GUIDANCE FOR COMMISSIONING HEALTH SERVICES FOR VULNERABLE MIGRANT WOMEN
Women's Health and Equality Consortium
The Women's Health and Equality Consortium (WHEC) aims to tackle health inequalities and advance policies and practices to improve the health of all women and girls.
WHEC partners are: FORWARD, Imkaan, Maternity Action, Positively UK, Platform 51, Rape Crisis (England and Wales) and Women's Resource Centre.
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Maternity Action
Maternity Action is a national charity working to challenge inequality and promote the health and wellbeing of all pregnant women, new mothers and their families.
www.maternityaction.org.uk
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<td>Active Communities Engage</td>
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<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>APMS</td>
<td>Alternative Provider Medical Services</td>
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<td>ASR</td>
<td>Asylum Seeking and Refugee</td>
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<td>BAMER</td>
<td>Black, Asian, Minority Ethnic and Refugee</td>
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<td>BMA</td>
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<td>CIC</td>
<td>Community Interest Company</td>
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<td>EEA</td>
<td>European Economic Area</td>
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<td>EU</td>
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<td>FGM</td>
<td>Female Genital Cutting or Mutilation</td>
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<td>GP</td>
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<td>IMR</td>
<td>Infant Mortality Rate</td>
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<td>IRIS</td>
<td>Identification and Referral to Improve Safety</td>
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<td>JSNA</td>
<td>Joint Strategic Needs Assessment</td>
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<td>KPI</td>
<td>Key Performance Indicator</td>
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<td>LES</td>
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<td>NAWP</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
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<td>NRPF</td>
<td>No Recourse to Public Funds</td>
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<td>OVM</td>
<td>Overseas Visitor Manager</td>
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<td>PCT</td>
<td>Primary Care Trust</td>
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<td>PMS</td>
<td>Personal Medical Services</td>
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<td>PTSD</td>
<td>Post-Traumatic Stress Disorder</td>
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<td>QIPP</td>
<td>Quality, Innovation, Productivity and Prevention</td>
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<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<td>UK</td>
<td>United Kingdom</td>
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<td>UKBA</td>
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Executive Summary

This is a summary of guidance for NHS Commissioners on commissioning health services for vulnerable migrant women. The full guidance contains expanded commentary with recommendations, review of legislation, good practice examples and links to useful research and resources.

1. Introduction

Aim of guidance
This guidance is written as part of the broader social inclusion agenda of the NHS. It aims to:

- assist commissioners to identify the migrant populations and health needs of vulnerable migrant women in their area.
- assist commissioners to understand the entitlements to NHS care of different categories of migrants.
- propose practical, cost effective, and appropriate methods of addressing these needs.
- improve health and wellbeing outcomes among both vulnerable migrant women, and among men and children, since women generally take responsibility for family health.

Vulnerable migrant women
This guidance focuses on vulnerable migrant women, which includes asylum seekers, women with refugee status or humanitarian protection, irregular or undocumented migrants, women who are members of particular marginalised communities or who are marginalised within settled communities because of lack of education, employment skills or fluency in English.

There has been little attention paid to migrant women’s health except in relation to HIV/AIDS, maternity services and to the effects of violence or trafficking. General health needs of broader groups of migrant women such as older women, lesbians, or women with disabilities, and of a wider range of prevention and treatment issues including cancer screening and prevention, sexual health and family planning and mental health, have been largely neglected.

This guidance seeks to broaden the scope of attention to migrant women’s health to include the full range of health conditions and health needs, many of which can be addressed within mainstream services provided that mechanisms are in place to overcome the distinctive barriers that face many migrants accessing and using health services.

Migrants in the UK
For some years mainstream research and policy has recognised ethnicity as a key element of social inequality, and there have been increasing (and welcome) interventions to address ethnic inequalities in most areas of social policy including health. However, changes in patterns of immigration and immigration policies have created many different types of migrants who have differing health needs and differing entitlements to access health care that are not simply reducible to their ethnicity.

Migrant groups include dispersed asylum seekers, refugees, seasonal agricultural workers, students, ‘Tier 1’ (highly skilled) migrant workers, dependants joining already settled family members, people with irregular migration status such as those who have overstayed their visa or who are working in breach of their visa conditions, women who have left violent partners and have no recourse to public funds, and people from inside and outside the EU. Local areas vary according to the size and distribution of these groups in their population.
**Why migrant health is important for commissioners**

Reducing health inequalities is one of the NHS’s top five priorities. Under the Equality Act 2010 public authorities are required to comply with the general equality duty. Many migrants are among the most deprived members of our communities and face barriers to accessing healthcare. Improving health outcomes for this group can result in efficiency savings to the NHS. Failure to reach vulnerable groups may also jeopardise the achievement of public health priorities and goals.

**2. Migrants and entitlement to health care**

The rules relating to NHS entitlement are very complex, and this combined with the complexities surrounding immigration status, has given rise to a great deal of confusion. The result of this confusion has been a common tendency for GP practices to refuse to register patients who are recent migrants, whatever their immigration status.

**Primary care**

Practices have a contractual duty to provide emergency treatment and immediate necessary treatment free of charge for up to 14 days to any person within their practice area. In addition, **everyone, whatever their immigration status is eligible for full GP registration**. GP practices have the discretion to accept all overseas visitors as registered NHS patients including refused (“failed”) asylum seekers. There are no regulations or national documents that state that any migrants should be excluded from primary care.

**Secondary care**

The entitlements of migrants to secondary care are more complex and are fundamentally different from those relating to primary care. Some groups of migrants are liable to be charged for secondary care, while others are entitled to receive it free of charge. At the same time some medical conditions are exempt from charging. Details of who is eligible for free treatment and who has to be charged, as well as of exempt conditions and circumstances, can be found in the Guidance on Implementing the Overseas Visitors Hospital Charging Regulations on the Department of Health website.

**3. Identifying migrant populations and their health needs**

**Gathering information**

In order to meet migrants’ needs, and to reduce the inequalities in health outcomes between them and other sections of the population, whether in areas of high migrant populations or even where there are only a few migrants currently, commissioners need to know who constitutes their population and identify their health needs.

Knowing the migrant population and its needs is a complex task because migrant populations often change over time for many reasons. Commissioners are responsible for the health of everyone in their area, not just for the patients registered at GP practices in their consortia.
How to include migrants in local demographic profiles

Local Joint Strategic Needs Assessments (JSNA) are a useful standard source of information on socially excluded groups which reflect contemporary local needs and aspirations rather than planning on the basis of historic demand. Information in JSNAs on migrants, particularly on women, depends on what data have been collected for particular local JSNAs. Such information is not always systematic and does not necessarily address the needs of migrants as a group or a set of sub-groups. Migration factors, including the date of arrival, the migrant’s immigration status, nationality and language, may amplify inequalities and barriers already faced by minority ethnic groups.

Information about local migrants can be obtained in various ways. For example:

- Generic community organisations including religious associations, community-based self-help and welfare organisations, cultural organisations, as well as service providing agencies which work with vulnerable migrants, can often provide information about the populations they serve and their needs. However, communities are frequently internally divided and heterogeneous, and not all community organisations or ‘community leaders’ speak for everyone. This is particularly true in relation to women.
- Front-line staff in both the statutory and voluntary sectors which deal with specialist issues often have expert knowledge about the migrant groups they work with and their language needs. Such organisations exist at both national and local level.
- Where GPs add ‘country of birth’ onto the GP practice systems for EMIS and VISION such information can be collated to identify the numbers and origins of migrants. ‘Flag 4’ registrations can also be used.

4. Commissioning services for vulnerable migrant women – principles

Community engagement

Strategies for obtaining information about vulnerable migrant women require significant engagement with communities and bodies that can advocate for or represent vulnerable groups.

NICE Public Health Guidance uses the term “community engagement” as an umbrella term incorporating the concept of “community development”. Community engagement is a broader term that involves policy development, long-term investment, working with target communities in a variety of ways, recognising diversity between and within communities, and attempting to develop a favourable infrastructure to work in partnership with local communities. It suggests a continuum in which increasing awareness, participation and empowerment contributes increasingly to improved health status and reduced health inequalities. Increased community engagement is an output of a JSNA with strong involvement by vulnerable migrant women.

Community development

Community engagement is undoubtedly a useful strategy and goal, and should involve migrants living in local areas. However, involving many migrant populations, particularly vulnerable migrant women, requires prior work of building trust and removing barriers to participation.

Health initiatives directed at seldom heard migrant communities, above all, need to be responsive and flexible, establishing and following up contacts, liaising with existing groups, and developing new projects to respond to issues identified by the people reached. Such work is commonly described as “community development”. It will consist of a combination of outreach and individual and group advocacy aimed to set up and/or develop groups which offer mutual support, self-help as well as other
goals. Underlying the specific activities engaged in, such work is based on mutual trust and respect, and serves to increase people’s capacity to take individual and collective action to improve their lives. This kind of work is often slow and painstaking and requires long-term funding and continuity of personnel to support the development taking place.

**Access to full GP registration**

Although GP consortia will not be responsible for commissioning GP services, they will have responsibility for improving primary care. Given their responsibility for non-registered patients, this means that they must ensure access to the GP services provided by their member practices.

The benefit of full GP registration and a comprehensive initial health check can thus help avoid costly hospital treatment as well as prevent the spread (and cost) of infectious diseases.

