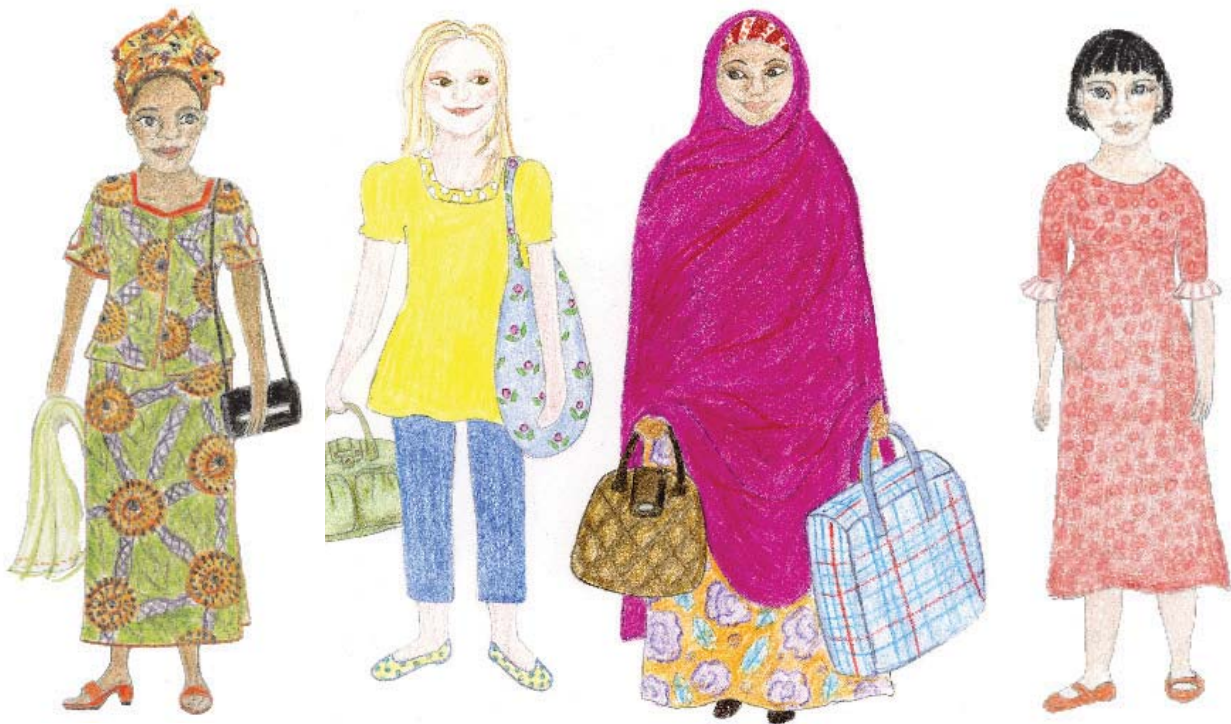


Maternity Care for Asylum Seekers and Refugees in Hillingdon A Needs Assessment

Anna Gaudion and Pascale Allotey



MATERNITY CARE FOR REFUGEES AND ASYLUM SEEKERS IN HILLINGDON

A NEEDS ASSESSMENT

ANNA GAUDION

PASCALE ALLOTEY

Public Health @ Brunel
The Centre for Public Health Research
...population health matters.

Health Opportunities Promotion & Education
HOPE

Suggested Citation:

Gaudion A & Allotey P. 2008. *Maternity care for refugees and asylum seekers in Hillingdon. A needs assessment*. Centre for Public Health Research, Brunel University. Uxbridge.

© Brunel University 2008

EXECUTIVE SUMMARY

Ongoing health inequalities require the constant monitoring not only of the quality of services provided but also the changes in the populations that require the services. Population movements, within the UK and internationally have resulted in rapid changes in the user profile of NHS maternity services.

The London Borough of Hillingdon provides an ideal opportunity to explore the adaptability in maternity services to respond to the needs of a changing demographic. It has a rapidly changing profile with a shift towards cultural and linguistic diversity. Hillingdon maternity services have a distinctive population; the migration impact of Heathrow airport, the presence of large numbers of unaccompanied asylum seeking children and women in transit through the airport.

A range of maternal health disparities had been identified through service providers and community based organisations but not systematically investigated. With the support of Health Opportunities Promotion and Education (HOPE) project and the Hillingdon Primary Care Trust, this needs assessment aimed to explore the needs of refugee and asylum seeking women for maternity care. Methods used included interviews and focus group discussions with providers and refugee and asylum seeking users of maternity services as well as a number of community based support agencies.

The needs assessment was commissioned by HOPE and carried out by the Centre for Public Health Research, Brunel University. It was supported by a steering group consisting of representatives from HOPE, the Hillingdon Primary Care Trust, the maternity services of the Hillingdon Hospital Trust and the Centre for Public Health Research at Brunel University.

KEY FINDINGS

A number of themes emerged consistently across the data sources.

1. There was a clear understanding amongst health care providers who participated in the study that maternity care could not, and should not be refused to anyone who presented for services. Where women were not entitled to *free* care under the NHS (eg visitors to the UK and failed asylum seekers), there were procedures within the Hillingdon Hospital to claim the cost of care from the user. However issues of entitlement and access may not necessarily be well understood by asylum seeking communities, resulting in late or non-presentation to maternity services.
2. Communication presented a challenge at all levels:
 - a. between providers and users – translation, interpreting and advocacy services are patchy. Official interpreting policy and procedures were not uniformly understood although it was generally perceived that interpreters were expensive and other means should be tried first. There was therefore an over reliance on family and friends and where available, multilingual members of staff.

- b. between different teams of providers - communication within different levels of health care services, between statutory health, social and immigration services, and the voluntary sector with regard to the care of vulnerable and migrant populations is generally poor. For instance, as a result of lack of communication between the Asylum Services and Social Services on the one hand and community midwifery staff on the other, there have been difficulties in locating women for follow up when they are relocated through the New Asylum Model (previously National Asylum Support Service). Furthermore, there has been limited engagement with community based support services that could be ease the burden on maternity staff.
 - c. between policy and practice levels – knowledge about changes in policy and guidelines does not filter through effectively to practitioners, eg screening for domestic abuse in pregnancy.
3. Women interviewed highlighted a number of pockets of good practice. These occurred in services that had assistants or advocates and staff who demonstrated cross cultural competence and compassion.
4. The lack of health records and antenatal care for women who did not present until the birth added a level of complexity to the responsibilities of maternity staff and increased the potential risk of complications and poorer health outcomes.
5. The perception of “overstretched” services was an issue that was reported consistently across participants in the study. Disadvantaged and vulnerable groups were by definition, “high risk” and service providers felt under-resourced to cope adequately with their needs. Women from refugee and asylum seeking backgrounds were conscious of the “busyness” of staff and were reluctant to impose even when they had a problem. They were therefore recipients of, instead of partners in their care and their maternity experiences bore little resemblance to the standard described in the National Service Framework.
6. Women expressed a preference for antenatal care locally in their communities. However many reported difficulties with access to GPs and community midwives for two main reasons:
 - a. they were unable to find GPs practices with whom to register; or
 - b. they were referred to the hospital for antenatal care. It was not clear whether the referrals were for social reasons (ie the difficulties of working with non-English speaking women) or for medical reasons. However for the women, a visit to the hospital was often a significant journey with monetary and other opportunity costs.
7. There was, to a significant extent, a lack of understanding of the refugee and asylum seeking context. This was particularly evident with regard to:

- a. Mental health needs
 - b. Domestic abuse
 - c. Young asylum seeking women who are pregnant or new parents.
8. Other unrecognised needs included information on the management of women who had undergone female genital mutilation/cutting
 9. There was a significant expression of negative attitudes towards refugees, asylum seekers (including unaccompanied asylum seeking children) and visitors to the UK who accessed maternity services. All three categories were often referred to as a homogenous group and antipathy sprung largely from the perception that their care was at the cost of care for more deserving UK citizens. There were also descriptions that demonstrated significant cultural stereotyping and a lack of understanding of the refugee trajectory.

RECOMMENDATIONS

Given the dynamic nature of the population it serves, there is a real opportunity for Hillingdon to play a leading role in developing the models of maternity care that enhance the health outcomes for women in exile and respond to their needs. Most of the issues raised by participants in this study are not new and are reflected in other recent studies and enquiries through the Confidential Enquiry into Maternal and Child Health (2007) and the Health Care Commission (2007). The findings also independently support the results of the comprehensive National Benchmarking Study of the Healthcare Commission released on January 25 2008, ranking Hillingdon in the least well performing trusts for maternity services¹. This needs assessment adds a particular perspective of refugee and asylum seeking women to these other studies, providing further impetus for a robust response.

The recommendations that arise out of the findings of this needs assessment offer some inputs for consideration in the commissioning of maternity services, supporting staff development, improving partnership working and engaging and involving women and communities in their care. While the focus is on refugee and asylum seeking women, these recommendations suggest strategies that may enhance care for all disadvantaged / vulnerable women.

Primarily this needs assessment highlights the need for:

An urgent review of pathways for maternity care for refugee and asylum seeking women from booking systems to postnatal care.

The following recommendations highlight different points in the pathways where action needs to be taken.

¹ Healthcare Commission (2008) Review of maternity services 2007: Scored Assessment. The Hillingdon Hospital Trust. Accessed 25 January 2008
<http://www.healthcarecommission.org.uk/db/documents/RASScoredAssessment.pdf>

1. The nature of vulnerability or disadvantage of refugee and asylum seeking women necessarily invites a multidisciplinary team approach. **The care of refugee and asylum seeking women should involve teams of staff including the woman and her family, interpreters, advocates and mentors, midwives, obstetricians, GPs and social services to ensure clearer managed pathways of referral and information sharing.** The team approach needs to be reflected in the care plan. This can only be achieved by enhancing communication between agencies and developing a joined up strategy for maternity care of refugee and asylum seeking women. Strategic involvement of the Home Office Border and Immigration Agency, given the use of Hillingdon health facilities by visitors that arrive and depart through Heathrow would enhance the understanding of policy changes and their implications to maternity care.
2. Given the current demographics and dynamic nature of the population in Hillingdon, it is critical that staff have accurate information and a good understanding of the population they treat. **Requirements for ongoing professional development should include regular information on the social, cultural and environmental contexts of the population served by the health service.** This should also include information on the refugee trajectory and circumstances of migration. Furthermore there is a need for a review of the organisational culture and management to ensure that staff are well supported and supervised in the delivery of high quality care and adhere to equality and diversity guidelines within the NHS.
3. **Communication within services, particularly with regard to changes in policy needs to be improved.**
4. There is an urgent need to provide a range of pathways of additional **support for women with mental health needs.**
5. The provision of interpreting services remains a challenge in health care. **The importance of appropriate interpreting services needs to be reflected in the commissioning of services for refugees and asylum seekers.** There are a number of models of ensuring multilingual communication such as with the use of health assistants, bicultural workers and cross cultural advocates. There needs to be a review and trial of models that would work appropriately for the population of Hillingdon. In addition, maternity staff need training on how to contact and use interpreting services
6. **Maternity services should explore new ways of reaching out to women in the community.** This could involve for instance the use of existing social networks to provide information or the use of antenatal clinics in non traditional sites such as church halls, Children Centres and community centres as a forum for more holistic engagement.
7. **Information for women needs to be developed in collaboration with them in an appropriate format informing them of the culture within maternity services.** It needs to address issues of access and engagement and what to expect within maternity care and other

services within a holistic multi-agency framework. Women should not be excluded from antenatal information sessions on the basis of language.

8. **Community based organisations, including those within the voluntary sector, that place maternity care within their remit of work need to engage more proactively with statutory agencies** to increase their visibility and involvement in team care. This can be done through community events that engage both the services and public. A specific suggestion from participants in the needs assessment was for events such as seminars and conferences that would enable the sharing of experiences and expertise.
9. **Community based continuity of care schemes need to be established for women from disadvantaged and minority groups.** There is now ample evidence to demonstrate the advantage of these networks to general health and wellbeing and particularly to maternal health for asylum seeking women. These could be facilitated within venues such as Children Centres, REAP, the Tumbler Youth Centre - West London YMCA, and local community groups. **There is a need for the commissioning and development of a mentoring /buddy scheme for women to have informal advocates and support.** The mentors would need to have some training and supervision within an organisation such as REAP. This scheme could also include community advocates working with midwives to run antenatal classes in the community and Children Centres. Training a community person to run baby massage classes for instance can help improve confidence, relaxation and build networks of support for vulnerable groups.
11. **There needs to be increased sexual health /health promotion work with unaccompanied asylum seeking children (UASC).**
12. There is clear evidence of underlying hostility based on a perception of differential access to various services. Given limited resources and the current and projected demographic profile of the Hillingdon population, there is a **need for a better understanding not only of the issues of the individual deprived groups, but also of the interactions between them and their access to and experience of maternity services.** We would therefore recommend:
 - a. A wider needs assessment that both identifies and compares the maternity care needs of different socially disadvantaged populations in Hillingdon.
 - b. Based on the findings of the above, the development of a broader framework for working across disadvantaged groups.
13. **The development of information systems for monitoring and auditing programs for disadvantaged groups in general and refugees and asylum seekers in particular.** This would involve a review of data collection systems that enable screening for the purposes of identification of both medical and social risks.

ACKNOWLEDGEMENTS

We would like to thank all the participants who helped to shape this report and to acknowledge the candid and honest perspectives that were given. The steering group were key to the success of the data collection particularly given the time constraints: John Aldous (chair), Priscilla Simpson (convenor) Heema Shukla, Jane Cook, and Saras-Tega-Kissun. Hilary Pickles, although not on the formal steering group provided critical advice and support and added assurance of the commitment of the PCT to engage in the project. We would also like to acknowledge the early contributions of Sally Dauncey and Ella Tighe.

Ann Morling who joined as the new Head of Midwifery in the data collection stage of the project provided a refreshing and important perspective to discussions and Suzanne Truttero LSA Officer for London provided valuable support and feedback on an earlier draft.

In particular we would like to acknowledge the help and interest from Sarah Crowther at REAP; Tigest Tejiwe at the Tumblers, Carol Ann at Asphaelia, and Ambica Selvaraj from HOPE and the Social Services.

The efficacy of the project was helped by the art work by Heidi Cutts, her fliers made people smile and were the first stage in getting people talking. We would also like to thank her for designing the front cover and for juggling the logos. Copyright for all the artwork used in this project remain with the artist.

The project was funded by HOPE and the Hillingdon PCT through a Healthy Living Programme grant from the Lottery Fund.

