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**Citation:** Germain, S. & Yong, A. (2021). Written evidence from the Gender & Sexualities Research Centre (GSRC) at City, University of London for Women's Health Strategy (City Law School Research Paper 2021/05). London, UK: City Law School.

This is the published version of the paper.

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*City Law School Research Paper 2021/05*

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at City, University of London for Women's Health Strategy**

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June 2021

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The City Law School

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London, Northampton Square, London, EC1V 0HB.

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## Written evidence from the Gender & Sexualities Research Centre (GSRC) at City, University of London for Women's Health Strategy

Sabrina Germain\* and Adrienne Yong†

### Executive summary

- We have looked at the impact of the pandemic on access to healthcare services in England, focusing on ethnic minority and migrant women. We have found that existing barriers faced by these women when seeking healthcare have been exacerbated by the pandemic.
- The intersection of someone's gender, race and immigration status raises a number of specific issues when it comes to access to healthcare, which is the focus of this submission.
- Under the core themes of the call for evidence, issues include health literacy and cultural barriers (Information and education on women's health, paragraphs 13-16), racialised medical perceptions and stigma (Women's voices, paragraphs 8-12; Research, evidence and data, paragraphs 26-28), economic and financial barriers (Women's health in the workplace, paragraph 22-25), legal barriers relating to immigration status (Women's health across the life course, paragraphs 17-21) and the COVID-19 public health crisis that has deepened these long existing issues (Impact of COVID-19 on women's health, paragraphs 29-40).

**Keywords:** COVID-19, access to healthcare, intersectionality, ethnic minority, migrant, women.

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## Introduction

1. [The Gender and Sexualities Research Centre](#) is an interdisciplinary research centre based in the School of Arts and Social Sciences at City, University of London. It analyses how gender and sexuality intersect with other social divisions and identities in a rapidly changing world.
2. We are Senior Lecturers in Law at The City Law School, City, University of London and GSRC Organising Committee members. We are interdisciplinary research experts in gendered and intersectional issues concerning healthcare law & bioethics and immigration & human rights respectively.
3. Our evidence is based on our research published as a peer-reviewed [commentary](#) in the Feminist Legal Studies journal and in an opinion piece in [The Conversation](#).

## Executive summary

4. We have looked at the impact of the pandemic on access to healthcare services in England, focusing on ethnic minority and migrant women. We have found that existing barriers faced by these women when seeking healthcare have been exacerbated by the pandemic.
5. The intersection of someone's gender, race and immigration status raises a number of specific issues when it comes to access to healthcare, which is the focus of this submission.
6. Under the core themes of the call for evidence, issues include health literacy and cultural barriers (Information and education on women's health, paragraphs 13-16), racialised medical perceptions and stigma (Women's voices, paragraphs 8-12; Research, evidence and data, paragraphs 26-28), economic and financial barriers (Women's health in the workplace, paragraph 22-25), legal barriers relating to immigration status (Women's health across the life course, paragraphs 17-21) and the COVID-19 public health crisis that has deepened these long existing issues (Impact of COVID-19 on women's health, paragraphs 29-40).
7. Our key recommendations are as follows:
  - a. **We recommend a decolonisation of medical schools' curriculum in the UK and the inclusion of specific training to eradicate systemic racism and racialised medical perceptions in clinical and preventive care settings.**
  - b. **We recommend raising awareness around reproductive and sexual health services by entering into a dialogue with ethnic minority leaders in their community.**
  - c. **We recommend designing educational activities that involve ethnic minority and migrant female leaders who have direct links to the community and can improve the dissemination of information to underrepresented groups of women.**
  - d. **We recommend reconsidering immigration policy on precarious and irregular migration in order to break the link between poorer health outcomes and an inability to access care under the current NHS charging model for migrants as a future cost-saving exercise.**
  - e. **We recommend that economic and geographical barriers in accessing healthcare services be directly addressed by the upcoming NHS reform. Ethnic minority and migrant women's needs and perspectives should specifically be accounted for in the integration of local healthcare services.**
  - f. **We recommend funding studies that specifically consider ethnic minority and migrant women's health to address the well-known data gap.**
  - g. **We recommend putting in place a preparedness strategy for the long term, as well as an agile response strategy, which both account for women's healthcare needs in**

the face of potential future pandemics.

