

“THE MOTHERS IN EXILE PROJECT”

Summary of research report

March 2010





“WHO ARE WOMENS HEALTH MATTERS?”

Womens Health Matters (WHM) is a registered charity run by and for women.

Established in 1987 WHM is an independent voluntary organisation, working with women across Leeds to enable them to make choices about their own and their families health. We also work with health care providers to improve services.

- WHM has a holistic approach to health and believe it involves all aspects of well being.
- We aim to make our services fully accessible and to support women to access services.
- We work with women so that together they can take control of their lives and health.
- WHM believes it is essential to listen to the concerns of women and recognise that women are experts on their own bodies and health.



“MOTHERS IN EXILE PROJECT”

What the project was about

- This research project was a response to the research gap in current service provision for asylum seekers, identified by Leeds Maternity Health Needs Assessment 07/08 – 08/09.
- The project involved carrying out in depth qualitative interviews with the aim of capturing details of experiences and determining patterns.
- Interviews covered all aspects of women’s care during pregnancy, birth and in post-natal period, including any experiences of children’s services. There was a particular focus on how women’s immigration status affected the way they accessed services.

The aim of the project was to look at the experiences of asylum seekers and refugees in Leeds and to give women the chance to tell their stories of being pregnant, giving birth and becoming mothers in exile.



By bringing women’s experiences together this project demonstrates gaps in current maternity services and identified good practice that is taking place. An important function of this project is to raise awareness among policy makers and service providers of the experiences and needs of pregnant women seeking asylum in Leeds.

“WOMEN CENTRED APPROACH”

Womens Health Matters is committed to a women centred approach. Women were put at the core of all aspects of planning and carrying out the research to ensure they had a sense of control and ownership over the process and the end result.

This meant:

- Introductory interviews with women to discuss the project, giving them time to consider their involvement, to ask questions and voice concerns.
- The list of topics covered in the interviews were given to all women to enable them to make choices about what they felt comfortable disclosing and discussing.
- Female interpreters, childcare and choice of venue were offered to all women.
- Time was given at the end of interviews to discuss other issues and offer signposting support and women were told this would happen in advance.
- A feedback event was held to thank women for their participation and to enable them to comment on the interviews and on the findings of the research before the final report was written.

In depth, semi-structured interviews were carried out with 20 women between the ages of 16 and 43. The majority of women had come from African countries as well as from China, Iraq, Syria and Palestine.



According to the Vulnerable Women’s Project (Refugee Council’s Health Access Project 2001) as many as 20% of refugees in the UK have severe physical health problems and two thirds have experienced anxiety and depression.

The report estimated that between 5% and 30% have been tortured including many who have been subjected to rape and sexual violence.

“WHAT WOMEN TOLD US”

IMPACT OF ASYLUM SYSTEM

Women asylum seekers are often incredibly isolated. Many women had no partner or family to support them. Some had lost family members and others had been forced to leave behind children.

Some women had experienced giving birth in another country but many were becoming mothers for the first time.

The current dispersal system means that women were often moved around the country and then around Leeds several times before they were properly housed and able to register with a GP. This meant some women did not see a midwife till late in their pregnancy, which is a risk for the health of mother and baby.

“..the life is very hard... Sometimes I just want to talk to somebody – but we are in a prison here.”

Frequent moves across or even out of the city make it difficult for women to build up support networks. It also makes it hard for maternity services to follow women and provide continuity of care.

Very poor housing has a serious effect on many women’s quality of life as well on their health.

“I have to put my baby on my back and start cleaning. There were rats all over, I put my baby’s bottle on the floor and before I know, they were dragging it... if you put anything down, they eat it. That was when I was so bad and I said this is better just to take your life than to live in this kind of horrible life.”

Women living in accommodation where food was provided missed meals when they attended hospital appointments.

Some women had spent time during their pregnancy living on the streets.

Women living on support in the form of vouchers had to walk, sometimes miles to buy food and to go to hospital, others did not have enough to eat.

ANTE-NATAL CARE

A few women, especially those who saw midwives at Surestart Children’s Centres had a very positive experience during their pregnancy.

