

# **Psychosocial Resilience and Risk in the Perinatal Period: Implications and Guidance for Professionals**

## **Asylum seekers & refugees: A cross European perspective**

### **Chapter overview**

In this chapter we explore issues of psychosocial resilience and risk related to asylum seeking and refugee women during the perinatal period, drawing on experiences from three diverse European countries; the United Kingdom (UK), Malta and the Netherlands. First we define the terms asylum seekers and refugees to allow us to focus on the issues that pertain specifically to women experiencing this form of migration. We also note the prevalence of migration in contemporary society. We explore recent research on asylum seeking and refugee women in the perinatal period to identify; the barriers women face in accessing care in their reception countries and their experiences of perinatal care. Through this work, the challenges faced by healthcare professionals to provide culturally appropriate and high quality care to these women who face a range of psychosocial challenges are also highlighted. We suggest possible ways to address some of these challenges including how health professionals can actively build on the resilience of asylum seeking and refugee women to improve their perinatal experiences. We conclude by focusing on the implications of these findings; drawing on examples of good practice from the UK, Netherland and Malta to provide recommendations for practice and service development.

### **Definitions and prevalence**

Contemporary society is characterised by an increasingly mobile global population with over 232 million people living outside their country of origin in 2013 (United Nations Department of Economic and Social Affairs (UN-DESA), 2014). This migrant population is diverse and includes people deemed to be legal as well as those considered illegal or undocumented. It also includes people who migrate voluntarily, such as economic migrants and students as well as people forced to migrate including refugees, asylum seekers and trafficked individuals.

This chapter focuses on forced migration, in particular asylum seeking and refugee women using the terms as defined by the United Nations (UN). Refugees are individuals who are outside their country of nationality *“owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion... and are seeking in accordance with international conventions refuge in another country”* (United Nations High Commissioner for Refugees (UNHCR), 1952, p. 14). Asylum seekers are individuals whose claim for refugee status has not been definitively decided by the country they seek refuge in (UN, 2014). In 2014 it was estimated there were more than

15 million refugees across the world, four-fifths of which were resident in low income countries, most commonly countries adjacent to their home countries; with the remaining fifth seeking refuge in higher income countries (UN, 2014). There has been a sharp escalation in the number of refugees with almost 60 million people displaced at the end of 2014 (UNHCR, 2015) and it is expected this will significantly increase with the intensification of the current conflict in Syria. Around four million people (one fifth of Syria's population) have fled the country since 2011. Of the three European countries this chapter focuses on, the Netherlands has received the largest numbers of asylum seekers to date with numbers almost doubling in 2014-2015, reaching 57,000 by the end of 2015. In the UK, there were 25,771 claims for asylum between June 2014-15. Malta, had the smallest number of asylum applicants with 1,692 in 2015 (Home office, 2015; Statistics Netherlands Statline, 2016; UNHCR, 2016).

### **The impact of forced migration on pregnant women and infants**

The UNHCR (2015) estimates that around half of the population of forced migrants are women and girls. Research indicates that asylum seeking and refugee women are particularly likely to experience high levels of socioeconomic and financial disadvantage and physical and mental ill health in the countries in which they seek to settle (Porter & Haslam, 2005; Yelland et al., 2015). Pregnancy and early motherhood commonly exacerbate these issues (Aspinall & Watters, 2010; Shortall et al., 2015; UNHCR, 2015) with women and infants at risk due to malnourishment, anaemia, communicable diseases and psychiatric disorders (Burnett & Fassil, 2004). Although there is a dearth of data specifically around asylum seeking and refugee women, migrant women in general are at a disproportionately higher risk of a poor pregnancy outcome including low birth weight, preterm birth, perinatal and maternal morbidity and mortality (Bollini, Pampallona, Wanner, & Kupelnick, 2009; Centre for Maternal & Child Enquiries (CMACE), 2011; National Institute for Health & Clinical Excellence (NICE), 2010). This is thought to be partly due to stress associated with the migration process, leading to conditions such as diabetes, raised blood pressure and chronic anxiety and depression (Brunner & Marmot, 2006).

