Master Thesis

„Pregnant asylum seekers in Graz

Analysing the current situation with a health promotion approach"

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Abstract

Migrants, in particular asylum seekers, are vulnerable communities in terms of their health and well-being. In particular pregnant women are a group with special needs.

The *hypothesis* examined in this study was that there is too little support during pregnancy of asylum seeking women in Graz, Austria. The *aim* of this study was to provide more insight into experiences and support of these women at time of pregnancy. The two research questions were: 1) What demographic and statistical data is available concerning asylum seeking women in Graz and the number of asylum seeking women who have given birth in Graz during the year 2006? 2) What is the current situation as seen by the target group regarding the experience of and support during pregnancy in Graz?

The *method* to explore this situation was to do the statistical research through internet and personal contacts. Further to conduct individual interviews with six key informants and subsequently with eight pregnant asylum seeking women. Three regions of origin, Africa, the former Soviet republics and former Yugoslavia, were chosen to be able to obtain deeper information from a smaller range of cultures.

The *results* of the investigation showed that there were 519 asylum seeking women in Graz and in 2006 there were 507 births of foreign women. Due to lack of statistical data it was only possible to estimate that there were 15-25 births by asylum seekers in 2006.

All of the respondents from the target group were under medical support, undertaking the MKP-examinations. There were overall positive statements, and the women described a range of sources of support. However, uptake of broader preventive and health promotion and health information services, in particular pre-birth courses was very limited. The major complaints explicitly described related to the language barrier.

Discussion - It may be that the women have limited knowledge about these possibilities, much less where such programmes can be found within public services. Therefore health information and health literacy are crucial in making these women aware of all that is possible in terms of support.

The *conclusion* is that regardless of the fact that all women were under regular medical support, there is still a lack of knowledge of what is actually available in terms of overall support, including courses for pregnant women and in particular migrant women.

Zusammenfassung

Migranten, im Speziellen Asylwerber, sind bezüglich Gesundheit und Wohlbefinden eine benachteiligte Personengruppe. Speziell schwangere Frauen stellen eine Gruppe mit besonderen Bedürfnissen dar.

Die *Hypothese* dieser Studie bestand in der Annahme, dass es zu wenig Betreuung für schwangere Asylwerberinnen in Graz gibt. Das *Ziel* dieser Studie war, mehr Einblick in die Erfahrungen und über die Betreuung dieser Frauen während der Schwangerschaft zu bekommen. Die zwei Forschungsfragen lauteten: 1) Welche demographischen und statistischen Daten sind bezüglich Asylwerberinnen in Graz vorhanden und wie hoch war die Anzahl der Geburten von Asylwerberinnen in Graz im Jahr 2006? 2) Wie wird die aktuelle Situation von der Zielgruppe gesehen bezüglich den Erfahrungen und der Betreuung in der Schwangerschaft?

Die *Methode* um diese Situation zu untersuchen bestand in statistischer Recherche über das Internet und über persönliche Kontakte. Weiters wurden persönliche Interviews mit sechs Schlüsselinformanten und danach mit acht schwangeren Asylwerberinnen geführt. Drei Herkunftsregionen, Afrika, ehemalige Sowjetunion und ehemaliges Jugoslawien, wurden ausgewählt um mehr Informationen über einige wenige Kulturen zu erfahren.

Die *Ergebnisse* dieser Erhebung zeigten, dass es 2006, in Graz 519 Asylwerberinnen gab und 507 Geburten von ausländischen Frauen. Aus Mangel an statistischen Daten war es nur möglich, eine Schätzung auf 15-25 Geburten von Asylwerberinnen für 2006 zu machen.

Alle Befragten der Zielgruppe wurden medizinisch betreut, die MKP-Untersuchungen wurden durchgeführt. Im Großen und Ganzen gab es positive Meldungen zu ihrer Situation, die Frauen beschrieben unterschiedliche Betreuungsmöglichkeiten. Der Zugang zu umfassenderer Vorsorge, Gesundheitsförderung und Gesundheitsinformationen, besonders Geburtsvorbereitungskurse war sehr limitiert.

Die hauptsächlichen Beschwerden bezogen sich auf die sprachlichen Barrieren.

Diskussion - Es mag daran liegen, dass sich die Frauen nicht dieser Möglichkeiten bewusst sind, noch weniger wissen wo solche Programme im öffentlichen Service zu finden sind. Deshalb sind Gesundheitsinformationen unerlässlich um den Frauen bewusst zu machen was an Unterstützung möglich ist.

Die *Schlussfolgerung* ist, dass trotz der regelmäßigen medizinischen Betreuung der Frauen nach wie vor ein großer Informationsmangel bezüglich der möglichen Unterstützung für Schwangere, im Besonderen Migrantinnen vorhanden ist.

Acknowledgment

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Statement under oath

I hereby declare that the work presented in this thesis was completely done by me and that I have not used any sources or help other than those explicitly mentioned.

Place/Date

Signature

Preface

The issue of migration is very interesting and important to me. This is not only due to the reason that I am not Austrian myself – in 1988, at the age of 13 I came from Sweden to Graz with my mother and her Austrian husband. Since then I have lived in Graz and I am now married to an Austrian and we have two children together. Although I had lived here for more than 10 years before I got pregnant.

This does not imply that I can or want to compare my situation with that of asylum seekers. We came to Austria from Sweden, another safe European country and over the years I have had the time to get to know the Austrian society and the new systems. However this gives me some kind of insight into how it is living in a new country - the foreign language was a big challenge also for me, although it might be easier to learn a new language as a child going to school.

Abbreviations frequently used in Austria during pregnancy period

MKP – Mutter-Kind-Pass	Mother-Child-Pass, a booklet for documentation within a care program for mother and child
LKH – Landeskrankenhaus.	General hospital in Graz
GKK – Gebietskrankenkasse.	Medical Insurance Institution
EKiZ – Eltern-Kind-Zentrum.	Parent-Child-Center in Graz.

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1. Introduction

There is a clear association between migration, ethno-cultural diversity, health and health care. On account of worldwide migration, globalisation as well as European enlargement, the diversity of European communities is becoming larger and larger even on the local level. The state of health of migrants and ethnic minority groups is often worse than that of the average population, often having complex and overlapping health and social needs. These groups are more vulnerable, due to their lower socio-economic status and often also lack of adequate social support and social networks. As for asylum seekers there may also be trauma as a result of pre-migration experiences. There is a risk for minority groups of poor access to preventive and health promotion programmes as well as not receiving the same level of health care regarding diagnosis and treatment compared to the average population.[1, 2]

Being pregnant in exile is even more of a challenge. A qualitative study of women's maternity experiences during the asylum process was carried out in London during 2001.[3] This study done by the Maternity Alliance included semi-structured interviews with 33 women, who were currently pregnant or had recently given birth.

The account of some of the key findings of this study will show that these women are in a difficult situation. "Already lonely, disorientated and grieving, half of the women also experienced neglect, disrespect and racism from the maternity services." [4] This was not the case for all of the women – most of them were satisfied with the antenatal care and half of the women also had positive experiences during delivery and on the postnatal ward. In London, there was also a problem of accommodation, some pregnant women and new mothers were placed in temporary accommodation that was generally very poor quality and often seriously overcrowded. All male hostels or hostels dominated by single men are not the right place for a woman - women (including young women under 18) were sometimes placed there and they were sexually harassed while using shared kitchen and bathroom facilities. Many women were worried about the outcome of their asylum cases; they expressed feelings of powerlessness, insecurity and vulnerability. Being far away from home during the pregnancy and postnatal period is particularly difficult and these women missed their mothers, other female relatives and friends – they suffered the lack of their normal social network. This study clearly indicates the importance of appropriate secure accommodation, support fort the

complex problems of asylum and the need for a supportive, familiar network for asylum seeking women in pregnancy in London.

The focus of this master thesis concerns the current situation of pregnant asylum seeking women in Graz. Asylum seekers are expected to have the least access to support and care during pregnancy and this is the reason why the focus is put on asylum seekers in particular and not all migrants. Asylum seekers have more recently arrived in comparison to refugees and have greater limitations to services.
Given the theoretical background, the situation of this group of women was analysed through personal interviews with some key informants and in particular with the pregnant women themselves. The purpose of this approach was to get a picture of their situation in order to gather statements to the following themes amongst others: their social circumstances, social network, and social support, access to health care and health information as well as their health belief and behaviour. Each of these factors, or health determinants, can have an influence on the health of the women and are relevant for a healthy pregnancy.

The principles guiding the health promotion approach of this study are stated within the Ottawa Charter [5] of the World Health Organisation (WHO) of 1986.
"Good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable through advocacy for health".

1.1. Interlinkage to an international project: ICAASE

OMEGA Health Care Center (henceforth only referred to as OMEGA) in Graz is part of an international project: "Innovative Care Against Social Exclusion" (ICAASE), the other four participating countries are: Sweden, Spain, Slovenia and Denmark. The aim of this project is "to improve and promote the health and well-being of children, women and their families at risk of social exclusion (as a consequence of regular or irregular migration) through innovative programs of coordinated health and social care". The target group consists of migrants, refugees and asylum seeking children, women and families, whose complex health and social needs place them at particular risk of social exclusion. This project has a duration of 30 months and was co-financed in 2004 by the

European Commission (Health and Consumers Affairs, Programme of community actions in the field of Public Health, 2003-2008).[6]
The special needs of many migrant communities can be effectively determined by investigating these needs, identifying high risk target groups and by seeking innovative models of care in which problems of employment, accommodation, social engagement and education are considered together with physical, emotional and psychological well-being of migrants. It is essential to consider the individual or, in particular, the family in the context of their everyday life rather than looking at it as a series of "problems".

Pregnant asylum seekers are part of the target group of ICAASE. Ensuring that these women have a healthy pregnancy is very important and to be able to do so it is valuable to investigate the current situation locally. It is this task that I have addressed in my research through individual interviews with women from the target group. Through key informants it was possible to identify respondents from the target group. Additional support was obtained through translation for some of the interviews. An international two day conference was held in Graz on May 10-11 2007 as part of the ICAASE project: "Inclusion and Migration – An international conference examining various aspects of Innovative Care Against Social Exclusion". Within this conference I had the opportunity to make a workshop presentation about the results of this research.[7]

1.2. Definition of terms

Migrant is a frequently used term and therefore this word as well as some other terms used in this paper, are defined below.

"Migration: the movement of persons from one country or locality to another" [8]
On one hand there is a *free migration* (e.g. working migration) and on the other hand *involuntary /forced migration*.

"*Forced migration* is a general term that refers to the movements of refugees and internally displaced people (those displaced by conflicts) as well as people displaced by natural or environmental disasters, chemical or nuclear disasters, famine, or development projects." [9]

"*Asylum seekers* are people who have moved across an international border in search of protection under the 1951 Refugee Convention, but whose claim for refugee status has not yet been determined."

"There is a legal definition of a *refugee*, which is enshrined in the 1951 United Nations Convention Relating to the Status of Refugees. Article 1 of the Convention defines a refugee as a person residing outside his or her country of nationality, who is unable or unwilling to return because of a well-founded fear of persecution on account of race, religion, nationality, membership in a political social group, or political opinion." Those recognized as refugees, are better off than other forced migrants, in that they have a clear legal status and are entitled to the protection of the United Nations High Commissioner for Refugees (UNHCR).

"MKP - Mother-Child-Pass"

In Austria, every pregnant woman is, at the beginning of pregnancy, offered a program, which is free of charge, of examinations and controls, to promote and maintain the health of the mother and the child, including the first few years of the child. This is a method to obtain a continuous care. The results of these MKP-examinations are documented in the so called "Mother-Child-Pass" [10] (Mutter-Kind-Pass, MKP), a small booklet. This is not an obligatory program; however it is the precondition for parents to be able to receive the childcare benefit.[11]

2. Information concerning migrants in Austria

First the numbers of migrants living in Austria, Styria and in particular in Graz are provided for the period included in this study, followed by the number of asylum applications. Further some general information on migration research in Austria is provided. Finally, the formal situation of asylum seekers in Styria, in particular Graz (for the period of this study), is outlined and a short overview of organisations working with asylum seekers in Graz is given.

2.1. Number of migrants in Austria, Styria and Graz

The numbers of foreigners living in Austria, which are stated below, shows that they represent quite a large percentage of the population and therefore it is important to know more about their situation in the new country.

In Austria, the last population census was made in 2001. In 2002 it was changed and now the census is register-based. Since 2002 it has been possible to classify the migration statistics according to criteria such as country of birth, nationality and duration of stay.[12] In the year 2006 there were 9.8%, that is 814.000 people from other nations living in Austria and of these, 586.660 came from outside the European Union (EU) 24. Furthermore 287.000 people were given Austrian citizenship between 1996 and 2005 and are no longer identified as foreigners in the above statistics. [13, 14]

In Styria in 2006, 5.7% of the population were foreigners.

