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The midwife as a border force: how hostile environment policies impact maternity care

Abstract

In the UK, hostile environment policies impact all areas of life for women seeking sanctuary, including access to healthcare. This reflective article uses a human rights-based approach to analyse how these policies impact maternity care. The theoretical concept of everyday bordering is used to reflect on how these policies prevent midwives from fulfilling the caring aspect of their profession. This article discusses three issues: charging for maternity care in the UK, PREVENT training and enforced destitution. Each topic is related back to the human rights framework and discussed alongside a critical view of the midwife as an agent of border control. The article concludes by calling for more primary research to evaluate the impact of hostile environment policies on midwives and women seeking sanctuary.

Keywords

Asylum-seeker | Hostile environment | Human rights | Refugee

Women seeking sanctuary in the UK are more likely to experience poor outcomes when accessing maternity services than those who are residents (Felker et al, 2024). Existing research highlights a multitude of reasons for this, including interpretation issues, lack of knowledge about how to access services, racial discrimination and isolation (McKnight et al, 2019; Bridle et al, 2021; Rowe et al, 2023; MacLellan et al, 2022; Longeran, 2025). This reflective article examines the issue through a human rights lens to critically consider how government policies enacted under the overriding 'hostile environment' milieu directly influence maternity services. The article considers how midwives are bound by contradictory legislation, such as the Equality Act (2010) and regulatory standards such as the Nursing and Midwifery Council (NMC, 2018) code of conduct, while also practicing in a setting shaped by hostile environment policies.

This article will explore the background to a human rights-based approach, the hostile environment and the concept of everyday bordering and consider how charging for maternity services infringes on human rights. The article will also cover a critical discussion of the mandatory PREVENT training midwives must undergo and an analysis of the enforced state of destitution that women live in and how this violates their rights. For the purposes of this article, the term women or people seeking sanctuary includes asylum seekers, refugees, those who have been trafficked and those who have other insecure migrant status. The term is used to challenge the dehumanising rhetoric often associated with labels such as asylum seeker or migrant (City of Sanctuary UK, 2020).

Human rights-based approach

This article uses a human rights-based approach to examine how maternity care is affected by immigration policies, based on the UK Human Rights Act (1998). Birthrights and Birth Companions (2019) have been influential in increasing recognition of the impact of human rights on women's experiences of childbirth in

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Table 1. Examples of how human rights can be violated in maternity services or government policy

Human right*	Example of violation
Article 2: everyone's right to life shall be protected by law	Policies charging for maternity care and the consequent risk to women's safety (Arrowsmith et al, 2022)
Article 3: no-one shall be subjected to torture or to inhuman or degrading treatment or punishment	Denial of pain relief (Birthrights and Birth Companions, 2019)
Article 8: everyone has the right to respect for his private and family life, his home and his correspondence	Issues regarding the right to make autonomous decisions about having children (Brunton and Waterfall, 2024)
Article 14: the enjoyment of the rights and freedoms set forth in this convention shall be secured without discrimination on any ground such has sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status	Racial discrimination, both systemic and individual, in maternity services (Birthrights, 2022)
Article 25: everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing and medical care and necessary social services	People being expected to live in unsafe accommodation, as is the reality for many people seeking sanctuary in the UK (Duclos et al, 2024)

*Based on the UK Human Rights Act 1998 and the Universal Declaration of Human Rights

the UK, applying this framework to ensure an individual's human rights are at the centre of all care decisions.

This article considers the link between human rights and policies embedded by the UK government as part of the effort to create a hostile environment (*Table 1*). The article builds on work from Maternity Action and Doctors of the World, both of which advocate for improved access to maternity services for women seeking sanctuary. In migration discourse, there are multiple examples of human rights-based challenges against legislation such as the Illegal Migration Act (2022). This includes the removal of asylum seekers to Rwanda for processing (Limb, 2022), denying protections to modern slavery victims and removing the right of appeals following age assessments (Joint Committee on Human Rights, 2023).

