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Health Promotion in Midwifery: Principles and Practice (4th Edition)

Chapter: The displaced/migrant client

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Introduction

This chapter will explore the personal and structural issues faced by migrant women and birthing people attending for maternity care in the UK. We will clarify different kinds of 'legal status' and how this, along with charging policies, impact on migrants' access to care and their maternal and neonatal outcomes. Improving equity of access and outcomes in maternity services is an important public health issue and this chapter will also detail migrant women's rights, and what midwives can do to support them.

Migration is a worldwide phenomenon. The numbers of people who have been forcibly displaced globally continue to increase as a result of climate-relate challenges, armed conflict, poverty and global political instability. In mid-2022, UNHCR estimates that around 103 million people are forcibly displaced worldwide. During global crisis, women and girls are worst affected, making up to 50 per cent of any refugee, displaced or stateless population (UNHCR, 2022). Migration occurs both within and outside national borders and has numerous impacts on individual health, as well as on local health systems and health policy response. In recent years, migration has been a dominant topic of political agendas and anti migration policies and sentiments have increased across the world. However, the protection of sexual and reproductive health rights and availability of sexual and reproductive health services is endorsed within international and human rights law. Loukamage et al (2022) remind us that Western medicine was established at a time characterised by patriarchy, racism and Euro-centrism which pathologized women's bodies - especially black and brown women's bodies. This can affect our clinical care as well as our training and attitudes as midwives. Indigenous and non-European groups are under-represented in the research which underpins our clinical practice which means that 'standard' biochemical and haematological markers are mostly based on research on white populations. At the same time, the lived experiences of these groups have been marginalised and women from Black, Asian and ethnic minority groups are more likely to report not being listened to by healthcare professionals (HCPs) (NHS Race and Health Observatory 2023). As well as facing multiple risk factors, migrant women face intersectional discrimination which compounds oppression and impacts on health outcomes (Selvarajah et al 2022).

To respond to the needs of those displaced, midwives and other HCPs need to be aware of a range of issues related to public health, migration policy and health systems, as well as key health concerns which those displaced faced at different points in their maternity journeys.

Definitions

Migrants in the UK are not a homogeneous group, nor are they treated as such by maternity services. Although many may encounter similar biases and barriers to NHS care, it is helpful to understand how the different 'status' of migrants affects their right to maternity care (Gov.UK 2014; 2020; 2023). See a summary of their entitlements in Table 1.

Asylum Seekers

Migrants who have arrived in the UK (through formal or informal routes) who apply for asylum in the UK based on *'a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion*'. (UN Convention Relating to the Status of Refugees 1951, Article 1). Gender-related violence, of particular relevance in maternity, comes under '*membership of a particular group'*. While their claim is being processed, asylum seekers are entitled to free maternity care but do not have the right to work or claim benefits. Instead they are supported by the UK Border Agency (UKBA) Section 95 support and can choose from the following:

- Subsistence only: Currently this is £47.39 per week and a travel voucher
- Subsistence and accommodation**:** Accommodation is provided, as well as all meals, plus £9.59 per week. Accepting this option may involve dispersal to other areas of the country with little warning.

Pregnant asylum seekers are entitled to an additional £3 per week during pregnancy and for every child under 3yrs, and to a one-off maternity grant of £300 after 32/40.

Refugees:

At the end of their application, asylum seekers may be granted **Refugee Status** or **Humanitarian Protection** for five years, after which they can apply for 'Indefinite Leave to Remain' and 12 months later they can apply for British Citizenship, which includes sitting the 'Life in the UK Test'. Indefinite Leave to Remain gives migrants to free NHS maternity care, benefits and the right to work. Another positive outcome of an asylum claim can be **Discretionary Leave to Stay** which comes with the same rights, but at the end of this period they need to reapply for asylum.

Refused Asylum Seekers

Asylum seekers have the right to appeal a negative decision, and once an appeal has been lodged they will be considered 'asylum seekers' again until a decision is made (this entitles them to free maternity care). They may reach a point where they

are considered ‘Appeals Rights Exhausted’ (ARE). At this point they will become ‘no recourse to public funds’ (see below). UKBA may also seek to repatriate them. However, they do have the right to submit a fresh claim for asylum on compassionate grounds (i.e. a life-threatening medical condition, new evidence or a change in the political situation in their country of origin).