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**5. Facilitative and support infrastructure**

**Funding mechanisms**

Potential funding mechanisms for specialist services for migrants include:

- modified Quality and Outcomes Framework (QOF), prioritising a different set of quality indicators more appropriate to the migrant population
- PMS (Personal Medical Services) or APMS (Alternative Provider Medical Services) contracts
- Local Enhanced Services

Both specialist and mainstream practices can use key performance indicators relating to vulnerable migrants for issues such as sexual health, chronic diseases, screening for Hepatitis B and C as a basis of assessment of performance even if these do not fall within the QOF framework. Such indicators could be linked to the provision of agreed enhanced services in mainstream services.

**Mechanisms for Service Planning**

Structures need to be in place to support commissioners to identify and commission services to address their local migrant population’s needs, especially those of vulnerable women migrants. There is no blueprint for these and, with current NHS changes, it is not yet clear what they will look like. However, whatever the broader body responsible for population health such as the proposed Health and Wellbeing Boards, there need to be local multi-agency migrant forums within which the health needs of vulnerable women migrants can be raised. Most importantly, there need to be mechanisms through which concerns raised in such forums can be transmitted to commissioners in order for action to be taken.

Just as in gathering data for JSNA, special care must be taken to ensure women have adequate representation on such forums. Particular efforts may need to be made to engage with women who are not in organisations or only in small or informally constituted women’s groups, or when dealing with stigmatised groups.
Staff training

Although general staff training is part of the commissioning agenda it is also important that senior staff involved in planning services for migrants have an understanding of the broader issues affecting migrant health. These kinds of issues will not necessarily be covered by existing equality and diversity training.

Many reports acknowledge the need for training of health workers in migrant health issues. This must include gender training so that issues primarily faced by women such as domestic and sexual violence and lack of personal autonomy or income, are recognised and dealt with in ways that respond to women’s needs, and are not attributed to ‘cultural difference’.

6. Service infrastructures

Services to facilitate access to primary care

In common with many other migrants, vulnerable migrant women face a number of well-documented barriers to accessing GP services. These stem both from obstacles within the primary care service and from their own circumstances and lack of understanding of how the NHS works.

“Gateway” services are services designed to facilitate access to primary care. There are many models of such services which have been developed in response to particular local needs.

Other possibilities for improving access include multi-lingual resources in chemists, A&E departments, churches, mosques and community organisations. Electronic or paper-based resources are useful as part of a wider strategy promoting access, however, they are insufficient in themselves to address many of the barriers to access faced by vulnerable migrant women.

Language services

Language services using professionally qualified interpreters need to be a key part of commissioning in primary care. Language services are fundamental for meeting equality standards and adhering to the NHS’ Quality, Innovation, Productivity and Prevention (QIPP) agenda. Data on local language needs can be derived from the JSNA if it has adequately identified the local migrant population.

For example, it is important to recognise that communities may be differentiated by language and dialect, religion, gender and age, as well as the length of time people have been in the UK.

Little attention has been paid to gender needs in general guidance about language services but vulnerable migrant women are likely to require gender sensitive interpretation services, with continuity of the person providing interpretation wherever possible. It is not appropriate to use children or family members in medical consultations.

There are a range of language support strategies, each with advantages and limitations: bilingual staff (clinical staff, receptionists); registers of bilingual staff to act as interpreters; link and support workers; advocacy workers and agencies; community volunteers; reasonable adjustments; face-to-face interpreting; and telephone interpreting.

Mainstream or specialist GP services

Full GP registration constitutes the ‘core’ of primary health care and is a condition of full participation in the NHS. However, local conditions will to a considerable extent determine the shape of such provision to vulnerable migrants in a particular locality, particularly whether services are provided within mainstream or specialist practices. Each form of provision has advantages and disadvantages.
7. Clinical services

Many clinical services recommended for vulnerable migrant women are the same as those for the general population. The services mentioned here are those which indicate additional or special provision for this group, some of which may need to be commissioned additionally to services in the clinical areas mentioned.

In particular this section highlights specialist services for vulnerable migrant women. There has been a tendency to subsume or replace specialist services by generic services for issues such as domestic violence or mental health under the misapprehension that this means mainstreaming Black, Asian, Minority Ethnic and Refugee (BAMER) issues. However, losing specialist services can have a detrimental impact on the health of the particular population which that service served, with a loss of expertise in language, cultural understanding, or understanding of the distinctive circumstances of particular groups. It also risks undermining the relationship between a specialist health or social care service and other services serving a particular community.

Initial assessment, immunisation and patient records

Registration of patients who are vulnerable migrants may require further input when the new patient is a migrant. These include additional elements in the initial health assessment, and special consideration to immunisations, as well as providing or continuing patient held records if the patient is likely to be mobile.

Hand-held records have been used for some time in maternity and diabetes care to promote better communication between patients and healthcare staff with the aim of improving outcomes. They were were introduced for asylum seekers in response to new policies of dispersal and were “intended to facilitate information sharing by health professionals during the asylum application process.”

Mental health

Psychological distress following migration, especially forced migration, is well documented, as is the complexity of diagnosing and addressing it and of distinguishing mental illness from ‘normal’ reactions to stress. Mental illness and mental distress is likely to be much more common among vulnerable migrants than among the general population.

How people experience psychological distress can vary and is dependent on many factors including gender, the circumstances people have come from, their reasons for migration, and the conditions in which they find themselves in the UK. Mental health problems of men and women may arise for different reasons and be linked to patterns of gender relations in countries of origin and how these are affected by the experience of migration.

Not all mental health needs require clinical services. There are examples of services, mainly, but not exclusively, within the voluntary sector, which try to reduce social isolation and provide meaningful activities as a means of improving migrants’ mental wellbeing.

Violence against women and girls

Domestic violence is recognised as a major public health concern and as a risk factor for chronic ill health and premature death in women. Physical health problems of domestic violence include gynaecological problems, chronic pain, neurological symptoms, and gastrointestinal disorders. Mental health can be especially affected, with high prevalence of depression, anxiety and post-traumatic stress disorder (PTSD) in women who have experienced it, lasting long after the violence has ceased. Violence often occurs during pregnancy, affecting an estimated 4-8% of pregnancies.

Violence experienced by migrant women includes forced marriage, ‘honour’ based violence, trafficking and female genital mutilation (FGM).
Primary healthcare services are likely to be the first and even the only professional contact of many women suffering domestic abuse, and vulnerable migrant women may have very little idea of where else to turn.

There are also additional implications of domestic violence for migrant women compared to the settled population. These are:

- Vulnerable migrant women may find it more difficult to leave situations of violence and abuse than settled women because of problems of language, social isolation, patriarchal cultural expectations, fear of repercussions from family members and the wider community, inappropriate responses and/or racism from mainstream agencies, and the impact of the ‘no recourse to public funds’ rule.
- Women who are in the UK on a spouse or partner visa may fear that they cannot leave a violent relationship without jeopardizing their leave to remain here during the two year ‘probationary’ period.
- Women are often reluctant to disclose experiences of gender-based violence at asylum interviews.
- Patients are rarely asked about domestic or other gender-based violence and health workers have little or no training in how to respond to disclosures about it. There is little in-service guidance for professionals on how to interact with a woman to enable her to disclose her experience of gender-based violence.

Reproductive and sexual health

Maternity

Recently arrived migrant women may have poor overall health, underlying and possibly unrecognised medical conditions, including congenital heart disease, HIV/AIDS or tuberculosis. They may have been subject to female genital cutting or mutilation (FGM), or be suffering psychological or physical sequelae of living in and fleeing from conflict zones. They may have fears about their immigration status and their entitlements to health care.

There is also evidence of much higher rates of infant mortality in babies born to women who were born abroad and/or who belong to settled BAME communities.

The NICE Guideline used the categories of “recent migrants (arrived within the past year), refugees and asylum seekers and women who have difficulty reading or speaking English” as one group of women with “complex social factors”, to reflect migrant women particularly at risk of adverse birth outcomes. Studies reviewed for the guideline showed that these groups faced numerous barriers in accessing maternity services, of which language and lack of information about the healthcare system were the most significant.

Reaching the women most at risk of late booking requires a multi-faceted approach, and will require close partnership working with voluntary sector organisations.

Sexual health

Since the publication of the national strategy for sexual health in 2001, there have been major improvements in sexual health provision nationally, and a shift towards a more integrated and holistic approach to sexual health. Nevertheless, there are significant continuing problems and inequalities within sexual health. In relation to vulnerable migrant women these are especially the association of teenage pregnancies with poverty and deprivation, the negative impact of sexual violence and abuse on the sexual health of survivors, high rates of abortion within some minority communities, and high rates of Sexually Transmitted Infections (STIs) among black African and black Caribbean populations.
There may also be particular local inequalities, for instance, sex worker outreach projects have reported that migrant sex workers find it difficult to access timely and free termination of pregnancies. Commissioning for sexual health for vulnerable migrant women should form part of addressing race and gender inequalities in sexual health.

### Health promotion

Ethnic inequalities in the reach of health promotion interventions are often attributed to a ‘deficit’ model about the groups concerned, where culture and beliefs, “ethnicity”, or lack of information are seen as reasons for poor uptake of screening or other health promotion initiatives. However, lack of uptake could rather be due to poor communication between professionals and minority ethnic women leading to a lack of understanding of the purpose or procedures of the screening programme with implications both for regular uptake and for informed consent and informed choice. Such problems can be exacerbated among vulnerable migrant women who may have other overwhelming immediate priorities such as poverty, poor housing, immigration concerns, childcare, language difficulties, and discrimination. However there are many examples of low cost and high impact health promotion interventions working with established community organisations and responding to the needs of vulnerable migrant groups.
Part 1 – Context

1. Introduction

Aim of guidance
This guidance is written as part of the broader social inclusion agenda of the NHS. It aims to:

- assist commissioners to identify the migrant populations and the health needs of vulnerable migrant women in their area.
- assist commissioners to understand the entitlements to NHS care of different categories of migrants.
- propose practical, cost effective, and appropriate methods of addressing these needs.
- improve health outcomes among both vulnerable migrant women, and among men and children, since women generally take responsibility for family health.

