DELIVERING IN AN AGE OF SUPER-DIVERSITY

WEST MIDLANDS REVIEW OF MATERNITY SERVICES FOR MIGRANT WOMEN

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DR JENNY PHILLIMORE AND JAYNE THORNHILL WITH ZAHIRA LATIF, MARCIANNE UWIMANA AND DR LISA GOODSON

INSTITUTE OF APPLIED SOCIAL STUDIES
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FOR FURTHER INFORMATION CONTACT
J.A.PHILLIMORE@BHAM.AC.UK
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EXECUTIVE SUMMARY

In 2006, 1 in 5 births in the West Midlands were to women born outside the UK (Gardosi, 2007). Outcomes in pregnancy are worse in migrant women than in the indigenous population (Lewis, 2007), and net migration to the West Midlands continues to increase considerably (ONS, 2009). Little information is available regarding health and health care provision to newly arrived migrants. The report Maternity, Mortality and Migration: The Impact of New Communities (Taylor 2008) highlighted the financial, social and structural difficulties, and challenges faced by migrant women giving birth in Birmingham and the complex situations pregnant women may find themselves in. In particular the report highlighted the plight of pregnant women with No Recourse to Public Funds (NRPF) and the resulting destitution faced.

Other literature has identified some of the issues, barriers and enablers to migrants accessing services, and risk factors for infant mortality (Kanneh, 2009. Ipsos Mori, 2008, NICE 2010), but little is known about the experiences and needs of migrants accessing maternity and post-natal services across the West Midlands and the ways in which those experiences impact upon the health of migrant mothers and their children.

Following the publication of the Maternity, Mortality and Migration report, the Department of Health in the West Midlands and the West Midlands Strategic Migration Partnership developed a further proposal to identify the impact of migration in general on maternity services across the wider West Midlands. Local Authorities and other agencies were considering the impact of migration at this time, and the affect on health services was also identified at the 2009 Migration Matters conference held in Birmingham. The rising number of births to non-UK born mothers had been noted during this period, and was being seen in areas which had not traditionally been affected by migration or the presence of significant settled migrant communities.

The Institute of Applied Social Studies was appointed to undertake a research project focusing on the experiences of migrant women who had entered the UK within the last five years who had accessed maternity services in the West Midlands. The research was overseen by a multi-disciplinary steering group whose membership is set out in the acknowledgements section. The study sought to:

- Identify the views and experiences that migrant women have about maternity services across the West Midlands.
- Identify the barriers and enablers that influence the engagement of migrant women with general practice, maternity and postnatal services.
- Identify the ways in which migrant women access health, social care and support services.
- Identify differing health beliefs of migrant women from different countries, and their expectations of maternity services.
• Explore the above issues in different categories of women including refugees, asylum seekers, failed asylum seekers, and economic and spousal migrants.

• Identify the views and experiences of health, social care and charitable agencies working with pregnant migrant women.

• Identify the challenges faced when providing maternity care to these women, and possible solutions to improve current services.

• Examine the approaches for communicating information about maternity services to migrant women and explore the ways in which services might be developed to better meet the needs of migrant women.

KEY FINDINGS

FINDINGS FROM WOMEN’S PERSPECTIVES

The majority of migrant women were able to access maternity services before they reached the 12th week of pregnancy. Language and communication difficulties were reported as a key reason for non-attendance. Migrant mothers had difficulties attending antenatal care due to transport costs, dispersal and family commitments, including not being given permission to leave the house.

The majority of migrant women were able to access some form of advice about local services and financial support available, although those in rural areas, asylum seekers and failed asylum seekers had more difficulties in accessing information. Language was again a problem in obtaining information, as were difficulties in finding culturally sensitive information.

Most migrant women had a positive birth experience and felt well informed throughout the birth. However a number reported that their language, pain relief and cultural and religious needs had not been met.

Over a quarter of migrant women were unsatisfied with the postnatal care they received, with the lack of attention to the needs of the mother being highlighted. Some women did not understand the purpose of the health visitor home visits and a lack of support with postnatal depression was raised by a number of women.

A wide range of financial, social and structural difficulties were faced by migrant women, in particular, abusive and controlling relationships, poor housing conditions and a lack of basic essentials.

Migrant women made a range of suggestions of how maternity services could better meet their needs including;
• Provision of translated materials
• Longer appointments where English is not the first language
• Assessment of financial situation
• Support for recognition of women in abusive relationships
• Catering for diets, particularly in recognition of culture and religious needs
• Provision of sleeping facilities following the birth for other members of the family
• Improved postnatal checks on the mothers health
• Help and understanding with postnatal depression

FINDINGS FROM PROFESSIONALS’ PERSPECTIVES

Barriers Facing Migrant Women

A wide range of healthcare professionals working in different settings and localities within the West Midlands were interviewed to gain their insights into the challenges associated with this client group.

One of the key issues was ensuring migrant women were able to access maternity services appropriately. It was felt that many migrant women did not understand the NHS system and were not familiar with how antenatal care is provided in the UK. In addition, not all women were able to register with a GP, some arrived in the UK late in their pregnancy or were dispersed to different areas late in their pregnancy.

Language was also a key barrier. In some areas, non-English speaking women represented 50-75% of service users, yet professionals struggled to get hold of interpreters to enable a proper assessment. Often interpreters were unavailable or did not understand a woman’s dialect. In addition there were confidentiality or sensitivity issues if the wrong interpreter was used.

Appointments with health professionals in the NHS were normally up to fifteen minutes long which did not allow enough time to develop rapport with patients, particularly for vulnerable women. Health workers told of the NHS performance driven culture, which measured performance on quantity of people that are seen, rather than the quality of service provided to each patient. Health visitors were said to have issues around screening for postnatal depression, and did not know where to signpost women for support. In addition very few had received training on the use of the Common Assessment Framework and the identification of social risk factors was not always undertaken thoroughly.

It was felt that some women did not access services because they are frightened, or did not feel they are respected. Some women, particularly those with immigration problems, were scared that their baby would be taken away from or they may be detained. Attitudes of some health staff were also seen as a problem. Women with complex problems were apparently viewed as difficult to manage by some health staff. Women were not always
greeted in a friendly and welcoming manner, or made to feel safe. Migrant women reportedly felt that healthcare workers did not understand their problems.

Migrant women also had difficulties in attending appointments due to a lack of money for public transport or due work or to childcare commitments. Overcoming immediate problems, or getting legal advice, tended to be prioritised over attending appointments. Frequent movers often either forgot, or did not have time to notify professionals about a change of address.

There were issues around isolation, support and access to services in rural areas, with reliance on Childrens Centres and faith groups.

Professionals suggested a wide range of approaches to overcoming these barriers, including:

- Cultural competency training
- Improved information and language services
- Greater provision of outreach work
- New approaches to service provision
- Changes to immigration policy
- Work to address poor attitudes and increase user feedback

**Voluntary Sector Providers and Partnership working**

Voluntary Sector Partnership working with NHS services varied across the West Midlands. In some locations partnership working was good with lots of networking meetings, multi agency groups, and sub groups. Whilst in other locations the relationship with the voluntary sector was not viewed as working well, on a strategic level. In rural areas there were not many voluntary sector organisations to support the women. Overall there was a good working relationship between Sure Start Childrens Centres and Health across the West Midlands. Sure Start Childrens Centres that served culturally diverse areas were seen to have done a lot of work in engaging with other services, providing a ‘one stop shop’ of services which suited migrant women well.

**FINDINGS FROM VOLUNTARY SECTOR ORGANISATIONS’ PERSPECTIVE**

Representatives from voluntary sector organisations who undertake work with migrant women gave their views on the barriers to accessing maternity care.

**Issues for destitute women.**

Voluntary sector organisations highlighted the plight of women who had No Recourse to Public Funds (NRPF). Respondents advised that the issues were similar to women with other status, but destitute women had nowhere to live. Getting to hospital for a scan was
exceptionally hard due to lack of funds to pay for transport. Poverty and vulnerability was said to often force destitute women into dangerous relationships. Some were internally trafficked around the UK. There were high rates of sexually transmitted infections, tuberculosis and female genital mutilation (FGM). The women faced social and financial support needs as they were unable to work and often lived in overcrowded accommodation. Accommodation and support was normally accessed through Voluntary Sector Organisations. Destitute women would benefit from support from one lead organisation rather than signposting to many.

**Rural issues.**

Rural respondents said it could be difficult to address the needs of rural women especially when there were cross boundary movements between West Midlands and Gloucestershire with women accessing services across both Counties.

**Training on Common Assessment Framework.**

None of the Voluntary Sector providers interviewed had received any training on the Common Assessment Framework. Only one organisation advised of having a risk assessment in place with a tailored support package where the whole family was involved in the process. Other interviewees advised they would alert the authorities if they felt baby was at risk or would try and contact services to help reduce social risks.

Successful initiatives to overcome barriers included:

- Awareness raising, help with booking appointments and making contact with services.
- Accompanying women to appointments and keeping women up to date with information.
- A doula project based in Birmingham successfully provided support to lone women.
- The HOPE destitution fund provides time-limited, subsistence grants to destitute and failed Asylum Seekers and women with NRPF, to help move them along with their asylum claim. Partner agencies work closely with the Children Centres, and a doula project.
- Building links with maternity services projects like Birmingham Link. An information surgery in the community for example: stalls at shopping centres.
- Sure Start Childrens Centres worked with local voluntary sector organisations and health care providers.
RECOMMENDATIONS

ENSURING LOCAL SERVICES MEET THE NEEDS OF THEIR MIGRANT POPULATIONS

Commissioners need to develop a detailed understanding of the health and social care needs of their local migrant populations, including identification of any barriers to accessing services. Local maternity care pathways should be reviewed in light of this needs assessment and the recommendations from this report.

PROVISION OF NECESSITIES

Many migrant women lack the basic necessities, including social support needed to have a healthy pregnancy, particularly those with no recourse to public funds. Local services have a key role in providing this much needed support as part of their existing statutory responsibilities in relation to child poverty and safeguarding. Continued support is also available from voluntary sector organisations and children’s centres, however there is an urgent need for additional provision.

LANGUAGE AND INTERPRETATION

Language is a major barrier to women’s engagement with maternity services. Interpreting and advocacy services are a vital component of appropriate maternity care for women who do not speak English as their first language. More action needs to be taken to improve migrants’ language skills as soon as they arrive in the UK. Local maternity services should ensure that appropriate interpreting services are proactively offered to migrant women who require them, at all stages of the pregnancy.

TRAINING FOR HEALTH PROFESSIONALS

All health and social care professionals who come into contact with pregnant migrant women need to be skilled in understanding and identifying the wide range of social risk factors which may leave these women vulnerable. Professionals need to have the available knowledge and resources to enable them to take action to help mitigate these risk factors and reduce the risk to mother and baby. Awareness of, and sensitivity to, cultural differences are key elements in the provision of appropriate maternity care for women from migrant groups.
PROVISION OF INFORMATION

There is a need to ensure migrant women are fully informed throughout their pregnancy, including awareness of the organisation of NHS and other local services, what to expect from their maternity care and where to go if they require help and support.

PARTNERSHIP WORKING

Barriers to partnership working were seen between voluntary organisations, local authorities and the NHS. Some agencies had limited understanding of the client group and would benefit from closer working relationships with voluntary organisations. This would help statutory agencies understand the complexity of migrant women’s needs and ensure that women have access to the necessary support. Local commissioners and maternity service providers need to explore opportunities for enhanced partnership working with voluntary organisations and local authorities.

CHILDRENS CENTRES

Childrens Centres bring together a wide range of services in one place centred on the needs of disadvantaged families. Childrens Centres based in ethnically diverse communities play a key role in engaging vulnerable migrant women and providing support and access to a wide range of services particularly for disadvantaged groups. Local commissioners should work in partnership with Childrens Centres to meet the needs of their local migrant communities.

UKBA AND IMMIGRATION POLICY

Improved communication is needed between UKBA and the health sector in relation to the dispersal of pregnant women. UKBA should review their existing policy and practice with regard to the dispersal of pregnant women to ensure that appropriate transition of care arrangements are in place. Such dispersals should not occur without documented discussion between UKBA officers, health professionals in the local area and proposed dispersal area, for women in the late stages of pregnancy or where there are known complications. UKBA should consider the development of an appropriate system to monitor cases where dispersal of pregnant women occurs.

\\footnote{UKBA were given the opportunity to comment on the above recommendations and we are grateful for their response. It should be noted that since the research was completed UKBA have consulted on a revised Health Asylum Instruction (October 2010) which also covers pregnancy. The proposed Health Asylum Instruction, if adopted, will address a number of our recommendations}
The Department of Health should continue to make the case in discussion with UKBA for a reduction in the cut off limit for dispersal, currently 36th week of pregnancy, on the basis of increased risk to child and maternal health and increased pressure on maternity services.

**DOMESTIC ABUSE**

Professionals need to be sensitive to the possibility that some women are in abusive relationships and require specialist support to ensure their health, and that of their baby, is protected. Health and Wellbeing Boards need to ensure the appropriate measures are in place as part of their safeguarding adults and children responsibilities. Local commissioners and maternity services need to have access to support services, to which they can refer those who are suffering from domestic abuse.

**FURTHER RESEARCH**

This study has provided an overview of maternity services for migrant women across the West Midlands. Further research is needed to explore in more detail experiences by ethnicity or immigration status, and by geographical area. Work is needed to identify good practice and to compare the experiences of migrant women to those of women born in the UK.
CHAPTER 1: INTRODUCTION AND CONTEXT

INTRODUCTION

In 2006, 1 in 5 births in the West Midlands were to women born outside Britain (Taylor & Newall 2008). Outcomes in pregnancy are worse in migrant women than in the indigenous population, and net migration to the West Midlands continues to increase considerably (Taylor & Newall 2008). In particular, many individuals from EU Accession States have moved to the West Midlands in recent years. While other sectors, particularly those concerned with employment and economic development, have gathered considerable intelligence regarding the needs of new communities, little information is available regarding health and health care. The report *Maternity, Mortality and Migration: The Impact of New Communities* highlighted the financial, social and structural difficulties, and challenges faced by migrant women giving birth in Birmingham and the complex situations pregnant women find themselves in. Other literature has identified some of the issues, barriers and enablers to migrants accessing services, and risk factors for infant mortality (Kanneh 2009; Ipsos Mori 2008; Redshaw et al. 2006). These include: poverty, language needs, relocation/dispersal due to immigration or to avoid detection, difficulties/delays in accessing benefits and entitlements; housing access and quality, access to NHS and GP registration, local service provision issues, and patient expectations, health beliefs, and behaviour. In the West Midlands a number of the key asylum seeker dispersal areas (Birmingham, Coventry, Sandwell, Stoke on Trent, Walsall and Wolverhampton) have high levels of infant mortality. However, little is known about the experiences and needs of migrants accessing maternity and post-natal services across the West Midlands and the ways in which those experiences impact upon health of migrant mothers and their children (Taylor & Newall 2008).

It was with regard to these gaps in knowledge that the Department of Health funded the Institute of Applied Social Studies to undertake a research project focusing on migrant maternity in the West Midlands. Through the adoption of largely qualitative focus, the research aimed to investigate the views and experiences of healthcare professionals and service users on the appropriateness of maternity services across the West Midlands. The study sought to:

- Identify the views and experiences that migrant women have about maternity services across the West Midlands,
- Identify the barriers and enablers that influence the engagement of migrant women with general practice, maternity and postnatal services,
- Identify the ways in which migrant women access health, social care and support services,
- Identify differing health beliefs of migrant women from different countries, and their expectations of maternity services,
• Explore the above issues in different categories of women including refugees, asylum seekers, failed asylum seekers, and economic and spousal migrants.
• Identify the views and experiences of health, social care and charitable agencies working with pregnant migrant women.
• Identify the challenges faced when providing maternity care to these women, and possible solutions to improve current services.
• Examine the approaches for communicating information about maternity services to migrant women and explore the ways in which services might be developed to better meet the needs of migrant women.

BACKGROUND

Over the past ten years the nature of immigration to the UK has changed and brought with it what Vertovec (2007: 1025) describes as “a transformative diversification of diversity”. Since the 1990s there has been a marked rise in net immigration and diversification of countries of origin, six new Parliamentary measures, and a proliferation of migration channels and legal statuses coupled with a huge rise in the numbers of people seeking asylum. These flows and channels have become known as new migration. High economic performance and associated need for migrant workers, an increase in asylum seekers due to global conflict, and EU accession are the main forces behind new migration. Robinson & Reeve (Robinson, 2006) argue that new migrants are arriving into a very different social, cultural and economic context to their predecessors although lessons can be learnt from the mass migration of the 1960s. There are distinct changes in local settlement patterns of new migrants reflecting their motivations as well as the context into which they arrive. Whilst many new migrants do move to existing areas of diversity, others are “spatial pioneers” moving to places with little history or experience of immigration.

The pace and scale of change can be evidenced by looking at some of the national immigration data. In terms of asylum 188,000 asylum applications were received in the UK between 2003 and 2007 (UNHCR, 2008). Foreign nationals made up 3.5% of the workforce in 1996, and 6% in 2006 (Audit Commission, 2007). The 2004 enlargement of the European Union greatly increased the scale and pace of migration. Nationally 662,000 National Insurance Numbers (NINOs) were issued to foreign nationals in 2004/5, almost twice as many as the previous year. In the 12 months to September 2009 720,000 NINos were allocate to adult foreign nationals of whom 265,000 were A8 nationals (ONS, 2009). However by June 2009 there was some indication of a decline in arrivals of economic migrants with 628,000 NINos issued to foreign nationals of which 186,000 were to A8 nationals (ONS 2010).
Vertovec (2007) argues it is not enough to see diversity in terms of ethnicity. We now encounter a wide range of other variables including immigration status, different associated rights and entitlements, divergent labour market experiences, gender and age profiles, and patterns of spatial distribution. He labels the diversification of diversity as “super-diversity”. In brief, dimensions of super-diversity include:

- **Countries of origin** – a move from those with historic, often colonial connections to the UK to people arriving from all over the world. For example, people from 170 different countries registered with GPs in Handsworth in the period 2000 to 2009. There is also differentiation within country’s by ethnicity, tribe, religion, local identity, and politics.

- **Language** – growth of multi-lingualism – over 300 languages have been recorded in use in London schools.

- **Religions** – increased variety within and between faiths and advent of new faiths

- **Migration channels and immigration statuses**
  - Workers
  - Students
  - Spouses and family members
  - Asylum Seekers and Refugees (ASRs)
  - Irregular, illegal, undocumented
  - New citizens

- **Gender** – shift from family to work migration

- **Space/place** – clustering around ethnic communities but also spreading into new areas i.e. rural, and UKBA dispersal areas.

With super-diversity comes a new mode of transnationalism as new technologies and cheap travel means people are more connected with communities outside of Britain than ever before, (Vertovec 2007: 1043). In her report to the Migrant Impacts Forum, Cook (2008) argues that unprecedented diversity means authorities need to rise to the challenge of meeting a wide range needs which will demand new skills and knowledge.
NEW ARRIVALS

ACCESSION COUNTRY MIGRANTS

There are a number of arrangements under which immigrants can arrive in the UK. The main category of migrants entering the UK is migrant worker. A migrant worker is an individual who has “arrived in the host country in the last five years, either with a job or intending to find a job” (Pemberton 2008:81). The European Commission Accession Treaty (2003) is a key factor in influencing A8 economic migration patterns. For a maximum of seven years transitional arrangements exist where the E-15 can apply national rules regulating access to their labour markets. The UK, Sweden and Eire have all opened their labour markets to Accession country workers. Those A8 migrants who wish to take employment for over a month have to register with Worker Registration Scheme (WRS). Registration is not necessary if they are self-employed or dependent. After twelve months of continuous employment, they are eligible for income related benefits and access social housing subject to the usual eligibility criteria.

ASYLUM SEEKERS AND REFUGEES

Asylum seekers are categorised as individuals who have applied for asylum and are awaiting a decision on their case. Failed asylum seekers are individuals who have exhausted the appeals process. Some are supported awaiting deportation or voluntary repatriation whilst others are supported under Section 4, the provision of accommodation and support via a payment card, because their country is unsafe for return, they are awaiting judicial review, or they have made further submissions in respect of their asylum claims – this is often called a fresh claim.

Refugees are individuals who have had their asylum claim accepted and been granted some kind of leave to remain, generally for four or five years. Refugees are entitled to work and to access public funds and services.

FAMILY REUNION AND SPOUSAL MIGRANTS

Family reunion or chain migration has been the focus of much legislation, in particular the 1962 Commonwealth Immigrants Act, which aimed to reduce the potential for commonwealth migrants to reunite with extended families. Providing they can support their families, A8 migrants can bring any member of their family either with them or to join them. At the early stages of A8 migration few migrants were accompanied by dependents (Home Office 2007). There is no mechanism for calculating the number of dependents who have joined Accession country migrants, but research evidence suggests a recent shift in arrivals from EEU to people bringing families or being joined by families (Koscielak 2007). Refugees
are also entitled to family reunion; migrants who have been granted other types of status such as Indefinite Leave to Remain in the UK can also apply for family members to join them in the UK but must be able to show that they can support their family members without recourse to public funds. It is possible to apply to be joined by partners, dependent children and dependent parents.

**UNDOCUMENTED MIGRANTS**

A final group of new arrivals are undocumented migrants, individuals who have no recourse to funds, housing or services and are often accommodated by other new arrivals. Estimates for undocumented migrants vary between 500,000 (Strangers into Citizens 2007) and 800,000 (IPPR 2009). The category includes failed asylum seekers evading the authorities, visa overstayers, and illegal or trafficked immigrants.

**MIGRANT MATERNITY**

Research undertaken by Taylor and Newall (2008) and Ipsos MORI (2008) has focused upon maternity and migration in Birmingham. A scoping study explored the general health needs of migrant workers in the West Midlands (Taylor 2008). The study highlights the possibility of increased use of maternity services and problems understanding the system or communicating with migrant workers, but does not focus upon maternity services or the specific needs of different migrant or ethnic groups. Evidence from these studies raise a number of challenges faced by migrant women trying to access maternity services. High on the list of problems is poverty with women unable to afford transport to appointments, lack of funds for a healthy diet and the impact of being on Section 4 support or No Recourse to Public Funds (NRPF) and thus having access to limited or no cash with which to purchase necessities such as baby clothes. Although pregnant women in the asylum system are entitled to some additional support (Rights of Women 2009), Taylor & Newall (2008) found that some women were being asked to pay for their treatment, information on maternity care entitlements is given in appendix 8. There was also some evidence that women were working in demanding jobs late in to their pregnancy.

