THE IMPACT OF SEXUAL VIOLENCE ON THE MATERNAL HEALTH OF ASYLUM SEEKERS AND REFUGEES

"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"[1, p 35]

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Refugee and Asylum Seeker Health, Dr O'Neill

ACKNOWLEDGEMENT AND THANKS

This module has been a wonderful opportunity to learn about Global Health and the reality of Asylum Seeking in the UK and I would like to convey my gratitude to all the voluntary organisations, health professionals, and Asylum Seekers who were kind enough to give up their time to teach me about their experiences. I would also like to thank Siobhan and Dr O'Neill for their help throughout this module.

ABSTRACT

Asylum seekers and Refugees are two of the most marginalised and vulnerable groups in society, who often flee their countries following experiences of conflict andviolence to seek sanctuary in the UK. Previous research has highlighted that the needs of asylum seekers and refugees are often not met upon arrival in the UK, but there is a lack of research into maternal health needs specifically. This paper explored the experiences and needs of asylum seekers and refugees in the UK,both broadly and with relevance to maternal health needs following experiences of violence. This was donefrom global, national and local perspectives, throughinterviews with asylum seekers and a review of the literature and publicationsavailable on the subject. It was found that despite the comparatively small asylum seeker and refugee populations in the UK, and the small proportion of applicants who are actually granted asylum, mistrust exists among the general public in the UK about the claims of these groups; an attitude propagated by the media. Refugee and asylum seeker health needs,particularly the very sensitive and complex requirements of mothers with experience of violence (in the forms of rape and domestic abuse violence), were not always met by the asylum and health care systems, which was also illustrated by the case study. The paper concluded by recommendingthe need for more research into the requirements of this vulnerable group, suggesting a need for more awareness and training in staff and the promotion of a more positive and empathic attitude towards asylum seekers and refugees as a whole.

CONTENTS

LEARNING OBJECTIVES

1. To gain an awareness of the reasons people apply for asylum and the different outcomes of their applications, with reference to the latest literature.
2. To develop a clinical perspective on asylum seeker and refugee health, including the most common problems affecting the health of this population group; mental health problems, victims of torture (assessment and diagnosis), victims of sexual assault, maternal health.
3. To investigate optimal methods for the provision of health care and other services for asylum seekers and refugees.
4. To consider relevant ethical issues among health professionals and medical students.

CORE LEARNING ACTIVITIES

1. To attend service learning visits.
2. To record case histories from refugees or asylum seekers.
3. To present a critical appraisal of a relevant journal article.

DEFINITIONS

Health

The World Health Organisation's[2, p1] definition of health is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". This has not changed since 1948.

Human Rights

"Human rights are basic rights and freedoms that all people are entitled to regardless of nationality, sex, national or ethnic origin, race, religion, language, or other status"[3, p1] . Universal Declaration of Human Rights (1948) by the United Nations General Assembly consolidated the human rights that belong to each individual of the world. It is adopted and applied by countries of the European Council as the European Convention on Human Rights (ECHR).

Health Inequality

"Health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups. For example, differences in mobility between elderly people and younger populations or differences in mortality rates between people from different social classes"[4, p1]

Asylum

"shelter or protection from danger" [5, p1]

Refugee

A Refugee is someone who "as a result of events and owing to a 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/her nationality and is unable or, owing to such fear, is unwilling…to return to it" [6, p1]

Asylum Seeker

An individual that has applied for the right to remain within the UK for the purposes of safety in accordance with the 1951 United Nations Convention relating to the Status of Refugees. Individuals maintain the status of asylum seekers while their applications are being processed, and if their applications are rejected, they are entitled to appeal against their decision – during which they also remain asylum seekers in status [7, p1]

Failed Asylum Seeker

"A failed asylum seeker is someone whose application for asylum has been refused by the UK authorities and has exhausted all rights of appeal… A failed asylum seeker has no legal entitlement to remain in the UK and should seek to leave the UK at the earliest opportunity" [7, p1]