TABLE OF CONTENTS:

<i>Executive Summary</i> _____	<i>i</i>
Key findings _____	i
Recommendations _____	iii
<i>Acknowledgements</i> _____	<i>vi</i>
<i>Table of Contents:</i> _____	<i>vii</i>
Chapter 1 _____	1
Background _____	1
Definitions _____	1
The Asylum Model - processes _____	3
The Hillingdon Context _____	7
Why the needs assessment? _____	9
Aims _____	10
Chapter 2 _____	12
Methods _____	12
Phase I: Mapping _____	12
Phases 2 and 3 – services needs from provider and user perspectives _____	13
Recruitment _____	14
Data collection _____	14
Data Analysis _____	16
Chapter 3 _____	17
The target population and available services _____	17
Findings on Service provision _____	20
Over Stretched services _____	20
Under-resourced _____	20
Resource intensive _____	21
Knowledge and Attitudes _____	22
Health Tourists _____	23
Training needs _____	24
Communication _____	25
Language and communication _____	25
Interpreters _____	26
Learning the dominant language _____	27
Inter agency communication _____	28
Access and engagement _____	31
Entitlement _____	31
Access _____	32
Other vulnerabilities _____	34
Mental Wellbeing _____	35
Domestic Abuse _____	36
Unaccompanied asylum seeking children (UASC) _____	37

Sexual health services	39
Cultural issues	40
Female genital circumcision	41
Chapter 4	43
Discussion and conclusion	43
Discussion	43
From needs to action – best practice	43
Conclusion	46

CHAPTER 1

BACKGROUND

Several recent reviews of maternity and other more general health care services have highlighted the disparities in health outcomes for particular population groups such as minority ethnic groups, travellers, the homeless, people living in poverty and so on. The focus of the needs assessment and this report was on refugees and asylum seekers, highlighting the challenges created by their specific context and the interaction of that context with the broader social determinants of health. This chapter provides some background information to situate this target population within Hillingdon, where the needs assessment was undertaken, and within the current discourses in maternity care.

DEFINITIONS

The 1951 Convention Relating to the Status of Refugees, the foundation document of international refugee law, was drafted in the spirit of humanitarianism in the wake of World War II. The internationally recognised definition of a refugee provided in the Convention is a person who:

owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it. (UNHCR, 1951)

Countries that ratified the Refugee Convention accepted in good faith the obligation and responsibility to provide refuge, and the entitlements and supports that they afford their own citizens. Once outside their country of origin a person who meets the conditions specified under the Convention may lodge an application for asylum through the United Nations High Commissioner for Refugees (UNHCR) or a potential host country government for refugee status. The term 'asylum seeker' applies to a person who has applied for recognition as a refugee in another country and is awaiting the outcome on their application. Illegal or undocumented immigrants are those who do not have the legal documentation to remain in the country of current residence. This category also covers asylum seekers whose claims for asylum have been rejected by the host country but who remain, often awaiting deportation procedures.

It is not uncommon for the terms refugees and asylum seekers and even in some cases, illegal immigrants, to be used interchangeably in the media and political discourse (de Bousingen, 2002, Steiner, 2000). However, the distinctions are important because they form the basis for policy decisions on the State's obligations to protect, levels of government subsidised access to health and other social support and welfare services, and the rights to seek employment. The focus on these administrative categories is so great now

that there has been a failure to remember the underlying humanitarian concerns of the Refugee Convention (Allotey et al, 2007).

There were 4,950 applications for asylum in the UK in the second quarter of 2007 (April –June); including dependents this figure increases to 5,920.² In 2006 the majority of principle applicants were under 35 years of age (82%); 15% were aged 35-40. 70% of the principle applicants were male. In the same year, an additional 3245 unaccompanied asylum seeking children under 17 applied for asylum in the UK, 10% more than 2005. The top 5 applicant nationalities for the second quarter of 2007 were Afghan, Chinese, Iranian, Somali and Zimbabwe³

In the consultation document ‘Planning Better Outcomes and Support for Unaccompanied Asylum Seeking Children’ the Home Office provides the following definition:

“An unaccompanied asylum seeking child is an individual who is under 18 and applying for asylum in his/her own right ... and is ... separated from both parents and not being care for by an adult who by law or custom has responsibility to do so”(Home Office, 2007.6).

In a Save the Children report (Free,2005) this definition is clarified further and becomes more descriptive. It describes unaccompanied minors as young people, under the age of 18 who arrive in a host country on their own and have been trafficked, smuggled or left behind by their relatives. Further it reiterates that a ‘child in need’ is a person under 18 who is unlikely to achieve or maintain a reasonable standard of health or development without the provision of services by a local authority (Free, 2005).

However, there is a, “...culture of disbelief shown by all levels of decision makers in relation to asylum seekers, particularly it would appear – unaccompanied or separated children who apply for asylum” (Bhabha and Finch, 2006.12). This culture of disbelief has a number of facets: firstly that children are merely appendages of adults and do not attract persecution in their own right; secondly, the perception that the only harm facing the child is a disruption to their education; thirdly that there is a failure to comprehend that political, economic and social instability, pervasive in many parts of the world, separates children from their families; and finally that children may arrive in the UK seeking protection (Bhabha and Finch, 2006). The impact of this culture of disbelief is attenuated because unaccompanied asylum seeking children (UASC), provided age is not disputed, are cared for under the UK child protection framework.

Whether this present system assists or hinders these young people from obtaining international protection under the 1951 UN convention is not for debate in this needs assessment; but in listening to the young women’s voices it does provide relevant context to the issues that they raise.

² (<http://www.statistics.gov.uk/cci/nugget.asp?id=261> accessed 19th October 2007

³ <http://www.statistics.gov.uk/cci/nugget.asp?id=261> accessed 19th October

THE ASYLUM MODEL - PROCESSES

Since April 2007 the home office has introduced a new process for managing and supporting people seeking asylum, it is called the New Asylum Model (NAM) and has superseded the National Asylum Support Service (NASS). The goal of the Home Office is to expedite the asylum claim process. Within the new framework an asylum seeker is assigned a case worker within 4 days of them asking for asylum. The case-worker will conduct the asylum interviews, make the decisions on the claim and conduct appeals. S/he will be responsible for housing and welfare support for the asylum seeker, integration if status is granted and assist with deportation if not. Out standing cases that have not been dealt with in the NAM process will not be incorporated into the system. The backlog of cases which have not been resolved will be dealt with separately.

Within this process, pregnant women and children between 1–3 years of age are eligible to receive £3 a week, children under a year receive £5 extra a week. This is in addition to other standard welfare benefits. These payments are made in recognition of the need to purchase healthy foods. Claimants must submit birth certificates for the children and a maternity form (MAT B1) to confirm pregnancy. To assist with the cost arising from the birth of a baby asylum seekers are eligible for a payment of £300 per child. It is paid if an application is made in writing and signed by the mother or father of the baby, the application must be received between one month before the estimated birth date and up to 2 weeks after the birth. If a maternity payment has been made but the baby is stillborn or a neonatal death the payment is not reclaimed and the case owners do not need to obtain a death certificate. This additional support is not paid to young asylum seekers who are supported by Social Services although similar payments are provided. A certificate (HC2) is issued by the Borders and Immigration Agency on behalf of the Department of Health and facilitates asylum supported applicants to receive help with health costs such as refunds of necessary travel costs to and from hospital for NHS treatment⁴.

The maternity context

There are no national statistics on asylum seekers and pregnancy, but a small observational study found that 13% of women asylum seekers arriving in Dover were pregnant (Le Feuvre et al, 1999).

Research on the experiences of asylum seekers and refugees in the UK conducted by the Maternity Alliance identified a number of recurrent themes to accessing and engaging with maternity services. They include lack of awareness of the refugee trajectory by health professionals, difficulty in accessing care including General Practitioners (GPs), lack of accessible information, cultural differences and racism (McLeish, 2002).

Access to services by asylum seekers and refugees is already encumbered by transience of residence, relative poverty and uncertainty within a long and complicated asylum process. Failure of the services to reach out to women and their families, lack of awareness of services or contact by the women

⁴ <http://www.ind.homeoffice.gov.uk/documents/asylumsupport/> (accessed 21st November 2007)

themselves results in a pattern of poorer outcomes for mother and baby (Lewis, 2007). Similarly the impact on maternity services of late booking or lack of prior booking into maternity services puts undue stress on maternity service providers. It is difficult for midwives in particular to support women with little or no knowledge of their individual physical, social and psychological needs.

A report examining perinatal mortality in the UK concluded that that stillbirths and neonatal mortality rates were higher in woman where poverty and or minority ethnicity were factors (CEMACH, 2006) More recently a hospital trust in Northwest London was investigated by the Healthcare Commission following an unacceptably high maternal death rate. Between April 2002 and June 2004 a total of 10 maternal deaths occurred in the hospital's maternity department. Eight of the deaths were women from black or minority ethnic backgrounds.

In 'Saving Mothers' Lives' (Lewis, 2007) it states that vulnerable women with socially complex lives are less likely to seek antenatal care early in pregnancy and thereafter to stay in contact. Evidence in the report demonstrates that the care provided for women who are seeking asylum in the UK does not always provide for their needs.

Black African women, including asylum seekers and newly arrived refugees have a mortality rate nearly six times higher than White women. To a lesser extent, Black Caribbean and Middle Eastern women also had a significantly higher mortality rate (Lewis, 2007.2).

The report reflects that this may not only reflect cultural factors implied in ethnicity but social circumstance. Significantly the report recognises that for this group of women there may be additional risk factors including poor overall health status, underlying and possibly unrecognised medical conditions such as cardiac diseases,

"Others suffered the psychological and medical effects of fleeing war torn countries; four women raped by soldiers were too ashamed to admit to being pregnant or to seek maternity care on arrival in the UK. One other woman, who spoke no English, was kidnapped, raped and trafficked into the country to work as a prostitute then left on the street when her pregnancy became too advanced. Women who have been trafficked have fears about their status, language difficulties and do not know where to turn for help. Trafficked women also feel ashamed of being forced into sex work which transgresses their own cultural values and beliefs and makes it difficult for them to reveal their situation" (Lewis, 2007.32).

The difficulty that women who are new to the country is recognised in the most recent and previous Confidential Enquiries into Maternal and Child Health,

"Two women who delivered at home died of postpartum haemorrhage. In both cases they had not sought any care during pregnancy; had delivered and died on their own, and were found later by relatives. One baby survived. Another woman who died...had not sought any antenatal care and delivered at home on the toilet: the baby drowned " (CEMACH, 2004.p37).

Deaths amongst the category of women classed as 'health tourists' is also discussed in *Saving Mothers' Lives*. It states that at least five women who died had come to the UK with pre-existing or past medical or obstetric complications for their care.

Significantly 48 women who died spoke little or no English. They had had limited access to translation services and in most cases family or friends were used as interpreters, several of these were children who may have been the only family member to speak English. The report reiterates that this is of concern because;

- The woman may be too embarrassed to ask for help about intimate matters or discuss fully her past history.
- Correct information may not be conveyed because the person acting as an interpreter may not have sufficient language skills, or they may withhold information
- The translator may be a perpetrator of domestic abuse.

The latter issue was highlighted as of particular importance as 70 of the women whose deaths were considered in 'Saving Mothers' lives' (Lewis, 2007) had been affected by domestic abuse.

Immigration of women from countries where female genital mutilation/cutting is performed is also worthy of note. The report considered the deaths of four women who died: three had not disclosed their condition and therefore planning of care and appropriate interventions were not done. There are a number of specialist services able to advise and support women living with FGC, therefore,

...women from countries where this is likely to be practiced should be sensitively asked about this during pregnancy and management plans agreed during the antenatal period (Lewis, 2007.33).

Recent and current policy direction from the Department of Health centres on the premise of individualised care for all women planned in partnership with the woman and her family.

All women should have easy access to and confidence in the full range of high quality maternity services the NHS offers. However there are some women who do not use or who under-use maternity services, most often those in disadvantaged groups or those who do not understand English or are unfamiliar with the NHS (DH,2004a.10).

In October 2004 the Department of Health published the "National Service Framework for Children, Young People and Maternity Services". Standard 11 states that women should have easy access to supportive, high quality maternity services, planned around their individual needs and those of their babies. It asserts that maternity services should be:

...Proactive in engaging all women, particularly women from disadvantaged groups and communities early in their pregnancy and maintaining contact before and after birth" (DH, 2004a.5)

Among the cited needs highlighted within the report is that women want:

“To receive adequate information and explanation about their choices for childbirth, including pain relief and hospital practices” (DH, 2004a.27).

Central to these recommendations is the understanding that early access and ongoing engagement with services improves outcomes for mother and baby (Shribman,2007). Policy recommendations included policies around good communication including interpreting service, choice and partnership working (DH, 2004a; DH, 2007a; DH,2007b).

More recently *Maternity Matters* (DH, 2007a) reiterated the imperative to involve women in planning their care and the philosophy of choice. The policy document represents a change in policy perspective heralded in 1993 by *Changing Childbirth* which takes the individual woman as central rather than the organisation.

The implementation of these policies at the local level has been variable. The Northwest London Strategic Health Authority for instance recognised the particular characteristics of the sector for providing care for a transient population. The inherent problems of providing appropriate, accessible care to ‘hard to reach’ populations were highlighted. The need for flexibility was emphasized particularly for women from disadvantaged and marginalized groups. The response here is important to note given the percentage of transient families (refugees, asylum seekers), who may only be resident in the area for a short period of time” (Northwest London Strategic Health Authority, 2006). In addition the area shows an escalation in birth rate of 8.2% in the last three years which is projected to continue. The strategy therefore aims to provide a template for effective, efficient and reliable maternity services and provides benchmarks for interpreting the information collected within this needs assessment. These include to:

- ❖ Provide flexible individual services with an emphasis on the needs of vulnerable women
- ❖ Make provision for translation, interpreting and advocacy services based on the assessment of the needs of the local population, Provision includes a mixed economy of interpreting and advocacy services-for home visiting, out of hours service and antenatal classes
- ❖ Encourage Maternity services to be proactive in engaging all women, particularly women from disadvantaged groups and communities.
- ❖ Commission Maternity Services within a context of managed care networks and include a range of provision for routine and specialist services for women
- ❖ Establish community based continuity of care schemes for women from disadvantaged and minority groups and communities.

Changes in legislation concerning ‘failed’ asylum seekers have added a further possible layer of confusion and dissuasion to access maternity services for some vulnerable groups. The amendments were intended to tackle a perceived problem of health tourism, which is where people come to the UK with a primary purpose of making use of free NHS services. Insights into the lived reality of the effects of the legislation and unintended confusions

created by the legislation have been widely documented (Gaudion et al 2006, 2007; Kelly, 2006; Project London,2006; Healthcare Commission, 2005:). In *Safe from Harm* (Kelly, 2006) examples are provided of women denied maternity care. The Refugee Council (2006) also reported 17 case studies of women who encountered problems accessing or engaging with maternity care from the inception of the legislation in 2004. In the enquiry into the maternal deaths at Northwick Park it became apparent that some of the staff were unsure about the entitlement to maternity care for overseas visitors, including asylum seekers. Maternity care is classed as 'immediately necessary' care and cannot be lawfully be withheld by the hospital if the woman is unable to pay. Where a woman is unable to pay (and for destitute failed asylum seekers this is clearly the case) there is a procedure for the hospital to record and subsequently write off the debt (DH,2004b.).This guidance is not always followed.

Teenagers who seek asylum are particularly vulnerable, alone in a foreign country where they possibly do not speak the language and having to adapt to a different culture and climate. They have limited financial backing and poor personal support structures. Their ability to plan for the future is truncated by their liminality within the system. Lack of access to childcare facilities may mean that they are unable to attend ESOL classes. If they delay accessing education services until they are 20 years of age they miss out on the 'Care to Learn' scheme.

