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Annette Williamson, West Midlands Perinatal Institute
Fiona Cross-Sudworth, West Midlands Perinatal Institute

FOR FURTHER INFORMATION CONTACT
d.newall@wmcouncils.gov.uk
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The Birmingham University research report *Delivering in an Age of Super-Diversity*\(^1\) has highlighted the diverse nature of the migrant population in the West Midlands. Migrant women giving birth in the West Midlands come from a wide range of backgrounds with varying health and social care needs. The circumstances in their country of origin, their reasons for migrating to the UK, and their circumstances in the UK all impact on their pregnancy and subsequent parenthood. Many migrant women will have a straightforward pregnancy with no health or social complications. However at the opposite end of the spectrum, many migrants are extremely vulnerable, having to cope with complex and challenging problems, putting them and their baby at risk.

Maternity services therefore face a difficult challenge in trying to ensure their services are appropriate and amenable to the needs of migrant women. Maternity services must be able to identify the health and social care needs of migrant women, many of which will be hidden and complex, and be able to refer women to the appropriate services to help them address their needs. On top of this, maternity services must address the barriers of language, culture, fear, confusion and a lack of empowerment experienced by many migrant women.

The views of the migrant women, health care professionals and local charitable organisations who took part in the research have highlighted that there are a wide range of issues which require cross-agency input to help improve services for pregnant migrant women. The research also highlighted examples of where local maternity services have failed to meet the needs of migrant women accessing their services.

This document has been developed as a toolkit to enable maternity services to take forward the recommendations from the Birmingham University research report in order to improve the accessibility and appropriateness of their services for the local migrant population. Maternity services and their partners should review existing maternity care pathways, using the resources from this document to help ensure local maternity services are migrant friendly.

This document includes the following resources:

- Background information on the policy context relating to maternity services for migrant women to support local services to advocate for a focus on this agenda.

• Links to epidemiological data on the scale and impact of migration on local maternity services to enable local areas to scope the needs of their local migrant population.

• Examples of good practice from across the West Midlands to stimulate dialogue and innovation.

• An example care pathway for migrant women, to provide a basis for the development of local care pathways.
The 2007 Confidential Enquiry into Maternal and Child Deaths reported on the risks faced by vulnerable women in childbirth.

‘Women from vulnerable groups experience a higher risk of death, morbidity, pre-term labour, intrauterine growth restriction, low birth weight and neonatal complications and have lower breastfeeding rates. Overall, women who live in the poorest circumstances are up to seven times more likely to die than women from other demographics’

Whilst unable to quantify the risks faced by migrant women, the confidential enquiry highlighted that 12% of all maternal deaths during the review period were in refugees and asylum seekers, despite only making up 0.3% of the UK population [UK High Commission for Refugees]. The report also highlighted the increased risk of infant mortality in BME ethnic groups and in those living in the most deprived circumstances, often experienced by migrants.

In the West Midlands the need for greater focus on the social needs of pregnant women, particularly in the most vulnerable women, has been highlighted. In particular there has been an identified need for the development of a personal development programme for maternity staff to increase competence in meeting the wider needs of vulnerable women. This has led to the commissioning of an accredited training programme on social care assessment for health visitors and midwives, delivered by Birmingham City University. Work has also been undertaken in the West Midlands to review the personal development needs of midwives throughout the entire maternity care pathway.

The Standards for Maternity Care report contains 30 individual standards for maternity care for the entire pathway from preconception to transition into parenthood. It brings together the recommendations from 50 previous reports, which contained a total of over 800 separate, often overlapping standards. Of particular importance to the needs of migrant women is standard 7 – Women with Social Needs;

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3 Royal College of Obstetricians and Gynaecologists Standards for Maternity Care - Maternity Audit Indicators (2008)
7.1 Maternity services must have in place inter-agency arrangements (through clinical and local social services networks) including protocols for information sharing and a lead professional, to ensure that women from disadvantaged groups have adequate support and benefit from other agencies (such as housing) referring women, with consent to local maternity services.

7.2 Services should be flexible, accessible and culturally sensitive and planned individually to motivate all women including the vulnerable and hard to reach to engage with maternity services.

7.3 Interpreting services should be provided for women where English is not their first language. Relatives should not act as interpreters. Funding must be made available for interpreting services in the community, especially in emergency or acute situations.

### NICE GUIDANCE

The National Institute for Health and Clinical Excellence has recently published guidance on maternity services for women with complex social factors, including recent migrants, asylum seekers and women who speak little or no English. The table overleaf summarises the evidence base identified by NICE relating to barriers faced by migrant women.

#### Barriers reported for recent migrants, refugees, asylum seekers and women with little or no English (NICE)

<table>
<thead>
<tr>
<th>Service barriers reported by women</th>
<th>Personal reasons which act as barriers reported by women</th>
<th>Barriers reported by providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Language – lack of interpreters, use of colloquialisms (17)</td>
<td>Not understanding the health care system and how to access it (9)</td>
<td>Language (4)</td>
</tr>
<tr>
<td>Discrimination, racism towards immigrants and non-English speakers (6)</td>
<td>Lack of social network (4)</td>
<td>Lack of availability of suitable interpreters especially for emergencies, out-of-hours and unbooked appointments (1)</td>
</tr>
<tr>
<td>Lack of continuity of carer (3)</td>
<td>Misunderstanding dates and times of appointments (1)</td>
<td>Unfamiliarity of health care system, what to expect, how to use it (3)</td>
</tr>
<tr>
<td>Not told about antenatal education (2)</td>
<td>Not understanding the purpose of antenatal classes, diagnostic tests. (1)</td>
<td>Minority women do not conform to rules – use emergency services instead of clinics, can be demanding expecting health care to live up to standards of care in their home country (1)</td>
</tr>
<tr>
<td>Refused registration with a GP (1)</td>
<td>Depression/ Fear/Anxiety/ other personal (5)</td>
<td>Lack of knowledge of cultural and religious differences (1)</td>
</tr>
<tr>
<td>Lack of transport (6)</td>
<td>Financial (6)</td>
<td>Negative attitude towards women from ethnic minorities (2)</td>
</tr>
<tr>
<td>Inconvenient time of AN clinic (8)</td>
<td>Lack of child care (3)</td>
<td>Lack of continuity of carer (1)</td>
</tr>
<tr>
<td>No directing agencies (1)</td>
<td>Fear of Immigration services (4)</td>
<td>Pressures and difficulties arising from immigration status (3)</td>
</tr>
<tr>
<td>Lack of cultural sensitivity among providers (2)</td>
<td>Dispersement policies for women with asylum seeker/refugee status (1)</td>
<td></td>
</tr>
<tr>
<td>Negative attitude of healthcare professionals (2)</td>
<td>Lack of assertiveness in dealing with the healthcare system (1)</td>
<td></td>
</tr>
</tbody>
</table>

No. in brackets = Number of studies reporting barrier

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* National Institute for Health and Clinical Excellence (NICE) Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors (2010)
The NICE guidance makes the following general recommendations on how maternity services can meet the needs of all vulnerable women;

**Service organisation**

In order to inform mapping of their local population to guide service provision, commissioners should ensure that the following are recorded:

- The number of women presenting for ante-natal care with any complex social factor
- The number of women within each complex social factor grouping identified locally

Commissioners should ensure that the following are recorded separately for each complex social factor grouping

- The number of women who:
  - attend for booking by 10, 12+6 and 20 weeks
  - attend the recommended number of ante-natal appointments, in line with national guidance experience,
  - have babies who experience, mortality or significant morbidity.
- The number of appointments that each woman attends
- The number of scheduled appointments each woman does not attend

Commissioners should ensure that women with complex social factors presenting for ante-natal care are asked about their satisfaction with the services provided; and the women’s responses are:

- Recorded and monitored
- Used to guide service development

Commissioners should involve women and their families in determining local needs and how these might be met.