However, the figure in Graz is much higher where 13.2% of the inhabitants are foreigners. This data is based on the registered foreign citizens living in Graz on 31.08.2006, of these 32.824 persons, 15 001 were women. [15]

The figures mentioned above show the total number of foreigners in Austria. To put the focus on asylum seekers there were 13.346 applications for asylum in Austria in the year 2006. [16]

The UNHCR, in their most recent analysis of applications on asylum compared the following countries: 44 European as well as 6 non-European countries (Australia, Canada, Japan, New Zealand, Republic of Korea and the United States of America

(USA)). In comparison with these countries Austria lies on rank 6 with a total of 132.150 submitted applications for asylum for the years 2002-2006. This is the absolute number of submitted claims. If the number of asylum seekers is compared to the size of the national population the situation is different. This is seen as an indicator for the capacity of a country to host asylum seekers. In this ranking Austria is listed as number 2 with 16 asylum seekers per 1.000 inhabitants behind Cyprus with 32/1000, followed by Sweden (14/1.000) and Luxembourg (12/1.000) is the country with the. Two more comparisons highlight this difference. During 2002-2006 the EU received on average of 3.2 new asylum seekers per 1.000 inhabitants. The main recipient during these five years was USA with 326.700 new asylum seekers and USA was ranked 25, with an average of only one asylum seeker per 1.000 inhabitants. The number of applications for asylum in the EU25 has however halved over the last five years, with the 25 countries receiving 53% fewer requests in 2006 compared to 2002. [17]

2.2. Research on migration in Austria

The numbers of migrants living in Austria were stated above – what about the research on this big group of people? In fact only in recent times has the lack of systemic research on migration and integration in Austria been examined. Experts see the institutional fragmentation of migration and integration research as the biggest weakness. In Austria, contrary to other European countries, the research on migration is still only conducted by small study groups or single researchers. In Austria there is no university or non-university research facility focusing on migration research only. In 2004, the Commission for Migration and Integration Research was established. This commission tries to link the research work in Austria, without doing basic research itself. The second Austrian report on migration and integration is under preparation.[18]

2.3. General circumstances for asylum seekers in Styria (in particular Graz)

It is important to know the general circumstances and living conditions of asylum seekers in Graz. They are living in Austria but they do not have the same rights as the national population - this is achieved only when they receive a positive decision of asylum.

The minimum conditions for the reception of asylum seekers in the EU were defined in a directive[19] in 2003 from the Council of the EU and all EU countries were to have

implemented this directive, by early 2005. However many aspects of the directive lack detail, leaving countries some freedom in the actual implementation of the directive.[20]

The law governing the formal care of foreigners in need of protection in Styria is written down in the "Styrian law of support 2005" [21], according to the "Basic Welfare Support Agreement" in the Article 15a B-VG of the Austrian constitution. People who are in need of protection are foreigners, who do not have sufficient means of subsistence –as is the case for most asylum seekers. This law was implemented on May 1 2004.
Under the terms of the Basic Welfare Support Agreement for Styria asylum seekers are inter alia offered accommodation, board, pocket money (€ 40 per month, but only at an organised accommodation) and health insurance. Social assistance is offered and non-cash- or cash-benefit for clothing. According to the Agreement, asylum seekers are accommodated in suitable lodgings with the exercise of respect for human dignity and with due regard for family unity. This can be either in an organised or individual accommodation. The financial situation is as follows: the maximum amount they can receive per month and per person in an organised accommodation is board and €40 of pocket money per month or €150 for self-catering. For those living privately the monthly rate is €180 for adults, € 80 for children and also € 220 as assistance for rent per family. This money is paid in part by the Republic of Austria (60%) and in part by the County of Styria (40%).

There is an option for asylum seekers to earn some more money, even though the asylum seekers who are supported under the Basic Welfare Support Agreement are forbidden formal access to the labour market. They have the possibility to do specifically defined small jobs. They can, with their own consent, do e.g. cleaning jobs or community service for an appropriate remuneration, but this does not mean that they are formally employed.
This description of the Basic Welfare Support Agreement is not exhaustive, but is meant to describe the basic entitlements to be able to better understand the situation of respondents during the pregnancy period.

2.4. Short overview of organisations working with asylum seekers in Graz

OMEGA Health Care Center

OMEGA Health Care Center [22] is a non-profit Non Governmental Organisation (NGO) working with migrants and asylum seekers. Their focus of support is on medical, psychological and psychotherapeutical care of traumatised people in a family orientated approach. Assistance in mother tongue for refugees and asylum seekers is offered. There is also a medical counselling and care in cooperation with the "Marienambulanz" [23], which is conducted by Caritas.

Caritas

Caritas [24] is the major provider of accommodation and support for refugees and asylum seekers in Graz. They are for example also offering legal advice. Caritas is responsible for the support of the asylum seekers in Styria according to the Basic Welfare Support Agreement. Since 1999 the primary health care centre "Marienambulanz" [23] has existed, which offers medical and social assistance free of charge to people with or without insurance; to those who have very little or no access to medical care. A multilingual team provide services to Austrian (one third of the ambulant patients) and non-Austrian citizens (two third). Caritas further offers other services for pregnant women in Graz, such as pre-birth counselling, although this is not a service only for asylum seekers.

Zebra

Zebra - Intercultural Centre of Counselling and Therapy [25], is an association working on migration and integration, flight and asylum. They are offering counselling for migrants, asylum seekers and refugees as well as psychotherapy and they are also having a section on educational work.

ISOP

ISOP – Innovative Social Projects [26] is an intercultural, non-profit NGO which is offering for example intercultural assistance in health matters as well as German courses for migrants.

DANAIDA

DANAIDA - Education and Meeting Place for Foreign Women [27] is an association who offers German courses for foreign women with parallel child care. They further offer courses of alphabetisation and an elementary education program.

3. Background & current state of national and international research

This chapter includes a consideration of national and international research at the time the study was initiated. First the health issue for migrants in general and then for female migrants are addressed. Then the special situation of female refugees is considered and then in particular that of pregnant women. As conclusion of this chapter there are some facts and literature concerning pregnant migrants.

3.1. Migrants and health

Migration does not automatically imply a health risk – rather it is the socioeconomic and psychosocial situation of many migrants which places them at risk of social exclusion and poor health. Referred to as “migrational problems” these are in fact the risks which result from social disadvantage[28]. The fact that people with lower socioeconomic status also have a worse health status is also shown in Austria – migrants often belong to these sections of the society. [29]

Once having arrived in the host country there has to be a way to ensure adequate access to health and social care for migrant communities. In this context it is fundamental that the EU and its member states continue to ensure that the principal of Health for All [30], as expressed by the WHO and the European Community (EC), applies equally to all, including these migration and transitional communities who are at risk of exclusion from the social and health services essential for the health and well-being of all. Refugee and asylum seeking communities are at risk not only due to cultural barriers but also as a consequence of the burdens of potential pre-flight trauma and the severe lack of autonomy and personal resources in the host country, such as a distorted family structure, the lack of familiar social networks and financial restrictions. There is often a social dependency, potentially poor housing and poor or no opportunity for work.

General problems for migrants in terms of improving and maintaining health status include:

- Language difficulties
- Different health attitudes and beliefs to the host community

- Illiteracy, missing general education
- More difficult access to information
- Little knowledge about the health care system of the host country
- The situation of migrant families between their communities and the national society.[31]

There is also a health economic interest in promoting and maintaining the health of migrant communities. The health system of today is getting more expensive also due to the linguistic and cultural barrier of communication.[32] Equity in terms of health means putting more resources into the health of migrants to get the same health outcomes as those of the host community.[33] Poorer health status amongst migrant communities results in the need for more expensive tertiary level care.

The health care for asylum seekers in EU25 was compared in a study done by the University of Copenhagen in 2004.[34] The aim was to compare the access of asylum seekers to medical screening upon arrival as well as their general access to health care. The method used was an email-survey in April 2004 to Government ministries or departments and to relevant NGOs in all 25 countries in the EU. These NGOs were identified through prior contact to the European Council for Refugees in Exile (ECRE). The response rate was 60% from the ministries and 20% from the NGOs with answers from 24 out of the 25 countries.
Medical screening upon arrival was provided in all countries but one, Greece. The amount of screening varied as well as whether it was done on a voluntary or obligatory basis. The screening was systematic for all new asylum seekers in the Nordic EU-countries. In Austria, France, Spain and England a screening is only done systematically for those living in refugee shelters. Concerning the general access to health care there were legal restrictions in 10 countries, where asylum seekers were only entitled to emergency care. Formal restrictions for pregnant women were found in 5 out of 23 countries. In some countries the access changed due to changes in their asylum process. In countries without formal restrictions there were practical barriers such as: insufficient knowledge about the access to the health care system of the host country, linguistic, cultural and structural barriers. Traumatised asylum seekers had access to specialised treatment in most countries. Overall health policies towards asylum seekers differ significantly and it has to be added that the health care systems differ in those countries compared.

Focusing on Austria, there is an increasing awareness of the need for data concerning migrant health, but no regular surveys or larger studies are done on the specific health situation and health needs of migrants in Austria. There have been occasional non-representative studies, which are only specific for migrants to a certain extent, conducted to identify different problems and deficits within the health care for migrants. A study by Wimmer-Puchinger, Wolf and Engleder, focusing on the health of female migrants in Austria, is discussed in the section 3.2.

The federal health policy, the Ministry for Health and Women, has more recently focused on the situation of migrants in the Austrian health care system. “Health is one of the basic human rights and it is not only a humanistic but also a humanitarian duty to maintain an equal access to the health care system to all people living in Austria”.[35] A project group was set up in 2005 to identify areas for improvement in the care of migrants, which included both intra and extramural care as well as the psychosocial care for migrants. The results of this investigation are contained in the following report: “Intercultural Competence in the Health Care System” .
The results of this report can be summarised as follows. There was shown to be too little intercultural competence amongst the staff of services examined and that this knowledge should be provided in the formal curricula of professions as well as through specialised training. A major problem identified was the language difficulty. There was clearly identified, a need for more translators, who also have knowledge about different cultures. It was pointed out that in communicational matters a main focus should be inter alia set on gynaecological and obstetrics patients. On the other hand, migrants must be given information about the different levels of care in the Austrian health care system – the possibilities for both intra and extramural care, as many migrants are not used to the concept of an extramural system from their home countries. This has to be done in combination with more translators for extramural care. Another concept that many migrants are not aware of is the idea of preventive care and are only used to the care required when a health problem occurs. The overall concept of hospitals should involve intercultural competence at all structural levels. It was suggested that a way to get more intercultural staff would be to make the possibility for migrants to be able to learn a profession within the health care system more easily accessible. It has to be added that the plan for the implementation of these recommendations is not included in the report of the Ministry.

3.2. Female migrants and health

The change or the loss of the sociocultural context is experienced in a special way by women. Through the early mechanisms of socialisation we learn the understanding of social roles and the body image, values and taboos. These are linked with the female identity, sexuality and reproduction.[36]

Wimmer-Puchinger, Wolf and Engleder have been concentrating on this specific target group in their study: “Female migrants in the health care system. Health care utilisation, access barriers and health promotion strategies”. Therein they specify that extensive research shows that there is no long tradition of a culture-sensitive health research on women with migration background. The data which is available is not complete. This is also shown in the outcome of a systematic review of refugee women’s reproductive health[37], which is outlined in the section 3.2.1.

Working on several levels is necessary to improve the care situation for female migrants. It was identified that in particular what is needed is more information material for this group of women, which should be in the respective mother tongue, both in written form as well as audiovisual information for those with lower literacy. David and Borde further suggest the use of more translators. These authors offer the example that German and Turkish women have different knowledge about the female body, contraception, preventive examinations as well as about the period of menopause.

The social disadvantages of women for example in the labour market, as well as socially, is even worse for female migrants. According to the Austrian Health Report for Women 2005, female migrants often have a bad health status and are more often affected by multimorbidity, psychosomatic and pain symptoms.[38] This is also shown in a study in Austria comparing the health status of female migrants with Austrian women.[39]

3.2.1. Pregnant migrants and health

Migrant status is associated with poorer infant outcome - according to the study by Trummer, Novak-Zezula et al[40], there is a higher infant mortality and lower birth weight than for non migrant women. Migrant status is also a predictor of severe maternal morbidity. Further maternal mortality can according to a study by Razum et al [41]. be seen as a sensitive indicator for inequity of health. It was shown that non-German women (especially from non-European countries) had a higher maternal risk (e.g. abortions, stillbirths and pregnancy induced hypertension) compared to German

women. Maternal risk is not associated only with the nationality; it is linked with overall socioeconomic status.

Migrant women often have a low educational and literacy level, which is associated with a low socio-economic status. These circumstances of low social class and coming from an ethnic minority can correlate with a higher risk of under-utilization of prenatal care. This is shown in a project in Nuremberg, which is described below.

In Nuremberg a project was started in 1998 for pregnant migrants: “Nuremberg’s Model for Antenatal Care for Pregnant Migrants” [42]. The number of migrants in Nuremberg is increasing. In 2000, 18.1% migrants lived in Nuremberg and 27% of these came from Turkey. The model was initiated by the Department for Prenatal Diagnosis and Obstetrics of the South Hospital in Nuremberg together with the Public Health Department of the City of Nuremberg, with the purpose of offering antenatal care in women’s mother tongue. Further there was the intent to decrease the perinatal mortality and to increase the interest in postnatal care and examinations of the newborn child.

In 1998, when the project started, very few pregnant migrants came to the antenatal classes, which were offered in Polish and Turkish, as well as a gynaecological consultation-hour in Turkish. The number of participants increased and in 2001 15-21 women (50% from Turkey) came every week – the classes were overfull. Since October 2001 two classes in parallel have been offered, one of them in Turkish. There were mother tongue personnel working with the women: a Turkish physician, a Turkish and a Polish midwife together with a pedagogue and a paediatrician.

