Improving Care for Refugees and Asylum Seekers
The Experiences of Midwives
Maternity Action is a national charity working to challenge inequality and promote the health and wellbeing of all pregnant women, new mothers and their families.

www.maternityaction.org.uk
Company no. 6478568  Charity no. 1128776

December 2011

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We gratefully acknowledge support from Comic Relief
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Improving Care for Refugees and Asylum Seekers: The Experiences of Midwives
1. Introduction and Methodology

This research is part of a training needs analysis for the Maternity Action course, ‘Improving care for asylum seeking women’. The course, which is for midwives, is a response to the very poor maternal health outcomes amongst refugee and asylum seeking women (CEMACH 2007). A full report on the development and piloting of the course is available at http://www.maternityactiontraining.org.uk/project_reports.html

The Questionnaire

A short questionnaire was drafted, to capture the experiences of Consultant Midwives and midwives working closely with refugees and asylum seekers (see Appendix 1). This was piloted with a midwife who was not connected with the project, then developed and approved. The questionnaire enabled the interviewer to establish whether the midwife worked closely with refugees and asylum seekers, then to seek her views on particular aspects of working with these groups of women and to find out about particular experiences.

The questionnaire explored barriers to providing care, asking about the specific barriers midwives face when providing maternity care for refugees and asylum seekers. It also asked how what would make it easier to provide better care, both in terms of the midwives themselves and by other midwives. It also asked if the midwife had had any contact with the Home Office or the UKBA and asked whether there was a particular case study she might be able to relay which could be used in the training. There was an opportunity for the interviewee to elaborate on any of the answers given, as well as the opportunity to mention anything which had not already been covered elsewhere.

At the start of the interview, all midwives were informed of its purpose, and assured that any information given would remain confidential and only disclosed with the individual’s permission. This included a short explanation about the work of Maternity Action.

Compiling the List

An initial list of Consultant Midwives and midwives who work closely with refugees and asylum seekers was compiled. This list was added to and developed throughout the course of the interview process. The Royal College of Midwives kindly agreed to circulate information about the interviews to their Consultant Midwives, many of whom cascaded this to their staff, sometimes passing on the names of midwives who specialised in working with refugees and asylum seekers.

All of the maternity units in the country, including midwife-led units, were contacted by phone and asked if they had a specialist midwife. An existing list of maternity services, which had been compiled for another project, was used. In most cases, this ‘refugee and asylum seeker’ specialism comes under the heading of ‘vulnerable women’, which may include women with mental health problems, teenage parents, women who do not speak English, and homeless women. The names of all of these midwives were added to the list, with their specific job titles noted.

Several names of specialist midwives were found via extensive online searching, using key terms, such as ‘specialist’, ‘refugee’, ‘midwife’, ‘asylum seeker’. This was also useful for locating midwives who have an academic interest in the issues around refugee and asylum seeking women and enabled a number of useful contacts to be made, including a midwife who had recently been awarded a bursary to undertake research into a similar area. Major search engines were used, which often revealed particular activities of specialist midwives, such as breastfeeding cafés, antenatal classes...
for women who do not speak English, and GP specialist practices.

If the researcher was informed that there were no refugees or asylum seekers in a particular area, this was also noted on the list. There was some concern over the knowledge of definitions amongst administrators and even some midwives when asked about refugees and asylum seekers; the researcher was told on several occasions -

_We have a lot of Polish women in this area._

When asked about barriers to caring for refugees and asylum seekers, one midwife mentioned a Portuguese teenager she had cared for. Many midwives also seem to put Roma communities in the same category as refugees and asylum seekers, and there were ambiguities around the definitions of ‘refugees’, ‘asylum seekers’ and ‘migrants’.

On at least two occasions, it appeared that a midwife working closely with refugees and asylum seekers did not seem to differentiate their needs from any other non-UK group.

On several occasions, the researcher was informed that all of the midwives care for all women, regardless of their circumstances. Occasionally, the contact details of the Community Midwifery Manager were given; an e-mail would then be sent to them with a request that they cascade it to the relevant midwives. This invited any interested midwives to contact Maternity Action to give a short interview. Very few midwives took up this offer, though useful information was gleaned when they did, such as a lengthy interview with a midwife who works at a maternity unit close to Heathrow airport and cares for asylum seekers on a daily basis.

Most midwife-led units did not have a specialist, and generally referred the researcher to the Head of Midwifery based at the nearest major hospital, often passing on their name. In several cases, one specialist midwife took responsibility for the refugees and asylum seekers across a considerable geographical area; sometimes even these ‘specialists’ had a plethora of other responsibilities.

The list of midwives was as detailed as possible, including contact details, bases, addresses, phone numbers, a mobile number if possible, e-mail addresses, and any relevant information, including job-shares, connections with midwife-led units and hospitals, and an indication of which area of the country was covered. Every call made was logged, with the time, date and outcome of the call. Any other useful information gleaned was recorded in the spreadsheet, for example, an individual’s involvement with relevant organisations, such as universities or NHS regulatory bodies.

It was quite usual for the person answering the phone to not know whether their unit had a midwife specialising in working with refugees and asylum seekers. However, they were usually quick to consult someone who knew, or to provide an alternative name of someone who would know, often accompanied by a phone number or e-mail address.

The list was added to and amended throughout the research period. Formal quantitative research targets were not set, but the researcher was keen to speak to at least forty midwives if possible, from across the UK. Early in the interview process, it became clear that a full day spent attempting to contact midwives to conduct interviews often resulted in just one interview. On average, just 12% of calls resulted in interviews.

**The Actual Interview Process**

Once the questionnaire had been approved and the initial list of names compiled, the phone calls began. Calls were not made in any particular order. Every call was logged, with the time, date and outcome of the call noted. When a midwife was not available, the researcher made a detailed note of when they would be available, then made a note in her diary as to when to call. This was important as community midwives were often with clients, or travelling between appointments. Calling at an appointed time created a professional impression, which helps to gain information relating to experiences of the individual. Midwives were being asked to give up some
of their time to help with the research, therefore it was important to try not to inconvenience them.

