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Navigating institutional constraints: A phenomenological study of specialist midwives' relationships with women seeking sanctuary

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ABSTRACT

Background: Women seeking sanctuary as refugees and asylum seekers face significant barriers accessing maternity services in the UK. Whilst existing research largely focuses on women's experiences, this study explores the lived experiences of specialist midwives navigating their relationships with women seeking sanctuary within complex institutional and socio-political contexts.
Aim: To explore the lived experiences of specialist midwives developing relationships with women seeking sanctuary.
Methods: A hermeneutic phenomenological approach was used to explore the experiences of six specialist midwives working with women seeking sanctuary in England. In-depth interviews were analysed interpretively, drawing on Foucault's theories of disciplinary power and governmentality, alongside the concept of positive deviance.
Findings: Five themes were identified: (1) bridging between services, (2) specialist knowledge, (3) adapting care, (4) building trust, and (5) navigating hostility. Midwives described relational practices that often defied institutional norms, positioning themselves as advocates and change makers.
Conclusion: Specialist midwives' were able to work within institutional constraints to achieve positive relationships with women. The ability to develop meaningful relationships with women seeking sanctuary was facilitated by protected roles which afforded time, autonomy, continuity and flexibility. These findings highlight the value of positively deviant practices in sustaining compassionate, relational maternity care. The study calls for investment in specialist midwifery roles to better support women seeking sanctuary and advance equitable maternity care.

Introduction

There is a welcome increase in attention within maternity services towards women seeking sanctuary (Royal College of Obstetricians and Gynecologists, 2022; Royal College of Midwives, 2024), with research largely focusing on women's experiences (Fair et al., 2020; Pierce et al, 2025). A significant gap remains, however, in understanding how specialist midwives experience their relationships with women seeking sanctuary.

This study adopts a hermeneutic phenomenological approach to explore the lived experiences of six specialist midwives, focusing on their experiences of relationships with women seeking sanctuary, within complex institutional and sociopolitical contexts.

We draw on Foucault's (1977) theories of disciplinary power and governmentality, situating the experiences of these midwives within wider institutional structures. Conceptually we also draw on positive deviance (Spreitzer and Sonenshein, 2003), examining how these midwives challenge institutional norms to effect change.

This paper begins with a background; followed by the methodological approach. Findings are presented across five themes: (1) bridging between services, (2) specialist knowledge, (3) adapting care, (4) building trust, and (5) navigating hostility. Foucauldian theory situates the findings within a broader analysis of institutional constraints, and we consider how these midwives are positively deviant, developing solutions to overcome constraints. The paper concludes by reflecting on how these midwives' positively deviant practices offer insights into

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navigating institutional constraints.

Background

In 2022 almost 1 in 3 live births in England and Wales were to women born outside of the UK (Office for National Statistics, 2023). Many have intersecting vulnerabilities including limited English language proficiency, being from a Global Majority ethnicity, living in poverty and being unfamiliar with services. Consequently, these women are more likely to experience poor outcomes than White, British citizen counterparts (Felker et al, 2024).

People seeking sanctuary are often poor as they are prohibited from working whilst their claim is processed, without access to public funds (Refugee Council, 2024; Maternity Action, 2022). The asylum process itself can be protracted, leaving individuals in prolonged states of uncertainty about their futures (British Red Cross, 2023). Many women referred to in this study were living in Home Office provided accommodation, such as hotels or housing operated by private sub-contractors. This accommodation is often unsuitable and has been shown to negatively impact physical and mental health (Refugee Action, 2023; Doctors of the World UK, 2021).

To explore the institutional dynamics shaping midwives' relationships we draw on two theoretical concepts, Foucault's theories on power and institutions; and the concept of positive deviance.

Foucault (1977) conceptualised institutions such as hospitals as sites of disciplinary power, where individuals are governed through surveillance, regulation, and self-discipline. This concept frames both women seeking sanctuary's position within a system of control through the Home Office, and how midwives' care work is governed through surveillance within the NHS.

Positive deviance (Spreitzer and Sonenshein, 2003) is an asset-based approach to understanding how positive outliers succeed in restrictive environments, through achieving better outcomes despite facing constraints. In this context, we apply the concept to explore how specialist midwives deliver exceptional care while navigating institutional constraints from the Home Office and NHS. The concept has previously been used within midwifery scholarship (Liberati et al, 2019; Dooley et al, 2024), reflecting a shift from focusing on risk and failure to examining success as a route to organisational change (Lawton et al, 2014). Here, the midwives interviewed are in specialist roles which are non-statutory and typically under-resourced, however, they develop trusting relationships and deliver effective care in highly constrained conditions. Positive deviance here illustrates what can be learned from these outliers, prompting reflection on how maternity services could improve for women seeking sanctuary.

