

# Accessing Maternal Health Care in a Hostile Environment

Haleema Adil, Deveney Bazinet, Catherine Cooke,  
Tiffany Kwok, Poppy Pierce, Sara Hillman, Kate Roll

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*A note on language:* To be gender inclusive we are intentional throughout the report to speak about “pregnant individuals” unless we are directly quoting one of our interviewees, recognizing that multiple gender identities have reproductive capacity. We acknowledge that those who do not align with the gender binary tend to experience higher levels of marginalization. While specific outcomes based on gender identities were not explored during our research, this could be a focus for future research and practices.



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# Executive Summary

Over the past decade, forced and voluntary migration has been increasing while simultaneously becoming more complex. The London borough of Camden has historically been home to many refugees, people seeking asylum, and undocumented migrants (RASU), and it has witnessed not only a rise in the population of these migrant groups but also changes to the barriers they face in accessing basic services, including quality maternal healthcare. Many of these barriers are directly tied to the UK’s so-called hostile environment immigration policies and the political climate they create to alienate and discourage “illegal” migrants from coming to the UK.

To better understand the experience of RASU individuals in accessing maternal care in this hostile environment we interviewed service providers: community organizations supporting these migrant groups and healthcare professionals involved in delivering maternity services. In mapping the direct impact of the hostile environment policies, how the hostile environment’s culture permeates into service provision, and the responses of services providers, we generate a number of recommendations. Although the research was limited to specific stakeholders, it contributes to the growing body of evidence on the detrimental impact of hostile environment policies, particularly for pregnant RASU individuals.

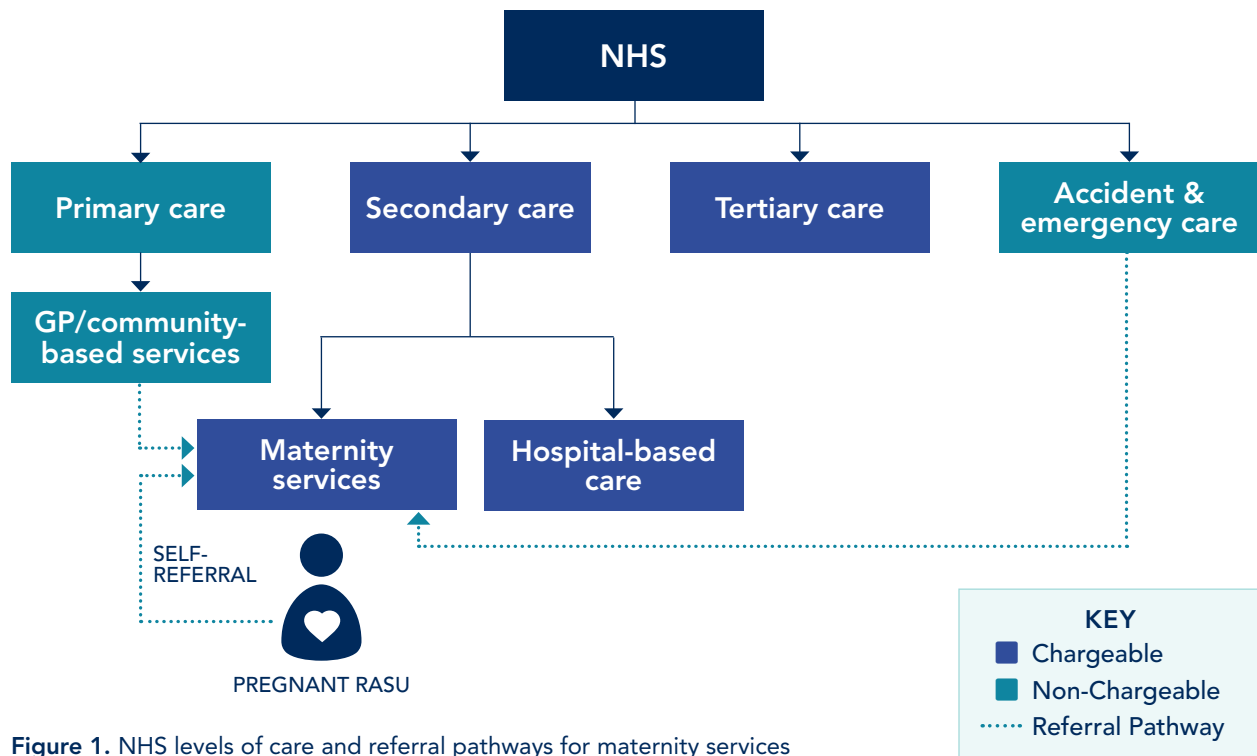


Figure 1. NHS levels of care and referral pathways for maternity services

## Context: The UK's Hostile Immigration Policies

In 2012 the appointed Home Secretary, Theresa May, stated that the government intended to implement immigration policies that would create “a really hostile environment for illegal immigrants.”<sup>1</sup> The “hostile environment policies,” enacted primarily through the 2014 and 2016 Immigration Acts, implemented immigration controls aiming to restrict access to basic public services and opportunities, such as housing, education, employment, and healthcare.

Although most of these policies are managed through the Home Office, a ministerial department responsible for the country’s security and economic prosperity, they implicate other central government departments and other

levels of government (e.g., local and municipal authorities), as well as citizens who are called on to enforce these policies. In a few short years, the impacts have been far reaching for migrants, creating a less welcoming society and a high level of uncertainty, as well as negatively affecting some of the most vulnerable and destitute individuals in the UK. Even with attempts to shift the narrative toward “compliant environment policies,”<sup>2</sup> in practice these policies have continued in the direction that May set out ten years ago, propagating the restrictive environment for migrants.