If a midwife received a call on her mobile on her day-off (not all of the community midwives had a work mobile), she was usually still prepared to talk to the researcher. In fact, the lack of time pressure meant that these interviews provided valuable information.

If the researcher was informed that there were no refugees or asylum seekers in a particular area, this was noted, along with any comments relating to all midwives providing care for women, regardless of their background. One midwife seemed surprised that the researcher was implying that any particular specialist care might be needed for refugees and asylum seekers. This midwife was very much the exception.

A couple of recipients of research calls stated -

_We don’t have that problem here_

when asked if they had a midwife specialising in working with refugees and asylum seekers. This perhaps reflects some societal attitudes towards refugees and asylum seekers, but this was not explored any further. This response tended to come from administrative staff, rather than midwives who actually work with the women.

If a particular midwife had left the organisation or was not involved with working with refugees and asylum seekers, this was logged, together with any alternative contacts. If the name of a non-clinical manager was given, they were generally not called, due to the nature of the research, which required information from midwives themselves, rather than from administrative managers.

Occasionally, midwives were reluctant to speak to the researcher without checking with their manager, receiving information in writing, or, on one occasion, checking with their Research Department. Once they were satisfied that the research was genuine and that it was to be used in the development of a training course for midwives, most were happy to help.

There was not a set formula used to dictate how many times the researcher telephoned a particular midwife, attempting to conduct an interview. Where a name of a specialist midwife had come up a number of times, the researcher endeavoured to contact her, leaving messages on office numbers, mobile numbers, and sending e-mails. Specialist midwives often work across multiple sites, spending a morning in one clinic, then the afternoon in another, making them difficult to contact. They often run other specialist clinics for other groups, including teenage parents or women with HIV. Often the person answering the phone was not sure when the midwife would next be at a particular site. Of interest also was the fact that if the specialist midwife was on annual leave, or on a course, her clinic was generally cancelled.

The researcher made a point of persisting in trying to contact specialist midwives who were known to work in an area where there is a concentration of refugees and asylum seekers, such as Leicester and Liverpool. This resulted in several very useful interviews with midwives with a great deal of experience in working with these groups of women. Many examples of good practice were given by these midwives, including the development of Local Care Pathways (LCPs) for asylum seekers, information-sharing days, and specialist practices.

Midwives were generally happy to give out the contact details for their colleagues who specialised in working with refugees and asylum seekers, though messages were often ignored. Often when e-mail addresses were requested for particular midwives, there was uncertainty about the format of e-mail addresses, or the spelling of specialist midwives’ names. E-mails bounced back on a number of occasions and had to be re-sent.

The researcher was keen to speak to as many Consultant Midwives as possible as they were often able to give a strategic perspective, as well as practical experience of working directly with refugee and asylum-seeking women. They were generally very willing to speak to the researcher, and some offered names of useful contacts, as well as suggestions about other relevant organisations, academic papers and an insight which was different from that of the midwife.
Whilst calling a maternity unit in the East of England, the researcher happened to speak to the Strategic Lead for Maternity Services in that SHA area. She was interested in the research and circulated the questionnaire to her colleagues, requesting that they contact the researcher to provide an interview, which several did.

**Practicalities**

The interviews varied in length. The shortest was less than five minutes, and the longest over forty-five minutes. The exact lengths of individual calls were not recorded, but it is estimated that they lasted an average of twelve minutes each.

The midwives were often pushed for time and apologetic that they were not able to speak for longer. On one occasion a midwife was called away before the interview had finished.

Midwives often seemed pleased to be asked to talk about their experiences, and it transpired that they rarely had the opportunity to do this. They were appreciative of the opportunity to share their experiences and their views on how things could be improved.

In one interview in particular, the midwife voluntarily reflected on the profound impact that meeting a certain asylum seeker had on her. She had become friends with an asylum seeker and cared for her throughout her pregnancy, staying in touch when she was dispersed to the other side of the country. They lost touch eventually, and the midwife assumed that she had been removed to her country of origin.

**Difficulties**

Contacting the relevant midwives was not straightforward. Approximately 432 phone calls were made to maternity services, midwife-led units and community midwives, resulting in sixty-two interviews.

Often the greatest challenge was actually finding a time when the midwives with the most experience of working with refugees and asylum seeking women were available to speak. It was useful to speak to Community Midwives, but many offices of Community Midwives are only staffed at certain times, with Community Midwives checking-in at the beginning of the day to collect messages, then spending the rest of the day travelling between appointments.

Where the interview questions were e-mailed as requested, it was rare to receive any response. It was assumed that this was due to time pressure, rather than lack of interest. Many midwives, when asked for their e-mail address at the end of the interview, gave their personal rather than work address, with some stating that they rarely check their work e-mail. One was quoted as saying,

*Don’t send it to my work address - I check my work e-mail about once every three months.*

Messages left on the answerphones of Consultant Midwives, Community Midwives Offices and the mobiles of midwives were often not returned. It is conceivable that midwives thought we were ‘cold-calling’, though the messages left were always clear and succinct. Consultant Midwives were often in meetings. Some phone numbers did not have answerphones. When phones were constantly engaged, the researcher would contact the switchboard, after finding the number on the internet, to see if she could be put through on another line.

Some interviews with Community Midwives took place whilst they drove between appointments, using ‘hands-free’ equipment in their cars. They were usually very happy to share their experiences, even pleased to be given the opportunity to talk about them, but they were often pushed for time and not able to speak for as long as would have been ideal. Many midwives struggled to think ‘on the spot’ when they were asked if they would be able to provide a case study. Several said they would call back with one, or e-mail, but in practice, case studies were only received retrospectively on one occasion.

In total, sixty-two interviews were conducted, mostly by phone. One was conducted face-to-face as the midwife was attending the same meeting as the Researcher; a couple were received in the post or e-mailed to the...
Researcher. Generally, the questionnaires which were not conducted by phone or in person did not provide much detail, making them less useful.

