The University Of Sheffield.

Being a 'professional friend': an exploration of the functioning and impacts of health navigation to improve access to healthcare for migrant women

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Abstract

Migrant women often experience poorer health than other populations, in part due to inequalities in healthcare access. Health navigation is a person-centred intervention to address barriers to accessing healthcare. This research project sought to characterise health navigation as an intervention for migrant women, elucidate its theoretical mechanisms, explore the impact of health navigators and their relationships with migrant women, as well as develop a model of how health navigation can improve access to healthcare. A systematic integrative review revealed the complexity of navigation for migrant women in terms of its roles, processes and characteristics. However, there were significant gaps in knowledge of perceptions of health navigation in a UK context, of the role of shared characteristics and experiences between health navigators and migrant women, and of the intervention's theoretical mechanisms.

To address these gaps, a multiple, instrumental case study was carried out at three navigation programmes within two contrasting organisational contexts in England. Semi-structured interviews (n = 31) were conducted with migrant women service users, health navigators, healthcare professionals, and social support professionals; additionally, organisational documents (n = 11) were examined. Data from interviews and documents were analysed using reflexive thematic analysis. Health navigation was found to be diverse, flexible and needs-driven, ultimately increasing service users' knowledge and promoting their empowerment - although structural factors shaped their degree of success. Health navigation was also perceived to have increased access to social and community services and reduced migrant women's social isolation, while delivering a range of benefits and challenges for other stakeholders. Successful delivery of health navigation for migrant women required a trusting and nuanced relationship with a female health navigator. While challenges remain in delivering health navigation, there is scope for improved policies and practices which can ensure greater sustainability of health navigation programmes while advocating for structural change.

Declaration

I, the author, confirm that the Thesis is my own work. I am aware of the University's Guidance on the Use of Unfair Means (www.sheffield.ac.uk/ssid/unfair-means). This work has not been previously been presented for an award at this, or any other, university.

Conference presentations arising from this thesis:

Oral presentations

"I needed somebody like her in my life": migrant women's experiences and perceptions of health navigation services to increase access to maternity care in the UK. Society for Social Medicine & Population Health Annual Scientific Meeting, Online, 11th September 2020.

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We stand on the shoulders of giants.

Table of contents

Abstract 2

Declaration 3

Acknowledgements 4

List of tables 8

List of figures 9

List of acronyms 10

Section 1: Introduction, background and rationale 12

Chapter 1: Thesis overview 12

Chapter 2: Understanding migrant women's health and the role of health navigation 14

2.1 - Introduction 14

2.2 – Motivation for study 14

2.3 - Background on migration 15

2.4 - Migration and health 16

2.5 - Migrant women's maternal health in focus 21

2.6 - Access to healthcare: Candidacy as a framework 24

2.7 - Service adaptations to enable access 27

2.8 - Health navigation 30

2.9 - Summary 40

Section 2: Does health navigation increase access to healthcare for migrant women? A systematic integrative review 42

Chapter 3: Literature review methods 43

3.1 - Rationale and review questions 43

3.2 - Methods 45

3.3 - Conclusion 52

Chapter 4: Literature review findings and discussion 53

4.1- Study selection 52

4.2 - Study quality appraisal 55

4.3 - Study characteristics 55

4.4 - Characterising health navigation 56

4.5 - Roles and functions of health navigation 68

4.6 - Theoretical basis of health navigation 70

4.7 - Outcomes 71
4.8 - Perceptions of health navigation 74
4.9 - Discussion 77
4.10 - Concluding thoughts 84

Section 3: Primary research **87**
Chapter 5: Methodology 88
5.1 - Introduction 89
5.2 - Methodology 90
5.3 – Ethical considerations 113
Chapter 6: Characterising health navigation interventions for migrant women 115
6.1 - Introduction 113
6.2 - Characteristics of participants 119
6.3 - Background to the case study services 123
6.4 - Organisational management of health navigation 133
6.5 - Aims of health navigation programmes 135
6.6 - Conclusion 147
Chapter 7 - Experiencing navigation: Migrant women's narratives 148
7.1 - Introduction 148
7.2 - Pre-navigational needs 148
7.3 – How have migrant women experienced health navigation? 153
7.4 - Perceived benefits for service users 156
7.5 – Conclusion 162
Chapter 8 - Experiencing navigation: Navigator narratives 163
8.1 - Introduction 163
8.2 – How have health navigators experienced their role? 164
8.3 - Perceived benefits for navigators 180
8.4 - Conclusion 183
Chapter 9: Navigational relationships and shared characteristics 184
9.1 - Introduction 184
9.2 - Relationships between migrant women and health navigators 184
9.3 - Shared characteristics and experiences between navigators and service users 190
9.4 - Universality: how relevant are shared characteristics and experiences to the functioning of health navigation? 200
9.5 - Conclusion 201

Chapter 10: Theoretical mechanisms of health navigation: applying the Candidacy framework 202
10.1 - Introduction 202
10.2 - Identification of candidacy 203
10.3 - Navigation 204
10.4 - Permeability of services 206
10.5 - Appearance at health services 207
10.6 - Adjudication by healthcare professionals 209
10.7 - Offers and resistance to services 212
10.8 - Operating conditions and the local production of candidacy 213
10.9 - Applying Candidacy to a logic model of health navigation for migrant women 215
10.10 - Conclusion 217

Section 4: Discussion and conclusions **219**
Chapter 11: Discussion 220
11.1 – Summary of key findings 220
11.2 - How do the field research findings add to the integrative systematic review findings? 221
11.3 - What were the strengths of this project? 232
11.4 - What were the limitations of this project? 234
11.5 - Implications for research, practice and policy 237
11.6 - Conclusion 241

References **244**

Appendices **277**
Appendix A 277
Appendix B 320

List of tables

Table 1: Overview of the domains contained within the Candidacy framework (Dixon-Woods et al., 2005)

Table 2: Principles of health navigation, as described by Freeman & Rodriguez (2011)

Table 3: Research questions for integrative review

Table 4: Inclusion and exclusion criteria for the final selection of studies on navigation for migrant women to be included in the integrative review

Table 5: Overview of the barriers to accessing healthcare experienced by participants described in each included study

Table 6: Representation of different occupations included in the literature, with their associated navigational role

Table 7: Overview of the two sites included in case study

Table 8: Example coding of a document (D1 - mother companions' handbook, Project MAMA)

Table 9: Example coding of an interview (N7 - navigator 7 at Haamla Service)

Table 10: Summary of documents included in the analysis

Table 11: Characteristics of interview participants, listed by group and study site

Table 12: Overview of typology of navigation interventions, mapping navigational roles to the functional domains of practical, administrative and educational support

Table 13: Overview of typology of navigation interventions, mapping navigational roles to the functional domains of emotional, social, advocational and cultural support

List of figures

Figure 1: Graphical representation of navigation's historical points of intervention along the clinical care continuum, with a comparison to current points of intervention

Figure 2: PRISMA flow chart of search strategy

Figure 3: Typology of health navigation devised by author, mapping navigational roles to their associated functional domains

Figure 4: Dynamic stages of the primary research at each study site

Figure 5: Proposed logic model on health navigation to improve access to healthcare for migrant women

List of acronyms

CASP - Critical Appraisal Skills Programme

CEDAW - Committee on the Elimination of Discrimination Against Women

EEA - European Economic Area

EU - European Union

GP - General Practitioner

MC - Mother Companion

MSW - Maternity Support Worker

NHS - National Health Service

ScHARR - School of Health and Related Research, University of Sheffield

UK - United Kingdom of Great Britain and Northern Ireland

UKBA - United Kingdom Border Agency

USA - United States of America

Section 1: Introduction, background and rationale

The first Section of this thesis is designed to offer an introduction on how this thesis is structured, in order to guide the reader, as well as the necessary background to migrant women's health outcomes and access to healthcare and the past and current narratives surrounding health navigation as a promising intervention. This seeks to provide a rationale for why this topic of research is of importance for study.

Chapter 1: Thesis overview

Migrant women experience poorer health outcomes than other populations, in part due to having poorer access to healthcare. Health navigation has been presented as a method of connecting women to healthcare, while targeting their barriers to access on an individualised basis. This doctoral project sought to explore health navigation for migrant women, and had the following overarching research objectives:

*1. To define the concept of health navigation as an intervention, its definitions and characteristics, when implemented for migrant women (addressed through **RQ1 of review, plus primary research**)*

*2. To elucidate the theoretical mechanisms which underpin health navigation when implemented for migrant women (addressed through **RQ2 of review, plus primary research**)*

*3. To assess the impact and effectiveness of health navigators, and explore their relationships with migrant women through navigation (addressed through **RQ3 of review, plus primary research**)*

*4. To develop a model of how health navigation can improve access to healthcare for migrant women (addressed through combination of **all findings from review and from primary research**)*

This thesis is divided into several sections. Section 1 (**Chapters 1-2**) presents an introduction to migrant women's health outcomes and access to healthcare, and health navigation as an

intervention, and provides a rationale for this focus. Section 2 (**Chapters 3-4**) offers a review of the literature in the form of a systematic integrative review, revealing the complexity of navigation in terms of its roles, processes and characteristics, but also offered key gaps in knowledge remain regarding its implementation in a UK context, its theoretical basis, as well as the role of shared characteristics and experiences between navigators and the women they serve in navigational interventions.

Section 3 (**Chapters 5-10**) is the main body of this thesis which presents the methodology and findings of a research study built on the conclusions of the review. The following research questions drove this Section:

How does health navigation improve access to healthcare for migrant women, when implemented as an intervention?

[a] How do navigation interventions operate in practice when used for migrant women who require healthcare (including maternity care), and what theoretical mechanisms underpin their operation?

[b] How are navigation interventions perceived and experienced in practice?

[c] What is the role of shared characteristics and experiences between navigators and migrant women, in terms of the functioning of navigation?

The primary research detailed in this Section centred on a multiple, instrumental case study exploring the characteristics and functionality of three health navigation interventions based at two case study sites in two different English cities. This study involved individual semi-structured interviews conducted with four different stakeholder groups, as well as the collection and analysis of relevant documents providing information on these interventions.

Finally, Section 4 (**Chapter 11**) concludes this thesis through discussion and contextualisation of the findings of both the review and the primary research by addressing each research objective in turn. This Section also includes an outlining of the strengths and limitations of the study, and its potential implications for research, policy and practice.

Chapter 2: Understanding migrant women's health and the role of health navigation

2.1 - Introduction

This Chapter begins by explaining the primary motivation for conducting this study, before introducing the background to health navigation as a tool to increase access to healthcare for migrant women. It begins with some background on migration, explores definitions of migration and the relationship between migration and health. This section also offers a summary of the intersecting social constructs of gender, race/ethnicity and class, which are thought to contribute towards migrant women's poorer access to health care and unfavourable health outcomes when compared to native-born populations.

The chapter then explores access to healthcare - including the ways in which it may be theorised through the lens of Candidacy - and the underlying philosophies driving attempts to adapt health services to improve access to healthcare for migrant women are examined. This, then, culminates in a detailed outline of health navigation as a promising intervention which can be implemented to increase access to healthcare for migrant women. The goal of this Chapter is to develop a rationale for conducting a review into the extant literature and, ultimately, primary research to address identified gaps in knowledge.

2.2 - Motivation for study

My personal motivation for conducting this study was to investigate the utility of individualised interventions purported to improve access to healthcare, as well as to explore the social, cultural, economic and political factors which continually shape the ability of marginalised populations - including vulnerable migrants - to access healthcare. This was preceded by a period of working on migration and access to healthcare issues within European civil society organisations, through which I developed an interest in migration and health research. Additionally, having previously only trained in quantitative methods, I had a strong desire to challenge myself by completing a sociologically-focused doctoral degree - which required the development of a qualitative research skillset.

2.3 - Background on migration

Human migration is a feature of contemporary society across the world. According to the International Organization for Migration (2019), 281 million people worldwide are currently residing outside of their country of birth. In 2016, 36.9 million people born outside of the European Union [EU-28] lived in an EU Member State and constituted 7.5% of the population of the EU-28 (Eurostat, 2018) while, in 2017, there were an estimated 9.4 million UK residents who were born outside of the UK (Office for National Statistics, 2018).

A migrant can be defined in many ways, based on place of birth, citizenship, parental place of birth and/or citizenship, or on their intended length of stay in a destination region (The Migration Observatory, 2017). The term 'migrant' is, therefore, problematic. According to the International Organisation for Migration (2018), a migrant is a person who "is moving or has moved across an international border or within a State away from his/her habitual place of residence, regardless of (1) the person's legal status; (2) whether the movement is voluntary or involuntary; (3) what the causes for the movement are; or (4) what the length of the stay is".

This presents some complexities with regards to public discourse and public policy on migration, since whether the individual in question is subject to immigration-related policies in a given context may depend on the definition of 'migrant' being applied. One example of this could be a foreign-born, British citizen who is resident in the UK; their entitlement to social provisions such as housing, healthcare and state benefits in the UK may not be limited by immigration controls, yet they could - in theory - be defined as being a migrant. The term 'migrant' refers to a vastly heterogeneous group, including refugees, people seeking asylum, trafficked persons, internally displaced persons, stateless persons, undocumented or 'irregular' migrants, migrant workers (whether deemed 'high skilled' or 'low skilled'), internal migrants and international students. This thesis adopts the International Organisation for Migration definition of a 'migrant', due to its accommodation of different migratory circumstances; this was an important consideration in light of the inclusive eligibility criteria applied in the literature review (**Chapter 3**) to capture international and internal migrants.

2.4 - Migration and health

In recent years, there has been a growing research interest with regard to the risks migration poses to public health (Abubakar et al., 2016; Abubakar et al., 2018; Rechel et al., 2013; Wickramage et al., 2018), as well as the policy initiatives required to target such risks at every stage of the migratory journey (Benach et al., 2011). Existing literature on migration and health draws comparisons between the health of migrants and that of non-migrants, predominantly in a Global North context. Much of this literature centres on the health inequalities some migrant groups experience. Achieving health equity - by way of action on such health inequalities - has been noted as a key indicator of health system performance (Kruk and Freedman, 2008; Perić, Hofmarcher and Simon, 2018; Smith et al., 2018).

2.4.1 - Understanding the intersection of migration and health

Migration may be permanent, temporary, circular or seasonal in nature. Although migration, social and health-related discourses have traditionally framed migration as being a singular, permanent relocation from a location of origin to a destination, the reality is more complex, and with a variety of health implications. In their framework, Zimmerman, Kiss and Hossein (2011) illustrated five different phases of migration, in which the health of migrants may be impacted. The first is a 'pre-departure' phase in which biological, social, environmental, personal and political factors can serve as 'push' factors, shaping individuals' decisions to migrate, as well as impacting on their health status. The authors note that this is a stage during which many forced migrants initially experience trauma, which also has longer-term impacts on psychological health and wellbeing.

The ‘travel’ phase refers to the ways in which the health of migrating people may be affected by the conditions they experience in transit, which could include environmental dangers, travel and border restrictions, and exposure to violence and exploitation. It should be noted, however, that some migrants travel in lower-risk circumstances, including international students and high-income migrant workers. Migrants then arrive at a new location with the intention of residing there permanently or temporarily, during the ‘destination’ phase. The study authors note that the majority of migration and health research focuses on this phase, having outlined the risks to migrants’ health posed by social, economic and legal factors. A fourth, ‘interception' phase refers to a period of detainment in detention centres or refugee camps imposed upon migrants in particularly vulnerable circumstances - including undocumented migrants, asylum seekers and trafficked persons - whereby punitive immigration policies present significant risks to migrants’ mental and physical health. The fifth and final phase is the ‘return’ phase, which entails migrants’ permanent or temporary return to their place of origin. This phase is defined by an accumulation of exposures to health risks throughout the preceding phases of migration, as well as the prospect of returning to a location where any resulting health needs cannot be met, both of which impact on returned migrants’ physical and mental health. This framework is useful for the conceptualisation of the health risks to which migrants may be exposed, as well as the variation in exposure to health risks across different migrant populations based on their social, economic and legal circumstances - offering helpful background on why some groups of migrant women may have particular health and social needs.

2.4.2 - Health outcomes across migrant groups

In the arena of migration and health, phenomena related to the morbidity and mortality of migrants have been discussed extensively, with much contrasting evidence on health outcomes across migrant groups. There are broadly two principal groups of literature. Firstly, there are studies which have focused on the 'healthy migrant effect' - an epidemiological concept which suggests that migrants may actually have better health outcomes than their native-born counterparts (Fennelly, 2007) - despite many originating from regions in which mortality and morbidity rates are higher than the regions to which they are migrating. This 'effect' was initially observed in the USA, with migrants generally having better infant, child and adult health, lower disability and mortality rates, lower risk of hospitalisation and increased life expectancy compared to USA-born populations (Muenning and Fahs, 2002). This is in spite of their reportedly having significantly poorer health insurance coverage and access to care for both children and adults (Singh, Rodriguez-Lainz and Kogan, 2013).

A second body of literature has explored the longer-term health effects of migration, primarily through longitudinal studies. Jatrana, Richardson and Pasupuleti (2017) found that non-English speaking migrants to Australia experienced a long-term health disadvantage in relation to physical health, mental health and self-assessed health, when compared to native-born populations. Elsewhere, another study based in Australia reported that refugees remained in poor general health three years after being granted refugee status in the country; female gender was also found to be a risk factor for poor health (Dowling et al., 2019). Similar observations were made in a European context. In the UK, refugees reported that emotional distress such as worry, stress and depression persisted 21 months after being granted refugee status, with the study authors suggesting that this contributed towards poorer health outcomes (James, Iyer and Webb, 2019). Lastly, there has also been evidence to suggest that refugees and family-reunited migrants in Denmark experienced increased rates of stroke, ischaemic heart disease and diabetes in the years following their arrival (Norredam et al., 2014).

The ‘healthy migrant effect’ theory should, therefore, be taken with caution. While it posits that migrants may initially experience favourable health status on arrival, it does not account for the possible emergence of chronic diseases over a longer timeframe. Equally, the ‘healthy migrant effect’ may not apply to particularly vulnerable groups of migrants who may have different health experiences to other migrant groups upon arrival in a new region (The Migration Observatory, 2014). The ‘healthy migrant effect’ cannot, therefore, be considered as evidence of health equity (Razum, Zeeb and Rohrmann, 2000).

2.4.3 - The impact of race, ethnicity, gender and class on migrants’ health

In addition to factors linked directly to their migration journey, the health of migrant groups is also shaped by their gender, class, and race/ethnicity. The population of focus of this research will be migrant women living outside of the region in which they were born. The barriers faced by some groups of migrant women in attempting to access care exist due to the fact that their “physical, economic and social well-being” is determined by gender, as well as “intersecting forms of discrimination linked to ethnicity, race and poverty” (Smith et al., 2016). The Committee on the Elimination of Discrimination Against Women (CEDAW) - part of the Office of the United Nations High Commissioner for Human Rights - declared that “to understand the specific ways in which women are impacted, female migration should be studied from the perspective of gender inequality, traditional female roles, a gendered labour market, the universal prevalence of gender-based violence and the worldwide feminisation of poverty and labour migration” (CEDAW Committee, 2008). While migrant women are not necessarily a vulnerable group purely based on their collective sex or gender identity, they can experience heightened vulnerability on account of their sex/gender identity when exposed to employment-related human rights violations as low-income migrant workers (International Organization for Migration, 2009), and gender-based violence, exploitation and abuse during or after migration (Barbara et al. 2017; Jayaweera, 2016). Female sex and female gender identity have implications for health risks, responses and access to healthcare, yet other social identifiers intersect with sex/gender to create particularly vulnerable circumstances for some groups of migrant women.

The concepts of race and ethnicity are both contested terms which must be defined for the purposes of this thesis. Johnson et al., (2019) define 'race' as "the group a person belongs to as a result of a mix of physical features such as skin colour and hair texture, which reflect ancestry and geographical origins, historically as identified by others or, increasingly, as self-identified", while defining 'ethnicity' as a "social group a person belongs to and either identifies with or is identified with by others, as a result of a mix of cultural and other factors including language, diet, religion, ancestry and physical features". Both 'race' and 'ethnicity' are social markers with social and political implications, and both are socially-constructed without meaningful biological basis (Bhopal, 2004). For this reason, 'race' and 'ethnicity' are frequently used interchangeably in research, policy, practice and in common parlance. In light of this, 'race/ethnicity' will be referred to throughout this thesis, in an attempt to capture the varied ways in which these concepts have been framed within existing literature, policies, health interventions, as well as the varied ways in which study participants may define these concepts.

Racialisation refers to the historical, societal and political processes through which racial/ethnic categorisation is applied to individuals and communities, based on perceived physical difference (Cashmore, 1996; Keskinen and Andreassen, 2017). The racialisation of migrant women has also led to their poorer access to healthcare, and poorer health outcomes. In a UK context, maternal mortality amongst Black women has been found to be more than four times the rate of White women, with women from Asian backgrounds facing rates double that of White women (Knight et al., 2020). Black/Black British and Asian/Asian British babies are twice as likely to be stillborn or die neonatally when compared to White British babies (Draper et al., 2020). In addition to these examples, migrant women remain at heightened risk of poor mental health outcomes - particularly those associated with perinatal mental health (Fellmeth, Fazel and Plugge, 2017). Macro-level structural factors such as deprivation and racism within the health system (Younis & Jadhav, 2020), as well as communication and linguistic barriers (Draper et al., 2020; Knight et al., 2020), are examples of factors which have impacted on migrant women's access to services.

Migrant women - especially those engaged in sex work - experience a form of 'othering'. This refers to the construction of minoritised identities in relation to the 'mainstream' (Weis, 1995), which can reinforce and reproduce power relations, often leading to marginalisation (Fine, 1994). Some groups of migrant women are 'othered' through sexist stereotypes grounded primarily in race/ethnicity, including the general social construction of racialised women as being exotic and domitable, although women of different racial/ethnic backgrounds have been subject to different stereotypes. This concept has been referred to as 'ethnosexuality', which makes reference to the inherent power imbalances within "symbolic and physical sensual spaces where sexual imaginings and sexual contact occur between members of different racial, ethnic and national groups", as devised by Nagel (2003). Such othering is compounded further by the politics of class, in that increased international trade via globalisation has widened global economic inequality and created the economic conditions for women in the Global South to seek migration to the Global North in pursuit of opportunity and survival (Williamson, 2017). Gender-based, racial and ethnic stereotypes - as well as the economic realities of women predominantly in the Global South - drive the huge demand for Black, Asian and indigenous women within the Global North sex and human trafficking industries, rendering them especially vulnerable to exploitation and violence (Chong, 2014).

2.5 - Migrant women's maternal health in focus

Evidence shows that migrant women can experience poorer health outcomes compared to native-born women with regards to maternal health. Several systematic reviews have identified that asylum-seeking women, refugee women and undocumented women experience poorer outcomes with regards to maternal mortality, severe maternal morbidity, mental health, and congenital and birth anomalies compared to native-born women (Bollini et al., 2019; Gieles et al., 2019; Heslehurst et al., 2018). In a systemic review of systematic reviews, Heslehurst et al. (2018) further outlined the macro-level, structural barriers faced by asylum seekers and refugees seeking perinatal care, including being of lower socio-economic status, facing unemployment and unsafe housing, and facing discrimination while living as a visible minority. It should be noted, however, that this review of reviews was unable to analyse these groups separately - despite refugees' and asylum seekers' contrasting legal circumstances, as well as national and racial/ethnic backgrounds - due to lack of differentiation between these groups within the included reviews.

It is important to note, however, that maternal mortality and morbidity may vary between groups of migrant women in different countries, as risk factors are unevenly distributed among them (van den Akker & van Roosmalen, 2015). Bollini et al. (2019) identified that the risks of unfavourable pregnancy outcomes were significantly lower in European countries which were observed as being more socially integrated; this was operationalised as the rate of migrants' naturalisation - namely, in Sweden, the Netherlands, Norway, Denmark and Belgium. This study highlights the fact that increased risk of experiencing negative health outcomes can be linked to poverty and deprivation, but also to exclusion from social and economic participation.

Migrant women in European countries - including refugee women, asylum-seeking women, undocumented women and uninsured migrant women - have been found to experience a low level of adequacy and quality of maternity care linked to the challenges they face in accessing care. This can range from difficulties communicating with healthcare professionals and refused registration at GP or primary care facilities, to discrimination and lack of knowledge of healthcare entitlements (Fair et al., 2020; Heslehurst et al., 2018; Khanlou et al., 2017; McKnight, Goodwin & Kenyon, 2019; Small et al., 2014). In addition to this, 65.9% of pregnant migrant women (who, in this case, were largely undocumented migrants, refugees, asylum-seekers and refused asylum-seekers) attending one of Médecins du Monde's European clinics had no access to antenatal healthcare previously, and 42.8% of pregnant women accessed healthcare later than recommended (Chauvin et al., 2014). A lack of access to timely antenatal care can result in poorer maternal health outcomes, increased use of emergency health services and higher costs to the health system (Di Mario et al., 2005). Furthermore, delays in migrant women accessing antenatal healthcare can lead to failure of service providers to detect communicable diseases such as HIV, hepatitis B and syphilis, and prevent their onward transmission (Shortall et al., 2016).

In the UK specifically, maternity care provision for migrant women has been a focal point of public discourse surrounding migrants' entitlement to healthcare. The UK has a residence-based healthcare system and applies a test to determine if migrant women are entitled to access maternity care free of cost. The issuance of out-of-pocket charges (albeit, not upfront) to some migrant women seeking access to antenatal care has proven deeply problematic - as well as a recent change in legislation to begin charging for secondary and community-based maternity care (UK Department of Health & Social Care, 2018). Pregnant migrant women without documentation - including refused asylum-seekers and visa overstayers - have been continually deterred from accessing timely maternity care due to its prohibitive cost, while simultaneously being further marginalised through lacking access to employment, state benefits, housing and other means of social participation (Feldman, 2020; Maternity Action, 2021). Research has been conducted into the effects of charging migrant women for accessing maternity care, finding that the prospect of charging has had emotional impacts on migrant women (Feldman, 2018), created ethical dilemmas for midwives and eroded trust between them and their patients (Feldman, Hardwick & Malzoni, 2019), and increased the workload of doctors (British Medical Association, 2019).

Across geographical contexts, it has been widely acknowledged that undocumented migrants - and other migrant groups - routinely face barriers to accessing healthcare in their destination region (Castañeda et al., 2015; Davies, Basten and Frattini, 2009; Marmot et al., 2012). These individual and service-level barriers can include language and communication limitations, differences in cultural values, financial and logistical issues and lack of familiarity with the destination region's health system, and can materialise as a consequence of health providers' lack of ability to fully adapt their services to cater to the needs of the increasingly diverse patient populations they serve. Cultural differences (and expectations) between migrant patients and healthcare professionals working within the health system may also pose a challenge (Suphanchaimat et al., 2015). These issues can be particularly pervasive for migrant women who are very new arrivals, are undocumented, are refused asylum-seekers, or are currently - or have previously been - trafficked persons (Westwood et al., 2016).

2.6 - Access to healthcare: Candidacy as a framework

Access to healthcare for all - including migrant women - is a crucial domain of high-quality health systems across the world, commonly defined as “access to a service, a provider or an institution”, which represents the “opportunity or ease with which consumers or communities are able to use appropriate services in proportion to their needs” (Levesque et al., 2013). Consideration of the range of frameworks describing and conceptualising access to healthcare is necessary, in order to gain a fuller understanding of this phenomenon. Candidacy (Dixon-Woods et al., 2005) was selected as being a conceptual framework of particular utility in understanding migrant women’s access to healthcare, due to its basis in access to healthcare for populations experiencing vulnerability.

Candidacy is a framework for understanding how patients' access to healthcare is determined through a process of joint negotiation between patients and health providers. It considers the processes of achieving access from the point at which a patient identifies a need for healthcare through to their receipt of a healthcare service, and takes into account the numerous structural, service and individual-level factors that can act as barriers to access. Applied to migrant women’s experiences, these barriers may include cultural and linguistic factors, discrimination, familiarity with and knowledge of the system, a financial burden associated with seeking care, or an imbalance of power between health providers (including doctors) and migrant women patients. Obtaining - or achieving - candidacy is conceptualized as a dynamic process of negotiation, since - over a given time period - patient candidacy may be challenged or may be enhanced. For example, social circumstances may improve, and personal experiences of service utilisation may build confidence, system knowledge and health literacy; all of which may enhance access.

The origins of the Candidacy framework lie in Dixon-Woods et al. (2005)’s critical interpretative review of qualitative and quantitative literature on access to healthcare for 'vulnerable groups’. The review aimed to understand the impact of barriers that these groups routinely face, despite the UK health system being largely free at the point of access. Dixon-Woods et al. (2005) contend that “accomplishing access to healthcare requires considerable work on the part of users, and the amount, difficulty, and complexity of that work may operate as barriers to receipt of care. The social patterning of perceptions of health and health services, and a lack of alignment between the priorities and competencies of disadvantaged people and the organization of health services, conspire to create vulnerabilities”.

Importantly, Koehn (2009) state that the model recognises “the operation of symbolic power in relationships” between individuals seeking to achieve access to healthcare and healthcare professionals and other providers in positions of relative power who must be negotiated with in order to have access to a desired service granted”. The model presents the process of achieving candidacy for a service in multiple stages (Dixon-Woods et al., 2005). This is outlined in **Table 1**.

Table 1: Overview of the domains contained within the Candidacy framework (Dixon-Woods et al., 2005)

Domain	Description
Identification of Candidacy	An individual's perception of self as a candidate for accessing a service
Navigation of services	An individual knowing how to contact appropriate services in line with own candidacy
Permeability of services	Inherent complexity of services, as well as cultural alignment between a provider and an individual patient
Appearing at services and asserting candidacy	Asserting claim to candidacy within the context of a clinical encounter
Adjudication by professionals	Validation of candidacy by health providers
Offers of / resistance to services	Services offered in response to claim of candidacy may be deemed/perceived as inappropriate by individual, and ultimately rejected
Operating conditions and local production of candidacy	Incorporating factors influencing future service provision as well as future clinical encounters between users and providers over time

Some limitations of the original Candidacy framework have been highlighted in subsequent literature, leading to refinements that are especially relevant in the context of migrant women seeking healthcare. According to Mackenzie et al. (2013), the original Candidacy framework did not account for the multiple identities, or social locations, that an individual occupies simultaneously when seeking access; this can lead to multiple 'candidacies' which can either compete or conflict with one another. A limitation of particular importance is that the original framework did not account for the impact of macro and meso-level factors on an individual's ability to identify themselves as a candidate for a service; such policies could either lead to one's candidacy being 'depressed' or 'refuted'. Taken together, the Candidacy framework and its proposed refinements provide a useful conceptual tool with which to investigate the individual, interpersonal, structural, cultural, organisational and political forces that shape access to healthcare. Candidacy will be applied to the findings of the primary research component of this project through exploring the impact of the health navigation interventions at the case study sites on migrant women's ability to access healthcare.

2.7 - Service adaptations to enable access

Having poor access to primary, secondary and tertiary healthcare as a result of individual, interpersonal, structural, cultural, organisational or political barriers can lead to significant unmet health needs and could contribute to a heightened burden of physical and mental ill-health (Shommu et al., 2016). In responding to these barriers, designers of health services have made attempts to adapt health services in order to increase access to healthcare for migrants.

2.7.1 - Background on service adaptation, cultural competence and cultural safety

Across different geographical contexts, service adaptation may take many forms and be implemented at different levels in order to increase sensitivity to patients' cultural diversity. Efforts have included individual-level adaptations such as producing patient materials in different languages (Healey et al., 2017), as well as institutional-level adaptations, such as hiring telephone interpreters to aid communication between healthcare professionals and their patients (Robertshaw et al., 2017) or implementing recruitment policies to increase cultural, linguistic, racial and ethnic diversity within the health workforce (Biscoff, 2003). Adaptation also extends to system-level change, whereby interventions are put in place within the health system to offer workforce-wide training and accreditation to increase healthcare professionals' knowledge and awareness of diversity, barriers to migrant health and culturally-sensitive practice (Brach and Fraserirector, 2000). Within such interventions, challenges persist in terms of the levels of quality achieved and material resources available, particularly in the UK context (Leeds Clinical Commissioning Group, 2015; Such et al., 2017).

Adaptations of health interventions reflect attempts to enhance cultural competence and cultural safety. Cultural competency is a contested concept and has been defined in multiple ways. Cross et al. (1989) originally defined it as "a set of congruent behaviours, attitudes, and policies that come together in a system, agency or amongst professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations". However, more recent understandings highlight the necessity for implementation of culturally competent actions from individual level to institutional and structural levels. According to Betancourt et al. (2003), cultural competency "acknowledges and incorporates—at all levels—the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs". Cultural competency has, however, been viewed as inherently limiting, given that it assumes a degree of homogeneity within a population, which could lead to over-generalisation, 'othering' of migrant populations and the reinforcement of racist stereotypes which may marginalise them further (Pon, 2009). One could view this as a fair critique; mainstream cultural competency training does often frame the culture of the patient as the 'problem' that needs to be understood and as being the barrier that should be overcome.

Cultural safety is a concept which goes beyond cultural competency, in that the latter refers to the attitudes, knowledge, skills and policies of providers used in adapting interventions, while the former recognises the bias caused by providers' own cultures and/or attitudes influencing their practices. Cultural safety highlights "power imbalances, institutional discrimination, colonisation and colonial relationships as they apply to health care'' (National Aboriginal Health Organization, 2008), and articulating how social, economic, political and cultural realities create power differentials, lead to health inequalities and impact on encounters between healthcare professionals (and other providers) and patients. This is of significant importance, given the existence of institutional racism within health systems (Allen et al., 2004; Likupe and Archibong, 2013; Nazroo, Bhui and Rhodes, 2020).

Some scholars contend that cultural competency and cultural safety remain distinct concepts, and that achieving cultural safety requires a full paradigm shift (Curtis et al., 2019). Elsewhere, however, it has been proposed that the long-term practice of cultural competency can eventually lead to the achievement of culturally safe care (Gladman, Ryder and Walters, 2015; National Aboriginal Health Organization, 2008). Cultural safety is potentially more confronting for health professionals and the institutions to which they belong, and has been perceived as being more difficult to implement (Johnstone and Kanitsaki, 2007). However, I would argue that cultural safety is better placed than cultural competency to deliver service adaptation, through adopting a reflexive approach which takes into account the ways in which power and privilege may manifest within the health system.

Providing one-to-one care is noted as a promising method of adapting interventions in pursuit of cultural competency/safety (Healey et al., 2017; Saha, Beach and Cooper, 2008), and may improve health outcomes for recipients (Healey et al., 2017), although one might consider the cost implications of providing such services. Such an approach may potentially better serve the needs of underserved populations - including migrant women.

2.7.2 - Existing health service adaptations for migrant women

Health service adaptations for migrant women - particularly in the context of maternity care - have been explored through several reviews of the global literature. The majority of models of maternity care for migrant women are located in the Global North, and have been community-based, involving specialised clinics external to mainstream services, as well as community groups (Coast et al., 2016; Rogers et al., 2020). Across the reviewed research, improved access to healthcare and improved uptake in services and acceptability to migrant women patients were noted. Most notably, existing adaptations have frequently involved the provision of bilingual or bicultural health and social care workers to provide outreach and education for migrant women populations. This represents a form of one-to-one care which aims to meet the needs of migrant women who use the services. However, some of these workers go beyond outreach and education - acting as 'health navigators' - and have a leading role in aiding migrant women with 'navigating' health systems and accessing care.

2.8 - Health navigation

Health navigation is an example of an interventional approach purported to embody the ideals of culturally competent/safe services, while prioritising the needs of each individual patient by way of enhanced, individualised care. Navigation may enable access to healthcare for patients or service users - especially those underserved by the wider health system - by way of connecting individuals to primary, secondary or tertiary health services via a lay or professional worker (a 'health navigator'), while simultaneously addressing their barriers to accessing healthcare.

2.8.1 - Background on health navigation

The notion of health navigation is rooted in breast cancer care for low-income African-American women in New York City (Freeman, 2013); termed 'patient navigation' in this scenario, it is important to note that 'patient navigation' and 'health navigation' have largely been used interchangeably, both within the literature and in practice. The initiation of this navigation programme in 1990 saw low-income African-American women navigated from receipt of an abnormal mammogram screening result to receipt of breast cancer treatment, with their financial, emotional, information and health system-based barriers targeted by navigators on an individualised basis. Five-year survival rates subsequently increased from 39% to 70% (Freeman and Rodriguez, 2011).

Typically, a health navigator simultaneously addresses a patient or service user's barriers - such as language, financial, transportation and social inclusion-related barriers - which act as social determinants of health (Natale-Pereira et al., 2011). Examples of navigators' tasks vary but tend to include booking clinic appointments for patients on their behalf, arranging transport to appointments, making applications for health insurance or financial aid, and making referrals to social and community-based services, including for housing, state benefit payments and employment (Freeman, 2013). Navigators may also maintain roles as advocates and liaisons, by acting as coordinators of care between a patient and a health provider, as well as promoting and upholding patients' rights to access to health services. In working in the interests of underserved groups in the USA - including low-income groups and ethnic/racial minorities - navigators have been shown to facilitate disease prevention and screening activities for chronic diseases such as cancers and diabetes (Bush et al. 2014; Roland et al., 2017) and communicable diseases such as hepatitis B and HIV (Hyun et al., 2016; Rhodes et al., 2016), ensure continuous health insurance coverage between providers - wherever applicable - to minimise disruptions in care (Wells et al., 2008) and foster trust between patient groups and health providers (Carroll et al., 2010).

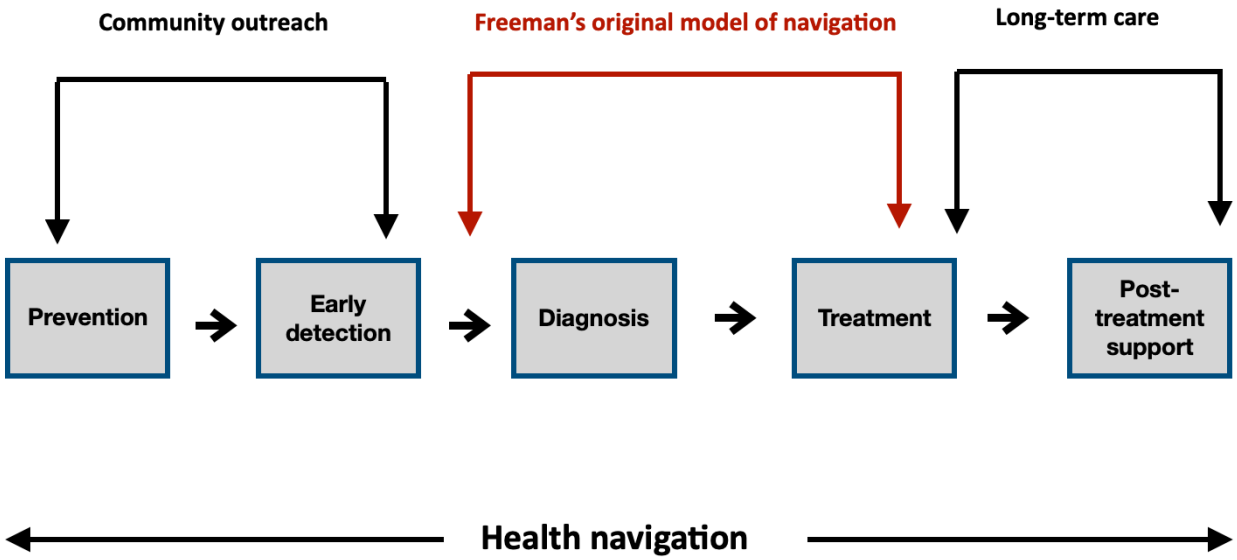
Navigation is usually framed as a form of integrated care, aiding patients and clients to navigate the health system across the care continuum and across clinical services, statutory social services and charitable services (Sofaer, 2009). There is, however, valid critique of navigation, in that it functions as a short-term measure, rather than a permanent systemic solution to the problem of inaccessible and disjointed health systems. (The Change Foundation, 2013). Nevertheless, one could also consider that a short-term increase in knowledge of health and of the health system among patients who have been navigated may not require long-term guidance in accessing healthcare.

2.8.2 - Founding principles of navigation

The potential of navigation programmes to improve access to healthcare for underserved groups has been given continued consideration in the years following Freeman's intervention, and navigation programmes have grown in popularity both within the health system in the USA and in other health systems across the world. As the profile of navigation has increased - both nationally within the USA and globally - one can observe that the model of care has shifted somewhat. As shown by Carter et al. (2018), the concept of navigation now encompasses different points of intervention along the clinical care continuum, from initial diagnosis to post-treatment. While the traditional model of navigation - as envisaged by Freeman - operates between the early diagnosis and treatment stages, navigation is now also deployed in the context of patient outreach and referral to screening and diagnostic services, as well as in the context of post-treatment support.

Navigation can now also be oriented in terms of navigating individuals through the health system (and beyond), instead of merely navigating individuals through a clinical journey, suggesting that not all navigation interventions operate within the clinical care continuum. **Figure 1** depicts the varied nature of how health navigation has operated thus far.

Figure 1: Graphical representation of navigation's historical points of intervention along the clinical care continuum, with a comparison to current points of intervention



Additionally, navigation now encompasses different health and disease foci (as well as interventions without any specific health or disease focus), and there is now the possibility of navigation being applied in a community context (Carter et al., 2018). The very definition of navigation has evolved, although the overarching goal of linking patients and service users to frontline care, specialist care, community health and social care remains central (Valaitis et al., 2017). In recognition of navigation's continued development, Freeman & Rodriguez (2011) defined nine 'Principles of Patient Navigation' (**Table 2**).

Table 2: Principles of health navigation, as described by Freeman & Rodriguez (2011)

1. Patient navigation is a patient-centered health care service delivery model. The focus of navigation is to promote the timely movement of an individual patient through an often complex health care continuum. An individual's journey through this continuum begins in the neighborhood where he or she lives, to a medical setting where an abnormality is detected, a diagnosis is made, and then treatment rendered. The journey continues from rehabilitation and survivorship to the end of life.
2. Patient navigation serves to virtually integrate a fragmented health care system for the individual patient. As patient care is so often delivered in a fragmented manner, particularly related to those with chronic diseases, patient navigation has the potential of creating a seamless flow for patients as they journey through the care continuum. Patient navigation can be seen as the guiding force promoting the timely movement of the patient through a complex system of care.
3. The core function of patient navigation is the elimination of barriers to timely care across all phases of the healthcare continuum. This function is most effectively carried out through a one-on-one relationship between the navigator and the patient.
4. Patient navigation should be defined with a clear scope of practice that distinguishes the role and responsibilities of the navigator from that of all other providers. Navigators should be integrated into the health care team to promote maximum benefit for the individual patient.
5. Delivery of patient navigation services should be cost-effective and commensurate with the training and skill necessary to navigate an individual through a particular phase of the care continuum.

6. The determination of who should navigate should be based on the level of skill required at a given phase of navigation. There is a spectrum of navigation extending from services that may be provided by trained lay navigators to services that require navigators who are professionals, such as nurses and social workers. Another consideration to take into account is that health care providers should ideally provide patient care that requires their level of education and experience and should not be assigned to duties that do not require their level of skills
7. In a given system of care there is the need to define the point at which navigation begins and the point and which navigation ends.
8. There is a need to navigate patients across disconnected systems of care, such as primary care sites and tertiary care sites. Patient Navigation can serve as the process that connects disconnected health care systems.
9. Patient Navigation systems require coordination. In larger systems of patient care, this coordination is best carried out by assigning a navigation coordinator or champion who is responsible for overseeing all phases of navigation activity within a given health care site or system. It is important to distinguish a system of patient navigation from the patient navigator(s) who work within the system.

The above principles address both the actions of navigators, and the ways in which navigation should operate in different contexts to ensure its success and sustainability. These principles present a useful overview of the central tenets of navigation: targeting the individualised barriers that particular patients / service users experience via provision of a mediating third-party through which they can be connected to the - sometimes fragmented - health system.

The first of Freeman's principles focuses on the notion of a 'disease abnormality' being targeted through a health service delivery model, which suggests a medicalised framing of navigation. This aligns well with the original conceptualisation of patient navigation. However, as indicated above, navigation has evolved from operating within clinical contexts exclusively. Using the theory of Candidacy, the primary research component of this thesis will describe and explore interventions in which navigation is positioned within a social and community context, and where the primary aim is not to resolve a specific abnormality, but to improve general health and wellbeing.

The fourth of Freeman's principles of navigation is a particularly interesting inclusion. As the concept of navigation has developed over the decades, that numerous navigation interventions still appear to lack a "clear scope of practice" remains problematic, as is the fact that navigators may not be easily distinguishable from other health and/or social care workers who work with the same groups of underserved patients. The term 'navigator' may encompass multiple roles. It has sometimes been assumed that navigation exists as a specific, stand-alone occupation (Palmer et al., 2007; Roland et al., 2017), however, navigators and community health workers have also been framed as being interchangeable roles (Verhagen et al., 2014), as well as navigators and other related health and social support workers.

Some have argued the importance of distinguishing between navigators, case managers and patient advocates (Wells et al., 2008). While there is considerable overlap between the three types of worker - case managers and patient advocates can indeed both have navigator roles - the traditional view of case managers is that they are often nurses or social workers operating in a primarily clinical context (while navigators now commonly operate within and outside of the clinical context), and patient advocates are said to be focused on improving the health system, rather than the health and wellbeing of individual patients more broadly (Wells et al., 2008).

A critique of the existing literature reveals that navigation has often been presented as if it is a standalone occupation when, in practice, it is a series of roles and functions that can be carried out by various cadres of health workers, that is driven - and shaped - by the needs of the population they serve (Darnell, 2007; Enard and Ganelin, 2013; Mailloux & Halesey, 2018). Relying on the aforementioned assumptions that navigators exist only as a stand-alone occupation and that termed 'navigators' are freely interchangeable with terminologies for other health workers is "clearly not sufficient in a serious policy discussion", and illustrates a "persistent definitional issue" within the discourse surrounding navigation (Centers for Disease Control and Prevention, 2016). While many community health workers often serve as navigators (Genoff et al., 2016), there is evidence to suggest that navigation roles are also fulfilled by other lay workers such as health advisors (Wagoner et al., 2015), health educators (Shommu et al., 2016), and patient advocates (Parker & Lemak, 2011), as well as professional staff such as nurses (Lee et al., 2011) and social workers (Davis et al., 2009).

As noted by Freeman's sixth principle, such variation does, however, suggest a spectrum of differences in training, skills and experiences with the health system. There are also different terminologies associated with the act of navigating clients to services. Terminologies which have been used for workers with navigational duties include community connectors, health focal points, intercultural mediators and 'navegantes' (the latter term being applied when working with Hispanic communities in the USA). Freeman's call for standardisation regarding the roles and characteristics of navigation should, however, be critiqued. One could consider whether navigation must be delivered by a distinct category of worker, or whether, alternatively, all health and social care workers should have navigational roles included within their remit. Addressing these concerns would also mean interrogating the meaning of 'navigation', and how it may address barriers to accessing healthcare.

Finally, in reference to Freeman's sixth principle on the professional, educational and personal backgrounds of navigators, there is some evidence to suggest that navigators with different characteristics and skill-sets deliver different 'types' of navigation (Wells et al., 2018). Most notably, the authors of the aforementioned study state that navigation to provide care coordination and referrals to underserved ethnic minority and immigrant communities is most often delivered by navigators who are recruited specifically for their ethnic minority background. Concurrently, navigation to deliver treatment or clinical trials support to a population is often delivered by navigators who possess a high level of education, and are of any racial or ethnic background.

To address the above reflections on Freeman's principles and the significant questions which remain on the topic of navigation, formal characterisation of navigation - and the scope of its functions - is still required. This would aid policy-makers, designers of programmes and interventions, researchers, patients and navigators themselves to understand what should be expected of a navigator in any given context, and how best they can be utilised to improve access to healthcare, for populations such as migrant women in particular.

2.8.3 - Candidacy as a potential theoretical framework for understanding navigation

Theories of Candidacy have been applied to studies of migrant health in high-income contexts (most notably, Canada and the UK), focusing on refugees, asylum-seekers and older immigrants (Chase et al., 2017; Koehn, 2009; van der Boor and White 2020). The application of Candidacy in these studies elucidated the complexity associated with migrants negotiating their access to healthcare, and provided a tool with which to detail the micro-level interactions which determine their ability to access healthcare, against a backdrop of macro-level, structural factors. There is an absence of studies that apply this framework to the experiences of migrant women, or in the context of navigational services.

As alluded to earlier, the theory of Candidacy offers a lens through which navigation can be explored. Migrant women who are very recently-arrived in a region - as an example of a group who often experience vulnerability - may face particular difficulties in negotiating their candidacy for a service, especially with regards to identifying their own candidacy in the first instance. This is likely because identifying oneself as a candidate for care largely relies on possession of knowledge of their rights and entitlements, as well as their knowledge of a new - and likely unfamiliar - health system. Having said this, cultural barriers - including different expectations of behaviours and norms - may affect the permeability of services, even when they are able to identify their own candidacy to make contact with an appropriate service.

2.8.4 - Navigation for migrant women

Existing reviews have suggested that migrants are likely to benefit from navigation for overcoming several barriers to accessing healthcare - including linguistic, cultural and legal barriers. This could lead to improved uptake of screening services, improved chronic disease self-management and increased knowledge of diseases and treatments (Genoff et al., 2016; Goris et al., 2013; Henderson et al., 2011; Hilder, Gary & Stubbe, 2019; Shommu et al., 2016). Navigation for migrant patients has been described as a form of brokerage (López-Sanders, 2017; Natale-Pereira et al., 2011).

It has been suggested that navigators who share membership of the same community with their clients (through shared language, ethnic background, culture or migratory experience) can foster a sense of trust in the health system (López-Sanders, 2017), which would be of added importance to migrants with irregular status, such as those who are undocumented or are refused asylum-seekers. However, there is only limited evidence to support this, and it has been suggested that health workers and professionals who share membership of a community to which their patients or clients belong may not actually engender a patient or client's trust in the health system (Altschuler, 2016). This element of 'peer-ness' that is often shared between navigators and their patients / service users requires further exploration to ascertain whether it is indeed a necessary contextual factor of navigational work, helping to facilitate access to healthcare for migrants.

For migrant women, receiving navigation may help to overcome barriers associated with financial resources, cultural needs and expectations, language proficiency and communication. Navigation can offer migrant women a bridge to women's health services operated by different providers within a fragmented health system. Specifically within the context of maternal healthcare, navigation has been shown to increase retention in routine postpartum care and increased uptake of reproductive health and child health services (Yee et al. 2018). Navigation could also potentially connect women to new mothers' resources and provide community and psychosocial support underscored by trust (McKenney et al., 2018), the latter of which would be of great benefit to migrant women experiencing social isolation due to their recent arrival in a host country, or their irregular status. Navigation for migrant women seeking mental health care can also provide self- management skills (Kelly et al., 2013), which could become a source of confidence and empowerment.

These elements of patient-centeredness may play a role in the structure of navigation interventions since - by assessing the difficulties a patient faces when attempting to gain access to healthcare - navigators could pursue the individual needs of their clients with a sense of justice and obligation and strive to address the power imbalance within provider-patient interactions. Provision of patient-centeredness could promote increased understanding of migrant women patients' (or clients') circumstances, and lessen the burden on migrant women to need to assert their own candidacy within a seemingly impermeable system (MacDonald et al., 2016).

2.9 - Summary

This thesis focuses on women who have migrated across or within borders. The key messages outlined within this Chapter are that - while some migrant women experience a health advantage upon arrival - other, largely minoritised groups of migrant women face an accumulation of health and social risks which impact on their ability to access healthcare, and impact their health outcomes. This raises questions about the ways in which their access can be negotiated. Equity-driven initiatives in health service design highlight the importance of cultural competence and safety, and the utility of an individualised approach.

Health navigation offers promise as an intervention rooted in increasing access to healthcare for underserved groups, and is continuously developing in scope. Despite the potential shown by health navigation in impacting on the health of migrant women, many gaps in knowledge remain as to how navigation can be defined, characterised, and modelled within the context of migrant women's health and maternal health, and its dynamics and functioning on the pathway to improved outcomes for migrant women.

Section 2: Does health navigation increase access to healthcare for migrant women? A systematic integrative review

This section of the thesis builds on the background to navigation as a promising intervention by critically reviewing the extant literature on health navigation for migrant women. It is divided into two chapters. **Chapter 3** sets out the range of methods followed in searching, identifying, assessing and evaluating the literature, while **Chapter 4** details the results of the review and provides a full discussion.

As a systematic integrative review, it aims to characterise health navigation for migrant women, the logic that underpins navigation interventions and the outcomes it delivers for migrant women's health and wellbeing.

By conducting this review, over two chapters, this section will also contribute partially towards fulfilment of **research objectives 1, 2, 3 and 4,** through combination with primary research findings:

1. To define the concept of health navigation as an intervention, its definitions and characteristics, when implemented for migrant women

2. To elucidate the theoretical mechanisms which underpin health navigation when implemented for migrant women

3. To assess the impact and effectiveness of health navigators, and explore their relationships with migrant women through navigation

4. To develop a model of how health navigation can improve access to healthcare for migrant women

Chapter 3: Literature review methods

3.1 - Rationale and review questions

The introductory review of the literature presented in **Chapter 2** identified a sufficient body of primary evidence to warrant conducting a systematic evidence synthesis, given that no such review currently exists. A review of the literature on health navigation as it relates to migrant women can provide greater understanding of this approach, how it may benefit this population, its scope and its implementation, as well as identify any gaps in knowledge. Specific research questions guide this review (in **Table 3** below).

