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Meeting the health and social care needs of pregnant asylum seekers; midwifery students' perspectives
Part 3; "The pregnant woman within the global context"; an inclusive model for midwifery education to address the needs of asylum seeking women in the UK

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SUMMARY

Aim: to describe the conceptualisation and development of an inclusive educational model. The model is designed to facilitate pre-registration midwifery students' learning around the health and social care needs of pregnant women seeking asylum in the United Kingdom.
Background: current literature has identified a concern about the standard of maternity care experienced by asylum seeking women accessing maternity services in the United Kingdom. In response to this, a doctorate study was undertaken which focused on examining the way in which a group of midwifery students approached the provision of care for asylum seekers. This study revealed difficulties that these students had both in identifying these women's needs and also in the wider care issues in practice. Consequently, one of the recommendations was to ameliorate these difficulties through midwifery education.
Methods: the key findings from this study were used together with relevant supporting literature to construct "the pregnant woman within the global context" model for midwifery education.
Results: The model is designed to facilitate a holistic assessment of need rather than focusing on the physical assessment at the expense of other aspects of care. It incorporates wider factors, on a global level, which could impact on the health and social care needs of a pregnant woman seeking asylum. It also prompts students to consider the influence of dominant discourses on perceptions of asylum seek;ing and is designed to encourage students' to question these discourses.
Recommendations: this model can be used in midwifery education to prepare students in caring for pregnant women seeking asylum. It may be especially helpful when students have close contact with pregnant women seeking asylum, for example through caseloading. Further research is recommended to evaluate the effectiveness of this model in enhancing the care of asylum seeking women in the United Kingdom.

Introduction

We are increasingly living in a global society. Improved communication and travel are resulting in expanded voluntary migration and consequential ethnic and cultural diversity in the United Kingdom (UK) (Somerville and Sumption, 2009). In addition, war and conflict in parts of the world continues to contribute to the forced migration of people and the ongoing arrival of asylum seekers in the UK. Evidence suggests that some migrants living in the UK are in poorer physical and mental health than the average UK population, which is further compounded for asylum seekers and refugees who have higher rates of morbidity and mortality following their arrival in the UK (Shaw et al., 2006).

Asylum seekers are often portrayed negatively in the UK with the popular press frequently labelling them as bogus and undesirable, coming into the country only to claim generous welfare payments and to benefit from the National Health Service (NHS) (Aspinall and Watters, 2010; Lewis et al., 2008a). Consequently, they may be subject to hostility and discrimination by the general public and there have been reported cases of violent attacks against asylum seekers (Greenslade, 2005). Arguably, this perception has been exacerbated in the current economic climate with asylum seekers being blamed for draining valuable resources from the state (Somerville and Sumption, 2009). However, in reality, asylum seekers are a heterogeneous group of people of different ages, countries and backgrounds who share the commonality of fleeing from atrocities that they have experienced and as such, should be treated as individuals (Ashton and Moore, 2009).

Pregnant women seeking asylum are in a particularly vulnerable situation (Aspinall and Watters, 2010). They are often unsupported

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in their application and are less likely to speak English than male asylum seekers. In addition, they may be pregnant as a result of rape and be traumatised by this experience (Refugee Council, 2009). They are likely to be housed in large accommodation centres where some women have reported feeling unsafe; being verbally and physically abused by male asylum seekers (Dumper, 2002; Aspinall and Watters, 2010). They may be in poor physical and psychological health, possibly suffering from malnourishment, anaemia, communicable diseases and psychiatric disorders (Burnett and Fassil, 2004). In addition, they have more complicated pregnancies and are at an increased risk of maternal mortality (Centre for Maternal and Child Enquiries, Centre for Maternal and Child Enquiries, 2011).

Whilst in the UK, the stress associated with the legal processes around asylum and the fear of an unsuccessful claim and subsequent deportation can further damage the pregnant woman's mental and physical health (Reynolds and White, 2010). In addition, some voluntary migrant women have reported difficulties negotiating their cultural and social identities in their host country and a lack of a supportive social network has been shown to negatively impact on the migrant woman's health (Meadows et al., 2001). This may be exacerbated for the asylum seeker, who in addition, has to face possible deportation, poverty, social exclusion and public hostility (Bollini et al., 2009). Chronic stress can lead to conditions such as diabetes, raised blood pressure, heart attacks, strokes and chronic anxiety and depression (Brunner and Marmot, 2006). Also, in pregnancy, stress increases the risk of prematurity and low birth weight babies (Cross-Sudworth, 2007).