Of the sixty-two interviews, fourteen were conducted with Consultant Midwives. The rest were conducted variously with Community Midwives, Specialist Midwives, those working in Children's Centres and other midwives who do not have a specialism in their job description, but work closely with Refugee and Asylum Seeking women in their general role. The specialisms included Safeguarding, Female Genital Mutilation (FGM), Black and Minority Ethnic (BME), Domestic Violence (DV) and Mental Health. Just four midwives had ‘Refugees and Asylum Seekers’ in their job title. One midwife has the job title, ‘Specialist Midwife for Equality, Diversity and Human Rights’. Another midwife used to be based in a Detention Centre which is no longer operational.

Some of these Midwives had management responsibilities, including ‘Midwifery Managers’ and ‘Supervisors of Midwives’. The Researcher also spoke to midwives who work in teams dedicated to working with vulnerable women, including refugees and asylum seekers. These teams have names such as ‘Gateway’ and ‘Crystal Team’.

A considerable effort was made to speak with those specialising in working with refugees and asylum seekers, as well as midwives working in specialist clinics. Unfortunately, numerous calls were not returned, despite constant attempts to speak with particular midwives.

In terms of the geographical spread of interviews, whilst efforts were made to speak to Consultant Midwives and those working with refugees and asylum seekers across the UK, the majority of the sixty-one interviews were conducted with midwives working in London, as figure 1 shows. Figure 2 shows where those midwives who the researcher contacted were based.
2. Barriers

Language and Communication

NICE guidance\(^1\) identified language as a key barrier faced by recent migrants, refugees and asylum seekers in accessing antenatal care. This is reflected in the feedback from midwives who consistently identified language and communication issues as a barrier to providing care for refugees and asylum seekers. While many midwives considered language to be a significant barrier, others were adamant that this could be readily overcome.

Language can be a barrier at the initial consultation, but the midwives can book interpreters and use Language Line, so this is not a good excuse for a midwife to use!

A Consultant Midwife agreed with this, stating, ‘language is not a problem. We accommodate a lot of language services and are quite used to using them’.

In terms of current practice, all NHS Trusts have an interpreting service and many use The Big Word or Language Line for telephone interpreting.

Policy on the use of interpreters varies considerably across the Trusts. Telephone interpreting has revolutionised interpreting in some areas, with some midwives reporting that they can readily access interpreters via phone interpreting services, even for short conversations such as to arrange an appointment. Several midwives commented on the impact of costs on policies on the use of interpreters.

Midwives face specific challenges in relation to language and communication. A lack of interpreters from particular language groups was an issue for midwives in some geographical areas. One specialist midwife stated:

Most of the asylum seekers I work with are Chinese, which is a problem as there are no Chinese interpreters at all.

Some midwives reported that face-to-face interpreters are not always available out of hours. Face-to-face interpreters often have to be booked twenty-four hours in advance, which is often not feasible in the maternity setting.

Midwives reported some instances of good practice in language support. Where services for refugees and asylum seekers operate, such as specialist clinics for pregnant asylum seekers, interpreters may attend at certain times, giving continuity to the women and being present in case a new patient attends who requires an interpreter.

However, there is also evidence of bad practice. Midwives reported that family members, including children and husbands, are sometimes used to interpret if an official interpreter is not available. Although often done as a matter of course, this is bad practice and goes against all guidance regarding the use of interpreters, including the specific recommendations of the CEMACH report\(^2\).

Cost is a consideration in the use of interpreters. Several midwives commented that concerns about costs affected their ability to use interpreters when they were needed.

Our midwives could book face-to-face interpreters easily, but we had a problem when, like many trusts, there had to be cost savings. One approach was to stop face-to-face interpreting, so staff had to go through a

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\(^1\) National Institute for Health and Clinical Excellence (NICE) Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors (2010)

complex internal authorisation process to book interpreters.

One midwife commented on the changing approach to interpreters within her maternity service -

We were put on 'special measures', partly because we were not routinely using interpreters. We had a big push to encourage staff to use interpreters, and ended up with a huge bill for interpreting. So now we have to try and avoid using them.

Midwives also reported that cost concerns left managers reluctant to approve translation of material into useful languages and dialects.

Midwives reported a lack of written information in the language spoken by refugee and asylum seeking women. They also identified a need for picture-based resources as some women have limited literacy in their own language.

A Specialist Midwife explained -

It would be ideal to have every language on tap, but there are serious cost implications. It's really important to ask questions about previous health, and rape, and whether they are happy about the pregnancy. Lots of the women are very depressed, and have left their families behind.

A Consultant Midwife who had worked closely with Refugees and Asylum Seekers in a detention centre said

Some sort of resources would have been useful for communication, such as picture books, but nobody would fund this! Even our own trust would not pay for translation!

Several midwives mentioned that they had designed resources to help overcome this problem, such as picture books and photographs. In most cases, the midwives had done this in their own time, outside of their contracted hours.

Midwives identified a number of other barriers to effective communication. Many women seeking asylum have fled situations where they have been persecuted by people in authority and may be reluctant to trust healthcare professionals in the UK. In some countries, health professionals have been known to take part in the torture of individuals. Women may also be embarrassed or ashamed to disclose experiences of rape and hence not feel comfortable communicating with anyone, especially those who are, in their mind, associated with the establishment.

An interview was conducted with a midwife who had been based previously at an emergency accommodation unit, which has since closed. She stated -

There were loads of barriers to providing care, including communication and language. The women wouldn’t trust anybody in authority. They thought the NHS staff were working for the immigration agency. Many of the women were rape victims, and they were embarrassed and ashamed. They would present very late, sometimes at 36 weeks, as they had often just arrived in the country.

