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Patricia Kennedy

University of Wollongong, pkennedy@uow.edu.au

Jo Murphy-Lawless

University College Dublin

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Abstract

This extended study, with both quantitative and qualitative elements, was designed and carried out in 1999-2000 to collect baseline data on refugee women's experiences, expressed needs and perspectives of the existing care services in order to inform the development of relevant maternity care policies for this vulnerable group and to plan models of best practice for the future.

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The Maternity Care Needs of Refugee and Asylum-seeking Women

A summary of research by Patricia Kennedy and Jo Murphy-Lawless

**The Maternity Care Needs of Refugee and Asylum-seeking Women
A Research Study Conducted for the Women's Health Unit,
Northern Area Health Board**

The original research was funded by the ERHA and copies of the full report (150 pages) can be requested from the Women's Health Unit, Northern Area Health Board, Eastern Regional Health Authority. The publication of this summary has been sponsored by the Applied Social Science Research Programme SSRC, UCD.

**Dr Patricia Kennedy,
Department of Social Policy and Social Work,
University College Dublin
and Dr Jo Murphy-Lawless.**

Background to the Research

In 1998, with the rising numbers of women refugees and asylum seekers coming into Ireland and subsequently giving birth here, the Women's Health Unit in the then EHB recognised that amidst all the other issues for refugees that demanded attention, research on the specific needs of women as new mothers was a priority. This was a special population of women with potentially quite specialised needs coming into a maternity care system that hitherto had not dealt on a regular basis with women coming from other cultures.

This extended study, with both quantitative and qualitative elements, was designed and carried out in 1999-2000 to collect baseline data on refugee women's experiences, expressed needs and perspectives of the existing care services in order to inform the development of relevant maternity care policies for this vulnerable group and to plan models of best practice for the future.

The full report is available from the Northern Area Health Board. In this summary, we have chosen to concentrate on the background, some of the critical issues we encountered in the course of the fieldwork, and the recommendations.

Motherhood

The experience of coming into the Irish maternity system for women refugees and asylum seekers arises in a context where already there has been an experience of profound loss. That can vary from loss of family, community and country to problems of dealing with violence, torture and rape. Often in situations of severe civil disruption, there has been no extant health service for women for sometime. In addition, experiences of loss and suffering create special dimensions of need for pregnant refugee women, with consequent impact on their physiological, psychological and social profile during pregnancy.

Research literature on pregnancy and new motherhood emphasises that mothers live their lives where the public and private meet at many different levels. Mothers' everyday lives are influenced by public expectations, prescribed roles, social, political, economic, and cultural constraints and circumstances while on a parallel level private, biographical, emotional, physical, and psychological experiences have to be coped with by these same mothers. The relevance of this biographical context for refugee women who have been dislocated from their extended families, cultures and societies cannot be emphasised strongly enough. Their needs go far wider than the exclusive focus implied by a model that speaks only of physical health in pregnancy and birth.

Fieldwork and Methodology

In line with the latest findings about the best time to interview women about their birth experiences, we did not want to approach women in hospital just after they gave birth. But we did want to get a sense of the issues facing this group of women from the perspectives of the maternity hospitals so that we could include them in the questionnaire. Thus, we undertook interviews with hospital personnel which included the Masters and Matrons of two of the Dublin Maternity hospitals, the social work teams and midwifery staff. Interviews were undertaken at various stages of the project. Issues raised by hospital staff related to:

- Language difficulties
- Arrivals of women in late stages of pregnancy
- Children's care needs while mothers were in hospital giving birth
- Different cultural expectations in relation to support in the postnatal period
- Circumcision of male infants

There were also major concerns about women's accommodation and social support needs.

We also conducted a wide range of other background interviews where additional suggestions about interviewing this group of women were made:

- To make people as secure as possible
- To explore the issue of social support – whether the woman has family and/or friends here
- To explore mental health issues as depression tends to occur not when people first - arrive here but as time goes on
- To be aware that domestic violence might be an issue for some women
- To ask questions in a sequence that was as non-threatening as possible and not to ask for any specific information about place of residence in their own country

Drawing on all this material, a 24-page questionnaire was piloted and finalised that included the following broad areas of inquiry:

- Customs surrounding pregnancy and birth in woman's own country;
- Birth history if woman has had children already
- Experience of first pregnancy in Ireland
- Experience of birth in Ireland
- Postnatal period in hospital
- Postnatal period at home
- Family and social networks
- Housing
- Current outlook
- Physical health

As already stated above, the complete data analysis on these areas can be found in the full report.

