

## CHAPTER 6

# Refugee women

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In the UK, refugee women face overwhelming obstacles to their health and well-being. Many have been through traumatic events and experiences, and exile and loss (both cultural and material) will add to their suffering when they are here. The refugee experience in the UK is not a comfortable one. These women face bigotry, ignorance, disinterest, hostility and poverty. Pregnancy and childbirth represent a dangerous time for these individuals, who can be particularly vulnerable. In order to provide the support and care that a refugee woman needs, the healthcare professional must understand who she is, what she has been through and the challenges that she faces when bearing a child in her country of exile.

### INTRODUCTION

Refugee women are among the most marginalised and misunderstood groups in the world today. They face not only the stigma of being refugees but also gender persecution, and they often suffer in a culture of silence because of their sex. Women and their dependent children represent ‘the overwhelming majority of refugee caseloads in almost every country’ (Marshall 2000). Many will find their way to the UK, either through cross-border flight or after languishing in a neighbouring country’s refugee camp, sometimes for years. Although these women are survivors who will have shown remarkable fortitude and resourcefulness to get here at all, they are also vulnerable and often severely traumatised by their experiences. A high percentage of them will be pregnant – some when they arrive, and others soon afterwards. This in itself may seem odd. Why should women want to give birth at a time of such hardship and uncertainty? First, they may not be pregnant through choice. The great majority (approximately 80%) of refugee women are Moslem and come from a culture of short birth spacing (Wali 1995). Secondly, they may be pregnant due to lack of available contraception, or as a result of rape. Finally, women who are already in their host country may choose to become pregnant. Possibly (as one doctor who cares for refugees has suggested) this has to do with a reaffirmation of life and an attempt to move towards normality by entering into a life experience that encompasses both ritual and tradition, as well as a new

beginning. Once they are in the UK, refugees experience deteriorating health, poor housing and poverty (Burnett and Fassil 2004, Yates, Crane and Burnett 2007, Palmer and Ward 2007). They are the subjects of resentment and sometimes violence. The policy of dispersal of refugees throughout the UK has led to problems with existing communities, an issue that was tragically illustrated by the murder of an asylum seeker in Glasgow in 2001.

Refugees are a diverse group, coming from extremely varied social and cultural backgrounds. It is important for healthcare workers to understand that the terms 'refugee' and 'asylum seeker' denote a situation rather than an identity and that refugees and asylum seekers should be treated as individuals with differing needs, hopes and fears. It is also imperative to appreciate that the needs of newly arrived asylum seekers are different from those who have been in the UK for some time (Burnett and Fassil 2004). However, there are certain common issues of which those caring for them need to be aware. It is vital to be able to understand and contextualise these experiences in terms of the pregnant woman if she is to receive the care that she needs. Van der Veer (1998) suggests that refugees are subject to trauma, which is similar to that experienced by immigrants, disaster victims and war veterans, but which is a unique amalgamation of all three.

One of the most important factors that contributes to an understanding of these women is a knowledge of the different statuses of refugees in the UK, as their living conditions and concerns will be significantly different – *see* Table 6.1. The asylum seeker does not have access to benefits, has no long-term security and faces the possibility of

**TABLE 6.1** The differing asylum definitions (Bennett, Heath and Jeffries 2007)

Asylum seeker	A person who has submitted an application for protection under the Geneva Convention and is waiting for the claim to be decided by the Home Office
Refugee status (status altered in August 2005)	Accepted as a refugee under the Geneva Convention and granted five years leave to remain. Granted Indefinite Leave to Remain (ILR) – permanent residence in the UK – if they have not, through own actions, brought her/himself within the scope of the Refugee Convention's Exclusion and Cessation clauses and, therefore, triggered a review. Eligible for family reunion
Persons granted Humanitarian Protection (HP) or Discretionary Leave (DL): (replaced Exceptional Leave to Remain (ELR) in April 2003)	Refused asylum but the Home Office has granted HP or DL for five years because it has recognised that there are strong reasons why those persons should not return to their countries at the present time. Status reviewed if subject triggers a review under the Refugee Convention's Exclusion and Cessation clauses. Eligible for family reunion
Unaccompanied minor/separated child	A person who, at the time of making his/her application, is under 18 years of age or who, in the absence of documentary evidence, appears to be under that age, and who is: <ul style="list-style-type: none"> <li>● applying for asylum in his/her own right</li> <li>● without adult family members or guardians to turn to in this country</li> </ul>
Family reunion	One spouse and children under the age of 18

