MOTHERS IN EXILE

Maternity experiences of asylum seekers in England

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Maternity Alliance
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Maternity Alliance
Maternity Alliance is a national charity, working to end inequality and promote the well being of all pregnant women, new parents and their babies.

DEFINITIONS AND ABBREVIATIONS

Asylum seeker A person who has made an application for refugee status.
Dispersal System of sending asylum seekers away from the place where they have arrived, to another part of the country where there is temporary accommodation available. Accommodation is allocated to the asylum seekers on a 'no-choice' basis.
Emergency accommodation (EA) Full board hotels in which asylum seekers are placed before being dispersed, while their applications for NASS support are processed.
Exceptional Leave to Remain (ELR) This permission to remain in the UK may be granted on humanitarian grounds to a person who does not qualify as a refugee.
Interim Provisions System under which local authorities are responsible for providing voucher support and housing to some asylum seekers who arrived in the UK before September 2000.
National Asylum Support Service (NASS) Government agency responsible for providing voucher support and housing to destitute asylum seekers who have arrived in the UK since April 2000.
Refugee A person whose application for refugee status has been accepted by the Home Office. Refugee status is granted to a person who can prove that she is unwilling or unable to return to her own country because of a well founded fear of persecution, for reasons of race, religion, nationality, membership of a particular social group or political opinion.
Vouchers Asylum seekers who have no other means of support receive subsistence vouchers, which can only be redeemed in specific shops, to meet essential living needs.
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KEY FINDINGS

This report describes a research study about the experiences of asylum seekers who are pregnant or have a baby during the asylum process. It is based on semi-structured interviews with 33 women carried out between April and September 2001.

The key findings are:

Full board emergency accommodation hotels put the health of pregnant women and babies at serious risk.
- Pregnant and breastfeeding women went hungry because the meals provided were not suitable. They had to miss meals to attend hospital appointments or if their baby was asleep or crying during a mealtime.
- There was no formula milk or baby food provided and no facilities to prepare any.
- Women were frightened of the risk of themselves or their babies catching infections from the filthy shared bathrooms.
- Women in hotels dominated by single men felt intimidated and were vulnerable to sexual harassment.

The dispersal policy has been applied inconsistently to the detriment of pregnant women and newborn babies.
- Some women in late pregnancy were refused dispersal when they were desperate to leave the emergency accommodation, others were dispersed away from their only friends just before giving birth.
- Women with young babies have been repeatedly moved around by accommodation providers.

Pregnant women and new mothers have been placed in temporary accommodation that was generally very poor quality and often seriously overcrowded. Lack of space put babies at risk of accidents and impaired normal child development. Women (including young women under 18) were sometimes placed in all male hostels where they were sexually harassed while using shared kitchen and bathroom facilities.

Restrictions on access to the £300 maternity grant left vulnerable mothers and newborn babies destitute at a critical period. Mothers have been forced to beg from strangers in hospital to get nappies for their newborn babies.

The level of voucher support was inadequate to support maternal and infant health. Pregnant women could not afford adequate food and could not find culturally suitable food in the supermarkets that accepted vouchers. They also could not afford to buy looser clothes as their body shape changed. New mothers went without food and warm clothes to buy necessities for their babies. Poor administration left some pregnant women and new mothers without any financial support at all for weeks at a time.

Most of the women were satisfied with their antenatal care and half also had positive experiences during labour and the postnatal stay in hospital. However, half of the women experienced indifference, rudeness and racism from the health professionals caring for them during delivery or on the postnatal ward. These women felt powerless to challenge hostile attitudes and fearful of the consequences if they attempted to do so. Offensive remarks went unchallenged by other health professionals.

Interpreters were generally provided when necessary, except for antenatal classes, which prevented many non-English speaking women from attending. In one case, however, a decision was made, without an interpreter present, to perform a Caesarean section on a woman who did not speak English.
Many women experienced sadness and anxiety in early pregnancy. Postnatally many described sitting alone crying endlessly, but none had been diagnosed with postnatal depression or offered any assistance. Many expressed strong feelings of powerlessness, vulnerability and insecurity about the outcome of their asylum cases. Women missed their mothers and other female relatives and friends particularly acutely during childbirth and in the postnatal period.

Women described extreme loneliness and craved female companionship, but found it difficult to build lasting new friendships in precarious circumstances. They greatly valued the social and practical support provided by refugee support groups.

Many women had not been given any information about what services and support were available to them. Several who had left behind children in their country of origin had not been told about the legal right to family reunification if they gained refugee status.
INTRODUCTION

Pregnant asylum seekers and their babies have been almost invisible within the asylum-seeking population in the UK. Of the 80,000 people applying for asylum in the UK in 2000, less than a fifth were women, and only a tenth had dependants. There are no statistics about the number of asylum seekers who give birth in the UK, but a 1999 study (1) in a Channel port town reported that nearly 13% of newly arrived asylum-seeking women were or might be pregnant.

The Maternity Alliance has been campaigning to protect the interests of asylum-seeking mothers and babies since 1995, when new legislation threatened to leave large numbers of asylum seekers entirely destitute. Asylum support policy has changed several times since then, but the special needs of pregnant asylum seekers and their babies have been largely ignored.

This report is an attempt to enable asylum-seeking mothers' voices to be heard in the policy debates. It describes a small qualitative study of women's experiences, based on semistructured interviews with 33 women who were either pregnant or had recently given birth.

BACKGROUND TO THIS STUDY

Asylum support policy

Asylum support policy has been in a state of flux since 1995. In order to deter alleged 'economic migration' under the guise of asylum claims, successive governments have changed asylum seekers' entitlements to financial support and housing. Before 1996, destitute asylum seekers were entitled to apply for social security welfare benefits on the same basis as UK residents. From February 1996, asylum seekers who applied for asylum after arrival ('in-country') instead of on arrival lost this entitlement, and were supported instead by local authorities under the National Assistance Act 1948 or the Children Act 1989. The original intention was that they should receive no support at all but this was successfully challenged in the courts. Those who applied for asylum on arrival before April 2000 remained entitled to claim welfare benefits.

This system placed extreme pressure on the resources of local authorities in the south east of England, where most asylum seekers were concentrated. To alleviate this pressure, in December 1999 asylum seekers were removed from the protection of the National Assistance and Children Acts and local authorities were given separate powers and funding ('the Interim Provisions') to support asylum seekers with vouchers and disperse them to different parts of the country for accommodation, while a new Home Office department, the National Asylum Support Service (NASS), was set up. From 3 April 2000, NASS took on the voucher support and dispersal of asylum seekers who applied for asylum on arrival, and during 2000 took on responsibility for new in-country claims.

Under the NASS system, when a destitute asylum seeker applies for accommodation and support, she is allocated to 'emergency accommodation' contracted through the voluntary sector. A voluntary sector 'reception assistant' helps her to fill out the NASS application form, which is only available in English. If NASS accepts the claim for accommodation and support, the asylum seeker is allocated free accommodation in a dispersal area on a no-choice basis, and is provided
with subsistence vouchers to meet essential living needs. The applicant may also choose to apply for accommodation-only or voucher-only support if she needs one but not the other.

'Essential living needs' are defined as 70% of Income Support rates for adults and the equivalent of Income Support rates for children. Thus at the time of this study a single woman aged 25 or over received £36.54 a week, of which £10 was cash and the rest vouchers. If she had children she received an additional £26.60 a week per child (see box 1). Where meals are provided at the accommodation, the amount of voucher support is reduced accordingly.

Box 1: Amounts of NASS financial support

<table>
<thead>
<tr>
<th>Age of woman</th>
<th>Total amount of NASS support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single pregnant woman 16-17 Single</td>
<td>£31.75</td>
</tr>
<tr>
<td>pregnant woman 18-25 Single</td>
<td>£28.95</td>
</tr>
<tr>
<td>pregnant woman 25+</td>
<td>£36.54</td>
</tr>
<tr>
<td>Couple expecting first child</td>
<td>£57.37</td>
</tr>
<tr>
<td>Single parent 18+, one child</td>
<td>£63.14</td>
</tr>
</tbody>
</table>

Research into the impact of Income Support rates on pregnancy and infant nutrition indicates that value of the vouchers has been set well below a level sufficient to support maternal and infant health. Even pregnant women relying on full rate Income Support cannot afford to eat a diet adequate for optimum pregnancy outcome(2). Mothers relying on Income Support often have to compromise on their own food to give their children an adequate diet. (3)

Criticisms of dispersal and voucher systems

Soon after NASS became operational, the negative impact of the twin systems of dispersal and voucher support on the physical, emotional and psychological well-being of asylum seekers became apparent. In June 2000, the Audit Commission warned that:

"Inadequate support services outside London present a major barrier to dispersal. For example, legal advice is a priority for asylum seekers, yet less than half of the immigration law firms contracted by the Legal Services Commission to provide immigration advice are outside London. Mental health services, English language support and refugee community organisations - which offer practical and social help - are also concentrated in the capital. Where services are inadequate, asylum seekers may gravitate back to London or become marginalized in the dispersal area"(4)

The effects of the voucher system on asylum seekers were heavily criticised in December 2000 by Oxfam, the Refugee Council and the Transport and General Workers Union in a joint report.(5) This documented the consequent hunger, poor health and stigmatisation asylum seekers routinely experienced, as well as the acute hardship they suffered when the vouchers were delayed. The report also drew attention to the inconsistency between the government's stated commitment to end child poverty(6) and its decision to 'pauperise' asylum-seeking children. Many organisations working with asylum seekers have voiced similar criticisms.
Changes announced in October 2001

Although the policy of withdrawing welfare benefits was intended to reduce the number of asylum seekers coming to the UK, the number of asylum claims has continued to rise. In October 2001, following an extensive review of the voucher support and dispersal systems and responding to sustained criticism from many concerned organisations, the Home Secretary outlined a new asylum support scheme. This will, he claimed, be "a message that is clearly understood in the rest of the world ... sending a signal to the rest of the world that the United Kingdom is not a soft touch."(7) Some details of the new scheme were added in February 2002 in the White Paper Secure Borders, Safe Haven: Integration with Diversity in Modern Britain.(8) The main features of the proposed new support policy are:

- Emergency accommodation will be replaced with 'induction centres', where basic health screening and multi-lingual information will be available. Single and pregnant women and other "special needs cases" will be housed in smaller units.
- Dispersal will continue, but "we will revert to a policy of dispersal based on language cluster areas."
- As an alternative to dispersal, some asylum seekers will be required to live in large 'accommodation centres' on full board with a small cash allowance, with 3,000 places to be created in four centres in the initial trial. Whether the asylum seeker has a partner and/or dependent children will be "important factors in the allocation process to ensure that appropriate accommodation and services are available."
- During the second half of 2002 vouchers will be phased out and replaced by cash. The exact mechanism by which financial support will be delivered has not been decided. In the meantime the cash element of NASS support will rise from £10 to £14.

Women asylum seekers and their children.

The great majority of asylum seekers are male, single and aged under 35. In 2000, there were 80,315 applications for asylum of which less than a fifth had a woman as the principal applicant(9). Only 10% of principal applicants in 2000 were accompanied by one or more dependants (spouse and/or children). There were also 2,733 applications from unaccompanied minors (asylum seekers under the age of 18).

Asylum support policy and pregnancy

The policy changes outlined above, which established an essentially deterrent system of support for asylum seekers, appear to have ignored the fact that a minority of asylum seekers are in far more vulnerable groups, such as pregnant women and young children. A mother in this study described her experience of being an "invisible" person lost in a system not designed to meet her needs: "I feel I am treated like the air." Some of the special needs of pregnant women were belatedly recognised with the introduction of a £300 maternity grant in vouchers in November 2000,(10) and a NASS policy bulletin addressing the dispersal of pregnant women in the summer of 2001.(11)

£300 maternity grant

A grant of £300 worth of vouchers for maternity expenses is available to mothers supported by NASS, provided they apply to NASS in writing, in English, between four weeks before their
due date and two weeks after the birth. The grant can then be issued from two weeks before the due date. This compares with the more generous period allowed to UK residents applying for the Sure Start Maternity Grant, which is a cash payment of £300 (£500 from April 2002) that can be issued from 11 weeks before the due date and up to three months after the birth.

Restricting issue of the grant for women supported by NASS to the last two weeks before expected delivery date has the potential to cause serious hardship, because of the enormous practical difficulties of shopping so late in pregnancy, and the significant risk of babies being born early.

Women who are supported by local authorities receive a maternity grant only if the local authority chooses to give one; these grants may be as little as £50, or nothing at all. Asylum seekers living in emergency accommodation are not entitled to a maternity grant, but at the time of this study women in emergency accommodation were in practice allowed to apply for a grant after their babies were born.

**Milk tokens**

Asylum seekers supported by NASS or local authorities do not receive milk tokens and vitamins under the Welfare Foods Scheme. This means that they cannot claim free liquid milk for themselves when pregnant or breastfeeding, nor free formula milk for their babies if bottle feeding. They are also unable to buy cheap formula milk at clinics because clinics do not accept asylum vouchers. Inability to obtain free or cheap formula milk may have a particularly serious impact on HIV positive asylum seekers who are advised not to breastfeed in order to reduce the risk of mother-to-baby transmission of the HIV virus.

The British Medical Association reports that doctors have witnessed mothers watering down milk for their babies in order to eke out their asylum vouchers and other anecdotal evidence shows that asylum-seeking mothers may introduce cow’s milk at a very early age because formula is unaffordable. There have also been reports of HIV positive asylum seekers occasionally breastfeeding when they run out of formula milk, which greatly increases the risk of mother to baby transmission of HIV.

The Department of Health has defended this omission of asylum seekers’ babies from a key public health safety net on the grounds that they may become retrospectively entitled to the missing milk tokens once the mother’s asylum request has been granted. Since the asylum process may take several years, the benefit to babies of asylum seekers of this concession is not obvious.

**Emergency accommodation and dispersal**

NASS’s policy bulletin on pregnant women, released in August 2001, states that:

“Our aim is to encourage a woman even in the late stages of pregnancy to leave the emergency accommodation and establish herself in her new home before the birth ... Where advice received from those providing medical care is that it would be inappropriate to expect a pregnant woman to travel, NASS will continue to house them in emergency accommodation until after their confinement...Women who request dispersal outside of the normal policy ... must provide evidence in writing of their pregnancy and reasons for exceptional treatment ... (Dispersal) will not take place for at least two weeks after the child is born.”
The unpredictable nature of dispersal policy has led to maternity care being disrupted and antenatal test results lost where the health professionals involved are unable to trace a forwarding address. There are also reports of a woman who did not speak English being put on a dispersal bus while in labour, and another family being dispersed on a day when the woman had undergone a termination the same morning. The Royal College of Midwives has commented in respect of NASS’s policy bulletin that:

“Consideration is needed as to what ‘establish’ means. A woman who has physically unpacked is not ‘established’ if she does not know the area, the services available to her, or anyone who can provide her with emotional and practical support in the community. She is not ‘established’ if she feels isolated or unsafe.”

On the other hand prolonged residence in emergency accommodation carries its own risks to maternal and infant health. Research into child poverty in Ireland, where asylum seekers are accommodated in full-board hostels with a small cash allowance, has reported “experiences of extreme deprivation.” These included malnutrition amongst expectant mothers, ill health related to diet among babies, and a pattern of women giving up breastfeeding within a few weeks because of the absence of an adequate diet.

**Healthcare entitlements of asylum seekers**

A guidance note issued by the British Medical Association in 2001 summarises the legal entitlements of asylum seekers to healthcare as follows:

- All asylum seekers and refugees are entitled to free NHS healthcare, including maternity care.
- All asylum seekers and refugees have the right to be registered with a GP.
- Healthcare professionals must not discriminate against asylum seekers in the provision of services.
- Asylum seekers with a low income are entitled to free prescriptions and a refund of fares to and from hospital by filling out an HC1 form to get an AG2 exemption certificate. Pregnant asylum seekers should receive their maternity exemption certificate for free prescriptions when they book for maternity care.

Asylum seekers, like other non-English speaking users of the health services, also have certain rights to language support services.

- Where an asylum seeker's consent is needed for a medical intervention, and she does not speak English, health professionals “should take all steps as are reasonable in the circumstances to facilitate communication with the patient, using interpreters or communication aids as appropriate.”

**Health needs of asylum seekers**

There have been many studies of the health needs of refugees and asylum seekers in the last few years. Box 2 shows the key concerns as summarised in a Greater London Authority consultation report under the headings of access to healthcare, problems arising from the refugee experience, and health problems related to the country of origin or ethnic group. Most studies have not, however, generally dealt with women’s specific health needs or maternity care in any detail, although a recent health policy report addresses the need for improvement.
in the provision of maternity services for asylum seekers at one emergency accommodation location. (30) This general omission of maternity from the research context stands in contrast to Ireland, where a comprehensive study of women's maternity needs has been carried out. (31)

Box 2: Key concerns about the health of people arriving to seek asylum in the UK.

Access to health care
- Weakness of procedures for initial assessment of health status at port of entry.
- Language: need for translation and interpreting support.
- Cost: difficulty in taking up rights to free or subsidised treatment, for example because of cumbersome HC1 /HC2 form-filling procedure.
- Lack of familiarity with UK health services and insufficient information about them in relevant languages (covering for example entitlement to treatment and confidentiality).
- Primary care: in particular, difficulty in getting registered with GPs.
- Lack of background understanding of refugee issues among some NHS staff.
- Need for services adapted to specific needs of women, children, cultural communities, and other groups within the refugee population.

Refugee experience
- Physical injuries from war and torture.
- Exposure to communicable diseases in transit, for example in refugee camps.
- Mental health conditions arising from their experiences before arrival.
- Mental or medical disorders arising from insecurity, anxiety and deprivation in this country, with some studies showing that incidence of such problems may be greater after a period of residence in the UK than on arrival.

Health problems related to country of origin or ethnic group
- Inherited disorders such as sickle cell disease, beta thalassemia.
- Problems associated with poor countries, e.g. Tuberculosis, HIV, lack of immunisation.
- Culturally-based conditions such as female genital mutilation.


Senior medical examiners from the Medical Foundation for the Care of Victims of Torture state that:

"The health of asylum seekers is affected by many aspects of their experiences, both past and present, including multiple loss and bereavement, loss of identity and status, experience of violence and torture, poverty and poor housing, and racism and discrimination ... The asylum process is lengthy, complicated, and intrinsically stressful, with the continual fear for the asylum seeker, until the process is complete, of being sent back to the original country." (32)

The same authors note that women are often more seriously affected by displacement than men. They summarise some of the physical and mental consequences of the refugee experience for women as: vulnerability to physical assault, sexual harassment, rape, poor health, depression, loneliness, and the stress of taking on overwhelming domestic responsibilities, including becoming head of a disrupted household. (33) They warn that a refugee woman may be particularly
vulnerable to domestic violence because of a lack of family and community support, and because her fear of being alone may outweigh her fear of violence. High levels of domestic violence were reported in a study of refugees in Hackney. (34)

**Asylum seekers and maternity care**

Pregnant asylum seekers may come into the maternity services suffering “an experience of profound loss…(which) creates special dimensions of need for pregnant women, with consequent impact on their physiological, psychological and social profile during pregnancy.” (35) Understanding, sensitivity and supportive care are therefore of utmost importance for these women.