Our research focuses on how the hostile environment policies affect access to and quality of maternal healthcare for refugees, people seeking asylum, and undocumented migrants (RASU). In particular, we examine care provision

1 Jamie Grierson, “Hostile Environment: Anatomy of a Policy Disaster,” *The Guardian*, August 27, 2018. [↗](#)

2 “A Guide to the Hostile Environment,” *Liberty*, May 2019. [↗](#)

in Camden, a diverse borough of over 275,000 people in London that has traditionally been a place to settle for these migrant groups. While some studies have explored the provision of care at health institutions in other London boroughs, or other cities in the UK, there is limited Camden-specific research. This research also contributes to the growing need for evidence that illuminates the challenges of the hostile environment policies

and offers insights for improved policy decision making and healthcare service design.

## The National Health Service

The UK's healthcare system is the National Health Service (NHS) and one of the key organizational units of the system is the NHS Trust. Each trust sets its own maternity guidelines, which define

### Box 1: Hostile Environment Policies Highly Relevant to Maternal Healthcare

#### NHS CHARGING PROGRAM

The NHS charging program, set in place in 2014, created a statutory duty for NHS trusts to charge certain status groups for secondary and tertiary healthcare, including maternity care. Groups being charged included: (a) people seeking asylum who have been refused asylum and have not yet submitted another application or who (b) are undocumented migrants. To safeguard the most vulnerable, there are exemptions to charging, including cases where pregnancy is a result of violence, or for victims of torture, trafficking, or female genital mutilation, however, the burden of proof for these exemptions falls on the individual. The minimum cost of maternity care is £7,500, but this can balloon to hundreds of thousands of pounds for complex cases. As a form of immediate care, NHS maternity services cannot be denied to anyone in the UK, and no one should be asked to make payment up front. However, an individual's status will determine whether they will be charged for the care they receive. There is a growing body of research that shows that charging for maternity care, and healthcare generally, deters access and leads to poorer health outcomes for parents and their children.<sup>1</sup> Although safeguards have been built into the language of the policy, these safeguards

are failing in their implementation, with increasing evidence that people are being wrongly charged.<sup>2</sup>

#### DISPERSAL POLICY

People seeking asylum are provided accommodation if they need it by the Home Office, though recent Afghan evacuees, who did not come on a particular refugee resettlement scheme, are also experiencing dispersal.<sup>3</sup> People seeking asylum are provided initial accommodation, usually in a hostel or hotel, and then "dispersed" to another temporary accommodation, usually in a flat or house. Generally, people do not have a choice of the housing they are placed in and sometimes can be moved multiple times in the course of their asylum application.

#### INFORMATION SHARING

Within the healthcare system, NHS trusts are required to share information with the Home Office if an individual has accrued a debt of over £500 for more than two months and there is no repayment plan in place. These debts can affect immigration applications, and information shared about an undocumented migrant could lead to deportation.

1 Rayah Feldman, "The Impact on Health Inequalities of Charging Migrant Women for NHS Maternity Care," Maternity Action, March 2017. [↗](#)

2 "Breach of Trust: A Review of Implementation of the NHS Charging Programme in Maternity Services in England," Maternity Action, September 2021. [↗](#)

3 "Healthcare Needs and Pregnancy Dispersal Policy," UKVI, January 2016. [↗](#)

the standard of care and interventions provided. The health system is further divided into levels of care, as Figure 1 represents:

- primary care, which includes general practitioner (GP) surgeries
- secondary care, which includes hospital care
- tertiary care, which includes specialist services
- accident and emergency (A&E).

Individuals move through these distinct levels by a referral process, and each level has different funding, priorities, and targets. Maternity care sits within secondary care but overlaps with other levels. There are multiple pathways to accessing maternity care: referrals through primary care (i.e., through a GP); completion of an online self-referral form; or directly through A&E.

Box 1 outlines key hostile environment policies that affect maternity care and are explored here. These policies conflict with some of the UK's national and global health commitments. In 2016, the National Maternity Review published "Better Births," a report that outlined a national vision for improved maternity care that included a focus on patient-centred care and improved maternal outcomes.<sup>3</sup> NHS trusts are also responding to the MBRRACE-UK report, published in 2021, which highlighted the specific discrepancies in maternal mortality for ethnic minorities.<sup>4</sup> These reports have helped to shift priorities within the healthcare system but ultimately these goals will not be met by restricting access or reducing care for vulnerable migrants. Internationally, the UK has also committed to the United Nations' Sustainable Development Goals (SDGs) and any policies that restrict access to quality maternal healthcare risks negatively impacting SDG 3 (Good Health and Well-Being), SDG 5 (Gender Equality), and SDG 10 (Reduced Inequalities).

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## Hardest to Reach: Refugees, People Seeking Asylum, and Undocumented Migrants

There are many different migrant groups in the UK, and the hostile environment policies have created conditions where an individual's status will impact their access to basic services, including healthcare. The policies' intention is to focus on individuals involved in "illegal" migration — specifically people seeking asylum or undocumented migrants — however, the wider-reaching impacts of these policies also affect those who have recognized status as refugees, as well as other migrant groups and racial minorities. An individual's status can shift multiple times during their stay in the UK. To account for these experiences, we focus on RASU individuals (refugees, people seeking asylum, and undocumented migrants), differentiating their circumstances where necessary. Box 2 outlines definitions of each status group.

RASU groups have multiple disadvantages in healthcare. They often arrive in the UK with experiences of trauma and violence, in a compromised emotional and mental state, and with a range of co-morbidities as a result of not receiving appropriate healthcare. They experience multiple and complex stigma and discrimination in both their communities and in healthcare settings. As a result, they are at higher risk of poor maternal health outcomes, which also extends to the health of the child.

