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A systematic review of asylum-seeking women's views and experiences of UK maternity care

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ABSTRACT

Objective: To explore and synthesise evidence of asylum-seeking women's experiences of maternity care in the UK.

Design: A systematic review and thematic synthesis of peer-reviewed qualitative evidence. Relevant databases were searched from 2000 until 2018. Study quality was appraised using the Critical Appraisal Skills Programme (CASP) qualitative research appraisal tool.

Setting and participants: UK-based studies which describe asylum-seeking women's views and experiences of maternity care.

Findings: Six studies were included for thematic synthesis. Seven common themes emerged; 'Communication challenges', 'Isolation', 'Mental health challenges', 'Professional attitudes', 'Access to healthcare', 'Effects of dispersal' and 'Housing challenges'. The review indicated that pregnant asylum seekers face significant barriers to accessing maternity care due to practical issues related to the challenges of their status and lack of knowledge of maternity services, together with professional attitudes.

Key conclusions and implications for practice: Mandatory provision of interpreter services, together with training for health care professionals could address urgent issues faced by pregnant asylum seekers. Further research and population-specific guidelines are needed to improve care for these women.

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Background

The world has recently seen the highest rates of forced migration recorded, estimated to be an unprecedented 68.5 million in 2017 (United Nations High Commission for Refugees, 2018). By the end of March 2018, a total of 42,352 people in the UK received support under the Immigration and Asylum Act 1999 (Home Office, 2018). The 1951 Refugee Convention defines asylum seekers as any person who has not yet had their claim for asylum accepted by the government but who 'owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable to or, owing to such fear, unwilling to avail himself of the protection of that country' (UN General Assembly, 1951).

Many asylum seekers will have endured the physical and psychological trauma of conflict, torture, deprivation of liberty, the

disappearance or killing of family and friends, rape, sexual and domestic slavery and enforced conscription (Kalt et al., 2013). They may also have had no fixed address over a period of time, in refugee camps or in the process of travelling, and may be suffering from the immediate health fallout of prolonged poverty and malnutrition (Koser, 2000; Bradby et al., 2015).

The implications for pregnant women within this population are particularly acute due to the additional physical and emotional demands of pregnancy. Asylum seeking women frequently present to maternity services late in pregnancy with sexual and emotional trauma, infectious diseases and underlying health conditions (Asif et al., 2015), often having received no maternity care on arrival (Asif et al., 2015). As a result, pregnant asylum seekers are at high risk of suffering maternal morbidity and mortality (Knight et al., 2018; National Institute for Health and Care Excellence (NICE), 2012). Although the number of pregnant asylum seekers accessing maternity care in the UK is unclear, recent Home Office statistics suggest that around 20–25% of all UK asylum applications are for women of childbearing age (15–49, as defined by the World Health Organisation) (Home Office, 2018).

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The Home Office has responsibility for processing asylum claims and providing for the needs of asylum seekers who qualify as destitute under Section 95 of the [Immigration and Asylum Act 1999](#) ([Immigration and Asylum Act, 1999](#)). Under this act, those who require financial support and accommodation are sent to one of a number of UK Initial Accommodation (IA) centres in Croydon, London, Birmingham, Derby, Liverpool, Wakefield, Cardiff and Glasgow where housing and food are provided for a period of around four weeks while a claim for Section 95 support is being considered. If successful, applicants are moved under the Home Office policy of mandatory dispersal which requires that asylum seekers are prepared to move to any area of the UK with greater availability of affordable housing stock until the point that asylum is granted or, if refused, the appeals process is exhausted. In many cases this can take in excess of six months ([Plimmer and Tighe, 2017](#); [Refugee Action, 2018](#)). During this time, asylum seekers are not entitled to work or to claim mainstream benefits and rudimentary subsistence is provided, sometimes in the form of cashless benefits or prepaid cards for groceries. Home Office policy states that asylum seekers should not be dispersed or move accommodation six weeks prior to or following the estimated due date in order to prevent disruption to maternity care around the time of childbirth ([UK Visas and Immigration, 2016](#)).

To date, no reviews have been published which explicitly explore the experiences of pregnant asylum-seeking women accessing UK maternity care. Although previous systematic reviews have explored the maternity experiences of 'immigrant women' across different countries ([Bollini et al., 2009](#); [Small et al., 2014](#)), the process of seeking asylum includes many additional challenges not faced by other migrant populations, which are likely to impact on women's experiences of accessing maternity care ([Burnett and Peel, 2001](#)), and which have not to date been explicitly identified from existing literature.

This systematic review will examine the existing qualitative literature on asylum seeking women's views and experiences of UK maternity care to establish what is understood of the barriers and facilitators to good maternity care experiences for this population.

Methods

The systematic review was registered by PROSPERO (registration number CRD42018057922) ([PROSPERO, 2012](#)).