The 'Western' model of maternity care is unfamiliar to some women from other cultures, and aspects of it may seem invasive and frightening. (36) Particular sensitivity and good communication are required in the care of pregnant women who have been raped or tortured, who may, for example, find internal examinations very distressing. (37) Continuity of carer is extremely important for these women, to avoid a situation where they may have to repeat an account of their traumatic history to a different professional on each antenatal visit. (38) The Black Women's Rape Action Project estimates that at least half of all women asylum seekers have been raped. (39)

Over 300 HIV positive women give birth in the UK each year. The great majority of HIV infections contracted through heterosexual sex that were newly diagnosed in 2000 were contracted abroad, particularly in Africa. (40) One HIV specialist midwife reported that 85% of her caseload of HIV positive pregnant women were asylum seekers. (41) The dispersal of HIV positive women away from the specialist centres providing their maternity care has posed problems in the past. However, NASS has now accepted that an HIV positive pregnant woman should be exempt from dispersal where a doctor or midwife confirms the need for specialist treatment in writing. (42)

Asylum seekers from some African countries may have undergone female genital mutilation (FGM) and need tactful, gentle and respectful examinations and information about the implications for labour and birth. (43)

Many asylum seekers present late for antenatal care. For example, the Irish study of the maternity care needs of refugee and asylum-seeking women found that nearly two thirds of the women had their first antenatal appointment at 22 weeks or over because many were in their second or third trimester of pregnancy when they arrived. (44) Two studies of refugee women have shown higher rates of some obstetric complications than the general population, and it is likely that these findings would be applicable to asylum seekers as well. Research in Enfield and Haringey in 1999 reported high rates of terminations, miscarriages and complications among refugee women. (45) A study at the National Maternity Hospital in Dublin in 2000 found that refugee women had significantly lower epidural analgesia, oxytocin acceleration and episiotomy rates than the general population, but more antenatal admissions (especially for spurious labour) and higher perinatal mortality. (46)

In a report on maternity services for newly arrived asylum seekers in the City and Hackney Boroughs of London, providers of maternity services identified communication problems as a key concern. (47) In particular, community midwifery was felt to be compromised where there was no advocate or interpreter available, and midwives were dissatisfied with the language support available to women in labour, since advocates worked restricted hours and Language Line
interpreters working at night were usually male. The national report on maternal deaths from 1997-99 has re-emphasised the importance of providing formal interpreting for women who do not speak English, rather than relying on a partner, friend or family member, in the context of antenatal screening for domestic violence. (48)
THE MATERNITY ALLIANCE STUDY OF WOMEN'S EXPERIENCES

The women

Between April and September 2001 we interviewed 33 women - 24 asylum seekers and nine refugees - who were either pregnant or had given birth during the previous 18 months. The focus was on asylum seekers because their experiences may be quite distinct from women in settled refugee communities, but nine women with recent experience of being an asylum seeker were included even though they had been granted refugee status or Exceptional Leave to Remain (ELR) at the time of interview. Women were asked in semi-structured interviews about their experiences of maternity care, vouchers, housing, and their health and emotions.

Four women were pregnant at the time of interview. The other 29 women had 31 babies, ranging in age from six days up to 18 months. Nine women also had older children with them in England. Eight women had left other children behind in their countries of origin.

The women interviewed were at all stages of the asylum process from newly arrived to having refugee status or appealing a refusal of asylum. They ranged in age from 16 to over 40 and came originally from 19 different countries. They had been in England for periods of between three weeks and over two years, and their ability to speak English varied from knowing only a few words to fluency. Half had husbands* with them and half did not.

All the women in this study had at some point had to rely on one or more of the official systems of support for asylum seekers. At the time of interview, women were supported in a variety of ways:

- Some were in emergency accommodation waiting for an application for support to be accepted.
- Some were provided with vouchers and temporary accommodation by the National Asylum Support Service (NASS), because they had claimed asylum since April 2000.
- Some were provided with vouchers or cash and temporary accommodation by a local authority, because they had claimed asylum in-country before April 2000.
- Some received means-tested benefits, because they had claimed asylum on arrival before April 2000, or had refugee status or ELR.

Full details of the interviewees and the study methods are set out in the appendices.

1. PROBLEMS ON ARRIVAL - EMERGENCY ACCOMMODATION AND FULL BOARD

Newly arrived asylum seekers who have nowhere to live are accommodated before dispersal in 'emergency accommodation' (EA) hotels with full board and no cash or vouchers. Although in theory an asylum seeker should be dispersed within seven days, a stay of several weeks is normal. One woman in this study was still living in EA five months after arrival. Another had been dispersed to a hotel with full board and therefore no vouchers, and lived there until her baby was nine months old.

*We use the term 'husband' because all the women with partners were married to them except one, who described her fiancé as 'husband'.
1.1 Food

Pregnant women often went hungry in the EA because the food provided was totally unsuitable. The hotel meals were repetitive, unhealthy, and poorly prepared, for example frequent dry chips and undercooked beans. This food was perceived as unpalatable, even disgusting by women of different cultures. The situation was particularly stressful for pregnant women with strong food cravings, who were all too aware they had to eat for the sake of the baby, but felt sick when they tried to eat the food provided. Their frustration at having all meals provided for them may also have reflected distress at being deprived of the key customary female role of food preparation.

There aren't good things here. It's very difficult, it makes you feel ill. I am afraid that it will affect my baby if I don't eat properly, because a pregnant woman has to eat well. I wish I could eat what I want, but here we are obliged to eat what we find at the restaurant. You have no choice. Pregnant women are obliged to eat this intolerable food because we are hungry.

My baby was small; it was because of the hotel. At the hotel I couldn't eat enough, you can only eat what they give you. I didn't want to eat that food, I really craved the taste of African food, the sauces, the soups, but they didn't have that there.

Meals were only available at restricted times, and only in the restaurant, so food could not be taken back to rooms. This posed problems for all the women. Pregnant women reported having to miss meals to attend lengthy antenatal hospital appointments; they were given neither food to take with them, nor money to buy food outside, so had to go hungry unless they could persuade a midwife to help them. Mothers of newborn babies reported missing meals because their baby was asleep at the time, or because they found it too embarrassing to eat in a public place with a tiny baby crying in their arms. Pregnant and breastfeeding women who were hungry between meals had no access to snacks, and one woman, breastfeeding her fifth baby, was very anxious that she could not breastfeed successfully on the diet provided.

When I was pregnant they just gave me the money for the transport to the hospital. I had to miss the meal here but they wouldn't give me any money for food. Sometimes the midwives gave me a little food when I told them I was hungry.

In the morning they give breakfast at 7 o'clock, maybe at that time the baby is sleeping, I can't take the baby up. We are not allowed to take food into our rooms.

I must go to the restaurant with her; I hold my baby in one hand, and my food in the other. When I go to that place she starts to cry ... I haven't eaten breakfast since she was born, I have only lunch and dinner, and sometimes I miss lunch because she starts to cry.

The food is fine, they give enough food. But you are not allowed to have a snack if you get hungry when you are breastfeeding.

1.2 Infant feeding

No one at one emergency accommodation hotel took responsibility for providing
infant formula for babies who were not breastfed. This is particularly serious for babies of mothers who are HIV positive, because they are specifically advised not to breastfeed in order to reduce the risk of transmitting the virus to the baby. One HIV positive mother had been wrongly told by the refugee agency administering her hotel to spend her maternity grant on formula milk. When that ran out she had no choice but to give her baby cow’s milk, which is entirely unsuitable for young babies and which made the baby sick.

Sometimes there is a problem when they don’t give me milk for two or three days and she is vomiting because I have to give her the milk we buy for adults. I had to fight to get the formula milk ... I am waiting, waiting, waiting, from 10 o’clock to 4 o’clock she didn’t drink anything ... I waited for the office to give me milk, or something to buy it with. They said ‘We don’t have money, so you must wait.’ I said ‘My baby doesn’t even have one bottle so what will she drink?’ ... A lady who works in the restaurant saw me crying, she said ‘What’s wrong?’ I said ‘My baby doesn’t have any milk,’ so she came down and bought some milk for my baby.

Mothers who needed to use formula milk also faced the problem of how to prepare feeds safely.

The ready-made was a bit expensive, and she couldn’t finish it and I had no access to a fridge so I had to throw the extra away. The health visitor advised me to start using tinned milk. I didn’t have enough money to buy a kettle ... so then came the problem of water. I carried boiling water from the kitchen in an empty milk container, but it could be dangerous, one day it could fall.

Food for older babies was also a problem. No baby food was provided by the EA, and the adult food was not suitable to be mashed up. Even if it had been, mothers were not allowed access to facilities to prepare the food.

In the hotel I had no access to the kitchen, and the food they gave us was chips or whatever, which is not very good for a baby.

There is no baby food ... I was really scared, what could the children eat?

(Mother of two children who became so desperate that she left the emergency accommodation to stay in a friend’s room)

Only one mother (dispersed into full board accommodation) had succeeded in persuading the hotel manager to provide baby food:

I was allowed £10 for me and her. Having to buy nappies, formula milk for her, it wasn’t enough, so I went to talk to the chief, and the hotel started giving me jars of food.

Other baby needs, for example clothes and nappies for a newborn baby, were also neglected. This was an extremely serious problem because the mothers living in EA, and waiting for their applications to NASS to be accepted, could not apply for any maternity grant until after their baby had been born and the birth registered.

1.3 Bathrooms

Most women had to share toilets and washing facilities with many strangers of both sexes. They were very conscious of the embarrassing or even culturally unbearable
I give my baby milk, and when she is asleep, I run to take a bath. Sometimes when I come back she is crying, I can't do anything - if I take her there she will die. Sometimes I take a shower at 3 o'clock in the morning, 6 o'clock - whatever time she is sleeping.

There is no place to wash the baby or to wash or dry her clothes ... I can't take my baby's clothes and wash them in the bathroom, because the men are always there. The men touch the ladies. And because it is one bathroom you can catch sicknesses ... Us ladies get too many infections. The bathroom is very dirty. I wash her clothes in a sink in my room. To wash the baby at the moment, I don't even have a dish to wash her in ... If I was not pregnant, I could stay in a place like this, but imagine if I am pregnant! How am I going to sit in that toilet?... If someone is pregnant you should transfer her to a place where she will be safe.

Bedrooms

Some rooms were dark and airless, the windows could not be opened properly, and several women were fearful of their babies catching a disease from contact with dirty carpets. There were problems with the provision of cots and bedding, including: no cot provided; dirty mattress provided; a refusal to change the cot bedding when a baby had had a nosebleed over it; and a cot mattress infested with insects.

It's very hot in the room, at night we can't sleep, ten times I wash [my baby] because she is sweaty ... The room smells, it's very humid. My baby and I sleep with our noses closed, and she sneezes ten times.

Single women generally had to share rooms with strangers. Sharing a room was felt to be particularly stressful for a pregnant woman who needs rest and privacy. This issue was raised by both of the HIV positive women. Both were from communities where being known to be HIV positive would be a source of shame, and a recent report on HIV and social exclusion points out that where women conceal their HIV diagnosis due to fear of stigma, they may be unable to access or manage treatments for fear of discovery. (50)

Her [the roommate's] friends come, I can't sleep, day and night they talk, they sleep with me in my bed, they don't care ... At that time I am nervous, I have many problems, I miss many things, I don't know anyone ... I stayed outside in reception until 2 or 3 o'clock, thinking, thinking.

The roommate I had here was so arrogant, I don't know which country she was from but she had white skin, even if I said 'Hi' she couldn't look at me.

The poor physical state of some EA rooms was very significant to these women because they were virtually trapped in the EA. In some cases they lacked the confidence or physical health to make use of such local facilities as did exist, for
example a park, and they had no money to use public transport to facilities further away. Even if they could go further afield, they would then be at risk of missing meals. Some described meeting up with their friends in the reception area of the hotel, but others found the male domination of the public spaces in the EA too intimidating.

_Sometimes I take [the baby] to a park, but I don’t go far, because I don’t know this country very well and I don’t have money for transport._

_How can I go out? We have no money, no right to work. We look at each other, that’s all._

### 1.5 Sexual harassment and personal safety

Single men dominated the public spaces in the EA and some of the women felt very vulnerable. There were instances of sexual harassment, so serious at one EA that the women-only floor had to be guarded against the men. Women also felt intimidated and lacked a sense of personal security, in respect of both fellow residents and also the hotel authorities, who at one location regularly 'swept' the building early in the morning to check whether the asylum seekers were using their allocated rooms. The single women did not open their doors to the all-male teams banging on them, so had their accommodation cancelled.

_The men touch the ladies._

_There were two other mothers there, at times we could meet outside our rooms, but the time came when I was fearful, you know there used to be fights down there, one time people fought during the night. It was so terrible, you know I had to lock myself in my room. Even in the dining room people used to fight, over cards or whatever, they had their differences from back home ...I started keeping to myself._

### 1.6 Personal needs

One woman who had lived in a full board hostel provided by social services described how no sanitary protection had been available. This would be particularly serious for women experiencing postnatal bleeding for up to six weeks.

_In that hostel they cook, they don't give you any money, you eat there and you sleep there, that's all. Even when you have your period, you can't even buy ... you use toilet paper, because you don't have money. They provide only soap in the bathroom, and toilet paper._

### 1.7 Staff

Experiences with staff at the hotels were mixed. Two women were very critical of the attitude of staff of the refugee agency administering one of the EA hotels. They perceived the agency's staff as indifferent to their problems, contemptuous of their integrity and prone to favouritism.

_The people working here treat us like a maid ... They are racists. If they see someone from their own country, who talks the same language, they help you ... I wish the people who work in this place would start to treat the mothers and babies nicely._
They say they have no money, but they have money here ... Maybe they think if you give us money - but we are mothers! We would use that money for our baby.

Women at the same hotel also spoke of individual acts of kindness from hotel staff, for example a restaurant manageress personally bought formula milk for the baby of an HIV positive mother who had none, and sometimes held the crying baby while the mother ate.

2 DISPERAL AROUND ENGLAND

2.1 Policy badly handled in practice

The stated aim of dispersing a pregnant woman before the birth of her baby, so that she may establish herself in her new home, appears to be applied inconsistently, to the detriment of the welfare of women and children.

Some women without any ties to London were desperate to get out of the EA but had been refused dispersal on the grounds of advanced pregnancy. On the other hand a woman who was within days of giving birth had been dispersed to a different part of the country away from her only friends, leaving her to undergo labour and the immediate postnatal period alone. Three women living in EA who had newborn babies were adamant that they wanted to be dispersed as soon as possible. Continuity of care from health professionals was much less important to them than reaching better living conditions, which they hoped to achieve through dispersal.

They were going to send me to Glasgow, but ... when the man saw how pregnant I am he said I couldn't travel that far ... I don't know anyone here in England ... It would be better for me to be transferred before the birth, because then they would give me vouchers. But here, it's terrible.

(Woman nine months pregnant, in EA for one month)

My baby is not safe in this hotel... They were making me stay here because I was pregnant, now I have had the baby they must transfer me because this is not a safe place. I would have preferred to be transferred before I had the baby ... I want to move as soon as possible. Even with knowing the midwives: they can't change the fact of where I am staying.

(Mother of six day old baby in EA)

I told them I need to get out of here. They said 'Wait, wait, the baby is not good for going out of here' ... We're all in one room, all the beds pushed together ... We used our own money for milk and Pampers, and food for the children - there is no food for the children ... We used up our money ... I want to go to any place where I can take care of my children, where they will give me vouchers and I can go to the supermarket, buy what I need.

(Mother of six week old baby and tour other young children, in EA for six weeks)

Moving at nine months pregnant was really hard. I would have preferred to have had the baby from the hotel where my friends would be there for me.

Some women had been moved from place to place, or been unexpectedly dispersed after a long settled period during which networks of support and trust had been slowly
established. In one case a woman was dispersed with her husband and six week old baby to the middle of a different ethnic minority community with a history of hostility to her own.

This is my third home and they are telling me I have to move again ... They take me here, they take me there, from room to room ... I feel very discouraged. I don't know where I'll have to go or when.

(Mother of ten month old baby)

NASS said they were going to disperse me to Bradford, the letter and ticket came on Tuesday and I was supposed to go on Thursday ... How did they expect me to move with my baby and all my luggage? That week, I thought I couldn't manage. I said 'My God, what should I leave, what should I take?... At that moment I felt helpless. It was a shock.

(Mother of eight month old baby, who had been settled for eight months after a previous dispersal)

NASS sent us to Bradford ... We were surrounded by Pakistani families, many families started questioning us ... we felt insecure and very frightened about the situation, because of the history of the relationship between Bangladesh and Pakistan.

(Bangladeshi mother dispersed with six week old baby)

2.2 Racism

Some of the women had been dispersed to areas where they experienced deep prejudice. There had apparently not been any attempt to prepare local communities for the arrival of asylum seekers in their midst.

People here are racists. They look at us with bad eyes. They shout at us when we're walking around, in the shops. When you go to the subway you can read the things that are written there about asylum seekers.

On the bus, English people run away from you ... one of them is sitting there and when you come and sit next to him he gets up and goes over there, he doesn't want to sit next to you.

2.3 Food

Some women were dispersed to places where they could not buy their own kind of food, in contrast to London.

You can find a bit of African food here, but if you want to get everything you want, you have to have a friend in London and send them some money, and they send you the food.

(Woman five months pregnant)

When I was pregnant, I ate, but I vomited. I had to eat things I didn't want to eat; everything I feel like eating is in London. I don't have anyone to go to London to buy me food.

(Mother of one month old baby)

2.4 Dispersal of HIV positive women

The two HIV positive women in this study had both been exempted from dispersal on
medical grounds, but they had not been found suitable accommodation within reach of the relevant hospital. Instead, one woman had been moved to a house shared by eight women, where she shared a room with two strangers; the other was still in dismal emergency accommodation five months after arriving in England. Both described sharing a room with strangers as particularly stressful.

My hospital doctor wrote a letter asking them to find me a flat or a house, so I can get vouchers and cook for myself, because I am taking medication and my baby is too, and the place I am staying is very dirty, and I had a Caesarean. The food I eat is not nice for me. I'm not OK at all. She wrote four letters, but they have ignored me.

3. HOUSING AFTER DISPERSAL - TEMPORARY ACCOMMODATION

Most of the women in this study were living in temporary accommodation at the time of interview, and many had experienced a number of moves since arriving in the UK. The standard of the housing was in most cases low, particularly in London, where there is extreme pressure on the stock of temporary accommodation. Generally the women living outside London were in slightly better accommodation. The temporary accommodation included a hotel with full board, a bed and breakfast hotel, hostels with shared cooking and bathroom facilities, bedsits, and one bedroom and two bedroom flats. The main problems identified included overcrowding, lack of space, a total lack of privacy through sharing rooms with female and male strangers, lack of hygiene, dampness, and unpleasant location.

3.1 Size and condition of accommodation

Lack of space and overcrowding were the problems most often mentioned. Families had to cope with their newborn baby as well as older children in a single small room. This placed the parents under intense pressure, and put the children at risk of accidents.

Staying eight months in one room in the hostel, with all the children and my husband just in one single room, it was a very difficult experience. It was also damp. At the time the baby was born we were still living there ... We had to share a kitchen and bathroom with eight other families. Until October the boys weren't going to school so we were all together in the room.