Immigration has contributed to the great diversity of Camden for decades. However, the increasing cost of living and housing shortages will restrict the number of new migrants moving into the borough, particularly through refugee

3 "Better Births: Improving Outcomes of Maternity Services in England," National Maternity Review, 2016. [↗](#)

4 Elizabeth S. Draper, Ian D. Gallimore, Lucy K. Smith, et al., "MBRRACE-UK Perinatal Mortality Surveillance Report, UK Perinatal Deaths for Births from January to December 2020" (Leicester: The Infant Mortality and Morbidity Studies, Department of Health Sciences, University of Leicester, 2022).

resettlement. According to the Greater London Authority, the number of asylum-seeking people who are being housed in the city is increasing, with current figures around 5,000. While there

are no published figures for Camden, it is estimated that there are hundreds of people seeking asylum who are being housed in the borough temporarily as they navigate their

## Box 2: Defining the Hardest-to-Reach Populations

**REFUGEES** refers to those in the UK who have received refugee status, which is a five-year leave to remain.<sup>1</sup> Individuals with this status have either come through a UN resettlement program, where they receive full refugee status on arrival, or they have been given this status as part of a successful asylum claim. Notably, those who come through refugee resettlement have a case manager from the UN migration body, the International Organization for Migration, to support their transition, while those who come through the asylum route must navigate the system and seek out support structures on their own. After five years, refugees can apply for further leave.



**All levels of healthcare are free.**

**PEOPLE SEEKING ASYLUM** are those who have come to the UK through “irregular means,” meaning outside of laws, regulations, and international agreements,<sup>2</sup> and have made an asylum claim with the Home Office. Those who are considered asylum seekers are those who have an active application open, or those who have submitted an appeal and are awaiting the outcome. Someone who has been “refused asylum” is someone whose asylum application has been rejected and they have yet to submit another application, or they are considered “appeals rights exhausted.”<sup>3</sup> There are multiple outcomes to a successful asylum claim, which include leave to remain, humanitarian protection, and other forms of leave.<sup>4</sup>



- **Active asylum seekers: all levels of healthcare are free**
- **Refused asylum seekers: primary care and A&E are free; secondary and tertiary care are chargeable, which includes maternity care (unless they qualify for an exemption).**

**UNDOCUMENTED MIGRANTS** are people in the UK without legal status and who have not actively made themselves known to the Home Office. The term covers a wide range of circumstances, including those who are struggling to keep up with application fees, those who do not have the resources to challenge a Home Office decision, or those without the legal support to navigate a changing and complex set of immigration rules.<sup>5</sup> It includes those who were a dependent to an abusive partner and leaving the relationship meant they lost their status.<sup>6</sup> It is also those who fear deportation back to a country that is not safe but are wary of the asylum system and choose the precarity of invisibility.



**Primary care and A&E are free; secondary and tertiary care are chargeable, which includes maternity care (unless they qualify for an exemption).**

1 “The Truth About Asylum,” Refugee Council, 2022. [↗](#)

2 “Key Migration Terms,” IOM, 2022. [↗](#)

3 “Refused Asylum Seekers — Financial Support and Housing,” Maternity Action, 2022. [↗](#)

4 “National Statistics: How Many People Do We Grant Asylum or Protection to?” Home Office, March 2022. [↗](#)

5 “A Guide to the Hostile Environment,” Liberty.

6 “Breach of Trust: A Review of Implementation.”

immigration processes. A representative from Maternity Action told us that Camden has a “large undocumented population” but a more specific figure could not be sourced.

## Immigration Status: Its Effect on Maternal Health Services

“How does the relationship between immigration status and related policies affect the access, provision, and delivery of maternal health services for refugees, people seeking asylum, and undocumented migrants?” This question emerged through secondary desk research, as well as through early informal conversations with healthcare professionals (HCPs) and community organizations (COs), who suggested that the hostile environment policies and the environment they were creating were highly influential on

how they are able to support RASU individuals. A visualization of our initial findings can be found in Figure 2. We gathered insights from relevant stakeholders on the interaction between policy and healthcare and its implications, and subsequently offered recommendations to improve access to maternal healthcare.

## Project Details

After reviewing the research on RASU groups and maternal health within Camden, we widened the scope to greater London and to the UK more broadly to better understand the landscape. While we originally aimed to speak directly with RASU individuals about their experiences, time constraints, and a reliance on external organizations to facilitate connections, did not allow for this. This was mainly due to organizations being preoccupied with the influx of RASU groups arriving in the country as a result of multiple global migration crises. Although it is imperative to hear