INTRODUCTION

The General Medical Council'sguidelines "Good Medical Practice" listed the "absolute duties" that all doctors registered with the Council were expected to fulfil. These "Duties of a Doctor"(Appendix 1) served to highlight for both the medical profession and public the standards of care that should be expected from registered physicians. The Beauchamp and Childress four prima facie ethical principles (Appendix 2) also provided"a simple, accessible, and culturally neutral approach to thinking about ethical issues in health care"[8,p184]. Together, theses guidelines help to ensure that basic human rights of individuals seeking health care are respected and fulfilled in medical practice, which is particularly pertinent to the care of asylum seekers and refugees, who seek sanctuary after fleeing areas of devastation and human rights violations.

ASYLUM STATISTICS

GLOBAL PERSPECTIVE

Fig 1[9, p7]

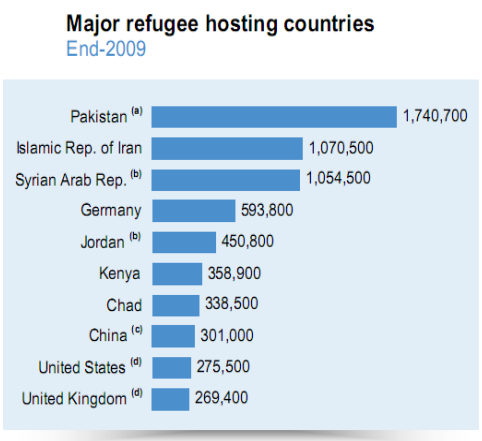
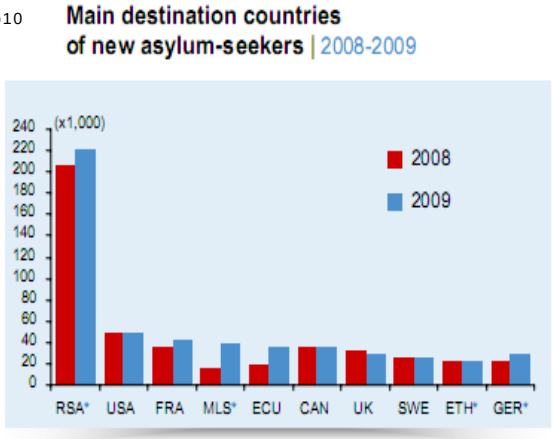


Fig 2 [9,p10]



RSA=South Africa; MLS=Malaysia; ETH=Ethiopia; GER=Germany

Figures 1 and 2 show that in 2009, Pakistan hosted the largest refugee population in the world and the Republic of South Africa was the most popular destinations for new asylum seekers.

NATIONAL PERSPECTIVE

Home Office statistics[10]showed that**;**

- Applications for asylum in the UKdecreased by 29% from 6,110 in 2009 to 4,365 in 2010.
- In 2010, initial asylum decisions and number of claims initially approved fell.
- 76% of initial asylum decisions were refusals, 15% were grants of asylum and 9% were grants of Humanitarian Protection or Discretionary Leave.
- Since 2007, the number of appeals made against initial refusals of asylum applications have increased, as have the number of appeals being dismissed.

UNHCR data[11] showed that in 2005, the countries of origin for the largest refugee populations in the UK were Somalia, Afghanistan and Iraq. The most applications for asylum in the same year came from Iran, Pakistan and Somalia.

LIVERPOOLTRENDS

Table 1[12, p1]: Asylum Seeker Population in Liverpool in receipt of subsistence only support, or supported accommodation

Year end	Subsistence only support	In supported accommodation
2009	25	1375
2008	40	1205
2007	80	810
2006	60	920

NB This table does not include asylum seekers who were not in receipt of support from the government

Table 1 shows the trends in the asylum seeker population in Liverpool, with a total 1400 individuals known to be receiving support from the government in 2009. ICAR[12, p1] stated that there was no data for the refugee population, but that their countries of origin were diverse and included Chad, Bangladesh, China, Sri Lanka, Sierra Leone, Somalia, Sudan,Iraq and Kosovo.