THE HILLINGDON CONTEXT

For a range of reasons the London Borough of Hillingdon, in common with other London boroughs is home to an increasing number of migrants, refugees and asylum seekers. Population projections for Hillingdon suggest that ethnic minority groups will be in the majority in several wards in the borough by 2021 (Pickles 2005). Although Hillingdon and Harrow are predicted to have the smallest increase, births are expected to increase by 18% from the 2001 statistics. In addition, an analysis of birth data reveals a significant increase in births to mothers who are first or second generation migrants. In 2006 this was 45% of the births in Hillingdon, more than double the national figure (Bowles and Reidy.2007). This will create a greater demand on the maternity services. In addition key population changes with a larger percentage of ethnic minority communities are predicted (Shukla and Bowles,2005). Other significant health statistics highlight a 10.3% increase in teenage pregnancies in the under-18 age groups since 1998 (Lim 2005), the second largest increase in teenage pregnancy in the North West Sector of London. Many of these have occurred in the wards of Yiewsley, Botwell and the Heathrow villages which are also recorded as some of the most deprived or high concentration minority ethnic wards.

The proximity of the London Heathrow International Airport to Hillingdon is also a possible factor in the demographics and health service provision within the borough. A report by Tym et al (2006) examined the impact of Heathrow airport on the provision and costs of services generated by migrants to the UK, principally asylum seekers and in particular unaccompanied minors. They found that there are fewer asylum seekers in Hillingdon than would be expected (Tym and partners, 2006). Although Heathrow airport is a gateway

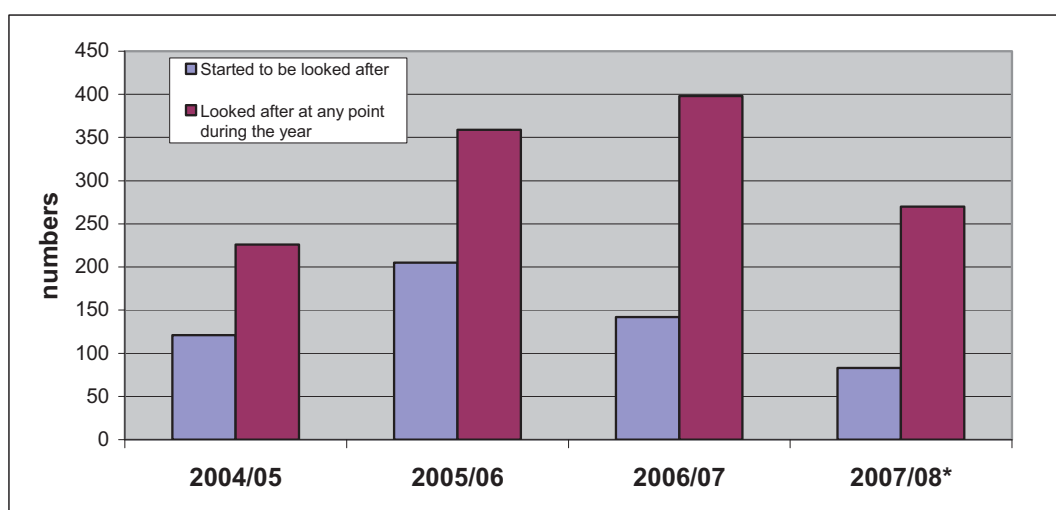
for asylum seekers and refugees, there are a number of factors that could explain the lower than expected numbers. The most significant factor is the ethnic diversity of the capital as a whole. Other factors include: the NAM dispersal system; the propensity for asylum seekers to settle, albeit temporarily, in other London boroughs, such as Newham where similar ethnic groups are more highly concentrated; and the cost of accommodation. Regularly updated figures on asylum seekers are provided through the data services of the London Asylum Seekers Consortium, City of Westminster.⁵

Heathrow does nonetheless, have a distinctive impact on Hillingdon with respect to unaccompanied asylum seeking children (see Table 1)

Table 1

UASC numbers between 01/04/2004 - 16/01/2008

	2004/05	2005/06	2006/07	2007/08*
Started to be looked after	121	205	142	83
Looked after at any point during the year	226	359	398	270



* Year to 16/01/2008

Source: London Borough of Hillingdon, Research and Statistics Team, Education and Children's Service

⁵ http://www3.westminster.gov.uk/publications/publications_detail.cfm?ID=1746 accessed 18th December. Main page
<http://www.westminster.gov.uk/communityandliving/ethniccommunities/asylumseekers/coreservices/>

UASC are designated the responsibility of social services and are currently not subject to NAM dispersal; however the Home Office is in the process of consulting on the possibility of introducing dispersing young people to different parts of the country (Home Office, 2007). This is in recognition that areas such as Hillingdon, Kent and Croydon take the financial and resource burden of caring for this group of clients. However the consultation document fails to reflect on the high level of expertise in Hillingdon and that dispersal will mean additional strain on the social and health staff, in other boroughs who may not have the skills to provide the same level of care and commitment.

The Refreshed Supporting People Needs Analysis in Hillingdon draft report (2008-2009) recognises the need for intensive support for all teenage parents and includes individuals who are leaving care and UASC within their remit. The London borough of Hillingdon recorded 166 teenage pregnancies in 2006 accessing the local maternity services. Although the largest proportion of this group are white indigenous teenagers this should not detract from the UASC who find themselves pregnant and new parents in a trajectory of uncertainty, poverty and vulnerability because of lack of familial support, language barriers, cultural difference and the lack of experience and confidence inherent in their youth. Updated figures on teenage pregnancies in the borough are available from the Teenage Pregnancy Coordinator.

In areas where there are high numbers of UASC the young people benefit from a well established infrastructure and pool of expertise, however the volume of demand can drive up costs and subsequently have a detrimental effect on the provision of care for indigenous children and young people (Home Office, 2007).

WHY THE NEEDS ASSESSMENT?

In response to the increasing numbers of vulnerable and excluded populations in Hillingdon, the Primary Care Trust set up a partnership project HOPE (Health Opportunities Promotion and Education) that was funded by a Lotteries grant with additional funding from the PCT. The goal of HOPE was to address the health inequalities of refugees and asylum seekers, travellers and gypsy communities and homeless individuals and families. The activities of the project have supported targeted access to health care and other services in otherwise difficult to reach populations and it has now received multiple awards (see appendix for further information on HOPE). However, gaps in services continued to be identified in each of these groups for which systematic data are required in order to assess the needs and develop the most appropriate interventions.

A senior midwife outlined the key ongoing challenges identified in the course of working with asylum seekers and refugees in particular. These included:

- i) refugee and asylum seeker women presenting for delivery without having had prior antenatal assessment;
- ii) an apparent over-representation of small-for-dates infants and other adverse maternal and infant events to refugee and asylum seeker women;
- iii) rape related pregnancies, particularly among asylum seeking women and

iv) failure to report for postnatal care.

There was a need for systematic data collection to assess the magnitude of these issues. In addition, it is critical to assess the experiences of the refugee and asylum seeker population that is by definition, vulnerable and at high risk for poorer health outcomes. The needs assessment was designed to provide the data to assist the Hillingdon PCT, maternity unit of the hospital and outreach programs such as HOPE to develop and implement effective strategies in response to identified maternity care needs of the refugee and asylum seeker population in the borough. This needs assessment supported and recognised national priorities towards decreasing inequalities in health by reducing the gap in health between different social and economic groups and areas.

Aims

The aims of the needs assessment were therefore:

- To review the needs of asylum seeking and refugee women in relation to holistic care
- To identify the gaps in maternity service provision for refugee and asylum seeker women in Hillingdon in order to make appropriate recommendations for changes to meet these needs.
- To support the provision of the highest possible standard of care during pregnancy, birth and the postnatal period.
- To gain insight from both the providers of support and the receivers in order to improve future priorities and resource allocation and consequently improvements in outcomes.
- To inform the design of appropriate interventions and inform potential future needs within the broader health service

For many women, the first significant contact with the health care system is during pregnancy and childbirth and therefore an exploration of the experience of this contact presents an ideal opportunity to assess the appropriateness and effectiveness of care.

The objectives of the needs assessment were:

- I. To identify and compile sources of information on the population of refugee and asylum seeker women that forms the client group for maternity services in Hillingdon.

The following set of questions were used to collate the above

- a. What is the distribution of refugee and asylum seeker groups across Hillingdon?
- b. What is the demographic profile of refugee and asylum seeker groups across Hillingdon?
- c. What are the numbers and profiles (age, marital status, immigration status, country of birth, languages spoken, and duration of residence in the UK etc) of pregnant refugee and asylum seeker women in Hillingdon?

- II. To map the services available to and required by refugee and asylum seeker women in Hillingdon with respect to maternity care.

The following set of questions were used to map the services

- a. What is the range of services that respond to the maternity care needs of refugee and asylum seeker women?
- b. What services are refugee and asylum seeker eligible to access?
- c. How knowledgeable are the staff members of various maternity services regarding immigration policy and access to services for refugee and asylum seeker women?

- III. To describe the experience of pregnancy, childbirth and the maternity services in refugee and asylum seeker women in Hillingdon.

The following set of questions were used to describe the above

- a. What is the pattern of utilisation of maternity services among refugee and asylum seeker women in Hillingdon?
- b. What is the experience of utilisation of maternity services among refugee and asylum seeker women?
- c. How does their socio-cultural context mitigate their experiences of the maternity services?
- d. What are the maternal and infant health outcomes of refugee and asylum seeker women?
- e. Are there particular services that exemplify best practice in the provision of maternity care and support for refugee and asylum seeker women?

These objectives were achieved to a varying extent. A Steering Group was set up to provide guidance for the project and to act as a point for dissemination of the findings. Organisations represented on the Steering Group included the Public Health Division of the Hillingdon Primary Care Trust, the HOPE project, that Maternity Unit of the Hillingdon Hospital and the Centre for Public Health Research at Brunel University.

The methods and challenges in data collection are described in detail in the following Chapter and the findings in Chapter 3.

CHAPTER 2

METHODS

INTRODUCTION

The design of the needs assessment was largely qualitative to obtain information that described the experiences of service providers and users and the service gaps. The needs assessment involved three main phases based on the objectives listed in the previous section. The phases were i) a compilation and mapping of information available on services and support for refugees and asylum seekers; ii) services needs from the perspective of providers; iii) services needs from the perspective of clients (refugee asylum seekers). These are described in detail below.

PHASE I: MAPPING

The mapping consisted of compilation and synthesis of available information on the numbers and distribution of asylum seekers in Hillingdon as well as the range of services available to pregnant refugees and asylum seekers in particular. Accurate data on the demographics of the target population are important for the assessment of needs and planning of services. However, these data are difficult to obtain; problems with legal status, questions of entitlements and the transient nature of the target population make it difficult to quantify the numbers of asylum seekers and refugees using health services and to develop a sampling frame for the purposes of the needs assessment. People are often reluctant to disclose their immigration status because of previous experiences leading to distrust of authorities and doubts about confidentiality (Burnett and Fassil, 2002). Collecting that data through formal administrative procedures is also difficult because of the potential risk faced by asylum seekers should there be irregularities with their documentation and the perceived stigma associated with the asylum seeking status (Almedom and Gosling 2003). The use of multiple sources of data, however, provided an indication of numbers and location of the target groups. The sources included:

- a. Statutory and voluntary agencies that support asylum seekers in the community;
- b. Summary data available from health service providers and the PCT;
- c. Community organisations working with ethnic groups and the immigrant population;

Key organisations were identified through community directories and databases and where possible, interviews were organised with key staff in the organisation not only to explore the range of services provided and compile demographic data, but also for further snowballing to identify other key agencies in the borough. In addition, information was solicited from organisations through surface and electronic mail. The organisations were sent a short questionnaire to report the services they provided to asylum seekers and refugees and in particular to pregnant women and new parents, the numbers of people they assisted, information about the language capacity

within the organisation and a brief summary of some of the key challenges. The mails were followed up with telephone calls.

In spite of this multifaceted approach, the response was disappointing - partly due to obsolete contact details. In addition, the response rate may have been affected by reduced staffing levels over summer holidays followed by the fasting period for Ramadan. Where responses were provided, the data requested was limited because staff reported that they provide services for people in need, regardless of immigration status and for that reason, they neglected to ask clients for their immigration status.

A total of 35 community organisations were contacted by e-mail, phone and letter within the borough of Hillingdon to map the services they provided, half responded and were prepared to engage with varying degrees of enthusiasm with the project.

PHASES 2 AND 3 – SERVICES NEEDS FROM PROVIDER AND USER PERSPECTIVES

Methods used for primary data collection for this needs assessment included:

- ❖ Key informant interviews
- ❖ Focus group discussions and public forums
- ❖ In-depth interviews.

These are described below.

The purpose of these was to obtain information from those whose positions or professions made them uniquely qualified to:

- a) identify and discuss the needs of refugee and asylum seeking women
- b) the needs of services and service providers who provide care and support to refugee and asylum seeking women.

Key informants were identified through internet searches and consultations with stakeholders such as staff within HOPE Project and REAP. Other key informants were identified through snowballing. The organisations from which key informants were identified covered a broad range of health and social care in the statutory and voluntary sector. Interview and focus group data were collected from:

- a) Eleven advocates from local community organisations,
- b) 12 individual key informant interviews with representatives of relevant maternity and related service organisations.
- c) Within the hospital there were 8 focus groups comprising mostly of midwives.
- d) 8 individual interviews were undertaken with refugee women from Afghanistan, China, Eritrea, Iraq, Sri-Lanka, Somalia and Uganda.
- e) Seven focus groups were conducted with a total of 35 women from Afghanistan, China, Sri-Lanka, Ethiopia, Poland, Somaliland, Russia.
- f) Interviews with 3 British Indians and 4 white British to obtain a non-refugee perspective on experiences of the maternity services.

- g) Two focus groups were conducted with women who were not asylum seekers and refugees (9 women).
- h) Two public forums were attended; a child protection day for the Somali community at Uxbridge College and a public consultation arranged by REAP on the Mayor of London's integration study.

Recruitment

The project outline, together with a small poster specially designed to highlight the points under consideration were circulated across the maternity services (appendix.1 and 2). The poster was endorsed by the new head of midwifery and circulated with an open invitation, extended to midwives and specialists to attend these forums during the mid-morning break. Tea, coffee and cakes were provided. Other forums took place during mandatory study days. These presented the opportunity for discussions with 6-8 members of staff at a time.

Participation was largely opportunistic. A few participants from the maternity services made extra time to talk to the researcher. Largely however, there was an indication that participants were strongly self-selected because they wanted to make their views known. The ethnic mix of staff reflected the mix within the hospital; predominantly white British. Details are not provided in order to protect the identity of individual staff members. Furthermore, there was no indication in the analysis of the data, that views expressed were associated with any distinct socio-demographic categories.

Although extensive data were obtained, the general response to these forums was disappointing. This reflects the response to a study conducted by Renewal Single Regeneration Budget (2001) - researchers encountered several challenges in collecting data partly because of the time and resources constraints of the organisations approached⁶. The study suggested the lack of buy-in to the study reflected an attitude towards asylum seekers as lower in priority relative to other service demands.

For recruitment within the community, a flier (appendix 3) was designed by artist Heidi Cutts and was used to advertise the project to the community. This proved very effective and generated interest. The flier gave contact details of the principal researcher. It was circulated by REAP to all the organisations on its database as a newsletter item. It was also used to extend an invitation for interested person to attend a focus group discussion based at REAP. At a 'Keeping Children Safe' conference which was well attended by Somali women the fliers for the needs assessment were quickly picked up by women keen to share their experience of using maternity services. In addition, stakeholders in the community were contacted and consulted. This resulted in further interviews and focus group discussions.