When considering the potential poor health of the pregnant woman seeking asylum, it would appear essential that the she receives good quality maternity care whilst she is in the UK. However, recent evidence suggests that asylum seekers often have negative experiences with midwives mirroring negative public opinions, demonstrating poor attitudes, rudeness and racism (McLeish, 2002; Lockey and Hart, 2004; Gaudion and Allotey, 2008; Briscoe and Lavender, 2009). In one study, midwives described asylum seeking women as health tourists, arriving at Heathrow airport to access the NHS then leave again. Women described midwives as “cruel”, disinterested and unfairly stereotypical (Gaudion and Allotey, 2008). In another study, a woman described being treated “like a dog” by some midwives (Lockey and Hart, 2004, p.786).

The National Institute for Health and Clinical Excellence (NICE), which makes recommendations to the NHS based on systematic reviews of the evidence, states that women with complex social problems, including asylum seekers, are deterred from attending antenatal appointments because of negative attitudes of healthcare staff (National Institute for Health and Clinical Excellence, 2010). When considering the potential poor health of the asylum seeker, it can be argued that this needs urgently addressing. One recommendation from these guidelines is to target the training of NHS staff, including midwives to prepare them to meet the needs of pregnant women seeking asylum. As the next generation of midwives, pre-registration students also require adequate preparation in order to effectively care for asylum seeking women.

A study was undertaken as part of a wider doctorate which is reported in parts one and two of this series (Haith-Cooper and Bradshaw, submitted). This study explored midwifery students' perceptions of the health and social needs of pregnant women seeking asylum. One of the key findings was that midwifery students appeared to be influenced by the negative public discourses, or patterns of thinking as discussed above around asylum seeking when assessing the woman's needs. As a result of this study, “the pregnant woman within the global context” model (see Fig. 1) was conceptualised and developed to be used in midwifery education when preparing students to meet the needs of asylum seeking women. This article will now explore the construction of the model and introduce its potential applicability in midwifery education.

Background to the Model

A vision emerged for a new model for midwifery education, which would address the main findings from the study, together with issues raised in the wider literature (Haith-Cooper and Bradshaw, submitted). “The pregnant woman within the global context” model appeared to fit with this vision. The pregnant woman would be situated in an international setting and midwifery care would encompass factors within this global context which may influence her health. For the pregnant woman seeking asylum, the global context would enable the user of the model to consider the woman's experiences of her home country when addressing her individual needs.

The new model would facilitate a consistent woman centred approach to care by positioning the woman centrally, working with her to identify her individual needs and to facilitate informed choice (Royal College of Midwives (RCM), 2008). In addition, the model would increase the student's awareness of discourses around asylum seeking and how these discourses are (re)produced. It would provide the opportunity to challenge how discourses may influence individual perceptions of pregnant women seeking asylum and their subsequent care.

This vision appeared to mirror the findings from a study, which is now dated but arguably still relevant today. Hart et al. (2001) found that midwifery students in the UK were taught to approach care focusing on the woman's individual needs whilst neglecting to consider wider social structures such as government policy which can lead to inequalities and oppression for some women in society. They concluded that midwifery education should focus on encouraging students to examine how these structures may impact on health. Although it may be argued that the curriculum has progressed since this study was undertaken, the findings from the doctorate study suggest that some students still appear to have difficulty considering the wider social structures influencing health. There is a need to balance an individualised approach to care against assumptions made about groups of women based on their social circumstances (Haith-Cooper and Bradshaw, submitted part 2). Achieving this balance was fundamental in the vision for an inclusive model for midwifery education. It also supports the wider public health role of the midwife; approaching care from a woman centred perspective, but looking beyond the clinical encounter to examine the background factors which may influence the health of the pregnant woman (Edwards and Byrom, 2007). The background factors can be equated to the social structures described by Hart et al. (2001).

No educational models could be found in the health care literature which addressed the vision for this model. However, a wider review revealed Bronfenbrenner's Ecological Systems model which has been used in social work education (Bronfenbrenner, 1994). This was originally developed to examine how child development is influenced not only by individual biology but also by the child's interaction with her/his environment. This environment consists of three layers; the micro, macro and global layers, that contain social structures such as family and school. Change or conflict between structures in any layer or between layers will ripple through to the child and ultimately influence the child's development.

In a similar way, it can be argued that the health of the pregnant asylum seeking woman is influenced not only by her biology but also by her interaction with the social structures contained within the three layers of her environment. Change or conflict between structures will ripple through to the pregnant woman and can impact on her health.

