

# Refugees in O&G: Considerations for Care

## Introduction Video



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# War and Women's Health

“It has probably become more dangerous to be a woman than a soldier in armed conflict”

– UN military adviser Major General Patrick Cammaert, 2008

Living in a war zone

- Lack of access to healthcare facilities
- Reduced access to food – blocked access, damaged infrastructure, ‘scorched earth’ approach
- Sexual violence as a weapon of war and increased HIV/AIDS risk
- Trauma and exposure to extreme stress

Refugee camps

- Lack of access to safe drinking water
- Poor sanitation
- Inadequate medical facilities – treatable conditions go untreated
- Lack of access to effective contraception
- Unsafe abortion used as emergency birth control
- Increased rates of domestic violence
- Exploitation by peacekeepers and humanitarian workers - sex in exchange for food
- Loss of trust in authority figures
- Separation from social support rendering women more vulnerable to threats against physical security
- Dependence on external aid and loss of independence

Adapting to a new country

- Ongoing health issues secondary to poor access to medical care
- Shock of living in a new environment
- Difficulties accessing healthcare
- Loss of home, community, country
- Stigma
- Post-traumatic stress disorder

# Challenges to Refugee Health

Sometimes people are forced to overlook the importance of seeking treatment as they must prioritise their basic needs, such as finding shelter, food and clean water.

–Leigh Danes, 2016

“Common experiences are pre-migration trauma - trauma from dangerous and protracted journeys to the UK - and post-migration trauma – stress from being in a new country while dealing with multiple losses and complicated systems ...”

–Anthea Kilminster, 2022

## Common health challenges of refugees and asylum seekers

### Poorly controlled chronic conditions

Hypertension, diabetes, epilepsy, badly healed injuries, out of medication



### Mental health and specialist support

Depression, isolation, PTSD, torture, FGM, sexual and gender-based violence



### Maternity care

Late presentation, FGM complications, trauma, poverty, malnutrition, holistic support



### Language translation needs

Do you need an interpreter?

What language/dialect?

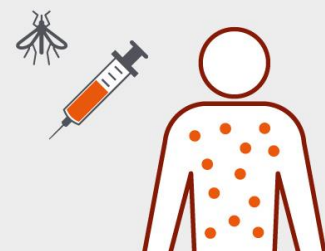
What gender?

Any cultural needs?



### Untreated communicable diseases

TB, HIV/STIs, parasitic infections, missing vaccines



Source:  
The BMA

Women who lived in neighbourhoods with high levels of violence... were five times more likely... to experience pregnancy complications...”

– Zapata, 1992

“Women were less likely to participate in tuberculosis detection programmes than men because the women had been ostracized or expelled from their families after being abused or raped...” – 1996 study on health of Somali women in Dadaab, Kenya, as reported in From Outrage to Courage

# Refugee Access to NHS healthcare

“Access to timely, safe and appropriate maternity care should not depend on a woman’s immigration status or ability to pay. Addressing additional barriers to a safe pregnancy experienced by migrant women is a vital part of ending the UK’s persistent inequities in maternal and perinatal outcomes.”

– RCOG Position Statement

“Holistic and person-centred care is essential to support resilience and help them adapt to life in the UK...”

– The BMA

However, access remains a key barrier:

“Within the UK itself, undocumented migrants are **struggling to register** with a GP, meaning that **vulnerable people** – including pregnant women, children and victims of trafficking – are being **refused access to primary healthcare.**”

– Leigh Danes, executive director of Doctors of the World Charity

Thus, late presentations with complications from previously unaddressed health challenges are common in this population

# Approaching a consultation

## Setting up the consultation

If possible, offer flexible appointments to improve access

Explain your role and remit

- Refugees may view healthcare professionals as a potential authority or persecutory figure
- Emphasise consultations are **confidential** and what this means practically
  - Including why and when confidentiality might need to be broken

**Orientate** the woman to your hospital, clinic or children's centre

**Ensure** that she knows that she is in a place of safety

**Alert** the safeguarding team should be alerted if there are any concerns

1

2

3

4

5

**Introduce** her to key people, such as team colleagues, MSWs and administration staff, if appropriate

**Assess** how safe the woman feels in her home environment or employment and how she is able to access care

- *Caring for vulnerable migrant women – RCM pocket guide*

## Communication Challenges

- Try to establish literacy level and language
- Offer a briefed, professional interpreter – **not** family /friends
  - Family/friends may impede conversations about sexual health, gynaecological complaints, domestic violence etc.
  - Without an interpreter the identity of the family member/friend cannot be confirmed – beware of trafficking