Some research exists focusing directly on the midwife's experience caring for women seeking asylum (Bennett and Scamell, 2014; Feldman, 2014; Goodwin et al, 2018); however there remains a gap in understanding the role of specialist midwives who work in this field. This is likely because these roles only exist within a handful of sites across the UK. The recommendations from NICE for antenatal care for women seeking sanctuary is encompassed within the "Pregnancy and complex social factors" [CG110] guideline, with a broad scope also including women who misuse substances, young women and those who have experienced domestic abuse (NICE, 2010). There is limited advice specifically on appropriate care provision for women seeking sanctuary, leaving this up to the discretion of individual NHS services.

This study aims to address this gap by exploring how six specialist midwives experience their relationships with women seeking sanctuary. In doing so, we illuminate how care is contextualised and shaped, by two key institutions, the NHS and the Home Office.

Ethics, Methods and Participants

Ethical approval was gained for this study from City St George's, University of London ethics panel REF: ETH2425-0829.

The approach of hermeneutic phenomenology was chosen to explore the lived experiences of specialist midwives, focusing on relationships with refugee women. Hermeneutic phenomenology supports a deep, interpretive understanding of how meaning is constructed through social and relational contexts (Neubauer et al., 2019). Semi-structured interviews were used to generate context-specific narratives about these relationships. The research process followed the hermeneutic framework outlined by Fleming et al. (2003), as adapted by Alsaigh and Coyne (2021) and Aijawi and Higgs (2007), detailed in Table 1.

Inclusion / Exclusion Criteria

The population group comprised midwives in specialist roles who work with women seeking sanctuary in England (Table 2).

The sample was limited to England as the implementation of entitlements to care can vary across the devolved nations (Maternity Action, 2022).

Recruitment

Convenience sampling was used, with midwives recruited via established research and professional networks.

Table 1
Methodological framework (Based on Fleming et al. (2003), Alsaigh and Coyne (2021) and Aijawi and Higgs (2007)).

Step	Process undertaken
1. Deciding upon a research question	Prior work related to PhD project. Question phrased so it was suitable for phenomenological inquiry.
2. Identification of Pre-Understandings	Pre-understandings of the primary researcher (KW) were explored through reflective writing and an exercise in asking oneself the questions which would be posed to participants. As a midwife with experience caring for refugee women, positionality was integral to explore prior to engaging in data collection.
3. Gaining understanding through dialogue with participants	Interview process.
4. Gaining understanding through dialogue with text	Process of transcription and analysis. i. Immersion with data ii. Investigating each sentence to expose meaning iii. Abstraction Iv. Synthesis v. Illumination of phenomena.
5. Establishing trustworthiness	Process of ongoing reflexivity to ensure integrity, credibility and trustworthiness of the findings.

Language use: The term 'people seeking sanctuary' will be used to include asylum-seekers, refugees, those who have been trafficked or have other insecure migrant status. This term is used to challenge the dehumanising rhetoric often associated with these labels (City of Sanctuary UK, 2020).

Table 2
Inclusion and exclusion criteria.

Inclusion	Exclusion
Registered Midwife with the Nursing and Midwifery Council.	Midwives whose registration with the Nursing and Midwifery Council has lapsed, retired midwives, nurses, birth workers, doulas, lay people.
Midwife with a specialist role which includes working with asylum-seeking or refugee women. Potential job titles: Public Health Inclusion midwife; Asylum-seeker and refugee specialist midwife; Vulnerable women's specialist midwife; Equality, Diversity and Inclusion midwife; Race Equity Lead midwife or a community midwife working with a specific group of 'vulnerable' women which includes refugees/asylum seekers.	Midwives not working within a specialist capacity to care for asylum-seeking women. Midwives with specialist roles such as diabetes specialist midwife; triage specialist midwife; mental health specialist midwife.
Working in England.	Midwives working outside England (including the devolved UK nations).
At least 6 months experience in specialist role.	Less than 6 months working in the specialist role.

Interview

Interviews were scheduled flexibly around each midwife's work commitments and conducted via Microsoft Teams, with recordings and transcriptions made with consent.

