Perinatal support Project Evaluation

Phase 1 Report - Spring 2022

University of Nottingham's Rights Lab

for Hestia and Happy Baby Community

Contents

Hestia *supports over 10,000 vulnerable adults and children each year to build a life beyond crisis, including survivors of modern slavery, victims of domestic abuse, and those enduring severe mental ill health, across London and Kent. The award-winning Phoenix Project, providing volunteer-led, long-term support focused on victims' recovery and integration into local communities, currently supports 70+ survivors of slavery who have exited the NRM.*

Happy Baby Community *facilitates safe and thriving communities across London for over 1000 mothers seeking asylum who have fled violence, abuse, or trafficking. They work to build meaningful relationships around the shared experience of motherhood, tackling together language and cultural barriers, inequalities, and the challenges of transitioning to motherhood whilst seeking asylum in the UK.*

The University of Nottingham's Rights Lab *are the world's largest expert modern slavery research group. Through five research projects, they deliver new and cutting-edge research that provides rigorous data, evidence, and discoveries for the global antislavery effort. The impact team supports collaboration across sectors, and our INSPIRE project elevates survivor-informed research to help end global slavery by 2030.*

Section 1: Introduction

This evaluation looks closely at a project of support given to a very specific, and relatively unknown, constituency of need. Quietly, carefully, these organisations have been building a safe, compassionate, and responsive service to the specific needs of women seeking asylum, many of whom have been fleeing violence and human traffickers. About half of all women in the Starting Well Project have been caught up in exploitative situations, including enslavement within commercial sexual exploitation, and who are now exiting that bondage. All women supported by the Project are, or were recently, pregnant. It is important to be clear about the gravity of this situation.

Over the past twenty years survivors of violence and exploitation have taught us a great deal about the reality of trauma, exploitation, trafficking and enslavement – about its dire impact on mental and physical health, on the personality and the will, as well as how these specific impacts are regularly ignored or misunderstood. Without direct experience, the state of being lived by the women who are exiting exploitation and pregnant can exceed our ability to comprehend it. It may reflect Dworkin's "phallic imperialism" – the total control and exploitation of the female body for the use, pleasure, and productive exploitation by those, almost exclusively men, who control a woman through violence, intimidation, and the regular use of sleep and food deprivation. We know now that this results in a mental state of atemporality and aspatiality – a closing-down of the mind to a single point in a constant present and single physical space. This extreme response acts to reduce pain and conscious engagement, within which the controlled body can be easily exploited. This is often followed by Complex PTSD requiring a specialist response, in addition to the inevitable physical damage.

For all of the women who have come under the care of this service provider, there is the further complexity of being foreigners seeking asylum within a context specifically designed to be a 'hostile environment' by the UK Home Office[1]. The larger policy implications are beyond this evaluation, but the simple brutal logic of treating women who are the victims of very serious and violent crimes as problematic 'migrants', calls into question their duties under international law. As foreign nationals, the economic prospects of the women are grim, and their health often suffers from a lack of decent food, clothing, and accommodation. The situation of participants of this study is dire. It is not surprising that this organisation has chosen a low profile, a logical response to a significant human problem within a challenging political context.

And yet… even in the face of criminality, public and cultural ignorance, and official intentional neglect, there have been clear and positive outcomes. Any pregnancy may be challenging but can still be a pathway to recovery and a new orientation to life, however precarious that may be within the political context. The creation of new life is the most profound fact of human biology, without which our curious, altricial, species would not exist. That new life brings a new focus; with solid support, and thoughtful care, the maternity and birthing process can be a pathway to change, even as it is an irrevocable step into motherhood with all the pressures and responsibilities that brings.

This introduction has aimed to illuminate and contextualise the specific challenges faced by these women and their babies – but we will set this broader context to the side and focus on the specific responses, and mechanisms of support offered to these new mothers. The experts in maternity, the midwives, the doulas, the nurses and doctors, the social workers, educators, administrators, and, crucially, the translators and communicators tying the wide variations in language and culture together, face *toward* the woman and her child. The Project explored and evaluated below is offered as an evolving model for change and improvement in the service to this unique constituency of need.

Section 2: Evaluation Overview

2.1 Impact evaluation overview

The National Maternity Review and the Department of Health and Social Care recognise the need to expand community-based support projects in order to address health inequalities and long-term health outcomes of children facing disadvantage. This collaboration between Happy Baby Community ('HBC') and Hestia is a response to this, designed to support asylum seeking mothers in London through pregnancy, birth and early parenthood, while focussing on improved mental health and wellbeing, infant feeding, and peer support. The women and infants supported through Starting Well project funding ('the project') have all experienced a perfect storm of health and social barriers to care. Given the complex needs associated with their histories, they face higher risks of physical and mental health challenges.

The project being evaluated invites and supports mothers seeking asylum from 5 months pregnant, through birth and the transition to motherhood and up to 6 months post-birth. After which they are welcome to continue engaging with the wider community networks and activity sessions that HBC offer. The project supports around 200 mothers per year across the activities laid out in this report.

Developed following two pilot phases of a tailored birth companionship project through HBC, and the existing support mechanisms in place between the two charities, the project includes birth companionship, health information classes, peer support, and for those who have experiences of modern slavery, casework support from Hestia's services. Each of these activities has been identified as meeting the needs of the client group, and supporting mothers to become confident, capable of, and supported to care for their children to build safe, stable futures.

Evaluation questions set by the project partners explore the impact of their interventions on mothers' mental health, feeding, social connection and practical needs. Other questions in terms of project operations also include service partnerships and evidence of the implementation of the project's principles (see Section 4.4 for full list). These, and the methodological approach to evaluating these questions, are laid out below.

2.2 Phased evaluation plan

Based on the requirements of a thorough evaluation, within the resource limitations of the project, the evaluation will be addressed in two phases. The detail of the evaluation questions, and how the methodology of the full evaluation will attempt to answer the questions is laid out below.

This report covers Phase 1 (Autumn 2021 to Spring 2022) and builds the foundation for the full evaluation. It focusses on desk-based analysis of literature, project and organisational documents, existing data and input from both charity partners, and developing themes and priorities, by building a framework for ongoing data collection. This phase sets the foundation for qualitative data collection regarding perinatal mental health, baby feeding, and the benefits of service partnerships (questions 1-3 and 6), as well as the basis for identifying evidence of the application of the project's principles (for question 5). Following this review, this report also sets out recommendations for the ongoing operation of the project, considering the emerging themes and potential data gaps, and finally, outlines a plan for the evaluation's data collection from Phase 2.

An approach and recommendations which support the organisations' collection and use of data, for monitoring and learning beyond the timeframe of the evaluation, was requested. Elements of monitoring are recommended in Section 6 of this report that contribute to the project's ongoing maturation and enrich Phase 2's understanding of the charities' activities.

Phase 2 will run during the final 6 months of the project (Autumn 2022 to Spring 2023), reviewing monitoring data from the charity partners, and undertaking key qualitative data collection through interviews and focus groups. The aim is a sample of 60 women, volunteers, staff and partner services to address questions 1, 2, 4 & 6 regarding perinatal mental health, baby feeding, the overall experience of the project's support, and the benefit of the project's service partnerships. This will provide evidence for the impacts of the interventions through the voices of the project's participants themselves.

2.3 Evaluation Questions

The research questions are:

1. Does the project support improvements to Perinatal Mental Health for the clients? (Primary outcome of the project)
2. Does the project help increase breastfeeding rates?
3. Does the project contribute to an increase in access to evidence-based information on feeding babies?
4. What is the overall experience of (a) women who are supported through the project, and (b) the women who provide support as perinatal volunteers?
5. How are the principles that underpin the project adhered to in practice, and how do they contribute to outcomes?
6. How does the project interact with other communities and systems (including hospital and community maternity services), and how this influences outcomes, including any evidence to suggest the project has potential to reduce operational and financial burden on services?

2.4 Methodology

1. Perinatal Mental Health

Three key approaches inform the priority objective of this Starting Well project: To support improvements in perinatal mental health. Firstly, in Phase 1 the project's activities, documents, and monitoring reports were reviewed, (Section 4). Secondly, the theoretical basis of this work was explored through literature (Section 3). This reviewed existing academic research and grey literature for themes that support the relationship between the project's principles and activities in order to meet the target group's needs. Finally, Phase 2 will interrogate and evidence the considerations from Phase 1 reviews through primary qualitative data collection with the project's participants. Interviews and focus groups will be undertaken to determine mental health related experiences in the context of the project's support. We will interview peer supporters who have already been through the project or had similar experiences of childbearing and motherhood while seeking asylum. This will help us understand some of the medium-term effects of support on mental health. The themes and identifiers for qualitative data collection are laid out further in Sections 5 and 7.

2. Breastfeeding rates

Infant feeding is explored in Section 3's literature review, followed by a review of records and documents from the project, such as health education class attendance, addressed in Section 4. Qualitative primary data collection in Phase 2 will involve asking a sample of mothers about their feeding experiences, including their choices and challenges. Breastfeeding counsellors working with the project will also be included in the data collection. The themes and framework for primary data collection are developed through this report and explained in Section 6, along with suggestions on how to understand the project's infant feeding rates in the context of national statistics.

3. Feeding information

While there are very few secondary data sources regarding 'access to evidence-based information,' we continue to refer to published materials and data sources and gather the experiences of participants to consider this. This illuminates the barriers to accessing other sources of information, for example language limitations and/or access to services in general for this client group. Our aim is to answer these questions: in what areas might the clients experience limited access to information? And, how and if this situation has changed given the intervention of the project? Through retrospective semi-structured qualitative interviews, we will learn if any of the support given through the project helped a mother learn something new about feeding.

