Maternity care for asylum seekers and refugees: problems and solutions.

“In the end I got an infection in my scar...I went to the midwife and said I’m feeling cold, all my body shakes... She looked at me like this and said ‘You are OK’... She said to another midwife: ‘These Africans...they come here they eat nice food, sleep in a nice bed and now she doesn’t want to move from here!’... I just cried she doesn’t know me who I am in my country... and the other midwife said ‘What’s wrong with these African’s?’ and some of them laughed”

Participant in study McLeish 2006.30

Anna Vanlint 4th Year Medical Student.
Abstract:

Asylum seekers and refugees are one of the most vulnerable groups within society. Many have experienced extreme past trauma or even undergone torture. Understandably therefore, their health needs are often elevated compared to the resident local population. Despite this, there are multiple barriers to this needy group accessing healthcare, including communication problems and racism. Also, once in this country many are forced to live in poor housing and below the poverty threshold, and some of those refused asylum are forced to become destitute further increasing their healthcare needs.

One of the most vulnerable subsets within this population are pregnant women. With previous research showing that women of non-white origin are at up to a seven times increased risk of death during pregnancy, clearly further investigation into this area is needed.

This article looks at the many challenges facing asylum seekers in this country and then focuses on the limited research into maternity services. It aims to highlight problems in this area and considers how these may be resolved.
**Learning Objectives:**

1) To understand the reasons for seeking asylum, the asylum process in this country and its effect on the individuals involved.
2) To explore the health needs of asylum seekers (including their access to NHS treatment) and whether these needs are being met.
3) To specifically look at the health needs of pregnant asylum seekers and their access to maternity services in this country.
4) To consider the current problems with maternity services and make suggestions as to how they could improve.

**Acknowledgements and thanks:**

Many thanks to Dr. J. O’Neill for facilitating this SSM and allowing me the opportunity to learn as much as I have from this experience.

Thank you to the many institutions who kindly opened their doors to me and about whom I have learnt so much. Especially Asylum Link, WRASSG and the women’s support group (see resource list).

Finally many, many thanks to all the asylum seekers and refugees who kindly agreed to talk to me and candidly spoke about their experiences, allowing me to gain a much better insight into their situations. I wish them all the very best for the future.
Introduction.

The UK is a signatory to the 1951 Geneva Convention which commits it to offering refuge to those attempting to escape persecution.\(^1\) It is also a signatory to the European Convention on Human Rights which “forbids inhumane or degrading treatment or punishment”\(^2\) a clause also contained in the new Human Rights Act as an absolute right.\(^3\) It is also a signatory to the United Nations Convention Against Torture. This prevents removal to a country or territory where torture may occur.\(^4\)

In 2008 25,670 people applied for asylum in the UK\(^1\). Of these 19% were granted asylum, 11% were granted either humanitarian protection or discretionary leave and 70% were refused\(^5\).

Asylum Seeker:
“a person who enters a country to claim asylum (under the 1951 UN convention and its 1967 protocol), individuals undergo the asylum process to have their claim assessed.”\(^6\)

Refugee:
A 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 to or, owing to such fear, is unwilling to avail himself of that country...”\(^1\)
Refugee status or ‘leave to remain’ which may be temporary can be granted by the Home Secretary. This allows the individual the same rights as a citizen of the UK.\(^6\)

Refused asylum seeker;
An asylum seeker whose claim has been refused by the home office. This decision can be appealed but these individuals have no right to stay in the UK. If the appeal is refused, all support is withdrawn and they are instructed to return to their country of origin.\(^6\)

Figure 1: Basic definitions.

There are multiple reasons why somebody may chose to seek asylum in the UK including fleeing war, political or social persecution, torture or exploitation. Asylum seekers, as described by Burnett and Peel, are not a homogenous population\(^7\). They arrive in the UK from varied countries and cultures and bring with them a wealth of past experiences, many of which affect their physical and/or mental health.