UK ASYLUM PROCESS

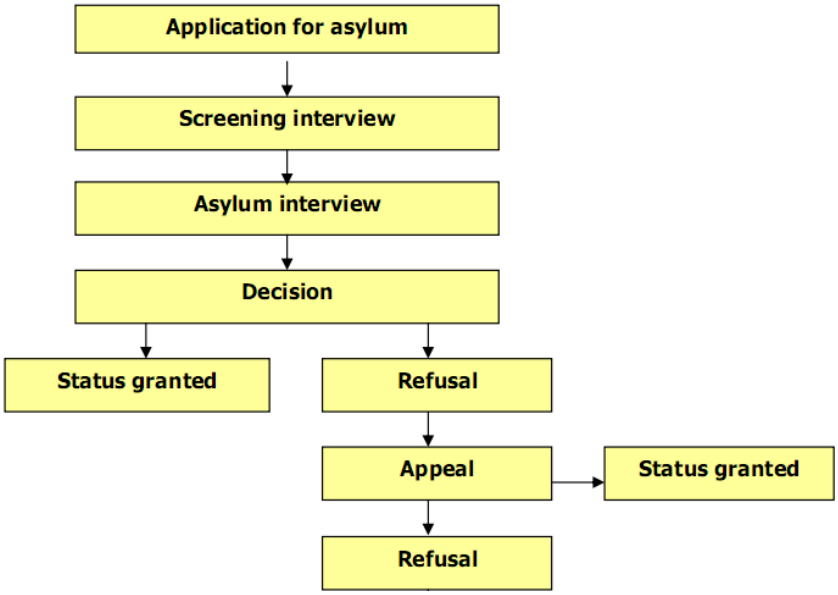


Fig 3 [12, p4]: The Asylum Process

The UK Border Agency (UKBA) at the Home Office is responsible for dealing with asylum applications. Applications can be made at the port of entry or at the UK Border Agency (Croydon) and based on a screening interview, the UKBAdecide how the application will be processed.

Asylum seekers are allocated a case worker to help with their welfare needs. They may be entitled to government support (accommodation and/or food) and need to find legal representation to assist with their application. If a claim is initially refused, the applicant may appeal against the decision. If this appeal is refused, theycan appeal again; this is known as making a “further submission”.

A positive decision from the UKBA would be granting;

- Refugee status
- Humanitarian protection
- Discretionary leave

These statuses provide a three or five year window for remaining in the UK, following which another application must be submitted. An individual can only stay in the UK indefinitely when granted Indefinite Leave to Remain or citizenship.

Table 2:Entitlements of Asylum Seekers[14, p3]

	Asylum seeker – claim in process	Asylum seeker – claim refused[iv]	Refugee
Financial support	Supported (70% of income support for adults; 100% for under 16s)	Supported (vouchers only, limited to certain goods and outlets)	Not supported
Housing	Housed	Housed	Not housed, but some rights
Primary care access	Can use NHS free. Entitled to free prescriptions, etc	Previously emergency care only, but now free (**see footnote**)	Can use NHS free
Secondary care access	Can use NHS free	As for primary care	Can use NHS free
Right to work	Not permitted to work	Not permitted to work	Eligible to work/obtain benefits

Table 2 highlights that "failed asylum seekers" who have refused claims have the fewest entitlements to public services, compared with refugees and asylum seekers.

CASE STUDY: DIONNE

An **alias** name was used to protect anonymity

I met Dionne at a weekly women's group. She was dressed well for the weather, with a polo neck, trousers, long black coat, and hat, all of which she kept on indoors. She described that she had not been as prepared when she first arrived in the UK. Four years ago she had arrived here in nothing but a t-shirt and skirt. Prior to her journey to the UK, she had not known what country she was heading to. And when she presented herself to the immigration office in Liverpool, she was told to return the following day. She tried to explain that she did not know English, knew nobody in the country, did not have any shelter, clothing or food and did not know where she was. In response, she was dragged out of the building. That night, Dionne tried her best to sleep standing in a nearby phone box.

