

Medical and social needs of pregnant asylum-seekers in Direct Provision

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Abstract

Introduction

The WHO has reported a trend for adverse pregnancy-related indicators for migrants. Asylum seekers arriving in Ireland are housed in “direct provision” (DP) while their asylum application is processed. This study aimed to examine the obstetric outcomes and social requirements of pregnant women living in DP.

Methods

This was a retrospective observational study taking place over a five year period, from January 2015 to December 2020. The results were analysed using SPSS and compared to the general hospital data from 2019.

Results

Fifty women living in DP were identified. Significantly higher rates of HIV infection, lack of pre-conception folic acid use, cervical cancer screening, low birthweight, unplanned pregnancies and late booking were found amongst pregnant women living in DP. Labour outcomes were similar to the hospital general population. The majority (88%) of women living in DP were referred to the social work department, the main reasons being poor social supports, finances and childcare.

Discussion

Pregnant women living in DP are at increased risk of specific medical and social needs. Maternity healthcare and social workers must be aware of these needs in order to provide optimal care to this vulnerable population.

Introduction

According to the United Nations High Commissioner for Refugees (UNHCR), 82.4 million people were forcibly displaced worldwide at the end of 2020, including 26.4 million refugees and 4.1 million asylum seekers¹. Women make up more than half of the refugee and migrant population². 4781 applications for asylum were made in Ireland in 2019, a 30.2% increase from 2018³.

Asylum seekers arriving in Ireland are housed in “direct provision” (DP) while their asylum application is processed. DP is a unique system in Ireland in which the state receives asylum seekers and provides for their basic needs. Under this system, asylum seekers have access to free healthcare, including antenatal care. The system has come under criticism in recent years by Irish and international human rights organisations, and the Irish government has committed to replacing direct provision with a new system of accommodation and support centred on a ‘human-rights’ approach⁴. In April 2020, the Irish Refugee Council reported approximately 7,400 people were living in DP or emergency accommodation⁵.

The WHO reports a marked trend for worse pregnancy-related indicators for migrants². Late booking visits and poor antenatal clinic attendance among asylum seekers and refugee women has been identified in multiple studies^{6,7}. One Irish study found that the average gestational age at booking was 33 weeks amongst a population of women with confirmed refugee status, while Murphy et al reported a median booking gestation of 30+4 weeks^{7,8}.

The findings for risk of preterm birth are contradictory, with some studies reporting increased risk^{9,10} while others report lower rates^{11,12}. Similar results are seen when looking at risk of low birth weight^{6,8,13}. Anaemia and gestational diabetes are consistently shown to be more prevalent amongst women of migrant status^{6,7,14}. Higher rates of positive serology, HIV, hepatitis B and syphilis when compared to the overall hospital rate are reported^{7,8}. Pregnant migrant women also experience higher rates of mental health disorders when compared to host populations and to the general migrant population^{15,16}.

An interesting concept throughout the literature is the “healthy migrant effect”, where migrant women are seen to have better perinatal outcomes compared to non-migrant women. This may be attributable to lower rates of smoking and alcohol use¹⁴ and a lower prevalence of high-risk pregnancy conditions¹². Another possible explanation is that those who migrate tend to be the healthiest and most fit. However, this is true for only some populations, as many refugees flee war torn countries and have come from countries where they have experienced long standing health disadvantages.

People living in DP centres have reported that DP centres greatly undermine their ability to care for and nurture their children's development¹⁷. Shared accommodation, lack of privacy and financial stress stemming from limited income are quoted as sources of ongoing stress and mean the social participation of children and young people is severely limited. A study by Moran et al reveals the importance of informal social supports in the lives of parents and families to help them to cope with the many risk factors they encounter in everyday life¹⁸.

Migrant women have been shown to be more vulnerable to violence during the migration process and after arrival¹⁹. In Ireland, a stakeholder survey report conducted by AkiDWA provided evidence of domestic violence and sexual harassment experienced by asylum-seeking women in DP²⁰. The Rape Crisis Network Ireland (RCNI) report found that DP exacerbates trauma for survivors and leaves them living in a system vulnerable to sexual violence²². The study found that one in seven female victims who experienced sexual violence became pregnant as a result of being raped²¹.