No recourse to Public Funds

This group is referred to using a range of (often derogatory) terms, including ‘overseas visitors’, ‘illegal migrants’, ‘undocumented migrants’, economic migrants’ and ‘health tourists’. It is difficult to estimate the number of migrants in the UK with no recourse to public funds as they live, by definition, under the radar. This group may have arrived in the UK by formal routes on tourist, student or spousal visas who have ‘overstayed’ or been unable to regularise their status. This group also includes women who have arrived through informal routes (boats across the Channel, for example) but who do not have the right to claim asylum, for example if they are fleeing poverty rather than persecution. It also includes refused asylum seekers who have not been returned to their country of origin.

Women and pregnant people with no recourse to public funds have access to free primary care and A&E, and have access to maternity care as this is considered ‘urgent and immediately necessary care’, but women will be subsequently be charged 150% of the national tariff. Trusts are required to check chargeable status of anybody presenting for care. Where payment is due they have a legal obligation to pursue any such debts, including using debt collectors, and are required to report any unpaid debt above £1000 to the Home Office.

A summary of what all pregnant women/birthing people are entitled to, regardless of their status, can be found in Figure 2.

Migrants with visas

One challenge to understanding migrant’s ‘entitlement’ to free maternity care is that there are a wide range of different visas available to migrants and new schemes are launched in response to political events (i.e. the Ukranian war or ‘Settled Status’ for Europeans living in the UK before Brexit). Those applying for temporary leave to remain for more than six months who are not otherwise exempt must pay a £624 Health Surcharge to cover the cost of any NHS treatment.

Babies and minors under 18

Babies born in the UK have the right to free NHS care, free education and social services support, but do not have the right to British citizenship unless at the time of their birth one of their parents is British or legally settled in the UK.

One third of asylum applications in the UK are made by women, but they are more likely to be initially refused compared to men (87%). This may be because women find it harder to document persecution: gender violence is more likely to happen in the private rather than public realm so they rarely have prison or police records, articles about them, or scars from torture. Nevertheless, half of the appeals lodged by women are successful. Whether the outcome of an asylum claim is positive or

negative, UKBA support will cease within 21 days which can lead to destitution – even for those who have been granted refugee status, this is rarely long enough to establish housing and benefits.

Note: Throughout this article, when we refer to *migrants* we include refugees, asylum seekers, undocumented migrant and any other displaced population.

Table 1 Summary of migrant's entitlements based on their legal status in the UK

Status	Has the right to Primary and A&E NHS Care	Has the right NHS Maternity Care	Has the right to work	Has the right to social support, housing, education	Notes
Asylum Seeker	YES	YES - free	NO	NO	Support ceases once their case is resolved.
Refugee	YES	YES- free	YES	YES	Same rights has British citizen
No recourse to public funds	YES	YES – but will be charged	NO	NO	
Pregnant migrants on Visas >6 months	YES	YES - free	Depends on the visa	NO	Have to pay the Health Surcharge
Minors under 18 years	YES	YES - free	NO	YES – education, social support	Right to citizenship depends on parents' status

Migrant and displaced populations: an overview of the UK context

In 2021, people born outside of the UK made up an estimated 14.5% (9.6 million) of the UK's population. Compared to the UK born, migrants are more likely to be aged 26 to 64. In 2019, about 53% of the foreign- born population were women and girls. Migrants are much more likely to live in some parts of the UK than others. In the year ending June 2021, about half of the UK's foreign- born population (48% in total) were either in London (35% – 3,346,000) or the South East (13% – 1,286,000) (Migration Observatory 2022).

Why is it important to discuss migrant communities' health?