It was envisioned that a model adopting these principles would be a useful tool for midwifery education. It could facilitate the student to identify how the health and social care needs of the pregnant woman seeking asylum could be influenced by her interaction with her environment. It would encourage the student to consider the woman's immediate “family” and community environment and her interaction with the broader societal landscape including the UK and her

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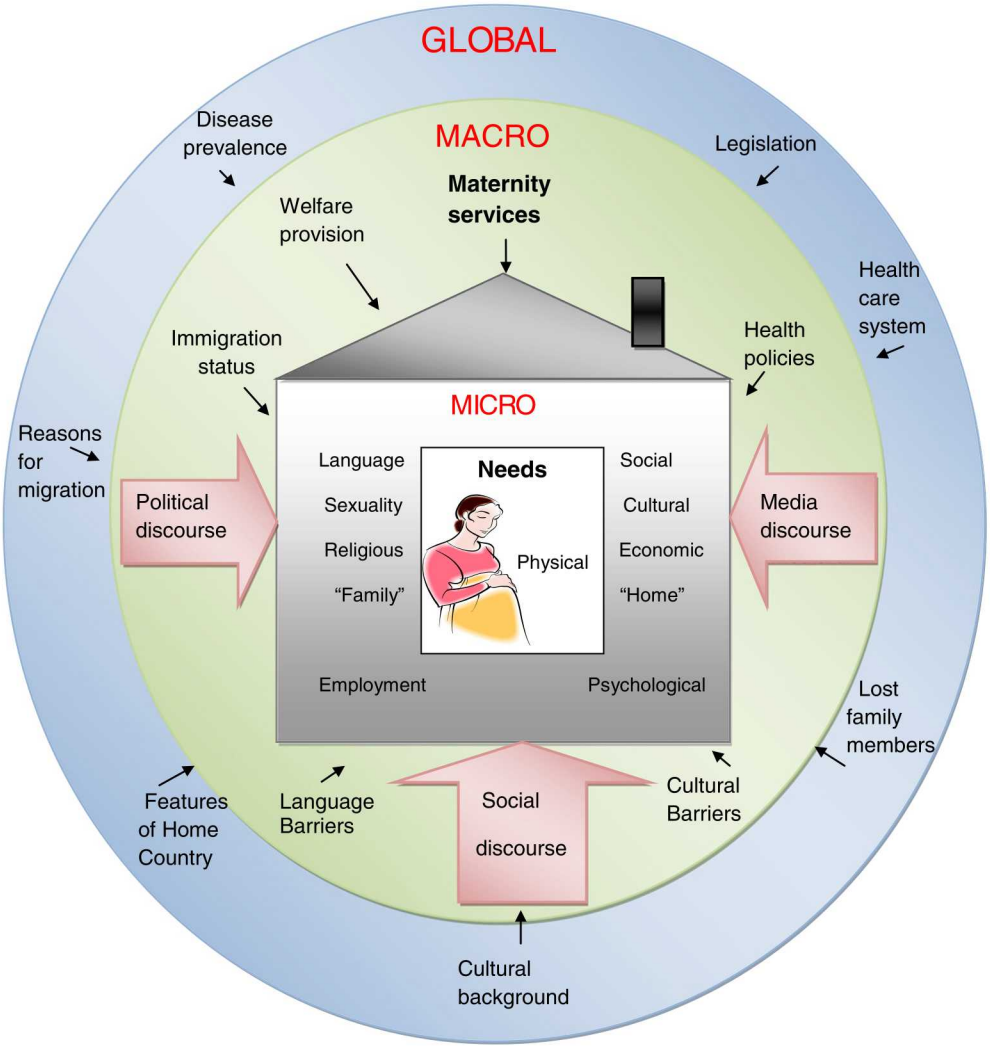

Fig. 1. The pregnant woman within the global context.

experiences of her home country. However, given the complexity associated with Bronfenbrenner's model, it is beyond the scope of this article to provide a detailed application of each aspect of the model. Instead, the intent is to utilise the principles of the three layers and provide an overview of the potential application of these in preparing students to care for pregnant women seeking asylum.

The Micro Layer

The micro layer of the environment is closest to the child (or in this case the pregnant woman seeking asylum) containing the individual's interaction with the social structures with which she has direct contact (Bronfenbrenner, 1994). In this context, this would include the midwife involved in the woman's care and other members of the household within which the woman lives. The household may not necessarily be family members if the woman is an unaccompanied asylum seeker. In addition, the environment may not be considered a home due to the transient nature of asylum seeking and being housed in large accommodation centres (Mulvey, 2010).

For the asylum seeking woman living with her family, it is important to consider her role within the family unit. Some migrant women appear to define health in the context of their family. Ill health is considered the inability to undertake normal family roles rather than considering the individual's symptoms (Meadows et al., 2001). It is essential therefore that the assessment of the woman's health considers the asylum seeker's role within the household. The micro layer, with its emphasis on the woman within her home could facilitate this.