### **Barriers and challenges to perinatal care**

Research around asylum seeking and refugee women in the perinatal period has predominantly taken a risk-focused approach. As discussed above, this work has focused on the prevalence of poor pregnancy outcomes (Bakken, Skjeldal, & Stray-Pedersen, 2015; Bollini et al., 2009; Bradby, Humphris, Newall, & Phillimore, 2015; Gibson-Helm et al., 2014; Gissler et al., 2009; Goosen, 2014). Other work has highlighted the challenges faced by maternity care providers in meeting the needs of asylum seeking and refugee women within existing restrictive legal and bureaucratic structures (Boerleider, Francke, Manniën, Wiegers, & Devillé, 2013; Feldmann, 2006; Suurmond, Rupp, Seeleman, Goosen, & Stronks, 2013). Research has also identified the challenges women face in accessing optimal care

that meets their specific needs (Da Lomba & Murray, 2014; Médecins du Monde, 2007; Platform for International Cooperation on Undocumented Migrants (PICUM)2011; Shortall et al., 2015). These challenges are explored further below using reference to existing literature and the voices of asylum seeking and refugee women.

### **Cultural constructions of health, illness and care**

Evidence suggests that asylum seeking and refugee women may lack an understanding of the health services available to them due to their cultural construction of health and illness (Chauvin, Simonnot, Douay, & Vanbiervliet, 2014; Phillimore, 2016) or a lack of health literacy (Chauvin et al., 2014; Riggs, Yelland, Duell-Piening, & Brown; 2016). For example, one woman explained how she was unfamiliar with the term 'midwife':

*"...and my experience when I got a midwife here is what is a midwife because back home in my country they say nurse" (Maternity Stream of Sanctuary, 2015).*

The woman therefore may either not understand the role of a midwife or see midwifery based care as inferior to more familiar medicalised care (Bryant, 2011; Inspectie voor de Gezondheidszorg, 2014). She may not understand the concept of preventative health care and thus not see the importance of attending antenatal or screening appointments (Carolan & Cassar, 2010; Feldman, 2013). One Somali woman explained:

*"What would my friends in Somalia say if I went a long way to hospital for a check-up, knowing that everything was OK with the pregnancy?" (Essen, Johnsdotter, Hovelus, Gundmundsson, Sjoberg & Friedman, 2000, p.1509).*

A lack of understanding of health care provision more generally may inhibit access to maternity care in a number of ways. For example, in the UK, asylum seeking and refugee women frequently experience difficulties registering with a family Doctor (GP). For some this is due to a lack of knowledge that in the UK, GPs are the initial contact point for care. Other women may hold the perception that they have the wrong documents to register with a GP (Lephard & Haith-Cooper, 2016; Psarros, 2014; Shortall et al., 2015). In the UK the GP is the gateway to the National Health Service (NHS) and not registering limits women's ability to access maternity and other health care (Bryant, 2011).

### **Charging for services**

Uncertainty around the financing of maternity services for asylum seeking and refugee women can have serious implications for women seeking health care. For example, the fear of being charged is reported to be a key barrier (Chauvin et al., 2014; Feldman, 2013; Psarros, 2014). In the UK, maternity care is deemed ‘immediately necessary’ care and must not be withheld based on the ability to pay. However, while maternity care is free to all women who are ‘ordinarily resident’ in the UK and some migrants, other women may be charged including refused asylum seekers and undocumented migrants. Recent changes to legislation to restrict entitlement to free NHS care have caused confusion amongst health professionals and women. One woman described how she:

*“Met a lady there that was telling me that you have to register and ... before you register you have to pay for your treatment...if I don’t pay they are going to report me to the United Kingdom Border Agency [Home Office]” (Maternity Stream of Sanctuary, 2015).*

Currently in the UK, asylum seeking and refugee women who are supported by the Home Office, as well as trafficked women (brought into a country for the purposes of forced labour or sexual exploitation) are exempt from all healthcare charges. However women who have exhausted the asylum process (this relates to women who have been refused asylum and are awaiting deportation) may be charged for some healthcare and while maternity care must not be withheld, these women can and have been charged (Shortall et al., 2015).