Table 3: Research questions for integrative review

RQ 1: What is 'health navigation' and what is it intended to achieve when it is delivered to migrant women?	[a] What are the intended outcomes of health navigation programmes, and what issues do they seek to address? [b] What are the characteristics of programmes (roles, practices, processes) and what do they look like in practice?
RQ 2: What theory or logic underpins health navigation programmes for migrant women?	[a] To what extent have health navigation programmes been shaped by explicit (or implicit) theory? [b] What are the mechanisms by which health navigation is expected to work to impact on intended outcomes?
RQ 3: What are the outcomes of 'health navigation' programmes?	[a] What is the scale and quality of the literature that has quantitatively assessed the effectiveness of health navigation interventions for migrant women? [b] What quantitative and qualitative outcomes have been documented and have navigation programmes been effective in achieving them? [c] How do the effects of health navigation interventions vary according to recipient and interventional characteristics ? [d] What internal and external factors influence the outcomes, implementation (and sustainability) of health navigation interventions for migrant women?

3.2 - Methods

An integrative review methodology was selected. Integrative reviews are a form of mixed methods review which are able to combine quantitative and qualitative data (Grant and Booth, 2009) and can capture a range of methodological approaches - including both experimental and non-experimental designs - in order to define concepts, review evidence, identify gaps in knowledge, review theories and analyse methodological limitations (Whittemore and Knafl, 2005). Integrative reviews also embed quality assessment of individual studies. The integrative review protocol was based on the framework presented by Whittemore and Knafl (2005), and the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Statement (Moher et al., 2009). A copy of the PRISMA checklist can be found in **Appendix A**.

3.2.1 - Literature search

Electronic databases were searched in the first instance, in order to identify literature fulfilling the study eligibility (**Table 4**). Both biomedical databases (Medline, EMBASE, CINAHL and PsycInfo) and social science databases (ASSIA and Social Science Citation Index) were searched. Time limits from year 1990 to 2020 were used to capture all possible relevant literature since the earliest navigation intervention in 1990 (Freeman, 2013), and the most recent search of these databases was completed on 19th July 2020. As part of the search strategy, a diverse selection of navigation-relevant terms was employed including "health navigator", "peer worker", "health mediator", "lay health advisor", "doula", "community health worker" and "promotoras de salud", in recognition of both the numerous terminologies that may be associated with navigation and the fact that navigation roles can be carried out by various types of health worker. Migration-associated terms were also used, such as "refugee", "immigrant" and "irregular migrant", as well as terms related to women's health, including "gynaecological" and "antenatal". For the purposes of this review, both international and internal migrants were included. Ethnic and racial categories such as "African", "Roma" and "Latina" also needed to be included in the search input, as migrant groups - most notably, those originating from countries in the Global South who reside in countries in the Global North - are not always explicitly referred to by their migration status in the titles and abstracts of papers. The term "Latino" in the USA may refer to those born in the USA who belong to the Hispanic ethnic/racial group, but sometimes this also refers to migrants born in Latin American countries who now live in the USA. Boolean operators (AND and OR) were used to build the search input, and a number of truncated terms, such as "health navigat*", "promotora*" and "traffick*", were used to capture terms derived from a common root word. Full search terms can be viewed in **Appendix A Table 1**.

In addition to using electronic databases, hand-searching of key journals of relevance was simultaneously carried out. These included *Women's Health*, *Maternal and Child Health Journal*, and *BMC Pregnancy and Childbirth*, as well as *Journal of Immigrant and Minority Health*, *International Journal of Migration, Health and Social Care* and *Journal of Human Trafficking.* Further papers were sought via one round of backwards and forwards citation searching of all studies included after the database search. Reference searching was repeated for every new paper identified until no further papers emerged. Finally, grey literature in the form of reports from governmental bodies (National Institute on Minority Health and Health Disparities, Centers for Disease Control and Prevention, Australian Institute of Health and Welfare, New Zealand Ministry of Health, Health Canada, Department of Health - South Africa and Public Health England), multilateral bodies (World Health Organization and International Organisation for Migration), and charitable organisations (British Red Cross, Refugee Council, International Rescue Committee, Refugee Council of Australia, Refugee Council of New Zealand and Scalabrini Centre) were also searched. Mendeley 1.18 was used to manage references.

3.2.2 - Screening and eligibility criteria

Literature on health navigation for migrant women was searched by the thesis author, with titles and/or abstracts of records from the database search - as well as from journal and grey literature hand-searching - sifted in the first instance. This was then followed by full text screening of studies which passed the initial sifting stage.

In accordance with the PICO model (Population, Intervention, Comparison, Outcome), studies were included if they met a series of criteria. The populations of interest were migrant women receiving navigation, navigators serving migrant women, and health providers engaging with navigation for migrant women. All ages and nationalities were included, and there were no limitations on study location, health or disease area of focus, or type of migration experienced. With regards to the latter, internal migration and displacement was included along with cross-border migration, as migrant women may still face barriers when accessing care within a large and/or multinational state.

The intervention of interest was health navigation; navigation was defined as an intervention whereby a lay worker or professional connects patients or clients to healthcare by addressing the barriers they faced. Personnel were identified as having navigational roles in line with this definition. This was to avoid relying solely on the definitions of navigation provided by authors. Authors of several studies included in this review did not explicitly define a given intervention as being navigational, despite the fact that descriptions of the intervention made it clear that navigation had taken place. No studies claiming to explore navigation as an intervention were found to be incorrectly employing the terminology.

The outcomes of interest were utilisation and uptake of health services by patients/service users, their satisfaction with health services, their (change in) health behaviours and/or health outcomes, or primary qualitative or quantitative data on the perceptions of the intervention by patients/service users, health providers and by navigators themselves. The 'Comparison' eligibility criterion was not applicable for this review.

All study designs were included; I also sought to include any reviews directly relevant to the research questions, but none were identified. Studies were excluded if there was no full-text of the study available. (**Table 4**).

Table 4: Inclusion and exclusion criteria for the final selection of studies on navigation for migrant women to be included in the integrative review

Inclusion criteria	Exclusion criteria
Population: : migrant women who are navigated, the navigators who support migrant women, or the health providers who engage with navigation for migrant women; all ages and nationalities of migrant women; all types of migration; any geographical context	Study contains duplicated data (already included via another study)
Intervention: a navigation-based intervention	No indication of study population being migrants
Outcome: exploring the effect of navigation on utilisation and uptake of health services by migrant women, their (change in) health behaviours and/or health outcomes, or on perceptions of the intervention	No full-text version of study is available
Any study design (qualitative or quantitative) or type of review	Study not in English language

Steps to reduce bias in the included studies were taken. Location bias was minimised by searching a broad list of journals and reports, rather than reliance on database searching alone. Furthermore, in-depth review of all full-text studies sourced from the electronic databases, online journals and reference lists allowed for easier identification of duplicated data across studies, thereby minimising duplication bias. No duplicate studies were ultimately identified.

3.2.3 - Quality assessment

Quality assessment was completed for every study fulfilling the eligibility criteria after full-text review. Quantitative (or mostly quantitative) studies - including both randomised controlled trials and non-randomised studies - were assessed according to a modified Downs and Black Scale (**Appendix A Table 2**), as used in previous research (Richmond et al., 2013; O'Conner et al., 2015). The modified Downs and Black Scale was chosen for its suitability for assessing quality for the aforementioned study designs, and for its simplification of its 'Power' domain by assigning a maximum of one point. This is compared to the five points available in the original Downs and Black Scale under this domain, making 28 points the maximum score that can be attained instead of the maximum 32 points available in the original Scale. This simplification of the 'Power' domain was useful, in that it was still able to articulate to what extent a given study had enough statistical power to detect an effect caused by health navigation. The quality of studies was deemed to be 'excellent' (24–28 points), 'good' (19–23 points), 'fair' (14–18 points) or 'poor' (<14 points) (O'Connor et al., 2015). Studies which were primarily qualitative in nature were assessed using the CASP qualitative checklist (Critical Appraisal Skills Programme, 2018), a validated, user-friendly framework; this was scored out of 10 points, with any study scoring more than 6 points deemed to be of adequate quality. More details can be found in **Appendix A Table 3**. Studies were not excluded due to being of 'lower' quality; this is because it was important to capture the limited amount of data in this area of research, while highlighting any current or historical methodological limitations.

3.2.4 - Extraction and synthesis

A structured extraction template was developed, piloted and refined in line with the research questions, using Microsoft Word (**Appendix A Table 4**). Data on study characteristics were extracted, including descriptions of the populations measured, summaries of the study interventions, elements of navigation described in the studies, and navigational characteristics identified. Data on statistical significance of the study results were also extracted, along with information on 'loss to follow-up' amongst the study populations; 'loss to follow-up' data was selected as an appropriate measure for extraction from studies due to the fact that presenting the breadth of missing data offers insight into study validity. Barriers to accessing healthcare experienced by study participants and navigators' roles and functions were identified through examining the descriptions of study recruitment, participants' characteristics and background to the navigation intervention within each study. I then sought to organise and make sense of data on participants' barriers, as well as navigational roles and functions, by developing categories.

Quantitative and qualitative data on the utilisation and uptake of health services by the study population, satisfaction with health services and (change in) health behaviours and/or health outcomes, and perceptions of the intervention were also extracted and organised into outcomes. Additionally, information on theoretical frameworks used in each study were extracted directly from each manuscript. NVivo 12 was used to inductively code data on navigational characteristics and any direct quotations from interview or focus group participants relating to their perceptions of navigation for migrant women. Extraction of qualitative data was completed iteratively, with coding of data from one study occurring simultaneously with reviewing the full-text of another study to help guide the development of themes during the synthesis.

For qualitative studies, a textual narrative synthesis was completed. Data on perceptions of navigation was organised by participant group (service users or patients, health providers, and navigators), and similarities and differences across the data were analysed (Lucas et al., 2007) to arrange codes into a hierarchical structure, in order to develop descriptive themes. Statistical meta-analysis was not possible for quantitative studies due to wide heterogeneity in outcomes and study designs, which meant that, as an alternative, a narrative review format of quantitative data was also followed. All findings were then framed and presented in line with the research questions.

3.3 - Conclusion

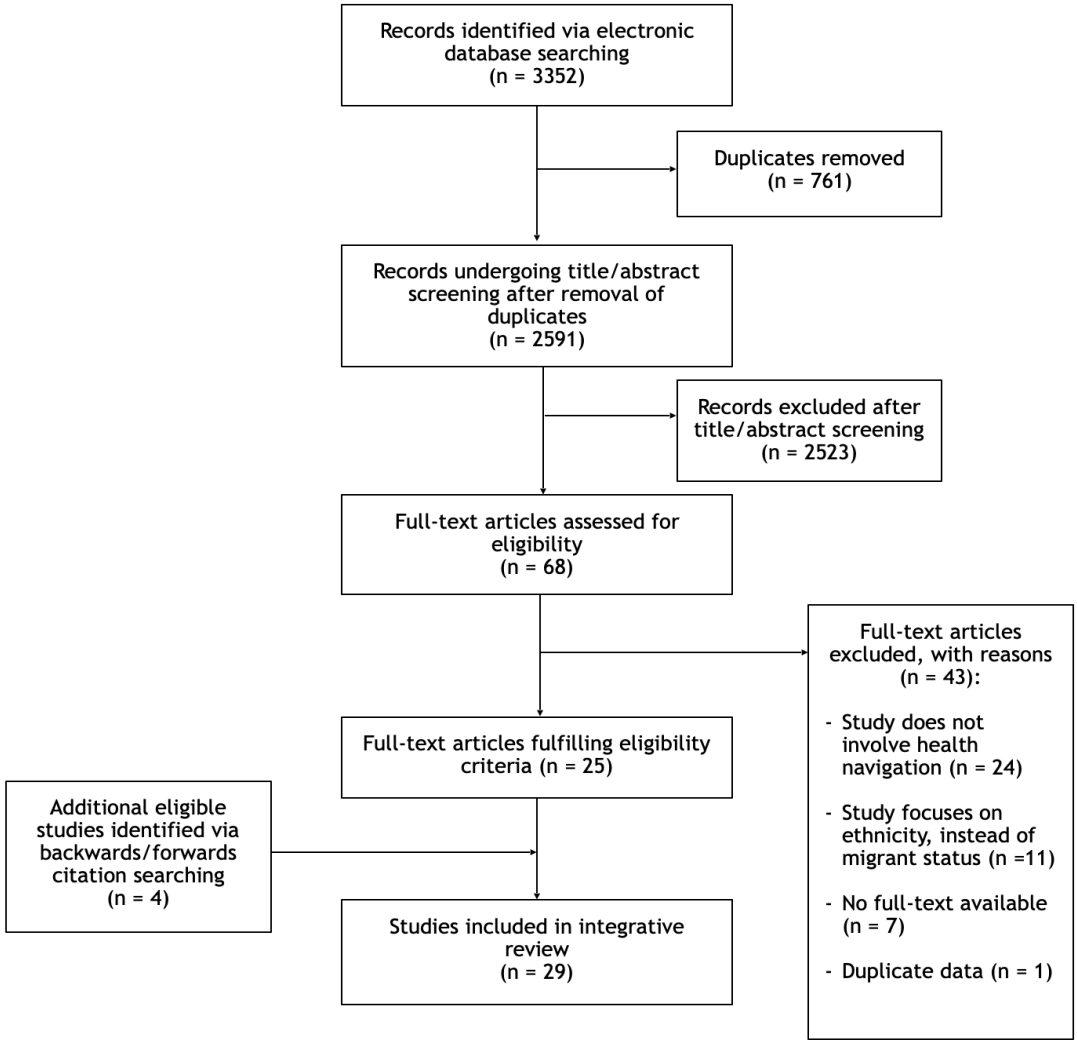
This Chapter has provided a detailed overview of the methods employed in reviewing the extant literature on health navigation for migrant women. These methods involved a broad search that was inclusive of all forms of navigation for women who engaged in all forms of migration, in all geographical contexts and sought both quantitative and qualitative data. The proceeding chapter will set out the results of this search.

Chapter 4: Literature review findings and discussion

4.1- Study selection

As outlined in **Figure 2**, 29 full-text articles were included in the review. Twenty-five of these included studies were sourced from electronic databases and the remaining four were identified through backwards and forwards citation searching. No additional studies were sourced through hand-searching of relevant journals or grey literature. Studies were of variable but generally 'good' quality, with only one study being of comparatively poor quality (Lo et al., 2010).

Figure 2: PRISMA flow chart of search strategy



4.2 - Study quality appraisal

The 29 included studies were critically appraised for quality (and potential of bias) [**Appendix A Table 2** and **Appendix A Table 3**]. Of the 29 included studies, 25 were primarily quantitative, and were scored from 13 to 24 out of 28 points on the modified Down and Blacks Scale. While almost all studies assessed using this scale scored highly with regards to external validity and the quality of their reporting, most studies scored poorly under the 'Power' domain due to the fact that the majority of studies did not include a sample size calculation . The remaining four studies (McCarthy & Haith-Cooper, 2013; Nguyen et al., 2011; Reavy et al., 2012; Torres et al., 2014) were primarily qualitative in nature, and were therefore assessed using the CASP tool. Three of these four studies scored at least 7 out of 10 points, while the remaining study scored 4 out of 10 points, due to a lack of detailed description of methods and justification for selecting them. Additionally, none of the qualitative studies reflexively examined the relationship between the researcher and participants and how this could influence the outcomes of the research.

4.3 - Study characteristics

The characteristics of all studies included in this review can be viewed in full in **Appendix A Table 5**. All studies were carried out in the USA with the exception of three - one study was conducted in the UK (McCarthy & Haith-Cooper, 2013), one study took place in Canada (Torres et al., 2014), and one study examined both the USA and Canadian contexts (Taylor et al., 2002). Seven studies were randomised controlled trials (Ell et al., 2009; Lam et al., 2003; Lutenbacher et al., 2018; Maxwell et al., 2010; Nguyen et al, 2009; Shokar et al., 2016; Taylor et al., 2002), ten studies were pre-post studies (Allen et al., 2014; Fang et al., 2007; Fernández et al., 2009; Han et al., 2009; Parra-Medina et al., 2014; Percac-Lima et al., 2012; Lo et al., 2010; McClung et al., 2013; Tran et al., 2014; Warner et al., 2019), two studies were retrospective evaluations (Percac-Lima et al., 2013a; Percac-Lima et al., 2013b), two studies had quasi-experimental designs (Ramirez et al., 2013; Wang et al., 2010), one study was a matched-pair group randomised design (Fang et al., 2017), one study was a cluster-randomised wait list controlled study (Han et al., 2017), one study was a retrospective chart review (Wagner, 2017) , and one study was described as an ethnosurvey with a photo-narrative component (Wasserman et al., 2006).

Screening and treatment for breast, colorectal and gynaecological cancers, prenatal and perinatal care - including paediatric care for the babies of new mothers - and human papillomavirus (HPV) vaccination were the health or disease foci of the included studies; only one study did not have a specific health or disease focus (McCarthy & Haith-Cooper, 2013).

Researchers in the included studies labelled their participant samples as being Hispanic (Latina), Korean-American, Chinese, Khmer, Hmong, Laotian and Vietnamese-American women, as well as migrant women speaking Serbo-Croatian, Somali and Arabic languages; several studies were not focused on women of any particular heritage or linguistic background (Reavy et al., 2012; McCarthy & Haith-Cooper, 2013; Torres et al., 2014; Wagner, 2017). Most women were aged between 18 and 65 years of age. All populations of migrant women represented cross-border migration, with all women in the included study populations being born in another country and having migrated to their current country of residence.

4.4 - Characterising health navigation

Across the included literature, assumptions surrounding the barriers to accessing healthcare experienced by migrant women served by navigators were either stated explicitly or described implicitly, with low levels of knowledge and awareness of health and disease being the most common (**Table 5**).

Table 5: Overview of the barriers to accessing healthcare experienced by participants described in each included study

	Low level of knowledge and awareness of health and disease	Insufficient health insurance coverage	Low household income	No / low proficiency in English language	No specific barriers mentioned
Allen et al. (2014)	✓		✓		
Ell et al. (2009)	✓		✓		
Fang et al. (2007)	✓	✓	✓		
Fang et al. (2017)	✓				
Fernández et al. (2009)			✓		
Han et al. (2009)	✓			✓	
Han et al. (2017)	✓				
Lam et al. (2003)	✓				
Lo et al. (2010)	✓				
Lutenbacher et al. (2018)	✓				
Maxwell et al. (2010)		✓	✓		

McCarthy & Haith-Cooper (2013)					✓
McClung et al. (2015)	✓				
Nguyen et al. (2009)	✓			✓	
Nguyen et al. (2011)					✓
Parra-Medina et al. (2014)	✓	✓			
Percac-Lima et al. (2012)	✓				
Percac-Lima et al. (2013a)	✓				
Percac-Lima et al. (2013b)	✓				
Ramirez et al. (2013)	✓				
Reavy et al. (2012)					✓
Shokar et al. (2016)	✓	✓			
Taylor et al. (2002)	✓				
Torres et al. (2014)					✓
Tran et al. (2014)	✓	✓			
Wagner (2017)					✓

Wang et al. (2010)	✓	✓	✓	✓	
Warner et al. (2019)	✓	✓			
Wasserman et al. (2006)					✓

A variety of terms were used to refer to the personnel who carried out navigation. These included patient/health navigators (Ell et al., 2009; Percac-Lima et al., 2012; Percac-Lima et al., 2013a; Percac-Lima et al., 2013b; Lo et al., 2010; McClung et al., 2013; Nguyen et al., 2010; Ramirez et al., 2013), peer navigators (Maxwell et al, 2010), lay health workers (Fernández et al., 2009; Han et al., 2009; Lam et al., 2003; Nguyen et al., 2009), promotoras de salud (Parra-Medina et al. 2014; Shokar et al., 2016; Tran et al., 2014; Warner et al., 2019), befrienders (McCarthy & Haith-Cooper, 2013), clinic health advisors (Reavy et al., 2012), multicultural health brokers (Torres et al., 2014), peer health advisors (Allen et al., 2014), peer mentors (Lutenbacher et al., 2018), [community] health educators (Fang et al., 2007; Fang et al., 2017; Wang et al., 2010), outreach workers (Taylor et al., 2002) and community health workers/mentors (Han et al., 2017; Wagner, 2017). Additionally, one study used 'bridge persons'- who were sometimes friends or female relatives of migrant women - to link these women to healthcare (Wasserman et al., 2006)

Navigators were of all ages and were, in some cases, reported to have attained secondary/high school or college/university-level education (Maxwell et al. 2010; Percac-Lima et al., 2012; Percac-Lima et al., 2013a; Ramirez et al., 2014). In 7/29 studies, navigators were paid employees or in receipt of a stipend, while, in 3/29 studies, they were unpaid volunteers; the remainder of studies made no reference to navigators' employment/remuneration status. The diversity of personnel who assumed the role of navigators was clear across the literature, and navigational roles extended even to individuals with whom clients had personal relationships.

In all included studies except for one study in which navigators only spoke English (Wagner, 2017), navigators were bilingual or trilingual, speaking both the language(s) of their clients and the language of the country of residence. Navigators were explicitly described as being female in 19/29 studies. Six studies described navigators as being 'bicultural', a term implying that they possessed and had proximity to both the culture of the country of residence and the culture they shared with their clients, although the studies did not offer detail on how biculturalism was defined. McClung et al. (2015) also described the recruitment of cancer survivors as navigators for migrant women undergoing cancer treatment. Elsewhere, some navigators were refugees sharing this status with the women they served (Reavy et al., 2012) and - in the context of maternity care - some refugee navigators were mothers themselves (McCarthy & Haith-Cooper, 2013). This suggests that a sense of peer-ness via shared - and also perhaps intersecting - characteristics and experiences is often assumed by designers of navigation interventions to be an important prerequisite for being a navigator serving clients who experience marginalisation due to their race/ethnicity, migrant status and gender. No studies described how navigators were assigned to clients, however.

Navigation took place at specific points across the healthcare continuum in the majority of studies (26/29). Navigators engaged in disease prevention (3/26), outreach for early screening (19/26), follow-up screening after receipt of an abnormal result (2/26), and also in supporting access to treatment (2/26). Navigation was not always restricted to specific points in the continuum (Lutenbacher et al., 2018; McCarthy & Haith-Cooper, 2013; Torres et al., 2014). In the McCarthy & Haith-Cooper (2013) study, refugee and asylum-seeking women in the UK were navigated to access health services as per their specific needs. Finally, 11/29 studies described navigation interventions lasting from 6 to 12 months, with navigation in the context of maternity care extending from pregnancy until several months - or up to two years - postnatally (Lutenbacher et al., 2018; McCarthy & Haith-Cooper, 2013; Wagner, 2017). The frequency with which navigators supported clients - whether weekly or monthly, for example - went unreported in every study apart from Han et al., (2017), Lutenbacker et al., (2018) and McCarthy & Haith-Cooper (2013).

Table 6: Representation of different occupations included in the literature, with their associated navigational role

	Peer Health Advisor	**Health/ Patient Navigator**	**(Community) Health Educator**	**Lay Health Worker**	**Community Health Worker**	**(Peer) Mentor**	**Peer Navigator**	**Befriender**	**Promotoras de Salud**	**Clinic Health Advisor**	**Outreach Worker**	**Multi-cultural Health Broker**	**Bridge Person**
Provide educational sessions	✓	✓	✓	✓	✓	✓		✓	✓		✓		✓
Teach driving skills						✓							
Provide information		✓	✓						✓				
Organise referrals	✓	✓		✓	✓			✓	✓	✓			
Follow-up calls / reminders		✓					✓						

Conduct calls / home visits		✓		✓	✓				✓				✓
Accompany to appointments		✓					✓	✓				✓	
Accompany during labour/birth												✓	
Accompany while shopping						✓							
Schedule appointments	✓	✓	✓	✓							✓		
Provide/ arrange transport		✓	✓	✓	✓						✓	✓	
Provide/ arrange translation		✓	✓										

Encourage greater English proficiency						✓							
Provide/ arrange childcare			✓						✓				
Assist with child protection												✓	
Assist with paperwork	✓		✓				✓					✓	
Connect to health, social and community services			✓					✓					

Facilitate treatment		✓							✓				
Provide mobile clinic	✓												
Offer moral support		✓		✓	✓		✓	✓					✓
Provide companionship						✓		✓					
Provide personal support	✓												
Provide health insurance assistance and advice		✓	✓						✓				

Assist with community development												✓	
Assist with immigration and social issues		✓											
Provide administrative support		✓											
Obtain supplies for baby					✓								
Source items of cultural significance												✓	

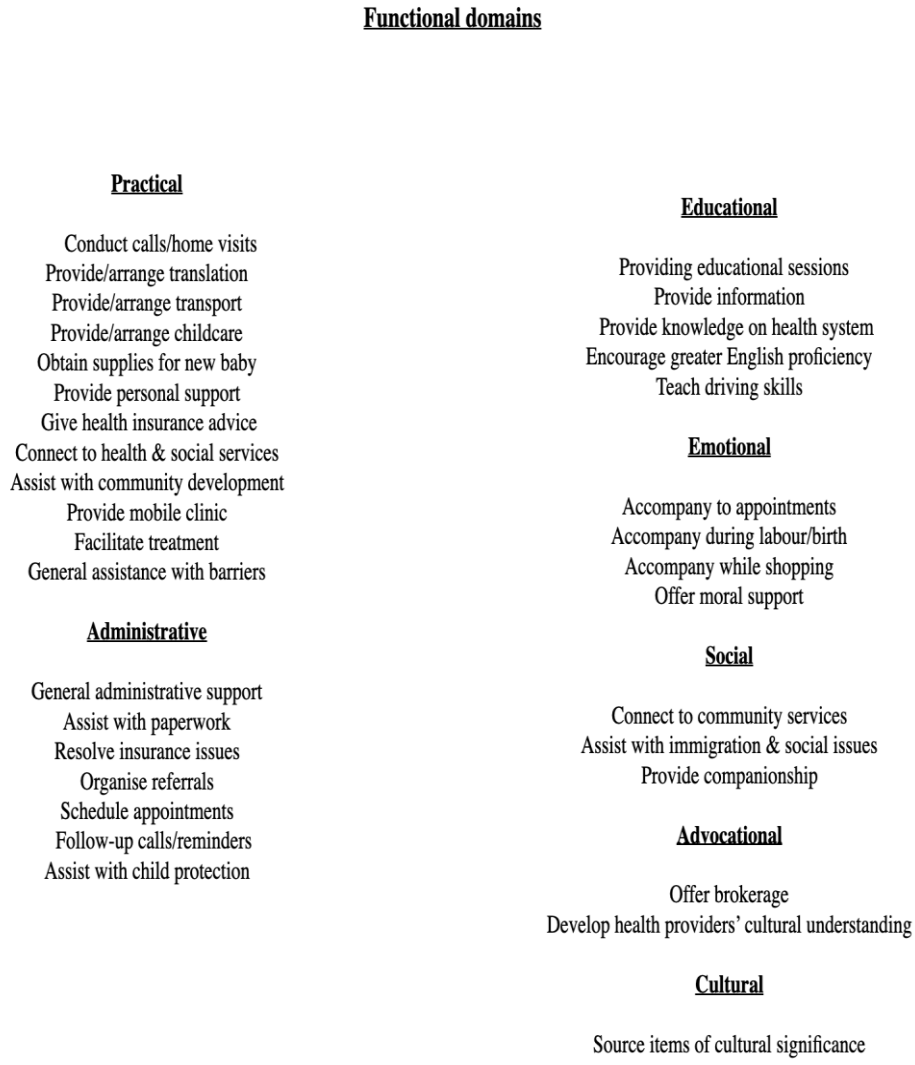
Develop health provider's cultural understanding	✓											✓	
Offer brokerage		✓										✓	✓
General assistance with barriers to healthcare					✓								

4.5 - Roles and functions of health navigation

All studies described navigators' support to migrant women to overcome any barriers that they experienced. I ascertained and developed a typology of role dimensions, through assessing the description of the intervention(s) in each paper; **Appendix A Table 6** provides an overview of these navigational roles. The roles were also categorised according to their functions, with navigators in each study providing educational, practical, administrative, emotional, advocational or social support to migrant women (**Figure 3**).

Most navigation interventions had an educational function embedded within them **(Appendix A Table 6),** reflecting an assumed need to address low health literacy among migrant women. Many of the roles described across the literature also involved an administrative function, such as organising referrals or assisting with paperwork. Roles with an advocational, social or cultural function appeared inconsistently and infrequently across the literature. All navigators - regardless of their terms of employment or the terminology used to describe their role - fulfilled roles spanning multiple functions.

Figure 3: Typology of health navigation devised by author, mapping different navigational roles to their associated functional domains



4.6 - Theoretical basis of health navigation

Across the literature, 15/29 studies did not state explicit use of any theoretical frameworks to describe the underlying logic or mechanisms of navigation. The majority of studies that were grounded in a framework utilised behaviour change theories, which reflected individualised framing of barriers to accessing healthcare. These included the Health Belief Model (Ell et al., 2009; Fang et al., 2007; Fang et al., 2017; Fernández et al., 2009; Han et al., 2009; Parra-Medina et al., 2014; Shokar et al., 2016; Wang et al., 2010), Social Cognitive Theory (Fang et al., 2007; Fang et al., 2017; Fernández et al., 2009; Shokar et al., 2016), Integrative Model of Behavioural Prediction (Allen et al., 2014) PRECEED/PROCEED Planning Framework (Lam et al., 2003), Transtheoretical Model (Han et al., 2009) and Health Behaviour Framework (Maxwell et al., 2010). Elsewhere, a minority of studies referenced theories which position an individual within a wider social context in considering how their access to healthcare is limited by external factors and how navigation may assist them to overcome these: the Ecological Model (Reavy et al. 2012), Ecological Systems Theory (Wagner, 2017), Socioecological Model (Nguyen et al., 2010), Socio-Cultural Explanatory Theory (Ell et al., 2009) and Cultural Safety (Reavy et al. 2012).

Much of the research into navigation for migrant women has therefore not yet examined the social and relational mechanisms involved in navigation, and has preferentially focused on individual barriers and behaviour change mechanisms to accessing healthcare rather than structural barriers.

4.7 - Outcomes

4.7.1 - Uptake of cancer screening and treatment services

The majority of studies assessed the impact of navigation on the uptake of cancer screening and treatment services (22/29). Seven studies reported a statistically significant increase in uptake of mammography screening among migrant women following a navigation intervention (Allen et al., 2014; Fernández et al., 2009; Han et al., 2009; Maxwell et al., 2010; Nguyen et al., 2009; Percac-Lima et al. 2012; Percac-Lima et al., 2013b). All of the aforementioned studies were found to be of 'good' quality with the exception of Allen et al. (2014) - a pre-post study - which scored lower than other studies in the domain of internal validity. Increases ranged from 7.5 amongst Vietnamese women (Nguyen et al., 2009) to 31.9 percentage points amongst Korean women (Han et al., 2009) from baseline. Similarly, uptake of clinical breast examination increased between 17.4 amongst Vietnamese women (Nguyen et al., 2009) and 23 percentage points amongst Korean women (Han et al., 2009), with self-reported uptake of breast self-examination increasing significantly by 36.2 percentage points amongst Korean women (Han et al., 2009). In addition, Latina migrant women in the USA who were navigated experienced a shorter delay from screening to breast cancer diagnosis (Ramirez et al., 2013).

In the case of screening for gynaecological cancers, USA-based studies also reported that navigation led to statistically significant increases in service uptake (Fang et al., 2007; Fang et al., 2017; Fernández et al., 2009; Lam et al., 2003; Wasserman et al., 2006), ranging from 10.4 percentage points amongst Latina migrants (Wasserman et al., 2006) to 66 percentage points amongst Korean migrant women (Fang et al., 2007). It should be noted, however, that Wasserman et al., (2006) presented an ethnosurvey which was found to be of markedly lower quality than other studies. Receiving navigation was also associated with fewer missed colposcopy appointments, decreased time to colposcopy follow-up appointments, and decreased severity of cervical abnormalities amongst Latina migrant women in the USA (Percac-Lima et al., 2013). Additionally, a pre-post study examined the effectiveness of navigation in relation to HPV vaccination for the daughters of Latina migrant women in USA. While there was no statistically significant increase in the number of women initiating HPV vaccination for their daughters after navigation, these women were more likely to complete the full course of HPV vaccinations if they received navigation compared to not receiving navigation [72.2% compared to 42.5%] (Parra-Medina et al., 2014). Finally, within colorectal cancer care, Shokar et al. (2016) reported that 80.6% of USA-based Latina migrants who received navigation engaged in colorectal cancer screening, compared to the 17% uptake amongst Latinas who did not receive navigation.

By contrast, in a randomised-controlled trial that achieved one of the highest scores in the quality assessment exercise, navigation did not result in statistically-significant increase in adherence to breast or gynaecological cancer treatment for Latina migrant women in the USA (Ell et al., 2009). While 90% of women receiving navigation (compared to 88% without navigation) completed chemotherapy treatment for breast cancer, 90% of women in both the navigation and non-navigation groups completed radiation therapy treatment. Similarly, while 94% of women receiving navigation (compared to 87% without navigation) completed chemotherapy treatment for gynaecological cancer, 84% of women receiving navigation (compared to 87% without navigation) completed radiation therapy treatment. Adherence to treatments was unusually high in this study, which the study authors suggest reflects the fact that all participants (within both intervention and control groups) received multifaceted care packages - including informational material, lists of resources and social support services - that could have facilitated treatment adherence to a point where navigation would have had little additional benefit.

4.7.2 - Maternal health

Navigation was shown to decrease the percentage of missed prenatal and paediatric appointments from 25% to 2.5% amongst refugee women in the USA (Reavy et al., 2012), as well as decrease maternal depressive symptoms and levels of stress, and improve breastfeeding and infant sleeping practices amongst Hispanic women in the USA (Lutenbacher et al., 2018). In one study - a retrospective chart review - there was no statistical difference in uptake of prenatal appointments, duration of breastfeeding, adherence to vaccination schedule for babies, or child health examinations for refugee and asylum-seeking women in the USA who received extended navigation (2 years) for perinatal healthcare versus those who were in receipt of navigation for 6-8 weeks (Wagner, 2017), suggesting that longer-duration navigation did not necessarily lead to improved outcomes.

4.7.3 - Psychosocial support

Tran et al., 2014 reported a statistically significant decrease in depressive symptoms, perceived stress and increase in perceived social support amongst USA-based Hispanic women who received navigation.

4.7.4 - Knowledge and awareness of health and disease

The effect of navigation on migrant women's health knowledge and awareness of health and disease was mixed, despite this being the primary focus of much navigational activity. In USA-based studies, it was found that navigation produces a statistically significant increase in knowledge of HPV as a cause of cervical cancer amongst Korean women (Lam et al., 2003), knowledge of cervical cancer risk amongst Chinese women (Wang et al., 2010), as well as knowledge of the age to undergo screening and the frequency required amongst Latina migrant women (Warner et al., 2019). However, there was no statistically significant increase in knowledge of cervical screening and of cervical cancer more generally amongst Latina migrants (Fernández et al., 2009).

Additionally, one study concluded that navigation increased awareness of breast cancer among Vietnamese women in the USA from 88.5% to 99.6% (Nguyen et al., 2009), and another study highlighted that navigated Korean and Chinese women in the UWSA displayed increased breast health literacy following navigation (Han et al., 2017; McClung et al., 2013). Elsewhere, no statistically significant increase in breast cancer knowledge was reported (Fernández et al., 2009; Han et al., 2009). Across the literature, only studies with a pre-post study design reported no statistically significant improvement in migrant women's knowledge and awareness of health and disease following navigation; this may, however, have been due to a lack of sensitivity in the questionnaire and interview tools used in these studies to capture changes induced by navigation.

4.7.5 - Factors affecting behaviour change in response to health navigation

Few studies described the potential factors which influence behaviour change in response to navigation. Higher educational attainment (high school or more) was associated with health behaviour change amongst both USA-based Serbo-Croatian and Latina women receiving navigation for breast and colorectal cancer screening (Percac-Lima et al., 2012; Shokar et al., 2016). Other factors which interplay with navigation included being below 65, having an awareness of screening and having had a doctor recommend screening in the context of colorectal cancer - these were noted as positively influencing health behaviour change to undergo screening for colorectal cancer (Shokar et al., 2016). One study noted that Korean women receiving navigation in the USA displayed higher self-efficacy and fewer psychosocial barriers associated with obtaining the care they needed as a result of the intervention (Fang et al., 2007).

4.8 - Perceptions of health navigation

Four studies reported data on perceptions of navigation - largely in the context of maternity care. This allowed for tentative interpretation of the ways in which navigation may operate as an intervention to improve access to healthcare for migrant women (McCarthy and Haith-Cooper, 2013; Nguyen et al., 2011; Reavy et al., 2012; Wagner, 2017).

Three studies described the perceptions of migrant women on the navigation they had received. Women reported trusting their navigators: “Having someone to talk to at a children’s centre where I felt safe made all the difference. She saved me” (McCarthy and Haith-Cooper., 2013). Although the aforementioned UK-based study was found to be of lower methodological quality compared to the other included qualitative studies, the notion of trust between navigators and migrant women was also outlined elsewhere. Nguyen et al., 2011 concluded that trust may have helped migrant women to share vital information with their navigator, who was noted as “always keep(ing) my confidentiality“. Providing one-to-one care may have been linked to trust, and this sense of trust could allow navigators to communicate effectively with migrant women and be better informed on women’s specific needs, better enabling them to connect women to the necessary services.

Additionally, navigated women were appreciative of the woman-focused, non-health-related support they received which addressed their perceived needs; this was outside of the scope of clinical interventions designed to increase uptake to diagnostic and treatment services. These included being able to practice English with their (non-bilingual) navigators in order to improve their skills (Wagner, 2017) - which would have offered educational benefit - as well as sourcing cultural foods during a hospital stay through the intervention of a navigator (Torres et al., 2014). The importance of social and emotional support provided to these women was highlighted across all three studies. While McCarthy and Haith-Cooper (2013) noted that navigators helped women to cope with social isolation, Wagner (2017) outlined how women perceived an increase in social support through their navigators visiting them, going on outings in the community with them, eating together with them, and transporting them to doctors’ appointments. Navigation was reported to have helped women build confidence in their own abilities to manage their pregnancy (McCarthy and Haith-Cooper, 2013). This was, in part, echoed in Nguyen et al., 2011, where women reported navigators providing vital emotional support which empowered them to engage with their own care - “[the] health navigator provides me with mental and emotional support. They helped me feel confident and much less worried.”

Three studies provided some evidence on the way in which navigators perceived their own role. The suggestion that receiving navigation encouraged greater confidence within clients was also reflected in the perceptions of navigators; they expressed a desire to help clients to become self-sufficient so that they could navigate the health system independently - they wanted to "give them the tools, we give them all the information, we try to motivate and guide, and let them try [on their own]" (Nguyen et al., 2011).

Navigation may have been a source of personal empowerment for both migrant women and those who support them, in that both parties gained self-confidence through engaging with navigational processes. In McCarthy & Haith-Cooper (2013), one navigator stated that "I used to think I was nothing, now I think I'm something and when I wear my Refugee Council badge I feel like a professional". Navigators expressed pride in being able to play a role in the communities to which they also belonged, but one study reported that the navigator's role was demanding and served as a burden on navigators' life outside of work (Reavy et al., 2012), which impacted voluntary navigators in particular. This was, however, also a reflection of the flexible, open-ended nature of their role in being able to respond to migrant women's needs. The same study highlighted that trust was fostered between women and navigators by way of effective communication - which, in turn, could have been facilitated by shared culture, language and/or experience living as a refugee in a different country - and that the relationship between women and navigators could sometimes resemble a form of friendship: "People call me asking what I think. They think that you can solve everything and it's hard for them to see if they are talking to you as a friend or a health advisor". In this study, a deeper level of understanding between women and navigators was noted and linked to navigators' personal experiences of being a refugee and understanding the circumstances of the women they support, although this may also have caused issues in identifying and maintaining interpersonal boundaries.

Two studies reported the perceptions of navigators held by health professionals and service providers (Torres et al., 2014; Nguyen et al., 2011). Navigators were viewed as being invaluable, in part due to their ability to understand different cultures, provide culturally safe services and support women in diverse areas, with one health professional declaring that they were "completely convinced that every single newcomer to the country should have a health broker" (Torres et al., 2014). In this study, navigators were tasked with helping health providers to understand the cultural backgrounds of recent arrivals and refugees; this was indeed a function of their work that was not designed to directly target migrant women. Health professionals elsewhere reaffirmed navigators' roles as cultural brokers, due to their shared characteristics with clients. Nguyen et al. (2011) also noted the role of navigation as expressed by providers - navigation "builds [the patient's] confidence in us and their willingness to participate...in the recommended treatments or tests that are being recommended because it becomes easy to understand what we're trying to say and what the value and importance of that is". In this way, navigators appeared to serve as a bridge between health providers and communities, and the work of navigators complemented the work of health providers.

Three papers quantitatively measured women's satisfaction with the navigation they had received. In Han et al. (2009), women gave the navigation-based intervention an average rating of 8.9 out of 10, suggesting a high level of satisfaction, while 79 percent and 86 percent of women were 'very satisfied' with the information provided by their navigator and the way their navigator interacted with them, respectively (McClung et al., 2013). In addition to this, Allen et al. (2014) found that 86 percent of women were 'satisfied' or 'very satisfied' with the navigation service they received, and 61 percent found it 'somewhat helpful' or 'very helpful' to speak to their navigator.

4.9 - Discussion

The findings of this review help reveal the characteristics, functions, and effectiveness of health navigation interventions for migrant women. The majority of the research questions outlined at the beginning of this chapter have been addressed through the review findings, revealing a number of gaps and limitations in knowledge.

4.9.1 - Health navigation can be characterised as a set of diverse roles and functions

There was wide variation in the range and scope of navigation-based interventions. Navigators were paid or voluntary individuals referred to using a variety of terminologies, completing a variety of tasks, and fulfilling a variety of functions in order to target migrant women's barriers to accessing care. There was no evidence available to verify whether the success of navigation interventions was associated with particular navigational characteristics. Generally speaking, navigation has expanded beyond the original model of patient navigation from diagnosis to treatment; as noted by Freeman (2012), it takes place at multiple stages of the healthcare continuum. This invites critique of Freeman & Rodriguez (2011)'s principles of patient navigation, which describe navigation's elements. Navigation cannot simply be described as being a stand-alone occupation, but it can be conceptualised as a set of roles and a series of functions which can be delivered to clients by a range of lay or professional workers. The fourth of Freeman and Rodriguez's principles argues for the need to distinguish navigators' roles from those of other workers, however, it is clear that navigational roles may be integrated into a variety of occupations when delivering this intervention for migrant women - and potentially for other target populations. Questions remain, therefore, regarding whether dedicated navigators can better address patients' needs compared to other workers with navigational roles.

One novel finding of this review was that informal caregivers such as relatives and friends sometimes serve as navigators for migrant women, similarly to professional and lay workers (Wasserman et al., 2006). It has previously been suggested that informal caregivers assume the roles of knowledge brokers, companions and navigators combined (Casey et al., 2013). However, no further evidence currently exists on the utility of informal caregivers as navigators for migrant women. Navigation for migrant women carried out by individuals working in specified occupations may be an extension of the navigational roles and functions carried out by informal carers, and such findings would be consistent with the contemporary discourse on the variety of occupations that incorporate a navigational element (Wells et al., 2018). Although navigators varied in their characteristics and methods used to deliver the intervention, the aim of addressing barriers to accessing healthcare remained the defining characteristic of navigation for migrant women.

4.9.2 - Navigation can successfully connect migrant women to healthcare - as measured by a variety of quantitative and qualitative outcomes

Across 25 quantitative studies using varied outcome measures, positive effects were generally reported. These studies were of variable - but generally 'good' - quality, with a range of study designs represented. The studies consistently reported navigation interventions as successfully connecting migrant women to preventative, diagnostic and treatment services. Importantly, however, the results of the quantitative quality assessment tool show that studies could have potentially been underpowered, which would lead to an overestimation of the effect size of navigation.

Evidence of navigation improving migrant women's knowledge and awareness of health and disease was mixed, despite migrant women's knowledge and awareness of health and disease being the most often cited barrier across the included literature which justified navigators' educational function. This echoed a scoping review on the use of navigators for ethnic minority and migrant populations in North America (Shommu et al., 2016). It is important to note that only three studies included in the aforementioned review focused on migrant populations, with the remainder of studies focusing on ethnic minority groups who may face similar - but not identical - barriers to accessing healthcare as migrants.

Additionally, the included qualitative studies described perceptions of navigation among clients, health providers and navigators themselves as being overwhelmingly positive, with trust-worthiness and cultural understanding noted as being key characteristics associated with navigators. There was very limited mention of the range of challenges associated with navigation, which likely include patients'/ service users' over-reliance on navigators, navigators' difficulties managing interpersonal boundaries with patients/clients and further marginalisation of migrant patients/clients through use of a 'non-mainstream' service. The primary research component of this thesis will explore challenges associated with navigation at the chosen case study sites.

4.9.3 - Navigation for migrant women functions by providing them with a direct link to the health system while targeting the specific barriers that they face.

In general, interventions in the included studies intended to connect migrant women to services by managing any perceived or actual barriers accessing healthcare. Through navigation, women appear to have been supported emotionally, socially, culturally, practically and educationally, and may have been encouraged and empowered to engage with their own care on an independent basis, although further evidence is needed to identify any longer term benefits of navigation. The implicit assumptions made by the designers of these interventions were that migrant women experience poor access to care, which could lead to poorer health outcomes compared to other populations. One example was navigators' educational and knowledge exchange function in nearly every study included in this review, implying that lack of knowledge of health and of specific diseases acts as a barrier to migrant women. The intended outcomes of these interventions were, therefore, to increase uptake of preventative, diagnostic, treatment and maternity care services, to increase knowledge and awareness of health and disease, and to improve women's satisfaction and perceptions of services. These could make women more likely to access care in an appropriate and timely way in the future - ultimately aiming to improve health outcomes and minimise health inequalities. However, the limited focus across the quantitative data - in particular, on navigation as an intervention to generate clinically-relevant outcomes - meant that the wider social, emotional and cultural functions of navigation for migrant women were likely to be missed. Qualitative data, by contrast, was able to identify and interrogate these functions through offering participants' perceptions of migrant women's needs, as well as offer some very limited insight into the wider benefits of navigation for migrant women, navigators and health providers.

4.9.4 - There was limited evidence that migrant women's individual characteristics influenced their change in behaviour following navigation

Higher educational attainment (secondary/high school and above) and being aged below 65 were characteristics among migrant women which significantly influenced health behaviour change among women receiving navigation for breast and colorectal cancer screening. Interestingly, in the case of educational attainment, elsewhere in the literature it has been noted that recipients of navigation have commonly been those with lower attainment who had not completed high school education (Robie, Alexandru & Bota, 2011; Goris et al., 2012). It should be noted, however, that evidence for any differential effect as a result of personal characteristics was very limited.

There was some speculation that shared characteristics between navigators and the migrant women they navigate could also influence navigational interventions. Although not tested rigorously in research, the 'peer-ness' of navigators - by way of the language, culture, gender or personal experience (of migration, for example) shared with the women they serve - is suggested to be integral to navigational processes. Included studies report that navigation is believed to foster understanding and trust between navigators and their clients. This sense of trust could allow for the possibility of closer, friendlier relationships between navigators and clients. It has been suggested within the community health worker literature that shared culture and language encourages members of marginalised communities to trust workers, in part because of the workers' ability to demonstrate understanding and respect for the community's values, which leads to a strengthened relationship between the community and the worker (Gampa et al., 2017). One could also argue that being a worker who shares a given characteristic with a target population provides a sense of authenticity. In the context of navigation, more qualitative research is needed to further explore this sense of peer-ness, to ascertain if a similar conclusion can be reached for workers with navigational roles, how navigators' 'insider' and 'outsider' identities could be negotiated, and the ways in which this impacts on navigation's effectiveness. Nevertheless, brokerage provided by navigators may rely on a sense of trust and peer-ness, and serve as a vehicle through which bidirectional communication between migrant women and the health system could be facilitated. This, in turn, could play a role in improving migrant women's access to healthcare.

4.9.5 - The theoretical basis of navigation for migrant women has been narrowly conceived

Of those included studies which made use of a theoretical framework, the vast majority were grounded in behaviour change theories. One example, the Health Belief Model, has also been embedded and tested within navigation interventions for other populations (Brekke et al., 2013; Vinneau, 2016), and this and other behaviour change frameworks focus on the behaviours of individuals which enable or prevent them from taking action. Very few of the included studies employed a sociologically-informed approach. There is a prevailing narrative within research in healthcare for migrant populations that emphasises migrants' individual behaviours and deficits in knowledge and/or education - with less attention paid to broad structural factors which pose significant barriers to migrants (Hiam et al., 2019; Holmes, 2012; Phillimore, 2016). Navigation may, in theory, serve to address individual barriers (such as low language proficiency, by providing or arranging language translation) as well as some of the service barriers (such as complex administration, by assisting with paperwork) which a service user / patient may face. However, through exclusively using behaviour change frameworks to describe navigation designed to achieve narrowly-focused clinical outcomes, the theory of how navigation addresses structural barriers for migrant women has not yet been fully articulated in the extant literature and remains poorly understood. Using sociological frameworks which capture the structural factors that pose significant barriers to migrant women would likely enhance our understanding of the processes of navigation. One such approach could be Candidacy (Dixon-Woods et al, 2005) - a lens through which I formulate an understanding of navigation for migrant women, later in this thesis.

Finally, navigational functions and mechanisms identified from the findings - such as providing moral support and companionship, as well as building trusting relationships with migrant women, and increasing migrant women's self-confidence - have wider relevance beyond increasing access to healthcare. Receiving navigational support in this way likely benefited migrant women in relation to the social determinants of their health, for example, by also addressing their social isolation and mental wellbeing, as well as practical and administrative navigational assistance to address their financial, employment and housing needs. This remains largely unexplored and there is value in identifying the specific mechanisms that may indirectly promote migrant women's health within the navigators' roles and functions. Taken with the aforementioned point on using other theoretical approaches to capture how navigation addresses structural barriers, there is a clear need to broaden our conceptualisation of navigation in order to more fully articulate the ways in which it operates and the benefits that may result.

4.9.6 - Limitations

There were limitations to the approaches taken in conducting this review. Only direct quotations from interview and focus group participants in qualitative studies were coded and synthesised, which limited the volume of data. This approach did, however, avoid potential inaccuracies derived from synthesising study authors' interpretations of the data. Despite critical appraisal of literature for quality and risk of bias, only literature in the English language could be searched, which meant that relevant literature in other languages - and from other geographical contexts - may have been missed. A number of quantitative studies measured post-navigation service uptake by participant self-report, which suggests that data on service uptake among this population may not be accurate; some studies did, however, report checking self-reported data against clinical data (Maxwell et al., 2010; Shokar et al., 2016) and assuring participants of their data anonymity and confidentiality - while emphasising the importance of accurate data (Han et al., 2009), although details on how these measures were carried out were not provided by the study authors. Additionally, the majority of quantitative studies included in this review reported loss to follow-up of participants (**Appendix A Table 5**). Finally, some quantitative studies lacked a control group, while others described interventions that combined navigation with other methods; assessment of the true effect of navigation interventions compared to those without navigation was, therefore, not always possible.

Paucity of data within the findings did not allow for me to address research sub-question 3[d] - on internal and external factors influencing navigation. Conducting this review revealed a paucity of qualitative and quantitative research on navigation for this population in contexts outside of North America; this is critical, given the vastly different global patterns of migration, as well as the contrasting health systems which navigation operates within. Notably, most migration takes place within country borders, as well as intra-regionally across countries in the Global South, yet despite adopting an open search strategy without limits on geographical context, Global South contexts were not reflected in the literature. Despite three of the four qualitative studies being of adequate methodological quality through employing the CASP tool, they often did not report on the ways in which navigation is experienced or on its expected outcomes, and very few negative perceptions were noted. It is possible that the ability to only source studies which reported overwhelmingly positive perceptions of navigation was the result of publication bias. There was also a paucity of data relating to maternity care - an area of great relevance, given the significant barriers that migrant women often experience in attempting to access it (Small et al., 2014). Additionally, knowledge gaps remain on the impact of different durations of navigation interventions, the frequency of activities carried out during navigation, and the long-term impacts of navigation on migrant women populations.

4.10 - Concluding thoughts

The integrative review described across Section 2 is, to my knowledge, the first review of the literature examining the nature and utility of health navigation for migrant women. It revealed that health navigation can be characterised as a person-centred intervention, which can complement existing health services in improving access to healthcare - and, by extension, health outcomes - for migrant women. Findings from this review suggest that navigation for migrant women is unstandardised, diverse and tailored. There was consistent evidence of reasonable quality - albeit of limited geography - that navigation can result in increased uptake of preventative and diagnostic health services, but evidence on whether navigation increased knowledge and awareness of health and disease among these women was mixed. Although the qualitative findings of the review suggest that a navigator's sense of 'peer-ness' in sharing a culture, language, gender or migratory experience with migrant women clients may potentially facilitate navigation - and, ultimately, access to healthcare - this deserves in-depth exploration.

This review confirmed that there is very limited evidence on health navigation for migrant women in a maternity context, and within a UK context. This provides a basis for additional research to further our understanding of the utility of health navigation for migrant women, and the theoretical underpinnings of navigation. In light of this, the results of the fieldwork component of my project described later in this thesis will seek to address the gaps identified in this review, by offering primary qualitative data on the theoretical mechanisms underpinning navigation for UK-based migrant women engaging with NHS maternity services, as well as the impact of navigation and the relationships between navigators and the migrant women they serve. In this way, findings from the fieldwork will be combined with findings from this review to fulfil the research objectives of this project.

Section 3: Primary research

The third section of this thesis is focused on the primary research component of my doctoral project. It is comprised of five chapters. While **Chapter 5** details my selected multiple, instrumental case study methodology, **Chapter 6** marks the beginning of the reported findings by characterising the studied health navigation interventions. **Chapters 7 and 8** then offer perceptions of the navigation interventions, centering the voices of migrant women service users and navigators, respectively. Finally, **Chapter 9** explores the dynamics of the central navigator-service user relationship, while **Chapter 10** utilises the data to build theoretical understanding of navigation for migrant women.

Chapter 5: Methods

5.1 - Introduction

This Chapter describes and justifies the methodology and methods used to address the following research question and three sub-questions for the primary research component of this project:

How does health navigation improve access to healthcare for migrant women, when implemented as an intervention?

