

Lephard E, Haith-Cooper M, Pregnant and seeking asylum; exploring experiences 'from booking to baby', *British Journal of Midwifery*, 24, 2, 130-136

Pregnant and seeking asylum; exploring experiences 'from booking to baby'

Abstract

Pregnant women seeking asylum in the UK may be particularly vulnerable with poor underlying health, more complex pregnancies and an increased risk of maternal and perinatal mortality. Studies have shown that some women seeking asylum have poor experiences of maternity care. This is despite the implementation of NICE guidelines to improve care for women with complex social factors.

This article reports on a phenomenological study undertaken in West Yorkshire, aiming to explore the maternity care experiences of local pregnant asylum seeking women, to inform service development. Six women were interviewed over a three-month period. The findings focused more broadly on their experiences of living in the UK whilst being an asylum seeker and pregnant rather than focusing on maternity care, although this was included. Five key themes emerged: 'pre-booking challenges', 'inappropriate accommodation', 'being pregnant and dispersed', 'being alone and pregnant' and 'not being asked or listened to'. These findings could be used as the basis for training midwives to understand how the difficulties women experience can impact on their health and social needs.

Introduction and background

Pregnant women seeking asylum in the UK are identified as a vulnerable group in society with specific concerns related to their health and wellbeing (Aspinall and Watters, 2010). They may have underlying health issues, suffering the physical and psychological effects of fleeing traumatic situations and tend to have more complex pregnancies. This has resulted in a higher rate of maternal and perinatal mortality than the general population (CMACE, 2011). It is therefore essential that midwives understand the health and social needs of pregnant asylum seeking women.

Between 2000-2010, studies have found that some pregnant women seeking asylum in the UK had poor experiences of maternity care, with midwives and other professionals not meeting their specific health and social care needs (Gaudion and Allotey, 2008, Waugh, 2010, McLeish, 2005, Briscoe and Lavender, 2009). In 2010, NICE implemented guidelines to improve maternity services for women with complex social factors, including asylum seekers. A woman-centred approach to care was advocated, underpinned by good communication with the midwife who would be working within a multi-agency context to ensure health and social care needs are met (NICE, 2010).

Despite the NICE guidelines, five years later, there is evidence that pregnant asylum-seeking women's needs are still not being met with poor antenatal care and a lack of communication between different health and social care services (Shortall et al., 2015). Also midwives have been found to stereotype migrant women and display poor attitudes (Phillimore, 2014, Psarros, 2014). NICE (2010) recommended that midwives undertake training to ensure they understand the specific needs of asylum-seeking women. However substandard care has been linked with an increased risk of perinatal mortality (Cross-Sudworth et al., 2015) including poor use

of interpreting services, poor information sharing with the woman and wider team and ad hoc approach to social care and support.

In 2011, the Maternity Stream charity was established to address these issues (Haith-Cooper and McCarthy, 2015). The aim was to facilitate local service providers to develop maternity care that meets asylum seeking women's needs. Listening to women's stories is key to this and consequently a phenomenological study was undertaken with the aim of exploring the maternity care experiences of local asylum seeking women to inform local services. This article will now describe this study and how the findings could be useful more widely across the UK.

Methods

A qualitative interpretative approach was adopted to facilitate an understanding of the experiences of women seeking asylum whilst accessing local maternity services. This approach is in line with the tradition of hermeneutic phenomenology where the aim is to understand the participant's lived experience and their perception of the meaning of these subjective experiences (Todres and Holloway, 2011).

Posters were displayed and participants recruited purposively through the voluntary sector and a children's centre (see table 1 for inclusion criteria). Also word of mouth led to an element of snowball sampling. Non-English speaking women were included in the study if an appropriate informal interpreter could be found that the woman approved of as there was no budget to pay for professional interpreters.

Semi-structured interviews were undertaken with six women, the minimum number suggested by Todres and Holloway (2011) to acquire 'profound in depth insights' (p183). These lasted up to an hour, giving the participant time and space to explore any detailed aspects of their experience that was important to them, rather than

simply answering questions that focused on the researcher's concerns (Green, 2005). The interview began with an open question encouraging the woman to relate her story. Prompts were only used when required (see table 2). The interviews were audio-recorded with permission. Two women declined and handwritten notes were made whilst they talked. The audio-recorded interviews were transcribed verbatim and the hand written notes were added into the data set.