“I used to have thoughts in my mind that I would be treated differently because I am an asylum seeker, but in fact I got a good service.”

Most women felt they had little or no relationship with their community midwife. In some cases this meant that serious physical and mental health problems were not being identified.

Women reported that their midwives did not discuss pain relief with them or help them apply for the maternity benefits they are entitled to.

Very few midwives referred women to the ante-natal classes able to support women asylum seekers and refugees.

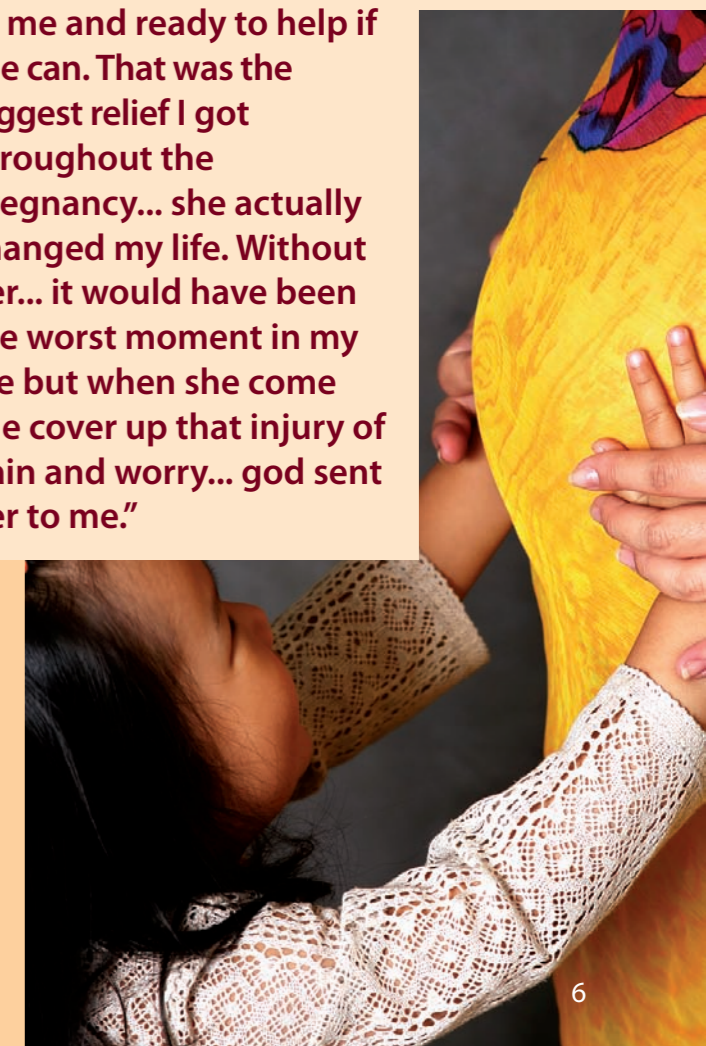
“I didn’t understand why she had no sympathy at all, no emotions, just so cold, so unconcerned about you, just, you don’t matter. If people know how much their attitude does to people who are in distress. It is too much you know... it is terrible.”

SUPPORT

Friendships and social networks are vital in reducing the isolation women experience.

Women benefited from the support of voluntary organisations through befrienders and from birth partners (doulas).

“I was feeling very happy and like a big relief in that I have someone to talk to who was willing to listen to me and ready to help if she can. That was the biggest relief I got throughout the pregnancy... she actually changed my life. Without her... it would have been the worst moment in my life but when she come she cover up that injury of pain and worry... god sent her to me.”



LABOUR

Women living on vouchers had no money to get to hospital to give birth and had no choice but to ring an ambulance or walk. Two women walked more than a mile to hospital while they were in labour.

“It’s upsetting and it makes you very angry to be thinking ‘I am walking to hospital, I’m almost giving birth, why am I in this situation, I came to these people to protect me and I’m not being treated as a person...”



Nearly half of the women had no-one with them when they gave birth.

Some women felt they had been neglected during labour. In some cases women felt their treatment by staff in hospital had been racist.

POST NATAL

Women felt particularly distressed and lonely in hospital post delivery. Very few staff seemed to understand the difficulties they faced.

