

caring

for vulnerable migrant women

RCM pocket guide for midwives and
maternity support workers caring
for vulnerable migrant women



Royal College
of Midwives



Background

Over 82 million people were forcibly displaced globally by the end of 2020, driven mainly by conflict (UNHCR Global Trends 2018).

In recent years, Europe has experienced an unprecedented influx of refugees, asylum seekers¹ and other migrants. This guide has been produced to support midwives and maternity staff in the vital role that they play in providing immediate and responsive care to this group of women.

What is a migrant woman?

Migrant women are a diverse group, some of whom are highly vulnerable. Some women may have escaped conflict in their home country, faced dangerous journeys to the UK, left family members – including children – behind, and may live in the UK with no social support network.

In recognition of the fact that every woman's circumstances are different, the contents of this guide are generically designed to serve as a practical resource, setting out principles of good care, examples of best practice and signposting for further support.

¹ A person who has applied for protection as a refugee and is awaiting a decision on their claim.

COVID -19 update

Overseas visitors to England, including anyone living in the UK without permission, will not be charged for:

- testing for COVID -19 (even if the test shows you do not have the virus)
- treatment for COVID -19, including for a related problem called multisystem inflammatory syndrome that affects some children
- vaccinations against COVID -19

No immigration checks are needed for overseas visitors if they are only tested, treated or vaccinated for COVID -19

Latest updates

The latest updates on COVID -19 charges for migrants can be found on via <https://www.gov.uk/guidance/covid-19-migrant-health-guide>

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Duty of care by health staff

1

Attending to the needs of all women is of paramount importance. Maternity care must not be refused, delayed or in any way disrupted by issues such as immigration status, charging or ability to pay².

You should provide woman centred care that is culturally sensitive and respectful of human rights. Continuity of care should be a priority.

Continuity of care by midwives has the potential to build trust between the woman and her midwife. It avoids re-traumatising with painful repetition of a story and can help vulnerable women feel more confident in accessing services.

² The National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2017, 3 (1A)

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Particular needs of vulnerable migrant women

Every woman and her circumstances will be different. Many will have had traumatic experiences. Women may need support with basic needs, such as food, clothing and shelter. A lack of knowledge of local services and the healthcare system may be a barrier to accessing appropriate care in a timely way.

Language needs and lack of local knowledge can impact on women's confidence in using amenities, such as public transport, children's centres and other local services. Eligibility and sources of financial support will vary, according to immigration status.

Professional interpreting services must always be used, to ensure effective communication and confidentiality. Never rely on family members, or friends, or anyone else accompanying a woman to her appointments, however keen they are to assist.





Personalised care and coordination will be essential to addressing each woman's individual needs.

Priorities for initial assessment

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Communication

Languages spoken and levels of literacy need to be established and appropriate professional support obtained.

-  **Do** Be mindful of body language, avoid terminology and consider explanations
-  **Do** Make effective use of interpreters, speak directly to the woman using eye contact, and bear in mind that extra time will be needed for appointments
-  **Do** Consider email contact or take note of other phone numbers, if necessary
-  **Don't** Rely on family or friends for translation

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Ensuring safety

- Orientate** the woman to your hospital, clinic or children's centre
- Introduce** her to key people, such as team colleagues, MSWs and administration staff, if appropriate
- Ensure** that she knows that she is in a place of safety
- Alert** the safeguarding team should be alerted if there are any concerns
- Assess** how safe the woman feels in her home environment, or employment and how she is able to access care

To provide immediate safety for someone and allow for a full health and social care assessment, consider admission.

Managing risk

There are safeguarding responsibilities for both mother and baby and while other agencies may not act until the baby is born, it is vital that any concerns are recorded and shared by the midwifery team via the appropriate assessment and referral frameworks as soon as these arise.

Key questions and observations:

1. Ask where a woman has come from, when did she arrive in the UK and how did she get here.
2. Is she in any immediate danger?
3. Are there any pre-existing safeguarding concerns?
4. Is she registered with a GP?
5. What financial resources does she have, including asylum support, benefits, or none?
6. Assess the level of support you think is required and make a personalised care plan.

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Confidentiality

Building a trusting relationship is of vital importance and women need to know that the information they give is held securely.

Any meetings and discussions should take place with respect for privacy and dignity. Advise women that personal information collected in healthcare settings will only be shared with the Home Office under limited circumstances for cost recovery and safeguarding purposes.

