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Link to original published version: <http://dx.doi.org/10.12968/bjom.2013.21.6.404>

Citation: McCarthy, R. and Haith-Cooper, M. (2013) Evaluating the impact of befriending for pregnant asylum seeking and refugee women. *British Journal of Midwifery*, 21 (6) 404-409.

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Evaluating the impact of befriending for pregnant asylum seeking and refugee women

Abstract

Pregnant asylum-seeking and refugee women are a particularly vulnerable group in society, who may be possibly living alone in poverty in inappropriate accommodation (Dunne, 2007) and experiencing hostile attitudes (Hynes and Sale, 2010). They may have poor physical and mental health, placing them at an increased risk of poor pregnancy outcomes (National Institute for Health and Care Excellence (NICE), 2010). Despite this, they are less likely to attend for timely maternity care. This article discusses the evaluation to date of an ongoing befriending project located in Northern England, targeting pregnant asylum-seeking and refugee women and helping to address difficulties that they may face. Volunteer befrienders, who themselves are asylum-seeking and refugee mothers, receive training to provide support and guidance to clients. Preliminary data suggest that befriending has advantages for both client and volunteer: clients appear to develop a trusting relationship with their befriender which facilitates self-confidence and helps overcome social isolation; and the volunteers feel that they are undertaking a worthwhile role and often move onto paid employment. Befriending may be a useful resource for midwives and ultimately improve pregnancy outcomes for asylum-seeking and refugee women.

Introduction and background

Asylum is the protection given to a person who is fleeing their home country in fear of violence and persecution, while a refugee has had their asylum claim accepted and has been granted leave to remain in the UK (UK Border Agency, 2011). The typical asylum seeker is perceived as young and male with women being dependent on a head of household (Dunne, 2007; Gedalof, 2007). In reality, this is not always the case: almost half of women seeking asylum are unsupported (Refugee Council, 2009). These women are often pregnant on arrival in the UK due to a lack of available contraception or as a consequence of rape (Refugee Council, 2009; Squire and James, 2009). Many women originate from countries in conflict where 'war rape' has become endemic, such as Rwanda where up to 50 000 women have been systematically raped (Refugee Council, 2009). Some women are raped on their journey to the UK and many raped after arrival (Refugee Council, 2009).

There is a general public perception in the UK that asylum seekers are often bogus and come to the country to abuse the welfare system (Mulvey, 2010). This perception is reinforced through negative media reporting (Greenslade, 2005) and has resulted in widespread hostility and discrimination, and even incidences of violence against asylum seekers (Hynes and Sales, 2010). This has led to the marginalisation of asylum seeking women in the UK and their resulting social isolation (Squire and James, 2009). It is argued that the asylum system in the UK is male dominated with the aim of deterring 'bogus' asylum seekers and does not consider the needs of women seeking asylum (Dunne, 2007; Aspinall and Watters, 2010). Women can claim asylum for the same reasons as men, but often have different reasons such as being the victims of human trafficking, forced prostitution or slavery (Dumper, 2005). They may also have experienced gender-specific violence including rape, female genital mutilation, forced abortion or domestic abuse (Reed, 2003; Ukoko, 2007). Despite this, on arrival in the UK, women asylum seekers are

often detained with men in initial assessment centres (Dunne, 2007). They may be dispersed into mixed sex accommodation, where they feel unsafe living with asylum-seeking men (Dumper, 2002). In addition, women may have had to take on the unfamiliar role as head of household or may have left their children behind in their native country (Refugee Council, 2009). They are less likely to speak English than men, further increasing their social isolation (Seu, 2003; Reed, 2003).