4. Mothers' overall experience

This question can only be understood through qualitative data collection amongst the clients and volunteers who experienced any Starting Well funded support. An important element of this research question is the viewpoint of peer supporters, who have both lived experience and have completed support through the perinatal support programme, and now continue in relationship with the community through supporting new referrals. Mothers who have completed the services and continue contact with the charities through volunteering as peer supporters, have additional time to reflect on the medium-term impact of the project on their wellbeing, skills and resilience and the health of their child up to 3 years old, while also reflecting on the services in its earlier period. Mothers who are in, or recently completed, the services will have a more up-to-date experience of the project following interventions and improvements.

It is important to consider the impact of the Covid-19 pandemic on the experiences of the women and the delivery of the service at different stages. Covid-19 may have had an impact on their personal history, health, access to care and support during labour, the availability of face-to-face activities, and may have engendered feelings of isolation. While the charities responded to the circumstances, adaptations to the delivery of the project were needed, that were not anticipated when the project was designed, such as moving group meetings and classes online, and the provision of tools such as phones to access these groups.

5. Application of principles in practice

This question is explored firstly though Phase 1's desk review, explored in Section 4 by identifying evidence of the principles in practice in the delivery of the project from an external perspective, and through identifying gaps requiring stronger evidence from primary data collection or opportunities for further monitoring.

6. Service interactions

It is important for the long-term delivery of the project and the women's experiences of care that positive trusting relationships are maintained with other services, particularly through invested organisational partnerships. In Phase 1, this is first outlined through a desk review of project documents such as quarterly reports (Section 4), addressing the existing stakeholder and referral partnerships. Phase 2 could explore the research question through surveys and/or interviews with key organisational contacts, to better understand the nature and impact of the stakeholder relationships from the external perspective.

Section 3: Literature review

This review focuses on understanding some of the published academic, policy, and practice context of three priority research areas for this evaluation: Perinatal mental health, infant feeding and the experiences of migrant women and trafficking survivors in maternity care in the UK. It is not exhaustive, but highlights some experiences, challenges and barriers experienced by the target group or raised by healthcare sector, to better understand the context in which the project sits and some of the issues the project is attempting to address. This review draws on literature from a range of contexts and situations that have relevance to the service and women supported.

Other areas for review such as the benefits of birth companionship for mothers were raised during HBC's pilot when the research focused more on birth outcomes and the impact of doula support, and any further areas for research could be raised in Phase 2 should key gaps be identified.

Perinatal Mental Health

Pregnancy, childbirth and becoming a mother are times of enormous significance in women's lives. They may involve changes to physical and emotional wellbeing and are generally considered a period of increased vulnerability for mental ill-health. Maternity care policy for England aspires to personalisation of services to fit women's individual circumstances, improved perinatal mental health and provision of services within a model of relational continuity[2]. National Institute for Health and Care Excellence ('NICE') guidance for the care of women with complex social factors acknowledges that additional work is required to meet the needs of particular groups of women[3]. NICE also provides guidance for healthcare providers related to perinatal mental health including the use of brief screening tools and pathways for subsequent care or treatment[4], including specialist trauma and bereavement services.

Compromised perinatal mental health may have enduring effects on women and their children. Mental health problems are distressing for women and have implications for a woman's relationship with her baby, attachment and parenting. Depression during pregnancy impacts negatively on the quality of relationship between mother and infant[5]. Prolonged anxiety during pregnancy is associated with increased risk of pre-term birth and babies born small for gestational age [6]. Kingston and colleagues' systematic review[7] identified associations between maternal psychological distress and slower cognitive development in toddlers. Enduring and severe perinatal mental health problems are associated with early childhood behavioural difficulties and negative impacts on educational attainment[8].

In a UK-based study amongst trafficked women, the majority of interviewees experienced some form of mental health problem[9]. Survivors of modern slavery commonly have a range of mental health needs[10] and may have pre-existing vulnerabilities for poor mental health due to previous or current abuse or inter-personal violence[11]. Previous trauma increases risk of childbirth-related PTSD[12]. Migrant women experiencing depressive symptoms have concerns about their mothering being considered deficient, which inhibits seeking professional help. Their experiences of cultural isolation, communication barriers and a lack of social support inhibit mothering in the way they wished[13]. An absence of social support has the potential to increase anxiety and depression during pregnancy [14]. Young women have welcomed group approaches to pregnancy care that may offer opportunities for learning and socialising amongst peers[15] [16].

A synthesis of vulnerable women's maternity care experiences revealed stigma, judgmental attitudes, insensitivity and negative care interactions that increase insecurities, and diminished self-esteem. Positive experiences result from providers' welcoming and supportive approaches,

acknowledgement of the woman's individual preferences and enabling of informed decision-making[17]. Care that includes negative interactions with maternity providers is a risk factor for post-traumatic stress disorder (PTSD) [18].

Access to health care systems can be difficult for some women, including those who are immigrants, due to unfamiliarity with the organisation of NHS maternity care[19]. Trauma informed care by nature has the potential to decrease the risk of re-traumatisation and posttraumatic stress disorder. Singla and colleagues' systematic review[20] found that interventions provided by non-specialist providers (nurses, lay counsellors etc) were sometimes effective for both preventing and treating depression and anxiety symptoms.

Infant Feeding

Breastfeeding is highly recommended for all infants worldwide. Women are encouraged to initiate breastfeeding "as soon as possible after birth, within the first hour after delivery"[21]. Short- and long-term benefits accrue from breastfeeding; it enables the regulation of newborns' body; acquisition of beneficial bacteria from their mother; lowers risks of infections[22] and reduce future risk of obesity[23]. Several studies show further benefits for the mother's health: decreasing women's risk of breast and ovarian cancer, type 2 diabetes mellitus and postnatal depression, and lowers rates of overweight and obesity[24] [25]. In the UK, both Public Health England and UNICEF's Baby Friendly Initiative promote it as the preferred method of infant feeding[26].

Nevertheless, there is evidence that some women might be hindered – especially those from vulnerable backgrounds – to start or sustain breastfeeding. Acknowledging this reality, the Royal College of Midwives emphasises the significance of proper guidance encompassing adequate advice, support, and information on alternative responsive methods of feeding (e.g., safe preparation of bottles for formula milk)[27]. This support should ideally be provided not only by the midwives, but also by family and friends[28].

Women from migrant and refugee backgrounds have perinatal healthcare needs that are understood internationally as a public health priority[29]. Barriers to receiving proper care include language and cultural challenges, insufficient support to access services and limited health literacy[30]. Acculturation within breastfeeding practices can occur: women from ethnic minorities that are familiar with breastfeeding, when moving to a country with low breastfeeding levels are likely to be influenced by the host country and decrease their rates[31] This is likely observed among migrants in the UK, given that the UK has some of the lowest breastfeeding rates in the world[32].

Experiences of Migrant Women and Trafficking Survivors in Maternity Care

From a group of trafficking survivors interviewed in 2017, over 32% reported diagnosed sexually transmitted infection and over 42% had undergone one or more terminations of pregnancy during the trafficking situation and more than one in four women became pregnant while trafficked. These indicate that maternity services offer an important contact point for identification and care, as well as the need for wider women's health services, especially in maternity, to be prepared for the impacts of sexual abuse on the woman when providing perinatal care. Further interviews among the target group described service charges, fears about confidentiality and negative attitudes from staff among challenges they faced while accessing NHS maternity care[33].

Maternity and mental health services admit feeling overwhelmed by the effects of asylum seekers and trafficked women's needs, and there is a growing recognition among professionals for the need for specialist roles and competency training when it comes to sufficiently supporting mothers with traumatic histories, with many having no formal trauma-informed training at all[34].

Mothers from Black, Asian, and ethnic minorities (BAME) face higher mortality rates[35], and those

facing multiple disadvantage experiencing poorer maternity care[36]. Additional or specialised support for groups varies between geographical areas, even within London[37]. Birthrights' ongoing enquiry into racial disparities in maternity care also found refugee, asylum-seeking and migrant women from a range of ethnic communities claimed their antenatal care was negatively impacted by a fear linked to their immigration status, through "intrusive questions about their immigration status during maternity appointments", and a failure to provide adequate interpreting services compounds these barriers[38]. Just overcoming language barriers is too narrow a perspective to understand important ethnic and cultural issues faced by BAME groups [39]. Instead, a concept known as 'cultural mediation' - developed in Europe for supporting refugees navigate legal, health and social care systems - facilitates mutual understanding of critical information, overcoming cultural barriers while providing verbal translation[40] and avoids unnecessary suffering[41].

Maternity Action's investigation into 'hostile' charges, found them to be causing high levels of stress and anxiety due to aggressive debt collecting and fears about implications on immigration applications[42] [43], and NHS staff not always knowing about exemptions for refugees, asylum seekers and victims of modern slavery. This additional stress, from experiences of destitution, homelessness, deportation, dispersal[44], subsequent financial hardship experienced by asylum seekers[45] and additional health problems, is recognised as having an adverse effect on immediate pregnancy outcomes such as pre-term birth and low birth weight[46]. Birth Companions charity also promotes that women's own voices must be at the heart of developing care for pregnant mothers facing multiple disadvantage, specifically stating: 'The government should work with specialists in the voluntary sector and elsewhere to deliver a culturally appropriate, proactive and systematic response to the needs of foreign national women and victims of trafficking, informed by those who have lived experience'[47].

Mothers facing multiple disadvantage reported continuous care as a key theme to reduce fear, reduce the need to review the same questions and histories[48], and providing trusted support through challenging births. The importance of this is also 'intrinsically linked' with the need for better mental health care[49] for the 12% of UK mothers facing complex social factors, in which the target group sit. HBC's birth companionship support scheme provides such continuous support to women facing stark health inequalities in labour and birth.

Section 4: Project delivery review

4.1 How it runs

Birth Companionship Support

The presence of a doula as a birth companion is a recognised and growing support mechanism for mothers, with research highlighting benefits such as a reduction in the need for medical interventions and pain relief, and positive impacts on a mother's perinatal mental health. Navigating the NHS maternity services can be a challenge (as noted in Section 3). Some mothers have no family member to support them, so doula accompaniment can help significantly in such cases towards the mother's wellbeing.