Individuals responsible for the organisation of local maternity services should enable women to take a copy of their handheld notes when moving from one area or hospital to another.

**Training for healthcare staff**

Healthcare professionals should be given training on multi-agency needs assessment, such as the Common Assessment Framework, and national guidelines on information sharing.

**Care provision**

- Consider initiating a multi-agency needs assessment, including safeguarding issues so that the woman has a coordinated care plan.
- Respect the woman’s right to confidentiality and sensitively discuss her fears in a non-judgemental manner.
Tell the woman why and when information about her pregnancy may need to be shared with other agencies.

Ensure that the handheld notes contain a full record of care received and the results of all ante-natal tests.

**Information and support for women**

For women who do not have a booking appointment, at first contact with any healthcare professional:

- Discuss the need for ante-natal care
- Offer the woman a booking appointment in the first trimester, ideally before 10 weeks if she wishes to continue the pregnancy, or offer referral to sexual health services if she is considering termination of the pregnancy.
- At the first contact and at the booking appointment, ask the woman to tell her healthcare professional if her address changes, and ensure that she has a telephone number for this purpose.
- At the booking appointment, give the woman a telephone number to enable her to contact a healthcare professional outside of normal working hours, for example the telephone number of the hospital triage contact, the labour ward or the birth centre.
- In order to facilitate discussion of sensitive issues, provide each woman with a one-to-one consultation without her partner, a family member or a legal guardian present, on at least one occasion.

In addition, **NICE makes the following recommendations which relate specifically to the needs of migrant women;**

Healthcare professionals should help support these women’s uptake of ante-natal care services by:

- Using a variety of means to communicate with women
- Telling women about ante-natal care services and how to use them
- Undertaking training in the specific needs of women in these groups

**Service organisation**

- Commissioners should monitor emergent local needs and plan and adjust services accordingly.
- Healthcare professionals should ensure that they have accurate and up-to-date information about a woman’s residence during her pregnancy by working with local agencies that provide housing and other services for recent migrants, asylum seekers and refugees, such as asylum centres.
- To allow sufficient time for interpretation, commissioners and those responsible for organising local ante-natal services should offer flexibility in the number and length of ante-natal appointments when interpreters are used, over and above the appointments outlined in national guidance.
Those responsible for the organisation of local ante-natal services should provide information about pregnancy and ante-natal services, including how to find and use ante-natal services, in a variety of:
- formats, such as posters, notices, leaflets, photographs, drawings/diagrams, online video clips, audio clips and DVDs
- settings, including pharmacies, community centres, faith groups and centres, GP surgeries, family planning clinics, children’s centres, reception centres and hostels
- languages.

**Training for healthcare staff**

Healthcare professionals should be given training on:
- The specific health needs of women who are recent migrants, asylum seekers or refugees, such as needs arising from female genital mutilation or HIV
- The specific social, religious and psychological needs of women in these groups
- The most recent government policies on access and entitlement to care for recent migrants, asylum seekers and refugees

**Information and support for women**

- Offer the woman information on access and entitlement to healthcare.
- At the booking appointment discuss with the woman the importance of keeping her handheld maternity record with her at all times.
- Avoid making assumptions based on a woman’s culture, ethnic origin or religious beliefs.

**Communication with women who have difficulty reading or speaking English**

- Provide the woman with an interpreter (who may be a link worker or advocate and should not be a member of the woman’s family, her legal guardian or her partner) who can communicate with her in her preferred language.
- When giving spoken information ask the woman about her understanding of what she has been told to ensure she has understood it correctly

**QIPPP**

In order to meet the demands of an ageing population, increases in lifestyle related disease and increased patient expectations, the NHS has been challenged to deliver on Quality, Innovation, Productivity, and Prevention (QIPP) to which NHS West Midlands has added a further P representing partnership (QIPPP).
The QIPPP agenda has become the overarching philosophy for all health care organisations and should inform all work programmes to ensure they deliver innovative, high quality care which is productive, engages partners and enhances disease prevention where possible.

Taking action to improve maternity services for migrant women would address all aspects of the QIPPP agenda;

### QUALITY

The research report identified a number of occasions where the care provided to migrant women was substandard. Often factors such as language, poor communication, attitudes and external circumstances affected the quality of care provided to migrant women. There were examples, within the small number of women interviewed, where substandard maternity care may have resulted in harm to the mother or child. Ensuring maternity services are more aware of and more adaptable to the needs of migrant women will have a large impact on the quality of care provided to these women.

Data from the West Midlands Perinatal Institute’s PEER study will help enable the comparison of key performance indicator results for migrant women with those of the whole population, highlighting where targeted action is needed to improve performance against these standards.

The West Midlands Perinatal Institute has recently undertaken a confidential enquiry on infant mortality in migrant women in Birmingham (see below). The findings of this enquiry should be acted upon by all maternity providers in the West Midlands to ensure the numbers of avoidable infant deaths are minimised.

### INNOVATION

Providing services to meet the complex needs of migrant women requires new ways of working. This report highlights examples of innovative practice across the West Midlands which are helping deliver the additional support that migrant women often need. It is important however that these services are evaluated to enable identification of effective approaches to improving services. Evaluation will also help identify where services are not improving patient outcomes or providing value for money and where the approach taken requires adaption to maximise positive outcomes.

### PRODUCTIVITY

Migrant women with complex needs can be seen as a burden on already stretched maternity services. Delays are often caused by the need for interpreters and women may fail to attend ante-natal appointments due to transport difficulties or a lack of understanding of the
importance of these appointments. Better organisation of translation services and the availability of community based clinics could help improve the productivity of these clinics. A detailed understanding of why women DNA ante-natal appointments would help ensure barriers to attending are removed where possible.

The research identified that some women frequently seek healthcare advice during their pregnancy when it was not always necessary. Improving the information provided to migrant women and ensuring they are empowered to cope with their pregnancy may help reduce unnecessary attendance from those suffering minor ailments.

Midwifery workload is often stretched and supporting women with social care needs can be time consuming. Appropriate use of the wider maternity workforce and wider partnership working with the voluntary sector could help ease the burden on the midwifery workload. This requires the development of close working relationships with the voluntary sector to ensure effective communication and appropriate referrals.