[a] How do navigation interventions operate in practice when used for migrant women who require healthcare (including maternity care), and what theoretical mechanisms underpin their operation?

[b] How are navigation interventions perceived and experienced in practice?

[c] What is the role of shared characteristics and experiences between navigators and migrant women, in terms of the functioning of navigation?

In addressing the above research question and sub-questions, this Chapter aims to contribute towards the achievement of **research objectives 1, 2, 3 and 4** of this project:

1. To define the concept of health navigation as an intervention, its definitions and characteristics, when implemented for migrant women (addressed by review RQ 1 and primary research)

2. To assess the impact and effectiveness of health navigators from the perspectives of different stakeholders, and explore their relationships with migrant women through navigation (addressed by review RQ3 and primary research)

3. To elucidate the theoretical mechanisms which underpin health navigation when implemented for migrant women (addressed by review RQ2 and primary research)

4. To develop a model of how health navigation can improve access to healthcare for migrant women (addressed through synthesis of all findings from review and from primary research)

This Chapter will begin by stating and justifying my interpretivist stance, which grounds my chosen methods. I then provide justification for pursuing a multiple, instrumental case study design to carry out an in-depth exploration into health navigation interventions operating at two separate study sites. Following this, I provide background on my chosen methods of data collection, management, analysis and participant consultation, and offer justification for why they have been selected for use in this project. Importantly, I also demonstrate the use of critical reflexivity, and how it has shaped the research. Finally, I offer reflection on the quality and rigour of my data.

5.2 - Methodology

A 'methodology' can be defined as a research strategy which outlines and justifies the choice of methods used to address a given research question (Howell, 2012). In this sub-section, I detail my chosen strategy.

5.2.1 - Ontology and Epistemology

The primary research I conducted was largely centred on the perceptions and experiences of multiple stakeholder groups, including both migrant women service users and health navigators. Given that this research was situated in various socio-cultural, political and organisational contexts, it was necessary to consider the ways in which my own ontological and epistemological viewpoints shaped the research process.

Broadly, an ontological position refers to one's understanding of the nature of reality and its construction (Crotty, 1998); my own ontological position was that of relativism, in which I perceived that 'truths' are intangible constructions that are relative to the worldview of the observer or the context in which they are observed (Baghramian, 2004). Additionally, an epistemological position refers to one's understanding of the nature of knowledge and its construction (Cohen, 2007); my own epistemological position was subjectivist in nature, acknowledging that no objective or external 'truths' exist (Creswell, 2003).

Taken together, my ontological and epistemological stances led me to adopt an interpretivist paradigm within my research, seeking to understand the meaning of health navigation through the subjective perspectives of my research participants and documents produced by service designers, and understanding there being multiple realities (Hudson and Ozanne, 1988). These realities are socially constructed and dependent on the perceptions and interpretations of different individuals (Mertens, 2009; Creswell, 2003) and that, according to Crotty (1998), interpretivism "looks for culturally derived and historically situated interpretations of the social life-world". Pursuing this research meant that my own ideological values, biases and experiences (for example, of politics, race/ethnicity, and migrants' entitlement and 'deservingness' of equitable access to healthcare) informed the process of carrying out the research, including the development of research questions and the study design. They have also shaped the way in which I collected data, and interpreted and reported the findings (as in Chilisa and Kawulich, 2012).

A notable strength associated with operating within this paradigm is that the role of the researcher is one of "interpreter and gatherer of interpretations", according to Stake (2008, p.135); the researcher and research participants work in close collaboration to realise participants' constructed realities in their specific contexts, which enable participants to tell their own stories (Crabtree and Miller, 1999). This aligns closely with the primary research component of this project in that it seeks to address the perceptions and experiences of those delivering, receiving and engaging with health navigation as an intervention.

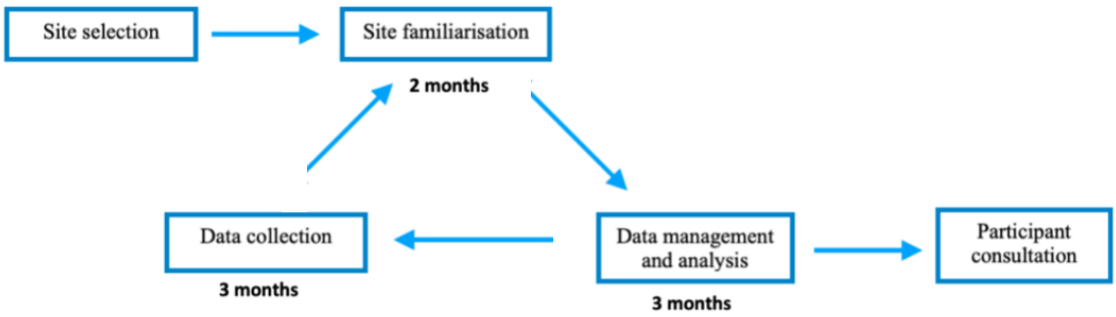
A criticism of interpretivism by some scholars is that its emphasis on the subjectivity of reality means that interpretivist researchers are especially vulnerable to bias, and have historically oppressed non-White and non-Western 'ways of knowing', thereby contributing towards the implementation of research projects that have not benefited marginalised communities (Fixico, 1998; Mshana, 1992; Mertens, 2009). In recognition of this, I committed to conducting critically reflexive research which centers the voices and perspectives of participants in the research, many of whom would have experienced marginalisation as a result of being racialised and othered - which included migrant women participants but, in some cases, also the navigators who served them. Through sustained engagement with these groups over the course of the research, I actively consulted both participants and host organisations with regards to the aims and findings of the research; further details on this can be viewed later in this chapter.

5.2.2 - Study design

A multiple, instrumental case study design was selected, in line with the interpretivist paradigm. A case is defined as "a phenomenon of some sort occurring in a bounded context" (Miles and Huberman, 1994) and - in this research - the 'phenomenon' studied was health navigation for migrant women, while the 'bounded context' was defined as the programme, organisation and/or geographical location where navigation was being implemented.

A case study design allowed for in-depth understanding of the function of navigation. Conducting a case study allows one to address a phenomenon in its context and generate richly descriptive data from a variety of sources (Hancock and Algozzine, 2016). Instrumental case studies are an appropriate tool for inquiring beyond the case itself, and can provide insight into the issue within its bounded context, in order to better understand mechanisms of action and build theory (Grandy, 2010; Stake, 1995). Multiple case studies can be used to replicate findings across cases, and provide enhanced robustness and reliability to a generated theory (Baxter and Jack, 2008). By investigating two cases, I aimed to gather knowledge and elucidate the theoretical mechanisms underpinning the interventions, before comparing and contrasting findings between the two cases.

Figure 4: Dynamic stages of the primary research at each study site



5.2.3 - Site selection

The first stage of the primary research was site selection (**Figure 4**). The case study sites were purposefully selected in different parts of the UK. In order to identify cases and participants for study, a purposeful sampling strategy was used in which "the inquirer selects individuals and sites...because they can purposefully inform an understanding of the research problem and central phenomenon in the study" (Creswell, 2007, p.125). Five case study sites were identified following an online search for UK-based health navigation interventions which were operational at the time, with navigation-related keywords such as 'navigator', 'befriender' and 'doula' being employed.

Once identified, the coordinators of each site were individually approached by email to gauge interest; of the five coordinators contacted, three expressed interest. An introductory onsite, face-to-face meeting was then organised with each of the three coordinators, during which the proposed research activities, timeframe for the research, and ethical procedures were discussed and negotiated. For one case (Project MAMA), I was invited to meet several navigators themselves, as well as some service users - one of whom I eventually recruited for interview. The main challenges associated with recruiting sites were establishing and maintaining regular communication in light of coordinators' existing workloads, as well as giving assurances as to the ethics and integrity of my research, given the vulnerability of some of the service users. On the latter, I successfully addressed any concerns voiced by the coordinators by sharing details of institutional ethics procedures, measures implemented to ensure participants' anonymity, confidentiality and safeguarding, and by sharing a draft of the interview protocols for them to review.

After receiving confirmation of interest from coordinators at all three case study sites, a decision was made to exclude one site located in the North of England. This was because of concerns around the small size of the navigation intervention, with there being only one navigator, who engaged with a small number of migrant women. By contrast, at Project MAMA and Haamla Service, there were at least ten navigators available per site, which presented more opportunity for participant recruitment. These two sites were then confirmed and included.

Table 7: Overview of the two sites included in case study

	Maternity Action for Migrants and Asylum Seekers (Project MAMA)	**Haamla Service**
Geographical location	Bristol, UK	Leeds, UK
Service focus	Focused on antenatal, labour, birth and postnatal care	Focused on antenatal, labour, birth and postnatal care
Service user targets	Designed exclusively for women who were refugees, asylum-seekers, newly-arrived, undocumented and/or trafficked	Designed for minority ethnic women, including women who were refugees, asylum-seeking, trafficked, Travellers, refused asylum, and/or women who have undergone female genital mutilation (FGM)
Navigator profile	Navigators are 'mother companions' (female volunteers with doula/midwifery backgrounds); they may also be mothers, and may be able to speak the same language as their clients and/or share experience of migration with their clients	Navigators are 'maternity support workers' (female, bilingual paid health workers) or 'volunteer doulas' (female volunteers with doula/midwifery background or willingness to be trained, who may have bilingual abilities); they may also be mothers and/or share experience of migration with their clients

Navigational support	Navigators provide one-to-one hospital birth support, home visits, emotional support, advice on birthing choices and NHS care pathways, accompaniment to appointments, and connect women to community resources	Maternity support workers provide one-to-one home visits, emotional support, advice on birthing choices and NHS care pathways, bereavement support, accompaniment to appointments, and connect women to social, religious and cultural services Volunteer doulas provide one-to-one home visits, accompaniment during labour/birth, emotional support, bereavement support, and connect women to social, religious and cultural services
Location of support	Implemented in women's homes	Implemented primarily in women's homes, but also in local children centres, and in hospitals
Referral system	Referrals received from GP surgeries, statutory agencies, community organisations and self-referral by migrant women	Referrals received from clinics, GP surgeries, community midwifery services, statutory agencies, community organisations and self-referral by migrant women
Management	Operated by a small charity (Project MAMA)	Operated by Leeds Teaching Hospitals NHS Trust

The two cases (**Table 7**) were selected for both practical and theoretical reasons. The practical rationale for selection was primarily that their geographical locations made them accessible - with each case located within a major city in England, and only limited financial resource was required to account for the cost of travel and accommodation to conduct the case studies. The cases were of theoretical interest because - while there remained a degree of overlap between the two case study sites - the navigation interventions differed with regards to navigators' prescribed roles, essential characteristics and the professional capacity in which they operate **(Table 7)**.

Most notably, the two selected case study sites sat within significantly different organisational contexts. Gathering information on the impact of contrasting bounded contexts - including locations, budgets and organisations - on the outcomes and the theoretical operation of phenomena has also been viewed as a valuable method of site selection for multiple case study research (Flyvbjerg, 2006). In addition to this, one of the cases (Haamla Service) contained two separate navigation interventions embedded within it, which offered further opportunity to draw internal comparisons within the given organisational context, between the intervention led by maternity support workers and the intervention led by volunteer doulas.

5.2.4 - Site familiarisation

After confirming the two sites, the second stage was to carry out informal site familiarisation over the course of the first two months at each site; this took place from May to July 2019 at Project MAMA, and from October to December 2019 at Haamla Service. The purpose of this was to informally familiarise myself with the intervention, and to learn about the key characteristics of the context in which navigation took place, which was useful to inform the development of methods of data collection (Barley, 2011). Of equal importance, familiarisation also aimed to cultivate a sense of trust with service users, navigators and any healthcare professionals or social support workers, in that some familiarity with myself as a researcher and my planned activities helped to negotiate their participation in individual interviews. This was of particular importance for these sites, given the fact that some service users were especially vulnerable, owing to their experiences with trafficking, exploitation, precarity as a result of their immigration status, and social isolation. For several days per week, over the course of two months at each site, I voluntarily participated in activities carried out when implementing navigation. At Project MAMA, these included day-to-day office-based coordination, helping with fundraising, assisting at open group sessions attended by service users, navigators, healthcare professionals, and social support workers as well as recruitment and training activities for navigators. At Haamla Service, advice provided by the NHS research ethics committee precluded volunteering (see **5.3 - Ethical Considerations** for further details), therefore site familiarisation only consisted of attending navigator-run, twice-weekly antenatal sessions for pregnant migrant women. Clinical settings were not included in the site familiarisation.

Contextual information about the case studies was collected during this period to 'situate' the study and its findings. This information was not included as a source of data, as this was not formal participant observation, which would have had further ethical implications. There were benefits to following this approach, as information about the context of the case study shaped the scope of the research. This was evident at Project MAMA, where site familiarisation aided in identifying - at an early stage of data collection - that social support professionals engaged far more with the navigation intervention itself than healthcare professionals were, thereby justifying their eventual inclusion as a participant group. Site familiarisation at Haamla Service also provided an opportunity to build an initial demographic profile of the service users who attended weekly antenatal classes. This allowed for early identification of a lack of English proficiency amongst service users and, therefore, the need for language interpretation during subsequent interviews, as well as allowing for timely mobilisation of financial resources to arrange this.

5.2.5 - Participant sampling and data collection

Individual in-depth interviews

Individual interviews for the research project took place over the course of several months at each site (June - August 2019 at Project MAMA; November 2019 - January 2020 at Haamla Service). Conducting individual interviews is a method of collecting data that can generate rich and detailed information on the phenomenon under study (Hancock and Algozzine, 2016). Individual interviews were the chosen method of data collection so that the perceptions and experiences of all stakeholders could be comprehensively gathered. It would also enable an understanding of the mechanisms of navigation in relation to shared characteristics and/or experiences between navigators and the women they serve and, in turn, building understanding of other mechanisms underpinning navigation and how it can impact on access to healthcare for this population of women.

Service users (migrant women), health navigators, as well as both health professionals and social support professionals who engaged with navigation indirectly were interviewed as part of the case studies. Similar to site selection for the case studies as described earlier, recruiting participants for an interview was completed by way of purposeful sampling. Navigators, health professionals and social support professionals were recruited by way of opportunistic sampling, a non-random approach by which participants are gradually identified and approached to participate in an interview (Miles and Huberman, 1994). In most cases, the coordinator managing each intervention gave in-person introductions to navigators and health professionals, while, in the case of volunteer doulas at Haamla Service, coordinators privately discussed the proposed research with the doulas, asked for their permission to share their contact details before passing on these details to me. In this way, there was some variation in the approaches taken by coordinators; this was because I had no direct access to volunteer doulas, as they were not present onsite, worked on an ad-hoc basis and did not have regular team meetings. Social support professionals were recommended by navigators themselves, with navigators informing them of the research and sharing their contact details with me, with permission.

In order to identify and approach service users for their participation in interviews, access to them was negotiated through gate-keepers. As outlined by Webster, Lewis and Brown (2014), gate-keepers can be an asset because they are likely to have an open, trusting relationship with service users. In this research project, gate-keepers were site coordinators and navigators.

After negotiating initial access to these participant groups at each site, I approached all individuals to discuss the proposed research interview and their rights as participants, providing them with an opportunity to ask any questions. Information sheets were prepared for each participant group in turn, outlining the aims of the research, the proposed activity in which the participants would take part, as well as the potential benefits and risks of participation (English versions of information sheets for service users and navigators can be found in **Appendix B**). These information sheets were provided in English, as well as in Arabic and Albanian for service users uniquely - owing to the efforts of volunteer translators. These languages were selected as they were the most widespread native languages amongst service users at both sites at the time of the case study research. All individuals were provided with an information sheet and asked for their permission to be contacted by telephone or email to confirm their interest in taking part in an interview. In one case, a participant was found to be illiterate and could not read the contents of her information sheet; a verbal, face-to-face explanation of the contents was offered as an alternative. For those who had been approached on a face-to-face basis, 'consent to contact' forms were completed and signed by each individual. All individuals were then re-contacted three days after being approached in order to gauge their interest in participating in the research, and to schedule a time and location for their interview, wherever possible.

In advance of conducting interviews, protocols for each participant group were developed in line with the research question and sub-questions, as outlined by Castillo-Montoya (2016) and Creswell (2003), including relevant questions and prompts that would help guide the interview process. A semi-structured interview format was followed, because the "predetermined but flexibly-worded questions...invite interviewees to express themselves openly and freely and to define the world from their own perspectives, not solely from the perspective of the researcher" (Hancock and Algozzine, 2016). Semi-structured interviews offer balance, therefore, with pre-prepared questions, which also create space for flexible and open-ended responses from participants. The questions in the semi-structured interviews were grouped into themes in order to help address the research question and sub-questions: the participants' perceptions of the characterisation and value of navigation, the relationship between navigators and service users (and the role of peer-ness within it), and the role that navigation has played in service users' health and wellbeing.

The coordinators at the study sites were actively consulted on the appropriateness of the interview questions presented in the protocols, in order to ensure sensitivity towards service users who experienced vulnerability, and that the content of the interviews adequately upheld participants' safeguarding. The interview topic guide for service users in English is included in **Appendix B**. The interview protocol for health navigators was then piloted during a trial interview with a navigator working at a health centre in the North of England. The trial interview took place in March 2019, and was conducted by telephone. Following the interview, the navigator offered feedback, and minor changes were subsequently made to several questions on the interview protocol in order to promote greater clarity and reduce repetition across questions.

Interviews were sought with navigators, service users and healthcare professionals, in the first instance. Social support professionals (including social workers, benefits advisers and youth advisers) were included in July 2019 as an additional participant group. This was due to the fact that gate-keeping navigators provided access to more social support professionals compared to health professionals, rendering health professionals at Project MAMA especially difficult to recruit, and necessitating a reconsidered participant recruitment strategy. Across both sites, interviews were additionally sought with former navigators and former service users who had previously engaged with the navigation intervention in question; this retrospective activity required full approval from gate-keeping coordinators and navigators who possessed the contact details of these individuals. Audio recordings of interviews were made using an encrypted dictaphone.

All but four interviews were conducted in English. To ensure that service users who were not proficient in English could be included in the research, three interviews were conducted using an Arabic interpreter. An interview was also conducted using a French interpreter; although the participant information sheet had not been produced in French, I was able to recruit a service user for interview using my own intermediate French language skills by providing a verbal summary of the information sheet. I also fulfilled her request to provide an English language information sheet for her husband to translate for her at home, and gained her consent both to contact her and to include her in the research.

Whenever a need for language interpretation for a service user was established, I approached professional, accredited interpreters present at the Haamla Service community antenatal groups for support. Approval was gained from Haamla Service to approach these interpreters at the antenatal groups, allowing me to describe to them my research projects and its objectives, and to arrange follow-up contact and interviews as jointly agreed with both interpreters and service users. All interpreters had already been providing live interpretation during the antenatal groups, and had worked with NHS and immigration services. In spite of their professional experience working with migrant groups - including those who were especially vulnerable - before conducting any interview via interpretation I shared copies of service users' participant information sheets and consent forms with interpreters and reiterated the importance of upholding confidentiality and anonymity for the purposes of the research. All four non-English interviews were conducted in my presence - with three being on a face-to-face basis and one conducted via telephone - and involved live interpretation of my interview questions, service users' responses and other verbal interactions.

As with interviews conducted in English, audio recordings were made of the interpreted interviews and only my (English) interview questions and interpreters' English translations of service users' responses were transcribed, coded and thematically-analysed (outlined below, in **5.2.6 - Data management and analysis)**. Attention was paid to the quantity and quality of the interpreted interview responses, however, there did not appear to be any difference in quantity or quality between interpreted and non-interpreted data, and no specific issues with the interpreted data were identified. The impact of reliance on interpreters will be discussed in the Discussion section of this thesis.

Documentary data

Documents have been described as 'social facts', which are developed, disseminated and used in 'socially organised' ways (Atkinson and Coffey, 1997). Documentary analysis is, according to Bowen (2009, p.27), the "systematic procedure for reviewing or evaluating documents—both printed and electronic (computer-based and Internet-transmitted) material". The purpose of documentary analysis is to elicit information from documents which aid with developing a rich understanding and providing insights of relevance to the research questions, as noted by Merriam (1988, p.118). Documentary analysis is, therefore, a suitable method to utilise for case study research. In order to complement participants' perceptions and experiences expressed via individual semi-structured interviews, documents were sought and interrogated to provide further, contextual information on the navigation intervention in question, the processes involved in its implementation, the recruitment and training of navigators, policies and the service designers' stated aims of navigation.

To be eligible for inclusion in the analysis, documents needed to be produced by the case study site or by a commissioned third party, and supply relevant information on the background of the intervention, their aims and/or policies which impact on the functioning of navigation. After giving written consent (the document consent form can be found in **Appendix B)**, co-ordinators at the sites provided me with annual reports, policy summaries, (blank) service user assessment forms, navigator recruitment and training documents and promotional leaflets. In addition to these, I retrieved publicly-available navigator job advertisements and PowerPoint presentations on Haamla Service from the internet; no publicly-available documents on Project MAMA were found, which was likely due to its being a relatively newly-established service. All retrieved documents were included in the analysis, therefore no sampling of documents was conducted.

Documents were collected, reviewed and analysed as a continuous activity over the course of studying each case, starting at the point of site familiarisation and running in parallel with both the conducting of interviews and the completion of data analysis. This was in order to allow for the cross-referencing of data collected through interviews, as well as codes applied to analysed interview transcripts. In reviewing each document, attention was paid to the original purpose of the document, its context, its target audience and its completeness, as advocated by Bowen (2009); this allowed for monitoring of credibility. An initial reading of each document also allowed for the content most relevant to the research questions to be identified, so that important information was isolated from that which did not appear to be important - a key skill for qualitative analysis, as described by Corbin and Strauss (2008). Each document was then coded inductively, as part of a 'six phase' thematic analysis (**Table 8**). Themes ultimately generated through analysis of documents were constantly compared and contrasted with the themes generated from interview data, which provided an opportunity to highlight and interrogate conflicting information. Full details of how documents were analysed in tandem with interview data can be viewed in the next section.

Table 8: Example coding of a document (D1 - mother companions' handbook, Project MAMA)

Documentary data	Code(s)
Each mama will be unique in her needs and requirements and as such, MC's will have to be malleable, sensitive and responsive in their approach. Each woman has come to be living in the UK often through complex and challenging and circumstances. It is an MC's role to support her whatever these may be, to hold space and listen attentively without probing or challenging her…Patience and empathy will be crucial and go a long way.	Awareness of trauma from past experiences; Navigation shaped by needs
Mamas will receive weekly/fortnightly/monthly sessions (depending on need and estimated due date (EDD)) with MC's. Support to discuss birth preferences, promote understanding and encourage informed choice; MC's will discuss hopes and wishes for birth, explore comfort measures and breathing for labour and provide consistent emotional support…Support to understand and access entitlements to healthcare.	Frequency of navigational support; Navigation shaped by needs; Navigators supporting birth planning; Identification of candidacy
Exclusions: What we cannot support with (in line with Boundaries Policy): Offer medical advice On-going accompanying to appointments	Boundaries of navigator role are well-defined

5.2.6 - Data management and analysis

All interviews were transcribed verbatim using word processing software and - along with scanned or digital documents - were then imported into NVivo, and separated and indexed into distinct folders based on data source.

A reflexive thematic analysis approach was selected for analysing the data, firstly for its inherent flexibility which allowed for it to be applied to a range of theoretical frameworks (Braun and Clarke, 2006; Clarke and Brown, 2013), but also for its suitability to my research questions on participants' perceptions and experiences of navigation - necessitating an exploratory, inductive, and data-driven approach. Additionally, reflexive thematic analysis provided an opportunity to be more conscious of the researcher's influence on the construction of knowledge during the research process, in that "the researcher strives to be fully cognisant of the philosophical sensibility and theoretical assumptions informing their use of TA [thematic analysis]; and these are consistently, coherently and transparently enacted throughout the analytic process and reporting of the research" (Braun and Clarke, 2019, p.594).

A 'six-phase' approach to thematic analysis was undertaken at each study site (Braun and Clarke, 2006; 2012; 2013). Firstly, I familiarised myself with the data by completing initial readings of each interview transcript and document in turn, noting initial reflections, where necessary. Following this, I then carried out more in-depth readings of each transcript and document. A mostly inductive, exploratory coding process was followed, in order to allow for the realities and experiences of interview participants, in particular, to be documented, interpreted and recorded. Data-driven codes were generated, and compared to and informed by the domains of the Candidacy framework. Line-by-line initial open coding on the interview and document data was carried out, to allow for the views, perspectives and experiences expressed in the interview and document data to be reflected (as in Crabtree and Miller, 1999; Creswell, 2007). Following this, codes were iteratively and continuously revisited, revised and reconfigured while coding subsequent interview transcripts and documents; **Table 9** offers an example of how data were coded. All codes were assigned a code label, description of eligibility to be assigned to the code, and an example quotation from the interview or document data. Codes were discussed with my doctoral supervisors. After coding of interview transcripts and documents was completed - as recommended by Saldaña (2013) - memos were produced for each coded manuscript or document to record reflections on the data and my initial interpretations of it, which also triggered further review and reconfiguration of codes. An example of a completed memo can be found in **Appendix B**.

Table 9: Example coding of an interview (N7 - navigator 7 at Haamla Service)

Transcript	Code(s)
I: How would you describe your role at Haamla? N7: What we do is antenatal classes - we provide women-only groups in the community settings with use of interpreters, which is really a need in this area. Mainstream groups don't have interpreters, so there's opportunity for the migrants to attend.	Offering community antenatal support groups; Navigators facilitating language interpretation; Navigators filling gap left by mainstream public service
N7: If their midwife refers a woman to the service for support, we support with pregnancy, with explaining things around maternity services, around housings, around benefits….any social issues, because we can signpost them, help them with items for the baby, or we can find a service who can help them better or deal with such an issue. We do go to their home and visit them ante-natally, we do support them post-nasally up to 6 weeks after the delivery. We do antenatal and postnatal home visits, antenatal and postnatal hospital visits as well - so if we need to go to the wards and support ladies there, we do.	Navigators helping to provide information; Navigators acting as signpost; Navigators facilitating material support; Navigators providing home visits; Navigators providing hospital visits; Navigation until 6 week post-natal
I: How do doulas fit into what you do? N7: We're a bit different than doula [pause]. If the woman needs a doula, it's one of the needs of the ladies. So if we go to a woman and she says that she's on her own for some reason, and would like somebody to be with her at the labour, that's a support we can offer to her through the doula service combined with Haamla.	Different types of navigators at study site; Service users' need for companionship; Navigators accompany during birth

The third stage of the thematic analysis process involved the collation of codes to build themes. After finalising the codes, I identified patterns of codes unifying around a 'central organising concept' and considered the ways in which different candidate themes related to one another to construct a hierarchy of candidate higher-order themes and sub-themes - as outlined by Braun and Clarke (2006). These candidate themes were then reviewed and reconfigured for consistency (Fox, 2014), as the respective fourth and fifth stages of the analysis. Each candidate theme was reviewed to ensure that codes derived from the theme - and the related data - were indeed unified around a central organising concept. This, then, led to the reconfiguring of candidate themes by reconsidering the hierarchy of higher-order and sub-themes, cross-checking and editing the names of themes - ensuring that each theme accurately and clearly captured a meaningful element of the data that would usefully address the research questions. **Appendix B** contains a transcribed interview, as well an NVivo 'treemap' illustrating the hierarchy applied to the codes when constructing themes.

Data analysis during these preceding stages was an iterative process, as advocated by Braun and Clarke (2006) and Creswell (2007). At each case study site, the analysis of data collected from initial interviews or documents took place concurrently with sourcing the remainder of interviews or document data, in order to allow for practical and systematic organisation and management of data within a limited time period, and to allow for codes and themes developed from interview transcripts to be compared to those developed from documentary content, and vice versa. The sixth and final phase of the analysis was the phase in which triangulation took place (described further below), and involved revisiting written memos, codes and treemaps after themes from interview and documentary data at the study site had been reconfigured. This was to ensure that the final themes remained 'close' to the data, and could indeed reliably inform the research questions.

While there was a possibility that data saturation may be reached during analysis before all intended interviews had been conducted and before the case studies were concluded at each site (Birks and Mills, 2015; Olshansky, 2015; Saunders, 2018), this did not appear to occur. On the contrary, case studies were concluded as a result of practical and resource limitations, owing to this research being conducted exclusively as a doctoral project. While new insights were emerging throughout the case studies, some repetition in themes allowed for existing claims to be strengthened over the course of the case studies, which gave them greater credibility.

Triangulation was carried out to ensure in-depth understanding of the features and mechanisms of each case study. This is a central element of qualitative inquiry (Creswell, 2003). According to Moran-Ellis et al. (2006), triangulation is an "epistemological claim concerning what more can be known about a phenomenon" when data are combined, and can be defined in multiple ways.

Triangulation was carried out at two levels in this project. Firstly, I triangulated interview data and documentary data - within each case study - which allowed for themes derived from all interview or documentary data to be combined for richness and to inform each research sub-question (Carter et al., 2014). As mentioned earlier, this was an iterative process, involving interwoven stages of document identification and initial coding, the conducting and coding of interviews and the development of candidate and final themes through the simultaneous analysis of interviews and documents. Convergence coding was then employed; this entailed comparison of final themes generated by interviews and documents to ascertain agreement, discordance and silence in themes between the two data sources, and concluding the degree to which each data source contributed to the research questions (as in Farmer, Robinson, Elliot and Eyles, 2006). According to Wood, Sebar and Vecchio (2020), this form of triangulation could create a 'coherent story', allowing for corroboration of data collected using different methods and for the ascertainment of credibility, in line with an interpretivist approach (Lincoln & Guba, 1985, In: Glaser, 2007). In this way, some inconsistencies and contrasts between interview participants' accounts of navigation and the accounts of navigation offered in documents were exposed; importantly, documents provided insight into how navigation at each study site was intended to operate, while the interview data confirmed or refuted it. This is demonstrated in **Chapter 6**, where I characterise the health navigation interventions through corroboration of documentary data with interview data.

Secondly, the cases comprising the multiple, instrumental case studies were also triangulated for analysis. Themes generated from interview and documentary data at the conclusion of each case study were compared between the two case studies - again, through convergence coding. Selecting two diverse study sites on which case studies could be developed allowed for a broader representation of health navigation for migrant women, which could "achieve a level of saturation that ultimately [reveals] common issues and themes", as demonstrated by Stavros and Westberg (2009, p.313). In practice, this meant that data from each study site were integrated as part of analysis, highlighting commonalities and differences in themes from across the case studies. This is demonstrated throughout the Results chapters in Section 3, where I begin each sub-section summarising the broader thematic trends from across the two case studies, wherever possible.

5.2.7 - Participant consultation

In designing this project and as a means of engaging in good research practice, I intended to offer a form of informal patient and public involvement by way of consulting participants about their views of the research at distinct points in the fieldwork. This followed initial consultation on the appropriateness of the research with the coordinators at each of the study sites. At the beginning of my engagement at each site - during the site familiarisation stage - I approached potential participants (as well as re-approaching coordinators), on a face-to-face basis, in order to present a brief outline of the research and its aims using a five minute Powerpoint presentation. The purpose of this was to introduce them to my project, explain the reason for my onsite presence and gather views on the proposed research activities; the latter reason would have allowed for any slight modifications in the methods to be considered. Due to logistical challenges, it was only possible to approach six service users and two navigators at Project MAMA, and two service users and two navigators at Haamla Service. Participants expressed initial interest in - and positive perceptions of - the planned research. One service user at Haamla Service mentioned the importance of confidentiality and how her living conditions and transport difficulties would raise practical issues for her to complete a face-to-face interview; I consequently reassured her of how her confidentiality would be upheld through conducting a telephone interview at her convenience, to which she responded positively.

Following the initial analysis and interpretation of data at the end of my research engagement at each case site, I formally shared the research findings with coordinators managing the interventions and with participants who expressed an interest in being re-contacted for this purpose. This was done through producing a lay summary of the preliminary analysis for each study site and disseminating it by email to these individuals. This was a 'member checking' exercise in which results were cross-checked with research participants, and was a means to generate trustworthiness in - and maintain validity of - the research results (Crabtree and Miller, 2000), presenting an opportunity for reflection on how far my interpretations articulated the realities of participants, as well as an opportunity for feedback from participants on how the research approach could be improved. Candela (2019) also argues that member checking should go beyond a simple validity exercise, and "could be used as a reflective experience" for participants themselves. For each site, summaries of the results using lay language were emailed to co-ordinators and participants who could be contacted via this method. Participants were asked for their views on my conclusions, whether they accurately reflected their accounts and if they had any thoughts on how the results could impact them. Participants were invited to respond privately and confidentially, with three participants from Project MAMA and one participant from Haamla Service choosing to respond. All responded positively - and with interest - to the results, stating that the research captured their realities. Where possible, service users were also approached on a face-to-face basis at the end of my engagement at each site to briefly share an overview of the findings, with two service users at Project MAMA voicing agreement and satisfaction with my conclusions. It was not possible to share and discuss these results with service users on a face-to-face basis at Haamla Service, owing to logistical barriers.

Member checking is, however, contentious, in that there is potential to cause harm to marginalised participants (Candela, 2019), particularly those who have experienced trauma, and may be at risk of being re-traumatised if needing to revisit discussions in which sensitive themes were mentioned. For this reason, I chose to conduct the member checking exercise by sharing a summary of the synthesised and analysed case study - instead of conducting individual follow-up discussions during which individuals would be presented with their transcribed and coded interview transcript. This is likely to have reduced the risk of participant distress (Birt et al., 2016).

5.2.8 - Critical reflexivity

Critical reflexivity is crucial when inquiring into the perceptions and experiences of participants by way of individual interviews. My epistemological approach - that of interpretivism - posits that knowledge is a social construct; in this way, critical reflexivity describes the methods through which researchers can reflect on how their own assumptions, values and perceptions may impact on the construction of knowledge when conducting research. This seeks to increase "the credibility of the findings by accounting for researcher values, beliefs, knowledge, and biases", according to Cutcliffe (2003, p.137). My own identity as a Black women - who has had lifelong experience of racial and gender-based oppression - likely impacted on the research process as it may have been less challenging for me to access a research context with other racialised women, due to my (initially) being perceived as a peer by some of the service users. In addition to this, I have previously had experience living as a racialised migrant in other countries, and facing barriers in accessing healthcare. Adopting an insider's identity (albeit unwittingly) allowed for easier access to some communities, and some understanding of the nuances associated with service users' experiences that a researcher without that identity may not possess (Padgett, 2008). However, this also created a risk of imposing my own beliefs and biases (Drake, 2010) and service users offering less detail and information due to perceiving me as already being knowledgeable on the spectrum of their experiences (Daly, 1992).

Unequal power structures in society which allow particular discourses to dominate may manifest themselves in an interview scenario; a researcher's characteristics - such as age, gender identity, educational attainment, socioeconomic status, epistemological perspective and perceptions of the interview participants' position of power can impact on the dynamics of the interview (Aléx and Hammarström, 2008) and, therefore, on the data and interpretations that can be produced from it.

I am highly aware of my relative power and privilege compared to some participants in this research; despite being a Black woman of working class origins, and from a family of West African and Caribbean migrants, I am also British-born, a native English speaker, well-educated, possess a high level of cultural capital and do not face the same barriers as recently-arrived migrant women in Britain. In light of this, I endeavoured to develop relationships with participants during site familiarisation and in the early stages of the interviewing phase, in an attempt to reduce any existing power imbalance. This was especially evident at Project MAMA, where I adopted a joint researcher-volunteer role at the weekly community group that some service users attended, which included cooking meals with service users, and helping to care for their children while service users practised yoga. This did, however, present risks, including a perception of my being merely a volunteer, which could have created a dependency among service users, in particular, who may then have felt pressure to participate in an interview. This was minimised by setting clear boundaries, clarifying and making known my joint researcher-volunteer role to potential participants, following organisational guidelines on managing interpersonal boundaries - as was carried out by Tinney (2008) and Garthwaite (2016) - and emphasising the voluntary nature of participation in the research project.

The inclusion of documents as a data source with which to triangulate interview data is a practical action to reduce the impact of a researcher's perceptions and biases. Documentary data has been described by Bowen (2009, p.31) as being " 'unobtrusive' and 'non-reactive' — that is, they are unaffected by the research process". This implies that the inclusion of more objective or neutral documentary data may help to address concerns associated with needing to employ critical reflexivity.

5.3 – Ethical considerations

Written, informed consent was given by participants to conduct and audio record their interviews, prior to an interview commencing, and all participants were clearly informed about their right to withdraw their participation at any point in the interview without providing a reason. A copy of the interview consent form is included in **Appendix B**. Participant confidentiality was imperative in conducting interviews - and at all stages of this research process - particularly with regards to service users. Some women may have had more generalised worries about sharing their data, given the fact that some service users possessed insecure or undocumented immigration status which created vulnerability, and given the political context in the UK in which these service users were situated. For internally-sourced documents, informed consent was obtained in written form from coordinators of host organisations.

To protect all participants and their right to confidentiality, audio recordings of interviews, typed transcripts of interviews and scanned or digital documents were uploaded and stored on a secure, access-restricted project folder on the University of Sheffield's institutional online server. Any information that could allow for individuals to be identifiable (such as names and contact details) included in interview transcripts or in (non-publicly-available) documents were redacted to protect individuals' right to anonymity, ahead of importing the files into NVivo for management and analysis. Paper copies of informed consent and 'consent to contact' forms were stored in a locked cupboard in a room requiring coded access, within an institutional building.

This research required ethical approval from the School of Health and Related Research (ScHARR) Research Ethics Committee (application reference 025447), as well as the NHS Social Care Research Ethics Committee (application reference 19/IEC08/0038); confirmation of these approvals can be found in **Appendix B**.

Ethical approval from ScHARR was obtained in April 2019 to commence study at Project MAMA. Although health professionals who engaged indirectly with the navigation intervention were actively sought as participants - with coordinators and navigators expected to be gate-keepers in accessing them - it emerged that these gate-keepers had had very limited, sustained contact with health professionals, resulting in only one health professional being recruited to participate in an interview. Through the course of my engagement at the study site, it emerged that gate-keepers had greater contact with social care professionals including social workers, benefit advisors and youth advisers, and that these individuals were best placed to provide insight on their indirect engagement with the intervention. In response to this, a minor amendment to the original application was sought and approved in August 2019. Subsequently, two social care professionals were successfully recruited and interviewed for the research, using a newly-developed information sheet and interview protocol.

Additional NHS Social Care ethical approval - as well as Health Research Authority approval - was required to commence study at Haamla Service. This was due to the institutional nature of the Service, which is part of the Leeds Teaching Hospitals NHS Trust. Conducting this research in this context meant that NHS buildings, facilities and resources were utilised, and NHS service users formed a key participant group. The Committee recommended a minor change to the design of the research at this site in relation to my intention to volunteer at Haamla Service during the site familiarisation period, as they stated that it raised issues around communicating and clarifying boundaries between researcher and volunteer roles. This suggests that NHS research policies have not necessarily fully considered the ways in which researchers must seek to build trust with minoritised populations - who may not trust statutory services. Although I had been mindful about articulating my dual researcher/volunteer role to service users, in particular, while conducting research at Project MAMA, this dual role was necessary in that context in order to gain exposure and proximity to service users, and to build trust. Maintaining a dual researcher/volunteer role was not necessary at Haamla Service, however, due to my already being able to engage with service users at the organisation's weekly antenatal groups throughout the course of the case study. In light of this and the Committee's recommendations, I ultimately decided not to pursue volunteering at Haamla Service and withdrew this proposed activity from the application. Ethical approval from the NHS was then obtained in October 2019 to commence study at the site.

Chapter 6: Characterising health navigation interventions for migrant women

6.1 - Introduction

Chapter 6 is the first of five chapters reporting the fieldwork results. It situates the three health navigation interventions at the two study sites within their organisational contexts, providing detailed background on their designs and operations. Firstly, this chapter will offer an overview of the features of the interview and documentary data and information on demographic information on participants, in order to provide background on the source of the documentary and interview data. The next part of the Chapter will then seek to characterise navigation, providing descriptions of its features, recruitment of navigators, navigational tasks, timelines, and insight into the way the interventions have been managed by the organisations at the study sites. Following this, there is some exploration of the purported aims of navigation.

Documentary data and interview data are continuously compared and contrasted throughout this Chapter, in order to draw a distinction between the ways in which navigation is intended to operate, and the ways in which it operates in practice.

This chapter addresses the overarching research question, by informing research sub-question [a]:

[a] How do navigation interventions operate in practice when used for migrant women who require healthcare (including maternity care), and what theoretical mechanisms underpin their operation?

[b] How are navigation interventions perceived and experienced in practice?

[c] What is the role of shared characteristics and experiences between navigators and migrant women who they serve, in terms of the functioning of navigation?

This chapter reports on the navigation interventions across the two study sites, Project MAMA (Bristol) and Haamla Service (Leeds). As outlined in **Chapter 5**, primary research involved documentary analysis, as well as individual, semi-structured interviews.

Across the two sites, 31 individuals were interviewed; 14 migrant women service users, 11 navigators, four healthcare professionals and two social support professionals. The mean duration of interviews with both navigators and healthcare professionals was 66 minutes, with social support professionals and service users at 64.5 minutes and 29 minutes, respectively. Eleven documents were included for review and analysis, with two documents relating to Project MAMA and nine relating to Haamla Service; details of these documents are provided in **Table 10**. The two documents from Project MAMA were sets of guidelines and policies for use by Project MAMA's navigators, while the nine documents from Haamla Service were a mix of annual reports for use within the Leeds Teaching Hospitals NHS Trust, promotional materials targeted at NHS colleagues and the general public, job descriptions for navigators and potential navigators applying for the role, and an external research report. There was no indication of the documents not being credible, although one document (HS9) was a third-party research report on Haamla Service; as only one quotation was extracted from the document and used in this thesis, the risk of extracting inaccurate or biased data was small.

While the majority of the documents provide an official narrative of the background to - and management of - the interventions at the study sites, the interviews offer the perspectives of participants. This, therefore, provides an opportunity for direct comparison between the purported characteristics of navigation and the ways in which it appears to operate in practice. Throughout this chapter, I will indicate which data sources contributed to each theme, and highlight any contrasting information between documents and interviews which offers insight into how implementation processes occur.

Table 10 - Summary of documents included in the analysis

Identifier	Name	Author	Date published	Description of contents
PM1	A mother companion's handbook	Project MAMA	2019	A guide for Project MAMA's navigators, including an outline of the role, expectations of navigators, relevant organisational policies and a code of conduct
PM2	Summary & strategy	Project MAMA	2019	A summary of programmes offered at Project MAMA, including information on organisation's background, personnel, logical frameworks, and methodology
HS1	The Haamla Service: Working with diversity in maternity services	Shaista Khan and Nada Abdul-Majid	2019	A PowerPoint slide deck providing a rationale for and overview of programmes at Haamla Service
HS2	Job Description	Haamla Service	Unknown	A document outlining Haamla Services' maternity support workers' role, and the knowledge, skills and experience required or desired for this role
HS3	Haamla Service	Haamla Service	Unknown	An A4 booklet providing a rationale for and overview of programmes at Haamla Service
HS4	None	Haamla Service	Unknown	An A5 leaflet advertising Haamla Service's volunteer doula programme to potential service users

HS5	An Integrated Dedicated Community Maternity Service for Vulnerable Women from Black and Minority Ethnic Communities (BME)	Val Watson	Unknown	An A4 poster providing a rationale for and overview of programmes at Haamla Service
HS6	Job Description	Haamla Service	Unknown	A document outlining Haamla Services' volunteer doulas' role, and the knowledge, skills and experience required or desired for this role
HS7	Haamla Team Referral Form For Black and Minority Ethnic Women	Haamla Service	2015	A blank form requesting potential service users' personal information, including details on NHS care, migration history, and any vulnerabilities (according to Haamla Service's definitions)
HS8	Annual Report 2007 / 2008	Haamla Service	Unknown	A report outlining Haamla Service's history and background, details on it s programmes, and an evaluation of its strengths and weaknesses
HS9	A Vision for Haamla: Summary report of feedback	Jane South	2009	A report on a workshop conducted by Leeds Metropolitan University, focused on service users' and healthcare professionals' perceptions of Haamla Service, and providing some background to the service, as well as some recommendations for the service's coordinator

6.2 - Characteristics of participants

The service user participants had various migration histories and statuses; service users either self-reported their migration status or it was communicated by a coordinator or gate-keeping navigator. Some service users had been granted refugee status, while others were in the process of seeking asylum. They were either pregnant or new mothers being supported by way of navigation at the time of interview, or had been former users of the service in the preceding months. Health navigators were mother companions (Project MAMA), maternity support workers (Haamla Service) or volunteer doulas (Haamla Service). Finally, healthcare professionals participating in the study were all midwives, while the two social support professional participants consisted of a youth advisor and a benefits advisor. Demographic information on age, gender, ethnicity, educational attainment and maternal status of participants was also collected in an effort to monitor whether diverse perspectives were collated from the interview process (see **Appendix B** for the interview guide, which includes questions on demographic information).

Table 11 - Characteristics of interview participants, listed by group and study site

	Service users (n=14)		**Health navigators (n=11)**		**Healthcare professionals (n=4)**		**Social support professionals (n=2)**
	Project MAMA (n=4)	Haamla Service (n=10)	Project MAMA (n=6)	Haamla Service (n=5)	Project MAMA (n=1)	Haamla Service (n=3)	Project MAMA (n=2)
				Age			
18 - 30	2	6	1	0	0	0	0
31 - 45	2	4	3	2	0	2	1
46 - 59	0	0	1	2	1	1	1
60 plus	0	0	1	1	0	0	0
				Nationality/ethnic self-identity			
White British	0	0	1	0	1	1	0
White Irish	0	0	1	0	0	0	0
White Other	0	0	1	0	0	0	0
Black Jamaican	0	0	0	1	0	0	0
Albanian	1	0	0	0	0	0	0
Bengali	0	0	0	1	0	0	0
Gambian	0	2	0	0	0	0	0
Ghanaian	0	1	0	0	0	0	0
Eritrean	0	2	0	0	0	0	0
Ethiopian	0	1	0	0	0	0	0
Kenyan	1	0	0	0	0	0	0
Nigerian	1	0	0	0	0	0	0

Oromo Ethiopian	0	1	0	0	0	0	0
Pakistani	0	1	0	0	0	0	0
Polish	0	0	0	1	0	0	0
Thai	0	1	0	0	0	0	0
Sudanese	0	2	0	0	0	0	0
Syrian Kurd	1	0	0	0	0	0	0
No self-identification offered	0	1	3	2	0	2	2
Educational attainment							
No schooling	1	2	0	0	0	0	0
Primary school	1	2	0	0	0	0	0
Secondary school	1	2	1	1	0	0	1
College / University	1	4	5	4	1	3	1
Maternal status							
Mother	4	3	3	5	1	3	1
Non-mother	0	7	3	0	0	0	1

All participants - across all groups and at both sites - identified as being female. There were no obvious demographic differences in age and educational attainment amongst service users, health professionals or social support professionals when making comparisons between the two study sites.

In **Table 11**, information on participants' identities was derived from the responses they offered during the interview, in order to avoid making erroneous assumptions about how they may identify themselves. This applied to all participant groups. By doing this, I sought to gain insight into participants' identities through the narratives they voluntarily provided; since I felt that foregrounding participants' identities would preclude an open dialogue about the identities participants felt were relevant when discussing their engagement with health navigation. Some participants - around half of the navigators and healthcare professionals, and both of the social support professionals - did not offer any self-identification of their race, ethnicity or nationality in their interview responses. While I attempted to follow-up with participants to give another opportunity to self-identify, this proved extremely challenging due to participants' professional and personal circumstances caused by the COVID-19 pandemic, as well as service users' transience. The vast majority of participants who did choose to offer insight into their identities at the time of interview were service users - all of whom were foreign-born migrants whose experiences in the UK were commonly defined by their perceived racial, ethnic, or national identity. While at least half of interviewed health navigators at Project MAMA self-identified as being White, navigators at Haamla Service were far more diverse. This contrast in workforce diversity can be understood in relation to the professional backgrounds of the navigators; this will be discussed later in this Chapter**.**

The majority of participants reported being mothers. At Haamla Service, women using the service were predominantly those without any children at the time of interview; they were preparing to be first-time mothers. Finally, while all health navigators at Haamla Service reported being mothers, some of their counterparts at Project MAMA reported not being mothers. Further reference will be made to participants' maternal status - as well as race/ethnicity and gender - in **Chapter 9** of this thesis, in relation to the influence of shared characteristics between navigators and service users.

6.3 - Background to the case study services

Project MAMA is a Bristolian service that was founded in June 2017, and launched in March 2018 (document PM1, p.2; document PM2, p.1). It is a small charity, which "operates as an unincorporated association" (document PM2, p.1). Its navigation service - in which 'mother companions' provide support to service users - is its main programme.

In contrast, Haamla Service has a much longer history, with a wider scope and significantly larger client base. Located in Leeds, the Haamla Service was "launched in 1994 as a three year fixed term project to address maternity health inequalities in minority ethnic populations" (document HS10, p.3). Unlike Project MAMA, Haamla Service is a commissioned NHS service as part of the Leeds Teaching Hospital NHS Trust, and is funded and managed within the Maternity Services Directorate, although recently it "has been operating independently" (document HS10, p.3). Further to this:

> The project then became part of the Leeds Health Authority because of Government changes at that time. In 1997 the project was due to end; an evaluation was carried out in order to consider future funding. A positive evaluation meant that the project was funded and commissioned by the United Leeds Teaching Hospitals within the Equal Access Dept with an additional 3 year contract. During this period the two main Acute Trusts of Leeds became the Leeds Teaching Hospitals Trust and Haamla became part of mainstream obstetric services (document HS10, p.4).

Haamla Service comprises several programmes, including antenatal appointments with specialist Haamla Midwives, the Leeds FGM Service, as well as support from maternity support workers and volunteer doulas; the latter two of these are both navigational interventions and are the focus here. While both interventions are forms of navigation seeking to connect migrant women to NHS maternity care, the volunteer doula service is distinct from the maternity support worker service in that it is especially focused on offering support around the time of labour and birth. In reference to maternity support workers, it appears that they were not in existence at the time of Haamla Service's inception in 1994. Although no timeline outlining the development of different programmes at Haamla Service was included in any of the documentary data, one maternity support worker stated that her involvement with Haamla Service begun while working at a local Sure Start:

> I initially started working with them [Haamla Service] 15 years ago. When the funding finished, the NHS looked at the work and decided there was a need to continue. Sure Start MSW's [maternity support workers] started working with Haamla in partnership, and Haamla then signed us on permanent contracts (navigator number 8).

These navigators, therefore, became integrated into the wider Haamla Service.

6.3.1 - Characterising service users

Across the case studies, migrant women - in particular, those who were newly arrived - were targeted as service users, although different definitions of 'migrant' were applied.

At Project MAMA, navigation was available to:

> Any pregnant woman who is a migrant to the UK and meets at least one of the following criteria: Is a victim/survivor of modern slavery / human trafficking; Has a history of mental health concerns; Is a survivor of trauma or abuse; Is lacking a birth support person; Is destitute (document PM1, p.4)

Furthermore, those who designed the service offer their definition of a migrant as someone:

> Holding refugee status; [is an] asylum seeker; refused asylum seeker; awarded discretionary/leave to remain; Zambrano Carer [a non-European Economic Area (EEA) national who is the carer of a British national]; unaccompanied minor; failed asylum seeker; undocumented / irregular migrant; awarded humanitarian protection status; [or an] EEA/ European Union (EU) national (document PM1, p.4)

With the exception of the latter category - nationals from EEA/EU countries - service users at Project MAMA commonly experienced challenging circumstances, and would likely face particular barriers to accessing healthcare.

The profile of service users was somewhat differently described at Haamla Service. The navigation services were available to "new migrants…non-English speaking [migrants]…[and] overseas students" (document PM9, p.1), and that, according to one maternity support worker at the study site, this would be particularly applicable to individuals who have "been in the country less than a year" (navigator 8). One service user, who was interviewed via an interpreter, described herself as being "new in this country at the time" (service user 8). However, one healthcare professional offered a different account, stating that, in general, many potential service users "will have right to remain, they've been here a few years" (healthcare professional 4). In practice, and as reflected by the criteria given in the documents, it was likely that there was considerable diversity in the migration trajectories of service users, and the duration of their stay in the UK prior to accessing the service. The inclusion criteria to access Haamla Service appeared to be wider than at Project MAMA, and there was no specific eligibility criteria for service users to have had experience with exploitation or trauma. This suggests that migrant women accessing Haamla Service were likely to be less vulnerable than their counterparts at Project MAMA, with some exceptions. Additionally, no document offered a precise definition of 'migrant' as it is applied by Haamla Service, which demonstrates the wide eligibility criteria for service users to access navigational support or, perhaps, a lack of consistency in how the term 'migrant' is understood.

6.3.2 - Describing referral systems

Referrals to navigation interventions were most frequently made by GPs (general practitioners) and midwives, indicating that service users had often already engaged with the health system prior to being navigated. This could suggest a limited reach of navigational services in these contexts.

At Project MAMA, referrals to the navigation service were through "either self-referring, or a referral partner completing a form on the Project MAMA website" (document PM1, p.4). These referral partners most often included healthcare professionals. One service user mentioned that when she was several months into her pregnancy, "the midwife referred me to them [Project MAMA]" (service user 1). Elsewhere, social support professional 1, who queried further support available to her client, had stated that the source of the referral would have been her client's Family Nurse Partnership - a national programme where specialised nurses provide care to young, first-time mothers (Family Nurse Partnership, 2020).

Similarly, at Haamla Service, referrals to maternity support workers or volunteer doulas were typically made after the pregnancy had been disclosed to a midwife or GP, but were also made from a "voluntary organisation/Hospital dept./Refugee Council…[or] a HAT/UKBA [UK Border Agency] case worker" (document HS1, p.6). This was corroborated by interview data, whereby one healthcare professional highlighted that "most of the time we get a referral through the GP" (healthcare professional 2*).* Elsewhere, it was reported by another healthcare professional that, additionally, "women can refer themselves" (healthcare professional 4) - a fact not mentioned in any of the documents, which may suggest a lack of consistency in Haamla's referral criteria. Referrals to either of Haamla Service's navigational programmes - whether involving navigational support from a maternity support worker or from a volunteer doula - could be made by specialist midwives working within Haamla Service. Interestingly, referrals could also be made by maternity support workers for a service user to access support from a volunteer doula, if a service user requested the presence of a doula around the time of labour and birth.