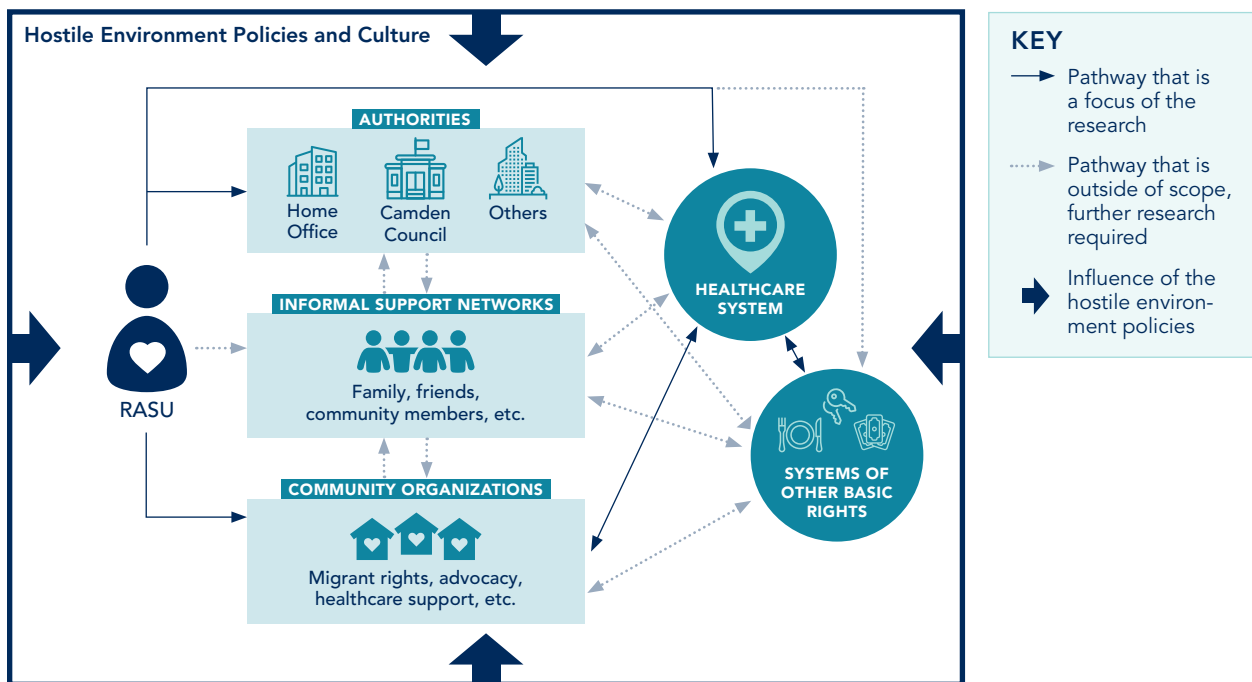


Figure 2. Pathways to accessing healthcare and other basic services



directly from RASU groups to develop an in-depth and nuanced understanding of the issue, the current political climate did not allow for this, and it remains a limitation of the research.

Consequently, our focus shifted to two groups of interviewees who had emerged as key stakeholders within the RASU landscape: HCPs and COs. Throughout the report, these groups may be collectively referred to as “service providers.” Obtaining immediate responses and active engagement proved to be difficult because service providers were overwhelmed with COVID-19 impacts and two recent migration crises from Afghanistan and Ukraine. However, over 30 official interviews (a combination of in-person and online interviews) were completed, with approximately one-third made up of COs, and two-thirds involving HCPs (including specialist midwives and obstetricians) at University College London Hospital (UCLH), which is part of the University College London Hospitals NHS Foundation Trust.

Among the service providers we interviewed, various people mentioned the substantial role of the Trust’s Overseas Visitors Team (OVT), a team within NHS trusts concerned with cost recovery through the charging program. They are responsible for identifying chargeable individuals in the hospital, and have final discretion in all charging decisions since there is no appeal process in place with the Home Office. Despite their role in executing many processes we outline in this report, our multiple attempts to speak to the OVT were unsuccessful so its role remains a major gap which should be explored in further research.

Prior to the interviews, we designed specific sets of interview questions to help us discover the intricacies and nuances of the collective and individual experiences on how immigration status affects maternity services. The hostile environment policies became our focal point, which enabled trends to be identified that desk research had not yet uncovered, particularly in



**Figure 3.** UCLH, site of our HCP research

the Camden-specific literature. Interviews were then transcribed, reviewed, thematically analyzed, and coded through the software Dedoose. We identified main themes and subthemes and viewed them in the context of existing literature. We drew insights from service providers working within Camden, and from COs working on RASU maternal health across London, across England (which has greater restrictions for migrants than Wales, Scotland, and Northern Ireland), and across the UK.

## Analysis

The hostile environment policies affect RASU groups’ access to, and quality of, maternal healthcare in two ways: (1) through a specific set of hostile policies that directly affect RASU individuals in their access to health services, as well as other basic services such as housing and food security; (2) through the hostile culture these

policies create in society, which permeates into the care that HCPs and COs provide. Providers and organizations have also had to respond to the hostile environment policies by using their own discretion and developing new means of supporting RASU individuals in their access to quality care.

## THE HOSTILE ENVIRONMENT POLICIES AND MATERNITY CARE

While there are many hostile environment policies and programs that affect maternal care, there are three main policies of concern: the NHS charging program, the dispersal policy, and information sharing. Restrictions to other basic services, particularly housing and food, can also create barriers in accessing quality maternal care.

**The NHS charging program.** CO interviewees shared examples where refugees and people seeking asylum were charged, despite being entitled to free maternal care. They also told of people within the chargeable population who had been charged despite meeting the criteria for exemption. Because charges apply to *all* secondary and tertiary care, one CO interviewee provided examples where pregnant RASU individuals with health issues requiring more specialized care (e.g., diabetes) were then forced to make difficult decisions about which care they could afford. Multiple CO interviewees highlighted how the burden of charging fell on the women giving birth, with one interviewee describing it as a “gendered way of targeting vulnerable women.”

It became clear in conversations with CO interviewees that the OVTs functioned differently across each NHS trust. The way in which individuals are referred to maternity care is “not a streamlined process at all” and “lacks clarity,” so the information on an individual’s immigration status when arriving to this level of care is inconsistent. Some trusts include questions on status as part of their standardized booking

processes for maternity services; however, in other cases the OVT seeks out this information. As one CO interviewee highlighted, the charging system is intended to be separate from the provision of care, but there are many cases where the OVT will ask HCPs to support this process.

Another reason for the inconsistency regarding charging across trusts is organizational culture, which one CO interviewee described as “fiefdoms that exist which will be culturally different to each other.” For example, an HCP interviewee described a working relationship with an OVT in a previous role where “the baseline was the safety of the woman and her baby.” However, in other cases, perceptions of OVTs were less positive. For example, interviewees described them regularly coming into the maternity ward to check people’s status; intruding in an “untimely manner”; being “aggressive” in their pursuit; and “chasing” chargeable individuals.

For HCPs interviewed at UCLH, their level of interaction with the charging program varied. There were six interviewees who described engaging with the OVT, which included reaching out to determine if someone was entitled to care or referring those seeking care to the OVT. However, five other HCPs felt they had little interaction with the OVT, or with the issue of charging; one HCP interviewee stated that all they knew about the OVT is that they were “literally a team that comes with a credit card machine.” These differing experiences, coupled with the inability to speak with the UCLH OVT directly, made it difficult to map out the charging processes within UCLH.