Vulnerable migrant women
This guidance for NHS commissioners focuses on vulnerable migrant women. This stems from the priorities of the Women’s Health and Equality Consortium whose broad aim is to promote accessible and appropriate health and social care services for all women. We use the term migrant inclusively to refer to anyone who moves to a country other than that of their usual residence so that the country of destination effectively becomes their new country of usual residence.¹

We use the term ‘vulnerable’ to describe women who have been adversely affected by circumstances which led to migration, especially those who have fled violence, conflict or persecution. We also use it to refer to women whose current legal, social, or economic situation gives them limited ability to access the goods and services enjoyed by the majority of the population, or, indeed to overcome the particular or general difficulties that migration has posed for them. Many migrant women suffer both vulnerabilities.

This has allowed us to include asylum seekers, women with refugee status or humanitarian protection, irregular or undocumented migrants, women who are members of particular marginalised communities or who are marginalised within settled communities because of lack of education, skills for employment or fluency in English. Among these groups there may be women with further specific vulnerabilities, for example young women, especially if they are unaccompanied asylum seekers, refused asylum seekers with no means of support, asylum seekers who have been dispersed to new areas with no social ties or support, women who have experienced domestic violence, women who have no recourse to public funds, or women in forced or exploitative domestic, sex or other work. It also includes lesbian, bisexual and transgender women migrants, especially those seeking asylum, who face particular challenges. The guidance does not address commissioning issues for vulnerable migrant women in immigration removal centres.

There are particular forms of vulnerability which flow from a woman’s migration status. Women with ‘no recourse to public funds’ as a condition of their visa, and those who have undocumented or irregular status, are, with very limited exceptions, excluded from the housing and benefits systems, although they may be able to seek support from the local authority for housing and financial

assistance in some circumstances. As a result, most of these women are at risk of destitution. Women whose partners are the primary applicants in an asylum claim are dependent on their partner both for their right to remain in the UK and for their entitlement to UK Border Agency housing and benefits. Relationship breakdown can leave them destitute or with irregular immigration status.

We use the term ‘vulnerable migrant women’ as a shorthand term to describe women migrants affected in these ways and living in precarious or difficult circumstances, rather than as an attribute of the women themselves. The term does not imply any lack of capability on the part of the women referred to, and this guidance gives repeated examples of how vulnerable migrant women can be involved in identifying their own needs and helping to shape appropriate solutions. Nevertheless, our approach is in line with good practice guidance for social care for refugees and asylum seekers which argues that “despite their personal and social resources – their resilience and capacity to endure – a high proportion of asylum seekers and refugees are likely to require a wide range of social care services.” Similarly, this guidance, while recognising the capacities of vulnerable migrant women, equally demonstrates the needs of this very disparate category for essential health services.

Despite growing recognition of distinctive health needs of migrants in general, there is little attention to migrant women’s health except in relation to HIV/AIDS, maternity services or to the effects of violence or trafficking. General health needs of broader groups of migrant women such as older women, lesbians, or women with disabilities, and of a wider range of prevention and treatment issues including cancer screening and prevention, sexual health and family planning and mental health, have been largely neglected.

This guidance seeks to broaden the scope of attention to migrant women’s health to include the full range of health conditions and health needs, many of which can be addressed within mainstream services provided that mechanisms are in place to overcome the distinctive barriers that face many migrants accessing and using services. In this way it addresses general health services for vulnerable migrants and can be used as a basis for commissioning services for migrant men as well as for women; it simply takes women’s health as the norm and thus ensures that gender dimensions of migrants’ lives are not ignored. For example, gender inequalities within families can result in women’s more limited access to ESOL classes, or to work (where that is permitted), and the migration process often alters gender roles as a result of family separation, death of a partner or relationship breakdown, or because of changed economic circumstances in the UK.

Relationship breakdown within the UK is likely to affect women especially adversely, especially as women’s migration status is frequently dependent on their partners. Where women on spouse or partner visas can provide evidence of domestic violence during an initial approximately two year ‘probationary period’, they can apply for Indefinite Leave to Remain under the domestic violence rule of the Immigration Rules. However, women who do not meet the eligibility criteria of the domestic violence rule are not entitled to welfare benefits, known as having “no recourse to public funds” (NRPF). This leaves many women experiencing domestic violence with a choice between destitution

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2 See the website of the NRPF Network for more information about the eligibility of people with no recourse to public funds http://www.islington.gov.uk/community/equalitydiversity/refugees_migrants/nrpf_network/default.asp


and remaining in a violent relationship. In some cases, the local authority may have obligations under community care law to provide them with assistance. Women asylum seekers who experience domestic violence and who are supported by the UK Border Agency (UKBA) are entitled to be provided with alternative accommodation or to be referred to a women’s refuge. However, many such women’s claims to remain in the UK similarly rest on their partner’s asylum claim, and they too might choose to stay with a violent partner rather than risk jeopardising their claim to stay in the UK.

Migrants in the UK

There are many different ways of describing the number of migrants in the UK, and estimates are based on figures collected for very different purposes. National figures give very little idea of what is happening at the local level, and ‘snapshots’ of migration inflows and outflows (flows) inevitably fail to characterise the populations of people born abroad who are variously settled in different areas (stock). Migration has become a major political issue in recent years as numbers of foreign-born people, both from outside and within the European Union have risen rapidly. Between 1993 and 2010 the foreign born population in the UK increased from 3.8 million to 6.5 million. In 2010 12% of the total population recorded was born outside Britain. But this figure does not indicate why people came here, for example, to study, to join family members, to work, to seek asylum, for other reasons, or without giving reasons, how long they have stayed, what they do, how many children have been born to people from abroad, what nationality or ethnicity they are, what circumstances they live in, or how many are men or women.

For some years, mainstream research and policy has recognised ethnicity as a key element of social inequality, and research. Ethnic monitoring systems have developed and there have been increasing (and welcome) interventions to address ethnic inequalities in key areas of social policy including health. However, changes in patterns of immigration and migration policies have created a variety of legal, social and economic situations in which very diverse groups of migrants find themselves. Local areas vary according to the numbers and origin of dispersed asylum seekers, refugees, seasonal agricultural workers, students, ‘Tier 1’ (highly skilled) migrant workers, dependants joining already settled family members, people with irregular migration status such as those who have overstayed their visa or who are working in breach of their visa conditions, women who have left violent partners and have no recourse to public funds, and people from inside and outside the EU. Members of these and other groups, depending on how they are categorised, have differing health needs and differing entitlements to access health care that are not simply reducible to their ethnicity.

Providers and commissioners of health services need assistance in ensuring that their services meet the needs of all these groups. Some progress has already been made in developing planning tools, for example, guidance on including migrants in Joint Strategic Needs Assessments, or exploring health pathways for dispersed asylum seekers.
Why migrant health is important for commissioners

Social justice
Reducing health inequalities is set out as one of the NHS’ top five priorities: “keeping adults and children well, improving their health and reducing health inequalities”. This goal can be justified in a number of ways, most fundamentally in terms of social justice. Professor Michael Marmot has said, “We do have an ideological position: health inequalities that could be avoided by reasonable means are unfair. Putting them right is a matter of social justice.” The goal of social justice is important and stems from a broader historic concern with health inequalities which forms part of the founding philosophy of the NHS.

Equality duties
Public bodies are now required to demonstrate that they have considered the equalities impacts of new policies and interventions. Under the Equality Act 2010 public authorities are required to comply with a ‘general equality duty’ which covers nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The general equality duty requires that those subject to it must have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not. This involves:
  - Removing or minimising disadvantages suffered by people due to their protected characteristics.
  - Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
  - Encouraging people from protected groups to participate in public or in other activities where their participation is disproportionately low.
- Foster good relations between people who share a protected characteristic and those who do not.

Migrants are not a protected group under the Equality Act. However, where they have protected characteristics, they are normally covered by the act as public authorities must have due regard to the equalities needs of their whole population, including migrants.

“Other than where there is a specific exception requiring or permitting discrimination based on nationality or length of stay, the Act protects migrants against direct and indirect race (nationality, colour, ethnic origins or national origins) discrimination. It also protects migrants against direct and indirect discrimination based on all of the other protected characteristics.”

The Equality and Diversity Forum stress that to comply with the Equality Act, in making decisions about commissioning services affecting particular communities, public authorities need to show that...

they have carried out adequate needs assessment, including consulting community members and organisations. They also need to ensure that the proposed measures are appropriate to meet the needs of the population in question.\textsuperscript{16}

The Equality Act has given rise to confusion among some public authorities as to whether providing uniform generic services to everyone in its area rather than specialist services to particular groups meets the equality duty. The experience of Southall Black Sisters provides an example of how, in some circumstances, specialist services are justified and recognised within the Equality Act in order to meet the needs of particular groups. This is important for commissioning decisions about what are the most appropriate services for particular groups of vulnerable migrant women.

\textbf{Equality legislation and specialist services}

Southall Black Sisters (SBS) is a local voluntary sector women’s organisation specialising in issues of domestic violence among BME women. In 2008 SBS mounted a legal challenge to Ealing Council’s decision to cut their entire funding in favour of providing a generic domestic violence service in the borough.