NMC Code 5.4 "Share necessary information with other health and care professionals and agencies only when the interests of patient safety and public protection override the need for confidentiality"

Removing barriers to ongoing care

3



Ensure contact numbers are given, especially for use in the cases of emergency. Check locations details for future appointments – providing clear directions, if required



Be aware that travel costs, confidence and lack of local knowledge may impact on a woman's ability to access services



Consider offering appointments at home and be flexible wherever possible

3

Support

Many women will be in need of practical support, having financial difficulties and housing needs. Some may experience extreme hardship and destitution as a result of welfare and support provision being restricted to very low levels and redeemable on a card, rather than given in cash.

Official documents, including a MAT B1 and FW8, should be provided without delay. Signposting information can be given to local charities, food banks, children's services, befriending and advocacy services which can offer support and basic resources.

It can be useful to explain the context of antenatal care in the NHS in the UK. Migrant women may have very different expectations of health and maternity services, based on their own previous experience. Consider her needs as an individual woman; cultural, social, spiritual. Is she able to talk about these issues, is there someone better placed to respond? Consider contacting hospital chaplains – these are able to offer support to members of all faiths and are trained in pastoral care.

Advice and resources

The **Asylum Support Appeals Project - ASAP (asaproject.org)** operates an **advice line for asylum seekers** on welfare, housing and legal issues.

Mental health

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The experiences and responses of vulnerable migrants and refugees can vary widely and change over time:

1. Women may feel elated on first arrival.
2. Women may be affected by multiple losses and grieving for people and places left behind.
3. Women may feel overwhelmed, distressed and anxious, or numb and detached.
4. Some women may have reactions which impair their ability to care for themselves and their family, or make them more vulnerable to danger.

However, it is important to recognise that many stress responses are natural ways in which the body and mind react to stressors and should not be considered abnormal.

4

The GOV.UK Migrant Health Guide³ mental health page gives a useful summary of the relevant mental health issues, and how psychological and social distress can manifest, including:

- emotional (sadness, grief, fear, frustration, anxiety, anger and despair)
- cognitive (loss of control, helplessness, worry, ruminations, boredom, and hopelessness)
- physical (fatigue, problems, sleeping, loss of appetite, medically unexplained physical complaints)
- behavioural and social problems (withdrawal, aggression, interpersonal difficulties)

The World Health Organization (WHO) has produced a guidance note with advice on protecting and supporting the mental health and psychosocial wellbeing of refugees, asylum seekers and migrants in Europe. It explains the challenges to mental health and psychosocial wellbeing faced by refugees and migrants and describes common mental health and psychosocial responses they may experience.

For assessment, treatment and ongoing support, a referral should be made to specialist perinatal mental health services.

3 Migrant Health Guide. 2017. Public Health England. www.gov.uk/government/collections/migrant-health-guide

Financial support for migrant women and children

Some women have their claims for asylum rejected, leaving them without any means of support and extremely vulnerable.

Asylum seekers who are awaiting a decision by the Home Office on their asylum claim, or are in the process of appealing a decision, may be able to claim some additional grants and payments. In these circumstances, women should write to the Home Office providing either a MAT B1 or a letter from her midwife or GP, as evidence of pregnancy and request these additional funds.

Where to get help

The **Asylum Support Appeals Project** can provide legal advice, welfare and housing support.

The **No Recourse to Public Funds Network** gives guidance on the duties and responsibilities of local authorities and partner organisations to this group of people, giving information on provision of housing, meeting care needs and emergency support.

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Violence, exploitation, choices and consent

According to Office of National Statistics (ONS) figures⁴, one in four women is a survivor of sexual violence. Forced migration increases the likelihood of this happening. It can take time for these experiences to be disclosed.

1 in 4 women is a survivor of sexual violence



⁴ Office for National Statistics (ONS). (2018) Domestic abuse in England and Wales: year ending March 2018. Published online: ONS.

According to a report by Maternity Action⁵ women were found to use a range of survival strategies, including transactional sex, illegal work and dependence on relationships that are unstable or abusive. Their lives and circumstances can be extremely precarious, and they may not be aware of the options for seeking protection from abuse.

Appropriate referrals should be made if concerns arise.

Key points:

- Some migrant women's immigration status will be linked to their partner's and this may add another level of vulnerability.
- Some women may feel triggered by intimate examinations. Appropriate enquiries should be made, together with sensitive explanation around choices and consent.
- It is of crucial importance to clearly record accurate and detailed information in relation to FGM, rape and sexual abuse. This evidence will be used to determine whether there may be any exemptions from NHS charging. In making NHS charging decisions, Overseas Visitor Managers (OVMs) will rely

on notes and evidence recorded in medical records, and should not require any additional clinical information from the woman. There should be no need for further interviews.

- Victims and suspected victims of modern slavery are one of the few groups of people for whom NHS care is entirely without charge. Information on the National Referral Mechanism (NRM) (England & Wales) is a framework for identifying and referring victims of modern slavery and ensuring appropriate support.
- Health professionals have no duty to report to authorities outside of the health and social care system, except on matters related to safeguarding. All healthcare workers have a professional responsibility to keep all patient information confidential, unless it is disclosed with the patient's consent, or for safeguarding purposes.