Ethical issues

Ethical approval was obtained from the University Ethics Panel 25/02/15, reference E431. Women who expressed an interest received a brief explanation, a cover letter and consent form. One woman who spoke no English had this information translated by a bilingual friend. Future contact was made after 24 hours by phone and a venue arranged. The researcher went through the consent form carefully before beginning each interview and it was made particularly clear that if issues arose concerning the safety of the woman or her child, a referral would be made to an outsider, but that in all other instances confidentiality would be maintained. Also that the researchers had no links with the Home Office and the data would only be used for research purposes, not affecting their asylum case. Participants were informed that they would be able to withdraw their consent up until the writing of the final report. Anonymity was maintained by removing names of study participants and organisations and allocating numbers to the women. Transcripts were stored in a password-protected computer file and locked filing box accessible only to the researchers, and once transcribed, audio-recordings were destroyed.

Data analysis

The principles of Burnard's stages of thematic analysis was adopted (Burnard, 1991) Although rather dated, this structured approach was found useful to guide the novice researcher. It involves read and re-reading to create an overall impression of the data, following set steps to develop themes, coding the data initially, with similar codes which were grouped together, and finally gathered under headings to form themes. The validity of the themes in the light of the original interview data was checked by the research mentor acting as a 'critical friend'. Some participants were also contacted to ensure that the themes were felt to reflect their experiences.

Findings

Four of the six women were from sub-Saharan Africa and two Eastern Europe. Four women had been in the UK longer than a year before becoming pregnant. Two arrived partway through their pregnancy. Five women were primigravida, one in her second pregnancy. Two women were supported by a partner. Five women had varying degrees of English language skills and one woman spoke no English and had an interpreter for the interview.

Although women were asked about their experiences of maternity care in the UK, it became obvious that they all wanted to discuss more broadly their experiences of living in the UK whilst being an asylum seeker and pregnant. This did include experiences of maternity care but not as the main focus. Five key themes emerged from the data related to being pregnant and an asylum seeker: 'pre-booking challenges', 'inappropriate accommodation', 'being pregnant and dispersed', 'being alone and pregnant' and 'not being asked or listened to'.

1. Pre-booking challenges

Before accessing maternity services, women faced difficulties related to being pregnant and an asylum seeker. This led to many of the women booking late for their antenatal care. Two women were already pregnant when they arrived in the UK in the back of a lorry. One was in the early stages of her pregnancy and in poor physical health. She was initially sent to Yarl's Wood detention centre and struggled to receive any health care:

'In (the) morning my friend (I sent her) downstairs in (to the) office rooms to tell the officer that she's sick, that she have to meet the doctor ... And she told me that the doctor will came in (at) 2 o'clock... And I told them I can't wait until 2 o'clock! ...can you bring me a (wheel) chair to go downstairs in (to the) health centre... And they told me, 'Why? What happened with your feet? You have to sign that you are disabled to take the (wheel) chair.' I told them, 'I'm not disabled, I'm just vomiting... 2, 3 days, I'm very tired, I don't have force to walk.' (P5)

P5 waited a long time in the facility's health centre before eventually being admitted to hospital. She was not referred to a midwife until she was around 20 weeks gestation.

Another challenge in early pregnancy experienced by women was registering with a GP which delayed the initial booking appointment. One woman had been in the UK for 3 years and had never seen a GP until she tried to register when pregnant. She experienced difficulties finding a GP that would accept her.

Some women discussed their lack of understanding of their free care entitlement. This was particularly relevant to one woman who discussed how her pregnant friend

who was a refused asylum seeker had no money and thought she was not entitled to access any care.