First, migration is a key political issue, not only in the UK but globally. Second, the MBRRACE-UK report (Knight et al 2022) state that black, Asian and women born outside of the UK have higher mortality rates than their British counterparts, which includes a four times higher rate in black women and a worrying increase in stillbirth and neonatal death among their babies. Furthermore, a confidential enquiry into maternal health estimated that a quarter of women who died were born outside the UK, of which 46% were not UK citizens (Knight et al 2016). Third, migrants are among the most vulnerable and excluded people in the UK, however, their maternal and child health outcomes can be improved by midwives who are in a position to make a difference. Reducing inequalities in health has long been part of the midwifery profession's goals and standards, as stated in the government's Better Births review (NHS England 2016), and in the Nursing and Midwifery Council's Code (NMC 2018). Migrant health is not only a public and human rights concern, it is also recognised as a key factor for integration into society, yet migrant sexual and reproductive health issues present some of the most important and still unmet, public health challenges. In the UK, the subject of immigration appears high on the political agenda and policies that limit health care access have become more prevalent. Current law and regulations related to maternity care and NHS charges for undocumented migrants are part of this (Garcia de Frutos, 2020). For further information see Chapter ** (Health Promotion and clients from Black, Asian and Minority ethnic groups).

NHS charging for maternity care in England

The UK and the overseas NHS visitors charging regulation system for maternity care The Immigration Act 2014 restricted free NHS care to those who have resided in the UK for five years or more. Those who do not meet the residence requirement, but hold a visa, must pay the 'immigration health surcharge' of £400 per year. *Overseas Visitors* must pay 150% of the face-value cost (NHS rate). In 2017, an amendment to the Immigration Act 2014 meant patients were required to give evidence of eligibility, sometimes up front. Consequently, NHS providers are now legally obliged to establish a patient's residential status and where appropriate recover the cost of the treatment (Shahvisi & Finnerty 2019). To date, NHS Trusts are required to inform the Home Office about patients who have an outstanding debt of more than £500 to the NHS for over two months. This can impact on future immigration applications. Previous restrictions to accessing health care in the UK have contributed to an increase in social and health inequalities that affect the most vulnerable migrant populations (Poduval et al 2015) and act as a deterrent from accessing necessary maternity care (Feldman, 2021). The introduction of these changes ignores ongoing concerns expressed by medical professionals, researchers and UK organisations about the increasing restrictions of access to health care by migrants, asserting not only ethical and public health reasons, but that it is more cost effective to provide continuous health care. Eligibility labels and the imposition of charges are incompatible with midwives' ability to provide appropriate and timely care, including interprofessional and specialist support (Feldman et al, 2019).

What are the implications of the law and regulations for undocumented migrants?

Maternity care cannot be denied as it is considered ‘immediately necessary’, however, it is not free for women who are not ‘ordinarily residents’ in the UK. The charges vary and range from £4000–£7000 for prenatal, intrapartum and postnatal care — up to 150% higher than the regular NHS tariff. Abortion services are chargeable and range between £900–£1400 (Shahvisi & Finnerty 2019). Family planning is free of charge (Department of Health and Social Care 2021), however women may either not be aware of this or be fearful of accessing institutions.

Health inequalities that could be avoided but are not are unjust. It is a matter of social justice (Marmot 2017). There is a vast amount of evidence that confirms facilitating access to maternity and abortion care plays an important role in maternal and child health outcomes.

Health outcomes and challenges in accessing maternity services in the UK

MBRRACE-UK reports show that year after year, women in deprived communities including those born outside of the UK, have poorer sexual and reproductive health (SRH)outcomes compared to women born in the UK. In addition, they face multiple barriers when accessing health care services such as, fear of deportation, NHS charges, lack of information, support and trust in the midwife and other HCPs (Poduval et al 2015, Shortall et al 2015, Juárez et al 2019, Nellums et al, 2020).