The following morning, Dionne approached two police officers for help, who returned her to the immigration office and laughed at her. The immigration office dismissed her again, so Dionne was forced to spend another night on the street. She described how absolutely cold she was and that for two days she had not drunk or eaten anything. The next morning, she went back to the immigration office, extremely sick, and she said it was only then that they decided to help.

"**You suffer in your country, then you come here and suffer**"

Dionne was finally provided with some support but found the Home Office extremely unsympathetic to her needs; they stopped her support when she became too ill to sign in at their offices. In Dionne's initial Home Office interview, her asylum claim was

refused because the credibility of her claim was disbelieved despite evidence from her doctor.

Dionne at the time of interview was seven months pregnant and was brought to tears thinking about what she would not be able to provide her first born with. She described that she had received good healthcare while she had been here, including free prescriptions but that as an asylum seeker she was not free. She felt like a criminal.

""**When you ask for refuge somewhere you hope for certain things, in this country it's not like that. When you come here you get more problems…..It's not easy to be an asylum seeker. It's so hard. It's so so hard.**"

MEDIA PORTRAYAL OF ASYLUM SEEKERS

Asylum Seekers are faced with an additional barrier upon arriving in the UK from public attitudes of uncertainty includingconcerns that immigration is out of control[15]**.** Home Office population trends show that such concerns are not the case, however **s**uch views can be heavily influenced by the media**.**

By 2005, there was an increase in the negative coverage of asylum seekers and refugees in the press, which Crawley[16] suggested reflected the increase in asylum seekers and immigrants entering the UK. The British press propagated negative ideas about asylum seekers and refugees by using imprecise or inflatedstatistics**,** using unrepresentative images, focusing on threatening stereotypes**,** misusing asylum related terminology and utilising offensive and inaccuratelabels like'asylum cheat' to promote their opinions[17]. Such a bias against asylum seekers and refugees enables the media to broadcast an inaccurate depiction of an already vulnerable social group.

Fig 4 [18]

Fig 5[19]

SEARCH METHODOLOGY

As part of the literature search for this paper, EMBASE, HMIC, MEDLINE and PsycINFO were searched via NHS Evidence Health Information Resources (www.library.nhs.uk). Ovid Online, ProQuest, Wiley Online Library and Ingentaconnect databases were also accessed via myAthens (www.athensams.net/myathens). The search terms used included; “maternal health”, “mother”, “asylum seeker”, “refugee”, “violence”, “domestic violence” and “rape” in the title, abstract, key word and full text categories.Publications, statistics and reports from Governmental and otherorganisations working with asylum seekers and refugees were found through use of Google (www.google.com).

LITERATURE REVIEW

Impact of Sexual Violence on Disclosure During Home Office Interviews

Bögner, Herlihy and Brewin (2007) British Journal of Psychiatry

Bögner, Herlihy and Brewin[20] (Appendix 3) in their introduction highlighted the significance of "credibility" in Home Office interviews with asylum seekers and refugees.

Theirtwo research aims were;

1. To investigate the impact of sexual violence on refugee/asylum seeker reporting of psychological problemsand disclosing of information.
2. To explore the factors influencing disclosure.

The participant sample comprised of 27 refugees and asylum seekers, who were divided into two experimental groups; those who had experienced sexual violence and those who had not. These participants were then given questionnaires assessing psychological problems and interviewed **(**semi-structured interview). Data were analysed statistically and using thematic analysis.

The authors found that disclosure in Home Office interviews was influenced by avoidance, PTSD, depression, disassociation and shame.Participants from the sexual violence group scored higher on these measures. Thematic analysis identified three themes for disclosure to the Home Office; no problems opening up (n= 7), finding it too hard to disclose (n= 12) and not being given the chance to (n=8). 10 of the 12 participants who could not disclose any information were from the sexual violence experimental group.