**PREVENTION**

Improving the health of mother and child during pregnancy and early years can have a large impact on the prevention of future ill health and inequalities. Migrant mothers and their babies are often some of the most vulnerable in our society, for whom simple preventative health approaches could have a large impact on their future health. For example; improving the diet of pregnant migrant mothers, ensuring early identification and treatment of HIV and working with other agencies to help ensure migrants are housed in accommodation suitable for a new baby.

**PARTNERSHIP**

Improving the health of migrant mothers and their children is not possible without better partnership working with all of the other statutory and voluntary agencies which these women come into contact with. Partnership working offers huge opportunities to improve the circumstances of these families and to help reduce future burden on the NHS.

Closer working relationships with partners, for example through use of the Common Assessment Framework, can help ensure women are able to access the appropriate services quickly and in a joint up manner, reducing duplication of effort amongst different organisations. Better partnership working will help ensure these often vulnerable women and their children do not fall through the net and are offered the necessary support at the earliest stage possible.
The NHS White Paper, Equity and Excellence: Liberating the NHS\(^5\) sets out plans to shape the future of the NHS. The white paper includes proposals to transfer responsibility for maternity services to the new NHS commissioning board and to set up maternity networks to deliver maternity care through a more integrated approach. The white paper also includes proposals to set up a new public health service to sit within local authorities and to establish Health Watch, an independent national body to provide public scrutiny of the NHS.

In addition, the public health white paper, due to be published in late 2010 is expected to provide further details as to how public health will be delivered within the new public health service.

Within the new structures it is expected that the NHS commissioning board, as part of their commissioning of maternity services function, will have responsibility for ensuring the implementation of the NICE guidance in relation to vulnerable women. Local Authorities, through their overview and scrutiny role and via Health Watch will also have a role in ensuring that local maternity services meet the needs of the local population. It is also expected that the public health service will play a role in ensuring that local health services are tackling inequalities, this should include the role of advocating on behalf of vulnerable populations, such as migrant women.

The full details of how maternity services will be delivered in the future are still emerging. What is clear however, is that there is a need to ensure that within the new structures the roles of identifying the needs of vulnerable groups and of advocating on their behalf are not lost.

IMPACT OF MIGRATION ON MATERNITY SERVICES

Data on the scale of migration in different areas of the West Midlands comes from a range of different sources, none of which give the full picture of the local situation. The research report provides information of the number of migrants living or employed in the West Midlands using UKBA, NINO (National Insurance Number) and Worker Registration scheme data.

There is very little data nationally on the impact of migration on maternity services. The West Midlands Perinatal Institute implemented the West Midlands regional maternity data collection programme in 2009/10 to improve the quality of maternity data available to monitor progress against key performance indicators. In addition the data collection system has allowed improved recording of the wide range of risk factors affecting pregnancy outcome, including social risk factors. These data have allowed the production of quarterly key performance indicator reports for the West Midlands, broken down to PCT and maternity unit level.

Using these data the Perinatal Institute is producing a series of short reports on the key risk factors affecting maternal care and pregnancy outcome, of which one on migrant mothers is expected before the end of 2010. These data will help compare the experiences and circumstances of migrant mothers accessing maternity services in the West Midlands compared to other maternity users. This report will provide key information to support a focus on improving maternity services for migrant women.

The Perinatal Institute has also undertaken a confidential enquiry into perinatal mortality in babies of migrant mothers in Birmingham. The confidential enquiry report is due to be published imminently. The initial results of the confidential enquiry process echoed the key issues identified by the research report, a further call to action to improve the birth outcomes of migrant women.
IMPLEMENTATION OF THE RESEARCH FINDINGS

The research recommended a number of improvements which are required to ensure maternity services are migrant friendly. We have identified four key areas of focus which should be considered when undertaking a review of local maternity services.

- Access to clear information for both women and healthcare professionals
- Ease of access to healthcare services for pregnant migrant women
- Attitude and cultural awareness of staff
- Availability of additional support for those that need it.

1. ACCESS TO CLEAR INFORMATION

Like all women, migrant women require access to comprehensive information to help guide them through their pregnancy and into parenthood. Being well informed on the stages of pregnancy, what to expect and what support is available will help empower migrant women to take control of their pregnancy and seek care when appropriate.

As a minimum, all migrant women should have access to information on the following:

- Pre-conception health information, including advice on contraception, registering with a GP and the organisation of the NHS.
- Information on how to access maternity services and on the importance of early booking.
- Information on the different stages of pregnancy, including:
  - What tests will be undertaken and why
  - How to keep healthy in pregnancy
  - What symptoms are normal and which require further investigation during pregnancy
  - Information on what ante-natal support is available and how to access it.

For migrant women who are seeking asylum in the UK or who have no recourse to public funds the following additional information should be easily available:

- Guidance on entitlements to NHS care throughout pregnancy, including access to maternity grants and milk supplements for asylum seeking women.
- Information on local charities that can support women through their pregnancy.
All pregnant women require access to good information regardless of whether or not they speak English. Written information in a range of languages is needed to ensure women have access to information. Use of pictures and simplified information can also be used to help increase understanding where reading is limited. The following websites provide maternity information in a range of different languages:

www.nhs.uk The NHS choices website contains a vast amount of health information which can be translated into twelve different languages by clicking on the relevant language at the bottom of the page.

www.healthinmylanguage.com An NHS Scotland website containing various translated health leaflets in a range of languages. Includes information on cot death and eating a healthy diet in pregnancy.
MAMTA, meaning motherly love in many South Asian languages, is a culturally sensitive programme designed to improve maternal and child health for black and ethnic minority women living in one of the most deprived areas of Coventry. The programme, funded by Coventry Teaching NHS and Coventry City Council, aims to empower women from the local ethnically diverse community to take control of their own and their children’s health.

The project was set up at Foleshill Women’s Training (FWT) Centre, an organisation in the heart of the community, to help reduce the high infant mortality rate in the Foleshill area.

The activities of MAMTA target local health inequalities by addressing the root causes of ill health. It does this by removing barriers to health such as culture and language and by offering a safe environment to support and advise women on health matters.

MAMTA works in partnership with health professionals to cascade important health messages to the community.

MAMTA offers a range of sessions for local women, all with language and crèche facilities, including:

- Preconception advice
- Workshops on health topics, e.g. nutrition and diabetes
- Parent Craft Sessions addressing nutrition, birth, smoking cessation and dangers for baby
- Support at Ante-natal Clinics
- Post natal sessions including breast feeding support
- Maternal health activities, e.g. mums and tots
- Child health activities e.g. information on immunisation and diet.

A number of other projects run from the FWT centre including a range of vocational and computer literacy courses and support for women looking to get into employment. This offers opportunities to increase recruitment of women into the MAMTA and likewise opportunities for the MAMTA attendees to find out more about the additional courses on offer at the centre.