Problems in Accessing Women: Final Fieldwork Sites

Our original fieldwork plan had to be adapted to what was at the time a growing problem of severely over-stretched services for asylum seekers. This factor in the autumn of 1999, combined with the acknowledged complexity and unpredictability that is part of the circumstances of a refugee population led to major disruptions in services. We eventually accessed women through public health nurses and community welfare officers and interviewed them in a variety of locations:

- Health Centre
- Hostels
- Bed and Breakfast
- Buildings of flats rented out to the Department of Justice for refugee families
- Flats and houses in the private rented sector arranged by families themselves (usually after the birth of the baby).

There were no cots for babies in any of the hostel or bed and breakfast accommodation; mothers and babies/young children were sharing single and double beds. In some settings, there were en suite toilet facilities and a shower, which were shared amongst all the residents in each room. In some cases, not even these were available, and the toilets and showers available on each floor were dirty. It was not all as bleak as this: one hostel where we interviewed was scrupulously clean and despite shared bedrooms and no cots, there was a warmly supportive atmosphere for pregnant and newly-delivered women. Indeed a frequent feature of lives for the women was the supportive friendships that developed among them in temporary accommodation.

The variability of conditions for women classified as asylum seekers and the deep anxieties they are experiencing because of this status, led us to want to compare these with the conditions of women who have the official status of programme. Hence we also interviewed in one additional site: one of the locations for Kosovan programme refugees, from where pregnant women came to maternity hospitals in Dublin. The programme refugees experienced significantly better service provision on all measures, including language support.

Final Sample Size and Baseline Demographic Data

Our final sample size comprised 61 extended interviews. The national breakdown was as follows:

Country of Origin of Respondents

Country of Origin	Number of Women
Nigeria	29
Romania	12
Kosovo	8
Cameroon	2
Ghana	2
Ukraine	2
Algeria	1
Bosnia	1
Iraq	1
Poland	1
Russia	1
Sierre Leone	1
Total	61

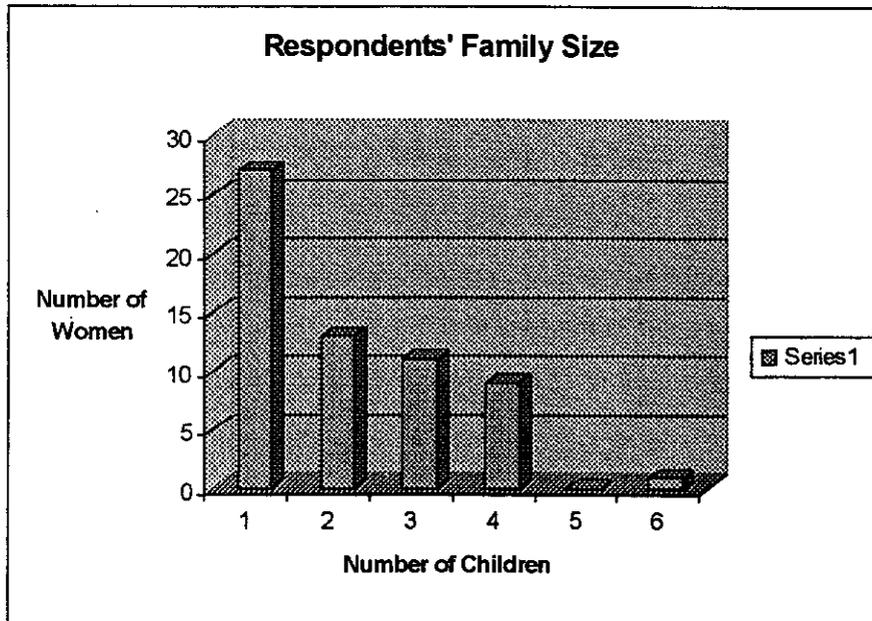
Age

The age distribution of women was as follows:
Age Distribution of the Respondents

Age Range	Number of Women
15-19	4
20-24	13
25-29	19
30-34	15
35-39	8
40+	2
Totals	61