Data collection

The protocol of the needs assessment was approved by the Ethics Committee of the School of Health Sciences at Brunel University. Information was provided in the form of posters and flyers and further information given to those who agreed to participate. They were assured that their contributions

⁶ <http://www.researchasylum.org.uk/?lid=123> accessed 14th November 2007

would be anonymous. Within the community, those who participated were given vouchers and venue hire, refreshments and travel were funded through the project, as were interpreters for women who opted to communicate in a language other than English. Permission was sought to record and transcribe the interviews where relevant.

The data are subject to the limitations of needs assessments conducted on a limited budget within a limited period of time. In addition, there was a change in research staff following the commencement of the project, further limiting the time available to undertake the project. The data collected was mainly qualitative and is reflective of the perceptions and view of those people who wanted to take part and have their voices heard. Within focus groups attempts were made to draw quieter participants out, a strategy that was particularly important in several of the focus groups discussions with midwives in the hospital. The more confident participants often dominated the discussions and may have inhibited the expression of alternate points of view.

The midwives were asked about their perspective within the themes outlined by the information flier, namely:

- what did they think were the needs of refugee and asylum seeking women?
- what did they need in order to provide the best quality care for this target population?
- how could services be improved more generally?
- What did they know about pathways for referral for specific health issues?
- what challenges presented in the provision of care for refugee and asylum seeking women? and
- was their practice constrained by questions of entitlement?

Discussions were open, frank and uninhibited. Participants led the discussions with little prompting from the facilitator. This was as true for providers as it was for user groups.

Interviews and focus groups with women in the community covered the following broad areas:

1. How easy has it been to negotiate the services?
2. What were your expectations of maternity services?
3. Have these expectations been met?
4. What have been your prior experiences of maternity services?
5. What other services have helped to enhance your maternity experience?
6. What have been the worst things about the maternity and related services?

7. What have been the best things about the maternity and related services?
8. How do you think your experience of maternity services could be enhanced?

Probes

- Differences between specific sections of services (antenatal, birth, postnatal, health visiting etc).
- Support from particular groups of staff
- Financial and opportunity costs
- Other forms of support – family, friends, community, support groups

Data Analysis

A thematic analysis was employed to analyse the information from focus groups and interviews. Although refugees and asylum seekers are not a homogenous group of individuals, previous research demonstrates that there are a number of common themes which in isolation or together may impact on the ease that asylum seekers and refugees experience in accessing and engaging with maternity services. These were the broad themes that guided the approach to organising and analysing the data:

- 1) Overstretched Services
- 2) Beliefs and understanding about asylum seekers and refugees
- 3) Communication
- 4) Access and Entitlement
- 5) Additional Constellations of vulnerability
 - a. Mental health
 - b. Domestic Abuse
 - c. Young people
 - d. Sexual Health Services
 - e. Female Genital Circumcision/cutting.

The findings are presented in the following chapter and the implications as they relate to the objectives of the needs assessment are discussed in Chapter 4.

CHAPTER 3

FINDINGS

THE TARGET POPULATION AND AVAILABLE SERVICES

The key organisations providing support for maternity care outside the hospital in Hillingdon were HOPE (main commissioner of this needs assessment), the Asylum Services, and Refugees in Effective and Active Partnership (REAP).

REAP

Refugees in Effective and active partnership (REAP) is an independent organisation that empowers refugees and asylum seekers to reach their full potential and rebuild their lives within the UK. Their funding is provided by the Association of London Government and Hillingdon with some further support from HOPE. Working with other agencies, REAP provides advice and support services for refugees, asylum seekers, their communities and organisations that support them. It has a number of core aims including; to promote a positive image of refugees, support their needs and to dispel myths; to engage constructively with other services providers and to address the lack of information about the entitlements and rights, good practice and available services⁷.

HOPE

Health, Opportunities, Promotion and Education (HOPE) is a partnership led program that aims to address the inequalities in health provision for asylum seekers and refugees, the Traveller community and single homeless people. The projects focus on access and engagement of health services, mental health, primary care and the wider issues that affect health such as accommodation and/or environment, leisure and cultural services and access to lifelong learning and training. The program has delivered a number of interventions including a college based course for local asylum seekers and refugees to train to become community advocates and interpreters; a series of basic skills and education for Travellers and single homeless people including IT, literacy, numeracy and budgeting; a programme of health promotion and awareness and support for services and providers to enable access and use by the target groups⁸. HOPE is able to engage effectively with communities through the services of health visitors. Further information on HOPE is provided in the Appendix.

The Asylum Services in Hillingdon

Asylum seekers in Hillingdon are allocated into different categories of service according to age and need. Those who enter through a port, in this case Heathrow Airport and declare their intention to seek asylum are cared for through the National Asylum Model (NAM). This assistance is provided by the

⁷ <http://www.reap.org.uk> accessed 19th October

⁸ <http://www.hillingdonhope.co.uk> accessed 19th October

Home Office Immigration and Nationality Department. Young people who enter the country under the age of 18 become “looked after children” and are the responsibility of the Local Authority. The Asylum team in Hillingdon is subdivided into a number of different sub-teams: The Asylum Intake Team, Children’s Asylum Team, The Youth Asylum Team and the Asylum

Other refugee and asylum support organisations

Other services that consented to be involved in the needs assessment are summarised in the table below.

Table 2 – Refugee and asylum support organisations

Name of Organisation	Service Provided
Asphaelia	Support and advice for unaccompanied asylum seeking children
Bell Farm Christian Centre	Advice and support for people in need, ESOL classes
Chinese Community Organisation	Voluntary - Advice and support for Chinese community
EACH	Drug awareness, education and support for Somali population. Supported by HOPE
Hillingdon Association of Voluntary Services (HAVS)	Co-ordination of voluntary organisations/
Health, Opportunity, Promotion and Education (HOPE)	Health promotion, education, community networking and support
Hillingdon Asian Women’s Group	Voluntary Activities within Asian community
Hillingdon Race Council	Advice and information on discrimination and related issues.
Hillingdon Women’s Centre	Voluntary Support to people in need. Advice. Mother and baby groups.
Tumblers	Advice, support and education for young people, particularly asylum seekers
Sure Start	statutory Health and social support for families 0-5 and antenatally
Refugees in Effective and Active Partnership (REAP)	Charity Education and networking of refugee organisations.
Social Services	Statutory Asylum team and unaccompanied asylum seeking children support
Somali Community Advice Centre	Advice re employment and education, ESOL and computer training.
Tageero	Access to health, training and education for asylum seekers and refugees
Victoria Climbié Foundation	Campaigning re child protection issues
Maternity Services Liaison Committee (MSLC)	Liaison between providers and users of maternity services
National Childbirth Trust (NCT)	Campaigns and provides education and resources for childbirth
National Children’s Home Hillingdon Children’s Rights Service	Charity Work with any child or young person who is looked after by the London Borough of Hillingdon.

Other registered organisations which were not engaged owing largely to the short duration of the project include:

- Afghan women's support
 - Anglo-Albanian Association
 - Connecting Communities
 - Community Voice
 - East African Community support
 - Eritreans in Hillingdon
 - Health and Social Access for Refugees in Hillingdon
 - Hillingdon Carers/Ethnic minority carers
 - Hillingdon Kurdish Association
 - Hillingdon Refugee Forum
 - Hillingdon Refugee Support Group
 - Hillingdon Caribbean Community
 - Refugee Aid and Development (RAAD)
 - Radicle, Community advice and support team
- Refugee and Asylum Seekers Project (2006)
- Somali Community Advice Centre
 - Swahili Muslim community of the UK

MAPPING THE TARGET POPULATION

The maternity services data provide some proxy information on the numbers of women from non-white backgrounds who access the services. However, these figures do not reflect immigration status and therefore also include the longer term UK minority ethnic resident population. Although there is evidence to demonstrate the challenges faced by the broader BME groups (CEMACH, 2007) the intention of this report is to focus on refugees and asylum seekers as a special population with particular needs.

There is an attempt by the hospital to obtain immigration status through an Overseas Officer. The purpose is largely to monitor and where possible, recoup the costs incurred by the treatment of visitors to the UK who are not eligible for free or subsidised care by the NHS. Potential non-residents / non-citizens are flagged by the following criteria:

- They are late bookers
- They have just arrived from abroad
- If they have no NHS number
- If they are a non English speaking

Further information is then obtained through an interview. The accuracy of these screening criteria is unclear. It also relies on women providing relevant supporting documentation as well as on community midwives and GPs providing adequate information in their referrals. Asylum seekers are exempt from fees unless their claims have been rejected. Current records show that there have only been 4 asylum seekers since March to November 2007 and 41 'health tourists' in the last year.

Data specific to unaccompanied minors (asylum seekers) were obtained from the teenage pregnancy coordinator in Hillingdon. 12 of the patients on the

teenage pregnancy register in March 2007 were UASC, most from countries in sub-Saharan Africa.

Other data that could be provide estimates would be the volume of use of official interpreter services. However this was conflated by inconsistencies in patterns of usage across different services.

FINDINGS ON SERVICE PROVISION

Main findings

1. **Maternity services perceived by providers and receivers as “over stretched”**
2. **Vulnerable populations represent a burden of care that is not resourced or supported.**
3. **Lack of understanding of knowledge and awareness of refugee trajectory and possible needs**
4. **Poor attitudes towards some vulnerable groups**

OVER STRETCHED SERVICES

The Hillingdon PCT reports about 4500 deliveries a year. Staff generally reported that standards in Hillingdon were good. There was for instance a local area agreement to support disadvantaged groups with breast feeding. Senior midwives reported that Hillingdon has an agenda for high risk women, and aspires to higher standards than other PCTs such as Ealing. Hillingdon had developed more protocols and this created difficulties in passing on care between Hillingdon and Ealing.

Under-resourced

Midwives noted the escalating demand for services in excess of the ability of staff to keep pace; the view was supported by other professionals as well as by users of the maternity services. Refugee and asylum seeking women who were interviewed explained that they could appreciate the pressure that midwives were under; they could see it themselves that they were overstretched. The work load was particularly apparent over weekend and consequently, users reported a reluctance to impose further with their individual needs.

“There is a lack of staff, too many women and not enough staff, the midwife was kind but too stretched. It was Sunday so there were less staff, 10 women having babies, they (the midwives) were rushing up and down”

“... I heard Hillingdon was not very nice so I asked for a tour but it was very nice... But they left me on dirty sheets, blood on them but I did not stay long. The midwives are really very busy. She left me with a beginner who I tried to support but the midwife was just in a hurry and the student was lovely but thank goodness nothing happened. The midwife was not kind, she could not

do kind and be in a hurry and you need someone to look at your face and be kind...sadly the student will change. ... after all I delivered my girl and it was all normal. I was really afraid and they do not explain everything and you need people to explain slowly when it is not your language but they said you cannot understand and they used complicated words so you do not understand.

Woman from Iraq.

One woman from Afghanistan was aware that the midwives were busy but was nonetheless upset that this had impacted on her care,

I had an infection or something. But I had a bad experience with the needles, every 4-6 hours they came and injected something in, they were in a hurry and I felt pain, I understand the difference, the higher person, manager she took 20 minutes, she was showing someone else and that time it did not hurt...I understood the difference, they were just in too much of a rush.

A Chinese young woman thought that her foreignness would inhibit her accessing good care because accompanying a friend in labour she had noticed that if:

“ It is busy they tell you if you speak English otherwise they go to the next patient. It makes me worry what will happen to me when I have my baby”

It has been argued however that the perception of “overstretched” services may reflect suboptimal organisation rather than an indication of shortage of staff. Based on figures from the 2006/7 LSA annual report for midwives, Hillingdon is well within the London average of a little under 35 deliveries per midwife in post (LSA 2007). In addition, midwives are supported by maternity support staff.

Resource intensive

The resource implications of high risk, vulnerable women are acutely felt by health providers; for instance bed occupancy in terms of cost, suitability and availability was an issue for midwives.

Asylum seekers present a particular challenge because they have no where to live or clothes for the baby and they effectively block a bed which is costly and a poor use of services.

However the Obstetric team did recognise the possible higher social need within this group,

Length of hospital stay may need to be addressed as the usual 6 hour discharge / 1 night / 3 night stays for normal delivery / instrumental delivery / caesarean section may be inappropriate in term of both medical problems and organising social input.

Mirroring Miranda Lewis' work (2005) a number of midwives reported that their workload increased through caring for asylum seekers and refugees. There was clear identification of patients whose social circumstances created a high need, such as lack of English language skills, and lack of familiarity with the health system in the UK. However there was little to suggest that these issues were specific to refugees and asylum seekers .In the context of a

service that is financially and resource stretched additional needs from a group of people who are not integrated increased the workload significantly for everyone.

...she was from Zimbabwe or one of those places...someone else had relatives in the East End of London...obviously here illegally...it creates more work.

Midwife

We get all these illegals from Heathrow, 9-10 admissions amount to nothing... we see these women rather than asylum seekers and refugees, illegals...busy day and immigration send you someone. ...

15 turned up last month unbooked...They had labels but they were not booked

Midwife

There is some support available through the community voluntary sector that could reduce the 'burden' of care. However the uptake of these services was reported as being very poor. A senior midwife explained that there just wasn't time to ring around the community when there were more pressing clinical issues that required attention. She reported that it felt like a quagmire of different organisations and that what was needed was a link person to whom midwives could refer to deal with non clinical support.

Knowledge and Attitudes

In general, with the exception of those who worked in practices that targeted disadvantaged groups, most maternity care staff could not distinguish between the different immigration categories of their patients. Many of the participants felt unable to discuss issues as they had not thought about them before and were unsure about the needs of this group of women. Although resources exist, for instance the directory of services produced by REAP, most maternity staff who participated in the study were either unaware of its existence or did not use it. There were a few individual members of maternity staff who understood the basic issues, contexts and backgrounds of asylum seekers and were very reflective in their responses during discussions. They spoke about the importance of providing the best care even within the constraints of limited resources.

There was some misunderstanding about the asylum trajectory with a perception that people fleeing their country of origin come to England to ask for sanctuary and safety; and this precluded health care. People who were brought in by the immigration services from the airport were dismissed as health tourists. However, there were clear cases of asylum seekers who had health problems, including maternity care needs. A 17 year old woman interviewed in the study had arrived as a refugee from Ethiopia. She had become pregnant in prison there and on arrival at Terminal 3 had been transferred directly to the hospital.

It was not altogether surprising that there was also some negativity towards the target population that was felt to be taking up an unfair share of resources. Some midwives reported that as a consequence of the resources that went to

supporting “those people”, they were not able to give as much attention to the white British population. What was surprising was the sometimes frank expression of hostility. Lay discussions, media reports and local politics appeared to feature significantly in the content of some of the focus group discussions on attitudes towards asylum seekers. The attitudes expressed were often complex and contradictory reflecting the opportunity presented by the needs assessment to discuss what appeared to be deeply entrenched values but with nonetheless a lack of information on which to develop consistent views.

Others say they came on a plane but they have not ...eventually they say they were on a lorry but they can never say what the person they were with looked like or a name...came from Africa somewhere.

Midwife

Young asylum seekers were referred to as “unaccompanied minors” by the midwives, and for the most part they were spoken about disparagingly. It was felt that they received too much in relation to the white teenagers in the borough and there was an overt resentment expressed.

The service provided for unaccompanied teenagers is over the top, they even have 1-2 weeks of support at night for feeds etc...the conversation in the community. If you are a teenager and not a citizen in the UK you get everything but if you are a UK citizen... They even get asked what microwave they would like. We look after the teenagers but not the unaccompanied ones they get enough, there are only 2 midwives in 3 days for teenagers so they just don't have the time...