For further information on the MAMTA project contact: Noreen.Bukhari@fwt.org.uk
Easy access to interpreting services is vital to ensure women are well informed throughout their pregnancy. Considerations to help improve interpreting services include ensuring additional time is allocated to appointments, establishing continuity of interpreter, training interpreters in basic medical terminology to help communicate effectively and ensuring interpreters are trained to deal with difficult circumstances such as still births. When using an interpreter, health professionals should ensure that they still maintain eye contact with the patient and talk to the patient directly rather than to the interpreter. Use of friends and relatives to help interpret should be discouraged to ensure the woman is able to open up about potentially sensitive and confidential issues.

It is also important that information on language needs is passed onto all those who will come into contact with the woman during her pregnancy to ensure they are able to arrange interpreting services in advance and identify relevant translated leaflets. Information on

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**POLISH ANTE-NATAL CARE PROJECT**

An increase in migration from Eastern Europe has led to an increase in the number of Polish women giving birth across the West Midlands. This is particularly the case in rural areas due to availability of seasonal agricultural work. A number of rural PCT’s across the West Midlands are making use of existing Polish midwives to improve maternity services for Polish women.

In Worcestershire, Polish midwife, Aldona Morrison has spent the last two years developing the Polish Ante-natal Care Project (PANCaP). Aldona undertakes ante-natal clinics at four sites across Worcestershire, reaching around 200 non-English speaking Polish women each year.

Ante-natal classes in Polish are delivered at key points in the mothers pregnancy, including the initial booking visit, to ensure any specific issues are identified early and to ensure the women know what to expect from the rest of their ante-natal care.

Aldona has also translated over 25 different maternity leaflets into Polish, producing a valuable resource for Polish women in the area. One of the most useful resources has been a set of key sentences for labour, written out in both English and Polish. This has allowed the other midwives to communicate effectively with the women during pregnancy when translators are not available. This is of particular value when consent is required urgently, for example if an emergency caesarean section is required.

GP’s across Worcestershire can refer women into the Polish Ante-natal Care Project and posters have been put up in factories where Polish women work to encourage them to contact the service. This has helped decrease the number of Polish women booking late in their pregnancy.
language needs should be captured in the women’s maternity notes.

As well as language needs, migrant women often come to the UK with very different expectations of maternity care. In some countries ante-natal care is very limited, whilst in others a more medicalised model of maternity care in the norm with regular internal examinations offered throughout pregnancy. It is important that women accessing maternity care in the UK know how the services are organised and know what to expect from their care.

**MATUREITY CARE PATHWAY FOR NON-ENGLISH SPEAKING WOMEN**

The majority of women giving birth in South Staffordshire have English as their first language. For the small number who don’t speak English, accessing maternity services at the local hospitals can be a challenging and often bewildering experience.

Identifying this as a problem, a project team of midwives from Staffordshire and Burton hospitals and representatives from South Staffordshire PCT was set up to develop a maternity care pathway for non-English speaking women.

The pathway outlines how language needs should be identified at registration and then passed on to professionals throughout ante-natal, intra partum and post-natal care. The pathway ensures that all those who come into contact with the women during her pregnancy and birth, for example the ultrasound department, are able to provide information in the women’s first language, either through language line or translated leaflets.

The pathway also highlights the need to discuss the women’s expectations of maternity care in England and to explain how the model of care in the UK may differ from that in the women’s home country.

The development of the pathway has highlighted additional areas for improvement, for example the need for a clear policy on Female Genital Mutilation (FGM). The challenge now is to embed the pathway within the other maternity policies and guidelines to ensure it is appropriately implemented and to ensure it is part of a wider programme of improvements in maternity services.

For more information on the pathway contact: wendy.hayes@southstaffspct.nhs.uk
The complex nature of the asylum process means that frequent dispersals to different accommodation in different areas of the country is common. This is a particular problem where pregnant migrant women have engaged with maternity services in one area and are then dispersed at short notice to another area, often without their maternity notes. For all pregnant women, continuity of maternity care is important, for vulnerable migrant women it may be more so.

Where possible maternity services should work with the UK Borders Agency (UKBA) to ensure pregnant asylum seekers are not dispersed out of area. Where this isn’t possible it is important to ensure there is a complete handover of care to another maternity provider.

**LINKING NEW ARRIVALS WITH HEALTH SERVICES**

Stoke on Trent is a dispersal area for asylum seekers, who in the past were moved into or out of the area without the PCT being informed. This could cause problems when the person is vulnerable, including those in the late stages of pregnancy. Often these relocations are at short notice and the women are unable to inform their previous maternity services who could have handed over care to the maternity services in the new area. Women can also be lost to follow-up due to the confusion and disruption of being moved to a new area, often leaving behind what social support they had.

Stoke on Trent PCT have been working with the dispersal accommodation providers to ensure that the PCT receives a weekly update on new arrivals entering the area. This information is used to facilitate the allocation of a GP to the newly arrived client. The PCT can also ensure that pregnant asylum seekers are linked in with local maternity services at the earliest opportunity.

The PCT are also made aware when individuals are to be moved out of the area. This allows them to ensure a handover of care to the new area, or in the case of women in the late stages of pregnancy, work with the UKBA to ensure the move is postponed until after the arrival of the baby, to ensure continuity of maternity care.

For Further information contact: JaneR.Howie@stoke.nhs.uk

In order to be able to plan and deliver maternity services that are appropriate to the needs of migrant women, PCTs and hospital trusts need to have an understanding of their local population and the impact of migration on that population. The section on the impact of migration across the West Midlands provides links to sources of information which will help local areas to develop a profile of women giving birth in their area to help inform them on what and where the areas of greatest need are.
PERINATAL EPISODE ELECTRONIC RECORDING (PEER)

As part of the Investing for Health – Perinatal & Infant Mortality Programme, West Midlands Perinatal Institute has established enhanced data collection from all of the maternity units in the West Midlands. Funding for data entry clerks was made available to ensure timely and accurate collection of data from the maternity notes.

The enhanced data collection has allowed better monitoring of key performance indicators and opportunities for detailed analyses of women’s risk factors and birth outcomes. Individual trusts and PCTs have direct access to the data via a reporting tool, allowing them to run of their own analyses.

The enhanced data collection includes information on the women’s country of origin, time in the UK, language needs and asylum status, enabling us to have a better understanding of the health and social care needs of migrant women.

Future developments in the PEER project include the piloting of electronic pens to enable direct reporting of the information from the midwife completing the pregnancy notes, alleviating the need for data entry clerks and enabling the provision of real time data.

For further information on PEER contact: michelle.southam@pi.nhs.uk

KEY POINTS: ACCESS TO CLEAR INFORMATION

All migrant women should have access to comprehensive information on pregnancy to ensure they are fully informed and empowered throughout their pregnancy.

Information needs to be easily accessible regardless of language spoken, this includes good access to interpreting services and leaflets in different languages, including the use of pictorial leaflets for those with limited reading abilities.

