.1547-5069.2002.00213.x

Sheikh, J., Allotey, J., Kew, T., Fernández-Félix, B. M., Zamora, J., Khalil, A., Thangaratinam, S. &., IPPIC Collaborative Network. (2022). Effects of race on perinatal outcomes in high- and upper-middle-income countries: An individual participant data meta-analysis of 2,198,655 pregnancies. *The Lancet, 400*(10368), 2049-2062. https://doi.org/10.1016/S0140-6736(22)01191-6

Slack, E., Rankin, J., Jones, D., & Heslehurst, N. (2018). Effects of maternal anthropometrics on pregnancy outcomes in South Asian women: A systematic review. *Obesity Reviews, 19*(4), 485–500. https://doi.org/10.1111/OBR.12636

Smith, V., Devane, D., M Begley, C., & Clarke, M. (2011). Methodology in conducting a systematic review of biomedical research. *BMC Medical Research Methodology, 11*, Article 15. https://doi.org/10.1186/1471-2288-11-15

Soilemezi, D., & Linceviciute, S. (2018). Synthesizing Qualitative research: Reflections and lessons learnt by two new reviewers. *International Journal of Qualitative Methods, 17*, 1–14. https://doi.org/10.1177/1609406918768014

Suandi, D., Williams, P., & Bhattacharya, S. (2020). Does involving male partners in antenatal care improve healthcare utilisation? Systematic review and meta-analysis of the published literature from low- and middle-income countries. *International Health, 12*(5), 484–498. https://doi.org/10.1093/INTHEALTH/IHZ073

The NHS Long Term Plan. (2019, January 7). *The NHS Long Term Plan*. https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

The British Psychological Society. (2016, April 4). *Perinatal Service Provision: The role of Perinatal Clinical Psychology*. https://cms.bps.org.uk/sites/default/files/2022-07/Briefing%20Paper%208%20-%20Perinatal%20Service%20Provision%20The%20role%20of%20Perinatal%20Clinical%20Psychology%202016.pdf

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology, 8,* Article 45. https://doi.org/10.1186/1471-2288-8-45

Thomson, G., Cook, J., Crossland, N., Balaam, M. C., Byrom, A., Jassat, R., & Gerrard, S. (2022). Minoritised ethnic women's experiences of inequities and discrimination in maternity services in North-West England: A mixed-methods study. *BMC Pregnancy and Childbirth, 22,* Article 958. https://doi.org/10.1186/s12884-022-05279-6

Toh, R. K. C., & Shorey, S. (2023). Experiences and needs of women from ethnic minorities in maternity healthcare: A qualitative systematic review and meta-aggregation. *Women and Birth, 36*(1), 30–38. https://doi.org/10.1016/j.wombi.2022.06.003

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care, 19*(6), 349–357. https://doi.org/10.1093/intqhc/mzm042

Tong, A., Flemming, K., McInnes, E., Oliver, S., & Craig, J. (2012). Enhancing transparency in reporting the synthesis of qualitative research: ENTREQ. *BMC Medical Research Methodology, 12,* Article 181. https://doi.org/10.1186/1471-2288-12-181

Watson, H., Harrop, D., Walton, E., Young, A., & Soltani, H. (2019). A systematic review of ethnic minority women's experiences of perinatal mental health conditions and services in Europe. *PloS ONE, 14*(1), Article e0210587. https://doi.org/10.1371/journal.pone.0210587

Withers, M., Kharazmi, N., & Lim, E. (2018). Traditional beliefs and practices in pregnancy, childbirth and postpartum: A review of the evidence from Asian countries. *Midwifery, 56*, 158–170. https://doi.org/10.1016/J.MIDW.2017.10.019

Woollett, A., & Dosanjh-Matwala, N. (1990a). Postnatal care: The attitudes and experiences of Asian women in East London. *Midwifery, 6*(4), 178–184. https://doi.org/10.1016/S0266-6138(05)80112-3

Woollett, A., & Dosanjh-Matwala, N. (1990b). Pregnancy and antenatal care: The attitudes and experiences of Asian women. *Child: Care, Health and Development, 16*(1), 63–78. https://doi.org/10.1111/j.1365-2214.1990.tb00639.x

Woollett, A., Dosanjh, N., Nicolson, P., Djhanbakleh, O., & Hadlow, J. (1995). The ideas and experiences of pregnancy and childbirth of Asian and non-Asian women in East

London. *British Journal of Medical Psychology*, *68*(1), 65–84.

https://doi.org/10.1111/j.2044-8341.1995.tb01813.x

List of Appendices

Appendix A

Summary of the Search Syntax for the Databases

(Scopus, MEDLINE and PsycInfo)

Search	Scopus	MEDLINE	PsycInfo	Total
1 “maternity service” OR “maternity care” OR antenatal OR pregnanc* OR postnatal OR perinatal OR childbirth OR childbear*	1,379,074	1,628,548	97,518	-
2 “South Asia*” OR India* OR Pakistan* OR Bangladesh* OR Bhutan* OR Nepal* OR Maldives OR “Sri Lanka*” OR “ethnic minorit*” OR migrant*	1,154,847	1,650,822	84,775	-
3 Experience* OR Perception* OR View* OR Attitude* OR Qualitative OR Perspective*	8,118,691	24, 480,023	2,021,268	-
4 NHS OR “National Health Service” OR UK OR “United Kingdom” OR GB OR “Great Britain” OR Britain OR England OR Wales OR Scotland OR Ireland OR British OR English OR Welsh OR Irish OR Scottish	3,199,623	9,436,595	285,244	-
5 1 AND 2	28,637	35,535	2,385	66,557
6 1 AND 2 AND 3	7041	7,860	1,136	16,037
7 1 AND 2 AND 4	1976	2,418	192	4,586
8 1 AND 2 AND 3 AND 4[5]	648	770	123	1,541

[5] The finalised syntax

Appendix B

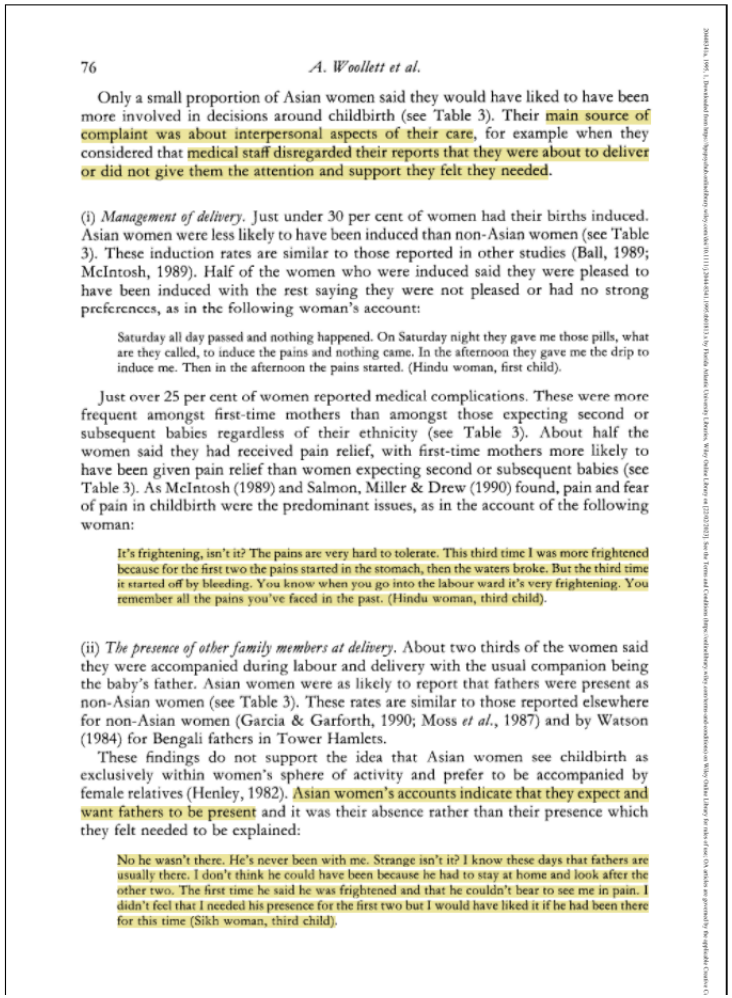
Summary of Feedback from the Specialist Clinical Psychologist (EW)

15th February 2023

Consulted with EW to clarify boundaries on maternity services/care (previously agreed remit is antenatal to postnatal). Agreed to include experiences around prenatal diagnosis within maternity care experiences as it is part of the maternity remit in the NHS. Agreed to exclude experiences addressing IVF and termination of pregnancy due to specialist care, NHS maternity services refer to Obstetrics and Gynaecology NHS services.

Appendix C

Example of Line-by-Line Coding of Woollett & Dosanjh (1995) on NVivo



76 *A. Woollett et al.*

Only a small proportion of Asian women said they would have liked to have been more involved in decisions around childbirth (see Table 3). Their main source of complaint was about interpersonal aspects of their care, for example when they considered that medical staff disregarded their reports that they were about to deliver or did not give them the attention and support they felt they needed.

(i) *Management of delivery*. Just under 30 per cent of women had their births induced. Asian women were less likely to have been induced than non-Asian women (see Table 3). These induction rates are similar to those reported in other studies (Ball, 1989; McIntosh, 1989). Half of the women who were induced said they were pleased to have been induced with the rest saying they were not pleased or had no strong preferences, as in the following woman's account:

> Saturday all day passed and nothing happened. On Saturday night they gave me those pills, what are they called, to induce the pains and nothing came. In the afternoon they gave me the drip to induce me. Then in the afternoon the pains started. (Hindu woman, first child).

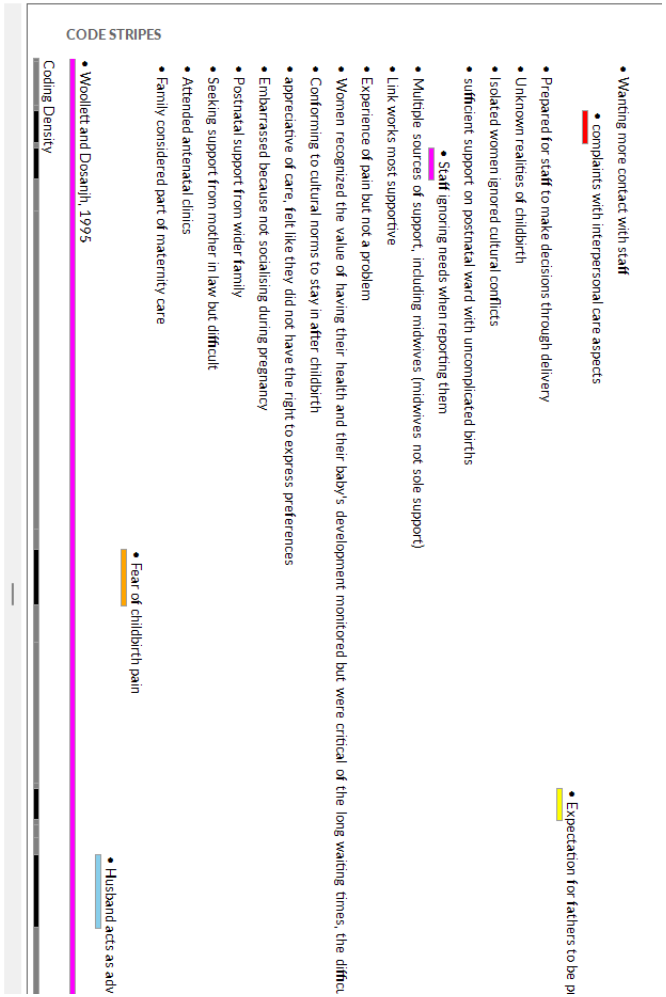
Just over 25 per cent of women reported medical complications. These were more frequent amongst first-time mothers than amongst those expecting second or subsequent babies regardless of their ethnicity (see Table 3). About half the women said they had received pain relief, with first-time mothers more likely to have been given pain relief than women expecting second or subsequent babies (see Table 3). As McIntosh (1989) and Salmon, Miller & Drew (1990) found, pain and fear of pain in childbirth were the predominant issues, as in the account of the following woman:

> It's frightening, isn't it? The pains are very hard to tolerate. This third time I was more frightened because for the first two the pains started in the stomach, then the waters broke. But the third time it started off by bleeding. You know when you go into the labour ward it's very frightening. You remember all the pains you've faced in the past. (Hindu woman, third child).

(ii) *The presence of other family members at delivery*. About two thirds of the women said they were accompanied during labour and delivery with the usual companion being the baby's father. Asian women were as likely to report that fathers were present as non-Asian women (see Table 3). These rates are similar to those reported elsewhere for non-Asian women (Garcia & Garforth, 1990; Moss *et al.*, 1987) and by Watson (1984) for Bengali fathers in Tower Hamlets.

These findings do not support the idea that Asian women see childbirth as exclusively within women's sphere of activity and prefer to be accompanied by female relatives (Henley, 1982). Asian women's accounts indicate that they expect and want fathers to be present and it was their absence rather than their presence which they felt needed to be explained:

> No he wasn't there. He's never been with me. Strange isn't it? I know these days that fathers are usually there. I don't think he could have been because he had to stay at home and look after the other two. The first time he said he was frightened and that he couldn't bear to see me in pain. I didn't feel that I needed his presence for the first two but I would have liked it if he had been there for this time (Sikh woman, third child).



Appendix D

Example of Theme Organisation for the Sub-Theme ‘Degrees of Passivity’

Degrees of Passivity
Passivity - decision making
Complying to HCP instructions
Prepared for staff to make decisions through delivery
Experience of pain but not a problem
Sense of needing to obey otherwise subject to judgement
Passivity - cultural difficulty
Difficult to express their preferences or be assertive
Muting voice
self-stereotyping as passive
Acknowledging difficulty with being assertive
Withholding assertiveness
appreciative of care, felt no right to express preferences
Reluctance to criticise maternity care
Fear of being judged
Fear of complaining or criticising
Wanting to ask questions about breastfeeding
Wanting more contact with staff
Developing assertiveness
Empowered to make choices
Felt listened to
Placed importance on being assertive to gain information
Want more midwife support to build relationship
Confidence with seeking support after previous childbirth
Coping with difficult staff relationships answering back

Appendix E

CASP Tool

www.casp-uk.net
info@casp-uk.net
Summertown Pavilion, Middle Way Oxford OX2 7LG

CASP Checklist: 10 questions to help you make sense of a **Qualitative** research

How to use this appraisal tool: Three broad issues need to be considered when appraising a qualitative study:

- Are the results of the study valid? (Section A)
- What are the results? (Section B)
- Will the results help locally? (Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

About: These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist, a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

Referencing: we recommend using the Harvard style citation, i.e.: *Critical Appraisal Skills Programme (2018). CASP (insert name of checklist i.e. Qualitative) Checklist. [online] Available at: URL. Accessed: Date Accessed.*

CASP
Critical Appraisal Skills Programme

Paper for appraisal and reference: .....

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- what was the goal of the research
- why it was thought important
- its relevance

Comments:

2. Is a qualitative methodology appropriate?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal

Comments:

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments:

CASP
Critical Appraisal Skills Programme

4. Was the recruitment strategy appropriate to the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

Comments:

5. Was the data collected in a way that addressed the research issue?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Comments:

CASP
Critical Appraisal Skills Programme

6. Has the relationship between researcher and participants been adequately considered?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments:

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

Comments:

CASP
Critical Appraisal Skills Programme

8. Was the data analysis sufficiently rigorous?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Comments:

9. Is there a clear statement of findings?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Comments:

CASP
Critical Appraisal Skills Programme

Section C: Will the results help locally?

10. How valuable is the research?	HINT: Consider • If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature • If they identify new areas where research is necessary • If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Comments:

Appendix F

PRISMA 2020 Checklist

Topic	No.	Item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	10
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist	
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	9-10
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	10
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	12-14
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	11
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	12
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	12-17

Topic	No.	Item	Location where item is reported
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	12-17
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	13-14
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	N/A
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	15-16
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	N/A
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item 5)).	14-16
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	N/A
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	N/A

Topic	No.	Item	Location where item is reported
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	14-15
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	N/A
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	16
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	N/A
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	15-17
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	18
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	18
Study characteristics	17	Cite each included study and present its characteristics.	20-25
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	20-25 and 80-82
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	N/A

Topic	No.	Item	Location where item is reported
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	20-25
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	N/A
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	N/A
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	N/A
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	N/A
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	N/A
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	37-40
	23b	Discuss any limitations of the evidence included in the review.	40-42
	23c	Discuss any limitations of the review processes used.	40-42
	23d	Discuss implications of the results for practice, policy, and future research.	42-44
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	11

Topic	No.	Item	Location where item is reported
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	11
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	N/A
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	N/A
Competing interests	26	Declare any competing interests of review authors.	ii
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	N/A

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. MetaArXiv. 2020, September 14. DOI: 10.31222/osf.io/v7gm2. For more information, visit: www.prisma-statement.org

Appendix G

ENTREQ Checklist

Item	Guide and Description	Location	Checked by independent reviewer (CG)
Aim	State the research question the synthesis addresses	1 and 10	✓
Synthesis methodology	Identify the synthesis methodology or theoretical framework which underpins the synthesis, and describe the rationale for choice of methodology	9-10 and 14-15	✓
Approach to searching	Indicate whether the search was pre-planned (comprehensive search strategies to seek all available studies) or iterative (to seek all available concepts until they theoretical saturation is achieved)	11	✓
Inclusion criteria	Specify the inclusion criteria/exclusion (with regards to population characteristics, methods and methodology, time frame, or type of publication)	12-13	✓
Data sources	Describe the information sources used (e.g. electronic databases, grey literature databases, relevant organisational websites, experts, information specialists, Google Scholar, hand searching, reference lists) and when the searches were conducted; provide the rationale for using the data sources	11-12	✓
Electronic search strategy	Describe the literature search (e.g. provide electronic search strategies with population terms, clinical or health topic terms, experiential or social phenomena related terms, filters for qualitative research, and search limits)	11-12 and 64 (Appendix A)	✓

Item	Guide and Description	Location	Checked by independent reviewer (CG)
Study screening methods	Describe the process of study screening and sifting (e.g. title, abstract and full text review, number of independent reviewers who screened studies)	12-13	✓
Study characteristics	Present the characteristics of the included studies (e.g. year of publication, country, population, number of participants, data collection, methodology, analysis, research questions)	20-25	✓
Study selection results	Identify the number of studies screened and provide reasons for study exclusion (e,g, for comprehensive searching, provide numbers of studies screened and reasons for exclusion indicated in a figure/flowchart; for iterative searching describe reasons for study exclusion and inclusion based on modifications to the research question and/or contribution to theory development)	13-14 and 18	✓
Rationale for appraisal	Describe the rationale and approach used to appraise the included studies or selected findings (e.g. assessment of conduct (validity and robustness), assessment of reporting (transparency), assessment of content and utility of the findings)	15-16	✓
Appraisal items	State the tools, frameworks and criteria used to appraise the studies or selected findings; reviewer developed tools; describe the domains assessed: research team, study design, data analysis and interpretations, reporting	15-16 and 68 (Appendix E)	✓
Appraisal results	Present results of the quality assessment and indicate which articles, if any, were weighted/excluded based on the assessment and give the rationale	19-25 and 83 (Appendix H)	✓

Item	Guide and Description	Location	Checked by independent reviewer (CG)
Data extraction	Indicate which sections of the primary studies were analysed and how data were extracted from the primary studies	13-14	✓
Software	State the computer software used, if any	12 (EndNote 20.5) and 14 (NVivo)	✓
Number of reviewers	Identify who was involved in coding and analysis	13-15	✓
Coding	Describe the process for coding of data (e.g. line by line coding to search for concepts)	14-15 and 66 (Appendix C)	✓
Study comparison	Describe how were comparisons made within and across studies (e.g. subsequent studies were coded into pre-existing concepts, and new concepts were created when deemed necessary)	14-15	✓
Derivation of themes	Explain whether the process of deriving the themes or constructs was inductive or deductive	14-15	✓
Quotations	Provide quotations from the primary studies to illustrate themes/constructs, and identify whether the quotations were participant quotations of the author's interpretation	29-36	✓
Synthesis output	Present rich, compelling and useful results that go beyond a summary of the primary studies (e.g. new interpretation, models of evidence, conceptual models, analytical framework, development of a new theory or construct)	29-36 and 37-40	✓

Appendix H

Detailed CASP scores

Authors (year)	Was there a clear statement of the research aims?	Is a qualitative methodology appropriate?	Was the research design appropriate?	Was the recruitment strategy appropriate?	Was the data collected in a way that addressed the research issue?	Has the relationship between research-participant been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	Quality Appraisal (Score)
Bowes & Domokos (1996)	Yes	Yes	Yes	No	Can't Tell	Yes	No	No	Yes	Low (6.5)
Cross-Sudworth et al. (2011)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	High (10)
Garcia et al. (2020)	No	Yes	Can't Tell	Yes	Yes	No	Yes	Yes	Yes	Moderate (7.5)
Goodwin et al. (2018)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	High (9)
Griffith (2010)	Yes	Yes	Yes	Yes	Can't Tell	No	No	No	Yes	Low (6.5)

Authors (year)	Was there a clear statement of the research aims?	Is a qualitative methodology appropriate?	Was the research design appropriate?	Was the recruitment strategy appropriate?	Was the data collected in a way that addressed the research issue?	Has the relationship between research-participant been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	Quality Appraisal (Score)
Jayaweera et al. (2005)	Yes	Yes	No	Yes	Yes	No	Yes	No	Yes	Low (7)
McFadden et al. (2012)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	High (9)
Miller, (1995)	Yes	Yes	Yes	Can't Tell	Can't Tell	Yes	No	No	Yes	Low (7)
Parvin et al. (2004)	Yes	Yes	Yes	Can't Tell	Yes	No	No	No	Yes	Low (6.5)
Woollett & Dosanjh (1995)	Yes	Yes	No	Yes	Yes	No	No	No	Yes	Low (6)
Woollett & Dosanjh-Matwala, (1990a)	Yes	Yes	Yes	Yes	Yes	No	No	No	Yes	Low (7)

Authors (year)	Was there a clear statement of the research aims?	Is a qualitative methodology appropriate?	Was the research design appropriate?	Was the recruitment strategy appropriate?	Was the data collected in a way that addressed the research issue?	Has the relationship between research-participant been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	Quality Appraisal (Score)
Woollett & Dosanjh-Matwala, (1990b)	Yes	Yes	Yes	Yes	Yes	No	No	No	Yes	Low (7)

This page is intentionally left blank

Section 2 Empirical Study

Exploring Birth Trauma Experiences in South Asian Women: An Interpretative Phenomenological Analysis

Abstract

Objectives

Research suggests that South Asian women may be more likely to experience distress following childbirth and less likely to receive psychological intervention, compared to White women. Additionally, South Asian women may be exposed to further risks that relate to birth trauma. Therefore, this study explored how South Asian women make sense of birth trauma and how they seek support.