A further need identified in all research in this field is the impact of language barriers on women’s ability to understand and access services. Poor or pressured interpretation services often meant women were unable to understand the services available. These problems were exacerbated by lack of knowledge of the system and cultural expectations and health beliefs. Issues around housing and dispersal have also been identified as problematic for some migrant women. The dispersal of asylum seekers and Section 4 cases during pregnancy could mean that women lost touch with service providers and continuity of care was disrupted. In addition migrant women and those with NRPF were often accommodated in poor, overcrowded housing. On occasion women were isolated from
social support to provide the help they needed when vulnerable. There was also some
evidence that there was a lack of awareness amongst professionals about the needs of
migrant women and poor communication between agencies.

A range of risk factors impacting upon infant mortality rates have been highlighted. These
include late access to services, lack of advice about support services available and healthy
lifestyles, and lack of funds impacting upon maternal diet and possibly intrauterine growth
(Kanneh 2009; Ipsos Mori 2008; Redshaw et al. 2006). Infant mortality was more common
where women were lone parents or underweight. Cultural practices such as female genital
mutilation (FGM) and consanguinity could also impact on health of mother or infant. Recent
research looking at antenatal screening found that the number of HIV positive pregnant
women and those with hepatitis B had increased in recent years particularly following the
arrival of immigrants from Africa (UK National Screening Committee 2009). Not all women
agreed to be tested and the numbers of babies infected with HIV had also increased.

No one model has been adopted across health services to meet the maternity needs of
migrant women. Indeed research to date has found that provision was patchy or even
nonexistent in many areas. Where provision did exist it was generally in the form of
outreach workers, word of mouth support or services provided by native speakers such as a
Portuguese drop in clinic or Polish midwife.

Clearly migrant women experience a wide range of problems when trying to access
maternity services. As yet there is a lack of knowledge as to whether all migrant women
experience those issues, regardless of status or location, or whether some problems are
specific to ethnic or immigration status groups or more prevalent in some geographical
areas. The methods employed in this study to explore some of those issues are set out in
detail in the following chapter.
CHAPTER 2: METHODOLOGY

The study was undertaken in a collaborative manner through a number of phases. The main focus of the work was investigating the views and experiences of migrant women service users, and healthcare professionals on the appropriateness of maternity services in the West Midlands for new migrant women who have entered the UK within the last five years (for research tools employed see Appendix 7). Different categories of migrants included refugees, asylum seekers, failed asylum seekers, economic and spousal migrants and undocumented migrants. Particular attention was paid to women who had No Recourse to Public Funds (NRPF) although identifying such respondents was difficult particularly in relation to undocumented immigrants seeking to avoid detection by UKBA.

PHASE 1. DESKTOP STUDY: CONTEXT SETTING

In the initial phase we sought to identify data sources on new arrivals in the West Midlands West Midlands within the last five years. We looked at Government statistics including UKBA data, NINO data, and Worker Registration Scheme data. In the short time frame of the project we were unable to access NHS data systems (including e-start new birth data and GP registrations). However, we were able to identify and analyse fertility and live birth data, the latter for the West Midlands. We used the data to identify categories for respondents, and locations in which to focus the research.

PHASE 2. QUESTIONNAIRE COMPLETION: SERVICE USERS

We designed a questionnaire exploring the views and experiences of migrant women on the appropriateness of maternity services across the West Midlands. The questionnaire was aimed at identifying the barriers and enablers that influence engagement of these women with general practice, antenatal, birth and post-natal services. Interviews were undertaken by female researchers; part of the University of Birmingham’s experienced community research team. Some 82 questionnaires were conducted on a face-to-face basis in familiar locations to the women. Interviews took place within voluntary sector and statutory organisations in Coventry, Wolverhampton, Sandwell, Birmingham, Herefordshire, Worcestershire and Stoke on Trent. A £10 gift voucher was offered to those taking part as compensation for time and travel expenses.

Women in the study came from a wide range of geographical locations and were of a range of different statuses. They were identified through discussions with NGOs and Children’s Centres and through a snow-balling approach. Sampling strategies were shaped by the quantitative data analysis (see Chapter 3) which indicated high proportions of Chinese,
Polish and African migrants living in the West Midlands. The data analysis also helped us to indentify the key locations for our research. The majority of migrants were located in Birmingham but significant numbers were also located in other key cities in the West Midlands. We were able to identify respondents in most of the areas identified with the exception of Rugby where we were unable to get a response from NGOs operating there. A small number of respondents were also located through the social networks of the community researchers. Some 44 were living in Birmingham, 7 in Sandwell, 5 in Coventry, 10 in Herefordshire, 2 in Stoke on Trent, 7 in Wolverhampton and 7 in Worcestershire. Of the 82 respondents only 12 were in employment, most of whom were A8 migrants. In terms of status 21 respondents were refugees, 28 spousal migrants, 17 asylum seekers, 3 failed asylum seekers, 9 A8 migrants, and two women were undocumented and had no recourse to public funds (see Table 2.1). The highest proportion of women (37, 45%) arrived in 2005, 30% (24) arrived in 2006, 13% (11) in 2007, 9% (7) in 2008 and 4% (3) in 2009.

Table 2.1: Immigration and employment status and location of questionnaire respondents

<table>
<thead>
<tr>
<th>City of residence</th>
<th>Refugee</th>
<th>Asylum Seeker</th>
<th>Spousal Migrant</th>
<th>Failed Asylum Seeker</th>
<th>Eastern European Migrant A8</th>
<th>No recourse to public funds</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birmingham</td>
<td>Employed</td>
<td>No</td>
<td>Yes</td>
<td>14</td>
<td>11</td>
<td>18</td>
<td>1</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>14</td>
<td>11</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>44</td>
</tr>
<tr>
<td>Coventry</td>
<td>Employed</td>
<td>No</td>
<td>Yes</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Hereford</td>
<td>Employed</td>
<td>No</td>
<td>Yes</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>1</td>
<td>3</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>Sandwell</td>
<td>Employed</td>
<td>No</td>
<td>Yes</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>2</td>
<td>3</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Stoke</td>
<td>Employed</td>
<td>No</td>
<td>Yes</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Wolverhampton</td>
<td>Employed</td>
<td>No</td>
<td>Yes</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Worcester</td>
<td>Employed</td>
<td>No</td>
<td>Yes</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>4</td>
<td>3</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>21</td>
<td>17</td>
<td>28</td>
<td>3</td>
<td>9</td>
<td>3</td>
<td>82</td>
</tr>
</tbody>
</table>

The vast majority of respondents were under the age of 30. Only one respondent was aged between 16-18, 11 between 19 and 24, 45 between 25 and 30, 19 between 31 and 35, 4 between 36 and 40 and 2 over 40. The respondents came from 28 different countries (see Appendix 1). The highest proportion came from China (17), with eight from Iran, seven each from Pakistan and Poland and five from Zimbabwe. All but four of the women, all of whom were pregnant, had children. Some 43 had one child, 27 had two children, six had three and two had four children. All but one of these respondents had given birth to at least one child in the UK. Women were asked about their housing situation. The largest number (49) lived
with a partner. However 27 lived alone, four with family and two with other asylum seekers. Respondents lived in a wide range of housing tenures with the largest proportion (24) renting from the council followed by renting privately (21). Ten respondents lived in UKBA provided housing and eight owned their own homes. Seven lived in properties rented from housing association and two in a hostel.

**PHASE 3. TELEPHONE INTERVIEWS: HEALTHCARE PROFESSIONALS**

A topic guide was designed to explore the views and experiences of healthcare professionals and charitable agencies working with pregnant migrant women across the West Midlands. It aimed to identify the challenges faced when providing maternity care to migrant women and the possible solutions. A total of 18 telephone or face to face interviews explored the views from a range of healthcare professionals including: community health staff (midwives and health visitors), GPs, pregnancy outreach workers, hospital staff, and staff from voluntary sector organisations working with migrant women. The data was analysed using a systematic thematic approach. Details of interviewees’ roles and geographical location are set out in Table 2.2.

**Table 2.2: Location and role of professional interviewees**

<table>
<thead>
<tr>
<th>Location and areas</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birmingham city centre, Sutton Coldfield, Solihull</td>
<td>Midwife</td>
</tr>
<tr>
<td>Birmingham</td>
<td>Independent Midwife</td>
</tr>
<tr>
<td>Birmingham</td>
<td>Project Manager for refugee and migrant women with a voluntary sector organisation</td>
</tr>
<tr>
<td>Birmingham</td>
<td>Sessional interpreter for the Chinese Community</td>
</tr>
<tr>
<td>Birmingham</td>
<td>Voluntary sector worker and Parish Nurse</td>
</tr>
<tr>
<td>Coventry</td>
<td>GP</td>
</tr>
<tr>
<td>Herefordshire</td>
<td>Development worker mental health</td>
</tr>
<tr>
<td>Herefordshire</td>
<td>Voluntary sector project worker with migrants</td>
</tr>
<tr>
<td>Lozells, Aston, Sparkhill, Handsworth Bham</td>
<td>Senior Community Development Worker</td>
</tr>
<tr>
<td>Sandwell</td>
<td>Commissioning of maternity services.</td>
</tr>
<tr>
<td>Sandwell and Birmingham</td>
<td>Consultant midwife</td>
</tr>
<tr>
<td>Stoke on Trent</td>
<td>Refugee health team head nurse</td>
</tr>
<tr>
<td>Vale of Evesham and Worcestershire areas.</td>
<td>Voluntary sector antenatal teacher/volunteer</td>
</tr>
<tr>
<td>West Midlands wide</td>
<td>Research midwife</td>
</tr>
<tr>
<td>West Midlands wide</td>
<td>Women’s worker with Asylum Seekers</td>
</tr>
<tr>
<td>Wolverhampton</td>
<td>Voluntary sector organisation senior adviser</td>
</tr>
<tr>
<td>Worcester</td>
<td>Locum GP</td>
</tr>
<tr>
<td>Worcestershire</td>
<td>Midwife</td>
</tr>
</tbody>
</table>
PHASE 4. IN DEPTH INTERVIEWS: SERVICE USERS.

We conducted 13 in depth interviews with migrant women maternity service users across the West Midlands, exploring in detail, some of the issues emerging from the questionnaire and telephone interviews (for case studies of individual women see Appendix 6). Ten of these women had also completed a questionnaire and had indicated when they completed that they were interested in taking part in further research. We sought to select respondents from a range of backgrounds and areas and to identify women who had a range of experiences with maternity services. Three women were identified separately. Details of the interviewees’ ethnicity, status and location are set out in Table 2.3.

Table 2.3: In depth interviewees’ details

<table>
<thead>
<tr>
<th>Location</th>
<th>Ethnicity</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birmingham</td>
<td>Black African</td>
<td>Failed Asylum Seeker</td>
</tr>
<tr>
<td>Birmingham</td>
<td>Chinese</td>
<td>Failed Asylum Seeker</td>
</tr>
<tr>
<td>Birmingham</td>
<td>African</td>
<td>Refugee</td>
</tr>
<tr>
<td>Birmingham</td>
<td>Zimbabwean</td>
<td>Refugee</td>
</tr>
<tr>
<td>Birmingham</td>
<td>Chinese</td>
<td>Refugee</td>
</tr>
<tr>
<td>Birmingham</td>
<td>Chinese</td>
<td>Failed Asylum Seeker</td>
</tr>
<tr>
<td>Birmingham</td>
<td>Pakistani</td>
<td>Spousal Migrant</td>
</tr>
<tr>
<td>Coventry</td>
<td>Black African</td>
<td>NRPF</td>
</tr>
<tr>
<td>Herefordshire</td>
<td>Eastern European</td>
<td>Eastern European</td>
</tr>
<tr>
<td>Herefordshire</td>
<td>Eastern European</td>
<td>Eastern European</td>
</tr>
<tr>
<td>Sandwell</td>
<td>Iraqi</td>
<td>Spousal Migrant</td>
</tr>
<tr>
<td>Walsall</td>
<td>Black African</td>
<td>NRPF</td>
</tr>
<tr>
<td>Wolverhampton</td>
<td>African</td>
<td>NRPF</td>
</tr>
</tbody>
</table>

PHASE 5. DATA ANALYSIS AND REPORT WRITING

We analysed the questionnaire data using the SPSS statistical analysis package, and the qualitative data using a systematic thematic approach.

It should be noted that the quotes given within the report represent the views of those interviewed, which have been reproduced as stated.
CHAPTER 3: MIGRANT POPULATIONS IN THE WEST MIDLANDS

There is no one source of data that can tell us the exact number of migrant women living in the West Midlands. We are reliant upon a variety of datasets that are incomplete and sometimes overlapping, to give us an indication of the main ethnic groups living in the West Midlands and the areas that they are living in. In this chapter we look at each of those data sets in turn and then draw some tentative conclusions about the main groups of migrants and key locations, on which to focus the research.

NATIONAL INSURANCE NUMBER (NINO) DATA

All new arrivals in the UK who wish to work are required to apply for a NINO although it is fair to say that not all workers are registered. There is no opportunity to de-register when leaving the UK. All NINO registrations relate to an individual’s home address at the point of registration. Analysis of overseas nationals’ National Insurance Number registrations for the period May 2004 to December 2008 showed that some 202480 people had registered for a NINO in that period (see Table 3.1). Of those individuals 90880 (45%) were women. NINO data gives us an indication of the number of overseas nationals employed within the West Midlands and where they are based. It should be noted that this data will exclude all those who are not employed, or employed legally, even if eligible to work, or who are undocumented and thus it does not give us a complete picture of migrant women resident in the West Midlands. However it is useful in that it can indicate where the main concentrations of migrant workers are based. The largest number of migrant workers registered in Birmingham (59090), followed by Coventry (25850), Sandwell (12750), Herefordshire (12290) and Stoke on Trent (9570) (see Appendix 2).

WORKER REGISTRATION SCHEME (WRS) DATA

In order to focus upon Accession country migration (referred to as A8 countries) we need to look at the Worker Registration Scheme (WRS) data. From 2004, nationals of A8 countries wishing to work in the UK were required to register with the Worker Registration Scheme (WRS). The data includes only those who have submitted applications to the Home Office and does not include the self-employed who do not need to register. The data is workplace based and therefore can only indicate place of work rather than the location of the housing in which the worker resides. The data does not represent the total stock of migrants from A8 countries in the UK because there is no mechanism for a worker to de-register once they leave the country. WRS applicants must re-register if they change employer.
Each application to WRS represents one job, not one applicant. Thus some migrants from A8 countries are double or treble counted whilst others do not register on the scheme at all and are not counted.

WRS data is useful to help us identify the main clusters of A8s both by geographical location and by nationality. The data indicates that 134,270 A8s had registered within the West Midlands by the end of 2007. WRS data shows that Accession country migrants are distributed differently from the NINO registrations. The largest concentration of A8s is in Herefordshire (21,280), followed by Birmingham (11,135) and Coventry (9,510). The majority of A8s in the West Midlands are Polish (51,665), all parts of the West Midlands have some Polish migrants registered. There are also substantial Slovakian (8,920) and Lithuanian (4,600) registrations in the West Midlands with significant clusters of migrants of these nationalities in Herefordshire (see Appendix 3).

It is possible to analyse WRS data by gender (see Table 3.1). The data indicates that some 40% of WRS registrations relate to women. It is notable that some areas have higher proportions of women than others. For example in Bridgnorth only 12% of A8s are women and in Herefordshire this figure is 37% whereas in Birmingham and in Coventry 46% of registrations are female. It is likely that gender based concentrations relate to the types of employment available. In Bridgnorth and in Herefordshire employment is largely in agriculture whereas in the conurbations there are a wider range of jobs available in hotels and catering, health and manufacturing.
Table 3.1: Total WRS registrations by gender May 2004 to March 2006 (ONS 2009)

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Total No. of Males</th>
<th>Total No. of Females</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birmingham</td>
<td>6,065</td>
<td>5,250</td>
<td>11,315</td>
</tr>
<tr>
<td>Bridgnorth</td>
<td>560</td>
<td>75</td>
<td>635</td>
</tr>
<tr>
<td>Bromsgrove</td>
<td>220</td>
<td>165</td>
<td>385</td>
</tr>
<tr>
<td>Cannock Chase</td>
<td>220</td>
<td>125</td>
<td>345</td>
</tr>
<tr>
<td>Coventry</td>
<td>2,675</td>
<td>2,290</td>
<td>4,965</td>
</tr>
<tr>
<td>Dudley</td>
<td>895</td>
<td>685</td>
<td>1580</td>
</tr>
<tr>
<td>East Staffordshire</td>
<td>1,675</td>
<td>1,185</td>
<td>2,860</td>
</tr>
<tr>
<td>Herefordshire, County of</td>
<td>6,630</td>
<td>3,975</td>
<td>10,605</td>
</tr>
<tr>
<td>Lichfield</td>
<td>1,445</td>
<td>725</td>
<td>2,170</td>
</tr>
<tr>
<td>Malvern Hills</td>
<td>450</td>
<td>350</td>
<td>800</td>
</tr>
<tr>
<td>Newcastle-under-Lyme</td>
<td>725</td>
<td>540</td>
<td>1265</td>
</tr>
<tr>
<td>North Shropshire</td>
<td>465</td>
<td>270</td>
<td>735</td>
</tr>
<tr>
<td>North Warwickshire</td>
<td>1,185</td>
<td>575</td>
<td>1,760</td>
</tr>
<tr>
<td>Nuneaton and Bedworth</td>
<td>810</td>
<td>355</td>
<td>1165</td>
</tr>
<tr>
<td>Oswestry</td>
<td>120</td>
<td>60</td>
<td>180</td>
</tr>
<tr>
<td>Redditch</td>
<td>1,235</td>
<td>935</td>
<td>2,170</td>
</tr>
<tr>
<td>Rugby</td>
<td>2,110</td>
<td>860</td>
<td>2,970</td>
</tr>
<tr>
<td>Sandwell</td>
<td>2,110</td>
<td>1,375</td>
<td>3,485</td>
</tr>
<tr>
<td>Shrewsbury and Atcham</td>
<td>460</td>
<td>395</td>
<td>855</td>
</tr>
<tr>
<td>Solihull</td>
<td>655</td>
<td>625</td>
<td>1280</td>
</tr>
<tr>
<td>South Shropshire</td>
<td>320</td>
<td>215</td>
<td>535</td>
</tr>
<tr>
<td>South Staffordshire</td>
<td>295</td>
<td>160</td>
<td>455</td>
</tr>
<tr>
<td>Stafford</td>
<td>885</td>
<td>630</td>
<td>1515</td>
</tr>
<tr>
<td>Staffordshire Moorlands</td>
<td>345</td>
<td>230</td>
<td>575</td>
</tr>
<tr>
<td>Stoke-on-Trent</td>
<td>1,965</td>
<td>1,115</td>
<td>3,080</td>
</tr>
<tr>
<td>Stratford-on-Avon</td>
<td>1,980</td>
<td>1,620</td>
<td>3,600</td>
</tr>
<tr>
<td>Tamworth</td>
<td>315</td>
<td>265</td>
<td>580</td>
</tr>
<tr>
<td>Telford and Wrekin</td>
<td>1,540</td>
<td>1,120</td>
<td>2,660</td>
</tr>
<tr>
<td>Walsall</td>
<td>2,055</td>
<td>1,065</td>
<td>3,120</td>
</tr>
<tr>
<td>Warwick</td>
<td>535</td>
<td>595</td>
<td>1130</td>
</tr>
<tr>
<td>Wolverhampton</td>
<td>1,615</td>
<td>980</td>
<td>2,595</td>
</tr>
<tr>
<td>Worcester</td>
<td>725</td>
<td>595</td>
<td>1320</td>
</tr>
<tr>
<td>Wyche</td>
<td>2,000</td>
<td>1,370</td>
<td>3,370</td>
</tr>
<tr>
<td>Worcester</td>
<td>410</td>
<td>260</td>
<td>670</td>
</tr>
<tr>
<td>Total</td>
<td>45,695</td>
<td>31,035</td>
<td>76,730</td>
</tr>
</tbody>
</table>

**UK BORDERS AGENCY (UKBA) DATA**

Some 7698 asylum seekers had been dispersed to the West Midlands and were still living in the West Midlands at September 2009. Whilst the majority of those who were dispersed to the West Midlands arrived as singles, a substantial proportion arrived as part of a group. Some 559 individuals arrived as part of a household of between two and nine people. The data only allows identification of the gender of the main asylum claimant. Previous research has demonstrated that in mixed households men are generally the lead claimant. While we
can identify 1122 asylum seeking women accommodated within the West Midlands at September 2009 it is likely that this figure is somewhat higher. There are women asylum seekers from 84 different countries living in the West Midlands. The highest proportion of women come from China (205), Zimbabwe (190), Somalia (113), Eritrea (60), Nigeria (38) and Congo (39) but there are also significant clusters of women from Pakistan, Iraq, Iran and Afghanistan. Most asylum seeking women are housed in Sandwell, Birmingham, Wolverhampton Coventry, and Stoke (see Appendix 4).

SPOUSAL MIGRANTS, UNDOCUMENTED MIGRANTS, REFUGEES AND FAILED ASYLUM SEEKERS

Whilst it is possible to outline some of the characteristics of the Accession and economic migrant and asylum seeking populations this data is not available for migrants of other statuses. Some 725,000 irregular migrants are estimated to be currently living in Britain (IPPR 2009) but no information is known about their whereabouts, ethnicity or nationality. There is no available information that can tell us how many failed asylum seekers, i.e. those who have exhausted the asylum process, remain in the UK or how many asylum seekers have gained refugee status. It follows that no information is available about their nationality or area of residence. Research undertaken for the Church Urban Fund in 2004/5 indicated that there were between 5000 and 10000 destitute asylum seekers within the West Midlands (Malflait & Scott-Flynn 2005). This number is likely to have increased given the continued dispersal of asylum seekers to the West Midlands. It is also important to note that significant numbers of women arrive in the UK each year either as a spouse or for family reunion. Information about these women is also not available.

Table 3.2 Fertility rates for women in England and Wales, 2004 to 2008 (ONS 2009)

<table>
<thead>
<tr>
<th>Country of birth³</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK</td>
<td>1.68</td>
<td>1.69</td>
<td>1.76</td>
<td>1.79</td>
<td>1.84</td>
</tr>
<tr>
<td>Outside UK</td>
<td>2.5</td>
<td>2.48</td>
<td>2.43</td>
<td>2.54</td>
<td>2.51</td>
</tr>
<tr>
<td>All⁴</td>
<td>1.79</td>
<td>1.8</td>
<td>1.87</td>
<td>1.92</td>
<td>1.96</td>
</tr>
</tbody>
</table>

BIRTH AND FERTILITY

National data indicates that the fertility rates for women born outside the UK are higher than those born in the UK (see Table 3.2). Fertility rates have been increasing in the West Midlands since 2002 (Francis et al. 2009) and are continuing to increase. In some parts of
the West Midlands there is evidence that this increase relates to the arrival of new communities (Taylor and Newell 2008).