Criteria for inclusion

All English-language, peer-reviewed qualitative studies containing data on the experiences of pregnant women seeking asylum in the UK from 2000–2018 were considered. The review defined asylum seekers as those having lodged a claim for asylum with the Home Office but not yet having refugee status. As much of the literature uses the use of the terms 'asylum seeker', 'refugee' and 'migrant' interchangeably, the latter terms were included in searches and papers reviewed to ensure the correct population was included. Studies that examined the perspectives of healthcare professionals in caring for pregnant asylum seekers were considered only where the experiences of service users were also included and data could be separated.

Search methods

A literature search for relevant studies was carried out in May 2018 by authors 1 and 2. This included searching the databases Psych INFO, Medline, EMBASE, CINHAL, Proquest Assia and Web of Science, as well as searching Google and Google Scholar for any unpublished studies. Reference lists of full text articles included in the review were also hand-searched to identify any potentially eligible studies. Broad search terms were selected to capture a wide

range of papers and followed the PICO search tool (namely Population and Outcome): [pregnan* OR matern* OR child bearing OR women OR mothers] AND [asylum seeker OR migrant OR refugee OR immigrant] AND [views OR perception* OR opinion* OR belief* OR experience* OR attitude* OR feeling*].

Selection of studies

All identified studies were screened for inclusion, using the definition of asylum seekers outlined above. After removing duplicates, authors 1 and 2 independently screened the titles and abstracts of retrieved studies and the full texts of potentially eligible studies. Discrepancies on decisions between the two reviewers were resolved with discussion at each screening stage.

Data extraction and quality assessment

Data from the included studies were independently extracted by two reviewers (authors 1 and 2) and summarised as shown in [Table 1](#). Themes from all included studies were discussed and compared and key themes agreed by all the authors. The Critical Appraisal Skills Programme (CASP) checklist ([Critical Appraisal Skills Programme, 2018](#)) was used by the same reviewers to assess the quality of the included studies. CASP is a recognised and widely used tool for identifying potential threats to the validity of research. The appropriateness of applying the concept of validity to qualitative studies is subject to debate ([Hannes et al., 2010](#)) but the authors felt CASP was an appropriate measure of validity and dependability insofar as it considers the appropriateness of methods, ethical considerations and rigor. Where there were discrepancies in the quality assessment between the reviewers, a discussion took place until consensus for each study was achieved.

Data synthesis

Data were thematically analysed ([Ritchie and Lewis, 2003](#)) allowing reviewers to draw out and agree common themes from the included studies. Consensus of themes was achieved without disagreement by all authors.

Results

Characteristics of included studies

The PRISMA statement ([PRISMA, 2012](#)) was followed. 1796 identified studies were reduced to 1774 once duplicates ($n=22$) were removed. Following initial screening, 1736 were excluded based on the eligibility criteria, leaving 35 remaining studies. Following full-text assessment, a further 29 were excluded using the eligibility criteria. Studies were excluded for focusing on the perspective of health professionals ($n=10$), for not focusing on asylum seekers (but rather, migrants, immigrants and refugees) ($n=8$), for not being peer-reviewed literature ($n=4$), for not having a maternity services focus ($n=3$), for not being based in the UK ($n=2$) and for not focusing on women's experiences ($n=2$). This left six remaining for inclusion in the review ([Fig. 1](#)).

Characteristics of the six studies which met the inclusion criteria are shown in [Table 2](#) ([Briscoe and Lavender, 2009](#); [Feldman, 2013](#); [Lephard and Haith Cooper, 2016](#); [McLeish, 2005](#); [Nabb, 2006](#); [Phillimore et al., 2010](#)). All included studies contained a mixed population comprising of women at different stages of the asylum seeker process, time resident in the UK or with different immigration status such as refugee ([Briscoe and Lavender, 2009](#); [Phillimore et al., 2010](#)) or economic migrant ([Phillimore et al., 2010](#)). In total, the experiences of 89 asylum seekers were included in the studies ([Briscoe and Lavender, 2009](#); [Feldman, 2013](#); [Lephard and Haith Cooper, 2016](#);

Table 1
Summary of findings.