The midwives also reported a general lack of understanding about the NHS. Some women were not familiar with the role of the midwife, considering birth to be a very medical process requiring a doctor, rather than a midwife. Some women were unfamiliar with antenatal care as this was not available in their home country. Many asylum seekers present for antenatal care without having registered with a GP, so do not understand the support services the GP is able to provide or refer to.
Engagement with Maternity Services

Many midwives mentioned that pregnant asylum seekers often present very late in their pregnancy, putting their babies at risk and leaving themselves with very little time to prepare for labour. A Community Midwifery Manager stated,

*Many lack an understanding of the system in the UK for provision for maternity care and therefore either book late and miss important advice or screening tests, and you are alerted to the situation by another professional. Initially some are unable to register with GP surgeries as they have no proof of identification.*

A Specialist Midwife suggested that ‘women from certain African and Chinese groups present late, or they don’t present at all’.

A Consultant Midwife suggested -

*These women are vulnerable. They often have no idea of the services they can access. This makes them more vulnerable as they don’t access services at the right time.*

One Community Midwife suggested, ‘these women undoubtedly book later than average and I am sure this is partly due to the distrust and anxieties they have’. Another said, ‘women turn up late, having had no antenatal care’.

One of the UK’s few Specialist Midwives for Asylum Seekers explained the importance of communicating effectively with pregnant asylum seekers, when they did not attend appointments. Rather than sending them a letter each time they missed an appointment, she developed the policy and instead phoned or sent text messages to the non-attenders as this was a less threatening way of communicating. Across a period of time, this became more cost effective and enabled the midwives to understand why appointments were being missed.

It became clear that many asylum seekers had not registered with a GP. Midwives reported that in some areas, there are well-established specialist practices for asylum seekers, which have unlimited language support and other services for asylum seekers; though these practices can only be used by those who have registered with them.

Many midwives commented that late booking or missed appointments may reflect the woman’s complex needs and competing priorities.

*A Consultant Midwife suggested*

*If a woman is in a scenario of not knowing where to get information from, who to get it from, and how to link into services, being pregnant might be the least of her problems. Asylum seeking women often have many other issues going on.*

A Consultant Midwife who has a great deal of experience of working with asylum seeking women mentioned how midwives and the NHS in general, should not pre-empt the woman’s needs -

*Their priorities are not our priorities. We pre-empt what we think their priorities should be. We have an excellent NHS, but do women from other cultures value it? They value being safe, being alive for their children. There is a degree of arrogance amongst us.*
Complexity of Rights and Entitlements

The midwives, including the Consultant Midwives, reported widespread confusion around the rights and entitlements of asylum seeking women and often a sense of helplessness that they cannot do more. Asylum seekers are not entitled to mainstream benefits and are instead reliant on payments from the UK Border Agency. Some refused asylum seekers are not entitled to any payments and are destitute. Refused asylum seekers are subject to charging for NHS care, including maternity care.

A number of midwives commented that information on entitlements was not very clear in the places where one would assume clear and succinct information should be found -

It’s not easy to find things on the Home Office website, and the Local Authorities don’t necessarily know.

Other midwives made reference to their lack of knowledge of entitlements in relation to leave, financial support, and vouchers. One stated – ‘I don’t really know much about entitlements; I’d like to know’.

There was a great deal of confusion around entitlement to NHS maternity care, with midwives questioning what asylum seekers and refugees are entitled to.

I’m not really sure what their entitlements are. There’s always the issue of payment; are they entitled to care, or not?

Midwives reported being unsure of regarding entitlements –

A lady came from Pakistan, on her husband’s visa. He had left her due to DV. No one was sure if she was entitled to care, housing or benefits.

Another reported the difficulties around making referrals when they are not sure about the rules -

It’s hard to understand the rules around entitlement, especially when making referrals.

There was a sense that neither midwives nor women they are caring for are familiar with entitlements, suggesting that information which is being conveyed may be inaccurate or unclear,

A Community midwife commented on the impact of confusion about entitlements on the care provided to asylum seeking women -

The lack of information regarding the asylum process which impacts on social support we can give. I would like information regarding their financial and social status and how this can impact on their pregnancy. I just feel I don’t always have enough knowledge to advise them. The system appears muddled for them and the information they are able to give is often poor, directly affecting the care we can offer.

Several midwives commented on the advocacy role played by midwives, and the importance of midwives understanding the women’s rights and entitlements.

Frequently, the midwives have to intervene. Sometimes they accompany women to appointments. They have an advocacy role. It seems to legitimise a claim if a midwife is involved. But midwives need to understand the context. They seem to have a remit to advise on rights and entitlements.

Another said –

The women don’t understand the system. It’s up to the midwives to have that knowledge.
Where women had No Recourse to Public Funds (NRPF), midwives were unsure of where to refer them –

When they are NRPF, where else can destitute families go?

Another midwife cited the case of a mother she had worked with recently. The midwife wanted to help her but was unsure where she should refer.

We had a lady recently from Nepal. She was experiencing Domestic Violence but had No Recourse to Public Funds, so was not entitled to support. She was seeking asylum, but there was nothing that maternity services could offer her. She was stuck as she had no money, or anyone to help her or anything.

Several midwives suggested that a ‘One Stop Shop’ or central website of information they could access would be a useful resource which they would use to provide women with accurate information.

The midwives interviewed identified a lack of understanding of the asylum process as another barrier to providing care. None of the midwives who took part in the research had received any training in how the asylum process works. Instead, they relied on what they picked up ‘on the job’ and the knowledge of colleagues. Several midwives mentioned that it would be useful to them to have knowledge of the asylum process to help them to understand the situation the women may be coming from.

Midwives often develop their own knowledge and understanding of the asylum process, which can create a risk of inaccurate understanding if they are not clear on particular issues, including status and the experiences asylum seekers may have had. It is possible that this inaccurate information is then shared with colleagues, which may have a detrimental impact on the women.

Poverty and Destitution

Many of the midwives interviewed described poverty and destitution as significant barriers to providing effective care. It is quite usual for asylum seekers to have very few possessions and a lack of access to services and support networks. Asylum seekers may arrive in a poor state of health due to the poor healthcare in their countries of origin. They may have conditions affecting their physical health, such as rheumatic fever, HIV, TB or they may have mental health problems due to the treatment they have experienced.

Women may be in the scenario of not knowing where to get information from, who from and how to link into services. Being pregnant might be the least of their problems.