Where to get help

Online information, advice and resources are available from the **Modern Slavery Helpline** or by calling **08000 121 700**. Refer to the Gov Migrant Mental Health Guide for womens health for information on sexual and gender based violence.

Female genital mutilation - FGM

What is FGM?

Female genital mutilation (FGM) is any procedure that involves the partial or total removal of the external female genitalia, or any other injury to the female genital organs for non-medical reasons⁶. FGM is a global problem with an estimated 200 million women and girls in approximately 30 countries (mainly in Africa) living with its consequences. It is an illegal practice in the UK and in many other countries.

Migration from practising countries has seen an increase in the number of girls and women living with, or at risk of, FGM in the UK.

It is crucial that midwives can identify survivors and girls at risk of FGM, in order to address the health and psychological care needs of this diverse population and understand the mechanisms for safeguarding girls at risk of FGM.

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Key points to consider:

- FGM is a severe form of violence against women and girls and a violation of human rights
- FGM should be treated as child abuse – as per guidance
- Where there is one form of violence against a woman or a girl, there may be other types of violence which must be explored
- Ask every pregnant woman if they have experienced FGM. Midwives should use communication strategies that put women at ease, avoid jargon, are sensitive and adopt a non-judgemental approach in order to support survivors to disclose. Some women may not be familiar with the term FGM as different community terminology is often used to describe the practice
- For survivors of FGM, the interaction with a midwife may be the first time that they can speak about and are able to disclose the abuse. For some women, this may also be the first time they have been made aware that FGM has taken place
- Offer de-infibulation to FGM survivors early in pregnancy, together with psychological support, as a measure of good practice. The NHS offers de-infibulation and other services via a number of national FGM Support Clinics, accessible by midwifery referral

- Report any incidence or risk of FGM in a person under the age of 18, as per your Mandatory Reporting Duty
- Ensure that you contribute to the NHS mandatory data collection on FGM in your area of work to support forecasting and service development

For further info, Advice and resources

The **FGM Specialist Network**: an e-platform created by the RCM and partner organisations that provides a secure forum for discussion, information sharing resources, support, links and appropriate data on FGM.

FGM Specialist Midwives Network www.fgmnetwork.org.uk

National FGM Centre: A partnership between Barnado's and the Local Government Association providing support for survivors of female genital mutilation www.nationalfgmcentre.org.uk

Daughters of Eve: Works to protect health rights of young people from female genital mutilation practising communities www.dofeve.org

Women who decline services

1. **Check their understanding** and ensure they know what these services offer
2. **Ask about possible barriers**, such as financial costs, work commitments or family approval
3. **Respect women's choices** – not everyone wants support
4. **Leave the door open**, ensuring that a woman knows that she can access support later
5. **Explain** that declining parts of a care package will not reduce the overall bill for maternity care, if chargeable
6. **Safeguarding children's services** cannot be declined

Women who may suddenly relocate or avoid accessing services

Migrant women may be in temporary accommodation or likely to move at short notice. This causes fragmentation of care and loss of continuity.

To mitigate this:

- Reinforce to the woman at the first time of meeting that, as her named midwife, she should let you know if she is relocating and where she is moving to. Consider placing an instruction in her notes with your contact details for use by any future care giver
- Ensure notes are always complete and up to date
- Include blood test results, scan reports, safeguarding alerts, medical, physical and mental health details

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When concerns arise over relocation of migrant women during pregnancy

Follow these steps...

- Health professionals who have any concerns that a pregnant women is due to be relocated during the protected time (defined as 6 weeks pre EDD and 6 weeks post birth) should contact AsylumSafeguarding@homeoffice.gov.uk
- This inbox is monitored Monday-Friday 8.30am-16.30pm.
- Health professional should state "Escalation of relocation during pregnancy" in the subject heading, to allow team to triage and quickly identify escalations
- An allocated staff member from Home Office Central Admin Safeguarding team will acknowledge receipt and confirm that they will investigate
- The original referrer will be contacted by Home Office staff with outcome of investigation and update to proposed relocation

Scenarios and suggestions

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Klea

Klea first presents at around 34–36 weeks having just arrived in the UK a week earlier. She reports, via an interpreter, having been sex trafficked from Albania and forced to work in brothels around Brussels, Belgium. When she became pregnant she was transported to the UK in the back of a lorry and released. She is visibly upset talking about her history and reports difficulty sleeping and eating and frequent nightmares. She has had no antenatal care.