Although many asylum seekers may reach the UK in reasonable health, research has suggested that many actually become ill during the asylum process\(^8\). The reasons for this are multi-factorial but include difficulty in accessing services (particularly for refused asylum seekers), language barriers and a lack of basic knowledge relating to their entitlement to these services\(^8\). Previous research also

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suggests that in the UK 1 in 6 refugees has a health problem considered severe enough to significantly impact on their lives and at least 2/3 have experienced either anxiety or depression.\(^9,10\)

One of the most vulnerable subsets of asylum seekers is pregnant women. Research has suggested that these women may be at up to a seven times greater risk of death during pregnancy than women of white origin.\(^11\) It is therefore of increasing importance that the challenges facing these women and their access to maternity services are accurately assessed and addressed.

Clearly the health of asylum seekers is affected by many things including their previous experiences, their journey to the UK, the asylum process, how they are perceived and portrayed by the UK population, as well as all the social issues they face in this country which place a barrier to their access to healthcare. It is therefore important to look at the interaction of all of these in turn before looking at the specific problems within maternity services in the UK.

**The Asylum Process:**

Due to the 1951 convention an asylum seeker cannot be penalised for ‘illegally’ entering a country.\(^1\) They must present themselves to the relevant authority on arrival. In the UK the asylum screening units are located in Liverpool and Croydon. Initial assessment means undergoing interview, being screened (including photographed and finger printed), security checked and then issued and official asylum registration card.\(^6\) A formal application then commences with the UK Border and Immigration Agency (BIA) and a ‘case owner’ is assigned to the case. An outline of the asylum process is shown in figure 2 below.

In the past few years the UK has been refusing somewhere in the region of 70-80% of its asylum claimants yearly (2008: 70\%,\(^5\) 2007: 84\%,\(^12\) 2006: 79\%\(^13\)). Many of these cases appeal and are subsequently refused again and then instructed to return to their country of origin immediately. If they do not return their rights are withdrawn, they have no status and they can be forcibly detained by the home office and returned to their country of origin.\(^6\) However many of these people are unwilling to return to their country of origin and for the home office there is currently no safe passage by which to return these people, so they remain in the UK with little or no support and many of them become destitute.

Amnesty International has been quick to criticise the decisions made in many cases as being made on “inaccurate information, unreasoned decisions about credibility, and failure to properly consider complex torture cases”.\(^14\) Many of these people have experienced severe physical and or mental trauma and torture. Many cannot produce documentary evidence of their old lives due to the situation through which they were forced to leave their country. Many are turned down simply because they bear ‘only’ psychological scars which cannot provide documentary evidence and those who do bear

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physical scars are often turned down because they don’t typify those caused by torture. There is often a culture of disbelief and cynicism which creates mammoth and often completely impassable barriers to those worthy of asylum.

Figure 2: The asylum process. 

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**Media Portrayal.**

The media provides a great source of information for much of the UK population relating to asylum seekers. It therefore has great power to influence people’s opinions. In the past concern has been voiced by the unfair and often inaccurate coverage regarding this and recent research has suggested this has led to misinformed and inflamed attitudes on the topic. Media coverage has led asylum seekers to be construed as a threat, dishonest and a burden on the welfare state. Reporting on asylum seekers describes ‘floods’ or ‘waves’ and commonly describes them as ‘bogus’ or ‘fraudulent’. All of this without providing a context for these comments or explaining in any way the reasons for seeking refuge in the UK, the conditions of their old life and journey or their treatment on arrival in this country. It also never offers a voice to the asylum seekers themselves.

There are exceptions to this negative coverage with some of the broadsheet newspapers offering a much more balanced view of the current situation, (see Appendix 3). However with the majority of column inches covering asylum issues in this way, it is easy to see how negative opinion and feeling are borne.