Midwife

Health Tourists

More than asylum seekers, there was a poorly disguised wariness of the “those people from the airport.” This described emergency cases often brought in by immigration services who had recently arrived and gone into labour or who are transferred from the immigration detention centre. Contrary to travel regulations, women in this category would have boarded the airport in a later stage of pregnancy than was allowed under the IATA regulations; or were experiencing pre-term labour. There were 41 such cases recorded in the last year. There were also those who were thought to use admission into the hospital as a means of evading immigration. A midwife noted,

People arrive in Heathrow; they claim they have abdominal pain and they come here in an ambulance. And then they just escape because immigration does not follow it up. We have a duty of care but it is a strain on Hillingdon. Sometimes they have no family, we ring immigration and get a reference number...but the women do not come back if we discharge them but it is not our responsibility. If you ring the detention centre you are put on hold. It is often difficult to communicate to the women. We have had particular problems with women from Nigeria and Rwanda.. They just come to have their baby...come to Hillingdon by ambulance...there is no way to check on their vaccinations...they don't tell you things, they are aggressive, aggressive with

GPs, want you to write letters for them to the Home Office, won't tell you even the name of their partner or if they have had children before.

Other midwives explained,

Some women come here on a flight antenatally only to disappear...They have nothing...we did a pack of toiletries for them, shampoo, shower gel, that sort of thing and we cleaned some clothes from lost property for them. They come in the winter and they have nothing, sometimes you feel sorry but there was this women who was dripping in gold and a fur coat ...came in through terminal 4...I thought she was a prostitute...they come in droves and then nothing for a while. No clothes, no luggage, no money but terminal 4 had no record; never had documentation...sometimes there are guards...that is for those who are trying to escape. They have flown in asking for asylum...they are in detention centres and they are brought here...A women was leaving the country, she said she was unwell so they brought her here...There never was anything wrong...they think they can escape...they know where they are going.

They are not truthful about their age, I can think of examples where they must have been 23 or 24. They tell some story, that they have been raped or forced into prostitution...heard that before, it is always the same story, it is probably true but they know that if they say they are 17 they will get more support...they go on to have another...partner is not with them though.

You can pick up the genuine cases as they are shell shocked and traumatised...the others have mobile phones... Always on their mobile phone, the woman from Nigeria, great big woman she left her gold watch behind.

and is there any protection for the staff? I mean are they screened for infections, are there precautions that the staff can take to protect themselves from getting things from these people. I mean things like HIV and AIDS.

The attitudes and concerns of the staff reflected in the descriptions of these cases highlight a strong sense of who does or does not deserve compassion and care:

If people are genuine it is ok but then there are those who are travelling, what are they called, healthcare tourists, NHS tourists, just drop in to have a baby, they take advantage...but there are the genuine needy, some people give everyone a bad name.

Training needs

There was a recognition from most of the maternity care providers that additional training around these broader population change issues was needed - from understanding the different terms used to describe refugees to awareness of the refugee trajectory and to understanding possible needs and being able to care for women in this position sensitively. A few had attended a session from HOPE but for most, the only information they had is what had been picked up through the media. There was also a discussion of how the needs of this target population could possibly be placed within a broader framework of strategies for Black and Ethnic Minority groups. One midwife admitted that;

We need more help because it is complex and complicated. I do not really understand how the asylum system works, just want to give my care. It is all a bit frightening, things are difficult to ask in the same way that talking about Domestic Violence is difficult... you have to be brave enough to ask these things and then have the time to listen and then you may have to do something.

Midwife

Recognising the complexity another midwife said,

It is difficult to give care because they start off with us and then disappear, they move out of area, are deported, disappear, you just do not know and some of them are not honest. It sometimes says on the referral form that they are asylum seekers but not always. It is difficult to know what the difference is.

COMMUNICATION

Main findings

- 1. Translation, interpreting and advocacy services are patchy. There was a clear understanding that interpreters were expensive and other means should be tried first. Interpreting services therefore continue to rely on friends and family or multilingual members of staff.**
- 2. Communication between agencies in general and with regard to the care of vulnerable populations in particular needs to be improved.**

LANGUAGE AND COMMUNICATION

Language and the need for translation services was one of the most important issues identified, particularly for community services. Available services for non-English speaking patients include different interpreting services within the borough and Language Line. There are about 94 different language groups living in the Hillingdon area. The standard procedure is that where appointments are booked, requests need to be made then for interpreters in the appropriate language. For women who turn up to the antenatal clinic without a prior booking, a team of support staff including the healthcare assistants provides translation and interpreting services for the predominant languages. In the last year, interpreters were requested for 47 different languages, and there is a 50% ethnic minority case load.

In recognition of the interpreting services provided through the health care assistants women who do not speak English are channelled through the hospital antenatal clinic rather than being seen in the community. Although this may offer an opportunity for a medical practitioner to conduct a clinical assessment and a cardio-vascular examination as recommended by CEMACH (Lewis, 2007).this could also be done by the GP. Regular antenatal

visits to the hospital mean a 2-3 change bus ride for some women in the more deprived areas of the borough; a significant opportunity cost.

Interpreters

The use of family and friends for interpreting in the maternity unit remains a predominant practice even though it is known that this practice is suboptimal. Interpreting services, particularly Language Line were described as “prohibitively expensive” and logistically challenging and therefore used only in extreme cases. Charges were incurred for instance when an appointment was made but the patient did not show up or arrived late. While there are interpreters in the clinic, use of family or friends was considered acceptable, although not ideal, for “normal” cases because “they do not really need” professional services.

The interpreting policy is to try and find a member of staff first, this may not be just within maternity services...it could be anyone, someone from the lab for example.

Midwife

However, staff across the board (midwives, health visitors) expressed that the poor infrastructure for interpreting services made their ability to care for this group problematic. Although ‘Language is Everything’ is the translation service used in both the Hillingdon Hospital and the LBH, this is not always consistent. In addition specific interpreters are not guaranteed. Consequently, there is little possibility of an interpreter following a woman through the health and social arena and the opportunity to build trust and understanding is lost.

There is no robust system for use of interpreters in spite of strong policy recommendations (Lewis, 2007; DH 2004a; DH, 2007b) It was recognised that the use of non-professional interpreters was not ideal particularly within families where there were strong cultural gender differentials. Having a male relative interpret was not always culturally appropriate. Examples were given for instance of the difficulty of eliciting information on domestic abuse if the interpreter was the potential abuser. The use of primary school aged children was also understood to be inappropriate as they could not be responsible for conveying information on or medical advice to their mothers. This however, did not preclude its occurrence.

Particular concerns were raised about the inability to convey proper information about the purpose and consequences of screening in antenatal care. This was a concern when no information was conveyed due to lack of interpreters or when the information was inadequate due to a lack of understanding of the people who were interpreting. A health visitor described a case where the interpreter also used the opportunity to proselytise, imposing her moral values on any choice the woman would make following the results of a screening test. Another ethical concern was raised regarding proper informed consent for procedures.

The ideal situation expressed was for 24 hour access to interpreters, especially on the labour ward. Some of the midwives found partners frustrating to deal with particularly with regard to pain control because they often did not seem to be providing full information to their wives. There was

also a need expressed for interpreters in parent craft classes which were poorly attended by non-English speaking groups.

They therefore do not know what to expect, they do not go on the tour because it is not translated and it makes the situation frightening for them when they come in. NCT costs. midwife

Pockets of good practice were identified where women who were seen by the specialist midwife for sexual health reported good use of interpreting systems. In addition the diabetic team has a training pack in different languages and reported regular use of interpreters. Leaflets explaining screening for Downs Syndrome for instance are available in different languages and on consultation people talked about this. Three Young Chinese women were able to convey that they had had blood tests: one for HIV and another for “*older women when something is not quite right with the baby*”.

The UASC mothers did have access to teenage parent craft classes. Support workers had asked for interpreters to be present where necessary. As a result the young women had benefited from the session and felt part of a young community of mothers when they too received a ‘goody bag’.

There was a perception among the midwives that other units such as Northwick Park and Ealing had a better system and that interpreters were available 24 hours a day in these units. However a senior key informant explained that there had been an excellent system of interpreters, fully integrated between the community and hospital since April. Unfortunately the new improved system does not seem to be known to the staff.

Learning the dominant language

There were a few dissenting views about the importance of interpreters; a number of midwives talked of not believing women could not speak sufficient English in hospital, given that they appeared capable of travelling on buses and shopping without interpreters.

You know they ...claim they do not speak English, some are genuine some are not...I test them by saying something inflammatory just to see if they understand...you just can't believe they cannot speak English...this woman claimed she had a sister in the country...she was rolling around the bed in pain not communicating.

Midwife.

This perspective was challenged by another midwife who explained she could quite confidently travel in Germany but should she be unfortunate enough to need to use the health service she thought her language skills would be inadequate. She went on to explain that when you are frightened or in pain you are more likely to think in your predominant language.

A patient advocate asserted that:

When some staff see that a woman cannot speak English, that she doesn't understand the system then she is really vulnerable...it is heartbreaking.... there is no respect, not valued and they get 'shoddy' care...the midwives do not take care even doing things like checking the placenta...they just don't

bother and you end up getting an infection. There is no trust you just do not feel safe.

There were a number of suggestions that arose from the discussion about the language proficiency of the patient groups. A Chinese advocate suggested that engagement with the services during pregnancy and early parenthood offered ideal opportunities to learn English. She thought the combination of non directive support and advice around pregnancy, birth and becoming a parent coupled with support engendered by meeting people and learning some English should be greatly encouraged. From an educational perspective her understanding of the National Service Framework (DH, 2004a) focused on broader educational needs of parents and young children to improve long term outcomes and reduce inequalities in health.

She suggested:

"...interpreters are not the answer, people always say that but it does not always help and that you cannot expect services to provide interpreters all the time...more important was to have a life long view...a self help project...these women are young and they have their whole life ahead of them and they needed to learn English... not learning the language means that there is a generation gap which leaves the children isolated and neglected because of the barriers at home"

At the Tumblers in the YMCA in Hayes there are a number of support groups for young people and an opportunity to learn English informally. However this provision could be improved if there was funding for crèche facilities. Learning a language and getting support would be better enabled where the mother did not have to concentrate on watching and caring for her toddler.

Health and social providers within both the statutory and voluntary sector highlighted the need for advocates or mentors who, with some training, could follow a woman through her pregnancy and post-natal period until the child was a year old. They could interpret and translate but they could also importantly provide support and signposting. Organisations such as REAP expressed a keenness to set up such a service but it would need funding for training, supervision and organisational issue. Befriending and building trusting relationships which focus holistically on the woman and encourage uptake and use of services may go towards changing inequalities in outcomes in time.

Two women in the non-asylum seeking focus groups expressed that they had felt that they could seek advice easily from their midwife in the community, and that their intra-partum care had been good. However there were explicit evocations from a number of women that although they had felt welcome in antenatal clinic this was not true of their whole experience. Women felt that service providers had ignored them or disregarded them. Many women commented that no one had smiled at them or tried to communicate.

INTER AGENCY COMMUNICATION

The lack of infrastructure for referring women and their families to other support agencies was highlighted repeatedly. Midwives asked for quick

reference guides providing pathways for appropriate referrals to address the range of issues with which they were presented. There was a general awareness of the plethora of organisations within Hillingdon and in London but that there were so many that it was over whelming. There were also suggestion for advocacy and link workers who could be a central point of contact for vulnerable groups.

A senior midwife described how in another unit that she had worked in there had been an organisation within the community where you could refer women. There they would be provided with support for a range of issues such as housing in their predominant language. This sort of non clinical support did not seem, she asserted, to be a priority in Hillingdon.

Some of the issues raised in the discussion suggested that if staff consulted a with each other, they could probably have access to some of the referral points – health visitors for instance were identified as being knowledgeable about referrals.

For the main part though midwives reported that they felt isolated in their care and provision for people with multiple social needs, and within this category women who are seeking asylum or refugees. It was noted on several occasions that there were no multidisciplinary forums with social services or mental health.

An important tension was raised, particularly as it related to discussion for a more proactive engagement with ethnic associations. This related to the issue of people's immigration status and the need to work with them regardless. It was felt by these voluntary organisation that care, support and advice should be provided according to need and people helped as individuals without necessarily linking support to their immigration status. Stigmatising labels such as those implied by immigration status were not deemed helpful in making their services accessible or in engaging people longitudinally and proactively.

There was a clear desire to engage women from vulnerable groups including asylum seekers and refugees in the Maternity Services Liaison Committee and the labour ward forum.

Reports from community organisations consistently highlighted the lack of referrals from the maternity services. Women from the community that accessed their services had often been through circuitous routes and could have otherwise been referred directly from the maternity services.

The reasons for non-referral need to be explored carefully. Although there was a general lack of knowledge about specific pathways, most maternity staff were aware that there were some services available in the community for refugee and asylum seeking women. The reasons for non-referral fell broadly into three categories: a lack of understanding about and a lack of a coordinated approach to referrals and service provision across agencies; a real reluctance to provide 'extra' services to a target population perceived to be already over-resourced; and preconceptions about the knowledge of the target population and their ability to access further support.

In general service providers described a lack of transparency about what was being provided so that at times services such as interpreters were doubly booked for one session, people complained of not being aware of care plans, others of care plans not being followed. Different professions felt that there was poor understanding of each other's roles and the limitations of these roles in relation to budgets and statutory care. Priorities were also different for the different agencies. One of the community based professionals hoping to start a program to support women was unable to obtain support from clinical staff who wanted to be paid to offer the service. This further highlights the lack of coordination of effort. For cross agency services to be provided, the structures need to exist that will allow expertise to be shared across without staff perceiving that they were having to perform tasks in addition to those for which they were officially employed.

Some women in the target population reported difficulties they had had in trying to work with the social services. Many of the specific issues expressed were similar to the challenges faced by the maternity services as social workers were regarded as being figures of authority. Women expressed a need for a trusted contact person. Repeated moves especially in pregnancy led to a lack of continuity of care from health providers and also concern that follow up appointments and screening tests could be 'lost.' One midwife described:

If housing moves them they are supposed to tell us. We have a strict rule here - if people do not attend by the third appointment then we have to go and see why and it is waste of resources because they have gone, moved or been dispersed up north. We want to pass information on, like blood results, but housing do not tell you where they are. Housing say it is confidential and won't give the new address...but we want to give a proper handover to their new health care provider.

In discussions with staff from social services a major issue raised was the real need for improved interdisciplinary working and joint agency planning and meetings. This needs to be at a policy level so that it becomes ongoing and reflective. It would provide opportunities for people to learn from one another and establish good working relationships. Certainly hospital liaison could be improved. Cases had occurred where women had been inappropriately discharged or they had been sent home with a new baby without the implementation of a care plan. Social services have a broader, long-term duty, especially for the UASC and it is therefore in the best interest of the mother and baby if they are informed and consulted about additional services that different providers give. Social services also championed the idea of a mentoring service for young women; currently there are support groups initiated by the young people themselves but it would be beneficial to have this extended. UASC may be more 'needy' than the local population because they may not know anyone and do not have an 'aunty' in any sense of the word to ask.