The authors concluded that immigration staff should be trained in PTSD, avoidance and other relevant issues, and psychological screening should be used before interviewing asylum seekers. Particularly, accommodationsneededto be made for victims of sexual violence.

The study had many strengths which included highlighting the significance of "credibility", a very subjective matter, to claims for asylum. The use of quantitative and qualitative methods provided rich data, ethical guidelines were followed with informed, written consent gained from participantsand study findings highlightingthat personal experiences candetriment "performance" in legal interviews.

The study however also had some weaknesses including the small participant sample, lack of control group, unrepresentative recruitment of participants and systematic differences between the experimental groups (e.g. receipt of therapy) that could have confounded the results.The reliability of the findings was also reduced by the potential for recall bias and use of interpreters.

DISCUSSION

Torture is routine in over 90 countries. Asylum seekers and refugees with children have complex needs, including sexual health needs resulting fromtorture, whichare some of the most frequently reported among UK asylum seekers[14, 21, 22]. This Discussion will explore the impact of violence on the maternal health of refugees and asylum seekers in the context of rape and domestic violence.

Rape has been used systematically as aninstrument of warin conflicts including those in Bosnia, Rwanda, and the Democratic Republic of Congo and represents the complex cultural and psychological dimensions to war; communities are attacked through the enemy's ownership of female sexuality and pregnancy from rape is used as a form of "ethnic cleansing"[23].

The Black Women's Rape Action Project estimates that at least half of all women asylum seekers had been raped[1].Victims of rape have an urgent need for the appropriate health careincludingtreatment for the physiological problems caused by rape(e.g. STDs and death from unsafeterminations)[24]. Pregnancy resulting from rape presents further psychological difficulties to mothers whichincluding desperation leading to infanticide of the children born, depression, stigma, and problems with future relationships[23, 24]. Sadly, there have also been cases of sexual assault in the countries where women flee to seek refuge, including the UK[1, 25].

Domestic abuse is another of the most frequently cited reasons for seeking asylum [26]. Domestic abusecan be categorised as physical, sexual, emotional and financial[27]. Domestic violence is a factor that is documented in the context of vulnerable groups that have the most urgent requirements for maternity services but do not use them, and as a result have higher mortality rates–which in one study was six times greater amongasylum seekers and refugees than in Caucasian women.Domestic violence has

also been association with poor uptake in antenatal care which contributed to maternal death[1].

Female refugees (particularlymothers) are also vulnerable to experiencing domestic violence on arriving in the countries where they seek shelter due to little social support and a desire not to be on their own[28]**.** The CEMACH Report[1] identified five women who were murdered by violent partners who had also behaved as their interpreters. Significantamounts of domestic abuse were also found among refugees living in Hackney, London[29]**.**

The Human Rights Watch[26]highlighted that the Home Office is not doing enough to support women seeking asylum in the UK for sensitive and complex issues like domestic abuse. Maternal Health Services are also still are not adequately addressing the needs of these mothers, with reports of health inequalities including inappropriate accommodation, poor post-natal health care, language barriers and racism towards the women[1, 21]. Although there are positives; with most asylum seekers satisfied with their antenatal care, and increasing awareness and research into the needs of this specific group, there is still a need for follow ups[1, 21]. Although government guidance requires maternity care to be available to all women, this is not always the case, with instances where failed asylum seekers are being forced to pay for care[30].

CONCLUSION

There are weaknesses in the immigration and health systemsin dealing with the maternal health needs of asylum seekers and refugees. These vary from the lack of flexibility and awareness of needs and culture specific issues among health and immigration staff,to the lack of stability in care provision due to the dispersal of women to areas that cannot provide specialist care. Also significant are language barriers[1].