- h. **We recommend dedicating more resources in future to tackling issues that specifically affect women's health and their access to healthcare as they have been worsened during the pandemic. An especial focus must be given to the needs of ethnic minority and migrant women as they are uniquely affected.**

### Women's voices

8. Ethnic minority and migrant women are vulnerable to medical prejudices and racist beliefs. This includes the [myth](#) that non-white people have a greater ability to cope with pain or an illness or that patients in the ethnic minority community are genetically or inherently more prone to develop underlying health conditions (Roberts [2008](#)). These concerns affect women's ability to voice their healthcare needs and for these needs to be adequately addressed by healthcare professionals.
9. Ethnic minority women have more limited access to specialised maternal care. Black women in the UK were [four times more likely](#) and Asian women twice as likely to die in pregnancy than white women. Multiple instances of women who died after presenting to healthcare services with pain were not investigated or followed up.
10. Stigma associated with certain lifestyles discourages ethnic minority and migrant women from seeking preventative care services. For example, the prejudice associated with premarital or non-normative sexual activities in some ethnic minority and migrant communities seriously affect women's access to [contraception](#) and sexual education services.
11. **We recommend a decolonisation of medical schools' curriculum in the UK and the inclusion of specific training to eradicate systemic racism and racialised medical perceptions in clinical and preventive care settings.**
12. **We recommend raising awareness around reproductive and sexual health services by entering into a dialogue with ethnic minority leaders in their community.**

### Information and education on women's health

13. Barriers to accessing healthcare are not always physical. More often it is gendered cultural barriers that discourage ethnic minority and migrant women from seeking care. These cultural aspects are not well understood or taken into account by the healthcare system and need to be considered more explicitly. Cultural barriers include information barriers which exist because women [lack confidence](#) in asking questions about accessing care, or are unaware of support that is available to them. This is known as "health illiteracy".
14. Health illiteracy discourages ethnic minority and migrant women from accessing mainstream services, leading them to instead [rely on their communities for support](#). As such, ethnic minority and migrant women often become the pillars of their community and are authorities figures with great influence in the community and an ability to widely spread knowledge that can educate and improve access to healthcare.
15. Health illiteracy can also give the wrong impression that women are a "problem" in the healthcare system, when in fact, mobilising women from ethnic minority or migrant communities can improve their ability to access care and work towards overcoming information and educational barriers.
16. **We recommend designing educational activities that involve ethnic minority and migrant female leaders who have direct links to the community and can improve the dissemination**

of information to underrepresented groups of women.

### Women's health across the life course

17. The NHS' universal and equal access services approach [does not translate to an equal experience for all](#). Women have systematically been more affected by [barriers in accessing healthcare services an issue made worse by the pandemic](#).
18. Vulnerable migrant women often suffer from [inappropriate or a lack of antenatal care](#). This increases the likelihood that their children will develop certain comorbidities themselves, entrenching disadvantage for another generation.
19. Migrant women in particular face financial barriers when seeking access to healthcare, being [charged fees for treatment](#) which are not applicable to non-migrants. The fees are a particular problem for those on low incomes and who are the sole breadwinner for their families. It also disproportionately affects women as many are in low-paying jobs, especially [single mothers supporting children](#).
20. Circumstances that leads an individual to migrate through ["irregular" means](#) translates to these individuals firstly, having poorer life health trajectories and secondly, more likely to have trouble accessing healthcare in their new State of residence. A disproportionate number of women may be affected due to a lack of equality globally on women's rights leading to more women seeking asylum to escape persecution.
- 21. We recommend reconsidering immigration policy on precarious and irregular migration in order to break the link between poorer health outcomes and an inability to access care under the current NHS charging model for migrants as a future cost-saving exercise.**

### Women's health in the workplace

22. Ethnic minority and migrant women are often [precarious or domestic workers](#) and are not protected by employment conditions that cover sick leave, creating a significant barrier in accessing healthcare services. As a result, they are less likely to take time off of paid-work to attend medical appointments to avoid any loss of income.
23. Access to healthcare and preventative services is significantly more limited for ethnic minority and migrant women who are also primary carers of children. Lack of childcare support often prevents women from attending screening appointments and getting appropriate care.
24. Instances of "postcode lottery" where specialised treatments are provided only in certain geographical areas are more likely to have a negative impact on ethnic minority and migrant women. The cost associated with transport creates a significant barrier to access healthcare services for women that are in precarious financial situations or unemployed.
- 25. We recommend that economic and geographical barriers in accessing healthcare services be directly addressed by the upcoming NHS reform. Ethnic minority and migrant women's needs and perspectives should specifically be accounted for in the integration of local healthcare services.**