Health needs

Pregnant asylum-seeking and refugee women often have poor physical health due to the poverty and deprivation experienced in their home country, which continues as they journey to the UK and after their arrival (Aspinall and Watters, 2010). Evidence suggests that African women in particular are likely to be malnourished, with conditions including iron deficiency anaemia, tuberculosis, malaria, HIV/AIDs and other sexually transmitted infections. Asylum-seeking and refugee women may also experience psychological disorders including post-traumatic stress disorder as a consequence of the persecution and violence that they have witnessed in their home country (Burnett and Fassil, 2004). In addition, women who are pregnant as a result of rape have to cope with the impact of carrying a child that is a consequence of violence. It may be culturally inappropriate to discuss the issue of rape and a woman may have been shunned by her husband, family and community. She may feel ashamed and unclean (Burnett and Fassil, 2004). The process of asylum, living in poverty, social isolation, loneliness and the uncertainty around the future have been found to lead to further deterioration of asylum-seeking and refugee women's physical and mental health (Bollini et al, 2009; Reynolds and White, 2010). In turn, poor health increases the risks of asylum-seeking and refugee women having a pregnancy ending in a poor clinical outcome including late miscarriage, stillbirth and neonatal death (National Institute for Health and Care Excellence (NICE), 2010), as well as being at an increased risk of maternal mortality. Asylum-seeking and refugee women account for 14% of maternal deaths in the UK, despite only comprising 0.5% of the population (Centre for Maternal and Child Enquiries (CMACE), 2011). This is partly due to language barriers but also because these women have little understanding of when and how to access maternity services in the UK so do not attend for timely antenatal care (Burnett and Fassil, 2004; CMACE, 2011).

When pregnant asylum-seeking women come to the end of the asylum process and fail to achieve refugee status, they are put in an even more vulnerable situation as they can be charged for maternity care which, in turn, can deter them from attending (Dumper, 2005). In addition, failed asylum seekers receive no welfare benefits up until the 32nd week of pregnancy and may be destitute with nowhere to live. This will impact on their ability to attend for maternity care and their health in pregnancy, particularly having a nutritious diet, which will influence both maternal and fetal outcomes (Ukoko, 2007). These women are also likely to be living in stressful circumstances and in order to receive some form of income, may be forced into prostitution (Refugee Action, 2006). When considering the circumstances in which pregnant asylum-seeking and refugee women find themselves, it is argued that in addition to their physical midwifery needs being met, they require referral to specialist social and psychological support services. However, in reality, midwives are not always able to assess these needs due to women not attending for care or midwives not perceiving the importance, or having time to address the woman's holistic needs (Briscoe and Lavender, 2009; Reynolds and White, 2010).

Consequently, asylum-seeking and refugee women have often reported poor

experiences of maternity care including poor attitudes, rudeness and racism (McLeish, 2005; Gaudion and Allotey, 2008; Waugh, 2010).

Befriending

Recent government policy (Department of Health (DH), 2010) has focused on strengthening the contribution of the third sector to society, suggesting that this will be essential in providing sustainable health care. Part of this vision involves the development and promotion of volunteering as a means of reducing inequalities and improving health outcomes for vulnerable groups. One form of volunteering is to become a befriender for a person in a vulnerable situation. Befriending is the process of developing and maintaining a supportive, non-judgmental relationship between two individuals over a period of time. This is a formal process, initiated and monitored by an external agency (Dean and Goodlad, 1998). There are examples of effective befriending programmes in other areas of health care including the older person (Lester et al, 2012), breastfeeding support for South Asian families (Douglas, 2012) and people with mental health problems (Mitchell and Pistrang, 2011). In the context of pregnant asylum-seeking and refugee women, it was proposed that befriending could be a useful intervention in addressing some of the difficulties that women face while living in the UK.

Refugee Council voluntary health befriending network

In 2011, the Refugee Council received funding from the Health and Social Care Volunteering Fund. This was to undertake a 3-year project to establish a health befriending network for asylum seekers and refugees living in four areas of England. In all the areas, pregnant women are befriended as part of this project, but in Leeds a specific maternity befriending programme has been developed. The objectives of this programme are to ensure that pregnant asylum seeking and refugee women understand their entitlements to and access maternity care in England in a timely manner, and to help asylum seeking and refugee women connect better to the local community, experiencing less social isolation.

After undergoing a successful application and interview process, English-speaking women, who are mainly asylum-seeking and refugee mothers, undergo four half-day training sessions (*Table 1*) to prepare them to act as befrienders for other pregnant women in the same situation. Unless a client requests otherwise, the befriender is then matched as closely as possible with a client who has a similar cultural background and speaks the same language. Support is provided to the client from early pregnancy up until 2 months postnatally, but excluding the birth. There is an expectation that the befriender will commit to meeting with her clients for up to 3 hours a week. However, in reality, many befrienders spent more time with their clients. The befriending role includes listening and supporting asylum seeking and refugee women, signposting them to appropriate services including those to meet health and social care needs, and accompanying them to appointments where required. The project co-ordinator provides information and supervision for the befrienders with monthly peer support group meetings and individual debriefing sessions. Befrienders also receive support from their peers.

