healthwatch Coventry

Maternity care: experiences of asylum seekers and refugees in Coventry

March 2023

Contents

Introduction

Healthwatch Coventry is the independent champion for NHS and social care. Our role is to represent the interests of patients and the public in local NHS and social care. We gather views and feedback and take this to those who run and plan services, to work for change. The Healthwatch role is set out in legislation.

Our Steering Group sets a programme of work and priorities to focus our work. This includes priorities to understand:

- Digital access (exclusion/ inclusion) in changed approaches to accessing for NHS services eg phone appointments, online services
- Access to GP appointments
- Better quality (relevant and understandable) information for the public about local NHS and care services.

About this piece of work

Why we did it

The Healthwatch Coventry mission is to hear the experience of NHS and social care services from those in Coventry who do not have strong voice or are ignored. We are committed to reaching new people by trying different ways of hearing experiences. We have long established links with voluntary and community groups in Coventry and are hosted by a local charity. Therefore we ran a small grants application programme to select community research projects led by voluntary groups.

We asked for applications in relation to our work priorities, to gather experiences of health and care or of barriers to health and care from less heard groups of the local population. Five applications were successful.

The aims

This piece of work was led by Carriers of Hope[1], a local charity, which supports asylum seekers, refugees and people with no recourse to public funds due to their immigration status when they are new to Coventry.

By creating a partnership with Carriers of Hope, Healthwatch Coventry created a route for asylum seeker and refugee women to be heard. The

[1] https://carriersofhope.org.uk/

focus of the work is on experiences of maternity care in Coventry, before birth, at birth and after birth.

How this work was done

Carriers of Hope conducted two focus groups with 21 women plus a woman acting as a translator and ten one to one interviews from October to December 2022. Participates were recruited from the "Let's Play" Parent and Toddler group at Hillfields Church (Learning English Together Through Play).

Research methods were tailored to the individual circumstances of the women involved and whichever way the women wanted to share their experiences and story was used flexibly. Euro-centric research methods are less likely to work with people in this client group.

Most of the participants did not speak English or had limited English.
The interviews and focus groups were in English and undertaken by the same researcher, Dr Lin Armstrong, with the help of interpreters from the group. Carriers of Hope have an active set of volunteers, recruited from the regular clients at Parents and Toddlers activity group.

Semi-structured questions were asked in four stages, see the report appendices for more details. A second record keeper /note taker was recruited from the group and notes from the researcher and note taker were discussed immediately after the session. Culturally appropriate work must include sharing positions of power within the research.

Some interviews took place in homes talking on the phone or on Zoom calls and some information was added from informal chats at the toddler sessions. Ten visits were carried out after a phone call.

The women disclosed only what they wished, and they chose the venue and time of their interviews. In this way, it was hoped to reduce the power of the researcher. Participants gave their permission for findings and data to be shared with Healthwatch Coventry.

Healthwatch Coventry provided support to Carriers of Hope for the piece of work through one of the Healthwatch Team. We shared good practice about gathering information through surveys and focus groups, GDPR etc and gave support to produce this report.

About participants

21 out of 31 required interpretation and translation services. Eleven of the participants spoke some English but still needed help with some questions. They spoke the following languages:

Languages spoken	Count
Albanian	2
Arabic	11
English	10
French/English	1
Kurdish Sorani	2
Tigrinya	3
Vietnamese	1
Hindi/English	1
Total	**31**

In focus group one there were nine women. Seven were Arabic speakers with little or no English, one was from Cameroon and one was Nigerian and had some spoken English. Arabic to English translation/interpretation was provided by another community member. In focus group two there were 12 participants, three speaking Tigrinya, two speaking English, and seven speaking Arabic. The methodology was to sit around a table with their children, eating food and translating for each other.

For the responses gathered though interviews with individuals in their homes five English speakers, two Kurdish speakers, and one Sorami speaker took part. There was also one Vietnamese speaker who used her phone for translation. Plus, two Albanian speakers who translated for each other.