In the Netherlands, no women, regardless of immigration status should be charged for care (Goosen, Uitenbroek, Wijsen, & Stronks, 2009). However many health professionals are not aware of the reimbursement procedures and subsequently request payment from women who have been refused asylum (de Jonge, Rijnders, Agyemang, van der Stouwe, den Otter, Muijsenbergh & Buitendijk, 2011).

By contrast there is little uncertainty around charging for care in Malta. Public health care is free at the point of contact for all residents including asylum seekers and refugees. Thus they have legal rights to access and receive state medical care and services as required. While there is no official legislation for undocumented migrants, the reality is that these individuals receive all their health care needs including access to free medications (Health Care for Undocumented Migrants and Asylum Seekers, 2009; Ministry for Justice and Home Affairs, 2005).

### **Dispersal in pregnancy**

In the UK, the government has a policy of dispersal. This is the 'no choice' movement of asylum seekers to different accommodation usually in different towns and which can occur frequently and with little notice. Pregnant women are exempt from dispersal during their pregnancy. However research has shown that women are frequently dispersed close to their due date and also on postnatal hospital discharge (Bryant, 2011; Feldman, 2014; Lephard & Haith-Cooper, 2016; Phillimore, 2014) as reflected in the following quote:

*"I was put in the coach with a lot of people and my baby is just the youngest one there (2 weeks)... I ended up in Leeds [a city in the UK] in the night... I don't know anybody"* (Maternity Stream of Sanctuary, 2015).

Dispersal can interrupt perinatal care, often for several weeks as women struggle to access care in their new location (Feldman, 2014). In the Netherlands dispersal during pregnancy is also problematic, with women potentially being moved to a different centre for asylum seekers and refugees every few weeks. In 2015 guidelines were revised to facilitate a smooth transfer between centres, however a report of the Dutch Inspectorate found that not all centres acted according to the guidelines (Inspectie voor de Gezondheidszorg, 2014). As a result of this report, health care providers revised the guidelines to include a verbal handover to prevent loss of health information which had often occurred to the detriment of women's care (Royal Dutch Organisation of Midwives, 2015). Dispersal is not an issue for women in Malta who once settled in accommodation outside their initial arrival location will not be relocated in this way.

### **Destitution**

In the UK, poverty and destitution faced by asylum seeking and refugee women can be a real barrier to accessing maternity services (Phillimore, 2016). Research has found that many women struggle to access the limited benefits they are entitled to. In addition, women who are refused asylum in the UK but receive Home Office support are given vouchers with no access to cash to spend on public transport and consequently can miss health appointments (Feldman, 2013; Lephard & Haith-Cooper, 2016; Phillimore, 2016; Waugh, 2010). This issue is reflected in a woman's quote below:

*"After I had my baby it was difficult to go to my appointment for my baby's immunisation because it was difficult to walk and the voucher was difficult to exchange for cash..."* (Maternity Stream of Sanctuary, 2015).

Asylum seeking and refugee women on low incomes can claim travel to appointments but this is only retrospective; many women and health professionals are also unaware of this policy (Phillimore, 2016). One study reported that midwives often give women their own money to help them attend for appointments (Bryant, 2011).

## **Deportation**

Some women may fear being deported as a result of accessing health services believing that health professionals are connected to immigration services and attending appointments may lead to them being traced, deported or having their babies removed (Bryant, 2011; Phillimore, 2016; Shortall et al., 2015). This fear being explicitly recounted within women's narratives:

*"I was scared that if I registered with the doctor ....they would find out and deport me. When I was 12 weeks pregnant I was told at that there was a doctor for the homeless and that if you went there they would not give your details to the Home Office."* (Maternity Action & Refugee Council, 2013. p.43).