forced repatriation. She may still be preoccupied with survival, and could be heavily involved with asylum applications or appeals. The refugee, on the other hand, will have access to all of the benefits available to a UK citizen, and she will know that she can live and raise her child in the UK, and she will be adjusting to her new life and dealing with the loss of her homeland.

The aim of this chapter is to consider these women in terms of who they are, how they came to seek asylum, and how the experiences of persecution, war, loss, flight and exile may have affected them physically and psychologically. In addition, strategies will be discussed that will help professionals to care for these women and to ensure that the journey through pregnancy and childbirth does not traumatise them further.

### WHO BECOMES A REFUGEE?

Member states of the United Nations are obliged to offer refuge to any person who steps on to their soil and requests asylum. It is then incumbent on that state to decide whether the person concerned will or will not be granted refugee status. The guide that is used to decide this is the 1951 United Nations Refugee Convention, which defines the refugee as follows:

. . . (any person who) 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 nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country . . . is unable or, owing to such fear, is unwilling to return to it. (United Nations 1951, cited in United Nations High Commission for Refugees 1998)

The statistics kept by the Home Office are complex and detailed but Table 6.2 gives an idea of the outcomes following applications for asylum over the years 2003–06.

The 1951 United Nations Refugee Convention is noted for its lack of reference to gender as a reason for persecution. Women still have a low status in the world, and are often subjected to maltreatment, sexual abuse and domestic violence by their husbands or families. The practice of female genital mutilation also abounds in many countries. As governments came under greater pressure from refugee numbers in the late twentieth century, the convention was interpreted in an increasingly narrow fashion, culminating in the assumption that a refugee, by definition, could only be someone who had been persecuted by government forces. For the thousands of women fleeing persecution by their families and husbands this meant being sent back to appalling living conditions. However, in 1985 the problem of vulnerable women was finally recognised, and it was agreed that women who faced harsh or inhuman treatment and received no help from their government could become refugees under the convention. Despite this, the majority of host countries are still reluctant to grant asylum on these grounds (United Nations High Commission for Refugees 2000).

It is important for professionals caring for refugees to be aware that there is an assumption that every refugee is an escapee from war or civil unrest, and that they will be missing their home and desperate for the company of their own race. The woman who has sought refuge from gender-based persecution may be reluctant to engage with

**TABLE 6.2** Summary of estimated outcomes of asylum applications (including appeal outcomes at Immigration Asylum Appeal (IAA) and Asylum and Immigration Tribunal (AIT) (Bennett, Heath and Jeffries 2007)

	2003	2004	2005	2006
Asylum applications	49 405	33 960	25 710	23 610
Recognised as a refugee and granted asylum	7 650	4 370	4 370	4 040
as a percentage of total applications	15%	13%	17%	17%
Not recognised as a refugee but granted HP or DL	5 245	3 720	2 850	2 185
as a percentage of total applications	11%	11%	11%	9%
Refused asylum, HP or DL, or withdrawn by appellant	33 635	23 860	16 000	13 375
as a percentage of total applications	68%	70%	62%	57%
Cases with decision not known	1 555	930	1 630	3 090
as a percentage of total applications	3%	3%	6%	13%

anyone from her own country. She may also be living in fear of being returned, or of being found by a UK-based branch of her family.

