A qualitative study using data from questionnaires, and a focus group, with a literature search. Ethical approval was obtained from St George’s Clinical Ethics Committee (CEC). Refugee and asylum seeking women, who attended the Women’s group CASAR, or beneficiaries of CASAR, were invited to participate in the study if they have a child age six years or less, born in the UK. 17 women completed the questionnaire and 5 also took part in the focus group. The questionnaire comprised 27 questions, and 10 main themes were discussed in focus group. Participants were fully informed of the purpose and nature of the study, and assured that all data would remain anonymous and confidential. The women were assisted with the questionnaire by myself due to the complicated nature of some of the questions. The focus group, led by a CASAR team member, was recorded in notes. All recorded information was anonymised and was only available to the research team.

Limitations

The recruitment targeted a specific local group for its sample (all were users of CASAR’s services) so findings are not generalizable. The sample size was also small. The focus group and questionnaires were carried out in English, which is not the first language of some of the participants, and some of their English may have been limited.

Some of the women may have had their last child up to six years ago and it is therefore likely some of the information may have been forgotten or misremembered by the respondents. Some participants felt uneasy sharing personal information with the rest of the group.

Acknowledgements

I would like to thank the women who kindly participated in this study. I would also like to thank Dr Jess Thomas, Professor Shirley Hodgson and Eleanor Brown for their help.

The experiences of refugee and asylum seeking women of maternal healthcare in the UK

Imogen Horn, Medical Student
St George’s University of London

Aim

To investigate the experiences of refugee and asylum seeking women in accessing maternal healthcare in the UK, and suggest ways to overcome the challenges to ensure a better outcome.

Background

The health of refugee and asylum seekers is a major concern for the UK public services. Evidence shows a failure to meet their complex health needs. Pregnant women are particularly vulnerable, with broad medical and psychosocial needs. Research indicates that women are six times more likely to die in childbirth than the general population (2). These women are much more likely to seek late and miss multiple appointments compared to the general population, which correlates with increased risk during the pregnancy and poorer outcomes. Data collected in asylum seekers and refugees at a Doctors of the World London drop in clinic found that 62% of women had their first antenatal appointment late, and 50% had five or fewer antenatal appointments (3). There is inequality of accessibility and provision of obstetric care. It is likely that exposures associated with migration may increase the risk of poor outcomes amongst refugee and asylum seekers. However maternity care in the UK is currently not providing sufficient standards of care for these women.

This project was carried out in collaboration with Community Action for Refugees and Asylum Seekers (CARAS), an organisation providing help and support for refugees and asylum seekers in London.

Methodology

The questionnaire respondents ages were: 1 under 18, 7 aged 18-25, 3 aged 26-30, 5 aged 31-35 and 1 aged 40+. Counties of origin: 8 Sudanese, 3 Afghan, 1 Sudan, 1 Yemeni, 1 Iranian, 1 Syrian, 1 Ethiopian, 1 Congolese, 1 Pakistani. The mean number of children per woman was 2.76, most had been born in the UK.

Questionnaire Results

The questionnaire respondents ages were: 1 under 18, 7 aged 18-25, 3 aged 26-30, 5 aged 31-35 and 1 aged 40+. Counties of origin: 8 Sudanese, 3 Afghan, 1 Sudan, 1 Yemeni, 1 Iranian, 1 Syrian, 1 Ethiopian, 1 Congolese, 1 Pakistani. The mean number of children per woman was 2.76, most had been born in the UK.

Gestation at first antenatal appointment (recommended 12-17 weeks)

The questionnaire respondents ages were: 1 under 18, 7 aged 18-25, 3 aged 26-30, 5 aged 31-35 and 1 aged 40+. Counties of origin: 8 Sudanese, 3 Afghan, 1 Sudan, 1 Yemeni, 1 Iranian, 1 Syrian, 1 Ethiopian, 1 Congolese, 1 Pakistani. The mean number of children per woman was 2.76, most had been born in the UK.

Number of antenatal appointments attended

Number of antenatal appointments missed

The questionnaire respondents ages were: 1 under 18, 7 aged 18-25, 3 aged 26-30, 5 aged 31-35 and 1 aged 40+. Counties of origin: 8 Sudanese, 3 Afghan, 1 Sudan, 1 Yemeni, 1 Iranian, 1 Syrian, 1 Ethiopian, 1 Congolese, 1 Pakistani. The mean number of children per woman was 2.76, most had been born in the UK.

Discussion

This project has revealed numerous inconsistencies and a range of barriers to treatment. Clearly lack of English is a major barrier. Many of the women are unable to understand the language of medical professionals, this is no surprise given the barriers to accessing formal education and training. Asylum seeking women are three times more likely to die in childbirth than the general population. Research shows a failure to meet their complex health needs. Pregnant women are particularly vulnerable, with broad medical and psychosocial needs. Research indicates that women are six times more likely to die in childbirth than the general population (2). These women are much more likely to seek late and miss multiple appointments compared to the general population, which correlates with increased risk during the pregnancy and poorer outcomes. However maternity care in the UK is currently not providing sufficient standards of care for these women. The questionnaire respondents ages were: 1 under 18, 7 aged 18-25, 3 aged 26-30, 5 aged 31-35 and 1 aged 40+. Counties of origin: 8 Sudanese, 3 Afghan, 1 Sudan, 1 Yemeni, 1 Iranian, 1 Syrian, 1 Ethiopian, 1 Congolese, 1 Pakistani. The mean number of children per woman was 2.76, most had been born in the UK.

Acknowledgements

I would like to thank the women who kindly participated in this study. I would also like to thank Dr Jess Thomas, Professor Shirley Hodgson and Eleanor Brown for their help. The questionnaire respondents ages were: 1 under 18, 7 aged 18-25, 3 aged 26-30, 5 aged 31-35 and 1 aged 40+. Counties of origin: 8 Sudanese, 3 Afghan, 1 Sudan, 1 Yemeni, 1 Iranian, 1 Syrian, 1 Ethiopian, 1 Congolese, 1 Pakistani. The mean number of children per woman was 2.76, most had been born in the UK.

Conclusion

These findings should be implemented to improve future experiences of refugee and asylum seeking women. The focus group participants and I have formed a short list of recommendations: longer appointments, continuation of midwife care, improved access to and provision of interpreters and written information in the correct language, more training for health care professionals to allow better understanding for example on FGM, entitlement, and to encourage cultural sensitivity, provision of mental health support, provision of interpreters and the introduction of accessible, flexible appointment schedules and more accessible clinics for example at childbirth centres or community centres.

References

(1) http://www.publications.parliament.uk/pa/cm200708/cmselect/cmhealth/422/422we128.htm

This is just a routine. They don’t care about the answer or what you’ve been through'.