Communication challenges	Isolation	Mental health challenges	Professional attitudes	Access to healthcare	Effects of dispersal	Housing challenges
Language barriers (1,2,3,4,5,6)	Social (1,2,3,4,6)	Previous trauma/oppression (1,2,4,6)	Cultural assumptions (1,3,4,6)	Lack of interpreters (1,2,3,4,5,6)	Powerlessness (1,2,3,4)	Shared/cramped (1,2,3,4,6)
Use of friends/partners to interpret (1,2,4,5,6)	Economic (1,2,3,4,6)	Depression/PND (2,4,6)	Experiences of kindness (1,3,4,5,6)	Delay in care (2,3,4,5,6)	Disruption of care leading to risk (2,5,6)	Poor hygiene/dirty (1,2,3,4,6)
Not understanding what was happening in labour (1,2,4,6)	Lack of support in labour (2,3,4)	Anxiety/stress (1,2,3)	Negative/hostile attitude of healthcare professionals (3,4,6)	Systemic assumptions (1,3,4,6)	Multiple moves during pregnancy (2,4,6)	Shared bathrooms (2,4,6)
Misinterpretation/presumed understanding (1,3,4)	Disempowerment (1,3,4)	Underlying (2,4)	Feeling of being treated differently to home population (1,3)	Cashless benefits impeding access (2,3,4,6)	Disruption to social networks (2,3,4)	Feelings of not being safe (2,3,4)
Unable to access information on benefits/grants (2,4,6)	Cultural needs not met (1,4,6)	Feelings of worthlessness (1,4)	Not being listened to (3,6)	Misinformation/no information (2,4,5,6)	Stressful journeys (2,3,5)	Multiple flights of stairs (1,2,3)
Gesture (1,4)	No one to look after children in labour (2,4)	Suicidal thoughts/attempts (2)	Racism (4)	Poor post natal care (1,2,4,6)	Dispersed against policy/medical advice (2,3)	Lack of cooking facilities (2,3,4)
Informed consent (4,6)	Separation from partners (2,4)	Displacement (1)	The 'gaze' of others (1)	Refused registration at GP (2,3,4)	Anxiety/stress (1,2)	Cold (2,3)
Need for accessible written information (5,6)	Midwifery support improved feelings of isolation (3,5)		Lack of awareness (1)	Lack of childcare (2,4,6)	Dispersed close to due date (2,3)	Unsuitable food/inflexible mealtimes (2,4)
Access to language classes (4)	Familial (1,4)			Access to antenatal classes (4,5,6)	Lack of orientation to new place (2,3)	Negative experiences of IA (2,4)
	Stigma (4)			Geographical orientation (2,4,6)	Continuity of care (2)	Access to personal hygiene (4)
				Lack of continuity (2,6)	Interventions repeated unnecessarily (2)	
				Poor access to midwifery care (5)		
				Fear of exposure (2)		

1. [Briscoe and Lavender \(2009\)](#); 2. [Feldman \(2013\)](#); 3. [Lephard and Haith Cooper \(2016\)](#); 4. [McLeish \(2005\)](#); 5. [Nabb \(2006\)](#); 6. [Phillimore et al. \(2010\)](#).

[McLeish, 2005](#); [Nabb, 2006](#); [Phillimore et al., 2010](#)). Three of the studies ([Feldman, 2013](#); [Nabb, 2006](#); [Phillimore et al., 2010](#)) also considered the experiences of health professionals but this data was easily separated and not included in the analysis. The studies were assessed using the CASP tool and five of the six scored low overall ([Feldman, 2013](#); [Lephard and Haith Cooper, 2016](#); [McLeish, 2005](#); [Nabb, 2006](#); [Phillimore et al., 2010](#)) and one was unclear ([Briscoe and Lavender, 2009](#)), suggesting that the findings should be interpreted with some caution. Indeed, many of the studies did not adequately account for the relationship between researcher and participant ([Feldman, 2013](#); [Lephard and Haith Cooper, 2016](#); [McLeish, 2005](#); [Nabb, 2006](#); [Phillimore et al., 2010](#)) or ethical considerations ([Feldman, 2013](#); [McLeish, 2005](#); [Phillimore, 2010](#)). However, all studies employed qualitative methodology appropriately and the research design was generally robust and suitable to address the research aims. Descriptions of data analysis techniques were generally absent ([Feldman, 2013](#); [McLeish, 2005](#)) or unclear ([Lephard and Haith Cooper, 2016](#); [Nabb, 2006](#); [Phillimore, 2010](#)) but these may be due to restrictions on word count by journals.

Study findings

Thematic synthesis of the included studies presented seven common themes emerging from the participant's experiences, with many of them overlapping. These findings are summarised in [Table 1](#) under the headings: Communication challenges, Isolation,

Mental health challenges, Professional attitudes, Access to Healthcare, Effects of dispersal and Housing challenges and are described below.

Communication challenges

All six studies reported challenges in communication between women and healthcare providers, particularly when language barriers existed. Absence of shared language and/or interpretation services led to a number of difficulties including presumed understanding and misinterpretation ([Briscoe and Lavender, 2009](#); [Lephard and Haith Cooper, 2016](#); [McLeish, 2005](#)). [Briscoe and Lavender \(2009\)](#) recounted a situation where important post-natal information was not communicated when midwives incorrectly assumed that one participant's husband spoke English. Similarly, [Phillimore \(2010\)](#) found that many women experienced clinical decisions being made without their understanding. Poor communication was found to be a particular issue during labour in four of the studies ([Briscoe and Lavender, 2009](#); [Feldman, 2013](#); [McLeish, 2005](#); [Phillimore et al., 2010](#)) where women reported not understanding what was happening to them, provoking fear ([Briscoe and Lavender, 2009](#); [McLeish, 2005](#)).