**Inadequate translation provision is linked to delayed care, and hinders women's ability to follow treatment plans**

– MMBRACE report into maternal deaths, 2021

# Safeguarding



## Refugee women are at a high risk of violence

- Evidence of high levels of violence against women and girls prior to, during, and following forced migration journeys
  - Under-reporting of this is common
- Sexual and gender-based violence has been seen to increase after migration
- Some women may culturally be less able to express themselves; these women are also at increased risk of domestic violence and exploitation
- Perpetrators can include family members, friends, members of their community, people in positions of authority

- Women may attend with a male partner/relative who answers the questions whilst the patient may remain withdrawn
- Women may not have their own mobile phone; the contact number is often the partners mobile

## **The priority is to organise a 1:1 meeting (+interpreter if required)**

- Signpost to the community team
  - may provide an opportunity for a 1:1 meeting in a less pressurised environment
- In consultations, try to shift the narrative in a non-confrontational manner e.g. “This consultation is about X’s health, it’d be good to hear her voice”

## **Risk Management – key questions and considerations**

1. Ask where a woman has come from, when did she arrive in the UK and how did she get here.
2. Is she in any immediate danger?
3. Are there any pre-existing safeguarding concerns?
4. Is she registered with a GP?
5. What financial resources does she have, including asylum support, benefits, or none?
6. Assess the level of support you think is required and make a personalised care plan.

# Taking a History

Remember that refugees are not a uniform group – they are individuals, each with uniquely complex situations that should be approached sensitively and in a personalised manner

“Positive interactions were experienced when health professionals had respect for practices from the country of origin or were of the same ethnicity or religion, and positive support increased confidence in asking questions and acceptance of the new healthcare system and practices ”

- Heslehurst et al, 2018

## Prioritise building a trusting relationship

- Use eye contact and speak directly to the woman
  - even if using an interpreter
- Be mindful of body language and tone of voice
- Explain that to best help them, they need to be forthcoming with their previous health issues

## Allow extra time for appointments

- Allow the patient to set the consultation pace if possible
- Allow time and space to build trust

## Approach complex cultural issues (such as FGM) sensitively

- This must be addressed both with the patient, and also at a community level to ensure it is not ongoing
- Be sensitive to cultural barriers and stigma and how this might impact the patient, for example when talking about mental health

## Ensure understanding

- Avoid jargon and explain terms used
- Ask patient to explain what they understand
- Afterwards, provide women with written information **adapted to their needs**

# Approaching Examinations

## Considerations

### 1) Is examination necessary?

- Have they recently been examined by another healthcare professional e.g. midwife?
- Will the examination findings change management?

### 2) Is examination necessary now?

- In non emergency situations, ideally the priority of the first consultation should be to establish trust that may then itself to examination
- Consider asking if the patient is comfortable to be examined in that moment, or would they rather have time to mentally prepare for an examination on a later date?

### 3) Are there any alternative options available?

- Important to consider as patients may refuse examination

## Approach

### **During the history, be alert to clues that the patient might find examination difficult**

- Intimate examinations may trigger PTSD symptoms

### Gain informed consent

- Explain why the examination is necessary and the purpose behind it – how will it help their management?
- Ensure they are aware that they can refuse before proceeding or at any point during the examination – remember refugees may lack trust in authority figures

### During the examination

- Explain the examination before and throughout
- Allow enough time; the amount needed will differ between women
- Consider offering analgesia beforehand
- Be alert and responsive to signs of discomfort
- Offer a supportive family member/friends presence if appropriate



# Managing Trauma in a Consultation

## Hyperarousal

Fight or Flight response overwhelms the rational ability to think and engage in the consultation

### Grounding techniques

- ask them to notice the feeling of their feet on the ground, the noises they can hear, describe what they can see, for example
- Physical contact if appropriate + consent

### Breathing and relaxation exercises

- Breathe in for 3, out for 5
- Progressive muscle relaxation

## Window of Tolerance

Able to both think and feel at the same time allowing for a productive consultation

### Activating techniques

- ask them to stand up, walk around
- Ask them their favourite music and play it aloud
- Give them a glass of water
- Brighten the lights

## Hypoarousal

Depressed feelings, low energy, Dissociated and unable to think or engage in the consultation

### Signs

*Panic*  
*Hypervigilance*  
*Defensiveness*  
*Reactivity*  
*Anger*  
*Racing thoughts*  
*Freezing*

*Asking questions*  
*Responsive*  
*Present*  
*Engaging*  
*Active listening*  
*Appropriately reactive*

*Numbness*  
*Lack of energy*  
*Passivity*  
*Disconnected*  
*Shut down*  
*Unable to say 'no'*