Following a conversational style, interviews relied on participants' reflection to revisit a care encounter with a refugee woman. In hermeneutic phenomenology, van Manen (2017) describes interviews as both a means to explore the phenomenon and to develop its meaning through dialogue (Lauterbach, 2018).

Data analysis

Data analysis and immersion began with repeated readings of the transcripts to gain a holistic understanding. NVivo 14 was used to manage data and to identify preliminary codes.

Each sentence was investigated to expose meaning, and abstraction took place through inductively generating codes which were synthesised into emerging themes. Themes were iteratively refined and interpreted in relation to the overall meaning, with consistent reference to the central research question throughout.

Analysis was led by the first author (KW), with thematic interpretations discussed collaboratively among all authors to enhance rigour. This was followed by a phase of deeper interpretation, where themes were situated within the broader context of maternity care provision in the UK. This stage reflects Heidegger's (1962) concept of the hermeneutic circle, acknowledging the interrelationship between the phenomenon, the researcher's understanding and the socio-cultural context.

Findings

Five key themes were identified that provide insight into midwives' experiences of their relationships with women seeking sanctuary: (1) bridging between services, (2) specialist knowledge, (3) adapting care, (4) building trust, and (5) navigating hostility.

1. Bridging between services

"I describe myself … as like the glue that holds all the services together … I'm more than happy to contact people on your behalf to remove that barrier of worrying about what's that appointment for … I'll do the referral for you. Like I will just hold everything together … I'm happy to be the go to." (P1)

The above quote summarises the importance of "being a bridge" which all midwives alluded to. All midwives expressed joy at being that "go to" person for the women, and a level of job satisfaction in having the knowledge and capability to navigate across multiple systems, *"It makes my job even more worthwhile … supporting women, you know, regardless of what they haven't or have got, it's such an amazing feeling"* (P5).

All the midwives spoke about the number of additional services they worked alongside including GPs, interpreters, local authorities, health visiting teams, local charities, hotel staff, the Home Office, housing associations and in one case the Ministry of Defence. These specialist midwives developed personal relationships with other key players helping them bridge gaps for women, *"I know the people in the Council responsible for our refugee integration work"* (P2). Midwives capitalised on existing contacts to enact change, *"if you know who to go to in the ICB [Integrated Care Board], why not go to them?"* (P6).

This was not only the case in navigating the maternity sector but also navigating the Home Office. One midwife stated, *"they'll* (the Home Office) *… listen better to the midwife. Well … they do. They shouldn't … they think of it as some sort of authority from the hospital or something and we should definitely capitalise on that"* (P3). This advocacy role between services was fundamental to building trust.

Having an individual midwife as the bridge between systems was useful for other professionals, "(midwives from) *other Trusts then kind of came to me for advice"* (P6) and *"she lives in this area, she's in this hotel, I contact this baby bank – done"* (P6). The midwives all used their skills and expertise from bridge building to shape development for other staff, to develop enhanced care pathways and open channels of communication between institutions.

2. Specialist knowledge

"Knowledge for me is going to be the power to … make more of a difference and just make sure that I set the women up from the very beginning with the knowledge that I've got … because I feel like … if I'd have known, I could have done a lot more for her" (P5)

A common theme was the midwife expressing how much the knowledge they required was different from standard midwifery. Midwives described how their role had been a steep learning curve in navigating the Home Office systems, women's entitlements to care and financial support, finding local refugee charities and baby banks.

Midwives commented on the need for the specialist role to be separate from generic roles surrounding vulnerability, *"We did have a specialist team … but their primary focus was safeguarding … so most of these families didn't get … additional time"* (P1). Some positions encompassed women with any additional social vulnerability such as child protection cases, women with substance misuse issues, teenage pregnancies and prisoners. Women seeking sanctuary were hence not prioritised because they did not necessarily present child protection risks.

Although safeguarding risks in relation to child protection were not generally a concern, the midwives did describe how their role involved safeguarding for trafficking. It was clear that these midwives required highly specialised knowledge surrounding the nuances of trafficking, red flags, and escalation. This knowledge was evident in the intuition midwives developed, *"do you not think if there's loads of* [specific ethnic group] *and loads of suitcases and people are heading somewhere that this isn't some sort of hub for trafficking?"* (P2).