(Mother of three children)

The other people complain that there is a lot of noise, the children crying. It is a very small room; there are only two beds, a table and a cupboard. The baby doesn't have space to walk. The children sleep together on one bed ...I don't have a baby's cot - he has fallen from the bed onto the floor so many times.

(Mother of disabled six year old and 12 month old baby)

One of the babies is OK but the other one has a problem with her legs, it is more painful, she cries all the time. She disturbs her sister. They sleep in the cot together, one at each end, because you know this is a small place and there is no room for a second cot. Their legs touch and they wake each other up ... You can see the situation is very bad. There is a big window right by the babies' cot, if we close it, it is too warm, if we open it, the wind comes straight into the house ... When I am cooking here, the smell of cooking wakes
I have Kosovan neighbours here, they come to my house and I go there, but we don’t have anywhere else to go ... I stay at home. What can I do?

It’s very difficult at night. My children and I sleep in the bedroom and my husband sleeps on the floor [in the other room]. He is very big - there’s not room for all of us.

The physical state of the accommodation was distressing for some women, both because of discomfort and because they attributed their babies’ poor health to it.

When I cook meat, the smoke alarm goes off. We can’t open the windows because they open wide and the children would fall out. It’s always noisy in our room. All our clothes smell of food. And there is no water in the toilet, the flush is rusted and doesn’t work. The people here told me I would have to pay to get it mended.

In our room, when it rains the walls become wet and it smells very bad, of damp. Sometimes I see a rash on my baby’s body, maybe because of the damp.

One woman was interviewed at home in a bedsit that was in a state of appalling disrepair. She had been rehoused from a hostel dormitory when she was pregnant, and was living with her ten week old baby in a dark back room, which was so damp that the carpet was mouldy and the bed, which was the only place to sit in the room, was wet to the touch. She had to keep her baby’s clothes in a neighbour’s room to keep them dry. Her shower and toilet were broken, and the toilet on the next floor also leaked into her room. She was extremely depressed and her baby was in very poor health.

There [in the dormitory] it was noisy, people were not friendly, there were many problems, but at least it was healthy. Can you smell here, it stinks. And at night I have to close the window [over the bed], so there is no fresh air; sometimes the baby chokes and I have to go outside in the corridor. I put him in the pram and I sleep on the floor so that we can sleep. So what kind of life is this? ... One day, my baby was sleeping there on the bed with me, and water just came on me - the toilet upstairs is just here, so if someone goes there and flushes it, some water comes down. Toilet water fell on me!... I can’t wash my baby here, I have to go upstairs. I can’t keep his clothes here, because of the stink. Even on this bed, you see why I don’t remove this duvet, it protects, so that this mattress doesn’t get all these dirty, dirty things.

Despite these difficult conditions, many of the women described staying at home most of the time. For some, there was nowhere else ‘safe’ to go, and they did not have the energy for wandering about for no reason. Some had ended up in flats that would be ‘hard to let’ because the physical environment was very unpleasant.

I have Kosovan neighbours here, they come to my house and I go there, but we don’t have anywhere else to go ... I stay at home. What can I do?

The baby and I wake up at 4am, I make some milk, I wash the clothes, I have some tea. When I finish, if I don’t see any distractions, I sleep. I only take my baby out when I need to go out for something. I don’t know the area.
This area is disgusting. Sometimes on Friday night it is really terrible, there are people drinking, fighting, so sometimes you can't sleep until one o'clock in the morning, and from my window I've seen people selling drugs on this corner - and I was scared.

One woman commented that lack of space in the room where they lived, combined with the absence of any space outside suitable for playing, was affecting her child's physical development.

My child can't walk very well, there is no room ... There is nowhere to take him outside to play - there are just hotels on the street. I don't have a pushchair.

On the other hand, three of the younger mothers expressed a clear longing to take part in 'normal' activities outside the home.

I go window shopping, because I can't buy anything, but I like to see how the look is now.

Sometimes we go to Greenwich Park, or to central London. It's just one bus to Greenwich, two or three to central London. We like to look around, start singing and dancing - really! We feel happy - we feel like normal people!

If I had more money I would like to go to the West End and buy a pizza.

(Pregnant 19 year old)

3.2 Lack of privacy and sharing facilities

As in the EA, lack of privacy was very stressful for the pregnant women who had to share a bedroom with strangers, including, in one case, a man.

In the hostel we had to share a room with one other person, it's really difficult to be with a person who you don't know where they're coming from, you don't know what they are doing, you don't know what kind of person he is. I stayed in the hostel for six months. There were insects there.

(Couple, both 16)

In the hostel we shared a room, four people in one room, just four beds. When you have to dress you go in the corridor, or when you are sleeping someone is listening to their music, when you want to read, someone is doing work. It was horrible.

Sharing a bathroom and kitchen was also problematic for some women, both for the opportunities it afforded for sexual harassment in mixed accommodation, and the practical difficulty of having to leave the baby behind in the room. Staff sometimes arbitrarily restricted access to the kitchen.

The house, I couldn't stay there, I couldn't have a shower - every moment the boys come in the bathroom. I was pregnant, and I needed to go often in there.... It was very difficult, very stressful.

(16 year old)
I was with people who drank, there were alcoholics there, they would hang about in the corridor. I was on my own, the only girl, we had to shore a kitchen and I had to walk down the corridor to the other end. I was afraid of the men ... When I saw someone else I wasn't afraid of, I used to go quickly into the kitchen with them.

When I'm cooking downstairs who will be looking after the baby?

### 3.3 Staff attitudes

Two women described the staff of hostels in very positive terms.

The staff were very good. They gave us a lot of help ... They gave us money for food, clothes, everything, if you needed any help you just had to ask him, he never said no.

However, for one family, it was the petty tyranny of the hotel manager that was making their stay very difficult.

The manager of the hotel is very unpleasant. They took the lock out of the door and for the past two weeks I haven't even had a lock ... Yesterday when we had to go to the hospital, my husband asked the manager if he could lend us a lock just for the time we are at the hospital, but the manager said it's Sunday and he's not going to talk to him, and he should shut up and go back upstairs ... We share a kitchen; but the manager has the key, and if he closes the kitchen and goes somewhere then I can't use it. That happens often. He usually says that the Polish people leave a lot of dirt so one night when we were cleaning he came and said he was just checking how well we clean.

The same family had been allocated a room disregarding the disabilities of the father and one of the children.

My husband also has problems with his spine and with his disc. He only lies down; I have to help him go to the toilet. He can't hold even one kilogram of weight in his hands so he can't help to carry the child. They were supposed to give me a room in the hotel on the ground floor but we are living on the second floor, and my husband has to use his hands and knees to go upstairs - he crawls.

### 3.4 Women who stay in alternative accommodation

Three women in the study had opted out of NASS accommodation and were staying in unsuitable alternative accommodation to avoid dispersal away from community or language support, or to escape the poor conditions of the EA. One family had fled their dispersal accommodation because of hostility towards them, and had been taken into an overcrowded flat by members of their own community. Another woman found that her 11 year old daughter could not cope in a hotel, having developed a terror of strangers after a horrific racist attack in her home country, during which a swastika had been carved on her arm. The third had left the EA because there was no food for her baby and young child. The women in this situation recognised that the alternative arrangements they had made were precarious.
You need your family with you, when I have a problem there is no one to be there with me.

use the heating ... Twice we had quite big rows and she told me to get out. I took the children and went outside for three or four hours and I came back home. I was crying, I told her I will go to different places and find something. She told me I have to find a place for myself because she can’t cope with the baby crying all the time ... My cousin has given us one week to leave.

(Mother of 11 year old and two month old baby)

Our friends have given us shelter, there are three rooms and we are using one room ... There’s no space for a cot, the baby sleeps in our bed...Of course there are problems but we haven’t got any choice. We have to accept it ... We don’t know how long we can stay.

(Couple with five month old baby)

3.5 Unaccompanied minors

Asylum seekers under the age of 18 who arrive without a parent or guardian are the responsibility of social services. Of the three women in this study who were under 18 when they arrived in the UK, only one was fostered. Even though she was living independently at the time of the study, in a hostel with 11 adult men, her relationship with her former foster parents and their adult children remained the most positive thing in her life.

They are like a family to me.

One of the other young women, aged 15 when she arrived, stayed first with friends, then with relatives in London. When she applied for assistance she was housed in a bedsit in Manchester.

It was difficult coming to a new city, because I didn’t have any family here. But I don’t have any problems now, apart from the house. The hotel won’t let anyone stay here, even your friend ... It’s boring just living alone! Sometimes I feel bad because I’m not with my family, sometimes I feel good that I’m in England and they’re taking good care of me and my baby. But you need your family with you, when I have a problem there is no one to be there with me ... I want to send money to my family but I can’t.

The third young woman, who was 16, was housed with her husband, who was also 16, first sharing a room with a man in a hotel without cooking facilities, then in a house full of young men.

It’s really difficult to be with a person who you don’t know where they’re coming from, you don’t know what they are doing, you don’t know what kind of person he is ... When I was pregnant I went to the doctor and I was anaemic, and a lot of things happened, because I couldn’t eat properly – I didn’t have a kitchen, just had to buy things like kebab, chips, fish. It was very expensive ... The house, I couldn’t stay there, I couldn’t have a shower - every moment the boys come into the bathroom. I was pregnant, and I needed to go often in there. Things happened, because my husband, when someone spoke rude to me or something, he was very angry. It was very difficult, very stressful.
4.1 £300 Maternity Grant.

Many of the women in this study had not been able to access a maternity grant. This was for one of four reasons. Some had not heard about the grant, and some were not entitled to one because the local authority supporting them did not give one. Some had applied but not yet received one. Others were not entitled to one because they were still living in emergency accommodation, but had been told that they could apply for a grant once after the baby's birth had been registered. After applying for a grant mothers generally faced a wait of several weeks before it was issued, during which no provision was made for their babies. At least six babies in this study were born at or before 38 weeks, which is the earliest a grant can be issued.

The women described the impracticality of shopping so late in pregnancy and the hardship they experienced waiting for the grant to be issued. One also described how she had to make a painful journey to the Register Office by public transport immediately after hospital discharge in order to obtain the birth certificate so that she could apply for the maternity grant without delay.

No one gave me anything for the baby. It will be hard to go shopping when I am nine months pregnant. I don't know how I will do it; I will be suffering from carrying these luggages. You have to do it little by little.

(HIV positive woman)

I am supposed to get £300 for the baby, it’s two months since her birth and I still haven’t had anything. They always say ‘Next week, next week’.

They should give you the maternity grant before you have the baby. They must know that the baby needs things, the baby must wear clothes ... but they give it after the baby is born.

They told me I needed to get the baby’s birth certificate [to apply for the grant]. I said ‘Please can you call a taxi for me because I am sick, I feel pain,’ and they said ‘No you have to take the bus there and back’ ... so I just walked slowly, but it was difficult for me because I have stitches, I am not feeling fine.

(Mother of six day old baby)

As a result of these problems, several mothers with no money and no vouchers went into hospital with nothing at all for their babies. One described this vividly.

When I had the baby I didn't have clothes for the baby, not a nappy, nothing. I took only one pyjama for myself and two T-shirts, that's all I have. So when she was born, they wrapped her in a towel.

Some women were given baby clothes or nappies by midwives or friends, but others were not so lucky. After a Caesarean delivery one destitute mother asked for help; the midwife gave her a sleepsuit for the baby but refused to give her any nappies.

She said, 'Go downstairs and buy, we don't have a nappy for you.' I said, 'Me I don't have money, my baby is crying because she doesn't have a nappy on.' She said, 'Borrow from someone.' I said, 'Borrow from who? And who will borrow me? Because I am new to this
country and don't have anything.' But she refused. She cried, my baby, she cried, she cried, and me I had pain, and I started to walk to find a nappy. I asked a woman who was in the hospital to have her baby, she felt sorry and she gave me two nappies. After that, the next day, again she needed a nappy and me I started to cry, because I couldn't change her clothes ... and in the end I got to begging again.

Eventually this mother was helped by a stranger visiting someone else at the hospital, who bought her nappies, clothes and baby toiletries from the hospital shop. The mother felt that the midwife who refused to help her had been influenced by her race.

The midwife said 'We are not allowed to give nappies.' But they give, I see by my eyes, they give to Indian women, they give them clothes and nappies. But for me, no.

It turned out that the midwife appeared to be mistaken about the hospital policy. The mother reported that her HIV specialist midwife did later bring her nappies and was angry with the original midwife.

### 4.2 Amount of weekly vouchers

Some women reported being unable to afford the kind of good diet they would have liked during pregnancy, in particular because they had to economise on food in order to save up vouchers for baby necessities. They could not afford to buy looser clothes to fit their changing body shape in late pregnancy. They described going without in order to protect their children, yet still being unable to feed their children as they would wish. In freezing weather women arrived for their interviews bare-legged and coatless.

Since when the doctor said I was pregnant I saved vouchers ... We knew we had to, because we had heard that social services would give us nothing. Because I was saving money from the vouchers when I was pregnant, we were eating less.

My clothes are very tight...I asked them could I have some vouchers to buy some dresses which are free [i.e. loose], but I haven't got them.

(Woman seven months pregnant)

All I can afford is food and nappies ... I forget myself. He is a child, he needs essential things to be happy.

We can't afford to give my little boy different things to eat so we give him soup or buy him fruit from time to time.

My daughter has two pairs of tights but I walk without.

(Mother of 11 year old and two month old)

I had to pawn my gold first communion chain for £5 to buy Calpol.

Two of the women described how their husbands, and in one case teenage children, prioritised the mother's food at the expense of their own.

When I was pregnant my husband bought me some fruits, because I didn't like to eat...
anything else. It was horrible for them, I all the time told them 'I want carob,' it's expensive. Sometimes two or three times a day I asked them and they bought it and gave it to me and I ate it in one minute and asked for more. I ate a lot of fruit that they bought for me - they protected me.

I knew I had to eat everything because I had the baby to grow up, but not my husband - he was not eating very well.

4.3 Restriction to certain shops

The fact that vouchers are restricted to certain participating shops was very problematic. These shops might be far away, involving a long walk or unaffordable bus journey. Buses did not, in any event, accept vouchers. The relevant shops frequently did not sell culturally palatable food, which was available in smaller shops or markets, and they were more expensive than markets.

They don't have African food in Kwiksave - they do in the market. If you feel hungry when you are outside you can't eat anything.

(Woman seven months pregnant)

It takes about an hour to walk to Sainsbury's... I don't have a pushchair.

(Epileptic mother of two month old baby)

4.4 Hostility and humiliation

Women using the vouchers felt conspicuously marked out as asylum seekers and were exposed to hostility from other shoppers.

When they count the vouchers at the checkout everyone looks at you. Everyone stares at people with vouchers ... At the checkout when people see you counting the vouchers they say 'Ugh!' and leave the queue and go to a different one.

When they see the voucher they feel 'Oh, a refugee,' like this, a bad reaction. But now I don't go to Sainsbury's any more, my husband does the shopping, because I was really worried and sad when the people see me, not like same, but in a different way. Because I had vouchers and the others pay with money.

Two women felt that the voucher system appeared to have been designed deliberately to humiliate them, particularly when those shops which were supposed to accept vouchers arbitrarily turned them away at the cash desk.

There are some shops which refuse to take the vouchers even though they are on the list. You go there, and they say 'No!' ... Vouchers are meant to ridicule us ... We look at the list, we see the name Mothercare: 'Ah, Mothercare takes vouchers, I'll go there.' Then you get to the checkout and they say 'No, we don't take vouchers.' They should tell you before you get to the checkout ... they are making a mockery of us, and it isn't good to be ridiculed in front of other people.

4.5 Vouchers from social services

Women supported by social services reported being given only vouchers and no cash at all when they were pregnant. After their babies were born they received some
cash instead of or as well as vouchers. A particular problem with the vouchers issued by social services was that shops would only redeem them for food, not other necessities. One woman had also encountered this problem using her NASS vouchers. This created enormous hardship for women who were denied the ability to buy basic toiletries and even nappies for their babies. Some responded with ingenuity.

All the time when I went to Sainsbury's if I took shampoo or something to wash, or things I need because I am a girl, they said to me 'You are not allowed. You are allowed just for food.'

We get vouchers for Sainsbury's, but only for food, we can't buy everything with those. Sometimes they won't let us buy nappies for the baby. So when I see anyone who is new there, because I know all the cashiers, I go there. When we first came here they wouldn't even let us buy soap, only food, but we can now, it's better.

4.6 The 'black market'

Three of the women mentioned trying to exchange their vouchers informally for cash to pay for things such as bus fares, or food that wasn't available in the designated supermarket. Two had been successful although one described how her desperation for cash laid her open to exploitation.

They used to give me vouchers, and a one-day bus pass for the day when you have to go and get the vouchers; they put a date stamp on it. And if you miss that day, like you are sick from pregnancy, that's it. I had sometimes to exchange my £10 voucher for £3 with someone, just because I need transport. I asked social services to give me cash, they said no, you are single, you haven't given birth yet.

My husband's cousin, who has papers to work now, has helped us. Sometimes I save some vouchers and he changes them for money.

With the vouchers you can't buy what you want to eat. You have to use them in supermarkets, not little shops. When I went to Tesco's and I didn't want to buy anything, I used to stand at the door and ask if anyone wanted to exchange them for money, but nobody did. If I needed to eat something African I couldn't buy it.

4.7 Gaps in the system

The voucher system does not work well even on its own terms. There can be lengthy bureaucratic delays moving from one part of the system to another and a number of women in this study had fallen into gaps and were receiving little or nothing. In one case this was because the local DSS failed to refer the family to the appropriate support.

At the moment I have nothing, I am waiting. I have been waiting for three weeks. They haven't told me when they will give me them [the vouchers]. It is very difficult. I try to drink a lot of water and sleep a lot.

(Woman five months pregnant)

I was given some emergency vouchers, £135, and I survived on that for five or six weeks ... I was really hard up. A lady from the church had to buy some milk for my baby. When I left the hotel the cook gave me some jars of baby food, which one of the other mothers
had left. If it wasn't for that I don't know how I would have survived. I survived on bread.
(Mother of nine month old baby)

First of all we went to the DSS, they said you're not entitled to the benefits, but they didn't tell us to go to social services. The health visitor found out we could go to social services, but it took about two months before we got any money ... We just sat at home in that place, didn't go anywhere. We had nothing to do at home ... I think [my baby] was born early because of my depression at the bad situation - I was eight months pregnant, I worried about it all the time.

One woman was initially refused support because a stranger had temporarily taken her in when she arrived at Heathrow. It was not until she was raped by another stranger while living rough after being turned out, that she was finally given assistance.

And then this man...started making many problems, and sometimes he would come and touch me, and when I said no he became very angry, very annoyed, until one day he just told me in the night, very cold, 'Get out, I'm tired.' And I was out, I was out almost one week. I was getting food in the bins, in these black plastic bags. I started begging. I begged a man, I asked him (I could only speak a little English) if I could do some work, some housework, if he could pay me. He just asked me to follow him. So when I followed him, he just attacked me, and ... Then the police were involved and they asked me where I was living, I told them 'Right now I am outside, I've got nowhere to go.' They took me to social services and social services sent me to a hostel.