From a midwifery perspective, the micro layer represents the bi-directional relationship between the woman and midwife and the influence that this relationship will have on both parties. The woman placed centrally in the model re-enforces the importance of this relationship. This emphasis mirrors the underpinning philosophy of the social model of midwifery (Walsh and Newburn, 2002). In addition, good social support has been found to be a way for migrant women to cope with the emotional difficulties around migration (Meadows et al., 2001). In particular, the unsupported asylum seeking woman, who may be socially isolated, may benefit from a trusting relationship with the midwife. However, not all women want this close relationship and may request that the midwife, as the expert, makes key decisions about their care needs, especially if the woman has fled from a country with a different health care system (Kent, 2000; Carolan and Hodnett, 2007). Consequently, the midwife should assess how the woman wants to approach and conduct the woman/midwife relationship.

All aspects contained within the micro layer build upon establishing this relationship and represent a holistic approach to care as advocated by Midwifery 2020 (2010). Some migrant women consider health to be holistic, incorporating physical and mental dimensions with religion and spirituality also seen as fundamental to settling into a new country

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(Meadows et al., 2001). Other holistic aspects which influence health during childbirth include cultural, social and language needs (Nursing and Midwifery Council, 2009; Department of Health, 2007). Physical health should only be one dimension of this assessment, not the dominant care aspect, as was found to be the case within the doctorate study, when some students approached care mainly from a physical perspective at the expense of the woman's other health and social care needs (Haith-Cooper and Bradshaw, submitted part 2). Assessing social care needs was considered to be the responsibility of other health professionals. However, in reality, the midwife has a role to play in identifying and referring women to different agencies, including for example 'Sure Start' to address issue such as poverty and social isolation (Ukoko, 2005).

Language barriers can be problematic in maternity services (Cross-Sudworth, 2007). However it is essential that the midwife overcomes these in order to work with the woman in planning her care (Nursing and Midwifery Council, 2009). The recent CMACE report into maternal mortality describes how an asylum seeker, who spoke no English, was stabbed by her husband, who acted as her interpreter (Centre for Maternal and Child Enquiries, 2011, p148). Language barriers were also cited in the case of a newly arrived bride whom the report concluded was either murdered, or committed suicide (Centre for Maternal and Child Enquiries, 2011, p152).

Each aspect of a holistic approach to health should be assessed by the student, but also the aspects in the other layers of the model which may send ripples through to this layer and impact on the woman's health. An example could be that the asylum seeking woman may have experienced female genital mutilation in her country of origin or as identified earlier, may be pregnant as a consequence of rape (Dumper, 2005). These ripples from the global layer could impact on her sexuality and also her psychological and physical health. This necessitates the need for greater knowledge and understanding and enhanced sensitivity within the woman/midwife relationship.

The Macro Layer

Although this layer is described as the outermost layer of the child's environment (Bronfenbrenner, 1994), in the context of the asylum seeking woman, it has been interpreted as encompassing the UK as the country which she has migrated to. This somewhat artificial but deliberate divide between layers has been developed to encourage the student to consider the influence of social structures within the UK on health. This "societal blue-print", contains the national dominant belief systems, laws and policies amongst other factors which may ripple through to the micro layer and influence the interactions between the individual and her immediate environment (Bronfenbrenner, 1994, p. 40). In this context, these ripples have been interpreted as power, with aspects of the macro layer exercising power (identified by arrows), which impact on the woman in the micro layer. In addition, the block arrows represent the social structures, which may be responsible for (re)producing dominant discourses around asylum seeking, discussed earlier (see Haith-Cooper and Bradshaw, submitted part 1). Arrows have been omitted from within the micro layer to illustrate the potential powerlessness of asylum seekers, who are argued as being amongst one of the most marginalised groups of people in society (Squire and James, 2009).