NHS midwives and obstetricians are employed by the state and expected to act in accordance with government-sanctioned policies. As a result, although midwives may strive to advocate for women, there is an inherent power imbalance omnipresent in each encounter a pregnant person has with a midwife. Human rights are commonly violated in everyday interactions that women and birthing people have with the UK maternity system (Birthrights and Birth Companions, 2019). For people seeking asylum, there are even greater levels of vulnerability to having these rights violated.

The hostile environment

The hostile environment policies lack specific objectives and instead aim to create an overall feeling of unwelcome. These policies were first introduced in 2012 under Theresa May (Travis, 2013); they take many shapes and have led to a significant increase in everyday bordering practices among the British public (Yuval-Davis et al, 2018). The policies extend to schools, banks, landlords, homelessness services, marriage registrars and the Driver and Vehicle License Agency, all areas where public servants are now required to carry out migration checks. The lack of clarity in these policies has led to an increase in societal hostility characterised by racialised undertones. For example, Reynolds (2016) conducted a survey of private landlords and reported that 44% choose not to rent to people who 'appear to be immigrants'.

In relation to health, these policies have had significant consequences for the wellbeing of the most vulnerable in the community (Weller et al, 2019; Walker and Farrington, 2021). The NHS Migrant and Visitor Cost Recovery Programme (Department of Health and Social Care, 2023) led to an increase in charging those not ordinarily resident in the UK for their care, deterring people from accessing services. This directly impacts women accessing maternity services, with evidence showing that women who are charged live in a state of perpetual anxiety around their debts being reported to the Home Office, which deters some from accessing care in the first place (Pellegrino et al, 2021; Arrowsmith et al, 2022). Although midwives may not be asked to enact these policies directly, instead referring to overseas visiting teams (Department of Health and Social Care 2024), they are rendered complicit in a system that wields control over women and birthing people's access to maternity care and the ability to make free choices in that system.

At the time of writing, only one study has explicitly examined the impact of hostile environment policies on maternity services for refugees, asylum seekers and undocumented migrants (Pierce et al, 2024). This study, set in a small area of London, found that hostile environment

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policies undermined healthcare professionals' duty of care, personal morals and the principles of the NHS. The study called for an increase in specialist midwifery teams and community-based organisations (Pierce et al, 2024).

Everyday bordering

The concept of everyday bordering, as outlined by Yuval-Davis et al (2018), is generally applied in human geography and sociology. The concept encompasses the process by which border controls have been extended and embedded in British society, so that practices of border control are now enacted by everyday citizens. This is a result of the extension of border control activities to the responsibility of normal citizens through hostile environment policies. The concept has been used by other scholars to consider the punitive nature of UK immigration controls for those who have left violent domestic situations and as such have been forced to apply for leave to remain (Cassidy, 2019).

Everyday bordering has a significant impact on social and political solidarity between 'us' and 'them', through a reconstruction of 'everyday citizen' rights and duties (Yuval-Davis et al, 2018). As such, this concept is useful when considering how the midwife enacts the role of border force, being required to implement hostile environment policies that undermine women's human rights when accessing maternity services.

The practicalities of embedding everyday bordering policies in the NHS are not objective, but rely on individual practitioners making decisions regarding both the urgency of care needed and questioning those who appear not to be 'ordinarily resident' in the UK (Cassidy and Davidson, 2024). This presents significant moral and ethical dilemmas for midwives, who must strive to uphold high professional standards and a duty of care, along with these newfound duties of border control (Feldman et al, 2019). All maternity care must be treated as immediately necessary, and should never be denied or delayed because of charging issues (Department of Health and Social Care, 2021). However, in practice, there are reports of women being asked to pay before care is provided, alongside women avoiding care they would otherwise want because they fear being charged (Feldman et al, 2019; Birthrights, 2022).

Yuval-Davis et al (2018) outlined a distinction between those living in the UK, stating that every single person is either a border guard or a suspected illegitimate border crosser. This article explores how midwives themselves must occasionally enact behaviours associated with border control.