"Asylum seeking women feel hospital is hostile environment and they don't want to go. They need more interpreters to explain and welcome them, help them find what they need there" – HBC mother's feedback

Following Happy Baby Community's pilot in 2020, birth companionship became the foundational perinatal support activity, and the primary contributor to the key outcomes of the Starting Well project. The pilot identified the benefit of a doula in collaboration with maternity staff; as well as improvement in mothers' experiences of feelings of safe care, trusted relationships, decreased inequalities, autonomy and respectful treatment[50].

"Having someone with me all through the pregnancy was amazing" – Hestia client's feedback

All pregnant mothers are offered a doula upon entering the HBC, with approximately 6-8 mothers (up to half of mothers) per month taking up the offer. Since Covid-19, mothers are geographically spread throughout London, so under this project, doulas operate on a one-to-one basis rather than the pilot's group coordinated approach.

HBC doulas provide mothers with antenatal preparation and birth planning sessions in the weeks leading up to the birth, as well as assistance with medical appointments, consistent companionship through labour and birth, and support in the first weeks with feeding, physical recovery and baby care. Research shows this support is essential for mental and physical wellbeing of the mother and contributes to the development of positive mother-baby bonding.

Given mother's psychosocial experiences, it has been observed through research that disadvantaged and vulnerable mothers may report more negative interactions with services, such as stigma, judgement and choices being ignored. Mothers who have a doula may benefit from the accountability this role brings to services during birth care, as they can help facilitate communication between mother and caregiver of cultural needs and individual preferences.

For those not opting to have a doula, HBC doulas and appropriate staff and volunteers support antenatal preparation on a 1-to-1 basis with mothers during community sessions to assist them to formulate and ask for preferences. This helps avoid re-traumatisation, which in turn benefits postnatal mental health of mothers.

Health, Education and Group Support

A key factor in reducing inequalities, and encouraging agency is access to information. However, many resources available to mothers in the UK are inaccessible due to language barriers, late access to antenatal care and class costs, such as through NCT. A recent qualitative study[51] including ethnic minority women's voices, highlighted women's desire to attend group classes, to access trustworthy information, build confidence, and reflected that being with other

women with common experiences of pregnancy helped normalise anxieties about birth, and build relationships. Mothers who choose not to have the 1-to-1 support of a doula within the can still access antenatal preparation with HBC through group sessions hosted by volunteer professionals and staff members.

Online education classes for mothers are offered to the whole community by HBC staff and volunteers, focussed on the themes of:

i) General physical and sexual health classes; including period products and the female body, contraception and vaccinations

ii) Group antenatal and birth preparation

iii) Feeding; including breastfeeding group sessions in Albanian and English, one-to-one for other languages, and introduction to solids for those whose babies are 4 months +

iv) Access and referral to other staff and professional support, such as one-to-one with breastfeeding counsellors

"It's very difficult to access antenatal classes in the NHS, due to language barrier. And it being mostly couples and not aimed for single women can be intimidating." - Lived experience mother at EAG

Immunisation and the reduction in rates of preventable disease is crucial to public health. The Starting Well funding helps to provide classes and support through HBC on childhood vaccinations and encouragement to engage with health services in early parenting. There has been a low uptake of the Covid-19 vaccine among the service users, so the project is supporting accessible evidence-based health information to ensure that mothers have a better-informed choice about this.

Additional training is given to prepare HBC staff, partners and volunteers to work with the target group, particularly to support the specific needs and circumstances of mothers recognising the context of their lives. Peer volunteers also receive ongoing training and support through monthly reflective sessions held by the project manager at HBC.

Themes of training provided for Doula workers include:

i) Cross-culture and cross-language communication and sensitivity, including awareness of female genital cutting

ii) Birth preparation including the 'Biomechanics of Birth' and guidance on teaching antenatal information and birth preparation to mothers

iii) Trauma informed perinatal care, including sensitivity to breastfeeding following sexual assault

Trauma-informed care and human trafficking awareness training for midwives is limited[52], so this training for doulas is an essential support to mothers during their maternity journey.

At the time of writing the project is beginning to return to in-person meetings post-Covid though many classes are still held online. While group meetings are beneficial for social reasons, whether the mothers will find in-person or virtual classes preferable for learning is yet to be determined, as there may be other barriers such as transport or health anxiety. For example, between February and December 2021, there were 53 attendees across 18 online Baby Massage sessions to support bonding; the impact of in-person sessions on attendance rates is not yet known. In general, there are currently no consistent records on attendance across classes, or feedback.

"I would have liked groups. I never knew why my son didn't breastfeed and didn't have any support around this." - Lived experience mother's feedback on project's design proposal prior to Starting Well grant award

Peer and one-to-one Support

All mothers entering the project are offered a peer supporter through HBC who calls them weekly from 5 months pregnant to 12 weeks postpartum. This forms an avenue of communication and feedback between HBC and the mothers, allows for regular check-in of health and wellbeing, and

supports referring to services and encouraging participation in wider HBC activities.

The peers are mothers with lived experience of birthing and the asylum system in the UK, some who have 'graduated' from the project, and then receive tailored training to support the clients. Recruitment and training sessions are held quarterly, and a significant number of mothers return to pass on the support they received, expanding the pool and growing the knowledge base of the community. This suggests a positive experience and a sense of community ownership. Volunteers are matched with mothers based on several factors such as language, nationality or experience. The support can be flexible through the mother's maternity care and is based on the needs of the mother and capacity of the volunteer to make sure the mother is sufficiently supported throughout the period.

"Being supported by peers who can understand and offer acceptance of this history, we have seen mums feel more confident in building a bond with their new baby. There has been a secondary benefit that the peer supporters themselves, report that the training has helped them think more about the support they offer their own children and those of their friends." – Q3 Report to funder

Peers are trained in delivering telephone calls, recording notes with CharityLog (HBC's client management system), sharing referral routes and addressing typical challenges which may arise. Calls are used to check on the mother's wellbeing, offer discussion with someone who has experience navigating the asylum and maternity systems, and to encourage participation with the wider community activities, classes, and group support. Altogether this supports relationship building and the transition out of peer support at 12 weeks post birth. Topic areas on a prompt to guide peer volunteers to support timely conversation, include:

Antenatal:

i) Preparation for birth including navigating the maternity system, education needs

ii) Accommodation suitability

iii) Connecting to wider community support and activities

iv) Referral needs

Postnatal, 0-3 weeks:

i) How is she and how is she feeling?

ii) Items she is entitled to through Initial Accommodation Units

iii) Feeding and other potential support needs

iv) Access to wider community support and activities

Postnatal, approx. 5 weeks:

i) Feeding and other potential support needs

ii) Access to wider community support and activities

Postnatal, approx. 10-12 weeks:

i) Is the mother ready to stop the weekly calls?

ii) Readiness to access wider community support and activities

Due to their regularity, the questions asked, and the nature of logging referrals and highlights from the calls, they provide HBC with the opportunity for monitoring details on a variety of topics.

Regular reflection sessions are offered through HBC to the peer volunteers, providing a safe place to raise challenges and recommendations. These monthly meetings can be themed to address a particular purpose or training area or are open for peers to bring their own discussion points. The aim is to support the volunteer's wellbeing and effectiveness.

Key perinatal support focus: Infant Feeding

In the UK, breastfeeding rates are of some of the lowest in Europe. Women that the project seeks to support experience a range of social and psychosocial factors that may compound challenges to infant feeding, such as inappropriate housing, dependency on baby bank donations for equipment, and sexual trauma which can hinder the desire to breastfeed, as well as barriers to statutory or helpline support for those for whom English is not their first language. Across peer and

group support and breastfeeding counsellors, HBC aims to enable mothers to feed in the way they decide and have the resources and encouragement to do so through the project. While the project refers to 'infant feeding', all forms of feeding are supported on an individual basis. There is an emphasis on breastfeeding support, including breastfeeding support groups held in English and Albanian, and no defined safe bottle-feeding education. At present there is no record of rates of breastfeeding among the group, but the challenges are well understood among peers and staff who encourage mothers and support them in making sustained breastfeeding possible.

"Mothers do not choose to bottle feed because they don't want to [breastfeed] but because issues arise like stress, poor food for herself, new to motherhood and no one to model it..." - Lived experience mother at EAG

Hestia's Casework support

Survivors of slavery and trafficking can access NRM support through Hestia's Modern Slavery Response Team (MSRT). During their period within the NRM, a person is awaiting a judgement that there are conclusive grounds that their experiences meet the definition of a case of slavery under UK law. During this period, they should receive key legal, psychological, medical, financial, and housing support through Home Office funding, as laid out by the European Convention on Action against Trafficking (ECAT). Following a positive or negative 'conclusive grounds decision', Hestia's official support for survivors ends. The Phoenix Project was designed by Hestia as a follow-on recovery project to the government contracted National Referral Mechanism (NRM) support. Without the Phoenix Project survivors would be left to navigate their recovery, often alone, bar any ongoing engagement with courts around prosecuting their traffickers. Phoenix is funded by Hestia's own donor fundraising activities, and other than a 'positive' conclusive grounds decision, the only limit to inclusion in the project is resource.

The partnership with HBC allows them to refer mothers who experienced trafficking/enslavement to Hestia's expert care within their close working partnership. This additional modern slavery support expertise is an area where Hestia adds value to HBC's perinatal support in a way that is not limited by the criteria of the government victim care contract. This provides mothers, through more regular contact with a professional caseworker, with a wide range of support beyond perinatal needs.

The work is outreach-based; service users meet with their caseworkers fortnightly in accommodation, offices, or appropriate public places, with phone support as required. Hestia does not hold regular group activities in the way that HBC does, but occasionally hold events such as International Women's Day celebrations. Examples of support include accommodation, mental health services, logistics with appointments including interpretation and transport, and support to access the job centre for work and benefits. Updates to case notes are recorded within 48 hours on a client management system, 'Inform', alongside risk assessments, co-produced support plan goals and personal aspirations.