A Specialist Midwife expressed frustration at the way in which women are treated after a decision is made about their status, mentioning the health implications as well as the practical, and comparing the treatment of failed asylum seekers with UK citizens on other benefits -

When women are given leave to remain, it appears that they are given support, told what they are entitled to, helped to integrate into society, helped with housing and benefits. But when women are told they cannot stay, they become destitute and are given meagre amounts of money. These women may have low iron levels; they may bleed after birth. There are serious health implications for the women and the babies. We need to give them more money to buy food for their children. Why are we treating them like second class citizens? There is a huge difference between their entitlements and those who are on benefits like Jobseekers’ Allowance. Asylum Seekers get £300 at 36 weeks gestation – how can we expect women to prepare for a birth at such a late gestation?

Midwives reported that many appointments are missed because asylum seeking women do not have money for transport. Several midwives mentioned that they have given destitute asylum seekers their own money to pay the bus fare.
Several midwives explained that they help refugees and asylum seekers in very practical ways, such as providing baby clothes and equipment.

_With asylum seekers, I try to collect equipment for them, like baby clothes. I direct them to Refugee Action, if they are section 4, and drive them to appointments occasionally._

There were other examples of how midwives had personally supported asylum seekers and evidence that some midwives are in contact with local charity shops who may be able to provide baby equipment.

Where activities are provided specifically for asylum seeking women, such as Parentcraft classes or projects in partnership with local organisations, it may be difficult for destitute women to attend due to not having money for transport. There are examples of such projects which exist but are poorly attended.

Several midwives gave examples of emergency situations they have come across. One cited a particular example of a destitute asylum seeker -

_We had one lady we came across has no recourse to public funds. She had a loaf of bread, and a nappy. That was all she had. She didn’t even have the money to travel to social services. Social services told me to pay for her transport and to claim it back on expenses. When women are discharged after having their babies, they may not have anywhere to go, so the midwives have a whip-round and buy them food._

One of the midwives commented on the need to avoid making judgements about women when they are destitute. The situation a woman may find herself in when she becomes an asylum seeker may be quite different to the situation she has come from:

_Midwives need to avoid having stereotypes in their minds. Often these women look poor as they are destitute, but they have been high flyers in their countries. We need to defy the stereotypes._

One midwife mentioned how women may become destitute if their application is unsuccessful, and put forward a suggestion as to how this could be avoided

_When a woman’s application fails, she should be removed rather than left destitute, otherwise she is at risk and may become vulnerable to criminals._

**Dispersal**

Dispersal often presents particular issues in the provision of care. Midwives expressed frustration at the profound impact which dispersal can have on the life of the asylum seeking woman and on their own capacity to provide care. The quality of communication between UKBA and the midwives varies considerably across the country, to the extent that in some areas UKBA itself is considered to be a barrier to caring for asylum seeking women, due to the sporadic nature of dispersal, and inappropriate timing.

_With dispersal, we might see someone for two visits, then they deliver, then the woman may be told that she is going, but she is not told where._

Midwives reported spending a great deal of time trying to locate particular women, only to find that they had been dispersed to a different area of the country. There were also serious concerns over women being dispersed too close to the birth, or too soon after, both of which may adversely affect the woman’s health.

The impact of dispersal on the continuity of care is significant, and this theme was raised a number of times by the midwives interviewed.

_Often we have late dispersals into the area, or women are dispersed after their due date._

One Specialist Midwife made her feelings about dispersal very clear –
There are serious issues around dispersal. Women should not be dispersed when they are more than 36 weeks, as they are so vulnerable. Women who are established in an area, where they have networks etc., should not be moved at all if they are pregnant. Little thought goes into dispersal.

Another Specialist Midwife in another part of the country suggested that UKBA do nothing for the women who have fled traumatic situations abroad –

The women start to get some sort of independence in their life. But the UKBA has control. The women are often overwhelmed and intimidated by the whole asylum process.

Whilst there did seem to be mechanisms in place for midwives to contact midwives in the area where the women were being dispersed to, these were not always reliable as women can be dispersed at very short notice. We’re not sure on the rules around dispersal. It’s hard to track women in the post-natal period when they may be moved.

Some women feel that the UKBA have control of their lives, which can overwhelm and intimidate women who are already vulnerable, having fled traumatic situations.

A small number of midwives reported effective partnership working with UKBA –

I have very good links with UKBA. I used to find that patients didn’t attend, then I would spend time trying to find them, only to find out that they had been dispersed to another part of the country. Now they inform me when people are being dispersed. I also have a manager I can call and say ‘I have lost a patient – where have you moved her to?’

Housing

There are many problems associated with housing and a number of midwives suggested that housing was a significant factor in the women’s experience. One specialist midwife in London felt that ‘housing seems to be the biggest problem’, and another concluded - It’s very difficult to do anything with housing problems’. Suitable housing is considered a fundamental component in the women’s wellbeing, as she may be experiencing many uncertainties in her life.

Several midwives mentioned that they help women to understand letters they may receive from housing providers, demonstrating the pivotal role of the midwife in the woman’s experience.

A Specialist Midwife suggested that midwives need to step into social issues, like housing, and find out where they are in the system. Midwives need to understand this so they can understand the woman’s situation, the root cause of her depression and any safeguarding issues.

Many of the midwives interviewed made reference to the difficulties they have with housing providers where asylum seeking women have been given accommodation, with some good practice evident, and some notably poor practice.

The housing providers notify me when the women are pregnant, so I’m able to provide care ASAP and get the women into the system. Often women are presenting very late, because they have only just arrived in the area, thanks to UKBA.

Another midwife reported how she has been ‘appalled’ with the housing provider –

They [the housing providers] are very difficult. I had a severely mentally ill woman with a young child, who was heavily pregnant with another. The landlord would not provide a washing
machine, saying they should do the washing by hand! Also, I find that the doorbells are not always working; the landlords don’t see this as important and trivialise everything.