The results of about 5000 births between 1998 and 1999 were examined and a significant difference was observed between German and migrant women in terms of prebirth care. Every fifth migrant woman went to the first prenatal examination/ultrasound later than the 13th week of gestation, explicitly later then German women. In comparison more than twice as many migrants went neither to a preventive examination nor to an ultrasound during the whole pregnancy. Another significant difference observed was the more frequent and longer prepartal hospitalisation of pregnant migrants compared to German women. In 1998 this difference of frequency and duration of prepartal hospitalisation was 16% vs. 12%; $p<0.01$ and in 1999 it was 19% vs. 14%; $p< 0.01$. This difference in frequency of the prepartal hospitalisation was no longer significant in 2000: 16.1% vs. 15.5%; $p>0.05$ and 2001: 22% vs. 18%; $p>0.05$. The higher perinatal mortality of 14‰ in 1998 in group of migrant women compared to 8‰ for the German population decreased and in

2001 it was similarly low: 10‰ versus 12‰. This was due to the higher utilisation of the preventive examinations.
There were ethno-medical trainings for medical staff that were initiated for this project and these were valuable for the sensitisation to the special needs of pregnant migrants regarding their origin, culture and religion as well as their different understanding of health and disease. The multidisciplinarity of the core team, including the medical staff as well as the social pedagogues proved to be important for the integration of the migrant women. It is clear from this study that migration and fewer antenatal care visits have an impact on the health status of pregnant migrant women.

Another model in which attempts to improve pre-birth care for migrant women is that developed by FEM Süd, a women's health centre situated in the Kaiser Franz Josef's hospital in Vienna. This was a project for Turkish pregnant women in Vienna, a subproject of "Migrant Friendly Hospitals", which was financed by the European Commission. In this project with the title "Birth preparation for Turkish speaking pregnant women" [43], a birth preparation course in Turkish was offered in four two-hour modules – with free attendance and with personal invitations. It was shown that it was not optimal to use modules, as the women often only came for the first module. Therefore, it was changed to a monthly open meeting for information, called "Around birth - Birth-info-sessions in Turkish"; this was well attended, in average ten Turkish women at each session. Each of these women was personally contacted as it was not enough to provide general open invitations to the Turkish women in a written form. FEM Süd works especially with women of lower socioeconomic status, among them female migrants. They are working to reduce the barriers of access to health care and health promotion for their target group as well as offering help and support for more specific health matters of these women. It is a multicultural, multilingual and multidisciplinary team working at the centre, offering counselling and information not only in German but also in Serbian, Bosnian, Croatian and Turkish.[44] This is a concept which has enabled many migrant women to be reached. The number of clients is rising and in the year of 2005 there were 26000 contacts, and out of these 40% were from a foreign country. Two thirds of the women have only finished compulsory education (9 years of school) and less then a third is active within the labour market.

A systematic review of refugee women's reproductive health was done by Gagnon, Merry and Robinson in 2002. The purpose of this review was to find out whether there are any differences between refugee or asylum seeking women in the countries of resettlement and their national counterparts, in terms of differences in reproductive

health indicators. Literature was searched on five electronic databases. In addition abstracts from the Conference Proceedings from the Reproductive Health for Refugee Consortium, 2000, were reviewed. A further method was the search for literature on websites of agencies that addressed refugees' concerns as well as academic centres focusing on refugees and a web search. Subsequently the studies were sorted in low, moderate and high quality. If the sampling strategy was clearly representative and if the used measurement strategies were considered to be reliable and valid for the population under study, the study was classified as high quality. Only the high quality studies were used trying to answer the research question of the review and in all forty-one studies were identified as high quality.

For the main part, the studies reviewed were found to be unsystematic and uncritical reviews or even case reports, where only individual situations were described. The authors of this systematic review found that the literature reviewed suggest that there might be several factors to consider which are related to the reproductive health of refugee women in the resettling countries and these factors are shown in Figure 1. Looking more closely at the high-quality studies fourteen of these focused on refugees exclusively and nine of them looked in particular on reproductive health indicators. Of these nine mentioned studies only six had a comparison of the health of refugee and non-refugee women. Whereas the other twenty-seven of the forty-one studies included unspecified immigrants and nineteen of these focused on reproductive health and they were still included in the report of the review due to paucity of evidence specific to refugee women.

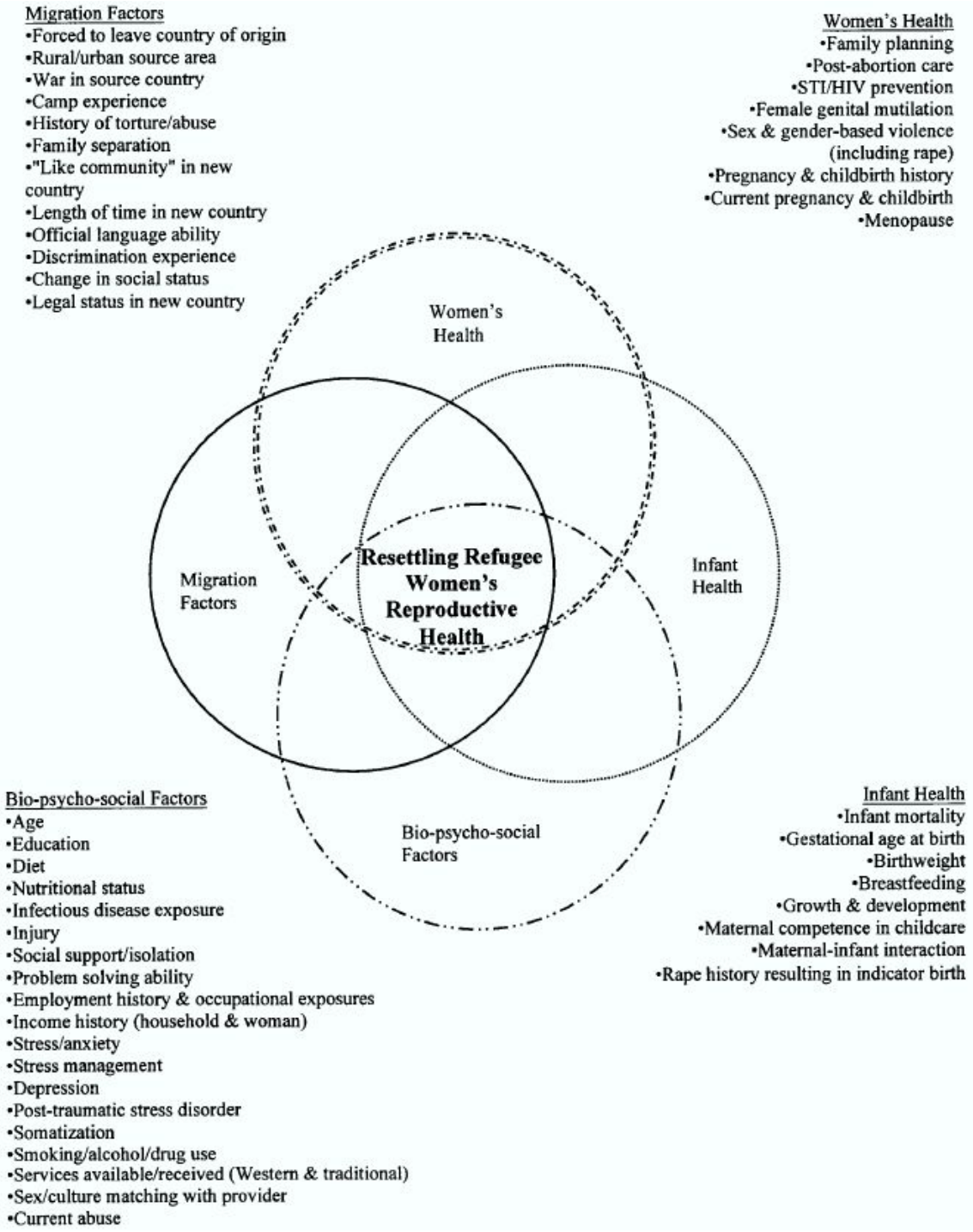

Fig. 1: Factors related to the reproductive health of resettling refugee women

Looking to the six studies with a comparison of the women's reproductive health, five of them were conducted in the USA and one in Greece. These comparisons in the USA regarding Indochinese women showed that these refugee women had a higher fertility rate and a higher rate of low birth weight infants, but the rates of infant mortality were lower compared to the national population. Further factors found were greater parity,

shorter interpregnancy periods, older mothers and, inadequate utilization of prenatal care. In Greece the refugee women (coming from Bosnia, Eastern Europe, former Soviet Union, Middle East and Africa) were found to have similar rates of low birth weight infants and pre-term deliveries in comparison to the Greek women. Overall findings in the refugee-specific studies were for example that fertility-rates were found to be high for the population which was born outside the resettlement country and higher for those with shorter periods of time in the host country. Further results were dissatisfaction with prenatal care as well as reduced prenatal care, which implicated fewer than three visits during the pregnancy.

The fact that this review only identified six studies which compared the reproductive health of refugee women versus the health of national women, while searching in five electronic databases as well as other web sites, stresses the fact that little has been published on this specific topic. The review also shows the lack of clarity used in published literature in defining the study population in terms of immigration status, migration history and sex. There are extremely few high-quality population-based studies found to support the findings of smaller reports such as the ones reported in Figure 1.

The conclusion of this review is that there are an inadequate number of studies comparing the reproductive health of resettling refugee women to the one of the national women and based on that data it is not possible to support or disprove the claims or higher health risks for the refugee women. This paucity of adequate data also inhibits planners and policy makers from making informed decisions with regard to the distribution of resources. Therefore this review further stresses that there is a great need fore more specific research on refugee women.

3.3. The special situation of refugee and asylum seeking women

Refugee women are often particularly vulnerable as they are without the protection of their homes, their government and often even without their family structure. Approximately 50 percent of any refugee population are women and girls. During their escape, they have to face the rigours of long journeys, official harassment or indifference and even sexual abuse. UNHCR has developed special programmes to ensure that these female refugees have equal access to protection, basic goods and services as they tempt to reorganise their lives. Documents defining these special programmes include: the “UNHCR Policy on Refugee Women” as well as the “Guidelines on the protection of refugee women”, the later was published in 1991.[45] Other organisations are also concentrating especially on women. The “Women's

Commission for Refugee Women and Children" was established in 1989 to address the particular needs of refugee and displaced women and children.[46]
The well being, the health and the security of women are very important. The Office of the United Nations High Commissioner for Human Rights (OHCHR) has proclaimed in 1974 the Declaration on the Protection of Women and Children in Emergency and Armed Conflict. [47]

To be able to look at the particular situation of refugee women it is useful to differentiate between male and female migrants. In general the life in the new country is influenced by the origin culture, but also by the reason why and conditions under which they left their homeland as well as which possibilities for integration and help they are able to get in the host country. Different motives forcing women to leave their homeland include: flight from war, demolition, or social and political conflict or pressure. This may have included traumatic experiences - including rape, torture and other exposure to violence against themselves or their families. Some enter the new country with the help of people smugglers, which can itself bring bad experiences. The number of women who are victims of trafficking is not exactly known. Other women had to follow their husbands on their search for work. All these factors can have an influence on the health of such women. A further factor that differs between men and women is the level of literacy and education and the different chances of education in the homeland. It is also dependant on whether they come from a rural or urban environment.

3.3.1. A focus on pregnant refugee women

During pregnancy, the life and well being of the woman as well as of the unborn child is of importance and being pregnant in a new country brings its own difficulties. The directive from the Council of the EU which was mentioned in section 2.3 defines the minimum conditions for the reception of asylum seekers in the EU, and identifies pregnant women as a group with special needs. [48]

3.4. Public health relevance & public health terms

The health of asylum seekers, in particular pregnant women, is a highly relevant issue. To obtain a healthy pregnancy for the mother will impact significantly on the health and well being of the child.

Below some relevant public health terms are described, which are to a certain extent also included in the interview guidelines. Then there is a special referral to health promotion for socially disadvantaged persons.

3.4.1. What is health promotion?

In 1986, health promotion was defined in the Ottawa Charter as the process of enabling people to increase control over the determinants of health and thereby improve their health. The Charter lists these conditions as the prerequisites for health: peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity. In the Declaration of Jakarta the following factors were added or completed: social security, social relations, and the empowerment of women, sustainable resource use and respect for human rights. Above all, poverty is seen as the greatest threat to health.[49]

For the achievement of these prerequisites there were three basic strategies for health promotion set up in Ottawa. First is advocacy for health, second enabling people to achieve full health potential and third is mediating between different interests in the society in the quest for health.

The Ottawa Charter also identified these five health promotion action areas:

- build Healthy Public Policy
- create supportive environments
- develop personal skills
- strengthen community action
- reorient health services.

Naidoo and Wills [50] describe in their book on health promotion that through the WHO the definitions of health promotion related terms have shifted from the prevention of specific diseases and identification of groups at special risk toward the health and well being of the whole population. It is no longer only the experts and the health professionals who are defining the relevant health issues; it is the persons themselves who should decide what issues of health are relevant to them and their social

environment. Therefore there are many actors in health promotion; it can be teachers, people working within the primary health care, social services and business managers. The responsibility for health is no longer seen as individual but as a responsibility of the community. Consequently, the impact on health should have an influence on decisions in organisations as well as in politics.

Health promotion for socially disadvantaged groups – which includes migrant communities to a large extent - is even more a challenge. Criteria for models of good practice in health promotion for socially disadvantaged groups have been subsequently developed. [51] Key criteria include important general factors in health promotion such as participation, empowerment and the setting approach as well as elements particularly relevant to migrant communities such as defining target groups and the use of multiplicators. The possibility of participation for the socially disadvantaged as a target group should be high and empowerment enables the target group to build up their strengths and resources. The orientation should be kept on the setting approach of the WHO. A further important criterion is that of easy access to the health promotion intervention, including methods of outreach.

3.4.2. Determinants of health

As determinants of health, WHO defines the range of factors which determine the health status of individuals or populations, these are: personal, social, economic and environmental factors. All these factors can influence health in a multiple and interactive way.

Concretely health determinants might include each of the following. Social support includes emotional support, information sharing and the provision of material resources and services. It is the assistance which is available to individuals and groups from within communities and it can be a buffer against adverse life events and living conditions. Social support can provide a positive resource for enhancing the quality of life.