"The experience of having my second child in the UK was amazing... My caseworker supported with all appointments and helped with appointments and visited me in hospital. The caseworker also organised the delivery of all the items I needed for a new baby." - Lived experience mother at EAG, Hestia services

Recently Hestia created, as a general policy, a time limit of 18-months for each user, which encourages clients to use the service well, support onward referral relationships, building to self-efficacy after that period, and avoiding creating too much dependency on Hestia. Care is person-led, co-produced with service users, and works towards service users making appointments independently. As well as needs referrals, Phoenix supports opportunities for skills development, such as language and literacy competency, computer skills, further education, budgeting and

money management including taxes, benefits and working rights, occupation, and CV building.

At the beginning of the partnership project with HBC, there were low numbers of shared clients. Both entities adjusted referral criteria to increase cross-over, and now Hestia works with around 8 mothers who participate in the project. Many more mothers under Hestia's MSRT (approximately 30) qualify for HBC's wider community support, so the two organisations do have a working relationship extending beyond the project's directly supported clients.

Key perinatal support focus: Mental Health and Wellbeing

In 2019, HBC identified a gap in services as women were 'lost' to the community group during their perinatal period, often returning with poorer mental health. This matched findings of Hestia's research into the needs of pregnant victims of modern slavery based on 150 pregnant clients and consultation with the Royal College of Midwives: 1 in 3 had suicidal thoughts; and 7 out of 10 felt very isolated. A core outcome for Starting Well was improving perinatal mental health, which became a key objective of the project's support, with resulting long-term benefits for mother and child.

"Someone to talk to you and emotional support when you have had a baby is really important to help you not to have depression." - Lived experience mother's feedback on project's design

Hestia have previously used The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS), with 72% showing an increase in overall wellbeing score from entry to exit of their support services. They continue to observe that mental wellbeing and confidence are among the key needs of Hestia's service users to achieve long term recovery and independence. Mothers tend to experience high levels of anxiety and isolation when they enter the service.

There is an awareness that postnatal support is lacking in statutory service provision[53], and an area in which the project could add value while moving forward to support the transition into motherhood in the UK. The current offering of the project already approaches some of these needs through referrals and peer networks and continues to discuss how to improve the postnatal care interventions. 'Lived experience' input through the project's Expert Advisory Group (see 4.3 for further details) is crucial in shaping this response.

"Look at the psychologic behaviour of mother after birth - a lot of PTSD, they're exhausted, not sleeping well, struggling alone, plus all her attention needs to go to baby so she doesn't pay attention to herself. Tell mothers in advance to look after themselves after birth, prioritising herself along with the baby" - Lived experience mother at EAG

4.2 The mother's journey through the project

Mapping the mother's journey

This image (*Figure 4.2.1*) shows the timeframe in which a mother would interact with the service, from 5 months pregnant (when they are eligible) through to exiting the Starting Well funded project. After the formal end of the project's support, mothers may remain with HBC's wider community activities, may be invited to classes and other support groups, and may volunteer with incoming mothers. Entry and exit referrals are explained below, indicating some of the key service partnerships involved with mothers. The last specific elements of the project are supporter calls at 12 weeks, along with the invitation to a class on the 'introduction of solid foods' which is a recommended transition when the baby is approximately 5 months old.

The yellow arrows on the left show the four activities, and the ovals indicate rough numbers of women engaging in that service activity per quarter, as noted by the partner's joint monitoring reports.

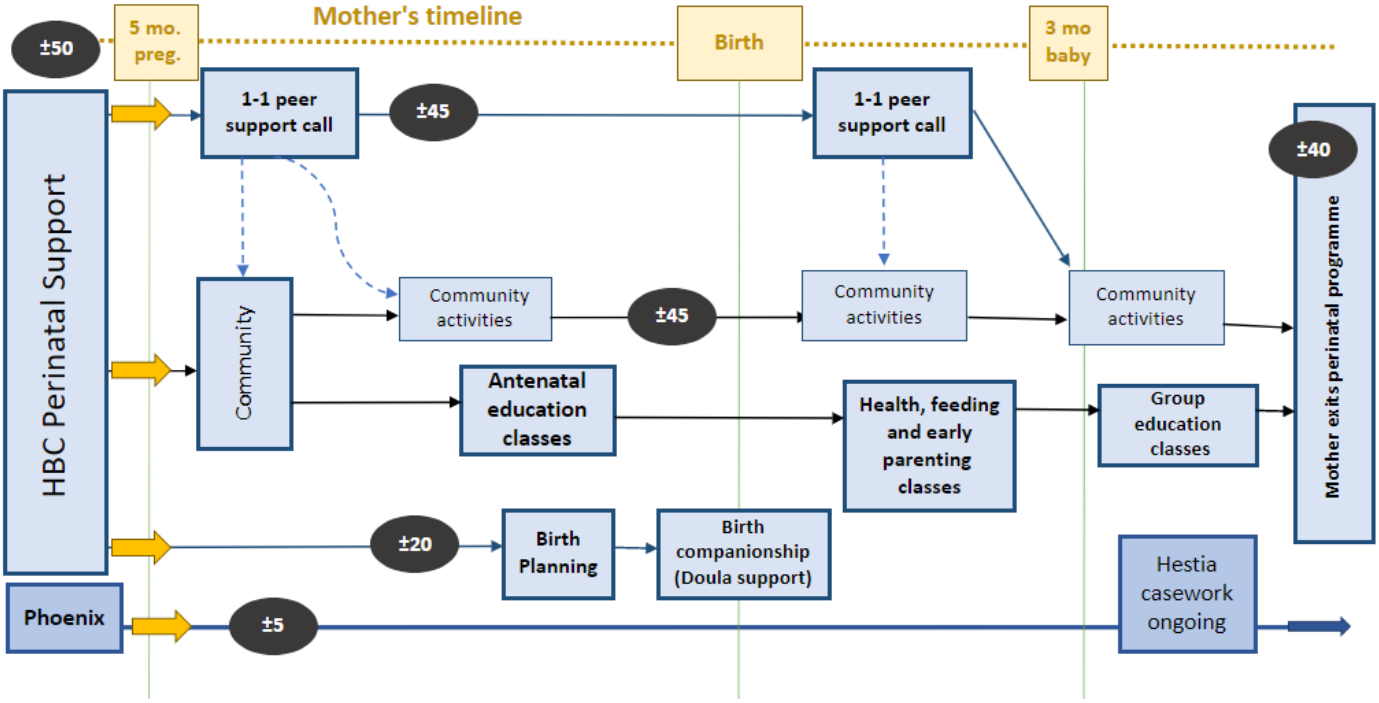


Figure 4.2.1 : Mother's journey through the project

Entry and Exit Referral Routes

To support the map of women's journey through the services, we list some of the referral links into and out of the project.

- Entry: Migrant Help referrals, midwives, GPs, health workers, perinatal mental health nurses, family support workers, self-referrals, Little Village, Pram Depot, Maternity Mates, Birth Companions and sometimes clients refer their friends.
- Exit: back into HBC regular community activity, plus referrals to other voluntary organisations like HomeStart, Baby banks, Children's Centres and local mother/ baby groups.

Key referrals during the project will be raised through peer support calls, conversations with staff and caseworkers, which may include safeguarding referrals, doctor and counselling appointments or meeting practical needs. Between February and December 2021, 74 emergency baby boxes were given to mothers in partnership with Pram Depot.

Those entering HBC support must meet the following criteria: have Leave to Remain under 12 months; or still be within an asylum-seeking process (all in transitional periods); who are pregnant mothers; or who have a child under 3. Some existing or previous service users who get pregnant again may come back into project. They can be referred in a number of ways such as through an online form and will go through an entry process that gathers information regarding health, status and practical needs in order to set up the necessary support.

4.3 Additional supporting aspects of the Project

Service Partnership

In addition to the referral services listed above and through the casework support the project offers, both partners work with other organisations including health commissioners, local authorities and other statutory and non-statutory bodies. These collaborations include other joint delivery of services, advisory roles, inter-agency knowledge sharing and training, mutual service design and strategy development, all of which extend the project's remit to assist in addressing long-term systemic challenges as well as the immediate bespoke support needs of mothers.

"I came to UK at 8 months pregnant, hard to trust anyone, to understand services and who was who and what was offered; professionals need to clarify who they are and what their role is, to not ask for repetition of their past story. It is so hard to have to tell story to someone you do not know or trust yet." – Mother's feedback to project's design

In the last 6 months, the project has built upon relationships with midwifery teams in five key hospitals, as well as deepening work with The Magpie Project and Migrant Help to work towards policy change proposals. There are further stakeholder engagement plans for the coming months, but more work is needed in Phase 2 to better understand the impact of the project on external service provision.

Expert Advisory Group

The Expert Advisory Group (EAG) is comprised of staff, mothers with lived experience of the asylum system, and relevant professionals. The group meets quarterly to discuss and guide decisions about the Starting Well project's delivery. The agenda is led by the operational staff, but substantial time is given to listening and discussing potential solutions and new ideas. This relates to one of the key principles listed below: 'co-design' with women, and ensuring that women with lived experience of birth, early motherhood, trauma and navigating the asylum system are included in the leadership of services that impact them.

There is an ongoing emphasis in many areas of health services and the anti-trafficking movement that co-production of services with those of lived experience is essential to developing the most relevant, appropriate services, especially where trauma and multi-agency working is concerned.

An example of this in action is interpretation provision and the importance of interpretation during labour, a view strongly expressed at the first EAG by women with lived experience. A key aim of the project is to engage with other stakeholders and increase awareness of mother's needs. Following the EAG discussion, a staff member joined the NHS taskforce group on interpretation in maternity services in order to advocate for the target group.