Participants had the following ethnicity:

Ethnicity	Count
Albanian	3
Cameroonian	2
Eritrean	3
Indian	1
Iraqi	2
Kenyan	2
Mauritian	1
Nigerian	4
Sierra Leonean	1
Sudanese	11
Vietnamese	1
Total	**31**

Where participants lived:

Postcode	Count
CV1	18
CV2	4
CV3	1
CV5	7
CV6	1
Total	**31**

The age group of all who took part was 19-36 years. For ten out of 31 women, this was their first child. A third of the focus group participants (7 out of 21) had experienced the loss of a baby or more than one baby.

Findings

1. Experiences prior to giving birth

Communication challenges

The refugee group is one of the most vulnerable in pregnancy. Over 90% reported missing communications about their health services. Most could not say who their health visitor was and what their care plan was. They, therefore, had little choice in the pregnancy and could not become a partner in their health care.

Another issue is finding the services in the first place or misunderstanding the different services in primary, secondary and specialist care.

For some women being alone in a foreign country without their mother affected them throughout maternity and birth.

Immigration status

Asylum legislation rules can directly or indirectly affect if a woman accesses maternity services. The women in the focus groups discussed how immigration status impacted them and others they know. They all knew about hidden pregnancies and they have friends who went to services late in pregnancy, or not at, all giving birth at home and avoiding midwives and health visitors.

For example, one woman in this group had been charged £6,000 for her first birth. Although pregnant again she would not be presenting to her GP because she could not afford the birth. The baby's father was willing to sign

the forms for his first son, but now did not want to be a part of the woman's life.

Experiences of losing a baby

Seven of the 21 women who took part in the focus groups had lost a baby.

A woman described being at work in her carer role and not being allowed to leave her place of work even though she had excruciating pain in her side. Her employer had no one to cover for her so said she would have to carry on working. Two hours later they had to call the ambulance because she had *"a baby up here in my tubes"* [an ectopic pregnancy]. The pregnancy was a source of sorrow which she spoke about when she went for her next baby's appointments, but she felt this was "just brushed off".
One woman who had a previous still birth said the receptionist at the hospital shouted at her because she should speak English. She found it difficult to say what had happened and she had no English words for it.

The women never complained and did not know they could.

Making connections with health professionals

22 out of 31 of the women had a story to tell that showed the connection between them and their health care services and health professionals had not developed into anything meaningful.

There was confusion over the roles of primary, secondary and specialist health care and services. The lead up to the birth was one of confusion for Arabic speakers. They mixed up midwives with health visitors in their relaying of their stories.

In one focus group six women reported they had seen the midwife first; four reported they saw the doctor first and two women said they presented themselves at the hospital as soon as they found out they were pregnant.

Some women said there was a lack of information about the upcoming birth but some remembered being given a leaflet.

No one in the focus groups knew their health professionals' names, even the women who spoke English. There was talk about an irregular approach to assigning care.

> - *"Every month there is a new midwife, they call in different staff all the time."*

- *"Once I learn a name because she said 'Hi I am Sarah', but she did not come again."*
- *"They are short staffed so whoever can come will come."*

The women said they had no calling or contact card and never knew their service providers. The two English speakers in focus group two said they had a flyer from the midwife so "sort of knew" their healthcare staff.

One woman said her baby passed away before birth, so she never went again to see her health midwife.

The way queries are answered seemed to be lacking in good communication between the women and their health care services at times. Some laughed at what they saw as the way *"The receptionists think they are doctors"*. There seemed to be a lack of confidentiality between the receptionist and two of the women. *"Yeah, they shout you out in front of the whole waiting list"*. Those in focus group two also reported that the receptionists in the hospital *"are not happy, are not smiling"*. There was a chat about whether they were under pressure because they are sometimes rude.

Some women had the same health visitor all the way through, Linda, whom they felt able to ask questions about before and after the birth.

The women expressed frustration at passing information on to medical teams. These are sometimes because their husband or child is interpreting for them and do not know the English for pregnancy terms.