SBS argued that specialist services were needed to address language difficulties and cultural pressures. They also stressed the value of their long experience in providing advice and advocacy in complex circumstances where legal aid was not easily available and where immigration and asylum difficulties and institutional racism made some women more vulnerable than others.

Ealing Council had failed to carry out a full and proper equality impact assessment and also misinterpreted race equality legislation by presuming that equal treatment means uniform treatment. The judge held that SBS’ work promoted equality and the Council’s failure to consider their equality duties properly was unlawful\textsuperscript{17}.

\textbf{Addressing barriers to health care}

Many migrants are among the most deprived members of our communities. Young migrants of working age who are in work are likely to enjoy good health and to make little use of health services.\textsuperscript{18} However, women of reproductive age, children, older people, asylum seekers, trafficked women, members of marginalised communities in poor housing and with low incomes may suffer from very poor health but fail to make effective use of health services.

These groups are often not visible to the mainstream population, but they may experience barriers to accessing health services and to good care. This means that they may have difficulty registering with a GP, booking early for maternity care, obtaining continuity of care if they fall ill, or accessing screening or immunisation programmes effectively. Such barriers include:

- problems of language and communication
- lack of understanding of how the NHS works
- fear of being reported to the Home Office


\textsuperscript{17} Institute of Race Relations News, 2008, Victory for Southall Black Sisters http://www.irr.org.uk/2008/july/ha000020.html

• fear that they will be charged and are unable to pay
• ignorance about entitlements by migrants and healthcare staff
• discrimination by reception staff and/or health professionals
• practice requirements for documentation such as proof of address
• organisational rigidities making services inaccessible to some women
• lack of culturally appropriate services

Overcoming these barriers, especially to enable full access to primary care, as key to all diagnosis, treatment and prevention, will lead to better public and individual health outcomes.

**Making efficiency savings**

Improving health outcomes for these groups can be justified not only on social justice grounds but also as part of the NHS’ Quality, Innovation, Productivity and Prevention (QIPP) programme, directing attention to more appropriate resource allocation.

Problems of access, late presentation and poor management of serious conditions can lead to far higher costs than would be the case if patients were seen earlier and were well-supported in their treatment and management of serious conditions. Such treatment costs include costs for inappropriate and excessive use of A & E services, urgent admissions, care of low birth and pre-term babies or caesarean sections in maternity services. For example the estimated average cost of an emergency caesarean section is £2,539 per birth, compared with an average cost of £1,324 per normal delivery without complications and co-morbidities.\(^\text{19}\) Similarly a US study has estimated that birth hospitalisation costs for pre-term babies were approximately twelve times those of term infants, and that on average total first year costs after birth discharge were three times those of term babies.\(^\text{20}\) So addressing the health needs of migrants in primary care may actually save money, even where migrants may be chargeable for secondary care but are not able to pay.

Similar arguments apply to ancillary services to improve migrants’ use of health services. For example, the evaluators of the government’s Gateway Protection Programme comment, “Making a straightforward arithmetical case for (where spending actually saves money in the round) is not simple, but discussions revealed a range of cases where the spending was undoubtedly an insurance against future higher costs. For example, quality interpretation in the provision of health services was essential in engaging the required number of GPs, and increased the likelihood of early reliable diagnosis, avoiding unnecessarily referrals or use of emergency services.”\(^\text{21}\) Other studies have shown that lack of good language support can lead to missed appointments, increased likelihood of clinical errors due to miscommunication between doctors and patients, risking misdiagnosis and unsafe treatment and poor health outcomes, all of which can lead to increased costs.\(^\text{22}\)

**Meeting national public health targets**

Failure to reach vulnerable groups may jeopardise the achievement of public health priorities and goals such as national mortality targets.\(^\text{23}\) Other public health priorities include the control of

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20 K. McLaurin et al., 2009, “Persistence of Morbidity and Cost Differences Between Late-Premature and Term Infants During the First Year of Life”, *Pediatrics* 123:2, pp653-659
23 Salway et al. 2010, “Fair Society, Healthy Lives: a missed opportunity to address ethnic inequalities in health”, *British Medical Journal*, 12 April
infectious diseases such as TB or HIV, or screening and early diagnosis of cancers, all of which are known to reflect social inequalities.

The Department of Health’s *Review of the Health Inequalities Infant Mortality PSA Target*, 2007, shows that the Infant Mortality Rate (IMR) in babies of mothers born in Pakistan was 10.2 per 1,000 live births in 2002–04, double the overall IMR (4.9 per 1,000 live births in 2002–04) for all babies born in England and Wales. The IMR in babies of mothers born in the Caribbean was 8.3 per 1,000 live births in 2002–04, 63% higher than the national average. Census data showed that the 43 areas with the highest numbers of infant deaths among the ‘routine and manual’ group had twice the proportion of black and minority ethnic populations as the national average in that group (14% vs. 7%). The review states, ‘This suggests that reductions in infant mortality for black and minority ethnic groups could have a greater impact on the target group compared to the population as a whole.’

2. Migrants and entitlement to health care

Migrants constitute a very diverse group according to where they come from, why they are in the UK, why they are in their present locality, their education and skills, their ability to speak English, whether or not they have families, their economic independence, their income, their age and sex, and their immigration status. As this list shows, immigration status is only one of many factors that define who they are, and it is often not clear, even to migrants themselves, what their immigration status is.

The rules relating to NHS entitlement are also very complex, and this combined with the complexities surrounding immigration status, have given rise to a great deal of confusion. The result of this confusion has been a common tendency for GP practices to refuse to register patients who are recent migrants whatever their immigration status. "We saw a significant number of citizens from EEA countries who, like asylum seekers, were entitled to primary and secondary care but unable to access it." 25

Primary care

Practices have a contractual duty to provide emergency treatment and immediate necessary treatment free of charge for up to 14 days to any person within their practice area.26 In addition, everyone, whatever their immigration status is eligible for full GP registration. GP practices have the discretion to accept all overseas visitors as registered NHS patients including refused ('failed') asylum seekers.27 There are no regulations or national documents that state that any migrants should be excluded from primary care.

There is great deal of confusion about GPs’ obligation to register a wide range people with very varied and often irregular immigration status. This confusion arises not only among GPs themselves but also among PCTs and companies working on behalf of PCTs who have been known to issue incorrect instructions to GP practices to de-register patients on account of their immigration status. Such instructions are mistaken, as GPs have full discretion to treat whoever they wish.

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“Practices, if their list of patients is open, may accept overseas visitors as temporary residents, if they will be in the area for 24 hours to three months, or may accept an overseas visitor’s application for inclusion in their patient list.”

This guidance from the British Medical Association (BMA) and the recent Department of Health guidance on implementing charges for overseas visitors both clearly state that proof of identity, address or immigration status is not a legal requirement. The GMS 1 patient registration form does not request such evidence for new patients to be accepted onto a GP list. Moreover, under the Equalities Act 2010, people applying for registration cannot be turned down for reasons relating to the applicant’s race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition. Overseas visitors have no formal obligation to prove their identity or immigration status to register with a practice.

Secondary care

The entitlements of migrants to secondary care are more complex and are fundamentally different from those relating to primary care. Some groups of migrants are liable to be charged for secondary care, while others are entitled to receive it free of charge. At the same time some medical conditions are exempt from charging. Details of who is eligible for free treatment and who has to be charged, as well as of exempt conditions and circumstances can be found in the Guidance on Implementing the Overseas Visitors Hospital Charging Regulations. It should be noted that entitlement is not always straightforward as a person’s immigration status is itself often not clear. In some cases a migrant might be able to take steps to change his or her status, resulting in an entitlement to free secondary care.

Here we briefly explain the charging regulations that may particularly affect vulnerable migrant women.

Migrants not liable for charging

In England, hospital charging for overseas visitors applies to people who are not ‘ordinarily resident’ in the UK. There is no very clear definition of ordinary residence but the Department of Health Guidance on Hospital Charging states that for the purpose of determining eligibility for NHS charging, NHS bodies need to establish whether a person is living lawfully in the United Kingdom voluntarily and for settled purposes as part of the regular order of their life for the time being. Anyone who is not lawfully present in the UK such as a visa overstayer cannot be considered ordinarily resident. A person is normally considered to be ‘settled’ in the UK who has been living here lawfully for six months or more and plans to stay longer. Some people are considered to be ‘settled’ in the UK who have lived here for less than six months but can show that they are intending to stay for longer, for example, if they have taken a job here or children have started school or they have taken out a lease on their accommodation. The following categories are also not chargeable:

- asylum seekers awaiting or appealing a decision and refused asylum seekers receiving Section 4 or Section 95 support from the UKBA or who have submitted a fresh claim.
- refugees, people granted humanitarian protection or discretionary leave.
- people granted indefinite leave to remain or who have been here for more than 12 months and have submitted an application for ILR before their previous leave expired.
- residents of European Economic Area (EEA) states or Switzerland.

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29 Department of Health, 2011, op.cit.
30 British Medical Association, 2011, op.cit.
32 Ibid. Para 3.5
• students pursuing a full time course of study of 6 months or more, or less than 6 months if substantially funded by the UK government.
• anyone who has been recognised as a victim of trafficking.
• a child in the care of the Local Authority.
• in most cases, the spouses or civil partners of people in the above groups, and their children (aged under 16 or under 19 if in full time education).
• if an overseas visitor has qualified for and has been receiving free NHS treatment, but her ‘charge status’ changes during the course of that treatment, she cannot be charged for the remainder of that particular course of treatment.