Health behaviours and lifestyles are determinants which are related to the action of individuals. Other relevant factors are income and social status, education, employment and working conditions, the access to appropriate health services as well as the physical environment in which people live. All these factors have an influence on the living conditions, which furthermore have an impact on the health status.[52]

For migrant communities the social support has a particular importance. There are legal restrictions for some within these communities, such as the restricted access to

the labour market for asylum seekers in Styria (see 2.3) and they are not able to influence and change their living conditions due to these restrictions.

3.4.2.1. Importance of socioeconomic status on pregnancy outcomes

Socioeconomic status plays an important role in the childbearing period of a woman.

The effect of racial density and income incongruity on pregnancy outcome has been shown in a study among African-American women in Chicago, USA.[53] The census tract socioeconomic status was measured for this study and "positive income incongruity" was defined as whether a woman lived in an area of higher socioeconomic status than the average African-American woman with a comparable education and marital status. This study wanted to find out if the effect of positive income incongruity varied in relation to if the woman lived in a predominantly black or mixed area.

The results showed that a woman who lives in a better quarter has a reduced risk of adverse pregnancy outcomes; however the fact that it is an African-American living as part of a racial minority means that this risk may increase. For a woman who lived in a predominantly black census tract the positive income incongruity is connected with a lower risk of low birth weight (odds ratio (OR) 0.91) as well as reduced risk of preterm delivery (OR=0.83) and this was statistically significant for gestation (p-value=0.01). This positive effect on the pregnancy outcome was not shown in mixed quarters, where positive income incongruity was not connected with low birth weight (OR=1.04) nor preterm delivery (OR=1.11). In mixed quarters there is a racial density effect, which seams to have an impact on the expected positive effects of positive income incongruity - that might implicate adverse consequences of racism.

4. Aim of thesis

The aim of the study is to provide more insight into the experiences and support of the target group at the time of pregnancy by examining a range of health determinants over this period.

Hypothesis and research questions

It is hypothesized that there is too little support throughout the pregnancy of asylum seeking women in Graz. Analysing this situation through interviews with some key informants and in particular with women from the target group will lead to more knowledge about the situation. To be able to obtain a better picture of this matter it is also important to know how many asylum seeking women there are in Graz in relation to the national population.

This hypothesis was explored through the following research questions:

1. What demographic and statistical data is available concerning asylum seeking women in Graz and the number of asylum seeking women who have given birth in Graz during the year 2006?
2. What is the current situation as seen by the target group regarding the experience of and support during pregnancy in Graz?

5. Methodology

In this chapter the methodology used to investigate the research questions is described. First the procedure for finding the demographical and statistical data concerning the number of asylum seeking women living in Graz as well as how many asylum seeking women have given birth during the year 2006 is described.
Subsequently, the approach used to identify and carry out interviews with key informants and members from the target group to be able to know more about the current situation for pregnant asylum seeking women in Graz, is outlined. To conclude this chapter there is a description of the method used to analyse the interview results.

5.1. Methodology of research question 1: Finding demographic and statistical data

Expecting that statistics for defining the number of asylum seekers in Graz would be more difficult to obtain in comparison to migrants as a whole a range of sources are described below, with the expectation that the data would be limited.

5.1.1. Number of asylum seeking women in Graz

5.1.1.1. Internet research

Information was sought on the number of asylum seeking women in Graz, categorised according to country of origin. This information was sought through internet. The following web sites were used for the search of this demographic data: Statistics Austria, Austrian Ministry of the Interior, County of Styria and the City of Graz.

5.1.1.2. Personal contacts

A further step was to have direct personal contact to obtain the required information. This included telephone calls, e-mails and personal visit. In each case the researcher first introduced herself, explained the intention of the research and the specific data which was needed.

The following offices were used to access the required data: Office for Refugees of the County of Styria, Department for Statistics of the City of Graz and Caritas Office for Regional Support for Refugees in Styria.

5.1.2. Number of births in Graz by asylum seeking women

To obtain the number of births by asylum seeking women for the year 2006 contact was be made with the following sources: City of Graz, registry office for births in Graz and Clinic for Gynaecology and Obstetrics of the Landeskrankenhaus (LKH) Graz. The LKH is the general hospital in Graz and also the only one with a public maternity service. However, it has to be considered that the LKH is not the only place in Graz, where asylum seekers can go for delivery. Other potential sources of information included County of Styria, County Health Report of Styria and Styrian Medical Insurance Institution (Gebietskrankenkasse, GKK).

5.2. Methodology of research question 2: Current status for pregnant asylum seekers in Graz

The aim of this thesis is to get to know more about the childbearing period for the target group. The chosen approach to get more details about their conditions in Graz was to conduct qualitative interviews with key informants and then with respondents from the target group. Accordingly there is a description of how interview partners were identified as well as the process of the interviews.

5.2.1. Identification of the key informants

Key informants were sought through direct contact with NGOs, active in support and governmental institutions working with asylum seekers and refugees including the LKH in Graz and the Parent-Child-Centre (Eltern-Kind-Zentrum[54], EKiZ) in Graz. This was essential, given the expected poor access to governmental institutions by the target group. Snow-balling technique was used to identify new key informants during each of the interviews with the key informants.

5.2.2. Narrowing down the target group & identification of interview partners

It would go beyond the scope of this thesis to include all nationalities of asylum seekers living in Graz. Therefore it was decided to focus on women from regions from which many asylum seekers are living in Graz. Further it was decided to obtain deeper information from a smaller range of cultures. Those ethnic groups chosen for focus include women from the former Soviet republics, women from Africa and women from the former Yugoslavia, each of which have been amongst the top 10 asylum applicant countries in recent years.

In order to include a sufficient number of women it was decided to include those women who were pregnant at the time of the interview, or whose newborn had a maximum age of nine months. As a convenience sample it was expected that 8-10 women would be included in the study.

Identification of respondents for interviews from the target group was made through suggestion from the key informants.

5.2.3. Ethical aspects of the interviews

The interviews were only conducted after clear information was given concerning the nature of the project, the confidential handling and use of information and that the interviews are completely voluntary. That is, the interviews with representatives of the target group were carried out with due regard for the standard protective principles governing research with human subjects which are defined by the World Medical Association.[55]

5.2.4. Interview process and documentation of interviews with the key informants

To get a picture of the situation of asylum seekers, and particularly pregnant women, questions were developed about the key informants own work with this group. As the key informants work in different ways with the women there were individual questions for each of them, as well as open questions about their work. In this way it was possible to get their perceptions of problems concerning the target group.

For the documentation of the interviews with the key informants it was decided to make personal notes on paper during the interviews and then to type these up shortly thereafter.

The outcomes of these discussions were used to help to develop questions subsequently asked in the interviews with the pregnant women.

It was expected that those persons actively supporting or working with the target group would be relatively fluent in German. Therefore these interviews were to be carried out in German, unless otherwise indicated.

5.2.5. Interview process and documentation of the interviews with women from the target group

Based on the health determinants which were described in section 3.4.2., the interview guideline was set up, which included a series of questions concerning the person, personal circumstances, the social circumstances, the social network and the social support. As well as these, questions concerning access to health care, health information and their health belief/behaviour were developed. A closing open question about being a pregnant asylum seeker in Graz was also included. There was a very last question at the end of the interview if the women had any questions of me. This preliminary interview guideline was further developed based on the interviews with the key informants.

For the documentation of the interviews with the respondents of the target group the chosen method was to use a digital voice recorder with the explicit permission of the women. Subsequently, the interviews were saved on the personal computer (PC), for further analysis.

The researcher of this paper is aware of the importance of mother tongue for communication. For the conduct of these interviews it was decided to use translators as the first option. However, many asylum seekers have themselves a range of languages they speak other than mother tongue. Therefore, because the researcher is fluent in German, English and French, where translation from the mother tongue was not preferred the interview was also possible in these languages.

5.3. Analysis of the interview results

English as common language for the analysis

For the analysis it was important to have only one language to deal with. Due to the fact that the interviews might be conducted in several different languages, all interviews were translated into English by the researcher herself, before analysis.

5.3.1. Theory of the method of Content analysis: "openness" versus "guidance by theory"

Qualitative content analysis claims to synthesise two inconsistent methodological principles: openness and "guidance by theory". It is also meant to take account of the whole empirical data base and that the results of the analysis are reproducible to a certain degree.[56] On this premise, qualitative content analysis represents a promising methodological approach.

The approach to discourse analysis which was proposed by Mayring[57], is, according to Gläser and Laudl still too closely linked with the quantitative roots and there is no real possibility to combine "openness" and "guidance by theory". A problem which concerns "openness" is the use of a closed system of categories or variables, in this way excluding all possible new contents encountered later in the process of content analysis.

An early "fixing" of categories or variables tends to reduce the content of a study construct to a relatively small and semantically closed space of one-dimensional variables, which may be solid in some of the so-called hard sciences. However, in the social sciences, this can be a serious hindrance and is difficult to justify.

Beginning from a critical review of Mayring's work, Gläser and Laudl proposed another approach which is based on a different comprehension of variables. This is a theoretical and methodological approach to framing complex multidimensional scientific constructs in theoretical sociology. They presume that a certain degree of semantic openness for unexpected new content is given, as long as one is using semantically open constructs and categories. This is also relevant when conducting interviews with the pregnant women.

5.3.2. Approach used for this research

The analysis of the documented interviews with the women from the target group included the following steps.

As mentioned above all the interviews were recorded and then saved on the PC. The approach to be used involved the identification of statements or short sentences as meaningful answers to the posed questions. These statements, while listening to the recorded interviews, were then written on to different coloured cards. Each card was marked with a letter to represent the woman and a number for the question.
The different colour made it easier to sort the cards and re-sort them into categories or themes.

6. Results

6.1. Results of research question 1: Demographic and statistical information

It was a big challenge to obtain useful and representative data concerning the number of asylum seeking women living in Graz as well as of the number of births by asylum seeking women in Graz for the year 2006. As expected there was not the equivalent official statistic available on asylum seekers as on all migrants.

6.1.1. Number of asylum seeking women in Graz

Using the internet as first source, data was found on the website of the Foreigners Council of the City of Graz, but only the number of foreign citizens in Graz, not the number of asylum seekers in particular. The total number of people, coming from a country other than Austria, living in Graz on July 31, 2006 was 32.596 persons, 13.3% of the inhabitants. [58]

Initiated through a telephone call followed by a personal visit to the Department for Statistics (City of Graz) further data concerning registered foreign inhabitants in Graz, divided by sex and citizenship, was obtained. This data is based on the number of persons registered in Graz on the 31.08.2006. In all there were 248.525 inhabitants and of these 32.824 were foreigners, of which 24.775 came from outside the EU. This data was broken down into male/female citizens (see table 1), in total there were 15001 foreign women, 11045 women from outside the EU and 5500 of these women were in the age between 20 and 40 years.

	Women	Men	Total
EU	3 956	4 093	8 049
Non-EU	11 045	13 730	24 775
Total	15 001	17 823	32 824

Table 1: Number of foreign citizens, divided by sex, in Graz on the 31.08.2006 [15]

Therefore, to be able to obtain data on asylum seekers in Graz, the next attempt was to contact the Office for Refugees of the County of Styria. This personal contact was first made through a telephone call and then subsequently through exchange of e-mails. In this way it was finally possible to obtain the numbers of asylum seekers. This was only non-identifiable data and divided by nationalities, for Styria and Graz separately. The number of asylum seekers in Styria on the cut-off date 27.6.2006 was 3846 and in Graz there were 1665 asylum seekers.[59]

The next step was to contact the Caritas Office for Regional Support for Refugees in Styria, who are responsible for the support and the lodging of the asylum seekers under the Basic Welfare Support Agreement. Subsequently the requested data [60] was obtained with the number of asylum seekers for the month of April 2007. This data was non-identifiable and included the sex, the nationality and the type of lodging (shelter versus privat accommodation).
The figure from June 2006 had not changed much till April 2007, when there were 1660 asylum seekers in Graz and of these 519 were women, see table 2. The proportion of women coming from the regions of focus in this study is shown in table 3.

Number of asylum seeking women in Graz	Number of asylum seeking men in Graz	Total number of asylum seekers in Graz
519	1141	1660

Table 2: Number of asylum seekers in Graz in April 2007, divided by sex

Region of origin	*Number of women*
Former Soviet republics	194
Former Yugoslavia	96
Africa	68
Other	161
Total	519

Table 3: Number of asylum seeking women in April 2007, divided into regions of origin

Concerning the current lodging for these 1660 asylum seekers who were living in Graz by the month of April 2007, the lodging was as follows: about a quarter were living in organised accommodation and approximately 75% had private accommodation, see table 4.

Lodging	Women	Men	*Total*
Organised Accommodation	174	302	476
Privat	345	839	1184
Total	519	1141	1660

Table 4: Current lodging for asylum seekers in Graz in April 2007, divided by sex

6.1.2. Number of births in Graz by asylum seeking women

Information concerning the number of births by asylum seeking women was sought through contact with a key informant, Mrs Roswitha Kober, the acting head nurse of the Clinic for Gynaecology and Obstetrics at the LKH Graz. Only in May 2006 did this Clinic start to note nationality and mother tongue at every admission for inpatients as well as for out-patients of the Clinic. In these statistics all women from the Clinic for Gynaecology and Obstetrics are included, that is, it is not possible to say how many women actually were admitted at the Clinic for Obstetrics. Therefore the number of births by asylum seekers in Graz was not possible to obtain based on this information.