As noted, both study sites accepted self-referrals from migrant women, which would not require any contact between a healthcare professional or authority and the navigation service. However, interview data did not make reference to any service user referring themselves to either Project MAMA or Haamla Service in practice, suggesting that self-referrals may not have been a common occurrence. This could imply that either migrant women eligible for the services have missed the opportunity to refer themselves, or that healthcare professionals and other public or third sector employees have effectively identified and referred the majority of migrant women who would be eligible.

6.3.3 - Matching navigators and service users

Across the data, there were indications that service users supported through navigation received inputs from multiple navigators at once, due to a need to guarantee availability of at least one navigator at the time of a service user's labour.

At Project MAMA, document PM2 (p.5) stated that a service user would have a minimum of "two dedicated volunteer Mother Companions". This was corroborated by interview data, whereby service users described having "two lady MCs [mother companions], who came to see me" (service user 2), or even "three of them" (service user 1). Matching navigators and service users in this way served to maximise the chance that at least one navigator was available to support a service user - especially if on short notice - on or around a service user's due date to give birth.

Similarly, at Haamla Service, although service users were supported by only one maternity support worker, those being supported by a volunteer doula were assigned at least two volunteer doulas. This was not mentioned within organisational documents, but was reported by a volunteer doula, who said that every service user had "a main doula and a back-up doula. You never know when your lady's going to go into labour…so you have two doulas, sometimes three (navigator 9). **Chapter 8** will include navigators' perceptions of this 'multi-navigator' approach, including the challenges of working as a team comprised of individuals from different professional backgrounds who employ potentially different approaches in their work.

Similar to the service at Project MAMA - although not mentioned within any organisational documents - interviews suggested that matching clients and navigators within the volunteer doula programme at Haamla Service was "based on doula availability around the due date" (healthcare professional 4). This was also confirmed by a doula who had volunteered with Haamla Service on a long-term basis, who stated that she had been contacted when the Service "urgently needed someone to support [a service user]" (navigator 11). However, responses from another volunteer doula provided additional context. According to this doula - who had also been volunteering with Haamla Service over a long-term period - there were other factors which determined how they were matched with service users. Although it largely depended on "who's available at the time… nine times out of ten that doula is the one that gets on with that lady. It's to save resources for things like interpreters" (navigator 9). This implies that matching could have been driven by service users' needs, as well as limited organisational budgets. This particular doula also claimed that "the system tries to grow together an older doula with a younger, less experienced one" which introduces the idea of how matching occurred in the context of a 'multi-navigator' approach. This would suggest that, typically, a service user was initially matched to a doula, and then to an additional doula based on this given doula's age and experience.

6.3.4 - Timeframe over which navigation occurs

Navigation interventions reportedly commenced during pregnancy and continued for between six and eight weeks post-birth. Information about the period during which health navigation was carried out at each study site were mostly sourced from documentary data.

At Project MAMA, navigation by mother companions started when a service user chose to accept support with her pregnancy, with document PM1 (p.2) describing the support as lasting until eight weeks after birth. Volunteer doulas at Haamla Service provided a form of navigation service which could be compared directly with their counterparts at Project MAMA. These navigators met service users “as early as possible…around six to eight weeks before the baby is due” (navigator 9). According to an organisational document, volunteer doulas continued until “the first six weeks of family life” (document HS6, p.2), which is a similar timeframe to Project MAMA. Elsewhere, and despite this not being mentioned within documents, a maternity support worker at Haamla Service stated that their intervention also lasted up to six weeks after birth (navigator 7).

6.3.5 - Knowledge, skills and experience required to deliver navigation

The formal requirements to become a navigator varied across organisational contexts, implying a lack of standardisation with regard to the professional and personal experience required to become a navigator.

According to document PM2 (p.5), mother companions at Project MAMA were required to possess a doula or midwifery background, as well as have experience in working with women from migrant populations. It should be noted, however, that some mother companions did not actually have any prior experience of working with this population, with one stating that "when I came to Project MAMA it was my first experience [of refugees]. I hadn’t had any direct experience at all” (navigator 6), illustrating a discrepancy between documentary and interview data. In practice, mother companions from Project MAMA often had backgrounds in private birth work; it is, therefore, unsurprising that navigators at Project MAMA were not an especially diverse group in terms of racial and ethnic identity, especially given the apparent lack of diversity within the doula and private birth work sector in the UK (Abuela Doulas, 2016).

In contrast, organisational document HS2 (p.2) stated that maternity support workers at Haamla Service were not required to have prior professional experience in birth work or maternity care, instead being expected to have a personal or professional understanding of pregnancy, labour and birth, as well as an understanding of 'current issues in maternity care'. They also needed to have an "ability to communicate effectively in at least one community language…some community based work with minority ethnic communities…[and] experience of working with women or women's groups" (document HS2, p.2). Similarly, for volunteer doulas, no prior professional experience in birth work was necessary and there was a requirement to speak a second language, according to document HS6 (p.1). However, volunteer doulas who were interviewed did not actually fulfil the language requirement. While no direct explanation for this was offered by any participant, there was mention of a shortage of unpaid doulas ("You're training people up and only getting two out of a cohort…it's hard" [navigator 9]); it is a possibility that this could have influenced Haamla Service's decision to recruit prospective doulas who did not actually possess all of the prescribed knowledge, skills and experience. As navigators at Haamla Service did not need to have professional experience in birth work or maternity care, they came from diverse professional backgrounds, including teaching and social care. The diversity in professional backgrounds of navigators - as well as the perceived benefits and challenges associated with it - will be explored further in **Chapter 8**.

6.3.6 - Navigational tasks

Data from both the documents and the interviews demonstrated that navigators delivered a range of navigational tasks - and had a range of functions - in order to support service users. **Tables 12 and 13** present a typology of navigational tasks carried out in each intervention, and arranged by functional domain. The typologies developed from the literature review (**Chapter 4**) and the primary research will be compared and contrasted with one another in the Discussion in **Chapter 11**.

Much of navigators' work was practical, emotional and educational, with at least half of all navigational tasks identified within the data being practical in nature. Broadly, all three types of navigator fulfilled similar functions. Volunteer doulas were the only navigators who did not carry out any administrative or cultural functions for service users.

Table 12: Overview of typology of navigation interventions, mapping navigational roles to the functional domains of practical, administrative and educational support

	Practical support										Administrative support	Educational support		
	Conduct calls / home / hospital visits	Conduct needs assessments	Post-natal baby health / mother wellbeing checks	Support with baby/self care at home	Source baby items	Help to develop birth plan	Breastfeeding support	Arrange/ provide translation	Arrange/ provide transport	Show around hospital/ clinic	Assistance with paperwork, including immigration and benefits applications	Provide health information	Provide information on the NHS system	Provide educational sessions
Mother companion (Project MAMA)	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	
Maternity support worker (Haamla Service)	✓	✓	✓		✓	✓	✓	✓	✓		✓	✓	✓	✓
Volunteer doula (Haamla Service)	✓	✓	✓		✓	✓	✓	✓	✓			✓	✓	

Table 13: Overview of typology of navigation interventions, mapping navigational roles to the functional domains of emotional, social, advocational and cultural support

	Emotional support			Social support		Advocational support		Cultural support	
	Accompany to apointments/ services	Accompany during labour/birth	Offer moral support	Connect to community services	Report safeguarding issues	Offer brokerage	Help to understand rights and entitlements	Arrange culturally sensitive birth preparation	Provide culturally sensitive brestefeeding suport
Mother companion (Project MAMA)	✓	✓	✓	✓	✓	✓	✓	✓	
Maternity support worker (Haamla Service)	✓		✓	✓	✓	✓	✓		✓
Volunteer doula (Haamla Service)	✓	✓	✓	✓	✓	✓	✓		

6.3.7 - Training provision for navigators

There was wide variation in the training offered to navigators prior to starting their roles, suggesting a lack of standardisation across interventions.

Project MAMA offered a "mandatory and robust training programme for volunteers", which included *"*Induction to Project MAMA Policy, Procedure & Handbook Training, Safeguarding Vulnerable Adults & Child Protection, Supporting Survivors in the Birth Room training, Migrant Access to Healthcare training [by Maternity Action], and Intercultural Awareness Training" (document PM2, p.6). This training was delivered on a face-to-face basis over four days.

Haamla Service provided extensive training to volunteer doulas, especially given their lack of requirement for experience in birth work. This training was "accredited at Level 2/3 Antenatal/intrapartum/postnatal support" (document HS1, p.10) and - according to navigator 11 - was three months in duration. It was comprised of sessions including:

> Health and safety, hospital tours, boundaries, confidentiality, working with interpreters and communication skills. Active birth course held over 2 days, breastfeeding training support held over 2 days, one full day child protection training, one full day domestic violence awareness training, antenatal class, breastfeeding awareness evening. All volunteers will complete the OCN assessment unit, which will consist of a variety of forms of activities, i.e. keeping a reflective diary, contributing to group work, written work and a short assignment (document HS6, p.2).

Interestingly, maternity support workers seemingly underwent less initial training than volunteer doulas prior to commencing their roles at Haamla Service, despite both roles maintaining the same requirements of no previous experience in birth work. One maternity support worker stated that she "didn't have much training to do what I'm doing". She continued:

> We do normal training like an MSW [maternity support worker] would do - we go every year for training. But we also pick up training along the journey. So, for example, we have FGM training, domestic violence training. trafficking training…it's how you know who to contact, how to refer people (navigator 7).

No reference was made during the interviews as to the utility of the training provided by the organisations. However, navigators across both study sites did make mention of profound difficulties in managing boundaries (**Chapter 8)**; in the case of Haamla Service, this was purported to be a core part of the training programme for volunteer doulas.

6.4 - Organisational management of health navigation

Navigation was managed by organisations, largely through supervising navigators, requiring navigators to maintain records of their engagement with service users, and giving navigators a voluntary status while 'paying' them some expenses.

Supervision was offered to volunteer doulas at Haamla Service and mother companions at Project MAMA, although no details on supervision for maternity support workers at Haamla were identified within any documents. Documents PM1 (p.7) and PM2 (p.6) stated that mother companions had "individual supervision once every month, [and] group, peer supervision once every month" as well as reflective supervision, which "provides a safe and confidential environment for all MCs [mother companions] to reflect on and discuss your work and your personal and professional responses to your work". The latter was described as being of benefit to mother companions after experiencing an especially traumatic case.

At Haamla Service, volunteer doulas were also offered individual supervision to be provided on a regular basis, as agreed "between volunteer doula and service development worker, [as well as a] support group…[and] supervision from health professional if needed" (document HS6, p.2). There was no indication as to whether group-level supervision or reflective supervision was offered to volunteer doulas, as was the case at Project MAMA. However, an absence of supervision protocols at Haamla Service - whereby navigators could be enabled and encouraged to reflect on how their work impacts them personally as well as professionally - would perhaps not be surprising, given the lack of specific focus on supporting vulnerable service users within Haamla Service's programmes, in comparison to Project MAMA's programme.

Navigators had administrative obligations to fulfil. Mother companions at Project MAMA had been asked to:

> Keep a log of all antenatal, birth and/or postnatal support to share with their partner MC…we ask that all appointments with clients are input into the shared PM Google Calendar, ensuring location of appointment along with time of meeting. Alongside this, we ask that the coordinator is informed, via text message or phone call, when meeting a client, and again, when 'signing off.' (Document PM1, p.5-8).

As the above suggests, this was not simply a matter of record-keeping, but also of personal security and safeguarding for both mother companions and the service users they support. At Haamla Service, maternity support workers were tasked with "maintain[ing] accurate and detailed records of work undertaken on behalf of the post and to provide written reports on request" (document HS2, p.2). There was, however, little exploration within the data of how maternity support workers or volunteer doulas could uphold security and safeguarding.

Both sites paid expenses to their navigators, with Project MAMA requesting that mother companions retain their receipts, travel tickets and parking vouchers in order to have their costs reimbursed, according to document PM1 (p.9). The volunteer doula program at Haamla Service also offered childcare provision for their navigators, according to document HS6 (p.2). In contrast, the maternity support worker programme at Haamla Service was not voluntary in nature - these particular navigators were employed by the NHS and received remuneration and staff benefits. **Chapter 8** will present perceptions of the voluntary nature of navigator roles - including the perceived benefits and challenges associated with them.

6.5 - Aims of health navigation programmes

Documentary data and participant interviews reported the aims of navigation interventions at the study sites, providing an opportunity to compare and contrast between accounts given by service designers, and accounts given through participants' perceptions.

6.5.1 Improving access to healthcare

Improving access to healthcare for migrant women was consistently reported as an aim of navigation. Facilitating service users' engagement with healthcare professionals and connecting them to health-promoting social and community-based services was the pathway through which the interventions sought to achieve this aim.

An aim of navigation at Project MAMA was to ensure that service users were connected to NHS care. Document PM1 (p.3) offered detail on this:

> MC's [mother companions] support clients to access the NHS where required and work in tandem with advice and care offered by NHS staff. MC's encourage a mama to liaise with her midwife and/or health visitor whenever she has specific issues to address relating to her pregnancy. MC's work in conjunction with partner agencies, support groups and antenatal classes to ensure women have the necessary and desired support networks around them.

In the above quotation, mother companions are presented as supporting service users to engage with NHS healthcare professionals providing their care, as well as connecting service users to support systems which would be of benefit during pregnancy and early motherhood and, in turn, promote access to healthcare. The latter, in particular, is consistent with mother companions' own testimonies. In navigating service users, they sought to connect them to "people that can support them during their journey" (navigator 3), such as individuals working at local authorities or at food banks. One mother companion stated that one aim of her work was "connecting the dots for the personal support", which has helped service users to "map out what's to be expected [from maternity care]" (navigator 4).

Both forms of navigation intervention at Haamla Service had the same broad aim of improving access to maternity care, as at Project MAMA. Both maternity support workers and volunteer doulas were required to "facilitate the clients' access to care" (document HS2, p.2) and to connect service users to "appropriate services" (document HS6, p.1), the latter of which could promote access to healthcare as well as directly or indirectly influence service users' health and wellbeing. Once again, this was consistent with information provided by navigators at the time of interview; in reference to maternity support workers, they "support[ed] with pregnancy, with explaining things around maternity services, around housing, around benefits….any social issues" (navigator 7).

6.5.2 - Providing a culturally-sensitive service

Navigation services were intended to be 'culturally sensitive', in order to promote inclusion of culturally-diverse communities within maternity care, and better meet their health, social and cultural needs, although there was little reference to this aim in interview data.

For Project MAMA, document PM2 (p.4) described how mother companions were tasked with giving service users the necessary information about their rights and entitlements to services, but also how navigators were able to "facilitate culturally-sensitive birth planning, using translation services when required". One navigator corroborated this, referencing her experience as an example of how navigators sought out opportunities to make the care they provide more culturally appropriate for their clients:

> What I'm interested in doing is to understand their culture around after the birth- what would normally happen after the birth in their culture, and seeing if we can bring some of that here…For example, in a lot of cultures, it's very common to have belly binding and massage, and that's a nice way of saying 'We can do that, would you like that?'. At the time, [redacted] and I went together and one of us held the baby, while the other did the massage. That was really nice.' (navigator 3)

Haamla Service also aimed to offer a culturally sensitive service to their service users, through both volunteer doulas and maternity support workers. According to document HS2 (p.3), maternity support workers, in particular, were expected to:

> Support the provision of a culturally sensitive breastfeeding support for mothers by NHS services and other appropriate groups or organisations…[have] knowledge of traditions and practices around pregnancy, labour and birth of at least one minority ethnic group….[and an] understanding of the cultures and faiths of the predominant minority ethnic communities in Leeds.

The above quotation identifies a requirement for maternity support workers to have specific knowledge and experience of different cultures. This is consistent with the prerequisite knowledge, skills and experience requested of maternity support workers, as previously outlined. Maternity support workers - being NHS employees working in both clinical and community-based environments - were expected to "ensure that cultural, religious and faith needs are supported during their [service users'] hospital stay…working with health professionals on the wards" (document HS8, p.8). However - aside from the provision of interpreters - interview participants did not make any reference to how either navigation intervention at Haamla Service aimed to provide care that was culturally sensitive, such as addressing service users' cultural preferences, or delivering training on cultural awareness. This is, therefore, a silence in the data, suggesting that offering a culturally sensitive service may not have actually been a navigational aim in reality, or that the services' offerings were merely assumed by interview participants to be culturally sensitive.

6.5.3 - Promoting a sense of community

Across the study sites, health navigation was portrayed in organisational documents and in the narratives of those providing the service as aiming to support service users' integration into local communities, to reduce social isolation and promote their general wellbeing.

At Project MAMA, organisational document PM1 (p.2) and document PM2 (p.3) outlined a commitment to "foster solidarity between mamas…[and] support women to settle into their new communities". As a result, it is assumed by designers of Project MAMA that "women who have received 1 to 1 support will feel more confident to attend a peer support group", and that service users would likely be less isolated and more likely to participate in their wider community. Interview data corroborated this, with navigator 3 stating that mother companions "can help them [service users]…to embed them into the community". Additionally, social support professional 1 - whose client was being supported by a Project MAMA mother companion - recognised that it was important for "them knowing more people and getting to know more people, not feeling alone".

Organisational documents describing Haamla Service highlighted the roles of navigators in helping to integrate service users into the community. While volunteer doulas could "go to your local children's centre and mum and baby groups with you" (document HS4, p.1), maternity support workers could help service users to "meet new friends and share experiences" (document HS5, p.1). Document HS9 (p.2) - a feedback report on a research event co-organised by Haamla Service and an academic institution - noted that:

> Haamla offered something different from other hospital/health services. It was more relaxed and friendly and women from BME communities can make friendships there. This is important as women often feel isolated.

Participant interviews about Haamla Service also emphasised the crucial role that community participation could play in integrating service users - especially those who are new arrivals to the UK - who do not have family or friends in the UK and/or have little proficiency in English:

> It's getting them out the house, it's somewhere for them to meet people. People talking from different cultures, different languages and get them connecting" (healthcare professional 2).

6.5.4 - Providing person-centred care

As the literature review revealed (in **Chapter 4**), health navigation is often framed as an example of delivering person-centred care. This was an articulated aim of the studied interventions, and was illustrated via interviews with almost all participant groups and organisational documents. Directly addressing the needs of individual service users and providing a level of continuity through having designated navigators throughout the course of a pregnancy and early motherhood were designed to achieve this aim, although there was no evidence for the latter at the Haamla Service interventions.

The case studies demonstrated how the existing care within mainstream NHS maternity services had been perceived by both navigators and service users to be insufficiently person-centred. One navigator at Project MAMA highlighted that NHS maternity care is "service-driven, not women-centred", while a volunteer doula at Haamla Service stated that mainstream NHS maternity services are *"*just not as one-to-one" (navigator number 9). The navigation interventions at the study sites were in stark contrast to this.

Navigators' aim of responding to the individualised needs of service users was an acknowledgement of person-centred care as a tool for improving access to healthcare, in that it allowed for the individual needs and barriers of service users to be targeted. Health navigation at Project MAMA was purported to be tailored towards the needs of migrant women. Although there was no specific detail within organisational documents on how such tailoring should be achieved, interview data did illustrate this. A mother companion provided a testimony whereby one service user was assumed to have educational and/or informational needs, but was instead seeking companionship:

> I think I went along to my first antenatal session with a mother with lots of books and information and things to discuss about the birth, but she didn't really want to go through much of that, she just wanted to get to know me, and for me to get to know her, and just to have a chat and keep it quite simple - rather than a full birth preparation session…every time we'd go to see one of the mums, I'd be led by them, really. I'd go with a vague plan and I'd have things I might ask them, but I'd be really led by their needs and how they felt on that day (navigator 5).

According to document HS8 (p.5), both forms of navigation at Haamla Service were "designed around their [service users'] individual needs and those of their babies". Voluntary doulas were tasked with providing "one to one support to expectant mothers", while, similarly, maternity support workers were expected to offer one to one support to service users in their homes (document HS6, p.3). Interviews with navigators gave further contextual insight into how one-to-one support was given, with a maternity support worker explaining how she met the needs of a typical service user in order to provide person-centred care:

> We'll do a home visit and we'll see what the situation is with the lady. Sometimes, she'll have applied for benefits but it's not come through and could take quite a while…so therefore she'll need her baby essentials before going to hospital. If they're sofa-surfing, we'll try and get their housing sorted before they go into hospital (navigator 8).

Interestingly, one maternity support worker also revealed that they would respond to a service user's need for extra support around the time of labour and birth by making an internal referral to the volunteer doula programme - the other navigation intervention at Haamla Service:

> If the woman needs a doula, it's one of the needs of the ladies. So if we go to a woman and she says that she's on her own for some reason, and would like somebody to be with her at the labour, that's a support we can offer to her through the doula service (navigator 7).

Volunteer doulas themselves were reported as responding to the needs of their service users by offering to "signpost and tell them [service users] that there's children centres for you, there's *this* service you can access" (navigator 10). In this way, they operated similarly to maternity support workers in aiming to meet the individualised needs of service users who were pregnant or who were new mothers.

Data from documents and interviews also gave insight into how achieving person-centred care could allow navigators to positively impact on the service user's mental health and wellbeing - particularly if the service user had experienced past trauma, whether related to a previous birthing experience or to previous experience of trafficking or exploitation. At Project MAMA - where service users were in especially vulnerable circumstances - those responsible for designing the service recognised the specific needs of these women, acknowledging that "many women may feel threatened or untrusting of others" (document PM1, p.4), and may be 'triggered' unintentionally by healthcare professionals. It was evident that mother companions were often acutely aware of how their choice of language could impact on their service users' emotions, given their previous traumas. They, therefore, tailored the ways in which they communicated with service users:

> A midwife might commonly use the expression "just relax, just try to relax", and you do say that when you want someone to calm down, but that can be a real trigger word for someone that's a survivor [of human trafficking]. Language is a big factor, I think, in terms of offering support that is more bespoke to these individual women…at the end of the day, you're supporting a woman, you're supporting a mother. They have things you have to consider, like a previous birth experience or trauma (navigator 5).

Although the service users at Haamla Service were generally less vulnerable than those at Project MAMA, there were, indeed, "trafficked ladies…who've had domestic violence, recovering drug addicts…[and] ladies who've been sexually abused when they were younger, so obviously at the point of birth that can trigger them" (navigator 9). This particular navigator mentioned how she adapted her care in consideration of service users' traumas and previous experiences, stating that she needed to be "very, very open-minded", and that she sought to offer maximal reassurance, telling service users experiencing trauma that " 'everything's going to be ok, we'll make sure you get support in the right areas you need' ", prior to sharing her knowledge of specific services and community initiatives to which she could signpost them to address their needs. Maternity support workers, however, did not offer detail on how they tailored their care for service users experiencing trauma; this likely reflected the lower number of service users who had experienced trafficking or exploitation/abuse and were been navigated by maternity support workers.

Having continuity of carer at the time of pregnancy, labour and birth was a critical time period for women to receive navigation. While not referenced in organisational documents, navigator 6 - a mother companion at Project MAMA - stated that having the same carer:

> Lessen(s) the load in this very specific time of pregnancy…it's a very specific time when your level of need goes up - for everybody. And when you've already got the issues and complexities in terms of language, in terms of day-to-day living…actually having the support at that specific time to help you on your journey is really beneficial.

None of the documentary sources, nor any of the interview respondents, explicitly discussed the notion of continuity of carer in relation to navigation at Haamla Service, which suggests that it was not yet an aim of the navigation services at this study site, despite current national NHS policies aiming for the provision of continuity of care for high-risk groups by 2024 (NHS England, 2019). One midwife at Haamla Service did, however, confirm that this will ultimately become central to national midwifery strategy in the coming years, which would likely impact on patients' experiences with NHS maternity care, including service users being supported through navigation.

> When we have the right staffing levels, we will be going over to continuity of care. Although that won't be 24/7 continuity if they deliver Monday to Friday 9 'til 5 - or if we come in another time for the patient - then we will be looking after them. Just as with everyone else, with midwifery, we are looking at new ways of working (healthcare professional 3).

6.5.5 - Empowering women

Navigation aimed to 'empower' service users. Across the interventions, organisational documents and interviews made direct reference to the notion of 'empowerment', revealing the different ways in which it was understood, as well as the different language used to describe it.

'Empowerment' was understood by some as navigators equipping service users with the tools to access public services independently. Document PM1 (p.3) outlined how service users at Project MAMA were to be supported by their mother companion:

> [Give service users] support to understand and access entitlements to healthcare….[and] women can advocate for their own rights and entitlements and feel confident and well-supported as they begin their parenting journey in the UK.

This was reflected in interview data, whereby service users were encouraged to "know how to get around on their own [by public transport] and be independent" (navigator 4).

Interviews at Haamla Service referenced how a volunteer doula "went to the library with her [a service user] to show her how to do it" (navigator 11). Similarly, a maternity support worker navigated service users with the intention of informing them of how various public services work, adding that she was there to help, not "to do things for you. I want to empower them to do things alone, because they can" (navigator 7).

There was variation in the language used when describing the act of equipping service users with the necessary tools to embark on their pregnancy and motherhood journeys. Documentary and interview data at Project MAMA specifically articulated this using the language of 'self-empowerment', which appeared to describe service users as actively empowering themselves with the support gained through navigation, instead of merely being framed as passive 'recipients'. The first reference to this was in the organisation's summary and strategy document, in which it was written that mother companions were to "encourage women to empower themselves" (document PM2, p.4). As corroborated by interview data, mother companions didn't simply view empowering service users as their work - rather, they were "working with women, to work alongside women, rather than helping" (navigator 2), presenting a less paternalistic description of empowerment.

Empowerment understood as enabling choice around pregnancy, birth and motherhood was also an aim of navigation at both sites; enabling choice aligns with national NHS maternity policy (NHS England, 2016). Encouraging service users to make informed choices around their own pregnancy and motherhood was a guiding principle behind Project MAMA:

> [We] offer practical and emotional support but not advice, to the mother and/or parents, empowering them in their own choices. Project MAMA birth companions recognise that women's' choices are valid and that a woman assumes responsibility for the birth, parenting style or feeding method that she feels is right for her and her baby (document PM1, p.3).

Interview data provided further detail. Mother companions at Project MAMA saw intrinsic value in enabling choice for their service users. One mother companion stated that “I feel women need to be able to say ‘no’ when they want to”, and that there was a need to be mindful of language, to “make sure that we say 'we're *offering* this’” (navigator 1). Another mother companion reiterated this, raising an interesting point about how they perceived enabling choice as giving power to service users to make their own choice, as service users are then in the position where they “have someone that they can say ‘no’ to” (navigator 4).

Organisational documents from Haamla Service also put an emphasis on enabling informed choice to “empower pregnant women…during the antenatal/postnatal period" (document HS8, p.6). In reference to navigation by maternity support workers, when conducting antenatal classes with service users, they sought to “give vulnerable women information and choice on topics around breastfeeding, birth, labour, pain relief, with eating and birth plans prepared” (document HS3, p.2). However, no participant interviews mentioned how navigators at Haamla Service sought to enable choice for service users, suggesting that navigators, in particular, may not have identified this as being an important element of navigation.

6.5.6 - Complementing the system vs. filling gaps within it

According to documentary data, as well as interview data from every participant group except for service users, health navigation had the broad aims of complementing the mainstream health system and other public services, or of ‘filling gaps’ in service provision.

Being a ‘complementary’ service refers to the ways in which health navigation may be conceptualised as aiming to provide a form of support that cannot be offered elsewhere by statutory services. At the Project MAMA study site, the service provided by mother companions was described as being “complementary to the statutory provision offered by the NHS” (document PM2, p.4), in that mother companions were offering an additional form of support. Following on from this, a healthcare professional offered a perspective on mother companions operating as a complement to mainstream NHS services - albeit as an interview participant who only engaged with navigation indirectly - stating that "we’re [the NHS] there to provide healthcare, and they’re [mother companions] there to be there for the woman” (healthcare professional 1).

At Haamla Service, documents stated that navigation sought to “complement the care received by Health Professionals in hospital and in the community” (document HS8, p.4). Reflecting the documentary data - and echoing the above sentiments at Project MAMA - the healthcare professionals at Haamla Service did not describe either type of navigator as providing clinical care as they did, but rather, befriending and connecting individuals to the necessary services and developing a bond with them. One healthcare professional working as part of the wider Haamla Service team offered further insight:

> I might not have time to go through all their housing options and discuss what benefits they’ve got. We might not have the time to discuss other aspects of support…because they [maternity support workers] have the time, often women will tell them things that they’ve never told us before, to do with their history or their past…when we go on, we automatically ask ‘what’s your blood pressure? How’s the baby moving today?’. We’re doing clinical things, whereas the MSW will go specifically as a support visit. There’s more time to open up (healthcare professional 2).

Both volunteer doulas and maternity support workers reportedly delivered tasks that healthcare professionals were too busy to do themselves, did not possess the knowledge to do, or that they did not perceive as being within their remit:

> They can do a bit more of the social aspect of things. They can take women to PAFRAS [a migrant and refugee support service in Leeds], go with them to the Council for housing… they can also take women to get baby items. They're very key to the team, and without them we'd find it very hard, because there's so much to do for each individual woman (healthcare professional 4).

Drawing distinction between the roles of healthcare professionals and navigators in this way appears to offer commentary on the role played by midwifery in the 'medicalisation' of childbirth, in that competing institutional pressures on midwives can reduce their capacity to deliver critical emotional support to those giving birth under their care (Dykes, 2009).

Elsewhere in the data, there was limited evidence that health navigation was also framed as aiming to 'fill gaps' left by struggling public services, rather than merely being complementary to them. Document PM2 (p.2) listed services provided by local statutory authorities and other charitable groups, as well as the existing gaps left by their work. This document implied that the navigation service was developed in response to these aforementioned gaps:

> [Existing services are] unable to provide holistic support…Unable to provide befriender/consistent named 1-to-1 support throughout pregnancy/labour/childbirth/postnatally…Cannot access translation services.

One mother companion supported this observation when she noted a lack of existing holistic support for one of her service users. There was a perception that no statutory service had been able to fulfil her service user's need for basic support in the home, and that "none of them are quite offering the help she wants" (navigator 4).

6.6 - Conclusion

Health navigation for migrant women at the study sites has been characterised throughout this chapter. Within these contexts, navigation has been presented as being variable and lacking in standardisation with regards to requirements to become a navigator, programmes of training offered to navigators, and the tasks and functions navigators have fulfilled. There were also notable differences in the demographics of their client bases - with service users at Project MAMA seemingly more vulnerable than their counterparts at Haamla Service. However, the broader aims of navigation were largely identical across the interventions, with navigation purported to be designed to increase access to healthcare, empower migrant women and foster a sense of community, by way of a culturally sensitive, person-centred intervention which operated outside of 'mainstream' public services. In addition to this, within the contexts studied, navigation was seemingly accessed by service users who had already had a degree of contact with the health system and had been referred for navigation from within the system, raising questions about how accessible these interventions have been and how many otherwise eligible migrant women may have been overlooked.

This chapter lays the essential groundwork from which to situate and conceptualise the next chapter, in which the perceptions of health navigation of migrant women service users will be explored in depth.

Chapter 7 - Experiencing navigation: Migrant women's narratives

7.1 - Introduction

This chapter presents the experiences of migrant women accessing health navigation services, offering insight into their pre-navigation needs, their perceptions of the benefits and limitations of navigation, their expectations of and reflections on navigation, as well as the challenges they faced through engaging with navigation. The voices and narratives of migrant women service users are placed at the fore within this chapter, with supportive or contradictory statements from other participant groups included, where possible and appropriate. All data are sourced from interviews. As mentioned previously, no service users engaging with volunteer doulas at Haamla Service could be recruited for an interview for this project, which precluded inclusion of their perceptions and experiences. This meant that migrant women's reported experiences at Haamla Service were exclusively from the perspective of those who had been navigated by maternity support workers.

This chapter addresses research sub-question ***[b] How are navigation interventions perceived and experienced in practice?***

7.2 - Pre-navigational needs

Migrant women service users reported having had a range of needs prior to accessing health navigation services.

7.2.1 - Needing to gain access to healthcare

Across the interventions, service users reported different levels of need for accessing healthcare, based on their previous experiences with attempting to access the services that they needed.

Some service users stated that they had already successfully accessed the care they needed before engaging with health navigators; this is concordant with the high frequency of referrals from GPs and midwives, as reported in the previous chapter. At Project MAMA, one service user being supported by a mother companion mentioned that she "didn't speak English and [she] didn't understand [English]. But in the GP, they use an interpreter, that's good" (service user 2). However, despite being generally able to access the services they needed, there was concern about the efficiency of the service, as well as the racial biases of healthcare professionals they had interacted with:

> I'm quite amazed with the system of NHS compared to back home…[but] I have problems sometimes…when I had an emergency….I couldn't lift my arm, and they told me I cannot see a GP and I should go to the pharmacy. So I told them that it's quite serious and I'm hurting…I was right on time, and it took them 1 hour or 45 minutes to attend to me. That one [nurse] was a racist - when she attended to me, she didn't give me what I wanted…she called a black lady (service user 4).

Racial bias amongst healthcare professionals will be mentioned again across the results chapters, particularly in **Chapter 10**, which applies the Candidacy framework to describe how navigation may help - or hinder - the process of accessing care in the context of healthcare professionals' implicit racism and classism.

At Haamla Service, sentiments around a general ease in accessing the NHS were reported by service users engaging with maternity support workers. One service user being supported by maternity support workers mentioned that "all the services are very good. Thank God, all the services I receive are comprehensive and complete, and I've not faced any problems" (service user 11). No service users at this site spoke of racism from healthcare professionals when recounting their experiences prior to navigation.

However, other service users engaging with the interventions reported having previously faced barriers to accessing healthcare, which created a need for assistance. At Project MAMA, one service user stated that, prior to being supported through navigation, she had not attempted to see a GP because she "didn't know if I needed something or not, I didn't know anything" (service user 3). This service user perceived herself as lacking knowledge of the NHS, which posed a barrier to her engaging with the system. Since arriving in the UK, she had only sought care from a dentist and some advice from a pharmacist. No service users at Haamla Service mentioned having previously faced barriers in accessing healthcare, however, according to midwives working within the Service, some service users of the maternity support worker and volunteer doula interventions "haven't sought any medical attention at all" (healthcare professional 4), especially given that some "have literally just landed in the UK and are pregnant" (healthcare professional 2). There would, therefore, be some scope for service users to benefit from enhanced access to healthcare by way of health navigation.

7.2.2 - Needing companionship and support

There was a clear indication that many service users engaged with navigation services out of need for companionship and general support. This was as a consequence of being single mothers, with little or no support from a partner, their family or friendship groups during their pregnancy, childbirth and/or early motherhood experiences.

At Project MAMA, service users expressed their desire for companionship and general support through navigation due to being single mothers who were undertaking the journey of pregnancy and motherhood alone. Service user 1 had a partner who had had little involvement in her pregnancy, saying that "my partner doesn't live with me, so I don't see him regularly like that. So I needed support". Elsewhere, it was common for service users at Project MAMA to have no contact with the father of their child. Service user 2's situation was difficult prior to navigation, because "I'm a single mum and I have two child, and I don't have anybody…for help in the house, for help in life ".

The testimonies of other participant groups at Project MAMA confirmed this. Mother companions identified the need for companionship and support, stating that the service was for "anyone who is alone" (navigator 4), and is in need of "just having someone there…someone to have a cup of tea with in the evening, particularly if they're not married, or don't have a partner, or have a partner and he's not around." (navigator 2). Additionally, a social support professional observed that her client - a service user at Project MAMA "hasn't got anyone, really. The baby's father is on the scene, but they're not in a relationship, and that's all been difficult" (social support professional 1).

Similar sentiments were shared at the Haamla Service site, although only in relation to service users engaging with navigation from volunteer doulas, and not from those engaging with maternity support workers. As no service users being navigated by volunteer doulas could be reached, comments from other participant groups were available, with a midwife stating that "We have our doulas as well - for women who are really on their own, and may need someone to support them in labour" (healthcare professional 2). In this way, there was no indication amongst service users at Haamla Service of a desire for greater companionship; this may be due to being less vulnerable than their counterparts supported via volunteer doulas or via mother companions at Project MAMA and, perhaps, the fact that the majority of service users interviewed at Haamla Service had marital partners and were not single mothers.

Poor mental health was also cited as a reason for why service users needed to seek companionship through navigation. One service user at Project MAMA stated that "the reason I had an MC [mother companion] was, first of all, that I felt so low, depressed because of my situation" (service user 4). Elsewhere, another service user - who was accessing navigation through a maternity support worker at Haamla Service - described herself as having felt "depressed and lonely" (service user 6).

7.2.3 Needing to source maternity-related information

Service users across the interventions described a need to access information on maternal - and general - health, as well as NHS maternity care. This was often a need that they expressed to healthcare professionals, who would ultimately refer them to the navigation service.

One service user at Project MAMA recalled her specific need for "information on the pregnancy" (service user 2) to aid preparations for birth and motherhood. Unlike Project MAMA, service users interviewed at Haamla Service included women who were first-time mothers (see Table 8). Prior to her referral to navigation via a maternity support worker, a service user stated that she could "remember asking the midwife and the GP about how I could learn [about pregnancy, labour, birth and motherhood], because it's the first baby for me" (service user 5). Other first-time mothers at Haamla Service wanted to receive informational support because they "didn't have a lot of information about my health, [and] taking care of myself while pregnant" (service user 8).

The significance of this informational element was implied within some service users' narratives. Respondents illustrated the barriers they had previously experienced in accessing sufficient health-related information, including not being provided with any explanation by healthcare professionals. One service user stated that after her visit to her doctor, "nothing happened. They just told me to go back home and do paracetamol. They don't tell me the detail about what's happened, what's going on…" (Service user 5). In light of this, engaging with a health navigator appealed to service users, given that navigation was a method of sourcing critical maternity-related information.

7.2.4 Needing to negotiate linguistic barriers

Despite limited availability of data, there were indications that service users perceived and experienced difficulties when attempting to communicate with healthcare professionals, and that this contributed a need for navigation.

In some cases, service users had experienced communication barriers when attempting to access healthcare, which may have been underlined by profound cultural or linguistic differences between the healthcare professional and the service user:

> Sometimes it's difficult for me. When I talk to the midwife, it's not the way I talk. My mum is not here - she's in Ghana now - but when she tells me 'take this, take this, take this', I understand. They [healthcare professionals] do their work, but the problem is, sometimes, I just don't understand. You know, how the white lady speaks, her tone - it's different. (service user 9)

This exemplifies the lack of cultural competence and cultural safety within NHS services, which then created a need for mediation between providers of care and the communities they serve - in the form of health navigation. The above quotation, in particular, outlines how healthcare professionals may not have been fully aware of how they failed to properly communicate with their patients, through failing to check for mutual understanding; this is especially pertinent in the context of providing care to individuals from culturally and linguistically-diverse communities. This is further underlined by an observation by healthcare professional 1 - interviewed as part of the Project MAMA case - that "those without language are the ones who aren't getting their voice heard in the room".

7.3 – How have migrant women experienced health navigation?

Interviews revealed that migrant women had variable experiences of engaging with navigation services. Much of the data referred to their expectations of the navigation service they accessed, and how these expectations compared with their eventual experiences.

7.3.1 Initial feelings about navigation services

Across the data, initial reactions to the prospect of navigation were mixed amongst service users and appeared to be shaped by their past experiences. Service users at Project MAMA described immediately responding positively to the offer of navigational support from mother companions, with service user 1 recalling that "when they [the midwife] told me, I said that was fine. I was happy when they told me that Project MAMA can help me with what I want, what I need". This particular service user described her needs as being centred on sourcing goods and equipment for the new baby, and that her mother companion(s) "asked me on what I want , and they gave me everything…so, I was really pleased". Thus, she perceived that her expectations were met.

There was also evidence of service users responding positively at Haamla Service, and having their expectations met. A service user who had been assigned a maternity support worker after arriving alone in Leeds recalled being happy that her maternity support worker had “said 'I can help you with everything’”, and that her expectations of companionship and being connected to community resources were met, with her eventually “feel[ing] nice…I feel better, and comfortable” (service user 6).

Some service users were initially less enthusiastic about the interventions. A service user at Project MAMA - who had previously experienced exploitation and, therefore, may not have been trusting of mother companions in the first instance - reported that she “was not sure what they will do or what help they will give”. However, her attitude changed. Having begun to receive mother companions’ support with attending appointments and with providing practical support to her at home, she stated that “after a few weeks, it’s good” (service user 2). There was similar, initial ambivalence at Haamla Service. One service user described her experience via an interpreter:

> At first, I didn’t know, really…I thought she [maternity support worker] was another midwife. But when we sat together and she explained to me, I understood…Haamla classes were on my thoughts because I was thinking of asking my midwife if such classes existed in the first place, but I did not ask the question. But when [maternity support worker] explained, it was bang on (service user 12).

There was evidence of the maternity support worker service exceeding service users’ expectations. In a similar vein to the aforementioned quotations, one service user ”wasn’t expecting the Haamla group [to be] as interesting as it was” (service user 14). Despite not being particularly enthused in the first instance, she still decided to attend a maternity support worker-led antenatal session, after being visited at home by the maternity support worker and informed about it. Ultimately, she voiced satisfaction with her decision, speaking of how she had thought that she would only attend for a week or two, but, instead, she “found it engaging, interesting and informative, so I have been going again and will continue with it”.

7.3.2 Positive reflections on the responsiveness of the service

Service users perceived navigation as being highly responsive to their needs. This was the case at both study sites. Service user 1 - supported by a mother companion from Project MAMA - gave the following testimony:

> Anytime I need them - they respond to me. Anytime I call them - they respond. Even if I'm going somewhere, they will go with me. If I tell them "this is what I want", they do it.

Service user 14 - supported by a maternity support worker from Haamla Service - echoed these sentiments, offering more detail on how her navigator delivered a responsive service:

> [She] has been very helpful, very responsive to our needs…when I first met [maternity support worker], she was very friendly, very open, very welcoming. During the session, she will actually ask us our opinions to engage us, and to discuss. If we ask her for a particular topic, she will think about it, she will not be set in…she takes our opinions and she will also explain if needed, even if it's just for one person.

The above quotation provides an example of how navigators could also deliver a responsive service to their service users in a community group setting - not just in clinical environments or in service users' homes - in pursuit of person-centred care.

7.3.3 Unmet expectations

Despite positive perceptions and experiences of navigation, some service users identified ways in which they perceived navigation to be limited. There was a perception amongst some service users that the amount of support available to them from navigators was insufficient for their needs. One service user - a single mother from West Africa who had experienced previous traumas from her migration journey - spoke of how she had "want[ed] more" from her Project MAMA mother companion, by way of baby equipment. She continued:

> If I maybe need something, and I can not able to afford, I ask to them "Ok, this is what I want, but I don't think I'm able to get it". It's not always possible" (service user 1).

Elsewhere, post-natal support for service users was also perceived as being insufficient. Service user 2 - also supported by a mother companion at Project MAMA - felt that support offered to her after the birth of her baby was too short in duration:

> [I would have liked] maybe more time after the child is born. I'm not sure, but just two weeks or three weeks. Because with the baby born…I was tired and needed to go to GP or any appointments. For myself…I have lots of appointments, and it's good to have someone to go together because…it's tiring.

Perceived limitations also extended to the types of navigational support available. One service user at Project MAMA thought that there should have been support in the form of mother companions organising group activities for service users and their children, which would aid with social isolation, and may have further contributed towards achieving the service's prescribed aim of helping service users to better integrate into society. She highlighted that such activities could include service users meeting to "go out and go to one park and just make a picnic…I really like to meet with someone to go to park, and walking, and talking" (service user 3), suggesting an unmet for socialising and that the service user remained isolated to an extent. Another service user believed that Project MAMA was limited by the lack of formal mental health support available, stating that she believed that there was a need for individuals "who could give therapy. It should be very confidential, and with people with enough professional experience" (service user 4).

The above suggests that service users sometimes had expectations of navigation that were beyond what was available, and beyond the remits within which navigators must operate. Interestingly, this feedback related only to the Project MAMA intervention, and may reflect a higher level of need amongst service users who experienced vulnerability compared to Haamla Service.

7.4 - Perceived benefits for service users

After considering the prior needs of migrant women, and their experiences of engaging with navigation services, interview data offered insight into the benefits of having experienced health navigation, as perceived by the women themselves.

7.4.1 - Gaining access to services

Service users across the data reported experiencing improved access to healthcare following navigation, and offered insights into how navigation achieved this. At Project MAMA, service users perceived that mother companions had facilitated access to services for them. One service user, a recently-arrived single mother from Eastern Europe, experienced improved access through a mother companion helping her to ascertain what she needed to bring to an appointment and then attending the appointment with her, stating that the mother companion "helped to explain it [a document] to me and went together with me" (service user 2). Elsewhere in the data, other participants confirmed service users' experiences of increased access. One mother companion perceived service users as achieving greater access to healthcare as a result of being navigated, given the likelihood that "mothers without an MC [mother companion] miss appointments or don't go to appointments because it's overwhelming…there's lots to navigate" [navigator 5]. This was also an observation at Haamla Service, with a senior midwife stating that service users were better able to access healthcare through the navigation interventions at Haamla Service due to Haamla's status as a programme operated by - and located within - the NHS system.

Although this was not evident at Project MAMA, it was clear that service users at Haamla Service perceived that increased access to healthcare was achieved as a result of gaining knowledge of their options for seeking care and of how to manage their pregnancy. Increased service user knowledge was, perhaps, unsurprising given the clear educational component at the centre of maternity support workers' roles. One service user receiving support from a maternity support worker described to her the symptoms that she often experienced. The response from the maternity support worker was to share details of which health professional the service user should approach for different scenarios, with the service user reporting the maternity support as having advised that "'if you feel stressed, see your GP'…and 'call your midwife if you need this, on this phone number' '' (service user 7). This service user also spoke of how she had "learned what to do, how to eat, go for a walk, get fresh air" (service user 7) from her maternity support worker.

Another service user at Haamla Service also mentioned the positive impact of having "understood a lot about what to take to the hospital…[and] how to dress the baby according to the weather, as the climate in Sudan is very different to here" (service user 11). This suggests that maternity support workers helped service users to become informed on how to prepare for birth, labour and early motherhood - whether through being attentive to one's own health and wellbeing or being of aware of what items would be useful to have access to when admitted to the maternity suite at hospital.

It was noted in the preceding section that not all service users had expressed a need for increased access to healthcare prior to navigation. This sentiment is further expressed in the data on perceived benefits of navigation, whereby some service users believed that their access to healthcare had remained unchanged, largely due to the fact that they had already been accessing healthcare in line with their needs. This was reflected at both study sites, with one service user at Project MAMA stating that she had "used the NHS before them [mother companions], so it's ok for me" (service user 1), while another service user at Haamla Service claimed that through engaging with maternity support workers she "didn't learn anything about accessing health service" (service user 8).

The concept of access to services as a perceived outcome was not limited only to healthcare. Some commented that supporting service users through navigation could also lead to improvement in their access to other services of benefit to their general health and wellbeing. Data was only available from interviews conducted with other participant groups at Haamla Service, however. While one midwife perceived that navigation "gives them the confidence to start seeking the help they need, to speak to other people to access other things" (healthcare professional 4), one volunteer doula mentioned how supporting a service user via navigation ultimately helped the service user to access the British education system: "They are learning how to navigate the system…they can use that as a building block to make further access. One of my clients is now at college doing an NVQ" (navigator 11). This suggests how navigation may aid service users in becoming acquainted with - and establish experience of - other non-NHS statutory services.

7.4.2 - Facilitating empowerment to increase access to healthcare

Empowering migrant women service users had been included as an aim of navigation at both study sites, with **Chapter 6** discussing the different ways in which services had defined 'empowerment'. Empowerment was commonly understood by participants as a sense of independence or confidence, and was perceived to be an intended benefit of health navigation for service users. This confidence and independence gained through being supported by a navigator helped service users to better access healthcare.

A Project MAMA service user mentioned earlier in this chapter - who had only visited the dentist and a pharmacist prior to engaging with navigation - perceived a growth in confidence and independence in managing her interactions with healthcare professionals. She explained that she "can speak everything with the doctor now …I was shy, but now I'm ok" (service user 3). Another user of Project MAMA's service went further, clearly acknowledging the role of navigation in enabling service users to gain knowledge and, in turn, confidence to deal with such scenarios, stating that mother companions "tell you you have a right to talk of what you want, a right to speech…and not all women know their rights, especially asylum seekers and refugees in the UK" (service user 4). These sentiments were supported by a mother companion herself:

> I'm amazed by how much the women seem to sort it out themselves - and there'll be times when we just nudge them to 'look at the back of your book'. I think definitely it helps to have somebody who can make sense of the different appointments…I think some people just manage to make sense of things. And I think also - women have lots of different ways of accessing information, with smartphones. It's, sometimes, just a nudge in the right direction and they're off (navigator 1).

This highlights how navigators could offer prompts to service users to reassure them of their own knowledge and encourage their independence in successfully accessing healthcare and other services. This also implies that navigators sought to not encourage service users' dependency.

Service users at Haamla also described how they had experienced improved confidence and independence which enabled them to access healthcare more easily. Similar to Project MAMA, the presence of navigational support and the encouragement it appeared to offer were of tangible benefit to service users:

> When I came to the UK, I found the language very difficult, social aspects and access to services was a little bit harder. However, the more I came to Haamla, the more confident I became. I feel that I can go and make my own appointments at the GP (service user 14)

This was mirrored by the testimonies of another service user, who, despite being highly educated in the medical sciences field, had experienced difficulties in communicating in English - including with healthcare professionals. After engaging with navigation, she described herself as feeling "very confident…so it is helpful to interpret and find out my knowledge, to communicate easily with doctors and midwives" (service user 13).

A service user receiving support from a maternity support worker in the early stages of her pregnancy faced a difficult housing and financial situation, and was going to be a first-time, lone mother. She recounted how this support had been of benefit to her:

> I remember thinking 'my God, it's going to be so hard' with everything, because I was hardly going out, you know. Most of the time, I'm home in the bed. When I eat, I was throwing up. I wasn't enjoying [the pregnancy] at all. But when she came, she helped me a lot and she give me confidence as well - that walking is good for me rather than staying in the house, and that it's good for my wellbeing…it reduces the stress. It has helped a lot. (service user 7)

In the above case, the service user had perceived that her improved confidence - derived from the knowledge gained by way of engagement with navigation - ultimately led to an improvement in her health and wellbeing during her pregnancy.

Finally, empowerment also encapsulated the notion of 'enabling choice' amongst service users, as outlined in the previous chapter. Interestingly, this had been included as a navigational aim only at Project MAMA, yet data relevant to this was extracted exclusively from Haamla Service users' interviews. This implies that the work of Haamla's navigators - in particular, maternity support workers - helped to inform service users of their maternity options and encouraged them to take ownership of their personal decisions around their birth, despite this not being a documented aim of the intervention. This could be exemplified by how a lone, first-time mother who had been assigned a maternity support worker had informed choice enabled for her, saying that "I feel better and comfortable…I feel happy - I know that after the birth I know what I can do" (service user 6).

7.4.3 - Fostering a sense of community and encouraging women's integration

Helping to socially integrate migrant women into their local communities was identified as an aim of health navigation across the interventions in the previous chapter. Service users - in particular, those who had experienced mental health difficulties - had also identified a need for a sense of community prior to being navigated. Data from across the navigation interventions described service users' participation in navigation interventions as impacting on how service users engaged with their local communities in the UK.

One outcome appeared to be that service users experienced less social isolation; this was reported across both study sites. At Project MAMA, service users mentioned how developing a relationship with mother companions helped to combat isolation, with one stating that she felt "more confident…at some point I was quite isolated, very isolated. But now…I feel at home" (service user 4).

Interviewees at Haamla Service shed light on how service users being connected to community initiatives via navigation impacted on their social lives. One service user, an older single mother who was a new arrival to Leeds and had been assigned a maternity support worker, reflected on her own experience and how she had benefited socially, stating that her maternity support worker "has helped me with talking, telling me to not be upset and help me come out and make new friends" (service user 6).

Aside from the above, navigation also aided service users to become more socially 'integrated' into their local community in the UK. Service users at both study sites highlighted the impact of engaging with a health navigator on their English language proficiency. At Project MAMA - where all mother companions communicated in English with service users - service users described improvements in their language proficiency after forming a relationship with their mother companions, claiming that their English "is better, I have more friends and I can speak with them and everything" (service user 3). Service users engaging with the maternity support worker-led intervention at Haamla Service - where maternity support workers were required to be bilingual - also described improvements in their language proficiency. One service user - a recent arrival who was interviewed through an interpreter - had low proficiency in the languages spoken by the maternity support workers at Haamla Service. Yet, she described having benefited from exposure to the English language:

> I found that I've been meeting new people, and that my English is getting better; I do understand English but it's the speaking that is hard. But I'm getting more confident now (service user 11).

Another indication of how navigation could aid service users to engage with their local communities was how service users perceived the UK through their experiences of navigation. Data on this was only available from the Project MAMA study site. One service user stated that - based on her experiences with British people she had interacted with via navigation - they "feel for you, they put you through, they make you feel that everything will be fine" (service user 1), suggesting that her engaging with British individuals who acted as her mother companions had helped to shape her view of them as collectively being empathetic and kind individuals. This was also emphasised through the testimony of a healthcare professional whose patients had used the Project MAMA service. They were confident of navigation's capacity to positively impact service users' experiences of the UK, saying of mother companions, specifically, that "if there's people like that who are willing to do that, then it [the UK] must be an ok place" (healthcare professional 1). This suggests that engaging with such navigators offers service users some reassurance of wider support and solidarity among the public.