People liable for charging

The following categories of migrants are generally liable for charging if they require hospital care:
• refused asylum seekers not in receipt of asylum support.
• visa overstayers.
• people with leave to remain of six months or less but who are not ‘settled’.
• people in the UK to work but not currently in work.
• part-time students or students on courses of less than six months (which are not substantially funded by the UK Government).
• others with irregular immigration status.

Services and conditions exempt from charging

• treatment in Accident and Emergency departments.
• family planning services.
• diseases which pose a threat to public health. There are 32 conditions listed. These include sexually transmitted diseases and HIV testing and associated counselling but exclude HIV treatment. All these conditions with the exception of HIV are exempt from charging from the point of diagnosis, even if a diagnosis is negative.
• treatments related to mental health legislation.

Treatments that are chargeable but must not be delayed or withheld

• Any treatment deemed ‘immediately necessary’ or ‘urgent’ by a clinician must be provided without delay whether or not a patient has been informed of or agreed to pay charges.

Immediately necessary treatment is any treatment which a patient needs to save their life, to prevent a condition from becoming immediately life-threatening, or which is required promptly to prevent permanent serious damage from occurring.

Urgent treatment is treatment which is not immediately necessary but which cannot wait until the patient may be able to return to their country. Both immediately necessary and urgent treatment are chargeable but have to be carried out whether or not a patient is able to pay at the time of treatment.\textsuperscript{33}

• All maternity services, including routine antenatal treatment are deemed as immediately necessary. The Guidance states explicitly:

“No woman must ever be denied, or have delayed, maternity services due to charging issues. Although she should be informed if charges apply to her treatment, in doing so, she should not be discouraged from receiving the remainder of her maternity treatment.”\textsuperscript{34}

\textsuperscript{33} Ibid. Para. 4.10
\textsuperscript{34} Ibid. Para. 4.7
In addition, the Guidance asks Overseas Visitor Managers (OVM) and clinicians to ensure that they inform pregnant patients that further maternity care will not be withheld, regardless of their ability to pay.

- Patients who are chargeable must always be allowed to see a clinician even if they say they cannot pay as it is the responsibility of the clinician rather than an OVM to determine the need for and urgency of treatment. Only when treatment is deemed non-urgent by a clinician can it be withheld, pending payment.\(^{35}\)
- In cases where it is clear that a patient cannot pay, for example if, given the patient’s circumstances, it would not be cost effective to pursue it, a debt may be written off, though it cannot be “waived” in advance.\(^{36}\)
- The Guidance makes clear that patients who may be in need of further immediately necessary or urgent treatment should not be discouraged from receiving it, even if they indicate that they are unable to pay. It states that, “in some cases, it may be appropriate not to present a bill until all immediately necessary or urgent treatment has completed, but patients should nevertheless be fully informed about the charges they might face.”\(^{37}\)

### 3. Identifying migrant populations and their health needs

#### Gathering information

In order to meet migrants’ needs, and to reduce the inequalities in health outcomes between them and other sections of the population, whether in areas of high migrant populations or even where there are only few migrants currently, commissioners need to know who constitutes their population and identify their health needs.

Knowing the migrant population and its needs is a complex task because migrant populations often change rapidly over time for many reasons. These include changes in public policy enabling or restricting new migrations, or policies such as dispersal of asylum seekers, family reunion with migrants already settled, changing situations in both sending countries and in the economic situation of local areas.

Commissioners are responsible for the health of everyone in their area, not just for the patients registered at GP practices in their consortia.\(^{38}\) It is therefore essential that commissioners identify people not registered with GP practices as well as drawing information from those already registered to provide a clear picture of the local population on which to base decisions about service provision.

#### How to include migrants in local demographic profiles

Local Joint Strategic Needs Assessments (JSNA) are a useful standard source of information on socially excluded groups which reflect contemporary local needs and aspirations rather than planning on the basis of historic demand.\(^{39}\) Information in JSNAs on migrants, particularly on women, depends on what data have been collected for particular local JSNAs. Such information

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35 Ibid. Para. 4.25
36 Ibid. Para. 4.41
37 Ibid. Para. 4.23
is not always systematic, and does not necessarily address the needs of migrants as a group or a set of subgroups. Migration factors, including the date of arrival, the migrant’s immigration status, nationality and language, may amplify inequalities and barriers already faced by minority ethnic groups.

Local JSNAs provide an opportunity for commissioners to play a proactive role in seeking out further information about groups whose needs they have reason to believe are not being adequately met, or who are experiencing poor outcomes.

Including migrant populations in Joint Strategic Needs Assessments

Including migrant populations in Joint Strategic Needs Assessments: A Guide suggests that JSNAs should combine migrant categories with other health determinants, leading to a more specific focus. For vulnerable migrant women this could be:

- Women using maternity services who have experienced female genital mutilation (FGM)
- Dispersed asylum seeking women without community support
- Bangladeshi women accessing breast screening

This focus would emerge in the JSNA and could suggest priority needs of particular groups.40

The Nottingham City Joint Strategic Needs Assessment April 2010 has an entire chapter devoted to asylum seekers, refugees and migrant workers as part of an approach that singles out issues and groups for dedicated chapters. This means that although these groups are mentioned in other contexts, for example under infectious diseases, they are not subsumed under these characteristics.41

Warren et al. 2010 show how mapping the postcodes of ‘Flag 4’ migrants provides opportunities to identify accessible locations for placing migrant-specific services such as drop-in advice sessions, and can identify particular GP practices who could be engaged in development work such as local enhanced services.42 The Health Protection Agency advises GPs to add ‘country of birth’ onto the GP practice systems for EMIS and VISION and has developed crib sheets for doing this. Such information can then be collated to identify the numbers and origins of migrants.43

Information about gender and migration background is important in order to know where best to direct services. For example, Newham’s JSNA states that nearly half (43%) of women referred to agencies helping victims of domestic violence have no recourse to public funds and 14% needed language support.44

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40 N. Rose et al. 2010 op.cit.
42 K. Warren et al., 2010, “Compilation of a local profile of immigration using GP registration data”, Ethnicity and Inequalities in Health and Social Care, 3:2 pp6-12
Generic community organisations including religious associations, community-based self-help and welfare organisations, cultural organisations, as well as service providing agencies which work with vulnerable migrants, can often provide information about the populations they serve and their needs. However, communities are frequently internally divided and heterogeneous, and not all community organisations or ‘community leaders’ speak for everyone. This is particularly true in relation to women, who need safe opportunities to speak for themselves on issues such as domestic violence, FGM or other aspects of sexual and reproductive health. Similarly stigmatised groups within minority communities such as lesbians or sex workers are unlikely to be represented by mainstream leaders. Front-line staff in both the statutory and voluntary sectors which deal with specialist issues often have expert knowledge about the migrant groups they work with and their language needs. Such organisations exist at both national and local level. Some community based organisations specialise in work with vulnerable ethnic minority groups or focus especially on women, many of whom are migrants. They have a wealth of knowledge about the populations they serve, and have often carried out community based research. Many also have long experience of partnership with statutory agencies.

**Sources of data from specialist agencies**

**The UK Network of Sex Work Projects – a national voluntary sector agency**

The UK Network of Sex Work Projects has produced both Good Practice Guidance Working with Migrant Sex Workers and a Directory of Services – Services for Sex Workers. The latter provides information on local services which may provide data about migrant sex workers; the former provides guidance on legal issues related to sex work as well as good practice for health professionals working with migrant sex workers. Accessed online at http://www.uknswp.org/resources/

**Local statutory sector specialists**

i) Reducing Infant Mortality Programmes

Even where specific interventions are of limited duration, evaluations of specialist interventions can produce a wealth of useful information. Examples of such interventions include local ‘Reducing infant mortality’ programmes which have collected data on high-risk groups and relative risks as part of evaluations of the interventions. See for example:


Both of these reports give useful migration information relating to groups at high risk for infant mortality, including data on local births by mothers’ place of origin.
ii) Strategic Migration Partnerships

Research linked to Strategic Migration Partnerships and other statutory agencies include much otherwise unavailable local data on migrants’ health. This is particularly useful where there are distinctive patterns of migration linked to local economies or government policies. See for example:


Local specialist community groups

i) Women’s Health and Family Services Tower Hamlets, London

Women’s Health and Family Services has provided health advocacy and education for women in minority communities in Tower Hamlets for 30 years. It has particular expertise about health issues in the Somali and Bangladeshi communities. http://www.whfs.org.uk/services.html

ii) Shantona, Leeds

Shantona began as an organisation for Bangladeshi women in the Harehills and Chapeltown areas of Leeds but now also serves other communities. It focuses on providing services to ‘hard to reach’ communities who normally do not access services unless they have serious health or family problems.

http://www.shantona.co.uk

Recommendations for commissioners

- Commissioners should explore how other JSNAs have included data on migrants and use existing documentary data sources such as flag 4 registrations where possible.
- Commissioners should ensure that the information about migrants in JSNAs is disaggregated by gender as well as ethnicity or nationality and that information about women takes note of their migration situation.
- Commissioners should encourage a range of reporting or Key Performance Indicator (KPI) measures to be developed on the basis of the JSNA to address health needs of vulnerable migrant women and other communities.
- To obtain information about vulnerable migrant women may require commissioners initially to seek information from national as well as local specialist agencies. However, they must recognise the resource implications for voluntary organisations of collating the information needed, and should budget for payments to such groups in order to obtain up-to-date and accurate data.
- Commissioners should ensure that they make provision for women to be represented in information sharing about migrant communities. This is particularly important where women are not well-organised or in dealing with stigmatised groups. Commissioners may need to find creative ways to hear women’s concerns, and be willing to invest in development of local groups to enable this to happen (see ‘Community development’, p30 below).
4. Commissioning services for vulnerable migrant women – principles

Community engagement

Once commissioners have acquired information about the migrant population and their health needs, attention must shift to what is to be commissioned. Commissioners need to pay particular attention to their duty “to reduce inequalities in access to healthcare and healthcare outcomes” in relation to their vulnerable migrant population.45

We have seen that strategies for obtaining information about this population require significant engagement with communities and bodies that can advocate for or represent vulnerable groups. Such engagement is not easily separable from the requirement to provide services or an existing process of service provision. For example, organisations that can provide evidence of need may already be providing some services to meet that need. Information gathering and sharing is part of a process of vulnerable individuals and groups collectively identifying needs and finding means to address them.

