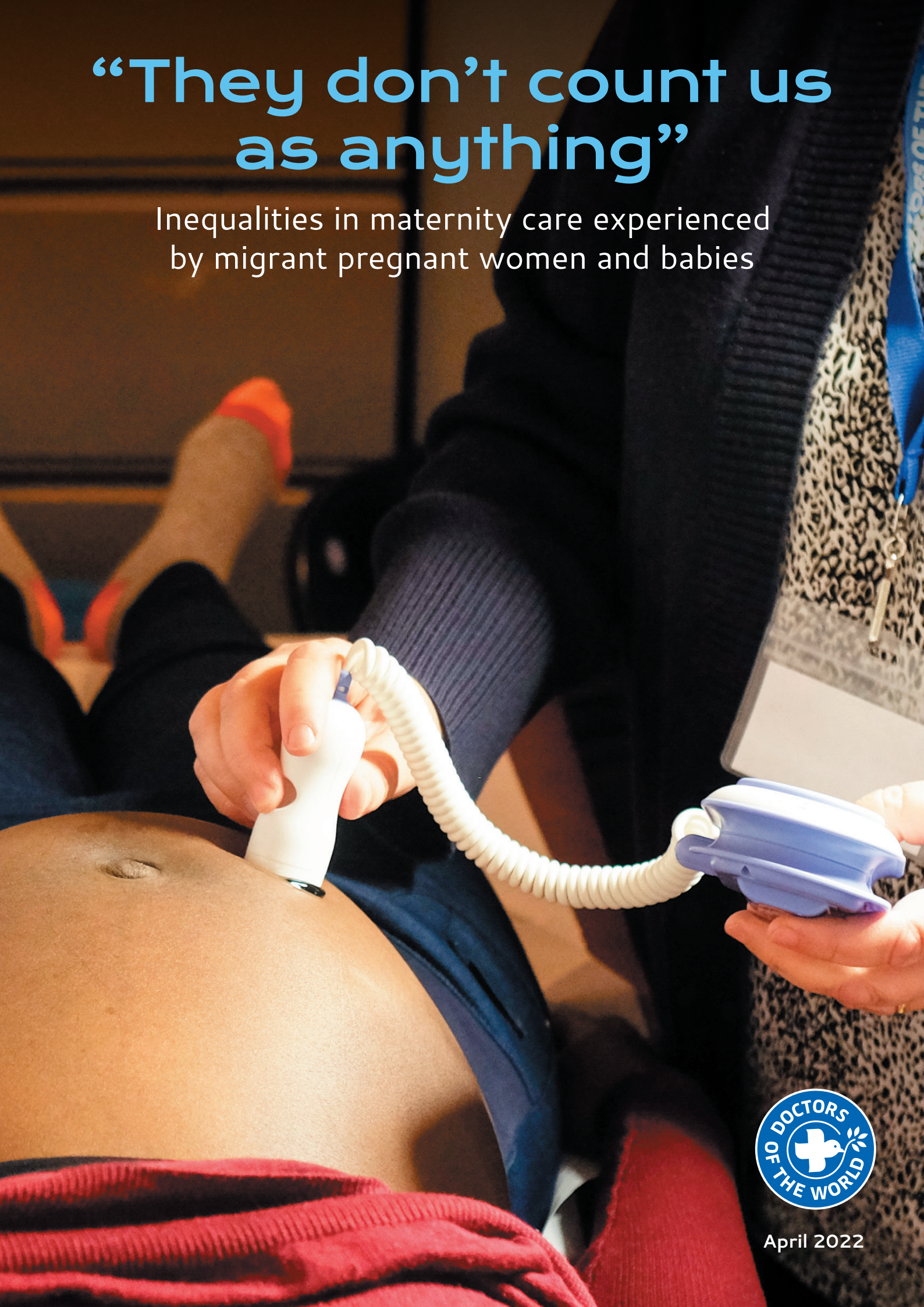


“They don’t count us as anything”

Inequalities in maternity care experienced by migrant pregnant women and babies



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Doctors of the World UK (DOTW) National Health Advisors Kemi and Pat provided specialist advice and testimony on their own experiences to the authors of this report. National Health Advisors are experts by experience of the UK immigration system or health exclusion. They work with the DOTW with coproduction principles to promote access to healthcare for all

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Executive Summary

Despite an increased focus in maternity services on ethnic and racial inequalities resulting in poorer outcomes, the experience of migrant women is often hidden from these data, research and improvement programmes.

To understand these inequalities and their impact further, Doctors of the World UK (DOTW UK) analysed data collected through provision of health support to 257 pregnant women accessing our service between 2017 and 2021.