Preliminary findings

There is an ongoing process of monitoring and evaluating the effectiveness of the programme through audit and generating qualitative data. With the assurance of confidentiality and anonymity where requested, both befrienders and clients consent to engage in activities to generate qualitative data, clients through evaluation questionnaires, usually completed over the phone by independent interpreters. The befrienders participate in focus group and individual interviews conducted by the project co-ordinator. Data are analysed and emerging themes approved with the project co-ordinator's line manager. Preliminary audit findings, covering September 2011 to December 2012, have been analysed (*Table 2*). As the data shows, the number of volunteers and clients engaging with the project far exceeds the targets set; 51 women (against a target of 20), who spoke a total of more than 30 different languages, volunteered as a befriender. They have been matched with 83 clients to befriend, most of whom were pregnant (the target was 60). Some clients already had children and some have subsequently become pregnant.

The clients have been referred to the project by midwives, children's centres and refugee community organisations. They have been helped to access a wide range of health services including maternity care, dentists, mental health services and HIV support. They have been introduced to resources such as drop-in centres, charity shops and supermarkets, and helped to find clothing for themselves and their baby. They have also been accompanied to appointments such as housing advice and solicitors. As the befriender training does not include being an interpreter, they do not offer such a service in professional contexts. Therefore health services should continue to use interpreters where required.

Preliminary qualitative findings suggest that befriending appears to be valuable for the clients in different ways. Clients appear to be developing the ability to speak out in some contexts as the following cases suggest.

Case studies

A befriender recalled her experience of taking a destitute client to an antenatal class which was being held in a local children's centre. Her baby was both large and breech and she was frightened about having a caesarean section birth with no place to live. Here, through her learning, the client developed confidence in her ability to give birth naturally and was determined to have a normal birth. The befriender built on this confidence, when she accompanied her to a consultant appointment. She encouraged the client to explain to the doctor that she wanted a normal birth, who to the client's amazement, agreed. The baby subsequently turned to a cephalic presentation and she gave birth on all fours, to a 10lb baby. She said to her befriender 'I can do anything now'.

In addition, the following case suggests that befriending could impact on maternal and fetal outcome.

A pregnant client who was HIV positive was not taking her medication because she believed she had been cured. She asked her befriender, who was also HIV positive, to attend a consultant appointment with her as she felt she had established a trusting relationship with her. The consultant advised the client of the importance of taking her medication but she did not believe him. She did, however, believe the befriender,

when she reinforced the consultant's advice. She continued to take her medication throughout pregnancy and her baby was found not to be infected with HIV

One client suggested that the befriender has helped her to cope with her social isolation. She was the only woman that she had spoken Arabic with since arriving in England, and remarked that 'she took me out of my loneliness corner'.

Some cases suggest that when the client forms a trusting relationship with the befriender, they reveal difficulties which may have otherwise remained hidden. This has included experience of domestic abuse where clients could be signposted to appropriate support agencies. One client was encouraged to return to the hospital she had just been discharged from when she revealed that her partner had been kicking her caesarean section wound. Another client had experienced domestic abuse and left her partner. However, she was being pressurised by her local community to return to him but also advised by social services that if she did return, her children would be removed. The client felt that the befriender offering unbiased emotional support helped her through her difficulties:

***'Having someone to talk to at a children's centre where I felt safe made all the difference. She saved me.'* [Client]**

Achievements beyond the project

Already, the project appears to have surpassed its initial aims. During the monthly support meetings, the volunteers began to discuss how they could move beyond the programme to facilitate more asylum-seeking and refugee women to access antenatal care and improve maternity services for these women. They now actively seek out other women and encourage them to sign up as clients. In addition, a number of befrienders represent the Refugee Council on different forums including the local Maternity Services Liaison Committee and the regional Health Innovation and Education Cluster. They have become involved in the education of both pre-registration and qualified midwives and supervisors of midwives, and have presented at national conferences. They have been invited to participate in the Local Supervisory Authority audit of maternity services and also in the patient public involvement agenda of local universities; sitting on committees and interviewing and assessing health-care students. Preliminary evaluation suggests that the volunteers themselves are benefiting from the project, developing their self-confidence:

***'I used to think I used to think I was nothing, now I think I'm something and when I wear my Refugee Council badge I feel like a professional.'* [Befriender]**

In addition, following working as a befriender, some women have secured paid employment in the voluntary sector and in schools.