One midwife was aware that some women trusted the Organised Crime Gangs (OCGs) more than midwives, who represented the institution. With limited time to develop relational trust, the midwife had learned to be frank with women about the likelihood of further trafficking,

"I'm a little bit more direct now and I say things like … sometimes we have quite a few [specific ethnic group] *women who come to this hotel following a boat crossing and then they disappear. We think probably the*

gangs are taking them away. And then I'll say, do you think that might happen to you? Are you still in contact with the gang?" (P6).

This direct style of communicating about the continued risks associated with OCGs is not a generic element of the midwife's role. The expertise and experience of this midwife was fundamental for her to provide this enhanced care.

Participants were curious about what women needed from them, and keen to get it right culturally, *"What do you need me to know about you in the greater context of your life? Where have you come from? Why have you come here? How can that inform how I support you?"* (P1). One midwife would make the effort to ensure cultural aspects of the woman's experience were respected.

All the midwives described seeking out further knowledge through training courses, working alongside other professionals and doing their own research. Some were keen that all midwives should be equipped to be *"global midwives"* (P4) able to care for and support women from anywhere.

3. Adapting care

All midwives adapted their care provision from the 'norm', increasing their capacity to develop positive relationships.

Time was a pertinent issue, with one midwife describing the restrictions, *"it really frustrated me that I didn't have that time … I just didn't have control of … my own calendar … there was no autonomy in what I did"* (P1). Midwives adapted the usual schedule of maternity care, *"I was giving her appointments that were about an hour, whereas in clinic the appointments should be about 20 minutes"* (P2). This also extended to seeing women more frequently and being flexible when women did not attend.

Midwives visited women in accommodation centres due to poor public transport, high travel costs, and women's unfamiliarity with services. They also valued home visits for a fuller understanding of wellbeing, *"I've picked up on a lot of things from going to women's rooms"* (P6).

These women had different questions from White British women, much more focused on basic needs, *"How long am I going to be staying in this hotel and how long until I get my Aspen card or … how can I access money?"* (P6). Midwives adapted care to ensure basic needs were met, *"postnatally we had to obviously provide things like sanitary towels"* (P4).

Midwives recognised that women had to juggle appointments with strict hotel mealtimes, "*It's not just like us coming from home … I think of it like school … You eat at this time"* (P3). In response, one midwife arranged for hospital-provided meals for women attending out-patient appointments.

Midwives were highly skilled in adapting language,

"a simple question like … can you tell me about the father of the baby? You … wouldn't think twice about asking that … Now I have to … do a little trigger warning and say it might be distressing, you don't have to answer anything you don't want to … Because so many … have been raped so 'father of the baby' is not really … a term that's even fit for purpose." (P6)

This quote highlights midwives' awareness that despite having interpretation services, that routinely used phrases could be inappropriate. This was also the case with discussing domestic violence, *"Are you safe at home, as in you have doors, you have locks on your doors and not necessarily doesn't translate to asking about … have you experienced domestic violence"* (P4). Due to their specialist knowledge, the midwives knew about these sensitivities and adapted care accordingly.

All six participants spoke about adapting care to remove language barriers through use of interpreters, accessing translated materials and adapting care for women who were not literate in their first language. Three also referred to more subtle communication barriers which they worked to overcome, *"I try to just write things down. I have a bit of paper in front of me. Rather than being sat in front of a computer"* (P5).

Midwives were aware of power imbalances, *"She just felt like I'm here and they're going to do whatever they need to do to me … initially she would just agree to everything … whether she understood or she didn't"* (P4). This was partly due to becoming accustomed to living within institutions, *"you tend to do as you're told"* (P3). Midwives worked to change this, ensuring women understood that, *"just because we wore uniforms … we didn't have rights over her body"* (P4). The midwives expressed pride at empowering women within the maternity setting, "*I felt proud because I felt like she had been empowered to make her own choices.*" (P6).

4. Knowing the importance of building trust

"I don't trust these people with, with lanyards … they may be associated with the Home Office or Border Force or the police, so why would I open up to her?" (P6)

Midwives emphasised that trust was essential, describing women as *"closed"* (P2) where trusted relationships did not exist. Midwives knew women were wary about them representing the Home Office, *"they see people such as myself with a lanyard and a uniform as not to be trusted"* (P6).

Midwives stressed the importance of first impressions, describing the first appointment as *"pivotal"* (P6) and feeling responsibility to *"get it right the first time"* (P4). When time allowed there was a clear difference, *"that whole hour and a half from her coming in with her head down … to then at the end of the appointment where she was just really open … really smiley"* (P5).