There was also evidence of communication barriers effecting informed consent ([McLeish, 2005](#); [Phillimore et al., 2010](#)). The use of gesture in an attempt to overcome the language barrier was a repeated theme ([Briscoe and Lavender, 2009](#); [McLeish, 2005](#)) and

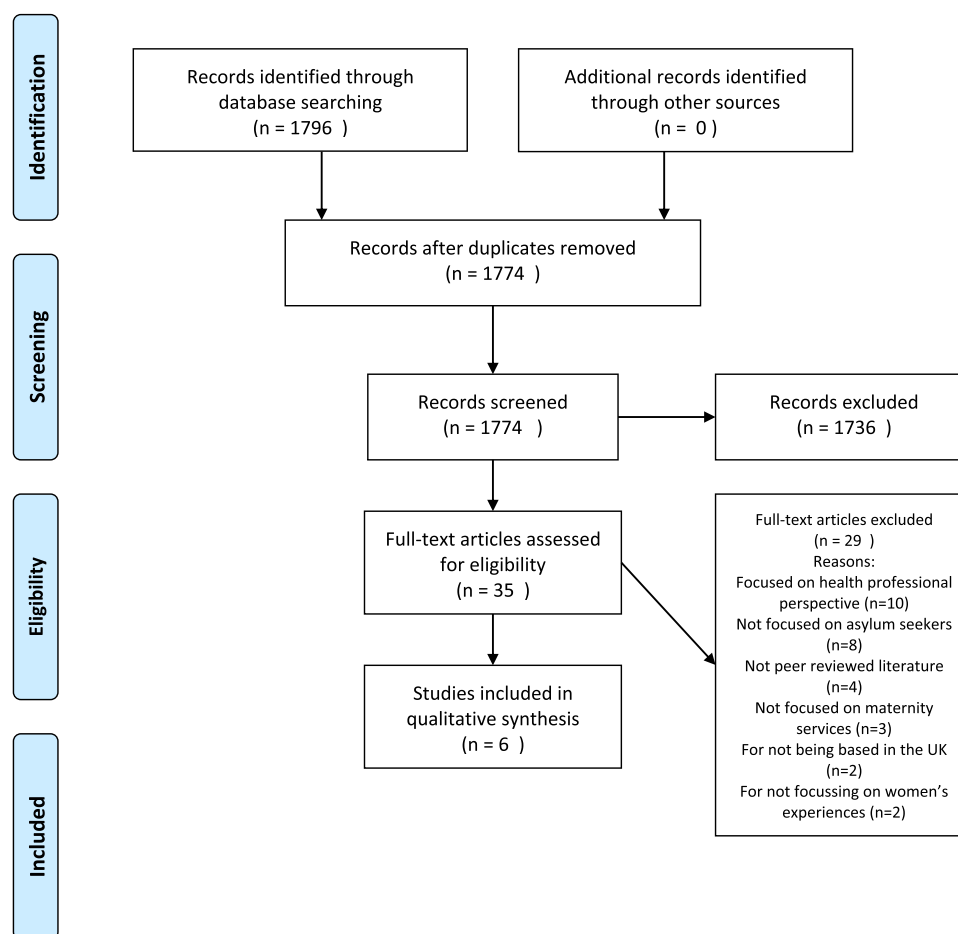


Fig. 1. Flow diagram to show the number of articles screened for inclusion in the systematic review.

Table 2
Summary of characteristics of studies.

Study	Study aim	Methodology & data collection	Analysis method	Sample	Quality of study (CASP assessment)
1. Briscoe and Lavender (2009)	To explore and synthesize the experience of maternity care by asylum seekers and refugees	Collective case study: semi-structured taped interviews at 5 points during antenatal and postnatal period.	3 key stages of analysis: decontextualisation; display and data compilation.	3 asylum seekers and 1 refugee	Unclear
2. Feldman (2013)	To investigate the health impact of dispersal and relocation on pregnant women and new mothers seeking asylum.	Qualitative: 20 face-to-face structured interviews with service users and 17 interviews with midwives.	Thematic analysis. Qualitative data presented as narrative accounts to illustrate themes.	20 asylum seekers who have experienced dispersal by UKBA during pregnancy or in the post natal period.	Low
3. Lephard and Haith Cooper (2016)	Exploring the maternity care experiences of local asylum seeking women to inform local services	Qualitative interpretative: semi-structured tape recorded or hand written interviews	Thematic analysis	6 asylum seekers	Low
4. McLeish (2005)	Describes asylum seeking women's experiences of maternity care in order to include mothers voices in policy debates.	Qualitative: semi-structured tape recorded interviews with service users.	Not stated	33 asylum seekers	Low
5. Nabb (2006)	To explore the perceptions of pregnant asylum seekers while in emergency accommodation in UK.	Exploratory qualitative: semi-structured interviews with service users and unstructured interviews with health professionals	Not stated	10 pregnant asylum seekers living in Initial Accommodation	Low
6. Phillimore et al. (2010)	Identify maternity care experiences of migrant women (including asylum seekers) including reference to barriers, access and health beliefs	Qualitative: 82 face-to face questionnaires and 13 in-depth interviews with service users and 18 interviews with healthcare professionals.	Questionnaire data analysed using SPSS statistical analysis package and qualitative data using thematic synthesis	Migrant women including 17 asylum seekers.	Low