Migrants’ SRH is complex and takes a socioecological approach to allow for the interplay between individual (micro) factors and environmental factors (Orcutt et al, 2021). Multiple factors have been identified as contributing to poor sexual and reproductive outcomes in displaced communities, such as:

- poor access to healthcare in the country of origin
- untreated existing or new health conditions occurring during the journey
- malnutrition
- exposure to violence
- engagement in dangerous activities as a means of securing food and or protection (sex industry, including exploitation through trafficking)
- increased rate of forced marriage/child marriage
- unmet contraception needs
- unsafe abortion
- language barriers
- fear of reporting sexual abuse due to stigma
- structural racism

In addition, migrants face complex challenges when accessing NHS maternity care services

- Fear of deportation
- Unknown health systems
- Language barriers
- Lack of funds
- Lack of documentation
- Unstable accommodation

Identified risks for maternal and child health outcomes

- Late booking
- Delays in accessing antenatal care
- Missing antenatal screenings
- Missed diagnosis
- Less antenatal appointments than recommended

Qualitative data has found that refugee women want to feel safe in the maternity system and in their communities. In addition to fair and equal access and treatment in maternity care (Evans et al, 2022). Midwives, and other HCPs, would benefit from additional training to understand how the wider issues described above and those related to the negative discourses around migration, and use this knowledge in practice when caring for women to help them feel safe.

Caring for migrant women: the midwife's role

Midwives have a well-documented public health role (Marshall et al 2019) which is embedded in the NMC Code and includes an obligation to advocate for the women they care for (Figure 1).

The Nursing and Midwifery Council's Code (2018)
1.5 – Respect and uphold people's human rights **3.4** - act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care **5.1** - respect a person's right to privacy in all aspects of their care **5.4** share necessary information with other healthcare professionals and agencies **only** when the interests of patient safety and public protection override the need for confidentiality **7.2** take reasonable steps to meet people's language and communication needs

7.3 use a range of verbal and non-verbal communication methods, and consider cultural sensitivities, to better understand and respond to people's personal and health needs

20.4 keep to the laws of the country in which you are practising

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

Figure 1 Midwives' obligations under the NMC Code (2018)

Maternity care is not 'one size fits all'. The code clarifies that midwives are expected to actively challenge discriminatory attitudes, show respect for all women and develop personalised plans to meet women's individual medical, social, emotional and communication needs. The key concepts which should guide maternity care for migrant women and birthing people, and vulnerable populations generally, are discussed below and summarised in Figure 2:Co-production - *Nothing about me without me:*

When considering care pathways for a vulnerable group, the first step for commissioners and managers is to understand their local population, and to consult with them in order to understand their needs and preferences (NHS 2018). Services should be designed to avoid stigma and bias. Information about your local population can be gathered through local Healthwatch and the Fingertips data service, and this should be followed by a co-production process involving your local Maternity Voices Partnership and other charities/stakeholders. A number of tools are available to support involving service users in healthcare design and carrying out equalities impact assessments (see online resources section).

Booking appointment

While migrant women are not a homogeneous group, they are more likely to have complex social, medical and mental health histories. Special care should be taken during the booking appointment to explore previous trauma, social isolation, housing needs and health history as well as migration status and personal preferences to safeguard their emotional and cultural safety.

Care-planning

Migrant women may be wary of figures of authority which can affect disclosure (Feldman 2021), so consideration of confidentiality and dignity are especially important. Relational models of care increase trust and minimise the need for complex histories to be repeated. Continuity of carer has been shown to improve maternal and neonatal outcomes, with the greatest impact seen in vulnerable groups (Sandall et al 2016; Rayment Jones et al 2015 – see Case Study 1)**.** Models of care which build social support, such as group antenatal care (Hunter et al 2018), may be appropriate for migrant women who are isolated. Specialist teams (such as those specialising in asylum seekers and refugees) can enable midwives to integrate clinical care with expertise in the social issues facing this group, although services should be mindful of women feeling stigmatised by such services. Poorly designed

care pathways can result in harm for vulnerable people (Pollard & Howard 2021). Midwives should follow the four principles of trauma-informed care (NHSE 2021):

- Recognition and compassion
- Communication and collaboration 1
- Consistency and continuity
- Recognising diversity and facilitating

Case Study 1: Continuity of Care

BACKGROUND: The Lambeth Early Action Partnership (LEAP), funded by the National Lottery Community Fund as part of its A Better Start initiative, utilises a public health approach to improve outcomes for families. Given the markedly higher maternal and neonatal mortality and morbidity risk for women living in the LEAP area (Lambeth South London), investing in enhanced pregnancy care became a priority.