"Postnatal care is weakest part of maternity services at the moment, especially for vulnerable women"- From a professional on the EAG

4.4 Principles in practice

The partner organisations consider these principles - the *way* support is provided – to be essential elements in achieving successful outcomes. It is important for this evaluation to capture how the project makes a difference through its practice in important qualitative individual and relational ways for mothers. While the impact of Covid-19 has led to variation in the details of how support is provided in practical ways, the principles remain the same.

Project documents, data and reports (up to January 2022) were reviewed to identify existing evidence of the ways the principles are enacted in the current project design and delivery. Additional

evidence will be required in Phase 2 from participants and staff's own experiences of the project, to ensure that the findings are supported by the views of the service users, volunteers, and staff. This section responds to Research Question 5 and considers the other research questions and the four activity streams.

Principles B, D, E, F and G (see below Table 4.4) were highlighted as priorities by the partners, so particular attention is paid to these (shown in pink below) for evidence in Phase 2. The 'Evidence needed' column is not exhaustive but indicates further questions to be explored in Phase 2, alongside items explored in Sections 5 & 6.

Hestia's Phoenix project ran a service satisfaction survey in October 2021 which had 18 respondents. It is noted that only a handful of Phoenix's respondents will be participating in the perinatal project with HBC, and as it is anonymous, it is not possible to identify if any are represented among these responses. However, they indicate the type of services being delivered for those who are supported by their services. Some related results from this survey are included in the table below as early representations of the perspectives of the project's participants.

Table 4.4 Exploring evidence of the project's principles

The project...:	Current context examples	Evidence needed
A ...is co-designed with the women	HBC is an organisation developed by women with lived experience. The results of the experiences of women who participated in phases 1 and 2 of the birth companionship pilot project contributed to the design of this project. Supporter calls are led by 'graduates' of the project, and the opportunity for reflection with staff encourages feedback. Mothers with lived experience are now taking on staff roles as well. The Expert Advisory Group includes mothers with lived experience who give feedback on areas of support, drawing on their experience. These mothers have pointed to challenges, such as "lack of knowledge of the health system, challenges to accessing transportation, no internet access for online classes, and no childcare". One example of feedback raised through care expediting change, and verified by the EAG as 'very helpful', was the implementation of new stickers on hospital notes and doula ID badges which helped affirm the relationship between mother and doula (see Section 6 for more details). Hestia's survey asked participants about their knowledge of or participation in meetings with staff to discuss the service: 65% agreed that they take part in these, 35% disagreed or were unaware, and Hestia recognised that there is an opportunity for stronger communication about these.	Hestia – impact of satisfaction survey? Do mothers feel that they can provide honest and comprehensive feedback and are heard and considered?
B ...supports the voice of the mother to be central to her own service provision	This principle is central to the core values of the partners and to doula care. It is emphasised in training materials for staff and volunteers, and particularly for doulas so that the doula can support the mother's wishes where possible through her maternity care. On 'arrival' into the project, mothers are asked what they might like to participate in and what support she might want, e.g. if she would like to be provided with a doula or a peer supporter (along with explanation of what that means). The group activities and classes are voluntary. This principle is best exemplified through the	Is this sense of 'feeling central to their own support provision' reported across the 4 support activities, under both partners, or is there a gap somewhere? Do mothers report feeling able to express their desires within both the project and maternity care? How does, or can, the

	regular supporter calls, as it is an opportunity for mothers to highlight needs and for issues to be escalated.	project identify and address these?
C ...gives opportunities for choice and control	Particularly through birth companionship, mothers are supported to exercise control in preparation and in supporting her choices in birth. Phoenix satisfaction survey found 100% respondents agreed with the statement 'I can control the kind of support I receive'	Phase 2: Mothers reporting experiencing the ability to exercise choice and control through birth and care?
D ...recognises challenges experienced and recognise resilience and skills of mothers	This tension is recognised at the core of trauma-informed birth companionship, which advocates for the mother's inherent strength while also recognising her challenges The opportunity for mothers to become volunteers and even project staff recognises the skills of mothers and the importance of their experiences. Furthermore, this serves as an example to newer participants, demonstrating the nature and extent of progress that can be made through the resilience and strength of similar women.	Do mothers feel they are supported meeting challenges and encouraged and recognised in their skills and resilience? Are there other ways mothers wish to be recognised that they are currently not experiencing?
E ...avoids intensification of trauma.	This principle is demonstrated through the training the doulas and volunteers receive addressing understanding trauma, attitudes to support those experiencing trauma, and examples of how it displays in the survivor's behaviour. This is beneficial as there is an apparent lack of such training among statutory services. The mother's histories may be taken at referral stage, but volunteers and staff are encouraged not to press for re-sharing, but allow space to share if it arises spontaneously, with the option to refer to counsellors for professional support where wanted.	Are there incidences reported? How might a mother raise a grievance within the project? What procedural steps are in place to reduce re/additional traumatisation? E.g. minimum number of points at which women are required/requested to re-tell their personal histories. Have any suggestions come through feedback received about how this can be reduced/eliminated? Have they been implemented?
F ...works in partnership with other organisations and services wherever possible.	As highlighted in Section 4.2, both partners have working relationships with a range of services including civil society organisations and statutory services, leading to referrals into and out of the project, as well as for wider relationship building and change making. Mothers are referred through group engagement, 1:1 support calls or through an allocated caseworker where relevant. Specifically, the project works with Migrant Help and the Rainbow Health Team who have statutory responsibility for the group's needs with asylum status and maternity services respectively. Out of a group of Phoenix service users surveyed in 2021, 90% agreed that their key worker tells them about other services that can help them, one commenting specifically that they are regularly offered counselling. The HBC Hub facilitates other voluntary organisations (e.g. Little Village baby bank, Cityharvest, Ourmala) to provide their specialist services to this community they would otherwise be unable to reach.	Do they feel they can ask for help, and ask for referrals to other services? Do service partners report positive working relationships and benefits they have had from this project? RQ6 Are representatives from any of the services brought in/do they volunteer for the various classes delivered, even on an ad hoc basis? Is training/sensitisation provided to other entities? It is understood that many mothers in this period have a hard time keeping track of all the different service offerings and phone calls they may need to undertake, e.g. maternity appointments while needing to maintain contact with the Home Office for application status. Do

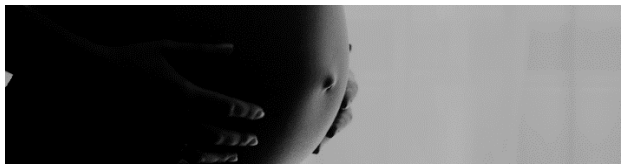
		mothers feel this project adds to the burden or helps navigate the systems and services?
G ...develops skills, knowledge and opportunities	This is the core of the health information classes, with the focus on birth, health and early parenting. Through the wider services of both organisations, mothers can also access further opportunities to develop through training, English classes and volunteering. The EAG offers an opportunity for some to feedback on additional suggestions of skills development. A third of respondents to Phoenix's survey said they felt they were given support for pursuing employment including enrolment onto skills courses, and three quarters of respondents agreed that they were given opportunities to develop skills and interests through volunteering and training. As the mothers' work on a one-to-one basis with the caseworker, they are able to focus on skills and opportunities they want to address.	Are there opportunities mothers would like to have on offer which aren't currently available? Are there opportunities for participants to suggest training or skills development support that they would like?
H ...considers the impact of perinatal period on future outcomes for mum and family	Project is less designed for long term engagement due to the transitory nature of the asylum process but appreciates that the perinatal period provides an opportunity to thrive in future, as the principles of skill, autonomy and empowerment are practised. Those who are supported by Hestia will address recovery and support in other areas of life such as work skills and budgeting. In a qualitative way, the intended impact is that mothers are able to build confidence and self-efficacy, with support aimed at long-term independence and thriving.	The staff keep contact with some mothers who move on - is there a possible question which could be asked here to consider how they are coping independently once moved out of the project?
I ...enhances connection to communities of support for their needs and interests, beyond perinatal needs.	Mothers are encouraged to participate in HBC's wider activities, particularly through support calls. Sessions include yoga and general baby group. Health classes support general knowledge and support around one's own body, selfcare and advocacy beyond birth and baby care. 85% of phoenix clients stated that they were able to have as much social contact as they liked, some commenting that they had gained back confidence and had made more friends outside of the project. Hestia does other events and skills workshops including for jobs, budgeting and ESOL.	Do mothers report feeling connected, opportunity to develop interest beyond birth and baby care? Mothers report engaging with other services or social groups through the recommendation or network of the project? Do mothers report attending non-perinatal group sessions? Do mothers comment on outcome of Hestia additional skills support?

Section 5: Evaluation LogFrame

While working through the project's materials for Phase 1 review, the evaluation team tried to understand the essence of the project: the long-term change and hope experienced by mothers through the project's support, and draw together the delivery, the research questions and the principles into one framework to be able to shape the evaluation indicators.

The goal identified and supported by the core project staff is:

Mothers are confident, capable of, and supported to care for their children and build safe, stable futures



Improvements in perinatal mental health, increased breastfeeding rates and women's access to evidence-based information on birth and early parenting are a part of the desired outcomes as a result of the activities. The LogFrame describes each of the 4 activity sets of the Starting Well-funded project in order to identify key indicators, assumptions, and verification sources for monitoring and evaluation purposes.