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**Britain sending refused Congo asylum seekers back to threat of torture**

Refused asylum seekers tell of imprisonment in DRC and violent persecution when they return

Diane Taylor
27 May 2009
www.guardian.co.uk

**Up to 80,000 bogus asylum seekers granted 'amnesty'**

James Slack
08 September 2006
http://www.dailymail.co.uk/

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Figure 3: Examples of media headlines involving asylum seekers.
Access to healthcare

Entitlement of asylum seekers for healthcare is complex. Their entitlement is dependent on their stage of the process, and in recent times has been subject to much change and debate. In general terms an asylum seeker with a claim in progress has access to primary and secondary care with all treatment being free on the NHS. However, it is when a claim is refused that this becomes complicated. Those who have been refused but are appealing are allowed access to primary and secondary care during this appeals process, but, if this is refused these automatic rights are withdrawn. It then becomes the case that the person then only has access to primary care at the discretion of a GP and access to secondary care only for ‘immediately necessary’ treatment. Very recent government moves makes it look likely that these asylum seekers may soon benefit from increased access to healthcare under certain circumstances, but the implementation of this is yet to be seen.

However, even for those asylum seekers with supposed full access to healthcare, many complain of difficulties registering with GPs. Healthcare professionals are often very fearful of treating asylum seekers due to language barriers, time pressures and cultural differences. There is also the perceived complexity of their cases as well as a fear that they will be demanding, a fact that is very rarely true.

It is true, however, that many asylum seekers have increased health needs relative to their comparable local population. Many come from countries where there is poor healthcare provision, some come from refugee camps where poor nutrition and sanitation are commonplace, and their journey to the UK may also have impacted on their health due to long journeys and overcrowded conditions.

Also, the health of many asylum seekers actually deteriorates once they are in the UK. This can be due to a loss of support from their family and friends, as well as the shock of entering a new culture. They commonly become socially isolated and suffer racism and hostility. They suffer loss of identity and social status. They also commonly have housing difficulties and many asylum seekers live below the poverty threshold. Poverty has a significant impact on both mental and physical health and these effects are well documented. It is therefore extremely concerning that a group with already elevated health needs are forced to live in these conditions.

With a vulnerable and needy group such as this, surely the NHS is not the place for judgement to be made on these patients. The first line of duties of a doctor states “make the care of your patient your first concern”. If this is upheld then a doctor’s place is to treat these patients’ health needs, not to be concerned with the status of their asylum claim.
**Methods:**

A search was carried out using the NHS health information resources Athens library database. The details of the search are detailed in the table below. This search included the following healthcare databases: AMED, BNI, CINAHL, EMBASE, HEALTH BUSINESS ELITE, HMIC, MEDLINE and PsycINFO.

<table>
<thead>
<tr>
<th>KEY WORDS USED</th>
<th>RESULTS GAINED</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEARCH 1: “Asylum seeker” OR “Refugee”</td>
<td>7427</td>
</tr>
<tr>
<td>SEARCH 2: “Antenatal care” OR “maternity services” OR “maternal health”</td>
<td>12580</td>
</tr>
<tr>
<td>SEARCH 3: Combine: Search 1 AND Search 2</td>
<td>28</td>
</tr>
<tr>
<td>SEARCH 4: Search 3: Duplicates removed</td>
<td>20 original</td>
</tr>
<tr>
<td></td>
<td>8 duplicates</td>
</tr>
</tbody>
</table>

Figure 4: Search Methods and results.

Additionally a plain text search using Google was carried out to find useful resources and also manual search of any useful articles was carried out and these references then sought through the previously mentioned databases.
Maternity Services:

With the multitude of problems facing asylum seekers that I have already mentioned, it is easy to see how these extend to maternity services. But with pregnant women being amongst the most vulnerable groups of asylum seekers, it is vital that we see how important it is that the needs of these women are effectively addressed.

The most recent National Service Framework for children and young people and maternity services acknowledges how severely disadvantaged asylum seekers are due to a multitude of social problems, including accessing and maintaining contact with maternity services. This framework also gives clear standards for maternity care including those aimed at improving services for vulnerable and minority women. The recognition of this need was likely, in part, to be due to the findings of the confidential enquiry into maternal deaths (Why mothers die 1997 to 1999). This study highlighted an increased rate of maternal mortality in all non-white women. This included a three times increased rate in Indian, Bangladeshi and Pakistani women, as well as a one and a half times increased rate in black women. Why mothers die 2000 to 2001 further highlighted that black African women were seven times more likely to die than white women. These rates included asylum seeking and immigrant women who were often seen to only be provided with antenatal care very late in their pregnancy or received none at all.