However, most of these women will be fleeing from situations of war. This is because in modern warfare the civilian population is deliberately targeted. On average, civilians represented approximately 90% of casualties in late twentieth century wars (Chinkin 1993, Paulson 2003). In *The Times*, 14 July 2008, Halima Bashir tells movingly of her story of being gang-raped near Darfur by Sudanese Government-backed Janjawid Arab militia. In 2005, Halima arrived in the UK and was granted asylum but has no idea where her family are or even if they are alive. She cites her case of rape being used as a weapon of war. Women bear the brunt of this, as they continue to be particularly vulnerable in times of war or civil unrest. Nikolic-Ristanovic (2000) suggests that this vulnerability stems from a combination of the following factors.

- ❖ Women are usually unarmed and do not have access to weapons. Most of them do not know how to use a weapon.
- ❖ They are less mobile. For example, they may be pregnant, or caring for small children or elderly relatives.
- ❖ They are usually reluctant to leave their homes, as their role is to look after the home in the absence of men.
- ❖ They need to provide for their families, which may lead to dangerous expeditions for basic necessities, such as food, and also prostitution.
- ❖ Women are often objectified as the property of their men. Attacking them is therefore often seen as a direct assault on the man concerned and on the honour of his family.
- ❖ Women will often stay in their homes until the last minute, when a final traumatic event, such as an attack, a rape or a threat to their children, causes them to flee. Many do this reluctantly, torn between their children and their husband, and

experiencing guilt about leaving their home and husband, who may return after the war. The account of Olivera, a Serb refugee, clearly illustrates this:

I can't forgive myself for leaving with the children. You know, I was taught to be always by my husband's side. I thought 'What would happen if he has to go to fight and then gets killed? Would my children tell me that I had left and let him manage everything alone and get killed?' (Nikolic-Ristanovic 2000)

### COMMON EXPERIENCES

Although, as a rule, generalisations are dangerous and should be avoided, they have a use in the refugee situation, if only to act as a paradigm in which to explore the many factors that will affect the pregnant refugee. As mentioned earlier, the refugee woman will have had a unique series of experiences that will have affected her prior to her encounter with the healthcare professional. Many of these women will be suffering from psychological trauma. Kielson 1979 (cited in Van der Veer 1998) suggests that the process of traumatisation of the refugee is a slow one and generally takes years. He divides it into three periods, namely the increasing political repression at home, the traumatic events that culminated in flight, and exile itself. This is a useful observation, as it shows how the woman has been moving towards becoming a refugee over a long period of time and will already be showing signs of long-term traumatisation. Seligman (1975) suggests that passivity is often observed as a result of trauma, and this view is supported by Gielis (1982), who introduced a concept of 'learned helplessness' caused by trauma. This has the following features:

- reduced motivation to react, including passive slow reactions, sluggish thinking, low expectations and no belief in the possibility of an improvement in the situation
- reduced capacity to learn that actions can lead to desired results
- negative feelings such as fear, depression, emptiness, and absence of desires
- self-reproach and low self-esteem.

This is particularly relevant with regard to the pregnant refugee, who could thus appear passive and uninterested in the outcome of her pregnancy as a result of this long-term trauma. So what factors lead to this level of trauma in the woman? Van der Veer (1998) has identified eight types of experience that the majority of refugees will undergo. Although no list could encompass the entirety of every individual refugee's experience, this is useful as a framework for exploring the effects of becoming a refugee on a pregnant woman.

- increasing political repression
- detention
- torture and rape
- other types of violence
- disappearance of relatives
- separation and loss
- hardship
- exile.