	Verifiable Indicators	**Means of Verification**	**Assumptions**
Project Goal:			
Mothers are confident, capable of, and supported to care for their children and build safe, stable futures			
Objective 1 – Birth Companion Support			
Objective 1: Mothers experiences of birth care are improved	**Objective Indicator 1.1**: # of mothers who report that their birth care contributed to their feeling safe, supported and heard	Implementation: Case notes from Charity Log Evaluation: Interviews, Focus Groups	Logistical, practical or other barriers do not prevent mother and doulas ability to meet and engage Trust built between mother and doula Maternity services are welcoming and willing to work with the doula Trust built with maternity services Wider project of support available to women
Outcome 1.1: Preparation Mothers are empowered to make informed decisions regarding their labour and birth	**Outcome Indicator 1.1.1**: # of mothers who report feeling informed to make decisions regarding their labour and birth	Implementation: Birth plans doulas develop with mothers Case notes from Charity Log Evaluation: Interviews Focus Groups	
Outcome 1.2: Birth companionship Mothers' emotional and practical needs are supported during birth and their care preferences are understood and respected	**Outcome Indicator 1.2.1**: # mothers who report feeling supported during birth	Implementation: Case notes from Charity Log Evaluation: Interviews Focus Groups	
	Outcome Indicator 1.2.2: # mothers who report that they were accompanied during birth	Implementation: Case notes from Charity Log Doula survey Evaluation: Interviews	
	Outcome Indicator 1.2.3: # mothers who report feeling safe during birth		

	Outcome Indicator 1.2.4: # mothers who report feeling heard and understood during birth	Focus Groups	
Outcome 1.3: Postnatal support Mothers' emotional and practical needs are supported after birth, including bonding and feeding	**Outcome Indicator 1.3.1**: # mothers who report their emotional needs (including mothers' well-being and bonding) were supported after birth	Implementation: Case notes from Charity Log Evaluation: Interviews Focus Groups	
	Outcome Indicator 1.3.2: # mothers who report their practical needs, including feeding, were supported after birth		
Activities: One to one professional birth and post-natal services (doula and breast-feeding counsellors) – before, during and after birth, translation provided where required i) Information – preparation for birth and post-birth ii) Consistent one-to-one support during labour, including advocacy where required iii) Breast-feeding counselling iv) Post-natal check-up – postnatal intensive support up to 2 weeks after birth from doula			

Objective 2 – Health Education and Group Support			
Objective 2.1: Mothers make informed decisions around birth, health and early parenting due to increased knowledge in these areas	**Objective Indicator 2.1**: # of Mothers who report feeling informed to make decisions around birth, health and early parenting	Evaluation: Interviews Focus Groups	Mothers are able to access classes logistically The mother feels confident enough to attend the offered classes and sees benefit in attending. Content is reviewed for accuracy and up-to-date research and procedure. There is sufficient funding for available interpretation
Outcome 2.1.1: Mothers knowledge on topics related to birth, health and early parenting is increased and accurate	**Outcome indicator 2.1.1**: # of Mothers who report increased knowledge on topics related to birth, health and early parenting	Evaluation: Interviews Focus Groups Feedback from class facilitators?	
Outcome 2.1.2: Mothers feel part of and contribute to an active community of peers and supporters	**Outcome indicator 2.1.2.1**: # of mothers who regularly* engage in community activities *min. 2 activities per month for min. 3 months	Evaluation: Interviews Focus Groups Case notes or class engagement data	
	Outcome indicator 2.1.2.2: # of mothers who report feeling a sense of belonging to a community	Evaluation: Interviews Focus Groups	
Objective 2.2: Support providers adapt services in line with learning obtained through group and support activities	**Outcome Indicator 2.2**: # of support services adaptations adopted, identified through learnings from project activities	Evaluation: Interviews Focus Groups	
Outcome 2.2.1: Partner services are adapted to incorporate feedback and learning from group support activities	**Outcome Indicator 2.2.1**: # of partner adaptations adopted, identified through learning from project activities	Evaluation: Interviews Focus Groups reports	
Outcome 2.2.2: Supporting services are adapted to incorporate feedback and learning from group support activities	**Outcome Indicator 2.2.2**: # of support service adaptations adopted, identified through learning from project activities	Evaluation: Interviews Focus Groups Spontaneous feedback Service surveys?	
Activities: Group-based information provision and support on maternal health, parenting and related topics i) General physical and sexual health class			

ii)	Group antenatal and birth preparation
iii)	Short- and medium-term feeding
iv)	Access/referral to other staff and professional support

Objective 3 – One-to-one and peer Support			
Objective 3: Mothers' wellbeing and connectedness pre- and post-birth is improved through comprehensive, responsive one-to-one and peer support	**Objective Indicator 3.1:** # of mothers who report that one-to-one and peer support contributed towards improvements in their wellbeing and connectedness	Evaluation: Interviews Focus Groups	
Outcome 3.1: Mothers' wellbeing is improved in their transition to motherhood through peer, social, and support networks	**Indicator 3.1.1:** One to one # of mothers who report that one-to-one support was beneficial for their wellbeing in their transition to motherhood	Evaluation: Interviews Focus Groups	
	Indicator 3.1.2: Connectedness # of mothers who report that wider social connectedness (beyond one-to-one supporter) was beneficial for their wellbeing in their transition to motherhood	Evaluation: Interviews Focus Groups	
Outcome 3.2: Mothers with expressed needs access relevant services and supports	**Indicator 3.2.1:** # of mothers with expressed who needs accessed relevant services and supports	Evaluation: Interviews Focus Groups	
Outcome 3.3: A comprehensive pool of volunteers provides effective one-to-one support for mothers	**Indicator 3.3.1:** #/% of mothers who receive weekly one-to-one support from an appropriate volunteer in a timely manner	Evaluation: Interviews Focus Groups	
Outcome 3.4: Peer supporters' skills and confidence to deliver effective support is increased	**Indicator 3.4.1:** #of peer supporters who report increased skills and confidence to deliver effective support	Evaluation: Interviews Focus Groups	
Activities: 1. Volunteer* recruitment and training 2. Weekly calls by volunteers* to mothers – wellbeing check-in for the mother and an opportunity for needs identification; pre and post birth, can start before birth and up to 12 weeks after birth. Can be more indirect/responsive to mother's expressed priorities/needs rather than following a 'curriculum'. 3. Charity log and referral process 4. Reflection sessions for volunteers* ***Volunteers: this includes peer supporters, doulas, health professionals, and breast-feeding counsellors.			

Objective 4 – Hestia Case Worker Support			
Objective 4: *Survivor mothers* develop personal confidence and relevant life-skills through bespoke medium-term case work support, and grow in self-efficacy	**Objective Indicator 4.1:** # mothers who report improved personal confidence and life-skills upon completion of case work support	Evaluation: Interviews Focus Groups	Trusted relationships with referral partners. Service users want to engage, and are able to engage in this season of their life.
Outcome 4.1: *Survivor mothers*' confidence and self-efficacy is increased	**Indicator 4.1.1:** # survivor mothers reflect their general self-confidence is improved over the time of engagement with the project (measure	Evaluation: KPI* data Interviews Focus Groups Case notes	

	includes positive mental health, wellbeing and trust building)		
	Indicator 4.1.2: # survivor mothers report improved self-efficacy (particularly independence in managing their own appointments and connections)	<u>Evaluation</u>: Interviews Focus Groups	
	Indicator 4.1.3: # of survivor mother who move on from intensive casework support into independent living	<u>Evaluation</u>: Interviews Focus Groups	
Outcome 4.2: *Survivor mothers*' life skills (beyond early parenting) are increased	**Indicator 4.2.1:** # of survivor mothers who demonstrate improvements in at least two prioritised life skills beyond early parenting (e.g. computer, money or language skills)	<u>Evaluation</u>: Interviews Focus Groups	
Outcome 4.3 Supporting services are adapted to incorporate feedback and learning from casework partnership and collaboration	**Indicator 4.3.1:** # of support service adaptations adopted, identified through learning from project activities	<u>Evaluation</u>: Interviews Focus Groups Service surveys	Services are open to listening and adapting through working with mothers
Activities: 1. Fortnightly meetings with caseworker 2. Phone support 3. Service referrals 4. Engagement with other skills workshops or appointments *Hestia's KPI method is currently WIP			

Section 6: Recommendations

6.1 Strengths of the project that should continue

1. Champion and deliver woman-centred care that is sensitive, working hard to meet recognised needs and challenges identified by mothers and gaps identified by services.
2. Continue to work with agility, adapting to change and challenge, such as has been demonstrated through the Covid-19 pandemic, changing policy landscape, and continuous self-improvement, to meet the needs of mothers.
3. Offer group meetings through the strength of HBC's community, as this is known to reduce isolation and have a positive effect on confidence and mental wellbeing. Research demonstrates that 'pregnancy circles' [54] and women look to group NHS antenatal education sessions to access information, alleviate fears and normalise experiences[55], improve opportunities for socialisation and meaningful relationships between antenatal care providers and mothers through continuity of carer[56]. Schemes that have continuity component are also positive from public health perspective, as they related to uptake of other health services, e.g. childhood vaccinations.
4. Champion community leadership from mothers with lived experience of the asylum system, birth and motherhood in the UK and other challenges of the target group. The appointment of two staff to lead user engagement within the project is important. In addition, the following is a reflection of lived-experience inclusion and the favourable experiences of mothers through the project:

"The program now has many mums who, supported in the first year, are actively engaged and supported by the Happy Baby Community in face-to-face community groups. It is a key outcome that many mums who have been through this program are keen to support other mums themselves and we have mums who are becoming birth support and trained peer supporters." - Extract from quarterly report to funder, Jan 2022

6.2 Changes already implemented

From its inception, the service has adapted to different circumstances. Some were necessary due to Covid-19, which put restrictions on planned interventions such as face to face group meetings, and the effects of the pandemic on policies for those seeking asylum. We note the agility of the service and responsiveness to the needs of the women, particularly meeting the observed needs of mothers and the feedback loop of the EAG.

"We are all learning from each other"

– HBC staff member at EAG

1. Doula support was extended to 3 weeks in recognition of the needs of new mothers. During this time, mothers receive calls every few days rather than once per week. After this period they will either be referred to a volunteer weekly caller or doula support may be extended for those requiring further intensive support. This was seen to be a high need period, confirmed by mothers as a time where close support felt crucial, especially for those living alone.
2. Women with lived experience are now employed at higher levels of responsibility as staff and/or volunteers of project, including a joint project manager.
3. Increasing language diversity among staff and volunteers is helping to build initial trust from with new mothers.