The focus of the macro layer is for the student to consider the aspects within this layer, the direction of power flow and the social structures (re)producing dominant discourses and how they may influence the pregnant woman seeking asylum and her interaction with her environment. An example could be immigration status as highlighted earlier. The UK border agency has the power to decide her immigration status. The uncertainties around this and the fear of being deported may influence her psychological and physical health as depicted within the micro layer. To increase her understanding, the student may need to read around the UK asylum process, an area in which many midwives have been found to lack knowledge (Reynolds and White, 2010)

It is argued that many midwives in the UK are unaware of wider political issues which may influence pregnant women (Leap, 2009). This is despite political understanding being a requirement of the Nursing and Midwifery Council (NMC), the regulatory body for the UK (NMC, 2009). The macro layer is designed to facilitate the student to explore social structures, including governmental level debate and reporting through the media, which may exercise power and (re) produce dominant discourses around asylum seeking. Also, how UK government policy, through for example inadequate welfare provision, may contribute to inequality and oppression for asylum seeking women (Sales, 2002). Stress resulting from living in poverty can impact on physical and psychological health and also increase a woman's risk of experiencing domestic abuse (Cross-Sudworth, 2009; Sales, 2002). It is argued that midwives are ideally placed to speak on behalf of vulnerable pregnant women and to convince politicians to target policies which exacerbate structural inequalities in society (Ukoko, 2007). The global context model could be used to facilitate this.

As discussed earlier, some asylum seeking women have reported negative experiences of maternity care in the UK and dominant discourses have been found to influence some students' perceptions of pregnant women seeking asylum (Haith-Cooper and Bradshaw, submitted part 1). The macro layer is designed to facilitate the student to explore how people in maternity services may (re)produce dominant discourses, which can then ripple through to the micro layer and have an impact upon the experiences of pregnant women seeking asylum. Using the model can thus facilitate the student to challenge such discourses and overcome stereotyping and discrimination that were identified as occurring in maternity services.

The Global Layer

Bronfenbrenner (1994) provides little explanation of the global layer of the ecological systems model. However, in this context, this layer has been purposefully constructed to encourage the student to go beyond the borders of the UK and consider maternal health from an international perspective. In the context of an asylum seeker, this would involve exploring the asylum seeking woman's life in her home country and the impact of this on her experiences once living in the UK.

In the doctorate study, students were engaged in reading around a fictitious asylum seeker's home country. This subsequently appeared to illuminate their understanding of negative experiences that the pregnant woman seeking asylum may have endured before fleeing to the UK. This led to a discussion around the impact of this forced migration on the woman's health. Issues such as how she may have lived, the culture shock of arriving in the UK and the possible similarities between particular aspects of the NHS environment and torture rooms in her home country were also considered (Haith-Cooper and Bradshaw, submitted part 1). Having this enhanced level of knowledge and understanding could facilitate the student to assess how experiences such as these may influence the woman's psychological health and how this can be sensitively addressed.

Another aspect included in the global layer relates to the political and economic situation in the woman's home country and the impact of war and conflict on her wellbeing (Suurmond et al., 2010). She may have war injuries or witnessed atrocities such as torture or the murder of family members (Burnett and Fassil, 2004). In addition, exploring possible reasons for leaving her home country may help in assessing her psychological wellbeing. The woman may have family, including children, who she left behind, or who have been killed or gone missing (Dumper, 2002). Obviously, this could have a significant impact on the woman's psychological wellbeing. Meadows et al. (2001) found that some migrant women had experienced emotional trauma in their

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home country and Burnett and Fassil (2004) identify that post traumatic stress disorder is common in asylum seekers.

It is arguably important that midwives have an understanding of infectious diseases prevalent in the asylum seeking woman's home country, in order that the assessment of her physical health is focused on potential infections (Suurmond et al., 2010). Carolan (2010) identified that women originating from African countries are more likely to have infections such as HIV/AIDS and malaria. Indeed it has been reported that between 2006–2008 six recently arrived migrant women died as a result of sepsis (Centre for Maternal and Child Enquiries, 2011, p85). In addition, wider issues around asylum seeking may influence physical health such as malnutrition caused by extreme poverty or a lack of resources during the journey to the UK, resulting for some in serious underlying medical conditions (Centre for Maternal and Child Enquiries, 2011). It is important for the student to be aware of this and seek to identify any potential impact on maternal and fetal health and agree actions to be taken including relevant medical intervention.

As identified earlier, consideration should be given to the asylum seeking woman's experiences of health care in her home country and how they may differ to those that she encounters when accessing the NHS maternity services in the UK. This would provide an insight into the woman's understanding and reaction to procedures that she may encounter whilst accessing maternity services. In Afghanistan, for example, drugs and herbs are used to treat minor illness, which can be purchased without a prescription (Feldmann, 2006). In other circumstances, women may not have had access to any health care in their home country, due to poverty and conflict and therefore may have no understanding of health care provision (Burnett and Fassil, 2004). A poor country is unlikely to have the technological advances which are available in the UK and a procedure, considered routine in the UK, may be viewed as extreme and potentially leading to death by some women (Briscoe and Lavender, 2009). Consequently, interventions such as ultrasound scans or cardiotocography may be confusing and frightening. Women from some countries do not consider the concept of psychological wellbeing, health being purely a physical phenomenon (Bhatia and Wallace, 2007). This may impact on the assessment of a woman's psychological needs and an asylum seeker is known to have died due to a perinatal psychiatric disorder (Centre for Maternal and Child Enquiries, 2011). In some countries, the concept of informed consent does not exist with health professionals making decisions on behalf of their client (Feldmann, 2006; Rashad et al., 2004). This could influence expectations regarding the woman centred approach to care and the equal partnership which the midwife may try to foster.