The women were often asked by staff why they could not learn a bit of English to help their children and their pregnancy. However some said in their country education is for boys:

> *"Women do not go to school in my country."*

There was an agreement that most of the women wanted to learn English but they asked where would they get the time? Who would have the children? Where do lessons take place? Can I afford it? The self-belief that they can achieve was also lacking in this group of women.

> *"I get up, drop my children at nursery and school, attend my English class, pick up my nursery child, attend hospital then run back to school. I do my homework, cook put them to bed, wash uniforms, do housework and fall asleep on the sofa."*

Translation and Interpretation services

This led to 100% of the women saying there is a need for a good, reliable interpreter service for security and trust to develop during their maternity care.

All of the women who need interpretation services said it was very hit-and-miss throughout the services. It seems the translators are in the hospital at times, but some women do not get the appointment times right as they need someone to read the letter written in English about the translator to them so they understand it.

Hiba's* experience told by her charity worker

Hiba had no money to go for her hospital appointment but had diabetes so she knew it was important. Her ability to claim back the bus fare was limited by a lack of clarity in the English forms. Carriers of Hope gave her a lift to the hospital. But found her baby's father, who lived in London, had translated the appointment time wrong from the appointment letter.

The interpreter was booked for two hours later and so he was not available.

The hospital staff were discussing amongst themselves that Hiba had missed two appointments and should not have any more.

The receptionist spoke loudly stating: *"You are at risk! You should come to your appointments"*.

The charity worker provided help by getting food, getting an interpreter and providing transport home. Then the pharmacy did not have the prescribed drugs so the charity worker made another trip to the hospital the next day and a further trip to the local pharmacy.

This all cost the charity money which is unlikely to be a sustainable way.

*Name has been changed

Some of the women in this group turned up at the hospital but their interpreter was not there indicating miscommunication. The women feel they need an interpreter from the start. One said *"I take my husband to the hospital but he can't come every time"*.

Antenatal education prepares women and can be delivered face-to-face, in hard copy and electronically to the majority. However refugees do not gain this knowledge. Smartphones allow access to online learning and Internet searching is common among pregnant women. It was clear that the women who spoke to us prefer to use word of mouth to inform each other about pregnancy and birth. This means this means the information can be incorrect. In each focus group came up with myths and inaccuracies about feeding or getting help.

Many participants felt underprepared for the post-birth period. One woman who felt differently about this had watched "You Tube" in her language and gained a lot of knowledge about caring for herself and her baby.

Poverty

Carriers of Hope statistics for this year show how many mothers need support. 37% of Carriers of Hope food bank families have upwards of six individuals in the household and over 1,000 children are fed by them. Baby bags were delivered to 130 pregnant women, 528 requests for nappies on top of the 22 children that get free nappies every week at "let's play." 132 toy bags were delivered to children at home. The client helpline is showing massive growth in families needing basics for living.

For the costs of having a baby the support available was not clear. The women's answers varied as each woman reported what they claimed:

> - *"£51 for two kids every month"*
> - *"I had no money at all"*
> - *"Could have got £500 at the birth".* [She thought she had applied but never got it]
> - *"£14 a week every Monday for 5 children;*
> - *"£21 a week for 1 child"*
> - *"I get £17 for 2 children".*

The women argued amongst themselves that there were benefits to be claimed. An English speaker explained it depends on your circumstances and status as an asylum seeker. Like how long your case has been going on for.

It appears there was similar confusion over a healthy start voucher: *"It is for milk and fruit for your baby"*. One woman had lost her PIN so never claimed it, another cannot remember being given a card and another said she did not get a card in the hospital.

Poverty affected their birth experiences because all of the women reported that they live in overcrowded, poor conditions. One woman was living in a hotel with her husband and five children in two rooms.

Due to poor housing, three women talked about hypothermia so they used many layers of blankets until Carriers of Hope supplied sleep suits and guidance about safer sleeping. None of the women remembers receiving safe sleeping advice from the hospital.