Methods

This study employed a qualitative design with interpretative phenomenological analysis. Public and participant involvement, reflexivity and trauma-informed approaches guided the research process. Recruitment was conducted using purposive and snowball sampling methods and was advertised through third sector organisations, specialist postnatal research groups and social media. Participants self-identified experiences of birth trauma. Participants completed a semi-structured interview via telephone or Google Meets.

Results

Interpretative phenomenological analysis developed four themes ‘the power of maternity healthcare professionals,’ ‘loss of connection,’ ‘disentangling discrimination’ and ‘pervasive cultural stigma in motherhood.’

Conclusions

This research highlighted the power differentials between maternity healthcare professionals and discriminatory interactions contributing to childbirth-related relational trauma. The birthing experience represented a multitude of losses for SA women. Formal support seeking was limited by cultural stigma and mistrust in the National Health Service.

Practitioner Points

- Maternity healthcare professionals to improve the relational experience and wellbeing of South Asian women during childbirth
- Clinical psychologists to be integrated within maternity services to support maternity healthcare professionals with culturally sensitive trauma-informed care
- Maternal mental health services to increase accessibility for South Asian women by raising awareness, reducing stigma, and building trust

Keywords: birth trauma; traumatic birth; maternal mental health; South Asian; qualitative; interpretative phenomenological analysis

Introduction

Worsening maternal mental health risks maternal physical health and the infant's development (World Health Organisation, 2022). *Birth trauma* (BT) underpin some maternal mental health difficulties, impacting about 45% of perinatal women[1] (Alcorn et al., 2010; Baxter, 2020). BT can trigger anxiety, tokophobia (fear of childbirth), bonding difficulties, relationship issues and post-traumatic stress disorder (PTSD) (Watson et al., 2021).

Birth Trauma

BT is not a clinical diagnosis and lacks a consistent definition (Elmir et al., 2010). Within the literature, sometimes BT reflects the physical trauma or injury experienced due to obstetric interventions during childbirth (Greenfield et al., 2016). Alternatively, sometimes BT is referred as the psychological distress arising from childbirth (Greenfield et al., 2016). This study aligns with the construct that BT reflects distressing experiences as a direct result from the events, injury and/or care received from childbirth and its aftereffects (Elmir et al., 2010; Greenfield et al., 2016; Leinweber et al., 2022). A lack of consistent definition for BT presents difficulties for clinical services and service-users, therefore exploring women's subjective experiences of BT is crucial (Beck, 2004; Greenfield et al., 2016). Especially, as women with BT are likely to avoid their distress and seldom seek support (Slade et al., 2021).

BT and PTSD

BT experiences can lead to PTSD, representing around 4% of women meeting full diagnosis, and 5-9% of women reaching subclinical levels (Ayers et al., 2006; Beck, 2004; Brown et al., 2022; Yildiz et al., 2017). However, the natural course of childbirth-related

[1] This study uses the term 'women' as reflected in the existing research and subsequent recruited participants. However, the researcher acknowledges that this may exclude other gender identities (Green & Riddington, 2020; National Institutes of Health, 2023)

PTSD is poorly understood (McKenzie-McHarg et al., 2015). Within the childbirth context, PTSD is referenced with variations of the term, for instance, ‘childbirth-related PTSD,’ ‘perinatal PTSD’ and ‘PTSD following childbirth’ (Akik & Durak Batigun, 2020; Ayers et al., 2016; Greenfield et al., 2016; Slade et al., 2021). The characterisation of PTSD, defined by *The Diagnostic and Statistical Manual of Mental Disorders* (5th ed.), represents intrusion symptoms, avoidance, negative changes in cognition and mood, and changes in arousal and reactivity (American Psychiatric Association, 2013). Additionally, posttraumatic stress is considered the response to BT, the intensity of these symptoms can range and lead to the development of PTSD (Beck, 2015). Although, it has been argued whether childbirth-related PTSD should be considered the same as PTSD, when reflecting on the unique experience of childbirth compared to other traumatic events (McKenzie-McHarg et al., 2015).

Predominantly, BT research has focused on meeting the diagnostic criteria for PTSD thus, focused on women at a clinical threshold for diagnosis. This assumes that women accessed services to have obtained the diagnosis, the gold standard for identifying PTSD (Yildiz et al., 2017). Many women who do not reach diagnostic thresholds for PTSD experience clinically significant distress following childbirth, negatively impacting maternal functioning (Elmir et al., 2010; McKenzie-McHarg et al., 2015). Thus, women with BT may not access appropriate services because they do not fit existing diagnoses.

Relevant Theory and Theoretical Issues

BT and childbirth-related PTSD research have been primarily atheoretical, therefore relevant theories of PTSD and stress have been deemed appropriate for gaining insights into the processes of BT and childbirth-related PTSD (Beck, 2015; McKenzie-McHarg et al., 2015).

The Cognitive Model of PTSD

Although childbirth-related PTSD is being considered distinct to BT, childbirth-related PTSD stems from BT experiences. Utilising this model indicates that PTSD is enduring when women process the trauma that sustains a sense of serious and current threat (Ehlers & Clark, 2000). The model suggests two main processes result in a sense of current threat. Firstly, individual differences in the trauma appraisal and secondly, individual differences in the nature of the memory for the event and its associations with other autobiographical memories (Ehlers & Clark, 2000). The experience of threat is characterised by intrusions, other re-experiencing symptoms, arousal, anxiety, and other emotional responses (Ehlers & Clark, 2000). It has been applied within BT to consider the demographic, clinical and obstetric influences (Ford et al., 2010; King et al., 2017).

The Diathesis-Stress Model

The Diathesis-Stress model proposes that each person has a degree of vulnerability predisposing them to psychological stress, and its onset is caused by stressful experiences (Broerman, 2018). However, the severity and impact of the stress depends on the extent to which the person is innately vulnerable (Broerman, 2018). When applied to BT, the model suggests a combination of predisposing factors before childbirth and the events during delivery and post-partum factors (situational events) initiate the trauma response (Ayers, 2004; Mckeever & Huff, 2003). Thus, providing an explanation for variability when women appraise their birth as traumatic, whilst some do not, regardless of experiencing similar processes during delivery (Ayers, 2004; Dahan, 2023).

However, the Diathesis-Stress Model and Cognitive Model of PTSD lack specific considerations for cultural differences (Ayers, 2004; Ehlers & Clark, 2000; Ford et al., 2010; King et al., 2017; Thalmayer et al., 2021; Zuckerman, 1999). Additional evaluations of these

theoretical frameworks in relation to women meeting and not meeting childbirth-related PTSD diagnoses, have been recommended (McKenzie-McHarg et al., 2015). Especially considering the limited predictability of the PTSD diagnostic criteria, advocating for the importance of subjective appraisal of BT (American Psychiatric Association, 2013; Creamer et al., 2005; Friedman et al., 2011).

Women's Experiences of BT

The mode of delivery and events of the birth such as physical injury, discomfort, and pain to the mother and/or baby can influence BT experiences (Ayers, 2004; Greenfield et al., 2016; Hollander et al., 2017). Particularly, as medical care during childbirth can feel invasive and unnecessary (Baxter, 2020; Brown et al., 2022; Reed et al., 2017). Perceived poor staff communication has been implicated in BT experiences (Baxter, 2020; Watson et al., 2021). Some women perceived maternity healthcare professionals (MHPs) as time pressured and resource limited which evoked feelings of anxiety and occasionally thoughts of death to cope with the trauma of childbirth (Elmir et al., 2010). Additionally, women reported feeling that clinical efficiency and live healthy infants were prioritised over maternal wellbeing and intuition, resulting in feeling disregarded (Beck, 2004; Reed et al., 2017).

Some women with BT recognised they had developed fears of the unknown and anxiety with their upcoming labour (Ayers, 2004; Watson et al., 2021). Women's fears were often exacerbated when actual childbirth events did not align with their expectations of childbirth (Hollander et al., 2017; Iles & Pote, 2015; Watson et al., 2021). Subsequently, women developed feelings of powerlessness, frustration, and self-blame (Byrne et al., 2017). Some women experienced unclear memories or gaps in their memory of childbirth and therefore struggled to make sense of childbirth, perpetuating BT (Watson et al., 2021). Recommended psychological interventions include trauma-focused cognitive behavioural

therapy (CBT) and eye movement desensitisation and reprocessing (The National Institute for Health and Care Excellence [NICE], 2018).

Perceived poor quality social support has been implicated in BT (Soet et al., 2003). Women reported feeling abandoned and alone during their labour and delivery, for instance, feeling alone when regaining consciousness following general anaesthesia or experiencing prolonged separation (Beck, 2004; Cronin-Fisher & Timmerman, 2023).

Maternal Ethnic Health Inequalities

Health inequalities are avoidable, unfair, and systematic differences between different groups of people (The King's Fund, 2022). These marginalised groups receive less or substandard care relative to their needs leading to poorer experiences and health outcomes (The King's Fund, 2022). NICE recommends that MHPs should screen antenatal and perinatal mental health (NICE, 2014). Yet, disparities exist, with Asian women most at risk of not being asked about their mental health or offered psychological intervention (Redshaw & Henderson, 2016).

Predominantly, maternal mental health research underrepresents women from ethnic minority backgrounds. From research that does exist, women from Black and South Asian (SA) backgrounds have increased risk of complications, stillbirths, and preterm births, compared to White women (Jardine et al., 2021). Black women were more likely to die from pregnancy complications, and Asian women were twice as likely to die or suffer injury, compared to White women (Mothers and Babies Reducing Risk through Audits and Confidential Enquiries, 2021). A third of Black, Asian, and mixed ethnicity women reported that they felt their poor treatment from MHPs was due to their race or ethnicity (Birthrights, 2022). Furthermore, ethnic minority women have experienced misinterpretations of their

culture by MHPs that negatively affected their care (John et al., 2021). These experiences have the potential to increase BT.

Rationale

The existing research exploring ethnic minority women's experiences of maternal mental health typically includes Black, Asian, and other minority ethnic women as a homogenous group, without detailed consideration for differences in experiences (Aspinall, 2021; John et al., 2021; Watson et al., 2021). SA communities are underrepresented in research and the most prominent ethnic minority group in England and Wales (Quay et al., 2017; Office for National Statistics, 2022). SA typically refers to people from India, Pakistan, Bangladesh, Sri Lanka, Nepal, Bhutan, and the Maldives (Minority Rights Group International, 2022). Individuals with SA ethnicity frequently share similarities in cultural beliefs, norms, and values, although inevitably diversity will exist (Anand & Cochrane, 2005; Onozawa et al., 2003). SA cultural differences are likely to influence the sense-making and expression of mental health difficulties (Anand & Cochrane, 2005).

The limited research focused on SA women indicated that Asian ethnicity in Western countries was a risk factor for severe perineal tears (physical BT), despite not being a risk factor in Asian countries (Wheeler et al., 2012; Wilson & Homer, 2020). Additionally, compared to White British women, Indian and Pakistani women were twice as likely to experience distress following childbirth and less likely to receive psychological intervention (Moore et al., 2019). Thus, signifying that SA women may be exposed to more influences that relate to BT.

Research Aims

This qualitative study aims to explore experience, meaning and perspectives to provide an in-depth and rich understanding of BT in SA women, using interpretative

phenomenological analysis (IPA) (Hammarberg et al., 2016; Smith et al., 2022). The research question is ‘how do South Asian women make sense of birth trauma and how do they seek support?’ Understanding the lived experiences includes social and cultural contexts which can inform clinical practice.

Method

Ethical approval was granted by the University of Sheffield Ethics Committee (Appendix A). Trauma-informed approaches informed the entire research process (Isobel, 2021) (Appendix B).

Design

A qualitative design with an IPA approach was adopted. IPA aims to explore lived experiences rather than attempting to frame or fit experiences into predefined categories (Shinebourne, 2011; Smith et al., 2022). IPA was chosen over qualitative approaches such as thematic analysis, despite being frequently utilised within the BT literature (Baxter, 2020; Braun & Clarke, 2006; Elmir et al., 2010; Priddis et al., 2018). Although thematic analysis offers a flexible qualitative method that can be used across different epistemologies to identify patterns of meaning within the data (Braun & Clarke, 2006). IPA is better suited to smaller samples to enable more detailed examination/interpretation of individuals’ lived experiences (Braun & Clarke, 2006; Shinebourne, 2011; Smith, 2009).

Sampling

Purposive sampling complimented with snowball sampling methods were employed. Purposive sampling is widely used with qualitative research to facilitate the identification of information-rich participants (Patton, 2002). Purposive sampling involved defining participant characteristics by purposefully including SA women with experiences of BT (Andrade, 2021).

Snowball sampling is considered to enhance access to SA participants (Lakhanpaul et al., 2017; Naderifar et al., 2017). Snowball sampling utilises the social network of a participant with target characteristics, shown to enhance recruitment of marginalised participants (Woodley & Lockard, 2016). This sampling method was considered within the context of SA participants reporting barriers of mistrust in research (Quay et al., 2017).

Sample Size

The study utilised a specific sample (SA women), not previously explored in BT research, considered to enhance information power (Malterud et al., 2016). Information power reflects that the more information the sample holds, whilst relevant to the study, the lower number of participants will be required, thus, guided sample size (Malterud et al., 2016). Using these principles for information power, a guide of 6-10 participants was followed and determined by the richness of the data (Sim et al., 2018; Smith et al., 2022; Turpin et al., 1997). More than 11 participants likely increased the risk of compromising the study quality (Bartholomew, 2021).

Participants

Eight SA women were recruited and satisfied the inclusion criteria, shown in Table 1.

Table 1

Study Inclusion / Exclusion Criteria

Inclusion Criteria	Justification/Additional Notes
UK resident	To keep the sample fairly homogenous (Smith et al., 2022)
Aged 18 years or above with capacity to consent	The research focused on adults and to manage ethical considerations around consent and safeguarding (The British Psychological Society, 2021)
Identifies as SA (Indian, Pakistani, Bangladeshi, Sri Lankan, Nepali, from Bhutan and the Maldives)	In accordance with the classification of SA ethnicity (Minority Rights Group International, 2022)
Experienced BT between six months and five years ago in the UK	A minimum time limit was implemented to avoid capturing participants in the early stages of BT, reduce the chance of capturing confounding experiences (for example, acute stress symptoms) and allowing time for the BT to resolve after childbirth (Ayers et al., 2016; Brown et al., 2022). Research indicated that memories of childbirth are clearly remembered up to 5 years after childbirth and up to 10 years after childbirth, in relation to specifically difficult childbirth experiences (Suzuki & Okubo, 2022; Takehara et al., 2014).
Identifies with BT experiences (using a checklist based on Greenfield's et al., [2016] description of BT) and did not result in the death of an infant	This aimed to capture women who meet criteria for clinical concern. Due to the sensitive nature and to avoid confounding BT experiences with traumatic bereavement (Ayers et al., 2016)
Able to access the telephone or internet	Research interviews relied on internet or phone access
Willing to be interviewed in English and willing to talk about the impact of traumatic birth experiences	To gain in-depth insights about the perspective / experience of BT (Smith et al., 2022)

Defining BT to Participants

Currently, there is no universal trauma screening tool within the maternal population (Grisbrook & Letourneau, 2021). Therefore, for eligibility, participants were asked if they identified with at least one of the below criteria, informed by the literature and consultation with an Expert-by-Experience. This checklist aimed to support participants to self-identify relevant experiences of BT, clinical concern and describing the sample.

Checklist for Participants (informed by Greenfield et al., 2016):

- At the time of birth did you have feelings of intense fear, helplessness, or horror?
- After your childbirth did you feel shocked, guilty, or numb?
- Did you (the mother) and/or the baby experience physical injury that resulted in longstanding distress?
- Did you experience fear of physical injury or death to you (the mother) or the baby and experience longstanding distress?
- Did you experience a lack of care (perceived as discrimination, unsupportive or inhumane) during childbirth which caused longstanding distress?

Recruitment

Difficulty accessing SA women was acknowledged. For instance, barriers to research participation have included cultural insensitivity and lack of efforts by researchers to ensure accessibility, whilst facilitators included financial incentives as motivators (Quay et al., 2017). The researcher (AS) shares the same ethnicity and offered a £10 voucher which was considered to maximise recruitment (Quay et al., 2017). SA women are underrepresented in NHS services, so NHS-led recruitment was likely to be sparse. Generally, women have

shown to avoid contact with healthcare professionals following BT (Fenech & Thomson, 2014; Slade et al., 2021). Therefore, recruitment was through third sector organisations, specialist postnatal research groups and social media (Facebook, Instagram, and Twitter).

Third sector organisations were identified based on established national charities for improving birth outcomes and advocating research in the UK (The Birth Trauma Association and Make Birth Better). Consultation with an NHS Specialist BT Clinical Psychologist identified organisations offering support to marginalised postnatal women (Community of Cultures). The specialist postnatal research groups were identified through networking with researchers with specialist interests in marginalised groups (ROSHNI-2 and the Perinatal Mental Health Research Group). Social media recruitment was chosen because women in the UK used social media to access childbirth-related information and share birthing stories (Howard, 2019; Luce et al., 2016). Thus, indicative that women were active online and willing to share their BT experiences. The third sector organisations and specialist postnatal research groups had affiliated social media pages.

Recruitment was conducted between July and September 2022.

Procedures

Following ethical approval, posters were advertised on social media, inviting participants to the research (Appendix C). Participants who responded to the study invitation were emailed the information sheet and researcher's contact details (Appendix D). Telephone or email contact was made to confirm eligibility and schedule the interview. Prior to interview, the consent form was completed (Appendix E). The researcher checked with the participant that they felt comfortable to talk about BT. A debrief sheet included the researcher's contact details and signposted to their General Practitioner for further clinical

support and access to third sector organisations (Appendix F). After each interview the researcher emailed the £10 voucher and recorded reflections to support analysis.