Poor living conditions during the migration process may influence pregnancy outcomes. Gewalt et al.'s study on pregnant asylum-seeking women in Southern Germany identified significant health challenges due to constraints in material circumstances and behavioural factors, such as poor hygiene standards, restless sleep due to noise and threats of violence, and poor nutrition²². In addition, lack of influence over room occupancy or privacy had negative impacts on women's mental health²².

In a report published by the National Women's Council 2021, migrant and asylum-seeking women reported that it was difficult for them to open up about their problems²³. One woman identified "unconscious biases" when healthcare professionals spoke to her, and felt they were unable to understand her background²³. The report highlighted the need for peer-led health care for migrant communities and those living in socio-economically disadvantaged areas, and the importance of involving women in the design and implementation process²³.

Aims

The aim of this study was to examine the obstetric outcomes and social needs of pregnant women living in DP. Additionally, we aimed to assess if specific screening for obstetric complications is required and if routine social work referral would be of benefit.

Methods

This was a retrospective observational study taking place over a five year period, from January 2015 to December 2020. Addresses of DP centres in the counties of Dublin, Meath, Kildare, Wicklow and Louth were obtained from the International Protection Accommodation

Services website²⁴. Hospital databases were searched and any pregnant woman booking to the Coombe Women and Infants University Hospital (CWIUH) during this time period with an address at any of these centres were included. Ethical approval was obtained. Data were collected from the electronic patient record and paper charts were also reviewed. Data were analysed using Statistical Package for the Social Sciences (SPSS) software Version 27.0 and results were compared to the general hospital data from 2019²⁵.

Results

Fifty women attending CWIUH and living in DP during the period of January 2015-December 2020 were identified, comprised of 17 nulliparous women and 33 multiparous women. In terms of ethnic origins, 45 women (90%) were black African, three (6%) were Caucasian, one (2%) was Middle Eastern and one (2%) was of other origin. Maternal age ranged from 19 to 42 years, with a median age of 30. Median gestation at booking was 12+5, with a range of 10+4 to 38+6.

There were 46 singleton pregnancies and four multiple pregnancies – three sets of twins and one set of triplets. 42 (84%) pregnancies reached term, with a total of 7 pre-term deliveries and one mid-trimester miscarriage.

Interview difficulties at booking due to language barriers were reported for 18 mothers (36%). Use of an interpreter was recorded for three mothers.

Some of the relevant perinatal issues and outcomes are displayed in Figure 1.

Outcome	Direct Provision n=50 (%)	Hospital average 2019 ²⁵ n=8284 (%)	p
No pre-conceptual folic acid	36 (72)	4307 (52) / 8284	0.005
Mental health issue	10 (20)	1712 (21) / 8152	0.862
Domestic violence	6 (12)	85 (1) / 8500	<0.001
Late booker	14 (28)	87 (1.1) / 7909	<0.001
Unplanned pregnancy	34 (68)	2128 (25.7) / 8280	<0.001
HIV positive	3 (6)	15 (0.2) / 7500	<0.001
Pre-eclampsia	3 (6)	199 (2.6) / 7653	0.143
Gestational diabetes	5 (10)	933 (12) / 7775	0.664

Exclusive breast-feeding	13 (26.5)	2784 (36) / 7733	0.168
BMI >30	19 (38)	1686 (20.3) / 8305	0.002
Anaemia at booking	9 (18)	Unknown	

Figure 1. Perinatal issues and outcomes.

Delivery information is displayed in Figure 2.

Outcome	Direct Provision n=50 (%)	Hospital average 2019 ²⁵ n=8284 (%)	p
IOL	14 (36) / 26	2596 (38.2) / 6796	0.932
SVD	26 (52)	4498 (54.3) / 8283	0.774
OVD	3 (6)	1002 (12.1) / 8281	0.273
Caesarean section	21 (42)	2618 (33.8) / 7746	0.221
PPH	10 (20)	1691 (21.8) / 7757	0.759
Pre-term birth	7 (14)	1518 (19.7) / 7705	0.312
Low birth weight	10 (20)	518 (6.7) / 7731	<0.001

Figure 2. Delivery outcomes

There was one reported case of female genital mutilation (2%). Contraceptive advice on discharge was documented as given for 24 mothers (48%).