Charging for maternity care

In the UK, maternity care is free at point of access, as it is deemed immediately necessary (Department of Health and Social Care, 2024). However, those who are 'not usually resident' in the UK are liable to face charges after accessing care (Bragg et al, 2024). There are safeguards in place to protect refugees, asylum seekers and victims of human trafficking and domestic violence; however, there are multiple examples of vulnerable women seeking sanctuary still incurring a charge or being wrongly charged for accessing services (Pellegrino et al, 2021). If an individual accrues a debt, this acts against them in any future asylum claims to the Home Office.

Charging policies are faceless and rely on NHS staff to deliver them on the ground, presenting a significant moral dilemma for those in positions of care (Feldman et al, 2019). Uthayajumar-Cumarasamy (2020) argued that 'nurses, doctors and other frontline staff are in danger of becoming an arms-length border control entity and an extension of the state's social apparatus of oppression'.

Charging acts as a deterrent for women accessing maternity care (Essex et al, 2020; Bragg et al, 2024) and a lack of antenatal care increases the likelihood of maternal morbidity and mortality (World Health Organization, 2016; National Institute for Health and Care Excellence, 2021; Felker et al, 2024). The European Court of Human Rights case Ternovsky v Hungary (2010) determined that Article 8 of the Human Rights Act encompasses the right to choose the circumstances of becoming a parent, including the place and circumstance of birth. Charging policies can violate this right; for example, if an individual is worried about charging, they may not access care they would have otherwise had, perhaps choosing an unassisted home birth as opposed to going to hospital (Brunton and Waterfall, 2024; Pierce et al, 2024). These policies also undermine Article 2, the right to life.

Charges are often incorrectly applied (Jones et al, 2022a). Maternity Action has been working alongside NHS partners to develop guidance for overseas visiting teams and maternity professionals to help them better understand policies and stop this from happening (Bragg et al, 2024). The guidance states that overseas visiting teams should trust midwifery or obstetric judgement regarding women who fall within exemptions for female genital mutilation, sexual violence, domestic violence or torture. It then further stipulates that 'finance staff should not request further evidence', indicating that multiple cases have involved finance teams directly requesting evidence to prove torture or violence against women (Bragg et al, 2024).

NHS charging increases women's vulnerability to domestic abuse and exploitation. Women entering the UK on spousal visas are entitled to NHS services if they pay the immigration health surcharge. However, leaving the relationship can invalidate this entitlement, making them liable for charges and more vulnerable to domestic abuse (Harris and Hardwick, 2019; Gower

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and McKinney, 2024). Evidence shows that violence often begins during pregnancy, affecting 20–30% of women (Women's Aid, 2019). This policy flaw increases the risk of abuse, as women may feel unable to leave violent relationships.

While exemptions exist for domestic violence survivors, many are unaware of them or may fear disclosure as a result of stigma, fear or dependence on their partner's immigration status (Heron et al, 2022). Definitions of abuse also vary culturally, and many women may not recognise certain behaviours as violence (Graca, 2017), with evidence showing that ethnic minority women often stay longer in abusive relationships because of intersecting cultural and structural barriers (Siddiqui, 2018; Azad, 2021). Fear of healthcare charging may further deter women from escaping abuse, potentially breaching Article 3, which prohibits inhuman or degrading treatment.

Charging policies have a significant impact on midwives, who must collect data about women that are then passed to overseas visiting teams. Midwives have a duty to provide person-centred care that fosters compassionate and trusting relationships (Kirkham, 2010; NMC, 2018). A report by Maternity Action highlighted that midwives felt that charges prevented them from advocating for women, feeling uncomfortable asking questions surrounding migrant status, as this damaged trust (Feldman et al, 2019). They also felt that charging policies made their job more difficult, as they presented a moral dilemma between providing holistic care (NMC, 2018) and enacting their duty to the institution by following protocol (Feldman et al, 2019). This demonstrates how certain policies infringe on a midwife's ability to uphold and protect the human rights of women in her care, knowing that if a woman is charged, it may land her in destitution or deter her from seeking care.

Impact of PREVENT

Women seeking sanctuary come from diverse religious, cultural and ethnic backgrounds. While broader issues of racism and stereotyping may affect many of these women, a full discussion of this is beyond the scope of this article. This article instead focuses on Muslim or visibly Muslim families, whose rights may be disproportionately affected when accessing maternity services. This focus is informed by the religious framing of PREVENT training, which is mandatory for midwives and may, on reflection, raise significant concerns.