Data Collection

Demographic information was collected at the end of the interviews to reduce the impact of the interview, presented in Table 2. Pseudonyms were used to preserve anonymity. Participants' age when they experienced BT (or if experienced multiple BT, age when they experienced their first BT) ranged between 24-40 years (average age was 37.63 years). No participants discontinued or withdrew from the study.

Table 2

Participant Demographics

Participant	Ethnicity	Immigration Generation	Relationship status	Method of birth associated with birth trauma	Time since birth trauma	No. of children at interview
Ameerah	British Pakistani	First	Married	Induction and caesarean section; Planned caesarean section	< 4 years < 5 years	2
Maya	Pakistani	Immigrant	Single	Vaginal birth	< 5 years	2
Nadiya	British Bangladeshi	Third	Married	Emergency caesarean section with general anaesthetic	< 5 years	2
Deepika	South Asian	Third	Married	Vaginal with episiotomy; Vaginal birth	< 2 years < 5 years	2
Bhavna	Indian	First	Co-habiting	Forceps delivery	< 1 year	1
Misha	Indian	First	Married	Emergency caesarean section	< 5 years	1
Naseema	Afghan	First	Married	Forceps delivery	< 2 years	1
Mahira	British Pakistani	First	Married	Caesarean section	< 3 years	1

Semi-Structured Interview

The interview was conducted by the researcher (AS) via telephone or Google Meets, depending on the participant's preference. The interviews were audio recorded using an approved device. A topic guide ensured continuity between participants and structure, whilst enabling flexibility for follow-up questions and clarifications (Busetto et al., 2020) (Appendix G). The eight interviews ranged between 37-87 min (average interview was 61 min).

Public and Participant Involvement

There were four avenues for public and participant involvement (Appendices H-J). The primary purpose was to invite feedback on the participant-facing research documents (information sheet, consent form and debrief sheet) and topic guide. This facilitated participant acceptability of research information. No study participants were involved in this process. Firstly, consultation with an NHS Specialist BT Clinical Psychologist for professional feedback during study design and analysis was completed. Also, to discuss the initial themes, findings, and proposed clinical recommendations. Secondly, consultation with a group of experts-by-experience comprising of five White British women and one Iranian women with experience(s) of BT. Thirdly, consultation with an Expert-by-Experience, a SA woman with experience of BT more than five years ago. Fourthly, consultation with a Clinical Psychologist and Racial Equity Consultant, to check themes and use of language to ensure inclusivity.

Data Analysis

Philosophical Underpinning

The research was situated from a critical realist stance, that knowledge is historically, socially, and culturally situated and underpinned by theories that help us get closer to an

individual's reality, but does not determine their reality (Bhaskar, 2010; Fletcher, 2017). A hermeneutic phenomenological approach aimed to make sense and interpret lived experiences of BT (Laverty, 2003).

Coding and Analysis

The interview data was analysed by the researcher (AS), employing the seven flexible stages for analysis by Smith et al., (2022). The first five interviews were transcribed by the researcher, the remaining three interviews were transcribed by a university-approved transcriber (Appendix K).

The researcher was immersed in the first interview transcript by transcribing and (re-)reading the data. Exploratory noting and coding at the descriptive, linguistic, and conceptual level were completed. Codes were discussed in research supervision (Appendix L). Experiential statements represented the participant's experiences. Personal experiential themes produced the highest-level organisation with subthemes (Appendix M). This process was repeated for subsequent transcripts and treated like an independent inquiry. Patterns of similarity and differences across the personal experiential themes generated, created a set of group experiential themes (GETs) (Appendix N). This was a dynamic and iterative process providing a new set of GETs clearly grounded in the data. A table of GETs with participant representation was generated (Appendix O).

Research Quality

To ensure research quality principles for evaluating the validity of qualitative research criteria was followed: sensitivity to context, commitment and rigour, coherence and transparency, and impact and importance (Yardley, 2015; Yardley, 2017).

Sensitivity to Context

The study conveyed warmth, compassion and employed reflective listening strategies to build rapport with participants. The topic guide was piloted on an NHS Specialist BT Clinical Psychologist and an Expert-by-Experience. The pilot interview ensured the questions were participant friendly, appropriate, and supported with culturally competent research (Kim, 2011).

Reflexivity

The researcher inevitably influences the qualitative research processes (Yardley, 2015). The researcher (AS) was a cisgender woman, Trainee Clinical Psychologist with an MSc Health Psychology, from a SA background without experience of childbirth (Appendix P for reflexive statement). A reflective log was kept throughout the research process to support with research quality (Yardley, 2015) (Appendix Q). IPA required the researcher to make sense of the participant trying to make sense of BT, therefore reflexivity was embedded within it (Smith, 2009).

Commitment and Rigour

The literature (previously outlined) justified the research and selection of participants (Yardley, 2015; Yardley, 2017). To demonstrate competence of data analysis, further IPA training and consultation with an IPA-experienced researcher was completed.

Coherence and Transparency

To achieve dependability, the process of IPA was clearly outlined (Smith et al., 2022). To evidence the research process, all copies of the research protocols and documentation (such as transcripts, research notes, tables of personal experiential themes and draft reports) were securely kept. This enabled completion of the independent audit and evaluation of

research processes, supporting transparency (Elman & Kapiszewski, 2014; Tracy, 2010) (Appendix R).

Impact and Importance

This study provided clinical and research implications. The Consolidated Criteria for Reporting Qualitative Studies checklist guided the write-up to ensure quality reporting (Tong et al., 2007) (Appendix S). Regular research supervision was contracted and utilised to reflect on the research processes.

Results

IPA analysis developed four GETs, detailed in Table 3. Each GET was illustrated by participant quotes with analytic interpretations. Quotes were chosen to ensure participant representation across the sample (Appendix T for additional supporting quotes).

Table 3

Summary of Themes

GET	Sub-Theme
The power of maternity healthcare professionals	Coerced into procedures / interventions
	Undignified and violated
	Ignored and dismissed
	Let down by the NHS
Loss of connection	Loss of reality during delivery
	Loss of bonding experiences
	Loss of partnership
Disentangling discrimination	-
Pervasive cultural stigma in motherhood	Keeping up the illusion of coping
	The shame of needing emotional support

The Power of MHPs

Power struggles and threat were represented between participants and MHPs. Participants described rare occasions of supportive maternity care experiences, usually highlighting a particular individual. “I feel like she [midwife] really helped me cos she was the one who did look when I said the baby’s coming” (Deepika).

Coerced into Procedures / Interventions

Participants reported feeling pressured to conform to the MHP’s agenda and often dehumanised in the process because of treatment “like a conveyor belt” (Misha) or a task to be “ticked off” (Naseema).

Regarding assisted births, participants experienced interactions with MHPs, “like I was deceived” (Bhavna), misinformed and offered false hope.

> They told us about the induction, but they glossed over it like you know “we’ll just help you start off the birthing process, and you’ll be able to walk out with the baby in your arms like 48 hours later maximum,” it wasn’t going to be any more painful, umm they kind of painted a pretty picture of it (Ameerah)

Participants perceived feeling forced and misled which created distress and feelings of powerlessness around the unknown risks of childbirth.

> I felt like I was being kind of forced, you know, doing something that I didn’t want, and I felt like just, just very scared, I think that’s what I felt. I was scared that I was not gonna make it, baby was gonna pass away or what (Naseema)

Participants sometimes perceived MHPs to be deceiving and recognised their attempts. “They [midwives] brought the doctor and the doctor was like ‘oh yeah, your baby’s

in danger' or something there was some really scary words that, that I remember, I remember knowing she's just like trying to scare me" (Deepika).

Undignified and Violated

Most participants described multiple occasions where MHPs were demeaning and childbirth "felt very like an inhumane situation" (Naseema).

Participants perceived that the process of consent was an ongoing process beyond medical procedures and were deeply shocked when consent was absent.

> You've decided that you're going to wash me without taking into consideration consent or even asking whether I want you to do that, literally whilst my mum is stood there, spread my legs open, start washing me and cleaning me, and I'm just thinking "I don't want to be washed there and cleaned" (Nadiya)

Participants perceived the violation of consent extended when transferred within the hospital. "They tried to wheel me somewhere and like I just remember like, my bum just being on show it was just like wheeling me whilst I was on my knees on a bed" (Deepika).

There were examples where participants' accounts were consistent with consent for procedures not being sought by MHPs, which subjected them to abuse and violation.

> I remember saying to him, "I just want you to stop touching me," like "I want you to stop now" and like "enough," and he was like "but you don't feel pain," I remember him like flicking my vagina, like "you don't feel pain though," like flicking, like to prove it (Bhavna)

> They were so brutal with the internal exam, you know, the speculum, she rammed it in there and just whacked it straight open without any kind of explanation and it

> actually scared me, it scared me, the pain scared me, I was just thinking "oh my god, is this what childbirth is gonna be like?" (Misha)

Ameerah described that her baby experienced severe health complications which prolonged her trauma experience and perpetuated by the treatment from a MHP, "she saw me and she said, 'it's because of women like you that your children end up in intensive unit because you don't do as what you're told'" (Ameerah).

Ignored and Dismissed

The BT experience comprised of the mother and baby's needs being ignored and dismissed. Consequently, participants described feeling like "I didn't matter anymore" (Bhavna) during a time of intense vulnerability. The impact of the experience of being ignored during childbirth was detrimental to maternal wellbeing and sense of self, as participants were "made to feel like an idiot" (Deepika), and "not being taken seriously" (Mahira).

Participants perceived MHPs were rejecting of their needs despite presenting with pain, fragility, and vulnerability.

> I called the Nurse, and she came in and I said, "I'm in so much pain, there is something seriously wrong," and she looked at me, she looked me in the eyes, and she said, "what do you expect me to do about it?" (Misha)

The immediate aftermath of the birth and participants' experiences of being ignored by MHPs, developed distress, and fearing mortality. "I was really cross because I wasn't listened to, I wasn't heard, I was in agony, my, my pain wasn't addressed, I'd been left alone all of the night feeling like I was going to die" (Nadiya).

The repeated episodes of participants feeling ignored, when trying to meet their baby's needs, as a mother, created a sense of distress. "I have rung the bell so much they're not coming, and I felt really helpless, and a few hours pass, and I called her, and she pretended not to see me, and I saw her turn her head away" (Ameerah).

Let Down by the NHS

Nearly all participants experienced disappointment and helplessness with their care, often resulting in distrust and resentment towards the NHS. Misha described how the NHS failed her but internalised this as a personal failure. "One thing that I was left with was that my body had failed me. Not that the health care system had failed me, which it had. It had 100%, it failed." (Misha).

The poor treatment of care perceived by participants informed subsequent expectations of care and mistrust. "I said to them 'you haven't taken care of us while we're in the hospital why should I believe that you will look after my child now?'" (Ameerah).

For Nadiya, responding to her perceived poor care through the complaints process represented a complex process to formalise her birthing experience. "I considered it, but then it was, can I be arsed writing a five-page complaint based on my experiences when actually I can't even process it myself" (Nadiya).

Participants experienced feeling abandoned by the NHS and subsequently had to "seek out private care" (Bhavna). Bhavna described suffering with "a gaping wound for four and a half months because the NHS said, 'we're not going to do anything about it'" (Bhavna). Naseema described attempts to avoid a repeat birthing experience by avoiding the NHS. "I've lost all my trust and it was give and take, next time I would go privately, just to make sure that I don't have to go through what I just went through" (Naseema).

Loss of Connection

A multitude of losses specifically, loss of reality, bonding experiences and partnership were perceived by participants.

Loss of Reality During Delivery

Over half of participants experienced a loss of reality during delivery which disrupted their worldview, representing a trauma response. Participants experienced feeling "really out of it" (Mahira), "a real disconnect" (Nadiya), "like a dead body" (Naseema), and "out of this world" (Deepika).

Participants experienced intense feelings of shock and disorientation following childbirth which altered expectations and the transition into motherhood.

> I was literally shocked. I didn't know, you know when you, I initially thought that it would be such a beautiful time enjoying my baby after delivery, but it was just very painful, and I was just in shock of what the hell just happened. I was literally frozen (Naseema)

Nadiya shared attempts to recalibrate to her physical presence.

> I'd woken up, I was in a quiet room with the blue curtains, surgical curtains tied, absolute quiet, couldn't hear ANYTHING at all with like a light shining down onto my face, I had no baby bump, I couldn't feel pain. I didn't feel sick so, either I'd died or he died and I couldn't work which one it was (Nadiya)

Deepika described feeling disconnected with childbirth and subsequent interactions with MHPs. "I felt really weird because I was like in the theatre bit with the first one and like everyone was like saying 'congratulations' to me, and I was like 'that's a weird thing to say'" (Deepika).

Loss of Bonding Experiences

Participants experienced grieving the lost bonding time “I won’t ever get that time back” (Naseema). Some participants appeared to direct blame towards the MHPs such as the midwives and obstetricians. “They gave me a little bit of time with her and then they took her away and this is another one of the traumas that they created” (Misha).

> It was like a loss, it was so heart wrenching cos I just wanted to be near my baby, and I think it was like a really maternal instinct, it was like “I want to be with my baby now like why are you keeping us apart?” (Ameerah)

The immediate maternal attachment opportunities were perceived to be interrupted for Bhavna as she was continuing to recover from the assisted birth which impeded on her ability to bond with her baby.

> I had no skin-to-skin, for a few minutes, had to give the baby to my boyfriend and I couldn't even enjoy that moment cos I was being stitched and I, I couldn’t feel pain, but I could feel every tug, like I could see like, blood spraying off of the string (Bhavna)

Nadiya also described the initial difficulties with bonding and providing care as a mother’s duty. “At the beginning I found it really difficult to connect cos I couldn’t hold him, I was in agony, I wasn’t doing the feeds, I wasn’t changing his nappy, obviously you know, I was in pain,” (Nadiya).

Loss of Partnership

Participants appeared to hold an expectation that the birthing experience was a partnership. Thus, experiencing separation caused distress and isolation. For one participant, distancing from her partner was due to the “COVID situation [which] was out of control”

(Naseema). Participants perceived to rely on their partner's support through the challenges of childbirth. Bhavna reported the process of being physically separated from her partner. "I remember them prizing my hand away from him to take me into the room to do the check" (Bhavna). Mahira experienced the loss of the early bonding time as a family.

> They'd taken me to the Recovery Ward and then that's when they said to my husband he now has to leave again. So, he was only there for literally just the birth and then he had to go and that felt really, really difficult (Mahira)

A loss of partnership was experienced prior to the coronavirus (COVID-19) pandemic. A perceived absence of Nadiya's husband whilst aware of the imminent delivery evoked experiences of panic and fear. "My husband had gone home, panic is, panic, 'is my husband gonna turn up?' 'Does he know I'm gonna be there?' 'Is he gonna know where I am?' 'Am I gonna be alone?'" (Nadiya).

Disentangling Discrimination

Nearly all participants reported experiences of discrimination (sexism and/or racism) from MHPs. However, participants identified discrimination from MHPs with variable degrees of certainty. In relation to specifically identifying racism, participants appeared to vary from feeling cautious to absolute certainty that they were a victim of racism.

Misha and Deepika appeared to search for reasons for poor maternity care experiences which led them to question racism. "It's when you look back you think if it was a White person would they have done that?" (Deepika).

> It's awful because was it, "because we were Indian?" "And we're people of colour?" There's a part of you that thinks "did this happen to me because I am Brown?" and you don't have anybody to ask, so your brain is whirling, thinking "what, because I was Brown, was I treated this badly, because I was Brown?" (Misha)

Whereas Mahira perceived clear victimisation of racism. “I’m just going to say it how it is to be honest, had this have been a White, British woman that wouldn’t have happened” (Mahira).

Sometimes participants perceived uncertainties around racism and instead related to experiences of receiving sexist care from MHPs.

> I know that there is a lot of conversations at the moment with women in general and you know women’s birth experiences being denied, pain medications with invasive procedures, I think I fit into that category of, the care women generally receive during um you know birth, is a conversation that’s being had at the moment, and I think that I fit into that (Nadiya)

Some participants tentatively perceived their experiences of being “Westernised” (Nadiya) (due to dual exposure of British and SA cultures) or part of a mixed-race couple (with a White counterpart) as protective to racism. “This is gonna sound awful, but I think because I have a White husband, I didn’t get it nearly as bad, which is an awful, awful thing to say” (Misha).

Pervasive Cultural Stigma in Motherhood

Participants expressed expectations to uphold cultural norms and standards as a SA mother. Most participants denied seeking support for BT. The illusion of coping sometimes worked, and the shame of needing emotional support was salient.

Keeping up the Illusion of Coping

Participants experienced the cultural expectation to be seen to be coping and focusing on the baby’s needs which neglected the needs of the mother. Participants perceived dismissal and minimising of women’s difficulties post-BT from others in the SA community.

> we don't accept help, so we don't, we're expected to look after ourselves and deal with it, um and that makes it a lot harder, it's like if you're like you're told you've had a hard time you're very much told well actually "look you've got this beautiful baby focus on the baby why are you thinking about all the horrible things that you went through" and it's like well actually that doesn't help me deal with my feelings (Ameerah)

For Misha and Naseema, the experiences of receiving cultural messages had been internalised and suppressed difficult feelings. "I find that I just end up going 'just deal with it, just deal with it, you can sort it out afterwards, you can fix it afterwards'" (Misha). "You always have to keep it 'hush' going through what you did" (Naseema).

Mahira described that within a mental health check as part of a midwife appointment, her automatic reaction was to show she was coping.

> It was definitely helpful for them to ask these questions, but I think I also wanted to, I wanted to show that I was coping I guess, so maybe that's why I minimised it. I didn't want to, maybe I didn't, at the time, I didn't think it was a problem (Mahira)

Deepika experienced the unrealistic expectations of adhering to SA norms of motherhood and proudly dismissed the cultural stigma to seek support for her mental health. "I'm breaking barriers [laughing]. I'm, we need to stop that, that's stupid, all of that, any cultural stuff saying that we shouldn't [seek help]" (Deepika).

The Shame of Needing Emotional Support

The cultural stigma in motherhood appeared to inhibit knowledge of maternal mental health and psychological therapy for participants.

Maya described a lack of awareness and skewed perception of support for BT. “Because in our countries, I’ve never heard anybody going through like for their mental treatment unless they are crazy” (Maya).

Mahira described navigating the personal struggles and fearing the outcome of disclosing difficulties “I think there was that fear of what would happen if I’d told them that I needed some more help and support, that I was really, really struggling” (Mahira).

Some participants experienced challenges when bringing up the topic of psychotherapy within their family. For Misha, this was perceived to trigger shame in her family. “You can’t talk to Indian parents about therapy. Well, I couldn’t, I felt bad about it because everything is taken so personally, you know, if you seek therapy it’s “what did I do wrong as a parent?” (Misha). Nonetheless, Misha reported to engage with NHS psychological therapy and navigated the accompanying experiences of shame. “I was so ashamed for getting healthcare, for getting therapy in the first place but it was the best thing” (Misha).

Whereas Bhavna appeared unashamed of engaging in therapy and described the helpful and timely access to private therapy. “Within three days obviously got um given the, the therapist who I’m still working with, she, she helped me obviously with the EMDR therapy for that particular incidence [childbirth]” (Bhavna).

Some participants experienced a sense of compartmentalising BT-related difficulties and self-preservation without the need for therapy. “I don’t need to revisit it for counselling purposes or for help, I don’t think that’s who I am, I’m quite a resilient person, I’ve dealt with it, I’ve moved on” (Ameerah).

Discussion

Four themes represented eight SA women’s lived experiences of BT. These experiences represented those widely cited in the literature, especially relational trauma, and

disconnection. Participants experienced discrimination although, discrimination was difficult to identify explicitly. Additionally, participants were unlikely to seek support due to perceived disappointment in NHS services and/or experiencing cultural stigma.

The Power of MHPs

MHPs were perceived to abuse their position of power, contributing to participants' experiences of feeling "forced." This reinforced a meta-synthesis representing ethnic minority women's birth experiences in the UK of experiencing mistreatment (MacLellan et al., 2022). Thus, indicative that these experiences were not exclusively perceived by SA women. Some participants felt MHPs disregarded consent and were "doing something that I didn't want" which may resemble how some women label this non-consensual experience as 'obstetric violence' (Perrotte et al., 2020).

Participants experienced being deliberately overlooked, "not listened to," and "ignored" through childbirth. Therefore, vulnerable to being overlooked by MHPs postpartum. SA women were less likely to disclose difficulties due to mistrust and offered limited opportunities to understand the events around their birth, supportive for memory processing of BT (Niles et al., 2021; Sigurðardóttir et al., 2019).