# Barriers to Care

## Social

### Temporary/uncertain status

- Inability to work
- Lack of finances
- Prioritisation of “*real life*” worries including food, safe housing
- Lack of transport to access care
- Lack of family and friend networks

### Issues with housing

- Frequent moving
- Fixed meal times in accommodation - reduced flexibility to attend appointments

## Structural

### Language barriers

- Limited ability to speak English
- Limited understanding of verbal/written information

### Challenges navigating healthcare system

- Lack of awareness of services and support available
- Lack of information provision about how to get support
- Assumptions of needing to pay for healthcare

## Personal and Cultural

### Reluctance to talk about mental health

- Lack of culturally appropriate therapists or services available
- Belief that depression isn't a real health problem
- Beliefs that health professionals and services are for physical health

### Lack of cultural acceptability to seek help

- Belief in women's strength and self-coping
- Fear of labelling, stigma, further isolation

### Fears of having their child removed

### Preference for female healthcare professionals in non-emergency situations

- Religious reasons
- Intimate body areas involved

**These barriers contribute to late presentations, often with complications from unaddressed health issues**

# Why is this important?

Adverse pregnancy outcomes amongst refugees represents “a double burden of inequality for one of the most globally vulnerable groups of women.”

## Experiences of healthcare

**Systematic reviews** of experiences of perinatal healthcare amongst asylum seekers and refugees have reported...

### Negative experiences of communication

- Reliance on interpreters leading to delayed care
- Reliance on body language and facial expressions to communicate
- Inability to express their concerns

### Discrimination from healthcare professionals

- Openly racist and discriminatory care
- Cultural stigma
- Disrespect
- Hostility
- Stereotyping and being treated as ‘primitive’

### Negative relationships with healthcare professionals

- Lack of confidence discussing issues
- Feelings healthcare professionals are too busy

### Cultural clashes

- Balancing feeling obligated to adapt to host country practices with preferences for traditional practices

### Clinical care

- Lack of knowledge/sensitivity discussing issues such as female genital mutilation
- Poor explanations of care, options for care not discussed

“Perinatal outcomes were predominantly worse among migrant women, particularly mental health, maternal mortality, preterm birth, and congenital anomalies”

*All data from Heslehurst et, 2018*

# Refugee Access to Antenatal Care

Refugees are classed as having 'complex social factors' and there are clear NICE guidelines on how to manage these patients

However, key barriers remain, including...

Lack of familiarity with NHS system

- Uncertainty about what questions to ask and what care they are entitled to
- May struggle to attend in hospital appointments without transport

Refugees are often in temporary accommodation and may be moved with short notice- their access to antenatal care may have been minimal/non-existent

- Missing multiple appointments may result in safeguarding concerns  
→ Perceptions that social care involvement may result in loss of their child may further impact engagement with health services
- Refugees may be unsure as to why they have been moved and may find it difficult to communicate this with healthcare professionals
- This is isolating, and is likely removing her from any social or support networks
- Additionally, it is a barrier to building a trusting relationship with healthcare professionals
- Each move will result in navigating a slightly different maternity system with different access to 'continuity of care' community teams with different criteria for eligibility



The 'Badger App' is used in some regions of the UK and contains all maternity notes to allow for the transferral of notes between the MDT

- Sharing notes negates the need for women to continually divulge trauma that impacts their care
- However, this requires access to a smartphone with internet connection
- Additionally, this app is unavailable in some regions of the UK; in these cases written notes are used
- Notes are in English and therefore inaccessible to patients

# Caring for Refugees in Labour

Inconsistent or lack of antenatal care can result in...

- Increased risk of complications during labour
- Increased risk of preterm labour as malnourishment and reproductive tract infections haven't been identified