The key findings of the report included that:

- **A very small proportion of women had been taking folic acid before conception compared to the national average² (6% vs. 25.9%).**
- **The vast majority women in the cohort (81%) had their first antenatal care appointment beyond the recommended 10 weeks of pregnancy. More than four in ten (45%) of the women did not have any antenatal care until after 16 weeks of pregnancy, compared to just one in ten women nationally.² Within this group more than four in ten women with undocumented, uncertain, refugee or asylum seeker status (45%) and six in ten women from Sub-Saharan Africa (62%) accessed care after 16 weeks.**
- **Mental health issues occurred in over a third of women, potentially exacerbated by the fact that over a third also received a bill for their maternity care of up to £14,000.**
- **The COVID-19 pandemic had a clear impact on this cohort of women. When stratifying antenatal and postnatal outcomes by a timestamp denoting contact with DOTW UK before or during the pandemic, differences were noted in most variables.**
- **More women reported feeling stressed during most of their pregnancy, and the proportion of women who felt supported reduced since the pandemic. The proportion of babies born with a low birthweight in the pandemic period was 11% compared to 6.5% in England and Wales in 2020.¹⁰ Women were almost twice as likely to report mood disturbance after birth in the pandemic period compared to pre-pandemic (RR 1.7, 95% CI 1.1–2.6).**

This evidence highlights the need for urgent action to address the inequalities experienced by migrant pregnant women and their babies. There is a pressing need immigration status to be considered as part of the ethnic and racial health inequalities agenda and for independent action to be taken to review the impact of NHS charging policy.

Recommendations:

To improve the care and outcomes for migrant pregnant women and their babies:

The UK government should:

- **Conduct an urgent public and independent inquiry into access to NHS services and health outcomes for people with insecure immigration status and incorporate this work into actions to reduce ethnic and racial disparities in healthcare. The inquiry should investigate the experiences of pregnant women and babies, identifying specific barriers in access to maternity services and impact on maternal outcomes.**
- **Immediately suspend NHS charging regulations for maternity care due to the harm this system causes to migrant women and their babies experiencing inequalities in maternity care.**
- **Strengthen the evidence base on the experiences of vulnerable migrant pregnant women with a focus on Black women and women with insecure immigration status to understand reasons for late access to care and outcomes, drawing on data held by government health agencies and commissioning further data collection if needed.**
- **Fund work to trial and evidence what works to improve access to maternal health care for migrant women.**
- **Maternity services should:**
- **Review and improve support to women with insecure immigration status as part of their work to improve equity and equality in maternity care.**

Introduction

Using unique data from the DOTW UK clinic this report explores the experiences of migrant pregnant women and their babies. Migrant women experience many barriers to care and are often missing from data and research reviewing wider pregnancy outcomes. This report reviews data collected by DOTW UK, where possible comparing outcomes to the general population and makes recommendations for improving healthcare access and outcomes for this group. The report reviews data from 257 pregnant women using DOTW UK services with insecure immigration status from 53 predominantly non-European countries. For the first time we have information on time to first Antenatal Care (ANC) appointment, uptake of prenatal vitamins, outcomes after the delivery of the baby including week of delivery, delivery type, mental health of the mother and access to routine neonatal care and immunisations for the child. This important report adds to the limited data available highlighting the inequalities in access to maternity care experienced by migrant women.

DOTW UK's work

DOTW UK is part of the Médecins du Monde international network, an independent humanitarian movement. DOTW UK has been a registered charity in England and Wales since 1998 and runs clinics and advocacy programmes providing medical care, information, and practical support to people unable to access NHS services. Our patients include refugees, asylum seekers, survivors of human trafficking, people experiencing homelessness, sex workers, migrants with insecure immigration status and Gypsy, Roma, and Traveller communities.

Our first UK clinic opened in East London in 2006, and a dedicated Women's and Children's clinic has been running since 2014. In 2018, with additional funding, the Women and Children's clinic was able to run on a weekly basis, offering prebooked appointments and drop-in slots.

The DOTW UK clinics are foremost a 'one-stop-clinic' where service users are supported in accessing the healthcare services they need. Pregnant women are supported in accessing primary care and maternity services. Data collection on pregnancy outcome was structurally embedded in the follow-up by means of a postnatal follow-up questionnaire that was introduced in July 2017. After ensuring the pregnant woman was successfully accessing primary care and maternity services, she would be marked for postnatal follow-up

one month after the Estimated Date of Delivery. The questionnaire has been adjusted to collect the most relevant information and ensure consent to data usage.

This report presents the data collected on pregnant women who presented to DOTW UK for their pregnancies between 2017–2021.