Family Size

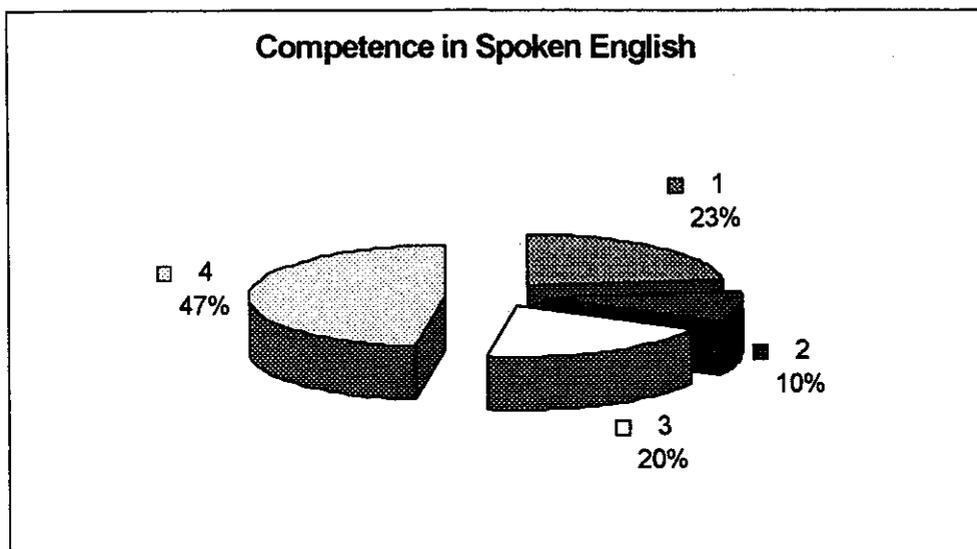
The distribution of numbers of children of the 61 respondents, presented below, indicates that 44 per cent of the women were first-time mothers. This is especially important in relation to their health and social support needs as all first-time mothers tend to be more vulnerable.



The data on how many weeks pregnant women were at their first antenatal visit confirms a predominant pattern of women arriving here in the second and third trimesters. Just under two-thirds of the sample were seen for the first time at 22 weeks or over, 38 per cent of these at thirty weeks or over. In this group of third trimester bookings, there were ten women who were 36 weeks or more pregnant at the time of their first antenatal visit.

Language

Language competency was varied, with West African women on the whole having excellent English. Many of the women coming from East European countries had learned what English they have on their own. The Roma women we interviewed had virtually no English and here we relied on a Romanian translator. We had an Albanian translator for all interviews with Kosovan women.



Legend:

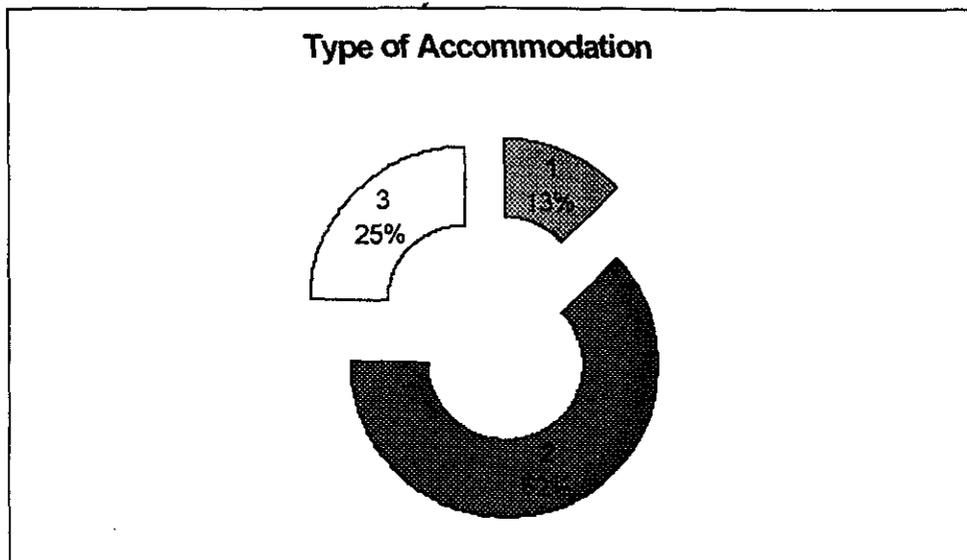
- 1= No English
- 2= Few Words
- 3= Simple Sentences
- 4= Fluent

Education

Of the 61 women, seven had attended primary school only. Twenty-eight had some experience of second-level schooling, though not always a complete round, while 26 women had some further education and training after secondary school.

