

Women and Children First?

Refused asylum seekers' access to and experiences of maternity care in Glasgow

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Foreword



I am delighted to commend this research report that looks at how refused asylum seeking women access and experience Maternity Services in Glasgow and it is completely appropriate that this piece of work was carried out in Greater Glasgow and Clyde

Health Board area, which has been the chosen city in Scotland for dispersal of those who seek the safety and security of asylum.

It is with some pride that midwives and others can look at the findings of this paper and be reassured that the principle of universal access to maternity is being upheld and that this provides some security to those women and their families who need to use the service.

Greater Glasgow and Clyde have established specialist services in Glasgow City to meet the specific maternity care needs of this group and there is a midwife dedicated to this role. This midwife provides support, expert clinical care and training for others within her role and is pivotal

in bringing services together so that even when a pregnant asylum seeking woman has insecure status this should not preclude nor constrain her access to services.

However, that being said, this report also highlights the areas where the services are not doing so well and where resources may need to be invested for the best outcome for mother and child. This is not just in the maternity services but in the wider challenges around the strategic approach to refugee integration.

If there is anything to be gained from the work that has been carried out on this then let it be used as a resource to identify existing gaps in the service and through multi-agency working plug these gaps. Let us remember that pregnant asylum seekers have been identified as an especially vulnerable group for maternity care and experience poor outcomes. Frontline services are crucial in delivering safe and compassionate care to these women.

'This report identifies that asylum seeking women and their children are regarded first and foremost as women and children by health professionals'

Let us never lose that culture or belief or we will become a poorer nation for it.

A handwritten signature in blue ink that reads "Gillian B. Smith". The signature is fluid and cursive.

Gillian Smith
Director

The Royal College of Midwives Scotland

Aim of the study

The aim of this project was to investigate female asylum seekers' experiences of accessing free National Health Service (NHS) maternity care in Glasgow, with a view to assessing the adequacy and implementation of statutory regulations and Scottish Government guidance, and measuring the current legal and policy framework in Scotland against international human rights obligations. The focus of this research was on women whose claim for asylum has been refused.

Key findings

This study broadly indicates that women asylum seekers, including women who have received a negative decision on their asylum claim, have access to free NHS primary and secondary care in Glasgow.¹ It suggests that asylum seeking women and their children are regarded first and foremost as women and children by health professionals, and that their insecure immigration status does not appear to preclude or constrain their access to maternity care in Glasgow. This is in line with Scottish statutory regulations and Scottish Government guidance on asylum seekers' health care entitlements.

It follows that Scottish regulations, Scottish Government Guidance and practices within the NHS in Glasgow in respect of women asylum seekers, including refused asylum seekers, uphold the principle of universal access to maternity care and are therefore consistent with the UK's international human rights obligations.

The research further indicates that, in addition to mainstream maternity care services, there are specialist services in Glasgow which seek to respond to the specific maternity care needs some asylum seekers may have.

Constraints on asylum seeking women's access to free NHS maternity care in Glasgow

However, despite evidence of the principle of universal access, a range of factors detrimentally impacting on women asylum seekers' experiences of accessing maternity care in Glasgow were identified in the course of this research.

Specifically, these difficulties relate to:

- **Interpreting:** the study reveals variation in the provision of interpreting services in Glasgow and identifies instances where women were not provided with an interpreter when required, where male interpreters were provided for maternity appointments, and where the professional role of the interpreter has been compromised;
- **The asylum process:** the study identifies a number of ways in which Home Office asylum support policies, particularly the complexity of the support system, the risk of destitution, and the provision of cashless support, impact negatively on women's experiences of pregnancy and access to maternity care in Glasgow;
- **Information provision:** the evidence suggests that asylum seeking women are often not aware of their entitlements to additional pregnancy or health-related support, particularly reimbursement or payment of travel costs, and that information about health and support services is not always being effectively communicated to asylum seeking women in Glasgow;

¹ The project focussed on the City of Glasgow which sits within the NHS Greater Glasgow and Clyde Health Board area, one of 14 regional NHS boards in Scotland.

- **Access to antenatal classes:** the research suggests that a lack of information, awareness and language barriers are constraining women asylum seekers' access to antenatal classes in Glasgow; and
- **Access to English language classes:** women in the study identified a lack of accessible English class provision for asylum seekers in Glasgow and linked this to their experiences of accessing maternity care.

‘Women and children first’

- To ensure that all asylum seeking women have full access to NHS maternity care, as well as NHS primary and secondary care in Scotland, the ‘women and children first’ principle must clearly underpin the Scottish Government’s policy on access to health care for this group and this must be clearly and publicly communicated to all frontline professionals, asylum seekers and those supporting them across Scotland.

Access to maternity care services

- NHS Scotland should ensure that all health care staff including receptionists and front-desk workers as well as clinical staff, receive regular and appropriate training on the needs, experiences and health care entitlements of asylum seeking women.
- Midwives should continue the good practice of ensuring pregnant asylum seekers are seen alone at the first maternity appointment, and, where necessary, at further visits, to carry out routine inquiry into domestic abuse. Routine inquiry should be carried out in a language the patient understands and should take account of the high prevalence of experiences of physical and sexual violence among women seeking asylum in the UK.
- Women should routinely be asked about Female Genital Mutilation (FGM) sensitively and in a language they understand and appropriate specialist support offered to women who disclose FGM if required.
- NHS Scotland should ensure that clear referral routes are in place to enable women to access specialist advice and support where appropriate.
- Health professionals working with asylum seeking women should ensure that information

on antenatal classes, their purpose and potential benefits, is conveyed to women in a language they understand.

- Where they request one, women must be provided with an appropriate interpreter for maternity appointments in a language they understand and training on working with interpreters should be provided to all health professionals.

Access to an interpreter and standards

- All refugee and asylum seeking women for whom English is not their first language should be reminded that they are entitled to the services of an appropriate interpreter.
- Training on working with interpreters should be incorporated into mandatory training for all midwives and frontline health professionals.
- Interpreters for maternity appointments should routinely be female, unless the patient requests otherwise; staff should always check at the start of an appointment that the patient is comfortable with and understands the interpreter provided.
- NHS Scotland should direct local health boards to facilitate the lengthening of GP consultations to account for the additional time required for effective communication through an interpreter.
- NHS Scotland should further explore the comparative benefits or otherwise of telephone and face-to-face interpreting, to include consideration of the cost implications of not providing adequate interpreting provision.
- Further research should be carried out into the role of the interpreter in complex maternity appointments, during labour and in childbirth in order to better understand the emotional demands placed on interpreters and the impact on the provision of appropriate care.

Information on maternity services and pregnancy-related support entitlements

- Local Health Boards should ensure that asylum seeking women are provided with targeted information that is specific and appropriate to them and in a language they understand, on entitlements and access to primary and secondary maternity care, including information about antenatal classes, their purpose and benefits.
 - Local Health Boards and Home Office contracted asylum support advice providers should ensure that asylum seeking women are provided with targeted information in a language they understand on the maternity-related support entitlements available to them under the Home Office asylum support system and as part of mainstream maternity provision by the NHS.
 - Local Health Boards should review the format and delivery of written information for women asylum seekers with a view to ensuring that it is user-friendly, communicated in plain English and translated into appropriate languages.
 - Local Health Boards should review when and how information about maternity services is given to asylum seeking women to ensure comprehensive information is delivered while minimising the risk of their being overwhelmed with too much detail.
- must ensure that the housing provided to pregnant asylum seeking women, including accommodation provided under Section 4, is adequate and appropriate to the needs of new mothers and their children.
- The Home Office should only move pregnant women in exceptional circumstances and women should not be forced to move accommodation within six weeks before the birth or before they have been signed off by the midwife after the birth.
 - We believe that all asylum seekers should have access to cash-based support; as a matter of urgency, pregnant women on Section 4 should have access to cash to ensure the health and safety of mother and baby.
 - Greater poverty awareness is needed in the provision of maternity care for women asylum seekers, including an understanding by health professionals of the difficulties women may face travelling to appointments.
 - The Scottish Government, COSLA and other agencies leading on implementation of the *New Scots: Integrating Refugees into Scotland's Communities*² strategy should take action to ensure that this group of women has equal access to the services and support to which they are entitled in Scotland, irrespective of the status of their asylum claim or Home Office policy impacting on devolved policy areas.

Impact of Home Office asylum support policies

- Pregnant women should never be faced with destitution as a result of Home Office asylum support policies at any stage of pregnancy, irrespective of the status of their asylum claim.
- The Home Office and its contractors

Access to English language classes

- The Scottish Government, Education Scotland, COSLA and other lead agencies implementing the *New Scots*³ strategy should ensure that English class provision for asylum seekers in Glasgow is accessible and appropriate to pregnant asylum seekers' needs.

² Scottish Government, *New Scots: Integrating Refugees into Scotland's Communities 2014-2017*, December 2013.

³ *Ibid*

Anecdotal evidence suggests that there is a lack of awareness on the part of service providers, health practitioners and refugee communities of the statutory regulations governing access to health care in Scotland for asylum seekers. The Scottish Government guidance in this area is clear in setting out the entitlement to free access to NHS health care in Scotland - both primary and secondary - for anyone who has made a formal application for asylum in the UK, whether pending or unsuccessful, while they remain in the country.⁴ There is particular concern that due to previous changes in charging regulations in England, proposed changes to access to services for migrants under the Immigration Bill 2013, and a general lack of awareness around NHS entitlements compounded by a fear of the authorities, women who have been refused asylum may not be accessing appropriate maternity care in Scotland. With this in mind, this project seeks to investigate women's experiences of accessing free NHS maternity care in Glasgow after a negative decision on their asylum claim.

Since 1999, a proportion of people seeking asylum in the UK under the 1951 Convention Relating to the Status of Refugees (Geneva Convention)⁵ have been accommodated by the Home Office in Glasgow. The UK Immigration and Asylum Act 1999 introduced this policy of dispersing asylum seekers arriving primarily in the south east of England to cities across the UK in order to ease pressure on housing in and around London. Since 2000, successive Scottish Governments have been committed to a principle of 'integration from day one' and to organising devolved policies and services in line with this principle. As such, policy and practice in relation to refugees and asylum seekers in some areas of social policy devolved to the Scottish Parliament have developed differently from in other parts of the UK. The regulations and guidance governing access to health care

for refused asylum seekers in Scotland are one example of this more progressive and inclusive strategic approach to refugee integration.

This project seeks to contribute to building a UK-wide picture of the impact and implementation of current law, policy and practice in the provision of health care to this particularly marginalised group of women.

⁴ Regulation 4 (c) of the National Health Service (Charges to Overseas Visitors) (Scotland) Regulations 1989; and, Scottish Government Health Directorate (2010 Overseas Visitors' Liability to Pay Charges for NHS Care and Services CEL09 (2010).

⁵ United Nations Convention Relating to the Status of Refugees 1951

The aim of this project is to investigate asylum seeking women's experiences of accessing free NHS maternity care in Glasgow, with the objective of assessing the adequacy and implementation of statutory regulations and Scottish Government guidance, and measuring the current legal and policy framework in Scotland against international human rights obligations. The project also seeks to uncover any practical barriers to accessing care that may exist for this particular group of women. The focus of this study is on women whose claim for asylum has been refused. For the purpose of the project, this group is understood to encompass women asylum seekers who have exhausted all legal remedies, including judicial review, as well as women who have received an initial negative decision but are awaiting the outcome of an appeal or judicial review. Women who have been refused asylum but have submitted a fresh claim for international protection are also included.

In summary, the project objectives are as follows:

- To assess whether women asylum seekers who have received a negative decision on their asylum claim are accessing free NHS maternity care in Glasgow on the same basis as an ordinarily resident UK citizen, in line with statutory regulations and Scottish Government guidance.
- To determine the extent, nature, and causes of any difficulties or barriers this group of women may be facing in accessing free NHS maternity care in Glasgow.
- To assess the implementation of statutory regulations and Scottish Government guidance on access to NHS primary and secondary care - with particular reference to maternity care - for asylum seekers who have received a negative decision on their asylum claim.
- To assess whether statutory regulations, Scottish Government guidance and practices pertaining to NHS maternity care for women asylum seekers who have received a negative decision on their asylum claim are in line with Scotland and the UK's international human rights obligations.
- To make policy and legal recommendations with a view to guaranteeing access to free and appropriate NHS maternity care for this group of women, in line with international human rights obligations.
- To suggest any areas where further research may be required.

There is abundant literature on the health care needs of asylum seekers and on the barriers they can face in accessing health care in the UK.⁶ Asylum seekers have been identified as ‘one of the most vulnerable groups in UK society, with often complex health (...) needs.’⁷ Research shows that, whilst most asylum seekers arrive in the UK in relatively good health, it is not uncommon for asylum seekers’ health to deteriorate upon arrival.⁸ As is the case with other vulnerable groups in the UK, the development and worsening of health problems, both mental and physical, are linked to a range of complex social factors such as ‘poverty, dependence and a lack of cohesive social support’⁹, which impact on asylum seekers’ health status.¹⁰ However, having to go through the asylum process further contributes to the deterioration of many asylum seekers’ health.¹¹ Moreover, there are physical and mental health issues such as the consequences of injury and torture which tend to be specific to asylum seekers.¹² Other conditions such as communicable and chronic diseases are more prevalent among migrants, including asylum seekers.¹³ Research further shows that, while asylum seekers may share common experiences and have similar health problems, they do not constitute a homogeneous group. Asylum seekers come from different countries and cultures and

as such have gone through a wide range of experiences. This in turn means that their health needs and interaction with health care services may vary greatly.¹⁴

Studies have found that asylum seeking women together with newly arrived migrant and refugee women are ‘disproportionately affected by health and social problems, placing them at greater health risk’.¹⁵ ‘[A]sylum seekers have been identified as an especially vulnerable group in relation to maternity care and pregnancy outcomes.’¹⁶ The National Institute for Health and Clinical Excellence (NICE) has identified four groups of pregnant women with complex social factors who may have additional needs. These include women who are recent migrants, asylum seekers or refugees, or who have difficulty reading or speaking English.¹⁷ Yet ‘[t]he UKBA has only acknowledged pregnancy as representing a very limited health need unless there is a major pregnancy complication.’¹⁸ Pregnant asylum seeking women’s vulnerability stems from a number of factors which include separation from family and friends, experiences of sexual violence and trauma, poverty, homelessness, poor or no command of the English language and a lack of understanding of services and entitlements.¹⁹ Previous lack of access to antenatal care, poor

⁶ See e.g. Sophie Haroon, *The Health Care Needs of Asylum Seekers*, Faculty of Public Health, Briefing Statement, May 2008; and Angela Burnett and Michael Peel, ‘Health needs of asylum seekers and refugees’, *British Medical Journal* (2001), vol. 322, 544-547.

⁷ Sophie Haroon, *The Health Care Needs of Asylum Seekers*, Faculty of Public Health, Briefing Statement, May 2008, p. 1. See also Chris Campbell, Sarah Zadik and Jenny McGill, *Glasgow & Renfrewshire Asylum Seeker, Refugee Antenatal and Postnatal Support – Needs Analysis*, 18 October 2011, p. 3.

⁸ Sophie Haroon, *The Health Care Needs of Asylum Seekers*, Faculty of Public Health, Briefing Statement, May 2008, p. 4; and Megan Waugh, The mothers in Exile project, *Women Asylum Seekers’ and Refugees’ Experiences of Pregnancy and Childbirth in Leeds*, Womens Health Matters, March 2010, p. 7.

⁹ Angela Burnett and Michael Peel, ‘Health Needs of asylum seekers and refugees’, *British Medical Journal* (2001), vol. 322, 544-547, p. 544.

¹⁰ Sophie Haroon, *The Health Care Needs of Asylum Seekers*, Faculty of Public Health, Briefing Statement, May 2008, p. 4. Other factors that impact on asylum seekers’ health are ‘loss of status, culture shock, uncertainty, racism, hostility (...), housing difficulties (...) and loss of choice and control’ (ibid., p. 4).

¹¹ Ibid., p. 4; and Gareth Mulvey, *In Search of Normality, Refugee Integration in Scotland*, Scottish Refugee Council, March 2013, p. 87-89.

¹² Sophie Haroon, *The Health Care Needs of Asylum Seekers*, Faculty of Public Health, Briefing Statement, May 2008, p. 4.