PCTs and maternity services need to have access to information on the needs of the local migrant and non-English speaking population to ensure services are designed to meet these needs.
2. ACCESSING SERVICES

Many migrant women are unfamiliar with the structure of the NHS, in particular the role of primary care and the need to register with a GP. When trying to register with a GP, migrants are known to have been turned away or wrongly told that lists are full. A number of PCTs have commissioned asylum seeker specific general practices to ensure tailored services are available, however there is also a danger of increasing stigmatization with this approach.

Women may be unfamiliar with the need to access healthcare services early in pregnancy, particularly if ante-natal services are poor in their home country. Early access to maternity services could be improved through direct access to a midwife, however issues surrounding GP registration would still need to be resolved.

PREGNANCY FAST TRACK

The majority of pharmacies across Birmingham now offer FREE pregnancy testing and a fast-track referral into maternity services. The pharmacy staff have undergone intensive NHS training and can now carry out pregnancy tests and refer women to a fast-track booking system in a bid to boost the number of women who have their first ante-natal appointment before 12 weeks.

Previous Birmingham Health and Wellbeing Partnership research revealed that only 39 percent of women in Birmingham had their first ante-natal appointment before they reach their 12th week of pregnancy. Through initiatives like pregnancy fast track they are committed to increasing this to 80 per cent.

Our campaign ‘Sooner, the Better’, is promoting the message that looking after a pregnant woman’s ‘passenger’ is of high importance to us all. The sooner women access maternity care, the better the likely outcomes for their babies as any potential problems can be picked up at an early stage.

Pharmacists will refer women with a positive test result to a midwifery referral call centre who will arrange an appointment with a community midwife. Women can also call this helpline direct on 0800 234 6511.

Alternatively, they can text MIDWIFE to 80800 at any time. Women who text this number will receive text confirmation that the message has been received and will be called back during the centre opening hours. Women can also e-mail info@pregnancyfasttrack.co.uk
Nationally there are examples of women being turned away from NHS maternity care, including during labour because of misinterpretation of the rules regarding payment for NHS care. Maternity care is classified as urgent and necessary care and should not under any circumstances be refused to women. Women may be referred to the Hospital Overseas Visitors Manager prior to being assessed by a midwife. This may frighten women, particularly if they are told they have to pay a large sum of money (£3000) for their maternity care and may result in women failing to attend future appointments or only seeking partial ante-natal care. Policies should be put in place in hospitals to ensure women are assessed prior to referral and follow-up arranged, and to ensure the hospital overseas visitors manager is aware of the rules regarding maternity care.

**ENTITLEMENT TO NHS 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 ante-natal 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.

<table>
<thead>
<tr>
<th>Status</th>
<th>Primary Care</th>
<th>Secondary Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asylum Seekers whose claim is still being considered or with an outstanding appeal. (Unsupported, Subs only, Section 95)</td>
<td>Entitled to free NHS treatment and able to register with a GP. May need to pay for prescriptions (unless exempt)</td>
<td>As for primary care, exempt from charges for NHS hospital treatment</td>
</tr>
<tr>
<td>Failed asylum seekers Including section 4 supported</td>
<td>GPs have discretion to register. Access to primary care should be unaffected, the same issue re prescription charges applies.</td>
<td>Ineligible for free secondary care treatment. Urgent and immediately necessary treatment should be provided, but individuals will be charged for it.</td>
</tr>
<tr>
<td>Refugee Status, Discretionary Leave or Humanitarian Protection</td>
<td>Access to primary care without charge. Course length and funding requirements as for secondary care.</td>
<td>Access to secondary care without charge. If course is over 6 months in duration or if less than 6 months but mainly funded by UK Govt, then secondary care treatment is free (normal prescription charges still apply)</td>
</tr>
<tr>
<td>Students from overseas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non EEA nationals who are working (Legally)</td>
<td>As for secondary care</td>
<td>Entitled to secondary care without charge. Individuals must have relevant proof of employment and work permit etc</td>
</tr>
<tr>
<td>Undocumented migrants</td>
<td>Primary care should be accessible. GPs have discretion to register patients.</td>
<td>Emergency treatment only, other services may be chargeable</td>
</tr>
<tr>
<td>Visitors from overseas</td>
<td>Individuals may be regarded as private patients.</td>
<td>Emergency treatment only, other secondary care services chargeable</td>
</tr>
<tr>
<td>EEA or EU nationals</td>
<td>Reciprocal health arrangements via European Health Insurance Card. Entitled to Primary Care</td>
<td>Reciprocal health arrangements via European Health Insurance Card. Entitled to secondary care</td>
</tr>
<tr>
<td>Family Reunion/ spouse Visa (Where leave to enter/ remain in the UK has been granted)</td>
<td>Entitled to free NHS treatment and able to register with a GP. From date of arrival. May need to pay for prescriptions (unless exempt)</td>
<td>As for primary care, exempt from charges for NHS hospital treatment from date of arrival</td>
</tr>
<tr>
<td>Victims of trafficking (from 1/4/09)</td>
<td>Entitled to free NHS treatment and able to register with a GP. May need to pay for prescriptions (unless exempt)</td>
<td>As for primary care, exempt from charges for NHS hospital treatment</td>
</tr>
</tbody>
</table>
Migrant women often only receive partial ante-natal care, this may be due a variety of reasons. One reason for women DNAnig appointments is a lack of funding for transport, particularly if they only receive voucher based support. Examples of women walking long distances to appointments, including during the late stages of pregnancy have been highlighted. There is a need to ensure that community midwives are easily accessible, taking into consideration the lack of access to transport faced by some migrant women. Local approaches, such as free transport scratch cards could be adopted to reduce non-attendance rates.

**KEY POINTS - ACCESS**

It is important that all migrant women, regardless of their asylum status have access to a GP to enable early engagement with maternity services.

Hospitals should ensure their overseas visitors managers are aware of the rules regarding access to maternity care for migrant women.

There is a need for easy access to community midwives, with services being provided in convenient locations to reduce non-attendance rates.
3. ATTITUDE AND CULTURAL AWARENESS

It is important that healthcare staff have a good understanding of the difficulties faced by migrant women coming to the UK. Whilst many migrant women may have come to the UK through choice, a large number have come through necessity, in order to flee difficult circumstances in their home country. Asylum seekers coming to the UK have often undergone terrible ordeals both in their home country and in their bid to reach safety in the UK.

The experiences of individual asylum seekers will vary, but examples of rape, torture and trafficking are not uncommon. Many migrants will have been separated from family and friends and may feel extreme isolation when they first arrive in the UK. As a consequence mental health problems are common amongst migrants to the UK. Once in the UK many migrants face racial abuse and discrimination and may be living in poor housing conditions with minimal financial support. Occurrence of domestic abuse is also common, and those in the UK on spousal visas may feel trapped in abusive relationships.

There is a need for greater awareness of the issues faced by migrants amongst health care workers. Increased awareness will enable healthcare workers to engage with migrant women better and will increase their ability to identify issues such as domestic abuse and FGM. An understanding and sympathetic workforce will help engender trust and ensure migrant women feel that their issues are being addressed.
It is important to ensure that maternity services are culturally sensitive, to help ensure women feel at ease throughout their maternity experience. Health care staff do not need to have detailed knowledge of all different cultural preferences but should have an appreciation of the importance of culture, ensuring all women have opportunities to express their cultural preferences.