5. HEALTHCARE AND THE MATERNITY SERVICES

The first guiding principle of maternity care, as set out in the Expert Maternity Group's report Changing Childbirth (52), is that "the woman must be the focus of maternity care. She should be able to feel that she is in control of what is happening to her and able to make decisions about her care, based on her needs, having discussed matters fully with the professionals involved."

The Expert Maternity Group also set out the specific principles on which the design of maternity services should be based.

"Every woman has unique needs. In addition to those arising from her medical history these will derive from her particular ethnic, cultural, social and family background. The services provided should recognise the special characteristics of the population they are designed to serve. They should also be attractive and accessible to all women, particularly those who may be least inclined to use them.

... (R)egardless of the complications and risks that may be apparent or anticipated, the woman's care should be planned on an individual basis, and all procedures and interventions discussed and agreed with her. During labour, the woman should feel that her psychological and physical needs are understood, her privacy is being maintained and her autonomy respected."

These are the standards against which the maternity care provided to asylum seekers should be judged.
5.1 Registration problems

Registration with a GP is the main gateway to the health services, but, because of the (as yet unfulfilled) intention that asylum seekers would be dispersed within seven days of arrival, the large emergency accommodation centres were established without considering the need to invest in local primary healthcare and advocacy services. The influx of asylum seekers needing temporary registration has created an enormous pressure on local GP practices and registration is also widely reported to be problematic for asylum seekers dispersed to temporary accommodation.” Registration is, of course, a priority for pregnant women in order to access mainstream community-based antenatal care. Women who are unable to register tend to present for care directly to the nearest hospital.

Two different solutions have been arrived at. On-site GP and nurse services are being provided at one EA hotel in this study (Eurotower), and funding is being sought to establish a drop-in maternity clinic. Near another EA hotel (Pembury), a new access clinic is being created with strong administrative support to ensure records follow dispersed patients. None of the pregnant women in this study had been refused registration at their emergency accommodation, but two had been refused registration from their temporary accommodation. No agency had taken responsibility for directing any of the women to primary healthcare and advocacy services - they had discovered these by word of mouth. This was true even for those women who had arrived in England conspicuously pregnant. The hotels themselves were said to call an ambulance for any medical issue.

Someone staying at the hotel, who spoke French and Lingala, gave me the address [of the clinic], and told me to go to the clinic first. No one from the Refugee Council or NASS told me where to go. NASS only told me that when I have contractions I should tell the hotel and they will call me an ambulance.

I think because there are so many asylum seekers in [the town], the doctors are not being helpful. They said I could register the baby, but not myself.

I was four months pregnant, and I really needed to register and everybody said to me 'No, no, we are full, we are full.' I said 'Where can I go?' I spoke to Refugee Forum and they called a lot of GPs and they said 'We are full.' But they explained the situation, that I was pregnant, and they found one.

5.2 Information about maternity and child health services

Some women in the study had been given good information about what to expect by their GP. However, several women had been given no information about how the maternity services worked. Others were not given any information about postnatal services, particularly the role of health visitors, and then felt at a loss to know which service to use. GP receptionists were identified by several women as particularly unhelpful, even obstructive. One mother mentioned that she sought advice from her GP on issues that would normally be covered by a health visitor, because this would be normal in her country of origin.
My doctor explained everything when I was first pregnant. She told me you will see midwives every month ... They did treat me good.

I was already pregnant when I arrived in England. I went to a GP first, and the GP sent me to hospital. I went to all the appointments ... I didn't understand how the maternity system worked. There were problems because I always need an interpreter.

I went to the surgery and asked to see the health visitor. The receptionist said 'We don't make appointment with the health visitor.' I said, 'OK, can I see the doctor?' When I saw the doctor, he said 'You have to go to the health visitor.'

Nobody has ever explained, if this happens you go and do this ... That lady at the clinic, you can literally see she doesn't agree with who or what you are ... I went there, and asked to see the GP for myself and the baby clinic for the baby ... I was ten minutes late. She (the receptionist) was like, 'NO! We are CLOSED!' I told her I was there for a sick baby, I was not there for weighing or anything, I thought maybe somebody - 'NO! That is not for us! That is for your GP! Go to your GP!'... The nurse was going in and out, after one hour she said 'What is happening?...' If I'd known earlier, when you came, I would have got them (the health visitors), because they were still inside. I don't know why that lady turned you away.' She gave me all the help I needed. But I expect that each time I go there I will see the same receptionist.

Only one woman in this study wanted to have a home birth, having already had three babies at home in her own country delivered by her grandmother. She was given misleading information by her GP.

I asked if I could have the baby at home. He said 'No, you cannot have the baby at home because if you do and there's an emergency I won't come to help you out.' Being my first time here, I didn't know how it works out, so I said 'Why, what am I supposed to do?' He said 'No babies at home, you need to go to a hospital.'

5.3 Antenatal care

Two women described considerable difficulties in accessing antenatal care because they had no money for transport. They were not aware of the scheme to reimburse women on low incomes for fares to hospital and in one case had no cash at all, so could not have benefited from reimbursement.

I attended all antenatal appointments. I walk to the hospital; it takes two and a half hours.

Women were generally very satisfied with their antenatal care, apart from one woman whose GP failed to write a letter referring her to the hospital when she presented for care seven months pregnant. She was the only woman in this study who described presenting late out of choice; others sought care at the earliest opportunity, but some had arrived in the UK in the final trimester of pregnancy. For some women, the antenatal care was in great contrast to the little or nothing available in their home countries.

Everything with the midwives was good when I was pregnant. They were ready to help me. They were really close to me.
The midwife who you talk to before birth, she has time, it’s nine months so you get to know each other, to understand each other properly.

If I don’t see my midwife after one week, I miss her ... I like her too much, she treats me good, I said ‘You are nice, you are like my mum, everywhere I don’t forget you.’

(HIV positive mother)

I was seven months pregnant when I arrived in England ... I didn’t have any medical care in Bangladesh. This is my first child. I think the medical care here is very good ... I went to all the medical appointments.

I’ve tried as much as possible to stay away from hospitals; it’s a place I don’t like. I was healthy in my pregnancy, thank God. I didn’t go in my pregnancy until the seventh month. I’ve been pregnant before in my country, and we didn’t have doctors where I lived, it was like a reserve, we had our babies at home. So I knew what my body goes through when I am pregnant. I am usually sick at the beginning, but we have herbs we use at home, special food we are supposed to eat to boost up my blood, home remedies for fatigue. I’ve had three babies before. We don’t see doctors unless there is an emergency ... When I went to see the GP at seven months pregnant, he was not very happy about it, but at the same time he didn’t look as if he was concerned ... He is a very cold person.

One woman had found staff on the antenatal ward hostile, and had switched her care to her GP, who she trusted, attending hospital only for scans.

There’s a male doctor on the antenatal ward at [the hospital] who I don’t like, the way he deals, he looks like someone who is racist, and there is another nurse there who is Jamaican, she too looks aggressive, there is no friendliness there ... I have not been to any more hospital appointments. My GP said ‘Don’t worry about that, I’ll be seeing you for antenatal clinics.’ She is looking after me. It’s only if I need a scan that she makes an appointment for me at [the hospital] ... I prefer just to go to the GP.

Two of the young women had not found their midwives to be a good source of information, even for specific concerns.

It was difficult to understand who I had to go to because I didn’t know anything about being pregnant. I didn’t plan it; it was accidental that I got pregnant. The midwives didn’t give me any information. I got some books and read them, they said you need a bag, in the bag you need these things. The books told me more than the midwives. It was really frightening, every day I thought I am really scared.

(16 year old)

The nurse has told me the baby should have its head down, and my placenta is too low. I don’t have anyone to discuss these worries with.

(18 year old)

5.4 Antenatal classes

The majority of women in this study had not been able to make use of antenatal classes. Some women had not been told about the classes, some had arrived in the UK too late in pregnancy to go to them, some were unable to attend because there was no
interpreter available for the classes, and others were not eligible because it was not a first pregnancy. A few of the women had chosen not to go to classes because they were too scared. Those who did attend the classes found them very useful and informative.

Before I had my baby, I went to antenatal classes - they were very good, but scary! I was able to ask questions, and they taught me how to cope when I was in labour, what to do ... They used to tell me 'Anything you want to ask, don't keep it to yourself.'

Several women said they wished they could have gone to classes, including one woman who was a qualified doctor and had had a child in her own country.

If I had been able to see the delivery room, I would have been much more comfortable; I didn't know what would go on there, how they would look after me. I was also a bit worried because I didn't want a male midwife. I didn't have a chance to discuss this with anyone.

Attending classes was not, generally, an opportunity to get to know other mothers, and only one of the women in this study had made friends at a class.

I went to the antenatal classes, it was very helpful. The other women were all English, I didn't feel I could be close to them. There wasn't an opportunity to meet them, we just listened.

I went to antenatal classes at my clinic - they taught me everything, how to grow up a baby from birth to one year, they gave me books, videotapes. I felt happy when I saw other pregnant women and I spoke to them about everything, 'I feel my baby moving', 'Yes, so do I.' I felt happy, I had friends.

5.5 Hospital experiences: staff attitudes

The labour, birth and postnatal ward experiences reported by women were very mixed. Around half of the women had had positive experiences and several were full of praise for midwives who acted towards them with great warmth and kindness. This was particularly valued by women acutely missing their own mothers and other female relatives who would normally have been present. Several women mentioned that the midwives had kept them in hospital to look after them when they learned that the women had no friends or family to help them. For others, small acts of kindness had made a huge difference.

After the Caesarean, they looked after me so well in hospital, that by the time I was discharged I was a bit OK. I told them there was no one to look after me, my friends are in London, I've just been sent to the hotel and haven't friends there. They said, 'We will keep you as long as necessary and look after you.' The midwives were so kind. They took a lot of care ... One of the midwives became quite a close friend and sent me cards.

Some of the midwives were really very friendly. It was a good experience ... One of the midwives finished her shift just before I had the baby, and the next morning she came looking for me, just to say congratulations and to see what I had.... It was nice.
She said to another midwife, 'These Africans, they come here, they eat nice food, sleep in a nice bed, so now she doesn't want to move from here!'

Those who were nice were really nice, they escort you to the toilet, they ask you 'Oh, you haven't got anyone, if you need anything my name is ... you just ask for me and I will come.' There was one of them, if I wanted to have tea, she could make a big jug of tea for me and bring it to my room. And anytime I needed tea when she was there I could have it.

Staying in hospital was good. The first day there was a lady there and I wanted to keep her and I kissed her, because she helped me a lot.

Another aspect of care which was valued was when midwives recognised that the mothers were strangers to the UK maternity system and treated women who had had other children in their own country with as much care as they would a first-time mother.

The midwives were so warm, it was my fourth baby but they treated me as if it was my first.

Around half of the women in this study were not so fortunate, encountering indifference, rudeness, and racism. They described health professionals acting with contemptuous disrespect for their individuality and total disregard for their feelings, apparently unable to leave their personal prejudices out of their professional practice. These experiences are far removed from the ideals of Changing Childbirth.

In hospital, I don't think the midwives were friendly with me. When I was delivering him, without my mum, and it was painful, I took one of their hands and she said to me 'Don't touch me!' And I had to say to her 'Sorry, sorry!' when I was in that difficulty, because I thought she might hate me and she might not help me.

In the end I got an infection in my scar ... I went to the midwife and said, 'I'm feeling cold, and all my body shakes' ... She looked at me like this and said, 'You are OK' ... She said to another midwife, 'These Africans ... they come here, they eat nice food, sleep in a nice bed, so now she doesn't want to move from here!' ... When she said this I didn't say anything, I just cried - she doesn't know me, who I am in my country. And the other midwife said 'What's wrong with them, these Africans?' and some of them they laughed.

They [the midwives with her during a very long and difficult labour] said 'Oh, we are so tired and she's just lazy ... Oh, that African food that they eat, they want to poo all the time.' I wanted to ask them, is it just African women who poo when they give birth? I was embarrassed, but what could I do?

Some were rude, like when I was crying, they said 'Hey, you give birth, you are like this and next year we will see you pregnant again ... Keep quiet! You're disturbing the other people.'

When I got there [the hospital] many midwives came just to ask me ... why I have to come here, why I have to be pregnant, where is my husband ... They are so inquisitive, they like to interfere in people's problems ... They are just curious, they don't want to help, and they laugh about you behind your back.

My baby cried, she needed milk. They said, 'You took milk before and it is enough.' I said 'It's not for me, it's for my baby.' They refused to give me a bottle. My baby cried, she cried so much, and some of them hid a bottle and brought it to me.
The lady beside me had just had a baby, this lady came up beside her while she was sleeping and said 'This baby is smelling, go and wash this baby. Even if you don't understand English this baby is dirty' ... this other lady who was accused of having a dirty baby, she was from Kosovo.

One mother felt humiliated that staff, who had not explained to her the system of meals in the hospital, then ridiculed her for her lack of knowledge, talking across her.

I didn't know how things are done, it's my first time in this country ... I didn't know there is a place you go to for food, because they didn't tell us - how are we supposed to know? So I called the lady over, and asked her if it would be possible to have breakfast. And she looked at me ... she told me 'Did you have a Caesarean? Can you walk? Then why are you asking if you can have breakfast?' I said 'I would like breakfast, I am enquiring how do I go?' But before she could answer, this other lady, the terrible one, pulled open the curtain from the next cubicle, and said, ‘... She is OK, she is fine. What does she expect, does she expect it to be brought over?' And they were laughing. What kind of people are they? They used a terrible expression, as though we're making them be like our maids.

Another newly-delivered mother who was HIV positive, who had already been racially abused by staff and who had various painful and poorly-treated post-operative complications was indignant at being made the butt of the midwives' humour when they joked that the reason she was coughing so much might be that she had a baby boy in her lungs.

I said 'Maybe you don't know me, maybe you think all Africans we don't go to school or we don't have education, but we know we don't get pregnant in lungs!' I can't control myself, I cry, I cry ... Africans we respect too much woman and baby, especially if like me, pregnant, she came from far, they treat her good because she will feel bad because she's alone and can't go back. But me, I came from far, and they don't treat me good, and they talk to me shit, and in the end they say I get pregnant in my lungs ... now I've seen the way they treat me in hospital, I prefer to go back to my country and to die.

Several women described a great contrast between the behaviour and attitudes of delivery suite staff and those they encountered on the postnatal ward in the same hospital.

I was lucky enough to have very good midwives during my labour. But afterwards, upstairs, the postnatal ward, you get to see not midwives, but those other - they wear blue uniforms ... I don't know if all the workers there are overworked, they are so bitter and haughty.

One woman, who encountered very unpleasant and racist treatment during a difficult delivery, described how she had been warned by her community midwife that she might meet unsympathetic staff at the hospital, and felt that this had helped her to cope with it better. Even so, she was still taken aback at the degree of hostility and unkindness.

The midwife who you talk to before birth, she has time, it's nine months so you get to know each other, you understand each other properly ... she told me 'I might be there, I might not be there, and don't think that everyone knows your problems.'
When they wanted me to stay in hospital because of my high blood pressure I refused. I went home. They took me by force. They rang the police and told them to bring me back to the hospital.

When they wanted me to stay in hospital because of my high blood pressure I refused. I said 'No, I am in good health.' I went home. They said 'No, you are ill.' They took me by force. They rang the police and told them to bring me back to the hospital... the police said 'You are in danger,' and then I thought it would be better to go to the hospital... they induced me at 38 weeks... They wanted to do a Caesarean but I refused. They said I didn't have the strength to push out the baby. I had an epidural, it was better.

I was made to stay at the hospital; I had to lie down whether I wanted to or not.

On the other hand a number of women who had normal deliveries spoke in very positive terms of the support they had received from midwives while in labour, drawing particular attention to the clear choices they had been offered.

The best thing about giving birth there? - everything! All of the people have been very good.

My baby was big, 7lb 10oz, so it was painful. I always understood what was going on - they explained it to me first, and I decided. I had not met any of the midwives before when I gave birth, but only a few hours and it's like we knew each other! Very nice people.

See section 5

Because she could understand also my reactions, she was really patient. She was just realistic, maybe she knew, because she prepared me, which I appreciate... and it's helped me to take it, because I was prepared... When I was there in the hospital, I found it quite unfair, but I couldn't dramatise it, because I was prepared. I was surprised though, because although you sometimes meet people who are not kind, there are things as a service provider you shouldn't do.

5.6 Experiences of labour and birth

Twenty one of the women had delivered vaginally, including the mother of twins. At least two of the babies were born before term, one at 32 weeks and one at eight months. The mothers attributed these preterm births in one case to harsh treatment at the hands of immigration officials, and in the other to depression caused by being left without any financial support due to administrative blunder. There were three emergency Caesareans and two elective Caesareans, one because of HIV status and one for other health reasons. Two women did not mention the type of birth.

Several women of Black African origin who developed high blood pressure mentioned feeling very frightened about induction or the prospect of having a Caesarean, and conveyed a clear sense that they did not feel the decisions had been fully theirs. The experience had been one of coercion, not partnership. In one case it was questionable whether informed consent had been obtained for these procedures at all, as the interpreter arrived only after the decisions had been taken, and the mother did not speak English. Health professionals appear to have taken a rather casual attitude to patient autonomy and to the Changing Childbirth concept of woman-centred care.
The midwife said if there was too much pain I could ask for gas and air or an epidural. My baby was born very quickly. The midwives and doctors were helpful. They said afterwards 'Thank you for an easy job!'

Of those women who described their labour, half said they had no one with them, a quarter had a husband or boyfriend, and a quarter had a friend or relative with them. One unsupported woman described the effect of her induced labour turning into an emergency when she had nobody to rely on.

It was very difficult because I don't have anyone here, I'm completely alone. The doctor explained everything to me: my blood pressure was going up, it was too high for the baby, the baby couldn't stay there. The Caesarean was to save the baby. Five hours after they broke my waters the baby's heart stopped, then started, then stopped, then started. It was an emergency. It was really very, very difficult. I wish I had had a friend who could have helped me.

Another described how even the company of her estranged boyfriend was better than giving birth entirely among strangers.

I had to call for my boyfriend, I had no choice. He talked badly about me during my pregnancy: 'You have been raped, in fact who says that's my pregnancy?' I could remember all these things, I was just crying. People maybe thought I was crying because I had pain, but I was thinking about many things. But at the same time I didn't have any choice. Better to have him than to have nobody, or all these strangers.

5.7 Postnatal stay in hospital

Postnatal stays in hospital varied between 12 hours and 15 days, and three women were readmitted after initial discharge, one for high blood pressure, one for a retained placenta and the third for unclear reasons. One woman was pleasantly surprised at how short the postnatal stay was.

When I have a baby in my country I stay in hospital one, maybe two weeks. This is different, born and out very quickly. It was good, I preferred to come home. When you have just one baby it is good to stay in hospital, but when you have two it is good to be at home.

Many women were taken aback by the lack of practical help and general support on the postnatal ward; this was clearly something they had not been prepared for. It was a particular shock to those who had been well supported by family for previous births, or to those who had strong cultural expectations of support. Some women mentioned feeling lonely and bored, particularly if they couldn't speak English and had no visitors.