## **INCREASING POLITICAL REPRESSION**

Wars do not start suddenly and refugees are not made instantaneously. Frequently, there is a slow political shift towards an opposing ethnic or political group. Many individuals initially experience the loss of privileges, with increasing restrictions being placed on their lives and work. They will see their own and their children's future slowly becoming less hopeful, and they may begin to be the subjects of abuse in the press and when they go out of the home. As the repression increases, there is a build-up of tension within the family, leading to an increase in domestic violence, and women will be under enormous stress as they work to keep their family safe in this environment. Living in a constant state of fear is both depressing and damaging to health, and there may also be a loss of faith and trust in others as neighbours and friends turn against them. Many refugees will find it difficult to trust anyone again. For the pregnant refugee in the UK, this loss of trust can be very difficult, as she will not automatically trust her care team, and she may require more time and understanding before she has confidence in them. Some women will also be very nervous in the presence of interpreters whom they do not know, as they often suspect them of being spies or members of opposing parties. It is vital for them to develop a rapport with an interpreter and remain with that person if possible. A high turnover of medical and midwifery staff will also worry the woman, as she has come from a world of disappearances and will wonder why different people are present at each appointment. It is vital that the voices of these women are listened to and heard, not only by midwives and other healthcare workers, but also at Government level to encourage the formation of more woman-centred strategies (Dumper 2005).

### **Detention**

Many women will have been detained for a period of time prior to their flight. This may have been a sudden arrest or an expected event. However, the mother will have been separated from her family, and she may have missed important family events or ceremonies. She will be unable to fulfil her role of mother, and this will lead to feelings of guilt and self-reproach, particularly if the arrest is due to any actions on her part (e.g. handing out leaflets). Detention also signifies the loss of hope of any improvement in the political situation, and it is often the catalyst that makes a woman flee.

### **Torture and rape**

Torture is common in repressive regimes. It frequently occurs during detention, and women are tortured as often as men. It would be impossible to determine how many refugee women have been tortured, as there is great stigma attached to it and many would never speak of their experiences, even to loved ones. However, United Nations High Commission for Refugees (UNHCR) figures have suggested that up to 80% of refugees have been tortured either in their own country or during flight.

One of the main aims of the torturer is to silence dissent by using techniques that take away the voice of the victim. These will involve physical violence in all of its forms: psychological violence (e.g. sensory deprivation), threats to the woman and her loved ones, particularly her children, the assault of loved ones in front of her, and sexual torture, including rape, mutilation of genitals and the administration of electric shocks to organs. Sadly, the list of ways that torturers have found to hurt their victims could go on for ever. However, this chapter will concentrate on some of the effects on the woman and her life afterwards. Rape will be discussed as a separate issue.

The physical sequelae of torture include scarring, chronic headaches, shoulder pain, back pain and haemorrhoids. Many women will suffer from chest complaints after having been imprisoned in damp cells. Some will complain of problems eating, possibly due to the forced ingestion of taboo substances such as faeces, oil and semen (Douglas 1966) during torture. These women will often have somatised complaints, which can be described as the physical manifestation of psychological pain. Hinshelwood (1996: 195) suggests that 'the body's language to communicate and live with the unspeakable is much more primitive and simple than the spoken word'. Survivors of torture often have difficulty sleeping and are plagued by nightmares and flashbacks.

Women who are pregnant at the time of torture frequently miscarry afterwards. The torturers will often convince them that they will never again bear healthy children because of the torture, and for women this is one of the most powerful long-term effects of torture. The following quote illustrates this clearly: 'Women who have been tortured feel the torture is inside them and that their insides are spoiled and, most particularly, their creative reproductive capacity' (Hinshelwood 1996: 195).

This sense of internal spoiling is not unusual, and it represents a major psychological stumbling block for the pregnant woman. Consider, for example, the moving story of Sylvia, who begged for a termination because of her belief that anything that came from inside her could only be evil and deformed (Agger and Jenson 1993). Hinshelwood (1996: 195) also writes of her client who believed 'her body to still be filled with blood and torturer's semen and dead fetus'. There are numerous descriptions of women asking for the removal of something evil that they felt was inside them and tangible. Hinshelwood (1996) suggests that a sensitive gynaecological examination can help to provide reassurance in these situations. Perhaps an ultrasound scan would also serve the same function if it was approached with this purpose in mind. Meeting medical staff and undergoing procedures can be particularly traumatic for the survivor of torture, because much torture is medicalised. Some of the instruments that are used for torture will look 'medical', and rooms will be given ironic, euphemistic names, such as 'intensive care' and 'operating theatres', by the torturers (Morris 2000).