Significantly staff from the social services were concerned that because they were constrained to work only with the UASC and not their partners, the needs of the family as a unit were not being met. Increased inter disciplinary working and a greater degree of transparency about what services provide

could lead to more of the partners and fathers of the babies being involved in supporting the mother and caring for their child. This is in line with the National Service Framework (DH, 2004a) policy on greater involvement of fathers.

There was awareness that greater dialogue and understanding between providers and receivers of care was needed. Attempts to involve community organisations in the Maternity Services Liaison Service had not yet been successful. Concerns were highlighted about relevant, accessible culturally sensitive 'parent-craft' classes for all women. The National Childbirth Trust has an interest in providing services for women who come under the umbrella of 'hard to reach' and could with good interdisciplinary working possibly begin to implement this.

ACCESS AND ENGAGEMENT

Main findings

1. **Providers asserted that women should always be given care regardless of their immigration status.**
2. **Entitlement to free NHS care is channelled through the Overseas Officer who is sensitive in her work and advocates that the women receive their care regardless of ability to pay.**
3. **Women encounter difficulties accessing maternity services through GP.**
4. **some asylum seekers experience difficulty in accessing primary care, a GP in particular**
5. **Non English speaking women are required to access care through the hospital which requires several bus journeys and large amounts of time**
6. **Opacity of system and lack of interpreters means that women are receivers rather than active partners in care.**

Entitlement

All referrals from general practitioners who are 'late bookers,' have just arrived in the UK, have no NHS number or do not speak English are directed to the Overseas Officer of the hospital. The overseas officer is responsible for filtering the health tourists from the people referred. She noted that asylum seekers and refugees are entitled to care and can be acknowledged as such very simply by their Home Office identification. Women then receive a letter with their booking invitation which states at the top Eligibility to Free NHS Care.. People who this applies to are requested to bring a form of documentation such as a marriage certificate, student paper passport or IND card. If women are seeking asylum and present their IND card they are exempt from payment and receive free care. However if they have no recourse to public funds, for example if their asylum claim has been rejected they are asked to pay for their care. Midwives and the overseas officer could

recall three cases in the last five years where women had left appointments because of this.

Clearly the Overseas Officer is in a very difficult position and evidently is sensitive to the importance of women receiving care especially in situations where they, in her assessment, are destitute; however local protocols deviate from the stipulation from the DH that women are not asked to pay in advance (DH, 2004b). There was awareness that some women are unable to pay. Informants discussed how the Trust needed to reclaim the money where possible and there was an understanding that at times this was convoluted and difficult situation. It was stressed that if the women were overseas visitors (for what ever reason) do not access care it is a matter of safety for both mother and baby. .

There was unanimous agreement from all service providers in the study that all women should receive care and that care should never be denied regardless of immigration status. The responsibility for the determination of payments or entitlement rested solely with the overseas officer. There was however, some confusion about the term 'immediately necessary care' particularly as it related to antenatal care and irregular immigration status. A couple of midwives recognised that fears about having to pay may put people off accessing and engaging with services, accounting for late and non-bookers. There was some concern expressed about the high mobility and a question about the level of responsibility of midwives to follow up women who did not turn up to antenatal appointments. The mobility, they thought, may be because they are moved by the NAM program. Within a stretched system too much time was spent trying to find women who were no longer in the area. Anecdotal evidence from agencies and the women themselves highlighted difficulties in accessing GP services. Many of the women gave positive descriptions of their reception and care within primary care; others described bemusement at being shouted at and told they were not welcome because they were asylum seekers, one young woman from China had been turned away from five surgeries.

There was a frequently raised concern that that Hillingdon would be perceived as a 'soft touch' for free maternity care because of the proximity to Heathrow airport. The discussion was in the broader context of people misusing the NHS so the concern was not directed solely at asylum seekers, refugees or even health tourists.

There is lots of abuse of The NHS...women know how to use it, if they book late it is because they want to, English people do that too ... and travellers.
(Midwife)

Access

There was a lack of understanding among several midwives, of possible barriers to accessing care given that care cannot be refused. A specialist midwife demonstrated understanding and empathy but was concerned that attitudes and behaviours from her colleagues may inhibit access and attendance,

“For some of these women there are many issues around the pregnancy, they may not have planned the pregnancy, may have been raped etc and they are in a strange country and some are just wary of services and when they meet poor attitude it defers them further...I mean it costs nothing to smile. When you do not speak the language you are more aware of other cues”

It was not possible to ascertain the antenatal care coverage in the target population, or any estimates of when the first visit occurred or average number of visits. The general pathway for women who participated in the study was to report first to a GP and obtain referrals into the health system through there. However this was not always straightforward. One woman reported that her GP has asked to buy a pregnancy test for £14 when she was about 10 weeks pregnant - it was prohibitively expensive and there was subsequently a delay in her first contact with the midwife when she was 26 weeks pregnant. There then followed a series of other difficulties making appointments and a referral to the hospital which was a 2-bus journey, difficulties with childcare during appointments, long waiting times etc.

Pathways for care were not always apparent to the women.

The midwife was very nice ...I am fond of her...she was really helpful...I went the next week and had a scan and they took bloods again, I do not know why they took them and then I had an appointment for another scan and I went but they said I did not need it so I travelled all that way for nothing...I do not know when I am seeing the midwife again” Tamil woman

For the women interviewed, the need for information was paramount. They found the maternity services somewhat opaque, and information on maternity service was hard to obtain, even through NHS Direct. Specific information needs included:

- what to expect in hospital,
- how to get to the hospital,
- when it was appropriate to use an ambulance,
- whether support of a friend was permissible,
- which door to enter in the hospital
- what choice and partnerships meant for care
- how to find an interpreter

While some of these seemed simple, the women felt that these were things not to have to worry about during labour – a time when they were feeling very vulnerable.

It was noted by staff in a number of community support organisations, both voluntary and statutory, that the residences of this group of women were often in deprived areas of the borough where there was poorer infrastructure and travelling to the hospital was difficult. Listening to the women, the difficulties of travel in a foreign country were evident; women talked of having to get two or three buses to attend appointments at the hospital which had direct and indirect costs associated with it. Women did not understand why they could not go to their local GP surgery which was within walking distance.

At a community forum for Somali women there were stalls promoting advice and support around child protection, drug awareness, public health community nurses, legislation about female circumcision/cutting and information about other community organisations; but nothing about maternity services and reproductive health, particularly with regards to de-infibulation and birth implications for circumcised and infibulated women. Although a midwife did speak at the end of the session to encourage women to attend antenatal care there was no information to take away about who to ring or where to go.

Midwives did recognise that there was a need for more information in the community but this is not resourced. However, some health professionals reported that refugee and asylum seeking women had more information about what services were available than the local disadvantaged populations who were even less likely to attend for care.

“If there is a group of people who do not come for care it is the Indian patients, they listen to their parents and do not come”.

Health care professional

There was some concern within the focus groups of health professionals, that the local white population was being neglected. This viewpoint was mirrored by community organisations which provide general support. One organisation was concerned about low levels of literacy in the white population which was not recognised. Thus information in a written format was not useful, but because of the stigma of not being able to read women did not admit that they did not understand. Information given at booking, appointment times, benefits etc was thus not taken up.

OTHER VULNERABILITIES

Main Findings

1. **Lack of awareness of possible mental health needs of asylum seekers and refugees.**
2. **Lack of a co-ordinated pathway for women needing mental health services**
3. **Lack of support for midwives in looking after women with mental health needs.**
4. **Poor support structure and pathways for midwives in asking women about domestic abuse.**
5. **An underlying negative attitude towards UASC by some maternity care providers**
6. **Need for increased interdisciplinary work to meet the needs of UASC**
7. **A need for a mentoring/advocacy service for women accessing care**
8. **A need for culturally sensitive sexual health services especially for UASC**
9. **A lack of awareness of and local access to services for women who have been circumcised.**
10. **A need for improved cultural awareness and understandings of the individual within this trajectory.**

Mental Wellbeing

Potential and particular needs of asylum seekers and refugees in relation to mental health are well documented (Burnett and Fassil, 2002) as is the association between maternal health and mental health. However consultation with the midwives revealed a patchy service and support system across the whole population. This, despite the finding of the 2004 report, 'Why mothers die' (CEMACH, 2004) and the publication of the National Institute for Clinical Excellence's clinical management and service guidance early in 2007 on antenatal and postnatal mental health. Within Hillingdon mental health service provision is currently under review. During the fieldwork for this project there were no evident pathways for referral across a broad spectrum of need from psychiatric input to more general support groups. There were a few exceptions where midwives reported their confidence in their referral systems to psychiatric services and support services, but for the most part, the situation was described as "chaotic." Some information about possible referral was available from Accident and Emergency.

In broad terms there was little awareness of possible effects of the refugee experiences on mental wellbeing or indeed that the pregnancy may be a result of rape and the resulting implications of this, the vulnerability of this client group was not recognised. A number of focus groups and individuals within maternity services talked about vulnerable groups of women, such as those with mental health problems, teenagers etc but asserted adamantly that asylum seekers and refugees should not be included.

Mental health services were clearly limited. The hospital had a clinical psychologist 2 days a week

"We have 1 clinical person in the whole hospital; but we need something specific to pregnancy because pregnancy can exacerbate issues. The mental health team just say let us know if they turn up but it is them that should be doing the arranging...what do we do, there needs to be support for staff around mental health, what we do if they get aggressive, it should not be the midwife who is leading on these issues but someone from mental health, you know if they are going to keep the baby or not...but that is general, not just asylum seekers."

Midwife

In general GP referrals made in the community seemed less problematic. Some GPs have counselling services.

"With regards mental health care, once people present with the need, they are looked after and referred, although sometimes there is resistance to treatment, especially taking antidepressants. It may be that some people do not get adequate support but once they present everyone has care according to need, they are all the same. So if the psychiatric team, crisis team, GPs we all go out when needed"

Further discussions on maternal mental health provide a good example of a general perception that the refugee and asylum seeking population is over-resourced. Midwives were aware that there were a number of programs particularly to support unaccompanied asylum seeking children. Given limited mental health resources, it did not seem fair, they reported, that a group that were seemingly over-resourced compared to the teenagers from the White host population, should be referred to this service as well. Teenagers were understood to have particular needs in accordance with policy direction but the unaccompanied children were denied recognition of their similarity in youth compounded by other problems.

Two women interviewed reported that they had mental health issues that affected their experience of early parenthood. The first, a young woman from Iraq, was grateful and pleased to be offered a chance of a vaginal delivery following the birth of her first daughter by emergency caesarean in a different unit. Unfortunately she had sustained a fourth degree tear and a post partum haemorrhage and had returned home tired and listless. She reflected on how she had coped at the time,

“no one helped me at home. I asked for help for children to go to school but they said no they did not have that service. My house is dirty and my big daughter is dirty for school. I can eat only fast food and my figure is still bigger, that upset me, where my stitches very big, swollen. My midwife said it was ok it is clean but I was very scared.”

She reported that she could still feel a flap of skin that felt ‘wrong’ and ‘not nice’ but that no one had seen her after the first few days at home. The researcher suggested that she see her GP and to ask for a woman doctor if this would make her more comfortable.

The second case was a young woman from Uganda who on turning 18 years of age was no longer eligible for housing. She became homeless. She was pregnant with a daughter under one year old. The situation did not change after the birth of the second child. Between times the maternity services had advocated on her behalf until housing was provided. She was distressed and described being depressed.

Her case was described in the local press and the midwives made reference to it to highlight the difficulties they had had in trying to work across agencies to refer her to more appropriate support than they could provide. However, agencies that had not been contacted that could have provided appropriate support included the Refugee Council. The midwife recalled that they had found the situation rather frustrating; they did not think she was suicidal but they were nonetheless responsible for her until she could be handed over to another agency. She was eventually supported by HOPE , Victoria Climbié Foundation and Maternity Matters. Advocates at the Victoria Climbié foundation said her case was not an isolated one.

DOMESTIC ABUSE

There is a high risk of domestic abuse in pregnancy [DH, 2005]. However, the midwives explained that they no longer had access to a specialist lead

midwife to whom referrals could be made and they felt ill equipped to handle domestic abuse themselves. They also expressed difficulty in asking the screening question for identifying women who were at risk of violence. They recognised that women seeking asylum and refugees may have a need for support and advice but were unsure of their entitlement or where to refer them. There was a perception that anyone who took an interest in providing signposting and support would have to be very dedicated because such positions were not recognised or rewarded. As a result of this a number of people were reluctant to be proactive in their approach in case they then became known as the one who knows and ended up carrying the burden. Within the sample of women with young babies who were English speaking and not seeking asylum in the UK, interviewed, no one had been asked about domestic abuse in their pregnancy.

A midwife recounted having met,

... a man from Iraq, his wife was pregnant, he had been tortured ... I read the thing his GP had written it was terrible but he asked me for help he wanted to stop hitting his wife...but I did not know where to send him. The local sure start worker would not help because he was not in their area and there is nothing in the community...I often wonder what happened?...

In a discussion with a group of Tamil women they spoke about accepting the role of their husbands as translators for clinical issues. However they were less satisfied about using them to discuss social questions that were raised by health and social care staff. They had never actually been asked about domestic abuse, but one woman who could read English had read about the possibility of it escalating or starting in pregnancy. Her strategy had been to keep quiet during her pregnancy so as “*not to make him angry*”. Two women within the group reported to the researcher that they were victims of domestic abuse and had received no information during their pregnancy.

UNACCOMPANIED ASYLUM SEEKING CHILDREN (UASC)

A variety of organisations from different disciplinary backgrounds provide services for young unaccompanied minors. These agencies include Social Services, Maternity Services, the Asphaelia Project, the Tumblers at the YMCA and voluntary organisations such as the Chinese community organisation. A range of other services directed at young people for example, Connexions are also available in the borough.

Although Social Services provide support for young women, they are constrained by time and limited resources and a constantly changing policy direction.

‘Packages’ of support are put into place for young women after the birth. The young women reported that their social workers had been ‘good’ in providing them with things for the baby and had been, for the majority of cases supportive. Young people referred to the Asphaelia Project considered themselves very lucky – for all its support Social Services is perceived as a statutory provider and therefore represent authority. Anxiety about their immigration status and wanting to demonstrate that they are coping well with

their situation were issues that restricted young pregnant women and mothers asking for help. Avenues of individual support are difficult to find. Within the Chinese community a volunteer provides support and advice. However she herself has no support or pathways for referrals

Young maternity patients are accommodated with other young people in a similar situation; this may, as in any relationship be positive or troublesome and is not necessarily supportive.

"I had a social worker but I do not get as much help as some of my friends. I have just one room, there are 5 rooms here all different people...all similar situation, shared kitchen. When I was 7-8 months pregnant they moved me here from Southall, they don't move till near the end because it is difficult to find somewhere safe, depends on social worker how much support you get, I am not so lucky, I need more support. Money is the biggest worry and I do not know the other girls, one did not clean up after herself"

Pregnant teenager with a 10 month old baby

The midwives who specialise in looking after teenagers were commended by the community,

From the perspective of the maternity services however, young unaccompanied teenagers were given preferential care and received more than the host 'white girls' and this was expensive and not necessary,

A number of professionals and the young people themselves commented that the main source of support was from peers. Although this in many ways is very positive it may lead to perpetuating poor or inaccurate information. For instance an observational study highlighted that due to housing being for the main part far from good shopping facilities young people are forced to live on a diet of bread and rice from the small shops and take away facilities near their accommodation. This advice the informant said was partly because they could easily buy such food without having to say very much. Additionally for some young people from abroad food available in England looks very different or they do not know how to cook it or simply it is too much to carry. Finally it must be remembered that they are teenagers, who may as one professional said think, like their host age group that they will live for ever and take no heed to healthy diet advice. Unlike teenagers who are integrated into the UK, these young people have no one to advise or help them. In recognition of this HOPE has a project to increase awareness around food and budgeting.