women reported that this non-verbal communication was used by both service users (Briscoe and Lavender, 2009) and health professionals (McLeish, 2005) as a way to be understood. In five of the studies, friends and family were inappropriately relied on for interpretation (Briscoe and Lavender, 2009; Feldman, 2013; McLeish, 2005; Nabb, 2006; Phillimore et al., 2010), which sometimes included children (McLeish, 2005).

Communication challenges were also noted in terms of the written information provided to women regarding their care and entitlements during pregnancy. Two studies reported the need for more accessible written information and access to handheld notes (Nabb, 2006; Phillimore et al., 2010) and recounted instances where women were unable to access information on benefit entitlements which lead to hardship (Feldman, 2013; McLeish, 2005) as well as unnecessary payments for prescriptions they could not afford (Phillimore et al., 2010).

Isolation

All studies discussed themes of isolation as a direct consequence of women's asylum seeker status, most frequently in terms of social and financial isolation (Briscoe and Lavender, 2009; Feldman, 2013; Lephard and Haith Cooper, 2016; McLeish, 2005; Phillimore et al., 2010). Relocation due to displacement meant that many of the women included in these studies were thousands of miles away from friends and family. Separation from partners (Briscoe and Lavender, 2009; Feldman, 2013; McLeish, 2005) and other family members (Briscoe and Lavender, 2009; Lephard and Haith Cooper, 2016; McLeish, 2005) resulted in feelings of social exclusion (Briscoe and Lavender, 2009).

Lack of social networks was also reported to have led to practical and emotional difficulties for women during labour where participants described having no one to look after their older children (Feldman, 2013; McLeish, 2005) and/or having to experience labour on their own with no birth partner (Feldman, 2013; Lephard and Haith Cooper, 2016; McLeish, 2005). However, in two studies (Lephard and Haith Cooper, 2016; Nabb, 2006) participants reported an improvement in feelings of isolation through contact with their midwife.

Financial, as well as social, isolation often resulted in feelings of disempowerment amongst women (Briscoe and Lavender, 2009; Lephard and Haith Cooper, 2016; McLeish, 2005), and was linked to their financial reliance on the Home Office due to a prohibition on paid work while their case was being assessed (Briscoe and Lavender, 2009; Feldman, 2013; Lephard and Haith Cooper, 2016; McLeish, 2005; Phillimore et al., 2010). The use of cashless benefits via voucher systems were also felt to increase isolation through social stigma (McLeish, 2005) with one woman describing the humiliation of being refused goods at non-participating shops and another having to beg for food due to a delay in receiving vouchers (McLeish, 2005).

Mental health challenges

Women's poor mental health, often without adequate support during their pregnancy, was a recurring theme (Briscoe and Lavender, 2009; Feldman, 2013; Lephard and Haith Cooper, 2016; McLeish, 2005; Phillimore et al., 2010). Participants in four studies reported poor mental health due to previous trauma and oppression (Briscoe and Lavender, 2009; Feldman, 2013; McLeish, 2005; Phillimore et al., 2010) including rape (Briscoe and Lavender, 2009; Feldman, 2013), experiences of conflict (Feldman, 2013), domestic violence (Feldman, 2013; Phillimore et al., 2010), torture (McLeish, 2005), and human trafficking (Feldman, 2013). Of the participants in Feldman's (2013) study, half reported experiencing mental health problems and two attempted suicide dur-

ing the pregnancy under discussion. Although symptoms of depression were widely reported by participants in three studies (Feldman, 2013; McLeish, 2005; Phillimore et al., 2010) McLeish (2005) stated that only two of the 33 women involved in her research had been offered psychological support. Anxiety and stress were also widely reported in three studies (Briscoe and Lavender, 2009; Feldman, 2013; McLeish, 2005) for reasons including negative feelings of self-worth (Briscoe and Lavender, 2009; McLeish, 2005), loss of autonomy (Briscoe and Lavender, 2009) and concern over impending Home Office decisions regarding asylum status (Feldman, 2013; McLeish, 2005).