Office of National Statistics (ONS) data shows the top 10 countries of origin for live births for non-UK born mothers. Pakistan, India, and Bangladesh are the most important countries (See Figure 3.1). The migrants from these areas are likely to be spousal migrants. The numbers of live births have increased significantly over the past five years for new migrants from Poland, Somalia, Nigeria, Sri Lanka and Germany. These migrants are likely to be a mix of refugees, asylum seekers and economic migrants.

**Figure 3.1: Live births (numbers and percentages) for the ten most common countries of birth of mother for non-UK born mothers, 2004-2008 (ONS 2009)**

![Live births for the ten most common countries for non-UK born mothers, England and Wales, 2004-2008](image)

At the time of undertaking the study we were unable to identify the exact country of origin of women giving birth in the West Midlands, data does enable us to identify areas where there are large numbers of live births and the West Midlands of origin (see Table 3.3). Appendix 5 breaks live births down by birthplace of mother and area of usual residence. The largest proportion of live births to mothers born outside the UK as a percentage of all births are in Birmingham (38.4% of all births), Coventry (33.2%), Sandwell (29%), Wolverhampton (23.6%), Walsall (19.3%), East Staffordshire (20.2%), Stoke on Trent (18.3%), Worcester (17.7%) and Rugby (17.4%). Some 12.5% of births in Herefordshire are to women born outside the UK. Close examination of the data shows that nearly half of the births in Herefordshire are to women born in the new EU. Elsewhere there is a mix of births to Asian women, new Europeans and in some of the more super-diverse areas such as
Birmingham and Coventry African women and women from the rest of the world (see Appendix 5).

Table 3.3: Live births to mothers born outside the UK in the West Midlands 2008 (ONS 2009)²

<table>
<thead>
<tr>
<th>Area of usual residence of mother</th>
<th>% of total live births</th>
<th>EU births as a % of all live births in the West Midlands</th>
<th>New EU births as % of all live births in the West Midlands</th>
<th>Rest of Europe births as % of all live births in the West Midlands</th>
<th>Asian births as % of all live births in the West Midlands</th>
<th>African births as % of all live births in the West Midlands</th>
<th>Rest of World births as % of all live births in the West Midlands</th>
</tr>
</thead>
<tbody>
<tr>
<td>WEST MIDLANDS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stoke-on-Trent UA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shropshire</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staffordshire</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Warwickshire</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Midlands (Met County)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birmingham</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coventry</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dudley</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sandwell</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solihull</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walsall</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wolverhampton</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worcestershire</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

² Note the total column represents the total number of live births to mother’s born outside of the UK.

The next column % of total live births - represents the total live births to mothers born outside the United Kingdom as a % of all live births in the West Midlands.

The next column EU births as a % of all live births in the West Midlands – represents the % of EU births as a % of total live births in the West Midlands and so on.

The columns do not compute to the figure in the % live births column because they represent different things i.e. 13.95% above represents the percentage of births to women born in the EU as a percentage of total live births in the West Midlands.

INFANT MORTALITY RATES

Detailed data analysis of infant mortality rates (IMRs) is undertaken in the West Midlands by the Perinatal Research Institute. Data is available indicating mortality rates for each ward in the region but not by ethnicity or immigration status. In general research indicates that infant mortality rates are decreasing more slowly in the West Midlands than other parts of England and Wales. Of particular concern is the high proportion of still births due to fetal growth restrictions (45.6%), and the particularly high infant mortality rates in UKBA dispersal areas (Taylor & Newall 2008). Francis et al. (2009) explore still births across the region. Their mapping of still births can be seen in Figure 3.2. There are concentrations of stillbirths in many of the regions dispersal areas, the most deprived areas and super-diverse areas.
Levels are particularly high in areas with a high Index of Multiple Deprivation score. For example high levels can be observed across the entire HoBTPCT area, in West Bromwich in Sandwell and Foleshill in Coventry.

Figure 3.2: West Midlands Map of Stillbirth Rates (1997-2005) by Ward 2004 (Gardosi et al. 2006)
While there are many gaps in the data, particularly around undocumented migrants and failed asylum seekers, we are able to identify some areas and some ethnic groups to help guide the respondent recruitment strategies for the next stages of the research. Clearly the super-diverse areas of Birmingham, Sandwell, Coventry and Wolverhampton, are home to many new arrivals and to existing minority communities that may support spousal migrants and possibly undocumented migrants. Herefordshire and Worcestershire whilst not as diverse as these areas, and not experiencing such high levels of live births from women born overseas, are also important as they have large populations of recently arrived Accession country migrants. In terms of focus it is important to identify migrant women from a range of communities. These could include spousal migrants from Pakistan, India and Bangladesh, Polish and Lithuanian Accession country migrants, and Chinese, Zimbabwean, Somali and other African asylum seekers, refugees and failed asylum seekers. Given the high numbers of undocumented migrants living in the UK it is important to ensure that the research reaches some women with no legal status. Ideally a mix of nationalities and geographical focus will enable some conclusions to be drawn about the impact of being NRPF on migrant women. The following chapter examines the perceptions of maternity services in the West Midlands arising from SPSS analysis of questionnaire data and systematic thematic data analysis of qualitative data.
CHAPTER 4: FINDINGS FROM WOMEN’S PERSPECTIVES

ACCESSING SERVICES

Most women accessed some kind of service when they were less than 12 weeks pregnant (67, 82%). Nine women (11%) attended between 12 and 16 weeks, two (2%) between 17 and 20 weeks, one between 21 and 30 weeks and three (4%) after 31 weeks. All A8 migrants attended before 12 weeks. Those who attended later tended to be asylum seekers, refugees and spousal migrants (see Table 4.1). The first services accessed were visiting the GP (56), being referred to a midwife for nutrition advice (53) and being advised about antenatal tests (47). Some 53 women had antenatal test before 12 weeks while 15 women did not. Women in Worcestershire and Birmingham were least likely to have antenatal tests before 12 weeks.

Table 4.1: Immigration status and point of attending pregnancy related services

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 12 weeks</td>
<td>17</td>
<td>11</td>
<td>23</td>
<td>3</td>
<td>9</td>
<td>3</td>
<td>1</td>
<td>67</td>
</tr>
<tr>
<td>12 - 16 weeks</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>17 - 20 weeks</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>21 - 30 weeks</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>31 - 36 weeks</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>21</td>
<td>17</td>
<td>28</td>
<td>3</td>
<td>9</td>
<td>3</td>
<td>1</td>
<td>82</td>
</tr>
</tbody>
</table>

BARRIERS TO ACCESSING SERVICES

Those unable to attend services before 12 weeks said they would have been able to attend services earlier had they had more information about what was available (8), better explanations about services available (5), had materials translated (4) or an interpreter (4) or had been registered with a GP (2) or known they were pregnant (2). Only a very small percentage of women advised that their change of address had impacted on their ability to register with a new GP before 12 weeks. One respondent advised that she had not made contact with maternity services until she was seven and a half months pregnant because “I did not make contact with maternity services for 3 months, even though I knew I was pregnant at four weeks through a home pregnancy test. To make an appointment with my GP I need to book on the day. If I left it till after 8.30am then there were no appointments left. I could not get up early enough to make appointment as my husband works nights as chef, and we do not get to sleep till 3-4 am in the morning”. Chinese NRPF Birmingham.

“I did not make contact with maternity services for 3 months, even though I knew I was pregnant at four weeks through a home pregnancy test. To make an appointment with my GP I need to book on the day. If I left it till after 8.30am then there were no appointments left. I could not get up early enough to make appointment as my husband works nights as chef, and we do not get to sleep till 3-4 am in the morning”. Chinese NRPF Birmingham.
At 4 weeks pregnant I took a bus to hospital as I was in pain. They confirmed I was pregnant. I had a problem with the English language and needed an interpreter. The hospital asked me to register with a GP then to ask for a midwife”. Black African NRPF

FOLLOW UP APPOINTMENTS

Having made initial contact with maternity services some 65 women (80%) were willing and able to attend all the appointments they were offered while 14 (17%) were not. The reasons for non-attendance included either no transport (11) or inability to afford transport (8), not being well (6), inability to communicate (3), dispersal (2) or domestic responsibilities (2).

All but one respondent in Herefordshire, and all but one in Worcestershire, attended their appointments while a third of respondents in Birmingham, two thirds in Coventry and all respondents in Stoke on Trent, did not attend. Eastern Europeans were most likely to attend (94%) while 50% of South Asians and two thirds of African respondents attended. Table 4.2 indicates that failed asylum seekers (FAS), NRPF and spousal migrants were the least likely to attend all follow up appointments.

Eastern European migrants spoke of their fear of missing appointments and had the perception that they would no longer be able to access services or be asked to pay later if they missed an appointment. Another Eastern European respondent from Herefordshire would have liked more frequent appointments from the midwife, and suggested they should take place every two weeks.

Table 4.2: Responses to were you willing or able to attend all follow up appointments?

<table>
<thead>
<tr>
<th></th>
<th>Refugee</th>
<th>Asylum seeker</th>
<th>Spousal migrant</th>
<th>Failed asylum seeker</th>
<th>A8</th>
<th>NRPF</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>1</td>
<td>3</td>
<td>7</td>
<td>3</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Yes</td>
<td>20</td>
<td>14</td>
<td>20</td>
<td>0</td>
<td>9</td>
<td>1</td>
</tr>
</tbody>
</table>

BARRIERS TO ATTENDING FOLLOW UP APPOINTMENTS

Women thought they would be able to attend more appointments if they had help with transport (12) or transport costs (10), an interpreter (10), better explanations of the benefit of appointments (10), more information (10), or culturally specific services (4) were
provided. Those who were unwilling or unable to attend all appointments tended to be spousal migrants, failed asylum seekers and women with NRPF. Some women did not have the cash to pay for journeys “it is so hard to live on vouchers only. I can’t go for an appointment” (DRC asylum seeker, Birmingham). Other commonly cited difficulties included the need to phone for appointments “Appointments are hard to get here. You have to call the number and they keep you waiting and you can’t (wait on the phone)……and you can’t make an appointment at the receptionist.” (Refugee, Birmingham).

Several non English speaking Chinese respondents from Birmingham required better explanations to how and where to access services, as they were “unable to find the exact address of services due to poor understanding of the places and how to get there on public transport.”

Time factors had a considerable impact on the respondents’ ability to attend appointments, and many advised that they could be left waiting for several hours to be seen. “It takes 1-2 hours to be seen...It can be a good idea to see people quick and manage the time of the patient.” and that “staff should be available for the appointment because I could spend two hours waiting to be seen” (Failed Asylum Seeker, Stoke on Trent). For others their immigration status meant they were unable to attend appointments either because they were detained or dispersed away from their GP and midwife.

“When the blood tests told I was HIV positive I declared myself to the Home Office immediately. The Home Office put me in detention centre so I could not attend my appointments. There were no maternity services there for me for the 2 months I was there. I was offered appointments but they were cancelled at short notice without anyone telling me why. After 2 months I was bought to a Birmingham hostel where they did everything to help me get a GP” African NRPF respondent (now an asylum seeker) who had registered with her GP as soon as she became pregnant.

Several spousal migrants and women with NRPF (primarily South Asian) found difficulty in accessing services due to being under the control of relatives including husbands, partners and in-laws. This was particularly evident in Birmingham and Coventry. Respondents were not allowed to leave the house, and had to ask permission to attend appointments “I needed a man with me, like my husband or brother. No one would let me out of the house otherwise” (South Asian spousal migrant Birmingham). “I did not get support from anyone, could not leave the house without permission from someone even in-laws, I was never allowed out on own” (South Asian spousal migrant Birmingham).
Women respondents said they would be willing to attend appointments if they did not have to rely on their husbands for interpretation “if I could have an interpreter who can speak to me, not only my husband it could help” (spousal migrant Coventry). For one woman this was particularly important because she did not want to have her baby but was unable to tell medical staff that she wanted an abortion.

“I attended all my appointments but did not know what was happening. Mostly my husband or my mother in law took me to the appointment, but often my husband was too tired after working a night shift and it was always a struggle to find someone to take me” South Asian Spousal Migrant. Birmingham

**ANTENATAL CARE**

Only 21 (26%) of women attended antenatal classes, and attendance was low across the West Midlands. African respondents were least likely to attend (13%) and A8 migrants most likely to attend (50%). Classes were provided by hospitals (13), community organisations (8) and the NCT (3). Midwives were the main source of information about how to access classes. Of those who attended classes, 13 women found them most useful, and 6 useful. Five other respondents found them not particularly useful.

**BARRIERS TO ACCESSING ANTENATAL CARE**

A number of respondents experienced barriers that prevented them attending antenatal care. The main barrier was lack of information about the classes (44). Also important were being unable to communicate with healthcare staff (25), lack of transport (21) or affordable transport (12), dispersal (6), concern about immigration status (6), not seeing the service as useful (9) or not being well enough to attend (8). See Table 4.3 for barriers by immigration status. Barriers occurred in all interview locations, and also impacted on barriers to accessing appointments in general.

In Herefordshire Eastern European women were very keen to attend their antenatal appointments. However, one Eastern European respondent in Herefordshire was unable to access any antenatal classes despite registering the pregnancy with her GP within 12 weeks of her pregnancy “I kept phoning every week to try and get on a class – the midwife tried to help but the hospital were very inefficient and never arranged classes and never organised a hospital visit” Another Eastern European respondent in Herefordshire resorted to using a Polish CD with online support about pregnancy and antenatal information.
Several respondents cited barriers to accessing antenatal services due to their husbands not being allowed in antenatal class to interpret for them.

As with follow up appointments women found waiting times of up to five hours problematic and several South Asian spousal migrants from Birmingham were unable to access antenatal services as their husbands were not available to take them to the appointments and they needed their husbands or in laws permission.

Table 4.3: Barriers to accessing antenatal services

<table>
<thead>
<tr>
<th></th>
<th>Refugee</th>
<th>A Seeker</th>
<th>Spousal</th>
<th>FAS</th>
<th>E European</th>
<th>NRPF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of knowledge or information</td>
<td>16</td>
<td>9</td>
<td>12</td>
<td>0</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Service not useful</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Did not have any transport</td>
<td>2</td>
<td>9</td>
<td>5</td>
<td>1</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Cost of Transport</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Unable to communicate with healthcare workers</td>
<td>5</td>
<td>5</td>
<td>11</td>
<td>0</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>18</strong></td>
<td><strong>12</strong></td>
<td><strong>16</strong></td>
<td><strong>1</strong></td>
<td><strong>6</strong></td>
<td><strong>2</strong></td>
</tr>
</tbody>
</table>

“**My ex husband was not allowed to attend and all the classes were in English so I could not understand and felt they were of no use. I did not feel comfortable enough to go by myself and there were other childcare issues**.” Eastern European migrant

**ENABLERS**

Women felt they could attend more appointments if they had better explanations about what was available (45) and how they could help (47), had translated materials (42), an interpreter was provided (34), transport provided (24) or transport costs covered (24) or help with childcare provision (15).

**ACCESS TO INFORMATION**

Most respondents had received some advice about which services they needed to access. The main sources of advice were the community midwife (46) and the GP (31) (see Table 4.4). Family and friends (8) and community organisations (7) were also important sources of information.
“My mother in law advised about the do’s and do not’s in pregnancy. She also advised me about cultural things for example eating a mixture of nuts and natural sweeteners during last months of pregnancy (a pan jeer)”. (South Asian spousal migrant, Birmingham).

Table 4.4: Sources of advice for migrant women

<table>
<thead>
<tr>
<th>Advice about which services to access</th>
<th>National Childbirth Trust (NCT)</th>
<th>Community midwife</th>
<th>Outreach workers</th>
<th>Family or friends</th>
<th>Community organisation</th>
<th>GP</th>
<th>Other Healthcare Professionals</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>46</td>
<td>2</td>
<td>8</td>
<td>7</td>
<td>31</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Advice about how to access services</td>
<td>1</td>
<td>45</td>
<td>1</td>
<td>8</td>
<td>6</td>
<td>21</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Advice about choice of services</td>
<td>1</td>
<td>41</td>
<td>1</td>
<td>6</td>
<td>5</td>
<td>17</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Advice about nutrition</td>
<td>1</td>
<td>67</td>
<td>5</td>
<td>3</td>
<td>0</td>
<td>13</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Advice about breast-feeding</td>
<td>1</td>
<td>65</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>9</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Advice about do’s and do not’s in pregnancy</td>
<td>1</td>
<td>60</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>8</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Advice about antenatal tests &amp; scans</td>
<td>1</td>
<td>66</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>11</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Advice about labour &amp; birthing process</td>
<td>1</td>
<td>47</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Advice about pain relief in labour</td>
<td>1</td>
<td>46</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Advice about relaxation/ birth ideas</td>
<td>1</td>
<td>41</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>5</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

The community midwife was the main source of information around a whole range of antenatal matters and helping women to prepare for the birth. GPs on the other had tended to signpost women to other services. Friends and family while important in helping some women to access services provided less advice around birth and breastfeeding. One exception to this was for South Asian spousal migrants, who were given advice from in-laws and close family members.

Furthermore 60 women (73%) received sufficient information to help them to access services. Information came from a range of sources with midwives (51), GPs (35) and friends (34) being most important. Other sources included community centres (16), family (14) and pregnancy outreach workers (6).

Women in Herefordshire were least likely to access sufficient information. One Eastern European Herefordshire respondent told of “a general lack of information, misunderstanding, and being unable to communicate.” A Russian respondent in Herefordshire advised that she had to phone her doctor in Russia to clarify all questions and give additional advice on medication supplemented by information in Russian books and magazines. While one Eastern European respondent from Herefordshire advised she “did not trust in English maternity services, so did not ask many questions”. Another Eastern European advised that she “went back to Lithuania to have additional tests during her
pregnancy, including Down’s syndrome”. Her 16 yr old son had assisted her in decisions during her pregnancy as he had an interest in chemistry and explained things to her.

Conversely, one Eastern European advised that her GP wrote out a schedule of what tests and scans were available and advised her to go to the hospital once she moved to Herefordshire.

Some 47 (57%) of women accessed advice about grants and other financial support. This included information about the Child Trust Fund (34), the Health in Pregnancy Grant (25) and Healthy Start Support (6).

Women in Worcestershire, Herefordshire and Sandwell and asylum seekers, failed asylum seekers and A8 migrants were least likely to access financial information. One woman with NRPF advised that she had no support for the first six months of her pregnancy and was paying for all her medical needs.

“I did not have information on rights or entitlements from anywhere. I do not know what benefits I could claim or should have claimed so I do not know what was missing. I need an interpreter to explain things. Someone to take the time and patience to explain things step by step.”

“My GP sent the applications for antenatal appointments at the hospital. Once a month visits were arranged for urine samples, and a general health check to be done at the hospital. However, I was given no information about entitlements or any financial help available. I received a maternity card but I did not know what to do with it.”

Eastern European migrant, Herefordshire.

“A friend advised me that I could claim free prescriptions. My GP or midwife did not advise anything so I claimed nothing. I assumed I could not claim because of my immigration status”. Chinese failed asylum seeker, Birmingham.

African respondents specifically highlighted the lack of information; advice; and support available about what foods could be eaten to enable themselves and their babies to be healthier during pregnancy. “I did not have any information; no financial help; did not know what I was entitled to; or housing available. All the information I got was word of mouth from friends” (African refugee).

Other respondents echoed the need for advice on foods to eat “you need to know what is good food to eat particularly the food I used to eat in my own country.” (Yemeni refugee, Birmingham). “I wanted,
I needed information about the milk. No one in the NHS or the midwife told me, except a friend from Jamaica who is a midwife” (Chinese refugee, Birmingham).

“I got no grants, I got free prescriptions, but no other support. I got no information about support available, how to take care of myself in pregnancy, what to eat during pregnancy, what exercises were good for me to do during pregnancy, or where to go for this information. No information was given to me about any antenatal classes. Now I get £35 voucher for myself and the baby”. African NRPF

South Asian spousal migrants with limited English language had great difficulty in accessing any information about what financial support may be available. One advised, “I do not know if my husband claimed for it. He was a greedy man and would have claimed. I did not get support from anyone. I could not leave the house without permission from someone even my in-laws. I was never allowed out on my own” another commented, “I got free prescriptions, no grants. Nothing else. Did not find out about any other support available, I was dependant on my husband who worked nights and needed his sleep”.

There was clear support from respondents for better language provision at all stages of the maternity process. More information was also important, particularly at the antenatal stage. One Chinese refugee did not understand anything about the blood tests until they were explained to her. She was really worried about the tests “I spoke to my father in law who is a surgeon in China, and mother in law in China who is midwife. They told me not to worry and that it was straightforward tests”.

South Asian spousal migrants that were able to access antenatal services did not understand the purpose of the tests and in most cases were not involved in the decisions “I was not involved in the decision. My GP and husband insisted on tests” “My GP and midwife advised me but I had no help to decide. It was as not really a decision. I was told what to do” “I had no choice, I was told which tests to take” were common replies. They also needed help to understand the results but there were not opportunities to speak openly to their GPs “I needed help from GP and midwife to explain tests and results but did not happen”.

“I could not communicate at the hospital with the midwives, I did not feel welcome, could not communicate or ask questions. I was referred to another hospital, they did not advise why. At my third appointment I had an interpreter. The whole process was rushed, and I did not know what to expect. I did not feel involved in any of the decisions that were made – someone else always made them for me” Chinese failed asylum seeker, Birmingham.

While a better quality service was important across all three stages (see Table 4.5). One Eastern European asked for “leaflets with all the translated options or in simple English” while another suggested she “needed an appointment with a social worker who could have given information on advice on rights and help with forms”. However, one African refugee
suggested, “just to have leaflets is not enough. We should have a written list of the things newcomer women are entitled to in different languages that are available to every newcomer”.