¹³ Ibid., p. 4-5; and Health Protection Agency, *Migrant Health, Infectious Diseases in Non-UK Born Populations in England, Wales and Northern Ireland, A Baseline Report – 2006*, November 2006.

¹⁴ Angela Burnett and Michael Peel, ‘Asylum seekers and refugees in Britain, health needs of asylum seekers and refugees’, *British Medical Journal* (2001), vol. 322, 544-547, p. 544.

¹⁵ Maternity Action and Refugee Council, *When Maternity Does Not Matter. Dispersing Pregnant Women Seeking Asylum*, February 2013.

¹⁶ Ibid., p. 13; and Chris Campbell, Sarah Zadik and Jenny McGill, *Glasgow & Renfrewshire Asylum Seeker, Refugee Antenatal and Postnatal Support – Needs Analysis*, 18 October 2011, p. 3.

¹⁷ NHS, National Institute for Health and Clinical Excellence, *Pregnancy and Complex Social Factors*, September 2010, p. 4.

¹⁸ Maternity Action and Refugee Council, *When Maternity Does Not Matter. Dispersing Pregnant Women Seeking Asylum*, 2013, p. 17.

¹⁹ Chris Campbell, Sarah Zadik and Jenny McGill, *Glasgow & Renfrewshire Asylum Seeker, Refugee Antenatal and Postnatal Support – Needs Analysis*, 18 October 2011, p. 3. See also Maternity Care and Refugee Council, *When Maternity Does Not Matter. Dispersing Pregnant Women Seeking Asylum*, 2013, p. 61.

nutrition, and reproductive health being affected by female genital mutilation (FGM) can also contribute to the complex health needs these women may have and to the risks this creates for mother and child.²⁰

Studies on maternity care in the UK have emphasised the '[n]eed for individual and continuing risk assessments for pregnant asylum seekers, refugees and recent migrants and for specific health legal and social issues to be considered.'²¹ Research has identified a number of issues including sexual violence, domestic abuse and the impact that the UK Government dispersal policy and, more widely, the whole asylum process and the status of asylum seeker can have on pregnant asylum seeking women's maternity experiences. Studies have drawn attention to the need for empathy and sensitivity in the care of women who have experienced sexual violence.²² For example, women who have been raped or tortured may find internal examinations very distressing.²³ The same sensitive approach is needed in respect of women who have undergone FGM.²⁴ Women who experience domestic abuse have been identified as a group with complex social factors and likely additional needs.²⁵ As is the case with any other group of women, pregnant

asylum seeking women who are affected by domestic abuse have a need for support and advice. It follows that '[e]nquiry about [domestic] violence should be routinely included when taking a social history at booking or at another opportune point in the antenatal period.'²⁶ It is also recommended that women should be seen alone at least once during this period.²⁷

A 2013 study by Maternity Action and Refugee Council shows how the UK Government's dispersal policy can detrimentally affect pregnant asylum seeking women in that it fails to systematically recognise the complex needs that pregnancy entails for this group.²⁸ A study of maternity care for refugees and asylum seekers in Hillingdon has found evidence of a lack of understanding of the refugee and asylum seeking context on the part of maternity care services.²⁹ Studies on maternity care provision in the UK have also stressed the need for a culturally sensitive approach to maternity care. 'The 'Western' model of maternity care is [indeed] unfamiliar to some women from other countries and aspects of it may seem invasive and frightening.'³⁰

²⁰ Nancy Kelley and Juliette Stevenson, *First Do No Harm: Denying Healthcare to People Whose Asylum Claims Have Failed*, Refugee Council, June 2006, p. 9. See also Natasha Tsangarides and Jane Grant, *Expecting Change; the Case for Ending the Detention of Pregnant Women*, Medical Justice, 2013.

²¹ National Collaborating Centre for Women's and Children's Health, *Pregnancy and Social Complex Factors. A Model for Service Provision for Pregnant Women with Complex Social Factors*, London: National Institute for Health and Clinical Excellence (NICE), 2010, p. 97.

²² Megan Waugh, *The mothers in Exile project, Women Asylum Seekers' and Refugees' Experiences of Pregnancy and Childbirth in Leeds*, *Womens Health Matters*, March 2010, p. 8.

²³ Jenny McLeish, *Mothers in Exile, Maternity Experiences of Asylum Seekers in England*, 2002, p. 15, referring to K. Maharaj and P. O'Sullivan, *Assessment of the Mental Health Needs of Refugees and Asylum Seekers in the City and Hackney, Newham and Tower Hamlets area*, The Refugee Mental Health Steering Group and East London and the City Health Authority, 2001.

²⁴ Jenny McLeish, *Mothers in Exile, Maternity Experiences of Asylum Seekers in England*, 2002, p. 15, referring to J. Schott and A. Henley, *Culture, Religion and Childbearing in a Multiracial Society*, Butterworth/Heinmann, 1996.

²⁵ NHS, National Institute for Health and Clinical Excellence, *Pregnancy and Complex Social Factors*, September 2010.

²⁶ Confidential Enquiry into Maternal and Child Health (CEMACH), *Improving Care for Mothers, Babies and Children, Why Mother Die 2000-2002, Sixth Report of the Confidential Enquiries into maternal Deaths in the United Kingdom*, November 2004, p. 251.

²⁷ *Ibid.*, p. 251.

²⁸ Maternity Care and Refugee Council, *When Maternity Does Not Matter. Dispersing Pregnant Women Seeking Asylum*, February 2013.

²⁹ Anna Gaudion and Pascale Allotey, *Maternity Care for Refugees and Asylum Seekers in Hillingdon*, Public Health@Brunel, The Centre for Public Health research and Health Opportunities Promotion & Education (HOPE), 2008, p. i-ii.

³⁰ Jenny McLeish, *Mothers in Exile, Maternity Experiences of Asylum Seekers in England*, 2002, p. 15, referring to J. Schott and A. Henley, *Culture, Religion and Childbearing in a Multiracial Society*, Butterworth/Heinmann, 1996.

Research on pregnant asylum seeking women's experiences of accessing maternity care in the UK shows that a number of factors can constrain their access to maternity services. While other women may face difficulties in accessing these services, women asylum seekers can be confronted with additional barriers which arise from their status and circumstances as asylum seekers.³¹ Language has been identified as one of the primary barriers to access³² as communication is critical to women's ability to access maternity care.³³ Language and communication cut across all aspects of women's experiences of accessing these services.³⁴ The ability to communicate is vital to positive experiences of antenatal and postnatal care as well as labour.³⁵ Research has found that language barriers are particularly acute for people with mental health issues.³⁶ It follows that access to adequate interpreting services is essential where asylum seeking women have little or no command of the English language. Yet research has repeatedly found problems with access to interpreting services and the quality of interpreting. One of the main issues relates to the use of relatives or friends instead of professional interpreters.³⁷ Asylum seeking women's poor

knowledge of their rights and entitlements as well as their lack of familiarity with the NHS have been identified as another barrier to full and effective access to maternity care services.³⁸ Access to specific yet comprehensive information in relevant languages is central to effective access to these services and any other supporting services.³⁹ Staff's lack of or poor knowledge of asylum seekers' rights and entitlements has also been identified as a problem.⁴⁰ Studies have also found that staff's negative attitudes towards asylum seekers can hamper access to maternity care.⁴¹ Studies of maternity care for asylum seekers in England have found that difficulties registering with a GP could inhibit access to maternity care.⁴²

Research has identified asylum seekers as one of the most vulnerable groups in UK society. Pregnant asylum seeking women have been found to experience complex social factors which place them at greater health risk in relation to pregnancy and maternal outcomes. While these social factors are shared with other vulnerable groups, their asylum seeker status adds to their vulnerability. Research shows that refused asylum seekers constitute a particularly vulnerable group.

³¹ Chris Campbell, Sarah Zadik and Jenny McGill, *Glasgow & Renfrewshire Asylum Seeker, Refugee Antenatal and Postnatal Support – Needs Analysis*, 18 October 2011, p. 4.

³² Megan Waugh, *The mothers in Exile project, Women Asylum Seekers' and Refugees' Experiences of Pregnancy and Childbirth in Leeds*, Womens Health Matters, March 2010, p. 9, referring to K. Harper-Bulman and C. McCourt, *Somali Refugee Women's Experiences of Maternity Care in West London: A Case Study*, *Critical Public Health*, 2002; and *Maternity Action, Improving Care for Refugees and Asylum Seekers, The Experiences of Midwives*, December 2011, p. 9.

³³ Chris Campbell, Sarah Zadik and Jenny McGill, *Glasgow & Renfrewshire Asylum Seeker, Refugee Antenatal and Postnatal Support – Needs Analysis*, 18 October 2011, p. 5.

³⁴ Megan Waugh, *The mothers in Exile project, Women Asylum Seekers' and Refugees' Experiences of Pregnancy and Childbirth in Leeds*, Womens Health Matters, March 2010, p. 47.

³⁵ *Ibid.*, p. 47-53.

³⁶ Nancy Kelley and Juliette Stevenson, *First Do No Harm: Denying Healthcare to People Whose Asylum Claims Have Failed*, Refugee Council, June 2006, p. 17.

³⁷ Chris Campbell, Sarah Zadik and Jenny McGill, *Glasgow & Renfrewshire Asylum Seeker, Refugee Antenatal and Postnatal Support – Needs Analysis*, 18 October 2011, p. 5; *Maternity Action, Improving Care for Refugees and Asylum Seekers, The Experiences of Midwives*, December 2011, p. 9; and Confidential Enquiry into Maternal and Child Health (CEMACH), *Improving Care for Mothers, Babies and Children, Why Mother Die 2000-2002, Sixth Report of the Confidential Enquiries into maternal Deaths in the United Kingdom*, November 2004, p. 251.

³⁸ Jenny McLeish, *Mothers in Exile, Maternity Experiences of Asylum Seekers in England*, 2002, p. 14.

³⁹ Anna Gaudion and Pascale Allotey, *Maternity Care for Refugees and Asylum Seekers in Hillingdon*, Public Health@Brunel, The Centre for Public Health research and Health Opportunities Promotion & Education (HOPE), 2008, p. 33; and Jenny McLeish, *Mothers in Exile, Maternity Experiences of Asylum Seekers in England*, 2002, p. 14.

⁴⁰ Nancy Kelley and Juliette Stevenson, *First Do No Harm: Denying Healthcare to People Whose Asylum Claims Have Failed*, Refugee Council, June 2006, p. 17.

⁴¹ Anna Gaudion and Pascale Allotey, *Maternity Care for Refugees and Asylum Seekers in Hillingdon*, Public Health@Brunel, The Centre for Public Health research and Health Opportunities Promotion & Education (HOPE), 2008, p. iii; and Jenny McLeish, *Mothers in Exile, Maternity Experiences of Asylum Seekers in England*, 2002, p. 73.

⁴² Anna Gaudion and Pascale Allotey, *Maternity Care for Refugees and Asylum Seekers in Hillingdon*, Public Health@Brunel, The Centre for Public Health research and Health Opportunities Promotion & Education (HOPE), 2008, p. ii; and Jenny McLeish, *Mothers in Exile, Maternity Experiences of Asylum Seekers in England*, 2002, p. 14.

The majority of asylum seekers whose claims have been rejected are destitute.⁴³ Critically, destitution has been identified as a contributing factor to pregnant asylum seeking women's vulnerability.⁴⁴ Living without access to cash, which is the fate of the vast majority of refused asylum seekers, heightens this group's vulnerability.⁴⁵ Paradoxically, in England, refused asylum seekers' health care entitlements have been reduced as their vulnerability and need for health care increase.⁴⁶ While refused asylum seekers remain entitled to free NHS maternity care, Gaudion and Allotey observe that curtailments of health care entitlements for these asylum seekers 'have added a further possible layer of confusion and dissuasion to access maternity services'.⁴⁷ In contrast with England, refused asylum seekers' access to free NHS health care has not been curtailed in Scotland and Wales.

⁴³ Nancy Kelley and Juliette Stevenson, *First Do No Harm: Denying Healthcare to People Whose Asylum Claims Have Failed*, Refugee Council, June 2006, p.

⁴⁴ Chris Campbell, Sarah Zadik and Jenny McGill, *Glasgow & Renfrewshire Asylum Seeker, Refugee Antenatal and Postnatal Support – Needs Analysis*, 18 October 2011, p. 3. See also Maternity Action and Refugee Council, *When Maternity Does Not Matter. Dispersing Pregnant Women Seeking Asylum*, February 2013, p. 61.

⁴⁵ Megan Waugh, *The mothers in Exile project, Women Asylum Seekers' and Refugees' Experiences of Pregnancy and Childbirth in Leeds*, Womens Health Matters, March 2010, p. 19 and 55.

⁴⁶ *Ibid.*, p. 8. The UK Government is considering further restrictions to refused asylum seekers' access to free NHS health care in England (see Section 4.3. on health care entitlements for refused asylum seekers in the UK).

⁴⁷ Anna Gaudion and Pascale Allotey, *Maternity Care for Refugees and Asylum Seekers in Hillingdon*, Public Health@Brunel, The Centre for Public Health research and Health Opportunities Promotion & Education (HOPE), 2008, p. 6.

4.1 Asylum support in the UK

This section outlines the legal and policy framework for the provision of asylum support in the UK. For a diagram outlining the different stages of the UK asylum process, see Appendix I. Provision for the UK Government to support asylum seekers is contained within the Immigration and Asylum Act 1999 (the 1999 Act). Support for asylum seekers is uniform throughout the UK;⁴⁸ it is provided by the Home Office UK Visas and Immigration Directorate (formerly the UK Border Agency or 'UKBA')⁴⁹ and delivered through a series of contracts with private companies. Asylum support does not form part of the mainstream benefit system provided by the Department for Work and Pensions and as such does not entitle recipients to any additional mainstream support. Asylum seekers may be granted support under Section 95 or Section 4 of the 1999 Act ('Section 95 support' and 'Section 4 support').⁵⁰ Eligibility for both Section 95 and Section 4 support is conditional on asylum seekers being destitute. According to Section 95(3), 'a person is destitute if—

- (a) he does not have adequate accommodation or any means of obtaining it (whether or not his other essential living needs are met); or
- (b) he has adequate accommodation or the means of obtaining it, but cannot meet his other essential living needs.'

Section 95 support is, in principle, reserved to destitute asylum seekers whose asylum claim

has not yet been determined. However, families whose household includes dependants under the age of 18 years-old may continue to receive Section 95 support if their asylum claim is refused until the youngest child turns 18, they leave the UK voluntarily or they are removed.⁵¹ It remains the case that support for refused asylum seekers without one or more dependants under 18 years-old is normally provided through Section 4 of the Act. In addition to being destitute,⁵² applicants for Section 4 support must satisfy one of the following five conditions:

- '[they are] taking all reasonable steps to leave the United Kingdom or place [themselves] in a position in which [they are] able to leave the United Kingdom, which may include complying with attempts to obtain a travel document to facilitate [their] departure';
- '[they are] unable to leave the United Kingdom by reason of a physical impediment to travel or for some other medical reason;
- [they are] unable to leave the United Kingdom because in the opinion of the Secretary of State there is currently no viable route of return available;
- [they have] made an application for judicial review of a decision in relation to [their] asylum claim (...); or
- the provision of accommodation is necessary for the purpose of avoiding a breach of a person's Convention rights, within the meaning of the Human Rights Act 1998'.⁵³

⁴⁸ Asylum is a reserved matter (Section B6 of the Scotland Act 1998).

⁴⁹ In March 2013, the Home Secretary announced that the functions of UKBA would be brought back into the Home Office and that asylum would sit within two new Home Office directorates: UK Visas and Immigration and Immigration Enforcement (Home Office Oral Statement, 26 March 2013, UK Border Agency, <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/news/ho-os.pdf>).

⁵⁰ Support may also be provided to asylum seekers who are destitute pending consideration of their application for support under Section 95 (Section 98 of the 1999 Act, known as 'Section 98 support').

⁵¹ Article 94(5) of the 1999 Act.

⁵² Regulation 3(1)(a) of the Immigration and Asylum (Provision of Accommodation to Failed Asylum-Seekers) Regulations 2005. The test for destitution under section 4 is the same as that used under section 95 (3) of the 1999 Act (Regulation 2 of the Immigration and Asylum (Provision of Accommodation to Failed Asylum-Seekers) Regulations 2005).