SA women have higher rates of operative vaginal birth and caesarean sections compared to Westernised women (Reddy et al., 2017). Most participants experienced an assisted or instrumental birth associated with their BT and perceived misinformation or being misled by MHPs. This experience reflects inadequate access to information and suboptimal communication with MHPs which has been identified as a disparity compared to White British women (De Freitas et al., 2020).

Loss of Connection

Participants experienced feeling “a real disconnect” and “out of this world” which may reflect experiences of dissociation. Dissociation in trauma lacks a clear definition, however, identified as a coping mechanism, women’s experiences have reflected the disengagement with childbirth to cope and resulted in the loss of self (Bateman et al., 2017; Byrne et al., 2017; Nijenhuis & van der Hart, 2011). Dissociation during childbirth has shown to predict childbirth-related PTSD and, dissociation-like experiences were described by participants in the current study (Harris & Ayers, 2012).

Participants’ experiences reflected the significance of immediate bonding time with the baby which felt like a “loss” when not possible. Skin-to-skin contact immediately after birth has shown to increase the woman’s confidence in caring for and breastfeeding their baby (Phillips, 2013). Additionally, participants’ experiences complimented other women who experienced a sense of disconnection, sorrow and anger when involuntarily separated from their baby which worsened maternal suffering (Palmquist et al., 2020; Stevens et al., 2019).

Participants’ partners were a highly regarded source of support and considered part of the birthing experience. However, most participants experienced separation which was “really difficult.” The significance of fathers during childbirth as a source of support has been previously reported with fathers also viewing childbirth as a partnership (Premberg et al., 2010). Thus, BT has been considered a shared experience within the couple (Attard et al., 2022).

Disentangling Discrimination

Most participants experienced varying degrees of racism from MHPs, from questioning whether it was “because I was brown?” to confidently recognising that “had this

been a White, British woman that wouldn't have happened." Perceiving racial discrimination during childbirth negatively influences interactions with MHPs (Janevic et al., 2020). Additionally, MHPs have implicitly related mistreatment with patient experiences of BT, suggesting some MHPs may normalise their routine care as mistreatment, particularly with regards to ethnic minority women (Salter et al., 2023).

The intersectionality framework proposes that social identity such as race and gender are interconnected and inform experiences of privilege and marginalisation (Crenshaw, 1989; Smooth, 2013). Therefore, an intersectionality framework, considers SA women's varying levels of privilege, power, and oppression (Crenshaw, 1989). Some participants experienced the intersectionality of gender and ethnicity within their BT experiences. Whilst one participant (Nadiya) related to gender inequality and fitting "into the category of the care women generally receive." Prospective research should explore BT through the intersectionality lens and, Abrams et al., (2020) has proposed guidance for this.

Participants viewed being "Westernised" as protective against discrimination. Women from ethnic minority backgrounds may not experience a difference in care based on their ethnicity due to being born in the UK, familiar with the maternity system or an ability to speak English (Puthussery et al., 2010). This may be explained by *acculturation*. Acculturation is the extent to which ethnic minority individuals adapt to the dominant culture and related changes in beliefs, and behaviours (Berry et al., 1986). Acculturation can provide positive or negative mental health outcomes for SA women (Anand & Cochrane, 2005).

Pervasive Cultural Stigma in Motherhood

Cultural stigma associated with being SA and adhering to SA cultural norms sometimes conflicted with the Western culture of motherhood for participants. Shame within SA cultures has shown to be prevalent and keeping difficulties "hush" (Gilbert et al., 2004;

Greenwald & Harder, 1998). Increased mental health stigma, a reluctance to disclose symptoms and seek support in the perinatal period, may be exacerbated by SA values around family honour and reputation (Amoah, 2021; Eylem et al., 2020; Shariff, 2009).

Cultural stigma and keeping up the illusion of coping suggested that SA women's BT memories were left unprocessed and vulnerable to the development of PTSD through the cognitive model of PTSD (Ehlers & Clark, 2000). Through avoidance, memories of BT may remain fragmented and emotionally charged, predictive of PTSD (Ozer et al., 2003). Unprocessed and unresolved trauma may have an intergenerational impact and result in maladaptive coping strategies (Bowers & Yehuda, 2016; Fenech & Thomson, 2014). Alternatively, externalising BT through discussions, expressing distress and labelling the experience as distinct to themselves are more adaptive, which can be supported by psychotherapy (Beck, 2004).

Strengths, Limitations and Research Implications

This study explored in-depth experiences of SA women with BT. The successful online recruitment, reflected that SA women may use online platforms to support their sense-making and/or seek support for BT. It would be pertinent to explore how SA women use online platforms as this can be a private experience and potentially mitigate associated support-seeking stigma. For example, focusing on online support-seeking behaviours and therapeutic interventions.

Most participants reflected that this study was their first opportunity to articulate their experiences, which was valued. Alternatively, the researcher sharing a SA identity with participants, thus an ingroup member, may have influenced the engagement process because participants may have felt more comfortable and trusting to share their detailed experiences, compared to a White researcher (Quay et al., 2017).

Although the study aimed for a relatively homogenous sample, there were key differences between participants. For instance, some SA women experienced BT during the COVID-19 pandemic. It has been well documented that COVID-19 negatively impacted the birthing experience for women, not exclusive to those from ethnic minority backgrounds (Diamond & Colaianni, 2022; John et al., 2021; Sanders & Blaylock, 2021).

Financial privilege was reflected in some participants' narratives when seeking support from private services. Demographic data around socioeconomic status was not collected. It may be beneficial to explore contextual experiences of BT, complimentary to the Diathesis-Stress Model (Broerman, 2018). Especially as women from lower socioeconomic backgrounds experience uncompassionate and impersonal care leading them to feel unsafe during childbirth (Vedeler et al., 2023).

Clinical Implications

The current findings emphasised the distressing relational aspects of childbirth that influenced SA women's BT. Currently, the UK has no policy for screening, treating, or preventing BT (Thomson et al., 2021). However, The NHS Long Term Plan (2019) has introduced funding to address the need for maternal mental health services, focusing on BT (NHS, 2021). These findings can help policymakers understand what it might be like to experience BT as a SA woman.

Integrating clinical psychology within a maternity service has shown to successfully support women with BT and offer an effective model of care (Williamson et al., 2021). Clinical psychologists should assist MHPs with supporting the wellbeing of SA women during labour and identifying vulnerabilities for BT, through culturally sensitive trauma-informed training, clinical supervision, and consultation. Through a formulation-led approach, clinical psychologists can offer psychological intervention adapted for BT

(McKenzie-McHarg et al., 2015; The British Psychological Society, 2016; Williamson et al., 2021). Currently, a multi-centre trial for adapted CBT for British SA women with postnatal depression is being conducted which could inform research and clinical practice for adapting BT interventions to SA women (Husain et al., 2021).

MHPs and maternity services should reflect on ways to improve the relational experiences with SA women by increasing cultural competence whilst establishing cultural safety (Curtis et al., 2019; Shorey et al., 2021). Cultural safety goes beyond cultural competence by supporting MHPs/services to be self-critical of power imbalances and reduce intentional or unintentional bias, to achieve healthcare equity (Curtis et al., 2019). This should be integrated in maternity care and afterbirth services. Afterbirth services are debriefing services following a distressing/traumatic birth, usually offered by MHPs, and valued by women (Thomson & Garrett, 2019). Additionally, clinical psychologists can support by offering reflective practice, informed by psychological frameworks such as The Power Threat Meaning Framework (Read & Harper, 2022).

Systemically, analysing maternity policies through an intersectional lens may support the identification of underlying factors that enable maternal inequalities to exist for SA women (Lapalme et al., 2020). Also, advocating for maternal mental health services to become more accessible, reduce stigma and prioritise building trust in SA women, considering how participants did not seek support for BT.

Conclusion

This research identified the complex interplay of experiences during childbirth contributing to BT in SA women. Specifically, highlighting the power differentials between MHPs and discriminatory interactions contributing to childbirth-related relational trauma.

The birthing experience represented a multitude of losses for SA women. Formal support seeking was limited by cultural stigma and mistrust in the NHS.

References

Abrams, J. A., Tabaac, A., Jung, S., & Else-Quest, N. M. (2020). Considerations for employing intersectionality in qualitative health research. *Social Science & Medicine, 258,* Article 113138. https://doi.org/10.1016/j.socscimed.2020.113138

Alcorn, K. L., O'Donovan, A., Patrick, J. C., Creedy, D., & Devilly, G. J. (2010). A prospective longitudinal study of the prevalence of post-traumatic stress disorder resulting from childbirth events. *Psychological Medicine, 40*(11), 1849–1859. https://doi.org/10.1017/S0033291709992224

Akik, B. K., & Durak Batigun, A. (2020). Perinatal Post Traumatic Stress Disorder Questionnaire-II (PPQ-II): Adaptation, validity, and reliability study. *Dusunen Adam The Journal of Psychiatry and Neurological Sciences, 33*(4), 340–350. https://doi.org/10.14744/DAJPNS.2020.00102

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Amoah, E. (2021). Predicting perinatal low mood and depression for BAME women - The role of treatment, perceived public, and internalised stigma. *Diversity and Equality in Health and Care, 18*(7), 387-397. https://doi.org/10.36648/2049-5471.21.18.251

Anand, A. S., & Cochrane, R. (2005). The mental health status of South Asian Women in Britain: A review of the UK literature. *Psychology and Developing Societies, 17*(2), 195–214. https://doi.org/10.1177/097133360501700207

Andrade, C. (2021). The inconvenient truth about convenience and purposive samples. *Indian Journal of Psychological Medicine, 43*(1), 86–88. https://doi.org/10.1177/0253717620977000

Aspinall, P. J. (2021). BAME (Black, Asian and minority ethnic): The “new normal” in collective terminology. *Journal of Epidemiology and Community Health*, *75*(2), 107. https://doi.org/10.1136/jech-2020-215504

Attard, R., Iles, J., Bristow, F., & Satherley, R. M. (2022). An interpretative phenomenological analysis of the experience of couples’ recovery from the psychological symptoms of trauma following traumatic childbirth. *BMC Pregnancy and Childbirth*, *22*, Article 798. https://doi.org/10.1186/s12884-022-05091-2

Ayers, S., Bond, R., Bertullies, S., & Wijma, K. (2016). The aetiology of post-traumatic stress following childbirth: A meta-analysis and theoretical framework. *Psychological Medicine*, *46*(6), 1121–1134. https://doi.org/10.1017/S0033291715002706

Ayers, S. (2004). Delivery as a traumatic event: Prevalence, risk factors, and treatment for postnatal posttraumatic stress disorder. *Clinical Obstetrics and Gynecology*, *47*(3), 552–567. https://doi.org/10.1097/01.GRF.0000129919.00756.9C

Ayers, S., Eagle, A., & Waring, H. (2006). The effects of childbirth-related post-traumatic stress disorder on women and their relationships: A qualitative study. *Psychology, Health and Medicine*, *11*(4), 389–398. https://doi.org/10.1080/13548500600708409

Baptie, G., Januário, E. M., & Norman, A. (2021). Empowered or powerless? Contributing factors to women’s appraisal of traumatic childbirth. *British Journal of Midwifery*, *29*(12), 674–682. https://doi.org/10.12968/bjom.2021.29.12.674

Bartholomew, T. T., Joy, E. E., Kang, E., & Brown, J. (2021). A choir or cacophony? Sample sizes and quality of conveying participants’ voices in phenomenological research. *Methodological Innovations*, *14*(2), 1–14. https://doi.org/10.1177/20597991211040063

Bateman, L., Jones, C., & Jomeen, J. (2017). A Narrative synthesis of women’s out-of-body

experiences during childbirth. *Journal of Midwifery & Women's Health*, *62*(4), 442–451. https://doi.org/10.1111/JMWH.12655

Baxter, J. (2020). An exploration of reasons why some women may leave the birth experience with emotional distress. *British Journal of Midwifery*, *28*(1), 24–33. https://doi.org/10.12968/bjom.2020.28.1.24

Beck, C. T. (2004). Birth Trauma: In the Eye of the Beholder. *Nursing Research*, *53*(1), 28–35. https://doi.org/10.1097/00006199-200401000-00005

Beck, C. T. (2015). Middle range theory of traumatic childbirth: The ever-widening ripple effect. *Global Qualitative Nursing Research*, *2*, 1–13. https://doi.org/10.1177/2333393615575313

Berry, J. W., Trimble, J. E., & Olmedo, E. L. (1986). Assessment of acculturation. In W. J. Lonner & J. W. Berry (Eds.), *Field methods in cross-cultural research* (pp. 291–324). Sage Publications, Inc.

Bhaskar, R. (2010). *Reclaiming reality: A critical introduction to contemporary philosophy*. Routledge. https://doi.org/10.4324/9780203843314

Birthrights. (2022, May 22). *Systemic racism, not broke bodies: An inquiry into racial injustice and human rights in UK maternity care*. https://www.birthrights.org.uk/wp-content/uploads/2022/05/Birthrights-inquiry-systemic-racism-May-22-web-1.pdf

Bowers, M. E., & Yehuda, R. (2016). Intergenerational transmission of stress in humans. *Neuropsychopharmacology*, *41*, 232–244. https://doi.org/10.1038/npp.2015.247

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Broerman, R. (2018). Diathesis-stress model. In V. Zeigler-Hill & T. Shackelford. (Eds.), *Encyclopedia of personality and individual differences* (pp. 1-3). Springer. https://doi.org/10.1007/978-3-319-28099-8_891-1

Brown, A., Nielsen, J. D. J., Russo, K., Ayers, S., & Webb, R. (2022). The Journey towards resilience following a traumatic birth: A grounded theory. *Midwifery*, *104*, Article 103204. https://doi.org/10.1016/j.midw.2021.103204

Busetto, L., Wick, W., & Gumbinger, C. (2020). How to use and assess qualitative research methods. *Neurological Research and Practice*, *2*(14), 1-10. https://doi.org/10.1186/s42466-020-00059-z

Byrne, V., Egan, J., Mac Neela, P., & Sarma, K. (2017). What about me? The loss of self through the experience of traumatic childbirth. *Midwifery, 51,* 1-11. https://doi.org/10.1016/j.midw.2017.04.017

Creamer, M., McFarlane, A. C., & Burgess, P. (2005). Psychopathology following trauma: The role of subjective experience. *Journal of Affective Disorders*, *86*(2–3), 175–182. https://doi.org/10.1016/J.JAD.2005.01.015

Crenshaw, K. W. (1989). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum, 1*(8), 139-167. https://scholarship.law.columbia.edu/faculty_scholarship/3007

Cronin-Fisher, V., & Timmerman, L. (2023). Redefining “Healthy Mom, Healthy Baby”: Making sense of traumatic birth stories through relational dialectics theory. *Western Journal of Communication*, *87*(1), 1–21. https://doi.org/10.1080/10570314.2022.2118548

Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S. J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. *International Journal for Equity in Health, 18*(174), 1-17. https://doi.org/10.1186/s12939-019-1082-3

Dahan, O. (2023). The riddle of the extreme ends of the birth experience: Birthing consciousness and its fragility. *Current Psychology, 42*, 262-272. https://doi.org/10.1007/s12144-021-01439-7

De Freitas, C., Massag, J., Amorim, M., & Fraga, S. (2020). Involvement in maternal care by migrants and ethnic minorities: A narrative review. *Public Health Reviews, 41*(5), 1–18. https://doi.org/10.1186/s40985-020-00121-w

Diamond, R. M., & Colaianni, A. (2022). The impact of perinatal healthcare changes on birth trauma during COVID-19. *Women and Birth, 35*(5), 503-510. https://doi.org/10.1016/J.WOMBI.2021.12.003

Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy*, *38*(4), 319–345. https://doi.org/10.1016/S0005-7967(99)00123-0

Elman, C., & Kapiszewski, D. (2014). Data access and research transparency in the qualitative tradition. *PS: Political Science & Politics*, *47*(1), 43-47. https://doi.org/10.1017/S1049096513001777

Elmir, R., Schmied, V., Wilkes, L., & Jackson, D. (2010). Women's perceptions and experiences of a traumatic birth: A meta-ethnography. *Journal of Advanced Nursing, 66*(10), 2142–2153. https://doi.org/10.1111/j.1365-2648.2010.05391.x

Eylem, O., de Wit, L., van Straten, A., Steubl, L., Melissourgaki, Z., Danlşman, G. T., de

Vries, R., Kerkhof, A. J. F. M., Bhui, K., & Cuijpers, P. (2020). Stigma for common mental disorders in racial minorities and majorities a systematic review and meta-analysis. *BMC Public Health*, *20,* Article 879. https://doi.org/10.1186/s12889-020-08964-3

Fenech, G., & Thomson, G. (2014). Tormented by ghosts from their past': A meta-synthesis to explore the psychosocial implications of a traumatic birth on maternal well-being. *Midwifery*, *30*(2), 185–193. https://doi.org/10.1016/J.MIDW.2013.12.004

Fletcher, A. J. (2017). Applying critical realism in qualitative research: Methodology meets method. *International Journal of Social Research Methodology*, *20*(2), 181-194. https://doi.org/10.1080/13645579.2016.1144401

Ford, E., Ayers, S., & Bradley, R. (2010). Exploration of a cognitive model to predict post-traumatic stress symptoms following childbirth. *Journal of Anxiety Disorders*, *24*(3), 353–359. https://doi.org/10.1016/J.JANXDIS.2010.01.008

Friedman, M. J., Resick, P. A., Bryant, R. A., Strain, J., Horowitz, M., & Spiegel, D. (2011). Classification of trauma and stressor-related disorders in DSM-5. *Depression and Anxiety*, *28*(9), 737-749. https://doi.org/10.1002/da.20845

Gilbert, P., Clarke, M., Hempel, S., Miles, J. N., & Irons, C. (2004). Criticizing and reassuring oneself: An exploration of forms, styles and reasons in female students. *British Journal of Clinical Psychology*, *43*(1), 31-50. https://doi.org/10.1348/014466504772812959

Green, H., & Riddington, A. (2020, December 22). *Gender inclusive language in perinatal services: Mission statement and rationale*. Brighton and Sussex University Hospitals NHS Trust. https://www.bsuh.nhs.uk/maternity/wp-content/uploads/sites/7/2021/01/Gender-

inclusive-language-in-perinatal-services.pdf

Greenfield, M., Jomeen, J., & Glover, L. (2016). What is traumatic birth? A concept analysis and literature review. *British Journal of Midwifery*, *24*(4), 254–267. https://doi.org/10.12968/bjom.2016.24.4.254

Greenwald, D. F., & Harder, D. W. (1998). Domains of shame: Evolutionary, cultural, and psychotherapeutic aspects. In P. Gilbert & B. Andrews (Eds.), *Shame: Interpersonal behavior, psychopathology, and culture* (pp. 225–245). Oxford University Press.