Table 4.5: Support needs identified

<table>
<thead>
<tr>
<th></th>
<th>Ante-natal %</th>
<th>Ante-natal Birth %</th>
<th>Birth</th>
<th>Post-natal %</th>
<th>Post-natal</th>
</tr>
</thead>
<tbody>
<tr>
<td>More information</td>
<td>48</td>
<td>11</td>
<td>26</td>
<td>6</td>
<td>26</td>
</tr>
<tr>
<td>Better language provision</td>
<td>78</td>
<td>18</td>
<td>61</td>
<td>14</td>
<td>52</td>
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<tr>
<td>Better quality service</td>
<td>52</td>
<td>12</td>
<td>44</td>
<td>10</td>
<td>43</td>
</tr>
<tr>
<td>Other</td>
<td>26</td>
<td>6</td>
<td>22</td>
<td>5</td>
<td>13</td>
</tr>
</tbody>
</table>

**SUPPORT FROM OUTSIDE THE HEALTH SERVICE.**

Most respondents were in receipt of some kind of support from people outside of the health service. Some individuals had access to support from a range of different people. Partners, relatives and friends were most important. A small number of individuals got help from colleagues, neighbours and community or religious leaders. Table 4.6 indicates the main sources of support.

Table 4.6: Support from outside the health service

<table>
<thead>
<tr>
<th></th>
<th>Ante-natal %</th>
<th>Ante-natal Birth %</th>
<th>Birth</th>
<th>Post-natal %</th>
<th>Post-natal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner/husband</td>
<td>73</td>
<td>53</td>
<td>69</td>
<td>50</td>
<td>73</td>
</tr>
<tr>
<td>Relative</td>
<td>26</td>
<td>19</td>
<td>15</td>
<td>11</td>
<td>32</td>
</tr>
<tr>
<td>Friend</td>
<td>55</td>
<td>40</td>
<td>14</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>Colleague</td>
<td>4</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Neighbour</td>
<td>6</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Social worker/ support worker</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Community/Religious leader</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>5</td>
<td>6</td>
<td>4</td>
<td>0</td>
</tr>
</tbody>
</table>

Women who had husbands in laws and parents who were in the UK, had some support. Other support came from UK friends. One Chinese failed asylum seeker advised “my husband did the housework and looked after other children. I had to send eldest child back to China because I could not find any child care for him in the UK, and I could not take care of him. Relatives provided us with temporary accommodation as my husband lost his job that came with accommodation. My husband had to give up job to take care of me when I
became pregnant”. Another Chinese refugee advised “friends and family gave support, friends helped translate info, once a friend attended hospital to translate. In laws were helpful”.

Some women had support from their husbands throughout the pregnancy “my husband was there to help throughout pregnancy. Has been there to interpret and to support me going to the appointments”. (Spousal migrant, Sandwell). One NRPF respondent told how her “husband helped with other children, and house work, he supported me emotionally and physically”.

Other women with NRPF told of the invaluable support received by friends “my partner and friends took care of me and were excellent. I am pregnant with my second child now. Without their support I do not think that I or my baby would still be alive,” a second advised how friends “brought food and helped clean the house, did shopping. Helped as much as they could”, and a third respondent how “friends gave baby clothes, friends purchased other things for me. I also had help from friend to know what support to apply for”. Most of the NRPF respondents advised they had no money and no resources except what friends and family provided.

One NRPF respondent advised how she had no support as she had been moved by UKBA to Birmingham “all (my) friends were left behind in London. I had no family in UK. I did not have friend in Birmingham. I had a problem with my legal status and no money, and not allowed to work”

One Eastern European migrant who lost her agency job when she became pregnant advised that she had to “ask 16 yr old son to go out to work and support her. We were living in very bad living conditions. Other family and friends gave moral and financial support”.

Other postnatal support from outside the NHS came in the form of vouchers from the Red Cross, and help with clothes for the baby and other basic essentials.

**PLACE OF BIRTH**

Most babies were born in hospital (75, 92%), although one was born at home and another in a midwife led unit. Although 40 women (49%) had visited the place where they gave birth before the event, 37 women had not (45%). Asylum seekers, and A8 migrants, Eastern Europeans and African respondents were least likely to have visited before the birth. Women in Coventry, Herefordshire, Sandwell and Worcestershire were least likely to visit the hospital before birth. The largest proportion of respondents (37, 45%) rated the place they gave birth as excellent, 19 (23%) as satisfactory, 6 as neither satisfactory, nor unsatisfactory, 4 as poor and 1 as very poor. Respondents spoke of receiving an “Excellent service, was nursed in a single room with good privacy, kept up to date with information and progress”, “from my point of view the services are brilliant” (Refugee, Birmingham).
In Wolverhampton all respondents spoke favourably of the maternity services they received “every time I went there they gave me a hug and a smile.” Chinese, refugee, Wolverhampton. “nothing can be improved, everything and everybody was good. It is better than China” (Chinese refugee, Wolverhampton). One African NRPF respondent from Wolverhampton did have one complaint “after having my baby I was asked to go home the same day. I refused to go home the same day and stayed for three days….they were annoyed”. However, she finished the interview with the statement “I had a wonderful experience. I do not think anything could be improved.”

While 35 (43%) respondents reported having had a birth plan, 38 (46.3%) did not. Those without a birth plan were most likely to be African (30%) or Middle Eastern (40%). The largest proportion of women (57, 70%) knew what to expect at the birth, (24%) did not. Those not knowing what to expect tended to be spousal migrants (36%) and South Asian (50%).

Similarly while many women’s needs were met at the birth (42, 51%), 34 (42%) did not feel that their needs were met. Needs not felt to have been met included language needs (22), sufficient pain relief (20), cultural and religious needs (14) and other (19).

One Eastern European respondent in Herefordshire was offered a Polish interpreter during the birth, instead of her own language (Lithuanian). She felt there was a lack of care and support that caused extra stress before the birth and had regrets that she did not return to Lithuania to give birth. Other issues for all migrants included not being given the water they requested (3), not being able to have family or partners sleepover at the hospital (3), lack of staff (4), lack of privacy (3). One refugee from DRC told how at the birth there was “No hot (drinking) water, the nurse was supposed to bring hot water for the birth. It was not good for me not to have hot water after giving birth”.

“My needs were not met. The nurses were not there for me and I did not get food and care because they thought I would be in labour for a long time (as I am Nigerian). Things were very tough for me in the hospital. The staff did not give me attention. I did not get pain relief. I felt neglected and ignored. I was so afraid, depressed and stressed. I did not feel helped and I was just accepting the situation. The staff gave me an injection to go to sleep, and I was told that I had to be left on my own. They left me on my own. I had my baby on my own.” African, NRPF

“No one attended to me for a long time. I was in a lot of pain. I was ignored and not taken to a delivery suite. Suddenly I saw a midwife that I knew. She took me to the delivery suite and 15 minutes later I gave birth. There was no doctor present, they were all off duty and my baby needed injection, as had a blood deficiency”. African NRPF
Refugees, asylum seekers and spousal migrants were most likely to find that their pain relief and language needs were not met. In terms of ethnicity Africans were most likely to state that their language and pain relief needs were not met while Eastern Europeans, Africans and East Asians were most likely to find that their cultural and religious needs were not met at the place of birth.

Most women (64, 78%) felt informed during the birth although 13 (16%) did not. Those who felt uninformed tended to be based in Birmingham, Herefordshire or Wolverhampton.

Several respondents suggested that if staff had a more attentive and caring personal attitude, together with interpreters, it would improve services. In Herefordshire Eastern European respondents echoed the need for more attention and faster responses, coupled with the need for staff to have a better attitude and give more explanations of what is happening.

Respondents from all locations suggested staff should be a bit more attentive and give extra time to people from a different country, and who do not know the system and cannot communicate fully. “I would like the midwife, nurses, doctors to be kind and understanding........... More support for me as a foreigner who sees everything as new” (Spousal migrant, Birmingham).

Eastern Europeans called for a better co-ordination between the GP and midwife, and more training for staff. While respondents from Birmingham commented on the lack of training that medical staff appeared to have, with midwifery and medical students in attendance.

A number of respondents (10, 12%) had received FGM procedures as a child that affected their experience of giving birth. These women were mainly asylum seekers (5) or spousal migrants (2) although one each of refugees, failed asylum seekers and NRPF also fell into this category. Women tended to be located in Birmingham (6) or Sandwell (3) although one was based in Stoke on Trent. In terms of ethnicity they were African (5), Middle Eastern (2), or South Asian (2). Of these women four received some support to help them overcome associated problems. They were asylum seekers (3) or a failed asylum seeker (1) and based in Sandwell (2), Stoke (1) and Birmingham (1). One respondent suggested that services could be improved for women who had received procedures “the midwife should know much better where to cut......I would like to emphasise the nurse should do her best to help, any ask others before doing anything they are not sure about”. Only one woman said she was asked to pay for the costs of the birth. She was an East Asian asylum seeker based in Coventry.

“I was told I needed to see the midwife but did not know why. The midwife seemed to be in training, and she said that she did not know what to write on the paperwork that the GP had given. She said she was in training”. South Asian, spousal migrant, Birmingham
“During the birth I could not communicate to the midwife, and my husband could not explain on my behalf, and was too shy to say things that I wanted him to say. My husband also felt uncomfortable to be put into that position, and felt that he would be ‘preaching’ to the medical staff if he asked them to do what I wanted. I had no pain relief, and felt the medical staff were inattentive and harsh”. Eastern European migrant, Herefordshire.

Lone women, especially women speaking little or no English told of the difficulties of knowing what to do, who to contact, or where to go once they had gone into labour. One respondent would have liked “a specific midwife, not changing all the time. I called the ambulance when I was in labour, it did not come on time.....it was so frustrating because I couldn’t speak any English and I did not have a midwife to call for help” (Chinese asylum seeker, Birmingham).

One week before labour I was bleeding and tried to phone the midwife in Birmingham but her phone was off. I could not contact anyone in Birmingham and called my previous midwife in London for help. The midwife in London said that I would have my baby soon and not to go far from the house. I went into labour and tried to telephone the midwife in Birmingham but her phone was switched off again. I called the hospital and they told me to take painkillers or have a bath to release the pain. I was on my own and did not have any painkillers. After one hour I called the hospital again, I told them I was on my own and they told me to take a taxi but I could not as I was in so much pain. The hospital said they did not know how long an ambulance would take and for me to call back in ten minutes. The ambulance did come. In the hospital the nurse did not want to tell me anything. It was painful, and I kept calling for a nurse but she really delayed in helping me. Finally she did examine me and helped me. My housemate was there for me and she brought the clothes for the baby. The ambulance had left my baby’s clothes bag at my home saying that it wasn’t needed as they did not know if I was going to stay in hospital or not”. Chinese Failed asylum seeker, Birmingham.

For one respondent in Sandwell, the birth experience had been particularly distressing, and had resulted in a still birth. “My waters had broken at home and we went to the hospital. We were told to go home but we refused and stayed in the hospital. There were problems because the midwife had not identified that the bottom was coming first not the head”. My husband had to raise the alarm in the hospital when he noticed the cord coming from the vagina”. The couple have requested a second opinion on the hospital report about this incident, which established that the clinical management of the cord collapse was not ideal, and for which the hospital has apologised. The couple have been told that incident resulted
from human error. The couple feel that they need professional help as the bereaved mother does not sleep and cries most of the time and continues to have nightmares about what happened. To date they have not been offered any further assistance.

### Postnatal Support

Women, with the exception of two respondents, received support from a number of areas following the birth. Sources of support included visits from the midwife (72), health visitor (68) or family and friends (65). Others were helped by a breast-feeding specialist (24) or attended mother and baby clinics (13) or the GP surgery (12). Respondents were offered help with care for the baby (62), breast-feeding (51) mother and baby activities (42), postnatal depression (28) and vouchers (19). For most (54, 66%) that support was sufficient to meet their needs although 27% of respondents felt their needs had not been met.

In Worcestershire, Sure Start Children’s Centres are given details of women that have given birth within their reach area to ensure all women are contacted. One newly arrived respondent told of how she was contacted “The Sure Start Children’s Centre do a birth visit, triggered by the hospital after the baby is born” (Spousal migrant, Worcestershire).

### Support Needs

Three women said they had nobody to support them after they had given birth. They were an African NRPF based in Wolverhampton, a South Asian spousal migrant based in Birmingham, and a very recently arrived Chinese asylum seeker based in Birmingham. The latter respondent was living in temporary accommodation, having given birth shortly after arriving in the UK and being “quite unknown of the services available”.

Women that had no one to support them told of being permanently tired, having to cook, clean and take care of the baby and needing to rest. Several respondents said they were “tired, exhausted, could not cope, did not get any rest and stitches were painful”. Another respondent advised “I was awake all night with no one to help me with the baby”. This situation was particularly acute for those women who were completely alone without support from partner, friends or family.

Respondents who received a visit from health professionals following the birth suggested that the focus was on the health of the baby and not the mothers’ needs. One Eastern European migrant in Herefordshire advised that follow up visits were “very short visits, with no support given, just a quick check that baby is OK.” A second Eastern European respondents stated that she “understood the purpose of the visit but I could not

“I needed help in collecting medication for my baby; help with washing clothes, washing machine, extra help. I had to do everything by hand and force myself to get on and do it. I got more stressed and depressed”

African Refugee
communicate at all. But did think that the midwife was trying to persuade me to breastfeed,” and a third stated “the midwife did not speak to me as I did not speak any English. The midwife just checked over the baby”.

Most of the respondents across the West Midlands felt the follow up visits were primarily focussed on the baby “with no thought for the mothers needs”.

South Asian spousal migrants speaking little or no English in Birmingham did not understand the purpose of the visits following the birth. “They were not helpful. I did not understand. My husband was doing all the talking the same as during my antenatal visits. I did not understand what was going on” “I could not ask questions as my husband was asleep so was alone and could not speak English. I did not understand anything the midwife said”.

Others that did speak some English still did not understand “ I did not understand the purpose of the visit. The midwife said the baby was ok, but did not ask any other questions or about me” (African, NRPF). One non-English speaking Chinese refugee in Birmingham did understand “I had a friend with me to interpret. All my questions were answered, but only because I had the confidence to ask through the friend”.

Four women reported receiving no help with their post-natal depression. They were based in Birmingham and were South Asian spousal migrants (2) or in Herefordshire and were Eastern European economic migrants (2). One south Asian spousal migrant who thought she was suffering with post-natal depression told how she never got to take her baby home as it was taken away from her by the father “when my baby was taken off me I did not get any support from the doctors. I was depressed but I could take care of my baby. Now they think I’m crazy.” Another South Asian spousal migrant who suffered from post-natal depression told how she “Got angry with people. I was tired, and cried for no reason. My sister in law recognised the symptoms and told my husband to take me to the GP”.

“I had very serious depression. We were a family of five living in one room and the social workers who visited said “you came here (to the UK) yourselves, so do not expect silver spoon service”. Eastern European migrant Herefordshire

“After the birth, they need to focus on the health needs of the mother. More information about post natal depression and what help is available in the Bangladeshi community. Medical professionals need to be able to recognise it, not ignore it. The whole family needs to be informed and involved in the process, so they know how to support a woman with post-natal depression” South Asian spousal migrant, Birmingham.
CONTINUITY OF CARER

Half of the women completing the survey had access to the same midwife throughout the pregnancy (see Table 4.6). There were no trends in terms of status or location. Some 58 women (71%) felt they were able to discuss everything they needed with their midwife.

Table 4.6: Access to the same midwife

<table>
<thead>
<tr>
<th>Immigration Status</th>
<th>Access to the same midwife</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Refugee</td>
<td>11</td>
<td>10</td>
<td>0</td>
<td>21</td>
</tr>
<tr>
<td>A Seeker</td>
<td>11</td>
<td>6</td>
<td>0</td>
<td>17</td>
</tr>
<tr>
<td>Spousal</td>
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<td>18</td>
<td>0</td>
<td>27</td>
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<tr>
<td>FAS</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
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<td>E European</td>
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<td>3</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>NRPF</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>40</td>
<td>1</td>
<td>81</td>
</tr>
</tbody>
</table>

Conversely, a small proportion of respondents felt that on occasions they were unable to talk through concerns with their midwife “as seemed rushed, as not enough time to talk through concerns” and “I felt that the visits were very rushed and short. I wasn’t weighed and my stomach wasn’t measured.” (Eastern European migrant, Herefordshire).

Similar sentiments were echoed from respondents across Birmingham “they did not give me time to ask different questions that I had. For example, I was worried about my baby who had a heart problem but I did not get enough information about how to handle my situation”. (South African refugee, Birmingham).

“I would like to have the same midwife throughout my pregnancy, because she can continue to help me......without, I am starting new every time I see a new midwife” (Spousal migrant, Birmingham).

RELIGIOUS AND CULTURAL NEEDS

Some 46 (56%) of women said that services met their religious or cultural needs while 35 (43%) of women did not feel that their needs were not provided for. These respondents included 60% of South Asian respondents, 58% of Middle Eastern, and 55% of Africans. Cultural needs were reportedly least likely to be met in Coventry and Sandwell, and most likely to be met in Worcestershire and Stoke (100% of respondents). Just over half of respondents from Birmingham (53%) reported that their cultural needs were met.
Respondents echoed similar sentiments “everybody was (treated) the same...none thought about religious or cultural needs”, “no one asked me about my cultural or religious needs”, “they just asked me if I am from Africa and a Christian that’s all”, “if they could ask me about what I would need or want as far as my culture and religious needs are concerned. I was just not asked”, “I wish they would ask me about it but they did not ask me anything about it.” These were typical of respondents’ replies.

Medical staff did appear to ask respondents about their religious or cultural needs but the focus seemed to be more on their religion. Several respondents suggested that medical staff should ask about their culture and pregnancy as well as their religion. One refugee from Birmingham echoed a common theme from respondents when she stated “I wish they would ask me about how in my culture people behave when they are pregnant and ask me about my religion and pregnancy. Assessment about religion and culture and pregnancy could help.”

FINANCIAL, SOCIAL AND STRUCTURAL DIFFICULTIES.

ABUSIVE AND CONTROLLING RELATIONSHIPS

Several women told how they found it difficult to get support when finding themselves in abusive relationships. One NRPF South Asian spousal migrant in Birmingham said “I needed somebody to trust me and believe what I was going through. Being abused and for a long time. No one helped me”

One NRPF South Asian respondent advised that she had wanted an abortion as her husband had raped her when he found out that she wanted to leave him. However, her husband made her contact a GP who did blood tests and ensured he attended every appointment with her. She was not involved in any decisions and was not aware of what was happening. She needed an interpreter so that she could tell someone about the abuse she was experiencing and to be able to speak openly to her GP about how to get an abortion. On one occasion she spoke secretly to an Urdu speaking midwife while she was getting changed away from her husband. The midwife gave her help-line telephone numbers and advised her to call the police next time her husband hit her. Because she was unable to speak English she could not follow the midwife’s advice.

Another South Asian NRPF in a controlling relationship advised that her husband made appointment for her with the GP following advice from her mother in law. Throughout the process she had no idea what was happening to her or why. Nothing was explained to her by the health service. The only information she received was from her mother in law and her husband. She wanted to be able to ask the questions directly through an interpreter, and felt important things needed to be said and were left out.
The controlling relationship theme was not solely confined to South Asian spousal migrants. In Coventry, one non English speaking Arabic respondent told, “the culture of my husband does not allow women to go out or know anything. I did not know what to do or where to ask for information and support. I needed information about all the benefits but I did not get any because I could not speak English. The family of my husband knew the language, so maybe they got the money of financial support. I do not know what was going on. I needed an evaluation of my family situation because I was not being treated well. If I could have someone who is not my husband it could make a big difference because throughout my pregnancy I did not say anything about my needs or problems. My husband was saying everything.”

**HOUSING CONDITIONS**

Housing conditions presented problems for many asylum seekers, Eastern European migrants and women with NRPF, and those on Section 4.

“The houses that they give us are so dirty and with small babies it is really bad for them and me.” “I was so ill and I wanted to go and live with my friend but they wouldn’t move me. The house was so cold…….there was no washing machine” (African Section 4).

“I had accommodation where you go to share with other people. This is really hard because everything should be clean for the baby” (South African asylum seeker, Birmingham).

The situation was also difficult for failed asylum seekers who were not receiving any state support

“When we first came here we were both working for two different restaurants. We were provided with small flats to live in. I lost my flat and job when I became pregnant and couldn’t work. I moved in with relatives and sent my other child back to China to his grandparents. Now I am living in shared accommodation with shared cooking etc. I need to learn English and get childcare for daughter that was born here before I can bring back my son.” Chinese failed asylum seeker, Birmingham

“NHS services should seek to help women who can’t afford anything particularly for those who are on section 4. Provision of money for transport itself can make a real difference because sometimes I would miss my appointments because of lack of transport.

The accommodation that I am in is just one room for me and the baby, and there is no room to welcome visitors I may want to have. No living room at all. Continuous support is really needed for migrant women with complicated situations.” African failed asylum seeker.
**LACK OF BASIC ESSENTIALS**

Respondents from across all categories told how they did not have the basic essentials for the baby, and churches and voluntary organisations supported many respondents with basic essentials for their baby.

“Help with clothes for the baby and other basic essentials should be provided” (South Asian spousal migrant Birmingham).

“I had to rely on hand downs from sister in law, I had nothing for the baby. Lot of things did not fit my baby; she was very small when she was born”. (South Asian spousal migrant, Birmingham)

“I did not have enough clothes for the baby and no money to buy any. I did not have car seat, clothes for the cold weather, until my friends helped me out”. (South Asian migrant, Birmingham)

“I wish I was having some cash to buy something for me and my baby. It is so hard just to use voucher only” (Asylum seeker, Birmingham)

“I could not get to the GP for myself, as I had no pushchair. The pregnancy caseworker did not help either, but she did refer me to the local Children’s Centre who gave me a pushchair after 1 month” (Chinese NRPF, Birmingham).

**OVERALL EXPERIENCE**

Women were asked to think about their experiences of maternity services and how welcome they had felt at each stage. At ante-natal, birth and post-natal stages most women had felt welcome (between 74% and 79%). Table 4.7 indicates that at each stage there were some respondents who had not felt welcome. The profile of the women who felt unwelcome varied according to stage.

**Table 4.7: Feeling welcome**

<table>
<thead>
<tr>
<th></th>
<th>Ante-natal</th>
<th>Birth</th>
<th>Post-natal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not welcome</td>
<td>5 (7%)</td>
<td>6 (7%)</td>
<td>4 (5%)</td>
</tr>
<tr>
<td>Neither welcome or unwelcome</td>
<td>7 (9%)</td>
<td>9 (11%)</td>
<td>8 (10%)</td>
</tr>
<tr>
<td>Welcome</td>
<td>64 (78%)</td>
<td>61 (74%)</td>
<td>65 (79%)</td>
</tr>
</tbody>
</table>
Table 4.8 indicates that the largest proportion of respondents was satisfied with the service they received. However respondents tended to be more satisfied with their community midwife, other health professionals and support groups than with GPs or antenatal departments.