## **Language barriers**

It is well documented that language barriers inhibit women's access to maternity services (Chauvin et al., 2014; Cross-Sudworth, Williams, & Gardoski, 2015; Tobin, Murphy-Lawless, & Tetano Beck, 2014; Waugh, 2010). Language difficulties can affect women's abilities to understand services available to them, book appointments and negotiate public transport to attend appointments (Phillimore, 2016). The quality and availability of interpreting services is also a key issue. Lack of, poor quality or inappropriate interpretation services may mean that women: do not attend subsequent appointments; lack confidence in those chosen to interpret for them, particularly if these are family members; or women are not provided with interpreters for key events such as during labour (Feldman, 2013; Haith-Cooper, 2014). One woman described how;

*"I overheard that I was getting an epidural.... I was asking my friend what is an epidural?"* (Tobin, Murphy-Lawless, Beck, 2013, p.836).

Appropriate and effective provision of interpreters has been problematic in the UK and the Netherlands with limited access to services due to budget cuts and changes to service organisation. For example, in the UK midwives have reported not being able to access interpreters, particularly in less common languages and for unplanned encounters (Haith-Cooper, 2014; Phillimore, 2016). While in the Netherlands changes in funding has led to some health professionals being unaware of the availability of services and therefore not using interpreters when caring for asylum seeking and refugee women (Inspectie voor de Gezondheidszorg, 2014).

## **Poor experiences of maternity care**

There is an increasing body of evidence that some asylum seeking and refugee women experience poor care when accessing maternity services and that this and a lack of

continuity of carer can be a barrier to attending for subsequent appointments (Lephard & Haith-Cooper, 2016; Phillimore, 2014). This poor care includes prejudicial or negative staff attitudes, a lack of understanding of and empathy for the life situations of asylum seeking and refugee women, poor communication and discrimination as well as poor co-ordination of specialist services such as referrals to doulas and Female Genital Mutilation (FGM) clinics (Shortall et al., 2015). In a study by Robertson one women described how;

*“They should have asked in a friendly way if we needed help... it was a very unpleasant experience, I felt like an idiot, as totally incompetent”* (Robertson, 2015, p. 63).

### **The way forward: Implications and recommendations for practice**

In the following section we discuss three key areas that can contribute to improving the quality of maternity care offered to asylum seeking and refugee women. We discuss the role of specialist services, the promotion of resilience among asylum seeking and refugee women and the need to support staff to allow them to provide optimal care.

#### **Specialist perinatal services**

In the UK, NICE highlight the need for appropriate and accessible antenatal care for vulnerable women including asylum seeking and refugee women. This includes improved service organisation, information provision and communication and training to ensure cultural competence amongst service providers (NICE, 2010). Despite this there are currently no specific pathways for maternity care for asylum seeking and refugee women within the NHS. Although some specialist services that provide innovative practice exist in the UK, the availability varies between areas (Cross-Sudworth et al. 2015) and are often provided by non-statutory and voluntary agencies (Balaam, Kingdon, Thomson, Finlayson, & Downe, 2016; Da Lomba & Murray, 2014). In the UK, the Haamla service is an example of a specialist maternity service for vulnerable migrant women in Leeds in the North of England. Community based midwives lead a team which provides continuity of care during the antenatal and postnatal period, specialist education and a doula service. They also provide a FGM clinic for pregnant women (The Leeds Teaching Hospitals NHS, 2015).

In the Netherlands pregnant asylum seeking and refugee women attend a specialist health care centre. Their maternity care pathway is similar to that of other Dutch women in that they are referred to a contracted midwifery practice, only seeing a doctor if there are medical problems. However, they are not allowed to give birth at home due to poor housing conditions, even though this birth choice is still relatively common for native Dutch women.