They come in the morning, they take the baby, they clean him, they give you paracetemol - that's all. You stay there, you are a new parent, you know nothing. Somebody comes in the night, asks you if the baby is OK, that's it. I was worried about the clip on his belly button; in the night when you ask questions they say 'Sleep now, it's time to sleep.'

During the first six days I just existed, waiting to go home ... you are alone as if you have been abandoned, all day with nothing to do.
When I came out of hospital I was surprised, because that is a nice and clean place, but here it is like Africa!

After he was born I stayed in the hospital for only one day, because it wasn't friendly there, in that hospital. When I said the second time, 'Please change my baby', they said, 'You have to change him on your own.' I thought that they didn't want me there, but in fact they did this to everyone – now I understand.

After the babies were born, they asked my husband to leave the hospital and when he went home I was alone with my two babies, and I had a lot of problems, and I couldn't take care of two of them. Sometimes I asked the midwife and she helped me to change the nappies and lifted the babies with me. It was so difficult to take care of both of them alone. Because they were my first babies I didn't know what to do, I was confused, it was bad for me.

I slept at the hospital for three days. The midwives, the first day, they didn't come to me. The second day they arrived to ask me if I know how to wash the baby, I said, 'What about the first day?' So I washed the baby myself, I did everything myself.

Afterwards I stayed in the hospital six days, because there was nobody at home. I didn't like staying there. I couldn't speak to anyone, there were no distractions.

There were also a few criticisms of the food provided in the hospital; one woman had sent a friend out to buy hot food instead.

The hospital food, they bring you food which is cold. You know when you give birth they must give you a hot thing, because in the stomach you feel like something is empty and you don't want a cold thing.

By contrast, several women who had no one to support them at home recalled the postnatal stay in hospital with pleasure, as a time when they felt well looked after.

It was good in hospital. When I was in pain I could give the baby to the midwife. It was better than being at home alone.

It was good at the hospital, the nurses help people all the time, they were asking 'What's your problem, do you have pain?' And when I had the baby they asked, 'Is she all right? Did she take milk? Did she take water?' They helped me. They showed me how to feed the baby, and everything. I stayed in the hospital about 10 days, because I told them about my baby's family, that I couldn't stay with them.

(15 year old mother)

Some women emphasised how the hospital seemed a place of relative safety compared with the unpleasant accommodation to which they would be discharged, and regretted the shortness of the postnatal stay - even if they had encountered offensive or racist attitudes while staying there.

When I came out of hospital I was surprised, because that is a nice and clean place, but here it is like Africa!

(Mother of five month old baby living in EA)

In the hospital it was safe, it was better for my baby than this place.

(Mother of six day old baby living in EA)
I stayed in the hospital for two days ... They said it is a normal birth, not an operation, so you have to come home again.

(Mother of six week old baby and four older children, living in EA)

For the woman who experienced painful post-operative complications, however, the hospital ward itself seemed a place of danger as she had lost all trust in the staff.

In the end I got an infection in my scar ... I shook too much, I felt cold, because my blood pressure was 86, but they didn't come to see how I am ... In the night I got more sick, one side swelled up. The doctor came and said 'Maybe she has malaria because she comes from Africa.' I said 'I don't have malaria but I have a pain here', but nobody answered me. They took blood, everybody came and took blood. One night an Indian midwife came, she was not polite but sometimes she was polite. I said 'Can you look at this side, because I have pain.' She said 'What's wrong?' and when she saw it she was scared, she ran upstairs and called a doctor ... They started to give me antibiotics in a tube, and a midwife came, who didn't even know how to put the tube in ... I said, 'If you don't know how to put it in, why don't you ask someone to help you?' She said, 'Who looks after you? ... Don't talk like this to me.' I thought, 'OK, maybe they will give me some medicine and I will die ... I need only to move from here alive, I don't want to die for my pain.'

5.8 Postnatal support after discharge

Postnatally the women were generally highly isolated, missing the customary practical and emotional support of female relatives and friends. Most of the women were pleased with the midwives' postnatal visits and the health visitor's input. For some, midwives and health visitors were a vital source of practical support as well as reassurance and advice, and one health visitor who visited families in emergency accommodation was praised for his attempts, albeit unsuccessful, to intervene on their behalf. Only one family was in touch with a Sure Start project but they had not found it particularly helpful.

The midwives who came here were very good. I really felt secure, if there was any problem I could call them, and they came every three or four days.

I go to the health visitors' clinic near here; they said to me I can go whenever I want to talk to them. Sometimes they put a video on and tell us how to help the babies if they choke and things like that. It is useful.

Initially my midwife brought me a breast pump, because my baby couldn't latch on.

When my baby was born my health visitor gave me a cot and some baby clothes.

It was hard to take my baby out ... I didn't have a pram. I had to carry her everywhere in my arms. Later the health visitor brought me one. I was so happy!

(Mother recovering from Caesarean)

The health visitor talks with me every day, he is a good guy, he fights with them [the hotel staff].

Sure Start didn't give us enough help, but I don't know whether we are entitled to it. We do keep in touch with them.
However, as with hospital experiences, some women's experiences after discharge were seriously marred by professionals with negative attitudes.

Another midwife came, a very prejudiced lady. She kept on talking to me like, 'This is not your first baby, I don't understand why you are so worried' ... She did not touch the baby - and the previous day I had been at the hospital, and I had told her how worried I had been - she would have at least looked at the baby. She did not look at the baby, she did not check me out ... She didn't have a warm or friendly manner, she didn't chat to me, she didn't even look at the baby.

In one case the health visitor had apparently not communicated clearly with a woman who had sought help for her baby's umbilical hernia, leaving the mother with the impression that nothing would be done about it because of the colour of her baby's skin. This encounter had left the mother outraged and very upset.

[The hospital said] 'We don't do anything about black babies with this'. I asked my health visitor, she said that yes, they don't want to interfere with black babies. Why? Because they are human beings, they are just black by colour. All of us have red blood, everything inside is the same, this [skin] doesn't matter, it's only a colour!

One first time mother lacked the confidence to ask the questions she wanted to put to the midwives, not trusting them to answer with kindness.

The midwives, when I came out they said 'You should ask this,' but they didn't tell me many things. But sometimes I fear to get hurt, so I don't ask, I just keep quiet.

A family who had arrived in the UK with a six week old baby had not managed to link into the health visiting service at all.

Nobody helps my family apart from the [Polish speaking] doctor, no health visitor or nurse.

Vulnerable mothers, powerful professionals

A recurrent theme for those women who had bad experiences was the desire to placate professionals who they perceived as hostile or unkind. Feeling entirely powerless themselves, they believed their safest course was to assume the worst about how professionals might misuse their power, and to be as compliant as possible.

I was chatting to a lady and she told me of the terrible experiences she had upstairs [on the postnatal ward], they're so mean ... so when they took me up, I thought 'Oh my God, I don't want to do anything to anger them.'

When I was delivering him, without my mum, and it was painful, I took one of their hands and she said to me 'Don't touch me!' And I had to say to her 'Sorry, sorry!' when I was in that difficulty, because I thought she might hate me and she might not help me.

Many midwives came to ask me 'Why are you coming here, why are you ...?' I didn't want to tell them, but at the same time I thought the ones who are looking after
me, they are the same ones who are going to be checking out my baby, and I felt confused if I have to tell them or I don’t have to tell them … I told them everything.

I said, ‘If you don’t know how to put it (the intravenous needle) in, why don’t you ask someone to help you?’… She said, ‘Who looks after you here?...Don’t talk to me like this!’ I thought, ‘OK, maybe they will give me some medicine and I will die.’ I was afraid. In the morning another midwife came and I said ’Look at my hand, it’s paining me too much.’ She said ‘Maybe you slept like this! Why didn’t you take care of your needle?’ I said ‘No, this one is not my mistake…I got a midwife who didn’t know how to put in medicine, but I don’t like to say her name, it’s not my business.’

On the other hand, one woman, who had a very good relationship with her GP, was aware of her right to change hospital and was seriously considering it.

There’s a male doctor on the antenatal ward who I don’t like, the way he deals he looks like someone who is racist, and there is another nurse there who is Jamaican, she too looks aggressive, there is no friendliness there. I was thinking, because they said, you have the option to go to [another hospital], maybe I will switch.

None of the women who had encountered racist attitudes in the health services had made a formal complaint.

5.10 Lack of understanding of practicalities for asylum seekers

Some women had found the advice they were given by midwives or health visitors not particularly helpful, and in one case actively undermining, because it did not take account of the reality of their living conditions.

The midwives were nice except one, who I asked to leave the room. She was asking why don’t I have the special equipment to clean the bottles? I don’t have money to buy special equipment. I have four bottles and I boil them, so that’s the only way I can sterilise them. She didn’t like it.

We just buy essential things for eating. When I was pregnant, all the time they suggested I had to eat fruit, but it was not possible to buy it all the time. I like fruit, but I didn’t eat it a lot.

When midwives tell you not to carry heavy luggages and so on, that’s in the case where you have someone to help you. If you don’t have anyone you just have to do it.

5.11 Care of older children during labour

One woman without any extended family or friends in the UK expressed great concern about arrangements for care of an older child while she was in labour.

I was very, very afraid at the beginning [of pregnancy], I was crying all the time, I was afraid and I was scared, what am I going to do? I felt very sad because I was afraid I was going to be alone at the delivery, my husband might be looking after our daughter.

The staff at one hospital made arrangements to care for the 18 month old child of a woman who was found to be in labour while attending an antenatal appointment.
It's hard for me to sleep - my head is paining me, I am like drunk. I don't sleep in the day, I don't sleep at night.

(HIV positive mother)

When I went to my appointment at the hospital, my husband couldn't go, he was at college, so I took the older boy with me on my own. When I got there ... the midwife told me I had to go to the labour ward. I said to the midwife 'I have to go to a friend's house to drop my little boy off,' she said I couldn't do that or I'd probably have the baby in the street. There was a woman doing a placement there, and they called her to look after my little boy.

6. HEALTH OF MOTHERS AND BABIES

6.1 Physical health of mothers

Two of the women in this study were HIV positive, one had epilepsy, one had severe pain in her hands (and in her legs during pregnancy), five of the women suffered from high blood pressure during pregnancy, and one from gestational diabetes. One of the women who was HIV positive experienced painful complications following a Caesarean section, including an infection in the scar. Postnatally many of the women said they felt exhausted and run down. Just one mother described her health as good.

It's hard for me to sleep - my head is paining me, I am like drunk. I don't sleep in the day, I don't sleep at night.

(6.2 Health of babies)

Two of the women disclosed that they had been raped previously, and it appeared probable from the circumstances described that at least one of the other pregnancies had originated in an act of rape, although this was not made explicit. None of the women mentioned female genital mutilation.

6.2 Health of babies

Fewer than half of the babies were described by their mothers as being in reasonable or good health. One baby had both legs in plaster and had been operated on because 'her legs point inwards instead of outwards,' she also had chickenpox at the time of interview. One baby had sticky eyes and cried all the time, one was suspected to have epilepsy and was always sick after food, one was allergic to milk, two had jaundice, one was thought to have 'too much blood,' and the ten week old baby who lived in the worst damp housing conditions was in very poor health. He had been resuscitated at birth and was not thriving.

Being here this one has fever all the time, he has a rash on his face, and then they said it was an infection ... He was 8 kg, now he is 6.5 kg. He has lost 1.5 kilos. He had a dry cough and an infection ... He has all the time skin problems, he is only two and a half months, a small baby like this shouldn't have antibiotics ... [The health visitor] said 'In winter, this baby will catch a disease.'

6.3 Feeding methods

Twenty two of the 29 mothers reported that they had initiated breastfeeding, and only three said that they had not. Four mothers of older babies did not mention how their babies had initially been fed. Two mothers had introduced bottles alongside breastfeeding within the first couple of months. Both had refugee status and were therefore eligible for milk tokens.
I both breastfeed and bottle feed her. In Congo, it’s normal to breastfeed, but here in Europe, when you work, you can give bottles.

(Mother of six week old baby)

Of the three mothers who had not initiated breastfeeding, one was following advice because she was HIV positive. The other two, both of European origin, had also bottle-fed their older children in their home countries. One stated that she didn't have enough milk to breastfeed and also that bottle feeding was normal in her own country. The other, who had epilepsy and a heart condition, said that she bottlefed because of her health problems.

Many of the mothers breastfed confidently during the interviews. Almost all these mothers had chosen to breastfeed as a matter of course. A few mentioned that it was the normal thing to do in their country, and one attributed her baby’s good health to the fact that she was still breastfeeding him at ten months, but it was not a topic that most women felt it necessary to discuss.

The oldest baby still being breastfed at the time of interview was 15 months; the mother said that breastfeeding was traditional in her country, but she was thinking of stopping soon. The mother of the twins stopped breastfeeding after one month because of insufficient milk and mastitis. Other mothers mentioned needing to start an English course or college as their reason for stopping breastfeeding earlier than they might otherwise have done.

One mother had been thwarted from breastfeeding by her baby’s inability to latch on, combined with her living conditions:

Initially my midwife brought me a breast pump, because my baby couldn’t latch on. Even in hospital I had problems, the baby would not feed properly from the breast, though I really wanted to breastfeed. The midwives were very helpful and one told me she had a baby with the same problem. But at the hotel there was a problem with the electricals, I think people on the floor overloaded it, and the breast pump blew, and stopped working - and then I had to use formula.

7. LANGUAGE ISSUES

7.1 Interpreters and advocates

Access to interpreting services and, ideally, to advocacy, has long been recognised as an integral part of an effective maternity service. The Department of Health’s report Changing Childbirth recommended that:

Where (a woman’s) first language is not English, interpretation facilities must be organised as early as possible and the woman given the name of a contact person who speaks her language ... When a maternity unit is providing a service to significant numbers of women who are unable to communicate in English, it is essential that providers should develop linkworker and advocacy schemes. (55)
The advocacy or client-centred approach to interpretation, where the role of the advocate is ‘to inform, empower and interpret for the patient,’\textsuperscript{(56)} may be of particular value to asylum seekers who have complex information needs and a particularly acute consciousness of their own powerlessness in relation to health professionals.

The policies of first concentrating large numbers of asylum seekers in emergency accommodation hotels, and then dispersing them around the UK, create an enormous linguistic challenge for the maternity services. Services near the EA hotels have to enable communication with newly-arrived women speaking a wide variety of languages, and some maternity units elsewhere in the UK with minimal experience of providing language support have to respond to the needs of non-English speaking women for the first time. Services have not always been successfully in meeting non-English speaking women's needs in the most appropriate or professional way. They often rely instead on informal interpretation by friends, husbands and even children, or on untrained bilingual staff.\textsuperscript{(57)}

Eighteen of the women in this study needed the assistance of an interpreter to communicate with English speakers at the time they were using the maternity services. Generally they were very pleased with how interpreters had been provided for all antenatal appointments and in some cases during labour, although several were happy to rely on their husbands to interpret during labour. By contrast, one woman had found communication difficult when only a telephone interpreter was available. Two of the women spoke very highly of their advocates, but unfortunately there were no reliable systems in place for referring women to advocates even where the service was available.

As was described in section 5.6, in one case a decision was made, without an interpreter present, to perform a Caesarean section on a non-English speaking woman. This apparent failure to obtain informed consent occurred at a hospital in London with an interpreting and advocacy service, with access to Language Line and where the language in question was not uncommon. It must therefore be questioned whether the health professionals had indeed taken ‘all steps which are reasonable in the circumstances to facilitate communication,’ as required by the Department of Health's Reference Guide to Consent for Treatment. \textsuperscript{(58)}

Interpreters were not generally made available for antenatal classes, which had prevented some women from attending. Interpreters were also not available on the postnatal ward nor for postnatal visits. Some women relied on relatives, including children, to interpret for postnatal visits from midwives or health visitors. In one case the midwife left written instructions in English, which were later translated for the mother by an outreach worker from a support project. No interpreters were available for emergency visits to hospital with a sick child.

\textit{i didn't go to any antenatal classes, because I didn't know any English. I didn't think it was possible to take an interpreter by myself and go and sit in the class to understand what they are talking about ... I would have liked to go, because it was my first child.}

\textit{There are no interpreters at the hospital [A&E]. I have to use sign language, pointing ...I only went to Accident and Emergency when the children were ill and my doctor was away but I couldn't communicate with them, and at 2 o'clock in the morning I came back home.}
The biggest problem not knowing English is the hospital. I would like to be able to explain everything about the babies ... If I go for an appointment, they arrange an interpreter, but if something unusual happens and I need to go, it's a problem for me.

One young woman explained why she felt being able to speak for herself was better than relying on an interpreter.

When I had my baby I had a translator, because I could only speak a little bit. I felt I had to understand really well. But now I like to speak for myself. If there is someone in the middle they can't tell them exactly what I want to say, but if I speak to you, I think you're going to understand me.

7.2 English classes

Learning English was a key priority for almost all the women who did not yet speak it. Availability of classes varied and women were often constrained by practical problems, such as lack of transport and the difficulty of their living conditions, and particularly the absence of affordable childcare. Where a creche existed, women were happy to use it, although one mother expressed fears in relation to her older child's nursery about sexual abuse, which she had never heard of in her own country.

I'm really worried about my son, because social services aren't going to pay for a nursery any more. I'm really worried because I need to study, I love studying.

I used to be in Hastings when I first came here and I tried to learn a bit of English there. But when I was pregnant I couldn't go there, because I had to walk for three kilometres. Nobody would pay for a bus pass for me, so I had to stop.

Two days a week I go to a church where there is an English class, there are 16 other women there and a creche for the baby. My first goal is to learn English, and then if possible to continue my education in college.

When I want to go to school they say 'Wait, someone has to look after your baby.' I say 'I haven't got anyone!' If I could get a nursery place, I really want to study, learn English.

One woman, who didn't have access to a course, had learned English from a friendly neighbour.

I have one neighbour from Romania, she has helped me to learn English, she always speaks to me just English, English, English. When I first saw her I was cleaning my window and she came and spoke to me, and I said to her 'I don't speak English' and she knocked at my door and said 'You are alone, but you need to speak to someone', and she has helped me always. When she arrived she didn't speak English either.

7.3 Women who could speak English

Those women who could speak English had quite different experiences. Accessing services was, of course, felt to be much easier.
If you don't know the language it makes many difficulties. Everything is available here but if you don't know the system you can't get anything ... Having an interpreter is good, but sometimes the advocate or interpreter doesn't get the point over to the doctor. But the real problem is when she goes to see the doctor on her own, and she won't understand anything.

One woman felt that people were perhaps more willing to give her material help because she put her own language skills to use interpreting at the hostel where she was living, and at a support project. Other women derived great satisfaction and a sense of purpose from helping others by acting as volunteer interpreters.

Sometimes I feel upset, then I wish Monday would come, because I feel I'm useful here [at the refugee project where she interpret], I talk with people. Sometimes for two or three days I have a lot of pain and stay in bed, but when I want to come here I try to be healthy.

On the other hand, asylum seekers who spoke English well were very distressed by patronising or rude assumptions about their ability to communicate. Some professionals used mime, or shouted, or made insensitive or offensive comments about them to colleagues in front of them.

There was a nurse - maybe she has a special view of foreigners - I mean I'm not speaking perfect English, but it was obvious I could speak English - when she was talking to me ...she was always using her hands ... She had to make these gestures. A lady looks Asian, a foreigner, and wears the hijab, so maybe she thinks I don't understand anything of English. She was insisting on using her hands. It was very annoying for me, because it was obvious I could speak English.