Grisbrook, M. A., & Letourneau, N. (2021). Improving maternal postpartum mental health screening guidelines requires assessment of post-traumatic stress disorder. *Canadian Journal of Public Health*, *112*, 240-243. https://doi.org/10.17269/S41997-020-00373-8

Hammarberg, K., Kirkman, M., & De Lacey, S. (2016). Qualitative research methods: When to use them and how to judge them. *Human Reproduction*, *31*(3), 498–501. https://doi.org/10.1093/HUMREP/DEV334

Harris, R., & Ayers, S. (2012). What makes labour and birth traumatic? A survey of intrapartum 'hotspots.' *Psychology & Health*, *27*(10), 1166–1177. https://doi.org/10.1080/08870446.2011.649755

Henderson, J., Gao, H., & Redshaw, M. (2013). Experiencing maternity care: The care received and perceptions of women from different ethnic groups. *BMC Pregnancy and Childbirth*, *13*, Article 196. https://doi.org/10.1186/1471-2393-13-196

Hollander, M. H., van Hastenberg, E., van Dillen, J., van Pampus, M. G., de Miranda, E., & Stramrood, C. A. I. (2017). Preventing traumatic childbirth experiences: 2192 women's perceptions and views. *Archives of Women's Mental Health*, *20*(4), 515–523. https://doi.org/10.1007/s00737-017-0729-6

Howard, S. (2019). Learning from birthing stories on Twitter. *BMJ, 364,* Article l1090. https://doi.org/10.1136/bmj.l1090

Husain, N., Lovell, K., Chew-Graham, C. A., Lunat, F., McPhillips, R., Atif, N., Aseem, S., Begum, J., Bee, P., Bhui, K., Bower, P., Brugha, T., Bhatti, N., Chaudhry, N., Davies, L., Gire, N., Islam, A., Kai, J., Morrison, J., … Morriss, R. (2022). Multicentre randomised controlled trial of a group psychological intervention for postnatal depression in British mothers of South Asian origin (ROSHNI-2): Study protocol. *BJPsych Open*, *8*(1), Article e2, 1-10. https://doi.org/10.1192/bjo.2021.1032

Iles, J., & Pote, H. (2015). Postnatal posttraumatic stress: A grounded theory model of first-time mothers' experiences. *Journal of Reproductive and Infant Psychology*, *33*(3), 238-255. https://doi.org/10.1080/02646838.2015.1030732

Isobel, S. (2021). Trauma-informed qualitative research: Some methodological and practical considerations. *International Journal of Mental Health Nursing*, *30*(S1), 1456–1469. https://doi.org/10.1111/inm.12914

Janevic, T., Piverger, N., Afzal, O., & Howell, E. A. (2020). "Just because you have ears doesn't mean you can hear" - Perception of racial-ethnic discrimination during childbirth. *Ethnicity & Disease*, *30*(4), 533–542. https://doi.org/10.18865/ED.30.4.533

Jardine, J., Walker, K., Gurol-Urganci, I., Webster, K., Muller, P., Hawdon, J., Khalil, A., Harris, T., van der Meulen, J., & National Maternity and Perinatal Audit Project Team. (2021). Adverse pregnancy outcomes attributable to socioeconomic and ethnic inequalities in England: A national cohort study. *The Lancet*, *398*(10314), 1905-1912. https://doi.org/10.1016/s0140-6736(21)01595-6

John, J. R., Curry, G., & Cunningham-Burley, S. (2021). Exploring ethnic minority women's experiences of maternity care during the SARS-CoV-2 pandemic: A qualitative study.

BMJ Open, *11*(9), Article e050666. https://doi.org/10.1136/BMJOPEN-2021-050666

Kim, Y. (2011). The pilot study in qualitative inquiry: Identifying issues and learning lessons for culturally competent research. *Qualitative Social Work*, *10*(2), 190–206. https://doi.org/10.1177/1473325010362001

King, L., McKenzie-McHarg, K., & Horsch, A. (2017). Testing a cognitive model to predict posttraumatic stress disorder following childbirth. *BMC Pregnancy and Childbirth*, *17*, Article 32. https://doi.org/10.1186/s12884-016-1194-3

Lakhanpaul, M., Culley, L., Robertson, N., Bird, D., Hudson, N., Johal, N., McFeeters, M., Angell, E., Hamlyn-Williams, C., Abbas, N., Manikam, L., & Johnson, M. (2017). A qualitative study to identify parents' perceptions of and barriers to asthma management in children from South Asian and White British families. *BMC Pulmonary Medicine*, *17*, Article 126. https://doi.org/10.1186/s12890-017-0464-9

Lapalme, J., Haines-Saah, R., & Frohlich, K. L. (2020). More than a buzzword: How intersectionality can advance social inequalities in health research. *Critical Public Health*, *30*(4), 494–500. https://doi.org/10.1080/09581596.2019.1584271

Laverty, S. M. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods*, *2*(3), 21-35. https://doi.org/10.1177/160940690300200303

Leinweber, J., Fontein-Kuipers, Y., Thomson, G., Karlsdottir, S. I., Nilsson, C., Ekström-Bergström, A., Olza, I., Hadjigeorgiou, E., & Stramrood, C. (2022). Developing a woman-centered, inclusive definition of traumatic childbirth experiences: A discussion paper. *Birth*, *49*(4), 687-696. https://doi.org/10.1111/BIRT.12634

Luce, A., Cash, M., Hundley, V., Cheyne, H., Van Teijlingen, E., & Angell, C. (2016). "Is it

realistic?" The portrayal of pregnancy and childbirth in the media. *BMC Pregnancy and Childbirth, 16,* Article 40. https://doi.org/10.1186/s12884-016-0827-x

MacLellan, J., Collins, S., Myatt, M., Pope, C., Knighton, W., & Rai, T. (2022). Black, Asian and minority ethnic women's experiences of maternity services in the UK: A qualitative evidence synthesis. *Journal of Advanced Nursing, 78*(7), 2175–2190. https://doi.org/10.1111/jan.15233

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: Guided by information power. *Qualitative Health Research, 26*(13), 1753–1760. https://doi.org/10.1177/1049732315617444

Mckeever, V. M., & Huff, M. E. (2003). A diathesis-stress model of posttraumatic stress disorder: Ecological, biological, and residual stress pathways. *Review of General Psychology, 7*(3), 237-250. https://doi.org/10.1037/1089-2680.7.3.237

McKenzie-McHarg, K., Ayers, S., Ford, E., Horsch, A., Jomeen, J., Sawyer, A., Stramrood, C., Thomson, G., & Slade, P. (2015). Post-traumatic stress disorder following childbirth: An update of current issues and recommendations for future research. *Journal of Reproductive and Infant Psychology, 33*(3), 219–237. https://doi.org/10.1080/02646838.2015.1031646

Minority Rights Group International. (2022). *South Asians*. World Directory of Minorities and Indigenous Peoples. https://minorityrights.org/minorities/south-asians/

Moore, L., Jayaweera, H., Redshaw, M., & Quigley, M. (2019). Migration, ethnicity and mental health: Evidence from mothers participating in the Millennium Cohort Study. *Public Health, 171*, 66–75. https://doi.org/10.1016/J.PUHE.2019.03.022

Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the

UK. (2021, November 10). *Saving lives, improving mothers' care: Lessons learned to inform maternity care from the UK and Ireland confidential enquiries into maternal deaths and morbidity 2017-19*. NPEU. https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2021/MBRRACE-UK_Maternal_Report_2021_-_FINAL_-_WEB_VERSION.pdf

Naderifar, M., Goli, H., & Ghaljaie, F. (2017). Snowball sampling: A purposeful method of sampling in qualitative research. *Strides in Development of Medical Education*, *14*(3), Article e67670. https://doi.org/10.5812/sdme.67670

National Health Service. (2021, July). *Supporting mental healthcare in a maternity and neonatal setting: Good practice guide and case studies*. https://www.england.nhs.uk/wp-content/uploads/2021/08/B0233-Health-in-Maternity-and-Neonatal-Settings-including-Neonatal-Loss-July-2021.pdf

National Institute for Health and Care Excellence. (2014). *Antenatal and postnatal mental health: Clinical management and service guidance* [CG192]. https://www.nice.org.uk/guidance/cg192

National Institute for Health and Care Excellence. (2018). *Post-traumatic stress disorder* [NG116]. https://www.nice.org.uk/guidance/ng116/chapter/Recommendations

National Institutes of Health. (2023, May 18). *NIH style guide: Inclusive and gender-neutral language*. https://www.nih.gov/nih-style-guide/inclusive-gender-neutral-language#:~:text=Both%20pregnant%20women%20and%20pregnant,)%2C%20present%20an%20inclusive%20alternative.

Nijenhuis, E. R. S., & van der Hart, O. (2011). Dissociation in trauma: A new definition and comparison with previous formulations. *Journal of Trauma and Dissociation*, *12*(4),

416–445. https://doi.org/10.1080/15299732.2011.570592

Niles, P. M., Stoll, K., Wang, J. J., Black, S., & Vedam, S. (2021). “I fought my entire way”: Experiences of declining maternity care services in British Columbia. *PLoS ONE, 16*(6), Article e0252645. https://doi.org/10.1371/JOURNAL.PONE.0252645

Office for National Statistics. (2022, November 29). Ethnic group, England and Wales: Census 2021. https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/bulletins/ethnicgroupenglandandwales/census2021

Onozawa, K., Kumar, R. C., Adams, D., Dore, C., & Glover, V. (2003). High EPDS scores in women from ethnic minorities living in London. *Archives of Women’s Mental Health*, *6*(Suppl.2), s51-s55. https://doi.org/10.1007/s00737-003-0006-8

Ozer, E. J., Best, S. R., Lipsey, T. L., & Weiss, D. S. (2003). Predictors of posttraumatic stress disorder and symptoms in adults: A meta-analysis. *Psychological Bulletin*, *129*(1), 52–73. https://doi.org/10.1037/0033-2909.129.1.52

Palmquist, A. E. L., Holdren, S. M., & Fair, C. D. (2020). “It was all taken away”: Lactation, embodiment, and resistance among mothers caring for their very-low-birth-weight infants in the neonatal intensive care unit. *Social Science & Medicine, 244,* Article 112648. https://doi.org/10.1016/J.SOCSCIMED.2019.112648

Patton, M. Q. (2002). Two decades of developments in qualitative inquiry: A personal, experiential perspective. *Qualitative Social Work, 1*(3), 261-283. https://doi.org/10.1177/1473325002001003636

Perrotte, V., Chaudhary, A., Goodman, A. (2020). “At least your baby is healthy” obstetric violence or disrespect and abuse in childbirth occurrence worldwide: A literature review. *Open Journal of Obstetrics and Gynecology*, *10*(11), 1544–1562.

https://doi.org/10.4236/OJOG.2020.10110139

Phillips, R. (2013). The sacred hour: Uninterrupted skin-to-skin contact immediately after birth. *Newborn and Infant Nursing Reviews*, *13*(2), 67–72. https://doi.org/10.1053/J.NAINR.2013.04.001

Pilkington, A., Msetfi, R. M., & Watson, R. (2012). Factors affecting intention to access psychological services amongst British Muslims of South Asian origin. *Mental Health, Religion & Culture*, *15*(1), 1–22. https://doi.org/10.1080/13674676.2010.545947

Premberg, Å., Carlsson, G., Hellström, A-L., & Berg, M. (2010). First-time fathers' experiences of childbirth - A phenomenological study. *Midwifery*, *27*(6), 848–853. https://doi.org/10.1016/j.midw.2010.09.002

Priddis, H. S., Keedle, H., & Dahlen, H. (2018). The perfect storm of trauma: The experiences of women who have experienced birth trauma and subsequently accessed residential parenting services in Australia. *Women and Birth*, *31*(1), 17–24. https://doi.org/10.1016/J.WOMBI.2017.06.007

Puthussery, S., Twamley, K., Macfarlane, A., Harding, S., & Baron, M. (2010). 'You need that loving tender care': Maternity care experiences and expectations of ethnic minority women born in the United Kingdom. *Journal of Health Services Research & Policy*, *15*(3), 156–162. https://doi.org/10.1258/JHSRP.2009.009067

Quay, T. A. W., Frimer, L., Janssen, P. A., & Lamers, Y. (2017). Barriers and facilitators to recruitment of South Asians to health research: A scoping review. *BMJ Open*, *7*(5), 1–14. https://doi.org/10.1136/bmjopen-2016-014889

Read, J., & Harper, D. J. (2022). The power threat meaning framework: Addressing adversity, challenging prejudice and stigma, and transforming services. *Journal of*

Constructivist Psychology, *35*(1), 54-67. https://doi.org/10.1080/10720537.2020.1773356

Reddy, M., Wallace, E. M., Mockler, J. C., Stewart, L., Knight, M., Hodges, R., Skinner, S., & Davies-Tuck, M. (2017). Maternal Asian ethnicity and obstetric intrapartum intervention: A retrospective cohort study. *BMC Pregnancy and Childbirth*, *17*(3), 1–7. https://doi.org/10.1186/s12884-016-1187-2

Redshaw, M., & Henderson, J. (2016). Who is actually asked about their mental health in pregnancy and the postnatal period? Findings from a national survey. *BMC Psychiatry*, *16,* Article 322. https://doi.org/10.1186/s12888-016-1029-9

Reed, R., Sharman, R., & Inglis, C. (2017). Women's descriptions of childbirth trauma relating to care provider actions and interactions. *BMC Pregnancy and Childbirth*, *17,* Article 21. https://doi.org/10.1186/s12884-016-1197-0

Salter, C., Wint, K., Burke, J., Chang, J. C., Documet, P., Kaselitz, E., & Mendez, D. (2023). Overlap between birth trauma and mistreatment: A qualitative analysis exploring American clinician perspectives on patient birth experiences. *Reproductive Health*, *20,* Article 63. https://doi.org/10.1186/s12978-023-01604-0

Sanders, J., & Blaylock, R. (2021). "Anxious and traumatised": Users' experiences of maternity care in the UK during the COVID-19 pandemic. *Midwifery*, *102,* Article 103069. https://doi.org/10.1016/J.MIDW.2021.103069

Shariff, A. (2009). Ethnic identity and parenting stress in South Asian families: Implications for culturally sensitive counselling. *Canadian Journal of Counselling and Psychotherapy*, *43*(1) 35-46. https://cjc-rcc.ucalgary.ca/article/view/58908

Shinebourne, P. (2011). The theoretical underpinnings of interpretative phenomenological

analysis (IPA). *Existential Analysis: Journal of the Society for Existential Analysis*, *22*(1), 16-31. http://existentialanalysis.org.uk/journal/

Shorey, S., Ng, E. D., & Downe, S. (2021). Cultural competence and experiences of maternity health care providers on care for migrant women: A qualitative meta-synthesis. *Birth*, *48*(4), 458–469. https://doi.org/10.1111/BIRT.12581

Sigurðardóttir, V. L., Gamble, J., Guðmundsdóttir, B., Sveinsdóttir, H., & Gottfreðsdóttir, H. (2019). Processing birth experiences: A content analysis of women's preferences. *Midwifery*, *69*, 29–38. https://doi.org/10.1016/j.midw.2018.10.016

Sim, J., Saunders, B., Waterfield, J., & Kingstone, T. (2018). Can sample size in qualitative research be determined a priori? *International Journal of Social Research Methodology*, *21*(5), 619–634. https://doi.org/10.1080/13645579.2018.1454643

Slade, P. P., Molyneux, D. R., & Watt, D. A. (2021). A systematic review of clinical effectiveness of psychological interventions to reduce post traumatic stress symptoms following childbirth and a meta-synthesis of facilitators and barriers to uptake of psychological care. *Journal of Affective Disorders*, *281*, 678–694. https://doi.org/10.1016/j.jad.2020.11.092

Smith, J. A. (2009). Hermeneutics, human sciences and health: Linking theory and practice. *International Journal of Qualitative Studies on Health and Well-Being*, *2*(1), 3–11. https://doi.org/10.1080/17482620601016120

Smith, J., Flowers, P., & Larkin, M. (2022). *Interpretative Phenomenological Analysis: theory, method and research* (2nd ed.). Sage.

Smooth, W. G. (2013). Intersectionality from theoretical framework to policy intervention. In Wilson, A. R. (Eds.), *Situating intersectionality* (pp. 11-41). Palgrave Macmillan.

https://doi.org/10.1057/9781137025135_2

Soet, J. E., Brack, G. A., & Dilorio, C. (2003). Prevalence and predictors of women's experience of psychological trauma during childbirth. *Birth, 30*(1), 36–46. https://doi.org/10.1046/J.1523-536X.2003.00215.X

Stevens, J., Schmied, V., Burns, E., & Dahlen, H. G. (2019). Skin-to-skin contact and what women want in the first hours after a caesarean section. *Midwifery, 74,* 140–146. https://doi.org/10.1016/j.midw.2019.03.020

Suzuki, Y., & Okubo, N. (2022). Lived experiences of women with memories of childbirth. *British Journal of Midwifery, 30*(3), 152-159. https://doi.org/10.12968/bjom.2022.30.3.152

Takehara, K., Noguchi, M., Shimane, T., & Misago, C. (2014). A longitudinal study of women's memories of their childbirth experiences at five years postpartum. *BMC Pregnancy and Childbirth, 14,* Article 221. https://doi.org/10.1186/1471-2393-14-221

Thalmayer, A. G., Toscanelli, C., & Arnett, J. J. (2021). The neglected 95% revisited: Is American psychology becoming less American? *American Psychologist, 76*(1), 116–129. https://psycnet.apa.org/doi/10.1037/amp0000622

The British Psychological Society. (2016, April 4). *Perinatal Service Provision: The role of Perinatal Clinical Psychology*. https://cms.bps.org.uk/sites/default/files/2022-07/Briefing%20Paper%208%20-%20Perinatal%20Service%20Provision%20The%20role%20of%20Perinatal%20Clinical%20Psychology%202016.pdf

The British Psychological Society. (2021, April 5). *BPS Code of human research ethics*. https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Code%20of%20Human%20Research%20Ethics.pdf

The King's Fund. (2022, June 17). *What are health inequalities*? https://www.kingsfund.org.uk/publications/what-are-health-inequalities

The NHS Long Term Plan. (2019, January 7). *The NHS Long Term Plan*. https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

Thomson, G., Diop, M. Q., Stuijfzand, S., Horsch, A. &., COST After birth Consortium. (2021). Policy, service, and training provision for women following a traumatic birth: An international knowledge mapping exercise. *BMC Health Services Research, 21*, Article 1206. https://doi.org/10.1186/s12913-021-07238-x

Thomson, G., & Garrett, C. (2019). Afterbirth support provision for women following a traumatic/distressing birth: Survey of NHS hospital trusts in England. *Midwifery*, *71*, 63-70. https://doi.org/10.1016/j.midw.2019.01.004

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care, 19*(6), 349–357. https://doi.org/10.1093/intqhc/mzm042

Tracy, S. J. (2010). Qualitative quality: Eight "big-tent" criteria for excellent qualitative research. *Qualitative Inquiry, 16*(10), 837-851. https://doi.org/10.1177/1077800410383121

Turpin, G., Barley, V., Beail, N., Scaife, J., Slade, P., Smith, J. A., & Walsh, S. (1997). Standards for research projects and theses involving qualitative methods: Suggested

guidelines for trainees and courses. *Clinical Psychology Forum, 1*(108), 3-7. https://shop.bps.org.uk/publications/publication-by-series/clinical-psychology-forum/clinical-psychology-forum-no-108-october-1997.html

Vedeler, C., Eri, T. S., Nilsen, R. M., Blix, E., Downe, S., van der Wel, K. A., & Nilsen, A. B. V. (2023). Women's negative childbirth experiences and socioeconomic factors: Results from the Babies Born Better survey. *Sexual & Reproductive Healthcare, 36*, Article 100850. https://doi.org/10.1016/J.SRHC.2023.100850

Watson, K., White, C., Hall, H., & Hewitt, A. (2021). Women's experiences of birth trauma: A scoping review. *Women and Birth, 34*(5), 417–424. https://doi.org/10.1016/j.wombi.2020.09.016

Wheeler, J., Davis, D., Fry, M., Brodie, P., & Homer, C. S. E. (2012). Is Asian ethnicity an independent risk factor for severe perineal trauma in childbirth? A systematic review of the literature. *Women and Birth*, *25*(3), 107–113. https://doi.org/10.1016/J.WOMBI.2011.08.003

Williamson, E., Pipeva, A., Brodrick, A., Saradjian, A., & Slade, P. (2021). The birth trauma psychological therapy service: An audit of outcomes. *Midwifery, 102*, Article 103099. https://doi.org/10.1016/j.midw.2021.103099

Wilson, A. N., & Homer, C. S. E. (2020). Third-and fourth-degree tears: A review of the current evidence for prevention and management. *Australian and New Zealand Journal of Obstetrics and Gynaecology, 60*(2), 175-182. https://doi.org/10.1111/ajo.13127

Woodley, X. M., & Lockard, M. (2016). Womanism and snowball sampling: Engaging marginalized populations in holistic research. *Qualitative Report, 21*(2), 321–329. https://doi.org/10.46743/2160-3715/2016.2198

World Health Organization. (2022, September 19). *Launch of the WHO guide for integration of perinatal mental health in maternal and child health services*. https://www.who.int/news/item/19-09-2022-launch-of-the-who-guide-for-integration-of-perinatal-mental-health

Yardley, L. (2015). Demonstrating validity in qualitative psychology. In Smith, J. A. (Eds.), *Qualitative psychology: A practical guide to research methods* (pp. 257-273). Sage Publications Ltd.

Yardley, L. (2017). Demonstrating the validity of qualitative research. *The Journal of Positive Psychology*, *12*(3), 295–296. https://doi.org/10.1080/17439760.2016.1262624

Yildiz, P. D., Ayers, S., & Phillips, L. (2017). The prevalence of posttraumatic stress disorder in pregnancy and after birth: A systematic review and meta-analysis. *Journal of Affective Disorders*, *208*, 634–645. https://doi.org/10.1016/j.jad.2016.10.009

Zuckerman, M. (1999). *Vulnerability to psychopathology: A biosocial model.* American Psychological Association. https://doi.org/10.1037/10316-000

List of Appendices

Appendix A

Ethical Approval Letter from the University of Sheffield granted 13th June 2022

The University Of Sheffield.