Accessing maternity services was also a challenge for women who had no cash for bus or taxi fares to attend for appointments. One woman who had her asylum claim refused described how she was given only but a *'butcher card'* (supermarket voucher):

'Sometime I go in Asda or Sainsbury.. (I) saw somebody from Eritrea like me, ask them (for) cash...I needed the cash ... Sometimes I have (to ask) her from (our) shared room, I said, 'Can you borrow for me bus money, sometimes she give me £5 ...' (P4)

2. Inappropriate accommodation

All but one woman identified difficulties with their living conditions. One woman discussed how she struggled to keep her newborn baby warm in the accommodation she had been provided. Half of the women said they felt shocked when they first walked into the accommodation they had been allocated:

'They give me a room (hotel room)...(It was) very small, it was smelling of cigarettes. The duvet was very dirty. The bed... the walls... everything was very dirty. (P3)

P3 also discussed how on discharge from hospital with her new baby, she was sent to another unsuitable hotel room:

'I stayed in the hotel for two months – eating sandwiches and I was on crutches. I can't go downstairs cos I was on top (floor). There were scary people. Men smoking, hanging round. So I can't go in dining room.' (P3)

Arriving at and leaving the accommodation was a problem for another woman:

'The access with the steps is quite hard, because you'd have to leave your personal belongings outside while you are trying to get the rest of your things...when I'm taking my pushchair out...I take the frame out first, then I go for the rest of ...the things ... Sometimes I even leave my handbag outside...when the baby is crying I get...confused ...' (P1)

Inappropriate accommodation also had an impact on health professionals who came to do a home visit with one woman not receiving letters and phone calls and also not hearing knocking on the door due to the distance away from her room.

Another woman was sharing a large house with other women and small children. When she needed to be elsewhere in the house she described how she found it difficult to ensure her baby was safe due to the distance between the rooms:

'...Most times I leave him in the room (when cooking) ...To take the baby in there is... It's too difficult, because the kitchen isn't spacious ...I have to keep running to the bedroom, to just see that he is ok...(You can be) somewhere trying to do, maybe laundry, or cooking, or having a shower and your baby is screaming in the room, without you knowing.' (P1)

Several of the women talked about the challenges of sharing space with a stranger, particularly those who were given a shared room when pregnant. This caused difficulties with keeping the room a comfortable temperature for both women and

with worries about disturbing the other woman if one needed the toilet in the night.

Many of the women discussed the emotional strain of being forced to live with strangers and how the strain took its toll on all the women:

'If you live with...other women (who) are asylum seeker like us - and everyone have problems like stress.. One is cleaning, one not. One is like, shouting, one is quiet. One is like ...the TV loud... That's why it's better to stay like - all by your own, or with the people that you know.' (P5)

3. Being pregnant and dispersed

Five women were moved by the Home Office to a different area during their pregnancy or in the early days with their baby, which they found particularly stressful. They felt socially isolated, not knowing anyone in the new location:

'I have to start again from zero... I was pregnant. And I was sicking (vomiting) all the time. They bring me here....I didn't have nobody here.' (P5)

Women also discussed the difficulties associated with the journeys to the new area. One woman was heavily pregnant, using crutches and had a suitcase to carry. She was asked to make her own way to the new accommodation. The woman couldn't get there alone. She finally arrived the following evening after waiting a full day sat in an office:

'My head was like to burst. They give me ... drink and a sandwich. It was the first time I had eaten all day.' (P3)

After finally arriving at her new accommodation the woman went into labour.

Other women discussed how they were given very little notice that they were moving which created practical difficulties in preparing for the move and an interruption to maternity care:

'I just got a phone call on a Friday morning saying oh ... we've found you an accommodation....we will be picking you up at ... ten...And the phone call came through at just after half past eight in the morning. And that was a week after I had the baby... (P1)

4. Being alone and pregnant

Women identified times when they felt very alone being pregnant in a strange country. This became more apparent in times of stress such as when in labour:

'Just crying, just thinking, I have just me...Why (is) my Mum not here...Cousin, friends... My sister...nothing ...' (P6)

One woman discussed how being alone in labour and not having the support of a birth partner led to her feeling disempowered:

'They want to give me epidural and take me to theatre. They could do anything. I was by myself, didn't have anybody. So I just accept what they want to do.' (P3)

There were times when women needed and appreciated support and women discussed how their midwife supported them in difficult situations. One midwife provided a letter to the Home Office on behalf of a woman who was supposed to be dispersed imminently. Another midwife was a source of constant support throughout a woman's pregnancy:

'... She (community midwife) understand...when I was like ... six month pregnant as well, they stop my benefit, she tried to call them and explain (to) them my about my situation.' (P2)

For another woman, the community midwife helped her to feel less lonely when she visited her on the postnatal ward at visiting time.