"After my experience, I have been helping many pregnant women in my networks and I found out that many immigrant women don't receive the care they need while they are pregnant.

No information was given to me on what to do while I was pregnant and there was no information given to me on how to take care of my child in the UK within the system. I didn't go to antenatal care until I was 16 weeks pregnant. I didn't know about any vitamins.

The NHS charging is something that affects migrant pregnant women a lot. Think about you have given birth to a child and they've given you a bill of £4000. I just went into depression stage. It got me really scared. I was even sometimes asking myself why did I even get pregnant in the first place to have this baby? It is devastating for a woman to be feeling that way and thinking that I put myself into trouble and I should have not gotten pregnant. Charging brought about so many things, what I could do with that child, what would happen with the bill. Charging migrant women is simply barbaric.

Because the experiences of what we've gone through back home, and how our country has been, women are not allowed to ask questions that much, so we think it's the same thing in this country, which is also affecting us as migrant women. There is no information mechanism for us to say this is what you need to ask or what you can ask. When we get pregnant, we don't ask the right questions until we are dying before we can ask questions that we need to ask.

Women who are migrants are not treated well; they don't count us as anything."

Kemi

Doctors of the World National Health Advisor

Background

Migrant women face many barriers when accessing ANC. In England, charging regulations for those unable to prove eligibility for free NHS care, such as undocumented migrants including refused asylum seekers, mean ANC is billed, with a warning that failure to pay could affect future visa applications. A debt of £500 unpaid at 3 months may be reported to the Home Office. It is worth noting that the cost of normal vaginal delivery varies between hospitals but tends to be between £5,000 and £7,000. Complications, such as instrumental delivery or Caesarean Section incur higher costs.

Although maternity care must never be withheld due to inability to pay, this caveat has done little to mitigate the impact the regulations are having on pregnant women. National guidance recommends women to have their first antenatal appointment by 10 weeks,¹ and the latest data for England show the majority (67.6%) of women have their booking appointment at or by 10 weeks gestation.² Conversely, previous research conducted in the DOTW UK clinic in 2016 with 55 service users found 2 in 3 pregnant women had not accessed antenatal care by 10 weeks, 1 in 4 had not accessed antenatal care by 18 weeks, and 1 in 3 service users had been deterred from healthcare because of charging regulations in place.³ Charging regulations also impact on healthcare workers, with a report by Maternity Action highlighting the negative impact on midwives.⁴ Worryingly, a recent Maternity Action report highlighted NHS Trusts' failures in applying the charging policy, resulting in potentially huge personal and financial impact on affected women, as well as deterring women from accessing care further.⁵

A 2019 systematic review of asylum-seeking women's views and experiences of UK maternity care reported 7 key themes: communication challenges, isolation, mental health challenges, professional attitudes, access to health care, effects of dispersal and housing challenges.⁶ All 6 studies reviewed found women had experienced challenges in accessing healthcare, either being wrongly charged (asylum seekers are exempt from charging) or refused registration by a GP. This finding is supported by DOTW UK 2018 data showing 19% of attempts to register patients with a GP in England were wrongly refused.⁷ There were also reports of difficulties communicating, particularly because of language barriers, and clinical decisions made on behalf of women, without their consent.⁸

Similar themes were identified in a qualitative study from 2021 exploring undocumented migrant women's experiences of NHS maternity services.⁹ The study identified many barriers to care including restricted agency and feeling powerless and socially isolated, having numerous socio-economic stressors including financial, housing and unemployment, combined with fear and stress among undocumented migrant women due to their legal status and uncertainty of their future in the UK. Half of the women who were interviewed reported delays in access to NHS maternity services.

More recent evidence indicates that inequalities in maternity care continue. A 2022 rapid review of ethnic inequalities in maternal healthcare undertaken by the NHS Race and Health Observatory highlighted a lack of adequate interpreting services and resultant communication barriers, as well as disrespect, stereotyping and discrimination within maternity services.¹⁰ The review also identified a need for future research to undertake quantitative data analysis to further explore reasons for inequalities in outcomes, and the need to engage closely with women themselves when undertaking research.

Methodology

Between 2017 and 2021 DOTW UK provided services and in some cases medical assessments to pregnant women through the East London clinic and outreach services. Social and health information were collected for these women using the DOTW UK standard social and medical questionnaire.

Postnatal follow-up was formalised in 2017 when a formal questionnaire (PNFU) was introduced to record data on access to maternity services, delivery outcome, access to healthcare services and wellbeing of mother and child postnatally. Women were contacted on three different occasions by phone, text and/or email. If there was no response after three attempts, women were marked as uncontactable and no further attempts for PNFU were made. PNFU questionnaires were completed with the help of interpreters where necessary.