7.5 – Conclusion

Migrant women service users reported a range of needs prior to engaging with navigation. Although perceptions of navigation were generally positive, there was evidence to suggest that some service users' needs went unmet. This is primarily because of a mismatch between some service users' expectations of what navigation could deliver for them, and what a navigator could realistically deliver within the remit of their role and the resources available. Nevertheless, service users reported a range of benefits following navigation, some of which were unintended; these benefits were increased access to healthcare through gaining knowledge and empowerment, reduced social isolation and increased access to other services which could also promote health and wellbeing. Reports from other interview participant groups supported service users' accounts. The next Chapter will follow a similar structure in reporting navigators' perceptions and experiences. Taken together, **Chapters 7 and 8** provide an in-depth exploration of navigation from both sides of the navigational relationship.

Chapter 8 - Experiencing navigation: Navigator narratives

8.1 - Introduction

This Chapter presents the navigational experiences of mother companions (Project MAMA), as well as maternity support workers and voluntary doulas (Haamla Service). Following the in-depth exploration of migrant women service user narratives, this Chapter offers insight into the other side of the navigational relationship. It provides details on health navigators' experiences of and reflections on their role, including the challenges they have faced and the benefits they perceive in delivering navigation for service users. Within this chapter, the voices and narratives of health navigators are brought to the fore, with supportive or contradictory statements from other participant groups included, where possible and appropriate. All data presented in this chapter are derived from interviews.

Similar to the preceding chapter, this chapter contributes towards addressing research sub-question [b]:

[b] How are navigation interventions perceived and experienced in practice?

8.2 – How have health navigators experienced their role?

All three forms of health navigator at the two study sites recounted their experiences of delivering navigation for service users, much of which involved negotiating boundaries within their organisational contexts.

8.2.1 - Managing expectations

Navigators' roles of delivering support to service users were underscored by managing service users' expectations of what support navigators could reasonably provide. Across the data, there were instances of service users overestimating what navigation could offer and, inevitably, being disappointed. Elsewhere, service users' erroneous expectations of navigation's offerings revealed a fundamental misunderstanding of what navigation aimed to achieve.

Managing service users' expectations required navigators to be "really clear about the service we offer" (navigator 2). Another navigator - a mother companion at Project MAMA - described these parameters further:

> It's about not doing too much, because I'm not always going to be there and I cannot always be there, and I cannot always do that. I think that's been interesting, because your impulse is to say 'of course I can do that'. But, actually, if you give too much to one person, then you can't give to other people, you cannot be there all the time and they become dependent on you and you're not there anymore. Supporting them to access resources and services is actually, in the long run, going to help them to be more independent, and that's one of the things I really love about Project MAMA (navigator 6).

In this way, managing expectations was crucial to supporting the ethos of navigational work, by committing to the aim of empowering service users to make independent choices about their birth and lead independent lives as pregnant women and new mothers. When the expectations of service users were mismanaged, there was potential for problems to arise. At Project MAMA, a simple miscommunication around post-natal support delivered by a mother companion led to a service user's inevitable disappointment when their package of support fell short of her expectations:

> One of the things with [a service user] was that we said we'd give her post-natal support for the 8 weeks after the birth, but she heard "we'll be there everyday for 8 weeks"….so, as soon as we realised that that's what her understanding had been of that, we corrected it, but then she was disappointed. It's hard (navigator 4).

This was not unique to Project MAMA. Maternity support workers at Haamla Service - who led antenatal and postnatal community groups as part of their role - found that service users would express a desire for more support beyond the 6-week cut-off period, with some service users still deciding to attend the community groups after the 6 weeks had passed. This was in spite of Haamla Service's clear guidelines dictating that the cut-off period should be respected. According to navigator 8, these service users insisted on presenting at the groups beyond this cut-off period, as "that was the only social place they could come once a week", highlighting a lack of available safe spaces to socialise within their local communities. Maternity support workers at Haamla Service also reported falling short of some service users' expectations. While navigator 7 mentioned that service users "might feel it's not enough because they had the perception of getting more", navigator 8 echoed this sentiment through using the example of service users who expect maternity support workers to place them as a priority on a housing list when they are pregnant. This was beyond the remit of their role and, ultimately, service users "are disappointed with that". The previous chapter similarly alluded to service users' reports of unmet expectations, suggesting a high level of need for tailored support among these groups of migrant women service users,

At times, the work of navigators may not have necessarily fallen short of expectations, but may have differed from what some service users had felt they needed, and what they expected. A volunteer doula at Haamla Service described one scenario she faced:

> I came and she [a service user] had had her baby. It was like 'thank you, but no thank you'. I had to hear that from someone at the hospital, who passed that message on to me. I think she was more interested in somebody looking after her child at home…I'm not actually here for the other child, I'm actually here for you. I don't think it was enough for the lady. I think she wanted something else. I'm not sure 'upset' is the word. I think I was more angry (navigator 10).

This scenario may have also been caused by a miscommunication between the volunteer doula and the service user. Unlike other examples of mismatched expectations, this particular scenario also resulted in profound disappointment for the navigator herself - an unpaid volunteer, who had made a time commitment to travel to the hospital in order to support a service user during her birth.

8.2.2 - Negotiating boundaries surrounding the remit of the navigational role

Across the navigation interventions studied, the work of navigators involved a significant amount of negotiation. Despite the existence of robust organisational policies on what form of support should be given to service users - and the duration of time that it should be given for - there was a degree of negotiation involved when needing to consider service users with specific needs on a case-by-case basis.

A mother companion at Project MAMA recalled the difficulties faced by a single mother with an older child who demanded much of her attention, and how navigational support was negotiated to meet her specific needs:

> She was alone a lot, and her little boy was really hard work…so I definitely did more post-natal for her than was the Project MAMA norm….and we talked about it within the group about how far we could reasonably extend that support. We definitely pushed it out a bit beyond, but it was also really good and it was difficult for her after the baby was born because of her other child. It was really hard work for her and she managed it brilliantly. I thought that really did justify some extra support and some extra time…even with extending the service for a couple of people…well, everyone [laughs]…that's not been an issue. We've just talked about why, and what, and how to extend it, but also how to contain it (navigator 4).

Interestingly, the above quote implies that navigators routinely negotiated with regards to the amount of support they could offer service users, based on their assessments of a service user's case, and how worthy they believed their case was for offering extra support. In this way, navigators had the power to inform the extent of navigation offered and, therefore, how far a service user's need for access to services, companionship, information and other forms of crucial support could be addressed. This is reminiscent of Lipsky's street-level bureaucrats, which show how frontline workers operationalise policy via their choices and behaviours with clients (Lipsky, 1980).

Finally, navigators also spoke of the time burden of completing tasks to support service users, which was overseen by the two organisations. This was seen as being a more onerous and overlooked burden in comparison to making oneself available as a volunteer for a given time period around the time of labour and birth. At Project MAMA, a mother companion considered “all the time that you give to it when you’re not with the mum too…like when you’re looking things up, or when mum has mentioned something to you and you’re trying to sort it out for her” (navigator 2). Volunteer doulas at Haamla Service added to this, stating that:

> Because you’re constantly aware of what’s going on in the community, what resources have been set-up…you actually pick up a lot without realising. It’s constantly with you - you’re constantly working, even though you’re not working! (navigator 9).

There seemed to be an unclear expectation of time commitments amongst mother companions at the Project MAMA site. While navigator teams “discuss how far after the baby’s born…it really depends on the woman” (navigator 3). One mother companion attributed this to the service being relatively new, and still under-resourced and underdeveloped, expressing that “my feeling is that down the line it will be more streamlined and clear” (navigator 1).

Similarly, at Haamla Service, volunteer doulas spoke of negotiating the end of the 6 week-long intervention. They discussed this proposition with the service coordinator, and “if they say ok, then go ahead. If not, we just stop it there” (navigator 10). Maternity support workers also noted the specific difficulties faced by their service users, and negotiated their support by carrying out ‘non-traditional’ tasks. This included taking a service user shopping, due to her inability to manage money effectively. One maternity support worker remarked “I wouldn’t normally do that, but she didn’t have a clue. So I went out to a baby shop and helped her buy the items” (navigator 8). These examples of needing to negotiate enhanced support would have been important in fulfilling the interventions’ aim of providing person-centred care. However, this sometimes came at an emotional cost to navigators, with indication from a maternity support worker that these difficult scenarios “could be challenging and emotionally-impacting" (navigator 7).

8.2.3 - Negotiating interpersonal boundaries with service users

There was a wide array of perspectives on whether being a navigator required a need to maintain boundaries within their interpersonal relationships with the service users they supported. This emphasises the subjectivity associated with managing a navigational relationship, and that navigators themselves wielded power and control over the dynamics of their relationships with service users.

At Project MAMA, mother companions made mention of the challenges associated with negotiating interpersonal boundaries, with navigator 2 offering some insight:

> It's a difficult one, being an MC [mother companion]. In other roles, I'm extremely professional, having very big boundaries. But in this role, it's difficult to know where they lie - you can close yourself off to a client if you are too 'boundaried' . If you're too gung-ho and professional…if you go down that 'I'm not going to let any of my personality or personal life out' way…it's a really difficult line, because some of the most meaningful conversations you can have with a client can be because you said "I've experienced that"

This implies that balancing the professional and 'friendly' aspects of a navigator's relationship with service users involved constant negotiation on the part of navigators, in order to be able to offer the companionship and emotional support that some service users seek, while respecting the rules and guidelines that navigators are expected to follow by the organisation responsible. Negotiation of interpersonal boundaries remained a necessity amongst mother companions at Project MAMA, despite the existence of organisational policies:

> There is a code of conduct, but it's personal because some MCs are probably more happy to share things than others. I'm a very relaxed person, so if someone asks me something, that's fine. But I'm not just gonna give information like I would to a friend (navigator 2).

In the above quotation, a distinction is made between service users and 'friends', emphasising that the relationship often required boundaries to ensure that it did not become informal in nature. However, not all mother companions at Project MAMA saw a need for negotiation of boundaries in their relationships with service users. Navigator 6, for example, perceived that there was not "a whole lot of divide between my professional life and my private life", and that this was because of the passion that she had for the role. This also led to her seeing herself not "as their caseworker…[but] as their companion".

Maternity support workers at the NHS-operated Haamla Service spoke of the balance between being a professional and being a friend when interacting with service users, as well as the necessity of maintaining boundaries. One maternity support worker stated that "it's really important to draw the line". She continued:

> They might invite you to the christening of the baby, or a party…but I prefer not to go down that route. Keep it professional, 9 to 5 and that's it - my phone's turned off. I would see them in the supermarket and can introduce them to my kids or my husband if they are with me…but there's a limit (navigator 8).

This suggests that the 'limit' itself was negotiable - navigators were simultaneously negotiating grey areas in their work with service users, yet the nature of this work also afforded them the flexibility to define their own interpersonal boundaries.

Finally, another aspect of negotiating within their interactions with service users was navigators needing to make sensible, personal judgements. A mother companion at Project MAMA described being a navigator as "feeling your way all the time" (navigator 1). She continued:

> It's about trying to work out when they need that help, and when it would be intrusive to be at an antenatal clinic and midwife appointment with them, and when it would be supportive. And that varies…some women want to feel independent and do it themselves. Also, it's how to explain - rather than assuming, "oh, I'll come with you to that appointment" or assuming she'll want it - but also explaining in an un-pushy way.

Although no comparable data from Haamla Service was available, this is, nevertheless, an interesting observation to include in this chapter, as the quote implies that there was a need for navigators to build up a relationship with service users in order to negotiate around - and respect - a service users' own boundaries. Further insight into the dynamics of the relationship between navigators and service users will be provided in **Chapter 9**.

8.2.4 - Negotiating boundaries between the navigational role and other commitments

Navigators across the three interventions needed to make choices about how they allocated their time - especially for unpaid navigators. They alluded to the inherent unpredictability of their roles as navigators, and how this impacted on their professional and personal lives.

One mother companion at Project MAMA spoke of what negotiating boundaries between the navigator role and her work resembled for her:

> I'm not in a position where I can't earn money, so I need to be careful about the balance of work - paid work and voluntary work - that I do. I'm always walking that line…the boundaries have been tested…but that's the thing with boundaries - you don't really know where they are until you reach them (navigator 4).

A maternity support worker at Haamla Service also recognised a need to negotiate boundaries, stating that "there are some boundaries that you have to put, otherwise it will affect your personal life" (navigator 7).

An area where all types of navigators at both study sites experienced significant challenges was in the expected time commitment to their work. Mother companions at Project MAMA reflected on the difficulties associated with being on-call. Navigator 1 was a former NHS midwife who was familiar with the practice of working on-call. Although she had previously been on-call when working within the health system - which had meant "being on call for part of Bristol and being called out" - in her current capacity as a mother companion this then took on a different meaning, whereby "now I have longer periods of being on-call, but it's for one woman".

Similar sentiments were expressed at Haamla Service. The role of a volunteer doula was seen as being "very demanding, because it's unpredictable. You go with [the] woman to her labour and you have no idea when the baby comes. You have to rearrange your life" (navigator 7). Maternity support workers had been prevented from completing doula training to support service users around the time of labour and birth.

Navigators faced difficulties in balancing voluntary and unpaid navigational roles with other commitments; this affected mother companions at Project MAMA and volunteer doulas at Haamla Service. Pursuing other professional commitments and hobbies were especially difficult when volunteering as a navigator. One mother companion at Project MAMA was a freelance, private midwife alongside her voluntary, navigational work. This presented time schedule conflicts:

> Occasionally, it can be stressful…if I'm really busy. With my day-to-day work, I'm on call a lot of the time; if I then have a birth and I'm up for 24 hours and then I have post-natal visits and doing the paperwork, but still have all the clients I have to see. Sometime, it's in fits and starts. I'm generally busy, but sometimes I'm a lot more busy. So sometimes the extra thing of having the extra visit, or the extra thing to do can sometimes feel a bit stressful (navigator 6)

Another mother companion described being anxious about keeping up with her hobbies including running, as "if I'm out somewhere running and I get called, then I have to get back to the house and be left sweating…so that's quite challenging" (navigator 1).

At Haamla Service, this was also felt amongst volunteer doulas, with one reflecting:

> It's not for everyone. I don't think some people really realise how much commitment it takes - especially around the time of labour. Your life's on hold for that couple of weeks, waiting. You don't want to go too far. If you've not got a back-up doula that's gonna be around as consistently as you, you really have to make sure you plan your couple of weeks quite well (navigator 9).

8.2.5 - Organisational support and limitations

Navigators at both study sites gave insight into how they carried out their roles, given the remits of their roles which were guided by organisational policies. In doing so, they expressed appreciation for their organisations' robust policies - which aided decision-making when negotiating boundaries - but mixed views on whether such policies should allow them to be remunerated for their labour.

There was evidence that mother companions at Project MAMA appreciated the clarity of the policies on the range of support they could provide in carrying out the role, with navigator 4 claiming that volunteering at the organisation had been "really nice, especially with [the coordinator] walking a really nice line, because it is really well supported and it is really clear. You can do as much as you're able to do well". Another mother companion appreciated the flexibility within the role, creating more space for a mother companion to negotiate their support to service users based on what they perceived their needs to be:

> How much you give to it is up to you. And with boundaries - I can compartmentalise and I know my emotional boundaries. But also…I know some things I do aren't within the job title - I know that - like going to get a mattress. That isn't, and I knew that. But I wanted to do it. I'm someone who actually quite likes fluidity of structure, and I can't stand being told exactly what I need to do and when" (navigator 3).

At Haamla Service, navigators also mentioned clear, robust organisational policies. This would be expected, given the fact it is an NHS-operated service which was subject to a multitude of institutional policies. One volunteer doula stated that:

> When you do the doula training - the training is very rigid, straight-forward but high in content. You just know your boundaries, you know what you're there to do, you know what you're there not to do…We all know what our role is. We all know what the protocol is, and the safety aspects, and the do's and dont's, and visiting certain areas and certain people and certain times of day. That's the only thing you have to think about - the rest comes naturally to you (navigator 9).

Furthermore, a maternity support worker shared how service users sometimes attempted to take advantage of maternity support workers and "like to pull your boundaries, and like to use you, but people can try to get more than they really need and we do have clients like that" (navigator 7). Health navigators, therefore, generally had positive perceptions of their organisations' policies, despite sometimes having negative interactions with service users.

As stated earlier, navigators at two of the three interventions were unpaid volunteers. Collectively, navigators held a range of views on whether they should indeed deliver navigation as a voluntary service. One mother companion at Project MAMA offered an interesting perspective on perceiving voluntary work as an attempted subversion of the status quo, in some way, which made the goal of achieving empowerment of service users more attainable:

> It'd be completely different if it was a salaried role. I wouldn't want to do what I'm doing right now in that capacity, because there's something 'level playing field' about the fact that MCs are not being paid. If I was paid, it's like a superhero swooping in…which is not beneficial for the women…we can swoop in and do stuff for 6 weeks and leave, but long-term that's not really very helpful…we're working with these mums, we're not working for them….you've got to be compassionate and caring, not too full of yourself. I think you've just got to be a kind person. And I don't think you would get people who aren't like that - because we're volunteers" (navigator 2)

Elsewhere, there was a view that volunteer navigators should have been paid for their work - according to another mother companion - as "you don't want to have too many more heads in the room…[and] you can't expect an MC to cover so many people on a voluntary basis" (navigator 4). This highlights how provision of a salary would have likely reduced the number of navigators available to support service users - thus, streamlining staffing, reducing the number of 'back-up' mother companions or removing the programme of 'back-up' mother companions entirely.

Remuneration of navigators was also presented as a question of sustainability. A volunteer doula at Haamla Service expressed how providing a salary for doulas would "probably get more people volunteering and have more regular attendees to births". In her view, a salary would better guarantee commitment from doulas and help to reduce high turnover in volunteers:

> There's an element of commitment that you should be expecting to get from them [volunteer doulas], and sometimes it doesn't occur…it's just hard for the system. You're training people up and only getting two out of a cohort…I think the hard thing has been the training and the fallout from people not committing to it. It's a little bit gutting. It's an NHS resource. People who come in without any intention of staying there are just wasting money and resources, and it's just frustrating….this last cohort that went through last year were really disappointing (navigator 9).

A midwife at Haamla Service provided additional comment which supported and further enhanced navigators' views on doula remuneration to increase service sustainability, highlighting that "you're always going to come up with that issue of never being 100% guaranteed that you're able to provide that doula, but trying to have a service with fixed term contract doulas would be very difficult to fund". If retaining the current number of mother companions was, instead, the goal of the service designers, then paying them a wage or stipend would have needed to be a long-term goal.

8.2.6 - Managing limitations of NHS and statutory services

Navigators across all interventions had been operating against a backdrop of increasingly limited public service provision. This meant that they had been witnessing the constraints placed on public services, which left them unable to fully address the most basic needs of some service users. This suggested that - despite navigation's perceived successes in addressing barriers - macro-level, structural barriers could not be resolved through navigation alone.

A mother companion at Project MAMA could not find a solution to a service user's serious housing issues, as "what she really wants is better housing, and that's something that I can't really help her with" (navigator 4). The mother companion then resigned herself to only being able to explain that there's a long and complicated process dictating who can get council housing, and when. These constraints not only increased the needs of service users and decreased navigators' ability to aid them, but also increased navigators' workloads and widened the remits of their roles, as highlighted by a maternity support worker at Haamla Service:

> Services have changed, money's getting tighter. There's only so much we can now provide. For example, we used to have one-stop centres where women could get advice on benefits, housing etc., but they've mostly all closed. ESOL [English for Speakers of Other Languages] classes, for example, they used to be run at every corner….but they've really cut down on them. I'm doing more stuff now - before, I would tell the women about the services and pinpoint them and they would go and access them. But now they're not available. So it's us doing more leg-work (navigator 8).

One example of increased 'leg-work' was the fact that maternity support workers were required to be bilingual - as outlined in **Chapter 6** - and provided language interpretation and translation as part of their navigational remit. While this "saves money for the NHS", as there was no need to book an external interpreter, navigator 7 acknowledged that "it's hard - when you run the [antenatal/postnatal] group - because you have to concentrate twice more, and sometimes I'm like 'I forgot to tell her' or 'I didn't translate everything' ". This challenge was also compounded by the difficulties of delivering a navigation service in a second language. This particular maternity support worker identified herself as a migrant to the UK, and had found working in the English language challenging, stating that "it took me a while to get all the vocabulary".

Mother companions at Project MAMA perceived that they were filling in gaps left by an increasingly constrained 'system', instead of merely operating as a complement to it. While one mother companion declared that "we can seem like we are the wonderful alternative to the mainstream system" (navigator 1), another mother companion described how they "take on a role that is way above what should be going on…with mental health referrals and things" (navigator 2). The latter then went on to recall her experience accompanying a service user during her birth, and providing assistance to the midwife outside of the remit of her role:

> I think I probably took on more in that scenario than the student midwife did! I think it worked out well for that lady because the student midwife was *clearly* incompetent…maybe it was her first birth or something. She couldn't even pass things to the midwives - *I* was passing things! And that's when it goes outside of your role - that's why you've got to be careful that you're not doing too much.

Taken together, navigators' challenges in carrying out largely unpaid labour to compensate for under-resourced 'mainstream' services are reminiscent of critique of the neoliberal state, whereby navigators and others external to the 'mainstream' are relied upon to struggle to fill its gaps (Koch and James, 2019).

8.2.7 - Managing relationships between navigators

Navigational teams were made up of individuals from different professional backgrounds. This was most observable amongst mother companions at Project MAMA, as well as volunteer doulas at Haamla Service. Across these interventions, navigators had backgrounds in private doula work, private and NHS midwifery and teaching, among others. This informed an interesting diversity of perceptions, but presented challenges in managing fundamental differences in worldview, which materialised through differences in professional experiences of maternity.

A former NHS midwife - who was now volunteering as a mother companion at Project MAMA - perceived that navigators who came from a doula background had "more middle-class views of birth" due to their experience of "giving care to women who could pay for it", highlighting a pervasive lack of diversity in the private birth work sector. She continued:

> I found with others in the group, that there was more of a focus on doing a particular way of preparing for the birth and looking at a particular kind of birth, which - in the end - it's ideal to have a lovely birth, but, I've seen lots of different births, and people have a lot of different views on how they want to give birth (navigator 1).

On the contrary, navigators from private doula backgrounds perceived those who had come from the NHS as being institutionalised. They defined this as someone who would "find it difficult to see that women do still have choice, and that it might not be what the midwife would like, but that's still a choice" (navigator 3). In this particular individual's view, this presented a conflict between what a healthcare professional would recommend according to clinical guidelines around birth, and what a patient would want their birth to look like.

Additionally, at Haamla Service, a volunteer doula reflected on the perceived difficulty navigators with midwifery backgrounds faced when needing to enable choice for service users, as this required one to not advise a service user as to what decision they should take. According to the volunteer doula, "not advising doesn't come naturally" to former midwives, but that, as navigators, they are working within "an environment that they've always been used to, but without the pressure" (navigator 9). This doula - who did not have any background in midwifery herself - held this view of other doulas who did come from a midwifery background, therefore perceiving them as being different to herself.

A mother companion at Project MAMA who had a private midwifery background also offered an interesting perspective, around navigators with NHS backgrounds dealing with their service users' traumas:

> When I was a student, there was a level of nosiness among midwives that I feel wasn't needed. It's one of the things we all have to learn through Project MAMA - a lot of these women have had a lot of trauma and we don't need to know some things. They will disclose if they want to, and that isn't in our role to ask those things...I can still empathise and be compassionate without needing to know the details. We've all had to learn that here, but I think maybe some of the ones with the NHS background might not have fully understood at the beginning, whereas for me that came very naturally (navigator 6).

The above quotation suggests that navigators working with vulnerable communities - such as mother companions at Project MAMA - must be sufficiently equipped to handle sensitive issues in order to offer service users a flexible and responsive service that is person-centred and trauma-informed in nature. This is positioned as a form of care that is not yet available within mainstream NHS services.

Additionally, navigators working within the same team to support one service user seemingly adopted different approaches. Reflections from a Project MAMA mother companion suggest that this encouraged effective collaboration, whereby "everybody has a different tone, everybody has a different approach…we all have different strengths" (navigator 2). Using the example of an older mother companion who had lived in the local area for decades and possessed a substantial amount of knowledge on local community resources to signpost a service worker to, it was suggested that having a navigational team - that is, two or three different mother companions who can offer support according to their availability - was highly beneficial when each mother companion has something different to contribute.

8.2.8 - Managing relationships with healthcare professionals

Navigators at the study sites readily interacted with healthcare professionals; although there were also interactions between navigators and social support professionals, these were only explored in the data from the perspective of social support professionals, and not navigators themselves. Often, these interactions were presented as positive and collaborative in nature, yet healthcare professionals' ignorance of the nature of navigators' roles - and the resulting assumptions they made about navigators - caused friction.

While navigator 1 - herself a former NHS midwife - had initially worried that there could be conflict with a midwife in the hospital "if you're coming from a different background,", there was an indication elsewhere at Project MAMA that healthcare professionals "knew the service I provided and knew that I'd be vaguely helpful" when arriving at the hospital to support a service user in labour (navigator 2).

At Haamla Service, volunteer doulas perceived there to be positive relationships with non-Haamla Service midwives when on a hospital ward, highlighting that "I've never been made to feel like I was in the way or like I was not needed. They're always appreciative. They know you're gonna take the pressure off a little bit" (navigator 9). Building on this, another volunteer doula felt that "most of the time, they [healthcare professionals] know who we are". However, there were cases of healthcare professionals not knowing or understanding the role of maternity support workers as navigators, and not appreciating the unique challenges associated with the role:

> Sometimes we might get other MSWs [maternity support workers] saying "how come they aren't doing this? How come they can't do bloods?"…our role is completely different…we can do baby weights and breastfeeding support, but we cannot do checking the baby clinically…while a normal MSW will have a list telling them they need to do a Day 3 visit, breastfeeding support and checking blood pressure, we go into a home and we go in with an open mind (navigator 8).

Sometimes it wasn't just non-Haamla Service midwives or other healthcare professionals who lacked familiarity with this navigator role. As one maternity support worker stated, often "our [Haamla] midwives don't know either - they may refer a woman saying that she doesn't speak English, but what do you want us to do? You need to book an interpreter." Similarly, at Project MAMA, the mother companion role was "still quite peripheral" (navigator 4), with some healthcare professionals remaining unfamiliar of why these navigators were present on the maternity wards with service users, and what the purpose of their role was.

This lack of familiarity with navigation as an intervention led to a perception amongst navigators that some midwives erroneously believed that navigators were undermining their work, and deeming them a 'threat'. At Project MAMA, a mother companion remarked that "for some reason, some midwives feel like you're taking their role away" (navigator 2). At Haamla Service, a long-serving maternity support worker recalled her past interactions with healthcare professionals who did not understand her work. She then highlighted that "more and more, the midwives realise our roles and know that we are there to support them, rather than to take over…yet sometimes they create extra work for themselves and we have to pick up the pieces after she [the service user] delivered" (navigator 8). This refers to the aim of how navigation could complement - or fill gaps left by- mainstream services, and how healthcare professionals themselves could be an obstacle to achieving this aim.

A midwife interviewed at Project MAMA offered a perspective which confirmed navigators' beliefs, whereby she had a very positive relationship with her patient's mother companion when they met each other in the hospital delivery suite. However, she acknowledged that "when it's birth, sometimes you want to form a direct relationship and when there's someone else there trying to also help, it can interfere as well". She provided further detail:

> It's not boundaries, but crowding the field. Sometimes it's nice to just have a moment with the patient. I wouldn't want them there all the time - I want to be like 'I've got this, I'm being respectful, she's ok with me, we don't need someone here all the time'. I like home visits - because of the whole power thing, being in the woman's home. She's the host. I would want to follow the woman's lead for that, and wouldn't necessarily want an advocate there as well. I would want to be like ' No, I'm going to treat this woman's home with respect', and either accept the tea she's offering or not - but according to my relationship with her. I can imagine not always feeling the need for two professionals (healthcare professional 1).

The above quotation outlines the midwife's concern about how a navigator could interfere with the relationship between a midwife and a patient, and may allude to a perception of navigators questioning her skills and, potentially, her ability to deliver culturally competent/safe care. This is, thus, one example of how healthcare professionals and navigators may come into conflict.

Regardless of potential concerns of navigator interference in their delivery of maternity care, healthcare professionals did speak at length about the generally good relationship between the two worker groups and the intrinsic value of navigational support for their patients, once again corroborating with navigators' accounts. One midwife described Project MAMA, for example, as being a preventative tool in the context of institutional racism and classism within the NHS which enables poorer health outcomes for migrant women. She stated that navigation was "unfortunately essential". She continued:

> If there was better training in the NHS, it probably wouldn't be so potentially lifesaving…I suppose I just hope for a world where we didn't need it [navigation from Project MAMA]. A world without wars and the rest of it, but also it's an absolute tragedy that half the work they're doing is undoing the racism that's already existing on the ward (healthcare professional 1).

Issues of racism and classism within the NHS as they relate to service users' need for navigation will be revisited in **Chapter 10.**

8.3 - Perceived benefits for navigators

Across the data, navigators reflected on the benefits they perceived to have received, as a result of their navigational work. These benefits centered on navigators' improved self-esteem, awareness, resilience and confidence, the latter of which also offered professional benefits for navigators.

8.3.1 – Navigators' self-development

In spite of the numerous challenges associated with supporting service users through health navigation, there was evidence of navigators perceiving the intervention - and their own role - positively.

For a mother companion at Project MAMA, supporting service users in this way "makes me feel good about myself" and that "I'm doing something…that I'm making a difference" (navigator 3). This feeling of personal satisfaction was also present amongst navigators at Haamla Service, whereby a volunteer doula shared that they were "rewarded just by being there, and knowing that I've supported someone" (navigator 9).

Supporting service users by way of navigation helped to develop important personal qualities amongst some navigators. At Project MAMA, a mother companion made reference to how engaging with vulnerable service users allowed for her to build up her own resilience:

> In a way, you have more likelihood of understanding someone's vulnerabilities or experiences when you're supporting a Project MAMA mum. In a way, it's sort of easier because you can have an abusive situation but you might be completely oblivious to it in someone you expect to be fine…you're preparing - from the second you begin working with somebody - for it to maybe be more difficult and more challenging. In a way, you're already a bit more resilient compared to if it just came out of the blue (navigator 4).

The above quotation illustrates the mindset that mother companions at Project MAMA possessed, whereby they were sensitive to the challenges faced by service users, who were generally experiencing vulnerability. Another mother companion described experiencing increased self-awareness as a result of delivering navigation to service users, stating that she was "learning more and more about myself and about what my boundaries are - what I'm willing to do, to not do, that sort of thing. It forces you to think about that" (navigator 2). This quotation references the difficulties faced by navigators in managing boundaries, as discussed earlier in this Chapter.

8.3.2 - Reflections on career aspirations

Similar to service users, navigators themselves also found that engaging with navigation increased their sense of confidence, with a mother companion at Project MAMA recalling that "with every woman you support, you're always learning. Each time you get more confident" (navigator 5). Confidence gained through delivering navigational support to service users led to the development of navigators' professional goals. One volunteer doula at Haamla Service felt that the confidence gained through her volunteering as a navigator inspired her to take her interest in maternity care further:

> "Now I have the experience, it's given me the confidence to look for courses, to look to see what's available out there. Now I feel I can do it [study midwifery]. I can really go for it" (navigator 10)

Another volunteer doula provided a different perspective, instead reflecting on how forming close relationships with service users as a navigator dissuaded her from pursuing a career as a midwife:

> After my very first experience of being with a lady and being at the birth, I just thought that I don't want to be a midwife. It changed what I thought and how I saw it. You don't get this time to dedicate to the ladies…it's all checklists and paperwork and making sure everything's right. I just thought the one-to-one care you get to give and the bonds you have with the lady and their family is amazing. I got more out of that than I think if I'd have been a midwife…for other people, it's a way to get to the next step. I'm sure they do get something from it - it'll either convince them it's the right thing to do or turn them against their original plan (navigator 9).

Both of the aforementioned testimonies on pursuing midwifery training suggest how volunteer doulas at Haamla Service sometimes viewed their unpaid, voluntary roles as a stepping stone to accessing paid healthcare worker roles in maternity care. This is notable when one considers the comprehensive, three-month training and educational package offered to all volunteer doulas before they were assigned to a service user, as outlined in Chapter 5. No data from maternity support workers, or from Project MAMA's mother companions was available on how fulfilling the role of a navigator impacts on one's career aspirations.

8.3.3 - Increasing and reinforcing social and political awareness

Health navigators spoke of how their awareness of social and political issues was impacted by their roles. Much of this awareness centred around issues associated with migration and access to healthcare. Navigators at both study sites highlighted how being a health navigator increased or reinforced their awareness. At Project MAMA, mother companions mentioned how stereotypes of migrants had been challenged by their experiences, with one speaking of gaining "a greater understanding of the plight of migrants - other than headlines. I still don't have a huge understanding but it's so much more than I did have. I have a huge respect" (navigator 3). One mother companion - who identified as being a migrant herself - also spoke of her increased awareness and empathy, given how different the experiences of service users were to her own:

> I'm more aware of their struggles. I get that if you were displaced, can't live in the country that you're from…that's really tough. I always had that understanding that having to flee or escape is really traumatic. But now, through Project MAMA, I've learned more - that's maybe through the training and updates and things - but I learned what those realities are (navigator 6).

Navigators at Haamla Service also reported increased or reinforced social and political awareness. A maternity support worker mentioned how her interactions with service users had allowed her to learn about their experiences, which "you wouldn't learn…from the telly. It does change your view… It teaches you a lesson, and brings you to the humble side of life" (navigator 7). Elsewhere at Haamla Service, a volunteer doula concluded that her interactions with service users led to the "realisation that we're all human, every single one of us is the same. We all go through the same emotions over the same things" (navigator 9).

For some mother companions at Project MAMA, their provision of support to service users confirmed their pre-existing views. One individual spoke of how pursuing the role had helped her to contextualise and reinforce her views on migration:

> I don't think my views have changed, but I think, in terms of how much thought I put into it…it's escalated. It's always been something I've cared about, but my opinion has not changed. I think it's something that I feel more passionately about. I'm closer to it, I understand it. When I read something in the news, it's less abstract - it's more 'oh my goodness, this person was telling me about that…that happened to them'. I think it's opened my eyes (navigator 2).

8.4 - Conclusion

Perceptions and experiences of navigation were, at least, partly influenced by the ways in which each intervention has been designed; this refers, for example, to the voluntary nature of navigation which shaped the way navigators themselves engage with their roles, manufactured several operational challenges, as well as informed how future sustainability for these interventions may be managed. Similar to the service users they support, navigators have perceived professional and personal benefits as a result of engaging with the intervention, but much of their navigational experience has been defined by a constant need to negotiate boundaries.

Additionally, mismatched expectations between service users and navigators - as well as insecure relationships with healthcare professionals - suggested a pervasive lack of clarity on the parameters of navigation, as well as an inherent difficulty of needing to negotiate boundaries in spite of the existence of organisational policies guiding the interventions.

The following Chapter will further address the perceptions and experiences of navigators, through the lens of the navigational relationship in order to elucidate the theoretical mechanisms which determine how navigation operates when implemented.

Chapter 9: Navigational relationships and shared characteristics

9.1 - Introduction

This chapter explores the intricacies of the relationship central to health navigation - that of health navigators and the migrant women they support. The rationale for analysis is to gain understanding of the ways in which navigation functions in practice. Using data from all interview participant groups, the Chapter will begin by exploring elements of the relationship between navigators and service users, before addressing the question of whether shared characteristics and experiences between navigators and service users impact on their relationship, and on the functioning of the intervention.

The research question addressed within this Chapter is sub-question [c]:

[c] What is the role of shared characteristics and experiences between navigators and migrant women, in terms of the functioning of navigation?

9.2 - Relationships between migrant women and health navigators

Interview data offered a rich and varied description of how the relationships between health navigators and service users were constructed, for what purpose, how these support the goals of the program or deviate from them, how relationships are negotiated through shared characteristics and experiences, how fluid these are and the extent to which they play a role in the functionality of navigation, as well as and how they might deliver good outcomes for migrant women.

Through exploring the dynamics of the relationships between navigators and migrant women service users from multiple perspectives, it is possible to understand how such a relationship develops, how it is maintained and the role it plays in how navigation operates.

9.2.1 - Prioritising service users' needs

Navigators at Project MAMA, specifically, were perceived as having an allegiance with - and a close relationship to - service users. This was positioned by healthcare professionals and social support professionals as being unique, which workers from the NHS and statutory authorities were unable to offer within their roles. A family support worker from the local authority noted that it would not be possible for her to work exclusively in the interests of a service user, stating that her duty of care was, in fact, to the service user's (unborn) child. This was due to the obligations of her role. This particular worker perceived that "it's nice to have someone sitting next to you who didn't necessarily have a professional agenda" (social support worker 2). Additionally, healthcare professional 1 noted that it would not be possible for her - as an NHS professional - to work exclusively in the interests of a service user, stating that "us healthcare professionals - we're half on the woman's side". She continues:

> We [healthcare professionals] also have a responsibility and I have to follow certain guidelines and protocols…or else I get in trouble. Emotionally, I'm on the side of the woman, but if I get told I have to do something - and I think I might get disciplined if I don't - I'm gonna persuade her to do it…anyone you meet in a hospital is gonna have a foot in both camps, but those Project MAMA volunteers are on the side of the woman - only and totally. Their allegiance is clear.

The above refers to those working within institutions - whether in maternity care or other specialities - as being obliged to follow certain regulations, regardless of whether this addresses service users' needs. This is reminiscent of concerns around pregnant patients' forced compliance and lack of informed consent in a maternity care context (Lyons, 2021). This implies that navigators at Project MAMA were in an advantageous position to provide support to service users, advocate in their interests and to meet their needs, due to the fact that they were not a part of mainstream services situated within public institutions, and were, thus, not constrained by their policies. In this way, navigators appeared to be well-placed to offer person-centred care to service users, which was identified as being an aim of navigation services. Participants at the Haamla Service site did not make any reference to navigators' allegiance to service users.

9.2.2 - Being a 'professional friend' to service users

Across the data, the relationship between navigators and service users was perceived as involving both a sense of professionalism and a sense of informality, requiring careful negotiation of boundaries. There was divergence in the perception of the nature of this relationship, with service users often perceiving this relationship as being friendly or familial, rather than professional.

A personal advisor at a local authority stated that mother companions at Project MAMA had developed a warm relationship with service users, observing that "it's a combination [of being professional and being friendly]. Definitely a warm relationship" (social support professional 2). Mother companions themselves described this dynamic during the interviews, with one declaring that "I suppose I'm a professional friend to my clients" (navigator 6).

This was also the case at the Haamla Service study site. Volunteer doulas also perceived themselves as being 'professional friends', describing an inherent balance between a professional relationship and an informal, friendly one. A volunteer doula offered further details:

> It has to be professional in the way you approach your clients, how you deal with them. But it has to be friendly to make them feel confident in how you deal with them, and that they can trust you (navigator 11).

A maternity support worker at Haamla Service did, however, perceive that their relationships with service users were more friendly in nature than they were professional:

> We give them advice, but we're not doctors…we always say 'we're not clinical, we give advice according to the guidelines, based on what the midwife would tell you or what the doctors would do'. But I want the friendship to be there, so that you're not scared to tell me things even if you do something wrong" (navigator 7).

The above quotation emphasises the notion of navigators acting as a bridge between a health provider and an individual in the community, whereby navigators rely on the informal aspect of their relationships with service users to foster a sense of trust, and further develop these relationships. This relationship between navigators and service users may also foreground a friendship between the two parties.

Although navigators at both study sites perceived their relationships with service users as being simultaneously 'professional' and 'friendly', there was evidence that service users themselves perceived this relationship differently. Social support professional 2 stated that her client - who had been referred to Project MAMA for further support from a mother companion - had perceived the relationship with her mother companion as "a friendship and in a slightly different way". This had led to disappointment when the mother companion declared that she was bound by organisational policies, had insisted on maintaining a professional element in her work and was unable to provide the level of closeness that the service user had desired. Elsewhere, service users made little mention of their navigators' sense of professionalism. A service user at Project MAMA did, however, describe her relationship with mother companions, emphasising its informal and non-professional nature:

> For me, they are like [my] *sisters*. [A mother companion] has this thing when you are there, it feels like there's a mother in the house. She is a lady that has two children - when she is there, it's like 'ah! Our mother is in the house today!' (service user 4).

Service users at Haamla Service also perceived a close, familial bond with their navigators. One particular service user who was being supported by a maternity support worker had mentioned that she could "tell them [the maternity support worker] anything - my secrets. They can tell me anything" (service user 6).

At both study sites, service users perceived a closer relationship with navigators compared to how the navigators themselves had perceived it. It is arguable that navigators did not develop a genuine friendship with service users in the way that service users perceived it to be, and were, instead, playing a role in order to carry out their duties as expected of them, foster trust and address service users' needs. Navigator 9 offered a perspective which supported this, stating that "I'm there to do a job, I'm not there as their friend. I've got a role, but to do that role I need to be their friend". While nurturing a friendly relationship remained an important part of this central navigational relationship, true friendship fell outside of both navigators' self-defined interpersonal boundaries and the organisationally-defined remit of their role. This is reminiscent of prior work on the 'performance' of emotional labour for those working as intermediaries between communities and the 'state', and needing to negotiate boundaries (Needham, Mastracci and Mangan, 2017).

9.2.3 - Fostering trust

Despite slightly differing perceptions of the nature of their relationship, there was consensus amongst participants at the study sites that the relationship between navigators and service users was underpinned by trust. This sense of trust was seemingly unique to the navigational relationship, and could, arguably, not be achieved between service users and healthcare or social support professionals who worked within 'mainstream' services.

At Project MAMA, mother companions highlighted that trust was engendered and built in the long-term as a result of mother companions "being reliable, being there" and "actually coming when you say you're coming" (navigator 6). This would likely have been of particular importance to the most vulnerable service users, who had experienced previous trauma as a result of negative interactions and relationships with other individuals prior to, during, or after their migration journeys. There was also an indication that the negotiation of boundaries involved in forming relationships with service users could have also been of importance when trying to develop a sense of trust, with mother companion 2 stating that "there's this other element of trust…where if you trust them with a little bit of you, then they might trust you with a bit of them". Service users' responses also suggested a level of trust, with one saying that "when I was with them, I was not scared" (service user 1), while another described feeling safe "because everything is confidential" (service user 2).

At Haamla Service, it was highlighted by maternity support workers that they were well-positioned to build trust within their relationships with service users. This was due to the nature of their role; they acted as 'complements' to the clinical work of midwives and were tasked with giving time and energy to befriending service users, which meant that service users would often "tell them [maternity support workers] things that they've never told us [midwives] before, to do with their history or their past" (healthcare professional 2). One maternity support worker offered further detail:

> You have women who are absolutely fine with [the] midwife and they get all the information from [the] midwife. But then you have women who won't ask questions, who feel shy - for some reason they don't open up during their appointments…if you go to a midwife appointment and you've got 15 minutes, that's not much time, whereas we can go to their house, introduce ourselves, and as you spend more time with women they're more open to talking to you. They ask questions they normally don't ask. And sometimes what I notice is I go first time to a lady] and she's just telling me exactly what I'm asking her, but then I see her three times and she's opening more and telling me things she normally wouldn't say at a midwife appointment. Sometimes you get a random text message - 'I don't know what to do, I have a toothache'…the only person who came into her head was me (navigator 7).

The above illustrates the often slow and complex process of building trust, in that maternity support workers required repeated visits to service users - particularly those who were isolated - in order to allow service users to feel more comfortable in engaging with them. This sentiment was repeated amongst volunteer doulas at Haamla Service. One volunteer doula noted that service users often talked only to volunteer doulas and shared their past experiences with them, instead of healthcare professionals:

> Sometimes they tell you things that aren't actually on their historical record, because they've never spoken to anyone before. They've never had that close contact where someone's given them that time to sit and talk to them (navigator 9).

This particular volunteer doula then explained that this was an impetus to share pertinent information with healthcare professionals - with the service users' permission - as "anything we can get out in terms of information, that can make someone else's job easier", including making it easier to address service users' identified needs.

The sense of trust between a navigator and a service user helped service users to reveal important information, which likely had wider benefits for health professionals and statutory workers for whom navigators functioned as a bridge to service users. The 'closeness' of this professional - yet friendly - relationship was core to how navigation operated, in that it enabled navigators to support service users in ways that healthcare and statutory workers may not have been able to, whether through advocating fully for their specific needs or through providing a form of companionship.

9.3 - Shared characteristics and experiences between navigators and service users

Themes and sub-themes from the interview responses of all participant groups across the study sites revealed the dynamics of the relationship between navigators and service users, contributing insight on the importance of shared characteristics and intersectionality on how the two parties interacted with one another, and on how this influenced the delivery or effectiveness of the interventions.

9.3.1 - Shared womanhood

A shared womanhood between navigators and the service users they supported was consistently perceived as being essential and non-negotiable across the study sites, in part due to service users' previous negative experiences with men.

Mother companions at Project MAMA believed that the navigation programme could only be delivered by women, because "there's a universality in being a women, even if you're coming from a very, very different place" (navigator 6). Importantly, much of the perceived necessity for a shared female identity arose due to the fact that service users had often experienced sexual violence from men.

These sentiments were also present at Haamla Service. Service users themselves described feeling that they would not be comfortable with a male navigator supporting them as they "can't ask [him] the right questions" (service user 12) and "might not be comfortable with a male in the room with us" (service user 14) if they needed to breastfeed their baby. In essence, this revealed a slight divergence in framing in that the apparent fundamentality of navigators of female gender could have also been understood as there being a need for navigators to, simply, not be male.

There was a perception that the necessity for a shared female identity between navigators and service users originated in cultural acceptability amongst service users:

> It has to be a woman in this role…[especially] if you're dealing with a lady who's from an Asian background…even though she [a service user] was in a lot of pain and she had to move around the bed, her bottom half wasn't there, it wasn't covered. She kept on covering herself, even though I was there. I just thought 'oh god, this lady's in pain, but she's still caring for her dignity'. Even before the baby, she was covering herself all the time, even if her [head]scarf was off…she wanted it on and I would help her put it back on again. And I had to keep pulling her dress down, because she didn't want to show her back or her legs" (navigator 10).

This suggests how critical a shared female identity could be for some service users, and highlights an area where different identities may intersect - in this instance, being a female, and being from a specific cultural background. The volunteer doula who provided the quote was herself a woman of South Asian origin, and was able to understand the importance of ensuring dignity for the service user within this context. A male navigator may not necessarily be able to engender trust, closeness and comfort amongst service users, which are aspects which appear to be critical to the functionality of the navigational relationship.

9.3.2 - Shared experience as mothers

Unlike shared womanhood, evidence on a shared experience of being a mother who had undergone pregnancy and childbirth was mixed. While there was an affinity between navigators and the service users they supported - and that a shared experience of motherhood contributed towards this - there were also indications to suggest that sharing such an experience could be counterproductive.

Most navigators participating in this research self-identified as mothers. At Project MAMA, social support professional 2, who worked at a local authority, observed that the mother companion who she had referred her client to "was identifying mother to mother", suggesting that this mother companion may have chosen to emphasise the fact that she was a mother, in order to develop a connection with the service user. The reason for this was that "shared experience of having been through pregnancy and birth - whatever that may have looked like - it's valuable". A mother companion herself also clarified that speaking frankly with service users about their experience of motherhood may not have been essential, but it was deemed beneficial as "it gives you an understanding of what the process is" (navigator 3). Service users reacted very positively to having a navigator who had experienced pregnancy and childbirth:

> She was telling me about the twins, how they grow, the experience with them. She was telling me 'this is what they do, this is what they do at this stage…'. I was really ok with that (service user 1).

There was further evidence from Haamla Service of service users placing value on navigators as mothers. Volunteer doula number 11 perceived that "being a parent would help", and also described a previous service user not being interested in engaging with other 'back-up' doulas from Haamla who she had been matched with, on based on their availability to support her. This was because she had a preference for the volunteer doula who had considerable experience of pregnancy, labour and birth, owing to her being both a mother and a grandmother. Service users engaging with maternity support workers also seemed to declare a preference, with some framing this as an opportunity to learn from navigators and follow their examples. One service user stated that:

> The lady will help us. She's said she's got three kids so - because I'm on my first one - she will help more, and she told us what to bring to the hospital for me and my baby. So I'm expecting even more to learn from her because she has babies already (service user 10).

This was not necessarily what navigators sought to achieve through sharing their experiences of motherhood. One volunteer doula at Haamla Service spoke of how she had mentioned her children only to aid in developing a trusting relationship with service users, and that "it's not really fair for me to try and get as much information from them as possible, and then shut myself down" and that she must "give a bit of myself as well" (navigator 9). This indicates a form of reciprocity, where navigators felt that there was a need to exchange information and reflections on motherhood with service users, in order to build a trusting, 'professional friendship' with service users.

Navigators at both study sites generally perceived detailing their experiences of pregnancy and childbirth to service users as also potentially detrimental when supporting service users during their pregnancies and births. A mother companion at Project MAMA offered insight:

> In a way, you can sometimes have that business where you put your own experience on…I haven't shared any of my experiences with childbirth with clients so far…that happens a lot between women, and I don't think it helps communication that much, to be honest. I think it makes it more difficult to put yourself in the woman's place" (navigator 1).

The above describes how a shared identity as mothers experiencing pregnancy and childbirth may risk imposing a navigator's previous experience onto a service user. This was also observable at Haamla Service, where a maternity support worker declared that she would "only tell them my positive experiences…tell them information that will benefit them, rather than tell them things that will scare them" (navigator 8). Taken together, these testimonies suggest how the risk of imposing a navigators' experiences on a service user could wrongly impact or influence service users in how they conceptualise pregnancy, childbirth and early motherhood, which could also impede navigators from helping to 'enable choice' amongst service users.

9.3.3 - Shared race/ethnicity

Participants offered a rich variety of responses when questioned about the prospect of shared race/ethnicity between navigators and the service users they supported. It should be noted that this data was led by participants' own understanding of the concept of race and ethnicity, whereby they most often did not define it or make a distinction between the concepts, as well as with the concepts of nationality or culture. Across the interventions, there was no consensus on whether service users should be assigned navigators of the same or similar racial or ethnic background to them.

Limited benefits were perceived by some, in relation to having this navigational dynamic. When asked about the prospect of being assigned a navigator perceived to be from the same racial/ethnic group, one service user at Haamla Service who had migrated from Thailand stated that she would find it helpful, as "maybe I will find a new friend" (service user 5) who understands her cultural context and is able to speak her language. Elsewhere, navigator 10, a volunteer doula who was of Bangladeshi background, also perceived some benefits. She offered some detail on how she felt that previous service users from a South Asian background had benefited from perceiving her to be of the same race/ethnicity:

> If they're just Asian…they do feel that they can trust you more, and open up more about what they want or how they would like you to be with them, what support they're expecting…it's just little things.

As suggested above, being perceived as being of the same race/ethnicity could build trust within the navigator-service user relationship, which would impact on its functioning, including helping service users to divulge more intimate - and important - information that they may otherwise not have shared with healthcare professionals or other workers involved in their care. This volunteer doula also alluded to an 'easing' within her relationship with the service user and a sense of being trusted, which was attributed to the perception of being from the same racial/ethnic group, although this equally made for increased flexibility in the boundaries she had placed with regards to the remit of her role:

> If you're there supporting the mother, they could ask you to do something else, like if they wanted you to call home and see how the kids are…you wouldn't do that normally. I think with boundaries…they feel they can ask that lady that thing, because she's Asian, she's same as me and she wouldn't mind. Maybe if it was a lady who was from a different background to me, she might find it rude. Maybe I find it easier to say to this lady rather than that lady - 'yeah'.

No interviewees at Project MAMA perceived a shared race/ethnicity within the navigational relationship as being essential. However, there was an indication that greater racial/ethnic diversity amongst the navigational team would be of benefit to both service users and navigators themselves. As mentioned previously, there was little racial/ethnic diversity among mother companions at Project MAMA. One mother companion reflected that there was scope to diversify the navigational team in the future, enabling the training of more individuals "from different ethnic backgrounds, different people supporting people who they recognise and can feel really relaxed with". This was because - according to this mother companion - it was "really important that there's a choice for everybody" (navigator 4). A maternity support worker from Haamla - herself of an ethnic minority background - also supported this potential initiative at their study site, stating that:

> If we have more ethnic minority support workers…from a Haamla point of view, that's fantastic. We speak more languages, we access more communities…that's better. I'm not saying an English person working with us is a mistake - it'll be good as well. But sometimes, ethnic minorities may be scared of that English person (navigator 7).

Shared race/ethnicity could, however, also be perceived as being detrimental to the success of navigation, and to navigators' ability to support service users. A Nigerian service user at Project MAMA, who had experienced trauma and exploitation, noted that she would "prefer to have white than Nigerian " as a mother companion. This was because:

> Whites have feelings more than Blacks. If Blacks know your situation, they might use it against you. But the Whites…they feel for you (service user 1).

In this scenario, the service user's ability to trust a navigator was - in part, at least - determined by her perceptions of navigators' race/ethnicity, and was seemingly as a result of her own previous experiences which had impacted on her ability to trust others within her community. In this way, the complexities of an insider cultural identity would have posed a barrier for other black or Nigerian individuals who acted as a navigator for this service user, likely impacting on the dynamics of the navigational relationships and how far the navigational aims could be achieved. There were other instances within the data where a lack of trust was attributed to service users having negative experiences with other individuals within their community, leading them to not welcome a navigator who was perceived to be of the same ethnic background as a service user. Navigator 4 mentioned that an Iranian service user had repeatedly felt judged by other Iranian women, and that "any assumption that she would want to hang out with women from her own culture was not helping".