This leads us on to the subject of rape and the devastating consequences of this for refugee women. In war situations, the incidence of rape increases dramatically (Seifert 1993), a fact that was most clearly demonstrated by the recent Balkan conflict. Before the war, rape was very rare, but during the war an estimated 20 000–50 000 women were known to have been raped (it is believed that the true figure is higher). Brownmiller (1993) suggests that this is because women's bodies have become an extension of the battlefield and therefore war is waged on them. Rape is also used with the intention of destabilising society and forcing citizens into exile. For example, many women in the Balkans were kept in rape camps until they became pregnant in order to interfere with the gene pool. Finally, there is a serious problem of rape in refugee camps, where women are unprotected and the incidence of rape is very high. Research has shown that rape during conflict is more brutal, often repeated and involves more than one rapist (Nikolic-Ristanovic 2000).

Although the refugee woman will not necessarily be pregnant as a result of rape, the fact of the pregnancy is likely to generate very ambivalent feelings within her. Many women never speak of their ordeals because it is so unacceptable to do so (some languages do not even have a word for rape, as they believe that a woman cannot be penetrated unless she is willing, and others punish rape victims as adulterers). On

arrival in the UK there may be pressure from the woman's family to have a baby and she will be unable to explain why this may be a problem for her. Some women who have previously become pregnant as a result of rape may have had a late termination or they may have had the baby and given it away. Nikolic-Ristanovic (2000) describes as 'one of the cruellest forms of torture' the conflict of knowing that one is carrying one's rapist's child, which is also one's own child. The children born of these unions are viewed as 'monstrous' and 'evil'. For these women, pregnancy will be a major memory trigger, and together with the concerns about internal spoiling it may result in significant traumatisation. Labour will inevitably bring back the memories of the previous experience. Zelina, a 13-year-old refugee who had been raped, had given birth to a child and had given it away, described her greatest fear as follows: 'that she would never be able to physically enjoy a man's company or love a baby' (Hinshelwood 1996: 195).

Therefore for these women, having a baby will be a pivotal moment in their lives, which may be a new beginning, but which will also be a painful reminder of what has happened. They will have fears about the baby and whether it will be deformed or evil because their internal reproductive organs have become a bad and unsafe place. Finally, many of these women will be terrified that they bear some kind of visible sign of their experiences, which will be discovered during an examination. To end this section, a vignette is taken from a speech by Gill Hinshelwood. We can assess torture, rape and torment in cool clinical language, but the cost to an individual can only be quantified in human terms. Asha's story brings to life the suffering and shame that is experienced by these women after being abused.

Asha arrived in England in 1994 when she was 18 years old. She knew no one. Once in England, she was sent to a bed-and-breakfast hostel, where she stayed in her room, locked away from noise and danger, and only emerged to find help when she could not control her vomiting. She was pregnant. She had an abortion and went back to her miserable room. When she was referred to me some seven months later, her presenting symptom was a carrier bag of medicines – some of which she had tried to take as an overdose. Asha had 22 different medicines in her bag for complaints of aches and pains ranging from head to foot. She sat strained and rigid, her face never lightening and never making eye contact . . . The past history that Asha slowly allowed us to hear was one of violence and brutality, beginning with threats and abuse directed at those entering the Kingdom Hall and abuse hurled at her in the street, and culminating in brutal rape by five policemen in a cell leaving her unconscious, bleeding and, as it later turned out, pregnant. She had been a virgin. Asha had very few words at her disposal to describe what had happened. Many of the words we use are felt to defile the person by the very utterance of them . . . She had coped over the last seven months by her disconnectedness, by being 'a backache', 'a sore throat', 'a painful knee'. This consultation with me was the first exposure she had allowed since that day when her clothes were torn off, a rag was stuffed into her mouth and five policemen took over her body, penetrated her, cursed her . . . Asha was a walking picture of shame. (Hinshelwood 1997)

### **Other types of violence**

Most refugees are subjected to terror prior to flight. Awareness of the destabilisation of a

regime and the increased unpopularity of one's ethnic group will be frightening. During these periods, stories of rape and torture abound, and there will be much agonising over the decision of whether to leave. The ongoing threat of violence will be present. There will also be terror of being returned; as only 20–25% of applications are upheld, the great majority of refugees will be sent back home.