Where their asylum status is uncertain, migrant women may be fearful of accessing maternity services for fear of being reported to immigration. They may be reluctant to disclose personal information to health care staff. This fear may be compounded by poor
English-language skills and a lack of understanding of the organization of the NHS. It is important that all staff working in healthcare settings have received cultural awareness training as the first point of contact with maternity services is often a GP receptionist or a junior doctor in A&E.

TRAINING FOR HEALTH PROFESSIONALS, COVENTRY REFUGEE CENTRE

Coventry Refugee Centre in collaboration with NHS Coventry has undertaking a year long project to increase health professional’s awareness of refugee’s health concerns. The Refugee centre has delivered a number of training sessions in order to address the health inequalities that exist within the asylum community. Sessions which have been run to date include;

- Introduction to the asylum process – helping you navigate the complex issue of the asylum process and the health issues that may arise from it.
- Refugee health - including TB, HIV, Hepatitis B and Sickle Cell disease
- Sexual health (including FGM)
- Mental health forum – identifying the mental health concerns particular to the refugee experience

The training sessions are aimed at health professionals and support staff within Coventry. Interest in the courses has however been high with professionals from outside of Coventry and from a range of different agencies attending the courses.

The Coventry Refugee Centre has also been running a series of health courses for refugees and asylum seekers. The courses provide clients with information and advice on a range of health concerns including parenting, healthy lifestyles, men’s health, women’s health and patient focus groups, e.g. for diabetic patients. The courses also provide information on NHS services and how to access them. Childcare and interpreters are available for all courses which has increased attendance.

For more information on the courses contact: philliphh@covrefugee.org
KEY POINTS – ATTITUDE AND CULTURE

Increase awareness of the health and social issues faced by migrant women amongst health care workers, including their circumstances and availability of social and financial support.

Increase awareness of the difficulties faced by migrant women who access maternity services including their differing expectations, cultural issues and lack of understanding of NHS.

As well as maternity staff, there is a need to ensure all NHS staff coming into contact with migrant women are non-discriminatory, and are aware of the potential vulnerability of some migrant women.
4. AVAILABILITY OF ADDITIONAL SUPPORT

For many migrant women, health care services alone are unlikely to address all their needs. The research report highlighted the complex social situations that migrant women often find themselves in and how socially isolated many women are. The green maternity notes used across the West Midlands now include a social risk assessment tool which should be completed for all women accessing maternity service. However the assessment tool needs to be backed up by well developed referral pathways to ensure women are able to access the support they need.

DOULA

For pregnant women who are isolated with little support available from family or friends, a doula can help provide the essential emotional support needed during pregnancy. The Birmingham Starfish Doula project is run by a team of volunteers who are on-call 24 hours a day to ensure women do not need to go through labour on their own. The volunteers aim to meet with the pregnant women before their due date and then will provide transport or a taxi to get the woman into hospital when she goes into labour. The doulas then support the woman throughout her labour and beyond.

After the birth the doulas can provide transport home for the woman and a member of the team will visit daily, if required, for up to 2 weeks to help with cooking/cleaning/washing/shopping/childcare etc. There is no charge to users of the service and all volunteers have received training and are CRB checked.

The doula project takes referrals from anyone including self referral and are happy to receive '11th hour requests'.

Further information on the Birmingham Starfish Doula project can be found at www.bethelnetwork.org.uk
PREGNANCY OUTREACH WORKERS

For many pregnant migrant women their medical risk of complications is low yet their social situation puts them at high risk, e.g. due to poor accommodation, lack of finances or risk of domestic abuse. For these women, a friendly face and ongoing support throughout their pregnancy can be a lifeline. Pregnancy Outreach Workers in Birmingham offer this support. Initially funded through NRF and now directly from the PCT, there are 26 WTE Pregnancy Outreach Workers across 13 of Birmingham’s most deprived wards. The outreach workers receive a combination of midwifery and direct referrals into the system via a dedicated helpline.

The outreach workers are women from the local community who have received three months of intensive training in dealing with women with a wide range of social risk factors including undertaking CAF training. The outreach workers are encouraged to develop their own directory of local services for the patch they work in allowing them to signpost women to a named person rather than a telephone number. The outreach workers help women navigate their way through the often complex range of support available to them, including benefits, accommodation, childcare, language and counselling support.

‘One of the pregnant ladies didn’t want to engage with statutory agencies during her pregnancy, and wouldn’t open the door to the midwives or social workers who came to visit her. The pregnancy outreach worker gradually gained the trust of women and was eventually allowed entry into her home. Through discussion with the women it became clear that the reason she was refusing to meet with the midwives or social workers was due to her embarrassment that she could not afford to carpet her home. The poor state of her accommodation and lack of basic comfort made the woman fear that her new baby would be taken away from her. The pregnancy outreach worker was able to help the woman complete an application for a small grant making organisation who were able to fund carpeting for the lady’s home. The outreach worker helped the women select the carpet and following it being laid, was able to encourage her to engage with the midwives and social workers.’

The pregnancy outreach workers work with the women through regular home visits throughout their pregnancy until two weeks after the birth when they hand over to family support workers or health visitors. The outreach workers speak a number of community languages between them and a number are working towards NVQ’s.

Increasing referrals into the service is an ongoing challenge requiring partnership working with midwifery services to raise awareness of the service and to demonstrate the benefits of referral. The FGM midwives at Heartlands hospital are particularly appreciative of the support the Somali speaking outreach worker can offer them by attending the clinics.

The Pregnancy outreach worker service is going to be formally evaluated through a Randomised Controlled Trial undertaken by the CLARCH (Collaborations for Leadership in Applied Health Research and Care) study at Birmingham University. This is a challenge due to the complex nature of the service but it is hoped that the benefits of the service will be captured by the study.

For more information on the Pregnancy Outreach Service contact:
Vicki.Fitzgerald@gatewayfs.org
Migrant women may have additional medical needs which can have an impact on their pregnancy, including HIV, TB, rheumatic heart disease, female genital mutilation and experience of domestic abuse. The CEMACH report identified that a number of maternal deaths resulted from these conditions and that in these women none of them had a routine medical examination during their pregnancy, missing the opportunity for remedial treatment.

The report recommended that migrant women should have their medical history taken and a clinical assessment of their overall health at booking or as soon as possible thereafter. It included that where a women is from a country where FGM is prevalent, they should be sensitively asked about his during their pregnancy to allow options for management of the FGM to be agreed.

Maternity services need to ensure appropriate referral pathways are in place for women with additional medical needs. Links to specialist providers and voluntary sector support organisations should be developed with clear referral pathways. Patient information leaflets should also be made available in a range of appropriate languages.
There are a large number of voluntary sector organisations working within the West Midlands who can offer support of some kind to pregnant migrant women. In many instances these organisations are plugging the gaps which health and social care services should themselves be addressing. This work largely goes unnoticed by statutory services and if usually underfunded and overstretched. Voluntary sector organisations have a great deal of experience in working with vulnerable and hard to reach populations, and have often developed innovative approaches to working effectively with these groups within limited resources.