It should be the responsibility of all healthcare workers to be aware that all asylum seekers in the UK have access to full maternity services irrespective of their asylum status. They should also be aware of the additional health needs these women may have, including obstetric issues caused by female genital mutilation, poor general health, concurrent health problems such as Hep B and HIV as well as the possibility of significant psychological problems due to previous traumas.

Previous research has explored the needs of pregnant asylum seeker women. Several recurring themes have been highlighted by this research. A study in the London boroughs of City and Hackney highlighted many communication problems experienced by these women, including linguistic and cultural. Again problems with the asylum system itself provided barriers, as a lack of continuity with antenatal care was seen to be a problem. Women would be dispersed to different locations before test results were available or treatment could be given, making follow up of these women near impossible. It was also noted that very little time or resources were made available for health promotion or education with these women.

Research carried out by community midwives in East Kent pioneered a management programme for these women through multi-agency collaboration. The results were promising as they improved accessibility to these services as well as providing national notes for these women which could be
taken with them on dispersal helping improve continuity. However, problems were still experienced when trying to create the necessary advocacy services for these women due to insufficient funding.  

In 2005 Jenny McLeish carried out qualitative research into the maternity experiences of 33 asylum seeker women. The study looked at women currently awaiting a decision on their asylum status, as these are even more vulnerable and marginalised than those who may be settled refugees. The women who took part were aged between 16 and 44 years. Four of the women were currently pregnant during the study and the other 29 had babies aged from 6 days to 18 months. The women came from 19 different countries and also showed great variance in their ability to speak English, ranging from fluent to just a few words.  

Recruitment to this study came from 7 different cities in the UK namely: London, Manchester Plymouth, Brighton, Oxford and Kings Lynn. The women were recruited through convenience and snowball sampling. Efforts were, however, made in the study to include a range of nationalities, stages of pregnancy and of the asylum process. A neutral location was also sought for the interviews such as an asylum support group or the patient’s home. The actual interviews were semi-structured in nature but the main purpose of them was to give a voice to the women’s experiences.  

One of the major problems voiced by the women in this study related to the difficulty they had accessing services. Many of them had no idea of their eligibility for services and no one had explained this to them. Problems also emerged with women who have been denied GP registration and so had no access to the services via this route. For those who had accessed care it was clear that physically getting to appointments was a great problem. It detailed women in poor health walking for up to two and a half hours to get to appointments. Other problems also included women missing meal times at their hostels to attend appointments and therefore being forced to go hungry.  

The research also highlighted a great short coming in the information given to these women. Very little was explained to them and any error they made trying to use the services was met with great hostility. Many women also found that the information given to them by midwives was actually unhelpful given their situation and the reality of the abject poverty they were living in.  

One of the major problem areas highlighted by this research related to patients experiences with midwives. Around half of the women experienced disrespect, contempt and even blatant racism. The women were made to feel powerless and perhaps consequently not a single one of the women who experienced racist attitudes lodged a formal complaint. There were, however, some positive responses in this area mainly relating to community and specialist midwives, whose positive efforts at building relationships were greatly appreciated by the women, particularly those with no other companion during labour.  

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Clearly there were also problems posed by communication. Within the study 18 of the women required an interpreter. For the most part these were provided during antenatal care but postnatally many of the women did not have translators on the ward or for subsequent visits, making this a frightening and confusing time for these women.

Assumptions of a lack of understanding or ability to communicate in those women who were fluent English speakers was also a problem. Many of these women were exposed to patronising, offensive and sometimes racist behaviour amongst the health professionals undertaking their care.