Legislation, from a global perspective would include human rights legislation, including the 1951 Geneva Convention and the obligation of the UK to protect those seeking asylum (United Kingdom Border Agency, 2011). In addition, some UK legislation is relevant from a global perspective with the NMC (2009) requiring that midwives have knowledge of equality and diversity legislation. The student would need to understand how measures such as these are designed to protect the pregnant woman seeking asylum and the implications of this legislation for the provision of midwifery care.

Incorporating Cultural Competence

As the focus of the inclusive model is the pregnant woman seeking asylum within a global context, it can be argued that respecting cultural differences should be embedded in this model. To address this, culture has been included in all three layers but with a different emphasis for each layer. Cultural competence is a term that has emerged in the literature, as a means of preparing practitioners to deal with cultural diversity in practice through developing cultural awareness, knowledge and skills (Suurmond et al., 2010). The most cited interpretation of cultural competence that could be found in the literature was Campinah-Bacote (1999), who focused on the need to understand minority cultures, customs and traditions which may impact on care and on developing the knowledge and skills to address these in practice.

This interpretation has been assumed in the micro layers of the model. Within the holistic assessment, the pregnant woman's, cultural customs and traditions, rippling through from the global layer should be discussed. The focus should be on how the woman can negotiate these within her micro environment. However, it has been found that following migration, some women struggle with this process of cultural negotiation due to the everyday discrimination that they can face (Meadows et al., 2001).

Campinah-Bacote's (1999) interpretation of cultural competence has been criticised as being too simplistic with a need for it to be understood and applied in a broader ethnic context (Nairn et al., 2004; Hart et al., 2003). This context can be equated to the macro layer of the model and the cultural barriers due to the incongruence between the woman's beliefs and the wider UK society in which she is living. In addition, it is argued that cultural barriers in society are entangled with other barriers such as poverty and language which can exacerbate inequality and oppression (Anderson et al., 2003; Nairn et al., 2004). Cultural competence needs to incorporate the critical examination of the interplay between cultural and other barriers which perpetuate inequality. When using the global context model, the student needs to consider how these may ripple through to the micro layer and influence the health of the pregnant woman seeking asylum. Achieving cultural competence would include questioning the inequalities and discrimination perpetuated by cultural barriers.

Application of the Model

This article has provided an explanation for the structure of an inclusive educational model designed to prepare midwifery students to care for pregnant women seeking asylum who they may encounter in clinical practice. It focuses on how the student can interpret issues in the global and macro layers when assessing the woman's health and social care needs in the micro layer. The student then needs to consider how she and the woman can address the identified needs when planning her midwifery care. This may involve simple solutions such as considering how the woman tells the time when planning antenatal appointments (Carolan and Cassar, 2007). It may involve referring the woman to other professionals within maternity services or wider agencies such as refugee charities which can provide social support and advice to women. The model could be used to facilitate the student to explore these options. However, as this article has suggested, some issues identified, such as challenging negative dominant discourses may be more difficult to address. Embedding this model into midwifery education could provide the opportunity to explore these issues and how they can be potentially resolved.

This model could complement woman centred teaching strategies used within contemporary midwifery education by encouraging the student to work with the pregnant woman to value her perspective and possibly learn from her about her background, as well as informing her about the context of the UK. In addition, this model could encourage critical thinking as the student explores the issues in each layer and the potential impact on the pregnant woman seeking asylum.

The global context model also appears to complement student caseloading activity, a NMC requirement for pre-registration midwifery education in which students must care for a small group of women throughout their childbearing experiences (Nursing and Midwifery Council, 2009). Like this model, caseloading appears to encourage students to adopt a holistic, woman centred approach to care provision (Lewis et al., 2008b). Using this model in conjunction with caseloading may encourage students to select pregnant women who are seeking asylum to caseload and to focus on understanding and dealing with the issues identified in practice. The prolonged contact with the

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caseloading woman throughout her maternity journey would provide the opportunity for the student to fully engage with the model over a period of time and explore contextual factors, which will impact on the care needs of women in her caseload.