Malta on the other hand has established an exemplary unified statutory provision of care. In 2008 the Migrant Health Unit (MHU) was established to help migrants, including asylum

seeking and refugee women access health services. The unit provides interpreting services, translated educational material and also undertakes community based health education initiatives to familiarise migrants with various aspects of their health needs, including sexual health and contraception, FGM clinics and specialist antenatal education based in the state hospital. In addition, the MHU trains health professionals in culture and diversity issues (Department of Primary Health Malta, 2008). Women are further supported by a unified social service structure, covering their social needs in the community and within the health service. In a small island community, this allows for easier communication between various branches of the service. There is also good communication between state and voluntary non-governmental organisations. Thus, perinatal migrant women with specific social needs are regularly referred to the hospital social worker services who liaise with the outreach social worker programme to help improve the woman's social situation outside the hospital.

### **Promoting resilience in asylum seeking and refugee women**

As demonstrated above, research on asylum seeking and refugee women has highlighted the challenges women face in accessing optimal perinatal care. While it is crucial that health professionals and researchers recognise the complex psycho-social, economic and cultural challenges and 'structural constraints' (Robertson 2015) faced by asylum seeking and refugee women there needs to be broader approach to understanding this topic. Recently there has been an increased interest in taking a salutogenic approach which, following the work of Antonovsky (Antonovsky, 1987), rejects the traditional risk focused, bio-medical paradigm, considering instead how health and wellbeing can be promoted through addressing issues such as resilience, capability and facilitating maternal coping strategies to overcome challenges to wellbeing (Lindström & Eriksson, 2010; Viken, Balaam, & Lyberg, 2016; Viken, Lyberg, & Severinsson, 2015).

Health professionals need to acknowledge the existent knowledge and skills of asylum seeking and refugee women, including past experiences of pregnancy and birth and actively engage, support and develop women's capabilities and resilience in responding to the situations they face (Balaam et al., 2016; Ngum Chi Watts, Liamputtong, & McMichael, 2015; Robertson, 2015). A more holistic approach considering asylum seeking and refugee women's position within their new societies has been proposed (Haith-Cooper & Bradshaw, 2013; Viken et al., 2015) in which the migratory and post migratory stressors experienced by women are acknowledged but attention is directed to the ways in which women react to these stressors by acknowledging the resilience, skills and capabilities they demonstrate.

Research has identified that early intervention may positively promote maternal wellbeing in perinatal asylum seeking and refugee women (Gagnon, Carnevale, Mehta, Rousseau, & Stewart, 2013; Viken et al., 2015). Interventions need to be designed to '*seek to increase and nurture social support networks*' and build on '*the evident resilience and resourcefulness of migrant and asylum seeking and refugee women*' (Ngum Chi Watts et al., 2015, p. 10).



Examples of such interventions can be seen at both local and national levels. In Malta, following public debate over the standards of health and living conditions of asylum seekers in detention centres (Médecins du Monde, 2007) the government now ensures that asylum and refugee women are offered alternative more suitable housing within the community during the perinatal period. Not only does this ensure better living conditions, it acts to promote a sense of community cohesion and social support among women who often assist each other during the perinatal period.

Other interventions that promote resilience amongst pregnant asylum seeking, refugee and other migrant women are provided by non-statutory organisations at a more local level. For example, the health befriending project and the Maternity Stream of the City of Sanctuary in the UK have provided asylum seeking and refugee women with opportunities to build upon their own resilience whilst also improving maternity care for others in a similar situation. These projects have provided opportunities for training and voluntary work enabling women to provide peer befriending support, contribute to service development and maternity education as users, as well as presenting and chairing at national and international conferences. (Haith-Cooper & McCarthy, 2015; McCarthy & Haith-Cooper 2014).