One woman explained the traditional clothes for hospitals. Many could not afford these. All of the women had received their baby things and hospital bags from Carriers of Hope and without these, they would be on the ward without clothes, wash items or a car seat to take the child home.

The women highlighted the challenges of affording items. *"You cannot leave the hospital unless you have a car seat"*. *"Yes they are £70 in Argos!"*
All participants had received ongoing milk, nappies and clothes for themselves and the baby from Carriers of Hope.

One participant had a husband that worked so paid for their equipment. *"But he doesn't have a job now so we need a bed for my son"*. This started a list of needs *"I need vests; I need a pram; I need clothes for my baby"*.
Carriers of Hope have a helpline, and all were referred to this.

The value of being in a group of friends

The importance of knowing other women came up frequently in the conversations. The value was they could share information for example tell women about helplines and support them. They also share resources *"friends give me a dressing gown, nice"*.

A woman living in a hotel had nowhere to cook or wash her clothes so the women were helping her by cooking extra when they could.

The majority 16 of the 31 participants had a husband who was able to attend some of the birth whilst looking after other children at home. One woman took a friend to the birth of her first child.

Relying on friends to tell them about travel to the hospital is the norm. They also spoke of not affording the money to go.

Women also make decisions about diet, exercise, and infant care, based on information provided during pregnancy by health professionals and friends. This could particularly be seen in the refuge where 20 women lived together. *"He needs more food now, make a pap".*

One very successful friendship was when the hotel staff changed sheets and did washing for a very poor lady who had given birth by a C-section.

Lack of power

Focus group one discussed fears about their health care and the lack of power to voice their concerns. 12 out of 31 said it was very hard to contact their doctor.

They all said when you are pregnant your doctor tells you *"it is normal in pregnancy"* and *"you cannot tell your doctor you are sick even when he should check or investigate he sends you home".*

Two of the Arabic women said their discomfort of being wet or itching or discharging was not normal pregnancy, but they were sent away from the doctors without investigations. One reported:

> *"The passage had bacteria that could have made my child deaf from infection".*

2. Experiences when giving birth

The women had given birth in University Hospital Coventry. One was transferred to Birmingham due to birth complications.

On the wards

In general most of the women were pleased with the hospital ward staff, however experiences varied.

One commented *"They were always around you" and "the hospital is better than in my country!"*

One woman also was grateful for her hospital stay this time. Her first baby was born during Covid and she was moved into a Coventry refuge without money or food, so she could not breastfeed him. She had lost contact with her boyfriend during the move and had no phone credit. Her second birth was three weeks early and she attended the Coventry hospital with a booked interpreter.

She recalled: *"The treatment was to make the baby to be born early at 11 pm night-time."* She said she gave birth alone since they had no childcare but she felt confident and was keen to say *"the staff were a good help when I rang the bell"*.

22 out of 31 women said their hospital stay was punctuated by shortage of staff.

- *"You can press the bell with pain and it always takes 15 minutes to respond."*
- *They agreed with each other that the staff need more help "they are so tired."*
- *"I was on wards 24 and 25 for five days. The night staff were made up of a bit older woman and they were rude and bullying to some of the women in there. One lady wanted help to breastfeed and they went back to their desk and said: "It's not rocket science, she should have got it by now". "They did not like to attend to anyone but talked very loudly to keep us awake. Some ladies had a very rough time."*

Another report was that the student nurse was made to do every job whilst the other staff talked at the desk, so the woman was reluctant to ask the student for anything because *"she was rushed"*.

Another said "[I] *wouldn't dare to tell them I needed their help"*

Some thought communication in the hospital was poor like this comment from a woman who had a previous baby die just before birth; *'I had first baby problems, but they did not know although my husband told them"*

Pain

There was an opinion from two African women that the doctor *"thinks I can manage pain - I cannot."* One woman described asking over and over for an epidural to give pain relief, but she never got one.