Conclusions

"The pregnant woman within the global context" model for midwifery education has been developed in response to a number of findings and theoretical concepts constructed through the course of a wider doctorate study. It has been designed as a tool to assist midwifery students in assessing the health and social care needs of pregnant women seeking asylum. It has been argued that due to the potential poor physical and psychological health of these women, an effective midwife/ woman relationship is essential. In addition, to understand the woman's perspective, it is important to consider the impact of her wider global context on her health.

Some voluntary migrants will have similar negative, but less extreme experiences than those of forced migrants (Shaw et al., 2006) and this model has the potential of being used to consider their needs also. Migrants, who have chosen to settle in the UK often experience poor public attitudes, discrimination and harassment. They may be socially excluded and have a lower standard of living, leading to poorer physical and mental health outcomes (Shaw et al., 2006). This model could be useful therefore for considering the impact of migration more generally by focusing on recently arrived pregnant migrant women and their needs in a similar way.

This article has explored how the global context model complements wider issues influencing midwifery education. It has incorporated significant principles underpinning the regulation of midwifery education and has also attempted to maintain congruence with woman centred educational strategies used in contemporary midwifery education. It is argued that the model could be implemented alongside caseloading activity to encourage the inclusion of asylum seeking women. Ultimately, the model can contribute to the development of a critical thinking midwife who can examine information gleaned through different sources, together with the woman, in order to develop the ability to question negative public dominant discourses around asylum seeking. Further research could evaluate the effectiveness of the model in achieving this aim and improving the maternity experiences of pregnant women who are seeking asylum.

References

Anderson, J., Browne, A., Henderson, A., Khan, K., Lynam, J., Semeniuk, P., Smye, V., 2003. Rewriting cultural safety within the postcolonial and postnational feminist project: towards new epistemologies of healing. Advances in Nursing Science 26, 196–214.

Ashton, L., Moore, J., 2009. Guide to Providing Mental Healthcare Support to Asylum Seekers in Primary Care. Royal College of General Practitioners, London.

Aspinall, P., Watters, C., 2010. Refugees and asylum seekers. A Review From an Equality and Human Rights Perspective. Equality and Human Rights Commission, Manchester.

Bhatia, R., Wallace, P., 2007. Experiences of refugees and asylum seekers in general practice: a qualitative study. BMC Family Practice 8.

Bollini, P., Pampallona, S., Wanner, P., Kupelnick, B., 2009. Pregnancy outcome of migrant women and integration policy: a systematic review of the international literature. Social Science & Medicine 68, 452–461.

Briscoe, L., Lavender, T., 2009. Exploring maternity care for asylum seekers and refugees. British Journal of Midwifery 17, 17–23.

Bronfenbrenner, U., 1994. Ecological models of human development. In: Gauvain, M., Cole, M. (Eds.), Readings on the Development of Children. Freeman, New York.

Brunner, E., Marmot, M., 2006. Social organization, stress and health, In: Marmot, M., Wilkinson, R. (Eds.), Social Determinants of Health, second ed. Oxford University Press, Oxford.

Burnett, A., Fassil, Y., 2004. Meeting the health needs of refugees and asylum seekers in the UK: an information and resource pack for health workers. National Health Service, London.

Campinah-Bacote, J., 1999. A model and instrument for addressing cultural competence in health care. Journal of Nursing Education 38, 202–207.

Carolan, M., 2010. Pregnancy health status of sub-Saharan refugee women who have resettled in developed countries: a review of the literature. Midwifery 26, 407–414.

Carolan, M., Cassar, L., 2007. Pregnancy care for African refugee women in Australia: attendance at antenatal appointments. Evidence Based Midwifery 5, 54–58.

Carolan, M., Hodnett, E., 2007. "With woman" philosophy: examining the evidence, answering the questions. Nursing Inquiry 14, 140–152.

Centre for Maternal and Child Enquiries, 2011. Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer: 2006–08. The Eighth Report on Confidential Enquiries into Maternal Deaths in the United Kingdom. CMACE, London.

Cross-Sudworth, F., 2007. Racism and discrimination in maternity services. British Journal of Midwifery 15, 327–331.

Cross-Sudworth, F., 2009. Ethnicity and domestic abuse: issues for midwives. British Journal of Midwifery 17, 212–215.

Department of Health, 2007. Maternity matters: choice, access and continuity of care in a safe service. HMSO, London.

Dumper, H., 2002. Is it safe here? Refugee women's experiences in the UK. Refugee Action, London.

Dumper, H., 2005. Making Women Visible. Refugee Council, London.

Edwards, G., Byrom, S., 2007. Essential Midwifery Practice: Public Health. Wiley-Blackwell, London.