The number of migrants as inpatients at the Clinic for Gynaecology and Obstetrics of the LKH for the time period from May 2006 till December 2006 are shown in table 5. This is not the number of births, only the number of the overall foreign inpatients, according to the answers of patients regarding their nationality and mother tongue.

Number of foreign inpatients	902 women	21.3%
Number of Austrian inpatients	3 326 women	
Total number of inpatients	4 228 women	

Table 5: Number of inpatients, Clinic for Gynaecology and Obstetrics, LKH Graz, May-Dec 2006 [61]

The figures in table 6 show the number of outpatients (split into foreign and Austrian citizens) of the Clinic for Gynaecology and Obstetrics of the LKH for the time period from May 2006 till December 2006.

Number of foreign outpatients	7 288 women	17.1%
Number of Austrian outpatients	35 269 women	
Total number of outpatients	42 584 women	

Table 6: Number of outpatients, Clinic for Gynaecology and Obstetrics, LKH Graz, May-Dec 2006

The statistics from the birth registry [62] in Graz show that in 2006 there were a total of 3492 births in Graz, 507 of these babies had a foreign citizenship (table 7). In this statistic it was not possible to see the number only for asylum seekers; however it was possible to see how many babies there were born from the regions of focus for this study (table 8). Based on these statistics one can only estimate that there were 15-25 births by asylum seeking women in Graz during the year 2006.

Number of Austrian births	Number of newborn with foreign citizenship		Total number of birth in Graz in 2006
2985	507	14.5%	3492

Table 7: Number of births in Graz in 2006, divided by Austrian and foreign citizens

Region of origin	*Number of births*
Former Soviet republics	30
Former Yugoslavia	145
Africa	44
Other	288
Total	507

Table 8: Number of newborn with foreign citizenship in Graz, in 2006, divided into region of origin

6.2. Results of research question 2: Current status for pregnant asylum seekers in Graz

6.2.1. Presentation of key informants

To obtain general information about the situation of asylum seekers in general and of pregnant asylum seeking women in particular interviews were made with a range of key informants working with this group. They accompany the women through the pregnancy in different ways. Below first the identification of these key informants is described followed by a presentation of each of them, to indicate roughly their competencies.

The approach to identify the key informants was to start at OMEGA. There it was decided to choose two persons out of the OMEGA staff who are working regularly with pregnant asylum seeking women; their names are Nomawethu Kelbitsch and Gerald Ressi. Due to the cooperation of OMEGA with Caritas it was possible to identify two further key informants through Nomawethu Kelbitsch: Christina Kraker-Kölbl and Elisabeth Huber-Kranz. Contact was also made with a community interpreter, who also is presented below. The last key informant, Roswitha Kober, was identified during the health promotion workshop for improvement of sexual and reproductive health of female migrants[63], a workshop within the ICAASE-project.

Nomawethu Kelbitsch
Nomawethu Kelbitsch is a nurse and midwife from South Africa, working at OMEGA with women's health. She is also working in cooperation with Caritas. She works for example in the Women's Residential House which is run by Caritas and this shelter houses only female asylum seekers, both single women and women with children. Her role there is to talk with these migrant women about women's health in general and about pregnancy in particular. She speaks English, Zulu, Suto, Afrikaans, German and French.

Dr. med. Gerald Ressi
Gerald Ressi is a psychiatrist working at OMEGA. He works with asylum seekers and refugees, both on an individual base as well as with whole families. He has got broad knowledge of issues of communication among different cultures and between migrants and health and social service providers. He does this work both in his office at

OMEGA, as well as through the approach of outreach. In this way it is possible for him to go and see asylum seekers in their familiar surroundings, for example he goes to shelters where they live, to schools or to kindergartens. He speaks German, English, French, Serbo-Croatian and Russian.

Mag Christina Kraker-Kölbl

Christina Kraker-Kölbl is the woman who leads the Caritas Women's Residential House which was described above. She has been working in this shelter for five years.

Mag Elisabeth Huber-Kranz

Elisabeth Huber-Kranz is working for the Department for Child and Family of the City of Graz as an intercultural specialist and she works with migrant women on an individual basis. She supports the pregnant women living in the Caritas Women's Residential House. Mrs Huber-Kranz also works in cooperation with the EKiZ, where she is teaching in birth preparation classes and also working as a doula[a, 64]. She has been living with her husband in Africa for two and a half years, in the English spoken part of Cameroon. She speaks German, English, and French and due to her stay in Cameroon she is able to speak pidgin[b, 65] English as well. For the support of, for example, Chechen women she works with a translator.

Community interpreter and doula

A further key informant was a woman who had searched for asylum herself and then was given refugee status. Meanwhile this woman was employed by ISOP, working with asylum seeking women as community interpreter for Russian – passing her knowledge on to them. She is also employed by the EkiZ as a doula.

Acting head nurse Roswitha Kober

Mrs Roswitha Kober is the intermittent head nurse of the Clinic for Gynaecology and Obstetrics at the LKH in Graz.

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[a] "A *doula* is a non-medical assistant in prenatal care, childbirth and during the postpartum period."

[b] "A *pidgin* is a simplified language that develops as a means of communication between two or more groups who do not share a common language, in situations such as trade. Pidgins are not the native language of any speech community, but are instead learned as second languages"

Languages used for conduct of interviews

All, but one interview with the key informants was conducted in German, only the one with Nomawethu Kelbitsch was held in English.

6.2.2. Results of interviews with key informants

In this section the information obtained on the situation of pregnant asylum seeking women in Graz, as results of the interviews with the above presented key informants, is described.

6.2.2.1. General information on asylum seeking women – in particular on pregnant women

Information on women from the Women's Residential House

According to Kraker-Kölbl, were 2/3 of the women currently come from Africa and since the beginning of 2006 there were many arrivals of women from Eastern Europe.

The Women's Residential House is able to house around 40 women with their children, in total there are 60 places.

The estimation of Kraker-Kölbl is that there were on average 5-6 births per year by women from the shelter. Furthermore, a few years ago (she has been working in the house for 5 years) the women often arrived already pregnant to Austria, either having got pregnant in their homeland or during their flight to Austria, or in the case of some women through rape .This has changed and now many of the women are becoming pregnant with their second child.

The opinion of Kraker-Kölbl is that these women become pregnant for a range of reasons. These may include, beside the normal family planning, a lack of access to or knowledge of contraceptives, that it is an issue of status to have a child; it may also be due to financial reasons because they then get the monthly amount of € 150 also for each child, or a further reason may be the legal matter, getting a baby to secure their stay in Austria, that they think they would not be deported with a small child.

Kraker-Kölbl tells that the women often give their baby an African and an Austrian name, as a form of bridging the gap between the cultures. A further example is the name of a Chinese girl, "Anting", which means "born in Austria".

German language ability of the asylum seekers

The opinion of Kraker-Kölbl is that the German language ability is in general rather bad. Frequently translation is made using a co-inhabitant who is paid for this task.

The community interpreter has the impression that if the women want to learn the new language they do so. Some of them are not interested in learning it, they are alone at home with many children and their husband is often away. Further she thinks that the men might speak more German, although then they do not speak it very well.

Concerning Chechen people Ressi has the impression that the women speak better German than the men. He further said that the bigger part of the African people living in Graz is Anglophonic. Due to the same language system as German, the persons from Former Yugoslavia have less difficulty in learning German.

Huber-Kranz has made the experience that while working with the asylum seeking women it is essential to often repeat information already given. For example she repeats the information given by a doctor in perfect English, in a form of English, which is often easier for the women to understand, due to her stay in Cameroon.

Some information in particular on African women

Information was obtained on some traditions of the African women and also on the matter of being a single mother.

The church is the place in Graz, where the African women can celebrate their traditions. Ressi mentioned that there are 9 African Christian communities in Graz.

Kraker-Kölbl said that for the African people the woman is impure after birth and 40 days after delivery the community pray for the woman and the baby is blessed, sometimes in combination with the baptism of the baby.

Concerning their tradition of the large amount of visits to mother and newborn during the immediate post-natal period, the women often admit that it is too much for them, if their opinion is actually asked for concerning these visits. However, they cope with it because the visits are also associated with many presents and even money.

A myth is that one should not ask pregnant women about the due date of the baby – this brings bad luck!

In Africa single mothers do not exist in the same way as in Austria, in Africa they would get help from their extended family or the village community or a marriage partner would rather be found to support her.

Ignorance of Austrian society

These women are not always well informed about the Austrian society and their laws. For example Kraker-Kölbl reports that many women often think that the baby automatically becomes an Austrian citizen at birth; the women do not know that this is no longer the case in Austria, like for example in USA.

Many of the women come from countries with a patriarchal structure and a traditional role for the woman. A marriage in these countries might be on a financial base.

6.2.2.2. Social network and social support of asylum seeking women

Social network and family of the women

The social network between the women in the Women's Residential House is according to Kraker-Kölbl quite good; most of the women support each other. In particular the women from Eastern Europe have a good network in Graz, as they often come with part of the family to Austria. They have a well functioning community in Graz, where they can get support. For the African women the church plays the role as some kind of compensation for the lack of their own families.

Huber-Kranz also has the impression that most of the women support each other, although some are rather isolated.

Ressi suggested that also the persons from Chechnya have large communities in Graz. Another characteristic issue of Chechen people is that the talk very much, in this way a lot of information is passed on between this communities by word-of-mouth.

Concerning partners of the women from the Women's Residential House, Kraker-Kölbl said that to her knowledge some of the women have partners who are asylum seekers themselves living in another shelter or that the men live privately, where there is not enough room for a family. Other women keep their partner/father of the child anonymous. Kraker-Kölbl reported that in November 2006 there were 21 single mothers living in the House and of these only 3-4 had partners.

Social support

OMEGA and Zebra were mentioned by the key informants as organisations where they know that the women go for further support.

Caritas offers a special support for the older children of a pregnant woman who is about to deliver her next baby. A social worker organises a foster family for the older children for the time of the delivery and until the mother returns from hospital.

6.2.2.3. Health care and health information - in particular during pregnancy

Information concerning the health care system

Concerning the health care system in general in Austria Kraker-Kölbl said that the women think that the health care system of Austria is much safer than in their homeland. There is also the belief that for example the delivery through a caesarean would be very risky in their homeland.

Due to her position as an acting head nurse, Kober made some statements on the situation of care for pregnant asylum seeking women at the Clinic for Gynaecology and Obstetrics. For the staff of the LKH there is the possibility to attend the advanced training in "Transcultural Care" and it is an eight hours course. This training is not obligatory, however due to interest in the matter and the need for it at the clinic, the course is always booked up. In 2006 the training was offered four times.[66] Kober reported that 85% of the staff from the Clinic for Gynaecology and Obstetrics has already attended it.

Kober further mentioned a problem which sometimes occurs at the clinic, the lack of female gynaecologists on duty, due to the fact that many women prefer to be examined by a woman.

For their general health issues the asylum seeking women go to their family doctor.

Reproductive health related issues

MKP-examinations

The community interpreter said that for the MKP-examinations most of the women she works with prefer to go to the outpatient clinic of the LKH or the GKK due to a higher chance of getting a translator, compared to the likelihood of getting a translator at a gynaecologist's practice.

She further reported that many of the women did not know that they had to go and see a doctor before the 16th week of gestation, at least in order to be able to profit from the childcare benefit. The community interpreter tells them this fact and this helps to spread the information to other women through word-of-mouth.

In contrast Kraker-Kölbl said that many of the women living in the Women's Residential House would rather go to the "Marienambulanz" (see 2.4) and then with a referral to a gynaecologist's practice.

Birth preparation and information on the situation during labour

Huber-Kranz becomes informed about the pregnancy of a woman living in the Women's Residential House, and subsequently she contacts the woman. She offers individual birth preparation, gives information about the pregnancy, the coming labour as well as about baby care. She also helps to arrange appointments for the gynaecologist and if needed accompanies the pregnant women to assist them also as a translator. She keeps contact with the woman and assists her also with the baby care or with information on breast feeding up to three months after the birth of the baby. After this time the shelter staff has again the responsibility for the young mother and the baby. The pregnant women are always able to get in touch with Huber-Kranz by telephone.

Through the EKiZ in Graz it is possible to get in touch with a doula (see , page 34), who supports the pregnant woman and can give her advice, emotional support and provide answer to questions which may arise. The doulas are also known in Graz by word-of-mouth, as the migrant women often do not know about the EKiZ itself. It is not clear how many women there are in Graz, who were actually supported by a doula. The women who are working as doulas can often also speak other languages than German and in this way it is sometimes possible for the pregnant woman to get support in their mother tongue or in a language more familiar to their own, like Russian for women from the Former Soviet union. As a doula, Huber-Kranz also accompanies the woman to the labour in the hospital and she can also assist at home births.

For Kelbitsch it is clear that women she works with have a lack of knowledge of the labour – no ante-natal-classes and that they don't have the family support and knowledge of older women as they would have in their homeland. She also remarked that the women who are living in the Caritas Women's Residential House have the opportunity to get information from Huber-Kranz and herself, but women living privately have often no ante-natal class. Kelbitsch made the following statement: "I am very much concerned about the quality of pregnancy, labour, delivery and post delivery of migrant women."

Kelbitsch explained her work with the women and what she teaches them. For example she tells the women about minor complaints during pregnancy (such as morning illness), explains the signs of danger and when to see a doctor and gives them information on diet in pregnancy. It is also her role to explain the examinations the women need to undertake for the MKP-program during pregnancy.

Important information to pass on to the pregnant women is the explanation of the situation during labour; Kelbitsch focuses mostly on the situation in the maternity service of the LKH, as most women go there for delivery. For the potential case of a caesarean section for the delivery she also passes this knowledge on to the women.