BIRMINGHAM AFRICAN WOMEN’S SERVICE

It is estimated that almost 66,000 females in England and Wales are affected by Female Genital Mutilation, a controversial traditional practice that takes place in many parts of sub-Saharan Africa. Migration of women from countries that practice FGM has increased in recent years, resulting in an increase in the number of women with obstetric needs as a consequence.

In 2002 a midwifery-led FGM service, the African Women’s Service was set up at Birmingham Heartlands Hospital to improve the care of women who have undergone FGM. The service aims to decrease the number of women with FGM who receive inappropriate interventions such as unnecessary caesarean sections and to increase education of staff at the hospital.

The service offers de-infibulation at 20 weeks gestation in accordance with guidelines form the Royal College of Obstetricians and Gynaecologists (2003) as well as providing women with pre-and post intervention counselling and support. Through the training and education of staff, de-infibulation can also take place during labour where requested or where the woman has not disclosed her FGM.

Knowledge of the service has spread through local communities and further afield, with one in ten women booking at Heartlands now having undergone FGM. A lack of midwifery-led FGM services across the country has resulted in some women travelling long distances to access the service.

The midwives who run the African Women’s Service are also part of the Birmingham Against FGM working group, who meet regularly to develop strategies to help women affected by FGM as well as to promote elimination of the practice in Birmingham.

For further information on the Birmingham African Women’s Service contact: alison.hughes@heartofengland.nhs.uk
Through the review of good practice undertaken in this report it became clear that health services often have limited awareness of the voluntary sector organisations which work in their area. There is a need for PCTs to undertake scoping exercises to identify and engage with local charities.

PCTs should explore opportunities for joint working with voluntary sector organisations. There is a need to be mindful, however, of over burdening these organisations with work that statutory agencies should be providing themselves. Opportunities to commission voluntary sector organisations to provide additional support services are likely to provide a more cost-effective solution than setting up replica services within the NHS.

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**FROM OUTSIDE TO INVOLVEMENT**

‘From OUTSIDE to IInvolve’ is a partnership project in Walsall involving NHS Walsall, Walsall Council, WELCOME (West Midlands Ethnic Liaison Committee), WARMA (Walsall Asylum Seeker, Refugee and Migrant Association), WRASSA (Walsall Refugee and Asylum Seeker Support Association), WRASMAIF (Walsall Refugee, Asylum Seeker and Migrant worker Inter Agency Forum) and Walsall Citizens Advice Bureau.

The project aims to improve access to health and social care for new migrant communities through a community development approach, using social networks and the arts as tools to engage and explore the needs of this vulnerable community. Migrant community development workers and volunteers from within the migrant communities will facilitate communication between members of the communities, voluntary groups, and health and social care service providers and commissioners.

The project, funded by the Migration Impacts Fund, aims to:

- Raise awareness of health and social care services amongst migrants by providing information in accessible formats and locations
- Strengthen migrant community and voluntary networks and give them a stronger voice in Local Involvement Networks
- Investigate and address barriers to accessing local services
- Improve information flows and partnership working between all agencies involved with new migrant communities

For more information on “From OUTSIDE to IInvolve” contact Debra Slade at Walsall Council (sladed@walsall.gov.uk) or Kate Warren at NHS Walsall (kate.warren@walsall.nhs.uk)
The Common Assessment Framework (CAF) process was developed to improve multi-agency working to safeguard and promote welfare in children. The CAF provides a standardised approach to assessing and co-ordinating services around the needs of the child. The CAF is used for children who have needs in any of the following areas;

- Children’s developmental needs
- Parenting capacity
- Family & environmental factors, and any specific needs of the parent/carer

Children (including the unborn child) of migrant women can face multiple problems which may impact on the wellbeing of the child. Migrant families often require the support of multiple agencies including housing and benefits support, they may also need support to address issues such as domestic abuse and mental health concerns which could affect the wellbeing of the unborn child. The CAF process can be initiated by midwives where they identify that the mother and unborn child have additional needs which require integrated support from a number of agencies that cannot be provided by maternity services alone. The CAF process is designed to reduce the need for multiple assessments and should help streamline the support received by the family.

Efforts are being made to improve awareness and to increase referrals into the CAF process by midwives; including providing training for midwives and providing support with conducting a CAF. It should however be noted that immigration status and new case law can create barriers to progress in joint working which may affect the CAF process.

Migrants who are in the asylum process often face financial hardship due to the minimal support they receive and the restrictions on working. In particular failed asylum seekers and those with No Recourse to Public Funds are in perilous situations and often find themselves destitute. Local authorities have a duty of care towards migrant families, but this support is often heavily restricted and not forthcoming.

The research study identified that many women were not aware of what financial support and grants they were entitled to. Those who are aware often find the application process complicated, particularly when they don’t speak English. Pregnant migrant women need to be supported to access the support they are entitled to.

Pregnant women and new mothers who have no recourse to public funds are of the most vulnerable individuals in our society. All statutory agencies need to work hard to ensure these women do not fall through the net and are offered the support they need.
<table>
<thead>
<tr>
<th>Single British Woman</th>
<th>Single Asylum Seeker supported by UKBA under section 95 or subsistence only</th>
<th>Single Failed Asylum Seeker supported by UKBA (section 4 support)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unemployed</strong></td>
<td>Not allowed to work</td>
<td>Not allowed to work</td>
</tr>
<tr>
<td><strong>Support throughout pregnancy</strong></td>
<td>Support throughout pregnancy</td>
<td>Support from 32 weeks* (support prior to this is only available for those who apply for voluntary return)</td>
</tr>
<tr>
<td><strong>£50-£65 per week dependant on age</strong></td>
<td>£35.52 per week (plus £3)</td>
<td>£35.39 per week on a payment card (plus an additional £3/wk from 34 weeks)</td>
</tr>
<tr>
<td><strong>£690 maternity grants</strong></td>
<td>£300 maternity grant, usually obtained after birth</td>
<td>£250 maternity grant in vouchers, usually obtained after birth</td>
</tr>
<tr>
<td><strong>Housing assistance</strong></td>
<td>No-choice accommodation, bills paid</td>
<td>No-choice accommodation, bills paid</td>
</tr>
<tr>
<td><strong>Free healthcare</strong></td>
<td>Free health care</td>
<td>Free primary healthcare (where able to register with a GP), free prescriptions through the HC2 scheme*. Charged for secondary healthcare*</td>
</tr>
<tr>
<td><strong>Free healthy start vitamins</strong></td>
<td>No access to healthy start vitamins</td>
<td>No access to healthy start vitamins</td>
</tr>
</tbody>
</table>

*Delays in the processing of support claims can result in women being left without support prior to giving birth*
There is a need for better partnership working with voluntary sector organisations to ensure migrant women can be linked with available additional support.