⁵³ Regulation 3(2) of the Immigration and Asylum (Provision of Accommodation to Failed Asylum-Seekers) Regulations 2005.

The condition most relevant to pregnant refused asylum seekers is the criterion relating to medical impediments to travel.⁵⁴ A pregnant woman who applies for Section 4 support must provide a maternity certificate (MAT B1 form) confirming her pregnancy; however, she will not usually be granted Section 4 support until she is at least 34 to 36 weeks pregnant. A pregnant woman relying solely on this criterion will therefore face destitution until she reaches the final stages of her pregnancy, unless she meets one of the other criteria for receipt of Section 4 support.

Section 4 support consists of accommodation and the Azure payment card.⁵⁵ This is a pre-paid card that may be used to buy food and other essential items in designated stores to the value of £35.39 per person per week.⁵⁶ Asylum seekers on Section 4 support do not receive any support in cash. The UK Government is of the view that a cashless system prevents support from acting as 'an incentive to remain (...) [and] an extended drain on limited public funds.'⁵⁷ The Azure card can only be used in designated supermarkets, charity and retail shops.⁵⁸ Asylum seekers on Section 4 support may apply for additional support to buy clothes for children to the value of £5 per child.⁵⁹ Additional support ceases to be available when the

child turns 16.⁶⁰ Additional support is also available to pregnant asylum seekers and new mothers on Section 4.⁶¹ Any additional support granted will be loaded onto the Azure card and will not be paid in cash. Section 4 support does not cover the cost of travel to reporting.⁶² Asylum seekers, including pregnant women, who live within three miles of their designated reporting centre, are normally expected to walk there.⁶³ Refused asylum seekers on Section 4 support will continue to receive support until the barrier to their leaving the UK is removed.⁶⁴ Section 4 support may be withdrawn where there is a material change in the asylum seeker's circumstances which affects his or her eligibility.⁶⁵ Regular reviews seek to establish whether refused asylum seekers are still eligible for Section 4 support.⁶⁶ Research in Glasgow established that it is not uncommon for people to move on and off Section 4 support, with the consequent disruption to women's lives and implications for their health and wellbeing.⁶⁷ More recent research revealed that destitution is a very real risk even for pregnant women: in a survey of support services in Glasgow over a single week in March 2012, five pregnant women and two new mothers sought help because they were destitute.⁶⁸

⁵⁴ Maternity Action and Refugee Council, *When Maternity Does Not Matter. Dispersing Pregnant Women Seeking Asylum*, February 2013, p. 11.

⁵⁵ The Azure card replaced vouchers in February 2010. In some cases, Section 4 support may take the form of full-board accommodation (UKBA, *Section 4 Key Points of Reference*, paragraph 10 <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/aboutus/workingwithasylumseekers/section-4-key-points.pdf>).

⁵⁶ UKBA, Section 4 Support, <http://www.ukba.homeoffice.gov.uk/asylum/support/apply/section4/> (accessed: 14 June 2013).

⁵⁷ UKBA, *Section 4 Key Points of Reference*, paragraph 11 <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/aboutus/workingwithasylumseekers/section-4-key-points.pdf>.

⁵⁸ For a current list of the retailers and charity shops where the Azure card can be used see: <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/asylum/vouchers.pdf>

⁵⁹ Regulation 8 of the Immigration and Asylum (Provision of Services and Facilities) Regulations 2007.

⁶⁰ Regulation 8 of the Immigration and Asylum (Provision of Services and Facilities) Regulations 2007.

⁶¹ See section 4.2. on support for refused asylum seekers who are pregnant or new mothers in the UK.

⁶² Asylum seekers who are not detained are asked to report to a reporting centre or a police station if they live a long distance from the nearest reporting centre.

⁶³ UKBA, Section 4 Key Points of Reference, paragraph 44 <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/aboutus/workingwithasylumseekers/section-4-key-points.pdf>.

⁶⁴ *Ibid.*, paragraph 15.

⁶⁵ *Ibid.*, paragraph 15.

⁶⁶ *Ibid.*, paragraph 16. In principle, there shall be no more than 3 months between reviews (*ibid.*).

⁶⁷ Gareth Mulvey, *Even Among Asylum Seekers We Are the Lowest: Life on Section 4 Support in Glasgow*, Scottish Refugee Council, 2009, p. 21.

⁶⁸ Morag Gillespie, *Trapped: Destitution and Asylum Support in Scotland*, Scottish Poverty Information Unit, Glasgow Caledonian University, 2012, p.10.

4.1.1 Asylum support for refused asylum seekers who are pregnant or new mothers

If no other criterion under Section 4 of the 1999 Act is met (see 4.1 above), pregnant women who are refused asylum will face withdrawal of Section 95 support within 21 days of receipt of a negative decision on their claim, and will face enforced destitution until they reach between 34-36 weeks of pregnancy to meet the criteria to receive Section 4 support.

Asylum seekers in receipt of either Section 95 or Section 4 support are entitled to claim an additional £3 per week during their pregnancy until the first birthday of the child; £5 per week for every child under 12 months; and £3 for children between 1 and 3 years.⁶⁹ They can also claim £250 from 8 weeks before the baby is due until 6 weeks after the birth.⁷⁰ However, additional support for pregnant women and new mothers on Section 4 is cashless, credited to the Azure Card, and may only be used for goods and services relevant to the antenatal and postnatal period. As is the case with other refused asylum seekers on Section 4, pregnant women and new mothers do not receive assistance with their travel costs to report to immigration officials if they live within three miles of the reporting centre. However, those with mitigating circumstances such as the late stages of pregnancy can apply to the Home Office with a view to adapting their reporting conditions. For example, the frequency of reporting may be reduced or they may be asked to report at a local police station.⁷¹ Refused asylum seekers may also be moved closer to the reporting centre.⁷² Asylum seekers are usually required to submit medical evidence in support of their request to vary their reporting requirements.

Additionally, pregnant asylum seeking women on Section 4 support may apply to the Home Office to request travel expenses to attend essential medical appointments, and, following a recent amendment to the wording of policy guidance, to request taxi vouchers specifically to enable them to travel to and from hospital when in labour.⁷³

4.1.2 Dispersal to Glasgow

Within the 1999 Act is contained the provision in Section 97 requiring the Home Office to 'have regard to the desirability, in general, of providing accommodation in areas in which there is a ready supply of accommodation'.⁷⁴ This has been interpreted in Home Office policy to mean that destitute asylum seekers awaiting a decision and refused asylum seekers qualifying for support are generally dispersed out of London and the south east of England to cities across the UK, including Glasgow.

Following dispersal to 'Initial Accommodation', which in Glasgow is a block of high-rise flats in the Springburn area of the city for 2-3 weeks, people will then be dispersed again to accommodation across the city while they await a decision on their asylum claim. Should their claim be refused and they become eligible for Section 4 support, people may then be dispersed again to different accommodation, which can be shared. Since 2000, Glasgow has been the only dispersal area in Scotland, so multiple dispersal moves have always occurred within one Local Authority and Health Board area, unlike in England and Wales where pregnant women may face multiple moves across different towns and cities and the consequent disruption this can cause to access to health care, schooling and other services.⁷⁵

⁶⁹ Regulation 7 of the Immigration and Asylum (Provision of Services and Facilities) Regulations 2007.

⁷⁰ Regulation 8 of the Immigration and Asylum (Provision of Services and Facilities) Regulations 2007.

⁷¹ UKBA, *Section 4 Key Points of Reference*, paragraph 44.

⁷² *Ibid.*

⁷³ UKBA, Section 4: Additional Services or Facilities under the 2007 Regulations, p.14.

⁷⁴ Article 97(1) of the 1999 Act

⁷⁵ Maternity Action and Refugee Council, *When Maternity Does Not Matter. Dispersing Pregnant Women Seeking Asylum*, February 2013.

Estimates point to between 2000–6500 asylum seekers being supported by the Home Office in Glasgow at any one time since 2000, equating to approximately 10% of asylum applicants in the UK. For various reasons, including the way the Home Office records data and the lack of data on where people go after being granted leave to remain through the asylum process, it is very difficult to get accurate figures for the total number of refugees and asylum seekers currently residing in Scotland. Using the figure of approximately 10% of asylum applicants to the UK dispersed to Glasgow against the total population in the UK of concern to the UN High Commissioner for Refugees, Scottish Refugee Council estimated there to be approximately 20,000 refugees, asylum seekers and others of concern in Scotland in 2011.⁷⁶

Around one third of main applicants for asylum in the UK are women, but many more women and girls will enter the UK as ‘dependents’ (spouse, partner or child) of a male main applicant and it is very difficult to get a total figure for the gender breakdown of the refugee population. A rough estimate would be that one-third to one-half of the 20,000 ‘population of concern’ in Scotland is likely to be women and girls.

4.2 Health care entitlements for refused asylum seekers in the UK

Refused asylum seekers’ health care entitlements vary across the UK. This is because health care provision has been a devolved matter since the creation of the NHS in 1947.⁷⁷ Although the focus

of this project is Scotland, this section provides an overview of refused asylum seekers’ health care entitlements in all administrations of the UK. The intention is to highlight the differences that exist across the UK in respect of refused asylum seekers’ access to free NHS health care. Access to free primary and secondary care are considered in turn as refused asylum seekers’ entitlements may also vary with the type of health care.

4.2.1 Access to free NHS primary care

Refused asylum seekers are currently entitled to free NHS primary care in Scotland⁷⁸, Wales and England.⁷⁹ In 2004, however, the Department of Health considered excluding overseas visitors, including refused asylum seekers, from free NHS primary medical services in England, save in respect of urgent and immediately necessary treatment.⁸⁰ The aim of the proposed restrictions was to strengthen the link between free use of the NHS and UK citizenship or residency.⁸¹ In 2010, the UK Government decided that there should be no change to the current rules on overseas visitors’ eligibility for free NHS primary care for the time being.⁸² However, in July 2013, the Home Office and Department of Health launched parallel consultations in the context of the new Immigration Bill, proposing to make changes to migrants’ access to health care. Again, the focus was on strengthening the link between free access to the NHS and UK citizenship or long-term residency and financial contribution to NHS services.⁸³ It proposed that categories of migrants should

⁷⁶ Scottish Refugee Council, *Improving the Lives of Refugees in Scotland after the Referendum: An Appraisal of the Options*, January 2013, p.16

⁷⁷ National Health Service (Scotland) Act 1947.

⁷⁸ Regulation 4 (c) of the National Health Service (Charges to Overseas Visitors) (Scotland) Regulations 1989; and Scottish Government Health Directorate (2010) Overseas Visitors’ Liability to Pay Charges for NHS Care and Services CEL09 2010, paragraph 32.

⁷⁹ Health Service Circular (HSC) 1999/018, NHS Executive, UK, 1 February 1999, Overseas Visitors’ Eligibility to Receive Free Primary Care, paragraph 3. This circular is now obsolete, but it still provides guidance. See also Welsh Health Circular 99 (32), Overseas Visitors’ Eligibility to Receive Free Primary Care, 25 February 1999, paragraph 8.

⁸⁰ Department of Health, *Proposals to Exclude Overseas Visitors from Eligibility to Free NHS Primary Medical Services*, May 2004.

⁸¹ *Ibid.*

⁸² Department of Health (England), *Review of Access to the NHS by Foreign Nationals*, February 2010, p. 4 and Annex 4.

⁸³ Home Office, *Controlling Immigration – Regulating Migrant Access to Health Services in the UK*, 3 July 2013. See also Department of Health, *Sustaining Services, Ensuring Fairness. A Consultation on Migrant Access and their Financial Contribution to NHS Provision in England*, July 2013.

be charged for all NHS services including primary care.⁸⁴ The proposals provided for charging exemptions for certain categories of migrants, including refugees, asylum seekers and ‘failed asylum seekers receiving Section 4 or Section 95 support’.⁸⁵ The UK-wide Home Office consultation noted that ‘changes should apply across the UK’ and suggested the UK Government would ‘engage with the Devolved Administrations in Scotland, Wales and Northern Ireland on how these principles could be applied nationally.’⁸⁶

Published responses to the 2013 consultations outlined concern among organisations working with migrants and refugees across the UK, representative bodies of health professionals, as well as individual respondents and members of the public, about the government’s proposals.⁸⁷ The 2013 Immigration Bill contains only two of the key provisions in relation to access to health care that were proposed in the consultation: the power to impose a health surcharge on migrants seeking entry to the UK and a change to the definition of ordinary residence for the purpose of accessing NHS health care.⁸⁸ It is not yet clear what the full impact will be of the introduction of the new Immigration Bill nor expected secondary legislation to follow in 2014.

In contrast with other parts of the UK, access to free NHS primary care in Northern Ireland is more limited in that eligibility is conditional on ordinary residency in the country.⁸⁹ Asylum seekers and refugees are considered ordinarily resident,

but there are no exemptions for refused asylum seekers.⁹⁰ However, GPs retain discretion to register any person as a patient.⁹¹ In a 2011 report, the Northern Ireland Human Rights Commission recommended that the link between ordinary residency and access to free NHS primary care be removed.⁹²

4.2.2 Access to free NHS secondary care

Refused asylum seekers’ entitlements to free NHS secondary care vary across the UK. In contrast with Scotland and Wales, refused asylum seekers’ entitlements have been curtailed in England and Northern Ireland.

England

The National Health Service (Charges to Overseas Visitors) Regulations 1989 (the 1989 Regulations) provided that certain categories of overseas visitors were exempt from charges.⁹³ Originally the 1989 Regulations exempted any person who had spent the previous 12 months in the UK and any person who had been granted refugee status or who had applied for leave to stay as a refugee.⁹⁴ However, subsequent regulations issued in 2004 made overseas visitors’ eligibility for free NHS secondary care subject to further conditions (the 2004 Regulations).⁹⁵ These regulations specified that the 12 months residency in the UK must be lawful and that exemptions from charges

⁸⁴ Home Office, *Controlling Immigration – Regulating Migrant Access to Health Services in the UK*, 3 July 2013, p.23

⁸⁵ *Ibid.*, paragraph 3.10.

⁸⁶ *Ibid.*, foreword and paragraph 1.7

⁸⁷ Home Office, *Controlling Immigration – Regulating Migrant Access to Health Services in the UK: Results of the public consultation*, 22 October 2013, Annex A p.26.

⁸⁸ Bill 128 2013-14 [as amended in Public Bill Committee]

⁸⁹ Department of Health Social Services and Public Safety (2000) *Family health services for persons not ordinarily resident in Northern Ireland*, Circular *HSS(PCD) 10/2000*. DHSSPS, Belfast.

⁹⁰ BMA Ethics, *Access to Health Care for Asylum Seekers and Refused Asylum Seekers – Guidance for Doctors*, January 2013, p.3.

⁹¹ *Ibid.*, p.3.

⁹² Northern Ireland Human Rights Commission, *Access Denied - or Paying when you Shouldn't*, NIHRC, 2011, referred to in BMA Ethics, *Access to Health Care for Asylum Seekers and Refused Asylum Seekers – Guidance for Doctors*, January 2013, p.3.

⁹³ Regulations 4, 5 and 6 of the National Health Service (Charges to Overseas Visitors) Regulations 1989.

⁹⁴ Respectively Regulations 4(b) and 4 (c) of the National Health Service (Charges to Overseas Visitors) Regulations 1989.

⁹⁵ National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2004

only applied to those asylum seekers whose applications were still pending.⁹⁶ Thus refused asylum seekers became liable to pay charges for NHS secondary care, save in respect of exempted hospital services.⁹⁷

In *R (Ya) v Secretary of State for Health*, the Court of Appeal confirmed that asylum seekers could not be regarded as ordinarily resident in the UK and that most of them did not satisfy the lawful residence requirement.⁹⁸ The Court, however, held that NHS trusts had discretion to provide secondary care to refused asylum seekers free of charge.⁹⁹ The 1989 and 2004 Regulations were revoked by the NHS (Charges to Overseas Visitors) Regulations 2011 (England) (the 2011 Regulations). The 2011 Regulations maintain the 12 months lawful residency requirement and it remains the case that only those asylum seekers whose claim is still pending are entitled to free secondary care.¹⁰⁰ Importantly and in contrast with previous regulations, the 2011 Regulations provide that asylum seekers 'supported under Section 4 or 95 of the Immigration and Asylum Act 1999' are exempt from charges.¹⁰¹ It follows that refused asylum seekers who are on Section 4 support or who continue to receive Section 95 support, are no longer liable to pay for NHS secondary care in England.¹⁰²

Northern Ireland

As is the case in England, some categories of overseas visitors may access NHS secondary care free of charge. These include persons who have lawfully resided in the UK for 12 months and asylum seekers whose claims have not yet been determined.¹⁰³ The 2011 Regulations do not apply to Northern Ireland. Thus, refused asylum seekers remain liable to pay for NHS secondary care, unless they are accessing exempted services.¹⁰⁴ This is irrespective of whether they are receiving Section 4 or Section 95 support.