Professional attitudes

Five studies reported experiences of professional attitudes, both positive (Briscoe and Lavender, 2009; Lephard and Haith Cooper, 2016; McLeish, 2005; Nabb, 2006; Phillimore et al., 2010) and negative (Briscoe and Lavender, 2009; Lephard and Haith Cooper, 2016; McLeish, 2005; Nabb, 2006; Phillimore et al., 2010). Midwifery care and relationships with midwives were regarded by participants as predominantly positive, particularly in community and specialist services settings (Feldman, 2013; McLeish, 2005). The overwhelming experience of midwifery care reported was one of kindness (Briscoe and Lavender, 2009; Lephard and Haith Cooper, 2016; McLeish, 2005; Nabb, 2006; Phillimore et al., 2010) with one woman likening her midwife to a member of her family (Lephard and Haith Cooper, 2016). Women reported a desire for midwifery care (McLeish, 2005) and described how this care acted as a factor in relieving feelings of loneliness (Lephard and Haith Cooper, 2016), in feeling less stigmatised (Nabb, 2006) and in being made to feel more comfortable (Briscoe and Lavender, 2009).

However, participants also encountered stereotyping by healthcare professionals which affected their care (Briscoe and Lavender, 2009; Phillimore et al., 2010). In one study, incorrect assumptions about a woman's language fluency meant that a request for interpretation was denied (Lephard and Haith Cooper, 2016), leading to distress. In another instance, Lephard and Haith-Cooper (2016) reported an experience where a midwife assumed, based on a woman's asylum status that she would want to terminate the pregnancy. Indeed, McLeish (2005) suggested that healthcare professionals' lack of awareness of participant's poverty and living conditions could undermine the health information that was being given. For example, in the assumption that women can attend antenatal classes when in fact access is prevented due to lack of transport, geographical orientation or language barrier (McLeish, 2005; Nabb, 2006; Phillimore et al., 2010).

In two studies, women reported feeling that they were treated differently to the home population due to their asylum status (Briscoe and Lavender, 2009; Lephard and Haith Cooper, 2016) and participants from three studies recounted experiences of hostility from healthcare professionals (Lephard and Haith Cooper, 2016; McLeish, 2005; Phillimore et al., 2010). One woman reported being scolded by her midwife for not having the right feeding equipment (although she was unable to afford it) and another recounted being racially abused by staff on the ward (McLeish, 2005).

Access to healthcare

In all six studies, participants reported multiple difficulties in accessing healthcare, and delayed access to care was noted in all but one study (Feldman, 2013; Lephard and Haith Cooper, 2016; McLeish, 2005; Nabb, 2006; Phillimore et al., 2010). Language barriers were a significant factor in women's ability to access care, due to the reasons outlined in the communication challenges section. Women also described physical barriers to accessing care, for example being unable to pay for transport, due to a reliance on

cashless benefits (Feldman, 2013; Lephard and Haith Cooper, 2016; McLeish, 2005; Phillimore et al., 2010). In other cases, lack of geographical orientation following recent dispersal to a new area was noted as a barrier to accessing care (Feldman, 2013; McLeish, 2005; Phillimore et al., 2010). Women also report limited or no means of childcare due to a lack of social networks or finance (Feldman, 2013; McLeish, 2005; Phillimore et al., 2010).

In some cases, women were denied access to care. For example, some women were refused registration with local GP surgeries (Feldman, 2013; Lephard and Haith Cooper, 2016; Phillimore et al., 2010) and one woman reported the experience of being wrongly charged for healthcare (Lephard and Haith Cooper, 2016). Women's lack of understanding of the role of healthcare professionals was also noted as a barrier to accessing care; Feldman (2013) reported that this was often a factor in non-attendance due to mistrust and fear of exposure. The dispersal system was also reported to have caused a disruption to accessing healthcare (Feldman, 2013; Nabb, 2006; Phillimore et al., 2010), which is discussed in more detail in the dedicated section below.

Effects of dispersal

The effects of the Home Office policy of mandatory dispersal to all parts of the UK emerged as a theme in all six studies, with one making it the primary focus of the research (Feldman, 2013). This was repeatedly reported in terms of how it disrupted maternity care for participants- leading to potential health risks, delay in treatment (Feldman, 2013; Nabb, 2006; Phillimore et al., 2010) and medical screenings being repeated unnecessarily (Feldman, 2013). In some cases, women were dispersed against both medical advice and Home Office policy (Feldman, 2013; Lephard and Haith Cooper, 2016), and in Feldman's (2013) report two participants gave birth the day after arrival in a new area. Three reports (Feldman, 2013; Lephard and Haith Cooper, 2016; Nabb, 2006) recounted experiences of stressful journeys during dispersal; one woman described being given crisps and no other food or drink on a seven-hour journey (Phillimore et al., 2010) and another was expected to carry all her belongings while using crutches (Lephard and Haith Cooper, 2016).