This was also the case at Haamla Service, whereby service users often feared judgement of their personal choices from within their community. This had the potential to lead to multiple issues for service users, and enforce barriers upon the navigational relationship. Shared race/ethnicity was purported to cause conflict if a volunteer doula "knows that culture and wants to abide by cultural rules" (navigator 9), but that their service user wanted to do something deemed 'non-traditional' in relation to their labour, birth or early weeks of motherhood. Potential for judgement from a navigator from within a service user's community was also perceived as a barrier, in that a service user may have known that navigator personally and, therefore may "decide to clam up and not say anything" (healthcare professional 4). Furthermore, knowing a navigator from within one's own community risked breaching the remit of their navigational role:

> If it was someone that I knew was from my community, even if I don't personally know her, I wouldn't go ahead….if something happened, like if confidentiality was broken, would she blame me? That's why I prefer to keep that distance. Even if it's not somebody I know directly, I'd just say 'no'. I wouldn't be comfortable. When I was doing interpreting before, I've been where I actually knew the family and they do get a bit personal, and ask you a bit more and you can go that extra length thinking that you can do that for them (navigator 10)

Shared race/ethnicity between navigators and service users was also sometimes perceived to be of detriment to the ability of service users to integrate into British society, despite one aim of navigation being to aid service users to become socially integrated. A Project MAMA service user identifying herself as being Syrian-Kurdish highlighted that:

> I don't want to meet the Syrian people, I want to meet the English people because it was better for my future, for my language, for my kids…because what can a Syrian do for me? Just for example, if she supports me, she can speak my language, yes she can teach me everything…but not like English people (service user 3).

This suggests a perception that English-born individuals were better equipped to serve as navigators for some migrant women service users, given this service user perceiving her mother companion as being rooted in British-English culture. Notably, there were obvious practical aspects of being a native English speaker who accumulated knowledge of 'the system' - which would be beneficial in supporting service users during the antenatal period. It was, however, unclear how far migrant women service users perceived and defined the diversity of 'English people', and whether they sought to interact specifically with White English individuals whom they may have perceived as best reflecting the culture they wanted to experience, and to integrate into.

Lastly, participants perceived that there were benefits to navigators and service users coming from different racial/ethnic backgrounds. One mother companion noted that they are "embedded in this society" and can serve as an example to show that "not everybody's like the people who don't want migrants to be here" (navigator 3). This implies that there was value in engaging with a British navigator who represented the ways in which Britain could be welcoming and accommodating to individuals who would commonly be perceived as being 'other'. At Haamla Service, one service user also reflected that having a navigator from a different background could facilitate the "exchange of information of each other's backgrounds and origins" (service user 8), which would have likely enriched the experiences of a service user who has recently arrived to the UK.

9.3.4 - Shared language

There was similar variety in perceptions in relation to the prospect of shared language between navigators and service users, with some participants perceiving there to be practical advantages to this, while others perceived it to be unnecessary or, at worst, counterproductive.

Firstly, data indicated that there were practical benefits to having a navigator who could communicate in a language spoken fluently by the service user they were assigned to support. At Project MAMA, navigator 2 perceived that "for some women it might be really appealing" for there to be a shared language between a navigator and a service user. A social support professional also noted that, although a shared language may not have been a necessity, it was of value as it could prevent "things being lost in translation" (social support professional 2), and that this was an inherent challenge when working with interpreters, who could sometimes act as intermediaries within the relationship between a navigator and a service user and garner control over the flow of information between the two parties. Shared language between a navigator and a service user would arguably remove this intermediate step and help ensure a direct means of communication.

One service user at Haamla did, however, remain neutral on the topic of having a maternity support worker who could speak her language, noting that "if there is an interpreter present, it doesn't really matter" (service user 11), seemingly having no concerns about the accuracy of translation between Arabic and English by a third party**.** Elsewhere at Haamla Service, a service user who spoke limited English shared that - if she were to have a maternity support worker who spoke Urdu - she would "feel ok because they speak my own language", and that she would feel more comfortable, because "I could explain my problem [to the maternity support worker]" (service user 6). This implies that shared language facilitated easier communication between the service user and the navigator, and, by extension, this was likely to impact on the service user's access to a desired service.

Shared language was also perceived as being potentially detrimental to service users, by participants at Project MAMA. The Syrian Kurdish service user, who was described in the previous section, offered another critical observation:

> If you look - what is the problem? Why can't people speak English? Because they always speak their own language. They need to speak English, slowly, slowly, everything *slowly*. You need to speak English first, because you're living here. You can't speak English because you speak your language (service user 3).

The above quotation suggests that service users' reliance on communicating in their preferred language with navigators could have impeded their ability to speak English. One could also argue that this also posed added barriers in achieving the navigational aim of aiding service users to socially integrate into British society. This was also an assertion made by social support professional 2, who declared that migrant families "value hearing English spoken".

There were participants at both sites who did not perceive a shared language between navigators and service users to be a necessity. However. a mother companion at Project MAMA stated that "you don't need to be able to talk. It's the art of being there" (navigator 3). A volunteer doula at Haamla Service expanded on this further:

> I spoke to one [volunteer doula] and asked her how did she manage when it comes to the fact that it's mainly ethnic minority women who use the service, and it was 'oh you don't really have to say much - you just smile. It's like sign language, a nodding of the head, or hand gestures'. And she had one where the lady was Pakistani and didn't speak much English, and she didn't know her language, and there wasn't any interpreter there at the time. And she understood what she was saying, you know, just through the nodding of the head, or the hand movements, and they got along fine (navigator 10).

This suggests that although a shared language could, in some ways, help or hinder the support navigators were able to offer to service users, it was perceived possible - albeit likely challenging - for navigators and service users to transcend language barriers by way of communication through body language, and by being physically present to support service users. This was, however, the view taken by navigators, with no evidence available to suggest that service users agreed with this assertion.

9.3.5 - Shared migrant experience

While only a small minority of navigators who participated in this research self-identified as a migrant, there were indications within the data that this commonality could be useful for engendering trust, but was not a necessity.

At Project MAMA, a healthcare professional noted that a mother companion - with whom she had worked when delivering a service user's baby - was herself a migrant, and that "that's a lot of where she gets this empathy from for this woman" (healthcare professional 1). A mother companion at the service spoke of how "there's enormous power in saying 'I've been in your shoes'" (navigator 6), but added that having a shared experience between navigators and service users of having migrated was not a necessity.

At Haamla Service, a maternity support worker discussed being able to use her experience as a migrant to relate interpersonally to a service user, encourage mutual understanding and develop a deeper navigational relationship:

> I'm a migrant myself. I remember when I was pregnant…I had no idea, I had no clue being pregnant for the first time in a new country…you can put yourself in their place. You understand better when you coming [sic] from the same background, but I do feel like sometimes I click with them when they say 'I don't have anyone here, I'm here on my own'. And I say 'yeah - I was like that, I know exactly how you feel'. So it's very easy for them to see ' yeah, she's been like this'. It's doable, I'm still here (navigator 7).

Service users' perceptions of navigators' migrant backgrounds - and the impact this may have had on their relationship and the support they would receive - was not explored in any detail, and was not highlighted as being a characteristic or experience of importance by this participant group.

9.4 - Universality: how relevant are shared characteristics and experiences to the functioning of health navigation?

A navigator's female gender was the only shared characteristic to be deemed critical for the functioning of navigation, rather than merely beneficial. In essence, it was unnecessary for navigators and the service users they supported to share any other identity. This meant that it would still have been possible to forge the close, trusting relationship between navigators and service users that drives navigation as an intervention, without the existence of commonalities in terms of racial, ethnic, linguistic, maternal or migration-related characteristics and experiences. This suggests a sense of universality, through which it was possible for people from different backgrounds - and possessing diverse characteristics and experiences - to build a navigational relationship with one another.

Mother companions at Project MAMA perceived that the most important aspect of the navigational relationship was that "we're women supporting women" and that there was no need "to be from their place of birth, or have the same ethnicity or even be a mother" (navigator 5). Another mother companion gave an insightful perspective:

> I don't ever go to a client pretending that I understand their experience, because I don't. Even to the point where I'll say 'actually, I've not been a mother, so I don't know'…there's so much of the clients' experience that I can't even begin to relate to….but I don't think that's a barrier (navigator 2).

In a similar vein, this navigator did not perceive a lack of shared characteristics or experience to be a barrier, as they perceived that it was still possible to successfully deliver the service without these commonalities. At Haamla Service, this lack of commonality - aside from a shared female identity - was seen as a positive. According to navigator 9 - a volunteer doula - it was an opportunity for both navigators and service users as they were learning something from each other. The doula also highlighted that being further removed from the experiences of service users was beneficial, as it would be "difficult to commit to a role like this without having some sort of emotional tie-in". From the perspective of numerous service users engaging with maternity support workers, there was no desire for any common ground:

> I just need to be able to interact and communicate with someone who knows the system. Or someone who can go and do things together with - like buying stuff. It's nice to have someone you can communicate with in the same language, but that's not the only case. If the person is willing to help, it doesn't really matter (service user 7).

In this way, with the exception of female gender, the evidence did not support the notion of shared characteristics and experiences between navigators and service users as being necessary for navigation to achieve its aims, and for service users' needs to be met. Alternatively, some service users expressed preferences for navigators with particular backgrounds, highlighting the need to tailor service delivery to the needs of migrant women accessing the service.

9.5 - Conclusion

This Chapter serves as a 'deep dive' into the dynamics of the central navigational relationship, revealing this relationship to be close, trusting and friendly, on a superficial level. However, there are indications that service users and navigators had different perceptions of this relationship, with navigators' needs to develop boundaries crucial to maintaining both the integrity and the sustainability of the interventions. Female gender - or at least, a lack of male gender - was perceived to be essential for building trust. Yet, no other shared characteristic or experience between navigators and service users was deemed necessary for the functioning of navigation, with navigators' personal attributes, behaviours and skills also likely to form part of the continuum of factors which impact on the central navigational relationship. In this way, with the exception of shared gender, navigators appeared to make use of - and capitalise on - commonalities with service users on an ad-hoc basis when they perceived it to be of benefit to their engagement with service users and to better meet service users' needs, but that these commonalities were not deemed to be essential. This finding contradicts the assumption within existing literature that navigation for migrant women service users delivered by a navigator from the same ethnic, racial or cultural background as the service users is a requisite.

Chapter 10: Theoretical mechanisms of health navigation: applying the Candidacy framework

10.1 - Introduction

This chapter explores navigation through the lens of the Candidacy framework proposed by Dixon-Woods et al. (2005). By applying Candidacy, the analysis seeks to understand how the work of navigators may improve access to healthcare for migrant women service users. The analysis focuses on navigator roles and the micro-level interactions they engage in with their service users and with healthcare professionals. This framework is particularly helpful in conceptualising and understanding the data - given its ability to articulate barriers that marginalised populations can face when attempting to access healthcare - yet, evidence generated through this research also exposes this framework's inherent limitations. Insights from applying the Candidacy framework - as well as findings presented in preceding chapters - inform the development of a logic model, which depicts health navigation's mode of operation. This logic model is presented at the end of this chapter.

This section addresses both research sub-questions [a] and [c], by contributing understanding on theoretical mechanisms underpinning navigation interventions at the study sites, as well as elucidating the impact and consequences of shared characteristics between navigators and service users on the negotiation of candidacy:

[a] How do navigation interventions operate in practice when used for migrant women who require healthcare (including maternity care), and what theoretical mechanisms underpin their operation?

[c] What is the role of shared characteristics and experiences between navigators and migrant women who they serve, in terms of the functioning of navigation?

The Candidacy framework component of this chapter is built primarily upon data from interviews with all participant groups. Navigational tasks, behaviours and practices were mapped onto the domains of the Candidacy framework, in order to offer potential explanations of how health navigation may impact on these domains. Each domain of the framework represents the 'journey' of a service user achieving Candidacy and successfully accessing services.

10.2 - Identification of candidacy

This element of the Candidacy framework describes the ways in which a navigator and a service user can negotiate eligibility for receiving services, and for potential service users to recognise themselves as candidates to access these services. As mentioned previously, mother companions at Project MAMA aided service users to understand their options regarding pregnancy, birth and early motherhood, as well as the ways in which the NHS operated. Receiving support to increase knowledge of one's rights and entitlements was perceived by all interview participant groups as helping service users to negate existing barriers, including lack of familiarity with the NHS system. Navigators were found to play a key role in aiding service users to recognise that they qualified for access to a service, enabling them to identify themselves as legitimate candidates for it. One service user - a single mother of four from East Africa - reported gaining knowledge of pregnancy, labour and birth from engaging with a navigator, and feeling empowered in the process:

> She taught me on all the stages I was going through with the pregnancy, she informed me of my labour pain stages and the things about being a mother that I did not know I learned through her. She gave me books to read, to see all the stages my body's going through, the right food to eat, and how to prepare my labour pains and all the positions. She prepared me, talking to me, introducing me to [redacted], and I got my knowledge from all that…[mother companions] deal with supporting women during pregnancy and direct women who don't know about their rights in the UK. They tell you you have a right to talk of what you want (service user 4).

In this instance, navigators providing one-to-one education on health and wellbeing topics to service users would have also helped to mitigate service users' existing barriers to accessing care, such as low levels of health-related knowledge and awareness. This service user identified themselves as a candidate for care in a hospital delivery suite after recognising the signs of labour and its progression, having learned about this through navigation and been empowered to take action.

Maternity support workers at Haamla Service provided antenatal and postnatal classes to service users as part of their role, and sought to "empower them [service users] to do things" (navigator 7). These classes were exclusively for women, with community-based interpreters booked for service users on request. Service users were provided with maternity-related information by maternity support workers; one healthcare professional stated that "they [service users] learn about becoming a mum, preparation for birth, feeding the baby" (healthcare professional 2). Although not individualised in nature, service users' knowledge of the health system and of health-related topics reportedly increased via attendance at these navigator-run groups, as outlined in **Chapter 7**. For example, as a result of maternity support workers informing them of how the NHS system operates, service user 14 reported feeling knowledgeable and confident enough to "go and make my own appointments at the GP". Additionally, at Haamla Service, there was evidence of navigators themselves identifying service users as being candidates for a given service, and then proceeding to inform them of this; a service user had approached a maternity support worker for advice on managing her toothache, with said maternity support worker then telling the service user that they were in need of an appointment with a dentist.

10.3 - Navigation

This domain of the Candidacy framework relates to the practical resources that can be mobilised to facilitate a service user's attendance at the service for which they have been identified as a candidate. As already highlighted, navigators mobilised numerous practical and relational resources to help navigate women. Across the case studies, navigators' roles involved physically connecting service users to the required clinics, GP surgeries and hospitals, in order to ensure that service users could locate the required service.

At Project MAMA, mother companions often decided to transport service users themselves, in their personal vehicles, with one service user recalling that the mother companion "could take me to hospital and bring me home" (service user 2). This particular service user also described how her mother companion had explained the need to source a document to access a service, before transporting her to a facility to retrieve it. One mother companion, however, stated that although she would often drive women to hospital, she would also sometimes escort them on the bus. On the contrary, neither form of navigator at Haamla Service was permitted to transport service users in their own vehicles as "we're not insured for that" (navigator 11), but they did accompany them on public transport, whenever necessary.

Beyond transportation, navigators also helped to guide service users around sites of healthcare access - informing service users of what hospitals were available, where they were located, and what facilities one could find there. At Project MAMA, mother companions would often "go to the first appointment with them so now they know where the midwife is" (navigator 3). One healthcare professional had observed the potential benefits of having "someone with them [service users] who just knows - 'let's sit here', 'these are the toilets you can use, these are the ones you can't' - someone who just knows the culture of how it would go." They acknowledged the importance of having a navigator who was knowledgable of the system, and that it was not necessarily a case of needing to have a navigator who was UK-born, as "people can be born and bred in England all their life and still be intimidated by it" (healthcare professional 1). It was also suggested by one social support professional that a service user who didn't yet know their way around would have benefited significantly through being assigned a navigator, allowing them to gain an understanding of the system they now needed to navigate. The notion of sites of healthcare access being intimidating emphasised the extent to which a lack of knowledge of how to physically navigate such systems was a barrier, but one that navigators could help service users to overcome by guiding them there, in person.

Similar sentiments were presented at the Haamla Service study site, where navigators (volunteer doulas) were tasked with demonstrating to service users that "there are different facilities in each hospital. And that when it comes to birth, there are different environments to do it in" (navigator 9). By helping service users to travel to the service - or, at the very least, offer them guidance on how to reach it - navigators likely helped to mobilise resources and facilitate service users' access.

Finally, there was some evidence that navigators offered emotional and wellbeing support that enabled women to feel more confident about attempting to access care. Service users' testimonies were the main source of this evidence. At Project MAMA, a service user reported that her mother companion gave her encouragement and listened to her speak about her prior experiences. Similarly, at Haamla Service, another service user reflected that her maternity support worker was highly compassionate and that she "tries to help me understand" NHS maternity care-related information (service user 5).

10.4 - Permeability of services

The notion of permeability in the Candidacy framework refers to the ease with which a service user can use the service which they have identified as meeting their needs and for which they are a candidate. This element was reflected in organisational documents at both study sites that referred to navigators being tasked with arranging language interpretation for service users. According to document PM2 (p.4), mother companions at Project MAMA offered service users a "phone translation service during NHS and other official appointments". A mother companion at Project MAMA shared their experience of involving interpreters that illustrates the concept of increasing permeability:

> We had a client who called me because they didn't speak any English and they were told they had to go to the hospital for the baby to be induced, and they didn't understand anything. I had to go to the hospital to meet them, and I could talk to the staff there, and I got a translator involved over the phone (navigator 6).

In slight contrast, maternity support workers at Haamla Service were expected to carry out language interpretation for service users themselves - given that they needed to be bilingual for the role - as well as to use language link services for any other languages (document HS2, p.6) Arranging this form of support as part of navigation likely helped to mitigate any language barriers that a service user was facing, allowing them the opportunity to reach the desired service and assert their candidacy.

10.5 - Appearance at health services

This domain focuses on service users asserting their claim to candidacy to receive the service which best met their needs (and which they perceived to deliver a 'good' outcome). Navigators sought to uphold the rights of service users within an NHS hospital context.

At Project MAMA, a service user mentioned that navigators "tell you [that] you have a right to talk of what you want, a right to speech…and not all women know their rights, especially asylum seekers and refugees in the UK" (service user 4). This illustrates the advocacy role played by navigators, as part of their remit. Navigators tended to want to take action if a service user was not receiving the appropriate quality of care, with navigator 2 stating that she was *"*very happy to make the phone call and go 'my client's been waiting a week, you told her she'd be waiting a day!'". Both types of navigator at Haamla Service were purported to function as advocates; in organisational document HS2 (p.3) and document HS6 (p.1), it was stated that navigators advocated for clients whenever necessary or appropriate to do so. This was evidenced by way of practical examples from interview data. In one case, a volunteer doula recalled a stressful labour experience - at the beginning of her time as a doula - and how she needed to advocate for this particular service user:

> She called me in the middle of the night and said 'oh God, what am I going to do?' In the middle of the night…she said she's in labour, so I said 'have you phoned the maternity assessment centre?' and she said 'yes, and they said I need to stay home'. So I had to phone them and explain to them who I was, and said she needs to go to hospital (navigator 11).

Navigators also played the role of being a bridge between a community of service users and healthcare professionals. At both study sites, navigators relayed very similar experiences. A mother companion from Project MAMA recalled the following:

> Doctors explained what they were going to do, what was going to happen, and they left the room…I said to the mother "did you understand what they said? Would you like me to go through all of that again with you?", and she said "oh, yes please, I didn't understand". But when we were in the room, she just nodded along and just accepted "ok, yep"…she kind of just said 'the medical team are going along with it'…she didn't really want to make a fuss or ask questions, so she just nodded along. And actually, she hadn't really understood what was happening (navigator 4).

The above quotation demonstrates the difficulties this service user faced in dealing with a power imbalance within this healthcare professional - patient scenario, which would have prevented her from being able to fully assert her claim to candidacy. This difficulty was, however, eased by way of mediation from the navigator, who recognised a significant failure in communication on the part of the healthcare professional and sought to rectify it. Similarly, at Haamla Service, healthcare professionals "tell the lady something and then leave the room, for you to just explain it in a bit more detail, to just reiterate so the lady understands it" (navigator 9). Within both of these contexts, navigators needed to ensure that the service user had understood what healthcare professionals were proposing to them and how this would impact on their claim to candidacy. This could then allow service users to formulate a clear response which could provide the opportunity for service users to assert their claim to candidacy.

Data from the Project MAMA study site illustrated the varied ways in which a service user could present at a service with a health navigator accompanying them for support. Similar insights were unavailable for Haamla Service. One mother companion accompanied a service user with complex needs to a meeting with health professionals, stating that "one of the points I went to the meeting to convey was that it's important for [the service user] that she knows where she's at" (navigator 4). This quotation refers to challenges around managing a chronic, physical condition during pregnancy and early motherhood experienced by the service user in question, when negotiating her care with the health professionals. The mother companion interviewed was accompanying the service user for moral support, and mediated interactions between health professionals and the service user to advocate for the service user's specific needs. Ultimately, the mother companion's efforts to liaise with healthcare professionals were successful, and facilitated the service user's desired hospital birth.

Another mother companion themselves highlighted that going to appointments with service users was of great benefit to them, “particularly if English isn’t their first language”. They added that the benefit was likely even greater “for mums who aren’t as confident…or just want someone with them” (navigator 2). Being assisted by a health navigator - an individual possessing an inherent understanding of both the health system and the challenges associated with engaging with the system as a foreign-born migrant - was perceived to be beneficial to a service user in terms of strengthening their claim to candidacy.

Service users themselves also reported their own appearance at health services. One service user spoke of working with her mother companion on her birth plan. Having already been asked by her mother companion about her preferences for her upcoming birth, she had now become knowledgeable enough on her options to make a choice. In order to have her candidacy for accessing the desired birth arrangements granted, she needed to get "an appointment to meet [her mother companions] to go to my midwife and talk about the labour, to do a plan” (service user 3). Additionally, another service user at Project MAMA now knew what service she wanted to access and which paperwork she would need to obtain to formally submit her candidacy, following her engagement with her mother companions in previous weeks. She recalled that “when I say “I need this paper, [mother companion] helped to explain it [to] me and went together with me.” (service user 2).

10.6 - Adjudication by healthcare professionals

This domain represents how healthcare professionals perceived and responded to service users’ healthcare needs. This revolved around their assessments of the service user, the health navigator who was supporting them in person and the claim to candidacy being asserted. Data relevant to this domain were sourced mainly from the Project MAMA study site. Although this section drew on a small quantity of data - especially with regards to the single healthcare professional participant who discussed implicit bias in her interview - the insights were of critical importance to this narrative. The small quantity of data was a result of most interviewees’ choice to not discuss the underlying social and political factors associated with access to healthcare, including economic austerity, classism and racism. These were important considerations, in that these factors were likely to play a role in how migrant women negotiate their candidacy via navigation and, therefore, how their journeys to achieving access through this intervention could be understood.

Interview data reflected the existence of a 'hostile clinical environment' for service users, especially given that they were migrant women from minority backgrounds. This illustrated the ways in which a service user's claim to candidacy may have been taken less seriously by a healthcare professional in the absence of a health navigator.

Going into hospital "can be quite hostile", according to a navigator at Project MAMA (navigator 5). One healthcare professional also noted that:

> The hospital is an intimidating environment, and it's meant to be…it's definitely 'our place', not the women's place - it's our department - we know how all the buttons work, we have the swipe access for the door, and we're gonna put you in the clothes that we want to put you in (healthcare professional 1).

In stating the above, this healthcare professional shared her views on how the institution at which she worked operated, alluding to the inherently powerful position that health professionals maintain, to the great disadvantage of a patient, especially one who has already experienced other forms of oppression. Such an environment was not conducive to meeting the needs of service users, and created the need for navigators to play a mediatory and advocational role in order to reduce the impact of this power differential. Navigators carrying out this task met the navigational aim of providing a responsive and sensitive service. As expected, the service users most in need of such assistance were those who did not speak English:

> [They are the ones] who aren't getting their voice heard in the room. It's clear why they're not getting their voice heard…but it's so tempting to cut corners and not fully talk to people, as it's just so much easier when they don't really speak your language…[but] there's care being missed (healthcare professional 1).

This sentiment was shared with another navigator, who testified that when healthcare workers cannot speak the same language as a service user - and cannot immediately access translation and interpretation services - they often "just talk loudly at them, just carry on talking but raise their voice" (navigator 6). This communication barrier reflected the (lack of) value attributed to the service user by the healthcare professional. Within a clinical context, the navigator was able to mediate understanding between service users and healthcare professionals, which could avoid the occurrence of what was likely to have been a dehumanising and confusing scenario.

Health navigators were sometimes themselves impacted by a 'hostile clinical environment'. One volunteer doula at Haamla Service - who was a Black Caribbean woman - recalled a racist encounter with a White healthcare professional after arriving at the labour ward to support a service user through her birth:

> There was one midwife who made me feel that I really shouldn't be there. I think it wasn't just me, because my client also felt that she was just doing her job and would prefer that it wasn't a Black person. I remember visiting my client at home after the birth and saying 'was it me, was I imagining it or did that midwife not like me?' She picked it up too (navigator 11)

This Black navigator of migrant background was seemingly challenged on account of her race, while supporting a service user to give birth. Service users were also likely to be subject to bias on account of their race/ethnicity and class. There was some indication that - for a service user to continue the process of gaining access to a particular service - the judgement of a healthcare professional would be focused on both the service user and the health navigator supporting them with their claim to candidacy. Inevitably, some decisions made by healthcare professionals in assessing a claim to candidacy might have been subject to implicit bias. One healthcare professional participant - whose patient had been a service user at Project MAMA - offered crucial insights into this:

> A black woman or ethnic minority woman who has poor English - so not really expressing themselves properly - they don't get the same standard of care. They do not. And it's just true. It's appalling, because I'm so proud of the health service - that no matter who you are you can walk in. We follow NICE guidelines for everybody, so that's not what we're talking about, really. It's that the care is so sub-standard when it comes to talking about a subjective thing (healthcare professional 1).

This healthcare professional had given the example of a former patient - a Black, migrant woman from East Africa - who had informed midwives and an obstetrician that she had just had a series of epileptic fits while on the labour ward, yet the entire ward team refused to believe her, putting her health and that of her unborn baby at risk. This, then, raises the additional prospect of the racial, ethnic and/or class backgrounds of health navigators - who would support a service user with their claim to candidacy - themselves being judged by health professionals involved in the service users' care. This particular interview participant believed that a navigator perceived as originating from the same community as the service user - and who was perceived to be of a similar class to them - "would [not] work as effectively" compared to a navigator who would be perceived as White and British. Interestingly, "a dark-skinned woman with a good accent, and good body language, would probably have the same effect" as a White British navigator, according to the health professional participant. This implies that a navigator's higher social position and level of cultural capital could have gone some way to counteracting some systemic racism and classism within the NHS, and shielding a service user from its effects. If a navigator supporting the service user was themselves of a more 'palatable' racial, ethnic or cultural identity - according to the adjudicating healthcare professional - then there may have been a higher chance of the service user's claim to candidacy being successfully adjudicated by the health professional, and access to the necessary service being granted.

10.7 - Offers and resistance to services

This domain refers to service users' decisions to accept or reject an offer to access a service to which they have been accepted as a candidate. Data on this domain was sparse across the two study sites, however, additional insights emerged from a mother companion at Project MAMA.

As mentioned in **Chapter 6**, documentary data and interview data outlined that one of the aims of the interventions at both Project MAMA and Haamla Service was to enable informed choice for service users, so that they had gained enough knowledge and guidance from navigators to ultimately be able to make independent decisions about their maternity care. **Chapter 7** also evidenced that this aim was achieved at Haamla Service. One mother companion at Project MAMA shared her reflections as a navigator tasked with achieving this aim, stating that "to offer that choice - one of the most interesting things is when people have declined that choice, that still feels like it's really empowering" (navigator 4). In this way, navigational assistance aided service users to identify and assert their candidacy, and once healthcare professionals adjudicated a service user's candidacy for a service, the service user had gained the confidence and independence to choose whether they felt that this service necessary, and whether it met their needs.

10.8 - Operating conditions and the local production of candidacy

The final domain within the Candidacy framework describes the factors which shaped continued construction of candidacy for a service. Much of the data that reflected this dimension of the framework lay in navigators' accounts of how they perceived their relationship with healthcare workers. Although mentioned very briefly in **Chapter 8,** there is scope for a fuller analysis here, using the lens of Candidacy.

At Project MAMA, accounts offered by participants suggested a mostly positive and collaborative relationship with healthcare professionals, although it came with caveats: "as long as you're doing things they're happy with, it's fine. But as soon as you start to question things a bit…" (navigator 3). This suggests the need for healthcare professionals - in this case, midwives - to maintain power and control over the service user's care. A theme related to this emerged within an interview with a social worker at the local authority, who had attended a meeting with her client (a service user at Project MAMA), a mother companion from Project MAMA and the client's healthcare professional regarding an assessment of the client's support needs at home. Social support professional 2 stated that:

> I think some professionals, like one particular health visitor at the meeting, are a bit suspicious of non-statutory organisations. I just felt like she wouldn't naturally refer someone to a charitable organisation.

The healthcare professional voiced distrust in the mother companion, arguably due to her status as a volunteer. The commonality across both of these scenarios is that, once a service user's candidacy for a service was adjudicated by a healthcare professional and the service user accepted access to the service with the help of a navigator, the perceived threat of a navigator - simply by questioning the 'authority' of a healthcare professional, or by intervening in their provision of care - may have become a source of conflict. This is because it may have highlighted healthcare professionals' and navigators' competing notions of a service user's needs, and how to address them. This may have also threatened the dominance of the healthcare professional over the service user, within an inherently power-imbalanced scenario.

Separately, there was an indication of how punitive immigration policies (the 'Hostile Environment') continued to define and shape a service user's candidacy for a service - even after they had already had their candidacy adjudicated by health professionals. As a navigator tasked with increasing access to healthcare for service users and working to support their general wellbeing, they delivered mostly individual, micro-level actions. However, macro-level, structural factors ultimately remained a barrier to service users' access, which meant that access to a service could not always be guaranteed, despite their best efforts:

> Some women try to not be known to the immigration system…we would never exclude these women and we wouldn't threaten to tell Home Office about them, unless they wanted to support that decision. Haamla would still support them…but they [service users] would get a bill at the end of it (navigator 8).

The above quotation makes reference to the fact that some service users faced financial barriers to accessing healthcare as a result of immigration-related policies. In this scenario, navigators could do little to overcome this structural barrier for service users within their role, given the upstream nature of the NHS migrant charging policy. While navigation itself remained accessible to service users regardless of their lack of legal immigration status in the UK, such a policy meant that accessible 'mainstream' maternity care could still not be guaranteed.

10.9 - Applying Candidacy to a logic model of health navigation for migrant women

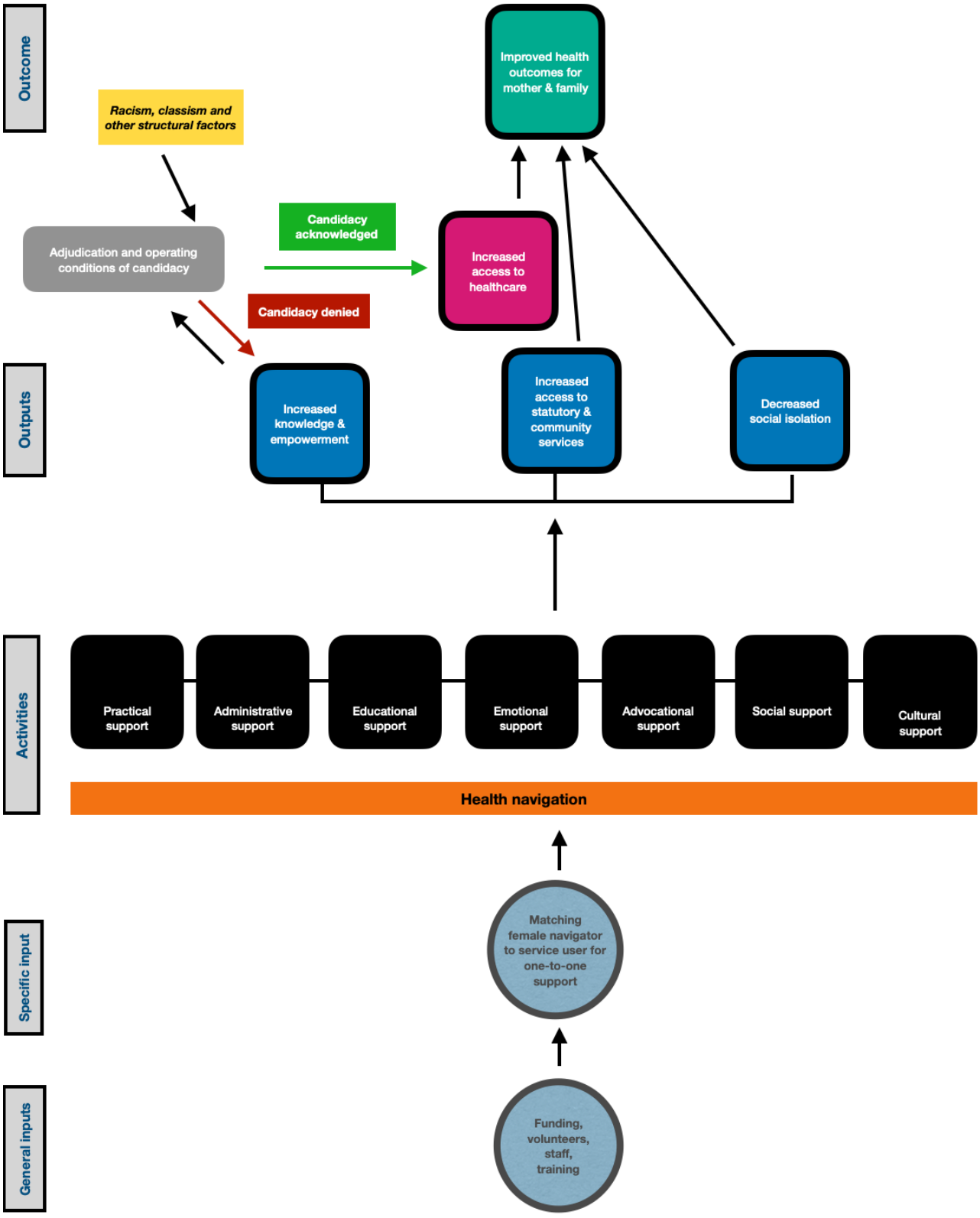
Based on the combined findings from the systematic review and the field research, I sought to construct a logic model to illustrate the components of health navigation as an intervention for migrant women. According to Julian (1997), a logic model "provides a tool for conceptualizing the relationships between short term outcomes produced by programs, intermediate system impacts and long term community goals". Using a logic model presents simplified visualisation of linkages between a programme targeting an issue within a specific community and the process it follows in order to generate its outcomes and goals (Julian, Jones and Deya, 1995; Linney & Wandersman, 1991).

My proposed model took into account the insights generated by Candidacy. **Figure 5** presents the model, with programmatic inputs, activities, outputs and outcomes. The logic model details two levels of 'inputs' - those general in nature (including resources from an organisation) as well as navigation itself as the specific input to which organisational resources are channeled. Navigation is then described in terms of the 'activities' through which it seeks to generate change - its functional domains. Navigators carrying out their functional domains then generate three main 'outputs' for service users - an increase in knowledge and empowerment, an increase in access to health-promoting services such as education, and a decrease in social isolation. At this stage, outputs then have the potential to create 'outcomes'. Increased knowledge and empowerment can indirectly improve a service user's health in the long term, by increasing access to healthcare. Improvements in service user's health may also be directly impacted by both increased access to health-promoting services and decreased social isolation.

Whether increased knowledge and empowerment is able to lead to increased access to healthcare is determined by the ability of navigation to positively or negatively influence service users' efforts to negotiate candidacy, which is shaped by macro-level, structural factors. It is at this point where both adjudication of service users' candidacy and operating conditions and local production of candidacy could take place. If a service user's candidacy to access the desired service is promoted and accepted, then increased access to healthcare is achieved as an intermediate output. In the long term, gaining access to healthcare and to health-promoting services - as well as decreased social

isolation - should lead to better health for a service user and their child. The accuracy and comprehensiveness of this model will be discussed in the next chapter.

Figure 5 - Proposed logic model on navigation to improve access to healthcare for migrant women



10.10 - Conclusion

The Candidacy framework was found to be a useful tool in explicating the various ways in which health navigators can assist women on their healthcare journeys to access the care that they need. This is the first time that this framework has been employed to analyse health navigators themselves, instead of the individuals seeking care. Candidacy illustrates how navigation is likely to impact on the process of service users establishing their own candidacy and achieving access to care, given that all of the domains contained within the Candidacy framework can be identified within the data. It is important to note, however, that this impact may not always be positive - as exemplified by healthcare professionals' adjudication of service users' claims to candidacy in the presence of navigators, or the policies which ultimately shape the conditions in which service users are seeking to have their candidacy acknowledged, both of which are depicted in the logic model.

Applying the framework articulates the complexity of negotiating access to healthcare, and suggests both the benefits and disadvantages of involving external personnel in the process, who need to employ an array of methods to ensure that access is granted for the service user. However, access to healthcare was only one aim and outcome of navigation for migrant women, as described in previous Chapters; which suggests that Candidacy was not able to capture the full range of navigational outputs. Additionally, this data exposed other inadequacies in the Candidacy framework, inviting consideration of the ways in which it could be extended and improved.

Section 4: Discussion and conclusions

Chapter 11: Discussion

11.1 – Summary of key findings

The primary research component of my doctoral project sought to address the overarching question of whether health navigation interventions were able to improve access to healthcare for migrant women within a UK context, by addressing the following sub-questions:

[a] How do navigation interventions operate in practice when used for migrant women who require healthcare (including maternity care), and what theoretical mechanisms underpin their operation?

[b] How are navigation interventions perceived and experienced in practice?

[c] What is the role of shared characteristics and experiences between navigators and migrant women, in terms of the functioning of navigation?

The primary data collected and analysed in Section 3 of this thesis provided insight into the ways in which health navigation operated in practice, the theoretical mechanisms underpinning this, the perceptions and experiences of different stakeholders involved in navigation, as well as the functioning of the central navigator-service user relationship.

This Chapter discusses the insights from the primary research, placing them within the context of the integrative systematic review findings detailed in Section 2 as well as other relevant, extant literature. Following this, I detail the methodological strengths and limitations of this project, prior to concluding this thesis with several recommendations in relation to future research, policy and practice on health navigation for migrant women.

There were several key findings from these preceding Chapters. Firstly - in characterising the health navigation interventions at the study sites - navigation was identified as a tool to increase access to healthcare for migrant women service users, largely through facilitating service users' gains in knowledge and empowerment. It was also found to offer numerous, additional benefits for service users and other stakeholders. Secondly, the navigation interventions were generally perceived positively by stakeholders. Thirdly, navigation was defined by a central relationship between

navigators and their service users; their relationship was close, trusting and often friendly in nature, although there was divergence between these two participant groups in how they fundamentally viewed this relationship. Fourthly, aside from the identification of a shared female gender between navigators and service users, this central relationship did not rely on any other shared characteristic between the participant groups to drive navigational processes which facilitate increased access to healthcare and other benefits. Lastly, applying the Candidacy framework to the data was found to offer a useful conceptualisation of navigation which explained the ways that navigation functioned, while exposing the framework's theoretical limitations. These key findings form part of the methodological, theoretical, empirical and practical contributions offered by this doctoral project.

11.2 - How do the field research findings add to the integrative systematic review findings?

The collection and analysis of primary data from the field research, following completion of the integrative systematic review, fulfilled the four research objectives of this project as initially outlined in **Chapter 1**. I will address each of these four objectives, in turn.

11.2.1 - Defining the concept of health navigation, and describing its characteristics, when implemented for migrant women

Across the findings from the field research, health navigation was reported as being a person-centered intervention delivered on a one-to-one basis and tailored to the specific needs of a service user, client or patient. It was designed to bridge the gap between migrant women and the health system, as well as other systems and services which may have been conducive to their health and wellbeing, such as housing, immigration and religious services.

Health navigation was delivered by 'navigators' - in this case, mother companions, volunteer doulas and maternity support workers - who came from a wide variety of backgrounds. Each form of navigator carried a different terminology, and with it, different requirements for knowledge, experience and skillset - all of which was defined by the policies and practices employed within their interventional context. This is in line with the findings of the integrative systematic review, in which thirteen different terminologies were found to describe individuals delivering navigation for migrant

women. Reviews of the literature on health navigation for other population groups also reported an array of different terminologies being employed to describe those who carried out navigational roles and functions (Carter et al., 2018; Shommu et al., 2016). This illustrates that health navigation was a set of diverse roles and functions, with those adopting and delivering these roles and functions ('navigators') being personnel in a range of organisational positions.

Navigators served a number of different functions for migrant women - whether administrative, practical or social in nature. This was evidenced within both the systematic review and the field research. In both sets of findings, there was some evidence of a consistent educational function associated with delivering navigation. This reflects an implicit assumption by service designers that a low level of knowledge and awareness of the health system in migrants' destinations and of health issues would pose a barrier to migrant women, although this has been observed in the Dutch, Canadian and Australian contexts (Jonkers et al., 2011; Metusela et al., 2017; Murray, Windsor, Parker and Tewfik, 2010). Additionally, service users perceived having improved access to healthcare after gaining knowledge when attending a maternity support worker-run, community-based educational session on their options for seeking care, and on how to manage their health throughout their pregnancy and into early motherhood. A perceived increase in knowledge among migrant women was, perhaps, unsurprising given the clear educational component at the centre of maternity support workers roles - yet this qualitative finding contrasted with the systematic review findings, which reported inconclusive quantitative evidence as to the impact of navigation on migrant women's knowledge and awareness of health and disease. There were no qualitative studies in the systematic review that included themes on migrant women's educational/informational needs, or navigators' capacity to address them.

In targeting migrant women in the UK as a sub-population for whom navigation could be of benefit, the design of interventions within the case studies suggested that they were intended to be culturally sensitive services, acknowledging a lack of cultural competence and cultural safety within mainstream NHS services. This was rooted in a recognition of the critical importance of culturally sensitive care, given its beneficial effect on patients' outcomes, their satisfaction with care and their willingness to engage with their care (Betancourt, Corbett and Bondaryk, 2014; Douglas et al., 2013). In the case studies, navigators were expected to provide or arrange language interpretation for service users at GP/hospital visits (as with volunteer doulas at Haamla Service), have sufficient knowledge and personal experience to be able to connect service users to cultural resources within their local communities (as with maternity support workers at Haamla Service), or facilitate a service

user's request for the arrangement of any cultural practices in relation to their pregnancy, labour and/or birth (as with mother companions at Project MAMA).

The underlying principle was to better enable access to NHS healthcare for service users, by assigning them navigators who could address service users' barriers while possessing an understanding of service users' cultural backgrounds. However, service users' and navigators' accounts of their navigational experiences within the primary research offered only limited evidence to support the notion that navigation was inherently - and extensively - culturally sensitive in practice. Similar observations could be made when reconsidering the functional domains of navigation, as explored within the included studies of the systematic review. Within many of the included studies, there appeared to be an assumption that recruiting 'bicultural' navigators would play a role in addressing migrant women's cultural barriers to accessing various preventative and curative services - yet, there was no evidence to suggest that this approach was effective, and culturally sensitive in nature. Navigators hired for their role due to their proximity to a patient / client / service user group's racial and/or cultural background may not always address these barriers, particularly if said navigator participated in internalised racism, defined within extant sociological literature as "the incorporation of attitudes, beliefs or ideologies about the superiority of other racial groups and/or the inferiority of one's own racial group" (Paradies, 2006). In addition to the possibility that such navigators may not be able to guarantee delivery of culturally sensitive care, the cultural functions of these navigators' roles were not explicitly described within the literature review, and did not appear to cut across other key navigational functions, such as practical, educational and emotional support.

Cultural sensitivity of health interventions has been assessed in various ways, according to Ahmed, Siad and Manalili et al. (2018), and range from workforce diversity initiatives and training workers on accessing interpreting services, to the adaptation of cultural knowledge and experience within a service to achieve cultural competence (Betancourt et al., 2016) or the recognition of culturally-related power imbalances in healthcare to achieve cultural safety (National Aboriginal Health Organization, 2008). Torres et al. (2014) concluded that the navigational assistance provided by community health workers/multicultural health brokers to migrant and refugee women at two interventions in Canada was culturally competent in nature, given that the forms of brokerage offered were reported to actively embed cultural understanding, and were explicitly rooted in the "wisdom, knowledge and cultur[al] ways of people…and are based on principles of social justice, equity and democracy". However, this was the sole example of a navigation intervention within the

literature review that was reported to be culturally sensitive. In conclusion, across both the primary research and the literature review, there is insufficient evidence to support the assertion that navigation for migrant women has, to date, been culturally sensitive. This also suggests that it may not be necessary for navigational interventions to be inherently culturally sensitive, in order to achieve some level of increase in access to healthcare for migrant women.

Importantly, the primary research and systematic review provided evidence that health navigation for migrant women no longer closely resembles the original model of patient navigation - as outlined by Freeman & Rodriguez (2011). Navigation did not always need to be driven by the desire to recruit service users to access a preventative, diagnostic or curative service within the health system - by way of addressing service users' barriers to accessing it. Navigation could also be driven by the needs of an individual service user, who seeks access to a preventative, diagnostic or curative service. Navigation for migrant women has moved beyond the clinical, disease/ill-health focus of the original patient navigation model, and has expanded to a broader form of systems-level navigation (Australian Healthcare Associates, 2020) which seeks to address multiple areas of care within and outside of the clinical care continuum, and can be delivered by a range of professional or lay personnel working within communities.

In considering how this conceptual shift has taken place, one can make several observations based on the framing offered by the nine principles of patient navigation (Freeman and Rodriguez, 2011). Firstly, principle one centered on service users, clients and patients' 'disease abnormality' as a target for action by way of navigation. This applied only to the studies included within my systematic review, as they contextualised migrant women's need for navigation as a service-driven, individual-level intervention which facilitated their being screened, diagnosed and/or treated for a condition. This did not apply to any of the navigation interventions explored within my case studies, as migrant women were largely referred to the navigation interventions (most often, by GPs and midwives) after already 'entering' the health system, for the purpose of having their specific needs targeted on a one-to-one basis in order to facilitate their access to healthcare during the time of pregnancy, labour, birth and early motherhood.

Additionally, principle four sought to define navigators as having a "clear scope of practice". The reality - as has been demonstrated by the findings of this project - is that navigation for this population has been characterised by a consistent lack of definition and standardisation. This has been demonstrated by the wide range of terminologies, roles and functions associated with the intervention, a lack of distinction of navigational roles and responsibilities, as well as a lack of clarity

among healthcare and other statutory professionals on what such navigational roles and responsibilities entail. This invites critique of whether the concept of health navigation in its current forms requires the clarity originally sought by Freeman and Rodriguez (2011), given that the evidence suggests that it can also be context-driven and defined by the needs of service users / clients / patients. In this way, the findings of this project have offered important insight into - and analysis of - the ways in which exploring navigation for migrant women through my chosen methods enhances understanding of how navigation could be defined, and what it aims to achieve.

Elsewhere in the findings, there were knowledge gaps on the characterisation of navigation. These gaps could be identified within the systematic review findings, and provided an opportunity for findings from the primary research to offer a useful contribution. These findings include the identification of the diverse ways in which navigation has been managed by organisations, including differing referral systems, matching between navigators and service users, navigational training programmes and recruitment and remuneration policies. While the vast majority of the included literature in the systematic review did not mention the employment/remuneration terms navigators were subject to, findings from the primary research detailed these arrangements. As stated in preceding Chapters, the majority of navigators involved in the primary research carried out their navigational roles and functions in a voluntary capacity, with the two interviewed maternity support workers at Haamla Service serving as the only paid employees; these descriptive findings are, however, unlikely to be generalisable from two case studies.

Exploration of this theme within the data provided an important nuance on the nature of remuneration for navigators, its utility and its impact on the functionality of navigation. On the former, there was evidence that some navigators expressed a belief that they should be paid, particularly in light of the significant time commitment associated with navigational work, issues with high turnover of volunteer navigators, as well as the emotional labour - and other boundary-related challenges - that navigators needed to negotiate while delivering the intervention. Elsewhere in the data, however, there was also a suggestion that navigators' unpaid labour at Project MAMA was an inherent challenge to the status quo, in that navigators viewed themselves as socially and economically privileged in relation to service users and, therefore, perceived the voluntary nature of their work to be transformative by (seemingly) reducing the power differentials that existed between navigators and service users. In contrast, receiving payment to carry out this work was perceived as upholding oppression and being unconducive to service users' empowerment - which was an aim of navigation.

Although lacking this broader socio-political commentary, existing research has highlighted that other UK-based doulas working with disadvantaged and vulnerable populations shared a preference for being unpaid for their work, perceiving intrinsic value in their voluntary activities (Spiby et al, 2016). Finally, there was an indication within the data that navigators sometimes became involved in volunteer navigation in order to equip themselves with the skills and experience to pursue their longer-term professional goals. This is concordant with research on volunteer doulas in the USA, who also perceived their voluntary work as a short-term opportunity to improve their career prospects (Low, Moffat and Brennan, 2006). Although not explored within the data, voluntary navigation for migrant women could potentially also be conceptualised as unpaid care work with wider implications for gender inequality (Overgaard, 2019), given that those volunteering their labour as navigators were - and are - overwhelmingly female and that female gender was, indeed, perceived to be an essential aspect of delivering the service.

11.2.2 - Assessing the impact and effectiveness of health navigators, and exploring their relationships with migrant women through navigation

Quantitative and qualitative findings offered exploration of the impact of health navigation on migrant women. This impact was shown to be largely positive, with the systematic review findings presenting navigation as a tool for increasing access to preventative, diagnostic and curative care in areas as diverse as breast cancer, maternity care and mental health, but also bringing other benefits which did not directly impact on migrants' access to healthcare, including reduced social isolation (McCarthy and Haith-Cooper., 2013; Wagner, 2017) and improved communication and social skills (Wagner, 2017) for migrant women, as well as improved confidence for navigators (Nguyen et al., 2010) and a perceived increase in cultural safety (Torres et al., 2014). There was also minimal reference to the burdensome nature of navigational work (Reavy et al., 2012). Findings from the primary research significantly expanded upon these observations - that of both the intended and unintended 'outputs' of navigation for migrant women. These included an increase in access to healthcare for migrant women service users, most often through acquiring knowledge and empowerment - although many service users had had prior access to healthcare, implying that the reach of the studied navigation interventions may have been limited. The findings involved exploration of what each intervention at the case study sites aimed to deliver according to the

official accounts of the service designers, as well as what stakeholders perceived the aims to be, in practice. To my knowledge, there has been no prior formal interrogation of the aims of health navigation for any population within the existent literature, and how these aims impact on navigation's functionality, and exemplifies one of the contributions of this doctoral project to the field.

As noted within the systematic review findings, the central navigational relationship was underscored by trust. Findings from the primary research did, however, provide a much more in-depth exploration of this relationship, which offered both corroboration and contrast with the review findings. The relationship between navigators and migrant women in the field research was shown to be positive and friendly - in line with the review findings. However, there were contrasting perspectives between navigators and service users, with the latter generally perceiving their relationship to be closer and more informal in nature compared to how navigators themselves perceived it. Furthermore, the 'friendship' aspect of this relationship necessitated a careful negotiation of professional boundaries on the part of navigators, which is reminiscent of previous global literature on the difficulties faced by doulas and lay carers/workers in managing their interpersonal relationships with patients and service users, largely due to their falling outside of the formal, mainstream system of healthcare provision (Curtis, Woodhill, and Stapleton, 2007; Daniels et al., 2010; Low, Moffat & Brennan, 2006; Meier et al., 2007).

A major point of contrast between the systematic review findings and the primary research findings was the possibility of a 'peer-like' relationship between navigators and migrant women. Indeed, the hypothesised existence of 'peer-ness' shaped - and provided justification for - the chosen methodology of the primary research, inquiring into whether shared ethnic/racial, gender and linguistic characteristics - and migration and motherhood experiences - between a navigator and the migrant woman to whom they were assigned had any bearing on the functionality of navigation. The findings from the primary research suggested that, while some shared characteristics and experiences within the navigational relationship could be beneficial, they were rarely necessary, with female gender being the only characteristic deemed to be essential. This is unsurprising, given service users' prior experiences of trafficking, (sexual) exploitation and male violence which created a preference for female-led navigation, but also reemphasised the feminisation of birth-work and critique around how essentialist and stereotypical notions of gender and femininity have pervaded the birth-work movement (Basile, 2012). Aside from this, service designers' 'matching' of a navigator to a migrant woman service user - based primarily on a perceived commonality in racial/ethnic or

migration background between them - was also shown to be potentially detrimental, given the potential to evoke feelings of judgement, suspicion and distrust when seeking to engage with a community via an insider racial, ethnic or cultural identity (Shah, 2004). There were also practical considerations as to why a shared language between navigators and migrant women was not always of benefit, with over-reliance on language interpretation viewed as being a barrier to migrants' ability to integrate socially, culturally and economically within their new, local communities. The latter point does invite critique, however, given the contentiousness of the notion of integration, and the ways in which it often positions migrant communities as being solely responsible for 'fitting in' and seeks to problematise their presence in the event of a perceived 'misfit' between migrant and host communities (Korteweg, 2017; Schinkel, 2018).

In essence, the vast majority of the prior literature explored in my systematic review centred on the use of 'bicultural' and/or bilingual navigators to deliver the interventions. Authors of these studies offered no reasoning as to the matching of navigators and migrant women based on racial, ethnic, cultural and linguistic factors. In this way, the implication of being matched with a 'peer' as a navigator was not adequately explored or reported by service designers, despite the impact that this could have had on the functioning of navigation. This suggests a tendency to foreground cultural difference and present it as an assumption that this is the core barrier to accessing services.

11.2.3 - Elucidating the theoretical mechanisms which underpin health navigation when implemented for migrant women

The findings from the systematic review offered very little insight into the theoretical mechanisms underpinning navigation for migrant women, with no prior studies having utilised any broad, sociologically-informed approach to understanding the individual-level, service-level and structural barriers that migrant women face when attempting to access healthcare.

