Feature

Project officers Anna Gaudion and Jenny McLeish at The Reaching Out Project, Medact, together with Claire Homeyard, consultant midwife (public health) at the Barking, Havering and Redbridge NHS Trust give a detailed account of the problems of access to maternity care faced by pregnant refugees, asylum-seekers and 'failed' asylum-seekers.

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Within any group of refugees, there are frightened people who head for a place that they regard as safe, within this there are number of pregnant women who are doubly worried: 'Will the end of the journey be a good place to bring a child into the world?' (Adie, 2005: 40).

Pregnancy and birth are not isolated biological experiences but a process embedded in a woman's life history (Ascoly et al, 2001). This article describes the various categories of immigration status associated with claiming asylum, and explores the issues around claims for asylum that may disadvantage women.

Women seeking asylum may suffer 'an experience of profound loss… (that) creates special dimensions of need for pregnant women, with consequent impact on their physiological, psychological and social profile during pregnancy' (Kennedy and Murphy-Lawless 2001: 8). Their loss may include a child, husband, parent or other member of their extended family or community; their home, job, health, possessions, status and culture (McLeish, 2002). Asylum-seeking women are often more seriously affected by displacement than men, being vulnerable to physical assault, sexual harassment, rape, poor health, depression, loneliness, domestic violence and the stress of overwhelming domestic responsibilities, including becoming head of a disrupted household (Burnett and Peel, 2001). Asylum-seekers from some countries may have additional health needs, for example, women born in sub-Saharan Africa are disproportionately affected by HIV (Health Protection Agency, 2005) and women from some countries (Somalia and Sudan) may have undergone female genital mutilation (FGM) (Powell et al, 2002).

These factors mean that pregnant asylum-seekers may particularly benefit from understanding, sensitive and supportive maternity care and the opportunities to build positive relationships with midwives (McLeish, 2002). Unfortunately many asylum-seekers find it difficult to access maternity care and those that do are not always treated well (McLeish, 2002).

Background – definitions

- The 1951 Refugee Convention (United Nations High Commissioner for Refugees, 1951) defines a refugee as 'any person who… owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his (or her) nationality and is unable or, owing to such fear, is unwilling to avail himself (or herself) of the protection of that country'. The Immigration and Asylum Act 1999 defines a claim for asylum as 'a claim that it would be contrary to the United Kingdom's obligations under the Refugee Convention, or under Article 3 of the Human Rights Act, for the claimant to be removed from, or required to leave, the UK'.
- An asylum-seeker is defined by the Immigration and Asylum Act 1999 as a person who 'has made a claim for asylum which has been recorded by the Secretary of State but which has not been determined'. Asylum-seekers are not usually allowed to work or claim welfare benefits while waiting for their asylum claim to be decided, and if destitute they receive a subsistence living allowance and are 'dispersed' to accommodation around the UK (Immigration and Nationality Directorate, 2006a; Immigration and Nationality Directorate, 2006b).
- The term 'failed' asylum-seeker is used to describe 'people who have had their asylum claims refused, who have lost their appeals, who have reached the end of the process' (Gerrard 2006). A person in this situation is expected to leave the UK and may be 'detained' (imprisoned in a special detention/removal centre) and 'removed' from the UK if she does not leave voluntarily (Immigration and Nationality Directorate, 2006a). Most are denied any state support during this time, but the UK does recognise that some people may not be able to leave immediately, for example because they are ill, in late pregnancy or their own country is too dangerous, and these people can apply for subsistence support (Immigration and Nationality Directorate, 2005a).
- A person may lawfully come to the UK as an immigrant for many other reasons apart from seeking asylum – for example, to study, work, marry or visit relatives (Immigration and Nationality Directorate, 2006a).

Applications for asylum in the UK have fallen for several years. According to Home Office statistics there were 33 960 applications for asylum in 2004

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(a 31% reduction on the 2003 figures) and the main countries of origin for those seeking asylum were Iran, Somalia, China and Zimbabwe (Home Office, 2005). War, human rights abuses and repression of ethnic minorities are common to all these countries (Refugee Council, 2005).

Worldwide, female refugees and children outnumber their male counterparts; yet only a small proportion of these enter the West as asylum-seekers (el-Bushra, 2000). Levels of self-advocacy, empowerment and confidence ultimately affect how a person is able to seek asylum and traditional gender relations mean that many women do not possess the skills and experience to do this (Cockburn, 2001). In 2004, 11 200 women applied for asylum in the UK in their own right and a further 3500 women and girls came to the UK as the partners or children of asylum-seekers. There are no statistics on asylum-seekers and pregnancy, but a small observational study found that 13% of the women asylum-seekers arriving in Dover were pregnant (Le Feuvre et al, 1999).