The community interpreter described the situation of a young primipara (woman bearing first child), without any German knowledge, who delivered without any assistance of a translator. Such women feel alone, with much fear and stress and a lot of pain and due to these circumstances they are not really able to cooperate, which results in a difficult labour.
The impression of Huber-Kranz is that the caesarean rate among African women lies above the average in Austria. According to Kraker-Kölbl and Kelbitsch the issue of delivering a baby with a caesarean section is taboo in the Women's Residential House.

The fact that the father can accompany the woman to the labour is not evident to all women. The community interpreter mentioned that this is not common within Islam. In Chechnya the men do not even come to visit the mother and the newborn in the hospital, the father first sees the baby only at home. Ressi spoke about the fact that in Chechnya the men are taboo during pregnancy, they bring bad luck. However the information that this is possible in Austria is getting around to the migrants in Graz and the men are more frequently coming to visit the women, and some fathers even wait outside the maternity room during birth.

Issue of family planning
With regard to contraception and whether the pregnancies are planned in general or not. Being such private matters the questions are difficult to really answer; therefore it is only possible to estimate the use of contraceptives. However Huber-Kranz reported that the issue of contraception is discussed with the women if needed.
In matters of contraception, the community interpreter said that contraceptives are not always used by the women she works with. There is often a desire to have many children, in particular their husbands want a big family and the women then listen to them. Although, most of these women want to have more than 2 children themselves, rather 4 or 5 children.
On this issue and also related to unplanned pregnancies Kraker-Kölbl and Kelbitsch reported that the women have to pay for contraceptives themselves and that these women may not have enough money to pay for it. Further, Kelbitsch also pointed out that even if they use contraceptives, they might not know how to use it properly.

Moreover Kraker-Kölbl mentioned that in the year 2006 there were 4 abortions from women living in the Women's Residential House. Before the abortion is done every woman has to see a team from the for Family Planning Counseling Service at the Clinic for Gynaecology and Obstetrics of the LKH, where they are informed about contraception, the intervention itself and the cost for the abortion. Kraker-Kölbl and Kelbitsch both mentioned that in Nigeria there exists not the same barrier and it is possible to go to the pharmacy and buy a pill for abortion. Kraker-Kölbl also said that in the case of an unplanned pregnancy these women would not put the child up for adoption after birth.

The staff of the Caritas Women's Residential House hopes that the information on for example MKP-examinatons (see *MKP-examinations* in this section) during the pregnancy and also on abortion has a multiplicatory effect - that other women get this information through word-of-mouth.

Health behaviour

Key informants were also asked about the health behaviour of the women during pregnancy, including balanced and healthy diet. These are personal lifestyles, which are very difficult to change. Women living in shelters often get prepared meals or food to cook on their own, in which case it is difficult for them to choose the food themselves. The community interpreter/doula tries to remind them often of the importance of healthy food. It is important for a pregnant woman to maintain an adequate level of iron, however the intercultural interpreter/doula said that every second woman she supports has got anaemia due to the lack of iron.

On the matter of diet Kelbitsch pointed out that the habit of eating raw food is not common in Africa due to the high risk for infections. Therefore eating salad is the worst for these women – one cannot cook it! She also explained that many women look down on a person who tells them what they should eat.

However Kelbitsch explains to the women that the intake of fruit and legumes is very important, in particular during pregnancy. Therefore she proposes to them what they can eat and how to prepare it.

Another interesting fact is that many of the African women are eating "pica" a kind of soil from Africa, which they buy in African shops in Graz or obtain it from someone who had brought it directly from Africa. The women eat this "pica" to get minerals. Kelbitsch is very precise in explaining to the women that this might be bad for their state of health – 20% of what they get through this "pica" might be good, the other 80% is bad. It reduces the iron uptake and there is also the risk of tetanus.

6.2.3. Conduct of interviews with pregnant women

In all there were eight women identified, who met the criteria mentioned in 5.2.2. Identification of respondents from the target group was made through suggestion from the key informants.
It was the intention of the researcher to do one more interview, but due to special circumstances, which are described below, this one was not finished.

6.2.3.1. Time and place for interviews with pregnant women

After identification of potential respondents from the target group, the key informants contacted these women to ask if they would agree to take part in the study. If the answer was yes, an appointment was made or the women were told that the researcher would contact them for an interview appointment.

All interviews were conducted during the day, except one, which was held in the evening. The duration of the interviews was between 25 minutes and one hour.
In four cases the interview took place in the woman's own room in the shelter.
Another two interviews were held in the office of OMEGA, with the help of a translator.
One interview was done at the maternity outpatient clinic of the LKH Graz, while the monitoring of the foetal heart beat was monitored through the cardiotocograph.
The last interview took place in the kitchen of the private apartment of this woman. The radio was on and the older child was playing.

An additional interview, interview number nine, was not finished. It was begun in the in the maternity outpatient clinic of the LKH Graz, where the woman and her translator were waiting to see a doctor for an examination of the woman. However, the woman gave a rather nervous impression and she had also another examination to do. Due to these circumstances the decision was made to break off the interview after the first few questions.
Many of these interviews were conducted in the company of the women's children, which frequently broke the line of the discussion.

6.2.3.2. Linguistic aspects of interviews with pregnant women

As expected the interviews were conducted in different languages, the special circumstances are described below.

Two of the women spoke enough German to be able to conduct the interview in German. One of these women had preferred to have a translator, but as she wanted to call for one, the personnel from the shelter convinced her that her German was good enough – and then it was possible to work through every question, it just took more time. The other woman spoke very good German. One of these women came from Serbia-Montenegro and the other one from Moldavia.

For three interviews there was the need for an interpreter, who translated from German into Russian – in two cases the women spoke only some single words in German to the researcher. The third respondent spoke quite good German but still there was often the need to translate some questions and words into Russian.

A woman working at OMEGA who is fluent in German and Russian translated for two of these interviews. For the third interview as well as for the one that was not finished it was the community interpreter, the key informant presented above, who translated. During the interview with her, she had offered her help. All three of these respondents were from the Russian Federation.

Due to the English and French language ability of the researcher, two interviews were done in English and one in French. Both of these respondents were from Africa.

6.2.3.3. Interview guideline for the interviews with pregnant women

After the interviews with the key informants it was possible to further develop the interview guide for the coming more intensive interviews with the women from the target group. Overall the guideline included seven main questions or categories with several sub questions. (See Appendix)

6.2.4. Results of interviews with pregnant women

During analysis the total of 330 identified statements were then sorted into 6 main categories and 13 subcategories by grouping meaningful answers or statements into cohesive groups based on both the interview guideline as well as new categories which arose during analysis.

In all, 318 of the 330 statements could be categorized into the closed system of 6 open categories and 12 statements were classified extras dealing with “other” pregnancy issues which did not fall into the mentioned categories.

CATEGORIES	Number of statements	Total number of statements
1.PERSONAL CIRCUMSTANCES		**131**
A Personal data	32	
B Pregnancy related health issues	4	
C Literacy – education:	13	
D Arrival in Austria and asylum matters	20	
E Accommodation and finances	23	
F German language capacity and attendance of courses	39	
2. SOCIAL NETWORK	29	**29**
3. SOCIAL SUPPORT	27	**27**
4. HEALTH ACCESS AND HEALTH INFORMATION		**88**
A access to health care	46	
B health information	21	
C information about pregnancy	21	

5. HEALTH BELIEF AND HEALTH BEHAVIOUR		**33**
A adverse substances	7	
B nutrition and changes in nutrition	12	
C exercises	5	
D issues concerning the newborn	9	
6. Being a pregnant asylum seeker	10	**10**
"OTHER"	12	**12**
		330

Table 9: The categories used during the analysis of the interviews with the pregnant women and the number of statements which were made concerning each category

In the section of the results of the interviews with the pregnant women, Elisabeth Huber-Kranz and Nomawethu Kelbitsch are only referred to as Elisabeth and Noma – as this is also what the women call them, when talking about them during the interviews.

6.2.4.1. Personal circumstances

Personal data

As described above the total number of interviews with women from the target group was eight. There was the opportunity to talk with four women from the former Soviet republics, including one from Moldavia, two from the Chechen Republic (Chechnya), and one from the Republic of Dagestan, the two latter are parts of the Russian Federation (Russia). Furthermore it was possible to talk with three women from Africa, including two from Nigeria and one from Togo. The last woman was from the former Yugoslavia, from Serbia-Montenegro. The women were between 24 and 32 years of age. Concerning the religion of these women it was not asked for their specific denomination, however three of them were Christian and four were Moslem.

Pregnancy related health issues

All women, but two, were pregnant at the time of the interview. One baby was three and the other one was nine months old. This pregnancy was for all women at least the second one. For five of the women this was even the second pregnancy and childbirth in Austria – one of them came advanced in pregnancy to Graz and delivered shortly after arrival.

One woman reported about a pain in the thigh during both pregnancies, the pain was relieved through massages and therapy and then the pain disappeared after each delivery. Two women reported morning sickness. Only one woman said that her swollen legs during this pregnancy period hindered her from walking around much.

Arrival in Austria and asylum matters

The women arrived in Austria between 2002 and 2006. Three of them came alone to Graz; one out of these was pregnant on arrival. One woman came with her baby. The other four came with their husband, and two of these women also with older children.

Seven of these eight women were asylum seeker, only one had already received a positive asylum decision. This fact was learned only during the interview; therefore this interview was still included in this study, as this woman was an asylum seeker when she was pregnant with her first baby.

Accommodation and finances

The current accommodation for these women was for all of them, but two, an organised shelter run by Caritas (two different shelters in Graz). The other two lived privately with their families. All of them cook their own food, the women living in an apartment in their own kitchen and the women accommodated in a shelter cook either directly in their room or in a common kitchen.

According to the Basic Welfare Support Agreement that was described under 2.3, the asylum seekers receive a certain amount of money each month. All the women living in the organised accommodations reported that they get €150 per person (also for each child) every month. Those living in a private accommodation with their family get money for accommodation and food, the exact amount of money was not mentioned, however the maximum amounts are outlined in the section 2.3. The family of the woman with the positive asylum decision, where the father had a normal job, had his salary, the family allowance [67] (which is from € 105.40 per month and child, depending on the age of the child) as well as the childcare benefit (which is €14.53 per day, about € 436.00 per month).

Literacy level – education

The literacy level plays an important role in the life of every person. To have a rough estimation it was decided to ask how many years they had attended school or if they had learned any profession. Furthermore there was the request if they had worked in their home country before they left.

The education of these women ranged from only 8-10 years of school till having a university degree. Six of the women had previously worked. They had professions ranging from working as a vendor or secretary till having a university degree. One of them said that she had no further education after school due to lack of money, because her parents died. Two women had not worked before the flight from their homeland.

German language ability and attendance of German courses

Speaking the language of the country one lives in makes daily life much easier. Language barriers are clearly identified as a problem for migrant communities. Therefore an attempt was made to estimate how much German the women speak. However, due to the fact that many interviews were conducted in a language other than German the women were asked for their own estimation of their ability to speak German. In addition they were asked if it is important to them to learn this new language. Therefore one question enquired whether they had attended a German course or if they intended to attend a course in the future.

All of the women said that they think it is important to learn German.

Of the eight interviews, two interviews were conducted in German. One woman had difficulties, and actually wanted to have a translator, but was encouraged by shelter staff to manage without, it was however necessary to repeat and paraphrase many words. The second woman spoke German very fluently with only some mistakes. A third interview was essentially conducted in German, as the translator who was present, was not needed for translation the whole time and many words were paraphrased.

The woman who spoke German fluently was also the one who pointed out that it was very difficult to understand all of the different dialects that are spoken in Austria – that it is often not enough to understand the German language alone.

In those cases where the interviews were conducted in a language other than German, the women were asked for their own estimation of their knowledge of German. They all answered that it is easier for them to understand German than to speak it and that they

only speak a little –enough to be able to buy food for example. They said that it is difficult to ask more detailed question for example at a medical appointment. Then they all prefer to have a translator if possible, or they try to speak English instead.

Looking to the attendance of a German course the situation was rather differing. Only three of these women had not been to a German course. On the other hand it was only two of the five that had continued to attend the course/s. The following organisations were mentioned when they were asked to tell where they had attended the course: OMEGA, ISOP and DANAIDA.

The woman who spoke the most fluent German had attended three courses and was one of the women who lived privately. The second woman, with whom the interview was conducted in German, had attended two courses, however she stopped going to the first course after four months and the second course she stopped going to after two months. She preferred not to conduct the interview in German, so in this case it was not possible to estimate how good her German actually is.

The other three women quit their course after only 2-4 weeks due to either that the baby was crying, or that the class started too early in the morning when the small baby had not slept well during the night, or due to pregnancy complaints. Two of these women want to attend a course as soon as the children are big enough to go to kindergarten or other childcare. The last woman had learned German just by listening to others.

Concerning the three women who have not attended any German class, one woman had planned to attend a course but as she got pregnant she decided to wait. She is now going to start the class shortly after the delivering of her baby. In the meantime she has tried to learn German only by listening.

The other two women want to wait before starting a German course till their children are bigger.

Two of the women also mentioned that their husbands speak a little German, one of them even better than the woman herself.