## Preparation for Labour

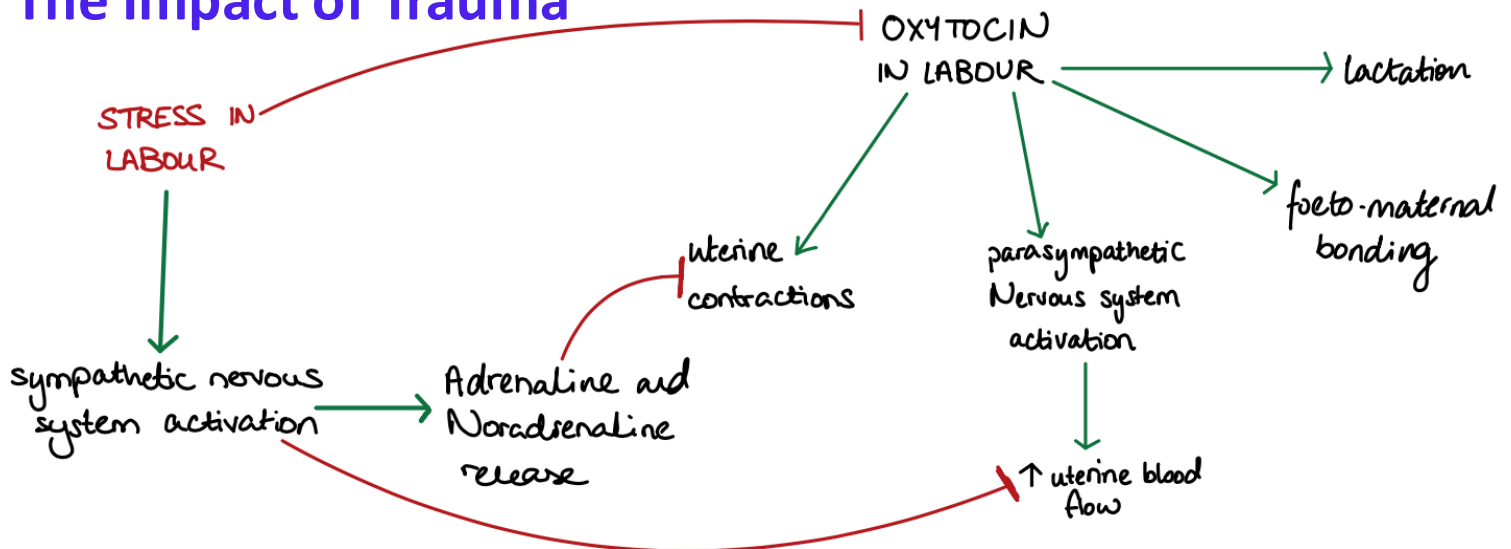
If antenatal care has identified high social needs or severe trauma, an elective Caesarean may have been scheduled

Refugees are unlikely to have attended an antenatal course, and thus may not have...

- Discussed their birth options
- Been informed of options for every eventuality in labour

These discussions may then be required during labour with the added layer of language barriers

## The Impact of Trauma



Chronic trauma can result in sensitisation of an individual's survival response system to anticipate threat

→ heightened physical reactivity to situations as if they are dangerous or menacing

This heightened physical reactivity may increase the activity of the sympathetic nervous system in labour.

**Thus, creating a safe environment in labour is paramount**

# Providing Postnatal Care

## Identifying Vulnerable Women

Women who may need extra support postnatally should be identified before leaving hospital

- Rates of postnatal depression significantly higher in women with refugee and asylum seeker status
  - Women may not be forthcoming about their symptoms due to fear of stigmatisation within their culture
- Community follow up with health visitors is also important from a safeguarding perspective

Consider putting vulnerable women in touch with local charities that can help provide support and social opportunities

- For example, project MAMA in Bristol can provide women with extra support during pregnancy, labour, and following birth

## Contraception

**Women should be offered long-acting, reversible contraception before discharge**

This is a crucial factor for future health because...

- Often, poor baseline health has been an issue prior to the pregnancy and this is exacerbated by pregnancy and birth
- Long acting contraception offers the opportunity to...
  - Treat underlying health conditions effectively
  - Deal with complications from labour
  - Optimise a woman's health before further pregnancies
- Additionally, a suitable gap between pregnancies is important if a woman has had a Caesarean section.

## Other Considerations

- Patients may have been unable to access cervical or breast screening programmes- these should be offered to them (age-dependent)
- Girls under 18 who have not been vaccinated against HPV should be offered this

# Further Reading & Resources

A model for service provision for pregnant women with complex Social factors, NICE guidelines:

<https://www.nice.org.uk/guidance/cg110/chapter/1-guidance>

RCOG position statement: Equitable access to maternity care for refugee, asylum seeking and undocumented migrant women:  
[shorturl.at/jotuN](http://shorturl.at/jotuN)

Caring for Vulnerable migrant women – RCM pocket guide:  
[shorturl.at/iF349](http://shorturl.at/iF349)

Maternity Action – charity promoting and protecting the rights of pregnant women including refugee women

<https://maternityaction.org.uk/advice/refugees-maternity-rights-and-benefits/>

**Why did Mrs X die, retold** – tells the story of the challenges women across the world face during pregnancy

[https://www.youtube.com/watch?v=gS7fCvCle1k&ab\\_channel=EmilyGoldner](https://www.youtube.com/watch?v=gS7fCvCle1k&ab_channel=EmilyGoldner)



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