Data on pregnant women were retrieved from the DOTW UK database and matched with data from the PNFU database. Any duplicates were removed.

Only data from women who completed a DOTW UK consent form agreeing for their data to be used anonymously for research purposes were included in the analysis.

Demographic data were retrieved from the service user's files. Information on gestational age at presentation was either calculated by use of the Estimated Date of Delivery (EDD) as determined by a scan, by the reported Last Menstrual Period (LMP) or as reported by the woman at initial presentation at DOTW UK for her pregnancy.

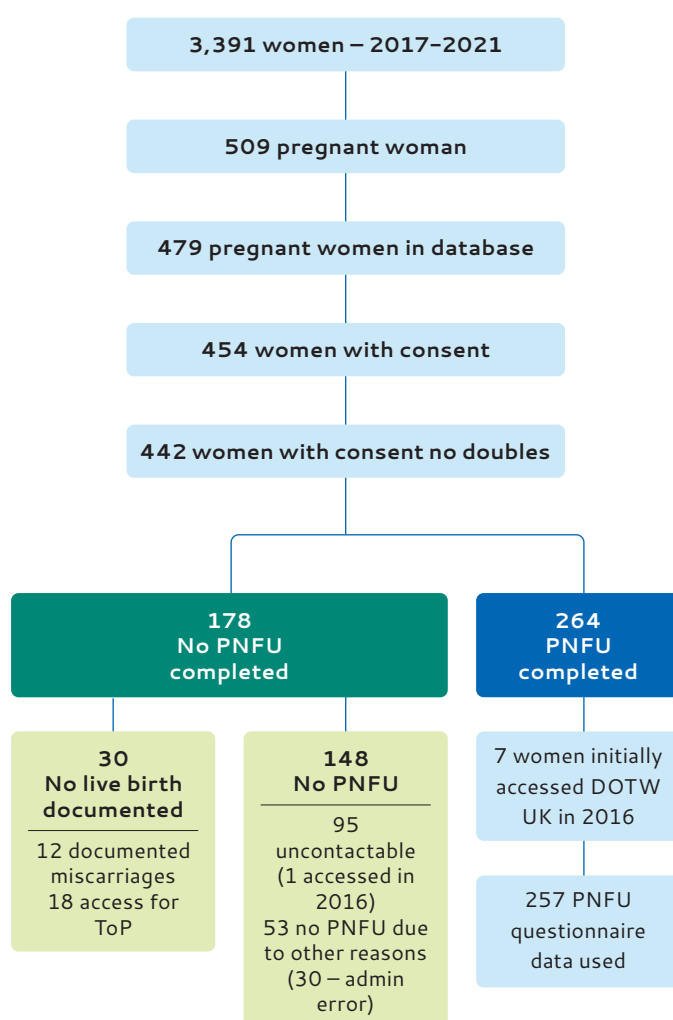
Age at presentation was calculated using the service user's date of birth and the date of presentation for support with her pregnancy.



Findings

From January 2017 until the end of December 2021, 3911 women were supported by Doctors of the World. Among these women, 509 were recorded as being pregnant, with 442 consenting for their records to be used for research purposes. As shown in Figure 1, 257 pregnant women completed PNFU questionnaires.

Figure 1. Flowchart of pregnant women attending the Doctors of the World Women's clinic and where PNFU questionnaires were carried out between 2017–2021



IQR: interquartile range
PNFU: post-natal follow up

Demographics

All pregnant women

Among the 442 pregnant women attending the DOTW UK clinic who gave consent for their records to be used for research (with or without PNFU questionnaires), the median age at presentation was 29 years (range 17–50). Gestational age ranged from 3–39 weeks (median 12/40, mean 15/40). Half of the pregnant women (49.4%, 221 women) presented to DOTW UK beyond 12 weeks gestation, and a fifth (19.4%, 87 women) presented beyond 24 weeks gestation.

Women with a completed PNFU

The demographic profile of the 257 women with PNFU data available (see Table 1) was similar to the full cohort of 454 pregnant women who attended DOTW UK. The median age among women with PNFU data available was 29 (range 17–50). As seen in Figure 2, half (50%, 129 out of 256 women with country of birth data available) were from Asia, 25 % (65 women) were from Sub Saharan Africa and 7% (19 women) were from the European continent. 150 of the 257 women with PNFU data available reported their immigration status during pregnancy, of whom half (51%, 77 women) reported being undocumented. A third of women completed their PNFU in 2021.

