

Description

‘New to the UK’; A report from conference on the needs of immigrant, pregnant and migrant women held at Oxford Brookes University in November 2018

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This blog began as a conversation between a Student Midwife, a service user advocate, and a Professor of Midwifery. We reflected together over a cup of tea on the learning gained at a conference where we heard from women with experience of pregnancy and birth as ‘migrants’ to the UK, midwives, an obstetrician, experts from charities and projects that work with migrant women, and academics. What are women’s experiences? What challenges do they face and ‘what works’? What is good practice in care? What changes to public policy do those working with these women advocate?

‘Cultural dexterity’



Obstetrician Brenda Kelly, introducing the day, spoke of the necessity of ‘increasing cultural dexterity’ in services and in individual professional practice, while speaker Mel Cooper from the University of Bradford challenged us to think about

language. We all need to think hard about labels, because there is a difference between voluntary and forced migration. Terms we use to label women individually and as a group shape our thoughts and behaviour.

We need to ask ourselves, ‘Was pregnancy a choice for this woman?’ (Haith-Cooper and Bradshaw, 2013). What is labelled ‘voluntary migration’ may have been something the woman was forced into by factors beyond her control – it is important to ask the right questions about the story, the culture and the legal status of women. What was important was



nd deportation. It helped us understand

It is difficult to express how moving it was to hear from two brave women who spoke about their experiences at the conference, explicitly with the aim of improving care for other asylum seeking, refugee and migrant women. Carina, as a Student Midwife, values opportunities such as those at the conference as golden – they create conversations between people about what good care looks and feels like. Midwives meet pregnant and birthing women who are new to the UK at a very vulnerable point and it is the duty of midwives to ensure they receive the highest quality of care – the holistic midwifery care they truly deserve. The focus must remain on midwifery care and not the complicated politics of ‘gate-keeping’ access to care – we heard from Maternity Action on research they have done and their concerns about the impact of charging for maternity care.

Cultural barriers?

Another potential barrier to women receiving care includes the usual cultural perception some women have that pregnancy is not a sickness and therefore does not require a health professional’s input or monitoring at all before birth. Carina’s view, reflecting on this, is that we need to carefully emphasise the importance and purpose of health to migrant women without creating the impression that pregnancy is now a sickness. The other thing to consider at a first meeting with a pregnant woman who may face financial charges is that the midwife’s authentic attempt to engage may be viewed suspiciously by the woman as a financial agenda.

Working towards public protection

We were impressed by the work of lobbying at government level we heard about from Maternity Action and professionals who have worked with the Refugee Council. Meaningful change to public policy to protect this group of pregnant women can only happen when women's stories are heard at every level, including government. The issues are complex at political level, no doubt, but the stories we heard from the women who participated in the conference suggested that some women are treated in arguably inhumane ways – for example, a woman with a new baby finding out that she is to be deported when four people in bullet-proof vests burst into the flat she lives in and order her to get dressed.



How can student midwives and others explore the experiences of migrant women, to be better informed to support and advocate for them? A speaker on the B!RTH project described how 7 plays by 7 international writers are available in various formats to help student midwives and others think about women's experiences across the world, and the narratives women might bring to their pregnancy, birth and early parenthood. Other speakers reminded us all to think, 'What have women seen? What has happened en route?' and 'Conceptually, does depression exist for this woman and her family?' In some cultures, there is a strong belief that women should not draw attention to themselves – worries about migration status might cause depression, but women may describe physical illness rather than the mental distress they are feeling. There were many useful ideas in the presentations for personal professional development through reflection on the various resources and research sources described to us, as well as the experiences of women described to us by them in person, as 'experts by experience.'

Essentials

Communication is absolutely key to high quality, human rights aware maternity care, of course. An interesting discussion developed at the conference about interpreting services. Some speakers and audience members felt NHS trusts limit interpreting services for financial reasons. It was also suggested that professional bodies may not be prioritising training professionals to work with interpreters because migrants and asylum seekers are 'people who won't sue'. One of the women who participated in the conference described how a caesarean section was recommended to her in a UK hospital, after many hours of labour, using sign language (her home language is Spanish). Hearing this, Lesley commented that interpreting is a basic safety measure, as well as being critical to respectful care.

Relationship based care



The importance of midwives as advocates

for women was raised, and one speaker suggested that there are ‘problems of bias and gatekeeping on the part of NHS trusts and staff that are not written into legislation’. Added to the fact that women who are new to the UK do not understand services, are worried about immigration status, may not know what a midwife is (as distinct from a doctor or nurse), then this would make it is all too easy for women to fall through the gaps, and be treated inhumanely, despite the good intentions of those dealing with them.

What can be done to improve the situation? One speaker (Rayah from Maternity Action) said, ‘Good care for everyone is good care for migrant women’. Other speakers and delegates spoke of the importance of continuity of carer in improving outcomes for women and babies. Concern was expressed by several at the lack of evaluation of the possible health impact for mothers and babies of increased anxiety and stress caused by charging women for maternity care. Also, that imposing charges on women who have no means to pay comes at the cost of undermining trust in midwives, making it less likely that women will seek or continue care that they need.

Leaving thoughts

We found much to reflect on together on the day and following the conference. Caring for women new to the UK, learning how to see, respect and advocate for and with them is a key part of a midwife's role. Women new to the UK may need to be supported to have confidence to be seen, find that services are safe for them, and have a voice in their own care and in the design of services, through charities that support them and through the outreach work of Maternity Voices Partnerships.

Women seeking asylum, women who are refugees and migrants, have often had truly horrific experiences, and what to us are unimaginable journeys. While they might expect that arriving in their new home will offer a better future, they often experience great difficulties, experiences that add to their trauma. First, midwives serving these vulnerable women should be community based and provide continuity of carer. But, whatever the organisation of practice, midwives should refuse any gatekeeping function, listen to women and understand their lives, and give them high quality respectful care. Finally, let's celebrate their courage.

With great respect and many thanks to Oxford Brookes Midwifery Society for providing such an insightful event

References

Haith-Cooper, M. and Bradshaw, G. (2013). Meeting the health and social care needs of pregnant asylum seekers; midwifery students' perspectives. *Nurse Education Today*, [online] 33(9), pp.1045-1050. Available at: https://bradscholars.brad.ac.uk/handle/10454/6689 [Accessed 4 Mar. 2019].

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Tags

1. asylum seekers
2. continuity of carer
3. gender equality
4. migration
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