Scotland

The 1989 Regulations also apply in Scotland.¹⁰⁵ However, Scotland has not introduced an equivalent to the 2004 Regulations. It follows that asylum seekers whose claim has been rejected remain eligible for free NHS secondary care in Scotland. Practitioners as well as voluntary sector organisations expressed concern¹⁰⁶ that restrictions to refused asylum seekers' access to free secondary care in England and statutory agencies' misrepresentation of differing entitlements across the UK could bring confusion to Scotland.

⁹⁶ Regulations 4(d) and (e) of the National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2004.

⁹⁷ These include treatment for serious communicable diseases, treatment in Accident and Emergency departments and compulsory psychiatric treatment. Since 1 October 2012, overseas visitors are no longer liable to pay for HIV treatment in England (The National Health Service (Charges to Overseas Visitors) Amendment Regulations 2012 (the 2012 Regulations)). Before the adoption of these Regulations, only the initial diagnostic and associated counselling were free for overseas visitors.

⁹⁸ [2009] EWCA Civ 225.

⁹⁹ *Ibid.*

¹⁰⁰ Respectively Regulation 6 and 11(b).

¹⁰¹ Regulation 11(c) of the NHS (Charges to Overseas Visitors) Regulations 2011 (England).

¹⁰² Department of Health (England), *Guidance on Implementing the Overseas Visitors Hospital Charging Regulations*, first published 1 August 2011, updated 31 October 2013, paragraph 3.63.

¹⁰³ Respectively regulation (c) and 3(d) of the Provision of Health Services to Persons Not 'Ordinarily resident' Regulations (NI) 2005.

¹⁰⁴ The secondary care services exempted from charges in Northern Ireland are the same as in England. However, the 2012 Regulations which make access to HIV treatment free for all in England do not apply to Northern Ireland.

¹⁰⁵ Regulation 4 (c) of the National Health Service (Charges to Overseas Visitors) (Scotland) Regulations 1989.

¹⁰⁶ For example, in 2011, Scottish Refugee Council expressed concern that inaccuracies in the summary of rules on refused asylum seekers' health care entitlements in Scotland in a UKBA 2011 consultation document could result in vulnerable people being denied treatment they were entitled to (UKBA, *Refusing Entry or Stay to NHS Debtors: Results of the Public Consultation on Proposed Changes to the Immigration Rules*, March 2011).

In an attempt to clarify the regulations in Scotland, in 2010 the Scottish Government re-issued its guidance on ‘Charges to Overseas Visitors’, confirming that refused asylum seekers remained entitled to free health care, including secondary health care, in Scotland. It clearly states that:

‘Anyone who has made a formal application for asylum, whether pending or unsuccessful, is entitled to treatment on the same basis as a UK national who is ordinarily resident in Scotland while they remain in the country. If their application to remain in the UK is successful, they will be granted refugee status and will continue to be exempt from NHS charges on the same basis as a person ordinarily resident in Scotland.’¹⁰⁷

Wales

In contrast to Scotland, Wales introduced the 2004 Regulations with the consequence that access to free NHS secondary care for refused asylum seekers was curtailed.¹⁰⁸ However, in 2009, Wales issued new Regulations which reinstated refused asylum seekers’ entitlement to free NHS secondary care.¹⁰⁹

4.2.3 Refused asylum seekers’ entitlements to maternity care in the UK

Maternity care includes antenatal care, birth and postnatal care as well as HIV treatment during pregnancy.¹¹⁰ Refused asylum seekers are entitled to access maternity care across the UK. However, whether they are liable to pay for maternity care depends on their entitlement

to free NHS health care. Accordingly, in both Scotland and Wales, refused asylum seekers are entitled to free NHS maternity care. Conversely, in England and Northern Ireland, they may be charged for maternity care. In England, only those refused asylum seekers who are on Section 4 or Section 95 support are exempt from charges.¹¹¹ Importantly, maternity care can never be denied or delayed because asylum seekers cannot pay. This is because ‘all maternity services, including routine antenatal treatment, must be treated as being immediately necessary.’¹¹² Moreover, international human rights law requires that the UK provide maternal care for refused asylum seekers, notwithstanding their immigration status.

4.3 International human rights obligations and maternity care

Maternity care forms part of health care. The latter is characterised as a basic necessity and as such is recognised in international human rights law as a basic social right inherent in human dignity. The right to health care is a core component of the right to health together with the underlying preconditions for health such as an adequate supply of food and nutrition and access to potable water and adequate sanitation.¹¹³ The right to health care as enshrined in international human rights imposes a range of obligations on States, including the UK, in respect of maternity care. The right to health care is recognised in a number of international human rights instruments. These include the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR) (Article 12), the 1979 Convention on the Elimination

¹⁰⁷ Scottish Government Health Directorate (2010) Overseas Visitors’ Liability to Pay Charges for NHS Care and Services CEL09 2010, paragraph 32.

¹⁰⁸ The National Health Service (Charges to Overseas Visitors) (Amendment) (Wales) Regulations 2004.

¹⁰⁹ NHS (Charges to Overseas Visitors) (Amendment) (Wales) Regulations 2009.

¹¹⁰ See, for example, Maternity Service Liaison Committees (MSLCs), An Introduction to Maternity Services in the NHS, Public Health England, 2013, <http://www.chimat.org.uk/mslc/about/nhs>

¹¹¹ Regulation 11(c) of the NHS (Charges to Overseas Visitors) Regulations 2011 (England).

¹¹² Department of Health (England), *Guidance on Implementing the Overseas Visitors Hospital Charging Regulations*, first published 1 August 2011, updated 31 October 2013, paragraph 4.7.

¹¹³ Committee on Economic, Social and Cultural Rights, General Comment No. 14 (2000), *The right to the highest attainable standard of health*, UN Doc. E/C.12/2000/4, 11 August 2000, paragraphs 4 and 11 (General Comment 14).

of All Forms of Discrimination against Women (CEDAW) (Article 12) and the 1989 Convention on the Rights of the Child (CRC) (Article 24).¹¹⁴ All these instruments are legally binding on the UK.

The ICESCR provides for the progressive realisation of rights to the maximum of States' resources.¹¹⁵ The ICESCR, however, imposes a number of core obligations on States with a view to ensuring minimum standards in respect of the rights guaranteed in the Covenant.¹¹⁶ Core obligations are non-derogable. Article 12 of the ICESCR gives rise to a range of core obligations.¹¹⁷ Initially, core obligations arising from the right to health care were primarily concerned with the provision of primary health care for all.¹¹⁸ These obligations, however, have grown over the years. General Comment 14 on the right to the highest attainable standard of health (General Comment 14) has identified further Article 12 core obligations. Importantly, Article 12 as interpreted in General Comment 14 places on States an obligation to 'ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups'.¹¹⁹ This forms the core content of the States' 'obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including (...) asylum seekers and illegal immigrants^[120], to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy'.¹²¹ General Comment 14 also lists a number of more specific obligations which are deemed of 'comparable priority' to core obligations.

Importantly, according to General Comment 14, States Parties to the ICESCR have an obligation to '*ensure reproductive, maternal (pre-natal as well as post-natal) and child health care*'.¹²² Thus Article 12 ICESCR enshrines the right to maternity care for all women irrespective, inter alia, of immigration status. In other words, Article 12 ICESCR enshrines the principle of universal access to maternity care.

Further obligations pertaining to maternity care arise from other human rights instruments. Like the ICESCR, these instruments uphold the principle of universal access to maternity care. Article 12(2) of the CEDAW provides that 'States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.' In Concluding Observations from its examination of the UK in July 2013, the CEDAW Committee urged the State party to '[s]trengthen the implementation of programmes and policies aimed at providing effective access for women to health care, particularly to women with disabilities, older women, asylum-seeking and Traveller women'.¹²³ Article 24 of the CRC reiterates the obligation to 'ensure appropriate pre-natal and post-natal health care for mothers'.

A failure to provide refused asylum seekers with adequate maternity care could also engage the obligations of the UK Government under the European Convention on Human Rights (ECHR). The latter was incorporated in the UK legal systems by the Human Rights Act 1998. The

¹¹⁴ The right to health care is also enshrined in Article 5 of the 1948 Universal Declaration of Human Rights. The latter, however, is not binding on States.

¹¹⁵ Article 2(1) of the ICESCR.

¹¹⁶ Committee on Economic, Social and Cultural Rights, General Comment 3, The nature of States parties' obligations (Fifth session, 1990), U.N. Doc. E/1991/23, annex III at 86 (1991) (General Comment 3).

¹¹⁷ General Comment 14, paragraph 47.

¹¹⁸ Declaration of Alma Ata, in World Health Organisation, 'Primary Health-care: Report of the International Conference on Primary Health-care' (1978), WHO, Geneva, pp. 3-4; General Comment 3, paragraph 10; and General Comment 14, paragraph 43.

¹¹⁹ Ibid. paragraph 43(a).

¹²⁰ Emphasis added.

¹²¹ General Comment 14, paragraph 34.

¹²² Ibid., paragraph 44(a). Emphasis added.

¹²³ Committee on the Elimination of Discrimination against Women (CEDAW), United Kingdom of Great Britain and Northern Ireland, Concluding comment, CEDAW/C/GBR/CO/7, 26 July 2013, paragraph 53(a) (emphasis added).

latter may be relied upon by individuals in British Courts to enforce their ECHR rights. The ECHR does not guarantee the right to health care, but the European Court of Human Rights (ECtHR) has constantly held that the ECHR could give rise to obligations, albeit limited, in the field of health care. For example, the ECtHR has repeatedly held that a State's failure to provide prisoners with adequate medical assistance breached Article 3 when the ensuing harm attained the requisite severity threshold.¹²⁴ Article 3 prohibits torture as well as inhuman or degrading treatment or punishment. Health care standards in Contracting States can also give rise to complaints under Article 2.¹²⁵ For instance, in *Cyprus v. Turkey*, the Court found that Article 2 (right to life) could be engaged 'where it is shown that the authorities [...] put an individual's life at risk through the denial of health care which they have undertaken to make available to the population generally.'¹²⁶ Besides, the ECtHR has accepted, in principle, that Article 8 (right to respect for private and family life) could generate obligations in the area of health care.¹²⁷ However, the ECtHR remains 'extremely hesitant about reading into the Convention a positive obligation to provide health care', beyond what may be regarded as extreme circumstances.¹²⁸

International human rights obligations uphold the principle of universal access to maternal care. It follows that maternity care and more broadly

health care provision for refused asylum seekers in the UK must, at the very least, satisfy the minimum standards set out by Article 12 as interpreted by General Comment 14 as well as meet the obligations arising out of other international human rights obligations.

¹²⁴ See e.g. ECtHR, *Keenan v. United Kingdom* (Judgment), (2001), Application No. 27229/95; ECtHR, *Khudobin v. Russia* (Judgment), (2006), Application No. 59696/00; and ECtHR, *Ireland v. United Kingdom* (Judgment), Application No. 5310/71, (1978).

¹²⁵ ECtHR, *Nitecki v. Poland* (Decision on Admissibility), (2002), Application No. 65653/01; and ECtHR, *Pentiacova and Others v. Moldova* (Judgment), (2005), Application No. 14462/03.

¹²⁶ ECtHR, *Cyprus v. Turkey* (Judgment), (2001), Application No. 25781/94, para. 219.

¹²⁷ ECtHR, *Pentiacova and Others v. Moldova* (Judgment), (2005), Application No. 14462/03. The ECtHR found the Article 8 complaint manifestly ill-founded (*ibid.*).

¹²⁸ L. Clements & A. Simmons, 'European Court of Human Rights, Sympathetic Unease', in M. Langford (ed.), *Social Rights Jurisprudence, Emerging Trends in International and Comparative Law*, Cambridge/New York/Melbourne/Madrid/Cape Town/Singapore/São Paulo/Delhi/Tokyo/Mexico City, Cambridge University Press, 2008, 409-427, p. 418.

During the design stages of the project, an advisory group was formed to seek feedback from experienced professionals on the scope of the project, the research strategy and methodology. In addition to the two researchers, the advisory group was comprised of key health professionals from Greater Glasgow and Clyde Health Board with expertise in working with asylum seekers: the Link Asylum Seeker and Refugee Midwife, the Glasgow Asylum Seeker Health Coordinator, a GP from a local medical practice with a large proportion of asylum seeking patients, a clinical psychologist and Team Leader of the Compass Refugee and Asylum Seeker Mental Health Team, and a midwife from the Homelessness Health Team. The researchers also consulted with the Head of Asylum Services and Asylum Services Manager at Scottish Refugee Council (SRC). The project received ethics approval from the Ethics Committee of the University of Strathclyde.

Data was obtained from interviews with women asylum seekers, secondary care professionals and voluntary sector workers based in Glasgow. A focus group discussion was also organised with staff at a Glasgow Medical Practice. The research data was gathered between May 2012 and April 2013. Asylum seekers interviewed for this project were identified and approached through Scottish Refugee Council's networks. The researchers circulated calls for participation to women's drop-ins, refugee community organisations, support groups, integration networks and refugee support organisations in Glasgow, and received a small number of referrals. Scottish Refugee Council handed out information about the research to female clients attending appointments and drop-ins, and on a number of designated days, volunteers proactively approached all female clients attending the drop-in service about the research.

Perhaps due to the precarious circumstances of the target group and other on-going stresses in their lives, it proved difficult to contact women to follow up a referral or note of interest and some women approached were reluctant to participate. The capacity of frontline workers and volunteers at Scottish Refugee Council to assist in sourcing potential participants was limited by pressures on staff time and the high volume of clients passing through the drop-in service with urgent support needs. Reduced resources at voluntary sector organisations more broadly is likely to have been a factor in the small number of referrals received. The small project budget also had an impact on the capacity of staff and investigators, as well as on the number of participants we were able to support with interpreters and travel expenses to take part. Whilst the researchers acknowledge the small sample from which the data is drawn, it was felt that the study provides a unique snapshot analysis of the views of women asylum seekers and health professionals in an as yet little-explored area.

The principal investigator conducted semi-structured interviews with nine women asylum seekers in Glasgow to gather information on their experiences of accessing NHS maternity care. All participants were interviewed by the principal investigator. Interviews took place at a location of the participants' choice. Four participants elected to be interviewed at Scottish Refugee Council premises and the other five participants were interviewed at home. Travel expenses were paid for participants who chose to be interviewed at Scottish Refugee Council. Female interpreters were used where participants requested them (four participants). Interpreters were provided through Scottish Refugee Council (a mixture of sessional and agency interpreters). In one instance, the participant came accompanied by her husband who acted as interpreter. The researchers acknowledge that his presence may

have influenced her responses. The researchers acknowledge more broadly that the use of interpreters may have influenced participants' responses and the accuracy of interview data. All interpreters were asked to sign a confidentiality agreement.

Interviews were recorded subject to the participants' consent: seven participants declined to be recorded. Where participants withheld consent, the principal investigator took notes. At the start of each interview, the principal investigator went through the information sheet provided to each participant, explaining the purpose of the project in simple terms and what was expected of participants. It was stressed that participation in the project was entirely voluntary and that participants could refuse to take part or withdraw from the project at any time, emphasising that participants did not have to give a reason for their decision. It was further emphasised that participation, refusal to participate or subsequent withdrawal from the project carried no risks to the women being interviewed and, in particular, that there were no implications for their immigration status or access to healthcare. The principal investigator made it clear to the participants that they could refuse to answer any given question and that they did not have to provide a reason. It was also explained to participants that any information obtained in the course of the interview would remain confidential and that no information that could identify them would be made publicly available. Participants were asked to sign a consent form confirming they had fully understood the information given to them in writing and orally prior to the start of the interview.