Downloaded: 13/06/2022
Approved: 13/06/2022

Aditi Sharma
Registration number: 200183769
Psychology
Programme: Doctorate of Clinical Psychology

Dear Aditi

PROJECT TITLE: Exploring the Lived Experiences of South Asian Women's Birth Trauma: An Interpretative Phenomenological Analysis
APPLICATION: Reference Number 045276

On behalf of the University ethics reviewers who reviewed your project, I am pleased to inform you that on 13/06/2022 the above-named project was **approved** on ethics grounds, on the basis that you will adhere to the following documentation that you submitted for ethics review:

- University research ethics application form 045276 (form submission date: 10/06/2022); (expected project end date: 31/07/2023).
- Participant information sheet 1105143 version 3 (10/06/2022).
- Participant information sheet 1105144 version 2 (18/05/2022).
- Participant consent form 1105145 version 3 (10/06/2022).

If during the course of the project you need to deviate significantly from the above-approved documentation please inform me since written approval will be required.

Your responsibilities in delivering this research project are set out at the end of this letter.

Yours sincerely

Department Of Psychology Research Ethics Committee
Ethics Administrator
Psychology

Please note the following responsibilities of the researcher in delivering the research project:

- The project must abide by the University's Research Ethics Policy: https://www.sheffield.ac.uk/rs/ethicsandintegrity/ethicspolicy/approval-procedure
- The project must abide by the University's Good Research & Innovation Practices Policy: https://www.sheffield.ac.uk/polopoly_fs/1.671066!/file/GRIPPolicy.pdf
- The researcher must inform their supervisor (in the case of a student) or Ethics Administrator (in the case of a member of staff) of any significant changes to the project or the approved documentation.
- The researcher must comply with the requirements of the law and relevant guidelines relating to security and confidentiality of personal data.
- The researcher is responsible for effectively managing the data collected both during and after the end of the project in line with best practice, and any relevant legislative, regulatory or contractual requirements.

Appendix B

A Summary of Ethical Considerations and Trauma-Informed Approaches Implemented Throughout the Research

Valid Consent

Clear and informative information sheets were provided for participants. All participants had an opportunity through telephone or email contact to ask questions about the study before agreeing to participate. Participants had the right to withdraw at any time, without giving a reason. However, when participants completed the interview, they were informed they had a two-week window (as transcription was completed and anonymised) in which they could withdraw from the study, without giving a reason.

Confidentiality

The information sheet outlined the participant's right to confidentiality in data management and reporting. All names in the reporting are pseudonyms and any identifying information was removed.

Internet-Mediated Research

The respect for the autonomy, privacy and dignity of individuals and communities was protected (The British Psychological Society, 2021). The researcher sought permission from each social media account administrator, prior to advertising the study in online communities (The British Psychological Society, 2021). A content or trigger warning which are warnings claiming to help individuals emotionally prepare or avoid distressing material were considered (Bridgland et al., 2019). However, this was not implemented due to research consistently indicating current trigger/content warnings were ineffective (Bridgland et al., 2019).

Prior to the research interviews, the researcher introduced themselves and action planned if there was a disruption to the connection.

Trauma-Informed Processes

Risk to Participants

Participants discussing trauma experiences in research have been considered to potentially create further trauma and elicit associated painful emotions (Seedat et al., 2004). Although this study is sensitive in nature, existing research indicated that participants found engaging in trauma-related research a rewarding experience, when there were informative information sheets and appropriate consent (Seedat et al., 2004). Individuals who have participated in trauma research have reported that they felt grateful for the opportunity to share experiences (Griffin et al., 2003).

Participant risk was managed by informing participants the nature of the study, confidentiality, and anonymity protocols in the information sheet. It was highlighted that participants had their right to withdraw and were encouraged to only share experiences they were comfortable sharing to reduce potential distress. The researcher checked in with participants to check distress levels if concerns arose and managed using trauma-informed approaches (Isobel, 2021). If distress arose during the interviews, the researcher had been trained in handling distress (as part of the Doctorate in Clinical Psychology competencies), the participant was offered to pause the interview, have a break, re-schedule to continue (if they wished) or withdraw with time to discuss any of their concerns as result of taking part in the study (Nonomura et al., 2020).

Participants were provided information/signposting to access further support via a debrief sheet. Participants were offered to receive a summary of the results, if they wished and results were fed back to the online communities of people who participated (Isobel, 2021).

Risks to Transcriber

Prior to sending the transcripts, a summary of the study was provided with a caveat that hearing detailed experiences of birth trauma could be distressing. Also, the researcher requested a meeting with the transcriber to discuss the research content further with an opportunity to ask questions. Therefore, the transcriber was invited to meet the researcher prior to transcription, during transcription and debrief after transcription. During the initial meeting with the transcriber, they shared they were an experienced transcriber with over 20 years of experience with experience transcribing other research interviews around child abuse and self-injury. The transcriber declined a debrief meeting however through email confirmed her wellbeing was maintained through the transcription process.

Risks to Researcher

Listening to stories of birth trauma could elicit distress in the researcher. This was be managed by the researcher recording reflections in a research log and by discussing any issues in research supervision.

References

Bridgland, V. M. E., Green, D. M., Oulton, J. M., & Takarangi, M. K. T. (2019). Expecting the worst: Investigating the effects of trigger warnings on reactions to ambiguously themed photos. *Journal of Experimental Psychology: Applied, 25*(4), 602-617. https://doi.org/10.1037/xap0000215

Griffin, M. G., Resick, P. A., Waldrop, A. E., & Mechanic, M. B. (2003). Participation in trauma research: Is there evidence of harm? *Journal of Traumatic Stress, 16*(3), 221-227. https://doi.org/10.1023/a:1023735821900

Isobel, S. (2021). Trauma-informed qualitative research: Some methodological and practical considerations. *International Journal of Mental Health Nursing*, *30*(S1), 1456-1469. https://doi.org/10.1111/inm.12914

Nonomura, R., Giesbrecht, C., Jivraj, T., Lapp, A., Bax, K., Jenney, A., Scott, K., Straatman, A-L., & Baker, L. (2020, June 12). *Toward a trauma-and violence-informed research ethics module: Considerations and recommendations*. Knowledge Hub. https://kh-cdc.ca/en/resources/reports/Grey-Report---English.pdf

Seedat, S., Pienaar, W. P., Williams, D., & Stein, D. J. (2004). Ethics of research on survivors of trauma. *Current Psychiatry Reports*, *6*(4), 262-267. https://doi.org/10.1007/s11920-004-0075-z

The British Psychological Society. (2021, June 7). *Ethics guidelines for internet-mediate research*. https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/Ethics%20Guidelines%20for%20Internet-mediated%20Research.pdf

Appendix C

Recruitment Posters Advertised on Facebook, Instagram, and Twitter and List of Accounts

The research advert was advertised on the following list of social media accounts:

- ROSHNI2 Research (Facebook, Instagram and Twitter) (29/7/22)
- Birth Trauma Research (specifically created to advertise the current study on Instagram and Twitter) (Instagram - 29/7/22; Twitter – 3/8/22)
- Make Birth Better (website and Instagram) (2/8/22)
- Community of Cultures (Instagram) (29/7/22)
- Nur Fitness (Facebook) (29/7/22)
- Teeside Asian Community group (Facebook) (29/7/22)
- UK Bangladeshi group (Facebook) (29/7/22)
- Perinatal mental health research group (2/8/22)

Appendix D

Participant Information Sheet

Aditi Sharma
Trainee Clinical Psychologist
University of Sheffield
Department of Psychology
Floor F, Cathedral Court
1 Vicar Lane
Sheffield S1 2LT
UK

Email: asharma14@sheffield.ac.uk

Participant Information Sheet

We would like to invite you to take part on a research project. Before you decide, it is important to understand why the research is being done and what it will involve. Please read the following information carefully and ask me any questions you have.

If anything is unclear, or if you would like more information, please contact the researcher. Thank you for reading this information.

If you would like this information in an alternative format such as larger font, please get in touch.

Important things you need to know

- We want to explore South Asian mothers' experiences of birth trauma. We also want to understand their ways of seeking help. In this research we hope to understand these experiences so we can help to improve services who support South Asian women with childbirth.

- There will be one interview with the researcher. This will be at a time convenient to you. During the interview you will be asked questions about your experience of birth trauma and your experience of care or help you received/ or did not receive. This will also include your thoughts on what was helpful or not.

- You will be reimbursed with a £10 Amazon voucher. You can change your mind and stop taking part in the interview at any point without giving us a reason.

How to contact us
If you wish to contact us, please drop an email to **Aditi Sharma** (Lead Researcher) at asharma14@sheffield.ac.uk and she will reply to you.

If this research project sounds interesting to you, please carry-on reading

Why have I been invited?
You have been invited to take part in this research project because you are a South Asian woman who has reported experiencing a traumatic birth.

You may have experienced a traumatic birth if you identify with at least one of the following:

- At the time of birth, you had feelings of intense fear, helplessness, or horror
- After your childbirth you felt shocked, guilty, or numb
- You (the mother) AND/OR the baby experienced physical injury that resulted in longstanding distress
- You experienced fear of physical injury or death to you (the mother) or the baby and experienced longstanding distress
- You experienced a lack of care (perceived as discrimination, unsupportive or inhumane) during childbirth which caused longstanding distress
- Your birth choices were not heard which caused longstanding distress

Do I have to take part?
No, it is up to you whether you would like to take part. If you decide to take part, you can keep this information sheet and you will be asked to sign a consent form.

You can withdraw from the study at any point before or during the interview. If you choose to complete the interview you can also withdraw within the two weeks following the interview without giving a reason. After 2 weeks of completing the interviews, withdrawing will not be possible because transcription will be completed and anonymised.

What will happen if I take part?
You will be contacted via telephone or email (please indicate which is your preferred method) by the lead researcher within 2 weeks. You will be asked to take part in an interview for roughly one hour where you will be asked some questions about your experiences of a traumatic birth and if you sought any help.

The interview will take place either by telephone or Google Meets at a time convenient to you.

This interview will be recorded and then transcribed. Following this it will be analysed using a technique called interpretative phenomenological analysis.

What are the benefits of taking part?
You will have the opportunity to share your experiences of having a traumatic birth and seeking help. A written report of the findings will be complied with the hope of providing information to ensure support is tailored to individuals and offered when needed.

What are the risks and disadvantages?
If you feel that there is a problem at any time, you can let the researcher know. This may be a topic that is difficult to talk about or could feel distressing. If you experience any distress whilst sharing your experience, the researcher will be able to discuss this with you and discuss what further support might be of help (for example, contacting your GP and signposting to some relevant organisations).

Will all the information be kept confidential?
All the information we collect about you will be kept strictly confidential in a secure and password protected folder. Your contact details will be temporarily stored in this folder and will be deleted when recruitment has finished. The recorded interview and anonymised transcripts will also be stored in this folder.

You will not be identifiable in any reports or publications.

The only exception to this would be if during the interview the researcher became concerned about a risk of harm to yourself, or someone you talk about. If this situation does arise, the researcher would have a duty to share these concerns with relevant professionals and would discuss the need to do so with you. The aim of this would always be to support yourself and those you mention and ensure safety.

Will I receive any reimbursement of expenses for taking part in this research?
Yes, if you choose to participate you will be reimbursed with a £10 Amazon voucher for your time. Even if you stop the interview or withdraw from the study, you will still be provided with a £10 Amazon voucher.

What will happen to the results of the study?
The results will be submitted as part of the researcher's Doctorate in Clinical Psychology thesis in May 2023. You can let the researcher know at the start of the study if you would like a copy of this and this can be sent to you. The results will also be submitted for publication.

The University of Sheffield is organising and funding this research. This project has been ethically approved by the University of Sheffield Clinical Psychology department, using the University of Sheffield's Ethics Review Procedure.

What if I wish to complain about the way the study has been carried out?
In the first instance you can contact the Lead Researcher:
Aditi Sharma – asharma14@sheffield.ac.uk
Alternatively, you can contact the Research Supervisor:
Dr Vyv Huddy – v.huddy@sheffield.ac.uk

If you feel that your complaint has not been handled to your satisfaction following this, you can contact Programme Director, Gillian Hardy G.Hardy@sheffield.ac.uk, or Dr Thomas Webb, Chair of the University Ethics Committee on T.Webb@sheffield.ac.uk

How will incidents be handled?
Initially, the Designated Safeguarding Contact (DSC), Vyv Huddy, will acquire details of the incident/complaint and offer relevant support to the participant. At this point, details will also be shared with supervisors and the research ethics and integrity manager. Where necessary, the matter will be referred to more relevant, or qualified individuals or organisations to be dealt with. The individual involved will be kept informed of this process throughout.

Contact Information
This research is being conducted by **Aditi Sharma** Trainee Clinical Psychologist. This research will be used to write a thesis which fulfils part of her doctoral training. If you have any questions about the research, you can leave a telephone message with the Research Support Officer on 0114 222 6650 and he will ask **Aditi Sharma** to contact you.

Additional Information about your data
New data protection legislation came into effect across the EU, including the UK on 25 May 2018; this means that we need to provide you with some further information relating to how your personal information will be used and managed within this research project.

The University of Sheffield will act as the Data Controller for this study. This means that the University is responsible for looking after your information and using it properly. In order to collect and use your personal information as part of this research project, we must have a basis in law to do so. The basis that we are using is that the research is 'a task in the public interest'.

As we will be collecting some data that is defined in the legislation as more sensitive (e.g. information about your health, we also need to let you know that we are applying an additional condition in law: that the use of your data is 'necessary for scientific or historical research purposes'.

Further information, including details about how and why the University processes your personal information, how we keep your information secure, and your legal rights (including how to complain if you feel that your personal information has not been handled correctly), can be found in the University's Privacy Notice https://www.sheffield.ac.uk/govern/data-protection/privacy/general.

Appendix E

Participant Consent Form

Aditi Sharma
Trainee Clinical Psychologist
University of Sheffield
Department of Psychology
Floor F, Cathedral Court
1 Vicar Lane
Sheffield S1 2LT

Email: asharma14@sheffield.ac.uk

Consent Form

Title of Project
Exploring the Lived Experiences of South Asian Women's Birth Trauma: An Interpretative Phenomenological Analysis

Name of Researcher
Aditi Sharma

Participant Identification Number

	Please check the appropriate boxes	Yes	No
1	I have read and understood the project information sheet, or the project has been fully explained to me. *N.B. If you answer No to this question, please do not proceed with this consent form until you are fully aware of what your participation in the project will mean.*	☐	☐
2	I have been given the opportunity to ask questions about the project.	☐	☐
3	I agree to take part in the project. I understand that taking part in the project will include participating in an interview that will be audio recorded.	☐	☐
4	I understand that for my participation I will receive a £10 Amazon voucher, even if I stop the interview or withdraw. I understand I am free to withdraw at any time without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any question(s), I am free to decline. I understand that if I participate, I have 2 weeks from the date of the interview to withdraw. This is because transcription will be completed.	☐	☐
5	I understand that my responses will be kept confidential meaning that I will not be identified or identifiable in the report or reports that result from the research.	☐	☐

6	I understand and agree that my words may be quoted in publications, reports, web pages, and other research outputs. I understand that I will not be named in these outputs.	☐	☐
7	I understand and agree that other authorised researchers may use my data in publications, reports, web pages, and other research outputs, only if they agree to preserve the confidentiality of the information as requested in this form.	☐	☐
8	I agree for the data collected from me to be stored anonymously.	☐	☐
10	I agree to assign the copyright I hold in any materials generated as part of this project to The University of Sheffield.	☐	☐

Thank you for agreeing to take part.

Name of Participant	Date	Signature
Lead Researcher	Date	Signature

Copies:
Once this has been signed by all parties the participant should receive a copy of the signed and dated participant consent form and the information sheet. A copy of the signed and dated consent form should be placed in the project's main record (e.g. a site file), which must be kept in a secure location.

Appendix F

Participant Debrief Sheet

Aditi Sharma
Trainee Clinical Psychologist
University of Sheffield
Department of Psychology
Floor F, Cathedral Court
1 Vicar Lane
Sheffield S1 2LT

Email: asharma14@sheffield.ac.uk

Debrief Sheet

Thank you for taking part in this study and sharing your experiences with me. If you have any queries or further questions, please do not hesitate to contact me:

Aditi Sharma
University of Sheffield
Department of Psychology
Floor F, Cathedral Court
1 Vicar Lane
Sheffield S1 2LT

Email: asharma14@sheffield.ac.uk

The purpose of the research
We wanted to explore South Asian mothers' experiences of birth trauma. We also wanted to understand their ways of seeking help. In this research we hoped to understand these experiences so we can help to improve services who support women with childbirth.

If you would like a sample copy of the findings, these will be available to you, if you wish. Please email me to confirm this request.

If you wish to withdraw from the study, please email myself or Dr Vyv Huddy (Research Supervisor) v.huddy@sheffield.ac.uk with your participant identification number **within 2 weeks** of the interview. You do not have to provide a reason for withdrawing.

Some of the responses you shared in this study may have been sensitive and/or distressing so you may have some further questions. If so, please do not hesitate to contact your GP or any of the services below or on the next page, who can offer some support and guidance.

Birth Trauma Association (BTA) support families who have been traumatised during childbirth. They are parents who wish to support other parents who have suffered and/or witnessed traumatic births.
Website: www.birthtraumaassociation.org.uk
Email: support@birthtraumaassociation.org.uk

They also have a closed group on Facebook. You can request to join by searching for ‘Birth Trauma Association’.

PANDAS is here to help support and advise any parent who is experiencing a perinatal mental illness. They are here to inform and guide family members, carers, friends, and employers as to how they can support someone who is suffering.
Phone: 0843 2898401

Support Me CIC is here to support minority ethnic communities to receive and engage in maternity care. They support all families during pregnancy, birth, and early parenting whatever their circumstances. They offer free support groups for different communities and languages.
Website: https://www.supportmecic.com/
Email: smematernalproject@gmail.com

Appendix G

Topic guide

Introduction

I would like to talk with you about your traumatic birth experiences. I am especially interested in understanding how you make sense of your traumatic experiences and how you sought help, if any.

This interview will last for approximately one hour. With your permission, the interview will be audio recorded and transcribed. Your participation in the study is entirely voluntary. You may choose not to answer any particular question, and you can ask me to pause or stop the audio-recording at any time. You also have the right to withdraw from the study within two weeks of the interview without giving a reason, and you will still be provided with a £10 Amazon voucher.

Do you have any questions before we start?

[Record process of consent – checking that the interviewee has read, understood, and signed the Consent Form]

1) Can you tell me how you would describe birth trauma, in general? What does this term mean to you?

2) Can you tell me about your pregnancy?
    - How did you feel?
    - Did this surprise you?
    - How did you manage this?

3) Can you describe your experience of giving birth?
    - How did you feel when you went into labour?
    - Were you offered any support?
    - What type of support?
    - What was helpful during labour?
    - What was unhelpful during labour?

    - How did you feel when you had given birth?
    - Were you offered any support?
    - What did you find helpful once you had given birth?

- What was unhelpful once you had given birth?

4) What aspects of your birth did you find particularly traumatic?

5) Did you feel that your ethnicity or culture had an impact on how you experienced the birth trauma?

6) Did you seek help for what happened?
   - Prompts: professional, charity, spiritual, or cultural

7) Is there any stigma when seeking help from _____?

   - Other than stigma, what affects you accessing and using NHS services for mental health and support services for birth trauma?
   - Prompts: cultural beliefs/attitudes, family/intergenerational issues, NHS system, other factors

8) Is there any particular help you wanted after the birth?

9) How has your relationship with your baby been since the birth?

10) Demographic information

How old were you when experienced the traumatic birth?	
How would you describe your ethnicity?	
What immigration generation are you from?	
What method of birth was associated with your traumatic birth?	
How many months post-partum from your traumatic birth?	
How many children do you have (how many children did you have when you experienced the traumatic birth)?	
Are you in a relationship?	

Closing the interview

Summarise the main issues discussed. What do you like about being a mum? What are your plans for the rest of the day?