INTERVENTION: LEAP worked with the local NHS Trust (Guy's and St. Thomas') to commission a Midwifery Continuity of Care (MCoC) team targeting pregnant people in the LEAP area with Black or other minority ethnicity and/or social risk factors. A named midwife provides longer and more frequent appointments, delivering continuity of care across the antenatal, intrapartum and postnatal period. The team was based in a local children's centre, benefitting from referral pathways to wider sources of support, including infant feeding and enhanced domestic abuse support.

OUTCOMES: Over 600 LEAP babies have been born since the service began in 2018. 90% of clients live in areas of highest deprivation, and 62% identify their ethnicity as non-white. This intervention showed significant reductions in pre-term birth rates and caesarean births compared with clients who received traditional midwifery care. 100% of clients reported that they trusted staff and felt like they understood their needs (Hadebe et al 2021).

ACTIVITY: (1) Why do you think MCoC will reduce pre-term birth rates? (2) How might improving vulnerable groups' experiences of maternity care impact on their clinical outcomes?

Case Study 1: Continuity of Care

Signposting

Migrant women may be unfamiliar with NHS processes, the role of midwives and health visitors, wider services and their rights under UK law (i.e. their right to have time off work to attend maternity care, or make informed choices). Midwives should clarify care pathways and signpost migrant women to external sources of support such as Children's Centres, Community hubs, advocacy groups such as Maternity Action and Birthrights, and local charities (see Case Study 2).

Financial support

Women on benefits should be supported to apply for the Healthy Start food card and the Sure Start Maternity Grant (this is aimed at primiparas, but can also be claimed by multiparas if it is their first baby in the UK). All women on low income, regardless of status, can apply for an HC1 Form which can help with costs, including travel to

hospital appointments (asylum-seekers will be given an HC2 Form by the Home Office, covering the same support).

Women with limited English proficiency (LEP)

The NICE Guideline for Pregnancy and Complex Factors (2010) specifies that interpreting services should always be used for women with LEP and midwives should not rely on friends or family to interpret. Where women speak limited English, midwives should check their understanding and offer to use interpreters. Additional, or longer, appointments may be needed (NICE 2010). Meeting women with LEP's communication needs includes consideration of how they can access to parent education and collating reputable sources of information about pregnancy in a range of local languages. Research has shown that women with LEP prefer to receive care from somebody who speaks their own language, rather than through interpreters (Rayment-Jones 2021), so consideration should be given to making better use of multi-lingual staff where available or working with volunteer doulas who speak local languages.

Case Study 2: Community Volunteer programme.

BACKGROUND Auntie Pam's was created in 2009 to provide a community-based resource in Kirklees to support pregnant women/birthing people, parents and children, funded by Public Health at Kirklees Council working closely with the local MVP to address poor maternal health outcomes and behaviours.

INTERVENTION: Auntie Pam's trains volunteers from the local community who speak a range of languages (Urdu, Arabic, Kurdish) who offer a time-rich, person-centred service, giving clients the chance to identify and talk through their issues, prioritise their own needs, solutions and goals. They also provide a baby bank, baby weighing facilities, and a drop-in information service covering housing, benefits, domestic violence, healthy eating, mental health, baby feeding support and smoking cessation.

OUTCOMES 80% of their clients come from the lowest 30% deprivation decile, many of whom are migrants, refugees and asylum seekers. Auntie Pam's have achieved the lowest rate smoking at time of delivery rates in Kirklees in the last 10 years. They use social marketing techniques and co-production to maintain and evaluate the service and their "whole-life" approach addresses the fact that if an individual struggles with money, relationships or housing they are less likely to identify poor health behaviours as a priority for change. For more information see www.auntiepams.org.uk

ACTIVITY: (1) How can midwives support women's wider social needs? (2) What local services near you can work with maternity services to provide additional support for migrant women?