The policy of dispersal was commonly experienced as having a negative effect on mental health by causing stress and anxiety (Briscoe and Lavender, 2009; Feldman, 2013), feelings of powerlessness (Briscoe and Lavender, 2009; Feldman, 2013; Lephard and Haith Cooper, 2016; McLeish, 2005) and a disruption to important social networks (Feldman, 2013; Lephard and Haith Cooper, 2016; McLeish, 2005). Indeed dispersal, or the threat of dispersal, meant that many women '*appeared to accept being powerless with quiet resignation*' (Briscoe and Lavender, 2009-pg21). The effects of repeated dispersal in pregnancy were particularly acute and further disrupted care (Feldman, 2013; McLeish, 2005; Phillimore et al., 2010).

Housing challenges

Housing conditions in the provided accommodation were criticised by participants in all but one study (Briscoe and Lavender, 2009; Feldman, 2013; Lephard and Haith Cooper, 2016; McLeish, 2005; Phillimore et al., 2010), who described poor conditions both in initial and post-dispersal accommodation. Women reported cramped and dirty multi-occupancy rooms (Briscoe and Lavender, 2009; Feldman, 2013; Lephard and Haith Cooper, 2016; McLeish, 2005; Phillimore et al., 2010) which were particularly unsuitable during the antenatal and postnatal periods due to cold temperatures (Feldman, 2013; Lephard and Haith Cooper, 2016), lack of cooking facilities (Feldman, 2013; Lephard and Haith Cooper, 2016; McLeish, 2005) and multiple flights of stairs (Briscoe and

Lavender, 2009; Feldman, 2013; Lephard and Haith Cooper, 2016). Feelings regarding a general lack of safety in the accommodation provided were common (Feldman, 2013; Lephard and Haith Cooper, 2016; McLeish, 2005) and one woman described IA conditions as 'like a prison' (Feldman, 2013-pg29). In Briscoe and Lavender's (2009) study, a woman recounted falling down the stairs three times due to poor conditions. Shared, mixed-sex bathrooms, particularly in IA, were reported as unsuitable and unhygienic (Feldman, 2013; McLeish, 2005; Phillimore et al., 2010), especially during pregnancy, and led to concerns regarding personal safety (Feldman, 2013). In Feldman's (2013) study one participant recounted being watched by a male resident while showering. Women also described experiences where they were refused access to personal hygiene products while in IA (McLeish, 2005).

Unsuitable food and inflexible mealtimes in IA were also criticised (Feldman, 2013; McLeish, 2005): food was described as inedible, culturally inappropriate and unsuitable for pregnancy or breastfeeding. Women often did not feel comfortable breastfeeding in the dining rooms of this type of accommodation, however they were not allowed to take meals back to their rooms so frequently missed mealtimes (Feldman, 2013). Strict schedules for mealtimes also meant that women sometimes missed meals due to lengthy or inappropriately timed antenatal appointments (Feldman, 2013).

Discussion

This review suggests there are a number of challenges experienced by pregnant asylum seekers accessing maternity care in the UK including communication, isolation, mental health, professional attitudes, access to healthcare, housing and the effects of dispersal.

The barriers reported in this review are often practical in nature. Women are unable to access appointments due to a lack of geographical knowledge in a new area or are unable to pay for transport due to a reliance on cashless benefits. When clinical contact is made, communication is often impeded by language barriers and the absence of interpreters, hampering care and the transfer of important health information. The Home Office policy of mandatory dispersal creates a disruption to care, requiring that women repeatedly seek out and access services as they are moved around the country. These findings suggest an overarching disconnect between the maternity health system, which assumes a certain level of resource and stability in caring for its intended mainstream population, and the lived experiences of pregnant asylum seekers.

The current Maternity Transformation Programme (National Health Service, 2017) seeks to achieve the vision set out by Better Births (National Maternity Review, 2016) to provide a woman-centred maternity service built around individual need and circumstance and valuing continuity of carer, particularly in meeting the needs of marginalised groups and offers an opportunity to address these needs.

There is no current national standard or guidance on service provision for pregnant asylum seekers in the UK or research available comparing services offered by individual Trusts however there is anecdotal crossover from Trust to Trust. Specialised services are already established in some areas of the UK (Royal College of Midwives, 2008), most notably those with high dispersal populations and IA centres (including Birmingham, Croydon, Glasgow, Liverpool), however the level of service is dependent on individual NHS Trusts and Clinical Commissioning Groups. In Leeds, the Haamla (Leeds Teaching Hospital NHS Trust, 2018) service provides a wraparound multi-disciplinary team of specialist midwives, bilingual support workers, interpreters and volunteer doulas offering antenatal and postnatal specialist care, antenatal classes, home visits and befriending to pregnant asylum seekers and other vulnerable groups. A model of service such as this could go some way to addressing the social and cultural difficulties faced by the

women in these studies with a focus on communication, flexibility and empowerment (Haamla Service, 2009).