Opinions about charging were also varied. Three interviewees felt divided, with concerns that the NHS was being “drained because of illegal people using the service,” or that there were people “trying to play the system a little bit.” However, at the same time, these interviewees also expressed concern that charging was affecting access to care for the most vulnerable

individuals. A third of HCPs were clear that charging was outside of their purview: one interviewee stated, “we’re here to provide care and not police care” and three others insisted that immigration is not their job. Three interviewees noted the difficulty and discomfort of discussing charging with individuals. A third of the HCPs shared the concern that charging was affecting the quality of care received, citing concerns that this was leading to a lack of integral clinical information being shared, late bookings, and avoidance of appointments, where individuals “end up accessing care [only] when it’s critical.”

**Dispersal policy.** There are policy safeguards in place to protect pregnant people from being moved unnecessarily, particularly in the later stages of the pregnancy. However, several of the providers we interviewed told us that they spoke with people who were being moved multiple times, including during the last weeks of pregnancy, sometimes with little warning, and often with limited information about why they were being moved. One HCP interviewee gave the example of an individual being moved at 39 weeks, which is “incredibly unsafe.” Another HCP interviewee noted that “somebody could be in Camden for 17 weeks, and suddenly the Home Office will tell them you’re moving out next month.” Many HCP interviewees wanted to “make sure that those new babies go home somewhere safe, warm, [and] dry” but they also expressed serious concerns about the quality of accommodation individuals were living in, often with hygiene, crowding, and safety issues.

Trusts have different procedures and cultures. One interviewee emphasized that one consequence of being moved multiple times during pregnancy was having to navigate multiple maternal care systems, some being more migrant friendly and with better processes in place than others. The interruptions in care and missed appointments noted by multiple HCPs occurred because of these relocations between trusts. CO



**Figure 4.** Entrance to the maternity department at UCLH

interviewees explained that moving disrupts trust and community-building processes and adds undue stress on the pregnant person.

**Information sharing and surveillance.**

Both HCPs and COs were concerned about information sharing and surveillance within healthcare, with one CO interviewee specifically noting the increased sharing of information between the NHS and the Home Office. In the case of charging, one CO interviewee noted that even though debt information should not be provided to the Home Office if a repayment plan is in place, details were still being shared. Not only can an NHS debt impact an immigration application — four CO interviewees noted that these debts were starting to go to debt collectors who were pursuing debts “aggressively.”

Multiple HCPs in our interviews were concerned about what they should do with immigration

information if it comes up during the course of care. One HCP shared an example of being surprised to hear that details from conversations with GPs were part of an immigration case — information they thought would be confidential. Information sharing does not always have to be intentional. As one CO interviewee pointed out: “mistakes are made when it comes to sharing information with the Home Office.” Some of the CO interviewees shared examples where the Home Office had requested information that they are not legally mandated to collect. Fears of information being shared with the Home Office may be a powerful deterrent to seeking care, particularly for undocumented migrants. The result is similar to that of charging: individuals access care only when it becomes critical.

**Impacts on other basic services.** There were many other hostile environment policies that limited access to basic services outside of healthcare. This has an indirect effect on access and quality of maternal care because health and wider well-being needs are intrinsically linked. Quality accommodation was a major issue that interviewees cited. Some also highlighted the limited access to public funds for food costs for pregnant parents and their children, and how their inability to work, as a result of their pending asylum application, further limited household income.

Multiple service providers correlated challenges pertaining to housing, food security, and income for RASU individuals with the higher rates of missed appointments and compromised health. They noted that these challenges take priority over attending appointments because they represent more pressing concerns. For example, one HCP interviewee shared an anecdote about someone in their care: “the thing that [the individual is] really upset about is the fact that she’s got three kids and a husband in a one-room temporary accommodation, and she has been on at the Council to rehouse them, and now they’ve got

another baby on the way and they don’t fit in this tiny, tiny house and she’s going out of her mind.”

## **THE HOSTILE ENVIRONMENT CULTURE AND MATERNITY CARE**

Beyond the hostile environment policies’ direct impact, these policies create a political climate of uncertainty and distrust that permeates into the healthcare system, influencing the RASUs’ experience of maternal health in multiple ways. There is also an important interplay between the culture that the policies create and the realities of austerity.

**Complexity and uncertainty.** Healthcare in the UK is a devolved and fragmented system with different levels of care and hundreds of different trusts and other health institutions. As one HCP noted, “hospitals are confusing and systems are confusing.” This is true for UK residents or for those who have been in the country for many years and is only intensified for RASU groups. The hostile environment policies increase this complexity and uncertainty in multiple ways. As one CO interviewee emphasized, these policies ask those who are not trained in immigration law, which includes the majority of OVTs and HCPs, to navigate or actively participate in a field that “is notoriously and incredibly complicated and complex and changing all of the time.” This results in deep gaps in knowledge across service providers and RASU individuals. CO interviewees highlighted a lack of understanding that RASU individuals have about their rights, as well as a lack of resources or knowledge to advocate on their own behalf. Multiple HCP interviewees discussed how they did not think their colleagues fully understood the hostile environment policies and related processes, which as one interviewee pointed out, can lead to “decisions [being made] that are just incorrect.”

Interviewees who spoke about this lack of knowledge often cited poor communication, as well as limited and difficult-to-understand

guidance concerning these policies, from the Home Office, other government departments, and the NHS trusts. Multiple CO representatives noted that the Home Office “was not following their own guidance and policy.” Within the healthcare space, many HCPs noted a lack of training as well as feeling ill-equipped to act on the specifics of the policies within the healthcare system: “I should be able to quote [the guidance] to you and I can’t. I’d have to go in and check it and that doesn’t feel great.” The lack of standardization across the sector can translate into inconsistent care for RASU populations.