Thank you for taking part

[provide debriefing sheet]

Appendix H

Summary of Public and Participant Involvement Feedback

Add-in	On the information sheet, include a photo of the lead researcher to help people feel comfortable and know who they will be talking to (EbE individual) On the information sheet, when describing BT experiences add a specific bullet point for "*your birth choices were not heard which caused longstanding distress*" because some people may not be able to link birth choices when talking about experiences of their care (EbE individual) On the debrief sheet, include a national organisation that specifically supports ethnic minority communities such as Support Me CIC because they will be culturally aware and familiar with cultural differences (EbE individual) On the topic guide, include demographic information on immigrant generation because there might be differences in experiences between first-generation and second-generation immigrant women (EbE individual)
Edit	On the information sheet soften the language to "*reported experiencing a traumatic birth*" rather than "*you have had a traumatic birth*." (Professional)
General Feedback	The EbE group reported positive feedback with no recommendations for any changes. The professional and EbE individual reported positive feedback with minor suggestions.

Appendix I

A Summary of Consultation with Specialist Birth Trauma Clinical Psychologist

During Study Design

- 3rd May 2022 – Email correspondence. Aimed to identify ways to describe birth trauma and/ or standardised measures. Outcome - lack of standardised birth trauma measures and agreed birth trauma is subjective. Keep birth trauma parameters broad.
- 22nd July 2022 – Email correspondence. Aimed to seek feedback on the Information Sheet, Consent Form and Debrief Form. Outcome – soften the language from "you have had a traumatic birth" to "reported experiencing a traumatic birth" on the Information Sheet.

During Analysis

- 7th and 14th December 2022 – Meeting and email correspondence. Aimed to discuss, review, and reflect on group experiential themes. Discussed themes and agreed they appropriately reflect the quotes provided and consistent with clinical observations in the Birth Trauma service. Discussed whether to focus only on the South Asian-related themes or to provide an overview of all the birth trauma experiences provided. Outcome – to include an overview of all the birth trauma experiences, including South Asian-related themes because it's part of their experiences and be linked with the existing research base to ensure representation of their experiences.

  Feedback "*Your understanding and connection with this topic really comes through but I think you also sound really balanced. The experiences of your sample are definitely consistent with the accounts we hear from traumatised women*."

Appendix J

A Summary of Consultation and Feedback from the Expert-by-Experience Group

The EbE group were consulted as part of the perinatal mental health peer support group with experience(s) of BT. They were verbally consented by the group facilitator (Peer Support Service Lead) and provided a summary inviting them to feedback with the researcher's details. The group facilitator and researcher met prior to the groups to discuss and provide a lay summary of the research. The researcher did not attend the group, this was to facilitate open and honest discussions however, left contact details if they wished to discuss any queries or provide additional feedback.

- 19th May 2022 – 22nd July 2022 - Email correspondence with Peer Support Service Lead for a Perinatal Mental Health Team
- 27th May 2022 – Initial meeting attended via MS Teams for introductions to researcher and research processes with the Peer Support Service Lead
- 16th June 2022 – Email received from Peer Support Service Lead reporting the group of four Mums provided approval of all the topic guide questions with "positive feedback" and "no suggestions for changes."
- 21st July 2022 – Email received from Peer Support Service Lead with two additional Mum's feedback "*I think the questions flow very well, the questionnaire is clear and concise. The wording and questions asked are effective at helping the respondent to open up about opinions and feelings. The tone of the questionnaire feels thoughtful and understanding which makes me feel comfortable to share experiences. Overall, I only have good things to say and personally can't find any faults.*" Additional feedback from the Peer Support Service Lead. "*It was a great questionnaire with no*

room for improvement and they were all really happy that birth trauma was the focus of your research. I think it validated their experiences, so they were all really happy to help."

Appendix K

Signed Confidentiality Contract by University-Approved Transcriber

Doctorate in Clinical Psychology, University of Sheffield

Transcribing Confidentiality Form & Guidance Notes

Type of project: Research thesis

Project title: Exploring the Lived Experiences of South Asian Women and Birthing People's Birth Trauma: An Interpretative Phenomenological Analysis

Researcher's name: Aditi Sharma

The recording you are transcribing has been collected as part of a research project. Recordings may contain information of a very personal nature, which should be kept confidential and not disclosed to others. Maintaining this confidentiality is of utmost importance to the University.

We would like you to agree:

1. Not to disclose any information you may hear on the recording to others,
2. If transcribing digital recordings – only to accept files provided on an encrypted memory stick
3. To keep the tapes and/or encrypted memory stick in a secure locked place when not in use,
4. When transcribing a recording ensure it cannot be heard by other people,
5. To adhere to the Guidelines for Transcribers (appended to this document) in relation to the use of computers and encrypted digital recorders.
6. To show your transcription only to the relevant individual who is involved in the research project.
7. If you find that anyone speaking on a recording is known to you, we would like you to stop transcription work on that recording immediately and inform the person who has commissioned the work.

Declaration

I have read the above information, as well as the Guidelines for Transcribers, and I understand that:

1. I will discuss the content of the recording only with the individual involved in the research project
2. If transcribing digital recordings – I will only accept files provided on an encrypted memory stick
3. I will keep the tapes and/or encrypted memory stick in a secure place when not in use
4. I will not use external storage programmes or website, such as Dropbox, for transferring recordings as it does not meet any of the University's data security guidelines
5. When transcribing a recording I will ensure it cannot be heard by others
6. I will treat the transcription of the recording as confidential information
7. I will adhere to the requirements detailed in the Guidelines for transcribers in relation to transcribing recordings onto a computer and transcribing digital audio files
8. If the person being interviewed on the recordings is known to me I will undertake no further transcription work on the recording

I agree to act according to the above constraints

Your name Sarah Fox

Signature Sarah Fox.

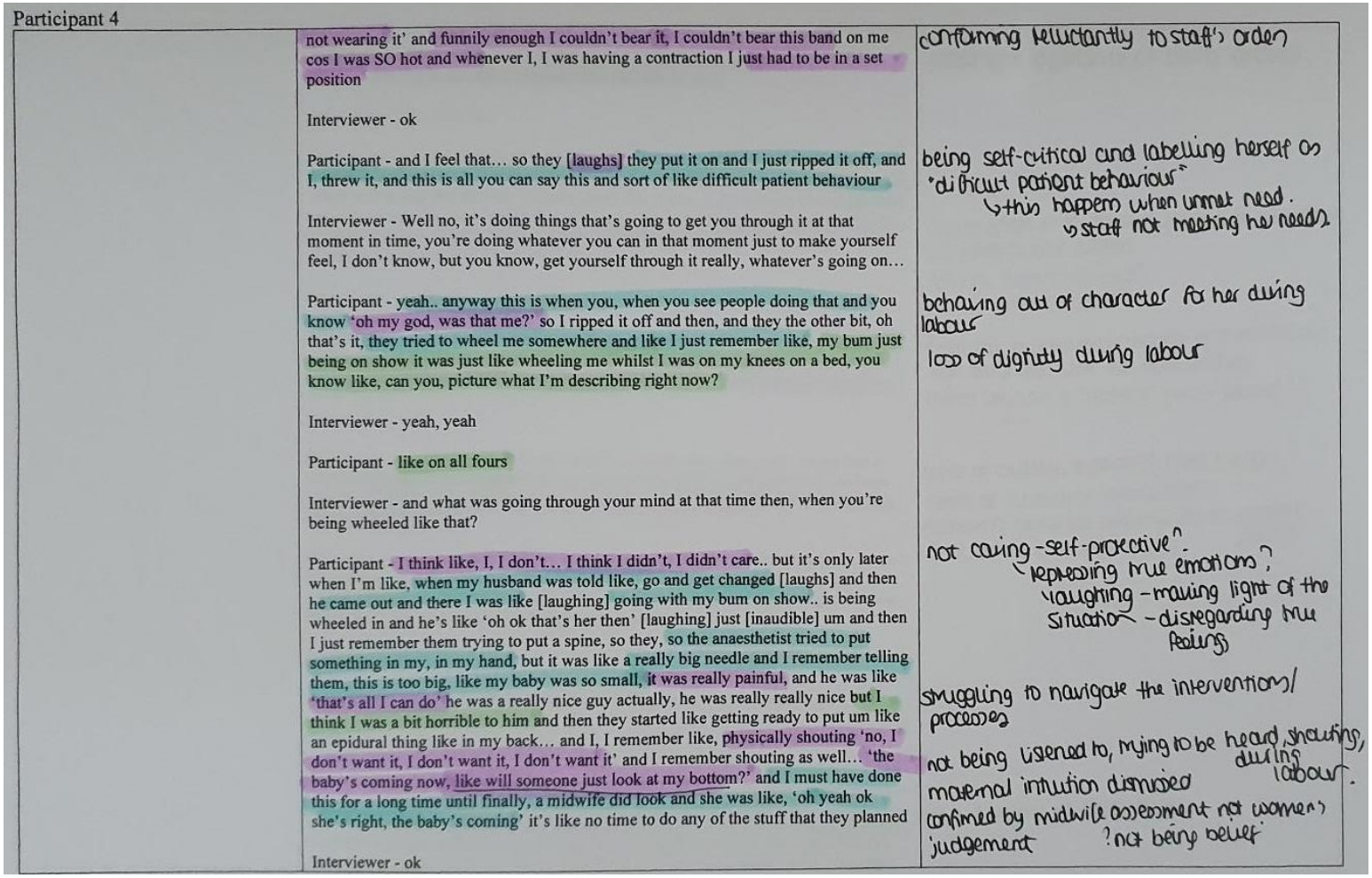
Date 20 Sept 22.

Occasionally, the conversations on recordings can be distressing to hear. If you should find it upsetting, please stop the transcription and raise this with the researcher as soon as possible.

Appendix L

Example Coding of Transcript

Blue denotes descriptive coding; purple denotes linguistic coding; and green denotes conceptual coding



Participant 4

not wearing it' and funnily enough I couldn't bear it, I couldn't bear this band on me cos I was SO hot and whenever I, I was having a contraction I just had to be in a set position

Interviewer - ok

Participant - and I feel that… so they [laughs] they put it on and I just ripped it off, and I, threw it, and this is all you can say this and sort of like difficult patient behaviour

Interviewer - Well no, it's doing things that's going to get you through it at that moment in time, you're doing whatever you can in that moment just to make yourself feel, I don't know, but you know, get yourself through it really, whatever's going on…

Participant - yeah.. anyway this is when you, when you see people doing that and you know 'oh my god, was that me?' so I ripped it off and then, and they the other bit, oh that's it, they tried to wheel me somewhere and like I just remember like, my bum just being on show it was just like wheeling me whilst I was on my knees on a bed, you know like, can you, picture what I'm describing right now?

Interviewer - yeah, yeah

Participant - like on all fours

Interviewer - and what was going through your mind at that time then, when you're being wheeled like that?

Participant - I think like, I, I don't… I think I didn't, I didn't care.. but it's only later when I'm like, when my husband was told like, go and get changed [laughs] and then he came out and there I was like [laughing] going with my bum on show.. is being wheeled in and he's like 'oh ok that's her then' [laughing] just [inaudible] um and then I just remember them trying to put a spine, so they, so the anaesthetist tried to put something in my, in my hand, but it was like a really big needle and I remember telling them, this is too big, like my baby was so small, it was really painful, and he was like 'that's all I can do' he was a really nice guy actually, he was really really nice but I think I was a bit horrible to him and then they started like getting ready to put um like an epidural thing like in my back… and I, I remember like, physically shouting 'no, I don't want it, I don't want it, I don't want it' and I remember shouting as well… 'the baby's coming now, like will someone just look at my bottom?' and I must have done this for a long time until finally, a midwife did look and she was like, 'oh yeah ok she's right, the baby's coming' it's like no time to do any of the stuff that they planned

Interviewer - ok

conforming reluctantly to staff's order

being self-critical and labelling herself as "difficult patient behaviour"
↳ this happens when unmet need.
↳ staff not meeting her needs

behaving out of character for her during labour

loss of dignity during labour

not coping - self-protective?
↳ repressing true emotions?
↳ laughing - making light of the situation - disregarding true feelings

struggling to navigate the interventions/ processes

not being listened to, trying to be heard, shouting, during labour.
maternal intuition dismissed
confirmed by midwife assessment not women's judgement ? not being believed

Appendix M

Example Table of Personal Experiential Themes for Nadiya

Disconnected from self	
	Pure confusion when waking up p13 Alone, isolated and trying to make sense of her body and baby after birth p9 Feeling depersonalised from delivery p12 Disconnected from body and the birthing events p9 Rejecting / disconnecting from son, cannot understand birth and no immediate identifying physical resemblance (looking pale) p10 Attempts to reorientated herself after birth p10 Absence of sickness indicated the end of childbirth p10 Loss of awareness during delivery p10 Disconnection from mind and body p10 Poignant and profound experience p13 Derealisation (ward feels unreal) p13 Waking up to a feeling of emptiness and numbness p12 Pure confusion when waking up p13
Healthcare staff breaking roles	
Misinformation	Misled a dream fantasy of recovery p15 False sense of quick recovery which fell short of her expectations p15 Unrealistic expectations of c-section recovery despite intellectual knowledge of recovery p15
Confusion	Confusion, no understanding of the medical procedures and processes p9 Confused and not understanding healthcare professionals' views p7 Unsure/uncertainty on the birth process, compliant in following medical advice p7 Staff not fully informing her on the options, procedures and potential outcomes p13 Worried about the placenta being ineffective p11 Balloon catheter was horrible, painful, and uncomfortable p7
Dismissed and undermined	Devoid as a human p12 Attempts of staff silencing her p9 Sense of abandonment / neglect from staff during labour p8 Blatantly being ignored by staff p10 Maternal intuition and informing nurses of her being in labour but they dismiss her p8 Staff undermining her reports of being in labour p8 Staff ignoring her requests p10
Oppression	Staff made assumptions and judgements about her birth without her p12 Being scolded and criticised by anaesthetist p9

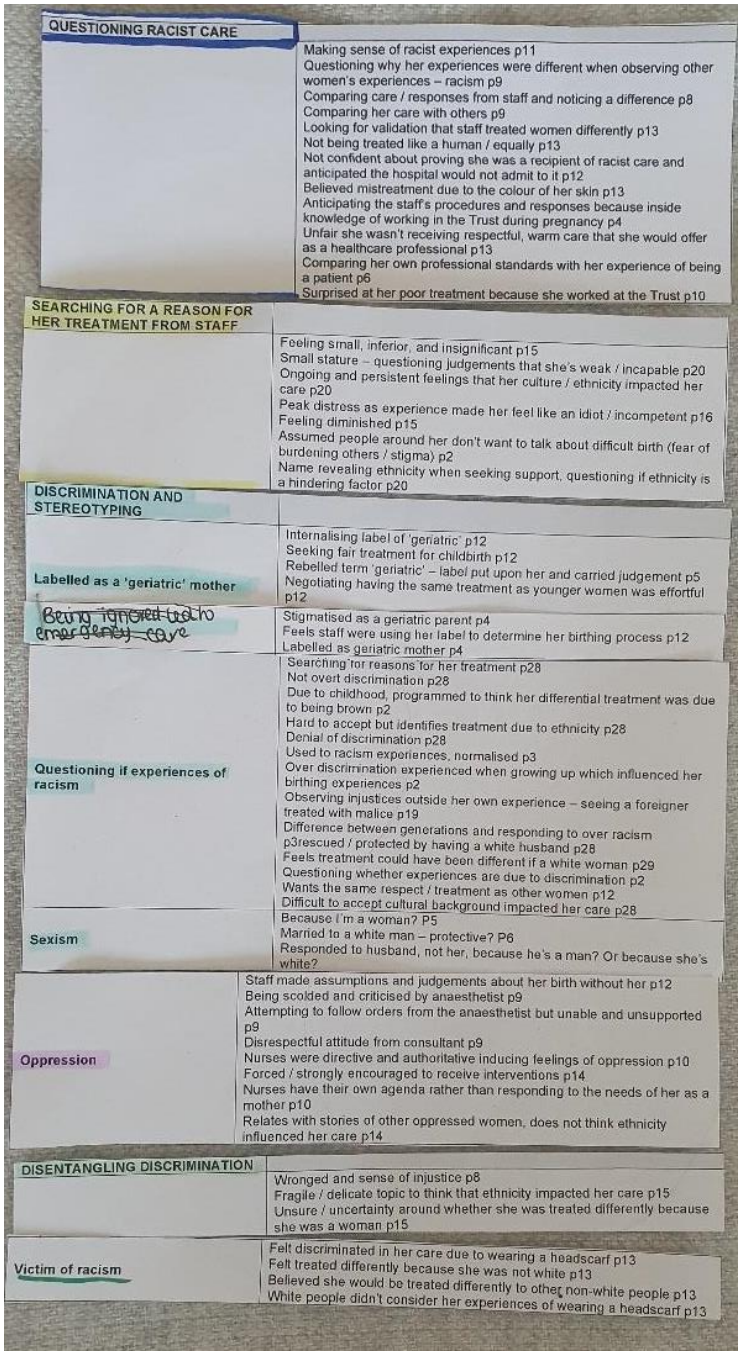
Silent Protest	Attempting to follow orders from the anaesthetist but unable and unsupported p9 Disrespectful attitude from consultant p9 Nurses were directive and authoritative inducing feelings of oppression p10 Forced / strongly encouraged to receive interventions p14 Nurses have their own agenda rather than responding to the needs of her as a mother p10 Relates with stories of other oppressed women, does not think ethnicity influenced her care p14 Residual anger from not being listened to by staff p8 Unfair and unjust treatment from staff p12 Tainted birth process p11 Seeking validating and accountability for her birthing experience p16 Remorse for birth experience and feeling ashamed because unprepared and not heard p11 Birthing experience made her feel weak p11 Pleading internally with a sense of regret of labour experience (silent protest) p8 Concerned about being viewed as obstructive p14 Balancing act between asserting self and not wanting to be viewed as obstructive p14 Asserting self within the family does not adhere to cultural norms p18 Fear / avoidance of becoming a burden p14
Fear of birthing alone	
	Fear of birthing alone p8 Fearing of giving birth alone (without partner) despite staff with her p9 Seeking advocacy from husband p9 Relief of husband's presence when starting delivery p9
Systemic issues influencing birth experience	
	Indicating wider systemic issues which caused anxiety p7 Notes not well documented by staff which led to blame and accusing her of abuse towards her baby p15 Staff causing unnecessary worry around the lack of beds p11 Threatened by social services p15
Dismissal of pain	
	Staff not attuned to her needs – not responding to pain p7 Pain beyond capacity p8 Writhing in pain during labour p9 Excruciating pain from the induction process p7 Justifying pain response to nurses in efforts to convince them she's in sufficient pain for further pain management p8 Receiving critical care in response to pain during labour p8 Not listened to around needs for pain management p8 Inexperienced recovery of caesarean p15

Near death experience	
	Existential threat experience p13 Questioning own mortality p8 Close to death p19 Preparing to die p9 Being pushed beyond her limits of capability p11 Desperation of wanting the baby out p11 Critical situation and feeling like she's dying p8 Showing survival instinct p9
Undignified care	
	Experiencing threats to dignity p7 Threat to dignity when waters broke during an examination, feeling dishonoured, disrespected, and insignificant p8 Exposed in front of mum p10 Feeling vulnerable when strangers surrounding her in theatre p8
Loss of control over birthing experience	
	Emergency, urgent responses being carried out in chaos p9 Loss of control p19 Wanting to escape p8 Staff lacked empathy which meant she missed out on being offered an elective c-section p11 Rebelling during labour because only form of control she has p8 Missed out (loss) of controlled and collected birthing experience p8 Questioning healthcare professionals' intentions creating a sense of mistrust through labour p7 Unprofessionalism of the staff in emergency situation to getting her to the labour ward p8 Labour was the resolution to sickness p7
Negotiating south Asian norms	
	Initial difficulties connecting with baby because not fulfilling duties as a new mother p19 Stigma with difficulties bonding with the baby an anticipating judgement within family p19 Distinguishing a difference between Westernised and non-Westernised South Asians p16 Being Westernised is a protective factor p14 Woke to South Asian pressures on women p4 p5 Boundaried with South Asian influences p17 Resigning / disconnecting from some aspects of culture p5 Holds different intergenerational thinking towards mental health compared to parents p17 There are harmful parts from South Asian culture p4

Appendix N

An Example of Grouping Personal Experiential Themes to Develop Group Experiential Themes, Colours Represent Different Participants