One midwife was particularly vocal about the treatment of asylum-seeking women, explaining

Some midwives aren’t aware about the UKBA grant. Women have to take their Maternity certificate to Refugee Action. How are they supposed to go and collect that with £3.50? UKBA expect them to have a long certificate, but that’s hard for them to get. I used to bully the housing people into helping them.

There are a number of issues raised here which make it difficult for the midwife to provide care. The midwives advocate on the woman’s behalf for even the most basic equipment. Situations such as this impact both the practicalities of providing care, and the provision of care itself.

A Community Midwife explained that refugee and asylum-seeking women are ‘socially disadvantaged, housed in undesirable places’. Another explained that the obligation on the housing provider is simply

To provide a roof and a baby cot.

The implication was that the housing provider does the bare minimum for the woman, often overlooking additional needs of the asylum-seeking woman.

Overcrowding was also mentioned as an issue which sometimes remains hidden:

Housing can be a problem. They say where they live, e.g. a 3-bedroom flat, but they don’t say that there are 8 people living in each room. They may be sleeping on someone’s couch, and have nowhere else to live. It’s hard to keep tabs on them as they move between the cracks in the system.

A Specialist Midwife expressed frustration at the time she used to spend locating families and mentioned a checking mechanism which has she has developed

I often go to a home to find that the family do not live there. Now I phone the housing provider first to check that is where they are.

There were some examples of good practice in relation to housing, but these were rare. These included midwives and housing providers being part of a partnership, which also involved social services. The purpose of the partnership was to help women in whichever way was most appropriate.

A Specialist Midwife stated

I have had a positive experience of the ‘Contract Compliance’ section of the UKBA, e.g. when the housing provider has not met the needs of the women re: housing. I often contact the ‘Section 4 team’ and they are very supportive.

Limited time and resources

A consistent theme in the interviews was that midwives did not have enough time to spend with asylum-seeking women to sufficiently address their needs and this is impacting on the quality of care provided.

Many midwives interviewed mentioned the need for individualised care for all women and the difficult of providing this with limited time and resources –

I try to make myself available for the vulnerable women and try to co-ordinate the best possible plan for the individual, but I come up against serious barriers.

One midwife remarked, when asked what could be done to make it easier to provide better care -

As a clinician, I would like to be a full-time specialist midwife. This role needs specialist
attention, someone who is able to access different types of organisations. And I would love to be able to provide postnatal care. I do not have the capacity to do this.

Specialist Midwives also remarked on the time constraints they face when working with asylum seekers with multiple complex needs;

The issues are so large, we can't deal with them in a short time. The women fear authority, and they don't understand the health service, so need to learn how to use services appropriately.

Specialist Midwives reported that they are rarely able to hold case conferences, under the Common Assessment Framework (CAF); midwives felt that they would like to ‘CAF’ every asylum seeking women they care for, to ensure that the relevant agencies become involved with the women’s situation, but this is beyond their means, both in terms of time and resources. Generally, CAF conferences are only held in exceptional circumstances by a few Trusts.

Specialist workers

Many of the midwives interviewed wanted specialist workers who would be able to give consistent, specialist care for asylum seeking women.

They reported that many trusts have specialists in particular fields, such as teenage parents, domestic violence and substance misuse, and some have teams dedicated to working with vulnerable women, but few have specialists whose job title includes refugees and asylum seekers specifically. Where there are specialists, this can mean that they are delivering just half a day of ‘specialist’ support, often in the form of a clinic for asylum seekers.

Those midwives working in specialist roles commonly reported that they had not received specialist training, and sometimes become specialist by default, rather than being recruited into a role. One outlined a particular need for training -

I spend .2 FTE working with asylum seeking and refugee women, which means I do two afternoon clinics a week, and see two women per hour. It would be helpful to have some counselling skills, to learn about how to discuss things like rape and HIV. The women don’t talk openly about their experiences. They want to come to the antenatal clinic and be looked after. Their actual delivery may bring back terrible experiences of rape, for example.

Midwives identified as a particular problem the lack of specialist knowledge in areas where there are not many asylum seekers. When an asylum seeker does arrive in an area, this can mean that there is no-one with knowledge and understanding of the health and other needs of asylum seekers, and this can impact on the quality of care provided.

Midwives need time to do things more slowly so that they can give asylum seeking women continuity of care, hence increasing the quality of care. They need proper teams of midwives to follow particular groups of women.

Midwives identified FGM specialists in particular as very important, as midwives do not routinely learn about FGM and the wider issues associated with it as part of their training. It appears that there is a lack of understanding about FGM and its health implications amongst some midwives, with very few specialist posts. FGM can have profound implications on the health of the woman.

One midwife suggested

We really need to have a specialist midwife or contact person to provide extra support and advice.

In addition to the support provided directly to asylum seeking women and to other midwives, specialist teams were valued because they are in a position to build effective networks within the asylum seeking communities, and on a wider scale with other organisations, such as community groups and NGOs.
However, one midwife mentioned that specialist midwives are not always used appropriately or at the right time.

One of the main barriers to providing refugee and asylum seeking women with the best possible antenatal care is that these women in their pregnancies are cared for solely by universal services and are not brought to the attention of specialist midwives for additional support, advice and signposting, until a crisis occurs.

A few midwives commented that assigning refugee and asylum seeking women to specialist teams could cause problems because of the stigma attached to specialist teams. They felt that this could impact on asylum seekers’ mental health, which may already be fragile. They also felt that it may make asylum seekers reluctant to seek help early on in their pregnancy. This pointed to the importance of appropriately skilled generalist midwives in addition to specialist services.

Outreach workers

Sometimes the ladies do not access care, so outreach is really important.

Midwives reported a profound need for outreach as significant numbers of refugee and asylum seeking women are not accessing maternity care services. Many said that specialist teams with responsibility for refugee and asylum seeking women would be beneficial -

We need a specialist midwife to develop an outreach service, visit community groups etc. But it is unlikely that the PCT would fund this.

Midwives expressed concern that the few existing outreach services are at risk of cuts, and some reported cuts to outreach services which had already occurred.