An Arabic speaker said she rushed to the hospital on the bus. Her husband could not go with her because he had other children to care for.

She told the staff at the maternity unit she was in labour and needed pain control. They said, *"My shift ends in ten minutes so you will just have to wait for the next shift."*

This woman gave birth sooner than the staff expected and was an inconvenience to the staff. *"It was a strong baby and pushed out before she finished her shift."*

Length of stay and discharge for hospital

One women shared her story:

"I was at home for my birth and had no money to get the bus to the hospital. My baby came out so a neighbour called the ambulance." This woman reports she was in the hospital three hours before they sent her home again. Within hours of being at home with her new baby, she could not walk so-called the ambulance again and was kept in for a week with complications.

In the focus groups women joined in with the discussion about a quick discharge from hospital beds, concluding:

- *"White ladies stay the night."*
- *"They think because you are black you are strong."*
- *"I gave birth at 3 am, had a C-section and was sent home by 10 pm. SERCO* [provider of government services] *booked a taxi or I would have to walk home with my new baby."*

Atifa's story*

Atifa was in hospital after giving birth by C-section when she heard staff discussing her discharge home:

"I had a bed next to the office, so I heard them discussing me saying I was strong. I was not feeling strong I had pain. My breastfeeding was going well so they just sent me home. I had no experience caring for a baby so I was frightened to go back to the hotel. The nurse said 'let's wait and night staff can make the decision I do not want the blame for putting her out of the bed'. The other nurse said, "I don't want to take the rap either, let's wait and the night staff can decide."

Atifa was sent home at 10 pm and was in a hotel room alone with her new baby until the staff got her food. Six weeks later she was moved from the hotel to the refuge and charities had given her baby sheets, cot and food bottles. She said she couldn't believe how kind people were because 'nurses' came in to see her C-section every day. She was taught to breastfeed and kept it going.

*Name has been changed

Communication

The communication barriers were a big issue for this group.

- *"Indians are lucky, most of the staff speak Indian languages, and none speak French or Arabic"*

The Sudanese women explained that Arabic interpretation is difficult since there are differences in spoken Arabic depending on where they come from.

- *"Interpreters from Syria and Iraq can't understand us and we can't understand them. I prefer an interpreter from Sudan"* [who speaks Sudanese Arabic].

Some expressed the lack of communication meant they had to ask their husbands if a male doctor could attend to them. The doctors never realised their gender may be a problem and so never asked.

A Muslim participant described birth causing embarrassment *"because don't accept being watched by a man"*. Other women realised it is likely there will be male doctors and this causes some anxiety in them. *"Women cannot ask for a woman doctor instead of a man and they just have to take whoever is on duty."*

Communication with partners and families

The women who did not have access to mobile phones of their own reported they could not update their family: *'The hospital has a complicated phone system and they could not ask how I was or when I would come out"*. So often the husbands and boyfriends did not know how their pregnant or birthing wife was doing.

For women who were the victims of trafficking and prostitution, the connections to the fathers were not sought so they gave birth alone in a strange area with no home to go back to.

When women are living away from the father, he has nowhere to stay so cannot visit. All taxi or travel money has to be paid upfront and claimed back later from the Home Office and this needs a good level of English and skill to fill in the forms.

3. After the birth

Breastfeeding

Some of the women talked about breastfeeding in a way that shared myths. No one said they had anyone observe them breastfeeding to help them.

Participants in focus group one concluded *"SMA is white baby's milk but gives black babies constipation so black children are better off on Aptamilk"*.

It seems the messages about breastfeeding are not fully understood by the majority of this group. Only one woman in focus group one and two in the home interviews, all with good English, appreciated how important it is to breastfeed a new baby.

Breastfeeding dropped off rapidly at home for the majority of women. The reasons given were:

- *"The baby was probably allergic to me because she vomited milk"*.