At the clinic here, there's a lady who's in charge, maybe she's just the receptionist, but the way she talked to me! It was as though she thought I was deaf, or didn't understand English.

They talked bad, and me, I understand English. If you don't know, it's better.

They talked as if I wasn't there ... You listen, and they were like, 'Ah, she can't make it, the baby has died. Imagine! 'What does it say in her notes? Her waters broke last night? No wonder the baby's heart is not beating properly, the baby has died, the baby might have died.' ... Although I was expecting some of them not to be kind to me, I didn't expect it to be up to that point about talking that easily about touching things like that in front of me.

On the other hand, one woman who spoke English, but not fluently, welcomed the fact that the midwives conducting the antenatal classes seemed to make an effort to include her.

I went to the antenatal classes, it was very helpful. I think they tried to speak in a simple way. I could understand everything.

8. EXPERIENCES WITH OFFICIALS

Women reported very mixed experiences in their dealings with officials who had the
power to make decisions about them, including immigration officers when they first arrived, social workers responsible for their support from local authorities under the Interim Provisions, and housing officers.

8.1 Immigration officers

Three of the women who had arrived in the UK pregnant mentioned bad treatment at the hands of immigration officers. One young woman thought that it was her experiences at immigration that caused her to go into labour at 32 weeks, soon after arrival in the UK.

_The baby came before time because of the treatment I had from the immigration. They didn’t know what to do with me, they want to give me asylum or they don’t want to. You know they play with you first. They gave me a hard time. So the baby was eight weeks early._

Another woman who arrived in the UK seven months pregnant, HIV positive and very ill, was detained at airport for three days without medical attention.

_ I said, ’I have pain, can you give me anti-pain?’ She said, ’No,’ so I sit here like this, three days. I sleep day, night, day, night, on the chair. I sat there three days ... So after three days I was crying, because I had pain and felt sick, and I said, ’If you don’t want me, send me back to Sudan, but I don’t like to suffer here, and have no money for a ticket.’ She said, ’No, we will ask you some questions and then you can go.’ I said, ’I want to see a doctor.’ She said, ’First finish the interview.’ I thought, ’What if I die at the interview?’_

A third woman was surprised at how little consideration she and her daughter were shown at the airport, despite her pregnancy and ill health.

_We arrived in the morning. I was pregnant, I have epilepsy and I have problems with my heart. They ignored all these things and they let me go at one o’clock in the morning._

8.2 Social services

Several of the women supported by social services were very unhappy about the attitudes of the staff who dealt with them. They encountered unkindness, indifference and racism, and hostility from the social workers towards refugee support groups who tried to intervene on their behalf. One woman was given varying amounts of vouchers without explanation and did not trust the social workers as a result.

_I went to social services and told them I was pregnant, I want more help, but they didn’t listen. They didn’t care about me, not at all ... [Refugee Forum] phoned social services, and social services were really angry with me: ’Why did you go there and tell your story to them?’ I said I needed help ... The woman said, ’If Oxford don’t take you, you’re not coming back to us any more, you’re going to live in the street.’_

(16 year old)

_The woman said ’If Oxford don’t take you, you’re not coming back to us any more, you’re going to live in the street.’_
you feel bad. One day when I was pregnant - you have to be there before 9, you put your name on the list and then you wait until they start serving at 10 - I reached there at 10, I couldn't wake up earlier ... It's very far ... I have to take two buses. You know what this woman told me? 'Who told you to be pregnant? If you know that you are late, then you can wake up at 5am!' Laughing at me. Another pregnant girl was there, she is from Germany I think, and [the woman] said, 'Hello darling, how are you? You look so tired today.' But she was as late as me! ... Social services are eating people's money for nothing.

(Woman housed out of the borough, who had to travel back weekly to collect her vouchers)

It seems like everything is under the table. Sometimes I get £90 in vouchers, sometimes £85. I don't know why. But they always put it down £90. Once I got £70 ... I am supposed to get £300 for the baby, it's two months since her birth and I still haven't had anything. They always say next week, next week ... I have nothing for the little girl. Social services didn't give me anything for her, only [a worker at the Children's Society] has helped me, a couple of times when the baby was very ill and I couldn't cope any more. Social services were arguing with her for helping me, but she told them she has a heart, not a stone.

One woman felt that the persistent unkindness that she met with at social services had distorted her judgment about people, pushing her into a negative spiral of always expecting the worst and finding fault.

Every day when I go to social services I have stress, and I have a headache. Because before I get there I just imagine the way they will treat me, and sometimes it also spoils you, because you have an idea fixed already, before you meet the person. And now if the person is nice, if it is just a little bit wrong you make it big. Why? Because you are used to them being rude when you go there.

By contrast two of the women had good experiences of very supportive social workers.

Social services in [this city] were really helpful: when I was pregnant they helped me with money, clothes for my baby, a lot of things.

The social worker here has helped me, when I wanted to start college she wrote me a letter, when I needed clothes, she told me how to find the Red Cross, she helped me find a nursery.

8.3 Housing officers

Women who got refugee status were eligible to apply for permanent housing. Their experiences with housing officers were also mixed, depending once again on the attitudes of individual staff.

Three months we were in a flat, but that place they asked me to leave the exact date I was in hospital, because our landlord wanted more money for the rent. I myself went to the housing office and told them it's the exact time for my baby, was it possible to give us a few more months ... There was a lovely lady in the housing office, I was talking with another man, and she was passing, she said 'What did you say?' and I told her, and she wrote something on the paper and gave it to the man and said 'No, she has to stay there.'
When the doctor told me I was pregnant I felt terrible. I cried for about three months ... Because I was young, and I thought I don't want this now.

Each time I saw a different person, who told me different things ... First one told me you need a letter saying they don't want you in their house, just that thing. I go, I come back. The second person gives me a list of all the things I have to bring. I said 'Why didn't you give me this before, it's very difficult for me going up and down in the last month of my pregnancy.' He said 'Maybe you didn't understand.' So I went, picked up everything, went back - just a couple of weeks before I had the baby they put me in a room, called an interpreter, he looked at my papers and said, 'But you are not for this place.' I said 'This is too much for me, I've had problems coming here, two buses coming here and two buses going back.' He said, 'Perhaps you didn't understand.'

9 WOMEN'S EMOTIONS

The women in this study described a range of emotions, which almost invariably included sadness, anxiety, loneliness and powerlessness. Most described feelings and behaviour, such as prolonged uncontrollable crying, which might be indicative of postnatal depression. Despite this, none had been diagnosed or offered any assistance, although two had been offered counselling when pregnant.

9.1 Emotions in pregnancy

Many women described great sadness and anxiety when they were pregnant, particularly in early pregnancy:

For the first five or six months I didn't want to keep it ... At that time I was crying all the time, all the time I was crying at home ... For four months I didn't come downstairs.

I was very, very afraid at the beginning, I was crying all the time, I was afraid and I was scared, what am I going to do. I felt very sad because I was afraid I was going to be alone at the delivery.

When the doctor told me I was pregnant I felt terrible. I cried for about three months ... Because I was young, and I thought I don't want this now.

When I was pregnant I had many problems, I ate nothing, felt sick all the time, cried all the time and felt nervous ... sometimes when I cooked for my husband I put in too much salt ... sometimes a little, little bit...I was cooking here, but my mind is like - I was thinking about the past, about my family, and about what has happened, just thinking, thinking all the time, I felt so upset.

Others described themselves as happy and excited during pregnancy, as well as worried.

I felt happy, but sometimes stressed, nervous - no house.

I was happy, thinking about my baby ... But I don't like having a baby before being married, because I studied at university and I am the first born in my family. If my family knew, they would be angry, but I don't have contact with my family ... Maybe they are dead, maybe they are alive, I don't know.
9.2  Postnatal emotions

Once the baby was born, some of the women drew a degree of comfort from their love for the baby and the practical preoccupations of motherhood. To some extent this distracted them from their distress and anxiety about their situation.

Before I gave birth I was low, I was crying all the time because I missed my mum and my dad. But now, I'm not saying I don't miss them - I miss them so much! - but I have my baby, and play with him all day, and it's much better - I don't have time to think.

This pregnancy, let me tell you, I'm happy for my baby, I haven't got any family, my dad is dead, my mum is dead, I don't know where my brothers are. I'm happy for my baby because this is my blood, at least I've got someone.

When I was pregnant I was unhappy, because I am all alone...I cried all the time, but I wanted the baby ... Now it's different, it's different because he is there. Before I was alone, but now we are a family. He is a whole family for me.

The distraction of absorption in motherhood was only intermittent. When the women described their postnatal emotions, many described sitting alone crying endlessly - an uncontrollable sadness and loneliness that sometimes shaded into hopelessness and despair.

It was a very sad way to spend the beginning of my child's life, it was a difficult time. I wish I could have had the baby in different circumstances altogether. Sometimes I used to cry ... maybe it was like postnatal...when you go down. It went on for a long time.

When I came out of hospital, my telephone didn't ring. I spent all day at home....it's a very, very lonely life.

You can feel very depressed, very lonely. At home I am used to 15 or 20 adults sharing the house, and their children.

I feel very lonely; I am far away from my family. I am all alone in my home and that's why I go to school, to be with other people.

I feel I am treated like the air. I cry all the time. I can't cope any more. I don't know who I need to ask for help.

I hope I will make it. I don't know. I'm so confused. I'm lost.

Sadness had led to some women becoming very withdrawn and reclusive.

When he was four months old I had two months not going anywhere, and my husband said, 'You have to go out.' At first I said 'Why should I go out, it's better staying home and looking at the TV?'... but now when I go out I don't want to come home.

When my baby was very small, if it wasn't for the telly I don't know how ... because I used to keep to my room.
9.3 Missing mothers, missing children

Having a baby was a time when the women desperately missed the presence of relatives and friends, especially their mothers, who would normally have provided strong practical and emotional support.

When he was born I cried for two weeks, every day, I didn't eat for two weeks, because I missed my family, I wanted my family to be there for me. At the time I didn't have any friends, just being at home ... When I think of those days I feel very bad.

Sometimes when he calls 'Mama' I feel so - I start crying ... When I went to the nurse for the first injections, I felt like weeping...I was thinking about my mother, and if she was here she would teach me, it's normal. Everyone understands the love of his parents when he has children.

It's hard, having a baby and thinking about my family. They are still in Somalia but I don't know whether they are alive or dead ... You try not to think about the past, just the present and future.

I was lucky with the first children, whereas your mother is around, and friends who can help you, in England you don't have anybody. I am missing that. If I was in Africa I would have some help, mother and friends looking after me, cooking for me, cleaning for me and buying things for me. Now I have to do all that by myself, it's just like starting fresh.

Eight women in this study had had to leave other young children behind in their country of origin, the youngest of whom was just 18 months old. The acute sadness of missing them and anxiety about what had happened to them clouded women's feelings about their current pregnancy and new baby. Several of the women were not aware that if they gained refugee status and their children could be found they would have the legal right to family reunification in the UK, facilitated under a United Nations High Commission for Refugees programme administered in the UK by the British Red Cross. They were also unaware that the British Red Cross might be able to help trace missing children.

I couldn't sleep at night, thinking about the children. I never knew, maybe they are dead, maybe they are alive, maybe something else happened to them, because in Freetown, when the rebels took it, they just cut off the hands of kids ... I'm waiting, because you just have to wait. It's very stressful, because the more you start thinking about it, the more you suffer from the thinking. Because when you start thinking, it just doesn't stop there, you are thinking wider, wider, wider, so you become stressed.

I don't have any news of my family. I think about my other children all the time, how they are, what they are becoming, what they have eaten. I don't think anyone can understand how this feels.

9.4 Powerlessness and reactions to it

Many of the women in this study expressed strong feelings of powerlessness and vulnerability, acutely aware of their dependency on a sometimes hostile, sometimes
unreliable, sometimes incomprehensible system, administered by people whose own input ranged unpredictably from enormous kindness to extreme vindictiveness.

Many things I feel I don't have any control over, but also the situation I am in makes me to believe that I don't have any value and I'm nothing for ever. Because even the animals from the zoo they treat them nicely. What can I say? Who am I? What can I say? Nothing. What can I do? Nothing. This is how I must live.

I am not happy at all, frankly not at all. We have no control at all.

Sometimes I just sit down and start crying, because we can't see another way of helping each other.

I am waiting for a response from the Home Office. I have been here a year, I have received nothing from the Home Office, no papers at all. The Home Office has forgotten me ... If they don't want me they should tell me they don't want me, but not leave me like this.

Women's reactions to these feelings went in three quite different directions. Some coped with a kind of quiet resignation, while some reacted with anger at the humiliation they were made to feel. For others, the indignities of present treatment compounded the trauma of past experiences and robbed them of their confidence and self-esteem.

You cannot fight them, you cannot force them, you just have to be patient ... I just think, everything is with God, he looks over us, he's the only one who guides us, what will happen will happen, because you have no option.

Of course there are problems but we haven't got any choice. We have to accept it.

Vouchers are to mark us out, so that people can mock us!...When you arrive at the supermarket you are ridiculed, everyone looks at you like this...Everyone stares at people with vouchers. It's not us who asked for vouchers, it's what you get when you apply, you are obliged.

I went to school back home, you know I was someone ... Many times they took bookings, I would go and interpret and advocate for someone. But still I can't advocate for myself. When it's for myself I feel very bad, I start crying, I don't talk ... I am rubbish. I've got nothing left. I haven't got any value.

9.5 Concern about effect of emotional distress on the baby

Women recognised that their emotional state could have an impact on their baby and several expressed a desire to protect the baby from their emotions of sorrow and distress. For some, however, their sadness was so strong that it could not be hidden.

When I am with my son I try not to think about my problems and show my emotions, because he knows when I'm in a bad mood. He doesn't understand things ...I have to be strong. Sometimes it affects my baby, because sometimes I cry all day.

I don't want to cry when I'm holding him. It's hard, because it's part of my life as
well. Sometimes I'm sad and I don't know if he feels it, but my health visitor told me that one day he was sad, he wasn't laughing, he was so quiet all the time. When he sleeps he cries without opening his eyes. I don't know how to avoid it, but I am just scared that it will affect his behaviour and his life in the future.

9.6 Positive postnatal feelings

For one young woman who had been in England for only three weeks, and had a five day old baby born eight weeks preterm, a positive outlook seemed to come naturally.

It has been very difficult, but you have to cope. You don't have anything, so you just have to appreciate what they give you...I still need many things, I can't buy anything. I can cope with it... I think good things are coming. You know what they say: good things come to those who wait! I do feel optimistic.

One woman who had been severely depressed in pregnancy was forcing herself to adopt a positive outlook.

I am sure people must keep themselves happy, if you feel bad all the time, bad comes to you ... if you pretend you are happy then you will be happier ... Women are very strong ...I try to forget my past, I don't want to remember my past.

Another woman recognised that this could be a useless charade.

I pretend too much to be happy ... I try to show people I am happy, but inside me I am dead.

9.7 Impact of asylum status on women’s emotions

Most of the women whose applications had not been finally decided were extremely fearful about being refused asylum and deported. The prolonged uncertainty, sometimes lasting for several years, placed them in a chronic state of insecurity. For most of the women, these fears were constantly in the background of their thoughts and on bad days occupied the foreground too. For a few, these fears appeared to be the dominant emotion, making it impossible to focus on the baby.

I feel very stressed these days, because I hear all the people saying they will send us back, and I think about what will happen to us, what they will do to us.

I don't know what will happen tomorrow, anything could happen. You wait for the post; you don't know what you'll get, good news or bad news, or no news.

I need to be sure where I am going to be. It is really difficult to live if you don't have a plan. Every day I look in the post: will there be any letters for me from the Home Office? Because I am stressed, I am desperate to know. When the post arrives I think oh my God, oh my God, good news I hope.

Now I feel so frightened at night because I heard from my friend, that the police go to people's home and catch them like a criminal, to take to Kosovo ...I can't understand why - why don't they give them one day to pack?

It's true, asylum seekers do think about their status more than about the baby.
because they know that anything about their baby relies on them and their status, and what their status is, that's going to be the outcome for the baby.

Conversely, for those who had been granted refugee status, the immense relief of the certainty of safety and being able to get on with life brought a kind of underlying happiness, even in the context of very poor housing conditions, particularly to those women who had their other children with them.

Before we got refugee status we were just worried about whether we would be allowed to stay...I feel very good now, very happy about my life.

I feel positive about life now. When the Home Office gave me a negative answer, I cried all the time, just cry, cry, no sleep just cry. But now I am happy because I have everything I want.

One woman summarised her feelings about the interaction between constant humiliations at the hands of those in positions of authority, and her sense of security having been given refugee status.

You have to take a little salt in your sugar.

9.8 Positive feelings about seeking asylum in England

Some of the women strongly emphasised the good things about reaching England, a place of safety for them and their children.

I like England, the people are good, it's a good future.

I am happy, because...I am normal going to church, in my country it's not normal for us to go to church, too many racist people, we were not allowed ... Here I go to the church every Sunday, and when it's finished they shake my hand goodbye.

I feel safe here that is very important. My children feel safe here. We're not scared of other things like drugs, mafia here.

Some, even when unhappy with their treatment in England, nonetheless quickly drew attention to the fact that it was better than what they had left behind.

I received very harsh treatment from the immigration and the midwives ... anyway I don't know what to say because this is better than home.

It's not what I imagined England would be like! But at the time I didn't mind because it was my life I had to save.

Others had a humility about what they, as strangers to England, could expect, and rejected any self-pity.

Back in Uganda I used to have friends, and if anyone had a bad experience we used to be there for them, sending cards. Anyhow I have no one to blame, because I knew I didn't have many friends here...Pembury Hotel [E] was better [than the temporary accommodation]: there were no fights, the room was cleaner. The food was difficult but I said 'OK, I know they can't provide me with my own food.'
As an asylum seeker, we can’t be as demanding, but the main problem is getting the accommodation, plus if we can get a work permit soon, then somehow we can manage with our life.

I don’t buy anything for myself, just for my daughter and my sons, I try to keep myself with just a few simple things, with the money we have. I didn’t let myself complain is it enough or not.

9.9 Negative feelings about seeking asylum in England

A number of women described the shattering impact of losing friends, families and a decent life when their country’s political situation changed and they fled to the UK, ending up in a position of total dependency and alienation.

Way back home we had everything, so when I came I was so depressed, it was more like I survived ... At this place [the housing office] I feel like I am begging...imposing and all that.

Sometimes you know you are better than someone, but because she has a position she treats you like anything. This is horrible. This is not a life.

For me everything was changed, here it is other words, other food, other people. In my country if you go outside everyone smiles at you, everyone speaks to you; here when I go outside nobody speaks to me, everyone looks at me different.

We don’t like being on benefit, really. You know that you are a doctor and you can work ... We graduated from college, worked for five years; it’s a waste if we don’t work.

For some, the treatment they received in the UK came as a shock, very different to what they had imagined.

That doctor came back and said ‘Are you happy?’ I said ‘I’m not happy, because they said that in England they treat good woman and baby ... but me I came from far and they don’t treat me good ... now I’ve seen the way they treat me in hospital I prefer to go back to my country and die.’