In the interviews, participants were first asked about their background, family situation and current immigration status. Two participants were

pregnant at the time of the interview. The other seven participants had at least one child under the age of one who was born in Glasgow at the time of the interview. Three participants had received a negative decision on their asylum claim as main applicants: one was awaiting the outcome of an appeal, another the outcome of a fresh claim, and the third had exhausted all legal remedies currently available to her. Two women were dependents on their husbands' asylum claims, both of which had been refused asylum but one had an appeal pending and the other had submitted a fresh claim which was also pending. Three participants had not been refused asylum at the time of the interview. Two of them were at the start of the asylum process and their claims had not yet been determined. One participant had recently been granted refugee status. Women who had not been refused asylum were interviewed because their experiences of accessing maternity care informed the research and provided a basis for comparing their experiences with those of women who had received a negative decision on their asylum claim. Participants were then asked about their experiences of accessing maternity care in Glasgow. Participants were advised that they could make any comments as they saw fit, ask questions and seek clarification, and raise issues that had not been touched upon by the principal investigator. All data was fully anonymised and each participant was ascribed a reference number. Interviews were transcribed by the principal investigator and an independent researcher, Helen Baillot, former Asylum Services Manager at Scottish Refugee Council. Data will be stored by the principal investigator for up to two and a half years and all interview transcripts will be destroyed at the end of this period. This information was outlined in the participant information sheet.

Data was also obtained from secondary care professionals. The principal investigator

interviewed two obstetricians based at Glasgow hospitals as well as a clinical psychologist within a specialist health team. These were semi-structured interviews. Secondary care professionals were asked about their experiences of providing health care in their respective areas of specialism to asylum seeking women. All interviewees were invited to add any comments as they saw fit. A focus discussion group was held with staff from a Glasgow medical practice providing primary care to a significant number of asylum seekers. The discussion group was attended by the practice manager, four general practitioners and one practice nurse. Participants in the discussion group were asked to comment on their respective experiences of working with female asylum seeking patients, and more specifically pregnant women and new mothers. Further data was provided by interviews with three voluntary sector workers with experience working with women asylum seekers, including pregnant women and new mothers. The interviewees were invited to comment on their experiences of working with these women in Glasgow. The interviews with secondary care professionals and voluntary sector workers as well as the focus group discussion with medical practice staff were recorded with the participants' consent. The data was transcribed by the principal investigator and Helen Baillot. Interviewees and participants in the focus group were asked whether they would consent to their name and/or position being mentioned in documents made available to the public. Data was fully anonymised where consent was withheld.

Section 6 contains the data analysis and findings from the research. The interviews carried out with women asylum seekers formed the basis for identifying the range of topics discussed in this report. The report also considers specific issues raised by other participants.

Four key themes emerged from the interviews conducted with asylum seeking women:

- Access to health care and maternity care services (6.1);
- Access to an interpreter and standards in interpreting provision (6.2);
- Provision of information on maternity care services and pregnancy-related entitlements (6.3); and
- Impact of the asylum process on women's experiences of maternity (6.4).

The analysis sections are followed by an overview of key findings and policy recommendations (Section 7).

6.1 Access to health care and maternity care

All asylum seekers, irrespective of decisions on the status of their asylum claim, are entitled to free NHS primary and secondary care in Scotland on the same basis as an ordinarily resident UK citizen, and all asylum seeking women have the right to access NHS maternity care free of charge while they remain in Scotland.¹²⁹ This section analyses the data collected on practices in Glasgow in respect of asylum seeking women's access to primary and secondary care, with a focus on maternity care. It provides an account of the experiences of the women interviewed in accessing health care in general and maternity care in Glasgow.

6.1.1 Access to primary and secondary health care

Practices within the NHS

The research data indicates that women asylum seekers have access to both primary and secondary care in Glasgow and that having received a negative decision on their asylum claim does not normally constrain or preclude access:

Immigration status makes no difference in our practice. Even failed asylum seekers get primary health care here. And I have not heard of failed asylum seekers being refused secondary care for maternity care. (Medical Practice Manager)

As far as I know, current guidance are [sic] pretty clear, full access to health care for asylum seekers, including failed asylum seekers. (GP1)

The research data, however, suggests that, in the past, refused asylum seekers have been denied access to free NHS health care in Glasgow, notwithstanding their entitlement to free NHS

health care in Scotland:¹³⁰

[Refusal of access] has not happened in a long time, but I remember a young girl a few years ago with appendicitis being refused. She had to go round hospitals. (Medical Practice Nurse)

Years ago some surgeries took people off the list when they were refused, people who have moved to other areas in the city and became failed down the line. They tried to register with a GP next to their new home, but they were refused because they were not supported by UKBA. (Medical Practice Manager)

Moreover, there is evidence that asylum seekers may still experience difficulties registering with a GP in Glasgow. The data suggests that these difficulties may be attributed to two factors. Firstly, until recently, a handful of medical practices in dispersal areas across the city received additional funding from the Health Board to register asylum seeking patients. Those which did not receive this additional funding may have been reluctant to register asylum seekers, including refused asylum seekers, and may have elected to refer them to other designated practices in Glasgow:

We signed for Glasgow local enhanced scheme – additional capitation fee for asylum seekers. We are just a handful of practices which signed up to the scheme. Non-signed up surgeries can register asylum seekers, but would not get the additional funding. They are likely to refer them to signed-up surgeries. But it is hard to know about what they have done. (GP1)

Secondly, the data shows that difficulties registering with a GP can also stem from a lack of knowledge of asylum seekers' health care entitlements among staff. The data points to a lack of training for both front-desk and clinical staff on asylum seekers and other migrant groups' health care entitlements. When asked whether they

¹²⁹ Regulation 4 (c) of the National Health Service (Charges to Overseas Visitors) (Scotland) Regulations 1989; and Scottish Government Health Directorate (2010) Overseas Visitors' Liability to Pay Charges for NHS Care and Services CEL09 2010, paragraph 32.

¹³⁰ Regulation 4 (c) of the National Health Service (Charges to Overseas Visitors) (Scotland) Regulations 1989.

received regular training on asylum seekers' health care entitlements, the medical practice manager who took part in the focus group discussion commented:

We get periodical updates. For a while, we were getting a document every few months from NHS... Goes out to all surgeries... Still certain things remain unclear. I go to a monthly meeting with other managers and the question of entitlement to health care comes up every time [but there is] no training. Some practices wonder why they should check entitlements. Some practices may say 'no' to be on the side of caution because they are unsure about asylum seekers. (Medical Practice Manager)

The practice nurse who took part in the focus group discussion added:

We have good reception staff, who can inform them [asylum seekers] on their rights. It would be of great help if that could be Glasgow-wide. (Medical Practice Nurse)

Women asylum seekers' experiences of accessing primary and secondary health care

None of the women who were interviewed for this project reported difficulties registering with a GP. Two participants had also accessed secondary care (separate from their maternity care) and both recounted they had experienced no problems in this respect:

The registration with a GP was easy. (Asylum Seeker 2)

I registered with a GP, no problem. I went to the hospital once, I had no problem. (Asylum Seeker 3)

I had no problem registering with a GP and I had no problem when I went to see a doctor at the hospital. (Asylum Seeker 4)

The women who had received a negative decision

on their asylum claim did not report any difficulties with accessing health care as a result of the change in their immigration status:

I did not feel anything. Nothing changed really. (Asylum Seeker 1)

I continued to be registered with a GP. (Asylum Seeker 6)

I always have a GP. (Asylum Seeker 8)

6.1.2 Access to maternity care

Universal access to maternity care

Interviews with secondary care professionals as well as the focus group discussion with staff at the Glasgow-based medical practice strongly suggest that access to maternity care in Glasgow is governed by the principle of universal access and that a principle of 'women and children first' takes precedence in the facilitating of access to maternity care, before consideration of a woman's immigration status:

Anyone can get access to maternity care. (Obstetrician 2)

There is no issue about restriction of access to maternity services 'cause once someone declares she is pregnant, we manage her. (Obstetrician 1)

If you are pregnant, then you are treated. (Obstetrician 1)

I've never seen anybody who's had difficulty accessing maternity care. Maternity care is very easy to access. Anyone who presents gets seen in maternity services very very quickly. (Obstetrician 2)

If they say they are pregnant when they come to register, they will be linked up pretty soon. (GP4)

They get absolutely excellent care in getting access to maternity care and we have a link midwife who sees them all. (Obstetrician 2)

Access to specialist maternity care

All asylum seeking women have access to a range of maternity care services in Glasgow, including women who have received a negative decision on their asylum claim. In addition to mainstream services, women may access specialist maternity care services in Glasgow. These services seek to respond to the specific needs that asylum seeking women may have:

We just have to look after them, and there are some built in things that we do in maternity services here specifically, for example, we have a female genital mutilation midwife. (Obstetrician 1)

Experiences of domestic abuse, sexual violence and torture were identified by health care professionals, women asylum seekers and voluntary sector workers as issues warranting particular attention in the care of pregnant asylum seekers:

There is a psychology service for the asylum seeking women who've suffered sexual abuse. (Obstetrician 2)

Pregnant asylum seekers with major complex issues, usually the ones who've had sexual abuse, violence, it's going to influence how they are managed. (Obstetrician 2)

One woman asylum seeker emphasised:

It is very important to help women who are pregnant and have had difficult circumstances, the women who have been tortured. (Asylum Seeker 2)

The need to see women alone at the first visit was stressed by both health care professionals and asylum seekers:

At the first visit the woman should always be seen on her own even if her husband or partner insists on coming in; that should not be allowed. We have an absolute obligation to see the woman on her own. (Obstetrician 2)

It can be a problem to see women on their own. There's sometimes a perception that it's somehow abusive to say 'that's not acceptable – I will see you on your own', but then we still do it. And you have to reassure the women that you are not going to be doing anything terrible to her. If you leave it to her choice, then even if she wants to be seen on her own, she then can't. We know that from all our work on domestic abuse for everybody. (Obstetrician 2)

I think it's a very good thing women are asked if they are abused when they come to the clinic. It's a very important thing they're seen without their husband. I was not abused, but I know women who were. I hope they can speak out. For me, it is very important that the NHS asks women if they are abused, especially if they are pregnant. (Asylum Seeker 2)

The same participant added:

I think that it is very important that these women are given counselling and the means to leave when they are abused. (Asylum Seeker 2)

One voluntary sector worker stressed that the needs of pregnant women who had experienced sexual violence before coming to the UK differed from those of women who were experiencing domestic abuse whilst seeking asylum in the UK:

If someone's pregnant because she's been raped but she's now in a safe situation, that's a different scenario than say someone who's living with an abusive partner. Women are routinely asked whether they are in an abusive situation, but it doesn't really apply to women who have escaped sexual violence and abusive situations. That's why

they are living in Glasgow. It's a different scenario. That isn't necessarily factored in, they're just asked across the board, they're asked the same kind of questions. (Voluntary Sector Worker 2)

Asylum seeking women's experiences of accessing maternity care

All participants interviewed were able to access maternity care services, both primary and secondary, in Glasgow, irrespective of whether their claim for asylum had been refused at the time they were accessing these services:

The GP told me that the midwives will come to see me after the birth of my baby. They came for 10 days after the birth and then they stop. The last day the midwife told me that it is the last day and from now on the health visitor will be the one who's coming to see me. (Asylum Seeker 1)

After the birth, I had home visits by the midwife and the health visitor. (Asylum Seeker 8)

Two of the participants, including one woman who had been refused asylum, were referred to specialists during and after their pregnancy:

My GP was helpful, she sent me to a psychiatrist. This was essential. (Asylum Seeker 2)

I had leg problems before and after having my baby. My GP referred me to a physiotherapist. (Asylum Seeker 1)

Overall the women who were interviewed had good experiences of accessing maternity care services in Glasgow:

I was well treated at my appointments. (Asylum Seeker 9)

I was well looked after when I gave birth. The midwife who was with me was very encouraging. I had no one, but the midwife was very supportive.

(Asylum Seeker 9)

With my second baby, the health visitor was very helpful. The second birth was a good experience even if I was still taking anti-depressants.

(Asylum Seeker 2)

When the baby was 12 days old, he had a fever. I went to the hospital with my baby. The workers carefully looked after my baby.

(Asylum Seeker 4)

I had no problem. (Asylum Seeker 4)

All were very nice to me. They were very helpful. (Asylum Seeker 5)

I was quite happy. (Asylum Seeker 6)

The midwife and health visitor were quite good. (Asylum Seeker 7)

Two out of the nine asylum seeking women who were interviewed reported instances where their experiences were negative:

After labour, I was not even shown how to breastfeed. It was my first baby. I didn't know that at first that's the first thing you do. I had to stay for about five hours without breastfeeding my baby. I did not know because I was tired and nobody told me, until when my friend came to visit. She's the one who asked me 'have you breastfed the baby' and I said 'no'. (Asylum Seeker 1)

With my first baby, the health visitor was a man. He did not do home visits and I had to go to the GP surgery to attend the clinic. I did not find the health visitor helpful. I told him about my difficulties with breastfeeding but he told me to continue, that the baby needed breastfeeding. I had to stop. I was very stressed. Later my GP gave me antidepressants. (Asylum Seeker 2)

Two further issues emerged from the data on participants' experiences of accessing maternity

care services in Glasgow: access to antenatal classes and the impact of the asylum process on women's experiences of accessing maternity care.

Access to antenatal classes

Three out of the nine asylum seeking women who were interviewed attended antenatal classes in Glasgow:

I went to the antenatal classes. It was a good experience. (Asylum Seeker 8)

Two of these three women had received a negative decision on their asylum claim when they attended the antenatal classes. One woman had signed up for antenatal classes at the time of her interview with the principal investigator.

None of the four women who had used an interpreter when accessing maternity care services in Glasgow had attended antenatal classes. One of these women explained:

I did not attend the antenatal classes. I knew about them but I did not want to go because of language problems. (Asylum Seeker 7)

One of the Voluntary Sector Workers who was interviewed observed:

Women may not attend antenatal classes because there is no interpreter. (Voluntary Sector Worker 1)

Another participant said:

I did not go to the classes. I was not interested. (Asylum Seeker 2)

One of the women who went to antenatal classes recalled:

I was hearing from some people that have been pregnant before that there are antenatal classes really cause the midwives they didn't really stress

or arrange any classes for myself. I had to look at my maternity book to see, because there was a number written for antenatal classes. I ended up phoning and finding out and they said yes you have to book it for yourself. So I did it. (Asylum Seeker 1)

One participant who was a fluent English Speaker explained:

I did not know about the antenatal classes. (Asylum Seeker 9)

Impact of the asylum process on women asylum seekers' access to maternity care

Issues arising from the impact of the asylum process and, in particular, of Home Office asylum support policies on access to maternity care arose as a theme among asylum seekers and voluntary sector participants. There was some confusion among the secondary health care professionals interviewed in relation to aspects of the asylum process and women's support entitlements, indicating that even clinicians with a lot of experience working with this group of women may not be aware of some of the other complicating factors going on in their lives. One of the voluntary sector workers interviewed commented on the need for health professionals to receive training so that they understand the particular circumstances of women in the asylum process:

There's certainly a lot of training needs there which I can see. Because of a lack of resources, there may not be a priority for the NHS. But it would really help if frontline staff and midwives and nurses and hospitals were very aware of the needs and the situations that women are in and also the pressures of having an asylum case.