### **Disappearance of relatives**

This can be extremely painful for the woman. Her relatives may have disappeared years previously, but the lack of closure will keep the pain fresh. Allodi and Rojas (1985) suggest that there is a higher incidence of mental health problems among refugees who have experienced the disappearance of a family member.

### **Separation and loss**

All refugees will experience separation and loss. The woman will have been forcibly separated from her home, and she will have lost her belongings and status. She will no longer have a social structure around her to help her through her pregnancy. She will also have lost all of the frames of reference that contextualised her as a person, both internally and externally. Afkhami (1999: 214) described this as a 'loss of who I was.'

Coehlo (1982) describes this loss as a form of culture shock, which is particularly pertinent with regard to the pregnant woman, as childbirth is an event imbued with cultural and traditional meanings that will not be relevant in the new social culture. The woman may have lost members of her immediate family, and she will also have lost her social group who would have welcomed the baby into the world. Eisenbruch (1984) suggested that these losses are a form of cultural bereavement, and that they require adaptation that could result in denial, anger and finally depression.

Many women will also have been bereaved in the literal sense, having lost husband, relatives, friends and children in the conflict. They may be recently bereaved, and they could be experiencing feelings of guilt both about surviving and about having a new baby.

There is also loss of the woman's cultural life; in the host nation there is little interest in or respect for a refugee's homeland. This lack of knowledge and desire to learn is profoundly depressing and deeply insulting for many refugees (Van der Veer 1998). There will be cultural confusion, particularly in relation to gender, and the woman will often feel isolated and cut off from the female support networks in her own society. The rules that governed her in her homeland may not exist in a Western society where there are few limitations for women, and this can result in a loss of stability and balance in the woman's family relationships. Groenenburg (1992) has noted that this leads to conflict and ultimately a higher divorce rate within these families.

### **Hardship**

Mrvic-Petrovic and Stevanovic (2000) stated that there is a widespread impoverishment of women refugees. This impoverishment often begins before the woman becomes a refugee, within her home country. Living in a repressive regime or an area of conflict inevitably leads to hardship of various kinds. There are frequently food and power shortages, and if the refugee is from a minority group, there could be poverty and hunger imposed by the regime itself.

During flight, refugees often experience the most gruelling physical hardship – they

may walk through storms, over mountains or through deserts to escape. Some will bribe their way into lorries run by criminals, paying a terrible price to escape, as these criminals often force the women to have sex with them, rape them, rob them, and often do not give them food or water for days at a time. At the borders, guards exact a price as well, often in the form of the belongings of and sexual intercourse with the women.

A huge number of refugees will begin exile in a refugee camp. These again are places of immense poverty and hardship. There are frequently food shortages, and women receive the smallest share of what is available (Marshall 2000). As aid agencies struggle to manage the vast needs created by these camps, many residents are left without heating, water or shelter for long periods of time (Kett 2005).

Finally, having arrived in the UK, these women will again face hardship. The life of asylum seekers is not an easy one. They are often housed in the least desirable properties in the least desirable areas and are forced to live below the poverty line with no access to money, paying for goods with vouchers. Single women are placed in hostels, which are often mixed and which charge fees that use up all of the asylum seeker's allowance. Asylum-seeking mothers do not even have the right to free milk and vitamins for their babies.

McLeish (2002) published a report on the plight of pregnant asylum seekers for Maternity Alliance. It paints a depressing picture of how these women, once in the UK, continue to suffer from loneliness, depression, separation from family members and sometimes violence, and they suffer poor physical and mental health as a result. Black African women, including asylum seekers and newly arrived refugees have a maternal mortality rate nearly six times higher than white women (Lewis 2007). Special emphasis is given to migrant women in the Confidential Enquiries into Maternal Deaths recognising that their particular experiences render them vulnerable during pregnancy and childbirth. These experiences include female genital cutting and, also, the need for translators to aid effective communication (Lewis 2007).