The field research component of my project sought to conceptualise health navigation for migrant women beyond the narrow framing of these existing studies by applying the lens of Candidacy (Dixon-Woods et al., 2005). This was the first documented attempt at employing Candidacy to study the influence of a health and social care worker on migrant patients'/service users' trajectories to negotiating their candidacy for accessing a desired service. There have only been two previous studies applying Candidacy to migrant populations, both of which were published within the last

four years (Chase et al., 2017; van der Boor & White, 2020). These studies detailed refugees' and asylum-seekers' trajectories to accessing healthcare within high-income contexts, providing insight on how individual-level, service-level and structural-level factors created a gap between entitlement and successfully accessing a service.

Candidacy proved useful in articulating the impact of assistance from a health navigator on migrant women's ability to successfully negotiate their candidacy. Navigators' power to influence a service users' trajectory to access was observable across all domains of the framework - from initial identification of their own sense of candidacy to the consideration of factors which shaped local production of candidacy. Navigators carried out roles and functions in response to a service user's particular needs - including providing information on a health service, arranging transport to it, and offering in-person mediation between the service user and a health provider. It was these roles and functions which intervened in the processes of ascertaining candidacy. In some cases, this intervention led to desirable results, whereby a service user who had previously not understood the information being shared by a doctor was now knowledgeable in what was being communicated, and could then make her own choice as to how to respond. In other cases, however, this intervention could put migrant women's candidacy at risk, due to how navigators were perceived and interpreted by the adjudicating health provider, or due to fundamentally racist immigration policies which could interrupt migrant women's trajectories to negotiating their candidacy or deter them from attempting to claim their candidacy in the first instance. This suggests that navigation was not necessarily able to address all barriers to access faced by migrant women.

As highlighted in preceding Chapters, navigation for migrant women operated within the context of a hostile environment. This referred, firstly, to the immigration-specific "Hostile Environment" set of policies that problematised and criminalised groups of migrants living in the UK during an era of economic austerity - affecting their entitlements to housing, healthcare, education and other human rights (Webber, 2019). The second point of reference was a broader, hostile clinical environment within the NHS; although there is little UK-based evidence for this currently in existence, data from other Western nations has suggested that institutional racism and classism pose major barriers to accessing care (Downing, 2004; Mahabir et al., 2021). As one of only two prior examples of literature applying the Candidacy framework to migrants' access to healthcare, Chase et al. (2017) described asylum seekers' journeys to securing their Candidacy to access a desired service. Unaided by navigation, asylum seekers were reported as responding in different ways to failure to access healthcare. While some asylum seekers gave up and disengaged from the candidacy process, or

didn't challenge health providers' decisions to withhold access, others sought to re-attempt their trajectory after a substantial delay or decided to (sometimes unsuccessfully) advocate for themselves. In these cases, it could be argued that assistance from a navigator could have influenced these outcomes, but that whether this influence helped or hindered the process of negotiating candidacy would have also been largely determined by structural factors such as racism and classism.

In spite of Dixon-Woods et al. (2005) opining that it was "difficult to determine [cultural brokers'] effectiveness in improving 'access'…in part because of difficulties in distinguishing which aspects of Candidacy they are intended to address", my application of the framework illustrated that navigation may usefully address all of the domains of Candidacy. When applied to the issue of navigation for migrant women, the Candidacy framework was able to capture structural influences that shape the production of an individual's candidacy. This reflects a limitation within the original application of the Candidacy model. Mackenzie et al. (2013) advocated for an extension of the Dixon-Woods et al. (2005) model in order to illustrate how an individual's candidacy can be questioned, suppressed or denied as a result of these structural factors, even if individual or service-level barriers have been overcome. In this way, this application of the Candidacy framework presents structural barriers as being especially 'potent'. This was one way in which the potential hindering of a migrant woman's candidacy as a result of racial, ethnic or class bias could be explained. Finally, a clear limitation of the Candidacy framework was that it does not have the capability to capture the broader range of benefits that navigation produced beyond increased access to healthcare for migrant women, including reduced social isolation and other social benefits. Despite these limitations, Candidacy proved useful in generating crucial insights into navigation's operation.

11.2.4 - Developing a logic model of how health navigation can improve access to healthcare for migrant women

In **Chapter 10,** I constructed a logic model illustrating the functioning of health navigation, including how resources were thought to have been mobilised ('inputs') to drive navigational functions ('activities'), which led to navigational 'outputs'. Increased knowledge, in turn, could lead to increased access to healthcare via acknowledgement of migrant women's claim to candidacy, indirectly impacting on their health (the 'outcome'). Additionally, other outputs such as reduced

social isolation and increased access to education and other health-promoting services could bypass increased access to healthcare to directly impact on their health.

This model was developed through combining findings from both the literature review and the primary research. Both components offered evidence for the resources needed to deliver navigation for migrant women (funding, paid staff and/or volunteers and training), which would lead to a navigator of female gender offering support to migrant women - including practical, emotional and educational support - in order to achieve access to healthcare and other 'outputs', all of which could ultimately lead to improved health and wellbeing. The model - and its underlying evidence - presented a direct relationship between service users' increased knowledge and empowerment following navigation and increased access to healthcare. This was observable within the literature review and across the interventions examined in the case studies; similarly, prior studies have found a link between low health literacy and inadequate access to healthcare (Huber et al., 2019; Levy and Janke, 2016; Tipirneni et al., 2018). In addition to this, however, the evidence informing the model also presented this relationship as being dependent on whether a service user's candidacy to access a given service is ultimately acknowledged. Although the data supporting this assertion appeared to be robust, there has not yet been any Candidacy-informed exploration of this relationship within the extant literature.

Finally, the model presented multiple routes to improved health and wellbeing through navigation, implying that navigation also led to other benefits for service users apart from increased access to healthcare, including reduced social isolation and access to other services and resources that help to engender health and wellbeing. Prior studies have linked improved health and wellbeing to reduced social isolation (Findlay, 2003) and improved access to education (Green and Cavanaugh, 2015; Hill and Needham, 2006), with the latter being an example of a public service which migrant women gained increase access to as a result of navigation. It should be noted, however, that the data highlighting the relationship between women's improved access to services outside of the NHS (including education) and their improved health and wellbeing was not necessarily robust, with only one of the case studies providing evidence for this.

Not all potential relationships could be depicted on the logic model, due to a lack of evidence from the literature review and from the primary research. In particular, there is uncertainty as to which specific navigational 'activities' (in this case, navigation's functional domains) could lead to which

specific navigational 'outputs', whether increased access to healthcare, increased access to other services and resources, or reduced social isolation.

11.3 - What were the strengths of this project?

This doctoral project had several points of strength, one of which is the variety of contributions it has offered. The first is its methodological contribution, by addressing an existing lack of qualitative research into health navigation for migrant women, which explored the perspectives and experiences of service users, as well as navigators and professionals. Secondly, the project offered a strong theoretical contribution by way of applying the Candidacy framework and consequently developing a logic model; this was the first attempt at applying a sociological lens specifically using the framework of Candidacy, in order to conceptualise navigation for migrant women, and, by extension, the influence of additional health and social care personnel on the central health provider-patient dynamic. Thirdly, an empirical contribution, in which rich data was produced to offer unique insight into the characteristics of navigation for migrant women both in the UK and globally, as well as the dynamics at play within the relationship between navigators and migrant women. Collecting this data partly involved recruiting 31 individuals for interview from four different participant groups. Diversity was observed in participants' demographics, including age, educational background, nationality and racial/ethnic identity, and these participants were recruited from two different organisational contexts (in two different cities in England), containing three different navigation interventions from which to study navigation for migrant women. Drawing from the four different participant groups, three different navigation interventions and the two different case study sites allowed for comparison and contrasting of the ways in which navigation functioned. Lastly, the findings of this project can inform both current and future practice of health navigation for migrant women, especially within a UK context.

There were some indications of the rigour of the data produced by the primary research. Assessing 'quality' in qualitative research has long been a contentious issue, in large part because of the nature of qualitative knowledge production, as well as the derivation of terms such as 'validity' and 'reliability' from quantitative research (Mays and Pope, 2000; Seale, 1999), but quality can also be referred to here in relation to credibility (Noble and Smith, 2015).

Firstly, a rigorous analytical approach was used for both interview and documentary data. Secondly, the inclusion of a member checking exercise to crosscheck and verify findings with study participants added credibility to the research. Finally, as a multiple, instrumental case study design was employed, combining two case studies brought common issues and themes from the case studies to the fore, as noted from the multiple case study design presented by Stavros and Westberg (2009). Such identified commonalities included the ad-hoc, flexible and needs-driven nature of navigation for migrant women, navigators' challenges with managing boundaries and the importance of a navigator's female gender. Insights from the combined cases aided with developing the logic model, addressed the overarching research objectives, and enhanced the research study's transferability and credibility.

Researcher reflexivity was a necessary consideration, given its importance for acknowledging and addressing researcher-derived subjectivity in the form of bias, perceptions, values and personal and professional experiences. One strength of this research was the effort made to acknowledge this subjectivity - and its impact on the research process - as far as possible. As outlined previously, within **Chapter 5**, I recognised that my own identity as a British-born Black woman from a working class family of migrants could pose barriers to reflexive practice if my positionality remained unacknowledged. I decided to engage in discussions of the research with others, in order to verify and challenge my interpretations of the data - while upholding the anonymity of research participants. This aided me in considering alternative interpretations from those who were further removed from the data. An example of this was when my supervisors briefly commented on one of my interpretations, which was that service designers of interventions included within the systematic review findings had merely assumed that navigators should be from the same culture, ethnic or racial background, and that this assumption was inherently racist. Following the discussion, I realised that my perception was influenced by my previous experiences with those who openly believed that they were meeting the needs of migrant communities and that there was no apparent need to ask migrant communities for their opinion or input which, in my view, denied this community their agency and reproduced oppressive power dynamics. These individuals had also done this intentionally, and explicitly stated that they did not see this as being problematic. However, I had, myself, made an assumption about the service designers represented in literature review. While there was a possibility that this presented a comparable scenario, there could have also been other practical reasons for designers of the services to match navigators to service users in this way. The discussion with my supervisors allowed me to see that this could have also reasonably been

about practical considerations around the existing make-up of the navigational team (and which individuals were available to be matched to service users) - and that the justification for this could not merely be assumed.

11.4 - What were the limitations of this project?

All research is inherently limited. Despite recruiting a diverse set of participants and two contrasting organisations to host this research, issues around transferability of the data will be raised. Of all participant groups, service users were the most difficult participants to recruit. A contributing factor to this is likely to be the fact that I was only able to access migrant women who chose to access the host organisations' community-based social or educational groups. This was the case at both organisations, and may suggest that the service users recruited for interview were less vulnerable than others who did not - or could not - access the community-based groups. One observation was that, at Haamla Service, no service users who had engaged with the volunteer doula intervention could be recruited, which meant that their perspectives were missing.

Although a range of informative documents were gathered for analysis to complement the interview process, a total of only eleven documents of varying length and richness were gathered from the coordinators of the interventions (with their written consent). One explanation for the limited availability of documents was that I needed to rely on both coordinators as gate-keepers to provide these documents, which inadvertently gave coordinators power to decide which documents they were to offer to me for analysis, granting them a degree of "social control" of the research and leading to potential selection bias (Andoh-Arthur, J., 2020; Broadhead, 1976). By extension, these concerns are relevant to the recruitment of service users and navigators for interview, as coordinators also played a gate-keeping role in this process. This was unavoidable due to the need to uphold safeguarding principles for service user involvement in the research, in particular, as coordinators were best placed to advise on which service users were not especially vulnerable and could be suitable for interview. In one case, at Project MAMA, a service user had expressed interest in being involved in the research, but when discussing her suitability for inclusion with the co-ordinator, I was informed that the service user had significant mental health concerns and would be too vulnerable to participate, especially as these concerns had increased after her giving birth in recent weeks.

Another reason why reliance on coordinators as gate-keepers was unavoidable was due to the fact that I had even lesser access to participants at the Haamla Service site, and not all navigators could be approached directly for interview. Maternity support workers and midwives could be directly approached at Haamla's office within St. James' Hospital, as that was where they completed their administrative work and meetings, given their status as paid, full/part-time employees. However, volunteer doulas provided only ad-hoc assistance and did not frequently journey to Haamla's office. In this way, I needed to rely on the coordinator to forward information about my research to them on my behalf, gain their consent for me to contact them so that I could then communicate with them directly and, if possible, arrange an interview. To summarise - using coordinators as gate-keepers had distinct disadvantages, but was ultimately necessary, and it could be strongly argued that fewer service users and navigators would have been recruited in their absence.

There were other methodological limitations to the research. Although initially included as an intended method of data collection, participant observations could not be carried out. This was due to the fact that the Research Ethics Committee at ScHARR viewed observations in the context of my research as presenting especially complex ethical issues. With regards to interviews specifically, several service users needed to be interviewed through language interpretation. While only professional interpreters were used, and not family interpreters - to better ensure accuracy in information transfer and to minimise risk to confidentiality (Ho, 2008) - the exact translation of the information exchanged between myself, the interpreter and the service users could not be guaranteed. Previous research has outlined that interpreters can play a role in the construction of interviewees' accounts, which has both methodological and ethical implications (Temple and Edwards, 2002). Additionally, at Haamla Service, there was one service user who faced challenges accessing an interpreter, as no interpreters who spoke her native language, Oromo, were available for hire. She was able to speak Arabic to an (upper) intermediate level, which meant that - through Arabic interpretation - she could reasonably participate in the community education group sessions and could be interviewed, but this still may have presented accuracy issues.

Interviews with some service users were often retrospective in nature, which meant that they were recounting their experiences with navigation in the preceding months, having delivered their babies and stopped being navigated. The passing of time between engaging with navigation and participating in an interview about navigation may have presented issues in the accuracy of memory recall, however this was judged to be a necessary compromise. This was because interviewing

months after being navigated presented benefits, from allowing service users to be interviewed during a less intense period (post-birth and post-early motherhood) - to giving them the opportunity to reflect fully on the totality of their navigational experiences.

While some of the semi-structured interviews were conducted on a face-to-face basis - including in community centres, in host organisations' offices and in service users' homes - the majority of interviews were conducted by telephone. It is acknowledged that the absence of visual cues, body language and contextual information - which are usually a feature of face-to- face interviews - may impact on a researcher's ability to guide an interview conducted by telephone (Novick, 2008). However, telephone interviewing offered greater flexibility for participants, which likely maximised the numbers of individuals who could participate. For service users in particular, this was an especially busy period due to being pregnant or having recently given birth, while simultaneously managing immigration and housing issues, and some service users had difficulties accessing transport. In interviews without language interpretation, the flow of the interviews conducted by telephone did not appear to differ from those conducted on a face-to-face basis.

The relatively short mean length of interviews with service users in comparison to other participant groups reflected specific challenges - most notably, the limited time availability of service users to participate in an interview, especially given their preoccupation with childcare responsibilities, and managing other priorities such as needing to attend employment and immigration-related appointments. To accommodate service users' limited availability, I would deviate from the generic order of questions on my interview protocol, where necessary, by prioritising interview questions most relevant to my research question and sub-questions, including questions around service users' need for navigation, their perceptions and direct experiences of navigation, and around shared characteristics and experiences. In addition to this, some service users did not wish to provide more detailed answers; despite giving verbal prompts to participants when there was an opportunity to gain more information or explanation, it was necessary to balance this with respecting participants' right to decide how much information to divulge, and to respect the voluntary nature of their participation in the research, as well as the fact that some service users had had profoundly difficult and traumatic experiences with migration and exploitation. In the case of all participant groups, there was little variation in interview duration between the study sites.

Although I have referenced researcher reflexivity as a strength - due to my actively considering how my positionality could affect my interpretation of data - I believe there are ways in which my reflexivity was still limited. There was an instance where I unwittingly adopted an insider identity when interviewing a service user, which likely had detrimental effects on the interview process. Existing literature has already outlined that researchers from the same racial/ethnic background (or perceived as being from the same racial/ethnic background) as a research participant may possess rich understanding of their context and will likely experience ease in access to the participant, creating an opportunity for heightened sensitivity and the likelihood of capturing more accurate information (Gunaratnam, 2003; Papadopoulos and Lees, 2002). However, this is highly contested. Reflecting on her own research, Twine (2000) outlined that "my experiences suggest that some Brazilians of color do not necessarily feel more comfortable discussing the topic of race and racism with those who resemble them racially …moreover, prestige hierarchies and the valorization of whiteness resulted in some Brazilians of color preferring to be interviewed by my white research partner". Twine's account speaks to my own experience. During an interview at Project MAMA, there was a sense that the service user did not want to divulge much information, which may have led to this particular interview being less rich in content than other interviews with service users. One contributory factor as to why this may have happened may have, indeed, been the fact that I was a fellow Black researcher conducting an interview with her, and that I had already identified myself as also being a woman of (partial) Nigerian descent, therefore constructing an insider cultural identity. This identity was then met with suspicion and a lack of trust, with the service user reporting that she had a preference for White people, as she perceived them as being more caring in nature. This was in the context of her having previously being exploited and mistreated by other Black Nigerians.

11.5 - Implications for research, practice and policy

The findings of this research project have implications for future research, policy and practice relating to health navigation for migrant women.

11.5.1 - Implications for research

The findings from both the field research and systematic review components of the project suggest a necessity for more exploration of the extent to which navigation for migrant women is culturally sensitive. This is due to a lack of indication within the data as to how deeply notions of cultural competence and/or cultural safety have actually resonated with service designers in constructing these interventions, as can be seen from a notable lack of data evidencing navigators' apparent cultural function. This is an important gap in knowledge, in that a lack of evidence of inherent cultural sensitivity within existing navigation interventions targeting migrant women does call into question its reputation as being a culturally competent/safe intervention, and its positioning as an alternative to the lack of cultural sensitivity within mainstream health services.

Navigation was shown to be a largely individual-level and service-level intervention, but one that was also able to reflect the existence of structural factors such as racism and classism, which sit 'upstream' of the intervention and, perhaps paradoxically, have contributed to the need for navigation interventions for migrant women. Race and racism, in particular, deserve further exploration within future literature, however, as there is scope to more closely study the ways in which migrant women's experiences and perceptions of navigation have been influenced by race and racism. Such work could also be grounded in public health-informed critical race theory (Ford and Airhihenbuwa, 2010).

Further research should also be conducted on navigation for migrant women in other geographical, political, social and cultural contexts. The research was borne out of an urgent need to study navigation outside of its North American origins, and there is much scope for exploring whether the conclusions outlined in this thesis hold when applied to other, non-North American contexts. Interestingly, there is now early consideration as to how the concept of navigation for marginalised groups is applied within a Global South context (Louart, Bonnet and Ridde, 2021).

Lastly, the impacts of navigation detailed in the findings from the field research were largely sourced from interviews with participants, and reflected their range of perceptions and experiences. Following identification of the range of likely impacts of navigation for migrant women, there is scope to measure and quantify these impacts. This would be a welcome contribution, given the

absence of quantitative data available on the selected case studies, and the wide paucity of quantitative data on navigation for migrant women available in a UK context, more generally.

11.5.2 - Implications for practice

Navigation interventions for migrant women could become more culturally competent and/or culturally safe through implementing practical changes at organisational level. In light of the finding that shared characteristics such as racial/ethnic or linguistic backgrounds may not be prerequisites for the successful operation of navigation but could still be beneficial for some, designers of navigation services may consider diversifying their navigational teams. This may allow for more navigators of different backgrounds to join the team, which could then give service users more choice in who they would like to engage with; some service users may prefer to be navigated by a native, monolingual British person of a different racial/ethnic background to navigate them, while others may prefer to be navigated by another person from their own community who is able to speak English and has sufficient knowledge of the NHS and other statutory and community services. It should be noted, however, that with an increase in diversity among navigator teams, organisations would need to become much more aware of how navigators' perceived or actual race/ethnicity may impact on how effective they may be in addressing service users' needs, due to the biases of healthcare professionals (and, arguably, other statutory workers). This would likely require significant resources for internal training and anti-racist education. In response to increased national recognition of the importance and utility of diverse doula teams (Doula UK, 2018; Abuela Doula, 2021), Project MAMA started collaborating with Doula UK on a diversity initiative during my time volunteering (and researching) at the study site, in an effort to start building a more diverse navigational team. As part of this initiative, one former service user at Project MAMA was funded to undertake a doula training course with Doula UK, with the possibility of herself becoming a mother companion.

Admittedly, such initiatives would require increased resourcing for organisations who operate navigation interventions and, for small organisations like Project MAMA, this would be a challenge. However, the findings indicate that there is a general need for increased sustainability of navigation interventions. Offering remuneration or a stipend to navigators would arguably contribute towards making navigation more sustainable, as this would address issues relating to turnover and high

burden of work. The extant literature does, however, also provide commentary on the utility and value of unpaid navigational work. Volunteer navigators operate outside of 'mainstream' NHS maternity care and offer a service which complements this mainstream care, yet the roles and functions that they adopt to support migrant women are crucial. Reflecting on volunteer navigators providing palliative care across Canada, Pesut et al. (2020) state that "the paradox is that volunteers make contributions that healthcare providers are not paid to do, and so the [navigational] role is thought to fall outside of paid healthcare services…[but if] volunteers are truly integral…then funding for the structures that support those volunteers is essential". Human and material resourcing are needed to strengthen the infrastructure of these interventions and provide sustainability; both Project MAMA and Haamla Service would benefit, given that Project MAMA, for example, is a largely volunteer run, three year-old organisation raising funds through its charity status, while the long-standing coordinator at Haamla Service left her post in 2020 and has still, seemingly, not been replaced.

11.5.3 - Implications for policy

Navigation interventions have been growing in popularity in the UK in recent years, with NHS Trusts, GP surgeries, social enterprises and charities operating their own independent navigation interventions for specific populations - from migrant women seeking maternity care to patients requiring support following a cancer diagnosis. However, unlike in the USA, where the provision of navigation has been included as part of the federal Affordable Care Act (HealthCare.gov, 2021), the UK does not have any national scheme or policy to offer funding and other resources to guide the implementation of navigation, more generally. This is likely due to the fact that a key role played by navigators in the USA is of enrolling underserved communities into health insurance schemes (Vargas, 2016), which would not apply within the context of the NHS. Development of an NHS England-wide navigation programme could potentially offer greater sustainability for navigation interventions, including funds for those serving as navigators for different population groups. However, there are risks that normalising navigation as a 'complement' or alternative to the 'mainstream' NHS system further marginalises some patient / client / service user groups - including migrant women - and re-enforces the inequalities in access to healthcare that navigation has been developed to address.

There are policy implications to the narratives around structural factors that are seemingly beyond the reach of navigation. Consideration of these upstream influences on migrant women's access to healthcare should prompt further discourse on what Department for Health and Social Care-led policy changes are necessary to tackle the macro-level barriers that affect migrant women, and the necessary course of action to take. The imposition of NHS charging for some migrant groups is thought to have already had a serious impact on maternal health inequalities for migrant women in the UK (Walker and Farrington, 2021), as well as on their general physical and mental health (Feldman, 2020). If action on migrant health inequalities - and maternal health specifically - is to be taken seriously, then it must reach beyond mere individual and service-level change and demand structural policy change.

Finally, navigation is currently operating within the context of the COVID-19 pandemic, with both Project MAMA and Haamla Service having temporarily transitioned to providing mainly remote and telephone emotional support to migrant women during pregnancy and early motherhood, home delivery of crucial supplies, increased referrals to community resources (such as domestic abuse services), alongside limited support at hospital at the time of labour and birth. Such transitions have, however, demonstrated the inherent resilience and flexibility of the navigation services at the study sites, in how they have adapted under profoundly difficult circumstances to continue to address migrant women's needs, and there has (informally) been positive feedback from service users at Project MAMA, which has highlighted the importance of this adapted support. Taken together, these changes in the socio-economic context in which navigation has been operating reflect the key features of navigation for migrant women and demonstrate why they have become so crucial for service users' welfare.

11.6 - Conclusion

This project has explored in-depth the ways in which health navigation interventions likely facilitates increased access to healthcare for migrant women populations. In undertaking an integrative systematic review and a multiple, instrumental case study, this project has fulfilled its objectives in describing and characterising health navigation as a concept, articulating the impacts of health navigation on migrant women (and other stakeholders), and elucidating navigations' theoretical underpinnings. In doing so, this project has contributed knowledge on what navigation for migrant

women has sought to achieve, how it goes about meeting these aims, and what factors could be at play that help or hinder its operation.

Taken together, this project has showcased health navigation for migrant women as being a diverse, flexible and loosely-defined set of roles and functions, whereby a navigator fosters a trusting relationship with service users in order to facilitate a one-to-one connection to healthcare and other important services, and bringing with it a range of benefits and challenges for migrant women and other stakeholders. Navigation was also perceived and evaluated as addressing the individualised needs of service users as a complement to mainstream health services, but its ability to positively impact on service users' access to healthcare appears to be shaped and determined by structural factors. This is likely to have a range of implications for current and future research, policy and practice on health navigation for migrant women, but also for health navigation as a developing intervention, more broadly.

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Appendices

Appendix A

Appendix A Table 1: Search input used when searching Medline, EMBASE, CINAHL, PsycInfo, ASSIA and Social Science Citation Index. The most recent search of these databases took place on 19th July 2020.

Health navigation-related search terms
Health Navigat* OR Patient Navigat* OR Peer Navigat* OR Care Navigat* OR Nurse Navigat* OR Cultural Navigat* OR "Community Health Worker" OR "Health Advisor" OR "Lay Worker" OR "Link Worker" OR "Lay Health Worker" OR "Lay Health Advisor" OR "Peer Worker" OR "Peer Health Worker" OR "Peer Advisor" OR "Peer Health Advisor" OR Doula OR Befriender OR Community-based Facilitat* OR Care Co-ordinat* OR "Health Mediator" OR "Cultural Mediator" OR "Intercultural Mediator" OR "Cultural Health Worker" OR "Multicultural Health Worker" OR "Cultural Health Promotor" OR "Multicultural Health Promotor" OR "Cultural Health Advisor" OR "Multicultural Health Advisor" OR Promotore* OR Promotora* OR Navegante* OR "Outreach Worker" OR "Health Advocate" OR "Bilingual Health Worker" OR "Health Focal Point" OR Support Worker
Migration and ethnicity-related search terms
Refugee OR Asylum-seeker OR Undocumented Migrant OR Traffick* OR New migrant OR Newly-arrived migrant OR New Arrival OR Recent migrant OR Recently-arrived migrant OR Recent Arrival OR Immigrant OR Refused Asylum-seeker OR Failed Asylum-seeker OR Foreign-born OR Irregular Migrant OR Illegal Migrant OR Minorit* OR African OR Caribbean OR Mexican OR Asian OR Chinese OR Jamaican OR Syrian OR Pakistani OR Afghan OR Iraqi OR Iranian OR Kurd* OR Somalian OR Sudanese OR Eritrean OR Nigerian OR Latina OR Hispanic
Maternity-related search terms
Maternity OR Maternal OR Pregnan* OR Antenatal OR Prenatal OR Postnatal OR Postpartum OR Childbirth OR Gestational OR Reproductive OR Mother OR Gynaecological OR Gynecological OR Abortion OR HPV OR Cervical OR Breast OR Ovarian OR Women OR Woman OR Female

Appendix A Table 2: Quality assessment of primarily quantitative studies, using a modified Downs and Black Scale (O'Connor et al., 201

Author (Year)	Study design	Reporting	External Validity	Internal validity - bias	Internal validity - confounding	Power	Total score
Allen et al. (2014)	Pre-post study	8	3	4	1	0	16
Ell et al. (2009)	Randomised controlled trial	10	3	6	5	0	24
Fang et al. (2007)	Pre-post study	7	3	4	3	0	17
Fang et al. (2017)	Matched-pair group randomised design	8	3	6	4	0	21
Fernández et al. (2009)	Pre-post study	9	3	6	3	0	21
Han et al. (2009)	Pre-post study	8	3	5	3	0	19
Han et al. (2017)	Cluster-randomised wait list control study	9	3	6	5	1	24
Lam et al. (2003)	Randomised controlled trial	8	3	6	4	0	21
Lo et al. (2010)	Pre-post study	4	3	4	2	0	13
Lutenbacher et al. (2018)	Randomised controlled trial	9	3	7	5	1	25
Maxwell et al. (2010)	Randomised controlled trial	8	3	7	4	0	22
McClung et al. (2013)	Pre-post study	8	3	5	1	0	17
Nguyen et al. (2009)	Randomised controlled trial	10	3	5	4	1	23
Parra-Medina et al. (2014)	Pre-post study	9	3	5	2	0	19
Percac-Lima et al. (2012)	Pre-post study	9	3	5	3	0	20
Percac-Lima et al. (2013a)	Retrospective evaluation	8	3	5	3	0	19

Percac-Lima et al. (2013b)	Retrospective evaluation	8	3	5	3	0	19
Ramirez et al. (2014)	Quasi-experimental design	9	3	5	2	0	19
Shokar et al. (2016)	Randomised controlled trial	10	3	5	5	1	24
Taylor et al. (2002)	Randomised controlled trial	10	3	6	5	0	24
Tran et al. (2014)	Pre-post study	8	3	5	3	0	19
Wagner (2017)	Retrospective chart review (with qualitative component)	9	3	5	2	0	19
Wang et al. (2010)	Quasi-experimental design	8	3	5	2	0	18
Warner et al. (2019)	Pre-post study	10	3	5	3	0	21
Wasserman et al. (2006)	Ethnosurvey (with qualitative photo-narrative element)	9	3	3	1	0	16

Appendix A Table 3: Quality assessment of primarily qualitative studies, using the CASP qualitative checklist (Critical Appraisal Skills Programme, 2018)

Author (Year)	Section A	Section B	Section C	Total score
McCarthy and Haith-Cooper (2013)	2	1	1	4
Nguyen et al. (2011)	4	2	1	7
Reavy et al. (2012)	4	3	1	8
Torres et al. (2014)	4	2	1	7

Appendix A Table 4: Extraction template

	Data input	Location in full-text?
Date of extraction		
Title		
Which eligibility criteria were met?		
Decision		
Reason for exclusion		
Author (Year)		
Study design		
Publication type		
Study participants (Location)		
Intervention		
Roles included in navigational work		
Navigator characteristics		
Duration of navigation (Frequency)		
Framework included?		
Main outcome(s)		
Statistical significance		
Loss to follow-up? (Number of participants)		

Appendix A Table 5: Characteristics of included studies

Author (Year)	Study Design	Study Participants (Location)	Intervention	Roles included in navigational work	Navigator characteristics	Duration of navigation (Frequency)	Framework included?	Main outcome(s)	Are main outcomes statistically significant? (Y/N) [Confidence interval and p value]	Loss to follow-up? (Number of participants)

Allen et al. (2014)	Pre-post study	36 low-income Latina women, aged 18+ (Boston, USA)	Navigation by peer health advisor or patient navigator	Health education, referrals, appointment reminders, mobile health vans and assistance with applications for state-based insurance	4 women navigators	6 months (frequency unknown)	Integrative Model of Behvioural Predicton	24% increase in breast cancer screening adherence 8% increase in all recommended screening for one's age 86% of women were 'satisfied' or 'very satisfied' with the programme 61% found it 'somewhat helpful' or 'very helpful' to speak to the peer health advisor	N (Not reported) N (Not reported) N/A N/A	53.2% (41/77)

Ell et al. (2009)	Randomised controlled trial	487 low-income, mostly Hispanic migrant women aged 18+ (Los Angeles, USA)	Oncology care, standard financial and support services, list of resources/ services & educational pamphlet **vs.** Oncology care, standard financial and support services, navigator & social work team	Initial assessment of barriers (by telephone), health education, self-management support, follow-up calls & make referrals (where necessary)	1 bilingual, bicultural navigator	12 months (frequency unknown)	Health Belief Model; Socio-Cultural Explanatory Theory	**Breast cancer:** 90% of women receiving navigation (vs. 88% without navigation) completed chemotherapy. 90% of women in both groups completed radiation therapy. **Gynaecological cancer:** 94% of women receiving navigation (vs. 87% without navigation) completed chemotherapy. 84% of women receiving navigation (vs. 87% without navigation) completed radiation therapy.	N (Confidence interval not reported, p >0.05). N (Confidence interval not reported, p>0.05) N (Confidence interval not reported, p>0.05) N (Confidence interval not reported, p>0.05)	39% (190/487)

Fang et al. (2007)	Pre-post study	102 low-income, uninsured and recently arrived Korean women, aged 19+ and without recent Pap screening (USA)	General health education **vs.** Cervical cancer screening-specific education and navigation by health educator	Informational support, scheduling appointments & translation	Bilingual, Korean navigators	6 months (frequency unknown)	Health Belief Model; Social Cognitive Theory	Screening rate increased by 66 percentage points in intervention group versus 5 percentage points in control group Higher self-efficacy and fewer psychosocial barriers associated with screening behaviour in intervention group	Y (Confidence interval not reported, p <0.001) Y (Confidence interval not reported, p <0.05)	Not reported

Fang et al. (2017)	Matched-pair group randomised design	705 Korean women, who were aged 21+ and non-adherent to Pap screening (USA)	General health educational session & list of healthcare facilities for screening **vs.** Cervical cancer educational session, Pap screening information, navigation assistance & reminder letter by community health educator	Scheduling appointments, translation, arranging childcare, arranging transport, informational support & health insurance advice	Bilingual, Korean navigators	12 months (frequency unknown)	Health Belief Model; Social Cognitive Theory	Average rate of screening was 72.1% in intervention group, compared with 10.1% in control group	N/A	16.6%

Fernández et al. (2009)	Pre-post study	707 low-income Latina women farmworkers, aged 50+ (New Mexico, Texas and California, USA)	Standard care **vs.** Initial phone contact by lay health worker followed by individual presentation & discussion in women's homes and assistance to overcome barriers	Health education & general assistance to overcome barriers	Bilingual, Latina women navigators	6 months (frequency unknown)	Health Belief Model; Social Cognitive Theory	**Mammography screening:** Screening completion was higher among women in intervention group (40.8%) vs. those not in group (29.9%) **Pap screening:** Screening completion was higher among women in intervention group (39.5%) vs. those not in group (23.6%) Intervention increased breast cancer knowledge, but did not increase Pap nor cervical cancer knowledge	Y (Confidence interval not reported, p <0.05) Y (Confidence interval not reported, p <0.05) N (Not reported)	33.1%

Han et al. (2009)	Pre-post study	100 Korean-American migrant women, aged 40+ with poor or limited English and non-compliant with mammogram (Maryland, USA)	Group education session, plus follow-up counselling and navigation assistance by lay health workers	Telephone calls or home visits, translation, scheduling appointments, informational support, organising transportation & making referrals (where necessary)	Bilingual, Korean-American women navigators	6 months (frequency unknown)	Health Belief Model; Transtheoretical Model	Intervention increased screening uptake by 31.9% for mammography, 23% for clinical breast examination and 36.2% for breast self-examination No increase in breast cancer knowledge	Y (Confidence interval not reported, p <0.001) N (Confidence interval not reported, p >0.1)	7% (7/100)

Han et al. (2017)	Cluster-randomised wait list control study	560 Korean women aged 21 - 65, who had not had either a mammogram or Pap in last 24 months (Maryland, USA)	Educational brochures **vs.** tailored cancer screening brochure, health literacy skills training, counselling and navigation by community health worker	Health education, telephone calls (on monthly basis) and general assistance to overcome barriers	High-school-educated women navigators, aged 40's - 60's	6 months (monthly)	N/A	18.5 times higher odds of receiving mammogram in intervention group 13.3 times higher odds of receiving a Pap test in intervention group 7.0 points mean increase in health literacy in intervention group compared to control group 1.3 points mean increase in positive perception of breast cancer screening 1.1 points mean increase in positive perception of cervical cancer screening	Y (Not reported) Y(Not reported) Y (Not reported) Y (Not reported) Y (Not reported)	Not reported

Lam et al. (2003)	Randomised controlled trial	200 recently-arrived Vietnamese-American migrant women, aged 18+ (California, USA)	Media education campaign **vs.** Media education campaign, plus lay health worker-led group education sessions and navigation	Health education, general assistance to overcome barriers, referrals (where necessary)	20 Vietnamese-American women navigators, aged 18+	Unknown	PRECEED/ PROCEED planning framework	Increased uptake of Pap screening in navigation group (from 62.1% to 76.9%) Little increase in uptake of Pap screening in control group (from 70.2% to 72.8%) Intervention with navigation increased knowledge of HPV as a cause of cervical cancer	Y (Confidence interval not reported, p<0.001) N (Not reported) Y (Confidence interval not reported, p<0.001)	0% (0/200)

Lo et al. (2010)	Pre-post study	109 Hmong women who had not had Pap screening in previous 3 years (California, USA)	Media outreach, educational session & navigation by patient navigator	Health education, scheduling appointments, translation, arranging transportation, emotional support & assistance with completing paperwork	Bilingual navigator	Unknown	N/A	63% of participants completed Pap screening	N/A	51.4% (56/109)

Lutenbacher et al. (2018)	Randomised controlled trial	188 pregnant Hispanic women, aged 18+ (Tennessee, USA)	Printed educational materials **vs.** Maternal health-specific home-based education & linkage to medical and social services by peer mentors	Health education, referrals	Bilingual, Hispanic women navigators	From under 26 weeks gestation to 6 months post-natal (monthly)	N/A	Increased breastfeeding self-efficacy, use of safe infant sleeping practices, in intervention group compared to control group, throughout follow-up period Greater decrease in maternal depressive symptoms in intervention group compared to control group, throughout follow-up period Lower levels of parental stress and higher levels of social and emotional help in intervention group compared to control group, throughout follow-up period	Y (Confidence interval not reported, $p<0.001$) Y (Confidence interval not reported, $p<0.001$) Y (Confidence interval not reported, $p<0.001$)	5.3% (10/188)

Maxwell et al. (2010)	Randomised controlled trial	116 Korean-American migrant women, aged 40+, with no/insufficient health insurance coverage (California, USA)	Telephone calls from case manager and a letter to invite them for mammography screening **vs.** Assistance from peer navigator	Health education, provided home visits, appointment reminders, accompaniment to appointments, helping to complete paperwork, translation, organised transportation & provided informational and emotional support	1 Bilingual, Korean-American migrant women navigator, aged late 40's and college-educated	6 months (frequency unknown)	Health Behaviour Framework	97% of women receiving navigation completed follow-up screening (compared to 67% in control group)	Y (Confidence interval not reported, p<0.001)	27% (21/79)

McCarthy & Haith-Cooper (2013)	Qualitative (with case studies)	83 pregnant refugee/ asylum-seeking women (England)	Social support and signposting by befrienders	Connection to health and social services, accompaniment at appointments	Mainly refugee and asylum-seeking navigators, who are mothers	Early pregnancy until 2 months postnatally (weekly)	N/A	Favourable perceptions of service by clients	N/A	N/A

McClung et al. (2015)	Pre-post study	28 Chinese women, aged 18+ and undergoing cancer treatment (California, USA)	Navigation by telephone, or in person, by patient navigators	Health education, referrals, translation, assistance with transportation, emotional support, health insurance advice, cancer prevention help, nutritional help, administrative help	6 bilingual, Chinese women navigators, who were cancer survivors	Minimum 2 months (frequency unknown)	N/A	79% of patients were very satisfied with information from navigator and 86% were very satisfied with the way their navigator interacted with them Improved patients' knowledge and participation in clinical trials	N/A N/A	Not reported

Nguyen et al. (2009)	Randomised controlled trial	1100 Vietnamese-American migrant women with no/low English proficiency, aged 40+ (California, USA)	Media education campaign **vs.** Media education campaign, plus 2 lay health worker-led small group education sessions and navigation	Health education, scheduling appointments	50 Vietnamese women navigators	6 months (frequency unknown)	N/A	Intervention group increased knowledge of breast cancer; control group showed decreased knowledge Intervention group showed increased awareness of breast cancer (88.5% to 99.6%); control group did not (86.6% to 89.1%) Increased uptake of mammography in intervention group (84.1% to 91.6%); uptake in control group saw little increase (89.6% to 91.8%) Increased uptake of clinical breast examination in intervention group (68.1% to 85.5%); uptake in control group saw less of an increase (73.1% to 79.0%)	Y (Confidence interval not reported, p<0.001) Y (Confidence interval not reported, p<0.001) N (Confidence interval not reported, p=0.18) Y (Confidence interval not reported, p<0.001)	0.01% (7/550)

Nguyen et al. (2011)	Qualitative	110 Thai, Vietnamese, Khmer & Laotian women; 15 service providers and 10 navigators (California, USA)	General navigation assistance by community-based health navigator	Informational support, translation, scheduling appointments, accompaniment to appointment, connecting to community resources, assisting with health system knowledge, emotional support, appraisal support, health insurance advice & assisting with immigration and social issues	10 Bilingual, Southeast Asian women navigators, aged 40 - 64	Unknown	Socioecological Model	Identification of most important services being provided by navigator, by patients, service providers and navigators themselves Navigators feel patients can trust them Navigators want patients to be self-sufficient, and patients feel that navigators enable this Service providers hold favourable view of navigators	N/A	N/A

Parra-Medina et al. (2014)	Pre-post study	372 Hispanic migrant women who were uninsured, and had a daughter aged 11-17 who had not received HPV vaccination (Texas, USA)	Educational brochure on HPV vaccination **vs.** Educational brochure on HPV vaccination, health education session for mothers and daughters (led by promotoras and student peer educators respectively) plus written information on accessing immunisation & follow-up telephone navigation	Health education, informational support, follow-up reminders of next doses of vaccine	Bilingual, Hispanic women navigators	6 months (frequency unknown)	Health Belief Model	84% of participants initiated HPV vaccination in both groups Intervention group were more likely to complete series of HPV vaccinations (72.2% compared to 42.5%)	N/A Y (Confidence interval not reported, $p<0.001$)	19.1% (49/257)

Percac-Lima et al. (2012)	Pre-post study	91 Serbo-Croatian-speaking refugee women, aged 40-79 (Massachusetts, USA)	Phone and face-to face contact with navigator, plus navigator-led educational group sessions	Health education; schedule appointments, arrange transportation, resolve insurance issues and accompaniment to appointment (whenever necessary)	1 bilingual, Serbo-Croat migrant woman navigator, who was college-educated	Unknown	N/A	Uptake of mammography screening increased from 44% to 67% Level of participants' educational attainment influenced health behaviour changes	Y (Confidence interval not reported, p<0.001) Y (Confidence interval not reported, p0.043)	Not reported

Percac-Lima et al. (2013a)	Retrospective evaluation	188 Somali, Arabic and Serbo-Croatian-speaking refugee women, aged 40 - 74 (Massachusetts, USA)	Mailed educational materials, followed by patient navigator engagement	Health education; schedule appointments, arrange transportation, resolve insurance issues and accompaniment to appointment (whenever necessary)	3 Bicultural, bilingual women navigators, with minimum high school education	Unknown	N/A	Mammography uptake amongst refugee women increased from 64.1% (in year prior to intervention) to 81.2% (after 3 years of the intervention)	N/A	Not reported

Percac-Lima et al. (2013b)	Retrospective evaluation	533 Latina women with abnormal Pap screening result (Massachusetts, USA)	Normal cervical cancer treatment **vs.** Cervical cancer treatment with navigation by patient navigator	Health education on cervical cancer, assistance with transportation, assistance with childcare, appointment scheduling & health insurance advice	1 Latina, bilingual migrant woman navigator	Unknown	N/A	Fewer missed colposcopy appointments over time (from 19.8% to 15.7%) for intervention group Increased 'no-shows' for colposcopy appointments (18.6% to 20.6%) in control group Decreased time to colposcopy follow-up in intervention group, compared to control group Decreased severity of cervical abnormalities over time in intervention group, compared to control group	Y (Confidence interval not reported, p=0.024) N (Confidence interval not reported, p=0.454) Y (Confidence interval not reported, p=0.01) Y (Confidence interval not reported, p<0.001)	Not reported

Ramirez et al. (2013)	Quasi-experimental design	425 Latinas with breast screen abnormalities, aged 18+ (USA)	Usual treatment **vs.** Usual treatment with navigation by patient navigators	Arranging transportation & general assistance with barriers	6 bilingual, Latina women navigators, aged 25 - 47 and educated to at least high school level	Unknown	N/A	Shorter time to diagnosis in intervention group (32.5 days) compared to control group (44.6 days) Timely diagnosis occurred more frequently with 30 and 60 day periods in intervention group, compared to control group	Y (Confidence interval not reported, p=0.007) Y (Confidence interval not reported, p<0.04)	11.5% (55/480)

Reavy et al. (2012)	Qualitative (with retrospective chart review component)	7 clinic health advisors working in prenatal and perinatal care for refugee women and their families (Idaho, USA)	Patient group appointments for both prenatal and paediatric baby care, plus navigation by clinic health advisors	Health education, organising transportation (where necessary)	7 bilingual women navigators, many of whom are refugees	Unknown	Ecological Model; Cultural Safety	Navigation by clinic health advisors can help increase the effectiveness of communication between clients and providers Decrease in missed prenatal and paediatric appointments from 25% to 2.5%	N/A N/A	N/A

Shokar et al. (2016)	Randomised controlled trial	784 predominantly Latina migrant women aged 50-75, without health insurance and due for colorectal cancer screening (Texas, USA)	Standard screening care **vs.** Health education via promotora, plus home testing kit & navigation **vs.** Health education via video novela format, plus home testing kit & navigation **vs.** Health education via video with promotora-delivered interactive elements, plus home testing kit & navigation	Reminder telephone calls and letter, scheduling appointments, appointment reminders, organising transportation, finding health coverage (insurance) and primary care physicians, and facilitating cancer treatment where necessary	5 bilingual promotas	Unkown	Health Belief Model; Social Cognitive Theory	Colorectal cancer screening uptake in the three intervention groups was 80.5% compared to 17% in control group Little difference in screening uptake across three intervention groups: 89.7% in promotora group, 85.1% in video group and 88.9% in combined video and promotora group Being aged <65, with higher educational attainment status, with awareness of screening and having had a doctor recommending colorectal screening were factors influencing health behaviour change in intervention group	Y (Confidence interval not reported, p<0.001) N (Confidence interval not reported, p=0.246 – 0.825) Y (Not reported)	0.08% (40/467)

Taylor et al. (2002)	Randomised controlled trial	402 Chinese women (Seattle, USA; Vancouver, Canada)	Usual treatment **vs.** education-entertainment video, motivational pamphlet, educational brochure and fact sheet during home visits; navigation from outreach workers **vs.** above materials sent in the post	Referrals, scheduling appointments, translation, arranging transportation (as necessary)	4 bicultural, trilingual Chinese women navigators	Unknown	N/A	Women receiving navigation intervention reported higher levels of Pap screening (39%), compared to those receiving materials via post (25%) and those receiving usual treatment (15%)	Y (Confidence interval not reported, p<0.001); Y (Confidence interval not reported, p=0.03); Y (Confidence interval not reported, p=0.02)	17% (80/480)

Torres et al. (2014)	Qualitative (case study)	16 multicultural health brokers & 7 health professionals, working in perinatal care for refugee and recently-arrived women (Alberta, Canada)	Social, informational and logistical support, by multicultural health brokers	Health education (on chronic disease), accompaniment to appointments, accompaniment during labour and birth, home visits to pregnant women and new mothers, family intervention for child protection, community development, organising transportation, helping women to fill in forms related to finance, education & employment	16 navigators of similar culture to study participants	Unknown	N/A	Navigational work carried out by multicultural health brokers (as described) Positive perceptions of multicultural health brokers by health professionals	N/A N/A	N/A

Tran et al. (2014)	Pre-post study	32 Hispanic women, aged 18+ (North Carolina, USA)	Support from promotoras/ lay health educators	Emotional support, informational support	48 Latina women navigators	Unknown	N/A	8 point decrease in depressive symptoms 4 point decrease in perceived stress 6 point increase in perceived social support	Y (Confidence interval not reported, p<0.01) Y (Confidence interval not reported, p<0.01) Y (Confidence interval not reported, p<0.01)	45%

Wagner (2017)	Retrospective chart review (with qualitative component)	50 pregnant refugee women (New York, USA)	Standard perinatal care with 6-8 weeks of navigation from community health worker/mentor **vs.** Extended perinatal follow-up care with 2 years of navigation from community health worker/mentor	Home visits, maternity education, assistance with transportation, obtaining supplies for baby, connecting to community resources	English-speaking navigators	Prenatal period until up to 2 years post-natally (frequency unknowm)	Ecological Systems Theory	No differences in perinatal outcomes (uptake of prenatal visits, duration of breastfeeding) between groups No differences in uptake of child health examinations and child vaccination status Favourable perceptions of service by clients	N (Confidence interval not reported, p>0.05) N (Confidence interval not reported, p>0.22) N/A	N/A

Wang et al. (2010)	Quasi-experimental design	134 Chinese low income, uninsured, recently-arrived women aged 18+, who had not had Pap screening within the previous 12 months (New York, USA)	Education sessions on general health & written materials on general health and cancer screening **vs.** Educational sessions on cervical cancer, navigation from community health educators	Health education, informational support, scheduling appointments, arranging transportation, assisting with paperwork (when necessary)	Chinese navigators	12 months (frequency unknown)	Health Belief Model	Screening rates across 12-month period were higher in intervention group (70%) than the control group (11.1%) Participants in intervention group were more likely to identify cervical cancer risk factors and symptoms, compared to control group	Y (Confidence interval not reported, $p<0.001$) Y (Confidence interval not reported, $p<0.01$)	Not reported

Warner et al. (2019)	Pre-post study	265 predominantly Latina women service workers or manual labourers aged 18+ (Utah, USA)	Educational session delivered by telephone & navigation assistance from promotoras	Health education, general assistance with barriers (including scheduling appointments)	Latina/o navigators	Unknown	N/A	Knowledge of age to undertake cancer screening and knowledge of frequency of screening increased following the intervention Adherence to breast and cervical cancer screenings reached 68.5% and 79.9% following intervention Adherence to FIT testing for colorectal cancer increased from 13.8% to 56.9% following intervention	Y (Confidence interval not reported, p=0.001) N (Confidence intervals not reported, p=0.47; p=0.28) Y (Confidence interval not reported, p<0.001)	16.7% (53/318)

Wasserman et al. (2006	Ethnosurvey (with qualitative photo-narrative element)	223 recently-arrived Hispanic migrant women, aged 15 to 44 with at least one USA-born child (North Carolina, USA)	Linkage to screening by bridge persons	N/A	N/A	Unknown	N/A	Advocacy organisations, bilingual Latino/as, bilingual non-Latino/as, promotora, medical professionals, non-bilingual Latino/a friend or relatives, sisters (or sisters in law) provided informational/brokerage support, moral, material, and advisory support as bridge persons. Bridge persons known to women via advocacy organisations increased probability of recent Pap screening by 10.4 percentage points Promotoras increased probability of recent Pap screening by 12.9 percentage points, but not many women knew one	N/A Y (Not reported) Y (Not reported)	N/A

Appendix A Table 6: Summary of role dimensions carried out by navigators across the included literature

Author (year)	Provide health education	Accompany clients	Provide/ arrange transport	Help clients to complete health insurance forms / advise on applying for health insurance	Advice on immigration and other social services	Schedule appoint-ments, referrals, follow-up calls and reminders	Provide/ arrange translation	Provide information	Provide emotional support	Provide treatment support	Link to social / community resources	Arrange childcare	Provide baby/ cultural supplies	Develop health provider's cultural understanding	General assistance with barriers (according to client's needs)
Allen et al. (2014)	✓			✓		✓									
Ell et al. (2009)	✓					✓									
Fang et al. (2007)	✓					✓	✓	✓							

Fang et al. (2017)	✓		✓	✓		✓	✓	✓							
Fernández et al. (2009)	✓														✓
Han et al. (2009)	✓		✓			✓	✓	✓							
Han et al. (2017)	✓					✓									✓
Lam et al. (2003)	✓					✓									
Lo et al. (2010)	✓		✓	✓		✓	✓		✓						

Lutenbach-er et al. (2018)	✓					✓								
Maxwell et al. (2010)	✓	✓	✓	✓		✓	✓	✓	✓					
McCarthy & Haith-Cooper (2013)		✓									✓			
McClung et al. (2015)	✓		✓	✓		✓	✓		✓	✓				
Nguyen et al. (2009)	✓					✓								

Nguyen et al. (2010)		✓		✓	✓	✓	✓		✓		✓				
Parra-Medina et al. (2014)	✓					✓		✓							
Percac-Lima et al. (2012)	✓	✓	✓			✓									
Percac-Lima et al. (2013a)	✓	✓	✓			✓									
Percac-Lima et al. (2013b)	✓		✓	✓		✓						✓			

Ramirez et al. (2013)			✓											✓
Reavy et al. (2012)	✓		✓										✓	
Shokar et al. (2016)	✓		✓	✓		✓								

Taylor et al. (2002)			✓			✓	✓							
Torres et al. (2014)	✓	✓	✓	✓									✓	✓	
Tran et al. (2014)								✓	✓						
Wagner (2017)	✓	✓	✓								✓		✓		

Wang et al. (2010)	✓		✓	✓		✓		✓						
Warner et al. (2019)	✓													✓
Wasserman et al. (2006)								✓	✓					

Appendix B

Example of participant information sheet (Service users)

Participant Information Sheet - W

The University Of Sheffield.

Improving access to healthcare for migrant women

An exploration of the functioning and impacts of health navigation on maternal and women's health

My name is Christy, and I am a researcher who is interested in migrant women's experiences of healthcare. You may have recently seen me volunteering and talking to different people.

I am a volunteer at Haamla Service, but I am also here to do some research for a university project. I am inviting you to take part in my research. This information sheet provides you with details of the research. It explains why I am doing this, what it involves and how you can take part.

Please take at least one day to read and think about this information carefully and - if you have any questions - contact me using the contact details below.

Why are we doing this research?

We want to understand how migrant women connect to maternity care services using a health and social care worker. We want to learn about the experiences of women new to the UK, as well as those of the workers and health professionals who are involved in their care.

This research will take place from April 2019 to December 2019, and will be for the purpose of completing a PhD degree.

Why have I been asked to take part?

We have asked you to take part because you are using a service where you have a personal health and social care worker. We would like to know what you think of this service.

Participant Information Sheet - W

The University Of Sheffield.