Accommodation

Accommodation is probably the single greatest difficulty facing women refugees. The chart below presents the accommodation circumstances of our interviewees:



Legend

- 1= Programme refugees
- 2= Self catering Hostel/or Bed and Breakfast
- 3= Private rented sector flat (with young baby)

The majority were in the self-catering/bed and breakfast accommodation which is part of the direct provision package to asylum seekers.

Some Fieldwork Findings

Accommodation

Descriptions of the accommodation were recorded in the fieldwork notes; below examples of this data illustrate the problems many women and their families encounter on a daily basis:

Three women and four children sharing a room in which there were three double beds side by side with a 2-3 foot gap between each and about three foot clearance at the end of the beds. One of the women was eight months pregnant, trying to entertain an 18-month-old toddler. One woman was breastfeeding a week old baby and playing with her 2 year old while the other woman groomed her toddler. There was a small bathroom in the corner, which had a shower, no bath. The women's possessions were piled up in heaps in the corners of the room. They had nowhere to store the powdered baby food, which was perched on a windowsill. They were drinking tea out of empty jam jars. There were no toys anywhere to be seen. There were no cots.

An African woman with a three-week-old baby and a toddler huddled in a small bedroom of a two-bedroom apartment. In the living area was a couple with a child and six male visitors. The woman in the bedroom had conceived when raped in her own country. She was now sharing an apartment with a family she had never met before. They regularly had groups of strange men calling to the apartment. She was exhausted and frightened. When her baby was born by caesarean she had had to leave the toddler in the care of the other tenants and said for both her and her child 'it was the worse week of their lives'.

Experiencing Birth

On the whole, as we indicate in the full report, most women managed to negotiate the difficulties of a foreign maternity service, including the hospitals with some confidence about the level of physical care they received. Communications with staff during antenatal visits and the labour itself about procedures appeared to be satisfactory on the whole, despite language difficulties. But staff members working under pressure of time and inadequate resources did result in less than adequate communication, which in turn was perceived as a form of racism, as experienced by the women themselves:

When I was crying and in pain, I got no sympathy from the staff, I had to ask 'Is it because I am black?'

Good standards of physical care did not prevent women from having fearful and anxious emotions during birth:

I was afraid, I was so afraid. My mother was not here. No one was here. I was afraid this child would die. I was so happy when I came out of hospital with my baby. I was crying all the time from happiness.

I thought I was going to die giving birth, it was so painful. I didn't understand what was happening. They said when the baby's head was being born but I was too scared to watch it.

Food and Eating Patterns during Pregnancy and Birth

The majority of women reported feeling very hungry during pregnancy. But their access to food or even a cup of tea was greatly limited because of hostel and Bed and Breakfast accommodation, where kitchens would be closed. After birth, women also reported feeling hungry and finding the kind of food available not what they were accustomed to having after birth.

Breastfeeding

Most asylum-seeking women are coming from countries where breastfeeding is a given for women. But continued breastfeeding is dependent on a materially and socially supportive context. Barriers to successful breastfeeding include exhaustion, stress and poor diet. There was evidence of the existence of such barriers among the women interviewed in our research. Women who found themselves sharing rooms with other women and babies often stated that they gave them bottles at night as they were trying to keep them quiet. In the accommodation we visited there were frequently unsafe facilities for bottle-feeding, with women having to boil kettles in already overcrowded bedrooms, and toddlers walking unsteadily among them. The diet required by lactating women to establish a good supply of milk was not easily available. Six women did not breastfeed at all, while others abandoned breastfeeding early on because of obstacles like these.

Coping Without the Extended Family

It was especially evident from the women that family members play a huge part in the social support system of pregnant and new mothers. Yet most of our respondents were here without that family network. Despite the emotional pain of often giving birth on their own with no immediate family member with them or even in the country, and with difficult and sad memories of events, family and children they had left behind, women were coping as best they could:

We were lonely and alone. We didn't know how to manage and I was very weak.

When I came here, with no family and the climate was so different, I couldn't stop vomiting for the first few days I was here.

The Future for Women Asylum Seekers

Refugee and asylum seeking women leave hospital with a new baby and a future which is marked by insecurity in terms of relationships, accommodation and income. The impact on women is considerable. One woman who has left her husband and two children behind her in Nigeria and who has no other family here, save her new baby, said bluntly:

We don't know what is going to happen. The future is bleak.