Frighteningly as well, many of the women involved in the study felt that during pregnancy they were coerced into making decisions relating to their healthcare. The worst of these cases, perhaps being an emergency caesarean section being carried out on a non English speaking woman without an interpreter, or a woman with hypertension being forcibly taken back to hospital by police after she had decided not to stay as an inpatient in hospital.

As with all asylum seekers those accessing the maternity services often have complex psychological needs. The majority of patients in this study had symptoms consistent with postnatal depression, however not a single one of them was diagnosed or offered any assistance with this.

Clearly this study displays some limitations, including the small size of the sample, the convenience sampling and the very subjective nature of the interview. Also due to the semi-structured nature the same information wasn’t gained from all participants and in this way lacked consistency. There was also obvious potential for recall bias, as many of the participants were not actively involved with maternity services currently.

However, it clearly demonstrates short comings within the maternity services and shows that in many cases they are failing these vulnerable and needy women. It also displays a clear level of racism not widely accepted as being present and shows many areas meriting further investigation.

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Limitations and further study:

Currently there are a great number of limitations in the research available regarding the needs of pregnant asylum seeking women, not least of which is the current deficit of research into this area. Limitations and suggestions for further research are listed below:

- There is little research into direct obstetric outcomes in these women. Although research has discovered that these women are at higher risk of dying further research is needed to discover the reasons for this.

- Although some research has already been undertaken into maternity experiences in these women, it has just been small samples in certain areas. Although all research into this area has supported the same recurrent themes thus far, much of this research has not been formally structured or explored the same aspects in each of the women. Whilst it is clear that this is a challenging area of study, it would give us a much more definite picture of the problems in the current services and perhaps make it easier to gain support for the necessary changes.

- Current research has looked at the experiences of pregnant women within the services but, there is no research detailing the experiences the services have of treating these women. Perhaps if this was looked into this we would have a further understanding of not only how the system is failing these women, but perhaps also a greater idea of the prevalence and causes of any racism within the services.

- With the results seen in the previous studies it is also obvious that the health needs of these women, both physically and mentally, are investigated further, so that they can be adequately met.
Conclusions and Recommendations:

It is undeniable from the current research available that the NHS is failing pregnant asylum seeking women on multiple levels. With maternal mortality at a rate up to seven times higher in women of black African origin compared to white women,11 it becomes clear that the current service being provided is not equal, nor does it protect vulnerable and marginalised groups, those often most in need of our care.

Asylum seeking women face many problems interacting with maternity services. These include problems accessing services and gaining information. There is often a lack of interpreters for these women which, at times, has led to them being coerced into decisions. One of the greatest problems seems to be the level of racism experienced by these women. With up to half of them experiencing racism during their antenatal care, the size of this problem may be far beyond a level which the NHS would currently like to admit.

There are also all the problems which go along with the asylum process: the poverty, social isolation and poor living conditions, all of which form another barrier to these women accessing services.

But the challenges come with trying to work out how these problems should be managed. It would perhaps be easier to solely blame maternity services and leave them to deal with the problem; however, this is unlikely to yield solutions. Whilst maternity services certainly need to look at how they can improve access for these women, the importance of funding education and interpreters and addressing the significant additional health problems many of these women have during pregnancy, the buck should not stop here. It should be the duty of the NHS to further investigate and remove any racism or discrimination currently held within its institution, so that all asylum seekers, whether accessing maternity or other services, are given the dignity and respect they deserve, regardless of their background.

Moreover, it is the responsibility of the Home Office and the government to be accountable for its role in all of this. With the asylum system actively promoting ill health and increasing levels of destitution amongst asylum seekers, it is very difficult to see how the health of this marginalised and vulnerable population can make any significant improvement without a fundamental change being made in current asylum legislature.

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References:


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28) Gaaseraud A. Maternity services for newly arrived refugee and asylum-seeking women in the City and Hackney boroughs of London. City and Hackney Primary Care Trust. 2001.


Top 3 References:


This was the most detailed piece of research currently available in my chosen area of interest. It is a truly interesting piece of research as it details the treatment 33 asylum seeker women experienced, giving us a clear picture of many of the problems these services currently have.