During this period, 44 (88%) of women living in DP were referred to the medical social work (MSW) department for support. 36.4% (16) of women were referred at booking and 63.6% (28) were referred later in their pregnancy.

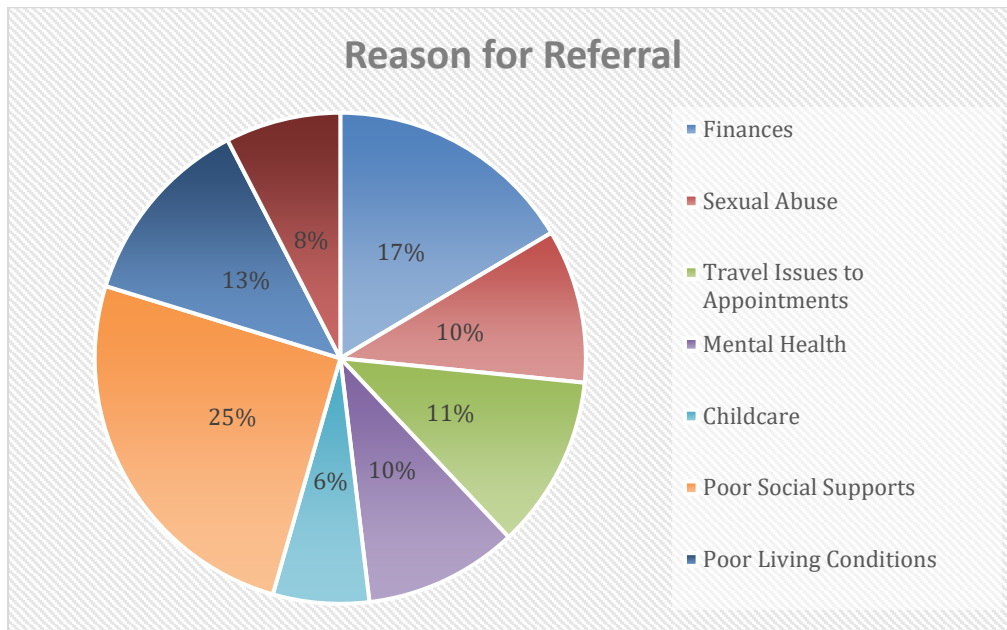


Figure 3: Reasons for referral to Medical Social Work Department

18.18% (8) of women experienced sexual abuse in their lifetime, with six out of eight women having experienced forced prostitution in their home country. 13.63% (6) of women reported experiencing domestic violence by an intimate partner.

The largest issue identified by women was lack of social support (n= 20, 45.45%). Of these, over 38% (8) of women in the study were referred to community supports in pregnancy by MSW. 22.72% (10) of women experienced poor living conditions in the DP centres. General issues included overcrowding, food preparation issues, storage of medication and threats of violence from other residents.

77% (34) of women remained in the direct provision system throughout their contact with the Medical Social Work Department. The remaining 23% (10) of women were granted status.

Discussion

Many of the significant findings from our study mirror those reported in the literature. Similar to the studies by Lalchandani and Murphy, our study cohort had a significantly high rate of late booking visits^{7,8}. As suggested by Murphy et al, this may be a reflection of late arrival to the country or lack of knowledge of how to access the healthcare system as opposed to systematic failure⁷. Public health measures may be necessary to improve this issue, and utilising inclusion health teams may help to improve antenatal attendance for these mothers. Inclusion health aims to reduce inequalities in healthcare for vulnerable populations, and thus is an important part of the solution in reaching these women.

All mothers in our population were successfully screened for blood-borne viral infections, with significantly high rates of HIV infection. This antenatal screening is vital in order to ensure adequate antenatal treatment and minimise the risk of mother-to-child transmission.