Other women expressed it this way:

I'm worried about taking care of myself and my baby. I think about that all the time. Where will they move me? If they don't put you in good accommodation, how can you do your best?

I wonder all the time to myself how will I manage.

Conclusions and Recommendations

It was in the areas of psychological need and social support that women often experienced major problems. Also, they faced overwhelming concerns about their and their children's futures with no access to work and employment. The recommendations set out below reflect these unmet needs and concerns.

Amongst writers on multicultural societies, there is a strong argument that each ethnic group has special and specific needs in relation to health. But paradoxically it is also argued that what is needed is not a 'cultural' approach, but one based on need, which in turn stems from the experiences of these groups in contemporary societies. There is a need for a system to be set in place which can rapidly collate and re-direct information as new needs arise from ethnic groups who begin to face the process of becoming a refugee.

The main areas of need identified by the women interviewed, the service providers, those from the statutory and NGO sectors who gave background interviews, as well as points gleaned from the literature are presented here. This is followed by suggestions as to how such recommendations can be implemented.

For the most part, it was agreed that the women who come to Ireland seeking asylum and as refugees experience good health care here but suffer unnecessarily because of shortcomings in several areas. For clarity, we have divided the conclusions and recommendations into four areas. These reflect the general structure of this report and are:

- General issues: that is, issues which are relevant to all asylum seekers and refugees not only those who are pregnant or have recently given birth
- The antenatal period
- Labour and delivery and the post-partum period
- The year following childbirth

General areas of concern include:

Information

There are very basic problems in relation to accessing information on rights, entitlements and services. Information needs to be made available in an accessible form and in the appropriate languages taking into consideration the literacy levels of those concerned.

Recommendation:

- Information leaflets that include the geography of all the maternity and related services in the appropriate languages should be prepared.
- Information leaflets should be readily available which explain the different types of 'status' which pertain to refugees and asylum seekers, that is 'leave to remain', convention refugee, etc.
- Access to videos already developed should be made widely available to explain the system of maternity care.
- Comprehensive information for maternity service users should include structure, entitlements, services and descriptions of such procedures as ultrasound and PKU.
- Information for health practitioners on the lines of the NI model (as described in Chapter Eight)

Racism

Institutional racism can be overt, covert, intentional and unintentional. In our research we came across examples of racism along this continuum. Institutionalised racism can result from an intention to provide a service, which will treat all people, the same in attempting to be equitable but this may in fact fail to acknowledge diversity and difference.

Recommendation:

- Cultural awareness training, orientation and sensitised race relations sessions for staff should be put on and paid for by the service provider. It is vital to get across differences in patterns of dealing with issues --like for example the tight swaddling that is common in other cultures but which here raise issues around cot deaths.
- Race awareness training packages

Inter-agency Co-operation

- There appeared to be an inadequate information base/flow for care workers in the community sector or between hospital and community sector to effectively respond

to the difficult dynamics and realities of refugee women's lives, the uncertainty of accommodation and so on.

Recommendation:

- Since April 2000, bi-monthly meetings are held in Mount Street at which professionals providing services to pregnant asylum seeking women meet and exchange information regarding needs and services. This has proved to be an effective process.
- The establishment of liaison/ advocacy workers, drawing examples of best practice from the Maternity Alliance in the UK; the Al-Hasaniya (Moroccan Women's Centre in London) and the Primary Health Care project for Travellers in Ireland (as described in Chapter Eight).

Language

There are major difficulties for women as service users and for professionals as service providers. This needs urgent action.

Recommendation:

- A standard translation service should be provided by the health authorities and not dependent on an NGO sector unless the government contracted the work to them on a formal basis.
- The establishment of a 24 hour telephone language interpretation service similar to Language Line, the London based service (described in Chapter Eight) is vital.

Accommodation

This was the most urgent issue raised by all the women and service providers interviewed in the course of this study. There is tremendous difficulty in accessing suitable accommodation for women who are pregnant/ or have recently given birth. Major inadequacies exist in relation to the supply and the standard of accommodation. This is just part of the wider accommodation crisis in Ireland and particularly in the greater Dublin area at present. Although accommodation for all asylum seekers and refugees is at crisis point, the women interviewed in this study had some very urgent needs specific to pregnancy and caring for new babies. These are in relation to personal hygiene, privacy, rest and sharing accommodation with new babies as well as toddlers.