### Research, evidence and data

26. Ethnic minority groups have generally been [under-represented in medical research](#) and women are also less predominantly the [subject of clinical trials](#). This makes conditions affecting ethnic minority and migrant women least likely to be addressed by medicine.
27. There is a [lack of data and studies on migrant health](#) in general as well, especially if the

individuals fall outside the legal scope of the immigration law framework (e.g. irregular migrants). The male labour bias in immigration law (Kofman [1999](#)) which rewards men for their traditional paid work also means more women are likely to fall outside the scope of legal protection, and therefore even less data will exist on their health outcomes.

- 28. We recommend funding studies that specifically consider ethnic minority and migrant women's health to address the well-known data gap.**

### Impact of COVID-19 on women's health

29. The pandemic has affected men and women differently. Women have borne more of the brunt of the pandemic in terms of increased [childcare](#), more precarious job security and [mental health problems](#).
30. In many areas the NHS has been affected by the pandemic, [services](#) and [screening procedures](#) were suspended in order to attend to COVID-19 infected patients. As the NHS resumes its activity, the backlog is likely to have a more negative impact on women who were less likely to seek help during lockdown because of heavier childcare duties or the inability to travel to service providers. Women are therefore more likely to face long waiting lists as services continue to deal with the significant backlog.
31. The [disruption in provision to healthcare services](#) partly explains why [ethnic minority women made up 55%](#) of the pregnant patients admitted with COVID-19 during March and April. These delays due to the disruption put these women at a higher risk of severe complications, which has already been the case for these groups due to their often being in poorer health generally.
32. New rules were implemented at speed in order to attempt to control the spread of the virus. Worse, they were frequently changing. The speed in which they were changing meant a higher risk of the rules being improperly understood, improperly followed and poorly communicated to ethnic minority and migrant women who already suffer from information and educational barriers.
33. The vast amount of information and changing rules also meant misinformation and confusion was rife. This added to fears that many ethnic minority and migrant women had of contracting the virus in clinical settings, a particular fear if they lived in [multigenerational households](#) or were the sole breadwinner for the family and could not afford to lose income. Fearing clinical settings also added to the risk of these women not seeking care when it may be needed until it was too late.
34. Ethnic minority and migrant women not seeking care when needed also adds to the underreporting of their medical conditions. This is worsened by the stigma associated with women seeking preventative care in context of their sexual and reproductive health, for example.
35. High fees associated with seeking healthcare as a migrant and other concerns related to having an [insecure immigration status](#) mean that more migrants would not have accessed appropriate healthcare in the past, putting them at [future risk](#) of falling into a high-risk health category. This is of particular concern in the context of COVID-19 because those with [underlying health conditions](#) are more at risk of developing severe complications from the virus.
36. Migrant women in abusive relationships would also be disproportionately affected by the pandemic. [Domestic violence increased](#) significantly during lockdown. Being under the control of an abusive partner may mean a woman is prevented from accessing healthcare. It would

also mean being forced to stay in the relationship if immigration status depended on an abusive partner.

37. Digital poverty in ethnic minority and migrant communities increased barriers to accessing healthcare remotely. Telemedicine did not reduce barriers to accessing healthcare in this context, and actually created an additional barrier for those subject to violence against women and girls because of what became an unsafe home environment due to confinement with an abusive partner.
38. [Existing structural inequalities](#) and barriers to accessing healthcare such as movement restrictions, geographical limitations and an increased burden of childcare were all worsened by the pandemic and negatively impacted access to healthcare services.
39. **We recommend putting in place a preparedness strategy for the long term, as well as an agile response strategy, which both account for women's healthcare needs in the face of potential future pandemics.**
40. **We recommend dedicating more resources in future to tackling issues that specifically affect women's health and their access to healthcare as they have been worsened during the pandemic. An especial focus must be given to the needs of ethnic minority and migrant women as they are uniquely affected.**

June 2021

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