With regard to birth outcomes, our population had significantly higher rates of low birthweight babies, but not of preterm birth. This suggests that a third trimester growth scan may be beneficial in this population, allowing for the detection of small-for-gestational age or growth-restricted fetuses. With 18% of mothers anaemic at booking, it is also important that maternity healthcare providers optimise nutrition and haemoglobin levels in these mothers in order to improve upon birth weight.

Rates of unplanned pregnancy amongst our study population were significantly high, for both primigravidae and multigravidae. In contrast, less than half of these women were given contraceptive advice prior to postnatal discharge. This represents an opportunity for maternity healthcare providers to improve on reproductive health promotion. In addition, empowering women to plan their pregnancies may improve rates of pre-conception folic acid use, which was also significantly low amongst our cohort. Rates of cervical cancer screening were significantly low, with 44% of women never having had a cervical smear. This is another important area for improvement. However, these particular issues – pre-conceptual folic acid use, contraception and cervical cancer screening – are typically the remit of primary care. The low rates seen for these indicators may reflect a lack of access to adequate primary and prenatal care for women living in DP centres.

With regard to breast-feeding, 26.5% of women in DP were exclusively breastfeeding at discharge, in comparison to the hospital average of 36%. While this was not found to be statistically significant, it is important to consider different cultural approaches to breastfeeding. Murphy et al⁷ mention evidence that suggested African women choose to top-up with formula in the early postnatal days to ensure their infants are receiving adequate nutrition. This further underpins the need for increased community supports, including education and support for breastfeeding in emergency accommodation settings.

In terms of social needs, again the findings in our study match the literature in terms of rates of sexual abuse and domestic violence¹⁹⁻²¹, lack of social support^{17,18} and poor living conditions²².

Most of the women in the study had been in the direct provision system for many years. The inefficient asylum-seeking process in Ireland has been well documented and is further compounding the psychosocial stressors experienced by these women.

Only 2% of women reported a history of FGM. In recent years, a question has been introduced at the booking history to identify women who have experienced FGM. In response to this, a

new referral pathway to MSW is due to be implemented which is expected to significantly increase the number of referrals received for this reason.

While 88% of women in our study were linked to MSW, the significant social requirements of these women mean that all pregnant women living in DP should be offered referral to MSW for support. The introduction of a new social inclusion MSW in the three Dublin maternity hospitals will be of great benefit to this vulnerable group.

Our study had several strengths. It deals with a relevant topic to maternity care nationally, and findings can be utilised by all maternity hospitals looking after women in DP. It has a multi-disciplinary approach, with authors from both medical and social work departments. The data addresses a large number of perinatal outcomes and has a number of significant findings. It had no costs and was quick to carry out. A limitation of this study is the retrospective study design. Relying on addresses of DP centres from the IPAS website to identify patients for inclusion may have resulted in exclusion of asylum seekers who had moved from DP centres to other temporary or fixed accommodation by the time of booking. Another limitation is that data were compared to just a single year population. This was done for ease of comparison, as the hospital produces an annual report, with 2019 randomly selected as a sample year.

The WHO outlines that particular attention needs to be paid to pregnant migrant women, and goes on to state that “care and social support during pregnancy are crucial to ensuring a safe delivery and healthy mothers and infants”². In their systematic review of systematic reviews, Helsehurst et al point out important differences between asylum seekers and refugees and the general migrant population, with asylum seekers and refugees having worse perinatal outcomes and experiences compared to both women from the host country and the general migrant population¹⁵. Only one systematic review out of the 29 included in their review looked specifically at asylum seekers and refugees. This indicates a need for further research looking at asylum seekers and refugees as a uniquely vulnerable population with different risks and needs than the general migrant population. Helsehurst also commented on the social isolation experienced by asylum seekers and refugees when compared to the migrant population¹⁵.

As maternity healthcare providers, it is imperative that we are aware of the specific medical and social requirements of asylum-seeking women living in DP, in order to ensure optimal care and outcomes for these mothers and their babies. It is also important for those working in tertiary care to link with clinicians from the primary care field, to provide thorough holistic care for these women before, during and after their pregnancy.

Declarations of Conflicts of Interest:

None declared.

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