Table 4.8: Proportion of respondents satisfied with the service they received

<table>
<thead>
<tr>
<th>Service</th>
<th>1 (excellent)</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 (poor)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>38</td>
<td>22</td>
<td>14</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Community midwife</td>
<td>49</td>
<td>24</td>
<td>4</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Antenatal department</td>
<td>38</td>
<td>26</td>
<td>5</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Support group</td>
<td>17</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Private health care</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Informal support</td>
<td>13</td>
<td>8</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Other health professionals</td>
<td>23</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

When asked for their overall comments on maternity services several respondents echoed similar sentiments. One refugee echoed a common response “Where I came from we do not have these services, so I am thankful for everything I got”. One Eastern European migrant commented “I enjoyed being pregnant in this country, felt respected and supported”. While a Spousal migrant in Birmingham said “I do not have any complaints. Everyone was polite to me. I am pregnant and I would like to go to the same hospital because I was treated well.” However, one respondent advised that while the maternity services overall were good “it depends on the hospital you go to and the nurses you met that day.”

HOW MATERNITY SERVICES IN THE UK COULD BE IMPROVED.

TRANSLATED MATERIALS AND INTERPRETATION SERVICES

The need for more translated materials was cited across all services, and interpretation services specifically in relation to the reliance on husbands or partners to interpret.

“Need interpreters at all appointments. Need to speed up waiting time – I had appointment at 9am and did not get seen till 12noon. Medical staff focussed on the equipment more than me. They were more interesting in collecting data than on mothers’ health and baby’s health. Women in our situation need free childcare so that can attend ESOL class”
“Need more community welfare centres for migrant women with language problems where they can communicate with people from similar backgrounds and learn about the systems in the UK. More interpreters, more childcare so that women can learn English. Language a big barrier, can’t communicate with anyone”

ASSESSMENT OF FINANCIAL SITUATION AND INDIVIDUALISED CARE.

Give more individualised care relating to migrant women’s needs. “More cohesion and look at each case individually and not do things just by the book” (Eastern European Migrant Herefordshire).

“Need every woman to have an individual evaluation so they can be helped. Make sure that migrant women have at least the things for the baby before having the baby”

“Assessment of migrant women’s’ financial situation so that they can get extra help on time and things like a pushchair. It is really hard for a pregnant woman particularly when she is on her own and it is her first baby”

“More information is needed about financial support, rights and entitlements for migrant women because until I was six months pregnant I did not get any information or know where to turn to or who to speak to”

SUPPORT FOR RECOGNITION OF WOMEN IN ABUSIVE RELATIONSHIPS.

“Medical staff needs to be able to recognise when a woman is being abused and help her. Should be an opportunity for an independent interpreter for all women that can’t speak English as standard. Should not rely on relatives for interpretation. Women should be given a choice, whether to keep the baby. It should not be assumed; it should be discussed with the woman”.

DURING THE BIRTH

Differences in dietary habits should be catered for, particularly in recognition of culture and religious needs. Respondents across all categories called for the provision of sleeping facilities following for other members of the family including husbands, partners and other children. Eastern European migrants called for better support for mothers after the birth, for example a baby unit over night, so mothers can get better sleep. Respondents across all categories suggested they needed a longer stay in hospital following the birth, particularly when they had no support, were living in poor quality or shared housing or had no facilities for their baby at home.
Some respondents across all categories felt their needs were not met during labour and wanted to be treated the same as other women.

“saying that a black woman stays in labour longer than a white woman. That is not really fair. Black women are like white women, no different at all, it has affected me badly”

“when I needed water and I was in pain, they did not give to me and I had to get for myself”

FOLLOWING THE BIRTH.

Respondents across all categories called for more postnatal checks for the mothers, as visits from health visitors and midwives focussed only on the baby. There was a particular need for support across all categories for help and understanding with postnatal depression.

“Family, possibly social workers to help with postnatal depression, not to feel isolated” (Spousal migrant, Herefordshire).

“More postnatal care for women, in China there is postnatal checks up to the age of 60. In the UK postnatal checks are only available if we request them”. (NRPF Birmingham).

BETTER UNDERSTANDING OF MATERNITY SERVICES ABROAD.

Eastern European Migrants thought that maternity services could be improved if health professionals in the UK had a better understanding of migrant countries maternity services.

“ the UK needs to visit Lithuania to see the differences for themselves. Needs to be better language provision in the UK”.

“the UK needs a better understanding of migrant countries maternity services, at least of the Eastern European countries. There is a need for better language provision”.

MATERNITY SERVICES OVERSEAS

Some 22 (27%) of respondents had accessed maternity services overseas. Of these 10 women said the services overseas were better and 18 thought language provision was better as services were provided in their first language.

Polish migrants stated that the overall service in the UK was better than their experience of maternity services in their country of origin, citing the lack of privacy in hospital, and the private system within which most people have to pay for services, as the main drawbacks. One benefit of the system was that the mother generally spent seven days in hospital
following the birth, and received 24 hour care of mother and baby to give mother a chance to recover after the birth. Generally Eastern Europeans felt more informed in their former county. They felt there was better communication, and more in depth monitoring during pregnancy, birth and after.

Chinese respondents stated that the Chinese system was less complicated, with all services located in one place, normally a hospital. In UK there are so many different places to go for help which made the system difficult to understand especially where women had language problems. In China most respondents would have had support from family, whereas in the UK they were generally on their own. Overall the standard of care in the UK was thought to be better “in China you have to get family member of friends in the know, in the hospital to get a good service. There is also a lot of corruption in China”.
CHAPTER 5: PROFESSIONALS’ PERSPECTIVES – HEALTH CARE WORKERS

ACCESSING SERVICES

Professionals reported that women faced a wide range of problems accessing services at different stages of their pregnancy. There was a widespread lack of awareness of the rights of migrant women and few specialist services available aimed at meeting the needs of migrant women who did not know what, where, when, and how to access maternity services. Not all women were able to register with a GP. Some arrived in the UK late in their pregnancy. If they arrived after 38 weeks pregnant it could be difficult for them to get an appointment in time with a GP and then to access services. There was apparently no system for fast tracking, so no matter how late they were in their pregnancy they still had to wait for a referral to a midwife.

Women were said to be dropping out of the system and not attending appointments, because they did not receive all the information they needed. Healthcare professionals felt that the system in the UK was driven so that the individual women had to ask the questions rather providing the women with the information they needed. They felt that some health professionals were not proactive and if migrant women did not ask questions or the right questions, because they could not speak English, or were uncertain what to ask, then they did not get the information they needed.

Lack of time was seen as an important issue by many respondents. Appointments with health professionals in the NHS were normally up to fifteen minutes long which did not allow enough time to develop rapport with patients, particularly for vulnerable women, where they will need to build a relationship and spend time to tease problems out. Health workers told of the NHS performance driven culture, which measured performance on quantity of people that are seen, rather than the quality of service provided to each patient. Some respondents felt that community based systems were better equipped to spend more time with women on a one-to-one basis.

Health visitors were said to have issues around screening for postnatal depression, and did not know where to signpost women for support services. Furthermore a Female Genital Mutilation (FGM) service was hard to advertise because it was not a separate service so the midwife had to give out her own mobile number. While professionals were aware that women’s service needs were often not met, they found getting accurate service user feedback challenging as newly arrived migrant women tended to be grateful for anything they receive and were thus reluctant to complain or criticise.
LANGUAGE

A further issue raised by professionals was that of appropriate language provision. In some areas non-English speaking women represented 50-75% of service users. Having interpreters at each session was viewed as important for women who could not speak English. Yet they struggled to get hold of interpreters to enable a proper assessment. Often interpreters were unavailable or did not understand a woman’s dialect. Alternatively there could be issues around confidentiality or sensitivity if the wrong interpreter was used “There can be issues if the husband accompanies the women…… Issues around confidentiality if an interpreter is used especially if they are from the same community”. Sometimes the interpreter provided was inappropriate, for example provision of male interpreter could distress women and lead to them not attending future appointments. There was apparently a big shortage of Somali interpreters in Birmingham and it was reported that Indian and Pakistani women often could not read the translated materials provided.

UNDERSTANDING THE SYSTEM

Getting health information across to the women was seen as a challenge. Many migrant women apparently did not understand preventative health approaches or have any previous health knowledge of the maternity services. The current system was argued to be too process driven. If the pregnant women’s lifestyle fitted into the system then it worked well. Those migrant women who were not settled and who had complex needs were said to fall outside the system because they tended to lose contact and then failed to re-engage because they did not know what to do.

It was also suggested that women do not access services because they are frightened, and they do not feel they are respected. Some women, particularly those with immigration problems, were scared that their baby would be taken away from them, or that they may be put in a detention centre. There was a lack of confidence about accessing statutory services that they feel may put them at risk.

Attitudes of some health staff were also seen as a problem. Women with a lot of issues like migrant women were apparently viewed as difficult to manage by some health staff. Women were reportedly not always greeted in a friendly and welcoming manner, or made to feel safe. There were also issues with some healthcare workers not understanding why migrant women might not want to give their address.

RESOURCES

Those on Section 4 and in receipt of vouchers could not afford, or did not have any means to pay for, transport to appointments. Even when the cost of transport was reimbursed they
needed the money in advance because they had no available cash. Some women struggled to attend appointments because they had wider childcare commitments and had no one who could mind their children, or collect them from school, while they attended an appointment. Once they gave birth many women were said to lack the equipment they need for the baby including cots, bedding, sterilisers, stair gate etc. Although women were entitled to a small grant to help them make such purchases healthcare professionals advised there was an issue with sub contractors not getting the equipment to families quick enough, if at all.

**CULTURAL, ETHNIC AND IMMIGRATION ISSUES**

Professionals recognised that migrant women faced a wide range of problems associated either with their immigration status or their low levels of income. Re-housing and geographical movement during the immigration process meant that women could be moved frequently, even at a late stage in their pregnancy, an issue that WMSMP has raised with UKBA. This left women outside of maternity services at a time when they needed them most. Furthermore many women faced a whole range of problems from their immigration status, to homelessness and domestic violence. Overcoming immediate problems, or attending solicitors’ appointments, tended to be prioritised over attending antenatal appointments. Frequent movers often forgot, or did not have time to, notify the hospital or other professionals about a change of address and so could not be contacted for follow-up appointments.

Health professionals working with migrant women felt that the existing healthcare system in the UK sometimes did not meet some cultural traditions of migrant women. Many hospitals did not serve culturally appropriate food and for health and safety reasons did not allow visitors to bring food in. Some women were said to lack education or to be subordinate to men and struggled to engage with the system themselves. Many women were isolated, and on their own, and had no one to advocate for them. Others experienced domestic violence and were reluctant or unable to talk about their problems. Professionals argued that they had observed a negative impact on both women’s and baby’s health when women remained in an abusive relationship, because babies were lower down in the womb and born with low weight. When women did go to places of safety they were often very isolated. Some women were prevented from attending appointments by controlling families. Professionals said that across cultures women could experience a lot of pressure to take a traditional approach to their pregnancy. For example Romanian and Romany women were self sufficient within their family networks, had support within their community and were reluctant to take-up the full range of services. Some women would only see female clinical staff. While with so many language or cultural differences no clear patterns of social and cultural issues could be identified, a number of issues were raised that related to ethnicity, status or cultural traditions. These included:
• For many Asian women a male doctor is problematic.
• Slovakian women can be harder to reach and they sometimes do not attend appointments. This may be due to the fear that the baby may be taken away.
• Black African-Caribbean women used the services less than other groups.
• Pakistani and Indian Women used the services more than any other group.
• Somali women did not like being induced, preferring to wait until labour happens naturally.
• Tamil women found it very hard to say they had been raped, and they did not talk about it, while Congolese women seem more able to talk.
• Asian women were seen to be more guarded and reticent.
• Polish women were better at supporting each other and getting out and about.
• Concerns from Polish women that they were not immediately referred to a gynaecology clinic as was the system in Poland. They expected more scans and more regular GP appointments than were available on the NHS. Some feared that without a National Insurance number they were not entitled to maternity care.
• A high foetal mortality rate in some areas due to marriage to blood relations, and associated need for preconceptual screening.
• Economic migrants struggling to get time off work.

All but one interviewee had met women that had undergone FGM procedures in their former country. The women tended to come from Eritrea, Sudan, Somali, Ghana and Somalia. Not all women advised health professionals that they experienced FGM. Professionals found it difficult to ask questions about this issue and some hospital staff were said to lack experience about how to deal with FGM. Women did not understand what parts of their body had been taken away, or how to communicate in the right biological words. They were worried that they would not return to their original state after giving birth and would then be rejected by their husbands. Professionals said there were increased risks in child birth, and tearing of scar tissue was a common complication. One interviewee advised “In the NHS there is a specialist pathway for women who have undergone FGM. We explain to women what will happen and what we legally can do and can’t do” In one area the question regarding FGM was included in the pregnancy notes. Other interviewees suggested more training was needed for health professionals. A question regarding FGM needed to be integrated into normal assessment. One hospital was said to have a have a very good and welcoming FGM clinic. One interviewee advised that women are routinely asked about FGM, and they are then referred to hospital care if they have had the procedure.

RURAL ISSUES

Professionals recognised there were issues around isolation, support and access to services in rural areas. Children’s Centres were providing an excellent service in most areas but more
support was needed in the rural areas of Herefordshire. Eastern European migrants in rural areas were said to be much more isolated than in urban areas and tended to operate through faith groups.

**OVERCOMING BARRIERS**

Professionals suggested a wide range of approaches to improving migrant women’s access to, and outcome in, maternity services.

**CULTURAL COMPETENCY TRAINING**

It was argued that cultural competency training could be introduced to all staff from consultants to porters and receptionist staff. At the present time the lack of training meant that some midwives were reluctant to work with this group because they worried about not understanding women’s needs. It was also argued the situation could be improved if people were employed from within communities.

**INFORMATION AND LANGUAGE**

Professionals argued that more interpreters were needed, preferably individuals who had a medical background. Language support was seen to be needed throughout the pregnancy, birth and post-natal care processes. They wanted to see more midwives employed with community languages. In addition to better interpretation the professionals we interviewed wanted to see more resources provided in different languages and formats. Suggestions included

- A simple leaflet explaining to women at first contact what to expect at different stages of the pregnancy
- An information booklet explaining what is on offer for maternity services
- A ‘Welcome Pack’ for newly arrived migrants in Herefordshire to make women more aware of what is available.
- A booklet on the immunisation system in the UK, which compared to services in their own country to ensure that babies do not get double vaccinations.
- Information on a CD.

**OUTREACH**

Professionals wanted to see more work in communities and an increase in partnership working with voluntary organisations. Community workers were seen to be important as they can act as the first step for women to make contact with health services, particularly where they speak the same language and have perhaps shared experiences. Having such a link was said to give migrant women some hope that they can trust the system. They also called for health workers to work out of informal settings. The Tapestry Project in Wiltshire
was seen as an excellent way to sit with women and informally share health messages. It was also suggested that more services could be located within the Children Centres. For example having GP surgeries in Children’s Centres where there can be access to crèches, childcare and other support. In rural areas more community link workers, and support workers were needed to help reduce women’s isolation and enable them to access what they needed.

Suggestions were made about providing support groups for pregnant women possibly through Children’s Centres matching female mentors to migrant women. Another suggestion was a “knowledge exchange”. For example a pregnancy class held at one Children’s Centre acted as a social exercise in exchanging knowledge about being pregnant. It was also a way of introducing women to understand what will happen through the pregnancy process including getting undressed (as some women never undressed in front of people or were naked). As a result the women that attended were more likely to feel comfortable about undressing during the pregnancy at maternity appointments. Another professional suggested the development of a buddy support system by women who have had a baby in the UK where they could meet with other women to explain the service, what to expect, and support can be tailored to their specific culture and language.

NEW APPROACHES TO SERVICE PROVISION

There was a recognised need to ensure that services operate to provide more flexibility according to individual need. Services should become more flexible with drop-in appointments available at evenings and weekends. This would enable economic migrants who could not get time off from work to still attend appointments. A one stop shop service was also suggested enabling women to access everything they needed at one place and thereby avoiding the attrition associated with referring to a different location.

Several respondents stressed the need for midwives to adopt a case load approach, whereby the remained with women throughout their pregnancy. This approach would enable them to build relationships with women, develop trust and tailor services to their needs. “There needs to be more gentle probing to find out the issues for these women for example a Nigerian women who is unable to have a natural birth can be shunned by her community, there are mental health issues, issues around FGM, diabetes, heart disease…. these issues need to be drawn out and can be difficult if using translators or if there are no translators”.

It was also suggested that a specialised service offering double appointment times and even longer for the first appointment would help ensure proper risk assessment. Services were needed that worked holistically to get to know the patient and obtain a greater understanding of their background. For example women who have been raped in their own countries have real issues for both the pregnancy and mental health that need to be addressed. Services could also offer screening for a range of issues that do not usually form part of the standard pregnancy screening for example TB, Syphilis, and hepatitis. It was
suggested that there was a need to educate professionals about FGM and to provide more specialist clinics. Better ongoing auditing was also suggested to ensure services responded to needs. Finally respondents outlined the need for better hand over information processes as women were often lost from the system when they move areas.

**IMMIGRATION POLICY**

Some argued that the DH needs to work more closely with UKBA and that UKBA policies need to change to take into account of the ways that the needs of pregnant migrants can be addressed. In particular women needed stable housing before they could focus on their pregnancy. Respondents also suggested that pregnant women, and those who had recently given birth, needed assistance with practical living issues for example: food, housing, immigration status, and poverty.

**ATTITUDES AND FEEDBACK**

Professionals argued that all GPs needed to better recognise migrant women’s needs. It was felt that attitude changes were required across the piece with staff needing to treat women with dignity and respect. “Attitudinal change is needed. There is quite an old NHS workforce. There is also the need to ensure that communication works both ways, by networking, updating both sectors with the knowledge of services available - being on the radar”. Receptionists were said to have a key welcoming role and needed to work be supported to help migrant women to access the services they need. More feedback was required from service users. Many women come from countries where you never criticise, and they were grateful for everything they receive. There is a need to ensure feedback channels are sensitive and empowering.

A final comment came from a professional who assists Asylum Seekers and failed Asylum Seekers to access mainstream health and maternity care:

“We need to address the safeguarding of women late in pregnancy and provide swift access for those with problems. To have one central contact so we can get a midwife quickly if required, and can bypass the appointment system. It is very important if women are being relocated or dispersed so late in the pregnancy. It is often impractical to contact GPs, and often surgeries are unsympathetic. We need to gain the views of service users. DH and UKBA need to be made aware of the impact on infant health and maternity and look at reducing the number of weeks pregnant for the cut off point for relocation to not more than 36 weeks”.
**VOLUNTARY ORGANISATIONS AND PARTNERSHIP WORKING**

Voluntary organisation partnership working with NHS services varied across the West Midlands. In some locations partnership working was viewed as good with lots of networking meetings, multi agency groups, and sub groups. In one area there was a reliance on a church group to sign post to Citizens Advice Bureaux and sexual health services. Whilst in other locations the relationship with voluntary organisations was not viewed as working well, as it appeared to be down to the workers on the ‘shop floor’ to develop relationships and was not strategic.

“No we do not work well together. Communication is poor. We are poor at addressing the issues. We could do so much better at working together. There needs to be much better signposting, more partnership working. There are many benefits for voluntary sector organisations and the NHS to work together and the NHS needs to draw on the voluntary sector organisations. The thinking does need to change – we need health promotion/midwives in a public health framework”.

“Not very well. The two cultures are different – NHS is performance driven about quantity of people coming in and out the system. Voluntary sector organisations are more interested in providing individualised services. Can we work together? We try”

In rural areas there were not many voluntary sector organisations to support the women but partnership working was viewed as acceptable. Overall there was a good working relationship between Sure Start Children’s Centres and Health across the West Midlands, but some rural locations advised this could be improved.

**TRAINING ON COMMON ASSESSMENT FRAMEWORK (CAF)**

Only three interviewees had received training on the CAF. Two professionals made referrals, and one advised CAFs were only completed for teenage pregnant women. “It is a grey area, we do make referrals. There is a reluctance to get children and family services involved.” On the whole professionals did not undertake CAFs: “we do not do it. We would provide extra support if a teenager required. They are often pregnant because they have been raped and need support from psychological services; however CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) are poor in responding to their needs”. Respondents did not appear to realise that the CAF isn’t only for teenage pregnancies. The CAF is designed to support services to meet the needs of any child (including unborn children). Migrant women who have complex needs which may affect the health of the baby either during pregnancy or after birth should be referred through the CAF process.

Social risks were identified in a number of ways depending on the location of the service. These generally lacked formal processes but included questions at the pregnancy booking
visit, and initial note taking, through observation, asking of questions or through a risk assessment tool.

There were difficulties in addressing social risk as some issues were not picked up or were skated over. In one area they were not aware of a standard set of questions to cover social risk. There were issues with communication and language, plus a lack of social and family support due to finances. In one urban area when social risk factors were identified they were referred to a pregnancy outreach worker. The use of the risk assessment tool was seen to be generally effective.

For Eastern European migrants their housing conditions were seen as a social risk factor with two or three families living in one house. In rural areas of Herefordshire and Evesham, farm workers were housed in caravans with no heating. There were often issues with work environments for example: the women are not allowed to sit down on a 12 hr shift; or have a frequent break. Most work for agencies and did not have employment contracts. If the women complained they did not get any more work.

In one location social risk was based solely on judgement, and was seen to be difficult. The interviewee had seen a questionnaire used but felt that addressing social risk factors were difficult because they almost always were referred on to other agencies.

### EFFICACY OF THE CURRENT SERVICE PROVISION

Interviewees felt that overall women were very appreciative of the service they received. Sure Start Children’s Centres that have a big mix of ethnicities within their reach areas were seen to have done a lot of work in engaging with other services. They acted like a ‘one stop shop’, and were located in the community. Recruitment to Sure Start Children’s Centres by word of mouth had apparently been very powerful.

A specialist service in a UKBA dispersal area offered a quick fast service, which was open and enthusiastic. It was supported by the PCT with adequate resources. Staff spent a huge amount of time updating address and phone details, to ensure that women did not get lost from the system. Staff chased up appointments at hospital and double checked that appointments were made. Extra support was offered to young women. The service funded taxis from the practice to the hospital, as this had been a real issue since the loss of free bus service.
SUCCESSFUL ENABLERS CURRENTLY AVAILABLE

- Community midwives available on a weekly basis, encouraged women to come forward and engage with the system.