Table 1: Age, gestation and immigration status among pregnant women attending the Doctors of the World Women's clinic and where postnatal follow-up (PNFU) questionnaires were carried out between 2017–2021

	Median	Range
Age at presentation (years)	29 (n=254)	17–50 (IQR 25–34)
Stage of pregnancy at presentation to DOTW UK (weeks)	14 (n=257)	3–39 (IQR 8–23)
Immigration status during pregnancy	Proportion	Percentage (%)
Asylum seeker / Application ongoing / Refugee	43/150	29
Undocumented	77/150	51
Documented (other)	16/150	11
Other	14/150	9

Figure 2: Proportion of pregnant women attending the Doctors of the World Women’s clinic and where postnatal follow-up (PNFU) questionnaires were carried out between 2017–2021 from each geographical area. The size of the area within the chart corresponds to the number of women from each area.



Termination of pregnancy and miscarriage

Women who attended DOTW UK for support with accessing termination of pregnancy (data available for 15 out of 18 women) presented on average with a gestational age of 7 weeks (median 6/40). Women who had a documented miscarriage (n=12) presented with an average gestational age of 8 weeks (median 7/40).

Pre-conception

Around one in twenty (6%, 9 out of 153 women with available data) started taking folic acid before conception, compared to over a quarter (25.9%) of women nationally.¹¹

Around two-thirds (63%, 97 out of 153 women with available data) started taking folic acid in the first trimester of pregnancy compared to 65% of women nationally taking folic acid at the start of pregnancy.¹²

Antenatal care

Information was available on the first antenatal care (ANC) appointment for 216/257 women. The majority (81%, 176 of 216 women with available data) attended their first appointment after the recommended 10 weeks and nearly half (45%, 97 of 216 women with available data) attended their first antenatal appointment after 16 weeks of pregnancy. This compares to 49.5% of women nationally attending their first appointment after the recommended 10 weeks, and 10.6% attending their first appointment after 16 weeks.¹³

When analysed by region of origin, women from Sub Saharan Africa presented to ANC the latest, with only 38% attending before 16 weeks (see Table 2).

In terms of immigration status, documented migrants were the most likely to attend ANC before 16 weeks at 80% compared to those with insecure immigration status at 55% which included asylum seekers (53%), undocumented migrants (58%) and people described as other which included refused asylum seekers (54%) (see Table 2).

Table 2: Antenatal clinic attendance by region of origin and immigration status among pregnant women attending the DOTW UK Women's clinic and where postnatal follow-up (PNFU) questionnaires were carried out between 2017–2021

Region of origin	Proportion	Percentage (%)
Asia	62/104	60
Europe/Georgia/Ukraine/Russia/ Middle East	24/38	63
Americas	12/20	60
Sub Saharan Africa	20/53	38
Immigration status (combined)	Proportion	Percentage (%)
Documented	13/16	81
Insecure (combining below)	66/119	55
Asylum application ongoing/asylum seeker/refugee	21/40	53
Other (includes refused asylum seekers)	7/13	54
Undocumented	38/66	58

Support during pregnancy

Data regarding support during pregnancy were available for 156 out of the 257 pregnant women with a completed PNFU questionnaire. The majority (72%, 113 women) were supported by the baby's father, 13% of respondents (20 women) were supported by family or friends and the remaining 23% either accessed no support or other types of support (23 women). Four in ten women (39.4%, 71 women) reported changes in mood following pregnancy, with symptoms varying from feeling low to full postpartum psychosis for which hospitalisation was required.

Healthcare charging

Over a third of women (37.8%, 88 women out of the 233 with available data) reported receiving a bill for healthcare. Bills ranged from £296 to £14,000 with half (50%) of those receiving a bill being charged more than £7000.

Delivery

Mode of delivery data were available for 254/257 (99%) of women in whom the PNFU questionnaire was applied (see Table 3). Of these, 150/254 (59%) had a spontaneous vaginal delivery (compared to 54% nationally),¹⁴ 8/254 (3%) had an instrumental delivery (compared to 13% nationally),¹⁵ and 96/254 (38%) had a Caesarean section (compared to 33% nationally)¹⁶ of which 56/96 (58%) were emergency Caesareans. Complications at the time of delivery arose in 87/253 (34%) of those whom data were available for.

Perinatal outcomes

The majority of babies, 215/254 (85%), were born at term (37–42 weeks gestation). Preterm births (<37 weeks) occurred in 22/254 (9%) and 17/254 (7%) were born post-term at >42 weeks (see Table 3). The birthweight of this cohort of babies ranged from 853–5000g (mean 3298; median 3320). 15/213 (7%) were born with a low birthweight (<2500g) and the remainder were either in the normative range (181/213, 83%) or weighed more than 4000g (11/213, 5%) (see Table 3).