Do I need to take part?

No - you do not have to take part in this research, and there will be no negative consequences if you choose not to. However, if you are interested, I will give you a copy of

this information sheet to keep and I will ask you for your phone number or email address. After a few days, I will contact you to ask if you have decided whether you want to take part. Afterwards, you will need to sign a consent form, and you will also be given a copy of this to keep.

You can withdraw from this research at any time until March 2020, without needing to give a reason.

What will happen, if I choose to take part?

I will interview you at a time and location of your choice, and the interview would last up to 60 minutes.

During the interview, I will ask you some questions and invite you to speak freely about your views and experiences of the service that you are using.

Will I be recorded, and how will this be used?

The interview will be audio recorded using an encrypted dictaphone, with your permission. The recording will be transcribed onto a computer as quickly as possible, and will be deleted after analysis. The interview transcript will be used only for analysis. No other use will be made of it without your written permission, and no one outside of the research project team will be allowed access to the recording.

How might I benefit?

At the time of the interview, you will be offered a £5 voucher for you or your baby as a token of our appreciation. We will also pay for your travel ticket to the location of the interview. It is hoped that the results of this research will help to find ways of improving access to healthcare services for migrant women living in the UK. These results will be shared with you.

What are the possible risks in taking part?

We do not anticipate that taking part in this research will involve any risks of danger, or physical discomfort. We acknowledge that the topic of the interview will be sensitive in nature. You are welcome to stop the interview at any time. You do not have to answer any questions that you do not want to answer.

What about confidentiality and anonymity?

All participants have a right to confidentiality and anonymity, and your personal opinions will **not** be shared with the organisation managing the service, and will **not** affect your access to the service. I will only share information that you provide if I or someone else believes that you – or someone else – in danger. If I do need to share information, it will be with the organisation providing the service, so that they can make sure you are safe.

The audio recording of the interview will be securely stored after completion of the interview. All of the information that you give during the interview will be anonymised. You will not be identifiable during the analysis of data, and you will not be identifiable in any report, publication or public presentation of the results of this research. You have the right to withdraw your data from the research project until October 2020.

No information on your children or your family will be used in this research.

How will my data be used?

We are required to follow the data protection laws. For this research, processing the data you provide to us is "necessary for the performance of a task carried out in the public interest" [Article 6(1)(e)] and "necessary for scientific or historical research purposes" [Article 9(2)].

The anonymised data collected from the interviews will be analysed by myself (Christy Adeola Braham), and only members of the research team will be able to access it. The anonymised data will then be presented in publications in years 2020 and 2021 - these will include a PhD thesis, academic presentations and articles in academic journals; if you want to have access to these, please contact me. Your data and your personal contact details (phone number/email address) will be deleted after these publications have been completed.

Due to the nature of this research it is possible that other researchers may find the data collected to be useful in answering future research questions. We will ask for your explicit consent for your anonymised data to be shared in this way.

Who is responsible for the research?

My supervisor, **Dr Liz Such** (Research Fellow at University of Sheffield), is responsible for the research. This research is also supported by Professor Sarah Salway (Professor of Public Health at University of Sheffield), and is funded by the University of Sheffield School of Medicine and Dentistry.

Participant Information Sheet - W

Who is the data controller?

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. The Dean of the University's School of Health and Related Research, **Professor John Brazier,** can be contacted using the details below.

Who has provided ethical approval?

Ethical approval has been granted by the School of Health and Related Research Ethics Committee [Application 025447], and the Research Ethics Committee at the National Health Service (NHS) [IRAS ID 261570].

What do I do if I have any problems?

If you have any issues or complaints relating to this research please feel free to use the contact details given below.

However, if you feel that the response you have received is unsatisfactory, please contact **Professor John Brazier** (Dean of School of Health and Related Research, University of Sheffield) at j.e.brazier@sheffield.ac.uk.

What if I become upset?

During the interview, you do not have to answer any questions that you do not want to, and you can also stop the interview at any time. If you would like it, I will also offer you some information on organisations who can offer you further support.

Contact details

Please forward any questions about this research project to **Ms Christy Adeola Braham** at the School of Health and Related Research, Regent Court, University of Sheffield. You can contact her by email (caabraham1@sheffield.ac.uk) or by phone (+447916142354). Alternatively, you can also contact **Dr Liz Such** by email (e.such@sheffield.ac.uk).

Thank you for your interest in our research.

Example of participant information sheet (Health navigators)

Participant Information Sheet - N

Improving access to healthcare for migrant women

An exploration of the functioning and impacts of health navigation on maternal and women's health

My name is Christy, and I am a researcher who is interested in migrant women's experiences of healthcare. I am inviting you to take part in my research. This information sheet provides you with details of the research. It explains why we are doing this, what it involves and how you can take part.

Please take at least one day to read this information sheet carefully and - if you have any questions or queries - do not hesitate to contact me using the contact details below.

Why is this research being done?

This research aims to understand how migrant women connect to maternity care services using a health and social care worker. These workers offer support to women and try to make it easier for them to access healthcare. This research focuses on the experiences and perceptions of migrant women, the health and social care workers who assist them, and health professionals who are also involved in their care (such as family doctors [GPs] and midwives).

This research project will take place from April 2019 to December 2019, and will be for the purpose of completing a PhD degree.

Why have I been asked to take part?

We have asked you to take part because you are a health and social care worker who delivers this service to migrant women. We would like to know what you think of this service, and the role you have in it.

Do I need to take part?

No - you do not have to take part in this research, and there will be no negative consequences if you choose not to. However, if you are interested, I will give you a copy of this information sheet to keep and I will ask you for your phone number or email address. After a few days, I will contact you to ask if you have decided whether you want to take part. Afterwards, you will need to sign a consent form, and you will also be given a copy of this to keep.

Participant Information Sheet - N

You can withdraw from this research at any time until March 2020, without needing to give a reason. If you wish to withdraw, please contact me, **Christy Adeola Braham,** using the details on page 4.

What would be involved, if I choose to take part?

I will interview you at a time and location of your choice, and the interview would last up to 60 minutes. During the interview, I will ask you some questions and invite you to speak freely about your views and experiences of the service that you are using.

Will I be recorded, and how will this be used?

The interview will be audio recorded using an encrypted dictaphone, with your permission. The audio recording will be used only for analysis and will be deleted after analysis has been completed. No other use will be made of it without your written permission, and no one outside the research project will be allowed access to the original recordings.

How might I benefit?

While there will be no immediate benefit in taking part, it is hoped that the results of this research will help service designers and policy-makers to find ways of improving access to healthcare services for migrant women living in the UK. These results will be shared with you.

What are the possible risks in taking part?

We do not anticipate that taking part in this research will involve any risks of danger, or physical or psychological discomfort. We will make every effort to reassure participants of their right to confidentiality and anonymity.

What about confidentiality?

All participants have a right to confidentiality and anonymity, and your personal opinions will **not** be shared with the organisation managing the service. I will only share information that you provide with someone outside of the research project team if I or someone else believes that you – or someone else – is in danger.

The audio recording of the interview will be securely stored after completion of the interview. All of the information that you give during the interview will be anonymised. You will not be identifiable during the analysis of data, and you will not be identifiable in any report,

publication or public presentation of the results of this research. You have the right to withdraw your data from the research project until October 2020.

How will my data be used?

We are required to follow the data protection laws. For this research, processing the data you provide to us is "necessary for the performance of a task carried out in the public interest" [Article 6(1)(e)] and "necessary for scientific or historical research purposes" [Article 9(2)].

The anonymised data collected from the interviews will be analysed by myself (Christy Adeola Braham), and only members of the research team will be able to access it. The anonymised data will then be presented in publications in years 2020 and 2021 - these will include a doctoral thesis, academic presentations and articles in academic journals; if you wish to have access to these, please contact me. Your personal contact details (phone number/email address) will be deleted after these publications have been presented. Your data and your personal contact details (phone number/email address) will be deleted after these publications have been completed.

Due to the nature of this research it is possible that other researchers may find the data collected to be useful in answering future research questions. We will ask for your explicit consent for your anonymised data to be shared in this way.

Who is responsible for the project?

My supervisor, **Dr Liz Such** (Research Fellow at University of Sheffield), is responsible for the research. This research is also supported by Professor Sarah Salway (Professor of Public Health at University of Sheffield), and is funded by the University of Sheffield School of Medicine and Dentistry.

Who is the data controller?

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. The Dean of the University's School for Health and Related Research, **Professor John Brazier,** can be contacted using the details below.

Who has provided ethical clearance?

Ethical approval has been granted by the Research Ethics Committee at the School of Health and Related Research, University of Sheffield and the Health Research Authority of the National Health Service (NHS) [IRAS ID 261570].

Participant Information Sheet - N

What do I do if I have any problems?

During the interview, you do not have to answer any questions that you do not want to, and you can also stop the interview at any time. If you would like it, I will also offer you some information on organisations who can offer you further support.

If you have any issues or complaints relating to this research please feel free to use the contact details given below. However, if you feel that the response you have received is unsatisfactory, please contact **Professor John Brazier** (Dean of School of Health and Related Research, University of Sheffield) at j.e.brazier@sheffield.ac.uk.

If your complaint relates to how your personal data has been handled, you can contact Anne Cutler, The University of Sheffield Data Protection Officer dataprotection@sheffield.ac.uk. Further information about how to raise a complaint can be found in the University's Privacy Notice: https://www.sheffield.ac.uk/govern/data-protection/privacy/general . If you feel your complaint has not been handled to your satisfaction, you can contact the Information Commissioner's Office.

Contact details

Please forward any questions about this research project to **Ms Christy Adeola Braham** at the School of Health and Related Research, Regent Court, University of Sheffield. You can contact her by email (caabraham1@sheffield.ac.uk) or by phone (+447916142354). Alternatively, you can also contact Dr Liz Such by email (e.such@sheffield.ac.uk).

Thank you for your interest in our research.

Example of interview guide

Interview guide for semi-structured interviews: Exploring the functioning and impacts of health navigation for migrant women from the client's perspective

Research questions

How does health navigation improve access to healthcare care for migrant women in, when implemented as an intervention?

[a] How do navigation interventions operate in practice when used for migrant women who require healthcare (including maternity care), and what theoretical mechanisms underpin their operation?

[b] How are navigation interventions perceived and experienced in practice?

[c] What is the role of shared characteristics and experiences between navigators and migrant women, in terms of the functioning of navigation?

Opening remarks

Interviewer: I'd like to thank you once again for being willing to participate in my research project by agreeing to be interviewed. As I have previously explained, this part of my project seeks to understand the experiences of migrant women using services like Project MAMA/ Haamla. I want to understand migrant women's views of the service, and learn more about the relationship between migrant women and the doulas/ mother companions/ maternity support workers [as appropriate] who provide the service to them.

First of all, may I check how long you have to spend with me today?

Are you comfortable? Do you need any refreshments?

During this interview, I will ask you about how you use the service, your views and experiences of the service and your relationship with your doula/ mother companion/ social prescriber. Is that okay?

You already completed a consent form which said that I have your permission to audio record our conversation with a dictaphone. Are you still okay with me recording our conversation today? *Yes/No*

If Yes: OK, thank you. Please let me know if at any point you want me to turn off the recorder or to remove something that you have said from the audio recording and from my written notes.

If No: Thank you for telling me. I will just write down some notes of our conversation.

I would like to remind you that what you say will be kept confidential and you will remain anonymous - except in the rare scenario that something you share with me reveals that you or someone else are in danger. You also have a right to end the interview at any time, without giving me a reason.

Before we begin the interview, do you have any questions? *[Discuss questions]*

If any questions *(or other questions)* arise at any point please feel free to ask them at any time during this interview.

[Start recording]

Introductory questions

Interviewer: To get us started, I would like to learn a little about your background, if that is okay with you. Could you tell me a little about yourself? How did you arrive in Bristol / Leeds?

Interviewer: Are you new to Bristol / Leeds? *Yes/No* [probe: how long have they been in town? Did they live somewhere else in the UK beforehand? How long for?]

Transition questions

Interviewer: You've already told me a little about your history in the UK. How are you finding your new life in this country?

Interviewer: It would be really useful to hear about your experiences with healthcare in the UK. Do you have a GP / family doctor? *Yes/No*

If Yes: When was the last time you went to visit your GP? Why did you make an appointment

to visit them? What happened? Was the GP helpful to you? [probe: how did you feel? How was the experience for you?]

If No: Have you visited a hospital in the UK? [probe: when? Why? What happened? How was the experience?]

Interviewer: How has your experience of healthcare in the UK compared to healthcare in your home country?

Interviewer: You have been using the service provided by Project MAMA/ Haamla, here in Bristol / Leeds. Why did you start using this service? [probe: Were/are there specific health needs? Did you need help with your pregnancy? Did you need information? Did you need support related to your cultural/religious needs?]

Interviewer: Were you using any other (NHS or external) healthcare service before you came to Project MAMA/ Haamla? *Yes/No*

If Yes: Which? Why did you stop using it?

Experiences and perceptions of navigation

Interviewer: Could you tell me about your journey of using Project MAMA/ Haamla - starting from when you first heard about it. [probe: Were you referred by someone, or did you refer yourself? What were you told about Project MAMA/ Haamla before you started using the service?]

Interviewer: How did you feel about Project MAMA/ Haamla before you started using the service? [probe: What were you expecting? Did the service meet your expectations]

Interviewer: What happened the first time you met your doula / mother companion / maternity support worker? [probe: how did you feel about her/them? First impressions?]

Interviewer: What does your doula / mother companion / maternity support worker do for you? [probe: how do you feel about this? Is it sufficient / appropriate?]

Interviewer: How would you describe the relationship between doula / mother companion / maternity support worker and your midwife/doctor? [probe: Collaborative? Challenging? Professional? Friendly?]

Interviewer: Has anything changed for you since you started using Project MAMA/ Haamla ? *Yes/No [probe: why? Why not?]*

Interviewer: What effect has gaining a doula / mother companion had on you? [probe: Has it affected your health? How has it affected you mentally/socially - change in confidence, social situation? Is it any easier for you to access NHS healthcare services? Why/ why not?]

Interviewer: Have you had any problems/difficulties with your doula / mother companion, or with Project MAMA/ Haamla as an organisation? *Yes/No*

If Yes: Which specific problems? Have you informed the organisation of these problems? Has the organisation addressed these problems?

Interviewer: How could the doula / mother companion / maternity support worker service be improved, in your opinion?

Interviewer: Would you recommend this service? *Yes/No*

If Yes: Why? Who would you recommend it to?
If No: Why not?

Interviewer: How would you describe this service to another woman / someone else who is thinking about using the service?

Exploring shared identity and experiences

Interviewer: How would you describe your doula / mother companion / maternity support worker? [probe: personality traits, characteristics, identity. Does she make you feel comfortable - why/why not?]

Interviewer: Tell me about your relationship with your doula / mother companion /maternity support worker. How would you describe it? [probe: professional; provider - client-based? Friendly? Sister-ly? More complex - a combination of these? Do you trust her/them?]

Interviewer: Is your doula / mother companion / maternity support worker:

- from the same country as you?
- of the same race/ethnic group as you?
- a woman [in maternity care context - has she experienced childbirth/motherhood herself?]

- able to speak your preferred language?
- also a migrant?

(*Yes/No* for all)

Interviewer: Do you and your doula / mother companion / maternity support worker have anything in common? *Yes/No*

If Yes: What? Has it affected (improved/been detrimental to) your experience of the service? Has it affected your ability to trust her/ the NHS (more)?

Interviewer: Do you think that it's important to have something in common with your doula / mother companion / maternity support worker? *Yes/No [probe: why / why not? What is important to have in common with each other, and what isn't? If ethnicity/language/ migration/motherhood not previously mentioned by respondent, then probe]*

Interviewer: How would you feel if you were given a different doula / mother companion / maternity support worker? [probe: what characteristics would a new one have to have? Who would be the ideal person for you?]

Closing remarks

Interviewer: Thank you for all the information and perspectives you have kindly shared with me so far. Before we finish this interview, I would just like to record a few pieces of demographic information, so I can see if I've captured a range of experiences. What is your age? Are you married, single or in a domestic partnership? What is your educational background - did you complete high/secondary school? Do you have any children?

Interviewer: Is there anything else you would like to say about your doula / mother companion / maternity support worker, or about Project MAMA/ Haamla? *Yes/No*

[End recording]

Interviewer: Again, thank you very much for talking to me today. As I told you earlier, information you have shared with me during this interview will remain anonymous when I review all of my data for this project.

I will be sharing the results of my project with all other women, doulas / mother companions and organisers involved with Project MAMA / Haamla, at a short, open meeting in July / December. It will also be an opportunity for everyone to tell me what they think of the results and for everyone to have their voice heard. Would you be interested in joining us? *Yes/No*

If Yes - I will send you information about this in the coming weeks / months

Example of transcribed interview

HP1 transcript

I: So just to get us started, I'd love to learn a bit about your background. So you're not from Bristol originally, are you?

H: No, I'm from London. With my relationship to race and migration…I am British in some ways, but my father is a Jewish South African - grew up in South Africa and was part of the anti-Apartheid struggle. So my childhood was spent in Mozambique as part of the socialist movements in Southern Africa. I moved back to the UK when I was 10. Although my parents are both white, I guess I come from a cultural background of being quite aware of black liberation struggles…black people are being empowered political people - that was my childhood. Then I moved to central London, Holloway, and then away a bit. And then I was an immigrant pregnant person in Spain and Germany, as I had the experience of going to the midwife and doctors appointments as a foreign language speaker, and how dis-empowering that was. And then, I worked and studied in Hackney which was a very multicultural place, and not like Bristol - where you have this white professional class and minority ethnic service users. Hackney is deeply multicultural - our MP's a black woman, the headteacher's a black woman, the head off midwifery's a black woman…black women in Homerton Midwifery Service - they're not healthcare assistants. On a management team, you have Hackney represented, and in Bristol you don't. So, although I'm White British by paper, I have a slightly different trajectory maybe. So that's a bit about where I come from in terms of race and migration, I suppose.

I: Ok, and how long have you worked in Bristol?

H: Four months. And I'm freshly shocked! That's why I'm keen to talk about it and express it before it becomes normal…the first few shifts I was gobsmacked, and now I've almost got a bit used to it. When it happens in a hospital, you get used to all sorts of weird things.

I: Gosh. So you're quite new here, at this NHS Trust. So how long did you work at your previous Trust?

H: So I was working in Hackney as a qualified midwife for a year and a half, but I'd trained the previous three years before that, and was a healthcare assistant before that. So I've been in maternity services about 8 years, but only working as a qualified midwife for a year and a half of that.

I: Ok, cool, and now you're in Bristol and you've been here for several months as a midwife.

H: I'm a band 6 midwife, which is your basic bog-standard midwife. You're an independent, autonomous practitioner, so you're fairly respected in your field.

I: Do you work only in the hospital, or also in the community?

H: So at the moment I'm placed in Central Delivery Suite - the high-risk labour ward - but only because that's where I happen to be. So I could be rotating, I could get an email next week to say I'm working somewhere else.

I: So what about your interest in this particular area - migrant and asylum-seeking women. Did you have professional experience of this population before this?

H: Well, only because if you're working in Hackney or Tottenham then of course you do…so I guess, politically, I have a deep commitment to quality of healthcare. From my background - my father was also involved in healthcare stuff in Africa. I'm deeply committed to the NHS and what it can offer people. The idea of offering really top-class quality care to everyone is so exciting, and, I guess, the people who need it most are those who have lower health outcomes, who are vulnerable, who don't have great housing. If someone's a super healthy, middle class person who's had a good diet all their life, it's still important they have good healthcare - of course it is - but it's such a deep privilege. I'm deeply moved by the FGM struggles, and the struggles of women in this country to break the chain…this idea of women empowering themselves in their communities to not do that to their daughters. It's just an incredible, really exciting movement around that. But also - and Project MAMA does this very well - the idea of healing trauma. If someone is likely to have experienced violence - this is maybe more to do with things like trafficking survivors or women who've experienced rape and sexual abuse or women who've had hard laboured work - if their bodies have not been respected and touched consensually and treated as holy beings, to be the midwife that acts to that woman like her body is a beautiful holy thing and treats it with respect, and through woman-to-woman respectful care you can give something back, or re-empower something that's been taken, to bring into my room or practise the idea that 'in this room you're powerful and respected and holy'…that's a great work, and can be a real privilege. In Tottenham, Edmonton…we had victims sexual trafficking who got pregnant…30,35 weeks pregnant and unable to conceal it anymore. And it can feel like a great privilege to say 'In this room, that's not how we do things'. So some, specific client groups do rock my soul a bit. And I guess I did come into midwifery from a political perspective, rather than healthcare…the idea of women giving healthcare to women, women's autonomy. I am also passionate about pro-choice, reproductive justice…the right to terminate a pregnancy if you don't want them, but also the conditions you face if you do want them. Because if you're in a domestic violence or homeless situation, then you don't have the option to bring up the children in the way that you want to. Or some black communities in the US who are scared of violence if you have a son.

I: So as a midwife you've been indirectly engaging with Project MAMA. Could you, I guess, describe what sort of service you think they provide?

H: That's a really interesting question, I think (laughs). A really interesting question, because in some ways, it's hard to know or put your finger on it concretely, and ask 'what do they do?', because they didn't actually offer healthcare advice. But I think the befriending thing…when I see them (women) come into the hospital…just to have someone with them. So one of the births I attended with [redacted] was…this woman's whole family were back in East Africa I think - including her previous children, which is heartbreaking. She was so…really gripping onto [redacted] in her labour and saying "are you my mother?". And in this moment, [redacted] was like "Yeah, yeah, in this moment, I am your mother!", and it was very funny, humorous, but so beautiful, as she was holding her hand. So it's having someone on your side. I think from what I've seen, it's navigating. The hospital is an intimidating environment, and it's meant to be. People try and make it as nice as possible, but it's definitely 'our place', not the women's place - it's our department - we know how all the buttons work, we have the swipe access for the door, and we're gonna out you in the clothes that we want to put you in. So to have someone with them who just knows - 'let's sit here' 'these are the toilets you can use, these are the ones you can't' - someone who just knows the culture of how it would go. That's not just about being British, but also being familiar with the hospital system, because people can be born and bred in England all their life and still be intimidated by it. I mean, everyone feels intimidated by hospitals, health professionals…that's kind of the point - power, control and hierarchy. I think for the woman, I think it's having someone who's definitely on their side, because even for us healthcare professionals - we're half on the woman's side. For someone like me - because of where I've come from, I'm clearly more on the woman's side. We also have a responsibility and I have to follow certain guidelines and protocols and whatever, I do also have to do that or else I get in trouble. I do have a foot in both camps, if you like. Emotionally, I'm on the side of the woman, but if I get told I have to do something - and I think I might get disciplined if I don't - I'm gonna persuade her to do it. The Project MAMA are not that, and that's what I think is really good about them compared to others. Anyone you meet in a hospital is gonna have a foot in both camps, but those Project MAMA volunteers are on the side of the woman- only and totally. Their allegiance is clear. In a complicated system like maternity healthcare, it's just vital to be a guide who's clearly on your side, who doesn't have any sort of agenda. That emotional support in labour - possibly they might not have family here or the family might be looking after the other kids. There's no 'spare people'. You haven't got a sister, and an aunt, and a mum…you might have one sister, but she's busy doing some other thing or take care of her own kids. The friend, the advocate, the guide through the service, someone being on your side, the continuity…and checking for understanding. They make its healthcare professionals slow down, and do checking-in. But then the other thing is the fact that it makes healthcare professionals just watch their language and watch themselves, and not be so patronising. When a black woman or ethnic minority woman who has poor English - so not really expressing themselves properly - they don't get the same standard of care. They do not. And it's just true. It's appalling, because I'm so proud of the health service - that no matter who you are you can walk in. We follow NICE guidelines for everybody, so that's not what we're talking about, really. It's that the care is so sub-standard when it comes to talking about a subjective thing…their talking about their own pain is disregarded. This is midwifery - it only works with good communication. Women have to feel safe and supported to give birth and nurture their babies - that's just how it works. I think Project MAMA keeps a check on that, and keeps that in balance a bit. If a Project MAMA person was there and they buzz, and say 'I think she still needs a little help breastfeeding' - I just feel that they [midwives] would spend more time with her, because they feel watched. It just acts as a surveillance thing.

I: Gosh. We can come back to this later, but something just came to mind - what would you think if there was a Project MAMA person who was black or was visibly radicalised?

H: I think a woman with an accent and a hijab would have less.

I: So if the Project MAMA person came from the same community as the patient…

H: …so there are 2 of them? I don't think it would work as effectively. The other things I'm talking about - the woman feeling supported, having someone at her side, helping her with the baby afterwards, playing the role of the family…that would probably work better, presumably. But this very specific thing of keeping healthcare professionals in check - I think they would fob them off. It's complex layers. I think a dark-skinned woman with a good accent, and good body language would probably have the same effect. I think it's complex, the signals we're receiving about who we can go 'oh there's the buzzer, I'll be back in a minute', and who we go 'Ok, so this is your plan of care, I've done the first check so I'm now going to enter it into the computer, and within the next 20 minutes, I'll be back. If anything occurs in the meantime, please press the buzzer'. Which is the same thing, but much more professional. The signals we're dealing with are complex, with skin colour being just one of many factors. If the midwives weren't so racist and classist, then there wouldn't be need for Project MAMA. In a deeply, truly multicultural and respectful midwifery service, you wouldn't need it.

I: That's just so interesting! And I'm glad you raised this. How many patients have you had who were Project MAMA clients?

H: Just the one birth. But there were a couple of other very brief encounters - checking people in and stuff like that.

I: Ok! So thinking about that patient….to your knowledge, was that lady using NHS services before Project MAMA?

H: Because the delivery suite is such a factory line, I only meet them when they come - so I didn't meet her before the labour.

I: Ok, that's fine. So could you tell me a bit about your journey of becoming connected to Project MAMA?

H: So I knew about it because I'm politically active. But otherwise - when a woman comes in, she has people with her in the delivery room and you just ask who they are. Maybe it's their sister, maybe it's their lesbian partner, maybe it's the husband. I knew [redacted] before, but if I hadn't met her before, it would've been the first time meeting her - in that delivery suite.

I: Ok, so you knew about Project MAMA before, via [redacted]. So was that the first time you heard about it -through her?

H: No, just the political scene. I knew birth companion people in London. It's just because I'm keyed into networks of political midwifery people, so it'd come up on my facebook. We just know what's going on.

I: So obviously Project MAMA is still quite new. So what did you first think when you saw it?

H: I thought 'yeah, good, good on them!'. Birth Companions has been going on for a while - it started off supporting women in prison and then expanded to women who need it, so it can be recent immigrants, drug addicts or sex workers. So that's been going on for a while, I knew about it and think it's great.

I: What were you told about Project MAMA?

H: Not much. I wasn't that knowledgeable on all their aims and objectives, but I vaguely know there's some politically-minded women supporting other women who really, really need it. I guess, from my perspective, I see it not just through the caring, but the political empowerment that can come through that. If we can create our own grassroots peer-to-peer network, we'd all be stronger and those women will have better lives and will be happier mums, and will be more engaged in the community. I definitely don't want to come from a place of pity. I'm not sure how people within Project MAMA see it, but - for me - if we can make each other feel better and support each other, than those women are more likely to advocate for their own needs when they need it. When their kids go to primary school, they're more likely to campaign for the after school club they need, or they're more likely to say they don't want that new road going through their area, if they've had good midwifery care and been empowered in the community. I think peer-to-peer is interesting, because those same women might go on to become Project MAMA volunteers and mother companions themselves. The bonds that you make in those early months - they can go on and on. If there's a group of women who know each other and have babies around the same time, that can form a support group and that can serve them in good stead for the rest of their children's lives, really.

I: Absolutely. That's very true. So when [redacted] came to the delivery suite, did you have any expectations of what might happen in the room with a Project MAMA person there?

H: My expectation in the room was something like an emotional support. Slightly different in things like for antenatal appointments, I suppose, because people don't tend to come with anyone for those. For most people, they have someone there at the birth.

I: And in light of what you were expecting - how did it turn out?

H: Yeah, she (mother companion) very much kept to her boundaries, which was good. I think there can be fears around if a doula would challenge you - absolutely not. She was just very much there for the woman, and that's great. There was nice communication. I think it's good if there's a division of labour because there is a lot to do. I think their training is a good because she very clearly knew what was her bit, and what was my bit, and I get that impression with the Project MAMA volunteers in general. That's very clear - they're there as friends and advocates, and healthcare professionals are there for their bit. And they're not there to speak for the woman… they're just there to be there. That went well, and everyone kept to their own roles.

I: Which is important. What were your first impressions of the patient? Did you have any?

H: This particular woman..she was quite lively and funny, and there was a certain level of humour. It was her fourth baby, and she was quite a confident woman. She just kind of 'knew'.

I: What do you think Project MAMA does for the patients?

H: I'm unclear as to whether they do anything like help them interpret notes and spend a little time - maybe after the appointment - going 'did you get that?'.

I: What do you think [redacted] and other MCs provide that the NHS can't?

H: Well, I don't really see it that way - I think that they're different roles. I think it's important that it is - the most well-meaning NHS person would still work for the NHS, and follow those guidelines. The NHS is a massive institution, and I think it's really important that these things are more grassroots and based in the political climate of co-empowerment, and be peer-to-peer and self-organised to a certain extent. I think there's a very different culture that comes with that community organising model. It's just a different thing. I wouldn't even advocate for a Project MAMA in every town - every town has to make it itself as that's kind of the point of it. It has to start with the people that are there, the communities that are there, We're there to provide healthcare, and they're there to be there for the woman. I see it as a family type of thing, a political type of thing, and not as healthcare provision.

I: And do you feel that the inclusion of MCs was necessary for that patient?

H: Totally and utterly necessary. I mean, we do without it all the time, and it's awful. These awful things happen - even think of mortality rates. I honestly think that this is lifesaving. We started off talking about mortality rates for black and minority ethnic women, and I'm sure if you broke that down further…I'm sure that recent immigrant background, language, class background would definitely come into all of that. Those are the women who don't have a Project MAMA person with them, right? I think it's preventative, because it keeps us in check, because it slows things down, because it checks understanding, because it amplifies that voice and it's less likely for things to

get missed. I really think it's…unfortunately essential. If there was better training in the NHS, it probably wouldn't be so potentially lifesaving.

I: So what kind of training do you think the NHS would benefit from?

H: I think we need racial bias training in Bristol, because I really think we need to start with that kind of understanding. I honestly think they don't see it, that they're aware of how differently they treat different people. There's alway, this excuse of 'oh, she was difficult, or she was a handful'. 'They', 'that lot', 'people like that', 'those people'…in London, it wouldn't fly. People would just be like 'what?!'…but they say that here.

I: Indeed. And, obviously, you had described scenarios in which having an advocate would be beneficial - or even lifesaving - to these women in the hospital environment. What effect do you think MCs have had on patients?

H: For those women - massive effect. Just massive. Massive for their experience of labour, and bonding with their baby. Probably massive in terms of their experience of being in Britain, actually. If there's people like that who are willing to do that, then it must be an ok place. And it probably puts them in touch with a lot of things - I think Project MAMA probably do a lot of signposting and things, to community groups and tea mornings and the rest of it. I wouldn't think it would be too much to say that it's a life changing effect. You know, as someone who's been pregnant abroad - navigating systems in a foreign country is very, very difficult, and if those systems you're trying to navigate are your basic support structures as a pregnant woman or a mother, or your community structures or getting second-hand baby clothes and that sort of thing…imagine being a pregnant woman who might've experienced trauma. The idea that somebody's on your side can say 'there's this tea morning, and you go in, and there's tea on the side, and it's free'…it's so important, those type of things, to have someone explain that to you. Or that when you go into a hospital, you won't be seen straight away, but you'll be sitting somewhere and you just wait and they call your name…how would you know that if you weren't told? It's not obvious. I think having somebody to smooth that oath for you can be life changing.

I: Yeah. And I wonder if accessing the NHS becomes easier for these women after they've had an MC.

H: Maybe, possibly. You could imagine a dependency thing too, though, in that you're used to somebody doing it with you and you feel just as intimidated, if not more so. And at some point, they [MCs] have to say 'I'm not also going to come to your baby [inaudible]' 'I'm not also going to come to your one year old's birthday'. That's where the peer-to-peer thing really helps - you could imagine two women going together, like 'I'll go with you if you come with me'. I think that has to happen, and that's what I mean about a grassroots, community-organising model, is that ultimately - from a political perspective - that's got to be the aim. The same sort of model as grassroots unions and all those sorts of things…the idea that what you're doing is injecting a community with enough help. And you do get that, friends translating for each other. People do hat for each other.

I: And that's interesting. So how would you describe your relationship worth Project MAMA MC's?

H: It's a mix, but I think it often is in the labour room - it's an intimate space. We remain professional, and informal.

I: OK. And any difficulties with Project MAMA as an organisation?

H: No, no.

I: I know you only had a brief exposure to the work of Project MAMA via [redacted], but can you think of any ways that things we could improve?

H: No, not really. I suppose there could be a bit of clarity about what the role is. I expected it to be a bit like the Birth Companions in London, so I had a bit of a model to map it on. But maybe people don't. Maybe a bit of clarity- even a card to say 'this is what we do do, and this is what we don't do' ' Do expect us to support women in labour, don't expect us to help with medical interventions'.

I: I think that's be helpful, actually. Good idea. Would you recommend this service to migrant women in vulnerable situations?

H: I do. I just think the need is just overwhelming.

I: And who would you think would benefit the most?

H: I guess - women who don't have other people to support them. Women who are vulnerable and have been disempowered through something like trauma. Very recent immigrants, because everything is just so overwhelming. But also, with language - not that Project MAMA people translate - but those without language are the ones who aren't getting their voice heard in the room. It's clear why they're not getting their voice heard - as it's so difficult without language - but it's so tempting to cut corners and not fully talk to people, as it's just so much easier when they don't really speak your language…there's care being missed. But the befriending thing, for people who don't have that network….it'd be really lovely.

I: And if you came across a patient who you think might benefit, how would you describe the service?

H: I would say 'I want to tell you about this other project which is not to do with the NHS, it's a separate thing'. I would first of all say that it's a separate thing. I'd also say that it's a group of people who volunteer and they act as your friend or helper. What I'd say is 'what they would do, is they'd come to your appointments with you and be like your friend or your aunt. They don't do advice and they don't do healthcare, but would just come with you and be your friend, and I can give you their phone number'.

I: Ok! Great, so now onto the next section on shared identity and experience. How do you perceive the relationship between [redacted] and that patient in the delivery room?

H: Very friendly, but that's because [redacted] is so lovely! The patient was clinging to her head saying, 'you're my momma!'…that's how friendly it was. It was intimate. [redacted] spoke so respectfully to her, but also using that humour as well. I don't know if that's achieved by all the other volunteers, and not just [redacted].

I: If you'd seen this patient afterwards, do you think having an MC there would've improved your relationship with your patient?

H: I can imagine it also being detrimental. When it's birth, sometimes you want to form a direct relationship and when there's someone else there trying to also help ,it can interfere as well. Sometimes the midwife might want to also form that intimacy in certain situations. But it takes a skilled helper to know when to sit back. It's not boundaries, but crowding the field. Sometimes it's nice to just have a moment with the patient. I wouldn't want them there all the time - I want to be like 'I've got this, I'm being respectful, she's ok with me, we don't need someone here all the time'. I like home visits - because of the whole power thing, being in the woman's home. She's the host. I would want to follow the woman's lead for that, and wouldn't necessarily want an advocate there as well. I would want to be like ' No, I'm going to treat this woman's home with respect', and either accept the tea she's offering or not - but according to my relationship with her. I can imagine not always feeling the need for two professionals.

I: So, do you think it's important for an MC and a patient to have anything in common?

H: Really interesting, yeah. Do you know what [redacted] had min common with that woman? Two things she had in common with this particular woman. She does have the experience of being a migrant, and I think that's a lot of where she gets this empathy from for this woman. But the other thing is that they were both older women, in a way - they'd both had lots of babies. It was that woman's fourth child, and she was no twenty-year old either. They both had this sort of women's comaderie of just being women, and having been around the block and done all sorts of things in their lives, and got to the point where they can make jokes about it. They had something in common, which maybe wasn't one of the cultural tick boxes. I would say it's a nice bonus (to have something in common), but not necessary. If they were too close…I think if they've got something culturally in common is one thing - like both refugees from East Africa - but maybe not actually being from the same village in Somalia. But I think they have to have some way of forming that

bond, but I think a skilled helper will find that common ground. It doesn't have to be a common ground that you put on a paper - they'll find that.

I: Right. And - last question - in you opinion, what makes an ideal MC?

H: I think they obviously need to be friendly and approachable and all of those things. They also need to be clear and boundaried, as I can imagine there's all sorts of places those boundaries can slip in hospital…so not always going round, and not lending money, knowing when to give a lift - 'yes, I'll give you a lift to your antenatal appointment but no, I won't give you a list to your auntie's'. You know, those kind of things. I actually think that it's probably helpful to have that political perspective, and using it to heal trauma. We're all a part of it. Not a patronising care-giving thing but more like 'here we are, two women and you've experienced this thing, and you've happened to land in this country which is my birth country, and together we're going to do things to heal the hurt. I'll learn things from you'. Coming from that political perspective, rather than that Christian helper kind of thing is probably useful. A political empowerment idea of equality. I'm sure they'd be quite nice if they come from a 'helping the poor people' kind of thing, but I'm sure they wouldn't be as good at it! (laughs).

I: Definitely! So that was my last question. Thanks so much, again! Any last comments on Project MAMA?

H: I think I've said it all, really. I suppose I just hope for a world where we didn't it (Project MAMA). A world without wars and the rest of it, but also it's an absolute tragedy that half the work they're doing is undoing the racism that's already existing on the ward.

White British
47yo
Single
2 children
University

Example of memo

SS1

SS1 is a personal advisor at the local council. She works with young people over the age of 18 who need support transitioning into young adults, and referred a client to the navigation service - primarily for emotional support during her pregnancy. She also highlights that navigators provided practical support in the form of accompanying clients to appointments and doing further signposting. She perceives them as filling a gap - she feels that they have more knowledge of community resources than she does, and more capability to do things such as accompanying to appointments. There are limitations to her role as a part-time worker in a statutory service with a heavy caseload, and - in her view - navigation goes some way to remedying that. Navigation removes the burden from both clients and healthcare and social care workers, perhaps?

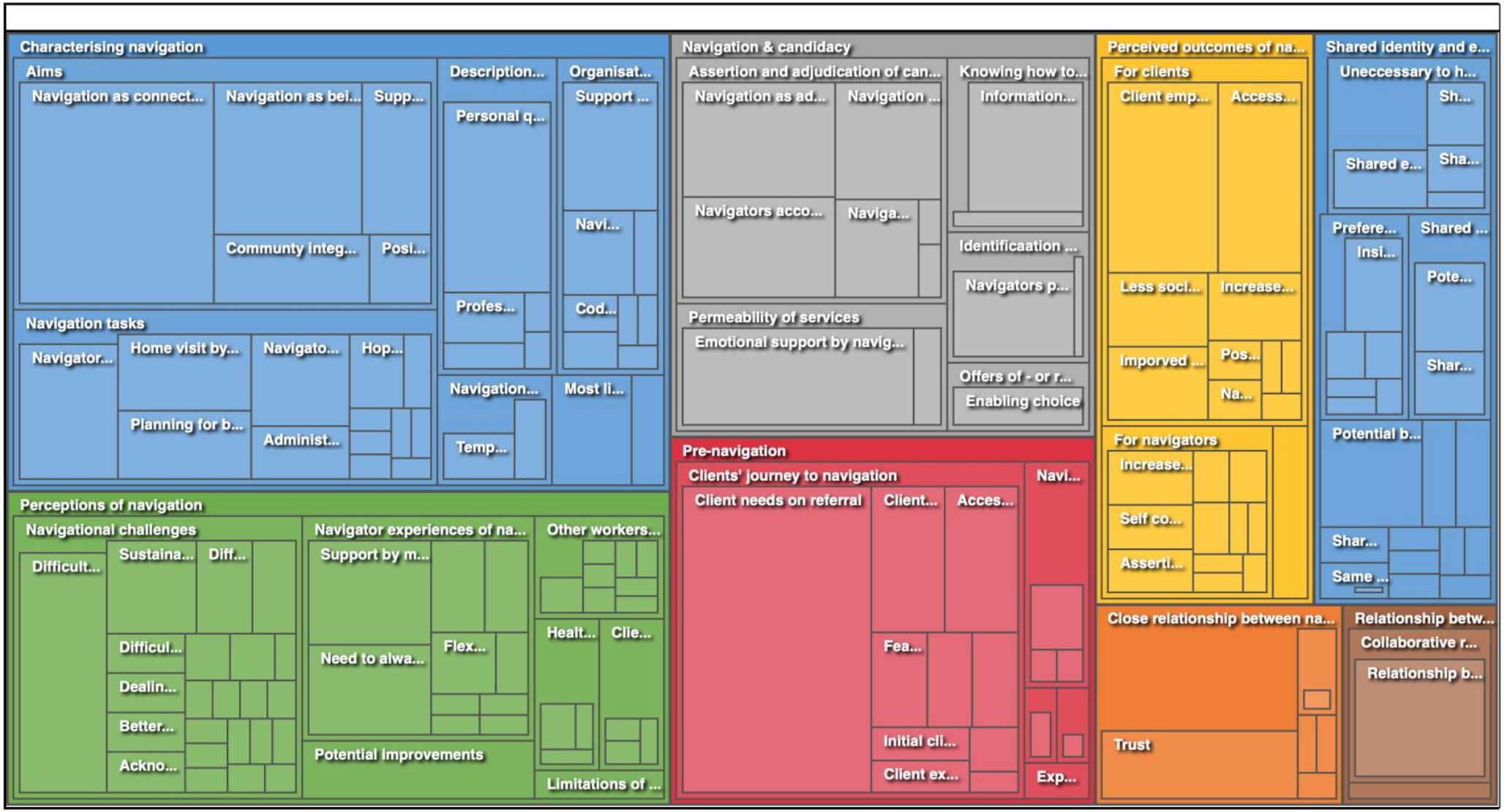
SS1 speaks very positively of the navigator she worked with, praising her for her willingness to offer support and for availability - especially given that this is in a context of public sector workers on part-time contracts. The navigator accompanied her client to appointments and to the birth, supported her work on a client's housing and sourced equipment for the client's baby. She highlights that the navigational support has been hugely important for the client in question, and that the client has been positively impacted by it in terms of her emotional and mental health. She sees her as dealing with boundaries well, and going above and beyond.

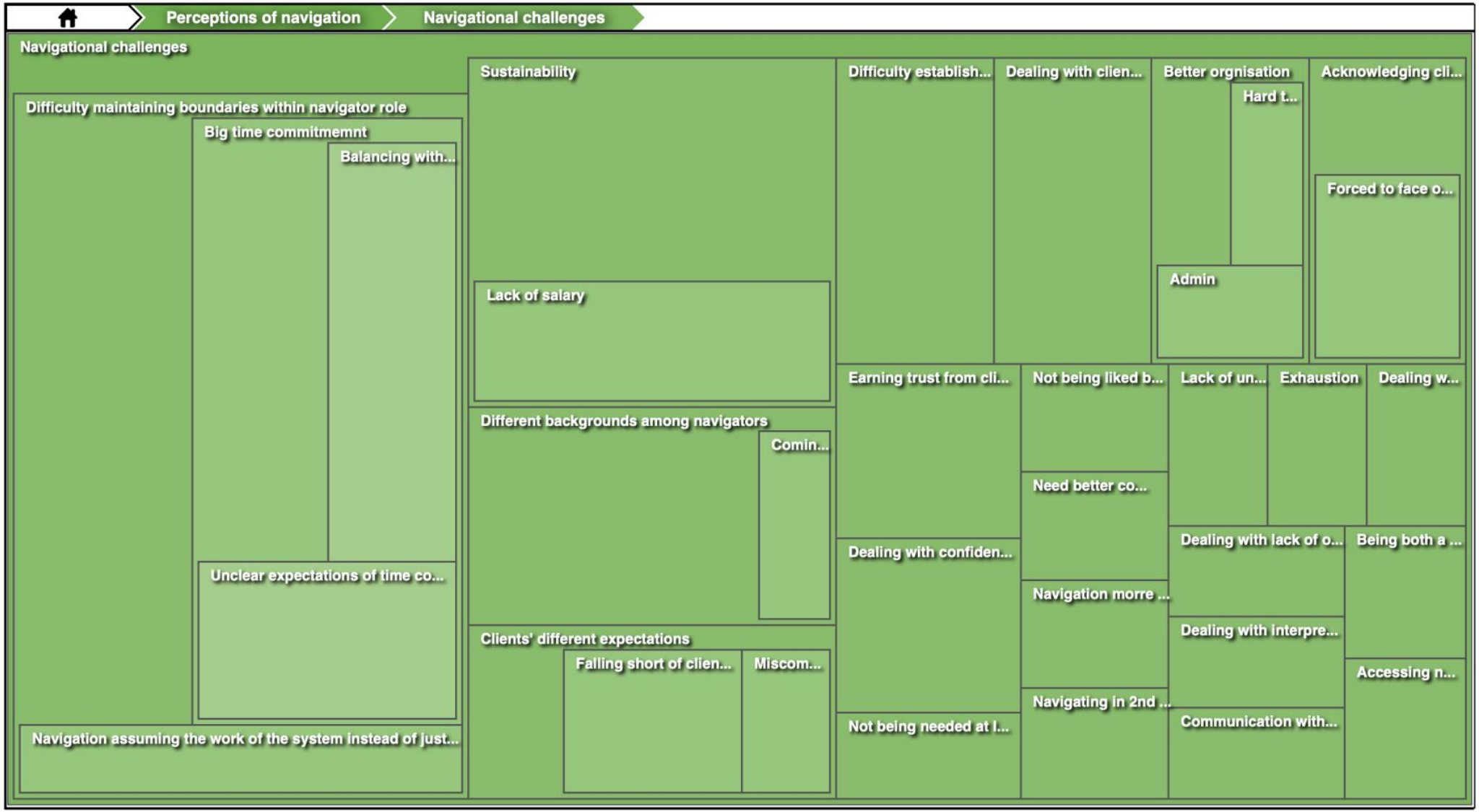
She is not fully certain about post-navigation access to healthcare, but assumes that clients have better knowledge of what services exist that will help them access these services on their own in the future; maternity care is a different terrain to general healthcare, such as GPs and A&E.

There has been a collaborative working relationship with the navigator, in spite of practical challenges around supporting the clients' housing needs and arranging interpreters. She perceived the navigator as a professional - similar to other social sector workers - but the voluntary nature of this navigation service does seem to still lead her to perceiving their work as being less restricted, more flexible and with fewer rules/regulations. Conversely, she is sensitive to the fact that navigators are volunteers, and that they are too often expected to fill the gaps left by statutory services. She said that there seemed to be a close relationship, and that the navigator was a professional friend who stayed within her boundaries. She strongly feels that a navigator being female is important, due to clients' negative/traumatic experiences with men. However, she doesn't feel that any other shared experience or identities are necessary to fulfil this role.

Rich interview, conducted by phone and with good flow. Did not speak raise themes of race/ethnicity, even when prompted. Did not allude to own racial/ethnic or national identity.

Example NVivo treemaps




Perceptions of navigation
Navigational challenges
Navigational challenges
Difficulty maintaining boundaries within navigator role
Big time commitmemnt
Balancing with...
Unclear expectations of time co...
Navigation assuming the work of the system instead of just...
Sustainability
Lack of salary
Different backgrounds among navigators
Comin...
Clients' different expectations
Falling short of clien...
Miscom...
Difficulty establish...
Dealing with clien...
Better orgnisation
Hard t...
Admin
Acknowledging cli...
Forced to face o...
Earning trust from cli...
Not being liked b...
Lack of un...
Exhaustion
Dealing w...
Need better co...
Dealing with confiden...
Navigation morre ...
Dealing with lack of o...
Being both a ...
Dealing with interpre...
Accessing n...
Navigating in 2nd ...
Not being needed at l...
Communication with...

Consent form (interviews)

Consent Form

Improving access to healthcare for migrant women

An exploration of the functioning and impacts of health navigation on maternal and women's health

Thank you for reading the participant information sheet. If you are interested in taking part, please confirm and consent to the following by writing your initials in each box:

Taking part in the interview

Initials

I confirm that I have read and understood the information sheet (dated 22/01/19), and that I have had the opportunity to ask any outstanding questions to the researcher.

☐

I agree to take part in the interview.

☐

I understand that I am taking part on a voluntary basis, and that I have the right to withdraw from the interview at any time, without needing to provide a reason. I also understand that I am free to decline, should I not wish to respond to a particular question during the interview.

☐

Consent Form

Protecting you and your data

Initials

I understand that I have a right anonymity. I understand that my name will not be linked with the responses I give during the interview, and that I will not be identifiable from the research results, or subsequent publications which may result from the research project.

☐

I understand that any information shared by me will be kept confidential, except if I appear to be in danger.

☐

I understand and agree that my words may be quoted in publications, reports, and other documents resulting from the research, and that I will not be named in these documents.

☐

The University Of Sheffield.

I agree for this interview to be audio recorded using a dictaphone. I understand that the recording of this interview will only be used for data collection and analysis, and that no other use of this recording will be made without my written permission.

☐

I understand and agree that other authorised researchers can have access to this data and may be able to use it (for example, in publications and reports), only if they agree to preserve the confidentiality and anonymity of the information as requested in this form.

☐

Name of participant	Date	Signature
Name of researcher	Date	Signature

To be counter-signed and dated electronically for telephone interviews or in the presence of the participant for face-to-face interviews

Participant to keep one copy of consent form, and one copy of information sheet.

Consent Form

The University Of Sheffield.

Contact details for further information:

Ms Christy Adeola Braham [Doctoral Researcher] - caabraham1@sheffield.ac.uk or +447916142354

Dr Liz Such [Research Fellow] - e.such@sheffield.ac.uk

Prof John Brazier [Dean of ScHARR] - j.e.brazier@sheffield.ac.uk

Consent form (documents)

Document analysis confirmation

This is to confirm that I give permission for the researcher (Christy Adeola Braham) to have access to select internal organisational documents of relevance to the research.

I am aware of the types of documents sought by the researcher and the justification for this, and I understand that no documents containing any individual's personal details will be used by the researcher.

I also understand that any individuals mentioned by name in any internal document that I provide to the researcher will be assigned pseudonyms by the researcher to protect anonymity, and that the researcher will redact any segment of information which allows an individual to be identified.

I agree that other authorised researchers can have access to the data derived from documents, and may be able to use it (for example, in publications and reports), only if they agree to preserve the confidentiality and anonymity of it.

Name of signee

Date

Position and name of organisation

Ethical approval - School for Health and Related Research

Downloaded: 17/04/2019
Approved: 11/04/2019

Christy Braham
Registration number: 170128911
School of Health and Related Research
Programme: PhD Public Health

Dear Christy

PROJECT TITLE: Improving access to healthcare for migrant women: an exploration of the functioning and impacts of health navigation on maternal and womens health
APPLICATION: Reference Number 025447

On behalf of the University ethics reviewers who reviewed your project, I am pleased to inform you that on 11/04/2019 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 025447 (dated 11/04/2019).
- Participant information sheet 1057743 version 2 (09/04/2019).
- Participant information sheet 1057742 version 2 (09/04/2019).
- Participant information sheet 1057741 version 1 (11/03/2019).
- Participant information sheet 1057739 version 2 (09/04/2019).
- Participant information sheet 1057740 version 1 (11/03/2019).
- Participant consent form 1057745 version 1 (11/03/2019).
- Participant consent form 1057744 version 2 (09/04/2019).
- Participant consent form 1057746 version 1 (11/03/2019).

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.

Yours sincerely

Jennifer Burr
Ethics Administrator
School of Health and Related Research

Ethical approval - NHS Social Care Research Ethics Committee

Health Research Authority

Social Care REC
Ground Floor
Skipton House
80 London Road
London
SE1 6LH

Telephone: 0207 104 8171

30 September 2019

Dr Liz Such
Research Fellow
University of Sheffield
School of Health and Related Research, University of Sheffield
30 Regent St
Sheffield
S1 4DA

Dear Dr Such

Study title: **Improving access to healthcare for migrant women: an exploration of the functioning and impacts of health navigation on maternal and women's health**
REC reference: **19/IEC08/0038**
Protocol number: **0**
IRAS project ID: **261570**

Thank you for your submission, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Vice-Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or NHS management permission (in Scotland) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

The latest guidance on these topics can be found at https://www.hra.nhs.uk/approvals-amendments/managing-your-approval/.

Ethical review of research sites

NHS/HSC sites

The favourable opinion applies to all NHS/HSC sites listed in the application subject to confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or management permission (in Scotland) being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS/HSC sites

I am pleased to confirm that the favourable opinion applies to any non-NHS/HSC sites listed in the application, subject to site management permission being obtained prior to the start of the study at the site.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance & indemnity - University of Sheffield]	1	17 June 2019
Interview schedules or topic guides for participants [Interview guide - service users]	1	09 April 2019
Interview schedules or topic guides for participants [Interview guide - health navigators]	1	09 April 2019
Interview schedules or topic guides for participants [Interview guide - health professionals]	1	09 April 2019
IRAS Application Form [IRAS_Form_19062019]		19 June 2019
Other [Data management plan]	1	13 June 2019
Other [Letter of support - Haamla Service]	1	08 April 2019
Other [Responses to NHS REC]	1	20 August 2019
Participant consent form [Consent to contact form]	1	10 April 2019
Participant consent form [Written confirmation of internal document provision]	1	12 March 2019
Participant consent form [Participant Interview Consent Form]	4	31 July 2019
Participant information sheet (PIS) [Participant_information_sheet - W]	5	30 September 2019
Participant information sheet (PIS) [Participant_information_sheet_-_HP 2]	5	30 September 2019
Participant information sheet (PIS) [Participant_information_sheet_-_N]	5	30 September 2019
Referee's report or other scientific critique report [Scientific assessment - University of Sheffield]	1	17 October 2018
Research protocol or project proposal [Study protocol]	1	12 March 2019