It would be ideal to have outreach midwives in the community who can go round hostels etc. meeting people, including community groups, to find those who are not accessing services. But I think lots of outreach posts are going to be cut, which will cause problems, then we’ll be back at square one. There are fears that the cuts will reduce outreach work and caseloading care.

Another midwife explained how the cutting of posts was affecting services.

There were two outreach workers who worked with asylum seekers with no recourse to public funds, but their jobs were recently axed by [a London PCT]. Up until the end of 2010, our staff would refer women onto them.
3. Improving Care

Outreach

The midwives interviewed identified a need for outreach to asylum seeking women as the women do not actively seek antenatal care, for a variety of reasons. Midwives are already working at capacity and often do not have time to outreach within their communities.

Some midwives identified a place for Maternity Outreach Workers, not necessarily midwives, who can build links with minority communities. It was considered that reaching out may not come naturally to some midwives, as it does not form part of their training, therefore experts are needed to develop outreach strategies.

Outreach is not generally within the remit of the midwife and if it is, it does not appear to be considered a key element. Outreach posts have been cut in some PCTs, hence there is a profound lack of outreach into asylum seeking communities.

Translated materials

Language and communication is one of the key barriers in providing care for refugee and asylum seeking women. Materials need to be made available in all relevant languages, and centrally funded so that local trusts are not required to bear the cost. There is a need for information such as booking forms to be available in relevant languages.

Whilst some services are very well set-up, with ready access to The Big Word or Language Line, there is scope for all services to have improved access to face-to-face interpreters.

Central website and national guidance

The idea of a central source of information for midwives working with refugees and asylum seekers was mentioned a number of times in the interviews. Midwives do not have the time to look for particular source of help each time they are caring for a woman with specific needs, therefore a central website would be very useful.

The idea of national guidance on working with refugees and asylum seekers came up in a number of the interviews.

In some areas there are Local Care Pathways, but we need to have a national plan which can be applied at a local level, and there doesn’t appear to be one.

A Midwifery Manager suggested, when asked what would make it easier to provide better care –

Producing a national directory for health professionals containing all the relevant information required to support and manage these women appropriately, including regional and local links, similar to the national ‘Domestic Violence’ information folder.

One Specialist Midwife suggested there was a need for national guidance from the Home Office and the Department of Health to enhance communication between these two departments.

There needs to be some sort of government response which can be filtered down to local level, as well as national or regional education and training.

Full-time specialists and specialist clinics

The midwives interviewed were conscious of time pressures on individuals and the pressure on
maternity services. Many mentioned that full-time specialist midwives with expertise in working with refugee and asylum seeking women would ease the pressure on them and allow the women to receive appropriate and more consistent care.

Appointing Specialist Midwives within maternity services would enable midwives to learn from these specialists, who could receive specialised training and be able to support their colleagues when required. Specialists develop a broad knowledge base, which would benefit midwives as well as asylum seekers and refugees.

Training

The need for training was apparent in the interviews with both the midwives and the Consultant Midwives. Several mentioned the lack of training on the topic for students. They stated that students are taught enough to be able to pass the examinations to qualify, but little about the backgrounds of women they are likely to be caring for.

None of the midwives interviewed had received any training specifically on working with refugees and asylum seekers and many identified a profound need for this as all knowledge and understanding is gained ‘on the job’. Midwives routinely attend training in Equality and Diversity as part of their statutory and mandatory training within their NHS organisation, and one Specialist Midwife mentioned that she runs training on working with immigrant communities, teaching people not to be judgemental etc.

Across the country, midwives receive training in many other areas –

Within my team, we have all been trained in DV (domestic violence) and child protection, but we have not had any training on asylum seekers. It would be good to have this, especially for sharing experiences and information.

Midwives in some parts of the UK receive training in FGM, though it is widely acknowledged that this is not routinely covered in the midwifery syllabus students follow. One Specialist Midwife, in an area where a significant proportion of the women have had FGM, explained -

We receive mandatory training on FGM, so we can all recognise it. Then we can refer women who have had FGM to our Specialist FGM Midwife and to Social Services.

Another Specialist FGM Midwife suggested

FGM needs to be included in Midwifery training. Students need to be taught how to assess, how to ask, how to raise awareness of the long-term health implications.

In particular, the possibility of local training on working with refugees and asylum seekers was considered useful

It would be difficult to put a training course on nationally, as you need to have the local knowledge with all the multi-agency working.

Another Specialist Midwife stated –

There is a big need for training. It is a huge learning curve for midwives, in terms of hearing these awful stories about things you could not dream up. It is shocking. Midwives need to avoid having stereotypes in their minds. Often these women look poor as they are destitute, but they have been ‘high flyers’ in their countries. We need to defy the stereotypes.

Another aspect of the need for training centres around the duty of care.

Midwives need training on what they can do for the women – where does the duty of care end?
Sufficient time to provide evidence-based, individualised care for all women

Common to many of the interviews was the fact that midwives feel that they do not have enough time to give to the women who need the most support. Many midwives reported that they do not have the time they need to give to each individual woman whom they come across –

*I try to make myself available for the vulnerable women and try to co-ordinate the best possible plan for the individual, but I come up against serious barriers. I can’t criticise the [local refugee organisation], but the logistics, especially the legal aspects, make things quite difficult.*

A Specialist Midwife was very clear about the need to identify and work closely with women according to their differing needs –

*From a safeguarding point of view, I think they should all be CAFd [hold a Common Assessment Framework conference] – as in an individual meeting for each individual asylum seeker. Then we could identify who would do what re: housing, immigration etc. This is done for some people, such as those who meet the criteria for safeguarding. We also need more Health Care Assistants and more midwives, to support each other.*
4. Contact with UKBA

Midwives were asked specifically if they had had any contact with UKBA as part of the questionnaire. The amount of contact varied considerably, with some midwives being in regular contact with UKBA and others having little or nothing to do with them. Where there had been contact, UKBA were described variously; sometimes they were ‘antagonistic’; other times they were ‘helpful’.

There are some examples of partnership working with UKBA, including a monthly meeting with a team working with asylum seekers, which is run by the local County Council and includes a representative from UKBA.

