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Childbirth in exile: Asylum seeking women's experience of childbirth in Ireland

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ABSTRACT

Objectives: the purpose of this study was to gain insight into women's experiences of childbirth in Ireland while in the process of seeking asylum. This paper will focus on one of the primary findings of the study, how lack of connection, communication and cultural understanding impacted the health and well-being of the women who participated.
Design: researchers adopted a structural approach to narrative analysis using Burke's (1969) dramatistic pentad to analyse 22 women's narrative accounts of their childbirth experiences. Ethical approval was granted, and the study was funded by the Irish Health Research Board.
Findings: Burke's (1969) dramatistic pentad revealed numerous accounts of Scene/Agent and Act/Agency imbalance in the women's experiences, highlighting lack of communication, connection and culturally competent care evident in their experiences and how this impacted the care they received.
Conclusion: inadequate, poorly organised maternity services complicated by lack of training in cultural understanding and sporadic access to interpreter services had a detrimental impact on care provision. Providers appeared to have little insight into the specific needs of this vulnerable group already traumatised by pre and post migratory stressors. The resulting lack of effective connection and communication exacerbated women's experiences of alienation, loneliness, and isolation and were universal in the women's accounts. Implications for practice need to focus in Burkean terms on 'How' (Agency) providers can meet the maternity care needs of asylum seeking women. Dedicated community based services, mandatory training in cultural competence, 24 hour access to interpreters, information leaflets in several languages are essential measures. Further research looking specifically at the antenatal care and childbirth education needs of ethnic minority women is needed. Also, there is an urgent need for further exploration of the barriers to communication and the utilisation of trained interpreters in the provision of effective care to non-English speaking ethnic minority women.

Introduction

Childbirth, a process fundamental to human existence, is one of the most significant cultural, social, psychological, spiritual, and behavioural events of any woman's life (Jordan, 1993; Callister, 1995; Nicholas, 1996; Callister, 2004; Callister, 2005). For women displaced from their country and primary culture, it is crucial to experience care during childbirth that is sensitive to their needs. Immigration and asylum seeking have become important social phenomena in Ireland since the mid-1990s. Half of all asylum applicants in Ireland are women, approximately 50 per cent of whom experience childbirth there (Murphy, 2005). For women in this study the asylum process was often one of extreme isolation and marginalisation where they exist in a liminal place between the 'no longer' their former lives, and the 'not yet' their hoped for new life in Ireland. The term asylum seeker is now the established term used to describe an individual seeking refugee status, however, it is a somewhat contested term (Kennedy and Murphy-Lawless, 2003). The term asylum seeker replaced that of refugee in common use in the mid 1990s as countries in the west tried to limit their responsibilities to taking in refugees as defined by the 1951 UN definition. During the asylum process women and their families are barred from paid employment and higher level education. They are housed in government accommodation centres

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which are often geographically isolated from the wider community and are subjected to the government policy of forced dispersal, meaning they can be moved anywhere in the country usually with just hours' notice. Many are alone in Ireland having left partners, families and children behind. Their childbirth experience is therefore often set against a back-drop of their own personal suffering, hardship, and loss of everything that is familiar to them (Kennedy and Murphy-Lawless, 2003).

There is currently very little published data on the experiences of women who give birth while seeking asylum in Ireland, and therefore scant evidence to guide best practice. This paper will focus on one of the primary findings of the study, that is, how lack of connection, communication and cultural understanding impacted the health and well-being of the women who participated.

Aim/purpose

The aim of this study was to gain insight into women's experiences of childbirth in Ireland while in the process of seeking asylum.