- *"The baby liked the bottle best- she sucked it better".*
- *" My child would not accept breast milk"*
- *"She was naughty and would not feed"*
- *"He cannot suck".*

One woman stopped at one-month-old, because of her child's *"allergies to breast milk"*. Two women stopped at two months old due to it being so painful. Two stopped at five months because the baby was so hungry they needed a bottle. Two women were still breastfeeding six months later.

This discussion started a conversation on how to get help for sore hot breasts. No one had heard of mastitis. There was a notion that by stopping feeding the breasts would get better.

One mother's baby had a tongue tie but she said she could not afford the £300 to get it cut and they are not entitled to NHS treatment so the baby remained tongue-tied.

Follow-up healthcare

Contacting and building a relationship with a health visitor was difficult for 22 out of 31 women.

Attending any services is affected by lack of childcare, travel expenses and perception that it will be a waste of time. There was a vagueness about understanding of the purpose of health visitor's appointments, but some said they found that their baby was "too little" and this was an anxious time for them. In focus group two, women also talked about "tiny babies", and "the loss of babies".

They all had a *"Red book" given to them on the ward and that "the pictures help"*. No one used their book but had it put away somewhere in case they get to weigh their baby. One woman, an English speaker in focus group two, said that since Covid there was a green book online, but it was in English.

When asked if the health visitor came to their homes to teach them about their new baby there was a mixture of answers. One said their health visitor came four times, but the majority said it is three visits or more if you have a C-section.

The advice from health visitors was thought to be helpful. Some of the women had different approaches to those the health visitors were advising. The differences had the potential to cause tension between health visitors and women. The idea of routines for the baby was the biggest cause of

concern. Some women fed on demand and had different child-rearing practices that were not known by the health visitor. The African mothers in this group swung their babies onto their backs to "back them" by wrapping a cloth around the baby and tying them onto their back. For example one woman said: "*they watched how I lifted my son and it was aggressive*".

Another woman said:

> *"She had come to talk to me about how I handle my child. My mother handled me that way when I was growing up, is there anything wrong with me? Why do they think their way is the only way? I am not going to break my daughter's arm, I love her but no, the workers don't see it that way. They said I was rough*".

One woman said the co-sleeping of her baby was not permitted by the health visitor but she did it anyway since the house was cold and she worried about her child dying. She lied to the health services to cover her "*bad parenting*".

A focus group discussion centred around the fact that follow-up care and health services could help you as a new parent. An English-speaking African woman said there was a centre for child health near where people live. This surprised some of the women in the group. A woman living in a hotel enquired where hers was as she had never gone with her baby. Three participants reflected they could not walk after the baby so never went to weigh the baby.

There were tips from some women to others but it is hard to tell if they were good tips about real baby health centres. The Harmony Hub and Hope Centre were given as a place to see your baby weighed but it was decided you need to speak English to book so of no use to this cohort.

Muslim boy babies should be circumcised early, but the parents could not afford the £500 to get this procedure and this saddened them. Others suggested men in Birmingham that would do this for half the price.

Post-natal depression

Depression after birth seemed to be underdiagnosed as some women said they did not tell their doctors and a specific issue of cultural differences needs to be taken into account for some mothers. Having depression and medication cannot be endorsed as they have concerns about stigma.

Three women interviewed admitted that they avoid initiating medical contact, under report, or minimise symptoms.

> • *"I did tell the doctor in the end because I was afraid, I would do something to myself but I dumped the tablets"*
>
> • *"I was told of a group for mental health that you ring up but they were full so I never rang again".*

The black women responded to the question about depression after the baby with a discussion about shame and the disgrace of it. The stigma in Africa made them uncomfortable about having a *"mental illness"* which could be seen as a personal failure or disgrace showing failure and weakness for example the comment *"Lazy women should get themselves together and put their baby first".*

Birth control

Participants showed awareness of contraception and described the methods they used. Three women said they might get pregnant again and that would be fine. Three women said they would have no more children. One woman seemed to believe it would happen if it did and she took no steps to stop pregnancy. Many families want more than four children.