The use of volunteer doulas for birth advocacy and social support in the pre- and post-natal period is employed in other IA centres and areas with high asylum seeker population and services have been found to provide additional continuity for vulnerable groups which is both empowering and complementary to midwifery care (McLeish and Redshaw, 2017).

The needs of vulnerable women were highlighted in the recent confidential enquiry into maternal death (Knight et al., 2018) which includes surveillance data on women who died during or up to one year after pregnancy between 2014 and 2016 in the UK. The report showed a five-fold difference in maternal mortality rates amongst women from black ethnic backgrounds and an almost two-fold difference amongst women from Asian ethnic backgrounds compared to white women. While there were three deaths recorded amongst asylum seekers, it is not currently known how many women are accessing maternity services from this population. The report recommends further research is needed to fully understand the reasons for these disparities and hence to develop actions to address them.

The findings from this systematic review suggest that challenges relating to language barriers are a major factor in pregnant asylum seekers accessing and fully participating in maternity care. Lack of access to interpreters have been found to be a feature in maternal deaths in the UK (Centre for Maternal and Child Enquires, 2011) including in five out of 10 maternal deaths reported at Northwick Park between 2002–2005 (Healthcare Commission, 2006), indicating the need for professional interpreters in pregnancy and labour is paramount. The lack of access to interpreters in labour, reported in these studies, is particularly concerning given the intimate nature of intrapartum care and the increased prevalence of gender-based violence in the asylum-seeking population (Phillimore et al., 2018). In a healthcare age of shared decision making and *no decision about me, without me* (Coulter and Collins, 2011), the use of interpreters should be a given. Improving interpreter provision in labour, even in a high-intensity hospital setting, is not an impossible task as shown by a recent Australian study (Yelland et al., 2017). Yelland et al. (2017) found that the engagement and support of midwives was crucial to the success of providing interpretation services in labour, which engaged a plan-do-study-act framework to instill cultural change.

The care and compassion of midwives was highly valued by the women in the studies reviewed and was found to reduce feelings of 'otherness' frequently experienced by this group. Midwives are in a unique position to bridge the clinical/social gap in their role as advocates and partners (Department of Health, 2007) in the birth process. However, the findings of this review suggest that cultural competency and anti-discriminatory practice needs to be improved to ensure that care is appropriate, respectful and in partnership with pregnant women. This could be achieved through improved pre- and post-registration training of midwives and other clinical and non-clinical staff involved in the care of pregnant asylum seekers. Training should cover both the social, clinical and psychological needs of this group as well as up to date information regarding Home Office policy and current socio-political population influences.

The recently reviewed NICE guidelines on Pregnancy and Complex Social Factors (NICE, 2012) do not consider the needs of pregnant asylum seekers as distinct from the wider BME population and no guidance exists for how to design and implement services for asylum seekers. This lack of distinction between populations is largely due to a scarcity of UK research on which to base recommendations (Hollowell et al., 2011) despite anecdotal evidence that the needs of such populations may differ significantly. Gaps in research may be indicative of cultural and political drivers that fail to prioritise the health of vulnerable women in general and asylum

seekers in particular. The findings suggest that there are variations in need at different stages of the asylum-seeking process itself as the experiences of pregnant women in IA or those newly arrived in the country appear distinct from those living in post-dispersal accommodation. As such, further research should aim to explore how the maternity care needs may vary by examining the experiences of women at different stages of the asylum-seeking process. A national evaluation of existing specialist services could also lead to the creation of a best practice model for providing maternity care to asylum-seeking women in the UK. Furthermore, clear national guidelines on the provision of such specialist services, through bodies such as NICE or the Home Office would help to address geographical inequalities in service provision. In the meantime, practical recommendations should include better provision of interpreters and the building of stronger links between maternity services and the Home Office in order to improve collaboration and data collection, ensuring care is timely, appropriate and facilitates smooth transfer through the dispersal process.

Strengths and limitations

This systematic review is unique in that it examines asylum seekers as a distinct population outside of the broader migrant, refugee or vulnerable woman paradigm. While this review included qualitative studies of the maternity care experiences of asylum-seeking women, many of the publications were found to lack dependability, usually due to an insufficient level of detail reported in the studies' design, meaning there is some question of the credibility of findings. There was also a lack of detail reported in the length of time women had been in the country or the stage of their asylum claim, which would have been beneficial in disseminating findings. However, themes across each of the studies were consistent and also reflected the findings from the wider body of research into migrant, refugee or vulnerable women.

Conclusion

This systematic review has identified the main challenges affecting pregnant asylum-seeking women in accessing and negotiating maternity care in the UK and has highlighted the needs of this vulnerable group as distinct from the home population. It would appear there is much maternity services could do to improve access and the experiences of this isolated group. There is limited good quality research in this area and further research is required to examine women's experiences at different stages of the asylum-seeking process and the effectiveness of specialised services in improving access and clinical outcome.

Conflict of interest

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Ethical approval

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