One midwife described how quickly trust could be broken, *"they had a negative experience in the hospital … they just disengaged in care"* (P1). As a result, midwives knew they had to be reliable, *"it took time and it took patience. It took consistency … if you're going to say you're going to do something, then do it"* (P6). This was integral for women where trust was easier to break and harder to repair.

Continuity of care allowed midwives to really know the woman and listen to their story. This happened through midwives focusing questions away from the usual structure of the antenatal appointment, *"you could see the family really appreciated that I wasn't going in there … with an agenda … I didn't go in there seeking just to tick boxes"* (P1).

Midwives were professionally curious and through continuity gained deep insights into women's lives, *"how the woman got here … what her job was"* (P5). The midwives adapted their approach to avoid seeming intrusive, *"ask for the woman to give you their story without you asking questions"* (P4). Continuity also allowed midwives to protect women from repeatedly sharing traumatic stories with different professionals, allowing them to build more meaningful relationships, *"a lot … stronger and more engrained than just going to a clinic and saying hello.. goodbye"* (P1).

Trusted relationships often extended to the wider family, with midwives engaging with other children and partners, *"they were continuing on as they would, rather than…interrupting their usual family dynamic"* (P1). They were welcomed into domestic life, sometimes sharing meals and staying longer, *"they keep asking me to book longer slots because they want to prepare me a meal"* (P1). Midwives enjoyed this family-centred aspect, *"See their children laughing and smiling. It's … an amazing feeling"* (P5).

Overall, midwives enjoyed sustaining meaningful, trusting relationships, "*it's been the highlight of my year looking after her … It's been very special"* (P2). Midwives became the person women could access, "*they must be talking about the fact that I provide this care … we do get a lot of the non-English speakers come to the hub and will say can I speak to* [midwife's name]?" (P1), often to complete a form or direct someone to primary care services. Another midwife described this role as a *"real lynchpin for women and a real source of stability"* (P2).

5. Navigating hostility

"People are quite judgmental and I get a lot of comments, of I don't know how you can do it. I couldn't do that job. I don't know how you can keep going back to that hotel. Make them walk here" (P5)

Four midwives reported xenophobic and stereotypical attitudes which complicated their work. They overheard staff blaming asylum-seekers for draining public serves (P4) and resenting specialist roles, suggesting resources were unfairly distributed "*'they should pay … What about the other women?'*" (P3). Midwives commented that society, politics and the media shaped the opinion of their colleagues, "*what people watch and hear on the TV … how much of that you believe and take in when you come into work"* (P3). Midwives knew these views could have negative impacts, "*It does impact care that they receive … especially with the midwives, it's an unconscious thing*" (P4).

Discrimination was a common issue, *"I hear it all the time"* (P4), including from those in the midwives' personal lives (P5). Midwives' responses varied from defensiveness, *"I feel quite protective now of the women in the hotel"* (P5) to advocacy with expressing a desire to *"fight against attacks"* (P4). Midwives reported that some colleagues misunderstood their role, thinking they wanted to impress values onto them, *"I don't have any interest whatsoever in changing anybody's mind … whatever you believe outside of when you step into the trust is … down to you, but as soon as you cross that boundary, whatever you do shouldn't affect anyone negatively"*(P4).

The hospital itself was described as hostile, *"big posters at the door with the immigration information … It stops people coming in"* (P3). Systemic hostility was also expressed by the difficulty some midwives had accessing interpreters *"I've tried numerous times to get a face-to-face interpreter but never managed"* (P2). Midwives commented that booking interpreters was difficult and were concerned that translations could be inaccurate.

Some felt challenging negative perceptions fell outside their professional role. Midwives acknowledged that these views were often unfounded and based on media discourse. Midwives felt that if people had more interactions with asylum-seekers that they would feel differently, *"sometimes I wish they would just go and see for themselves what it's like. You know, hear it from these women themselves and feel their pain"* (P5).

Those in more strategic roles enacted change by including cultural safety in mandatory training. One midwife felt advocacy should extend beyond the role of the midwife, "*we have to be advocates… not just in the system. We are the system. We will advocate for them in the system but* [also] *outside"* (P3). Most midwives were pioneers in their role, improving training for staff and actively working to break down the barriers to effective care delivery.