In times of extreme hardship, the woman will be more concerned about survival than anything else. The pregnant asylum seeker will be likely to have this mind set. She may seem more preoccupied and concerned about housing or her application for refugee status than she is about the baby or attending antenatal clinics at the right time. This is not an indication of lack of interest, but rather it is simply her way of coping with the enormous hurdles that lie in front of her. She will need flexibility and understanding from the midwives, and even help with organising her time so that she can attend her appointments and receive the support she needs (Lockey and Hart 2004, Harris, Humphreys and Nabb 2006, Ukoko 2005).

## **Exile**

All refugees, for whatever reason, have been exiled. They have been exiled from the smell, the feel and the sights of home, and this sense of not belonging often remains with refugees for the rest of their lives. Many of them will be concerned with events at home, and will be disturbed if there is news coverage of a particular event. The pregnant woman will be adapting simultaneously to her new social setting and her pregnant state. She will be aware that her child will be born into exile and may never know its country of origin. She will also be coming to terms with the fact that she has become a refugee and her child will be born with this identity and denied his or her birthright. This can cause overwhelming feelings of guilt and sadness. In exile, the woman may also have a

great deal more responsibility than she had before. She may suddenly be the head of the household and be faced with decision making for the first time in her life.

## REMEMBERING

People who have been through significant trauma will have a different way of remembering events. In fact, it is probably misleading to use the term 'memory' in this context, as it implies a sense of an event being viewed in the past, whereas for the traumatised refugee quite the opposite will be the case. Langer (1991) identified a concept of durational memory in Holocaust victims. This is a form of remembering that does not age or fade with time. Durational memories are fresh and are described as being 'like yesterday'. They are also physical or sensory, involving smell, sensations and emotions rather than details and overviews. This means that the woman can be remarkably vague (to the point of being difficult to believe) about details, but will nevertheless remember and feel the event as if it were yesterday. Seifert and Hoffnung (1987) suggest that this is due to an overload of information in the long-term memory causing spillage into the short-term memory, which results in flashbacks and nightmares. They also suggest that the short-term memory is then filled up inappropriately, resulting in problems with regard to memory and concentration.

This is a crucial factor to consider when caring for the refugee woman. Her pregnancy, the examinations and the birth may all trigger durational memories that could be very damaging and frightening. She needs to be treated as if her experiences had happened yesterday, as chronological time has no relevance in this situation. She should not be expected to remember things easily, so information that is given to her should be repeated and written down.

## CONCLUSIONS

Faced with this list of appalling experiences and tragedy, it seems difficult to envisage that anything more than understanding can be offered to the refugee woman who is facing childbirth in the UK. However, this is not the case; as with resourcefulness and knowledge healthcare professionals can adapt their approach to the needs of the woman and greatly improve her care.

One of the most difficult problems for these women is lack of knowledge – of who they are, where they are from, what they have been through and what is important in their lives. In the busy world of the NHS these issues are rarely addressed, but they are vital to the person who has lost most of this knowledge (O'Donnell, *et al.* 2007, Coker 2004). We need to be able to show interest, learn a little about the countries they come from and acquaint ourselves with some of the major cultural features (particularly birthing rituals) of our refugee patients. The ability to discuss refugee topics with these women will be a step towards reducing the stigma attached to their position. It is also vital for the carer to understand the importance of survival issues to the refugee. It is pointless to assume that they feel safe now and therefore there is no longer a problem. They will *not* feel safe – they will fear strangers, fellow nationals, people in uniform, and of course the Home Office, which may send them back to their homeland. Instead of fighting this, and trying to impose the healthcare professional's own set of values on these women, it would be more productive to help them work through the survival

issues or to direct them towards someone who can do this (Derluyn and Broekaert 2007, Feldman, *et al.* 2007).