It is often assumed that all asylum-seekers will be treated equally in the process of asylum determination (Crawley, 1996). However, men and women experience the process of seeking asylum differently (Ascoly, 2001). The 1951 Refugee Convention (see above) uses gender-neutral language to describe a 'refugee', but there has traditionally been a narrow, male-orientated interpretation of what constitutes 'persecution', a 'political opinion' or a 'particular social group', excluding gender-specific experiences of women (Foote, 1994).

Refugee law recognises typically male forms of political resistance to form the basis of a legitimate claim for protection, but there are significant difficulties for women whose fear of persecution arises out of forms of protest or ill-treatment which are less overtly political (Castel, 1992). For example, women's political action may take supporting forms such as hiding people, passing messages and providing community services such as food, clothing and medical services (Ceneda, 2003).

Both men and women are affected by state-engineered violence because of their political affiliations, but it is predominantly women who are affected within the sphere of the home (el-Bushra, 2000). In order to constitute persecution, violation of a woman's human rights must be in the hands of a force that the state is unwilling or unable to control. Although there may be little to differentiate the position of a man in a torture cell from that of a woman who is repeatedly abused in her own home, the claimant must demonstrate a strong and consistent pattern of governmental refusal to protect her from such abuse (Crawley, 1996).

'Home Office caseworkers do not engage with the Convention's criterion: 'membership of a particular social group' and do not apply it to women's claims. In an Iranian case, the Home Office refused to accept that domestic violence meant that a woman was a member of a 'particular social group'' (Palmer and Ceneda, 2006: 40).

In war, rape may be one of the repressive weapons employed to destroy the 'other' (Ager, 1994). For the perpetrator, rape is associated with notions of masculinity, power and dominance, with the intention to violate the enemy community as well as the individual woman (Giddens, 1990). The victims, living in societies which emphasise that sexual relations occur only within marriage, are stigmatised within their communities and may not ever verbalise their trauma (Giles, 1994). Children born as a result of rape are viewed ambivalently by their communities and women perceived as carrying the enemy's child may be 'forced' into having abortions (Korac, 1995).

State-sanctioned rape is not listed as an international crime; rather the offence against women is viewed as secondary to the crime against their ethnicity. Rape has rarely been considered as torture under the Refugee Convention (Muhmud, 1996). In a recent report, Asylum Aid cite the case of a woman who was refused asylum in the UK after she had been arrested, detained and raped because of her cousin's political activities and family members' political links with the fallen Mobutu regime. In a letter refusing asylum the Home Office wrote: 'Rape not linked to political opinion, imputed political opinion not accepted' (Palmer and Cededa, 2006: 38).

Recently there has, however, been a growing official recognition that the specific forms of harm women may have experienced, such as rape, violence within the family, or FGM may amount to persecution, and that women in a specific country can constitute a 'particular social group' under the Refugee Convention (Immigration and Nationality Directorate, 2005b). Many asylum-seeking women are nonetheless either unaware of the relevance of these type of experiences to their application for asylum, or are too ashamed to disclose to the immigration authorities intimate and humiliating experiences such as rape (Ditscheid, 2003; Kerrigan, 2003; Foote, 1994; Osaki, 1997).

Barriers to accessing maternity care

Although there are some examples of good practice in designing maternity services to meet asylum-seekers' needs, many asylum-seekers find it extremely difficult to access maternity care (Harris et al, 2006). The latest Confidential Enquiry report, *Why mothers die 2000 to 2002* (Confidential Enquiry into Maternal and Child Health, 2004) shows the stark differences in maternal death rates between white women and black African women, including asylum-seekers and refugees. Black African women had major problems in accessing and maintaining contact with maternity services and suffered a maternal mortality rate seven times higher than the former group.

Research undertaken by the charity Maternity Alliance (McLeish, 2002) identified some of the problems encountered by asylum-seekers in using the maternity services. Many women do not have any family in this country, do not speak English or understand how the health system works. Most of the women surveyed by the Maternity Alliance had not been given information about the kinds of services and support available to them. A majority of those who did gain access to maternity services were satisfied with their antenatal care.

However, half the women surveyed described experiencing indifference, rudeness and racism from maternity professionals. These women also reported feeling powerless to challenge hostile attitudes because they feared retribution. Asylum-seekers are more vulnerable and less able to challenge substandard maternity services than perhaps any other group in society (McLeish, 2002).

'Failed' asylum-seekers and payment for NHS maternity care

Standard 11 of the *National Service Framework for Children, Young People and Maternity Services* (Department of Health, 2004) requires that women should have easy access to supportive, high-quality maternity services that are flexible, individualised and have an emphasis on the needs of vulnerable and disadvantaged women. However, a recent change in legislation constitutes yet another barrier to accessing maternity services. Since 2004, NHS Trusts are required to establish whether people using their hospital services are ordinarily and lawfully resident in the UK, and to charge those who are not (NHS, 1989).