Figure 2 Case Study 2: Community Volunteer Programme

No access to public funds

Women and birthing people without access to public funds experience both emotional and financial challenges due to being charged for care. Midwives can

provide continuity of care to build trust, explaining the importance of attending all their appointments and providing reassurance that they have a right to receive maternity care regardless of their ability to pay. Midwives can help women navigate what can be a frightening situation, encouraging them to engage with the Foreign Visitor's Department to arrange an affordable repayment schedule in order to avoid aggressive debt collection or their debt being reported to the Home Office. Midwives cannot offer immigration advice, but can signpost women to organisations such as Maternity Action, Doctors without Borders, Praxis or Citizen's Advice.

Gender based violence

Migrant women without recourse who disclose that they have been subject to gender-based violence (FGM, sexual violence, domestic violence, trafficking) may not be aware that they can apply for asylum which will entitle them to receive Section 95 support and free maternity care while their case is being considered. They should be referred to local services and the British Red Cross for support (British Red Cross 2023).

Asylum-seekers

Asylum-seekers are regularly dispersed from one part of the country to another with little notice. For pregnant asylum-seekers, already at risk of premature birth and poor outcomes, dispersal represents additional risk as it may separate them from their support system, impact on continuity of carer and result in the loss of important information about her pregnancy. Midwives have a role in advocating for asylum-seekers if they are threatened with dispersal. Changes to the woman's medical status (i.e. developing pre-eclampsia; a diagnosis of HIV or Tuberculosis; mental health treatment) could have a material impact on a woman's asylum claim. Templates for letters of support can be found on the Maternity Action website and these are taken into consideration when dispersal decisions are made. Pregnant women should not be dispersed six weeks before or after their due date, but where dispersal does occur, the midwife should ensure effective handover of care (Refugee Council 2021; UK Visas and Immigration 2016).

Cultural safety:

When caring for migrant women, midwives must consider clinical issues such as the accuracy of identifying APGAR scores, pulse oximeters, jaundice, mastitis and cyanosis on dark skin (useful resources include Mukwende et al 2020, NHS Race and Health Observatory 2023; NHSE Cultural Competency training). However, focusing on physiological differences can lead to pathologizing black and brown women's bodies, preventing them receiving high quality care which responds to their individual needs NHS Race and Health Observatory 2023). Midwives must explore their own internalised bias (discover this with the Harvard test – see resources) and guard against stereotyping. Cultural safety does not mean understanding everything about a particular culture or ethnicity: it means understanding colonial legacies and historic power imbalances, and within that context ensuring that you provide individualised, person-centred care grounded in respect. What does the person sitting in front of you want and need? Using inclusive language and listening to

women's voices, respecting their unique identity, is a key tool of decolonisation and addressing oppression (Loukamage et al 2022).

Conclusion

Migrant communities face multiple complexities when they arrive in a new country. Research has found that women and families from migrant backgrounds suffer poorer maternal and child health outcomes. Midwives play a key role in public health and working towards improving equity as a means to reduce health inequalities. Maternity health care professionals need to understand what all migrant women are entitled to (Figure 2) and keep up to date with latest guidance and recommendations to provide kind, high quality, competent and safe care.

Figure 2 Entitlements of all pregnant migrant women/birthing people, regardless of legal status

All migrant women are entitled to:

- Confidentiality and respect
- High-quality maternity care
- NHS Maternity Care (but some may be asked to pay)
- Free primary care (registration is at the GP's discretion)
- Free A&E care
- Using Children's Centres
- Citizen's advice bureau
- Foodbanks
- HC1 Certificates (to help with costs including travel to appointments)

Key Learning points

- Pregnant migrant women and their babies are more vulnerable to adverse outcomes
- Migrant women's legal status may vary
- Migrant women cannot be denied maternity care in the UK, regardless of their ability to pay, but some may be charged for their care
- Midwives have a professional obligation to consider a woman's status, her needs and preferences when developing personalized care plans
- Midwives cannot offer immigration advice but can signpost migrant women to relevant organizations and write letters of support.
- Midwives should provide continuity of care and additional appointments or interpreters as required

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