Very useful in helping me gain a true understanding of the many health problems facing asylum seekers and refugees


This article again gave me a multitude of information on the health challenges facing asylum seeker populations. It also gave me background information on asylum and dispelled several asylum myths.
Appendix 1:

Personal Reflection:

I am a well travelled individual who has always taken a great interest in the rights of asylum seekers and other socially disadvantaged groups. However, during this placement it has amazed me how little I actually knew on the topic. Some of the stories I have heard relating to the treatment of asylum seekers have shocked and appalled me and it has opened my eyes as to just how much needs to be done to ensure the basic human rights of these people and their health needs are met. Furthermore this experience has inspired me to become more actively involved in groups helping to campaign for this to be achieved.

I believe this SSM has given me the opportunity to far broaden my experience in these areas which I believe will improve my practise in my future career. Additionally I believe all medical students would greatly benefit from being given the opportunity to gain experiences such as these and in turn this would hopefully improve knowledge and understanding of this complex area in the doctors of tomorrow.
Appendix 2:

Case Study:

55 yr old female, M, originally from Zimbabwe, arrived in the UK in 2006. In Zimbabwe M’s daughter was an active member of a party opposing the current government. As such she was kidnapped and tortured due to this involvement. Miraculously she escaped her captors and fled to England where she was granted asylum. During this time her parents (including her mother M, father and sister) were repeatedly harassed regarding the whereabouts of this daughter, any knowledge of which they denied. During this time M also became ill (later she was diagnosed with diabetes) and feared she may die so wished to see her daughter one final time. She then travelled to England to see her daughter. Her daughters previous captors became aware of this and publically denounced M as a traitor to the government for hiding the whereabouts of her daughter. They threatened M and stated that as soon as she returned to Zimbabwe she would be detained and as she believes most certainly killed. Her family left within Zimbabwe also had to go into hiding in an attempt to escape the captors.

So despite the fact that M wished to return to Zimbabwe she was then forced to seek asylum in the UK. Fortunately at this time she could stay with her daughter but this soon became a very difficult situation for both of them as her daughter struggled to support them both. Also during this time M’s health was deteriorating further as she was unable to gain access to a GP and therefore gain necessary medication to treat her diabetes.

In 2007 M’s claim for asylum was refused. According to M the main grounds of their refusal related to a lack of knowledge of the political party threatening to capture her. However there is currently no safe route of return to Zimbabwe so M then became destitute. She only survived due to the kind support of her daughter despite this causing an increasing burden.

Finally in early 2009 M was offered accommodation from NASS and £30 a week to live on. This relieved the burden on her daughter however the accommodation is of a poor standard and the £30 is provided in Tesco vouchers, not allowing M to spend the money how she wants, or often even in the most effective way. M now also has access to a doctor who is treating her diabetes, however, there are still only certain places she can go where people will agree to treat her.

M has had great difficulty in contacting her family left in Zimbabwe and fears greatly for their lives. Being an asylum seeker in England M feels like she has lost her identity and all of her confidence. She cannot work or learn and feels her life has lost all meaning. Currently she says her main hope is just that someday soon her situation will improve.

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M’s case is just one example of the many people whose cases I learnt about during SSM. The problems M encounters with healthcare, housing and destitution are commonplace in asylum seekers. As are the loss of identity and confidence. Speaking to many of them a complete loss of confidence in the asylum system is also commonplace.

Many thanks to M and all the asylum seekers who allowed me to gain an insight into the problems they face in their everyday lives.
Appendix 3:
The following is a newspaper article which recently appeared in the Independent. It shows a positive and supportive media portrayal of asylum seekers.
Appendix 4:
Good Medical Practice (2006)\textsuperscript{25}
Below details the GMC duties of a doctor. The first point is of great relevance to the treatment of asylum seekers as mentioned in the text. However, if you read through many of them support the notion that it should not be a doctor’s place to be picking and choosing which patients he or she treats. They also support the notion that ethically and morally a doctor should not refuse treatment to patients in need.