Such an information gathering process pre-supposes the idea of ‘community engagement’ since it is specifically aimed at identifying excluded groups and involving them in decisions that affect them, as a strategy for health improvement and reducing inequality. In addition, current commissioning philosophy is based on the NHS White Paper’s slogan of “no decisions about me without me”.46 Community engagement involves planning, developing and managing services, as well as contributing to activities which “aim to improve health or reduce health inequalities.”47

The National Institute for Health and Clinical Excellence (NICE) Public Health Guidance uses the term “community engagement” as an umbrella term incorporating the concept of “community development”. Community engagement is a broader term that involves policy development, long-term investment, working with target communities in a variety of ways, recognising diversity between and within communities, and attempting to develop a favourable infrastructure to work in partnership with local communities. It suggests a continuum in which increasing participation and empowerment contributes increasingly to improved health status and reduced health inequalities.48

In line with this approach the guide to including migrants in local JSNAs encourages “co-production” of knowledge between migrant communities and statutory agencies. Indeed the guide’s authors believe that “a key output from JSNA is engagement of the migrant community through their involvement in the process. Therefore a likely positive outcome of a JSNA is increased understanding of health service provision among migrant populations, and more timely and appropriate uptake.”49

Community development

Community engagement is undoubtedly a useful strategy and goal, and should involve migrants living in local areas. However, involving many migrant populations, particularly vulnerable migrant women, requires prior work of building trust and removing barriers to participation. Such work must recognise that such women may be severely disempowered through poverty, current and past race and gender discrimination, traumatic experiences, language and educational barriers, and immigration policies which serve to reinforce their social exclusion.

45 NICE, 2008, Community engagement to improve health, Public Health Guidance 9 www.scie-socialcareonline.org.uk/profile.asp?guid=b6be7b8b-c0f9-4cb7-a93f-523beb8214d1
47 NICE, 2008, op. cit.
48 ibid. p8
49 N. Rose et al. 2010, op.cit
Very often such women are not part of any recognised “community” as part of their vulnerability stems from social isolation. They may “belong” to an ethnic, national or religious group such as European Roma which itself is marginalised and discriminated against. In some cases, women belonging to an ethnic or national minority are hidden from wider public interaction through patriarchal cultural norms which deny women visibility outside the household. Other vulnerable migrant women may be dispersed asylum seekers in a variety of towns and cities without any existing support networks while others may be part of local, ethnic, or religious communities but without the ability to mobilise appropriate support to meet their health or other needs – often referred to as ‘social capital’. Some vulnerable migrant women in difficult personal circumstances, for example experiencing domestic violence, or exploitation as coerced sex or domestic workers, are unable to register their needs in the “communities” to which they are deemed to belong. This is especially likely among young women who may have been trafficked. Unaccompanied young women asylum seekers may also be very isolated in these respects.

Such groups have traditionally been regarded as “hard to reach”, focusing on factors such as the above which prevent their engagement with services. A revised term, “seldom heard”, is gaining currency to emphasise the responsibility of agencies to reach out to excluded groups to ensure they have access to services.

Health initiatives directed at seldom heard migrant communities, above all, need to be responsive and flexible, establishing and following up contacts, liaising with existing groups, and developing new projects to respond to issues identified by the people reached. Such work is commonly described as “community development”. It will consist of a combination of outreach and individual and group advocacy aimed to set up and/or develop groups which offer mutual support, self-help as well as other goals. Underlying the specific activities engaged in, such work is based on mutual trust and respect, and serves to increase people’s capacity to take individual and collective action to improve their lives. It has been described as an “asset approach”, building on the assets and strengths of specific communities and leading their members to take action on their own behalf.

“The asset approach values the capacity, skills, knowledge, connections and potential in a community. …. The more familiar ‘deficit’ approach focuses on the problems, needs and deficiencies in a community. It designs services to fill the gaps and fix the problems. As a result, a community can feel disempowered and dependent; people can become passive recipients of expensive services rather than active agents in their own and their families’ lives.”

This kind of work is often slow and painstaking and requires long-term funding and continuity of personnel to support the development taking place.

“Current funding is for very short-term projects. We have insufficient time to do what needs to be done… Funders usually want new projects but you need decades to change things. We can’t change things in two or three years. We have to work with young people to change things.”

The following example of community development with vulnerable migrant women shows how the particular projects or interventions can initially be triggered from either the statutory or voluntary sector.


However, to transform a need into a project, an infrastructure enabling communication between different types of organisation, good leadership, long-term commitment and a willingness to provide funding or to assist groups in seeking funding, is necessary for a project to be viable. The following case study shows mutual engagement between a health service which recognised the knowledge base of a community group and was willing to work with it to develop a mutually beneficial resource.

A successful community development project

Ileys Community Association Sandwell– FGM Bookmark Project

In 2009, Ileys Community Association, a refugee community organisation in the West Midlands, working at grassroots level, gathered anecdotal reports of negative perceptions and experiences of childbirth in Sandwell. Somali women were raising concerns about what they perceived to be high numbers of caesarean sections and complex deliveries amongst their community. Initial informal discussions showed that many women were not accessing the full range of antenatal care available to them and some were not attending any appointments once their pregnancy had been confirmed.

The group asked the community development worker employed by the PCT in the area to help to find out more about why the maternity service was not working well for them. Investigations with the women suggested that the high rate of caesarean sections at the local hospital was due to poor communication between midwives and Somali women who had experienced FGM.

The local maternity service was itself keen to lower the rate of caesarean sections among Somali women. With the help of the community development worker and a local New Communities Health Group, Ileys Community Association, Sandwell PCT and local midwives together developed a proposal to encourage early booking and better communication between Somali women and midwives. This would enable women with FGM to have a reversal operation by 20 weeks pregnancy and avoid the need for a caesarean section later.

The group obtained funding from the PCT and worked together to develop an “FGM Bookmark” communication tool on female circumcision which allows women to indicate visually the type of FGM they are affected by. This helps them communicate their needs to the midwives involved in planning their care without embarrassment.

Since the development of the bookmark, strong links have been established between the women’s group and midwifery staff from two local hospitals, and women have a clearer understanding of maternity services and local health facilities. There has been a reduction in caesarean section rates at the hospitals concerned and women are now more willing to give birth there.

The success of the bookmark project can be attributed to the opportunities given to the Somali women to make their voices heard and to play a leading role in articulating their needs and in designing the communications tool. This itself was possible because of long-term community development in the area which involved:

- an active refugee community organisation involving Somali women in consultation and participation from the start.
- a community development worker employed by the PCT and trusted by the community.
- the New Communities Health Group providing a forum for information sharing and involving the participation of the PCT and local authority as well as representatives of new communities themselves.
- willingness by maternity staff to listen and respond to the concerns of the women themselves.

For more information about the FGM bookmark project contact Hodan Rashid hodan.rashid@ileyscommunity.org
There are many community development projects which demonstrate opportunities for self-development of participants as well as improving the quality of participants’ interactions with a wide range of health services. These include improving maternity access and care, enhancing mental health, achieving earlier cancer diagnosis and other health promotion among minority groups including better diets, smoking cessation, cancer screening, and infectious disease prevention. Other successful community development projects include improved chronic disease management, better understanding of the NHS as a system, improving the quality of primary care consultations and improving the health of older women. Many of the examples of good practice in this guidance have used community development approaches with vulnerable migrants.

**Access to full GP registration**

Although proposed Clinical Commissioning Groups will not be responsible for commissioning GP services, they will have responsibility for improving primary care. This will include reviewing the quality and accessibility of services provided by GP practices within their area. Given their responsibility for non-registered patients, this means that they must also ensure access to the GP services provided in their area.

The structure of the NHS in the UK is such that access to health care means patient access to GP services. These are the gateway to all NHS services other than emergency care and are essential to improving access to NHS services in general, and enabling continuity of care. Full registration enables a full health check to take place which can identify treatment and further referral needs and address additional issues especially relevant to migrants. Commissioners have a financial interest in reducing unnecessary use of emergency services but this is often only possible if treatment can be obtained from a local GP. The benefit of full GP registration and a comprehensive initial health check can thus help avoid costly hospital treatment as well as prevent the spread (and cost) of infectious diseases. It can also be a means of building trust and establishing a relationship between practice staff and patients.

**Recommendations for commissioners**

- As part of their strategy to ensure that all migrants living within their catchment area are fully registered with a GP practice, commissioners should commission training for clinical and non-clinical staff at GP practices to inform them of migrants’ entitlements to GP registration and its importance in reducing health inequalities. Such training should make clear that GPs have discretion to fully register all migrants regardless of their immigration status.
- Consortia should commission work to develop “gateway” mechanisms of access with community organisations to identify migrants who are having difficulty registering with a GP. “Gateway” services and strategies will vary in different areas depending on the size and nature of the local migrant communities but must include systems of language support.