Baby's health

Three women gave specific examples how their work had a detrimental impact on attending appointments or seeking help for issues related to their child.

A woman working in a low-paid care role found working hours and travel time prevented her from getting her child vaccinated. *"I have to go, I cannot get work elsewhere so I cannot take time off."*

Some women need to work such long hours and shifts that they neglect to take their children to check-ups. One woman's child is not speaking at nearly three years and she thinks she should find a place to take him to, but she is too busy working to find out.

There was also an issue with the transience of refugee and asylum-seeking women when finding their local services. One woman needed help for their two-year-old who was not growing well but they did not know where to take her. They had been rehoused twice and never kept a consistent relationship with a health visitor.

Conclusions

We found that communication challenges was the biggest issue impacting this group of women during their pregnancy, birth and post-natal care. This led to a lack of information about how to access services at each stage of the maternity journey and therefore a lack of helpful support. The connections with services and professionals were not meaningful and the women with linguistic barriers and cultural differences suffered most from a lack of knowledge during pregnancy.

Lack of effective interpretation/translation and communication support is a significant issue. From the stories gathered this impacted on care and outcomes. Gaps in Arabic interpretation were flagged. The women were not empowered and felt without a voice.

For these women the current approach of trying to support pregnant asylum seeker and refugee women through normal service pathways and approaches isn't working very well. Healthcare managers and workers need to understand how difficult it is for them to navigate services. Some women attributed behaviours towards them to racism and lack of cultural understanding.

The cost of bus fares, dependence on the others for transport and childcare difficulties all lead to lost appointments. We also identified issues related to breastfeeding support and barriers to mental health identification.

The participants' had challenging day to day lives influenced by poverty, housing conditions, being in an unfamiliar environment and cut off from family. The women talked about the stress of competing priorities, family conflicts, childcare issues, poverty, and reporting to the Home Office. There was some confusion about the cost of services/eligibility for services and support. Some also had transient lives, being moved and rehomed a number of times.

Recommendations

The Coventry and Warwickshire Integrated Care Board (ICB) is responsible for maternity services. This piece of work supports the current focus on health inequalities and work to identify those who face barriers and poorer health outcomes.

Coventry and Warwickshire has set up the Coventry and Warwickshire Local Maternity and Neonatal System a partnership of maternity and neonatal service providers, commissioners, Local Authorities, and service users who are

working together to transform maternity services. This report highlights experiences, issues and recommendations for this group to take forward.

This report provides the insight of lived experiences to maternity care providers to help them work with others to deliver more culturally appropriate services.

The findings are also relevant for new joined approaches at Coventry 'Place' and for work in local communities. Community based approaches are potential solutions as alternative ways of delivering access to services.

Healthwatch Coventry recommends work to:

1. Review provision to understand the best way to provide maternity information and care to asylum seeker and refugee women:

   a) to look at alternative models of providing services that will reach the women and overcome barriers of access.
   b) to address continuity of care by creating connections with named health care professions, as this is important for establishing trust with asylum seeker end refugee women.

2. Develop ways to ensure women can understand information about appointments. Sending letters in English about translation/ interpretation is not effective.

3. Address the accessibility and effectiveness of interpretation/translation services, this must be improved.

Acknowledgements

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https://carriersofhope.org.uk/
https://www.facebook.com/carriersofhopecov

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Appendices

Semi-structured questions were asked in four stages

1 What was your experience of healthcare services when you had your baby?

- How did you receive information, how did the services communicate with you, did you receive interpreters or interpretation of information?

2. Any thoughts about health care throughout the pregnancy

a) How did you manage financially when your baby was born and afterwards?
b) What experience of support/communication did you have:
   - On the ward, from the nurses/ your doctor
   - From your health visitor, post-birth support?

3. The birth and post-natal support for your baby

a) What support did you have before, during and after birth?
b) Did anything affect your parenting?

4. What experience of support/communication did you have?

a) On the ward, the nurses
b) From your doctor
c) From your health visitor, post-birth support?

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