People never choose to be what they are. Me, if there were no problem in my country, I don’t think I could ever choose to be an asylum seeker in this country. There is a lot of discrimination, even racism. Sometimes you go somewhere and someone doesn’t want to touch you.

I want to leave this country. I’d like to ask them to buy me a ticket to leave this country, because ... I’m tired of staying like this, because the Home Office has forgotten me.

9.10 Defensiveness about reasons for migration

The women who took part in this study were not asked about the circumstances that had led them to seek asylum, but some volunteered this information. Several of the interviewees were very conscious of and distressed by the low public opinion of asylum seekers, in some cases because of personal experience of racism. They were
at pains to refute the popular perception of asylum seekers coming to the UK for purely economic reasons. Some expressed the wish to go home as soon as political circumstances changed.

We go to the subway; you can read the things that are written there about asylum seekers. You know, we didn't want to come here. We came here because of the war.

She [the midwife] said, 'These Africans ... they come here, they eat nice food, sleep in a nice bed, so now she doesn't want to move from here.' When she said this I didn't say anything, I just cried. She doesn't know me, who I am in my country ... I came here, but not because I get a nice bed - no! In my country I get nice food, a nice bed, but because of war, I ran.

Before we got refugee status we were just worried about whether we would be allowed to stay, we were scared we would have to go back. We weren't worried about money, believe me. All people say, you just go for the money, but it's not true.

When there were some elections I thought this is my chance, things will change and I can go home, but it wasn't the case.

9.11 Impact of racism

Two of the women described the devastating psychological effects of hostile and racist treatment at the hands of those who had power over them.

Sometimes when you ask you don't get what you want. Even if you don't get what you want they can tell you no in a nice way. Sometimes it comes like a bomb, you know, and it makes you feel very bad ... Even if you know you won't give me any money, at least don't destroy me by making me feel powerless. I know I'm powerless, but don't repeat it. I know I'm powerless, but even if I'm miserable don't make me feel it and stick on that misery.

When you are healthy, OK you don't feel hurt if someone is rude to you, but when you're not feeling well, you feel a lot of pain. And there's the thought that maybe it's because I'm a refugee that they're doing this to me ... If some people are rude, it's by nature, but there are some people who make you feel small - it's personal. It's in the manner, the way they talk to you, the way they look at you.

Several women expressed strong views about what kind of people should be in positions of power over the lives of asylum seekers.

They must be very nice people, to help the [refugee] people, because you are not coming for fun, you are coming because of bad things.

Sometimes you meet nice people, sometimes you meet bad people, but these ones who are not friendly, what I would advise is that they should consider people's feelings. I don't expect someone to give me money, but at least to make me feel good about myself.

To improve things, tell the people at the clinic to change their way of doing things, consider the feelings of refugees ... they are there to help people. If they don't like refugees they shouldn't work there.
9.12 Mental health services

Although most of the women described themselves as being or having been postnatally in a psychological state that would probably be considered depression, none had received any assistance with postnatal depression from health visitors or any other source. Only two had been diagnosed and offered counselling when pregnant.

One woman was receiving counselling from the Medical Foundation for the Victims of Torture, because of her past experiences. Another, who was haunted by traumatic memories and became severely depressed during pregnancy, had been offered counselling but refused it. Neither woman felt that talking to a counsellor would really help.

But before it was making me angry to talk about it, because you tell someone ... you go, you talk, you cry every day, and someone says, 'Oh you cry as much as you like.' I was feeling like, he's laughing at me, like you enjoy watching me cry. And I used to run away. So they changed me to another, and another, and another. If you talk and go and tell someone, it won't change. It's me. Because I try to live with this myself. I try to pretend ... but still my life is not changing. It's like it will never change.

They sent a psychologist to my house, they sent three people to me, I said no I don't want you to come and talk to me because every time I talk about my problems it makes me worse. I have to do it myself.

10. SOCIAL AND PRACTICAL SUPPORT & ACCESS TO REFUGEE SUPPORT PROJECTS

10.1 Starting again

A fundamental part of the refugee experience for most women in this study was being torn away from pre-existing social networks of friends and family, and having to start again. The challenge of reconstructing their lives came at a time when they had few emotional resources to invest in nurturing new friendships. Just two of the women had come to the UK with a fairly large number of family members. Some of the others had one or two friends or acquaintances or relatives already in the UK. Others arrived knowing no one at all. One woman vividly described the sense of total dislocation.

Look at where I am. I've got no family. I've got no history. My history is just what I talk about. Where is my family? Where are my people? Here I am ... this is not life.

10.2 Forming new friendships

Some women living in the same hotels or shared houses tried to support each other by forming friendships and sharing baby clothes. Women sought each other out, particularly in situations where they were living in an overwhelmingly male environment.

When I got to the hospital I didn't have anything for the baby ... A friend who I made in the hospital gave me some clothes from her baby, she is from the hotel too. Some donors gave her the clothes, because she has been here for a long time.
The other people here are asylum seekers. We know that we've got the same situation at least. I'm lucky that here we are friendly, we understand each other, maybe because we are mothers, because here we all have babies apart from one old woman, we all have the same problems, we are all single mothers, we've got this man business, we've got bad conditions. We look after each other's babies, we try to put them together and talk ... When I came home [from hospital], I was crying, I knew the room was very bad, but when I came my neighbours welcomed me, they had prepared a surprise for me, we went to one of their rooms, we celebrated there.

For some women it was especially important to have someone who had experienced the same problems to talk to.

When I meet my friends, we speak about our lives, and some with families in Somalia have horrible things ... we speak about that together ... We have to talk - it's no good to keep quiet. If you keep a problem in your head it hurts every time you think.

In general, though, women described finding it difficult to build lasting friendships in circumstances where everyone was preoccupied with their own problems. Friendships were transitory due to people being dispersed and moved on to other accommodation, or might be impossible because of language differences.

It has not been easy to make friends. I have made some friends in the hotel, but some get houses, others are busy with school. I spend a lot of time alone. I really, really need my family with me.
(16 year old)

The people where I live aren't helpful, first of all everyone minds his own business, everyone has their own life to lead. They are friendly in a way, you can sit down to chat together, but not that close - not enough to say 'I'll do this for you'.

If I ask people to go to a place with me, they say 'No, we can't go now, we're busy.' So I just stay with my problems. People promise for a day and then they forget.

When I lived at Plymouth I always cooked upstairs because I couldn't speak to the other three women.

One young woman, far from being supported by those around her, was expected by her seven male fellow residents to keep house for them. This was despite the fact that she was six months pregnant when she arrived in the house and stayed there until her baby was born. She did not feel in a position to refuse.

I stayed here for three months in a house sharing with other people ... boys. For three months I cooked for eight people there, and washed, ironed, everything - it was very, very hard. They were young boys, very hungry! I thought I cannot live here; I was really tired, because at lunch they wanted to eat, at dinner, in the morning. And all the boys were very not tidy! They leave their shoes there, their trousers there, and I had to tidy everything. I couldn't say no, because they were really very mad with me, shouting ... No one looked after me.
(16 year old)

Several women described how they did not feel readily able to trust the strangers.
they were with. It was necessary to keep a certain emotional distance from the ‘friends’ made by chance in the course of the asylum process.

I am on my own. At times you try to get to know someone but they push you away, so you think, it's just better to stay to yourself. Not everyone is nice. Some people are inquisitive and they don’t even know you ... That's why at times you don’t want to get close to people.

Sometimes my friends help [to look after the baby], but we don’t know people very well, so we have to be careful.

Because of the complexities of the political situations in their countries of origin, women did not necessarily seek out compatriots for friendship and support. One woman described her fear of encountering someone from the wrong side of an ethnic conflict in which both her parents had been murdered.

Burundians are rare here. I met some, but not many. And when you meet them you don’t trust them, I don't expect anything from them. I don’t know if you are Hutu or Tutsi or Twa, so I don’t trust you. So even if you are Burundian we don’t like each other. If I talk to you I have my limits.

By contrast, one family had received a great deal of support from their own community, including being taken in by strangers when they left their NASS accommodation.

By the grace of Allah, we always find someone when we are really in need. We got some help from our friends there, and then by the grace of Allah we found this particular family when we came here …For our friends, from a human point of view they can’t neglect us. We have no choice, but they also have no choice, because they know we have nowhere to go. So somehow we are managing.

10.3 Friends and relatives

Women who had friends or relatives in England tended to receive a lot of practical help from them, including second hand baby equipment and support during labour. The presence of relatives in England did not always guarantee a safety net, and one woman, whose husband and six year old son were disabled, was coping entirely on her own.

In a normal day sometimes I'm so busy I don't even get time to brush my hair. I have to wash everything with my hands; I can't afford to go to the launderette. When my children are asleep I wash their clothes, I have to keep the children clean. My husband only lies down, I have to help him go to the toilet ... When I go shopping I have to hold the baby, the older boy doesn't go out because he's got breathing difficulties, I have to take the baby with me because my husband can't look after him. I carry him in one arm and the shopping in the other hand...The older boy still uses nappies so I have to buy nappies for him and the small one...I have to look after my husband and the children on my own, my family is not a close family and they have their own problems.

Under the current dispersal policy, an asylum seeker’s personal preference to be dispersed to a particular area because, for example, friends or family are there,
cannot be taken into account when the dispersal decision is made. For one woman this had led to her being dispersed, nine months pregnant, away from the only people she knew in England. Consequently she had to undergo labour alone.

See section 2.1

10.4 Women accompanied by their husbands

Fourteen of the women were in England with their husbands. Several women drew a distinction between their husband and themselves in terms of social support. The women accepted without criticism the fact that the men spent most of their time out of the house with their friends. Because of this frequent absence, the women accompanied by their husbands craved female companionship as a remedy for profound loneliness just as much as the women who were on their own.

When I first came here I was crying every day, alone, just being at home all the time. My husband goes out all the time ... he has many friends.

I didn't have any friends in London, I was really worried, I need friends to talk to. I was very lonely. The man doesn't stay home, he can go out and find friends, but for the woman it is difficult.

I am always tired, it's very tiring to be stuck at home, I stay at home all alone, what can I do? There is no one to help me. A typical day, I feed the baby at 3.30am, I look after my children from six in the morning when I feed the baby ... I do some washing, in the afternoon the children sleep for an hour so I do the hoovering and the cooking. My husband helps with the children in the evening. He is out during the day, he goes to his course, or he goes out to talk with his friends.

On the other hand one of the husbands who was present at an interview described himself as carrying the real burden.

She is totally dependent on me; the real pressure is on me. She doesn't have to think that much about money, accommodation, because I do those things. She has got someone to turn to but I don't have anyone to turn to.

Although all of the husbands, except one, who was disabled, looked after the children at least some of the time, the women had low expectations of their contribution to the household and their practical abilities.

My husband is not the kind of man who can be a wife ... [at home] I was very dependent on my mother and mother-in-law, I didn't have to do everything with my own hands. But here I do. My husband is helpful, but there are things that only a woman can do, men cannot do it.

My husband tried to help me with the baby but he can't, he's a man, he doesn't know everything.
10.5 **Vulnerability and new relationships**

Five women had met partners while living in England and all five had been rejected by their partners when they were pregnant. Three of the women described how extreme loneliness and poverty had made them vulnerable to what they saw with hindsight as unsuitable relationships. One young woman was befriended by a boy at college who won her trust by buying her food at the canteen, and other things she needed. She became reliant on him because she could not buy any food at college for herself, since she only had vouchers which the canteen did not accept, and also because she could not afford to live independently on the low level of voucher support: "**£30 is not enough - that's how I got pregnant**". Another woman couldn't locate her only relative in England when she first arrived alone. While very depressed about leaving her other children behind, she "**ended up with someone**". The third woman was molested by a man who took her in when she first arrived, was then raped by a stranger and then became pregnant in a relationship.

*At the time it's not that I was ready. But I was so lonely, I needed someone, and in that condition you just meet anyone. And when I was pregnant, this man said 'No'. I don't know who told him I was raped here, because I never told him that, but then he found out. I don't blame him that much, because ... African people, you know, once you are raped you don't have any value.*

Although this woman had been rejected by her partner, he wanted to see his son and she remained dependent on him, because overnight visits to him were her only respite from appalling living conditions. She wanted him to marry her, to secure her son's future, but at the same time recognised that he was exploiting his power over her:

*Sometimes that man takes advantage of me because he knows that I've got nothing, that I'm just nothing without him. He knows it, he knows there is nothing I can do about it because I've got nobody, I've got nothing, I have nowhere to go.*

10.6 **Refugee support groups**

Fourteen of the women in this study were recruited through refugee support groups, and a further three were in contact with these groups. Sixteen women were not in contact with any groups, in some cases unaware that they were available near by. Women who had access to refugee support groups greatly valued them on a number of levels. They saw them as a 'safe' space to relax and be occupied in outside their hotel or other accommodation, as a place to meet other asylum seekers and refugee women, and as a place to meet English people and practice English. Groups were also valued as a source of practical help with second-hand clothes and baby equipment, as an intermediary for problems with accommodation and vouchers and as a point of access to good legal advice about their asylum applications. Only one woman was dissatisfied with the service she had received. The others were very positive.

*I felt bad. The only time I used to look forward to was Friday, when I could go to a church group for asylum seekers, where they give you moral support. It was hard to take my baby out anywhere else, I didn't have a pram. I had to carry her everywhere.*

*I had only been to the Barnardo's drop-in twice. I like it – I went there because I had some difficulties with my asylum case and I thought they will help me a bit.*
Another way it's good is to talk and meet with other people; I find it easier when I talk with someone.

They have helped me so much ... They have done everything! They found a nursery place for my daughter, and it was very good because she was so lonely ... There were cooking classes, sewing so I could sew my curtains; they helped me to have a fridge completely free from a man, he even delivered it for us. There was also some social relationship inside that project, so you just felt comfortable going there.

One woman drew a clear distinction between the positive attitude of community groups and the indifferent one of the social services.

At [support project] I've got a lot of second hand clothes, much nicer than what they give you at social services. They [social services] give you a piece of paper to go to a charity, but this charity doesn't let you choose, they just give you a plastic bag like that, so when you reach home you open it and the clothes have holes in them. But the communities, they help ... they really help. They listen to you, they know your problems, they come to visit you, they are friendly, they respect you.

One mother regretted that, because social services were discontinuing her bus pass, she would no longer be able to attend a refugee group.

I used to come to that church [hosting refugee group] because I had a bus pass, but now I can't go. Sometimes maybe, but not regularly. When we go to that church my baby is really happy, because there are children to play with.

Most of the women were very glad to find a source of second hand clothes, but there were some reservations.

They give not-new clothes. We don't know where they come from - maybe the person has died!

Social services have a room where you can pick up some clothing once a month, so I took five pairs of clothing and some small T-shirts but they are too small now. The last time I washed and ironed them she had a rash, they are not from one person but maybe from hundreds of families, so I don't want to go back - I'm afraid. I might ask for help in the churches.

11. INFORMATION NEEDS

A common theme in many of the women's experiences was the lack of information about what support, services and assistance were available. No agency is responsible for assessing an asylum seeker's needs and passing on to her all the relevant information. A number of the women had eventually found someone on whom they felt they could rely and to whom they would then turn with all their problems, for example a health visitor or a social worker or a worker from a refugee support project. Even those professionals were not necessarily aware of all the options, and they sometimes lacked their own emotional support to cope effectively with the traumatic experiences recounted by the asylum seekers they were assisting. Other women had found out about their entitlements or available assistance by word of mouth or chance encounters.
During the interviews it became apparent that many women were unaware of:
- The scheme to reimburse hospital fares both for asylum seekers receiving vouchers and those receiving income support
- The existence of support projects and relevant children's facilities in the vicinity
- Local sources of charitable help
- The possibility of social services support
- The maternity grant
- How to access the health services and advocacy support
- What to expect during labour, including complications and interventions, and what to expect from postnatal support
- The possibility of family reunification through the Red Cross

Just one woman identified the 'One Stop' services, which are run by refugee agencies and are meant to provide a single point of contact for asylum seekers in some areas, as the logical source of this information:

It would be good if asylum seekers were given much more information about how everything works in England ... I think somebody should go to the One-Stop to ask for all these things, and have someone to explain it all the them, so they will know exactly where to do this and that ... Otherwise they will just be like someone who is blind, just walking, but don't know where he is going. They should give them proper advice, so they ... know what they are going to have ... They could give advice and a booklet to take away and read, and then come next week and take the next steps.

The One Stop had not, however, fulfilled this role for her. It had run out of relevant booklets and failed to give her crucial information about social services support. She was relying instead on a Refugee Council advice worker.

The most useful person I have met is [a Refugee Council advice worker]. He has done a lot for me. Everything I have achieved is from him. He has helped me, explained the things I didn't know.

12. FUTURE HOPES

The women in this study were asked about their hopes and dreams for the future, assuming they were granted asylum or leave to remain. Several mentioned very practical hopes, such as a permanent home; many others mentioned studying, starting work, getting a good education for their child and being reunited with their other children. One woman was well on her way to requalifying as a doctor able to practise in the UK, and had the specific ambition of gaining a senior house officer post. Others were hoping to work as nurses, as policewomen, with children, and in IT.

One woman summed up her hopes.

In the future I hope that everything, all the opportunities that English children are given will be given to my baby. For myself, to integrate myself well, study, work, learn the language, learn a trade.

Another had an even simpler dream.

We want only a normal life.
DISCUSSION

The experience of exile cast a deep shadow over the experiences of motherhood described by the women in this study. Women seeking asylum may arrive in England having lost everything they value: children, husband, parents, extended family, community, home, job, health, money, possessions, culture. The women in this study described feelings of desperate loneliness, grief at the losses they had suffered, disorientation, humiliation at their enforced dependence on strangers, and chronic uncertainty about the outcome of their asylum cases. While grieving for what they had lost, living with the traumas they could not forget, and afraid to make plans for a future which might not be theirs, these women also had to adapt to the insistent practical and emotional demands of motherhood.

Some women faced the challenge of the transition to motherhood for the first time, and some gave birth in the context of grieving for other children. Having a baby gave a new purpose and focus to fractured lives while at the same time raising the stakes for the asylum claim, because mothers were painfully aware that the baby's future depended on the outcome of their case.

These mothers survived in a support system that often treated them with suspicion, indifference and contempt. It should be a source of shame to this country that pregnant asylum seekers and their babies are going hungry, that newly-delivered mothers have to go begging for nappies, that mothers and young children are placed in dirty and damp accommodation dangerous for their health, and that some health professionals can, with impunity, treat vulnerable women with disrespect and outright racism. Experiences of poverty, poor housing and racism are not, of course, confined to asylum seekers. But asylum seekers are more vulnerable and less able to challenge unfair treatment than perhaps any other group in our society.

The forthcoming changes to the asylum support system present an opportunity to design in, from the outset, the special needs of pregnant women and babies. Pregnancy and the first months of a baby's life are an exceptionally vulnerable time, both physically and emotionally. Neglect during this critical period may have lifelong consequences. For example, babies born to malnourished mothers are more likely to be born at a low birthweight (under 2,500g), putting them at higher risk of disability and early death than heavier babies. Babies whose HIV positive mothers cannot afford formula milk are more likely to be occasionally breastfed, which greatly increases the risk of the HIV virus being transmitted to them. Babies of postnatally depressed mothers can be at risk of impaired cognitive functioning in their early years.