(Voluntary Sector Worker 2)

Another voluntary sector worker remarked:

In the research that we did, a lot of people were happy with their midwife. The issues were about midwives not having enough time to deal with all their issues. But their issues were very likely to be so much more than what a midwife is expected to do. The needs are so much more than what the services can do. (Voluntary Sector Worker 1)

The voluntary sector workers' comments on the impact of the asylum process and an indication that maternity care providers may not be fully aware of the impact this can have on women and their ability to access care were echoed in the interviews carried out with asylum seeking women in Glasgow:

We got a letter to tell us that we've to move out of the house...and they told us our support is going to end...I was six months pregnant at that time...so we went to see the lawyer...and we applied for Section 4. I think we only stayed for two weeks without support...I was a bit lucky because my friends were really supportive, most of the time they made sure that, like especially the last few months of my pregnancy, they made sure that I have like a bit of maybe £5 in my phone so that if anything happens I can manage to call. (Asylum Seeker 1)

This same participant felt that maternity care providers did not always understand the pressures asylum seeking women were under and in particular the lack of access to cash that women on Section 4 will be faced with:

The midwives they'll only be concerned with you, how you are feeling and everything, but not to say how did you come here, do you need help with anything, so they [don't] say anything about that. They just go in and ask you how you are keeping and you just tell them about your pregnancy and then that's it. If this is the scan, we'll see you in the next scan. If you feel you've got any problems,

here's the number to call. They don't even ask you 'do you have a phone or a landline to call the number'. (Asylum Seeker 1)

I was very stressed because of my asylum claim. I felt very sad and very stressed during my pregnancy. I think this was bad for my pregnancy. (Asylum Seeker 2)

The same asylum seeker recalled:

During my second pregnancy, I felt much more secure. I had papers. (Asylum Seeker 2)

6.1.3 Findings

The research data indicates that immigration status, and more specifically having received a negative decision on their asylum claim, does not preclude women asylum seekers' access to free NHS maternity care, and more generally free NHS primary and secondary care, in Glasgow. It is also suggested by the data that women asylum seekers have access to all maternity care services in Glasgow in accordance with the principle of universal access. The data suggests that there is some provision in Glasgow for addressing the particular needs of pregnant asylum seekers with complex issues such as sexual violence, female genital mutilation or domestic abuse.

However, the data indicates that asylum seekers can experience difficulties when attempting to register with a medical practice in Glasgow. The data reveals that these difficulties may be attributed to two factors. Firstly, medical practices may be reluctant to register asylum seekers because staff may be unsure about their health care entitlements. The data points to a lack of regular staff training in the area of health care entitlements for asylum seekers in Scotland. Secondly, medical practices that did not originally

sign up for the Glasgow local enhanced scheme – an additional capitation fee available for asylum seekers allocated to designated practices - may have been inclined to refer asylum seekers to medical practices that had signed up to the scheme.¹³¹

Overall, the asylum seeking women who were interviewed for the project had positive experiences of accessing maternity care services in Glasgow. Two of the participants recounted instances where they had not been satisfied with the standard of maternity care they had received. However, neither of these women linked their negative experiences to their status as asylum seekers.

The research data suggests that there might be issues with women asylum seekers' access to antenatal classes in Glasgow. Four participants either did not know about or did not mention accessing antenatal classes, two did not want to attend or did not feel able to either due to language barriers or time pressures, and three women attended classes. The data points to the existence of two possible barriers to access to antenatal classes by women asylum seekers in Glasgow, namely language barriers and a lack of information and awareness. It would be useful for further research to compare these findings with other groups of women in Glasgow to establish whether this is an issue particular to asylum seeking women.

The data also confirms what other research has highlighted recently, that having to navigate a complex asylum system, being moved around and living without access to cash as a result of Home Office asylum support policies, and facing profound uncertainty about the future, can all impact significantly on women asylum seekers' experiences of accessing maternity care services.

6.2 Access to an interpreter and standards of interpreting provision

It is well established in the literature that language barriers can significantly constrain access to maternity care services. It follows that the availability and use of appropriate interpreting services is critical to overcoming such barriers and ensuring that women who are not confident in spoken and or written English can access maternity care services fully. Two main themes emerge from the research data: the first relates to asylum seeking women's access to an interpreter in Glasgow and the second to standards of interpreting provision.

6.2.1 Access to an interpreter

Three out of the nine women asylum seekers who were interviewed by the principal investigator had used an interpreter when accessing all maternity care services in Glasgow. One participant indicated that, whilst she normally requested an interpreter, she felt she did not need one when she went to see her GP. Another said that she did not really need an interpreter during the antenatal period because she had enough English. However, after the birth of her baby, she did generally ask for an interpreter for appointments, especially when dealing with the baby's vaccinations.

The research data suggests that women are normally provided with an interpreter when they request one. One secondary care professional based at a Glasgow hospital maternity department stressed:

We are actually much more generous with interpreting than most of the other services because we will get an interpreter or interpreting services for every consultation. (Obstetrician 2)

The same secondary care professional added:

¹³¹ The local enhanced scheme no longer operates in Glasgow.

I say we quite often have them [interpreters] when we really do not need them. (Obstetrician 2)

Three out of the four women who had used interpreters reported instances where they did not get one, despite having requested one for an appointment. One of them said that once or twice there was no interpreter when she had a consultation with her GP; she added:

I could understand a little bit. (Asylum Seeker 5)

Another asylum seeker recounted that:

Once or twice I did not get an interpreter when the health visitor came. I could understand simple things. Things were quickly explained to me at the next visit [where] there was an interpreter.

(Asylum Seeker 6)

Another women asylum seeker reported that:

When I was going to give birth, I was not asked whether I needed an interpreter by the hospital staff. I did not ask for an interpreter. There was no interpreter when I gave birth. I did not understand some things. I saw the doctor at the hospital, but I had no interpreter. I did not understand most things. After the birth, I did not ask the midwife or the health visitor to explain. I tried to understand things with a dictionary. (Asylum Seeker 7)

The other interviewees reported that an interpreter was present during labour:

When I went to hospital to give birth, I got an interpreter as soon as I arrived. (Asylum Seeker 6)

One interviewee had two different interpreters 'because labour was very long', but did not identify this as a problem (Asylum Seeker 4). All women indicated that they always had a different interpreter, but they did not necessarily perceive this as a problem.

Two out of the four women reported instances

where they had been provided with a male interpreter, although, in their experience, this remained the exception:

Sometimes the interpreter was a man; but not during my labour. (Asylum Seeker 4)

Two or three times, I had a male interpreter, once with the GP and another time with the health visitor. It was a little bit embarrassing. I prefer to have a female interpreter. With the male interpreter, I felt a bit shy to talk about my pregnancy.

(Asylum Seeker 6)

A nurse at a Glasgow medical practice indicated that she would try to get a female interpreter, but commented:

I think that they realise that if they [the patient] do not accept the interpreter, there will be delays.

(Medical Practice Nurse)

One obstetrician based at a Glasgow hospital maternity department observed:

I was surprised to see a male interpreter; now this must be three years ago. I was struck by his empathy and she [the patient] had no problems with the male interpreter. It was an unusual situation and there was a very significant time constraint for that particular case. I had another experience of a male interpreter, this time over the phone. Again the couple had no problem with that, but they were in a relatively tight window and there was an acute medical problem. I think that's the only two male interpreter events that I can recall. (Obstetrician 1)

The same secondary care professional added:

I've occasionally come across situations where a female interpreter was preferred the next time because the patient did not wish a male interpreter.

(Obstetrician 1)

In contrast with this account, a voluntary sector

worker reported:

I've seen some examples of appalling practice in terms of male interpreters being used very often, women being told that they can request a female interpreter or maybe being told that the only interpreter available is a man.

(Voluntary Sector Worker 2)

It should be noted that the cases referred to by this voluntary sector worker were not confined to Glasgow or Scotland and were spread over a number of years.

The same voluntary worker opined:

Having male interpreters working with vulnerable women, I think that's just completely out of the question. (Voluntary Sector Worker 2)

Secondary care professionals, voluntary sector workers and staff at a Glasgow medical practice raised the issue of the kinds of interpreting services that were available, and more specifically the use and suitability of telephone interpreting in the context of maternity care provision for women asylum seekers. The research data reveals mixed views on the suitability of telephone interpreting.

One secondary care professional based in a Glasgow maternity hospital stated:

We have an informal agreement that for the first visit there's a person; we have a physical presence there, and if there's going to be something very sensitive discussed we would actually get a person along; but for your average ante-natal review appointment the phone system is actually perfectly adequate, but in fact it's not often used; we still very often have a person there and that's often because the patient wants a person there. (Obstetrician 2)

The same health care professional opined that telephone interpreting presented a number of advantages. In this participant's view, more

frequent use of the telephone system could help cut costs incurred by the provision of interpreting services:

It's much more expensive to have a person there and it's also because clinics don't always run to time, patients don't always turn up at the right time so we do waste a lot of money by having interpreters hanging about for a long time. If we used the phone system better, more effectively, then we would save a lot of money and we would give an acceptable service because you can put the phone on speaker phone and it is like having someone in the room. (Obstetrician 2)

The same secondary care professional remarked:

Sometimes they may not get an interpreter, because that's the other problem about having the interpreter there in person because the interpreter's booked for 10am and the woman turns up at 2 o'clock the interpreter's gone and we can't get another one but we can still use the phone system and that's again another fantastic reason for using the phone system that you can always use it so it doesn't matter if they turn up late. (Obstetrician 2)

The same secondary care professional further observed:

One of the difficulties we have is if the woman speaks a language where there aren't many interpreters, it's a very small community and there's a significant chance she's either going to know or be related to the interpreter. So again, using the phone system gets away from that as it's a completely anonymous situation and I'm surprised that they don't embrace it more enthusiastically. We're told that we should use that as our priority but I'm aware that in my clinic it's very rarely used although that is what we're told to do. (Obstetrician 2)

The same health care professional added:

But we do get people saying that they'll get their husband to interpret because they don't want anybody else in the community and the phone system would get round that problem. [The phone system] preserves their confidentiality too. (Obstetrician 2)

The secondary care professional whose views are reported above was very supportive of telephone interpreting overall:

I think there may be a perception that it isn't going to be a great idea because people want someone there. But in fact once they try it, it's incredibly effective. Because as I said you put it on speaker phone so it's not as if you're having a phone conversation and handing the phone receiver backwards and forwards, you switch the phone on and you have a conversation as on Skype except you don't see the person, so you can have you know an open conversation...

...The midwives who have used it say that it works fantastically well and the women they have spoken to where it has been used in our clinics say it's fine, it's great, it works very well. (Obstetrician 2)

A GP and a nurse from a Glasgow medical practice reported occasional instances where they had tried to use telephone interpreting services, but no interpreter was available:

You can only get one phone interpreter. Once the interpreter was not available, the patient phoned her pal. (GP1)

Commenting on the suitability of telephone interpreting, another GP from the same medical practice said:

I have tried [telephone interpreting] a couple of times; it's better than nothing. (GP4)

One of the voluntary sector workers interviewed opined:

There are issues with telephone interpreting. There is a lack of visual contact.

(Voluntary Sector Worker 3)

Positively, secondary care professionals stressed that using family members as interpreters was no longer accepted practice.

One secondary care professional based at a Glasgow hospital maternity indicated:

We do also have the issue of family members, husbands and partners wanting to act as interpreters and, I can't answer for everyone, but I don't accept that and it would be policy that we would not use them as interpreters. (Obstetrician 2)

This was confirmed by another secondary care professional also based at a Glasgow hospital who stated:

We have moved away from relatives being the occasional interpreter. (Obstetrician 1)

6.2.2 Standards of interpreting provision

Overall the four women asylum seekers who were interviewed and had used interpreters when accessing maternity care in Glasgow reported positive experiences:

I thought the interpreters were very helpful. (Asylum Seeker 5)

I was happy with the interpreters. (Asylum Seeker 6)

Another asylum seeking woman said:

Most of them [the interpreters] were ok. (Asylum Seeker 4)

However, the same participant recalled:

One interpreter was not polite, was not so nice. The interpreter was with me at a GP appointment

six weeks after the birth of my baby.

(Asylum Seeker 4)

The question of standards of interpreting provision in Glasgow was also raised in the interviews with secondary care professionals and voluntary sector workers as well as in the focus group discussion with staff at a Glasgow medical practice. The research data reveals mixed views on standards of interpreting provision.

One secondary care professional based at a Glasgow hospital maternity department commented:

I've rarely found an interpreter wasn't helpful and useful. (Obstetrician 1)

Another secondary care professional also based at a Glasgow hospital maternity department reported having very occasional issues with the quality of interpreting:

I'm aware that there's some not great but on the whole it's pretty good in fact I've been quite impressed by a lot of the interpreters. (Obstetrician 2)

Staff at a Glasgow medical practice reported more varied experiences in their dealings with interpreters. One GP remarked:

With interpreters, we do not know how capable they are and whether they have any specific training. (GP1)

The same GP recalled a recent example to illustrate the point:

The other day I used the word 'anaemia', which is pretty common; I am sure that the interpreter did not know what this word meant. (GP1)

Another GP in the same practice observed:

You can get very experienced interpreters and they are wonderful. And you can get a batch of

new interpreters and this can be a real struggle.

There can be problems with interpreters giving their opinions, asking questions on behalf of the patient. (GP4)

A practice nurse present at the focus group discussion added:

If they [the interpreters] are rephrasing in another language, this [the question] can take a completely different meaning. And I have to stop and say what they were saying took too long.

(Medical Practice Nurse)

The medical practice manager commented:

Basically when an interpreter turns up, you do not really have the choice. You just have to go with what you have. We have raised concerns about interpreters in the past, very infrequently. There is not really a mechanism [to feedback concerns].

(Medical Practice Manager)

The voluntary sector workers who were interviewed reported problems with interpreting standards:

There are various problems with interpreters whether it's boundaries, whether it's the language level, whether it's their interpreting skills.

(Voluntary Sector Worker 1)

I have sat in on appointments where interpreters had really been very unprofessional, not made eye contact, seemed physically bored and not interpreting accurately.

(Voluntary Sector Worker 2)

I have come across problems with interpreters.

(Voluntary Sector Worker 3)

Training was clearly identified as a critical factor in the provision of adequate interpreting services. One GP stressed:

Training is essential. (GP4)

It [training] should [also] be very specific I

think, especially working with women who have experienced gender-based violence.

(Voluntary Sector Worker 2)

In the focus group discussion with staff at a Glasgow medical practice, the practice manager remarked:

When they changed to the Health Board [¹³²], I asked them about specific training, but they remained very vague. They took on 210 interpreters so they would have availability for everybody. It is a money saving exercise because if the main services can't provide, it gets put out to private companies, which costs a lot of money. So we have all these new interpreters, some not as well trained as others. The Health Board taking charge has not really improved quality. (Medical Practice Manager)

One of the GPs present at the focus group discussion raised a further issue relating to the length of GP consultations and the system's failure to account for the presence of an interpreter:

Very recently, there has been a very unfortunate change. As you can imagine, we need more time than with usual consultations. We used to have 15 minutes, now we have ten. The use of an interpreter is not taken into consideration. (GP2)

6.2.3 The role of the interpreter

An interesting issue arising from some of the interviews with health care and voluntary sector workers is that of the blurring of professional boundaries between patient, health care professional and interpreter. This issue, among others around interpreting in healthcare settings, is being explored in an innovative project through Glasgow Refugee Asylum and Migration Network.¹³³ It would be interesting to explore this issue further in light of literature around the ability

or otherwise of interpreters to be just 'means of communication' and the concept of emotional labour.¹³⁴ In such an emotional setting as child birth where particularly in the case of refused asylum seeking women the interpreter may be the only non-clinician present, the question of whether it is possible for the boundary between interpreter and patient to remain intact and the impact this has on communication and consequently access to appropriate care is pertinent.

One voluntary sector worker explained:

Interpreters find themselves in a funny position because often women don't have a birthing partner so they've got someone who speaks their language next to them who then somehow might feel like they're the birthing partner...they're not...yet at the same time maybe a woman would project that on to them and maybe the interpreter would gravitate towards that support role.

(Voluntary Sector Worker 1)

A secondary health care professional also highlighted concern in this regard:

Sometimes it is the case that...patients get to know interpreters very well and they see them as a friend...and sometimes in our drive to provide people with the sensitive supportive services I think we do sometimes lose sight of our boundaries.

(Obstetrician 2)

6.2.4 Findings

The research data suggests that women asylum seekers who request an interpreter will generally be provided with one for maternity care appointments. The data also suggests that their immigration status and whether they have received a negative decision on their asylum claim, do not constrain access to an interpreter. However, there

¹³² In 2011, NHS Greater Glasgow & Clyde Health Board brought its interpreting services in-house. Previously, these had been contracted by agency interpreters.

¹³³ <http://www.gla.ac.uk/research/az/gramnet/getinvolvedactive/projects/traningmodel/resources/>

¹³⁴ Baillot, Helen, Cowan, Sharon and Munro, Vanessa, 'Second hand emotion? Exploring the contagion and impact of trauma and distress in the asylum law context', *Journal of Law and Society* (2013), Vol. 40, Issue 4, 509-540.

is evidence of instances where women asylum seekers who needed an interpreter when accessing maternity care were not provided with one. The data suggests that this may occur when women do not explicitly ask for an interpreter. Some of the GPs who took part in the focus group discussion experienced situations where they had not been able to use telephone interpreting because an interpreter was not available in a particular instance.