The majority of contact made with UKBA was instigated by the midwives themselves, either to clarify a particular woman’s status, to find out where someone was if she had disappeared, or to ask that a woman be excused from having to present in the late stages of pregnancy. Several midwives mentioned that they had written to UKBA outlining the needs of particular women whilst they had been detained, for example, to request that they receive meals in their rooms when they were recovering from a Caesarean section.

The nature of the contact varied –

* I have a couple of contacts at UKBA who can confirm status and entitlements; but this is quite informal.

One Specialist Midwife who has regular contact with UKBA stated

* I regularly speak to the immigration centre in [name of area], to establish when women need to report, why they aren’t getting their £3 extra, or to find out why they haven’t put a hold on reporting. They are helpful when I call, though the women do not find them helpful.

Another explained that she had had a positive experience of the ‘contract compliance’ section of the UKBA, such as when the housing provider has not met the needs of the women re: housing. I have often contacted the section 4 team and they have been supportive.

Another Specialist mentioned how she had developed a relationship with UKBA because of the problems with dispersal –

* I have very good links with UKBA. I used to find that patients didn’t attend, then I would spend time trying to find them, only to find out that they had been dispersed to another part of the country. Now they inform me when people are being dispersed. I also have a manager I can call and say ‘I have lost a patient – where have you moved her to?’

There were also examples of communication initiated by UKBA, rather than by the midwives.

* I am often contacted by UKBA when they want confirmation of a pregnancy date of a particular woman, as the woman may have given my name as a contact.

There was a sense amongst the midwives interviewed that there needed to be better communication with UKBA, and a better understanding of the situations of pregnant women, who continue to be dispersed inappropriately. Whilst there is some communication between UKBA and the midwives in some areas, the communication could become more formal, hence more useful to the women who are affected by issues such as being dispersed late into their pregnancy, or being required to sign on.
5. Examples of good practice

The interviews revealed numerous examples of good practice across the UK, some of which are outlined here. 250 women coming forward to be de-infibulated. They had not been aware of the service previously.

Integrated Care Pathways and Specialist Teams

Some NHS Trusts in the UK with a large population of refugees and asylum seekers have developed Care Pathways specifically for these groups. These enable clear communication within the trust and with other agencies, ensuring that all those involved with the care have a role and that the expectations are clear. These Care Pathways often include referral to teams of Specialist Midwives, Common Assessment Framework Conferences for women, and referrals to community organisations who may be in a position to offer other types of support.

In compiling the list of Specialist Midwives in the UK, it became clear that there are many examples of Specialist Teams of Midwives working with pregnant women who are vulnerable for a number of reasons.

English as a Second or Other Language (ESOL) for pregnant women

ESOL classes for pregnant women were given as an example of engaging with pregnant women who did not speak English. As well as empowering women, antenatal care can be included within this.

Outreach

There were some examples of effective outreach, including an FGM service which advertised its service on a British-based Somali television station and resulted in
6. Conclusion

Strong themes came out of the interviews, notably the lack of time to sufficiently support particular women. There were issues around sourcing and using interpreters in some areas, with profound differences in the accessibility to language services in various parts of the country. A general lack of understanding about the NHS amongst asylum seekers means that many pregnant women fear authority and may present in the latest stages of their pregnancy, which may pose threats to their health and that of their baby, and leaving them vulnerable.

A lack of a central information source about services, entitlements and asylum processes was also a key factor in the barriers faced by midwives caring for refugees and asylum seekers, along with a lack of training for midwives in the subject as a whole.

Poverty and destitution is another significant barrier, as pregnant asylum seeking women may be left without access to any services, further complicating their situation. Midwives told of the challenges they face when they have to discharge women who they know have nowhere to go.

Dispersal and the factors associated with it may also affect the care, due to women being dispersed late in their pregnancy. It is not unusual for a woman with a newborn child to be dispersed to a different area of the country, making ensuring she has the care she needs a challenge. Whilst there were some examples of good practice and partnership working between the midwives and the UKBA, there were more examples of bad practice mentioned. Housing companies are also renowned for being unsympathetic towards the needs of asylum seeking women.

Suggestions as to how the situation could be improved included more outreach within asylum seeking communities, better access to translated materials, a central source of information which midwives can consult, and local care pathways for asylum seekers and refugees. There are several examples of specially-developed care pathways which are in use in parts of the UK where there are large numbers of asylum seekers.

The interviews conducted provided a succinct overview of the experiences of midwives working with refugee and asylum seeking women, providing useful background information for the development of the 2-day training package which aims to address the issues raised in the interviews.
7. Appendices

Appendix 1 – Interview Questions

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<td>Interviews with consultant midwives and midwives with a specialist interest in asylum seekers</td>
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<tr>
<td>Maternity Action is a national charity which works to challenge inequality and improve the health and wellbeing of all pregnant women, new mothers and their families.</td>
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<tr>
<td>This survey is to explore what could be done to better support midwives to provide the highest quality care to refugee and asylum seeking women. We will use this information to inform and develop training and resources for midwives and in our campaigning work. Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission.</td>
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What is your name, position and employer?

Please describe your role and how it relates to refugees and asylum seekers?

What are some of the barriers to providing refugee and asylum seeking women with the best possible maternity care?

What could be done to make it easier for you to provide better care to refugees and asylum seekers?

What could be done to improve the care provided to refugees and asylum seekers by other midwives in your service?

Have you had any contact with the Home Office (UK Border Agency)?

If yes - why did you have contact with them and what happened? Would you be able to tell me a story of a particular woman you worked with, which we might be able to use as a case study?

Would you like to mention anything else that we haven’t mentioned already?

That is the end of the interview

We are preparing a training course and supporting resources for midwives to improve care for refugee and asylum seeking women.

We would like to keep you informed about the project. Are you happy for us to contact you?

If yes – what is your email address?
Maternity Action interviewed 62 midwives working with refugees and asylum seekers in different locations across the UK. This research informed the development of a two day training package for midwives aimed at improving maternity care for refugees and asylum seekers.