Busy with issues around housing, education and concerns about immigration meant that many of the young people had not reflected on the care they had received but accepted it. There was however an acute need for information about how to care for their baby.

The nurse responsible for Looked after Children in the borough felt there was a need for continuing contact once young people no longer have access to housing at 16 and that certainly there needs to be continued input when a young person has a child.

Agencies and advocates in the community felt that the 18th birthday cut off point was too low for this group of young people and that it should be

recognised that there was a need for an older 'parent' figure to be around. Again there were suggestions that a mentoring system would be useful.

The young people themselves valued the support from agencies such as Asphaelia especially after the baby was born and the midwife had stopped visiting, otherwise the experience felt very lonely and isolated. Frequently the support was needed after the midwife had stopped visiting and between visiting the health visitor. Advocates explained that there is often an anxiety about asking health professionals as they are viewed as people in authority. Questions about where and who to contact if concerned about the health of their child were frequent. A number of professionals and voluntary sector advocates asserted that this group of young people were particularly vulnerable and needed mothering themselves, that they needed the support of someone they trusted who was a little older and who could accompany them to attend groups or going to the baby clinic.

Insecurity and anxiety about their future occupied a number of the young people interviewed. Juggling being a new parent and studying was mentioned as particularly stressful for the young mothers, this was because their continued support was tied up with being in education.

One young mother, a teenage asylum seeker from Uganda exemplifies system failures in the Every Child Matters agenda. Caught between immigration and social service provision she was made destitute, first in her pregnancy and later with a young toddler and a new born baby. She talks positively of maternity services in the antenatal period, the midwife and doctor were very kind she informed the researcher but she felt let down by her social worker. Policy regulation and gaps in service provision were to provide a series of events which claimed media coverage of a young woman sleeping in the street with a new born baby and a toddler. The events started in Hillingdon and are not according to staff at the Victoria Climbié Foundation an isolated event.

SEXUAL HEALTH SERVICES

The need for co-ordinated sexual health services particularly for UASC was highlighted by community health providers. Because of language and cultural issues it was felt that young people were not able to utilise the services for information and sexual health advice. Although young asylum seekers are assessed when they first enter the country and are given an annual health check, sexual and reproductive health are not priorities and are not covered adequately. In addition once the young people are 'de-accommodated', they are no longer seen for a health check thus reducing further the time and resources to revisit sensitive issues such as sexual health.

"Looked after children have a higher rate of teenage pregnancies and risk taking activities...but we don't have enough time to talk to them in an hour. In the hour we focus on emotional wellbeing, drugs and sexual health and a physical examination...it is rare that we know someone is pregnant. ..When you ask about sex they say they will wait till they are married. Young people get their emotional needs and information from their peers."

Of particular concern from many of the people interviewed in the community was the importance of sensitive information that took account of their age, religion and culture reproductive health advice for young people. It was remarked by health and voluntary personal on more than one occasion that the UASC at times acted in a sexually inappropriate way and that they needed guidance because it may be that they were just trying to fit in. Previously a health worker had provided a mobile health advice service that covered sexual health that went into the main accommodation sites. Although there is an excellent sexual health clinic at the Tumblers aimed at young people, it was reported by an advocate that this was not as successful as the mobile unit.

Professionals highlighted that there was a lack of proactive support and advice around contraception for young people especially on discharge from midwifery care or after a termination of pregnancy. Young people were found to be using contraception incongruously and to have a poor understanding of different options.

Because of the background for UASC with no parental figure and alone in an alien land relationships were possibly formed unequally. The young women not empowered to say no or to be confident in their family planning methods. Fear about support and status may mean that the young women are hesitant to talk to their social worker and this itself may make them more vulnerable.

CULTURAL ISSUES

Coding for ethnicity may not be uniform or correctly assigned but the evidence from past and the most recent CEMACH reports (CEMACH, 2004; Lewis, 2007).reports reflect poorer outcomes for Black, ethnic minority and refugee women than for white women. The CEMACH report suggests that this may not only reflect the cultural factors implied in their ethnicity but the fact that they may have recently migrated to the United Kingdom in less than optimal circumstances and additional that their current social situation may not be optimal. Professionals interviewed in the course of this needs assessment demonstrated an awareness of this and the need to address it. They revealed an understanding of complexity of different cultural practice in relation to gender and a concern that domestic abuse may occur more in the non-dominant cultures. Gender relations, in particular were cited as concerning especially where there was a lack of interpreters. Midwives were concerned that information was filtered by the husband and that replies were his perspective rather than the woman's. This has obvious implication for sharing of information and implications of safety for mother and baby highlighted in Saving Mother's Lives (Lewis, 2007).

Women from the Somali community were aware that at times uptake and engagement with maternity services was not fully utilised. They reported that they found many of the 'booking' questions regarding their social situation very intrusive and that they did not want to share their personal situation with a health service person. Their physical privacy was important as was the importance of having where possible a female person to examine them. A common issue raised, particularly by the Moslem women interviewed was the need to be asked before additional people such as students could observe

examinations. They also valued being able to have the curtains around them when breast feeding or resting, particularly women who had removed their head scarves.

Other cultural issues discussed included the need to wash after the birth of the child. A young Chinese woman explained that culturally she was not supposed to touch water after the birth.

In the Afghan women's group the talked about the apparent rush in everything. After the birth they just wanted to be with and breastfeed their baby. They commented that although they appreciated that the hospital was busy and that there was a need for them to vacate the labour ward that they were tired and that it had felt all too rushed and was it not possible for them to have a shower later.

Women requested to be treated as individuals and that health and social providers did not just make assumptions about their needs based on broad stereotypes.

In one of the early consultations, a man from Somalia voiced an anxiety within his community that there seemed to be a high number of stillborn babies. The underlying question was why and could this be prevented. This was echoed later in a discussion among a group of professionals. Concern was raised about the higher rate of unexplained stillbirths in the villages near Heathrow airport. The group suggested the possible effect of the airport, the major roads and factories and that this was an area of high deprivation and therefore the impact of poverty. However, the conversation moved on to a suggestion that the higher rate of stillbirths in local Somali women may be related to cultural issues such as women being given potions to induce labour by their mothers-in-law and concerns about to whether this was related to the sex of the baby. There was an interest voiced by the professionals to gain a deeper understanding in order to try to reduce the still birth rate within this demographic, coupled with a need for explanations through post-mortem examinations.

These babies are not IUGR (intra uterine growth retardation). They are unexplained and term. Does anything come out of the post-mortem to show that the women had taken something...no of course not they do not have a post-mortem, Muslim women don't.

Excerpt, focus group discussion

FEMALE GENITAL CIRCUMCISION

Female circumcision was raised by maternity staff as an issue that could apply to some refugee women as well as a large local British Somali population. There were discussions about the usefulness of including a data entry field within the notes for the women to be asked routinely. However, a senior midwife suggested that women would not want to disclose that information because they did not think it was important to discuss during pregnancy. Available information included: posters and cards for FGM pasted in the washrooms written in 3 languages.

"...they only tell you what they want you to know...these girls that have had female mutilation ..they just do not give out information...and you get to

Hillingdon Maternity Needs Assessment – Refugees and Asylum Seekers

delivery and midwife is faced with the situation...can only do an episiotomy not a reversal...it as been on the news recently but it is a child protection issue...there used to be midwives in the community before who were trained in this issue but not now, not any more”.

Professionals who were not health based suggested that midwives were in a unique position to discuss issues around circumcision. Women could be signposted to safe practitioners for their sons and informed of the law and reasons for the legislation with regard to female circumcision. This was felt to be part of the child protection role inherent in professional practice.

But from a Somali woman’s perspective a system that follows up on all possible risk factors is important. She explained that at Charlotte’s there was a proactive effort to follow women up to screen for Thalassaemia and Sickle Cell, detailed information was provided and antenatal classes were very good. Those supports were not available in Hillingdon, and she had not realised she could have a de-infibulation prior to the birth of her child.

CHAPTER 4

DISCUSSION AND CONCLUSION

DISCUSSION

This document began with a review of the current benchmarks for care within maternity services in North West London and it is to this that we return in summing up the findings. The challenges faced within Hillingdon in providing care for refugee and asylum seeking women are echoed in other Trusts within the capital and nationally.

This needs assessment was conducted recognising the need for holistic cross sectoral care. Nonetheless maternity services are unequivocally central. Maternity services were presented in the qualitative data as stretched, a picture painted by the midwives, other health and social providers and the women of not enough midwives. Although clearly there are changes in demographics and demand within the capital, the Annual Report for supervision in London demonstrates that Hillingdon is within the average ratio of women/ midwife in London (LSA.2007). However, it needs to be recognised that maternity services are only one segment of a team of health and social providers.

There is also a need to recognise that although the focus is on refugees and asylum seekers, experiences described in this needs assessment and the implications for services more broadly are equally applicable to other categories of vulnerable women.

FROM NEEDS TO ACTION – BEST PRACTICE

Throughout this report there are numerous examples of kindness and compassion from individual midwives who endeavour to provide the best service they can. There were clear indications during the consultation period that the work of the midwives who specialise in caring for teenagers has had positive impact.

For any woman presenting for maternity care, there is a need for a partnership with the team of carers. For refugee and asylum seeking women this team may or may not include members of immediate family, and may need to include interpreters, social workers, hospital and community midwives and mental health support. Recognising this team as core to maternity care is the first step to the development of a multi-agency strategy for care of a population that is very much a part of the demographic of Hillingdon.

Engaging with community

There was a sense, with the midwives who participated in the study that the onus was on them to be responsible for vulnerable women. However there are opportunities to 'share the burden' and take the work to 'where women are' in community centres and Children Centres. The Ara Darzi report entitled A Framework for Action, Healthcare for London (2007) champions this approach.

In Hackney, North East London for instance, the midwife/delivery ratio is similar to Hillingdon. There are a number of examples of flexible service; a Children Centre in a predominantly Orthodox Jewish part of the borough facilitates advocacy and birth support for women. Midwives run a clinic from the centre and are thus more visible and known within the community. Accessing a service becomes significantly easier if you know the midwife. Antenatal classes and postnatal support groups are held within an environment where additional services can be provided.

In addition midwives work out of two Children Centres in Shoreditch and Clapton Park. The rationale for this is to improve clinical outcomes and improve social and neighbourhood support structures for women who are vulnerable. Working within the community, near where women live, shop and take their young children to school, the project aims to make access easier in pregnancy and goes towards reducing social isolation and enabling a smooth transition of care from maternity services to a range of family support systems.

In Peckham, South London, the Southwark Traveller Action Group (STAG) facilitates excellent interagency learning and advice. They have three health workers, two of whom are Travellers. The interagency team work with maternity services means that midwives are alerted to pregnancies within the population and a relationship of trust and awareness can be developed.

Greater visibility within the community of the maternity services, the role of the midwife and how to contact one may help women to access services earlier. Clearly attending an appointment with a GP, being told to buy a pregnancy kit and return once pregnancy has been confirmed is not good care. Women who are less confident in using the services available are unlikely to explain any difficulties they are having, including the cost of buying a pregnancy kit, they are also less likely to explain why they become 'late bookers'.

Young women seeking asylum in the 17-19 year old age group were clearly in need of more support. Organisations in the community such as Asphaelia and the Tumblers at the YMCA provide superb support and advice but would welcome additional information about maternity services, working with maternity services and improved links between services.

The planning and implementation of these types of programs require strategic leadership at the level of the commissioning of services and a fostering of an institutional culture where there is a strong focus on the well being of the users, regardless of immigration categories.

Inputs from communities and women

There has been little evidence to suggest that marginalised, disadvantaged or excluded community would actively resist efforts that are made to 'draw them in.' Women were keen for opportunities to learn English, to learn about the maternity unit, but those were not available. These efforts do not necessarily require an intense injection of resources, but rather a concerted effort at genuine participation that demonstrates mutual respect towards a mutual benefit. Examples exist of engagement through different models of paid and

voluntary bicultural workers or advocates (see for instance Multicultural Centre for Women's Health⁹).

In Newham the Birth and Breastfeeding service offers training for local women who subsequently provide support to women through pregnancy, birth and the post natal period in a number of community languages. The women act as advocates and have some training and supervision thereby facilitating better provision of partnership working. The innovative project culturally matches women with buddies from their ethnic background. The volunteer buddies complete a training course which is accredited to the new CAD level 1 which for some buddies can be the first step towards a foundation course in midwifery.

A five year study in Hackney, London demonstrated that providing women from minority ethnic communities with a supportive advocate had a significant effect on maternal and infant health. The researchers speculated that this may be because the women felt more confident to voice concerns and ask questions when they had the support of an advocate (Tew et al, 2006).

A number of current interventions in Hackney aim to improve information to women about maternity and other services. These include bilingual maternity support workers who improve access to maternity services for vulnerable women, particularly those women whose first language is not English. In addition Volunteer pregnancy and birth support workers provide a trusted 'aunty' in the broader sense. Lastly a peer education system for maternity services means that women are able to access information from a trusted person who is within their community, understands their culture and yet can highlight what to expect and what is expected.

The ongoing projects that have radiated out from HOPE such as the current cooking and pampering groups have helped to reduce social isolation as well as informing people in a non directive way how to improve their diet. HOPE also provides life-skills training and projects; language based counselling service for Tamil speakers; and funds projects with a network of partners across voluntary and statutory sectors

The vast institutional knowledge and networks, formal and otherwise will be lost when it closes in April. There was a poor understanding of community organisations and people who could help but HOPE was visible, if underutilised. Asylum Seekers and refugees are transitory, networks held within HOPE are well known throughout the capital, not only to enable information to be shared but to advise and support agencies in the statutory and voluntary sector.

Interpreting

There is a need to make provision for translation, interpreting and advocacy services based on the assessment of the needs of the local population. Provision would include a mix of interpreting and advocacy services for home visiting, out of hours service and antenatal classes. There are excellent examples of interpreting within the antenatal clinic where the health care assistants speak a number of community languages. In one of the GP

⁹ <http://www.mcwh.com.au/>

practices, for the most part, staff across the board described interpreting and translation services as chaotic and expensive. In spite of guidelines from the Department of Health and CEMACH members of the family are used. This has clear safety issues. Nationally there are no answers but other Trusts provide examples of working in alternative ways to try to meet the needs of non-English speaking clients.

Some vulnerable women, in particular those who do not speak English are channelled to the antenatal clinic because of the good use of interpreters within the department. Although it may be beneficial for migrant women to see a doctor for a cardiac assessment in line with the CEMACH guidelines, for the women living in the more deprived parts of the borough this necessitated lengthy bus travel. One woman interviewed was completely bemused as to why she could not be seen at her local GP practice. A GP could do the cardiac assessment and refer as necessary.