In the UK, public sector workers, including educators, local authorities, the police and healthcare professionals, are required to complete the government's PREVENT training. This programme is framed as a safeguarding measure to prevent radicalisation (Home Office, 2023). However, Amnesty International (2023) found that PREVENT violates human rights law and has called for its abolition. The strategy is seen to breach several rights, particularly Article 14, by contributing to discrimination and undermining freedoms of expression, thought, conscience and religion.

While it is not exclusively focused on Muslim communities, PREVENT has faced sustained criticism for inciting community-level suspicion towards Muslims (Younis and Jadhav, 2020; Amnesty International, 2023; Runnymede Trust, 2024). Although the training also addresses far-right extremism and knife crime, the programme has been criticised for a colourblind approach, overlooking the role of race and how it is applied (Younis and Jadhav, 2020). Evidence shows that PREVENT has a disproportionate impact on Muslims; in healthcare settings, they are eight times more likely to be referred to PREVENT than non-Muslims (Runneymede Trust, 2024).

Younis and Jadhav (2020) suggested that PREVENT reflects a false assumption that clinicians are operating in a post-racial society, free of racial bias. However, this is contradicted in maternity care, where many ethnically minoritised women experience person-centred care as the exception, not as routine (MacLellan et al, 2022). Stark inequalities persist in maternal outcomes, with the MBRRACE-UK report showing black women are three times more likely to die, and Asian women twice as likely, as their white counterparts (Felker et al, 2024). Additional risks are observed among recent migrants and women with limited English proficiency (Felker et al, 2024).

The intersection between race and religion is crucial. The Invisible Report found that Muslim women often hesitate to discuss concerns related to religious values for fear of negative judgement from healthcare professionals (Gohir, 2022). Many report discriminatory treatment because of their faith, not being listened to and overall worse experiences (Gohir, 2022).

Islamophobia remains pervasive in British society (Runneymede Trust, 2024), influencing the midwife-mother relationship. Muslim men are often stereotyped as controlling or violent, framing them as threats in safeguarding narratives. This can undermine trust and reinforce surveillance. One study found that midwives viewed partner involvement as a barrier to building rapport with Pakistani women, interpreting male presence as a sign of dominance (Goodwin et al, 2018). Such views echo broader Western tropes of 'mistrusted masculinity' (Jørgensen, 2024), where Muslim fathers are cast as dangerous and unfit to engage positively with public institutions, including the NHS.

This harmful framing is amplified by media narratives, such as the 'Muslim grooming gang' rhetoric, which reinforce stereotypes of Muslim men as both religiously fanatical and misogynistic (Cockbain and Tufail, 2020).

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Even if PREVENT were abolished, these deep-seated community suspicions would remain, but PREVENT institutionalises these views, legitimising the association between Muslims and terror. In doing so, it transforms healthcare environments from spaces of care to sites of racialised scrutiny (Younis and Jadhav, 2020).

For midwives, there is a fundamental tension. PREVENT positions them as enforcers of state surveillance, relying on subjective assessments to judge who may pose a threat. This clashes with the core values of the NHS Constitution, as well as the Equality Act (2010) and the NMC (2018) code of conduct, which stipulate inclusivity, equality and non-discrimination. The result is a deep contradiction between policy and professional ethics.

An enforced state of destitution

The reality of day-to-day living for women seeking sanctuary is affected by hostile environment policies both to the detriment of their health and in violation of their rights. This article focuses mainly on finance, accommodation and food insecurity as measures that directly influence women's health and, as such, impact their human rights. These policies act indirectly to infringe on women's human rights and access to health. These systems of insecurity are so well embedded, it is difficult for midwives to enact tangible change to women's situations, further influencing a midwife's ability to do their job (Feldman et al, 2019).