- Midwives from migrant women’s own communities. Midwives that gave good advice and signposted to other support services.

- One service was awarded third place at a maternity conference in 2008 for their translating service. This service had also introduced a Polish scanning clinic and Polish clinics every Thursday in each of the four hospitals across the county. Midwives took phone calls in the evenings, and the pregnancy hand held notes were written up to include some Polish translation.

- Advertisement of FGM services.
CHAPTER 6: PROFESSIONALS’ PERSPECTIVES – VOLUNTARY ORGANISATIONS

KEY ISSUES AND BARRIERS IN SERVICE PROVISION

ACCESSING SERVICES

Voluntary sector professionals found that many women came from countries that did not have dedicated maternity services and thus are not used to western models of health care. Women worried about scans and tests, and were generally fearful about health care. In many countries women are used to presenting later on in pregnancy or more used to having home births. They needed support with GP registration and help to set up all their appointments. In some areas GP surgeries were not taking registrations regardless of the guidance issued by their health authority. Women were said to find getting a health certificate stating they were pregnant difficult because GPs did not understand the need for this. Within the system there was said to be a general lack of awareness of the needs of this group. Concerns were outlined around the birth, and the culture of women leaving hospital in 24 hours, and also women being sent home after Caesarean section when they had no transport. One woman was sent home early and it was a full year after that she was sewn up after a difficult tear. Another example was given of a situation where a woman was sent home whilst her baby remained in hospital, without being given the option of staying. She had no hope in breastfeeding as she lived three bus journeys away from the hospital. Respondents were concerned that there was little flexibility in the system to account for women’s needs and a lack of communication generally “There is a need to improve the flow of information between Children’s Centres, GP’s and Midwives on who is pregnant. An information sharing protocol is needed”.

LANGUAGE

All of the interviewees had service users that did not speak any English and these represented between 30-95% of their total service users. Like the health professionals the voluntary sector respondents noted a lack of interpreters, particularly at the early stages of pregnancy, when it was important to ensure women’s anxieties were addressed. They identified language barriers even when interpretation services were available. There were three language support services available in one urban area; however waiting times for these services were lengthy. Women were not able to express themselves if they were worried about confidentiality and needed an independent professional interpreter if wanting to discuss confidential or personal issues, which proved problematic if there was no
female interpreter. Those who spoke English found it difficult to understand medical terminology. Voluntary sector professionals were concerned that after women had given birth they seemed to be offered information on financial support only in English, and no attempt was made to translate or ensure that they understood. Staff were apparently not always proactive about getting interpreters. On the whole professionals found it difficult to make women aware of health issues, and to pass on accurate information. They also outlined a need for bilingual health workers.

**RESOURCES**

Respondents outlined their concern about poor housing conditions including unstable accommodation with no fixed address to enable follow on. Those who had recently received rights to remain in the UK were often said to be in the most vulnerable position. Respondents discussed the levels of poverty experienced by migrant women. They experienced a range of practical problems including: getting to appointments; destitution; poverty if on vouchers and a general lack of essentials for the baby. They argued the £250 voucher was difficult to use, because there is a very small window for women to access the voucher, and there are often delays and they don’t receive the vouchers until after the birth.

**CULTURAL, ETHNIC AND IMMIGRATION ISSUES**

Respondents outlined a wide range of cultural and ethnic issues that related to women’s ethnic or immigration status. Some were common to particular groups of women while others were specific to ethnic groups. One respondent claimed that between 50-70% of women making asylum claims have been raped. On the whole asylum seekers were difficult to engage in services because they were frequently moved.

Some women were restricted by in-laws and are unable go out alone. Attending appointments could be difficult if no one was available to go with them. Others were in controlling relationships and not permitted to attend appointments. Asian women were said to avoid services if they were victims of, or worried about, domestic violence. Women were concerned medical staff would see their bruising. Some women in this situation were apparently denied food and money by their partner. One interviewee had seen very severe cases of domestic violence including a woman who had three miscarriages because of

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3 At the time of this research individuals in receipt of section 4 support from the UKBA received support in the form of vouchers. The maternity payment was given to qualifying individuals in the form of vouchers. Shortly after the research was completed the UKBA moved to the AZURE payment card which can be used in a wider variety of shops. The maternity payment is now credited electronically to the AZURE payment card.
domestic violence. The system is geared to helping women leave relationships. However professionals said many women were not prepared to leave. Organisations provide women with counselling, but work was also needed on the perpetrator. Women that do leave domestic violence situations may end up isolated and alone.

Some women were not prepared to attend appointments for fear of being charged. Often lone women were isolated and too proud to admit that there is no one at home. These women were said to require special attention after they had given birth. Education levels, were said to be mixed, with some women having high education levels but a lack of confidence because they were traumatised by their experiences.

Spousal migrants often relied on traditional practices passed from mother-in-law to daughter-in-law and mother to daughter. In some communities postnatal depression and mental health were not discussed publicly. The women would rather stay quiet than risk stigmatisation. More established communities found it easier to take up services and if their community is supportive and positive for example Somali communities communicated well with services, and the Yemeni community was settled and engaged. Chinese women were also said to be keen to access the service. Although, women from the Southern parts of China were more withdrawn. While Eastern Europeans did access services in urban areas there was apparently little interpretation available.

Despite the problems outlined by all respondents it was clear that some women were satisfied with the services they received:

“On the whole the feedback is that Chinese women feel the service is excellent and the quality of care much higher than in China, they have been very positive. The attitudes of staff are better in the UK”

**DESTITUTE WOMEN**

Voluntary sector organisation respondents were very aware of particular issues for destitute women accessing maternity services. “Women who have no recourse have nothing and won’t want to leave the hospital. It is a real issue as they do not have anywhere to go with the baby. They are allowed to stay in the country up to three months after the baby is born, and if both are fit then they will be returned to own country”

Respondents advised that the issues were similar to women with other status, but destitute women had nowhere to live. They were sleeping on sofas. Getting to hospital for a scan was exceptionally hard due to lack of funds to pay for transport. There is a process for reimbursement of travel expenses but claims had to be made retrospectively and women did not have the up-front funds to purchase tickets. Poverty and vulnerability was said to often force destitute women into dangerous relationships. Some were internally trafficked around the UK. Some women were made pregnant whilst captured. There were incidences of sexually transmitted disease, tuberculosis, and FGM. The women faced social and
financial support needs. They were unable to work; lived in overcrowded accommodation typically HMO’s. Their needs were seen to be complex. Accommodation and support for accessing other funding was normally reached through voluntary sector organisations. For destitute women being referred to different organisations can be a problem, as they need support from one organisation. “If your immigration status is not stable then you have no recourse to public funds. This is a barrier that is difficult to overcome. They also need support from one organisation. Our organisation can access a wide range of services under one roof. We can help with accommodation; help with language, completing benefits application forms”

**FEMALE GENITAL MUTILATION**

All interviewees had met women that had undergone FGM procedures in their former country. Some women wanted to protect their daughters from FGM and were fearful that people might find out and there would be repercussions if they did. It was difficult for women to talk about FGM and to trust professionals particularly as some women struggled to accept that FGM has happened to them.

**RURAL ISSUES**

One respondent noted difficult working conditions for rural women and gave the example of Asian women working in fields with babies on their backs. Rural respondents said it could be difficult to address the needs of rural women especially when there was cross boundary movements between the West Midlands and neighbouring regions with women accessing services in more than one area.

**OVERCOMING BARRIERS**

**CULTURAL COMPETENCY**

Like the health professionals the voluntary sector professionals agreed that there is a need for increased cultural awareness through training staff to check the women’s understanding of needs and not to make assumptions that every woman’s needs are the same. Respondents felt it was important that all staff gain a better understanding of cultural differences and different needs. For example Chinese women are given ginger and herbal tea straight after the birth. Their husbands can support their wives and stay overnight in hospital. Women then have a convalescence period where they are looked after. Further training was suggested to help health professionals to understand the issues that destitute women face.
INFORMATION AND LANGUAGES

Respondents felt that much more information was needed about maternity services. In the first instance they felt that women needed to be made aware of the benefits of accessing services at the beginning of their pregnancy so they stay engaged throughout. Where women were in controlling relationships it was necessary to get that information out to get the whole family involved and show them the importance of attending appointments. All newly arrived women needed to be educated about their rights and the support that is available.

Respondents suggested the development of a translated checklist offered at the beginning of a pregnancy that sets out what you get and when. They wanted to see more explanations offered from midwives of what happens at each stage of pregnancy and what should be expected. One respondent suggested a simple translated card leaflet placed next to the pregnancy test and kits that are available in chemists saying what to do next “…see your GP …take folic acid”. They also wanted to see the general pregnancy literature translated into other languages with the use of visuals and migrant and refugee community organisations given more leaflets on maternity services; health promotion; services available and current projects, to pass on to their service users.

OUTREACH

Respondents pointed to the need for more outreach workers to go to out to women and let them know what is available while encouraging them to access help and services. They also argued that community transport might be provided to collect women for appointments. One respondent wanted to see the development of better ways to maintain contact so they could reach out and offer support to women who drop out of the system.

NEW APPROACHES

Like health professionals, voluntary sector respondents agreed there needed to be new approaches developed to take into account the diverse needs of migrant women. More joint working with the NHS was needed. They wanted to see more support from other agencies, and more opportunities for voluntary sector partnership working with the statutory sector. In particular they wanted more local partnerships, involving small, local, organisations to keep provision local and accessible. Respondents wanted to see more joined up working wherein organisations worked together to know where to go to get interpretation and translation and were able to signpost to other services.

Voluntary sector organisations recommended more local service provision to be offered in the community, especially in rural areas. Alternatively others wanted to see the
development of a one stop service. Also suggested were more flexible services offered at different times of the day and a text message system to remind women without diaries to attend their appointments. The need for a fast track service to hospital for women, who arrive in the West Midlands at a late stage in their pregnancy, was also mentioned. Finally it was argued that more research was needed into the cultural difference between pregnancy and birth in different countries so that the UK could learn from other systems. Associated with this idea was the suggested that opportunities need to be created for newly arrived migrant women to share their pregnancy experiences. One respondent thought the Pregnancy Outreach Service should be expanded across the West Midlands while another thought the volunteer doula projects should be expanded through recruitment and coordination of more volunteers. Respondents argued that examples of good practice needs to be circulated to voluntary sector organisations so they can communicate better with women and let them know where to go, and what to expect.

ATTITUDES AND FEEDBACK

While it was argued that some Children’s Centres make women feel welcome apparently these centres were mainly used by the confident women that spoke good English. All Children’s Centres should be encouraged to reach out to migrant women. Respondents also felt that staff should be aware of women’s needs and how to deal with these appropriately. More information was needed about migrants’ experiences of maternity services and where women did participate in consultations they should receive feedback so they knew what the outcomes of their participation were.

PRACTICAL SUPPORT

Respondents outlined the importance of providing women with practical support such as paying for a taxi or other transport service up to the hospital. Women needed protection from the hazards of their home environment whether that was poor quality housing or domestic violence. Also in practical terms they needed more flexibility in the delivery suite, with somewhere for women to wait if they come in during the early stages of labour so they are not sent home without funds or transport and asked to come back later.

VOLUNTARY SECTOR PROVIDERS AND PARTNERSHIP WORKING

Voluntary sector partnership working with NHS services was varied across the West Midlands. In some locations partnership working was seen to be improving, with joined up working progressing well. There were problems regarding the provision of post-natal
services in some areas where there were few health visitors, covering a wide geographical area. Women did not always get followed up if an appointment was cancelled.

In other locations partnership working less well developed with little liaison with the community midwives. “We need to work together more, things have changed, but more needs to be done. We as community organisations can link into communities and the NHS should use this to connect and understand the needs of the communities”.

Respondents were working hard to develop relationships and there was a lot of potential to work together. Voluntary sector organisations could offer support alongside the NHS provisions. In many locations services worked well because of partnership work with Children’s Centres, that provided integrated health services including antenatal services, and linked with pregnancy outreach teams. “They work well because of Sure Start Children’s Centres and Healthy Start”

**TRAINING ON COMMON ASSESSMENT FRAMEWORK (CAF)**

None of the Voluntary sector providers had received any training on the CAF. There was an issue relating to the identification of social risks as only one organisation advised of having a risk assessment in place with a tailored support package where the whole family was involved in the process.

Other interviewees advised they would alert the authorities if they felt the child was at risk or would try and contact services to help reduce social risks for example: alerting the housing department to make improvements.

**SUCCESSFUL ENABLERS CURRENTLY AVAILABLE**

- Awareness raising and help with booking appointments and making contact with services. Providing someone to accompany women to appointments and keeping women up to date with information and research.

- The HOPE destitution fund provides time-limited, subsistence grants to destitute and failed AS and women with NRPF, to help move them along with their asylum claim. Partner agencies work closely with the Children Centres, and the doula project to help women get the basics. They also work closely with pregnancy outreach team.

- Building links with maternity services projects like Birmingham Link. An information surgery in the community for example: stalls at shopping centres.
- Children’s Centres were seen to be very positive in supporting migrant women and worked with local voluntary sector organisations
- A doula project based in Birmingham was seen to be successful at providing support to lone women.

**EXAMPLES OF GOOD PRACTICE SEEN ELSEWHERE**

1. A Domestic Violence perpetrator programme in Walsall. They work with perpetrators to change behaviour. A family approach to challenging domestic violence.
CHAPTER 7: OVERVIEW

This study has identified a wide range of issues facing migrant women accessing maternity services. Whilst the lack of a known population meant that the study was not based on a randomised sample and clearly the sample size meant that it was not possible to test the statistical significance of the findings, it covered a wide range of areas, nationalities and immigration statuses and was able to identify issues that faced almost all migrant women as well as some area, status, faith and nationality based issues. Many of the issues that were common to our wide ranging sample are likely to be generalisable across the wider population of migrant women in the West Midlands and beyond, with the possible exception of highly skilled and professional migrants using private medical services. It is worth stressing that the interviewees were largely identified via organisations. Time constraints meant that it was not possible to seek out those individuals that were hard to reach. This may mean that the survey respondents were more likely to be engaged with a wider range of maternity services, particularly if they were identified via Children’s Centres, than those who were not in contact with an organisation. Further research with a longer timeline is needed to focus on those individuals who are not engaged with existing groups or organisations. In addition larger scale research is needed to focus on a wider range of migrants and collect quantitative data and look for statistically significant relationships.

While the majority of women do appear to access maternity services before 12 weeks a significant proportion are unable to. The main barriers to accessing the system apply to accessing all appointments as well as the initial contact. These largely focus upon inability to understand the system, lack of language skills, and poor access to translated materials or interpretation that could help explain the system, and lack of funds to pay for transport. Those in receipt of vouchers or NRPF find accessing what they need very difficult because they lack cash to pay for basics such as bus fares. Those who are employed and self-supporting are reluctant to attend appointments that involve several hours wait, whilst asylum seekers and failed asylum seekers can have their access to maternity services curtailed or interrupted by dispersal or detention. This is particularly problematic in the later stages of pregnancy.

GPs and midwives were the main source of advice, information and care and women did appear to benefit from continuity of care where they were able to access the same midwife throughout their pregnancy. Across all areas women struggled to understand the advice they were given. This was a particular problem in Herefordshire and for African women across the West Midlands. Many women were dependent on friends and family to access the information they needed. Lack of understanding of the system could leave women feeling anxious especially where they were given tests without being reassured that they
were routine. In many cases women were not given the option to make decisions about tests, or care.

Some women received a good service and felt welcome. Others said the quality of service was poor, that staff were rushed and sometimes rude. There appeared to be little acknowledgement that new migrant women had special needs and no capacity to provide interpretation when needed or any mechanism to explain the system. Many cultural needs were not met and there was little appreciation that approaches to pregnancy might be very different in other cultures. Women were expected to fit into the UK system without guidance or explanation of how to fit in. While some women had good birth experiences others felt they had been neglected and their needs ignored, on occasion because they were migrants. During labour some women were left unattended and their pain relief needs not attended to. Not all midwives were able to provide the specialist care needed to women with FGM.

After the birth women felt isolated. Lack of ability to communicate with midwives, and health visitors, left women feeling unvalued. Some women were isolated after the birth and received little support. There was a lack of knowledge about post-natal depression in some communities, how to diagnose and treat it. There was little evidence of provision of counselling for those with depression or who had lost their baby.

Migrant women experienced a particular set of problems that may exacerbate infant mortality. Poor housing conditions that were overcrowded, damp, and dirty, were commonplace especially for asylum seekers, migrant with no recourse to public funds, and failed asylum seekers. Lack of funds for these women also meant that they were unable to access health care, basic equipment needed to look after their babies or to eat a healthy diet. A particular problem for spousal migrants and some women with NRPF was abusive and controlling relationships. Women were only permitted to attend appointments with partners. No attempt was made to communicate separately with women as it was assumed that partners or family always had the women’s best interest at heart. There were no avenues where women in abusive relationships who were unable to speak English could seek help.

In terms of assistance needed to improve access to maternity services and outcomes more generally, a clear need is better communication. Women expressed a desire to learn English so they could understand what was happening to them. Clearly the provision of ESOL classes is outside the remit of DH, but it is an area that could have enormous impact on health outcomes of new migrants and perhaps an area where the DH should be working.
with Department for Business, Innovation and Skills. More practical is the provision of materials translated into a wide range of language that set out how the maternity system works, what to expect and when, and where to go for help and financial support. Once in appointments interpretation services are needed. It is not clear why midwives and health visitors did not use interpreters in appointments with new migrants but it is necessary to ensure that some kind of interpretation is on offer. In addition there needs to be some kind of help to access to financial support and signposting to voluntary sector organisations for those who are no recourse to public funds or failed asylum seekers.

Furthermore midwives need to be educated to appreciate the vulnerable situation of some migrant women, to treat them with respect regardless of their status, and to deal with them as individuals rather than speaking to spouses or relatives. This may include some kind of mechanism to enable abused women to get help in their mother tongue. It also needs to be recognised that new migrant women have the potential to be particularly isolated after the birth. Checks should focus on mother as well as child, interpretation needs to be provided and referrals made to organisations such as Home Start\(^4\) where women lack support.

The findings from the professional interviewees reflected much of the data collected from migrant women. Communication and understanding the system were a major problem. Some professionals found that up to 95% of their caseload was with women who did not speak English. The system was seen as being geared to a white middle class way of engaging with services and was not suitable for other cultures and women who had chaotic lives, for instance were moving frequently. Professionals found it hard to give advice or information with existing materials and that interpretation quality could be poor. They were also concerned about using relatives to interpret and worried about confidentiality. The system was not easily adapted to take into account cultural needs and prevented culturally appropriate responses such as allowing women who were overdue the opportunity to give birth without being induced.

Other problems identified included domestic violence or controlling relationships which prevented women from getting the help they needed or impacted on the health of both woman and unborn child. Professionals too raised the problem of unfit housing and the lack of knowledge of health professionals more generally around culturally specific issues such as FGM. Health professionals were concerned that appointment time allocations did not provide enough time to help women to understand the system, reflecting the impression

\(^4\) www.home-start.org.uk
that migrant women got, that they were rushed. There were concerns that many migrant women were very anxious for a range of reasons, some to the point that they did not attend appointments for fear that their baby would be taken away or they would be detained. While some voluntary sector organisations had worked closely with health to enable outreach services to use community facilities, on the whole there was said to be a lack of partnership work.

Many of the issues faced by migrant women were similar across the West Midlands. However some differences were noted. Women in rural areas were said to be particularly isolated and services in those areas lacked knowledge and experience about how to work with women who did not speak English or understand the maternity system. Whilst services in Wolverhampton and Coventry appeared to be reaching many women, the situation in Birmingham, and to a lesser extent Sandwell, was very complex. The sheer diversity of migrant women living in the conurbation, in terms of ethnicity, religion and immigration status meant that health professionals were unable to develop specialist knowledge about particular groups and their needs. In these areas asylum seekers were frequently moved around, when they needed a settled service, and women with NRPF suffered from lack of basic necessities including food.

There were some services provided that were aimed specifically at migrant women although the presence of these often depended upon the interest or good will of an individual or organisation. Services for migrant women were not provided on a routine basis even where migrants formed the bulk of clients. Professionals realised that much needed to be done to improve the situation and that systems needed to change and service be provided in a much more individualised way. Further research was needed to explore other approaches, not just in the UK but in other diverse parts of the world. In the meantime professionals argued that they needed more time, cultural competency training, and continuing relationships with clients so they could build rapport and trust and greater feedback from new migrants about what they wanted. A whole range of approaches were proposed from knowledge exchange systems whereby women educated themselves in support groups about the UK system whilst developing social networks, to text messaging reminder services for women who did not keep diaries. The final part of this report focuses upon some of the key recommendations of this study, based upon the combined suggestions or professionals and migrant women.
CHAPTER 8: RECOMMENDATIONS

1. ENSURING LOCAL SERVICES MEET THE NEEDS OF THE LOCAL MIGRANT POPULATION

Commissioners need to develop a detailed understanding of the health and social care needs of their local migrant populations, including identification of any barriers to accessing services. Local maternity care pathways could be reviewed in light of this needs assessment and the recommendations from this report.

- All migrant women should be encouraged to register with a GP on arrival to the UK and should be offered a full health screen with medical examination.
- Migrant women need sufficient opportunities to express their cultural and religious needs.
- Additional appointment time should be allowed for women with complex needs and where there are communication barriers.
- Midwifery caseloads could be organised to reflect the complexity of women being seen.
- The importance of continuity of care, with both midwives and health visitors, is of particular importance to migrant women with communication difficulties.
- Opportunities for offering flexible appointment times with evening or weekend sessions should be explored.
- A range of services could be provided as ‘one stop shops’ in key migrant areas.
- All migrant women and their babies need to be adequately supported after birth.

2. PROVISION OF NECESSITIES

Many migrant women lack the basic necessities, including social support needed to have a healthy pregnancy, particularly those with no recourse to public funds. Local services have a key role in providing this much needed support as part of their existing statutory responsibilities in relation to child poverty and safeguarding. Continued support is also available from voluntary sector organisations and children’s centres, however there is an urgent need for additional provision.

- All pregnant women regardless of asylum status should have adequate and timely financial support to enable them to have a healthy pregnancy.
- National level discussions are recommended to explore the possibility of the Healthy Start Scheme being extended to include asylum seeking women.
• Women with No Recourse to Public Funds should be supported to access emergency support, including food parcels and baby equipment

• Lack of funds for transport should not be a barrier to accessing maternity services, e.g. through providing transport or use of pre-paid scratch cards

• Commissioning voluntary sector organisations to provide for the basic needs of migrant women where necessary

• Recognising the importance of social support for isolated migrant women and ensuring support networks are available for these women, e.g. African women’s support groups and use of voluntary doula projects.