4. A new sticker and badge system has been implemented for hospital birth companionship – a sticker on the cover of the mother's file highlights to medical staff that she has a doula ready to be contacted, and a badge for doulas to wear in the hospital – both are considered very helpful from mothers with lived experience, especially in consideration of those who have limited English.
5. Staff have been given the task of calling every mother 3-4 weeks after her recorded due date, to check what support she is engaging (or not) and ensure the new mother's needs are met.
6. Reflective sessions available to doulas were rolled out to all staff, volunteers, and peer supporters in recognition of the intensity of the support role. These sessions aim to improve effectiveness, reduce risks of burnout and secondary trauma, and make sure support systems are available.

6.3 Recommendations and opportunities for the further development of the project

These suggestions may already be under consideration. Likewise, these may be longer term considerations to include in future resourcing plans. These suggestions highlight emerging opportunities drawn from the literature review, the team's expertise, and review of current delivery.

Core delivery of service:

1. **Support mothers' own nutrition in postnatal care**: this is key not only for her own birth recovery and physical resilience, but is known to support mental health, milk production for those breastfeeding and support follow-on stages of infant feeding. Help with shopping and meal preparation in the first days can be a lifeline for new mothers, and those struggling to rest or manage other appointments might find this practical support helpful. Mothers may rely on food banks where fresh fruit and vegetables are limited, so providing additional resources might be helpful. Sharing food is also a social connector, so initiatives such as fruit platters at group sessions as well as ethnic food events may help build relationships as well as support health education.
2. **Consider adding postnatal home-visits from volunteers**, not just in the first few weeks to ensure mother has her own basic care needs met (such as nutrition mentioned above), but also less frequent, semi-structured home peer visits to support attachment and encourage other areas of parenting. This model is supported by various studies of statutory and charity parenting programmes for vulnerable families, and benefits physical, mental, emotional and social health for both mother and child[57]. This can be a challenge due to the spread of locations but may be worth exploring with the EAG to gauge desire for such support.
3. Given the challenging living circumstances of many mothers seeking asylum, **introduce specific safe bottle-feeding education**. Expertise exists within the project's staff and volunteers to support education in this, but no specific intervention exists to support mothers with safe bottle practice, especially given the challenges around sterilisation and equipment use. Those who predominantly breastfeed may also benefit from this support, for expressing, for feeding when the infant is older, or supporting other mothers.

Operations

1. **Develop KPIs and increase record keeping measures**: Identify and record Key Performance Indicators based on change for the mothers. While record keeping is a common challenge in voluntary organisations, developing ways to support record keeping can be very useful for monitoring, evaluating impact, future grants, and the safeguarding of

clients when incidents occur. This includes systematising feedback opportunities and recording data from touchpoints already in place such as the supporter calls. These may include subjects such as: exclusive or partial breastfeeding for how long and why; mothers who self-identify with increased confidence and coping in motherhood; or ongoing participation in HBC group activities and external communities.

2. **Share strengths between the two partner organisations**: One of the strengths of Hestia's support is building in clients' self-efficacy and readiness to navigate the next stages of life with confidence and gaining skills and experience beyond the perinatal period. Further development of this aspect of the new allocated caseworker could be considered, particularly for those who are finished with peer-calls and are more settled into mothering. This could encourage mothers to further independence, particularly in her own appointments, and help build budgeting, computer literacy, language and work skills. One of HBC's strengths is cross-cultural community building through groups, which other Hestia clients may benefit from.
3. **Collect feedback from classes**: even in simple and informal ways, feedback can be collected to measure the impact of group activities. An example in relation to mother's access to evidence-based information on feeding could ask for a show of hands in a group class setting 'who knew the information beforehand', or 'who had learnt something new'. A session facilitator could note, for example: 'approx. half of the class indicated that they had been shown this by their midwives', or '5/10 attendees didn't know this before'. Further notes could support useful feedback identifying knowledge gaps for future planning or funding: 'one commented that they learnt new English words for body parts in the class which helped them understand what the health visitor had told them this week.'

<u>Monitoring Impact</u>

The benefit of ongoing monitoring is understanding how activities are helping meet overall goals and provide the evidence of impact, especially observing change over time.

1. **Introduce a mental health and wellbeing screening tool:** The evaluation brief requested a proposal of monitoring methods for measuring the project's impact on mother's wellbeing and perinatal mental health, which more quantitively tracks the wellbeing of the group. While various scales exist including those used by midwifery services, there are limitations on language and accessibility, cultural relevance, and appropriacy for those experiencing trauma. The Warwick-Edinburgh **Mental Wellbeing Scale** (WEMWBS) has been used by other community-based organisations supporting people from diverse backgrounds, including parenting, youth, refugee, and wellbeing organisations, and includes statements which align to the project's values and principles, including confidence, social connection, and agency. It is verified in 25

languages and provides guidelines when interpretation is required. Responses can be collected at entry and exit as a minimal reflection of change over time, but there are ways to consider the statements during existing touchpoints such as peer phone calls, or one-off reflective conversations based on the WEBWMS themes. While these will not provide a full picture of the women's difficult and complex experiences of their circumstances, they may reflect general trends to the partners. We recognise the challenges facing the mothers on a practical level, and the already resource intensive support given to mothers on a regular basis, so this may be something to consider in future planning, following review with the EAG and partners.

2. **Introduce breastfeeding rates measures:** in response to research questions 2 and 3, data reflecting the extent of breastfeeding at birth and age 6-8 weeks could be recorded in line with national statistics. While no distinct comparison group exists in external data due to the particular demographic nature of the client group, rates of feeding methods within the project can be understood within the wider context of UK national and regional practice through NHS Digital's Maternity Services Data Sets (MSDS). These show babies' first feed and the breastfeeding rates at 6-8 weeks. For example, it is understood that a staff member calls all mothers 3-4 weeks post-birth, whatever support they receive. This could be an opportunity to ask simply: 'do you remember if your first feed was your own milk, donor, or formula?' This can be followed up during supporter calls with a question at age 6-8 weeks, captured by the volunteer in the CharityLog: 'are you breastfeeding all the time, some of the time, or not at all?' As noted from the topic guide for calls, there is already a prompt to ask more personally about how they are managing and if they need help.

3. **Record birth outcomes notes**: some of the data collected by doulas following births in the pilot research may be insightful as to monitoring outcomes for mothers, and it is helpful to revisit this survey method and continue it within birth companionship. The data collection instruments could be adjusted to capture some of the KPIs and key research questions of this project, including records of how mothers felt, negative interactions from staff, records of traumatic experiences, as observed or collected by the doula so as not to add burden on the mother. This may help the organisations to increase understanding of mothers' needs as well as collect evidence and learning for the project's ongoing improvement.

Section 7: Phase 2 Plan

7.1 Evidence Gaps

Through a good understanding of the delivery of the project and the context in which the mothers find themselves, we can see that the project supports a strong foundation for positive experiences, working towards the overall goal of mothers becoming confident, capable of and supported to care for their children to build safe and stable futures.

This process so far most crucially misses the voices of project participants, and the majority of gaps identified can be better understood through primary data collection which calls upon the mothers' own experiences of the project's support.

Existing evidence gaps in response to the evaluation questions are:

1 Perinatal Mental Health

The literature review identified themes of personalisation of care, the support of non-medical persons, continuous carers, specialist trained services, trauma-informed care, cultural inclusion, language support and group educational settings, as beneficial towards supporting improved perinatal mental health, all of which can be identified within the intended design of the project. To understand whether the mothers across the group express that their mental health has been supported by any or multiple of these activities, primary data collection is essential. As indicated by the Logframe in Section 5, themes which indicate improved mental wellbeing such as confidence, self-efficacy, autonomy and trust will be explored. We will interview peer supporters who have already been through the project to help us understand some of the medium-term effects of the project's support on mental health as well.

2 Breastfeeding rates

From an external, expert perspective the charity is well set up to support breastfeeding, with one-to-one and group support available to all mothers in some way. Phase 2 will ascertain whether the mothers found their interaction with the project helpful to starting or maintaining feeding, and if they felt they could ask for help when they needed it, and whether the resources were helpful or if there were any difficulties or gaps. As mentioned in Section 6, without recording feeding behaviour across the group, it will be difficult to know quantitatively if the project helps increase rates.

3 Feeding information

While we understand the barriers women face to receiving support through services, Phase 2's primary data collection will ask mothers if they feel their knowledge has increased on topics relating to feeding, as well as birth, health and early parenting through health education and group support provided by the project.

4 Mothers' overall experience

This question can only be understood through qualitative data collection amongst the mothers, both project participants and peer volunteers, who have experienced the project's support. The Logframe in Section 5 laid out the key themes and indicators which we will draw upon to understand the experience of the mothers across the project's activities.

5 Application of the principles in practice

Through analysis, we will identify examples of principles outworking in the project's delivery. The five key principles still ask:

The project....:	Evidence Needed
B ...supports the voice of the mother to be central to her own service provision	Is this sense of 'feeling central to their own support provision' reported across the 4 support activities, under both partners, or is there a gap somewhere? Do mothers report feeling able to express their desires within both the project and maternity care? How does, or can, the project identify and address these?
D ...recognises challenges experienced and recognise resilience and skills of mothers	Do mothers feel they are supported meeting challenges and encouraged and recognised in their skills and resilience? Are there other ways mothers wish to be recognised that they are currently not experiencing?
E ...avoids intensification of trauma.	What incidences have been reported during the perinatal period? How might a mother raise a grievance within the project? What procedural steps are in place to reduce re/additional traumatisation? E.g., a minimum number of points at which women are required/requested to re-tell their personal histories. Have any suggestions come through feedback received about how this can be reduced/eliminated? Have they been implemented?
F ...works in partnership with other organisations and services wherever possible.	Do service partners report positive working relationships and benefits they have had from this project? RQ6 Are representatives from any of the services brought in/do they volunteer for the various classes delivered, even on an ad hoc basis?
G ...develops skills, knowledge, and opportunities	Are there opportunities mothers would like to have on offer which aren't currently available? Are there opportunities for participants to suggest training or skills development support that they would like?