Most women had suffered from depression, stress or anxiety through their pregnancies. For many this intensified after they had given birth. Only a small number of women received support for mental health problems.

“They didn’t notice or ask anything about my family, if I was on my own here. I was more lonely when I was looking at my baby, I felt more sad because I was alone.”

Health visitors provided important support to some women before and for a long time after their pregnancy

“The health visitor is good... I said to her I can’t speak English well, I have bad luck, just I live for my children – she gave me confidence and speaks with me.”

INTERPRETING AND COMMUNICATION

Many of the women who said they needed an interpreter did not have one at any time. Some were refused an interpreter even when they asked for one

“If I had an important question to ask I couldn’t because I don’t speak English well enough – I wanted to know – am I in danger? Is my baby in danger?”

Women who understood and spoke some English reported that staff in hospital frequently made no attempt to communicate with them

“When you are at the hospital you expect that people will... try to reassure you. But they did not speak.”

“There is no effort, people are not going out of their way to communicate.”



“RECOMMENDATIONS”

PROVISION OF CARE FOR ASYLUM SEEKERS AND REFUGEES

- Establish a specialist city-wide team of midwives to ensure that asylum seeking women’s needs are met and that receive continuity of care.
- Continuation of a named lead midwife with responsibility for asylum seeking women and refugees with complex needs, including destitute women.
- Robust health and social risk assessment should take place at every stage of the maternity system from booking to post-natal wards and visits.
- Community midwives should be able to spend more time assessing women’s needs.
- Invest in advocacy support for pregnant asylum seeking women.
- Adapt and extend the existing scheme supporting low income women travelling to hospital to benefit asylum seeking women including those on Section 4 support.

TRAINING

- Training for health professionals should include:
- Understanding the practical and emotional realities of life in the existing asylum support systems.
 - Understanding that using interpreters is essential for establishing medical, social and emotional needs.

“I got the feeling when the midwives were coming they would talk to other white women, chatting and laughing, you can hear them asking about them, their life... but with me they never asked... they just come and feel my stomach, I don’t know why, I don’t know.”

- How to support women who have suffered trauma and increased awareness of the potential for women to experience flashbacks during labour.
- Increased awareness around FGM.

INTERPRETING

Identify gaps in current bank of interpreters, actively recruit more female interpreters.

COMMUNITY PRACTICE

- Women should be reassured that they are entitled to free care from a midwife and GP.
- Give women information on how to raise concerns or make complaints about their treatment and how to change their midwife. Reassure women this will not affect either their asylum claim or their treatment.
- Provide all women with the same information and choices about pain relief.



- Identify at ante-natal appointments women who are unable to pay for transport to hospital and ensure that, in discussion with women, strategies are put in place to prevent them walking to hospital in labour.
- Identify women who will be alone in labour and make appropriate referrals to doula services.
- Increase referrals to specific ante-natal classes, Choto Moni and Haamla and continue to invest in these groups.

HOSPITAL PRACTICE

- Ensure women who find out they are pregnant in hospital are referred to community midwife.
- Establish a subsidised scheme which enables women on Section 4 support to come to delivery by taxi rather than being forced to ring an ambulance or walk.
- Ensure all women receive one free scan picture of their baby.

OTHER CONSIDERATIONS

Although the aims and objectives of this report have not been to inform or change immigration policy, it seems appropriate that there should be some response to the impact these policies have on pregnant women and their children.

- The particular emotional, practical and physical needs of asylum seekers during pregnant, labour and in the post-natal period, should be taken into consideration along with medical grounds which affect when and where people are dispersed.
- No pregnant woman, child or their parents should be left destitute.
- Bring an immediate end to the detention of children and their families.

“THE AIM OF THE PROJECT”

The aim of the Mothers in Exile project was to give women the opportunity to tell their stories of being pregnant, giving birth and becoming mothers.



By bringing these experiences together this research has been able to demonstrate gaps in services and to identify where appropriate support is taking place. By sharing their stories as part of this project women are helping to raise the awareness of policy makers and service providers of the specific needs of pregnant women who are seeking sanctuary in Leeds.

For a copy of the full report please contact Womens Health Matters

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