3. LANGUAGE AND INTERPRETATION

Language is a major barrier to women’s engagement with maternity services. Interpreting and advocacy services are a vital component of appropriate maternity care for women who do not speak English as their first language. More action needs to be taken to improve migrants’ language skills as soon as they arrive in the UK. Local maternity services should ensure that appropriate interpreting services are proactively offered to migrant women who require them, at all stages of the pregnancy.

• Access to ESOL classes should be extended to all migrants who have limited knowledge of the English language.

• Local maternity services should review their existing provision of interpretation services, taking into account issues such as inappropriate use of family members or male interpreters and interpreter’s familiarity with medical terminology. Patient experience surveys will help ensure interpretation services are high quality.

• Interpretation needs should be identified at booking and communicated to all those involved in the delivery of an individual’s maternity care.

• Opportunities for providing ante-natal classes and health language classes in community languages should be explored with voluntary sector organisations.

4. TRAINING FOR HEALTH PROFESSIONALS

All professionals who come into contact with pregnant migrant women need to be skilled in understanding and identifying the wide range of social risk factors which may leave these women vulnerable. Professionals need to have the available knowledge and resources to enable them to take action to help mitigate these risk factors and reduce the risk to mother and baby. Awareness of, and sensitivity to, cultural differences, are key elements in the provision of appropriate maternity care for women from migrant groups.
• Cultural competency training should be integrated with mandatory NHS equality and diversity training, this should focus on training staff to be receptive to difference and to explore cultural and religious needs

• Additional cultural competency training should be provided for those who regularly work with migrant populations, this should address the wide range of issues linked to migration status and nationality

• Health professionals should be empowered to explore social risk factors with migrant women, including where there are language barriers.

• Health professionals should be aware of issues around FGM and available local services for women affected.

• Maternity staff should be trained in the use of the Common Assessment Framework and should be aware of how this also applies to the needs of the unborn child.

• Health professionals should be aware of, or able to signpost migrant women to, sources of help in accessing financial and non-financial support

• Health professionals and other NHS staff who come into contact with migrant women should have knowledge of the asylum process, including NHS entitlement and support for women who are destitute.

5. PROVISION OF IMPROVED INFORMATION

There is a need to ensure migrant women are fully informed throughout their pregnancy, including awareness of the organisation of NHS and other local services, what to expect from their maternity care and where to go if they require help and support.

• Information about the way that the NHS and maternity services are organised, including the provision of antenatal care which may not be provided in their country of origin.

• Information on pregnancy as provided through the Pregnancy Planner on the NHS Choices website but provided in a range of languages.

• Information about maternity entitlements, including those for pregnant asylum seeking women.

• In the absence of nationally available translated material, local maternity services should make efforts to ensure translated information is made available as appropriate for the local population.
6. PARTNERSHIP WORKING

Barriers to partnership working were seen between voluntary sector organisations, local authorities and the NHS. Some agencies had limited understanding of the client group and would benefit from closer working relationships with voluntary sector organisations. This would help a range of agencies understand the complexity of migrant women’s needs and ensure that women have access to the necessary support. Local commissioners and maternity service providers need to explore opportunities for enhanced partnership working with voluntary sector organisations and local authorities.

- Local Commissioners and providers should engage with voluntary sector organisations to develop an understanding of the range of support offered and how to signpost women to the most appropriate services.
- The ‘any willing provider’ policy should be used to explore opportunities to commission services from voluntary sector organisations where their specialist knowledge and skills may prove valuable.
- There needs to be a concerted effort to bridge the gaps between NHS, local authority and voluntary sector organisations particularly in the more rural areas.

7. CHILDREN’S CENTRES.

Sure Start Children’s Centres bring together a wide range of services in one place centred on the needs of disadvantaged families. Children’s Centres based in ethnically diverse communities play a key role in engaging vulnerable migrant women and providing support and access to a wide range of services particularly for disadvantaged groups. Local commissioners should work in partnership with Children’s Centres to meet the needs of their local migrant communities.

- Continued work to ensure an improved flow of information between Children’s Centres, GP’s and Midwives allowing better identification and engagement of vulnerable families.
- Overcoming isolation in rural areas by ensuring that Children’s Centres are aware of newly arrived migrant women and are able to engage them with local services.
- The proposed increase in health visitors based in children’s centres could be a vehicle to provide more integrated local support to the most vulnerable families.
8. UKBA AND IMMIGRATION POLICY.

Improved communication is needed between UKBA and the health sector in relation to the dispersal of pregnant women. It is recommended that UKBA review their existing policy and practice with regard to the dispersal of pregnant women to ensure that appropriate transition of care arrangements are in place. Such dispersals for women in the late stages of pregnancy or where there are known complications should not occur without documented discussion between UKBA officers, health professionals in the local area and in the proposed dispersal area. UKBA should consider the development of an appropriate system to monitor cases where dispersal of pregnant women occurs\(^5\).

The Department of Health should continue to make the case in discussion with UKBA for a reduction in the cut off limit for dispersal, currently 36\(^{th}\) week of pregnancy, on the basis of increased risk to child and maternal health and increased pressure on maternity services.

- No woman who is known by UKBA to be pregnant should be dispersed without confirmation from a relevantly qualified health professional that the women is safe to travel and for cases of late stage pregnancy that such dispersal will not adversely affect child or maternal health.

- UKBA should ensure that in all cases where a women is known to be pregnant the PCT in the area where she is to be dispersed is notified or her arrival.

- UKBA should cease the dispersal of women who are 36 or more weeks pregnant. In cases where this is absolutely unavoidable (e.g. section 4 homeless applicant), such dispersals should not be undertaken without an appropriate medical assessment of the health of the mother and unborn baby and opinion being sought as to the risk of travel and dispersal. If dispersal is agreed, UKBA must ensure that adequate transition of care arrangements are in place from the PCT in the local area and the one responsible for the area where she is to be the dispersed.

- UKBA should review the current disparity between maternity payments for those on section 95 and section 4 support and ensure that women are able to access such payments in a timely fashion.

- UKBA should reconsider the detention of pregnant women in light of the Coalition Governments ending of the detention of children.\(^6\)

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\(^5\) UKBA were given the opportunity to comment on the above recommendations and we are grateful for their response. It should be noted that since the research was completed UKBA have consulted on a revised Health Asylum Instruction (October 2010) which also covers pregnancy. The proposed Health Asylum Instruction, if adopted, will address a number of our recommendations.

\(^6\) UKBA confirm their position is that pregnant women should not normally be detained. The exceptions to this general rule are where removal is imminent and when medical advice does not suggest confinement before the due removal date, or, for pregnant women of less than 24 weeks gestation, at Yarl’s Wood as part of a fast-track asylum process.
9. DOMESTIC ABUSE.

Professionals need to be sensitive to the possibility that some women are in abusive relationships and require specialist support to ensure their health, and that of their baby, is protected. Health and Wellbeing Boards need to ensure the appropriate measures are in place as part of their safeguarding adults and children responsibilities. Local commissioners and maternity services need to have access to support services, to which they can refer those who are suffering from domestic abuse.

- Health and social care professionals should receive training in identifying vulnerable women and establishing an effective and integrated referral process to ensure rapid access to the required support.
- The Department of Health and other organisations should work with UKBA to look at the support available to women without leave to remain and those with no recourse to public funds, who are escaping abusive relationships.
- Women should be enabled to have time away from partners during appointments
- Work should be undertaken with the whole family to stress the importance of appointments, and mother’s health for a healthy baby
- A range of approaches of tackling domestic abuse should be explored, for example the development of schemes aimed at working with perpetrators
- Support groups should be available for women who have experienced domestic abuse to help reduce isolation

10. FURTHER RESEARCH.

This study has provided an overview of maternity services across the West Midlands. Further research is needed to explore in more detail experiences by ethnicity or immigration status, and by geographical area. Work is needed to identify good practice and to compare the experiences of migrant women to those of women born in the UK. At local level a range of actions are recommended, including:

- Collection of, and easy access to, Flag 4 GP registration data across the West Midlands
- More in depth study into the experiences of economic migrants living in rural areas
- Examination of the experiences of African migrants in the West Midlands
- Exploration of the experiences of spousal migrants in the main urban areas
• More research into the extent of women who have experienced FGM, their needs and experiences

• Research to gain a greater understanding of the needs and experiences of NRPF women across before, during and after birth
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### APPENDIX 1: PROFILE OF Respondents

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Before the Birth

She wanted an abortion as her husband had raped her when he found out that she wanted to leave him. However, her husband made her contact the GP who did blood tests. She was not involved in any decisions as to what tests should be done. The GP and her husband insisted on her having the tests. She did not know what was happening to her. Her husband was always with her everywhere, and she went only went to appointments that her husband took her too. All she remembers is seeing the GP and a midwife, and going to all appointments that her husband took her too. She needed an interpreter so that she could tell someone what was happening to her. She needed to be able to speak openly to her GP and had wanted to know how to get an abortion, and who could help her as she did not want to have the baby.

On one occasion she spoke secretly to an Urdu speaking midwife while getting changed and while her husband was not around. The midwife gave her help-line telephone numbers, but she told the midwife that she could not speak any English so what should she say? The midwife advised her to call the police next time her husband hit her. She felt there was nothing the midwife could do to help her.

She had no financial support and doesn’t know if her husband claimed for it. She says he was a greedy man and feels that he would have claimed. She did not get support from anyone, and was not allowed to leave the house without permission from someone, even her in-laws. She was never allowed out on own.

During the birth

Her sister in law took her to the hospital. During the birth she understood nothing and did not understand what was happening. She had to rely totally on her sister in law who told her when to push, and what to do in labour. She was very distressed throughout the whole process and needed help with relaxing, but even her sister in law ignored her pleas for help.

Following the birth

She was tired permanently. She had to cook, clean and take care of the baby with painful stitches and needed to rest. She had to rely on ‘hand me downs’ from her sister in law, and had nothing at all for her baby. Many of the things she was given did not fit her baby, as the baby was very small when born. She had a visit from the Health Visitor at home but it was not helpful and she did not understand anything that was said. During the visit her husband was doing all the talking as he had done during the antenatal visits. She did not understand what was going on. She had no support at home and the situation got worse after the baby
was born. She had no baby milk for the baby, and no one would go to the shops to buy it for her. Eventually she left the house and went to live with her brother.

Support needs

She feels that medical staff need to be able to recognise when a woman is being abused and be able to help. There should be an opportunity for an independent interpreter for all women that can’t speak English as standard, and medical staff should not rely on relatives for interpretation. Women should be given a choice, whether to keep their baby – it should not just be assumed. Women should be given a choice at their very first appointment and be able to speak with medical professionals without the partner being there to translate. Women should be free to say what is going on. There is a need for recognition that women may be in a violent relationship and need help.

She has now left her husband, but feels it would have been better if her child had not been born. The child now has no father and she is living in her brothers’ house. She feels this is no life for her child. Throughout the pregnancy she had no control over: the whole process; did not know what was happening; had no one to turn to; and nowhere to go. She had no family in the UK until her brother arrived, which is what has enabled her to now leave her husband.

CASE STUDY 2: CHINESE FAILED ASYLUM SEEKER: ARRIVED UK 2005. NON-ENGLISH SPEAKER

Before the birth

She did not make contact with maternity services for 3 months, even though she knew she was pregnant at four weeks through a home pregnancy test. To make an appointment with her GP she needed to book on the day. If she left it till after 8.30am then there were no appointments left. She could not get up early enough to make appointment as her husband worked nights as chef, and they did not get to sleep until between 3-4 am in the morning.

She had blood tests and was advised she would need other appointments. The next appointment was at the hospital for a scan and blood tests when she was five months pregnant. She could not communicate with the midwives; she did not feel welcome; and could not communicate or ask questions. She felt the whole process was rushed, and she did not know what to expect. She did not feel involved in any of the decisions that were made – someone else always made them for her. Her hospital was changed and she did not know why, but the new hospital provided an interpreter at her third appointment. The waiting times were long and on occasions she waited for 3 hours to be seen. She wanted to attend antenatal class but couldn’t as could not understand English. She did not have any information on rights or entitlements from anywhere, and did not know what benefits she could claim or should have claimed. She wanted someone to take the time and patience to
explain things to her step by step. She paid for all her prescriptions. A friend later advised that her GP should have given her a maternity card so that she could get free prescriptions.

**During the birth**

She found it difficult to communicate and could not understand what anyone was saying. Some staff tried to use signs to explain to her and she used signs to say she wanted gas during the birth. She was not able to get any information or to express anything to the staff. During the birth she needed an interpreter, but was left alone and had to shout for help. When the baby was born she was black. Nobody advised why this had happened but the baby’s colour returned after three months. She has since read in a Chinese book that this is because of a lack of oxygen during the birth. She was really worried about her baby but could not ask any questions.

**Following the birth**

Her husband left his job to help with the baby and they lived off their savings. There were lots of problems with the baby for example: a skin rash; the baby would take the feed; the stools were green, and the baby had a cough. She could not speak to the midwife or GP, and had to use body language and mime, and her GP would mime back. The Health Visitor came around 6 weeks after the birth and advised on maternity grants and council housing, but the Health Visitor could not advise precisely which ones she was entitled to or assist her with filling in the application forms.

**Support needs**

She would like a Chinese speaking help-line to give information on rights and entitlements and feels that GP’s and midwives should be able to provide info on rights and entitlements. She would like to have had a good, patient, midwife to give all the info that she needed - someone with the time to reassure her, and help her feel more relaxed. She feels there should be a system where entitlements are automatically triggered, rather than being dependent on the individuals’ ability to claim through applications forms. Women can only do this if they know what they can claim for. She really wanted some family in the UK to take care of her other children so that she could attend an ESOL class and is now considering sending her daughter to China so that she can attend ESOL. She says it is frustrating and worrying that she can’t communicate and tell her GP how worried she is about her daughter’s development. She can’t ask questions or understand what the GP is trying to say to her. It makes her very angry sometimes.
Before the birth

She found out she was pregnant at 10 weeks. She was feeling sick and her GP advised her that she might be pregnant and to go to the antenatal hospital department for a pregnancy test. She wasn’t given any information other than asked if she wanted to keep the baby or not. She did not know what to do. She was referred to a midwife and the midwife made sure that the baby was alright. The midwife told her which blood tests would be taken. She feels they were only interested in the baby. She did not know what was going on and her questions to staff were not answered. No one told her what was happening and she did not understand anything. She was given no information on her rights or entitlements, and even now she is not getting any support from anywhere. She had no information about support available; how to take care of herself in pregnancy; what to eat during pregnancy; what exercises were good for her to do during pregnancy; or where to go for this information. No information was given to her about any antenatal classes. She was lacking information on what happens during the birth; how to take care of baby following the birth; or services and support available. She was sick for most of her pregnancy, lost a lot of weight, and was vomiting most of the time. She was concerned about the problem of not having legal status, as her visiting visa had expired. She had no money and no resources except what friends and family provided.

During the birth

She went to hospital in an ambulance. She said the nurses were not there for her and she did not get food and care. The staff said they thought she would be in labour for a long time because she is Nigerian. She says things were very tough for her in the hospital. The staff did not give her attention, and her needs were not met. She did not get any pain relief, felt neglected and ignored, was afraid, depressed and stressed. She had no choice but to just accept the situation she found herself in. Throughout her stay in hospital she felt neglected as she was a black woman, and the staff had told her that black women take a long time in labour so had left her on her own. The staff gave her an injection to go to sleep, and she was left her by herself to have her baby alone after a short time.

Following the birth

She left hospital in a taxi. Friends and her partner supported her but she did not have enough clothes for the baby and no money to buy any. She did not have car seat, or any cold weather clothes. The midwife visited her at home after the third day but she did not understand the purpose of the visit. The midwife advised her that the baby was OK but did not ask any questions about her own needs. The midwife left books and leaflets for her to
read. She was having problems with breastfeeding, and her baby had body rashes. No one helped her except her friends who told her what to eat and do.

Support needs

She did get free prescriptions, but no other support, nor a grant or information about grants. She says services should be improved and that migrant women should be treated with more respect. She feels here is prejudice and discrimination when staff say that a black woman stays in labour longer than a white woman, as she feels there is no difference between black and white. The whole process has affected her badly. She says the nurses should consider the cultural needs of migrant women for example: washing or cleaning of the baby when it is born, and consideration given to the cultural needs of migrant women.

CASE STUDY 4: AFRICAN REFUGEE: ARRIVED UK 2008. ENGLISH SPEAKER

Before the birth

She accessed maternity services at seven and a half months pregnant. She arrived in the UK when she was pregnant but was unaware of her condition. When she suspected she was pregnant she was living in a hostel, and the staff advised her to go to a GP and midwife. She was told that in the UK women go to the GP for medical reasons. She had not known this. Her caseworker contacted the midwife and an appointment was arranged. A scan showed that the baby had **HYPOPLASTIC LEFT HEART SYNDROME**. Nothing was explained to her and she did not know what would happen after that. She only had one antenatal appointment which was the day before her baby was born. She had several blood tests but she did not know why they were taken, and she did not have a choice. Staff did not explain any of the tests or the implications of the results. All of these procedures were new to her.

During the birth

She took a taxi to the hospital, as she believed she was about to give birth. The staff did not think the baby was coming but she felt it was near. The staff did not listen to her and she felt there was no understanding between the client and the nurses. She was ignored and left in pain, and says the staff did not pay attention to what she was telling them. After five minutes of the nurses ignoring her pleas the baby started to arrive, while the staff rushed around trying to find her a bed.

Following the birth

The baby was born with Hypoplastic Left Heart Syndrome, which meant that the left side of the heart including the aortic valve and the mitral valve were malformed. There is no cure for this condition. She had no contact with a GP until after her baby was born. She had no help with access to entitlements until the cardiac liaison sister helped her to get in touch
with a voluntary sector organisation. Following the birth her baby underwent three open-heart surgeries and was in hospital for a long time. She had a problem with travelling to the hospital from her accommodation to see the specialist and her baby. Her friends helped her as much as they could by giving emotional support, baby clothes, cooking for her and generally helping with her baby so that she could have some rest. She needed help collecting medication for her baby; and help with washing clothes. As she had no washing machine she had to do everything by hand and forced herself daily to get on and do it getting more stressed and depressed. She has to pass all the baby’s food, milk and medication through a nasogastric tube. The tube regularly comes out and she has to keep calling a taxi to the hospital for them to put it back in every time.

Support needs

Her baby will always be on medication, and will need medical attention for life. She would like to be fully trained to enable her to take care of her child rather that rushing in a taxi back to the hospital every time there is a minor problem. She would like to be shown what to do with the nasogastric tube and be able to do it for herself. She feels she is not valued as her as a mother because staff will not teach her how to do it. She says the nurses should not assume that black women stay in labour for a long time, but should treat each woman individually, just like white women. Sometimes her situation overwhelms her and it is hard to handle. She says women that have children with special needs need continuous support following the birth. She believes the government should support the small organisations that are doing the job of providing the services the NHS should provide.

CASE STUDY 5: EASTERN EUROPEAN MIGRANT: ARRIVED UK 2006. NON-ENGLISH SPEAKER

Before the birth

Her ex husband made an appointment for her to see a GP as soon as she thought she was pregnant. The GP offered her a morning after pill, which was declined, and she was asked to come back for a blood test. Her blood pressure was measured and she was informed about tests and scans. Her GP wrote out a schedule of tests and scans and she was advised to contact the hospital for antenatal appointments. Once a month visits were arranged for urine samples and general health checks. She felt that the visits were very rushed and short. She was surprised that she wasn’t weighed and her stomach wasn’t measured. She was not able to communicate with the staff, but felt that her bare essentials were met. She did not understand the results of the tests but thought that staff were trying to say to her everything was OK. She returned to Lithuania to have additional tests including a test for Downs syndrome. She was not given any information about entitlements or financial help available, and although she did receive a maternity card she did not know what to do with it.
She was offered antenatal appointments but did not attend as her ex husband was not allowed to attend with her, and all the classes were in English. She did not understand what was being said so felt they were of no use. She did not feel comfortable enough to attend the antenatal classes by herself, and there were other childcare issues. She felt isolated and discriminated against, and thought that because she was a migrant she did not have the right to everything.

**During the birth**

A friend gave her a lift to the hospital when she was in labour. She was surprised that the staff did not ask to take off her day clothes. Only later did a nurse ask her ex husband to ask her to take off her jeans. During the labour the staff did not address her at all, but directed everything through her ex husband and he interpreted.

**Following the birth**

She drove herself and her baby home from the hospital when the baby was less than one day old. It was hard for her to look after the new baby and her other children and take them to school. The midwife visited when the baby was four days old. Although she understood the purpose of the visit, she could not communicate at all with the midwife, although she did think that the midwife was trying to persuade her to breastfeed. She had only one visit from a health visitor during the first year of the baby’s life. She did not trust the UK services and addressed most of her problems and needs, including inoculations, on short visits back to Lithuania.

**Support needs**

She would have liked better communication and more in depth monitoring during her pregnancy. She felt more informed in Lithuania mainly due to speaking the language but also because the system is more extensive. She thinks it would be useful for DoH to visit Lithuania to see the differences in service provision firsthand. She is generally very happy with maternity services in the UK, but felt isolated during the pregnancy and post birth. She just had no choice but to get on with life and get by. If she had any questions or issues she would go back to Lithuania to receive what she sees as a better quality of care and medical advice.
APPENDIX 7: RESEARCH TOOLS

Questionnaire

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Section 1: Support received while pregnant

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| 1.10 | What kinds of advice or information have you received during your pregnancy? For each type of advice that applies ask where did you get it from? (tick all boxes that apply) |

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<tr>
<td>Advice about pain relief in labour</td>
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<tr>
<td>Advice about relaxation/ birth ideas</td>
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<tr>
<td>Other (please specify)</td>
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</tbody>
</table>
1.11 Did you have access to the same midwife throughout the pregnancy?
Yes □ No □ Don't Know □

1.12 Were you able to discuss everything you needed to with the midwife?
Yes □ No □ Don't Know □

Section 2. Access to Information

2 Were you offered sufficient information to help you access services
Yes □ go to 2.1 No □ go to 2.2

2.1 Where did you get the information from? (Tick all that apply)
Friends □ Family □ Community centre or services □ Midwife □ Pregnancy outreach worker □
GP □ Websites □ Notice boards □ Other health provider □ NHS Choices website □
Other please specify □

2.2 Where you given advice or information on grants or other financial support that may be available?
Yes □ go to 2.3 No □ go to 2.4

2.3 If Yes, which?
Health in pregnancy grant □
Child Trust Fund □
Healthy Start Support (vouchers for food, vitamins and milk) □
Other □ (please specify)

2.4 What further information did you need?

Section 3. Before the Birth

3. Did you attend any antenatal classes?
Yes □ go to 3.1 No □ go to 3.3

3.1 If yes, who provided the classes and where did you hear of them (tick all categories that apply)

<table>
<thead>
<tr>
<th>Friends</th>
<th>Family</th>
<th>Community Centre</th>
<th>Midwife</th>
<th>Pregnancy outreach worker</th>
<th>GP</th>
<th>Websites</th>
<th>Notice Boards</th>
<th>Other Health Professional</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Childbirth Trust NCT</td>
<td>Hospital</td>
<td>Community Organisation</td>
<td>Pregnancy outreach worker</td>
<td>Other (please specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3.2 How useful were those classes? (1 most useful - 5 least useful)
1 □ 2 □ 3 □ 4 □ 5 □
3.3 Was there anything that stopped you accessing ante-natal services (ie services while you were pregnant) (tick all that apply)?