Table 3. Delivery and birth outcomes among pregnant women attending the Doctors of the World Women's clinic and where postnatal follow-up (PNFU) questionnaires were carried out between 2017–2021

Outcome	Proportion	Percentage (%)
Spontaneous vaginal delivery	150/254	59
Instrumental delivery	8/254	3
C section	96/254	38
Of which – Emergency C section	56/96	58
Term delivery (37–42 weeks)	215/254	85
Preterm (<37 weeks)	22/254	9
Post-term (>42 weeks)	17/254	7
Birthweight in normative range (2500 – 4000g)	181/213	85
Low birth weight <2500g	15/213	7
Large birth weight (>4000g)	11/213	5

Post-partum

Of the 257 women with postnatal follow-up data, Vitamin D supplementation was being given by 102/145 (70%) of mothers asked. GP registration had been completed in 226/255 (89%) of cases and 208/252 (83%) of those asked had been to their 6-week check appointment. A red book had been given in 250/253 (99%) of cases and 232/253 (92%) of women said they were aware of the UK vaccination schedule and how to book these appointments for their baby. Of those asked, 151/155 (97%) of women said they would get their child vaccinated.

Impact of COVID-19 on pregnancy

In 2020, pregnant women attending DOTW UK were asked whether COVID-19 had impacted their pregnancy. Over a third (37%, 34 out of 92 women) felt the COVID-19 pandemic had impacted their pregnancy. During their consultations, many women reported feeling isolated. Some reported that they were not able to have their birth partner with them in the hospital. Several women said they felt scared due to the pandemic, and this hindered access to their GP or other services; one woman said "I was scared in the beginning of the pandemic, I couldn't seek help due to fear from the virus. I had to look after myself until I heard about Doctors of The World, and they helped me access the services."

Several outcomes were analysed according to whether contact with DOTW UK (as defined by the timestamp recorded in the DOTW UK database) was before or after the UK lockdown began on 23rd March 2020. This was crudely used as a way of comparing outcomes of the pregnancies and births that occurred prior to, and during, the COVID-19 pandemic (see Table 4)

Antenatal care attendance

The majority of women had their first antenatal appointment after the recommended 10 weeks both pre-COVID (81%, 85 of 105 women with available data) and post-COVID (82%, 91 of 111 women with available data). More women felt stressed during most of the pregnancy during the pandemic (38%) compared to pre-pandemic (25%), but this was not statistically significantly different. Most women felt supported during their pregnancy both pre-pandemic (94%) and during the pandemic (89%).

Delivery

There was no significant difference between the proportion of women who had a caesarean section before and during the pandemic (37% and 39% respectively). The proportion of caesarean sections which were undertaken as emergency procedures (as opposed to planned) was higher during the pandemic, but this did not reach statistical significance (58% vs 74%, $p=0.1$).

Table 4: Outcomes before and during the COVID-19 pandemic among pregnant women attending the Doctors of the World Women's clinic and where postnatal follow-up (PNFU) questionnaires were carried out between 2017-2021

Outcome	Pre-pandemic (%)*	Pandemic (%)*	RR	95% CI
Antenatal clinic attendance before 10 weeks gestation	19 (n=111)	18 (n=105)	1.0	0.89-1.2
Felt stressed during most of pregnancy	25 (n=36)	38 (n=117)	1.5	0.82-2.8
Felt supported during pregnancy	94 (n=35)	89 (n=118)	0.94	0.85-1.04
C section (n=254)	37 (n=135)	39 (n=119)	1.0	0.76-1.43
Of which - Emergency C section	58 (n=38)	74 (n=46)	1.3	0.9-1.8
Preterm delivery (<37 weeks)	10 (n=135)	7 (n=119)	0.6	0.3-1.5
Low birth weight <2500g	4 (n=101)	11 (n=113)	2.5	0.8-7.4
Aware of immunisation schedule and/or how to book	88 (n=134)	96 (n=119)	1.1	1.0-1.2
Will get their child vaccinated	100 (n=36)	97 (n=119)	0.97	0.93-1.0
Change in mood post birth	21 (n=132)	36 (n=119)	1.7	1.1-2.6