Finance

Asylum-seeking women in the UK are reliant on asylum support payments of £49.18 per week under Section 95 (Gov.uk, 2024). Pregnant asylum seekers can claim an additional payment of £5.25 per week from 10 weeks' gestation, as well as £9.50 per week for a child under 1 year old and £5.25 per week for a child 1–3 years old (Bragg et al, 2024). The process for applying for additional payments is complex, and every year there are multiple cases of women's asylum claims being rejected and women being left destitute during the process of appealing their rejection (Arrowsmith, 2022).

The Royal College of Obstetricians and Gynecologists (2022), the Royal College of Midwives (2022), third sector organisations (Brunton and Waterfall, 2024) and academics (Ellul et al, 2020) have argued that the current UK system exacerbates destitution, deprivation and stress. Despite this, there has been limited political action to acknowledge the cumulative disadvantage faced by this demographic. Instead, there is increasing reliance on an under-funded third sector to support women to access the services they need (Brunton and Waterfall, 2024).

Healthy start vouchers increase access to vitamins, fruit and vegetables for those in the UK on the lowest incomes, but are currently not accessible for women seeking asylum (Barrett et al, 2024). The exclusion of these women from entitlement to a healthy start is a clear example of a policy that is damaging to health (Helen Bamber Foundation, 2024). This policy is subject to change, as there is a consultation underway to consider whether eligibility to healthy start vouchers should be extended to all families with no recourse to public funds and those seeking asylum (Project 17, 2024).

Accommodation

Housing has a significant impact on health (World Health Organization, 2018; Rolfe et al, 2020). People seeking asylum in the UK are often housed in initial accommodation centres, which are largely repurposed hotels and have been reported insuitable for pregnant people seeking sanctuary (Birthrights and Birth Companions, 2019; Jones et al, 2022b). Reports show women being housed in shared accommodation with men, hotel accommodation with limited availability of nutritious food and accommodation with limited access to facilities such as bathrooms and laundry or cooking facilities (Arrowsmith et al, 2022).

Dispersal policies mean that women can be moved at almost any stage throughout their pregnancy and, as such, will need to change maternity provider (Birthrights and Birth Companions, 2019). This disruption in care can be detrimental to health outcomes, with the potential to jeopardise the fundamental right to safe and appropriate care under Article 2 (the right to life).

When housed in full-board, accommodation providers are supposed to provide sanitary towels and equipment for women to sterilise bottles, but there are multiple reports of this not being the case (Helen Bamber Foundation, 2021). Instead, some women resort to washing bottles in small hotel sinks, which are also used to wash soiled clothing. The Home Office is also legally required to make weekly payments to pregnant women and children under 3 years old in full-board accommodation centres because of their additional nutritional requirements (Arrowsmith et al, 2022). However, a legal case against the Home Office found that they had broken the law by withholding this payment (Deighton Pierce Glynn, 2023).

The quality of accommodation is poor, with reports demonstrating a lack of privacy, vermin problems, lack of heating, poor quality food and overcrowding (Jones et al, 2022b; Human Rights Watch, 2023; Refugee Action, 2023). Significant issues can result from this overcrowding, including the spread of contagious disease and delayed childhood development (Refugee Action, 2023). The way that housing is arranged by the UK government is hostile by design, according to Refugee Action (2023), with 'private contractors ... subsidised by the government to run a system of violence, punishment

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Key points

- Midwives in the UK are impacted by government policies such as those enacted under the hostile environment.
- The concept of everyday bordering highlights how a midwife can, in some circumstances, embody the role of border control.
- A human rights-based approach shows how the hostile environment policies can be detrimental to women's care.
- Midwives are in a difficult position, bound by professional duties to provide compassionate, woman-centred care alongside duties to a system where vulnerable women can be charged for care and subject to discrimination.

and control – one that disproportionately impacts on people of colour and clearly bears all the hallmarks of racism and segregation'.

Housing systems consistently fail to support refugees and asylum seekers to maintain good health and this is having an impact on an intergenerational level (Duclos et al, 2024). When midwives attempt to make changes to women's housing situation, they are often overwhelmed with complex systems that are difficult to penetrate (Birthrights and Birth Companions, 2019). An individual healthcare professional's potential to make change is limited when the underlying structures of discrimination that impact unstable housing are so well embedded in the system (Duclos et al, 2024).