- Lack of knowledge or information about services available
- Not registered with a GP
- Did not think the service would be useful
- Concern about the cost of treatment
- Concern about immigration status or deportation
- Did not have any transport
- The cost of transport
- Unable to take time off work
- Lack of childcare for other children
- Concern that religious or cultural needs would not be met
- Unable to communicate with healthcare workers
- Relocation or dispersal
- Not well enough to attend services
- The system was too slow
- Other (please specify)

3.4 What could have helped you to access those services? (Tick all that apply)

- Being registered with a GP
- More information about services available
- Better explanations of how services would help you
- Free treatment
- Guarantee that your immigration status will not be reported to the authorities
- Transport provided
- Transport costs covered
- Provision of services out of working hours
- Childcare provision to enable attendance
- Evaluation of cultural or religious needs
- Provision of culturally specific services
- Translated materials
- Provision of an interpreter to help communication with professionals
- Other (please specify)

3.5 How many weeks pregnant were you when you first informed a health professional that you were pregnant?

- Under 12 weeks
- 12 to 16 weeks
- 17 to 20 weeks
- 21 to 30 weeks
- 31 weeks to 36 weeks
- 37 weeks to full-term

3.6 If you accessed services before you were 12 weeks pregnant can you please tick all the services you accessed? (please specify)

- Registered pregnancy with a GP
- Was referred to a midwife who advised on nutrition etc
- Advised about antenatal tests available prior to 12 weeks
| 3.7 | Had antenatal tests before 12 weeks □  
|     | Please indicate: NHS □ Private □  
|     | Accessed A & E for pregnancy related services □  
|     | Accessed other hospital department □  please specify __________________________ |
| 3.8 | For those who accessed maternity services later than 12 weeks. What could have enabled you to access services earlier? (tick all that apply)  
|     | Being registered with a GP □  
|     | More information about services available and what they offer □  
|     | System needed to be sped up □  
|     | Better explanations of how services would help you □  
|     | Assurances that the treatment would be free □  
|     | Guarantee that your immigration status will not be reported to the authorities □  
|     | Transport provided □  
|     | Transport costs covered □  
|     | Provision of services out of working hours □  
|     | Childcare provision to enable attendance □  
|     | Translated materials □  
|     | Provision of an interpreter to help communication with professionals □  
|     | Did not know that I was pregnant □  
|     | Other □ (please specify) __________________________ |
| 3.9 | Were you able or willing to attend all the appointments you were offered?  
|     | Yes □ if yes go to 3.12  
|     | No □ if no, go to 3.10  
| 3.10 | If no, what were the reasons why you did not attend all your appointments? (tick all that apply)  
|     | Did not think the service would be useful □  
|     | Concern about the cost of treatment □  
|     | Did not have any transport □  
|     | The cost of transport □  
|     | Unable to take time off work □  
|     | Lack of childcare for other children □  
|     | Domestic responsibilities □  
|     | Concern that religious or cultural needs would not be met □  
|     | Unable to communicate with healthcare workers □  
|     | Relocation or dispersal □  
|     | Not well enough to attend services □  
|     | Other □ please specify __________________________ |
### 3.11
What could help you to attend more of your appointments? (tick all that apply)
- More information about services available
- Better explanations of how services would help you
- Free treatment
- Transport provided
- Transport costs covered
- Provision of services out of working hours
- Childcare provision to enable attendance
- Evaluation of cultural or religious needs
- Provision of culturally specific services
- Translated materials
- Provision of an interpreter to help communication with professionals
- Other (please specify)

### 3.12
Did the services provided meet your religious or cultural needs?
- Yes
- No
- If yes, what provision was made? (Please specify)
- If no, what else could they have done? (Please specify)

---

### Section 4: Support received during the birth

#### 4
Where did you give birth to your baby? (Tick one)
- Maternity unit in a hospital
- Midwife-led unit and birth centre
- Private hospital
- At home
- Other (please specify)

#### 4.1
Did you visit that place before you gave birth?
- Yes
- No

#### 4.2
How would you rate the place you gave birth? 1-5
- (Excellent) 1
- 2
- 3
- 4
- 5 (Poor)
- Probe reason for response

#### 4.3
Did you have a birth plan?
- Yes
- No

#### 4.4
Did you know what to expect at the birth?
- Yes
- No
- If yes, how did you find out about what to expect?

#### 4.5
Were all your needs during the birth met?
- Yes if yes, go to q 4.7
- No if no go to q 4.6

#### 4.6
If no, what needs were not met?
- Insufficient pain relief
- Language needs not met
- Cultural or religious needs not met
- Other (please specify)
4.7  Did you feel informed about what was happening whilst you were giving birth?
Yes ☐  No ☐

4.8  Did you have any surgeries or procedures as a child that affected your experience of giving birth?
Yes ☐ (probe for details, and then go to 4.9)  No ☐ go to 4.10

4.9  If yes to 4.8, did you receive any support to help you overcome any problems associated with those procedures?
Yes ☐ (specify support below)  No ☐
If yes, please specify the support that you received?

4.10  How could the services that you received when giving birth be improved?

4.11  Were you asked to pay anything relating to the birth?
Yes ☐ (specify below)  No ☐
If yes, what were you asked to pay for?

Section 5: Support received after the birth

5.0  Who gave you support after you went home with your baby? (tick all that apply)
Nobody ☐  Midwife visits ☐  Health visitor visits ☐
Postnatal clinics ☐  Breastfeeding specialist ☐  Mother and baby activities ☐
GP ☐  Friends and Family ☐  Other ☐ (please specify)

5.1  What type of support did you receive? (tick all that apply)
None ☐  Breastfeeding support ☐  Mother and baby activities ☐
Help with ‘baby blues’ (post natal depression) ☐
How to care for baby ☐
Healthy Start Support (vouchers for food, vitamins and milk) ☐
Other please specify ☐

5.2  Has that support been sufficient to meet your needs?
Yes ☐  No ☐ specify below
If no, or if nobody supported you, what further support did you need? (please specify)

Section 6: Experiences of maternity related health care.

6  Thinking about the services you have received, were you made to feel welcome? (ask for each stage)
Stage 1: Antenatal services
Welcome ☐  Neither welcome or unwelcome ☐  Not welcome ☐
Stage 2: Birth services
Welcome ☐  Neither welcome or unwelcome ☐  Not welcome ☐
<table>
<thead>
<tr>
<th>Stage 3: Post-natal services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome □ Neither welcome or unwelcome □ Not welcome □</td>
</tr>
</tbody>
</table>

6.1 Have you had support from anyone outside the health service throughout your pregnancy? (ask for each stage)

Stage 1: Attending ante-natal appointments
- Partner/ husband □ Parent or other relative □ Friend □ Colleague □ Neighbour □
- Social worker/ support worker □ Community /religious leader □ Other □ (please specify)

Stage 2: During the birth
- Partner/ husband □ Parent or other relative □ Friend □ Colleague □ Neighbour □
- Social worker/ support worker □ Community /religious leader □ Other □ (please specify)

Stage 3: After the birth
- Partner/ husband □ Parent or other relative □ Friend □ Colleague □ Neighbour □
- Social worker/ support worker □ Community /religious leader □ Other □ (please specify)

6.2 How satisfied were you with the maternity services you received in this country?

<table>
<thead>
<tr>
<th>GP services</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Excellent) □ □ □ □ □ (Poor)</td>
</tr>
<tr>
<td>Community Midwife services</td>
</tr>
<tr>
<td>(Excellent) □ □ □ □ □ (Poor)</td>
</tr>
<tr>
<td>Local hospital antenatal department</td>
</tr>
<tr>
<td>(Excellent) □ □ □ □ □ (Poor)</td>
</tr>
<tr>
<td>Support group (please specify) ..........................................................</td>
</tr>
<tr>
<td>(Excellent) □ □ □ □ □ (Poor)</td>
</tr>
<tr>
<td>Private health care</td>
</tr>
<tr>
<td>(Excellent) □ □ □ □ □ (Poor)</td>
</tr>
<tr>
<td>Informal support within your community</td>
</tr>
<tr>
<td>(Excellent) □ □ □ □ □ (Poor)</td>
</tr>
<tr>
<td>Other health professional (please specify) ............................................</td>
</tr>
<tr>
<td>(Excellent) □ □ □ □ □ (Poor)</td>
</tr>
<tr>
<td>Other – (please specify) ........................................................................</td>
</tr>
<tr>
<td>(Excellent) □ □ □ □ □ (Poor)</td>
</tr>
<tr>
<td>Other – (please specify) ........................................................................</td>
</tr>
<tr>
<td>(Excellent) □ □ □ □ □ (Poor)</td>
</tr>
</tbody>
</table>

6.3 How could the maternity service in the UK be improved to make your care better? (ask for each stage and tick all that apply)

Stage 1: Before the birth
- More information □ Better language provision □ Better quality service □ Other □ (please specify)

Stage 2: During the birth
- More information □ Better language provision □ Better quality service □ Other □ (please specify)

Stage 3: After the birth
- More information □ Better language provision □ Better quality service □ Other □ (please specify)

6.4 Thinking about your maternity experiences as a whole please state which issues caused the most impact upon your ability to access the services you needed? (ask respondent to prioritise by numbering i.e. 1 as most important, 2 as next important and so on)

<p>| Lack of knowledge or information □ |
| Need to work □ |</p>
<table>
<thead>
<tr>
<th>Lack of friends or family to help you</th>
<th>Lack of secure accommodation</th>
<th>Lack of a named midwife</th>
<th>Lack of time for maternity professionals to explain the system</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision of services out of working hours</td>
<td>Childcare provision to enable attendance</td>
<td>Evaluation of cultural or religious needs</td>
<td>Provision of culturally specific services</td>
</tr>
<tr>
<td>Translated materials</td>
<td>Provision of an interpreter to help communication with professionals</td>
<td>Lack of knowledge or information about services available</td>
<td>Not being registered with a GP</td>
</tr>
<tr>
<td>Concern about the cost of treatment</td>
<td>Concern about immigration status or deportation</td>
<td>The cost of transport</td>
<td>The lack of transport</td>
</tr>
<tr>
<td>Unable to take time off work</td>
<td>Lack of childcare for other children</td>
<td>Concern that religious or cultural needs would not be met</td>
<td>Unable to communicate with healthcare workers</td>
</tr>
<tr>
<td>Relocation or dispersal</td>
<td>Not well enough to attend services</td>
<td>Other (please specify)</td>
<td></td>
</tr>
</tbody>
</table>

**6.5** Have you previously accessed maternity services in a different country?

- Yes ☐ specify country below
- No ☐

If Yes, which country? (please specify) ..........................................

In what ways was that experience different? (ask for each stage)

**Stage 1 : Before the birth**

- More information ☐ Better language provision ☐ Better quality service ☐ Other ☐ (please specify)

**Stage 2 : During the birth**

- More information ☐ Better language provision ☐ Better quality service ☐ Other ☐ (please specify)

**Stage 3 : After the birth**

- More information ☐ Better language provision ☐ Better quality service ☐ Other ☐ (please specify)

**6.6** Do you have any other comments about the maternity services that you have accessed and how they can be improved? (please specify)

**6.7** Would you be willing to take part in a further interview? (explain there will be an incentive of £20)

- Yes ☐ (complete form with contact name and telephone number)
- No ☐
Professional Topic Guide

Topic Guide for telephone interviews with healthcare staff and Voluntary Sector Organisations

NAMW – Newly arrived migrant women.

1. General information about the clinic/VSO/ and the role of the respondent

job title, responsibilities

type and structure of clinic

What maternity services do they provide?

Geographical area covered by the service?

Characteristics of the area covered by the service (rural/urban, level of deprivation, NASS dispersal area)

2. Categories of migrants

What categories of NAMW do you provide services to?

Refugees □ Asylum seekers □ Spousal migrants □ A8/A2 EU migrants □ Women with no recourse to public funds □ if ticked, which? undocumented immigrants □ Overstayers □ Former unaccompanied asylum seeking children □ unsuccessful asylum seekers □

Are there any ethnic communities in your area?

Yes □ No □ If Yes, please specify which communities

Are there any particular ethnic groups that you deal with frequently?

Yes □ No □ If yes, please state which ones

In a typical week how many NAMW access your services?

3. Access to services

How do the women access your services?

(ask them to talk through the process of how NAMW are referred to their clinic/service).

How are they generally referred?

How are the appointments made?

4. Current System and Experience

In terms of provision of maternity services to NAMW, what do you think are the main issues? Probe and ask why they are saying that.

How well, if at all, do you think that this system works?

For those women who do not make early contact with maternity services -what do you think are the best ways to encourage NAMW to make earlier or more frequent contact with maternity services?

What barriers do you think may deter NAMW from making early contact with maternity services?

What are the barriers for NAMW accessing the full range of maternity services?

How do you think these barriers may be overcome?

What barriers do you think prevent NHS STAFF and VSO from reaching out to NAMW?
How do you think these barriers may be overcome?

When NAMW have contacted maternity services, what are the challenges for ensuring they continue to engage with maternity services? Probe

What, if anything, could be done to encourage/support them to continue engaging?

Are you aware of any problems with early infant mortality among these groups of women?

Can you tell me what problems you are identifying for NAMW and infant mortality?

What are main issues the NAMW are experiencing?

How well do you think the NHS and VSO work together in the provision of maternity services to NAMW?

Have you had training on the completion of a common assessment framework (CAF) for the unborn baby?

Yes ☐ No ☐

How often do you complete a CAF for the unborn baby?

If the mother is a teenager with additional needs, is a CAF generally completed to address these needs?

Yes ☐ No ☐ If no why?

How do you normally identify and address social risk factors?

What are the difficulties in identifying and addressing social risk factors?

How well do you think the NHS and VSO work together in the provision of maternity services to NAMW?

5. Non English Speaking Women

We are trying to find out the differences in the issues for women who do not speak English, and women who are able to communicate in English.

What types of non English speakers do they tend to deal with?

Refugees ☐ Asylum seekers ☐ Spousal migrants ☐ A8/A2 EU migrants ☐

Women with no recourse to public funds ☐ if ticked, which? undocumented immigrants ☐ Overstayers ☐

Former unaccompanied asylum seeking children ☐ Unsuccessful asylum seekers ☐

In a typical week how many non English speaking women would attend their services?

How are the non English speaking women referred to their services?

How does your service engage with non English speaking women?

What are the main languages that are spoken?

(Probe on the range and proficiency of languages).

Compared to women who do speak some English, what are the main challenges of working with women who have limited language skills? Probe

How well, if at all, do you think the current provision of services to non English speaking NAMW works? Probe, why do they say that?

What do you think are the best ways to encourage non English speaking women to make earlier or more frequent contact with maternity services?

How could non-English speaking women be supported antenatally?
What barriers do you think may be deterring non English speaking NAMW from contacting maternity services? (probe all)

Language ■ Cultural ■ Family ■ Religion ■ Access to information ■ Fear ■ Privacy ■ Partner ■ Reported to the immigration authorities ■ Other barriers ■ probe

How do you think these barriers may be overcome? (probe on what types of support their staff would need)

How does the way in which they need to be supported differ from women who do speak English?

Ask all

How do women who can speak English be supported to use the system better?

6. Differences in ethnicities and accessing maternity services.

Have you observed any differences between different ethnic groups?

Yes ■ No ■

If yes, what are these differences?

What barriers have you identified?

How can these barriers be overcome?

Have you observed any differences between different immigration status?

Yes ■ No ■

If yes, what are these differences?

What barriers have you identified?

How can these barriers be overcome?

What are the issues for destitute women?

What are the barriers?

How can these barriers be overcome?

7. Social and Cultural Influences

Are there any social or cultural issues that you have come across that impact on NAMW accessing maternity services?

Prompt on:

a) Lack of social support? What problems do these women experience?

b) Educational level? What problems do these women experience?

c) Domestic violence? Have you come across instances where women are experiencing domestic violence?

Yes ■ No ■ If yes, What problem does this present?

d) Marriage to blood relations? If yes, what problem does this present?

8. Female Genital Mutilation (FGM)

Have you seen women that have undergone FGM accessing maternity services?

Yes ■ No ■ If yes, What problems do they face?

How can these problems be overcome?
What Countries do these women generally come from?

9. Enablers

What are the things that you have done that you think are most successful in enabling NAMW to access maternity services?

What changes would you like to introduce to your services?

Is there anything that holds you back from making those improvements?

Have you seen any initiatives or services elsewhere that have helped women to access services and meet their needs better?

Yes □ No □ If yes, what are these initiatives or services?

What is good about them?

Finally, thinking about maternity services to NAMW as a whole, where do you feel changes are most needed, to help women access services?

Is there anything else you want to say about this subject?

**In depth interview topic guide**

Case study topic guide

Age

Ethnicity

Languages spoken

English language ability

Immigration status

Date of arrival in UK

How many weeks pregnant were you when you discovered that you were pregnant

**Initial contact with, and information about, maternity services**

How long after you found out you were pregnant did you get in contact with maternity or medical services?

Probe reasons for making contact at that point

Who did you see for your first maternity related appointment

How did you know who to contact

What happened when you went for your first appointment

After that appointment did you know what would happen next?

Can you tell me what services you went to after your first appointment (get them to tell the story of their contact with maternity services each time asking

How they heard about the service

how useful the services were,
whether they knew what was going on,
whether they felt welcome and
whether all their questions were answered)
Where did you get information about maternity services, rights and entitlements from?
Did you have all the information you needed?
If no, what information was lacking
How could your access to information be improved?
Did you attend all the maternity related appointments you were offered?
If not what appointments did you miss and why?

Tests and procedures
Did you have any tests at any point in your pregnancy
What tests did you have
Who helped you decide what tests to have
Did you know what the tests were for and did you understand the results of the tests
What else did you need to know to help you understand the tests or their results?
Were there any complications in your pregnancy
If yes explore the nature of the complications and what help was given (did they understand what was going on)

Support received
While you were pregnant what other kinds of state support did you access to help you with your pregnancy (for example free dental treatment, free prescriptions, grants)
What other kinds of support did you access (explore access to classes etc)
Were you supported in anyway by friends and family when you were pregnant
If yes what kinds of support did you get?  How as this helpful?  What other support might have helped you
If no, what kinds of support did you need, can you think of any ways in which this lack of support impacted upon your pregnancy or your ability to access maternity services during pregnancy
Did you experience any problems during your pregnancy that
Impacted on your ability to access services
Impacted on your pregnancy more widely
For example problems with accommodation, employers, not having legal status, transport

The birth
Now I want to ask some questions about your experience of giving birth
How many weeks pregnant were you when you gave birth?

Where did you give birth and how did you get there?

Did you know what to expect, if not what was different to what you expected?

Did you know what was happening while you were giving birth. If no explain what you didn’t understand.

Were all your needs met? If not tell me what was missing.

Did you have someone to help you during the birth. If not what was the impact of being there by yourself.

Would you say your birth was straightforward? If not did you understand what was going on. Were the options explained to you.

Did you have a caesarean section? Did you understand why you needed a c-section?

**After the birth**

How old was your baby when you left hospital?

How did you get home?

Did you have anyone to help you once you got home? If yes what did they do for you?

If no what problems did this cause for you?

Did you have everything you needed for the baby? What was missing? How did you overcome this?

How old was the baby when the midwife visited?

Did you understand the purpose of the visit? How helpful was the visit? To what extent were all your questions answered?

Did you experience any problems once you were home with your baby? What were these? How and to what extent were you able to overcome them?

Did you have any contact with a health visitor in the first 6 months of your baby’s life. If yes what contact, when and how useful?

Did you have any other contact with health professionals for birth or new baby related issues in the first 6 months of your baby’s life?

Is there anything else you needed to help you and your baby in the first six months?

**Overview**

Have you given birth in any other countries? If yes how did the experience differ from the UK?

How could maternity services more generally be improved to help meet the needs of migrant women?

Is there anything else that you would like to say about maternity, birth or post-natal services?
APPENDIX 8 MIGRANTS AND CHARGING FOR MATERNITY CARE

- Migrants who are lawfully working for a UK based employer, studying on a course of at least 6 months or who have come to England to permanently reside will not be subject to charges for secondary care under the NHS (Charges to Overseas Visitors) Regulations 1989, as amended.

- Asylum seekers are also not subject to charges.

- Failed asylum seekers are generally liable for charges, but will also be exempt from charge for any course of treatment they are receiving that commenced during the time their asylum claim was being assessed by UKBA. This includes maternity care.

Immediately necessary treatment, which includes maternity treatment, must never be withheld but charges will be levied if the patient is not exempt from charge under the Regulations. Immediately necessary treatment is that which a patient needs to save their life, or;

- to prevent a condition from becoming immediately life-threatening
- or promptly to prevent permanent serious damage from occurring.

Relevant NHS bodies must always provide treatment which is classed as immediately necessary by the treating clinician irrespective of whether or not the patient has been informed of, or agreed to pay, charges, and it must not be delayed or withheld to establish the patient’s chargeable status or seek payment.

Due to the severe health risks associated with conditions such as eclampsia and pre-eclampsia, and in order to protect the lives of both mother and unborn baby, all maternity services, including routine antenatal treatment, must be treated as being immediately necessary. No woman must ever be denied, or have delayed, maternity services due to charging issues. Although she should be informed if charges apply to her treatment, in doing so, she should not be discouraged from receiving the remainder of her maternity treatment. Hospital Overseas Visitors Managers and clinicians should be especially careful to inform pregnant patients that further maternity care will not be withheld, regardless of their ability to pay.