*Of those where data is available for the variable

RR=Relative risk, 95% CI= 95% confidence interval

Perinatal and postnatal outcomes

Although there were no significant differences in the occurrence of adverse perinatal outcomes i.e., prematurity and low birthweight before or during the pandemic, the proportion of babies born with a birthweight <2500g in this cohort, during the COVID-19 period, was higher than the England and Wales average reported by ONS for 2020 (11% in our cohort vs. 6.5% in England and Wales).¹⁷ The proportion of babies born at <37 weeks was higher pre-pandemic compared to after the pandemic began (10% vs 7%) and although this didn't reach statistical significance, the pre-pandemic proportion was higher than the national average in 2019 for England and Wales (10% vs 7.8% of births).¹⁸

There was no significant difference with regards to primary immunisation questions asked before- and after the COVID-19 pandemic began. The majority of women in this cohort were aware of the UK immunisation schedule and how to book these (88% pre- vs. 96% post-pandemic) and the vast majority (100% pre- and 97% during pandemic) said they would get their child vaccinated.

However, when looking at mood fluctuation in the postnatal period, pandemic mothers in our cohort had 1.7 times the risk of having low mood (95% CI: 1.1-2.6) compared to pre-pandemic mothers.

Discussion

This report summarises important outcomes for the migrant pregnant women who accessed DOTW services between 2017 and 2020. Half of these women reported coming from the Asian continent (China and the Philippines being the most frequent countries) and a quarter from Sub-Saharan Africa.

The majority of pregnant women who accessed DOTW services in this time period did so in the second and third trimesters of their pregnancies and although the majority started taking folic acid in the first trimester, a very small proportion had been taking folic acid before conception compared to the national average (6% vs. 25.9%).¹⁹

The vast majority of women in the cohort (81%) had their first antenatal care appointment beyond the recommended 10 weeks of pregnancy. More than four in ten (45%) of the women did not have any antenatal care until after 16 weeks of pregnancy, compared to just one in ten women nationally.²⁰ Within this group more than six in ten women from Sub-Saharan Africa (62%) accessed care after 16 weeks.

Although the majority of women reported being supported by the biological father or friends and family, mental health issues occurred in over a third of women, potentially exacerbated by the fact that over a third also received a bill for their maternity care of up to £14,000.

When looking at the study period overall, the mode of delivery and perinatal outcomes (including rates of prematurity and low birthweight) were broadly comparable to the national average.

The COVID-19 pandemic had a clear impact on this cohort of women. When stratifying antenatal and postnatal outcomes by a timestamp denoting contact with DOTW before or during the pandemic, differences were noted in most variables (although most were not statistically significantly different).

More women reported feeling stressed during most of their pregnancy, and the proportion of women who felt supported reduced. The proportion of babies born with a low birthweight in the pandemic period was 11% compared to 6.5% in England and Wales in 2020.²¹

Worryingly, women were almost twice as likely to report mood disturbance after birth in the pandemic period compared to pre-pandemic (RR 1.7, 95% CI 1.1–2.6).

When women were followed up with their babies in the postnatal period, the overwhelming majority had registered their babies with the GP, had received a red book and had had their 6-week postnatal check. Vitamin D supplementation was also being given to babies by 70% of mothers. Reassuringly, close to 100% of women both pre- and during the pandemic were aware of the UK immunisation schedule, how to book these and even during the pandemic, 97% of mothers said they would take their child to be immunised.

Conclusion

This report highlights inequalities in access to antenatal care experienced by migrant women which are likely to lead to poorer outcomes for their pregnancy and health of their children.

The data did not evidence the reason for the delayed access, but it did demonstrate significantly delayed access for two groups: women from sub-Saharan Africa (six in ten) and those with undocumented, uncertain, refugee or asylum seeker status (four in ten). Whilst ethnicity was not recorded for the women, this evidence highlights the need for the racial health inequalities agenda to better understand the relationship between immigration status, race and ethnicity and access to NHS services and health outcomes.

More broadly, the evidence in this report highlights the pressing need for independent action to be taken to review the impact of NHS charging policy as a whole on individuals and health inequalities with over a third of the women receiving a bill of their care. A growing body of evidence suggests that the NHS charging policy erodes migrant and Black and Minority Ethnic communities' trust in the NHS and undermines access to all health services.

The data in this report should be used alongside data held by Government health agencies, such as NHS England and Improvement, the Office for Health and Improvement and Disparities and UK Health Security Agency. These agencies could hold key data needed to determine the real impact of immigration processes including health charges and fears about NHS services working with immigration enforcement on health and maternal outcomes.

The report also highlights a significant increase in postnatal mood disturbance in this cohort of women following the COVID-19 pandemic, confirming what has already been reported in the literature²² with regards to the severe indirect consequences of the pandemic on perinatal mental health in the UK.