Discussion

The interviews revealed how relationships between women and midwives were formed within institutional structures characterised by discipline, surveillance and power. Despite these constraints, midwives' demonstrated the ability to navigate the complexities of both the Home Office and the NHS to create trusting relationships. In doing so, they embodied forms of positive deviance (Spreitzer and Sonenshein, 2003), developing adaptive strategies, allowing them to provide effective care within institutional constraints.

Working in an institution: The NHS

The midwives were constrained by the institutional rules of the NHS Trust, a finding supported within midwifery literature (Feeley, 2023). Barriers to relational fulfilment included limited time, inflexible systems and standardised processes ill-suited to this demographic. Standardisation of maternity care can be criticised for undervaluing relationship-based care (Kirkham, 2017), which Feeley (2023) argues is essential for safety in its fullest sense.

The midwives interviewed rejected standardisation, acting as positive deviants. Midwives adapted what was routine, so care became meaningful and personalised. This is echoed elsewhere, where midwives bent institutional rules to adapt care for refugee women (Goodwin et al, 2018; Kasper et al 2022; Filby et al, 2020). This flexible application of institutional rules is not universal, with other studies demonstrating how bureaucratic barriers such as time constraints significantly affected relational development (Pierce et al, 2025; Olcon et al, 2023). Generally, midwives in the UK now see women less frequently, with midwifery time limited due to standardisation. This increased reliance on linear management of time by the clock, illustrates prioritisation amongst community midwives to be 'on time' according to an institutional rhythm, as opposed to 'in time', through relational investment (Deery, 2008).

Some midwives interviewed had support of managers to have diary autonomy and could invest more time in relational care. This increase in autonomy from the institution, meant midwives could be positive deviants through planning workload dependent on individual need. A lack of autonomy saw midwives struggling to defend the need to enhance care, as this contradicted efficiency targets, making it harder to justify.

This reflects disciplinary power and surveillance in maternity services (Foucault, 1977), where midwives work in systems monitored by quantifiable metrics, shaping behaviour by institutional demands rather than professional autonomy or client needs. Midwives spending more time with fewer women risk being seen as underperforming, penalising relational, complex care (Sandall et al., 2018) despite the potential value for safety and public health overall. In this study, some midwives provided care in their own time, outside the institutional boundaries of the shift. This aligns with experiences of other health care professionals who reported working outside their usual hours, going above their clinical duties to provide care outside institutional norms (Pierce et al, 2025). We argue that midwives should be supported to do this relational work within their shift. Undervaluing this work is to the detriment of relational care which remains central to midwifery (Feeley, 2023).

Throughout the interviews, institutional symbols of the NHS such as uniforms or lanyards were inadvertently identified as barriers to relationship development. The NHS provided iPad or laptop was identified on multiple accounts as a communication barrier. Midwives were positively deviant, often rejecting these barriers instead using pen and paper, sitting next to the woman rather than behind a desk and purposefully separating themselves from symbols which might associate them with authority.

Living in institutionalised accommodation: The Home Office

Many of the women midwives described were living in Home Office accommodation such as contingency hotels, army barracks or dispersal housing. This accommodation often does not meet basic standards with poor food quality and limited access to sanitary products, negatively impacting physical and mental health (Jones et al, 2022). The institutional symbols reflected here included locked doors, a lack of control over mobility and an overall erosion of personal choice (Series, 2022).

Burridge and Darling (2024) capture this paradox with the term 'carceral hospitality', describing hotels which outwardly suggest leisure and comfort, yet operate under logics of control and containment. This tension profoundly shapes peoples' experiences, disrupting domestic routines and undermining a sense of belonging.

Within this context, the midwives emerged as positive deviants, going beyond the constraints of their roles to build trust and meaningful connections. Several midwives described being invited to stay longer with the women and being offered refreshments. These acts enabled women to express their identity, sustain social bonds and reclaim some control over their lives (Ballentyne and Drury, 2023; Series, 2022).

Through developing a relationship, midwives actively challenged institutional barriers, employing sensitive communication despite limited time and resources. This helps shift the dynamic from 'us' (the UK) and 'them' (the asylum seeker), to create 'we', fostering belonging and resilience in the face of an otherwise fragmented asylum experience

(Wells et al 2024). This illustrates how positive deviance amongst these midwives helped them create meaningful connections despite the constraining institutional settings, which also inevitably improves maternal and neonatal outcomes.