Background

Migration to Ireland occurred in unprecedented numbers from 1995 onward, peaking in 2002 with 11,634 applications for refugee status (Office of the Refugee Applications Commissioner, 2010). Movements of women in such large numbers do not occur in isolation. Forces related to globalisation have had a direct impact on the movement of women internationally (Office of the Refugee Applications Commissioner, 2012), impacting levels of inward immigration across the world in countries considered to be more developed, thus making the issue of women's experiences of childbirth while engaged in the asylum process an issue of international relevance. In the mid 1990s the new found Irish prosperity acted as a pull factor for migrants fleeing untenable situations to consider Ireland a suitable option. In April 2000 the Irish government introduced the direct provision system[1], whereby asylum seekers are housed in government funded accommodation centres. Standards vary across the country and the system has been criticised for inhumane conditions including overcrowding, inadequate facilities, and lack of access to cooking facilities especially for new mothers who find it hard to keep set dining times. The geographic location of these centres adds to the social exclusion and isolation experienced by many women (Fanning, 2002). Basic needs for food and shelter are provided, and a weekly welfare payment[2] of just €19.10 per adult and €9.60 per child is made. Women expressed feelings of powerlessness, and having no control over their day to day lives as demeaning and a source of constant stress. Living largely in isolation from the community around them with no freedom of movement, no choice of food, no ability to buy and cook familiar foods is a daily stressor. Lack of privacy and for some women appalling overcrowding and unsafe conditions overshadowed their daily existence. The boredom of endless days with no opportunity for paid employment although many of the women are highly educated is a source of deep frustration and a cause of depression especially given the level of poverty and deprivation in which many live. Their hope is in the Irish justice system, their longing for a better life some day in the future keeps these women going, yet the fear of never seeing that day is a kind of living hell. The asylum process can last between 2 and 6 years, while the women seek to prove the legitimacy of their case through the court system in order to secure refugee status.

These conditions increased the impact of fear, loneliness and isolation on women alone in an alien environment who had been traumatised in their own country. Some participants had experienced extreme violence, rape and torture or witnessed the murder of family members before fleeing their own country. One woman described how she felt in the hospital while giving birth:

> Yeah, it was, at one point I was wishing to go back and face whatever I'm going to face, at least if I face it with the people I know it's better than to face this with strangers. It would have been better. But it was too late to make a decision. But if I'd have known I wouldn't even have come. I would have faced whatever; if it's dying I would have died better than coming here to go through all these things alone.

The pre and post migratory stressors add to the challenges of providing effective care to this vulnerable group, as their needs are complex and multifaceted. Whilst many individuals and communities in Ireland have been supportive of people seeking asylum in Ireland, a large proportion of the Irish population lack basic information to understand the asylum issue, which can in itself lead to suspicion and racism (Fanning, 2002). Also, perceived best practice in childbirth is increasingly associated with the technological or medical model of birth that dominates mainstream maternity care in advanced economies (Tobin, 2010), women coming from different cultural backgrounds can find that their maternity care needs require an individual approach within a model that does not easily cater for them (Liamputtong Rice and Naksook, 2003; Callister, 2005, 2006). To complicate matters further, women coming to Ireland found themselves in the centre of a maternity service in an on-going state of crisis that is well documented and multifaceted (Tussing and Wren, 2006; KPMG, 2008; Kennedy, 2010). Pregnant women in particular became the focus of much negative reporting in the press and this was fuelled by politicians who blamed them as being the source of pressure that was causing the crisis in the Irish maternity system. However the crisis in the system was the result of years of consistent under investment from public funds which meant services were operating in ancient hospital buildings that could no longer provide for the volume of women coming through, and as yet there is no viable primary health care strategy to ease the burden (Tyrell, 2004; Burke, 2008; Kennedy, 2010). Midwives and other providers were already over stretched and the increased workload of caring for new immigrants, with language and cultural barriers, many of whom had little or no antenatal care exacerbated midwives stress. Inadequate training in cultural competence sometimes resulted in lack of understanding of the needs of this group of women and also resulted in increased incidences of resentment, sub optimal care and racism (Lyons et al., 2008). In addition, Ireland lags behind the rest of Europe in offering women choice in childbirth. Although a small number of independent midwives operate around the country, they are largely unsupported by the health service (Devane et al., 2005). Women who are pregnant while in the asylum process have a particular set of individualised needs that require an approach that is caring, competent, and culturally sensitive (Kennedy and Murphy-Lawless, 2003). However, this kind of service remains extremely limited in the current climate of medically dominated hospital based provision, where few women have access to alternative childbirth options (AIMS, 2010).

[1] The system of Direct Provision Accommodation Centers for asylum seekers was introduced by ministerial circular of the Department of Justice, Equality and Law Reform in April 2000, with a separate circular introducing compulsory dispersal. Asylum seekers are dispersed to full-board accommodation in one of 56 centers managed on behalf of the government by private contractors (Bartlett, 2009).

[2] A community welfare payment received from the HSE. A weekly payment of €19.10 per adult and €9.60 per child, or €2.73 and €1.37 per day, respectively (AkiDwA, 2010).