The guidance supporting these regulations makes it clear that every woman booking for maternity care at a hospital must be asked, firstly: 'Where have you lived for the last 12 months?' and secondly: 'Can you show that you have the right to live here?' Every woman must be required to provide documentary evidence of her right to live in the UK, such as her birth certificate, passport or entry clearance documents. To avoid breaching

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race discrimination laws, the same questions and standard of proof must be applied equally to all women 'regardless of address, appearance or accent' (Department of Health, 2004b).

Although asylum-seekers and refugees are lawfully resident and are entitled to free NHS care, since April 2004 these charging regulations apply to people whose asylum claim (including appeals) has failed (NHS, 2004). If an asylum-seeker is already using the maternity services at the time her claim fails, her care will remain free of charge, but if she books for maternity care after her claim has failed, she will be charged.

There is a further complication in that maternity care (antenatal, intrapartum and postnatal care) is classed by the charging regulations as 'immediately necessary treatment' and therefore cannot lawfully be withheld by the hospital if the service user is unable to pay (Department of Health, 2004b).

Case studies collected by the charities Medact and the Refugee Council indicate that the overseas visitors managers who assess liability to pay, do not always appreciate the importance of explaining this procedure to pregnant women. They sometimes effectively turn women away from the hospital by making demands for payment that cannot be met. These women sometimes attempt to book for care at a different hospital or return to give birth without having had any antenatal care, or they may take the risk of giving birth unattended, with potentially serious consequences (Refugee Council, 2006; Medact, 2005).

When the Healthcare Commission investigated the maternity services of North-West London Hospitals NHS Trust, following the occurrence of nine maternal deaths in three years, it reported that staff were unsure about the entitlement to maternity care for overseas visitors, including asylum-seekers: 'On at least two occasions, this lack of clarity resulted in women leaving an antenatal clinic without receiving care and treatment. One of the Trust's documents stated that a female asylum-seeker was told that she would have to pay £2300 to have her baby. The woman was in the advanced stages of pregnancy and said that she could not pay and would have her baby at home' (Commission for Healthcare Audit and Inspection, 2005: 42).

During the panel discussion following the launch of the film *Florence: the experience of becoming a mother in exile* (Gaudion, 2004), midwives and other clinicians raised concerns over the potential confusion surrounding the new regulations and the implication for particular client groups (Gaudion et al, 2005: 389).

The charging regulations were designed to tackle the problem of perceived 'health tourism' – people coming to the UK to make use of free NHS services. In practice, they are also affecting women who have been living in the UK for long periods, with minimal resources and who will give birth in the UK (Refugee Council, 2006; Medact 2005). It is accepted that some 'failed' asylum-seekers may be unable to leave because of advanced pregnancy or because their countries are currently unsafe. They are temporarily allowed to remain in the UK but are unlikely to be able to pay for health care, as they are usually banned from working (Immigration and Nationality Department, 2006a) and receive only subsistence support (Immigration and Nationality Department, 2006b).

Members of minority ethnic communities often rely on word-of-mouth recommendation to access services (McLeish, 2002) and women may be deterred from seeking maternity care when others have had negative experiences. Groups working with asylum-seekers have also voiced concerns that some women who are entitled to free care are being wrongly denied access owing to confusion over eligibility (Medact, 2005) and there is no safety net (McColl et al, 2006).

The policy of restricting eligibility to free NHS care has been criticised as a false economy by the British Medical Association in the context of maternal-to-infant transmission of HIV: 'Appropriate interventions before, during and after birth can reduce the risk of HIV transmission from mother to child from 25% to 35% to under 2%, but in order to achieve this, ongoing medical care and social support is crucial. Aside from the ethical and public health factors, there is also an economic argument. Fewer HIV-infected children requiring complex monitoring and treatment will potentially mean lower costs to the NHS' (British Medical Association, 2005).

Conclusion

There are as yet no reliable statistics on the numbers of asylum-seekers and 'failed' asylum-seekers in need of maternity care, nor on the numbers of pregnant women who do not receive antenatal care as a result of the charging regulations. Midwives need to learn from the available examples of good practice to create services that are proactive in engaging with marginalised women such as asylum-seekers, and in helping them to overcome barriers to care. Midwives can also empower pregnant women who may be subject to the charging regulations with the knowledge that maternity services cannot lawfully be withheld even if they cannot

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afford to pay for them. Overseas visitors managers should ensure that all pregnant women seeking maternity services have timely access to a midwife and that decisions about liability to pay for services are not communicated in a way that may deter them from receiving maternity care.

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