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Part 2 – Commissioning services for vulnerable migrant women

5. Facilitative and support infrastructure

Funding mechanisms

Potential funding mechanisms for specialist services for migrants include:

- modified QOFs, prioritising a different set of quality indicators more appropriate to the migrant population
- PMS (Personal Medical Services) or APMS (Alternative Provider Medical Services) contracts
- Local Enhanced Services

Both specialist and mainstream practices can use key performance indicators relating to vulnerable migrants for issues such as sexual health, chronic diseases, screening for Hepatitis B and C as a basis of assessment of performance even if these do not fall within the QOF framework. Such indicators could be linked to the provision of agreed enhanced services in mainstream services. Eling argues that “without the introduction of performance indicators that mirror those being introduced in specialist practices, asylum seekers and other potentially vulnerable migrants registered in mainstream practices are unlikely to be able to receive the care that meets their needs.”

Examples of specialist services using alternative funding mechanisms

Using a modified QOF

The Arrival Practice in Stockton on Tees is a specialist PMS practice which has developed its own QOF in conjunction with the Director of Public Health around the domains of:

- Language and communication (the practice knows the languages and literacy of its patients and communicates with them in these languages)
- Interpreting (interpreters are provided for all patients who need them)
- Health assessment (new patients are invited for health checks and followed up if they don’t attend)
- Maintaining the practice list (writing to people who may have left the area to make sure the practice has no ghost patients)


55 Eling, 2010, op.cit. provides details of these and other specialist GP practices.
Referral (giving patients copies of information written about them)

- Enhanced access to records (ensuring medical records are easily available for people who move at short notice)
- Prescribing (simple labelling of prescriptions to ensure people understand what they are for)
- HIV/AIDS (offering testing for HIV and STIs to high-risk groups and managing people with HIV with immunisations)
- Immunisations (aim of providing full catch-up coverage for all patients one year after arrival)
- Tuberculosis (screening for TB)
- Additional quality and cultural competency (improving communication skills through video, encourage team and multi-agency working, giving good information to patients through video, encourage team and multi-agency working, giving good information to patients)  

**Alternative Provider Medical Services**

Until 2010 the Cape Hill Medical Centre was an APMS (Alternative Provider Medical Services) practice managed by a Community Interest Company (CIC), Pathfinder Healthcare Developments. It provides an enhanced service for refugees and has a separate refugee and asylum seeker and homeless enhanced patient list of about 900 people out of a total practice population of 11,000. Patients who are asylum seekers, refugees or homeless can remain registered on the list for up to 18 months after receiving refugee status as long as they are living in the area of Sandwell PCT.

A team of health workers (GPs, nurse practitioners, health care assistants, link worker, mental wellbeing worker) provide the enhanced service. The GPs also work for the main patient list; this prevents burn-out and ensures they do not become de-skilled. This arrangement also promotes knowledge transfer to the mainstream practice within which the specialist service is embedded. It is cost-effective as most of the mainstream staff can be shared with the specialist service, and it protects the specialist service from changes in funding which may be caused by fluctuating numbers of asylum seeker and refugees.

**Local Enhanced Services (LES)**

**NHS Nottingham City LES**

GPs participating in the LES are required to identify a lead clinician for asylum seekers, to keep a register of all asylum seekers registered with the practice, and to perform a new patient health check using the NHS Nottingham City’s own New Patient Health Check for New or Newly Dispersed for Asylum Seekers, identifying any medical problems and carrying out screening as appropriate. The LES contract stresses ensuring that patients understand processes such as referral and expects interpreters to be booked for the initial health check and that Language Line be used for shorter consultations. Participating GPs are also required to inform and educate patients about using the NHS and to integrate asylum seekers into the practice’s general health promotion programme.

LES participants are required to audit the service regularly and share anonymised information from the New Patient Health Check to NHS Nottingham City on request. This information is intended to inform the future commissioning of services.  

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56 For more details of the Arrival Practice QOF see http://www.pcc.nhs.uk/uploads/QOF/april_07/qof_arrival__asylum_seeker_pms.pdf

57 See NHS Nottingham City, 2011, Local Enhanced Service: Care of Newly Registered or Newly Dispersed Asylum Seekers (whose application is under consideration or appeal) available at http://www.maternityaction.org.uk/commissioningguidance.html
Mechanisms for Service Planning

The UK Border Agency has funded twelve Strategic Migration Partnerships (SMPs) in the UK whose function is to bring together regional bodies to plan and deliver services for migrants. Several of the regional SMPs have carried out “scoping exercises” to explore health service provision to meet the health needs of new migrant populations in their regions. They highlight the need for leadership, strategic coordination and information sharing about migrant health, and reveal inadequate responses to the health needs of migrant populations in local areas. The reports also reveal enthusiasm from individual regions to learn from each other.58

It is clear from the reports that there is considerable variability in local awareness of provision for migrant health needs, and that in the absence of “political champions, strategic leadership and coordination or where there is limited understanding of the needs of migrant populations, then the health sector’s response is likely to be confused, uncoordinated and will impact on migrants themselves and the staff who provide services.”59

Structures need to be in place to support commissioners to identify and commission services to address their local migrant population’s needs, especially those of vulnerable women migrants. There is no blueprint for these and, with current NHS changes, it is not yet clear what they will look like. However, whatever the broader body responsible for population health such as the proposed Health and Wellbeing Boards, there need to be local multi-agency migrant forums within which the health needs of vulnerable women migrants can be raised. Most importantly, there need to be mechanisms through which concerns raised in such forums can be transmitted to commissioners in order for action to be taken.

Local forums can enable health professionals with migrant and refugee responsibilities from mainstream and specialist services, including commissioners, public health, maternity and sexual health services, social services and community development, and members of local involvement networks (LINks) to meet with representatives of refugee and migrant general community and women’s organisations. Just as in gathering data for JSNA, special care must be taken to ensure women have adequate representation on such forums (See p27 above). Particular efforts may need to be made to engage with women who are not in organisations or only in small or informally constituted women’s groups, or when dealing with stigmatised groups. Such a forum should meet regularly to review policy and practice, and to provide national and local policy and practice updates.


Good Practice example

Sandwell new communities multi-agency health group

This group evolved from the New Migrants Communities Network to enable a clearer focus on health issues. Its membership includes representatives from the local race equality unit, the PCT, the voluntary sector, and West Midlands Strategic Migration Partnership. It is chaired by the PCT-based community development worker. The group not only provides a forum for local organisations to discuss health issues but it is also a conduit between them and staff with strategic and decision making roles, who are in a position to present new development initiatives to the PCT, for example interpreting services for cancer patient and the FGM bookmarks project (see above p32).

Staff training

General staff training is itself part of the commissioning agenda but it is also important that senior staff involved in planning services for migrants have an understanding of the broader issues affecting migrant health. These include social and legal aspects of migrants’ lives, for example, the implication for women of the “no recourse to public funds” visa condition, of rights and entitlements to health and community care of different migrant groups, maternity rights, or rights of migrant women who have experienced domestic violence, will raise the profile of migrant health issues locally. These kinds of issues will not necessarily be covered by existing equality and diversity training.

Many reports acknowledge the need for training of health workers in migrant health issues. Essential issues include working with interpreters, understanding the asylum system and migrants’ entitlements, understanding migrant experiences, and cultural awareness. This must include gender training so that issues primarily faced by women such as domestic and sexual violence and lack of personal autonomy or income, are recognised and dealt with in ways that respond to women’s needs, and are not attributed to ‘cultural difference’. Community-based women’s rights organisations and BAMER specialists on violence against women and girls can assist practitioners to develop gender sensitive cultural awareness.

Training should include familiarity with clinical and mental health issues which may disproportionately affect migrants, such as HIV, TB, past trauma, or sexual violence. Depending on local knowledge and particular issues training can be commissioned from local specialists or from specialist agencies.

60 Information from D. Newall and S. Leaker

Good practice examples

i) Maternity Action – National training in maternity care for refugee and asylum seekers

Maternity Action is a national charity which campaigns to improve the lives of pregnant women, their partners and families, and has a particular focus on vulnerable and disadvantaged groups, especially refugee and asylum seeking women.

It has developed a two-part training course for midwives, accredited by the Royal College of Midwives, to improve maternity care for refugees and asylum seekers. The course was piloted in four areas in England, Scotland and Wales and is now being delivered across the UK. The training programme is delivered either to Trusts which are willing to release staff and host the training days, or as open courses.62

ii) Refugee Health Team LSL – Training local primary care staff on refugee issues

The Refugee Health Team (RHT) is a multidisciplinary team working across Lambeth, Southwark and Lewisham (LSL) that provides health care to refugees and asylum seekers. Most services are provided at non-NHS venues in partnership with the voluntary sector. The team aims to improve access to the NHS for this client group and provides relevant health interventions.

It offers free training on various issues relating to refugee and asylum seeker health to NHS colleagues working in Lambeth, Southwark and Lewisham Primary Care Teams.63

Recommendations to commissioners

• To ensure that work with vulnerable women migrants is not relegated by default, commissioners should ensure that there is a multi-agency forum in place specifically for the purpose of developing services and reviewing needs. Commissioners should ensure that they make provision for women to be represented in information sharing about migrant communities. This is particularly important where women are not well organised or in dealing with stigmatised groups.

• Commissioners need to ensure that training is clearly identified in tenders and service reviews, and that it is a formal KPI in any new contract. Much staff training can be provided by specialists involved in the types of project described in this guidance. Often the process of developing an intervention will involve training health care staff involved in it to understand the issues better.