Some women discussed how their birth partner was highly valued in labour, providing emotional but also practical support:

'When I had like back pains..'Oh F, I have pain!'...she (would rub) my back all the time. She used to leave her husband her family her - kids just for me and, I'm blessed to have her with me in hospital.' (P5)

5. Not being asked or listened to

Women described situations where they found communication challenging. This was due to a number of reasons, language barriers being the obvious. However there were more subtle reasons. One woman who spoke some English felt she did not understand fully what was being said by the midwife and requested an interpreter to help her to communicate more effectively:

'I asked them we cancel the meeting until we get an interpreter... I didn't understand you and you didn't understand me'. She said, 'No, it's ok we can go on – you understand English' (P3)

One woman explained how her midwife did not know anything about the situation she was in and the difficulties of being an asylum seeker until part-way through her

pregnancy because she never asked about her immigration status. On the other hand, some women felt labelled as an asylum seeker with staff making assumptions about needs. In one case the need to terminate the pregnancy:

*'They do me... vaginal scan? To check the baby ... They ask me **again** if you want to take out the baby?'* (P5)

There were examples of labelling and assumptions being made based on a woman's perceived cultural background:

'I saw a consultant ... She was not nice. She was very abrupt. 'Did you circumcise?' ...I didn't know women can be circumcised! 'I'm asking you, are you circumcised?!' I don't understand.'(P3)

Women also described how they felt they were treated differently due to their asylum status:

'Sometimes I feel like when I used to go in (to see) GP or ... in hospital, I feel like the doctors or nurses...not seen us with same eye like English people' (P5)

The feeling of being seen differently was sometimes acute. In one case, a woman attended a walk in services and the receptionist shouted at her asking where her passport was. In another situation, one woman described how she felt as a result of another receptionist's conversation:

'When we go to register in our nearest GP, the women in reception ask us...you have to bring ... bills. And I told her, we don't have bills, we are in NASS accommodation..'So you're not working?'...And I feel like..I didn't choose to not work!...I'm forbidden to ...til my case ... And I feel...very bad.' (P5)

There were examples of situations where women did feel they were listened to. This related to mental health but also more generally. One woman discussed how she felt the community midwife was very respectful, asking her opinion on her care. Another described how the midwife acted as an advocate telling other staff to stop a procedure on her behalf. However, some women did not feel listened to. One woman did not agree with the midwife's written record of the conversation they had. Another woman felt ignored during labour:

'When we reach there (hospital), they take me in (the) toilet and close the door. I open (the) door and baby was coming. They close (the) door, and started talking'
(P3)

Discussion

This study confirms that women who are seeking asylum in the UK and are pregnant face significant difficulties on many levels. Although the aim of this study was to explore local women's lived experiences of maternity care as an asylum seeker, in reality this was only a small part of what women wanted to discuss reflecting findings from previous studies (Kennedy and Murphy-Lawless, 2003, Briscoe and Lavender, 2009) In this context, the difficulties around everyday life in the UK appear to continue to be more significant to women than the maternity care they receive.

Dispersal created major difficulties for most women in this study, supporting findings from previous research (Feldman, 2013, Bryant, 2011, Reynolds and White, 2010). Women's established support networks were effectively removed and they were forced into social isolation. Women and their babies were moved into damp, cold,

unhygienic accommodation with physical barriers such as stairs making it difficult to keep physically and mentally healthy and feel safe. Care was disrupted, exacerbated by the accommodation; with problems such as not receiving appointments, not hearing health professionals arriving and not finding it easy to access the entrance of the building to get to appointments. In 2012, Home Office guidance was introduced stating that women should not be dispersed during a 'protected period' of four weeks either side of delivery (Gov.UK, 2014). Clearly for these women, the guidelines were ignored.