Report of incident

Being asked if any problems had arisen due to language difficulties, one of the women first denied this, but then she spoke about the linguistic barrier and told of her experiences at the LKH. “That is the most thing that make me to change, because it is not the doctor that controls you this month that will control you next month”. Her opinion was that there was no real continuity of care. Talking about the staff of the Clinic for Obstetrics of the LKH, she said: “some of them that they looked at you, that you have

been here for years, they will say to you: “You do sprechen Deutsch, nix English” (the woman laughed). They will be speaking Deutsch to you. They will not like to communicate with English. So I’m not really happy. That’s why I wanted to change.”
She pointed out the situation when she went to collect her Mother-Child-Pass: A female doctor was speaking German to her. The woman asked: ”Can you please come with English?” “No”, answered the doctor, saying that she does not know English (even if the woman had heard her speaking good English). “So she was communicating with Deutsch. Asking questions and marking things in my Mutter-Kind-Pass”. And so she said to her: “What if I can’t understand?” - but the doctor did not care, just continued in German and marked things in the Mutter-Kind-Pass. “So she …throw the Mutter-Kind-Pass that I should take it. That is I stopped going to….” Due to these experiences the woman changed from seeing a gynaecologist at the LKH to a doctor in private practice. At this point it has to be added that the same woman also said: “I really love Austria, anyway I’m enjoying it.”

6.2.4.2. Further health determinants

It was not always possible to make a clear border between social network and social support, however concerning social network there is a focus more on informal networks such as family, friends and broader ethnic communities. Social support refers more to formal support.

Social network

All asylum seekers have lost most of their familiar social network. Many of these women have come to Austria alone, some with their family as was mentioned above in this section (see *Arrival in Austria and asylum matters)*. They had to leave parents, brothers, sisters as well as their friends. One of these women had even left an older child back home.
In general asylum seekers often have to make new friends in Graz. In some cases they do already have relatives in Graz or some family members join them later.

To be able to get to know more about the personal situation of respondents they were asked about their social network in Graz. For example if there are any family members or other relatives living in Graz, as well as whether they are in contact with their family back home. Further questions inquired about their friends, if they have friends that they had known before they came to Graz or if their friends included mostly people they had got to know in Graz. It was also interesting to know if there were Austrians among

these friends. They were moreover asked whether friendships are predominantly within the shelter or whether there is a special community in Graz they belong to. Other questions inquired about what resources they can rely on - to whom they turn to if they need some kind of help or support.

All the women but one are in contact with their family back home. Five of the eight women came with at least one family member to Graz. Only in one case did some relatives arrive later on in Graz.
Five of the women said that they have friends within the shelter; one woman even lives next to her relatives. Most of them also have friends who are living privately in Graz. Two of the African women meet other African friends at least every Sunday in church. One African woman said that she has friends from her country and that they sometimes cook their original food for each other.
In general, the women have friends from their own homeland or at least the friends come from a country which has a language which is also familiar to the women or they have a second language in common, such as Russian for the people from the former Soviet republics.
Only one of the women gave the impression that she does not have many friends –she just mentioned one other woman who lives outside the shelter. She also said that she had had more contacts to the other asylum seekers in the former shelter she lived in before, compared to her current accommodation.

Respondents were asked if they for example could ask one of their friends to look after their children. This did not seem to be that usual, only for the woman who is living in a shelter with her family was it possible to ask her relatives living in the same shelter to help them with babysitting. In two other families it was the father who looked after the children. For the other women child care, through help from their friends, was rarely possible.

Some women asked if financial help was meant when the question arose of who the persons were that they could turn to for help. Only for one woman this was actually the case, that she got money from friends. This woman said that she had an asylum problem and she got a lot of help from her friends at church, that they pray for her but also offer financial help to pay for her lawyer. She spoke also about an asylum problem concerning her newborn baby, she should have searched for asylum directly after the birth in Austria, but she did not, as she did not know that she had to and nobody had told her to do so.

It is not very usual for the women to have Austrian friends. Only two of the women said that they can call 2-3 Austrians their friends; one of these women is living privately. The other women may know other Austrians, but they do not refer to them as close as a friend. On the other hand one woman said: “She is like a family member”, talking about Elisabeth.

Social support

Asylum seeking women have to get used to completely new surroundings and systems of the new society they are living in. Are they aware of what kind of social support they can get? Respondents were therefore asked which organisations they know in Graz and if they have visited these organisations or if they just know that they exist. Secondly, they were asked from whom do they get support and in what form?

There are a range of organisations to help asylum seekers in Graz, which were described in section 2.4. All women but two live in shelters in Graz run by Caritas. The question of who would look after her bigger child during the labour and subsequently her stay in the hospital, made one woman very worried. Then she spoke to the staff of the shelter and they confirmed that someone would care for the child (described in section 6.2.2.2) and then the woman was very relieved.
Only one of the women used the Caritas pre-birth counselling for pregnant women. One of the women who lived privately said that she knows that there is also a counselling service with i.e. legal advice, also run by Caritas.

The women can also get second hand clothes through Caritas. One woman just pointed out that the distribution of these clothes is not well organised – it is done by the principle first come, first served. It is not announced beforehand and she only knows about the distribution from word of mouth, but the clothes are gone very quickly after they are deposited at the reception of the shelter.
OMEGA is an organisation that all of these women know about. All but two of the women have also visited this center. The husband of a further woman has used the service offered by OMEGA, but not the woman herself.
Zebra is known by seven of the eight women, all of whom have been there for assistance. They got help in asylum matters. One woman told me that her husband goes to Zebra if he receives papers that he cannot understand himself.
Another two organisations were also mentioned: ISOP and DANAIDA, as well as the “Marienambulanz”.

The woman who speaks good German and who lives privately said that after four years in she Graz tries to solve all problems herself.

Access to health care and health information

This could be described as a part of health literacy. “Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.” [68] It would go beyond the scope of this thesis to go into detail concerning health literacy. Health literacy in ones own mother tongue within a familiar health care system can be limited enough, but in a foreign country, often with a foreign culture, a foreign language and a new system to negotiate it is even more difficult.

In the interviews the women were asked about the Austrian health care system. In this way it was attempted to find out the knowledge of the women about this system, as well as their access to it and how they got this knowledge. Where and whom do the women ask if they need information concerning health services, where do they go if they are sick? Do they have one specific general practitioner – a family doctor that they always go to?

The women obtained their knowledge about the Austrian health system mostly through word-of-mouth information from other migrants, the newcomers are told where to go and what to do by the persons who have been longer in Austria. All of the women are now seeing a family doctor when a health issue arises.

The “Marienambulanz” is known by almost all the women; only in two cases was it not possible to determine whether or not they knew of it, due to communication difficulties. Most of the women had been there as patients in the beginning when they came to Graz, only one said that she had always had a family doctor. The woman who had already lived in Graz for four years even said that she still goes to the “Marienambulanz” sometimes just to see and talk with the personnel, as she had become friends with them.

It was important to know whether and where the women went for the regular medical controls associated with pregnancy, the MKP-examinations. For this reason respondents were also asked if there is a special paediatrician they go to see with their older children.

The medical supervision throughout the pregnancy was secured for all women I talked with. The MKP- examinations were done in some various locations. More than half of them, five women, went to the outpatient Clinic for Obstetrics of the LKH in Graz for the controls. Two women went to a gynaecologist's practice and the last woman went to see a doctor at the outpatient clinic of the GKK.

For the older children of all the respondents but one a paediatricians' practice had been chosen; only one of the mothers goes with her older child to the paediatric clinic of the LKH when a health problem occurs.

Some of the women made general statements about the health care system in Austria. The woman from the Republic of Dagestan is very pleased with the medical system as it is better than in her country. The Moldavian woman said that she had not been to the doctor in Moldavia as often as in Austria and she is also very pleased with the system and that it is possible to choose which doctor one wants to go to.

Information on health

Respondents were also asked a range of questions concerning health information. Where is it possible for these women to get health information and in what form? In what way is there a language barrier in this matter? It was not a self-evident issue to explain to the women, they often did not know what was meant with "health information" and what exactly was wanted.

Most women said that they never take any information leaflets at the hospital or at a doctor's practice because they do not understand enough German. Many do not even know that there is information in that form to get. Clearly, it was never expected by them that information leaflets might be available in their mother tongue or other languages that would be easier to understand.
The women also reported about the information they got from Elisabeth and Noma.

One woman who is living privately now talked about the time when she was living in a shelter. There they had regular information meetings with a translator, or specific days when they all could go to the "Marienambulanz". Over time she had learned how everything works.

Information about pregnancy and coming labour including conditions in their homeland

The respondents were asked from whom/where they got the information about pregnancy and the coming labour and also if they had attended a prenatal class.

The women had got their knowledge about the pregnancy and the childbirth in different ways. Some had talked with friends or relatives who had been pregnant. One woman said that she had called her own mother back home during her first pregnancy and for this second one she read books on the topic.

Four of the women told me that they were informed about pregnancy and the labour by Elisabeth and Noma, in this way they received an individual birth preparation. They could always ask these two women for help or explanations, including the examinations included in the Mother-Child-Pass. As mentioned earlier in section 6.2.1, two of the key informants also worked as doulas with pregnant women. Therefore, two of the women obtained information as needed, from their doula.

None of the women had attended an organised prenatal class in Graz. Some didn't even know that such a class existed. Naturally, there was the problem of the language barrier and further the fact that payment is required in general classes.

By including the question of whether there are prenatal classes in their homeland it was possible to get to know something about the situation of pregnant women in some of the countries of origin. In Chechnya, there is no birth preparation offered to women, but in Moldavia it exists. Furthermore, in Chechnya it is a taboo to talk about pregnancy and labour at all and in the Republic of Dagestan one does not talk about it either. Concerning existing ante natal classes in Nigeria one woman knew of such a class, the other did not.

One woman was afraid of her second labour because she had experienced a relatively easy first delivery. She was not afraid in advance for the first labour, because she did not know what she should expect.

One of the women talked about the labour of her first child. The staff at the LKH Graz was impressed that she, as she was young, was so well prepared for her first delivery. Her knowledge was gained in a project developed for foreign pregnant women in Graz. She had had the opportunity to be the first woman included in this project. It involved the provision of a translator for the foreign women, to be able to undertake a birth preparation course at the EKiZ to learn about the birth, how to breathe as well as exercises for pregnant women. This translator had a certain amount of hours to help

the woman prepare; she could also accompany her to medical appointments and to the labour itself. In the end, the woman managed through the childbirth herself, without speaking much German, as it was a rather short delivery, being the first one. Her translator, who had been informed about the labour, came 5 or 6 minutes after the child was born.

In Austria, it has become almost expected that for Austrians, the father-to-be accompanies the woman to the labour. Therefore it was interesting to know what these women think and if they are aware that it is possible in Austria to be accompanied by the husband or a friend. How had they managed this matter for the first labour? What were they planning to do - who might join them for the coming labour?
As almost expected there was no common answer to this matter. In Chechnya the father has no legal right to accompany the woman. Although a Chechen woman said that her husband may join her here in Graz, otherwise her doula would join her. Two other women went alone for one of the previous labours and with a friend to the other labour. The women who have a doula will be accompanied by her.

Report of incidence
The lack of understanding that can occur due to missing German language knowledge is exemplified below.
One woman told about her first labour when her husband suddenly came into the maternity room, even if this was not agreed before. “What are you doing here?” she asked. “I don’t know” he said. She thinks that her husband was asked by the staff in German if he wanted to join his wife and that he answered yes without really understanding the question. He then went to wait outside again.

Health belief and health behaviour
The following questions guided this part of the interview. “What do you do to stay healthy?” Or: “What is important for a healthy pregnancy as well as a healthy baby?” However, this was an issue that was difficult to explain to the women, they did not really understand the term “health belief”.
Are there any changes in the health behaviour during the pregnancy?

Importance of exercises during the pregnancy
None of the women went to some kind of special gymnastics for pregnant women, due to lack of information about such courses and also lack of money. They were aware

that it is good to get exercise, talking walks. One of the doulas also gave the women some exercises to do during pregnancy and told them to walk much during the day.

Adverse health substances

Further, it was enquired if the women were aware of any substances that would adversely affect their child or themselves during pregnancy. Not drinking alcohol and not to smoke were the answers. One said that she had stopped smoking when she became pregnant. All of them were informed that they should not eat raw meat and should stay away from cats. They had learned this from the doctor, a friend or in school and from the media.

Nutrition and changes in nutrition

Nutrition is a very important factor for the mother-to-be. Information about nutrition was provided to four of the women by Elisabeth and Noma. Elisabeth also teaches the women how to cook later on for the babies.

Concerning nutrition during the pregnancy the women also gained information from others. In two cases a doctor told them to eat and cook with less fat. On nutrition the doulas also gave information. The women try to eat healthy and to eat more fruit and vegetables than usual, or to drink more fresh milk or eat more meat. The importance of drinking more frequently was also pointed out by Elisabeth said one African woman.

Almost all of the women said that they had changed their nutrition in some way after getting pregnant. One woman asked Elisabeth herself what to eat to have rich and good breast milk.

A Chechen woman was glad that she could reflect on and then decide what is good for her and the unborn baby, in contrast to the situation in Chechnya, where she just ate what she could get during the war, with no possibility to choose.

Issues concerning the newborn

For the newborn baby the evidence clearly supports breastfeeding as the preferred option during the first months of life. What is the opinion of these women? All the interviewed women breastfed their older children and they were planning also to breastfeed the baby they are currently carrying. One of the women made a remark concerning the napkins for the baby – she had read about it and was thinking about using fabric napkins because these napkins would be better for the skin of the baby and she knew about the possibility of receiving financial support, from the City of Graz, to buy them.

6.2.4.3. Being an asylum seeker and pregnant in Graz – personal statements

At this point some examples from the experiences of the women in their own words are presented. As can be read below, the most frequently mentioned problems are of a communicational matter – the language barrier.

Positive statements

A woman from the former Soviet republics: “No problems being a pregnant asylum seeker”, on the contrary she is very pleased, especially with the examinations in the LKH. At home the medical status was very bad.”

Talking about herself: “There is no difference being asylum seeker or Austrian and pregnant” but she added that she had heard from other foreign women that they had been treated differently to Austrians.