Feldmann, R., 2006. Primary health care for refugees and asylum seekers: a review of the literature and a framework for services. Public Health 120, 809–816.

Gaudion, A., Allotey, P., 2008. Maternity care for asylum seekers and refugees in Hillingdon. A Needs Assessment. Centre for Public Health Research, Brunel University, Uxbridge.

Greenslade, R., 2005. Seeking Scapegoats. The coverage of asylum in the UK press. Institute for Public Policy Research, London.

Hart, A., Lockey, R., Henwood, F., Pankhurst, F., Hall, V., Sommerville, F., 2001. Addressing Inequalities in Health: new directions in midwifery education in practice. English National Board, London.

Hart, A., Hall, V., Henwood, F., 2003. Helping health and social care professionals to develop an "inequalities imagination": a model for use in education and practice. Journal of Advanced Nursing 41, 480–489.

Kent, J., 2000. Social Perspectives on Pregnancy and Childbirth for Midwives, Nurses and the Caring Professions. Open University Press, Buckingham.

Leap, N., 2009. Woman-centred care or women-centred care: does it matter? British Journal of Midwifery 17, 12–16.

Lewis, H., Craig, G., Adamson, S., Wilkinson, M., 2008a. Refugees, Asylum Seekers and Migrants in Yorkshire and Humber, 1999–2008. Yorkshire Futures, Leeds.

Lewis, P., Fry, J., Rawnson, S., 2008b. Student midwife caseloading - a new approach to midwifery education. British Journal of Midwifery 16, 499–502.

Lockey, R., Hart, A., 2004. Improving consultation with disadvantaged service users. British Journal of Midwifery 12, 784–789.

Mcleish, J., 2002. Mothers in Exile. The Maternity Alliance, London.

Meadows, L., Thurston, W., Melton, C., 2001. Immigrant women's health. Social Science & Medicine 52, 1451–1458.

Midwifery 2020, 2010. Delivering expectations. Department of Health, Cambridge.

Mulvey, G., 2010. When policy creates politics: the problematizing of immigration and the consequences for refugee integration in the UK. Journal of Refugee Studies 23, 437–462.

Nairn, S., Hardy, C., Parumal, L., Williams, G., 2004. Multicultural or anti-racist teaching in nurse education: a critical appraisal. Nurse Education Today 24.

National Institute for Health and Clinical Excellence, 2010. Pregnancy and complex social factors. A model for service provision for pregnant women with complex social factors. National Institute for Health and Clinical Excellence, London.

Nursing and Midwifery Council, 2009. Standards for Pre-registration Midwifery Education. Nursing and Midwifery Council, London.

Rashad, A., Macvane-Phipps, F., Haith-Cooper, M., 2004. Obtaining informed consent in an Egyptian research study. Nursing Ethics 11, 394–399.

Refugee Council, 2009. The vulnerable women's project. refugee and asylum seeking women affected by rape or sexual violence. Literature Review. Refugee Council, London.

Reynolds, B., White, J., 2010. Seeking asylum and motherhood: health and wellbeing needs. Community Practitioner 83, 20–23.

Royal College of Midwives (Rcm), 2008. Woman Centred Care; Position Statement. RCM, London.

Sales, R., 2002. The deserving and the undeserving? Refugees, asylum seekers and welfare in Britain. Critical Social Policy 22, 456–478.

Shaw, M., Dorling, D., Smith, G., 2006. Poverty, social exclusion and minorities, In: Marmot, M., Wilkinson, R. (Eds.), Social Determinants of Health, second ed. Oxford University Press, Oxford.

Somerville, W., Sumption, M., 2009. Immigration in the United Kingdom: the recession and beyond. Equality and Human Rights Commission, Manchester.

Squire, C., James, J., 2009. Refugee woman. In: Squire, C. (Ed.), The Social Context of Birth. Radcliffe, Oxford.

Suurmond, J., Seeleman, C., Rupp, I., Goosen, S., Stronks, K., 2010. Cultural competence among nurse practitioners working with asylum seekers. Nurse Education Today 30, 821–826.

Ukoko, F., 2005. Sure start midwife: giving a voice to the voiceless. British Journal of Midwifery 13, 776–780.

Ukoko, F., 2007. Childbearing women with no resources to public funds: the health and social implications. MIDIRS Midwifery Digest 17, 585–587.

United Kingdom Border Agency, 2011. *Asylum* [Online]. Home Office, London. Available: http://www.ukba.homeoffice.gov.uk/asylum/ [Accessed 1st February 2011].

Walsh, D., Newburn, M., 2002. Towards a social model of childbirth: part one. British Journal of Midwifery 10, 476–481.

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