Photo 1 – Example of Development of "Disentangling Discrimination" theme



QUESTIONING RACIST CARE	Making sense of racist experiences p11 Questioning why her experiences were different when observing other women's experiences – racism p9 Comparing care / responses from staff and noticing a difference p8 Comparing her care with others p9 Looking for validation that staff treated women differently p13 Not being treated like a human / equally p13 Not confident about proving she was a recipient of racist care and anticipated the hospital would not admit to it p12 Believed mistreatment due to the colour of her skin p13 Anticipating the staff's procedures and responses because inside knowledge of working in the Trust during pregnancy p4 Unfair she wasn't receiving respectful, warm care that she would offer as a healthcare professional p13 Comparing her own professional standards with her experience of being a patient p6 Surprised at her poor treatment because she worked at the Trust p10
SEARCHING FOR A REASON FOR HER TREATMENT FROM STAFF	Feeling small, inferior, and insignificant p15 Small stature – questioning judgements that she's weak / incapable p20 Ongoing and persistent feelings that her culture / ethnicity impacted her care p20 Peak distress as experience made her feel like an idiot / incompetent p16 Feeling diminished p15 Assumed people around her don't want to talk about difficult birth (fear of burdening others / stigma) p2 Name revealing ethnicity when seeking support, questioning if ethnicity is a hindering factor p20
DISCRIMINATION AND STEREOTYPING	
Labelled as a 'geriatric' mother	Internalising label of 'geriatric' p12 Seeking fair treatment for childbirth p12 Rebelled term 'geriatric' – label put upon her and carried judgement p5 Negotiating having the same treatment as younger women was effortful p12
Being ignored to the emergency care	Stigmatised as a geriatric parent p4 Feels staff were using her label to determine her birthing process p12 Labelled as geriatric mother p4
Questioning if experiences of racism	Searching for reasons for her treatment p28 Not overt discrimination p28 Due to childhood, programmed to think her differential treatment was due to being brown p2 Hard to accept but identifies treatment due to ethnicity p28 Denial of discrimination p28 Used to racism experiences, normalised p3 Over discrimination experienced when growing up which influenced her birthing experiences p2 Observing injustices outside her own experience – seeing a foreigner treated with malice p19 Difference between generations and responding to over racism p3rescued / protected by having a white husband p28 Feels treatment could have been different if a white woman p29 Questioning whether experiences are due to discrimination p2 Wants the same respect / treatment as other women p12 Difficult to accept cultural background impacted her care p28
Sexism	Because I'm a woman? P5 Married to a white man – protective? P6 Responded to husband, not her, because he's a man? Or because she's white?
Oppression	Staff made assumptions and judgements about her birth without her p12 Being scolded and criticised by anaesthetist p9 Attempting to follow orders from the anaesthetist but unable and unsupported p9 Disrespectful attitude from consultant p9 Nurses were directive and authoritative inducing feelings of oppression p10 Forced / strongly encouraged to receive interventions p14 Nurses have their own agenda rather than responding to the needs of her as a mother p10 Relates with stories of other oppressed women, does not think ethnicity influenced her care p14
DISENTANGLING DISCRIMINATION	Wronged and sense of injustice p8 Fragile / delicate topic to think that ethnicity impacted her care p15 Unsure / uncertainty around whether she was treated differently because she was a woman p15
Victim of racism	Felt discriminated in her care due to wearing a headscarf p13 Felt treated differently because she was not white p13 Believed she would be treated differently to other non-white people p13 White people didn't consider her experiences of wearing a headscarf p13

Photo 2 - Initial Overview of All Group Experiential Themes

Appendix O

Overview of Participant Representation for each GET

GET and Sub-themes	Participants							
	Ameerah	Maya	Nadiya	Deepika	Bhavna	Misha	Naseema	Mahira
The Power of Maternity Healthcare Professionals	✓		✓	✓	✓	✓	✓	✓
Coerced into procedures / interventions	✓		✓	✓	✓	✓	✓	
Undignified and violated	✓		✓	✓	✓	✓	✓	
Ignored and dismissed	✓		✓	✓	✓	✓	✓	✓
Let down by the NHS	✓		✓	✓	✓	✓	✓	✓
Loss of Connection	✓	✓	✓	✓	✓	✓	✓	✓
Loss of reality during delivery	✓	✓	✓	✓			✓	✓
Loss of bonding experiences	✓		✓		✓	✓	✓	✓
Loss of partnership	✓	✓	✓		✓		✓	✓
Disentangling Discrimination	✓		✓	✓	✓	✓	✓	✓
Pervasive Cultural Stigma in Motherhood	✓	✓	✓	✓	✓	✓	✓	✓
Keeping up the illusion of coping	✓	✓	✓	✓		✓	✓	✓
The shame of needing emotional support	✓	✓			✓	✓	✓	✓

Appendix P

Reflexive Statement

The researcher was a cis female Trainee Clinical Psychologist and conducted all the research interviews. None of the participants were known by the researcher. Her qualifications included an undergraduate degree psychology degree and master's in health psychology. The researcher had British Indian ethnicity, both parents are immigrants from India thus influenced by dual cultures.

The researcher had no prior clinical experience working in birth trauma which was seen as a strength as did not hold prior assumptions or expectations about the birth trauma. this was consistent with the research's philosophical underpinning that each individual holds their own truth, and the research makes sense of this through her lens. However, at times, a lack of clinical experience, felt like a limitation in the early stages of data collection as she held limited knowledge around the medical birth procedures.

Through the analysis of the data, the researcher started an elective clinical psychology in a specialist birth trauma service within the NHS. The specialist birth trauma clinical psychologist during consultation was the placement supervision. Also, the researcher held eight years' experience of working within the NHS system and experienced some of the reported systemic issues. As a therapist, the researcher utilised person-centred and strengths-based approaches.

Appendix Q

Reflective Log Excerpt

1st August 2022 - First interview (Google Meets)

I was struck by how open and honest she was about sharing her experiences. I was surprised how *readily* she was describing her experiences. Actually, it sometimes felt like she was so casual and blasé with her birthing story, is this because she was disconnecting, or avoiding? I anticipated that there was going to be lots of distress. I had not prepared for this; I need to be mindful that participants may not find it as challenging as I may assume.

Hearing about her pregnancy and experiences of feeling judged by healthcare professionals, I wondered if she felt that I was judging her at the beginning. She repeatedly described how active she was during pregnancy and justifying how she was not 'lazy.'

There were discussions around assisted birth procedures and having an induction. Whilst I had a vague idea of the process of induction I need to research and educate myself about assisted birth procedures. I think it will help me feel more confident about asking follow-up questions and contextualise experiences.

Hearing about her experiences of healthcare staff and their communication, I was mindful of my feelings of shock and anger despite reading some of these experiences in the research. These experiences were really brought alive when she shared her detailed experiences. I must keep a log of my feelings to ensure these do not influence the types of questions I might follow-up with or influence the analysis.

She explained she was grateful for having her voice heard, I noticed surprising gratitude for being able to research this area. Also, I really related with her general family experiences and shared cultural dynamic. I need to ensure I am self-aware and avoid over-identifying with participants by continuing to record my experiences and reflections.

Appendix R

Audit Checklist

Worthy Topic	
1. Is the topic of research relevant?	Yes / Partially / No
2. Is the topic of research clinically significant?	Yes / Partially / No
Rich Rigor	
3. Does the study state clear theoretical constructs?	Yes / Partially / No
4. Does the study comprise of rich data?	Yes / Partially / No
5. Does the study clearly and sufficiently describe the sample (demographic and background information)?	Yes / Partially / No
6. Does the study describe how birth trauma is conceptualised?	Yes / Partially / No
7. Has the data been sufficiently coded?	Yes / Partially / No
8. Has the data been systematically coded (aligning with 7-step process for IPA)?	Yes / Partially / No
9. Has the researcher engaged in a reflexive and iterative process to define group experiential themes?	Yes / Partially / No
Sincerity	
10. Does the researcher record self-reflexivity including values, biases, and personal experiences of birth trauma?	Yes / Partially / No
11. Is the researcher transparent about the IPA methods and challenges?	Yes / Partially / No
Credibility	
12. Are participant quotes sufficient to provide evidence of themes and sub-themes?	Yes / Partially / No
13. Does the researcher engage in triangulation or provide appropriate justifications for not engaging in triangulation?	Yes / Partially / No
14. Has the researcher engaged in appropriate supervision to support research quality?	Yes / Partially / No
Resonance	
15. Do the research findings have impact?	Yes / Partially / No
Significant Contribution	
16. Does the study extend current knowledge of birth trauma?	Yes / Partially / No
17. Do the study's implications improve clinical practice?	Yes / Partially / No
18. Does the study make recommendations for research?	Yes / Partially / No
Ethical	
19. Does the research have appropriate ethical approval?	Yes / Partially / No
20. Does the research consider trauma-informed approaches?	Yes / Partially / No
21. Is the research considerate of cultural sensitivities?	Yes / Partially / No
22. Are the participants experiences appropriately represented?	Yes / Partially / No
Meaningful Coherence	
23. Does the study achieve its reported aims?	Yes / Partially / No
24. Does the study situates its findings with pre-existing research?	Yes / Partially / No

Name of Researcher Aditi Sharma **Researcher Signature** Aditi Sharma

Name of Auditor Charlotte Grahame **Auditor Signature** CGrahame

Appendix S

The Consolidated Criteria for Reporting Qualitative Studies checklist (COREQ) by Tong et al., 2007

Number / Item	Guide and Description	Location	Checked by independent reviewer (CG)
	Domain 1: Research team and reflexivity		
Personal characteristics			
1 Interview/ facilitator	Which author/s conducted the interview or focus group?	Procedures, Reflexivity, Appendix E	✓
2 Credentials	What were the researcher's credentials? *E.g. PhD, MD*	Reflexivity	✓
3 Occupation	What was their occupation at the time of the study?	Reflexivity	✓
4 Gender	Was the researcher male or female?	Reflexivity	✓
5 Experience and training	What experience or training did the researcher have?	Reflexivity, Appendix Q	✓
Relationship with participants			
6 Relationship established	Was a relationship established prior to study commencement?	Recruitment, Procedures	✓
7 Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	Procedures, Appendix D, Appendix E, Appendix F, Appendix G	✓

Number / Item	Guide and Description	Location	Checked by independent reviewer (CG)
8 Interview characteristics	What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	Reflexivity, Appendix Q, Appendix R	✓
	Domain 2: Study design		
Theoretical framework			
9 Methodological orientation and theory	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	Design, Data Analysis	✓
Participant selection			
10 Sampling	How were participants selected? e.g. purposive, convenience, consecutive, snowball	Sampling	✓
11 Method of approach	How were participants approached? e.g. face-to-face, telephone, mail, email	Recruitment, Procedures	✓
12 Sample size	How many participants were in the study?	Sample Size, Results	✓
13 Non-participation	How many people refused to participate or dropped out? Reasons?	Data Collection	✓
Setting			

Number / Item	Guide and Description	Location	Checked by independent reviewer (CG)
14 Setting of data collection	Where was the data collected? e.g. home, clinic, workplace	Semi-Structured Interview	✓
15 Presence of non-participants	Was anyone else present besides the participants and researchers?	Procedures, Semi-Structured Interview	✓
16 Description of sample	What are the important characteristics of the sample? e.g. demographic data, date	Recruitment, Table 1	✓
Data collection			
17 Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	Public and Participant Involvement, Sensitivity to Context, Appendix H	✓
18 Repeat interviews	Were repeat interviews carried out? If yes, how many?	-	×
19 Audio/visual recording	Did the research use audio or visual recording to collect the data?	Semi-Structured Interview	✓
20 Field notes	Were field notes made during and/or after the interview or focus group?	Procedures, Coherence and Transparency, Appendix R	✓
21 Duration	What was the duration of the interviews or focus group?	Semi-Structured Interview	✓

Number / Item	Guide and Description	Location	Checked by independent reviewer (CG)
22 Data saturation	Was data saturation discussed?	Sample Size (Information power)	✓
23 Transcripts returned	Were transcripts returned to participants for comment and/or correction?	-	×
	Domain 3: Analysis and findings		
Data analysis			
24 Number of data coders	How many data coders coded the data?	Coding and Analysis	✓
25 Description of the coding tree	Did authors provide a description of the coding tree?	Coding and Analysis, Appendix M	✓
26 Derivation of themes	Were themes identified in advance or derived from the data?	Coding and Analysis	✓
27 Software	What software, if applicable, was used to manage the data?	-	×
28 Participant checking	Did participants provide feedback on the findings?	-	×
Reporting			

Number / Item	Guide and Description	Location	Checked by independent reviewer (CG)
29 Quotations presented	Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? e.g. participant number	Results	✓
30 Data and findings consistent	Was there consistency between the data presented and the findings?	Results, Discussion	✓
31 Clarity of major themes	Were major themes clearly presented in the findings?	Results	✓
32 Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	Results, Discussion	✓

Appendix T

Additional Supporting Quotes

Theme 1: The Power of Maternity Healthcare Professionals

"I got allocated an actual midwife who was gonna see us through, she was lovely but because I was really upset with the first one" (Bhavna)

"You ask us, you make a big deal about the birth plan, has anyone actually read it". And then at that point they sent in a lovely Nurse and she read it and she talked to us about it" (Misha)

Sub-theme	Additional Participant quotes
Coerced into procedures / interventions	"I think that it was to scare me to doing what I was told" (Ameerah) "induction, nobody had even prepared me as such that it was gonna be TWICE as painful, you know, than natural birth, I just felt so unprepared I felt so deflated and defeated" (Nadiya) "they brought the doctor and the doctor was like 'oh yeah your baby's in danger' or something there was some really scary words that, that I remember, I remember knowing she's just like trying to scare me" (Deepika) "I truly felt like that's it's three thirty in the morning, like the next day and he was thinking to himself, this is one lady I can get off my list, cos she's almost there and this will just speed it up quicker and I could just strike her off my list" (about the doctor and using assisted birth methods) (Bhavna) "He just came in and he said to us, something like, you know, "we have to induce you and if you don't want our help you can just go home" (Consultant Doctor) (Misha) "I felt like I was being kind of forced, do you know, doing something that I didn't want, and I felt like just, just very scared, I think that's what I felt. I was scared that I was not gonna make it, baby was gonna pass away or what" (Naseema)
Undignified and violated	"I remember clearly saying to the Consultant "you do realise I am, I am a woman having a baby, I am not a baby having a baby, I don't expect you to treat em like a teenager". Not even a teenager should be treated like that, teenage pregnancies shouldn't be treated like that, you are a mother at that point, it doesn't matter what age you are, you are becoming a mother, you should be treated with dignity and respect not as a child (Misha) "I felt like I was just left to it and I was just a piece of body on this table and everybody could just do what they wanted to do. It was very, very scary." (Naseema)

Sub-theme	Additional Participant quotes
Ignored and dismissed	"so I don't have any recollection of my son until day 3 umm so when I went upstairs it was like 2pm, 3pm and 9, 10 the baby was still not latching on I had no milk for him because they knew I wanted to breastfeed, so the hospital I asked them to provide some milk I said can I have some milk for the baby and the nurse refused it, my son went from you can say 9pm up until 6am without a feed, his blood sugar dropped to 0.4 and he almost fell into a coma um they didn't pick up on this" (Ameerah) "you're made to feel like an idiot, cos… either they don't trust you, or they don't think you don't know what you're talking about or that's how I felt obviously" (Deepika) "I can't handle that pain along with the, the contractions but she just, I remember her giggling and then just doing it anyway" (Bhavna) "I would be so scared to do it again like scared about like doctor involvement, scared about not having my wishes listened to, and.. and things like that" (Bhavna) "It was only when I had to be transferred to the Delivery Suite where like I lost control. It was like all invisible and then everybody seemed to be ignoring, no one was saying what was going on and just, in terms of fear it just overtakes you and you think you're going to die." (Naseema)
Let down by the NHS	"I had to do it over the phone and I just felt like the whole thing was really her making excuses and… and I did make it in the end I forced her to say that they shouldn't have consented me at this time, you know what I did, on the consent form, when I signed it, I signed the time and I remember saying to her, have you got my notes there, can you see the time? Could you see I wrote the time, can you tell me what the time is, and you can see it was like 10 minutes before the baby was born, and I was like, why I don't think I should have been consented at this time do you think I was like fit? To consent? Like to just discuss all the risk and benefits and… I think that I needed her to say that to me.. even though I knew it I don't know why like I, I didn't feel like it did anything" (Deepika) "I had to go private again to a private gynaecologist to get my wound repaired and I had to have surgery for that and I think things like that it's like I've had to actually seek out private care, for surgery, for something you messed up" (Bhavna) "in my head I thought 'well maybe I can just complain about it later', but then that, you know, I never did because my feeling was 'actually, this is not going to get taken seriously', and again I was thinking about in the context of the pandemic, maybe that's what, you know, maybe they were short staffed, overwhelmed, so I felt like I was constantly making excuses for their behaviour but actually in hindsight that's not acceptable, that's not okay" (Mahira)

Theme 2: Loss of Connection

Sub-theme	Additional Participant quotes
Loss of reality during delivery	"they were they were giving me, injections you know like didn't know they were giving me, but you know, then I gave birth, then when it was my first son, so I didn't know what's like happening to me and then without any awareness that I'm going through and I give… you know birth" (Maya) "the going under general anaesthetic and then to waking up.. alone ..with no bump, with no baby… with no pain… and nobody around… is one of the POIGNANT times of my. Entire. Life. Ever" (Nadiya) "I was still hazed, I was still a little bit out of it and I was, I wasn't necessarily in pain but I was just really out of it and then I could see that my baby was next to me but I was like "well whose helping me to look after my baby" at this point." (Mahira)
Loss of bonding experiences	"it was it was like a loss it was so heart wrenching cos I just wanted to be near my baby and I think it was like a really maternal instinct, it was like I want to be with my baby now like why are you keeping us apart?" (Ameerah) "My baby being snatched away, obviously as soon as it was born, not having an opportunity to look at my baby, my baby being rushed off to strangers" (Naseema)
Loss of partnership	"my husband had to go home because they didn't allow partners there" (post-delivery) (Ameerah) "when you are giving birth, so that, and that, there is no body with you and you are dealing with yourself, alone" (Maya) "and I remember them prizing my hand away from him to take me into the room to do the check" (Bhavna) "That was very scary because I thought to myself "anything can happen in that time, I'm just here by myself", and sometimes you just need someone to comfort you, because you are just getting to know these strangers who are going to be looking after you for the whole shift kind of thing. Yeah, with the Covid situation was out of control because there was nothing they could have done. It did add to a bit of fear as well." (Naseema) "they'd taken me to the Recovery Ward and then that's when they said to my husband he now has to leave again. So he was only there for literally just the birth and then he had to go and that felt really, really difficult" (Mahira)

Theme 3: Disentangling discrimination

Sub-theme	Additional Participant quotes
-	"um I feel like I was treated like a 'young stupid Asian girl that's gone and got knocked up after marriage'" (Ameerah) "from my observations of from witnessing and experiencing how my mum was treated is probably why I think there is such a clear distinction between the… I hate the word Westernised but I don't know what a better word is, um, westernised and non-westernised women" (Nadiya) "As soon as I entered that environment downstairs in the Delivery Suite, I just got, like no one explained to me, no one introduced themselves to me, jus the normal etiquette, just because obviously I was wearing a head scarf" (Naseema) "I remember getting on to the ward and just not having any support whatsoever from staff members, call out for help and buzzing for help and just not having anybody respond and it just felt like I wasn't taken seriously with whatever concerns I did have, but I distinctively remember that the other kind of two Caucasian women or white British women, it seems like they had a lot more support and staff were being very responsive to them, yeah." (Mahira) "Because there were no explicit remarks or things being said or done it felt like I just couldn't raise that, I couldn't raise that and if I did, I would be somebody who was just being difficult is how I imagined I would be perceived." (Mahira)

Theme 4: Pervasive cultural stigma in motherhood

Sub-theme	Additional Participant quotes
Keeping up the illusion of coping	just say, 'oh it's happened to every woman' 'you don't need the support at that time' things like that in our community the woman's says that you know, and they won't let you go out, you know, seek help (Maya) "if I was struggling to bond, I'd absolutely seek help from a professional but I never discussed that with a.. my.. household, because of the stigma associated of 'you're a mother, why can't you bond with your child what sort of mother are you'" (Nadiya)
The shame of needing emotional support	"they said it was not going to be easy anyway, getting into the counselling. They said "I will put you down" and "these are the support networks, these are the sites that you could access", but nothing was very helpful at that point, you know when you kind of need it the most." (Naseema) "I don't know why there is a big part of me that still has that stigma of not wanting the help and support." (Mahira)