“The lord is my strength”, said one African woman.

“Dieu merci pour sociale”, ”je suis bien encadré de Caritas” and “tous cela je ne sais pas comment remercier” – I quote her in French and she thanks God for the social support and assures that she is well attended by Caritas and she does not know how to thank them for everything.

Only a few days before delivery a Chechen woman said to me: “Thank God there were no problems; friends told me where to go. There was only the language barrier. Luckily no problems, I only wish to have a healthy baby.” This woman had lived in fear, because of the Chechen war, during her earlier pregnancies.

Linguistic barrier

“The problem is only the language – it’s the only problem I have” – the statement of an African woman. She felt that she was treated like an Austrian, not like a foreigner, she felt good in the LKH.

One of the women was talking much about pain as the first delivery (in her country) had been very painful due to an episiotomy[c, 69] done without local anesthetics. This is the reason why she is afraid of the coming labour. It seemed that she had not been able to solve this problem or find a solution for it yet. This is also related to the communication problem due to lack of German ability; she might not have understood what the doctor or medical staff had explained to her. She further spoke of what her friends had told her on this issue. Although more details were sought during the interview, no more were obtained as there was the language barrier; her German was not very good.

[c] *Episiotomy* is a surgical incision through the perineum made to enlarge the vagina and assist childbirth and it is performed under local anesthetics and is sutured closed after delivery.

7. Discussion

The aim of this thesis was to provide more insight into the experiences and support of asylum seeking women in Graz at the time of pregnancy by examining a range of health determinants over this period. The hypothesis to be investigated was that there is too little support during the pregnancy of asylum seeking women in Graz. In order to be able to get a better picture of the situation of the pregnant asylum seeker in Graz it was essential also to know how many female asylum seekers there are in relation to the whole population of Graz. Therefore the hypothesis was explored through these two research questions: 1) What demographic and statistical data is available concerning asylum seeking women in Graz and the number of asylum seeking women who have given birth in Graz during the year 2006? 2) What is the current situation as seen by the target group regarding the experience of and support during pregnancy in Graz?

One limitation of this study might be considered to be the fact that I am a physician, with a Western perspective and without deeper knowledge about the different cultural groups within the target group. However the issue of migration is very important and interesting to me. As a Swedish woman, I came to Graz in 1988; I have some kind of insight into the perspective of the target group. The situation of being new in Austria, having difficulties learning German and getting to know the new society with its own systems - although without having legal difficulties and restrictions associated with the search for asylum.

The chosen method to explore this situation of pregnant asylum seeking women in Graz was to conduct individual interviews first with key informants and subsequently in particular with respondents from the target group. As it was not possible to cover all nationalities of asylum seekers living in Graz in this thesis it was decided to obtain deeper information from a smaller range of cultures. This resulted in eight interviews with women from three different regions: Africa, the former Soviet republics and former Yugoslavia.

The statistical results in combination with the results of the interviews made it possible to get a rough overview of the situation of pregnant asylum seekers in Graz. Through the interviews with the key informants it was possible to obtain a broader picture of the

situation and the more intensive interviews with respondents from the target group gave a more detailed view.

Statistical results

To start with the results of the first research question it was in the beginning only possible to obtain the figures for foreign inhabitants in general and not for asylum seekers in particular. The total number of registered persons living in Graz on the 31.08.2006[15] was 248.525 and of these 32.824 were foreign inhabitants (15001 women), of whom 24.775 came from outside the EU and 11045 of them, were women. Subsequently the required data was obtained, there were 519[60] asylum seeking women and in total 1660 asylum seekers in Graz in April 2007. Concerning the number of births by asylum seeking women in Graz for the year 2006 it was only possible to obtain the number of foreign citizens, who gave birth, regardless of their legal status. In the year 2006 there were 3492 births in Graz, 507 of these babies had a foreign citizenship. Based on these statistics one can estimate that there were 15-25 births by asylum seeking women in Graz during the year 2006. However, it was not possible to obtain precise statistics on asylum seekers only.

Potential bias in the identification of respondents

The method to identify interview partners from the target group was to use the knowledge of the key informants. This might be seen as a potential bias as the choice of pregnant women was consequently not random. This bias would be that women who have reasonable access to support (at least to key informants) were included in this study. On the other hand, it was assumed that there would not be a very large number of pregnant asylum seeking women at the time for inclusion in the study. As mentioned above the estimation of the number of births by asylum seeking women for the year 2006 was 15-25. A further potential bias could be that all women but two lived in organised accommodation during the time of the interview; only two women lived in a private apartment with their families. This bias is similar to the one mentioned above, the situation of lodging implies that the women living in organised accommodation may have a higher level of possible contacts to carers and the access for the women to support during pregnancy may be easier compared to women without this additional form of support, which is presumed to be available at organised accommodation. On the other hand, it is also possible that women living within the organised shelters make use of services most easily accessible to them (such as professionals visiting the centres) and may therefore be aware of or interested in broader opportunities for support.

Discussion of interview results

The experience of the pregnancy period of these women was overall described in positive terms. However, the weak points in terms of the experience of these women and the support for pregnant asylum seekers in Graz are outlined below.

Language barrier

The language barrier was mentioned by all women; this barrier still causes or caused a problem for them in their daily life in Graz.

The importance of communication is not really realised until the communication fails. Nonverbal communication, such as empathy, eye contact, mimic, inflexion and body language influences the communication and is even more important when the verbal communication is not as expected.

Each culture is characterised through a specific attitude, patterns of thought, valuations and language. The risk for a stereotypic definition of a culture is higher when communication problems occur. The relationship between a patient, who has a problem with the language, and the doctor, is better as soon as a translator is present. The qualification of a translator should include not only the ability in languages, but also the two different cultures concerned and also have some knowledge about the special field he or she is working in. The translator should tell the whole information and do so in an impartial and neutral way. Working in the medical field means that the translator also has to maintain confidentiality. This is the reason why neither a child, the husband nor a close friend should translate. [70]

The linguistic barrier was mentioned also as a practical barrier of access to health care in the comparative study on health care for asylum seekers in EU25 done by the University of Copenhagen. (see section 3.1) The language difficulty was also an issue within the report “Intercultural Competence in the Health Care System” of the Austrian Ministry for Health and Women. In this report the need for more translators, who also have knowledge about different cultures, was clearly identified. Moreover the focus on improved communication was in particular claimed for gynaecological and obstetrics patients. The need for more translators was also discussed by David and Borde. These authors further identified the need for more information material for female migrants, which should be in the respective mother tongue, both in written form as well as audiovisual information for those with lower literacy.

Courses – ability to attend – childcare possibilities

The issue of attending German courses was often mentioned in combination with the problem of childcare. For all of the women who planned to wait until they would attend a German course, the reason for their reluctance was that they wanted to wait till their children were big enough to be in a regular form of childcare. In most cases this seemed to be kindergarten at the age of three years. Courses including childcare may not be generally available (although this is offered for German courses at DANAIDA), or may not exist in an adequate number or they are not known by the women. There seems to be a clear need for formal and informal childcare for these women, in particular for those women having children below three years of age. One woman from the Women's Residential House said that someone played with her children two or three hours every week. However, among the women the informal childcare was not common; they could in general not ask a friend to look after their children.

It is important to give the women information about all possibilities of childcare that already are available. In the case of lacking childcare there are innovative approaches needed to facilitate the attendance of courses for migrant women in general, whether German courses, health education sessions or courses in particular for pregnant women such as antenatal classes. One innovative approach could for example be in offering courses in settings where these women go regularly; this could be an approach of binding the language and the culture, that the women feel safe if they are in familiar surroundings, with their own language and culture. To be even more effective, the offer of parallel childcare would be valuable.

Furthermore language plays a role in limiting the attendance at other courses other than German classes. Prenatal classes in German may be known to the women, but due to their perceived poor knowledge of German this is a reason not to attend the class. In the project "Nuremberg's Model for Antenatal Care for Pregnant Migrants" [42] which had the purpose of offering antenatal care in women's mother tongue, it was shown that the number of participants in the antenatal care programme increased as a result of this intervention. When this project started, very few pregnant migrants came to the antenatal classes, which were offered in Polish and Turkish. Two years later the classes were overfull and from that time onwards, one class was regularly offered in Turkish. A further project where the effort of offering information in the mother tongue of migrants showed a high attendance was the project of FEM Süd "Birth preparation for Turkish speaking pregnant women". This was organised as a monthly open meeting for prenatal information in Turkish.

Another reason that can have an impact on the attendance of a course is simply the fact that the women do not know about existing courses, for example a general antenatal class. Further, it may be that their financial situation might not allow them to attend, in that in Graz, a general antenatal class often requires payment.

Courses versus individual support

It is a fact that none of the interviewed women had attended an organised prenatal class in Graz. However they had been able to obtain information in an individual way, through Elisabeth Huber-Kranz, Nomawethu Kelbitsch or a doula. It was shown in different forms how valuable the individual approach can be to the women. For example the accompaniment of a doula to the labour gives the women a sense of security. In the project from EKiZ, in which one of the women had the opportunity to participate, the women received individual prebirth-information in combination with a translator. This is an example of a specially tailored and highly individualised support, which had a good outcome for the woman. The fact that the woman was so well prepared for her first labour was also positive remarked by the staff of the maternity service of the LKH.

There might be many reasons why targeted (and free) individual support works well. This could be due to the issue of childcare, language difficulties or lack of money, as discussed above. An important factor why the individual approach works well may be that the women have found trust in the person supporting or educating them. This approach seems to work very well; there might be a greater need for this innovative way to work with these pregnant women.

Access to antenatal care – late access or under-utilisation of antenatal care

Regardless of the fact that the medical supervision during pregnancy was secured for all respondents from the target group the doula reported about many women that did not know that they had to go and see a doctor before the 16th week of gestation, at least in order to be able to profit from the childcare benefit. She informs these women about the importance of seeing a doctor and it also spread to other women through word-of-mouth.

A report from July 2007 concerning pregnant migrant women in London describes the lack of access to antenatal care. Médecins du Monde, set up a clinic in London in 2006 due to concerns that some people were not entitled to care by the National Health Service (NHS). In particular pregnant migrant women, who are identified as a group with special needs, were at risk. However 44% of the pregnant women who attended

the clinic were at least in the 23rd week of gestation at the time of their first attendance.[71]

Referring again to the project "Nuremberg's Model for Antenatal Care for Pregnant Migrants" the outcome of the analysis of 5000 births between 1998 and 1999 showed that every fifth migrant woman had a late access to antenatal care, later than the 13th week of gestation. In comparison to German women more than twice as many migrants went neither to a preventive examination nor to an ultrasound during the whole pregnancy.
The systematic review of refugee women's reproductive health by Gagnon, Merry and Robinson showed that in the refugee-specific studies the overall findings were for example the reduced prenatal care, which implicated fewer than three visits during the pregnancy.

Conclusion
Concerning the hypothesis of this study, that there is too little support during the pregnancy of asylum seeking women in Graz the following can be said.
All of the respondents from the target group were under medical support, attending the program within the MKP-controls for mother and child. Among the comments on being a pregnant asylum seeker in Graz there were overall positive statements, and the women described a range of sources of support, including friends predominantly from the same cultural grouping and targeted professional support. However, uptake of broader preventive, health promotion and health information services, in particular pre-birth courses was very limited. It may be that the women have limited knowledge about these possibilities, much less where such programmes can be found within public services. Therefore health information and health literacy are crucial in making these women aware of all that is possible in terms of support. The major complaints explicitly described related to the language barrier.
The conclusion is that regardless of the fact that all women were under regular medical support there is still a lack of knowledge of what is actually available in terms of overall support, including courses for pregnant women and in particular for migrant women.

Appendix

Questions for the interview with the pregnant women:

1) Person /Social circumstances:

- Which country do you come from?
    - Religion?
- How old are you?
- When did you arrive to Austria/Graz?
- Do you have children/is it your first? How old are they?
- Did you come alone/with family/friends to Graz?
    - Family - children/partner/parents/other relatives in Graz?
- Studies/profession? In your country? Did you work?
- Language capacity
    - Enough to communicate?
    - Is it important for you to learn German?
    - German course?
- Do you have Austrian friends?
- Accommodation: Where do you live now?
    - Shelter: Do you cook by your own?
    - Remuneration job?
    - Does your older child go to a kinder garden?
- Finances? How many € do you get/month? From whom?

2) Social network:

- What resources are there within the family, friends, community and shelter in Graz? (From your home country?)
    - Who helps/supports you? Who do you ask?
    - Relatives in Graz?
    - Friends in Graz? From what country?

3) Social support:

- From whom? NGO? Organisations? OMEGA, Danaida, ZEBRA, ISOP, Marhama, Caritas, Marienambulanz? Do you know this organisations?
- Support in what form?

4) Access to health care:

- Knowledge about health care system?
- How would you describe your access?
    - What do you do when you need something/are sick?
    - Where do you go for other problems? Private doctor/LKH?
    - Where do you go for MKP?
    - Paediatrician?
- Who accompanies you to the labour?

5) Health information:

Are there any language problems?

- Where/from whom do get info?
- In what form do you get it?

- Attendance to a birth preparation course?
- Information/knowledge from whom (your mother/aunt/family) concerning the pregnancy/labour?
- Pregnancy problems?

6) Health belief:

- What is important for healthy pregnancy/healthy child?
- Are you planning to breastfeed your baby?

Are there any changes in your *health behaviour* during your pregnancy?

- What do you do to stay healthy?
    - Nutrition? Is there knowledge about adverse health substances?
    - Changes in nutrition?
    - Exercises?

7) Is there something more you want to tell me about your pregnancy as an asylum seeker in Graz?

Something you want to ask me before we finish?

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