For any woman, bearing a child in the UK can represent a loss of control over one's body, particularly in the hospital setting. This can be very challenging for the refugee patient, who has seen all control removed from her life in previous years. In particular, victims of torture need to have control over their bodies, as they have been subject to a total loss of autonomy during the torture. The loss of control over one's body, associated with pain such as labour, may trigger durational memories, flashbacks and terror. Because of this, the healthcare professional should ensure that any decision – even simply touching the woman – is made by the woman herself without pressure or coercion. Any refusal of an examination or treatment must be regarded as an informed choice. For example, some survivors of torture have said that they would prefer to die rather than undergo a procedure that triggered a flashback (Matthews 1997).

This chapter has provided a snapshot of the refugee woman and her life. We can see that the effects of experiences such as rape and torture are overt and numerous. Basic functions such as eating and sleeping are disrupted, as are mechanisms for communication, due to fear and lack of language. The woman's body has acquired a new set of meanings through her experiences, and these make it a dangerous place for her. We can also see how the violation of boundaries during rape and torture leads to a sense of social pollution. It is hardly surprising that many women refugees struggle to come to terms with their lives in the UK. There is a high rate of suicide and depression among refugees in this country (Aldous, *et al.* 1999). However, most refugees will carry on, despite feelings of desperation and severe traumatisation. They are survivors and that is what they do, often at immense personal cost. Importantly, Amen (1985) suggests that refugees often cope well until they are faced with something unexpected, or until physical illness undermines their ability to cope, and then they collapse. This is why pregnancy and childbirth represent such a dangerous time for the refugee woman, as it is a time of emotional significance and great vulnerability, when the woman will miss her home, her family and her loved ones more than ever and require greater support than before. Mrvic-Petrovic (2000) supports this view, stating that women refugees are especially vulnerable to new stressors when pregnant.

This chapter has focused more on what *makes* refugee women than on what *happens* to them in the UK, because if we are to understand the context of their lives, it is necessary to look back to the start of the fear and repression and how the process of becoming a refugee has affected these women. During pregnancy and childbirth they require knowledge, sensitivity and understanding. The midwife should be alert to signs of trauma and be aware of the complex issues in the refugee woman's life.

### KEY POINTS

- ☞ Women seek asylum for a variety of different reasons.
- ☞ Refugee women are stigmatised, and experience poverty and hardship in their host country.
- ☞ They will be diverse and will have had widely different experiences, but certain common factors will be present.
- ☞ Many will have endured physical and mental abuse, which they will be reluctant to discuss. This could have profound psychological effects.
- ☞ Apparent lack of interest and apathy may be misleading and require the carer to consider the possible causes, such as trauma and a preoccupation with survival.
- ☞ The rape and torture of refugee women is common.
- ☞ Traumatic memories remain recent and painful.
- ☞ Pregnant refugees are particularly vulnerable and require special care and consideration. The midwife needs to understand and anticipate the difficulties that may arise.

### USEFUL ADDRESSES

Medical Foundation for the Care of Victims of Torture  
111 Isledon Rd  
London N7 7JW

Tel: 0207 697 7777 [www.torturecare.org.uk](http://www.torturecare.org.uk)

Provides medical consultations and treatment, medical documentation of torture, practical help and advice, marital, family and child therapies, and a range of complementary therapies.

Refugee Council  
240–50 Ferndale Rd  
Brixton SW9 8BB

Tel: 0207 346 6700 [www.refugeecouncil.org.uk](http://www.refugeecouncil.org.uk)

Campaigns for refugee rights, provides direct services such as day care, housing advice, etc. and produces information on refugee issues.

Liberty  
21 Tabard Street  
London SE1 1LA

Tel: 0207 403 3888/0207 374 8659 [www.liberty-human-rights.org.uk](http://www.liberty-human-rights.org.uk)

Offers legal advice and assistance on all areas that affect asylum seekers and refugees.

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