The research data does not allow for definite findings in respect of the comparative benefits or otherwise of using telephone interpreting in maternity care settings. Different participants suggested that there could be some benefits to telephone interpreting, such as anonymity in sensitive discussions and that it can mitigate against the high cost and implications of waiting times for face-to-face interpreting. Others suggested that telephone interpreting is not always able to meet need; that there can be disadvantages to the person you are communicating with not being visible; and that in their experience, patients tended to prefer a person in the room. Thus, it is clear that further exploration is needed of the suitability of different forms of interpreting provision in different contexts, and the extent to which telephone interpreting should be used in the context of maternity care provision for women asylum seekers and other groups.

The research data indicates that the use of male interpreters on the whole remains an exception; however, there were some cases reported by participants where male interpreters had been provided for women asylum seekers' appointments. The asylum seeker participants who had been provided with a male interpreter did not voice serious concerns in this regard. However, interviewees did suggest that the presence of a male interpreter can cause unease and that women

asylum seekers may prefer to have a female interpreter when accessing maternity care services.

A further issue that emerged from the research data relates to the reduction of the standard length of GP consultations from 15 to 10 minutes and the system's failure to account for the existence of a language barrier, the presence of an interpreter or the use of telephone interpreting, and to lengthen the duration of the consultation accordingly.

The research data clearly evinces variations in the quality of interpreting service provision in Glasgow and identifies a lack of systematic and specific training for interpreters involved in the provision of health care for women asylum seekers as an issue. However, it should be noted that we did not interview any interpreters or interpreting providers for this research. Comments elicited on interpreting were made by service users, health care providers and voluntary sector workers, and are not intended to provide a complete picture, but rather to suggest areas it would be important to explore further. One of these areas is the role of the interpreter and the impact of the inevitable blurring of professional boundaries in an emotional setting such as labour and child birth on both the provision of appropriate care and the wellbeing of the interpreter. The importance of ensuring frontline service providers are trained and supported with guidance on working with interpreters as a factor in ensuring a high standard of interpreting provision has been documented in the literature.¹³⁵

6.3 Provision of information on maternity and health related support entitlements

It is well established in the literature that, without access to appropriate information and understanding, women asylum seekers will not be able to fully access maternity care services.

¹³⁵ See for example: Rebecca Guhan & Helen Liebling-Kalifani (2011): The Experiences of Staff Working With Refugees and Asylum Seekers in the United Kingdom: A Grounded Theory Exploration, *Journal of Immigrant & Refugee Studies*, 9:3, 205-228.

It is also accepted that poor information can cause women to miss out on support entitlements, such as reimbursement for travel expenses to hospital appointments by the NHS, or additional Home Office asylum support entitlements for pregnant women. The research data, and in particular the interviews conducted with women asylum seekers, demonstrate that access to information on their maternity and health-related entitlements can be an issue in Glasgow.

6.3.1. Access to information on maternity and health related support entitlements

Overall the asylum seeking women interviewed for this project had no problem accessing information on primary and secondary maternity care services:

When I said I was pregnant, my GP told me what to do. The midwife gave me the information on scans and other things. (Asylum Seeker 4)

Hospital staff told me about maternity care. (Asylum Seeker 6)

The midwife gave me the information I needed on health care for pregnant women. (Asylum Seeker 3)

I had the information. (Asylum Seeker 8)

However, the interviews with asylum seeking women do point to the existence of some problems with accessing information about antenatal classes in Glasgow:¹³⁶

I did not know about the antenatal classes. (Asylum Seeker 9)

I was hearing from some people that have been pregnant before that there are antenatal classes really 'cause the midwives they didn't really stress or arrange any classes for myself. I had to look at my maternity book to see, because there was a number written for antenatal classes. I ended up phoning and finding out and they said yes you

have to book it for yourself. So I did it. (Asylum Seeker 1)

Moreover, there was evidence that some asylum seeking women lacked an understanding of the system and their entitlements to health care more broadly, as one participant recounted:

I did not go to the doctor (...) I did not know I could get health care. I was getting maternity care. (Asylum Seeker 9)

While overall women were satisfied with the information they received on maternity care services, with the exception of antenatal classes, the interviews reveal a very different picture in respect of access to information on maternity and health-related support entitlements. The research data shows that, in some instances, women asylum seekers did not get the information they needed in a timely fashion, if at all:

I went for the maternity review, I wasn't told anything what I was entitled to, because that's why I got it [maternity review] at the end. I think I was more than eight weeks pregnant, because I did not know you had to apply for that. (Asylum Seeker 1)

One of the voluntary sector workers observed:

I think there is an issue generally with women not being told what financial support they are entitled to. (Voluntary Sector Worker 1)

Eight out of the nine women who were interviewed for this project did not know that they could claim back travel expenses to get to and from NHS hospital appointments¹³⁷, nor, in the case of those in receipt of Section 4 asylum support, that they were entitled to additional support from the Home Office to travel to maternity appointments and to hospital when in labour.¹³⁸

I did not know I can get the money.

¹³⁶ Issues with asylum seeking women's access to antenatal classes were highlighted in Section 6.

(Asylum Seeker 2)

We did not know I could get the money.

(Asylum Seeker 3)

I did not know.

(Asylum Seeker 5)

Only one participant knew she could get her travel expenses reimbursed:

When I went to the hospital before and after the birth of my baby, I got the bus. I got my money back. (Asylum Seeker 6)

However, even in this case, where the participant knew about her entitlement to travel expenses at the time of the birth of her baby, she stated that before being told by her friend about financial support available, she paid for everything herself (Asylum Seeker 6).

One voluntary sector worker pointed out that women asylum seekers' ability to navigate the Home Office asylum support and NHS systems varied greatly:

Some of the women I work with are incredibly assertive and very quickly become aware of what their rights are and some of the women would not want to ask or make assumptions and they're just very intimidated by the whole situation. So they just go with the information that they're given and accept that. They're just going through the motions really. (Voluntary Sector Worker 2)

One asylum seeker explained:

I had back pain when I was pregnant. I took paracetamol. I did not go to the doctor because I did not want to push it. I was seeking asylum and I did not know I could get health care. I was getting maternity care. (Asylum Seeker 9)

The research data further suggests that asylum seeking women can experience difficulties absorbing, understanding, and interpreting the information they are provided with by health professionals. One woman interviewed understood that she was not entitled to the services explained in a leaflet because she was an asylum seeker:

When I was pregnant, they just gave me some papers and letters. But when you need them it was like it doesn't apply to asylum seekers, it was like for people who are the British people. Since you are not a British citizen, it was like not applying to us. It wasn't really clear that asylum seekers are also entitled. They give you papers and they never find out if you understand English that you can be able to read all that information.

(Asylum Seeker 1)

The same woman added:

They never explained anything really 'cause they just give you some papers. Then they will ask you 'have you done this, have you done that' and I say 'no'. I did not know that when you start finding out.

(Asylum Seeker 1)

This same interviewee recommended that maternity service providers develop information specifically targeted at asylum seeking women:

If they know that there's an asylum seeker who's pregnant get some special information for asylum seekers to know what they are entitled to.

(Asylum Seeker 1)

Another participant highlighted the volume of written information given, suggesting this might not always be the most effective way of communicating to asylum seeking women:

They gave me a lot of documents. It was not always clear what I had to do. (Asylum Seeker 7)

¹³⁷ All those on a low-income (including refugees and asylum seekers) accessing NHS services are entitled to apply for help with additional healthcare costs such as travel expenses to hospital appointments, dental care, glasses and contact lenses, and wigs and fabric supports. Asylum seekers supported by the Home Office under Section 98 are automatically sent an NHS Charges Certificate (HC2), which entitles them to this help. Refused asylum seekers on Section 4, and, in Scotland, those not receiving any Home Office support, will need to renew their certificate every six months.

¹³⁸ See Section 4.1.1 for details.

One voluntary sector worker remarked:

The information is there, but is hard to digest. Too many things are going on in their lives.

(Voluntary Sector Worker 2)

The interviews with women asylum seekers also indicate that friends, other asylum seekers and informal networks were an important source of information on maternity-care entitlements:

These things you are hearing maybe from somebody who's been through that experience.

(Asylum Seeker 1)

After the first baby was born, I got benefits from the Government. I got the information from a friend.

(Asylum Seeker 5)

I got the information from a friend when I was several months pregnant.

(Asylum Seeker 6)

One asylum seeking woman recounted that her friends had formed a 'pregnancy group' with a view to supporting other asylum seeking women:

My friends have made up a group, a pregnancy group. They live in the same area and they check on mothers and they give information.

All the women are Chinese. I've learnt from their experiences.

(Asylum Seeker 6)

Only one woman identified the hospital midwife as the main source of information on her maternity-related entitlements. No other health care professional was identified as a source of information on maternity-related entitlements in the interviews conducted with asylum seeking women:

The midwife at the hospital asked me if I knew about the support for pregnant women.

(Asylum Seeker 9)

One of the participants mentioned 'organisations' as an alternative source of information:

Sometimes friends gave me the information, sometimes organisations.

(Asylum Seeker 2)

6.3.2. Findings

The research data shows that overall, women asylum seekers, including women who have received a negative decision on their asylum claim, have access to information on maternity care. However, the evidence suggests that formal sources of information on maternity care services are primarily in a written format and several of the women interviewed did not necessarily understand the content of the information given to them. A particular issue with understanding the benefits of or knowing about antenatal classes arose in the interviews with women asylum seekers. Moreover, one asylum seeking woman interviewed for the research was unsure about her health care entitlements beyond maternity care, and, worryingly, felt hesitant to attend the GP when she felt unwell while pregnant.

The data indicates that most women experienced difficulties with accessing information on additional financial support entitlements related to health and maternity care. The vast majority of women did not know they could seek reimbursement of the money they had spent on public transport to get to hospital maternity appointments, nor that they could seek additional support from the Home Office for travel expenses to maternity appointments and to hospital when in labour.

Moreover, some women explained that they had difficulties understanding the information that they were given because it was overwhelming and not necessarily specifically targeted at asylum seekers.

The women asylum seekers interviewed by the principal investigator identified informal networks of friends and other asylum seekers as the primary sources of information. There was also evidence

of women self-organising into support groups in order to help each other through pregnancy with information and advice.

6.4 Impact of the asylum process on women's experiences of maternity

The research data highlights aspects of the asylum process that women identified as impacting on their experiences of accessing maternity care services in Glasgow. In particular, limited access to cash and multiple accommodation moves or issues with accommodation were mentioned on several occasions (by five and six women respectively). There was also an indication that some of the women interviewed lacked awareness of their rights and entitlements and were struggling to access English language classes.

6.4.1 Limited access to support in cash

In the course of the interviews conducted with women asylum seekers, limited access to support in cash emerged as a significant factor that negatively impacted on their experiences of accessing maternity care services in Glasgow.

Asylum seekers on Section 4 support, including those who are pregnant, do not have access to cash. They are provided with an Azure payment card, pre-loaded with a specific amount each week, which can be used in designated supermarkets and charity shops to purchase essential items only. The money cannot be saved and cannot normally be carried over from one week to the next (except in the case of families) and it cannot be exchanged for cash. Any additional Home Office support women are entitled to on account of their being pregnant is credited to the Azure card, so pregnant women do not have any legitimate means to access cash

for emergencies or to travel by public transport.

Although there is provision under Section 4 support regulations for pregnant women to be able to request payment of travel fares to hospital appointments in advance on production of an appointment card, research participants who were, or had been, on Section 4 support reported difficulties paying for public transport fares to attend maternity care appointments. Only one woman interviewed knew that she could be reimbursed for travel expenses to hospital appointments by the NHS on production of an HC2 certificate. Five of the nine women interviewed spoke about the lack of access to cash as a factor in their experience of accessing maternity care in Glasgow.

At first for my antenatal check-ups, it was kind of just ten minutes walking. But when I changed, I was about 36 weeks; they changed it to Springburn Centre so I had to get a bus. Sometimes I have to walk because at that time I wasn't getting cash so I had to walk there. (Asylum Seeker 1)

A clinical psychologist within a specialist mental health team stressed:

People may struggle to pay their bus fares. There is a need for greater poverty awareness, and not only for asylum seekers, for other groups too. (Clinical Psychologist)

One asylum seeking woman reported:

And the most difficult thing is that they know, the midwives, they know they are dealing with asylum seekers and this is the problem they might be having like if you're on Section 4 support, you don't have cash, but they never ask if you have the money to call the hospital if you need help during the night or anything, no. You have to find it for yourself. (Asylum Seeker 1)

One voluntary sector worker observed:

Access to it [NHS treatment] in the sense of getting to appointments if you are on Section 4 support, it's very difficult. I know you can get your money back, but if you have got no money at all, getting to appointments is very difficult. There are a lot of people who miss appointments because of this.

(Voluntary Sector Worker 1)

The same voluntary worker further remarked:

People are told to save money, but when you're on Section 4, when you're going in labour, it's very difficult to save money up for a taxi to get to the hospital and obviously ambulances don't come unless it's a real emergency. I know women who said they walked [to hospital in labour].

(Voluntary Sector Worker 1)

One woman interviewed by the principal investigator recounted:

When I was 38 weeks, I got a taxi to the hospital. My lawyer had told me to contact the Red Cross. They gave me £10 and I used the money to pay for the taxi. (Asylum Seeker 9)

One voluntary sector worker pointed out that Section 4 support was also problematic for pregnant women in that it constrained their access to healthy foods:

Access to healthy foods is a big issue. If you are on the Azure card, you're constantly getting told by health care professionals that you need to eat fruit and veg and for some women they are coming from cultures where their diet is substantially better than the average Glaswegian diet, but they are not able to access the foods they need to eat healthily and they're caught in this situation of being told what to do but not being able to do it.

(Voluntary Sector Worker 2)

6.4.2 Accommodation and homelessness

It has been established in the literature that multiple moves of accommodation can have a significant negative impact on pregnant asylum seeking women's experiences of maternity care in the UK. The data suggests that pregnant women housed by the Home Office in Glasgow have experienced difficulties with accommodation and are sometimes moved from one property to another, in some cases several times. Six women interviewed for the research mentioned accommodation as a factor that had impacted on their experiences. One woman reported experiencing abuse from another woman she was housed with in shared Home Office accommodation (Asylum Seeker 9).

Two of the voluntary sector workers raised the issue of accommodation:

Accommodation often becomes the biggest issue because women are often moved while they're pregnant to unsuitable accommodation.

(Voluntary Sector Worker 2)

Another voluntary sector worker raised the issue of accommodation as a factor influencing women's access to maternity care and wellbeing during pregnancy; this interviewee also notes the risk of homelessness for women who have been refused asylum and are pregnant but do not yet meet the eligibility criteria for Section 4 support¹³⁹:

...before...we saw a lot of pregnant women that... didn't have places or were just staying with friends but now we feel that, I don't know if there's been a conscious change...or if there's still people slipping through the net...but the people I've seen tend to now be accessing [accommodation]...and it's not appropriate accommodation at all, it's like hostels, where you can't cook and you have to get takeaways every day, but it's a roof...

(Voluntary Sector Worker 1)

The same worker further commented:

It's really hard to manage especially when someone's not got any [money]...but then obviously they get Section 4 at seven months and then they can start to settle down a bit but that is really tough seeing pregnant homeless people and it's not uncommon because quite often potentially people find themselves in situations where they have to sleep with people to have a roof over their head and therefore are more likely to get pregnant, I mean that is sort of what you feel might be happening...(Voluntary Sector Worker 1)

6.4.3 Limited access to English language classes

It is well-established in the literature that the ability to communicate is vital to asylum seekers' positive experiences of antenatal and postnatal care as well as labour. The ability to communicate also helps asylum seekers to navigate the asylum system and manage everyday life, and ultimately facilitates their integration into UK society.¹⁴⁰

One woman asylum seeker interviewed by the principal investigator recalled:

When I had my second child, my English was better. I could sit with the doctor and ask questions. I felt I had more power because I understood English and could ask questions. I could understand what was going on.