<table>
<thead>
<tr>
<th>The duties of a doctor registered with the General Medical Council</th>
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<tbody>
<tr>
<td>“Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and you must:</td>
</tr>
<tr>
<td>• Make the care of your patient your first concern</td>
</tr>
<tr>
<td>• Protect and promote the health of patients and the public</td>
</tr>
<tr>
<td>• Provide a good standard of practice and care</td>
</tr>
<tr>
<td>o Keep your professional knowledge and skills up to date</td>
</tr>
<tr>
<td>o Recognise and work within the limits of your competence</td>
</tr>
<tr>
<td>o Work with colleagues in the ways that best serve patients' interests</td>
</tr>
<tr>
<td>• Treat patients as individuals and respect their dignity</td>
</tr>
<tr>
<td>o Treat patients politely and considerately</td>
</tr>
<tr>
<td>o Respect patients' right to confidentiality</td>
</tr>
<tr>
<td>• Work in partnership with patients</td>
</tr>
<tr>
<td>o Listen to patients and respond to their concerns and preferences</td>
</tr>
<tr>
<td>o Give patients the information they want or need in a way they can understand</td>
</tr>
<tr>
<td>o Respect patients' right to reach decisions with you about their treatment and care</td>
</tr>
<tr>
<td>o Support patients in caring for themselves to improve</td>
</tr>
</tbody>
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and maintain their health

- Be honest and open and act with integrity
  - Act without delay if you have good reason to believe that you or a colleague may be putting patients at risk
  - Never discriminate unfairly against patients or colleagues
  - Never abuse your patients' trust in you or the public's trust in the profession.

You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions.\textsuperscript{25}

Figure 5: General Medical Council. Good Medical Practise: The duties of a doctor registered with the general medical council. GMC Publications. 2006
Appendix 5:

Journal Club Presentation:

The following displays the slides used in my powerpoint presentation at journal club. The powerpoint relates to the findings of the key article used in this SSM.
Appendix 6:

Resource List:

1) Asylum Link Merseyside. St Anne’s Church, Overbury Street, Liverpool. Telephone: 0151 709 1713. Email: asylumlink@yahoo.co.uk

2) Wrexham Refugee and Asylum Seeker Support Group (WRASSG) Trinity House, Wrexham. LL11 1NL. Contact: Peter Jones. Telephone: 01978 357 826. Email: peterkeithjones@yahoo.co.uk


4) Sahir House, HIV Charity. 80 Rodney Street, Liverpool. Telephone: 0151 707 0606
Appendix 7:

Timetable:
The following pages details my timetable for this SSM including visits attended. Below is a brief timetable of how my available time outside these visits was managed for researching and writing my SSM.

**Week 1: 6\textsuperscript{th}-10\textsuperscript{th} July.**
Spend allocated self study time looking into areas of interest.
Decide on specific topic and choose key article.
Create powerpoint presentation (see appendix 5) on chosen article for journal club.

**Week 2: 13-17\textsuperscript{th} July;**
Spend self study time further researching area of interest.
Include full search using Athens library database.
Spend time reading articles including: those detailing basic needs of asylum seekers, the asylum process, asylum statistics, health needs.
Focus on more reading into maternity services.
Create a plan for writing up the SSM.

**Week 3: 20-24\textsuperscript{th} July**
Mon: Write ‘introduction’ section ensuring key statistics and definitions are included.
Tues: Write ‘asylum process’ section including flow diagram.
Wed: Write ‘media’ section including suitable examples. Start on ‘accessing healthcare’ section.
Thurs: Complete ‘accessing healthcare’ section and ‘maternity services’ section.
Fri: Move in to limitations, conclusions and recommendations.
Weekend: Re-read and review all sections individually including assessing grammar, punctuation and spelling. Complete references and consider appendices.

**Week 4: 27-31\textsuperscript{st} July**
Mon-Wed: Review all sections, make necessary alterations. Ensure all references are correct and complete all appendices.
Thurs: Hand final draft into convenor.
Fri: Complete SSM, hand final copies into faculty.

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