Recommendations

- Women should have access to a bath during pregnancy and in the months following childbirth.
- Women should have privacy in the post-partum period
- There should be adequate space in accommodation so that cots can be supplied for all infants and appropriate cots/beds for other toddlers and children.
- There should be adequate space available so that each woman can have a safe place to keep a steam steriliser for the baby's bottles.
- A steam steriliser should be made available to each woman who is bottle-feeding.

Inability to Work

The interviewees expressed despair and frustration at not being able to work, not only on their own behalf but also on behalf of their partners. Alienation from the labour market denies people the opportunity to develop new relationships and to become integrated into the host society. It denies people the opportunity to participate and to contribute to society as well as providing people with the chance to use their skills and talents and to earn an adequate income.

Recommendation

- There is a need to review the right of asylum seekers to enter the labour market.
- Access to training must be improved and facilitated.
- Childcare should be put in place to enable parents enter the labour market and/or avail of training.

Poverty/Unemployment Trap

Refugees and asylum seekers, like the general population in receipt of social welfare payments find themselves experiencing the poverty/unemployment trap. The answers to this complex problem must be viewed in the context of the wider social welfare system and the adequacy of payments.

Recommendations

- That the National Poverty Strategy (NAPS) pay particular attention to the specific needs of refugees and asylum seekers if social exclusion for this group is to be avoided.

Child Poverty

In the course of this study child poverty was very obvious if one accepts that children not having access to cots, adequate diet, toys, etc is an indication of poverty. They were also denied the opportunity to participate in society and to meet other young children as their parents considered they had no access to pre-school groups, etc.

Recommendation:

- That child poverty be tackled as part of the broader social welfare system and that any measures introduced to tackle child poverty should give special attention to this particular group. Increases in child benefit would be one way of directly targeting children in poverty.

Domestic Violence

Domestic violence was encountered by the researchers as a serious problem for some women seeking asylum.

Recommendation:

- There is a need to develop culturally appropriate support mechanisms for this group. There is a need for those providing emergency accommodation to women experiencing domestic violence to be aware of the needs of ethnic minorities.
- The regional groups established to develop services in this area should ensure that they incorporate the particular needs of refugees and asylum seekers into their programme planning.
- There is a need to provide clear written information for women explaining their legal rights to residency status as there is a mistaken belief by women that their status is always linked to the partner who may be violating them

Antenatal Care

Many asylum seeking women arrive in Ireland very late in pregnancy. Thus, they often do not have the opportunity to avail of antenatal care. Other women report not accessing antenatal care because of difficulties in accessing such services through lack of childcare; language barriers; tiredness; distance. While some of these are issues which are experienced by the general population, others are not. Women reported not attending

antenatal education primarily because of language difficulties and feeling 'different'. Such classes are a potential valuable source of support for women.

Recommendations

- Provision of antenatal classes locally and not tied to the maternity hospitals (based on the general non-incorporation of asylum women into the hospital system); form of this would need to be thought out because of numbers of women arriving in late in pregnancy but even if it were an introductory session for them, this would be helpful in grounding the women in their hospital experiences.
- For women arriving very late to the hospitals, that is after thirty-eight weeks pregnancy, and who are thus in imminent likelihood of delivering, special support measures should be developed for the very last of the antenatal period and should be carried over to the postnatal period after discharge.
- Making provision for more time and careful listening in the antenatal setting. PHNs when interviewed said that asylum women need a great deal more time. Some of the women interviewed complained about lack of time.

Childcare

Lack of childcare was identified as a major problem for this particular population who had no family support in this country. This need for childcare was evident at various levels: from the women who had 24 hour care of their children in overcrowded, cramped temporary accommodation where they were not only sharing bedrooms with other women and children, but beds with one or two young children; to the women who had nobody to mind their children while they went for antenatal care; to the women who were hospitalised for labour and delivery and sometimes longer than usual stays because of complications. Also, there were women who wanted to enter the labour market.

Recommendations

- Play buses/play workers could be made available to those in temporary accommodation on a regular basis.
- NGOs should be given funding and assistance to develop crèche/ nursery facilities so that women can avail of their wider services.

- Many women attending antenatal care need create facilities. This is an issue, which needs to be addressed by maternity hospitals.
- The booking letter to be used in Mount Street by GPs etc. could be modified to include needs on childcare at time of delivery etc. There still would exist the problem reported by some women in this study who had foster care arranged prior to delivery but once labour started were unable to avail of same.