6 Service interactions

We are yet to understand if the project's partnerships through referrals, training opportunities, common clients and other ways of working benefit those external services at all and contribute towards reducing the burden upon those services. Additional data collection will be essential to answering this.

Other questions to explore regarding relationships with external support services might include:

- Do mothers feel they know what options are there?
- Do they feel they can ask for help, and ask for referrals to other services?
- Is training/sensitisation provided to other entities?
- It is understood that many mothers in this period have a hard time keeping track of all the different service offerings and the phone calls they may need to undertake, e.g. health and maternity service appointments while needing to maintain contact with the Home Office for application status. Do mothers feel this project adds to the burden or helps navigate the systems and services?

Other considerations

- We also hope to also understand what gaps in services mothers see, and recommendations which could be explored by the project, or the project's advisory relationships with practitioners and policy makers.
- Additional data collection opportunities for the day-to-day running of the project were recommended in Section 6, for example records of feeding rates or opportunities for wellbeing screening. These provide the opportunity for additional insight on some of the indicators for impact reflected across the wider group.
- If time and budget for the evaluation is constrained, we will work with the partners to evaluate priority areas and identify opportunities for more streamlined data collection methods which still enable us to gain further understanding.

7.2 Phase 2 Planning

Before beginning Phase 2, we intend to review this report with the EAG as well as seek recommendations from them regarding our approach to data collection. We wish to gauge from those with lived experience of trauma and challenges during their perinatal period any things to consider while working with mothers.

Planned Activity	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Beyond
EAG review Ph1 report and Ph2 proposal for data collection											
Preparation, ethics and tool development											
Data collection and transcription											
Secondary data review											
Analysis and report writing											
Report dissemination and impact											

**Secondary data review includes surveys, reviewing documents, monitoring and any further secondary data*

We have applied for additional funding which, if successful, will support Phase 2 data collection activities, support publication in academic journals, and disseminating and presenting to diverse stakeholders from Healthcare, CSO, Government and Academic sectors. We expect to know if this application is successful by the end of April 2022.

7.3 Phase 2 Methodology

The suggested methodology is proposed as the preferred approach which can be discussed with key project staff and the EAG. Based on research priorities and resources, we plan to engage a maximum total of 60 participants from across 4 key categories. The selected participant groups are:

1. Mothers: total of 30, 5 of whom have received Hestia's Casework support
2. Peer volunteers: total of 10, who received perinatal support through HBC and now volunteer
3. Doulas & Infant Feeding counsellors: total of 6, two of whom offer infant feeding support
4. Project Staff: both Hestia and HBC, two key members from each organisation (total of 4)
5. External staff: both NHS Maternity staff and other voluntary organisation partners (up to 10)

A fifth category, below, will be engaged in qualitative surveys or focus groups as opposed to interviews in order to reduce the time commitment from service staff, which may be discussed with project partners. Surveys could remain anonymous to encourage more forthright feedback, whereas focus groups may allow for richer discussion.

We plan to introduce the evaluation activity to the community through group events, staff and information sheets. All mothers, volunteers and staff would be invited to join, and then we would undergo a sampling process, reaching out if we are missing particular perspectives. Factors for this include:

- Spread of languages and nationalities
- Spread of ages of infants to capture some who were supported earlier in the project (2021 babies) and some later (2022 babies)
- Mix of those who had a doula or not, were under Hestia support or not, and who received breastfeeding support or not.

While undergoing lived-experience consultation for a related perinatal research project, the evaluation team understood that it would be acceptable, if not preferable, to undertake focus group discussions as well as one-to-one interviews. This is efficient for the team pragmatically, but more importantly it also allows us to make the most of existing group dynamics, help with rapport

and support clarification of purposes. One way of doing this, particularly for volunteers (peers or professional perinatal support), could be for the evaluation team to utilise one of their regular reflective sessions, which are already in place, thereby reducing time pressures while still allowing space for reflection for the participants. The range of languages spoken among mothers may limit the scope of this approach; this could be mitigated by holding different groups in English, Albanian and another key language, with additional participation collected on a more one-to-one basis.

All participants will be provided with a short explanation describing the purpose of the meeting and review the terms of information storage and analysis process, who we are, and will be given the opportunity to provide informed consent. Those participating should have the opportunity to participate in their own language, supported by interpretation services.

The topics will not explore any personal histories or traumatic details, especially prior to the project, but we recognise that these may be shared spontaneously by the participant. A distress protocol will be in place, and the methodology and tools will be approved by the University of Nottingham's Ethics review process before data collection is carried out.

After more robust primary evidence collection in Phase 2, followed by analysis of primary and secondary data, we will generate a final report including recommendations for other services looking to support mothers with similar experiences to those participating in this project.

7.4 Topic Guide

The topic guide included below reviews some of the essential themes drawn from this report that need to be included in primary data collection in Phase 2. These have been drawn from literature, the project analysis, evidence gaps and the Logframe, found in Sections 3-5. Once the tools have been developed in more detail later this year, the format will be signed off by project partners and the EAG.

The topics are shown for the generalised groups of mothers (currently or recently supported by the project, and peer volunteers who had received project support in the past), project support providers (i.e. doulas, staff, other professional volunteers who directly support the project and its activities) and external service support providers (including midwifery services and local community partners).

<u>Mothers who have experience receiving support from the project</u>

- General Interaction with project: stage of perinatal care/ age of child, what support they get or things they've participated in, how they heard about the project, was there any further information they needed when thinking about joining
- Mental Health
- Birth support (with doula) – experienced feeling safe, supported and heard, practically and emotionally supported during and after birth
- One-to-one or peer support, reporting this support contributed towards improvements in their wellbeing and connectedness, support navigating services

- Groups and health classes, access to information including skills development and training, feeling informed to make decisions around birth, health and early parenting
- Infant feeding
- Negative Incidences during perinatal support
- Experience of Principles B, D and G
- Gaps and opportunities
- For those relevant: Hestia Casework: improved personal confidence and life-skills
- Peers only: transition out of the service, reasons for volunteering, training, further impact of ongoing relationship with the project.

Doulas, staff and caseworker

- Background info on role and responsibilities, including languages spoken
- Skills sharing and education with mothers
- Trauma, grievances and safeguarding
- Training, initial and ongoing, including any gaps or needs
- Anecdotes from working with mothers
- Things they have learned or adapted because of mothers (including adaptations adopted, identified through learnings from project activities)

External service providers

- Background information on role and nature of partnership
- Positive experiences
- Negative or challenging experiences
- Are representatives from any of the services brought in/do they volunteer for the various classes delivered, even on an ad hoc basis?
- Learnings they have taken from the project's partners, workshops or the mothers (or want to)
- Recommendations for the project staff or intervention

Section 8: Conclusion

This is a service operating in a tough climate with a special and vulnerable constituency and the partners have demonstrated that they are sensitive to the needs of this special group. The project addresses the disempowerment experienced by mothers within other settings by listening, being with, and opening the door to participation - with indications of positive results. The community the partners are cultivating, supported by external service relationships and pro-actively peer-led, personalised care and attention to detail, is important for contributing to safety, confidence, and recovery.

Having a baby is never easy, being an asylum seeker in a foreign country that is determined to present a 'hostile environment' makes it all the harder. The provision of this suite of services is important to offering women in these circumstances across London a safe place to belong and sensitive, expert support to navigate the transition to motherhood, immigration procedures, health services and formation of a new community and her place within it.

A continued commitment to careful, sometimes subtle, ongoing improvements guided by clients and good practice is an excellent path for this project to follow, working towards seeing participating mothers emerge feeling confident, capable of and supported to build safe and stable futures for themselves and their children. We look forward to engaging more directly with the project participants, staff and volunteers to establish a deeper understanding of the impacts of this important work through the remaining months of its implementation.

Appendix 1: Literature Review and Context criteria

Terminology

Key theme focus	Target group
Mental health, perinatal mental health, mental wellbeing, trauma, stress, Trauma-informed care	Asylum seeking, displaced, refugee, migrant
Breastfeeding rates and barriers, Feeding babies information, support, breastfeeding counselling	Modern slavery, trafficking, sexual exploitation
Community support, voluntary support, peer support, charity, volunteer, NGO	BAME
Maternal, perinatal, antenatal, postnatal, maternity, midwifery, NHS, health service, GP	Disadvantage, vulnerable, complex social factors
Doula support; volunteer doula, trained doula, Continuous birth support	
Early parenting, new mums, mother, attachment, bonding	

Parameters: prioritising but not limited to...

- English language papers
- Time frame: Priority – since 2015, if drawing low yield – since 2010 (and if highly relevant – since 2000)
- UK focus, (unless directly related to research questions, expand to EU, Canada, Australia and NZ for similar healthcare and migration settings)
- Pregnancy and up to 1yo infant (when looking at vaccinations, feeding and weening focus)
- Evidence level: review (eg systematic review/ narrative metasynthesis (qualitative focus))

Policy context

- NHS Five Year Forward View (2014) https://www.england.nhs.uk/publication/nhs-five-year-forward-view/ and Next Steps (2017) https://www.england.nhs.uk/publication/next-steps-on-the-nhs-five-year-forward-view/
- Maternity transformation and 'Better Births' paper by National Maternity Review https://www.england.nhs.uk/mat-transformation/ - https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf
- Perinatal Mental Health Care Pathways https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/perinatal/nccmh-the-perinatal-mental-health-care-pathways-short-guide.pdf?sfvrsn=4f52dbb3_4
- Healthy Child Project https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Project.pdf

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