There are difficulties in providinghealth care for mother asylum seekers and refugeesbecause of their complex health needs and the obstacles they face to gettingthe services they require, like their unfamiliarity with the NHS andnot being informed of services and entitlements[1, 31].

The shortcomings in the immigration and health care services available to asylum seeker and refugeemothers in the UK mean that some of the individuals fleeing their countries are at risk of domestic violence and maternal death[1], and being failed by countries that have uphold signed the Geneva Convention for Human Rights.

RECOMMENDATIONS

To increase the sensitivity, empathy and awareness among health and immigration staff about the both the maternal experiences and needs of asylum seekers and refugees, but also the needs of asylum seekers and refugees more broadly. Particularly from a medical perspective, doctors have a duty to root out health inequalities and promote well-being for all individuals.

To promote health services that are better equipped to deal with the maternal needs of asylum seekers and refugees by training staff, increasing their awareness of

relevantissues, and promoting access to information on entitlements and health care among female refugees.

To encourage more research into the maternal health needs of victims of torture, as sexual violence is one of the most frequently cited reasons for seeking asylum and is a complex issue that has far reaching consequences.

REFLECTION

The Asylum Seeker and Refugee Health Module was a very interesting experience that has increased my awareness and enabled me to meet groups of society that are often not seen and gain a deeper understanding of their amazing and often, sadly difficult stories. Meeting refugees and asylum seekers who have described themselves as “imprisoned” and expressed feelings of neglect has reaffirmed my desire to help people from vulnerable groups and I hope to start volunteering and doing so soon.

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APPENDIX 1: GMC Duties of a Doctor (GMC, 2010)

- Make the care of your patient your first concern
- Protect and promote the health of patients and the public
- Provide a good standard of practice and care
- Keep your professional knowledge and skills up to date
- Recognise and work within the limits of your competence
- Work with colleagues in the ways that best serve patients' interests
- Treat patients as individuals and respect their dignity
- Treat patients politely and considerately
- Respect patients' right to confidentiality
- Work in partnership with patients
- Listen to patients and respond to their concerns and preferences
- Give patients the information they want or need in a way they can understand
- Respect patients' right to reach decisions with you about their treatment and care
- Support patients in caring for themselves to improve and maintain their health
- Be honest and open and act with integrity
- Act without delay if you have good reason to believe that you or a colleague may be putting patients at risk
- Never discriminate unfairly against patients or colleagues
- Never abuse your patients' trust in you or the public's trust in the profession.
- To be personally accountable for professional practice and prepared to justify decisions and actions.

APPENDIX 2: Beauchamp and Childress Principles of Medical Ethics (1979)

1. Autonomy – An individual has the right to control their own self and make their own decisions without control or influence from other parties (pg 121).
2. Beneficence – Acting in a manner that will advantage others (pg 260).
3. Justice – That others should be treated equally, and thereby, fairly (pg 328).
4. Non-maleficence – To avoid purposefully doing harm to others (pg 189).

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APPENDIX 3: Impact of Sexual Violence on Disclosure During Home Office Interviews. (Bögner, Herlihy and Brewin, 2007)

APPENDIX 4: PRESENTATION OF PAPER APPRAISAL

Seeking asylum and motherhood: health and wellbeing needs

Becky Reynolds & Judy White

Community Practitioner; Mar 2010; 83, 3; pg 20

Tessa Muid and Ellen Mekonnen

3rd Year Medical Students, University of Liverpool Medical School

Introduction

- Pregnant asylum seekers (AS) are vulnerable - higher mortality
- Difficult personal experiences
- Many health needs - present late & complications
- Barriers - language, system, payment
- Misunderstood by the public
- Paucity of research

Objectives

- Determine the health needs and wellbeing of pregnant asylum seekers or new mothers
- Determine whether needs are being met by managers and practitioners
- Provide recommendations