### **Preparing health professionals**

It can be argued that health professionals' lack of knowledge of the life experiences and care needs of asylum seeking and refugee women contributes to many of the difficulties faced by these women in the perinatal period. In light of this it is vital that professionals are both trained on issues of culture and diversity as well enabled to develop an understanding of the complexities of the lives of asylum seeking and refugee women and how to meet their holistic needs (Goosen, van Oostrum, & Essink-Bot, 2010; Haith-Cooper & Bradshaw, 2013; Suurmond et al., 2013). A tool that can be used in training is the evidence based model 'The pregnant woman within the global context'. This tool is designed to enable health professionals to consider the asylum seeker and refugee woman at the centre of her care and consider how challenges within her reception and her home country will impact on her health and social care needs (see Haith-Cooper and Bradshaw, 2013 for a more detailed explanation of this model). The model can be used in conjunction with a film which considers some of the issues in more depth, discussing the experiences of asylum seeking and refugee women living in England (Maternity Stream of Sanctuary, 2015).

There is also a need to provide resources for midwives so they can support asylum seeking and refugee women to overcome the language barriers they face thus increasing their health literacy and understanding of health services in the reception country (Bennett & Scammell, 2014; Haith-Cooper & Bradshaw, 2013; Lyberg, Viken, Haruna, & Severinsson, 2012; Riggs, Yelland, Duell-Piening & Brown, 2016). Measures to help facilitate effective communication between health professionals and women include the provision of adequate interpreting services (Grech & Cheng, 2010), the development of picture-based resources

for women who have limited literacy in their own language (Bryant, 2011) as well as the increased use, where appropriate, of mobile applications which may help address language barriers (Haith-Cooper, 2014).

The table below provides some prompts for health professionals to consider in their interactions with asylum seeking and refugee women.

Table 1: Tips for health professionals in their everyday practice

- **Communication:** feeling safe and trusting the caregiver is vital. Use professional interpreters. Speak slowly. Using 'safe' open questions such as: 'Tell me about yourself?' and 'How does this compare to back home?' Listen if she wants to talk, if she doesn't, reassure her that this is ok. Explain how confidentiality works within the maternity services.
- **History taking:** consider the woman's social situation. Has she got the resources to access maternity care? Is she receiving the financial support she is entitled to?
- **Advocacy:** support the woman in challenges she faces such as lobbying to avoid dispersal and to access appropriate housing.
- **Signposting:** to local refugee organisations, support groups, specialist services such as FGM support, peer/ doula support schemes.
- **Cultural context:** explain the organisation of healthcare services. Discuss woman's expectations of childbirth and how any cultural requests can be met.

## Conclusions

Drawing on current evidence and examples from the UK, Malta and the Netherlands this chapter has examined aspects of the perinatal care of asylum seeking and refugee women. We have identified as key the need for a clearer understanding of the socio/cultural/economic and legislative factors which effect the both the nature of the care that health professionals can currently provide asylum seeking and refugee women and the ability of women to access care within existing care settings.

There is a need for change in mainstream health services to ensure they meet asylum seeking and refugee women's needs. Health professionals need training to ensure they feel confident to provide care which meets the complex needs of asylum seeking and refugee women. Women need to be able to access care without the fear of being charged for services. The good practice of an integrated, rather than piecemeal approach to health and social care in Malta through the migrant health unit could be adopted elsewhere. In addition, the provision of specialist perinatal services would appear more effective than mainstream statutory services. A fast track system for women booking late for antenatal care would ensure they can access services (Phillimore, 2016). Alongside these services,

peer support interventions including befriending are a relatively inexpensive but an effective means of building resilience in asylum seeking and refugee women.

There is a need for ongoing research in this area including the impact of the wider political/social/cultural and economic situation on perinatal asylum seeking and refugee women's health and wellbeing, including pregnancy outcomes. This research needs to include a variety of both quantitative and qualitative approaches, to be specifically focused on asylum seeking and refugee women, rather than subsumed within broader research on migrant women, and to adopt a salutogenic approach focusing on building resilience to address the complexity and heterogeneity of women's lives.

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