Labour and Delivery

Most of the women in this study reported high levels of satisfaction in relation to the medical treatment they received in the maternity hospitals. However some of the issues raised as problematic included: language; diet; lack of privacy; having to return for the heel prick test on the fourth day; lack of circumcision services for male infants.

Recommendations

- Translation services should be available twenty-four hours.
- Cultural differences in relation to diet should be addressed, especially the hot/cold dimension.
- Hospitals should endeavour to make it known to women that it is possible to have the heel prick test (PKU) done in health centres.
- The maternity hospitals should re-assess their policies on circumcision. Women should be given clear and accurate written information in their own language on where and how they can avail of such services.
- Cognisance should be taken of the fact that there may be cultural/language barriers preventing the women from asking for help with baby care.
- Women should be encouraged to attend for postnatal six-week check –ups for themselves and be made aware that they have a choice in this regard of attending either the maternity unit or their own GP.

Material Needs

Women reported not having adequate clothes, toiletries, baby clothes, etc for their hospital stay and reported not knowing that they could receive money from the CWO for same. The area health boards have stated that its policy is to inform every woman of her entitlements in this regard.

Recommendation

That women should be given written information on what exactly they are entitled to in this regard.

The Postpartum Period

Social Support

The women interviewed in this study for the most part reported having left behind very strong systems of social support. Women were used to expecting and receiving high levels of support from their own communities and in particular, the women of all generations in those communities. They felt particularly isolated and lonely during pregnancy and following childbirth.

Maternity care services in Ireland in the community are very limited at present: a woman may have her antenatal care, antenatal classes if she chooses these, 2-3 days in hospital after giving birth, followed by one visit from the public health nurse, and her six week postnatal check-up. There is a need to enhance these services for asylum seeking and refugee women.

Recommendations

- In line with the recommendations of the 1994 Report of the Maternity and Infant Review Group, it would seem appropriate that where possible public health nurses would make contact with women prior to delivery. This would extend support during the antenatal period.
- That women who have settled in Ireland could train as link workers/advocates and be employed as such.
- That family support workers be more readily available to asylum seeking and refugee women and in the long term that women who have been refugees themselves could be trained and employed in this capacity. This would provide practical support in the absence of an extended family and it would also be seen to help local integration in the period after birth.

- Possible exploration of special support unit for third trimester pregnancies, special workers in Mount Street to help them link in with hospitals, GPs and community public health nurses before birth
- It is possible that supportive accommodation be developed for mothers and babies during pregnancy and the first months of the baby's life.
- The Community Mothers Programme, already in existence in some health authorities could be adapted to meet the needs of refugee women by harnessing the expertise of mothers who have been in Ireland for a while who have experienced the asylum process themselves.
- The health centre where women attend with their children for developmental check-ups and immunisations could be a valuable meeting place for women. Supportive groups could be developed there if pressures of time and space allowed. Perhaps the NGOs could be facilitated and funded to provide such services.

I was not encouraged to ask questions, as the doctor was too busy.

I was afraid, I was so afraid. My mother was not here. No one was here. I was afraid this child would die. I was so happy when I came out of hospital with my baby.
I was crying all the time from happiness.

They should have the social worker come and talk to the pregnant woman to explain. We feel so dependent. We should be able to discuss with the social worker about getting baby clothes or diapers and these things.

They treated me well, whenever I needed anything.
Everything went well, no injection or anything.

We were lonely and alone. We didn't know how to manage and I was very weak.
I wonder all the time to myself how will I manage.

We don't know what is going to happen. The future is bleak.

I thought I was going to die giving birth, it was so painful. I didn't understand what was happening. They said when the baby's head was being born but I was too scared to watch it.

I'm worried about taking care of myself and my baby. I think about that all the time. Where will they move me? If they don't put you in good accommodation, how can you do your best?

When I came here, with no family and the climate was so different,
I couldn't stop vomiting for the first few days I was here.

This is not normal. It is not normal for people like me not to be working in our own country. It is not right.

When I was crying and in pain, I got no sympathy from the staff,
I had to ask 'Is it because I am black?'

The different groups from the same country are suspicious of each other if they haven't been getting on back home, and that can have a knock on effect.



Social Science Research Centre
University College Dublin
Belfield, Dublin 4
Ireland