Be alert to:

01

Immediate safety and need for housing

02

Mental health

03

Extra time needed for booking

04

Signposting to sexual health services

Elizabeth

Elizabeth came to the UK from Nigeria six years ago on a student visa, but this has now expired. Her family had saved to send her overseas to be educated and have since disowned her. 21/40 weeks pregnant, she is living in the same house as the father of the baby, now in a new relationship, and other people she came to know through him. She usually sleeps in the front room and must wait for everyone to go to bed before she can. She has no financial support and relies on a church for food hand-outs. She has been told she must leave the property before the baby arrives. With no recourse to public funds, she is terrified of being billed for her care and deported.

Be alert to:

05

Domestic abuse

06

Likelihood of avoiding services

07

Lack of financial resources and ability to safely provide for her baby

Medya

Medya arrived from Iraqi Kurdistan with her husband and four children six months ago. Initially staying with friends, the family became homeless and were sent to live in Home Office Initial Accommodation (IA) two weeks ago while awaiting decision on asylum. Medya had one midwife appointment in London but was moved before her first scan. She is 26/40 by LMP. She reports experiencing FGM as a young child and tells you she became very sad after the birth of her third child. She is anxious about the safety of family left behind in Iraq.

Be alert to:

08

Mental health and trauma

09

FGM – are her children at risk?

10

History disclosed previously to maternity services

Amal and Hiba

Amal has just been discharged home from hospital with baby girl Hiba who is three days old. They are living in one small room with Amal's husband and three year old son in dispersal accommodation. The property appears damp and cramped, with a number of other families also living there. You notice rat faeces on the floor while walking through the kitchen. Amal does not appear to have any baby equipment and reports the family are all sharing one bed.

Be alert to:

11

Child wellbeing and development

12

Environmental health

13

Safe sleeping advice

14

Charities that may offer practical assistance and support

Parisa

Parisa is an Iranian woman living in a house belonging to extended family. She is 32/40 weeks pregnant and has an uncomplicated pregnancy. She has missed two consecutive antenatal appointments and two earlier in the pregnancy. She speaks good English but has no phone, so you are unable to contact her.

Be alert to:

- 15 **Information she has not yet been able to disclose**
- 16 **Living arrangements, long term**
- 17 **Access to financial and other resources**

For further information and advice

Sexual health services: www.nhs.uk/service-search/sexual-health-information-and-support/locationsearch/734

STIs: www.nhs.uk/conditions/sexually-transmitted-infections-stis

Facts and fiction

Facts

GP registration is not dependent on immigration or residency status

Immigration status is not relevant and women do not need a fixed address or identification to register with a surgery. GP practices have a legal obligation to register all patients for primary care, unless their lists are full. Also, they will refer pregnant women to the health visiting service for pre-birth assessments, further support, links to local networks and relevant organisations.

Asylum seekers receive very few benefits and these are not in cash

Asylum seekers receive monetary assistance equivalent to £5 per day, which is credited to a special payment card. Pregnant women receive an additional £3 per week⁷.

All migrants need specialist care or have experienced trauma

No. Many migrant women will be in the UK by choice and understand the immigration and health and social care systems; they may be happy, healthy, financially independent and well supported.

All migrants are chargeable for NHS care

No. Residency is the key and establishing this is not a midwife's responsibility.

British people all have free access to the NHS

No. Residency status and other factors determine chargeable status.

Tourists cost the NHS hundreds of millions of pounds

No. The scale of health tourism is overstated. Estimates say it's less than 0.06% of the NHS budget.

Midwives have a duty to report immigration status

No. Individual NHS staff do not directly report information to the Home Office. The NHS can share personal information about a patient with the Home Office and vice versa under limited circumstances related to cost recovery and safeguarding.

Legal position

The duties of midwives with respect to charging

All maternity care (including termination of pregnancy) is classed as 'immediately necessary' or 'urgent'. Women should not be refused this care, or face delays in accessing care, for any reason relating to charging practices. Midwives are regulated by the Nursing and Midwifery Council Code, Professional Standards of Practice and Behaviour for Nurses and Midwives.

For further information and advice

For more information on the NMC Code visit [The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates - The Nursing and Midwifery Council \(nmc.org.uk\)](https://www.nmc.org.uk/standards-of-practice-and-behaviour-for-nurses-and-midwives)

Please refer to *Maternity Action's Consolidated access guide on improving access to maternity care for women affected by charging* for further information.

Links, resources and support organisations

Migrant Health Guide, which includes a women's health page:

Women's health: migrant health guide - GOV.UK (www.gov.uk)

Maternity Action: www.maternityaction.org.uk

Patients not Passports: www.patientsnotpassports.co.uk

Refugee Council: www.refugeecouncil.org.uk

Shelter UK: www.shelter.org.uk

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