CONCLUSION

Meeting the challenges of service provision for asylum seekers and refugees within the holistic framework of health and social care during pregnancy, intrapartum and the post natal period is not easy. While categorisation might be appropriate in some contexts, refugees and asylum seekers are not a homogenous group and each individual presents from a different culture, ethnicity, religion, identity, family structure, educational background; each with unique life experiences that inform their interpretation of and reaction to health and illness. Their needs are correspondingly diverse, they may for example have pre-flight mental health problems irrespective of the mental trauma endured in their escape and journey to the UK; the baby may be a result of rape or it may be planned to replace lost family or simply unplanned as so many pregnancies are. In sum 'these' women are all individuals becoming mothers in exile. The latest confidential enquiry, Saving Mothers Lives (Lewis, 2007) includes five women who died who were classed as health tourists. Black and ethnic minority women including asylum seekers and refugees are six times more likely to die around childbirth than their white counterparts. If for no other reason than this the care provided should strive to be the best available. Not better - the women do not ask for that - but rather for care that demonstrates equity. Communication on all levels is important in providing this, no midwife or mother or other health or social provider need work in a silo, information sharing is crucial, but the midwife and mother as central cannot even begin to do this where there are no interpreting services. Communication is not just about language or literacy; it is about body language, about smiling, at looking at a woman directly.

Women from refugee and asylum seeking backgrounds are often described as 'hard to reach.' But maybe there is an alternative way of looking at the situation, maybe if structures, information and transparency of services improve communities would reach in?

Rapid appraisal of the findings of this document point to aspects of care to be improved. Some of the issues are structural and require back up from commissioners of services, others are small individual behaviours that can

make a difference in encouraging a women, especially someone who is socially excluded to access and engage with services. It is not necessarily about specialist services and support but treating women as individuals and being able to sign-post and refer as necessary in-order to maximise good outcomes for mother and baby. There are a number of positive examples of good practice in Hillingdon cited in this report; the way forward is to build on them.

References

Allotey P, Pickles H, Johnston V. (2007) Duties to refugees and asylum seekers in host country medical systems. In Richard E Ashcroft, Angus Dawson, Heather Draper, John McMillan (eds) Principles of health care ethics – second edition. John Wiley London Chapter 90: 663-670

Bhabha J and Finch N. (2006) Seeking Asylum Alone. Unaccompanied and separated children and Refugee Protection in the UK.
http://www.humanrights.harvard.edu/conference/SAA_UK.pdf .
 (accessed 21st October)

Burnett A and Fassil Y. (2002) Meeting the Health Needs of Refugees and Asylum Seekers in the UK: An information and Resource Pack for Health Workers. London: Directorate of Health and Social Care, Department of Health.

Borders and Immigration Agency, The Home Office. (11.4.07) Asylum Support (Allocation of support, Eligibility and assessment of asylum support, Maternity payments and additional support, HC2 certificates)
<http://www.ind.homeoffice.gov.uk/documents/asylumsupport/>
 (accessed 21st November 2007)

Bowles.C and J.Reidy (2007) Increasing diversity in Hillingdon. Hillingdon Public Health Report 2006/7. www.hillingdon.nhs.uk/publichealth
 Accessed 18th December 2007.

Confidential Enquiry into Maternal and Child Health. (2004) Why mothers die 2000-2002: the sixth report of the confidential enquiry into maternal deaths in the United Kingdom. RCOG. London.

Confidential Enquiry into Maternal and Child Health. (2006) Perinatal Mortality Surveillance Report 2004. England, Wales and Northern Ireland. CEMACH.

Darzi.A (2007) A Framework for Action, Healthcare for London. NHS London.

Department of Education and Skills. (DfES) (2003) Every Child Matters. London.

Department of Education and Skills. (2006) Teenage Pregnancy: Accelerating the strategy to 2010. DfES Publications. Nottingham.
www.everychildmatters.gov.uk.

- Department of Health. (1993) Changing Childbirth. HMSO. London.
- Department of Health. (2004a) National Service Framework for Children, Young People and Maternity Services, standard 11. HMSO. London.
- Department of Health. (2004b) Implementing the overseas visitors' hospital charging regulations: guidance for NHS Trust hospitals in England. HMSO: London.
- Department of Health. (2005) Responding to domestic abuse: A Handbook for Health Professionals.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4126161
 (Accessed 20th September 2007).
- Department of Health. (2007a) Maternity Matters, choice, access and continuity of care in a safe service. HMSO. London.
- Department of Health. (2007b) Review of Health inequalities Infant Mortality PSA Targets. HMSO: London
- Free E .(2005) Local Authority Support to Unaccompanied Asylum Seeking Young People. Changes since the Hillingdon Judgement (2003). Save the Children England Programme. Leeds.
- Gaudion A, Bragg R ,Homeyard. C. (2006) Professional ethics and charging for care. Practicing Midwife. 2006. Dec 9. (11)16-17.
- Gaudion A, McLeish J, Homeyard.C .(2007) Access to Maternity care for failed asylum seekers. In International Journal of Migration, Health and Social care. Sep 2006 Volume 2, issue 2. p 15-21.
- Hamilton C and Matthews A. (2007) Evidence from the office of the Children's Commissioner on the de-accommodation policy and practice of the London Borough of Hillingdon.
- Healthcare Commission. (2007) Women's experience of maternity care in the NHS in England. Key findings from a survey of NHS Trusts carried out in 2007.
http://www.healthcarecommission.org.uk/_db/_documents/Maternity_services_survey_report.pdf. (Accessed 14th December).
- Home Office, Immigration and Nationality Directorate. (2007) Consultation paper. Planning Better Outcomes and Support for Unaccompanied Asylum seeking children.
- Home Office. Information relating to unaccompanied Asylum Seeking Children. <http://www.homeoffice.gov.uk/about-us/freedom-of->

[information/released-information/foi-archive-immigration/1289-unaccompanied-children-asyl?view=Html](#) (Accessed 18th October 2007).

Home Office. Immigration and Nationality Directorate .(2007) Planning Better Outcomes and Support for Unaccompanied Asylum Seeking Children. Consultation Paper, February 2007. <http://www.homeoffice.gov.uk> (accessed 18TH October 2007).

Kelly N and J Stevenson .(2006) First do no harm: denying healthcare to people whose asylum claims have failed. Refugee Council.
http://www.refugeecouncil.org.uk/NR/rdonlyres/9A4F66C5-2D32-4534-ABE6-FA63C828DF49/0/Healthaccessreport_jun06.pdf

Le Feuvre P .(1999) Asylum seekers and general practice: observational study of new arrivals in a Kent town. East Kent Community NHS Trust: Canterbury.

Lewis M. (2005) Asylum, Understanding public attitudes. The institute for Public Policy Research. London.

Lewis G (eds) .(2007)The Confidential Enquiry into Maternal and Child Health (CEMACH) Saving Mothers Lives: reviewing maternal deaths to make motherhood safer 2003-2007. The seventh report on the confidential Enquiries into Maternal Deaths in the United Kingdom. London. CEMACH.

Lim L .(2005) Sexual Health in Hillingdon Annual Public Health Report. 2005. Hillingdon primary care Trust.p.27-31.

www.Hillingdon.nhs.uk/publichealth.

(Accessed 13.9.07)

London Asylum Seekers Consortium. Weekly Statistics to May 2007. Family, Adults, children and Unaccompanied Asylum seeking children (UASC).
http://www3.westminster.gov.uk/publications/publications_detail.cfm?ID=1746
accessed 18th December.

McLeish J. (2002) Mothers in exile. Maternity experiences of asylum seekers in England. London: The Maternity Alliance.

London Supervising Authorities of London (LSA) Annual Report. April 2005-March 2006. Suzanne Truttero. Midwifery Officer.
http://www.midwife.org.uk/pdf/annual_report/London_LSA_Annual_Report_2005-2006.pdf (accessed 14th December 2007)

National Children's Bureau .(2006) Young Asylum Seekers and Refugees and Supported Housing. National Children's Bureau. www.ncb.org.uk/arc.

Pickles. H. (2005). Preface in Hillingdon Annual Public Health Report. 2005. Hillingdon primary care Trust..

[http:// www.Hillingdon.nhs.uk/publichealth](http://www.Hillingdon.nhs.uk/publichealth)

(Accessed 13.9.07)

Project: London (2006) Helping vulnerable people to access health care. Medicine du Monde.

<http://www.medecinsdumonde.org.uk/doclib/155511-plartwork.pdf>

(accessed 25th August 2007).

Refugee council Conference. Safe from Harm? Meeting the health needs of asylum seekers and refugees. November 1st 2006. Speaker Notes: Nancy Kelly, Head of UK and International Policy.

http://www.refugeecouncil.org.uk/NR/rdonlyres/9A2FCE51-70B5-4F6D-A4DB-1E139D366969/0/healthconf_speech.pdf.

(accessed 9th August 2007).

Rama-Dominguez M and C Lovis (2006) GP Surgeries Outreach Advice Services. Healthy Advice. Citizens Advice Bureau. April 2006-Sep 2006.

Reid M (2006) Service Provision for Unaccompanied Asylum seeking children from a Hillingdon perspective. www.ncb.org-uk/arc

Renewal single regeneration budget (2001) Refugees in West London: Baseline mapping study. (<http://www.researchasylum.org.uk/?lid=123> accessed 14th November 2007)

Shribman S. (2007) Making it better for mother and baby. Department of Health. HMSO. London.

Service Quality Specification: Maternity services. March 2006. www.nwlha.nhs.uk

Shukla H and C Bowles. (2005) Population trends: looking ahead to 2021 in Hillingdon Annual Public Health Report. 2005. Hillingdon primary care Trust.p.5-18.

[http:// www.Hillingdon.nhs.uk/publichealth](http://www.Hillingdon.nhs.uk/publichealth).

(Accessed 13.9.07)

Symonds S .When is a child not a child? Asylum, age disputes and the process of age assessment. Immigration Law Practitioners' Association (ILPA).

Schedule 3, Nationality, Immigration and Asylum Act 2002.

<http://www.opsi.gov.uk/acts/acts2002/20020041.htm> (accessed 21st October 2007).

Teenage Pregnancy Unit (2007) Teenage Conception statistics for England 1998-2005

Tew J, Gould N, Abankwa D, Barnes H, Beresford P, Carr S, Copperman J, Ramon S, Rose D, Sweeney A and L Woodward. (2006). Values and methodologies for social research in mental health. National Institute for Mental Health in England and Social Perspectives Network in collaboration with the Social Care Institute for Excellence. Policy Press. Bristol.

The London Borough of Hillingdon. Refreshed Supporting People Needs Analysis 2008-2009.

Tym R and partners (2006). The Impact of Heathrow Airport on Hillingdon. Oxford Brookes University

UNHCR 'Definition and Obligations' <http://www.unhcr.org.au/basicdef.shtml>

Example Notice for discussion with maternity staff



An invitation for tea/coffee and cake

and an informal discussion about the needs of asylum seekers and refugees within maternity services and how these can be best met.

9.45am - 10.15am
First Floor Classroom
Thursday 30th August
Monday 3rd September

anna.gaudion@brunel.ac.uk

Maternity needs assessment for asylum seekers and refugees



Brunel University is conducting a health needs assessment on maternity services for asylum seekers and refugees. We are interested in the perspective of both care providers and receivers. If you have any comments using the labels on the bags as a guideline please ring or email Anna Gaudion. All material received will be treated anonymously. I would be happy to meet small groups of staff or individuals.

anna.gaudion@brunel.ac.uk

tel. 01895 267 339

Mailout questionnaire for mapping of services

Please return completed questionnaire (2 pages) by 17th September 2007 to Anna Gaudion,
Mary Seacole Building, Kingston Lane, BRUNEL UNIVERSITY, Uxbridge, UB8 3PH.

1. Does your organisation currently work with refugees/asylum seekers in Hillingdon?

Yes No

2. If no, please indicate whether in the past your organisation has worked with refugees and asylum seekers (or specific projects within the organisation)?

Yes No

3. When was your organisation/refugee-specific project established (year) _____ and where is core funding obtained _____ ?

4. Which other geographical areas/boroughs are covered by your organisation?

5. Please give an estimate of the number of refugees and asylum seekers requesting your advice and support per month _____.

6. Please list the countries of origin of your refugee and asylum seeking client group.

7. Please describe generally the nature of your activities and services.

8. Do you use external interpreting services? Yes No

a) If yes, please list the agencies/companies

9. Do you provide interpreters? Yes No

a) If yes, which languages are the working languages of your organisation?

English _____

10. Does your organisation provide maternity-related or parental support services?

Yes No

11. Does your organisation refer asylum seeking women to maternity-related or parental support services?

Yes No

If yes, please

a) list all local and other services to which you refer (or have referred in the past)

b) give an estimate of the number of pregnant refugee/asylum seeking women and new mothers presenting to you per month _____.

c) what is the nature of the support/advice require by pregnant refugee/asylum seeking women? _____

d) give an estimate of the number of new mothers who seek your support/advice (after their baby is born). _____ per month.

e) describe the nature of the support and advice that is sought by these new mothers?

12. What are the organisation's major challenges in providing services to refugee and asylum seeking women?

13. In what way does your organisation/project succeed in meeting the needs of refugee and asylum seeking women?

Your Name (Block Capitals): _____

Position: _____ In this position since (year): _____

Telephone: _____ Email: _____

Contact details:

Priscilla Simpson - Project Manager
Healthy Hillingdon, Civic Centre 2S/04,
High Street, Uxbridge, Middx, UB8 1UW

Tel: 01895 277140

Email: psimpson@hillingdon.gov.uk

Jane Cook - Nurse Advisor

Tel: 01895 486001

Email: jane.cook@hillingdon.nhs.uk

Ambica Selvaraj - Specialist Health Visitor

Tel: 01895 486001

Email: ambica.selvaraj@hillingdon.nhs.uk

Hesa Primary Care Centre, 52 Station Road,
Hayes, Middx, UB3 4DD

HOPE is funded by the Big Lottery and Hillingdon PCT until 2008



LOTTERY FUNDED



Hillingdon
Primary Care Trust



Health Opportunities Promotion

Education (HOPE) is a partnership project that works with excluded groups in Hillingdon:

- Traveller and Gypsy communities
- Refugee and Asylum Seekers
- Homeless individuals and families.

Aims of HOPE project

- To address health inequalities
- To work in equal partnership with our clients
- To network with agencies
- To embrace diversity which will enhance and enrich our society.

HOPE provides support to access health care and other services that impact on health.

Through providing opportunities and access to:

- Training for providers
- Education
- Employment
- Skills development
- Community development projects
- Leisure

This is achieved through collaborative partnerships and networking with both voluntary and statutory agencies.

HOPE works with:

- Hillingdon Primary Care Trust
- London Borough of Hillingdon
- Healthy Hillingdon
- Hillingdon Minority Forum
- PALS - Patient Advocacy Liaison Service
- Hillingdon Citizens Advice Bureau / RASP - Refugee and Asylum Seekers Project
- The Yeldall Centre
- Tumbler Youth Centre
- Bell Farm Christian Centre

Examples of HOPE activities

Refugees and Asylum Seekers

- Language based groups and English classes (ESOL training)
- Health advice and health promotion sessions and activities for unaccompanied minors
- Assessment and clinical support including counselling for individuals and families
- Information and activities through Welcome To Your Libraries (WTYL) projects.

Travellers and Gypsies

- A programme of health sessions that includes healthy lunches
- Health advice and health promotion sessions and activities
- Assessment and clinical support for individuals and families
- Hillingdon traveller interagency forum.

Homeless Individuals and Families

- Health advice and health promotion sessions and clinical support for homeless families and single homeless
- Health advice sessions and activities for unaccompanied minors
- Assessment and clinical support for individuals and families
- Play sessions