The frequency of policy changes also contributes to confusion in the provision of care, as another CO interviewee noted: “there’s been so many policies introduced over the years to lessen people’s rights and to make it much more complex for people to understand.” For example, multiple CO and HCP interviewees talked about a 2017 policy that required passports to be shown when booking at UCLH. After the policy was revoked, it was not adequately communicated to RASU groups and HCPs that passports were no longer required, which deterred undocumented migrants from accessing future care and left many HCPs and healthcare administrators uncertain about what information was required during booking. Such uncertainty is still observable today. When service providers struggle to stay on top of changing requirements and the increasing vulnerability of RASU individuals, this also affects their ability to work in collaboration and build coalitions that can better support RASU individuals.

For example, GPs — one of the most utilized referral pathways to maternity care — regularly encounter confusion about policy requirements. Several interviewees commented on the lack of clarity within the 150-page policy document that was handed to trusts on the NHS registration policy, which outlines how patients access primary care. Often GPs believed that proof of address was necessary to be registered, as did

some individuals working at the surgeries’ front desks, despite this being unnecessary given that people can access primary care without proof of address. This demonstrates the lack of clarity regarding HCPs’ knowledge which acts as a major barrier for RASU individuals. Other barriers include the lack of resourcing available to help people understand and comprehend these new practices, and the lack of a standardized communication pathway for policy changes regarding updated practices.

**Distrust.** Several CO interviewees emphasized that the hostile environment policies were perpetuating a narrative about “illegal” immigrants that was influencing those working in the healthcare system. As we noted earlier, some of the HCPs were concerned that the NHS was being exploited by certain immigrants, though one CO interviewee noted this was in part due to a “fallacy of health tourism, where you’re very suspicious that there are women coming to this country specifically to get free health care.” As the OVTs seek out people to charge, several COs shared examples of individuals being profiled in the wards based on their race and language, including UK residents.

A large proportion of HCPs emphasized the importance of continuity of care, which is when a pregnant person receives maternity care from the same midwifery team throughout the pregnancy. This is paramount for RASU groups because it facilitates greater trust building and enables them to better navigate the complex healthcare system. This being said, a positive or negative experience with the HCP can impact this continuity. Positive experiences can increase engagement with the healthcare system. As one HCP interviewee noted: “certain communities will share knowledge [about the healthcare system] because someone else has told them about the community feeling safe there and would have recommended them to go there.” However, negative stories can also spread through

communities and deter future engagement with the system. As trust in the healthcare system has broken down for many RASU individuals, it has made the job of HCPs more difficult, particularly where clear communication and language comprehension are absent.

**Austerity measures.** Almost a third of the HCPs spoke about additional challenges as a result of NHS funding cuts, expressing how they felt the NHS had low funds, that they were “constantly fighting to get more funding,” and that “lack of staffing is a massive hurdle.” While these cuts have repercussions for care across the NHS, they specifically affect the funding that is available for specialized programs for RASU individuals. However, a compounding issue, noted by several HCPs, was that there are currently inadequate staffing numbers for these care models to be properly integrated within UCLH, even if they were to receive funding. Austerity measures have also been used as a political tool to justify some of the hostile environment policies, particularly cost-recovery measures like charging.

These austerity measures also affect the humane administration of the hostile-environment policies. Numerous CO interviewees talked about immigration services being outsourced to nongovernment entities, including Migrant Help for immigration-related issues, and private sector providers for provision of accommodation for people seeking asylum. While these entities are focused on cutting costs, the large volume of people reaching out to them can impact the quality of service provision. For example, there have been multiple cases where Migrant Help provided individuals with incorrect or misleading information. Outsourcing, coupled with budget, resourcing, and staffing cuts within the Home Office itself, affects the health outcomes for the RASU population.

## SERVICE PROVIDER RESPONSES TO THE HOSTILE ENVIRONMENT

Working under the threat of the hostile policy environment, the service provision of COs and HCPs is crucial to RASU individuals’ access to quality maternal care. RASU individuals are immensely vulnerable, which reinforces the need for a holistic biopsychosocial approach that acknowledges the interplay of various challenges they may be facing. Service providers are going beyond their remits to uncover and meet these needs.

**Community organizations.** CO interviews emphasized the dramatic shifts the community sector has gone through in the last decade as a direct result of the hostile environment policies, making it increasingly difficult to provide a high standard of quality care and support to RASU individuals. With an increasing number of RASU individuals being denied services, in addition to reductions in legal aid support, CO interviewees noted that the number of people needing support is also increasing, even as their needs are changing. New organizations have emerged, and existing organizations have expanded or adapted their services. For example, Maternity Action, a UK-based maternity rights organization, created a legal team specializing in cases of wrongful charging.

Several CO interviewees emphasized the increased need for advocacy and campaigning, both on behalf of specific immigration cases, as well as for an overall abolition of the hostile environment policies. It has been challenging for COs as they continuously reprioritize as a response to the changing environment, while simultaneously trying to secure adequate funding. This has also required COs to be innovative in their approach. For example, one interviewee described working with an OVT in a trust outside of London to develop a maternity care payment plan for an undocumented migrant where one penny a month would be offered in cash — since

the charging department does not accept cash payments, the bill would ultimately be written off.

**Healthcare professionals.** Many HCPs spoke about the need to use their own discretion and goodwill, beyond their clinical duties, to provide RASU groups with adequate maternal care. The collective ambition was to ensure RASU pregnant individuals were being comprehensively cared for. Many HCPs sought to address some of the migration-related challenges the RASU groups faced because they were intrinsically linked to people's engagement with maternal care, and consequently pregnancy-related health outcomes. This manifested as HCPs creating strategies to combat the negative implications of the culture created by the hostile environment despite this placing a greater responsibility on themselves.

Interviewees emphasized that there was a lack of continuity and clear information sharing between HCPs and COs. Without these formal communication pathways in place, HCPs face more pressure to look for organizations that could be beneficial for RASU pregnant individuals. HCPs are already massively overstrained and may not have the capacity to research such resources and make the necessary referrals. Therefore, these additional steps depend on how proactive HCPs can be. Interviewees also conveyed the immense responsibility that comes with caring for such a vulnerable group, leading them to take on additional tasks and act as facilitators to ensure that these women were not, as one interviewee noted, "falling through the cracks." All HCPs were motivated to seek out these services on behalf of the individuals they cared for, despite limited capacity to do so.