The role of society

Midwives' experiences of their relationships were also influenced by societal discourse surrounding migration. When interviewed, midwives referred to xenophobic and discriminatory views held by staff members. In the UK, anti-asylum seeker sentiment is growing (Cole, 2009; State of Hate, 2025), fuelled by media and political discourse. Although the number of asylum-seekers in the UK is relatively insignificant in global terms, political and media attention invariably shows a contrary picture (Hynes, 2011).

Foucault conceptualised discourse as a system of knowledge producing and regulating what is accepted as truth (Foucault, 1972). Negative media rhetoric legitimises societal-based discrimination, individual discrimination and reinforces structural inequality (Rojo and van Dijk 1997, Goodman and Kirkwood 2019). The impact is not neutral, with most health care professionals gaining knowledge about people seeking asylum from the media (Harrison et al, 2019). The impact is evident in care provision and outcomes, with stereotyping well documented in high-pressure environments such as Emergency Departments (Harrison et al, 2019).

Within maternity services, Black and Asian women suffer disproportionately poor outcomes, partly due to racism and structural discrimination (MacLellan et al., 2022; NHS Race and Health Observatory, 2022). Additional layers of stigma associated with seeking asylum only increase inequality. Systematic reviews of asylum-seeking women's experiences of UK maternity care (McKnight et al, 2019) and of midwives' experiences (Letley, 2022) report themes such as negative professional attitudes, racism, structural barriers and communication breakdowns, which indicate discrimination. Discourse can sustain discrimination, with narratives such as the claim that asylum-seekers are depriving British people of resources reflecting a distorted reality given the poor living conditions those seeking sanctuary (Lynn and Lea, 2003) yet shaping professional consciousness. Discourse is central to the maintenance of power, through what is said, and hence becomes possible to enact within healthcare institutions.

The interviews highlighted midwives were positively deviant, challenging negative rhetoric, working with community organisations and using their position to advocate for staff training on cultural safety. When working with people seeking sanctuary healthcare professionals tend to have limited communication with community-based organisations (Pierce et al, 2025). Where links with community sector groups do exist, they are invaluable and strengthen relationships (Verschuuren et al., 2023; Filby et al, 2020). Studies examining midwives' relationships with people seeking sanctuary also demonstrate how vital the bridging role is between midwife and community services (Kasper et al, 2022). Forming relationships within the local community allows women to reshape their sense of identity and belonging, illustrating how the relationship with a midwife has immense transformational potential beyond the puerperium.

While some midwives were motivated to drive change, not all identified as agents capable of challenging negative perceptions. Research suggests midwives should engage with the politics of migration (Evans et al., 2022) and use their professional position to advocate for women (Filby et al., 2020). As evident in these interviews, working with people seeking sanctuary can lead to personal ideological transformation, inspiring healthcare professionals to confront social inequalities and foster solidarity (Tomkow et al., 2024). Supporting the work of others (DeSouza, 2013), we argue that midwives should cultivate a political and social consciousness, with positive deviancy extending beyond individual acts, towards collective movements rooted in social justice and cultural humility.

Those interviewed resisted the constraints of institutional power. Through developing trusting relationships and connecting women to local community resources, midwives pushed the boundaries of standardised care, supporting women's agency and belonging.

Conclusion

This research used a hermeneutic phenomenological approach to explore the lived experiences of six specialist midwives as they navigated relationships with women seeking sanctuary. Five key themes were identified, and within the discussion were contextualised within the broader socio-political context shaped by the institutional influences of the NHS, the Home Office, and prevailing social discourse. Foucauldian concepts of disciplinary power and governmentality were used to critically consider how midwifery practice is impacted by institutional forces. Additionally, the concept of positive deviance (Spreitzer and Sonenshein, 2003) was applied to consider how midwives work within the system to foster change, advocating for women and develop meaningful relationships. These findings demonstrate the vital importance of specialist roles, which afforded the midwives precious time, autonomy and resources to provide compassionate care and develop trusted relationships. As such, this research contributes to ongoing policy discussions around equitable maternity care, calling for sustained investment in specialist midwifery roles to better support women seeking sanctuary.

CRediT authorship contribution statement

Katherine Waterfall: Writing – original draft, Project administration, Methodology, Formal analysis, Data curation, Conceptualization. **Christine McCourt:** Writing – review & editing, Supervision. **Marina Daniele:** Writing – review & editing, Supervision.

Declaration of competing interest

There are no competing interests to declare.

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