(Asylum Seeker 2)

Another participant emphasised:

My only problem at the moment is that I can't go to English classes. I want to improve my English before the baby comes. I went to classes at the City of Glasgow College and I passed the Intermediate Level 3 class. I want to go to the next level class, but I was told that there was no places. I was told to ask other colleges, but they had no places.

(Asylum Seeker 3)

Shortages in the provision of English classes for asylum seekers in Glasgow have been reported;¹⁴¹ one voluntary sector worker observed:

I think that a lot of the colleges have cut provision of English language classes. I think that's something that happened fairly recently and some of the places that were doing free English classes, they've all had funding issues. Also I have the impression that if you are learning English at a very basic level, there's more provision. But if you're learning English at a higher level, there's less provision because you're expected that that's enough. We've helped with college applications and they've been competing with 50, 60 for places, not always for English courses but for quite basic courses.

(Voluntary Sector Worker 2)

6.4.4 Findings

The research data suggests that the asylum process, and, in particular, the asylum support system, can have an impact on asylum seeking women's access to maternity care in Glasgow. Above all, the women interviewed highlighted difficulties they faced travelling to and from appointments and when in labour with limited or no access to support in cash. Several women reported issues such as struggling to pay public transport fares, seeking help from friends to pay for taxis when in labour, saving up cash for emergencies and having to call an ambulance where no other option was available to get to hospital. The data also suggests that limited access to support in cash restricts women asylum seekers' access to healthy foods and therefore precludes them from fully following health care professionals' advice in relation to nutrition and diet.

¹³⁹ See Section 4.1. of this report for detail of the eligibility criteria for Section 4 support.

¹⁴⁰ Sylvie Da Lomba, 'Legal status and refugee integration', *Journal of Refugee Studies*, Special Issue: Critical Reflections on Refugee Integration: Lessons from International Perspectives, (2010) 23 (4), pp. 415-436, p. 423.

¹⁴¹ Gareth Mulvey, *In Search of normality: a Study of Refugee Integration in Scotland*, (2013) p.60.

The data highlights the impact of inappropriate or insecure accommodation provision by the Home Office on refused asylum seeking women's access to maternity care and raises the issue of destitution and its affect in particular on the wellbeing of women who are pregnant or may be vulnerable to exploitation.

The research data also confirms that being able to communicate in English can empower women and improve their experiences of maternity care services. The interviews with women and voluntary sector workers indicate that despite it being well established that learning English is an important tool for integration shortages in English language provision in Glasgow may be constraining women's opportunities to improve their English language skills.¹⁴²

¹⁴² *Ibid.*, p. 9.

7.1 Key findings

This research suggests that women asylum seekers, including women who have received a negative decision on their asylum claim, are able to access free NHS primary and secondary care in Glasgow. Moreover, it suggests that asylum seeking women and their children are seen first and foremost as women and children by health professionals, and that their insecure immigration status does not appear to preclude or constrain their access to maternity care in Glasgow. This is in line with Scottish statutory regulations and Scottish Government guidance on asylum seekers' health care entitlements.¹⁴³ It follows that Scottish regulations, Scottish Government Guidance and practices within the NHS in Glasgow in respect of women asylum seekers, including refused asylum seekers, uphold the principle of universal access to maternity care and are therefore consistent with the UK's international human rights obligations, which place an obligation on the UK, and therefore on Scotland, to ensure access to maternity care for all women in the UK.

The research further indicates that, in addition to mainstream maternity care services, there are specialist services in Glasgow which seek to respond to the specific maternity care needs some asylum seeking women may have. For example, there is a specialist mental health team working with refugees and asylum seekers and it was indicated by health professionals that services for women who have undergone female genital mutilation also exist. As is the case with mainstream maternity services, these services may be accessed by refused asylum seeking women.

The participants' accounts of accessing maternity care services in Glasgow were overall positive. Whether the participants had received a

negative decision on their asylum claim was not identified as a determinant factor in shaping their experiences of accessing maternity care. This is distinct from the situation in other parts of the UK. For example, in England, the legislation currently makes refused asylum seeking women not in receipt of Section 4 support liable to charging for maternity care. Health professionals in London report that pregnant women booked into maternity care at a hospital will routinely be directed to the Overseas Visitors Office for an assessment of their chargeability before being permitted access to care.¹⁴⁴ Participants in this research did not indicate this practice to be occurring in Glasgow. In the current political context, with the 2013 Immigration Bill going through the UK Parliament, which is expected to increase charging for access to NHS health care in England, it will be important to ensure frontline professionals are aware of these differences and that they uphold the letter and spirit of the principles underpinning the provision of NHS services in Scotland.¹⁴⁵

Despite evidence of universal access in Glasgow, a range of factors detrimentally impacting on women asylum seekers' experiences of accessing maternity care were identified in the course of this research. Specifically, these difficulties relate to:

- **Interpreting:** the study reveals variation in the provision of interpreting services in Glasgow and identifies instances where women were not provided with an interpreter when required, where male interpreters were provided for maternity appointments, and where the professional role of the interpreter has been compromised
- **The asylum process:** the study identifies a number of ways in which Home Office asylum support policies, particularly the complexity of

¹⁴³ Regulation 4 (c) of the National Health Service (Charges to Overseas Visitors) (Scotland) Regulations 1989; and Scottish Government Health Directorate (2010) Overseas Visitors' Liability to Pay Charges for NHS Care and Services CEL09 2010, paragraph 32.

¹⁴⁴ *When Maternity Doesn't Matter - Dispersing Pregnant Asylum Seeking Women*, Seminar: Part II, London, Maternity Action and Refugee Council, 9 July 2013 (video available online: <http://vimeo.com/70641681>)

¹⁴⁵ Scottish Refugee Council, *Serious Concern raised over Immigration Bill Proposals*, 20 January 2014 (available online at: http://www.scottishrefugeecouncil.org.uk/news_and_events/latest_news/2259_serious_concern_raised_over_immigration_bill_proposals)

the support system, the risk of destitution, and the provision of cashless support, impact negatively on women's experiences of pregnancy and access to maternity care in Glasgow

- **Information provision:** the evidence suggests that asylum seeking women are often not aware of their entitlements to additional pregnancy or health-related support, particularly reimbursement or payment of travel costs, and that information about health and support services is not always being effectively communicated to asylum seeking women in Glasgow
- **Access to antenatal classes:** the research suggests that a lack of information, awareness and language barriers are constraining women asylum seekers' access to antenatal classes in Glasgow
- **Access to English language classes:** women in the study identified a lack of accessible English class provision for asylum seekers in Glasgow and linked this to their experiences of accessing maternity care

Most of these factors were experienced by participants irrespective of whether they were awaiting an asylum decision or had been refused asylum. However, this was not the case with the constraints on access to maternity care in Glasgow arising from Home Office asylum support policies. The type of asylum support and indeed whether women are entitled to support from the Home Office at all depends on the status of their asylum claim. Voluntary sector workers interviewed for the research raised concerns about pregnant women in Glasgow being 'homeless' and at risk of exploitation if they have been refused asylum and are less than 34 weeks pregnant, or if they have not yet lodged an asylum claim. If entitled to any

support, for example, if they are heavily pregnant, refused asylum seeking women will generally receive this under Section 4 of the Immigration Act 1999. Thus any subsistence payments, including maternity payments, are loaded onto the Azure card and women do not have any access to cash. The research confirms that a lack of access to cash can mean that women on Section 4 struggle to pay for public transport fares to get to and from maternity care appointments and their ability to follow the nutrition and dietary advice of health professionals can be constrained.

7.2 Policy recommendations

To ensure that all women asylum seekers, including those refused asylum, have full access to NHS maternity care as well as NHS primary and secondary care in Scotland, the 'women and children first' principle must clearly underpin the Scottish Government's policy on access to health care for this group. The adoption and clear communication of this principle to all health care workers in Scotland would help to ensure women's access to free NHS services is not constrained unlawfully on account of their immigration status. This is particularly important in the light of the UK Government's proposals to further regulate migrants' access to health services in the UK. The Scottish Government's refugee integration strategy, *New Scots: Integrating Refugees in Scotland's Communities 2014-2017*¹⁴⁶, provides a platform for some of the recommendations below to be incorporated.

Access to maternity care services

- NHS Scotland should ensure that all health care staff including receptionists and front-desk workers as well as clinical staff, receive regular and appropriate training on the needs, experiences and health care entitlements of

¹⁴⁶ Scottish Government, *New Scots: Integrating Refugees into Scotland's Communities 2014-2017*, December 2013 .

asylum seeking women.

- Midwives should continue the good practice of ensuring pregnant asylum seekers are seen alone at the first maternity appointment, and, where necessary, at further visits, to carry out routine inquiry into domestic abuse. Routine inquiry should be carried out in a language the patient understands and should take account of the high prevalence of experiences of physical and sexual violence among women seeking asylum in the UK.
- Women should routinely be asked about Female Genital Mutilation (FGM) sensitively and in a language they understand and appropriate specialist support offered to women who disclose FGM if required.
- NHS Scotland should ensure that clear referral routes are in place to enable women to access specialist advice and support where appropriate.
- Health professionals working with asylum seeking women should ensure that information on antenatal classes, their purpose and potential benefits, is conveyed to women in a language they understand.
- Where they request one, women must be provided with an appropriate interpreter for maternity appointments in a language they understand and training on working with interpreters should be provided to all health professionals.

Access to an interpreter and standards

- All refugee and asylum seeking women for whom English is not their first language should be reminded that they are entitled to the services of an appropriate interpreter.

- Interpreters for maternity appointments should routinely be female, unless the patient requests otherwise; staff should always check at the start of an appointment that the patient is comfortable with and understands the interpreter provided.
- NHS Scotland should direct local health boards to facilitate the lengthening of GP consultations to account for the additional time required for effective communication through an interpreter.
- NHS Scotland should further explore the comparative benefits or otherwise of telephone and face-to-face interpreting, to include consideration of the cost implications of not providing adequate interpreting provision.
- Further research should be carried out into the role of the interpreter in complex maternity appointments, during labour and in childbirth in order to better understand the emotional demands placed on interpreters and the impact on the provision of appropriate care.

Information on maternity services and pregnancy-related support entitlements

- Local Health Boards should ensure that asylum seeking women are provided with targeted information in a language they understand on access to primary and secondary maternity care, including information about antenatal classes, their purpose and benefits.
- Local Health Boards and Home Office contracted asylum support advice providers should ensure that asylum seeking women are provided with targeted information in a language they understand on the maternity-related support entitlements available to them under the Home Office asylum support system and as part of mainstream maternity provision by the NHS.

- Local Health Boards should review the format and delivery of written information for women asylum seekers with a view to ensuring that it is user-friendly, communicated in plain English and translated into appropriate languages.
- Local Health Boards should consider designing and delivering information specifically for asylum seekers which notes their entitlements to care in line with Scottish Government guidance.
- Local Health Boards should review when and how information about maternity services is given to asylum seeking women to ensure comprehensive information is delivered while minimising the risk of their being overwhelmed with too much detail.
- Greater poverty awareness is needed in the provision of maternity care for women asylum seekers, including an understanding by health professionals of the difficulties women may face travelling to appointments.
- The Scottish Government, COSLA and other agencies leading on implementation of the *New Scots: Integrating Refugees into Scotland's Communities*¹⁴⁷ strategy should take action to ensure that this group of women has equal access to the services and support to which they are entitled in Scotland, irrespective of the status of their asylum claim or Home Office policy impacting on devolved policy areas.

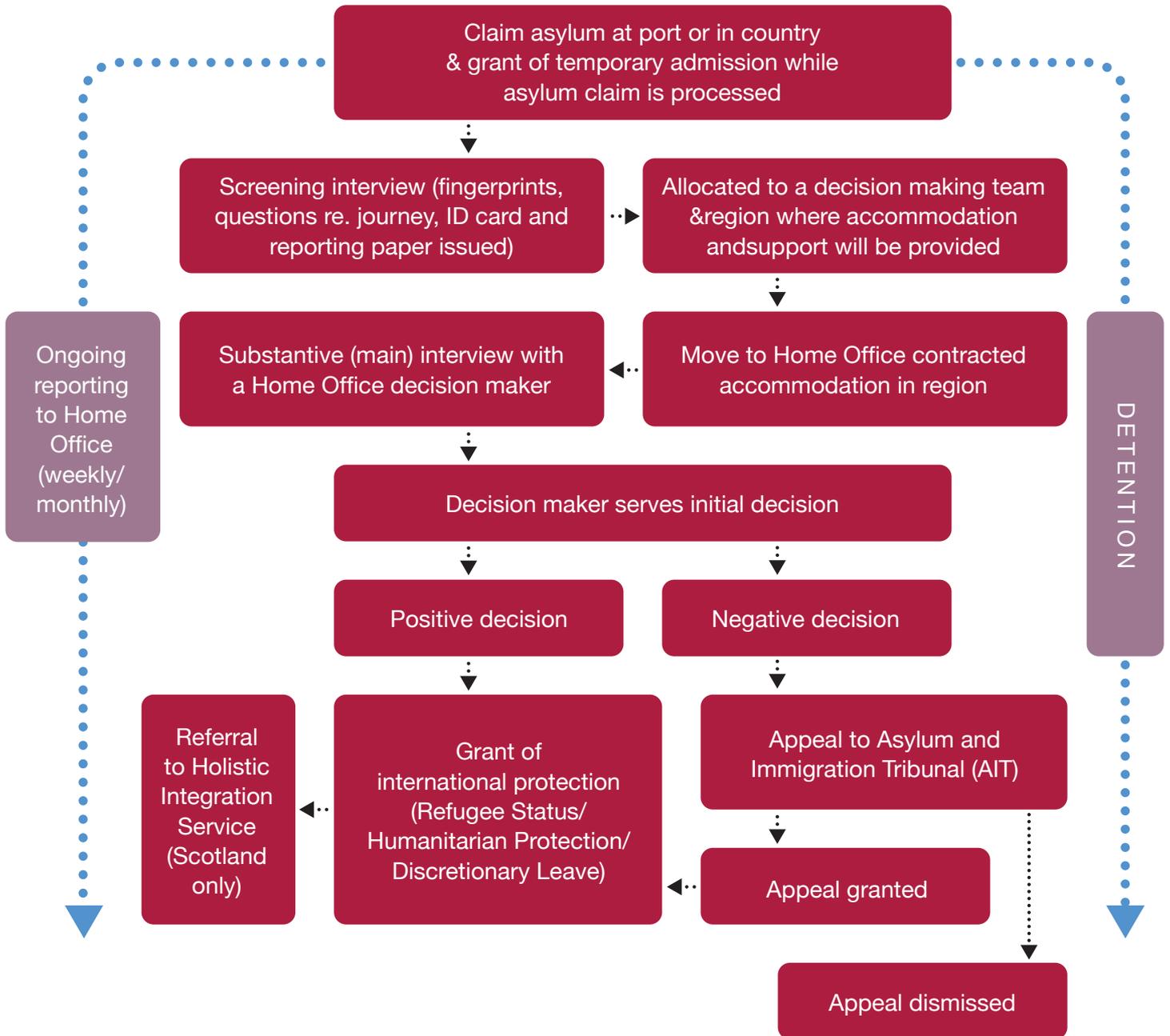
Access to English language classes

- **Impact of Home Office asylum support policies**
- Pregnant women should never be faced with destitution as a result of Home Office asylum support policies at any stage of pregnancy, irrespective of the status of their asylum claim.
- The Home Office and its contractors must ensure that the housing provided to pregnant asylum seeking women, including accommodation provided under Section 4, is adequate and appropriate to the needs of new mothers and their children.
- The Home Office should only move pregnant women in exceptional circumstances and women should not be forced to move accommodation within six weeks before and after birth and until they've been signed off by their midwife.
- We believe that all asylum seekers should have access to cash-based support; as a matter of urgency, pregnant women on Section 4 should have access to cash to ensure the health and safety of mother and baby.
- The Scottish Government, Education Scotland, COSLA and other lead agencies implementing the *New Scots*¹⁴⁸ strategy should ensure that English class provision for asylum seekers in Glasgow is accessible and appropriate to pregnant asylum seekers' needs.

¹⁴⁷ Scottish Government, *New Scots: Integrating Refugees into Scotland's Communities 2014-2017*, December 2013 .

¹⁴⁸ *Ibid.*

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