Some HCPs described offering care to individuals whose entitlement to healthcare services was ambiguous, fulfilling a core principle of the NHS: access to services is based on clinical need, not

on an individual's ability to pay. Several HCPs mentioned delivering care "off the books," with some fearing negative repercussions for their actions, such as losing their license. One interviewee noted, "I wouldn't tell certain people that I do give care when I shouldn't," and another said, "I feel like I could get into trouble which is silly because it is my duty to offer care."

A majority of interviewees highlighted that they write letters for numerous applications to housing officers and local council members on behalf of RASU individuals. A proportion of HCPs also communicated that they "buy these mothers baby clothes and other necessities" until formal or charity support can be organized. Some interviewees also discussed ordering taxis for RASU individuals to ensure they attended appointments. They would support in this way even if they knew their contribution would have a limited effect, or even if they were unaware of who the recipient would be.

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## Recommendations

Both the community and healthcare providers spoke about the growing movement to abolish the hostile environment policies altogether, with a particular emphasis on the NHS charging program. This is the position of numerous migrant rights and healthcare advocacy organizations, including a recent statement from the Royal College of Obstetricians and Gynecologists.<sup>5</sup> This movement insists on the immediate need for the government to suspend rigid immigration regulations and centre international human rights obligations and the well-being of RASU groups in future immigration policy design. As an interim measure, greater accountability structures will ensure that policy safeguards are being adhered to for all basic services.

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5 "RCOG Position Statement: Equitable Access to Maternity Care for Refugee, Asylum Seeking and Undocumented Migrant Women," Royal College of Obstetricians and Gynaecologists, 2022. [↗](#)



Figure 5. Aspirations of UCLH

While systemic and wider policy change are essential, certain actions can be implemented concurrently to enable greater support for RASU groups seeking maternal healthcare. Recommendations are divided by collaboration between service providers, the community sector, and the healthcare sector.

## Collaboration between Service Providers

Interviewees from both sectors voiced solutions that would require greater collaboration, establishing channels of communication, and coordination of action and information sharing. Both sectors are overburdened and could be supported through coalition building and resource sharing. Collaborative recommendations include:

- A health navigator role within the hospital setting to serve as a bridge between the clinical and community settings, while providing robust information on community

organizations and other resources which could be useful for RASU individuals.

- Maternity education classes co-led by HCPs and COs to aid pregnant individuals navigating the healthcare system. They would allow individuals to learn from others' experiences while also facilitating knowledge distribution through various channels. This
  - encourages RASU individuals to make autonomous decisions
  - provides a space for them to find comfort and solidarity with other pregnant individuals from similar backgrounds
  - empowers RASU individuals who have experience with the system to lead the trainings as well.

There is a need to separate access to health care from immigration policy to support these vulnerable groups by improving their overall health and well-being. This can be approached through health-justice partnership models that



enable welfare and legal advice for both social and economic issues for those who need it.

## Community Sector

Stronger connections should be established between individual COs to enable simpler pathways of support for pregnant people and their families, as well as easier sharing of the available resources. Interviewees noted that there are many materials and support available, but it is difficult to seek out and access them all. Multiple organizations are creating similar resources, so there could be opportunities to create joint resources. Some other recommendations include:

- having champions or liaisons who can set up pregnant individuals with the appropriate health care and support.
- greater provision of health literacy and sharing of available services to enable quicker GP registration and subsequent access to other healthcare services.
- support in advocating for greater government investment in the NHS to address current constraints, and collaborations between community organizations to address some of these gaps as an interim measure (e.g., making translators available).

## Healthcare Sector

There are multiple recommendations for UCLH that could bolster the measures already being put in place by HCPs to improve access and engagement for RASU pregnant individuals, many of which focus on continuity of care. These include:

- Specialized HCP roles or specialized teams that hold robust knowledge of RASU needs. Existing RASU specialist teams at UCLH should be adequately resourced to support all

RASU groups and be brought in to support all cases involving RASU individuals.

- A training program for all HCPs that ensures a baseline knowledge for effectively caring for and empowering the RASU population. This would need to be continuously updated to reflect changes in policy and terminology, while also drawing on insights from RASU individuals themselves. Training could include:
  - migration pathways to the UK, common statuses and titles, and what each means for entitlement to care
  - information regarding the temporary accommodations that are relevant to their local trust or hospital to enable transport facilitation.
- Creating standardized guidelines to care for this group, which include all the organizations that may provide further support, in addition to all the methods of referral.
- Creating standardized checklists or a “pop out form” to be displayed on all RASU patients’ profiles. This could include information such as key contact information, whether they have a case worker, social worker, or family support worker, what COs they have been linked to, and other COs they could be further directed to.
  - This would reduce ambiguity and ensure that individuals receive consistent care from HCPs while facilitating continuity of care in case they get relocated.
- Longer appointment times to enable a complex social needs assessment which the current maternity care structure disallows.
- Simpler and increased methods of referral into maternity care (e.g., not solely through a GP or online form completion).

## Limitations

Although our research focused on status and the hostile environment, two adjacent barriers were consistently raised within interviews: (1) cultural confusion in understanding the healthcare system and (2) language barriers. Specifically, within many RASU cultures, the concept of antenatal care is not necessarily considered a standard part of pregnancy and therefore acts as a barrier to access and engagement with maternity services for pregnant RASU individuals and their support network(s). Simultaneously, limited cultural competency among HCPs has created challenges in accommodating the cultural needs of the populations they care for. Similarly, language barriers, and limited access to a viable translator when receiving care, often prevented individuals from both providing adequate consent to care and understanding the workings of the healthcare system, which impacted the quality of care received. Although we were unable to cover these barriers in depth, we believe that they are key themes to explore in future research because they permeate many of the experiences that RASU individuals face when accessing quality care.