Limitations

This report is limited by the fact that some variables contained a substantial quantity of missing data. This is due to the fact that some questions were added later in the time period. This has resulted in small denominators for some variables, particularly when stratifying by timestamp before and during the COVID-19 pandemic. When there were small numbers in each cell, data was combined in order to maintain anonymity in the data. The data did not contain the ethnicity of the women only country of origin.

Recommendations

The UK government should:

- **Conduct an urgent public and independent inquiry into access to NHS services and health outcomes for people with insecure immigration status and incorporate this work into actions to reduce ethnic and racial disparities in healthcare. The inquiry should investigate the experiences of pregnant women and babies, identifying specific barriers in access to maternity services and impact on maternal outcomes.**
- **Immediately suspend NHS charging regulations for maternity care due to the harm this system causes to migrant women and their babies experiencing inequalities in maternity care.**
- **Strengthen the evidence base on the experiences of migrant pregnant women with a focus on Black women and women with insecure immigration status to understand reasons for late access to care and outcomes, drawing on data held by government health agencies and commissioning further data collection if needed.**
- **Fund work to trial and evidence what works to improve access to maternal health care for migrant women**

Maternity services should:

- **Review and improve support to women with insecure immigration status as part of their work to improve equity and equality in maternity care.**

Endnotes

- 1 NICE. Recommendations | Antenatal care | Guidance | NICE NG201 [Internet]. 2021 [cited 2022 Mar 28]. Available from: <https://www.nice.org.uk/guidance/ng201/chapter/Recommendations>
- 2 NHS Maternity Statistics, England – 2020–21 – NHS Digital [Internet]. [cited 2022 Mar 28]. Available from: <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-maternity-statistics/2020-21>
- 3 Doctors of the World. Deterrence, delay and distress: the impact of charging in NHS hospitals on migrants in vulnerable circumstances [Internet]. 2017. Available from: https://www.doctorsoftheworld.org.uk/wp-content/uploads/import-from-old-site/files/Research_brief_KCL_upfront_charging_research_2310.pdf
- 4 Maternity Action. Duty of Care: The impact on midwives of NHS charging for maternity care – Maternity Action [Internet]. 2019 [cited 2022 Mar 28]. Available from: <https://maternityaction.org.uk/midwives-report>
- 5 Maternity Action. Breach of Trust: A review of implementation of the NHS charging programme in maternity services in England [Internet]. 2021 [cited 2022 Mar 28]. Available from: www.maternityaction.org.uk
- 6 McKnight P, Goodwin L, Kenyon S. A systematic review of asylum-seeking women's views and experiences of UK maternity care. *Midwifery* [Internet]. 2019;77:16–23. Available from: <https://doi.org/10.1016/j.midw.2019.06.007>
- 7 Doctors of the World. Registration Refused: Access to GP services for migrants in vulnerable circumstances. 2019.
- 8 McKnight P, Goodwin L, Kenyon S. A systematic review of asylum-seeking women's views and experiences of UK maternity care.
- 9 Nellums LB, Powis J, Jones L, Miller A, Rustage K, Russell N, et al. "It's a life you're playing with": A qualitative study on experiences of NHS maternity services among undocumented migrant women in England. *Soc Sci Med*. 2021 Feb 1;270:113610.
- 10 Kapadia D, Zhang J, Salway S, Nazroo J, Booth A, Villarroel-Williams N, et al. Ethnic Inequalities in Healthcare: A Rapid Evidence Review [Internet]. 2022. Available from: https://www.nhs.uk/wp-content/uploads/2022/02/RHO-Rapid-Review-Final-Report_v.7.pdf
- 11 NHS Maternity Statistics, England – 2020–21 – NHS Digital [Internet]
- 12 Ibid.
- 13 Ibid.
- 14 Ibid.
- 15 Ibid.
- 16 Ibid.
- 17 Birth characteristics in England and Wales – Office for National Statistics [Internet]. [cited 2022 Apr 4]. Available from: <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/bulletins/birthcharacteristicsinenglandandwales/2020>
- 18 Ibid.
- 19 NHS Maternity Statistics, England – 2020–21 – NHS Digital [Internet]
- 20 Ibid.
- 21 Kapadia D, Zhang J, Salway S, Nazroo J, Booth A, Villarroel-Williams N, et al. Ethnic Inequalities in Healthcare: A Rapid Evidence Review. 2022.
- 22 Filippetti ML, Clarke ADF, Rigato S. The mental health crisis of expectant women in the UK: effects of the COVID-19 pandemic on prenatal mental health, antenatal attachment and social support. *BMC Pregnancy Childbirth* [Internet]. 2022 Dec 1 [cited 2022 Apr 4];22(1):1–10. Available from: <https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-022-04387-7>



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