Implications for midwifery services

Contemporary midwifery practice frequently involves working in stressful environments with increasing staff shortages and the threat of more efficiency savings (Bird, 2012; O'Sullivan and Dromey, 2012). At the same time, midwives are expected to provide individualised, woman centered care, encompassing the cultural, social and psychological factors which influence childbirth (Nursing and Midwifery Council (NMC), 2009). Pregnant asylum-seeking and refugee women

often have complex health and social care needs which midwives may have difficulty in meeting due to limited resources, but also due to poor attitudes and a lack of understanding of their needs (Briscoe and Lavender, 2009; Reynolds and White, 2010). The preliminary findings from this project suggest that befriending may become a valuable service for pregnant asylum-seeking and refugee women living in the UK. However, it could also become a useful resource for midwives working with asylum-seeking and refugee women. At the booking interview, as a midwife assesses a woman's holistic needs, she could refer a woman to a befriending project as a way to address some of these needs. Working with a befriender could facilitate the midwife to increase her understanding around asylum seeking; the woman's reasons for leaving her home country, the asylum process and the difficulties that she may have living in the UK. The midwife could become more aware of the role of charities and other voluntary sector organisations in the local area and how to refer women to appropriate services. As the befriender and asylum-seeking and refugee woman may share the same cultural background, the befriender could be a valuable asset for the midwife when addressing the woman's cultural needs. However, this partnership must not undermine the midwife and asylum-seeking and refugee woman's relationship or the woman's opportunity to make informed choices.

Conclusion

Increasingly, midwifery practice appears to involve working in an environment with limited resources. Asylum-seeking and refugee women often have complex care needs, which midwives need to meet. Working with befrienders has the potential to benefit midwives in terms of time and cost savings. If, for example, women are encouraged by their befriender to attend for regular and timely antenatal care, then pregnancy complications could be prevented or detected and managed early. In addition, befrienders offer a valuable educational resource for midwives.

Asylum-seeking and refugee women appear to benefit from having a befriender with the development of a trusting relationship with a woman who has been in a similar situation. The befriender speaks the same language and understands the client's social and cultural background and the difficulties clients may be facing becoming a mother. In addition, there appear to be benefits for the volunteer. As well as making a valuable contribution to society, befriending increases knowledge about asylum related issues and also can build self-esteem and self-confidence. In this project, many women who have been befriended are now themselves training to become a volunteer. One woman stated that she didn't want other woman to suffer as she had suffered. Although this article presents preliminary findings from a project, limited to one area in England, it suggests that befriending may be a way forward in meeting the health and social care needs of pregnant asylum-seeking and refugee women. There are other similar projects being developed around the country which midwives will be able to refer to. These include a NCT-funded project *Birth and Beyond* which commenced in 2011 and is being undertaken in four areas of the UK, training volunteers over a 10-week period to provide similar support to vulnerable pregnant women. In West Yorkshire, the focus is on asylum-seeking and pregnant women. In addition, there are other related befriending projects aimed at helping meet the general health needs of asylum seekers and refugees. Ultimately, with an increasing policy shift towards involving volunteers in health-care provision, befriending may increasingly become utilised as a resource within the NHS.

Table 1. Examples from the befriending training programme

- Debriefing the befriender's own experiences of seeking asylum and accessing maternity services and coping with stress should difficult memories be triggered
- The role of the befriender and the importance of confidentiality, developing boundaries and understanding the limitations of her role
- Effective listening and empowerment skills. Enabling clients to build on their coping strategies to speak on their own behalf, without the befriender becoming a barrier between the client and health professional
- An overview of the asylum system in England and the work of voluntary and statutory health and social care services and community groups.
- How to signpost clients and other people within the befriender's community to these services
- A comparison between the maternity care offered to clients in their home country and the UK, and problems that may be experienced accessing health and maternity services
- Increasing understanding around issues such as female genital mutilation, the role of doulas and specialist midwives, HIV, bereavement and mental health support, risk management, child protection and domestic abuse.
- Understanding how to refer women to appropriate services

Table 2. Preliminary audit findings

Target per year of project/ Total for first 15 months

Number of volunteers recruited 20/51

Number of clients matched with volunteers 60/83

Number of clients signposted to refugee community organisations 120/525

Number of clients signposted to health services 120/1636

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