Likewise, given the limited scope of this study, we were unable to engage in depth with local authorities and other key stakeholders. This warrants further research to better understand the intricacies of relationships and complexities within the hostile environment. Further research should investigate the roles of local government, such as the Camden Council, as well as the OVT.

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## Lessons Learned

Our research consolidated a priori assumptions and corroborated existing research on the unjust situation for numerous RASU pregnant individuals, and further highlighted the issues they face as a result of government policies. While the discourse surrounding each RASU individual's maternity

journey and their interactions with various barriers is nuanced, the consensus among HCPs and COs was that these punitive and ethically fraught policies disrupt the delivery of humane maternity care to this population.

Commonly identified challenges for RASU individuals accessing and engaging with maternity services included greater difficulty in navigating the healthcare system, distrust, and fears of being charged or sanctioned by the Home Office. Findings highlighted HCPs' concerns that many of the RASU individuals they were caring for were subsequently missing appointments or booking in during the later stages of their pregnancy, with some avoiding antenatal care entirely.

For HCPs, the ambiguous and complex nature of government policies has led to misunderstandings and an absence of knowledge about policy and how to adequately provide care, with the most frequently mentioned challenge being the lack of infrastructure in place to support HCPs in caring for RASU individuals. HCPs and COs collectively agreed that the policies in place undermine their duty of care, personal morals, and the basic principles of the NHS, and ultimately creates lasting consequences for pregnant RASU individuals and their babies.

Finally, there is a need for constant research into the experiences of RASU individuals and the groups that support them, namely healthcare providers and community organizations. These insights should be open to all those improving service pathways, as well as to those making a case for more RASU-centred immigration policies. As the hostile environment grows in intensity within the current UK government, it has become evident that efforts to support RASU individuals must not rely solely on political terms and buy-in. There must be long-standing, targeted efforts to prioritize the ground work and research, for the sake of the RASU population's health and well-being.

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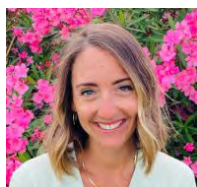
## Research Team



**Haleema Adil** is a fourth-year medical student at University College London who has recently completed her intercalated bachelor's degree in women's health. Growing up in Karachi and London, Haleema is interested in the sociocultural determinants that can impact healthcare access. She is passionate about identifying barriers in healthcare access allowing greater engagement for vulnerable groups, widening participation for underrepresented students in medicine, and advancing equity for women in surgery.



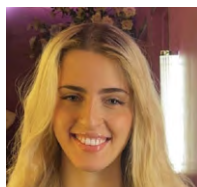
**Deveney Bazinet** is an MPA candidate in innovation, public policy, and public value at University College London. She obtained her bachelor of arts degree in international development and environment studies from McGill University and has over six years of work experience in the field of sustainable development. In her work, she brings a focus on equity, empathy, and meaningful collaboration.



**Catherine Cooke** is an MPA candidate in innovation, public policy, and public value at University College London. She has a background in research into gendered issues, particularly those that examine the intersection of other sociocultural factions. She carried out Bermuda's first research into gendered violence on the island and has continued to work with relevant public sector organizations on this issue. She is passionate about contributing to knowledge collection about underrepresented groups and ever-evolving gender equity questions.



**Tiffany Kwok** is an MPA candidate in digital technologies and policy at University College London. Her interests lie in service delivery and modernization, digital policy, and development. She has worked in the public, not-for-profit, and think tank sector, and is an alumni of the University of Toronto, with a bachelor of arts in political science and urban studies.



**Poppy Pierce** is a fourth-year medical student at University College London with a bachelor of science degree in women's health. She is particularly interested in inclusion health, after co-creating a health assessment used by UCLH during the pandemic to help refugees, asylum seekers, and homeless individuals access health services. Poppy seeks to make meaningful contributions to this field of work and has recently completed a research project on the impact of digital health on vulnerable and marginalized pregnant women.



**Sara Hillman** is an associate professor and sub-specialist in obstetrics and maternal and fetal medicine. She has an active clinical role running a prenatal genetics clinic and acts as an attending consultant on a labour ward. She has a passionate interest in global maternal and new-born health, having collaborated with colleagues in India and Nepal over several years. Her latest undertaking involves implementation of a training program about massive obstetric hemorrhage, in conjunction with obstetricians in South West Tanzania.



**Kate Roll** is a political scientist interested in vulnerability, with a particular focus on how people in poverty and following conflict gain greater social and economic security. She currently serves as an assistant professor in innovation, development, and purpose and head of teaching at UCL's Institute for Innovation and Public Purpose and the faculty lead for public policy for The Bartlett. Her multidisciplinary work brings together politics and policy, business ethics, and development studies. Committed to grounded research, she has conducted in-depth field research in Timor-Leste, Indonesia, the Philippines, and Kenya.

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**The Reach Alliance** began in 2015 at the University of Toronto as the Reach Project, a student-led, faculty-mentored, multidisciplinary research initiative. The Reach Alliance has since scaled to include the University of Oxford's Saïd Business School and Blavatnik School of Government, the University College London, and Tecnológico de Monterrey. Reach's unique approach uncovers how and why certain programs are successful (or not) in getting to some of the world's hardest-to-reach populations. Research teams, comprised of top students and faculty from across disciplines, spend twelve months investigating each case study. Once the data collection process is complete, teams write case reports that are published and disseminated across the Reach Alliance's diverse network of policymakers, practitioners, academics, and business leaders.

Inspired by the United Nations' call to eliminate global poverty by 2030 as part of a set of Sustainable Development Goals (SDGs), our mission is to pursue the full achievement of the SDGs by equipping and empowering the next generation of global leaders to create knowledge and inspire action on reaching the hardest to reach.



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