Food insecurity

Food insecurity is defined by the World Health Organization (2025) as not having physical, social and economic access to sufficient, safe and nutritious food that meets dietary needs and food preferences to support an active and healthy lifestyle. There is copious evidence that food availability, access, stability and quality is poor in initial accommodation hotels (Jones et al, 2022b, Refugee Action, 2023, Duclos et al, 2024).

Food insecurity has a negative impact on physical health, particularly for women during pregnancy and while breastfeeding. Crucially, women living in hotels have a lack of agency over food choice and timing of meals. During pregnancy, a woman may need to change her diet or alter eating times to manage common issues such as food aversions, nausea and heartburn or, significantly, hyperemesis gravidarum, gestational diabetes, anaemia or vitamin deficiency. Multiple reports have noted that the food is poor quality, repetitive and not suitable during pregnancy (Feldman et al, 2019; Arrowsmith et al, 2022; Jones et al, 2022b). Multiple health complaints among asylum-seekers have been attributed to the quality of food, including weight loss, stomach pains and rectal bleeding (Jones et al, 2022b), with 75% of those living in hotels facing hunger and malnutrition (Refugee Action, 2023).

Food insecurity also has a detrimental effect on mental health. This is particularly the case for parents, who are unable to provide for their children (Trussell, 2022). A lack of control over one's life (including accommodation, facilities and diet) significantly impacts the mental health of refugees and asylum seekers across the UK (Pollard and Howard, 2021). Pregnant women are likely to have compounding factors that make them more vulnerable to deteriorating mental health, including experiences of torture, sexual violence, domestic abuse, conflict, being in a minority ethnic group, bereavement and acculturation difficulties (Rowe et al, 2023). In addition, women may feel guilty regarding their inability to follow medical advice to improve their diet, given their limited autonomy over their living circumstances. Asylum seekers have limited autonomy and agency over their situation, and this powerlessness in itself can increase apathy and low mood (van Eggermont Arwidson et al, 2022; Moore et al, 2022). If women do have mental health issues, this demographic are less likely to seek professional help because of different cultural conceptualisations and stigma towards mental illness (Firth et al, 2022).

Midwives can attempt to work with hotel service providers to lobby for improved access to food, navigate local third sector organisations and write to the Home Office on behalf of women living in these conditions (Brunton and Waterfall, 2024; Fuller, 2024) but not all midwives have the knowledge or capacity to be this proactive. Midwives must navigate a complex middle ground between border force, social work and liaising with the third sector to meet women's basic needs, maintain a trusting relationship and comply with duties to the public sector (Sanders, 2021). Further research is needed into whether midwives themselves identify with the notion of being a 'border force', and potential strategies to overcome this limitation to their practice.

Conclusions

This article used a human rights-based approach to demonstrate how midwives may unconsciously embody the role of border force in embedding policies shaped by the hostile environment. Midwives are in a unique position to promote health and wellbeing, with a window of opportunity to make a positive impact on the lives of women and families in their communities. Where midwives are bound to also be compliant with hostile environment policies, their ability to foster positive relationships, promote healthy lifestyles and provide safe care may be severely compromised.

The concept of everyday bordering highlights how midwives are rendered part of a system where the responsibilities of a border force are held by normal members of British society. Here, even the most compassionate midwife is limited in their capacity to

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make a change by structural issues beyond their control. The impact of these policies not only prevents midwives from doing their jobs, but also violates the human rights of women seeking sanctuary in the UK.

This analysis should be used to argue against the use of charging for maternity services and hotel accommodation for pregnant women and in critique of the mandatory PREVENT training package. Research has demonstrated the insufficiency of hotel accommodation for pregnant women and the negative consequences of charging for maternity care. Further research is therefore urgently required to evaluate the impact of PREVENT training on midwives' relationships with women and, more broadly, the impact of hostile environment policies on midwives and women seeking sanctuary in the UK. **BJM**

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CPD reflective questions

- How might a human rights-based approach suit other topics in maternity services?
- How could you challenge the rhetoric surrounding everyday bordering in your role as a midwife?
- Do you feel that elements of your practice are affected by hostile environment policies?

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