Accessing health care was difficult for some women in this study and there was also confusion about entitlement to care and whether women would be charged for services. This reflects recent studies where women have had difficulty registering with a GP without a passport when in reality, this is not required (Psarros, 2014, Shortall et al., 2015), where women fear being charged for services deterring them from accessing care (Shortall et al., 2015, Psarros, 2014) and where there is a lack of understanding about entitlements to travel costs to attend appointments (Da Lomba and Murray, 2014).

Despite the majority of the women's stories focusing on living as a pregnant asylum-seeker in the UK, they did discuss their experiences of maternity care. There were some positive experiences described with staff being respectful and acting as an advocate. However, there were also situations where women felt their care was poor and they were treated differently to others. There was also evidence of a lack of cultural sensitivity shown around FGM. Latest guidelines related to caring for women who have undergone FGM suggest a sensitive and non-judgemental approach should be adopted (Royal College of Obstetricians and Gynaecologists, 2015).

These findings add to the body of evidence of studies from the last decade where negative experiences of maternity care were described (Lockey and Hart, 2004, Gaudion and Allotey, 2008, Harper Bulman and McCourt, 2002, McLeish, 2002) and more recent studies (Shortall et al., 2015, Psarros, 2014, Phillimore, 2014). This suggests that despite the 2010 NICE guidelines, there is still a lack of understanding from midwives about the needs of pregnant women seeking asylum, and poor attitudes do still exist.

Implications for practice

NICE (2010) recommend that midwives undertake training to ensure they understand the specific needs of asylum-seeking women. This should include a woman-centred approach to care, good communication and working within a multi-agency context to ensure health and social care needs are met. The findings from this study support the NICE guidelines in that the training needs are broader than just focusing on women's maternity care needs. In 2011 'The Pregnant Woman within the Global Context' evidence-based model was designed to facilitate midwives to visualise the woman as the centre of her care and consider how factors within the UK and her home contexts will impact on her health and social care needs (Haith-Cooper and Bradshaw, 2013). This is a useful tool for midwives to use when assessing, planning and meeting the needs of pregnant asylum-seeking women. With consideration to the model and the findings from this study, table 3 makes suggestions of concrete activities midwives can undertake to support pregnant asylum-seeking women.

Conclusion

Women seeking asylum in the UK continue to have some of the poorest maternal and perinatal outcomes compared to other women. There is a need for midwives to better support these women and to do this their needs must be understood.

Qualitative research can enlighten midwives and policy makers to potential issues of concern (Green, 2005) and it is hoped that this study will help midwives understand the type of challenges asylum-seeking women who have babies in the UK might be facing in everyday life as well as accessing maternity care . It is clear from the research that the experience of individuals is hugely impacted by wider social factors including housing policies, immigration status and cultural barriers. It is hoped that these women's voices will add a personal dimension to issues, policy and labelling around asylum, and enable midwives to better 'act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it' (NMC, 2015). However, this is a small local study and it cannot be assumed that the findings can be generalised across the UK, especially in areas where specialist midwifery services exist. It is suggested that future research could examine the impact of such specialist services on asylum-seeking women's experiences and also outcomes of maternity care.

Key phrases

- Pregnant women seeking asylum in the UK are a vulnerable group with complex health and social needs, complicated pregnancies and a higher rate of maternal and perinatal mortality

- Despite the implantation of NICE guidelines in 2010 to address the needs of women (including asylum seekers) with complex social factors, there is evidence that women still experience poor maternity care, with midwives not meeting their specific health and social needs.
- Findings from this study support previous research, that the difficulties around everyday life in the UK appear more significant to asylum-seeking women than the maternity care they receive, though these difficulties do impact on access to and experiences of maternity services.
- As stated in the NICE guidelines, midwives need training around the complex wider health and social needs of pregnant asylum-seeking women and the 'Pregnant woman in the Global Context' model can be a useful tool to facilitate this.

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