Method

- Qualitative Study
- Sample - Health Professionals, single IAC 220 people
- Method -11 individual semi-structured interviews
  - 40-90 minutes
  - Recorded, transcribed and analysed with framework analysis
- Consent acquired but no formal ethical approval was required

Findings

1.	Health Needs	present late, no former notes,undiagnosed complications, no proper care pathway
2.	Women in transition	dispersal - lack of notice & continuity of care, Home Office Syndrome
3.	Access to services	language barriers
4.	Working environment	interagency working & changing field
5.	Access to resources/info	meal times, sanitary products

Summary

- Various health needs identified
- Recommends:
  - increased independence of AS
  - support, education & communication between HP
  - maternity care pathway
- Study limitations:
  - No AS or wider views gathered
  - Paucity of literature
  - Small Sample Size (11) and single IAC involved

THE END

APPENDIX 5: Contacts and Useful Websites

1. Siobhan Harkin – Administrator
   Healthy Inclusion (formerly Global Inclusion)

   Tel: 0151 355 4008
   Email: healthyinclusion@yahoo.co.uk

2. Maggie at Asylum Link Merseyside
   St Anne's, 7 Overbury Street
   Liverpool L7 3HJ

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3. Ewan Wilkinson
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4. Keiran Lamb
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   Tel: 0151 285 4493

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7. Dr Timothy O'Dempsey
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8. Philippa at Liverpool STAR
   Email: liverpoolstargroup@googlemail.com

9. Sue Rixon
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   Percy Street
   Dispersal Centre
   Liverpool

Tel: 0151 708 9988

10. Ms Qureshi at Doctors of the World
    London
    Email: fqureshi@doctorsoftheworld.org.uk

A. www.gmc-uk.org
B. http://www.who.int
C. http://www.amnestyusa.org
D. http://news.bbc.co.uk
E. http://nrif.homeoffice.gov.uk
F. http://www.unhcr.org
G. http://www.dh.gov.uk

APPENDIX 6: TIMETABLE

Global Health: Week 1

	30th August	31st August	1st September	2nd September	3rd September
A.M	**BANK HOLIDAY**	Course Induction 11am Please refer to itinerary	Asylum Link Merseyside Illa Kamal St Anne's, 7 Overbury St Liverpool, L7 3HJ Tel: 0151 709 1713	Wrexham – (8 students) 9.00am Welsh Refugee Council Trinty House, Trinity Street, Wrexham: Contact: ZelkoMalecic 10.00am Methodist Church Regent StreetWrexham.LL111RY Contact: Biddy Crossfield T: 01978 290006	8.45am Convenor Review AddactionCroxteth 83-93 Stonebridge Lane Croxteth Liverpool L11 4SJ T: 0151 546 1141
P.M.	**BANK HOLIDAY**	Group 1: LASAR Group 2: LCIP		WRASSG Contact: Yvonne Parish Tel: 01978 357 826 12.00pm	1pm Fade Library Regatta Place Summers Road Brunswick Business Park Liverpool L3 4BL Contact: Keiran Lamb T: 0151 285 4493

Global Health: Week 2

	6th September	7th September	8th September	9th September	10th September
A.M	As per week 2 itinerary	As per week 2 itinerary	As per week 2 itinerary	As per week 2 itinerary	As per week 2 itinerary
P.M.					

Global Health: Week 3

	13th September	14th September	15th September	16th September	17th September
A.M	**Prison visits**	**Prison visits**	**Prison visits**	**Prison visits**	**Talk by Ewan Wilkinson re climate change tbc**
P.M.					

Global Health: Week 4

	20th September	21st September	22nd September	23rd September	24th September
A.M				Convenor review 3 Stanlaw Abbey Centre 9am Preparing for publication (optional) 9am Siobhan Harkin	Students to hand in completed SSM (10am to 12 midday) Email copy to Siobhan Harkin: healthyinclusion@yahoo.co.uk and one to Kieran Lamb: Kieran.lamb@fade.nhs.uk
P.M.					Free afternoon!

Updated: 1st April 2010