Ignoring the special needs of pregnant asylum seekers and their babies is, therefore, a very short-sighted strategy. A significant proportion of these mothers and children are likely to be granted asylum and to remain in the UK for the rest of their lives. The NHS and education authorities will end up paying the price for potentially preventable ill-health and disability. On the other hand, those families who are not granted asylum may be returned to countries with perilous social and political conditions and where no health infrastructure exists. The babies' chances of survival may be affected by their mothers' health in pregnancy and their own health and development while in England. Either way, these babies deserve as good a start in life as any other baby born in this country.

Detailed recommendations about how support and services should be improved follow in the next section. Many state the obvious; but the obvious has somehow been overlooked in the current system. It should be remembered that investment in services to meet the needs of
the most disadvantaged people has the potential to improve services for all. For example, although in terms of support policy asylum seekers have been ghettoised, a pregnant asylum seeker also necessarily has contact with mainstream maternity services. Improving the availability of appropriate language support would also benefit other non-English speaking users of the maternity services. Improving access to GP and maternity services for asylum seekers in emergency and temporary accommodation could also benefit other homeless families. Ending a policy of arbitrary dispersal could reduce pressure on maternity units where midwives they feel there is no option but to keep a newly delivered mother in hospital because there is nowhere safe and supported to discharge her.

Although some of the women who took part in this study appeared to be on the edge of total despair, it was very striking how many women also displayed remarkable strength, resilience and humour in coping with their misfortunes. Their dreams were of a future when they would be safe and settled, when they could lead ordinary lives and when they or their husbands could work to support their families properly. Like any mothers they wanted, above all, what would be best for their children, but they were acutely conscious that as asylum seekers they had no power to give it to them. During their time in the UK, whether temporary or permanent, all of these mothers deserve to be treated with humanity, dignity, and respect.

*Women are very strong. Nine months seems like nine minutes. I try to forget my past.*
I feel I am treated like the air. The men touch the ladies. If someone is pregnant you should transfer her to a place where she will be safe. Her friends come, I can’t sleep, day and night they talk.

My baby was small; it was because of the hotel, I had to miss the meal here but they wouldn’t give me any money for food. Sometimes I miss lunch because she starts to cry.

They don’t give me milk for 2-3 days and she is vomiting. I didn’t have clothes for the baby, not a nappy, nothing.

**RECOMMENDATIONS FOR ACTION AND GOOD PRACTICE**

**Guiding Principle:**

All agencies in contact with asylum-seeking pregnant women, new mothers and babies should recognise and meet their social, psychological and physical needs. The new support system should provide specifically for the needs of pregnant asylum seekers, new mothers and their babies.

1. **Recommendations on induction centres and accommodation centres.**

   1.1 Single women and families should always be accommodated separately from single men. Where women and single men are housed in the same building, separate bathrooms and common areas should always be provided.

   1.2 Priority should be given to placing pregnant women and new mothers in self-catering accommodation. Pregnant women and new mothers should not be placed in the proposed accommodation centres.

   1.3 Pregnant women and new mothers should not be required to share a room with strangers.

   1.4 Where pregnant women and new mothers are placed in full board accommodation, there should be more flexibility in the timing and location of meals, and the meals should meet nutritional and cultural standards defined in consultation with refugee groups.

   1.4.1 Caterers should ensure that pregnant women and new mothers have access to sufficient food which is nutritious and culturally acceptable.

   1.4.2 Arrangements should be made to ensure that women attending antenatal appointments do not miss meals, for example by providing a packed meal or cash.

   1.4.3 Women with babies should be able to take food back to their rooms.

   1.4.4 Pregnant women and breastfeeding mothers should have access to nutritious snacks between meals.

1.5 Responsibility for provision of necessities for mother and baby should be made explicit, including: a cot with clean bedding, nappies, sanitary towels for postnatal bleeding, and, where appropriate, formula milk, bottles, sterilising equipment and baby food.

   1.5.1 Where no maternity grant has been received there should also be provision for baby clothes to be supplied.

1.6 Advisors should be present regularly on site to provide comprehensive information about the support, dispersal and healthcare systems, including how to access the maternity services and the maternity grant.

2. **Recommendations on dispersal**

   2.1 Pregnant women and newly-delivered mothers should be consulted on the timing and destination of dispersal. Their need for practical and emotional support during labour
and in the post-partum period should be considered alongside any medical grounds affecting dispersal.

2.2 Pregnant women and newly-delivered mothers should only be dispersed to areas with adequate support services, including language support and health visiting services.

2.3 Families with young children should not be dispersed more than once without consent.

2.4 Where an HIV positive woman is exempted from dispersal on medical grounds, she should be rehoused promptly in self-catering accommodation near her treatment centre.

3 Recommendations on temporary accommodation

3.1 Environmental health standards should be strictly enforced by NASS or social services when they provide accommodation or source it from third parties.

3.2 Pregnant women and new mothers should not be required to share rooms with strangers.

3.3 Single women and families should not be placed in accommodation with single men.

3.4 Self-catering facilities should be available to all pregnant women and new mothers.

3.5 Asylum seekers should have a well-publicised, effective and accessible means of redress if they are victimised by staff, and in cases of disrepair.

3.6 Asylum seekers under the age of 18 should be placed with a foster family or in supported accommodation.

4 Recommendations on vouchers and the new support system

4.1 The Maternity Grant should be available to asylum seekers on the same basis as the Sure Start Maternity Grant, from the 29th week of pregnancy up until the baby is three months old. An equal grant should be available to all supported pregnant asylum seekers irrespective of the body responsible for their support.

4.2 Pregnant and breastfeeding asylum seekers and their babies should have full access to the Welfare Foods Scheme, which currently provides milk tokens and vitamins. In the short term, child health clinics should accept asylum vouchers for low-cost formula milk. Hospital consultants and GPs should be made aware of the possibility of prescribing formula milk for babies where breastfeeding is contra-indicated.

4.3 Financial support should be set at a level demonstrably adequate for maternal and infant health.

4.4 Pregnant asylum seekers and new mothers under the age of 25 should receive the same level of financial support as women aged 25 and over.
At the moment I have nothing. I try to drink a lot of water and sleep a lot.

The administration of the current and any future support systems must be urgently improved to ensure that asylum seekers are not left destitute. Asylum seekers should be guaranteed immediate access to the system administrators in cases where support is not received.

5 Recommendations on healthcare and the maternity services

They said I could register the baby but not myself.

5.1 Pregnant asylum seekers should be guaranteed access to GP services where necessary on arrival, and permanent registration after dispersal.

5.2 Access to midwifery services for asylum seekers in emergency accommodation or induction centres should be facilitated through on-site or local drop-in antenatal clinics. Asylum seekers should be informed of the option of direct access to hospital and community midwifery services without GP referral.

5.3 The midwifery and other health services should be involved in the planning of the location of any proposed new induction or accommodation centres.

5.4 Pregnant asylum seekers should carry their own complete GP, maternity and child health notes to facilitate continuity of care in the event of dispersal.

5.5 Maternity and child health services in dispersal areas should be informed of the impending arrival in their area of asylum seekers who are pregnant or have a young child. Maternity and child health services in the area from which asylum seekers have been dispersed should be given a forwarding address for test results and notes.

5.6 Pregnant asylum seekers should be given clear information on GP, maternity, health visiting and child health services and how to access them. Information should be available in a language and format that is accessible to women, including written material and individual advice. This should be available not just at the proposed Induction Centres but also at the regional ‘One Stops’ as well as within the health service.

5.7 The information provided should recognise that asylum-seeking women may be coming into a healthcare system that is entirely unfamiliar to them, and that they are unlikely to access antenatal classes. There should be clear explanation in advance of what their choices and rights are, and of what they can expect, for example:

- the roles of different health professionals.
- who to approach with particular concerns.
- potential complications and treatment options including induction, assisted delivery, and Caesarean section, and the decisions that may be required. See also recommendation 5.12
- the level of support that will be available postnatally, on the ward and in the community.

5.8 In recognition of the particular vulnerability of asylum seekers, funding for interpreting services, and in particular for advocates and linkworkers, should be expanded. Interpreting and advocacy services should be extended geographically, so that all maternity services in dispersal areas can provide an adequate level of support. They should also be expanded locally, so that an out-of-hours advocacy service can be offered and more female interpreters and advocates can be recruited.
to out-of-hours services. It should be a clear target to provide interpreting or advocacy support for antenatal classes and for postnatal visits. Maternity staff should be made aware of the particular importance of providing formal interpretation in the context of routine screening for domestic violence.

5.9 Anti-racism training for NHS staff should be strengthened. Management should take a more proactive role in ensuring that staff do not exploit the vulnerability of asylum seeking clients with racist abuse.

5.10 Asylum seekers should be given clear information about how to make complaints about offensive treatment, including a named individual who will support them in the process, and a guarantee that making a complaint will not affect either their care or their asylum claim.

5.11 Training for NHS staff should include:
- communication with people who do not speak English as a first language.
- the practicalities of asylum seekers' lives in the support systems.
- how best to support clients in a fragile emotional state of loss, grief and fear.
- where to refer asylum seekers for specialist support such as mental health services.

5.11.1 In particular staff need to be sensitised to the importance of fostering a sense of partnership not powerlessness in all decisions about a vulnerable woman's care.

5.11.2 Managers should work towards a culture of reflective practice for all staff.

5.12 Staff must ensure that and proposed interventions and choices are fully explained and that genuine informed consent is obtained for any intervention.

5.13 Maternity care providers should liaise with accommodation providers to ensure that pregnant women do not have to miss meals in order to attend for antenatal care, for example by scheduling appointments appropriately.

6 Recommendations on social and practical support

6.1 Refugee community groups, befriending organisations and networks providing practical help to asylum seekers should be funded in all dispersal areas. Outreach work should be funded to ensure that isolated new mothers have the opportunity to remain in touch with local sources of support.

6.2 English language classes supported by free childcare facilities should be funded in all dispersal areas and where possible made available in emergency accommodation or induction centres.

6.3 Specialist health visitor posts should be funded to meet the needs of asylum seekers in emergency accommodation, induction centres and dispersal areas. Health visitors should be able to identify antenatal and postnatal depression in women from different cultures, so they can offer appropriate support or make referrals where necessary.

6.4 In recognition of the emotional burden which may be carried by professionals in supporting asylum seekers who have had traumatic experiences, they should have...
access to effective mechanisms of peer support, debriefing and, where appropriate, counselling.

13.

7 Recommendations on co-ordination

7.1 Within every dispersal area, there should be a commitment to multi-agency co-operation on asylum issues and a named co-ordinator to enable co-operation.

7.2 To enable any professional in contact with an asylum seeker to signpost all relevant local services, effective resource packs should be developed.
Appendix 1 ABOUT THE WOMEN

Country of origin

<table>
<thead>
<tr>
<th>Country of origin</th>
<th>Number of women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan</td>
<td>1</td>
</tr>
<tr>
<td>Angola</td>
<td>1</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>1</td>
</tr>
<tr>
<td>Burundi</td>
<td>1</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>1</td>
</tr>
<tr>
<td>Democratic Republic of Congo</td>
<td>6</td>
</tr>
<tr>
<td>Eritrea</td>
<td>1</td>
</tr>
<tr>
<td>Ghana</td>
<td>1</td>
</tr>
<tr>
<td>Iran</td>
<td>1</td>
</tr>
<tr>
<td>Iraq</td>
<td>6</td>
</tr>
<tr>
<td>Kosovo</td>
<td>1</td>
</tr>
<tr>
<td>Lithuania</td>
<td>1</td>
</tr>
<tr>
<td>Nigeria</td>
<td>2</td>
</tr>
<tr>
<td>Poland</td>
<td>1</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>4</td>
</tr>
<tr>
<td>Somalia</td>
<td>1</td>
</tr>
<tr>
<td>South Africa</td>
<td>1</td>
</tr>
<tr>
<td>Turkey</td>
<td>1</td>
</tr>
<tr>
<td>Uganda</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>33</strong></td>
</tr>
</tbody>
</table>

Pregnancy and age of baby

Four women were pregnant at the time of interview. The other 29 had 31 babies ranging in age up to 18 months including one pair of twins and two brothers born 14 months apart. Thirty of the babies were born in England; one arrived aged six weeks. Fourteen of the mothers were already pregnant when they arrived in England.

Age of baby at time of interview

<table>
<thead>
<tr>
<th>Age of baby at time of interview</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under one week</td>
<td>2</td>
</tr>
<tr>
<td>One week - one month</td>
<td>3</td>
</tr>
<tr>
<td>One month - three months</td>
<td>8</td>
</tr>
<tr>
<td>Three months - six months</td>
<td>7</td>
</tr>
<tr>
<td>Six months - twelve months</td>
<td>7</td>
</tr>
<tr>
<td>12 months -18 months</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>31</strong></td>
</tr>
</tbody>
</table>
Older children

Nine of the mothers had between one and four older children with them in England, ranging from toddlers to young adults. Eight women had left other children behind when they came to England, including one mother whose youngest child was just 18 months old when she left. Some had no information about their older children. One mother of a newborn baby knew that her three year old child was dead.

Immigration status at the time of interview

The women had been in England for periods ranging between three weeks and two years.

<table>
<thead>
<tr>
<th>Status</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting for an initial decision</td>
<td>18</td>
</tr>
<tr>
<td>Appealing initial refusal</td>
<td>6</td>
</tr>
<tr>
<td>Refugee status</td>
<td>6</td>
</tr>
<tr>
<td>Leave to remain</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
</tr>
</tbody>
</table>

Support at the time of interview:

<table>
<thead>
<tr>
<th>Type</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>In emergency accommodation</td>
<td>5</td>
</tr>
<tr>
<td>NASS vouchers and accommodation</td>
<td>5</td>
</tr>
<tr>
<td>NASS vouchers only</td>
<td>1</td>
</tr>
<tr>
<td>NASS accommodation only (waiting for vouchers)</td>
<td>1</td>
</tr>
<tr>
<td>Social services vouchers and accommodation</td>
<td>3</td>
</tr>
<tr>
<td>Social services cash and accommodation</td>
<td>3</td>
</tr>
<tr>
<td>Social services vouchers only</td>
<td>1</td>
</tr>
<tr>
<td>Income Support</td>
<td>11</td>
</tr>
<tr>
<td>Jobseeker’s Allowance</td>
<td>1</td>
</tr>
<tr>
<td>Part time work</td>
<td>1</td>
</tr>
<tr>
<td>No support</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
</tr>
</tbody>
</table>

The five women living in emergency accommodation had been in England between three weeks and five months. The woman with no support had left the EA because she felt she
could not protect her family's health if she stayed; she was currently relying on the charity of friends to support her family of four. A further seven women had been dispersed out of EA by NASS. Of these, one was not currently receiving any vouchers apparently due to administrative error, and one was receiving only vouchers as she had left the dispersal accommodation. Six women were accommodated by social services and currently receiving either vouchers or cash from social services, and one was receiving only vouchers because she was unwilling to be dispersed and was staying with a relative.

Of the eleven women receiving Income Support at the time of interview, eight were eligible as a result of having been granted refugee status or Exceptional Leave to Remain. A further three were eligible for Income Support because they had applied for refugee status on arrival before 3 April 2000. One refugee received Jobseeker’s Allowance, and one of the asylum seekers had a husband who had refugee status and supported them with part time work. Of these eleven women just two were in privately rented accommodation; the other nine were in temporary accommodation as homeless families.
Appendix 2: STUDY METHODS

Thirty three women participated in this study between March and September 2001. A further three interviews were arranged but not carried out due to changed circumstances. The women were recruited through a combination of convenience and snowball sampling, although we attempted to include a reasonable range of nationalities, stages of pregnancy and early motherhood, stages of the asylum process and different types of support.

A flyer was produced stating the aim of the study, the broad topics of the proposed interview, and the offer of £15 worth of nappies to be given to participants (the Refugee Council had advised that offering cash could prejudice an asylum seeker’s entitlement to NASS or social services support). The existence of the study was then publicised to refugee support groups, refugee agencies and health professionals, who acted as intermediaries making first contact with potential participants. In four cases participants suggested that a friend be included in the study.

When a woman’s consent to participate had been secured, either through an intermediary or directly, arrangements were made to meet the woman either at her home or at a neutral location (such as a refugee support group). At the start of the interview it was explained that participation in the interview or any part of it was entirely voluntary, and that the purpose was to give the participant an opportunity to describe her experiences and what she felt about them. She was asked to give her permission to use her story as part of a campaigning report and was assured of complete confidentiality. Interviews were tape recorded and subsequently transcribed by the researcher.

Interviews

In English 17
In French without interpreter 5
With professional interpreter 8
Interpreted by friend 2
Interpreted by husband 1

The participant’s husband was present for some or all of the interview in six cases. During the majority of the interviews the participant was also occupied with caring for or feeding her baby and sometimes an older child as well. Friends were also sometimes in the room and in one case a group of three women were interviewed together at their request.

Location of interviews

<table>
<thead>
<tr>
<th>Place</th>
<th>Number of women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manchester</td>
<td>3</td>
</tr>
<tr>
<td>Plymouth</td>
<td>3</td>
</tr>
<tr>
<td>Hastings</td>
<td>1</td>
</tr>
<tr>
<td>Brighton</td>
<td>1</td>
</tr>
<tr>
<td>Oxford</td>
<td>2</td>
</tr>
<tr>
<td>Kings Lynn</td>
<td>1</td>
</tr>
</tbody>
</table>
London emergency accommodation  6
London - other accommodation  16
Total  33

Interviews were carried out at three emergency accommodation hotels: Eurotower (Stockwell), Pembury Hotel (Finsbury Park), and Thorncliff Hotel (Heathrow).

Limitations

These methods of recruitment and interviewing have clear limitations. This was small-scale qualitative research. The reliance on intermediaries to make contact with participants skewed recruitment in several ways. The study mainly included women who were in regular contact with either a support project or a health professional (although through snowballing we did make contact with some more isolated women). Some intermediaries only put forward the names of women who they felt could cope with an interview, and expressly excluded women whose circumstances, they felt, were too raw and distressing to be described to a stranger. Not all intermediaries filtered participants in this way - one put forward a woman specifically because it was felt that having someone listen to her experiences could be therapeutic. There was also a selection bias in favour of women who could speak English, as intermediaries could make arrangements most conveniently with these women.

The presence of a woman's husband at the interview was not ideal, as women tended to be considerably less forthcoming and particularly inhibited about discussing their feelings. The men frequently interrupted their wives. The women also tended to be less open when an interpreter was present.

Women's views about being involved in this study

Once they were sure that their anonymity would be protected, all the women who took part in this study were keen to put their experiences on record and when interviewed at home they showed the researcher great hospitality. Interviews that were planned to be about one hour in length sometimes lasted more than two hours as women spoke with great passion and indignation about their lives. Although many were in tears as they described what had happened to them, several also said they felt better for having had the chance to talk about their problems, and expressed the hope that telling their stories could make life better for other mothers in the future.
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54 Gaaserud A, Maternity Services for Newly-arrived Refugee and Asylum-seeking Women in the City and Hackney Boroughs of London. City and Hackney Primary Care Trust, 2001.


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