Early identification of medical and social risk factors is required along with comprehensive referral protocols.

Migrant mothers should be supported to access the financial support which is available to them.

Destitute women require urgent assistance, maternity services should act as advocates to ensure these women are able to access the financial and social support they require.
MATERNITY CARE PATHWAYS

The previous section sets out the recommended standards which maternity services should be reviewing themselves against in order to ensure they are delivering migrant friendly maternity services. It is recognised that the level of additional support and services required will depend on the size and vulnerability of the local migrant populations. The availability of additional support in the community will also vary between urban and rural areas.

The following care pathway outlines the recommended support required to ensure the needs of migrant women are identified and addressed. The pathway is presented as a model care pathway based on examples of good practice and discussion with key professionals working within maternity and migrant health services. The aim is for this care pathway to be used as a tool to help stimulate discussion around the development of local care pathways to meet the needs of migrant women. Development of a local care pathway for migrant women will help ensure that local services are delivering appropriate and joined up services to address the needs of this vulnerable group.
Community Midwife
– make appointment
for booking - Is Interpretation required?

Booking Appointment

Standard Midwifery
Led-Maternity Care

- Dating Scan
- Anomalies Scan
- Screening
- Community Midwife appointments

Labour

Normal Post-natal Care

Comprehensive post-natal handover to Health Visitor

Social – can be instigated at any point in AN or PN care

Health Visitor
Referral in pregnancy and if available refer to link/outreach worker

Initiate CAF referral

Link in with local organisations

Local Children’s Centre for support & classes e.g. ESOL

Does patient have health conditions which may affect pregnancy?

Obstetric

Referral to obstetric &/or specialist Services e.g. FGM

Local AN / parentcraft class options: e.g. women only, community languages

Pharmacy

CMW direct contact e.g. via children’s centre

GP

• Book interpreter for all appointments.  
  • If immediate visit needed, use language line for instant translation.  
  • Provide translated leaflets where available  
  • Ensure language needs, details of translators & what has been discussed and decided are recorded in patients notes

• Consider using doula for support in labour

• Is patient high social risk?

• Is support from >2 agencies required?

• Is woman destitute, significantly deprived or vulnerable?

• Is woman socially isolated?
CONCLUSION

The research undertaken by Birmingham University into the experiences of migrant women accessing maternity services and the views of those delivering maternity services have highlighted where maternity services are failing to meet the needs of these vulnerable women. In particular it demonstrated how migrant women can become lost within the maternity system, leaving them feeling disempowered and frightened throughout their pregnancy.

The resources in this toolkit should help local maternity services to review their existing maternity care pathways to ensure they are adequately addressing the issues raised in the research. The aim should be to put migrant women at the heart of their maternity care to ensure they are able to access the required support to give them and their baby a healthy start in life.

The toolkit highlights the four key areas which should be considered as part of a review of local maternity services including;

- Access to clear information for both the woman and those organizing maternity care, ensuring adequate interpretation services are available to improve communications
- Ease of access to health care services for migrant women regardless of immigration status
- The attitudes and cultural awareness of health care staff to ensure women are feel welcomed and supported by maternity services
- The availability of additional support for women who require it, including those with no recourse to public funds and victims of FGM and domestic abuse.

The model care pathway presented in this document is intended for use as a basis for local care pathway development or as a reference to compare against existing pathways. Information on a number of examples of good practice from around the West Midlands should help provide ideas for local innovation and dialogue with local voluntary sector providers. Local reviews of maternity care pathways will also be supported by the links to national policy documents and data on migrant populations to help scope local migrant needs. Finally, reference to the QIPPP, Quality, Innovation, Productivity, Prevention and Partnership programme highlights how improving maternity care for migrant women should not be overlooked at a time of financial pressure and how large savings can be made locally by ensuring the delivery of appropriate care for migrant women.
**DEFINITIONS**

**Common Assessment Framework (CAF):** The CAF is a standardised approach to conducting assessments of children’s additional needs and deciding how these should be met. The CAF promotes more effective, earlier identification of children’s needs particularly in universal services.

**UKBA =** The UK Border Agency is responsible for securing the UK border and controlling migration in the UK. The UKBA manages border control for the UK, enforcing immigration and customs regulations. The UKBA also considers applications for permission to enter or stay in the UK, and for citizenship and asylum.

**No Recourse to Public Funds (NRPF):** Individuals who have been refused asylum and reach the end of the process are deemed to have ‘No Recourse to Public Funds’ The following groups of migrants have No Recourse to Public Funds;

- **Unsuccessful asylum seekers**
  An asylum seeker whose claim for asylum has been fully and finally determined and has been refused asylum, or any leave to remain in the UK. All support and/or accommodation from the Border & Immigration Agency (BIA) ceases 21 days after the decision to refuse asylum is been made. Cessation of support and accommodation only applies to single adults or childless couples, as families will continue to receive Section 95 support. (We recognise there may be other reasons why former asylum seeking families may be destitute.)

- **Illegal immigrants**
  Individuals who entered the UK without the necessary entry clearance.

- **‘Overstayers’**
  Individuals who previously had formal ‘leave to enter’ or ‘remain’ in the UK but whose period of leave to enter/remain has expired and a fresh application for leave to remain in the UK was not made within the required timescale.
• **Victims of domestic violence who are subject to immigration control**

These individuals may fall under one of the other forms of immigration status, generally they may be here under a ‘spouse visa’ arrangement.

• **Former unaccompanied asylum seeking children**

Children who arrived in the UK unaccompanied by a responsible adult and are assessed to be under 18 become the responsibility of the Local Authority in the area where they initially present. In many cases an individual will be entitled to leaving care support, under The Children (Leaving Care) Act 2000, until they are 21 (to 24 if in further education), however this is not always the case and former care leavers may become destitute at either 18 or 21. Local Authorities may support some individuals who turn 18 for a period of time, but at present there is no specific funding for former unaccompanied asylum seeking children whose asylum claim has been refused and turn 18.

• **A8 European Union citizens & A2 countries**

Individuals here under the workers registration scheme for the 2004 accession countries are entitled to register for work under the Workers Registration Scheme, their ability to access Public funds is dependant on them having worked within the UK for a specified period of time. In some situations an individual may be injured at work and be unable to return to work, yet not satisfy the entitlement criteria for state benefit etc.

**Destitution:** According to the Immigration and Asylum Act 1999 a person is deemed destitute if:

- They and their dependants do not have adequate accommodation or any means of obtaining it (irrespective of whether their essential living needs are met) :or
- They and their dependents have adequate accommodation or the means of obtaining it but cannot meet their essential living needs.

Asylum seekers who have been receiving UKBA support already fall into this category by virtue of the fact that they were granted asylum support originally.

There are several routes into destitution, including,
• Ill health, pregnancy or other change in circumstances in economic, illegal or ‘irregular’ migrants
• Domestic violence for migrants in the UK under a spousal visa
• Turning 18 or 21 for former asylum seeking children
• Asylum claim is finally rejected