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6. Service infrastructures

Services to facilitate access to primary care

In common with many other migrants, vulnerable migrant women face a number of well-documented barriers to accessing GP services. These stem both from obstacles within the primary care service and from their own lack of understanding of how the NHS works.

Barriers to registration from reception and practice staff

- Refusal or reluctance to register migrants perhaps due to reasons of time or resources.
- Inhospitable and sometimes hostile GP surgery staff who may perceive migrants as a burden on the healthcare system and resources.
- Rigidities in the registration process including unnecessary or unrealistic requirements for documentation such as proof of address, passport, ID card, which destitute migrants may not have. These requirements can be built into computer systems preventing reception staff from exercising discretion.
- Lack of understanding of entitlements, including GPs’ discretion to register refused asylum seekers and undocumented migrants, or confusion leading to exclusion of people who are fully entitled.
- Decisions to exclude may be taken by reception staff regardless of the urgency of the condition for which treatment is sought.
- There are often no interpreting services to assist with registration or practices refuse to book them.

Barriers to registration from migrants’ own circumstances and/ or lack of local knowledge or understanding of the NHS

- Difficulties in finding and locating GP practices.
- Lack of understanding of the role of GPs and of how the NHS works.
- Different experience and expectations of healthcare systems.
- Poor living conditions and/ or stress caused by the effects of uncertain immigration status leading to the subordination of health problems in their priorities.
- Fear of authority and the idea of “being registered”

“Gateway” services are services designed to facilitate access to primary care. There are many models of such services which have been developed in response to particular local needs, mainly provided within the NHS. Most of these services not only facilitate access, but also include the provision of support services in various ways.

Examples of “gateway” services

Health advocacy service – Hounslow
This pilot project from 2006-8 was funded by the King’s Fund. Two half-time bilingual advocates carried out individual and group outreach to identify asylum seekers in Hounslow, initially to help them register with a specialist practice for refugees and asylum seekers. Their job became more difficult when the specialist practice closed as advocates encountered reluctance by some mainstream practices to register asylum seekers. Outreach took place in at a weekly women’s group, a children’s centre, the local further education college which ran a programme for new communities, and in hostels for asylum seekers. Advocates also provided assistance with problems other than GP registration and contributed to PCT training on needs of refugees and asylum seekers.


Health Visitor for Gateway Protection Programme – Norwich
Norwich is one of several towns in England hosting the Gateway Protection Programme (GPP) which offers refugee status to people in conjunction with the United Nations High Commission for Refugees. It was formerly administered by the Refugee Council. A Health Visitor funded by the Home Office has been seconded to the GPP to work with Norwich’s GPP population of over 200 Congolese and about 40 Iraqi refugees. The Health Visitor is expected to stay involved with the individuals she supports for one year.

Her activities include supporting refugees to access and use the NHS, and assisting NHS staff to work with interpreters and to understand the needs of the families in the programme. She carries out physical health screening after the refugees arrive in Norwich and helps with GP registration at many different GP practices in the city. Women who are pregnant on arrival are immediately referred to the maternity service. She has carried out a great deal of development work, initially in partnership with the Refugee Council which developed a volunteer programme to support this population, and also setting up women’s groups in response to men’s domination of drop-in services and ESOL classes.

(Contact jacqueline.mosley@nchc.nhs.uk for more information)

Newham DVD
Healthcare in Newham: It’s here for you is an 8-minute DVD in 23 community languages and English which has been distributed to all 66 GP practices in Newham. The Newham DVD provides information to potential patients about accessing health information, advice and treatment in Newham, including how to register with a GP.

NHS East London and City has expanded the DVD initiative to cover London with a 25 minute DVD in 15 languages, “Healthcare in London – It’s here for you.”

http://www.youtube.com/watch?v=8gX8e62ESog&feature=related

continued...
From Outside to INvolvement – Walsall

The ‘From Outside to INvolvement’ project in Walsall developed from a local needs assessment in Walsall which found that over 1200 new migrants were arriving in Walsall from abroad every year (Warren et al, 2010). This identified four key areas of health need: maternal and child health, health protection, mental health, and access to primary care.

A partnership venture (health, council, voluntary sector) funded by the Migration Impacts Fund, to improve access to health and social care for new migrants. Three multilingual tools were designed for the project to facilitate access and use of services. These are a Traffic Light System Card (in 19 languages) which suggests health service choices and priorities according to the symptoms for which someone is seeking help, a Wallet Card (in 12 languages) requesting help for a variety of situations including health, education, and employment, and a Language Identification card (in 24 languages) to show services the client’s language.

These resources are available at: http://www.maternityaction.org.uk/commissioningguidance.html

Refugee Link Worker – Hackney

City and Hackney PCT has had an established health advocacy service for many years. The service includes the role of bilingual Refugee Link Worker with a specific remit to assist refugees and other new migrants register with GP and access other health services. Much of the work is educational, working within migrant and refugee communities and at a local migrant drop-in advice service to ensure people understand how the NHS works and are aware of services available. Her work includes advising on rights relating to health and on how to use services appropriately. Individual advocacy can include helping to provide interpreters for GP appointments and accompanying people to first visits and registration with GPs as well as to other appointments. Other work includes carrying health promotion messages into migrant and refugee community organisations and to liaise between health service providers and members of migrant communities.

There is a particular focus on ensuring that refugees and asylum seekers have equitable access to community health services, recognising that they often suffer from mental health problems, social isolation as well as dealing with financial, housing and immigration problems. http://www.homerton.nhs.uk/patient-information/health-advocacy/index.html

Doctors of the World – Project: London – Tower Hamlets

Project: London’s volunteer doctors, nurses and support workers provide information, advice and practical assistance on how to access mainstream health services. Its clinic provides basic healthcare until it has assisted its service users register with a GP or access other support services.

All Project: London’s doctors and nurses have professional registration. Most currently work in the NHS and volunteer for Project: London in their spare time. The support workers come from many backgrounds. Project: London provides specific training for all its volunteers. http://www.doctorsoftheworld.org.uk/projectlondon/
Other possibilities for improving access include multi-lingual resources in chemists, in A&E departments, churches and mosques, community organisations. Electronic or paper-based resources such as welcome packs or the ‘From OUTside to INvolvement’ materials developed in Walsall are replicable or adaptable for other areas. They are very useful as part of a wider strategy promoting access. However, they are insufficient in themselves to address many of the barriers to access faced by vulnerable migrant women.

**Recommendations to commissioners**

1. Commissioners should develop and agree strategies to improve access for all vulnerable migrants in their locality, and develop a common policy on access. Services should be commissioned in line with this policy which have a consortium-wide remit whether or not they are concentrated in a particular practice, in a particular role or team, or whether they incorporate support services to all practices in the consortium.

2. Commissioners should produce materials to inform migrants of how the NHS works and the importance of GP registration. These should be in multiple languages and in a range of formats, taking account of different levels of literacy. Such materials can be adapted from other areas but should be developed in collaboration with local refugee and migrant organisations.

**Language services**

Language services using professionally qualified interpreters need to be a key part of commissioning in primary care. “Being able to speak to patients in their own language is a fundamental pre-requisite to professional, clinical practice. The preference for patient and practitioner would be to always provide a patient with limited English proficiency with a practitioner who speaks that patient’s own language. There is now a growing wealth of research to evidence the benefits of language concordance between patients and providers.”

However, where that is not possible, it is essential to provide professional interpreters rather than relying on informal interpreting by family and friends. Using family and friends undermines standard principles of privacy and confidentiality which allow patients to disclose and discuss sensitive subjects with their medical practitioner. It is also inappropriate for children to hear personal and medical information about their parents or other relatives. For this reason, policy and guidance documents advocate that children, in particular, should never be used for interpreting in health services.

There are few cost benefit studies of language services. In a study of interpreting services in four Massachusetts health centres, Jacobs et al. found that though the total cost per person using interpreters per year of providing interpreter services was $279 (£174); the average cost across all patients was only $2.40 (£1.50) per year. On the basis of observation of improved service utilisation and take-up of preventive services by non-English speakers, they argue that improving language access for patients who have limited English proficiency may lower the cost of their care in the long run.

Language services are fundamental to meeting equality standards and to the QIPP agenda. “By taking action to ensure communication support for a wide range of different members of the community, commissioners can contribute significantly to the Quality, Innovation, Productivity and Prevention agenda for their area.” The Department of Health has identified language and communication as a significant barrier common to socially excluded people “both when initially accessing care, and

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68 Ibid, p16
also once in the system and at all stages along the patient journey (and commissioning cycle). 69 Good communication is also essential to enable informed consent which is a legal requirement for carrying out health procedures. 70

Data on local language needs can be derived from the JSNA if it has adequately identified the local migrant population. This is another reason for a focus on characteristics of migrants rather than simply on ethnicity to meet equality objectives. For example, it is important to recognise that communities may be differentiated by language and dialect, religion, gender and age, as well as the length of time people have been in the UK. This means that good interpreting is not just a question of providing a speaker of a particular language, but that overcoming language barriers requires understanding the character and network of migrant groups. 71 A study of user perspectives of interpreting services found that people’s “decisions about requiring an interpreter were influenced not merely by their level of English-language proficiency but also by the circumstances in which they were accessing services, as well as changes over the life course.” 72 This has particular relevance for vulnerable migrant women who, especially if discussing sensitive or painful issues such as sexual or domestic violence or sexual health problems, may wish to use women interpreters with maturity and experience. 73 Little attention has been paid to gender needs in general guidance about language services but vulnerable migrant women are likely to require gender sensitive interpretation services, with continuity of the person providing interpreting wherever possible. This can be facilitated by locally provided services. It would be most effective to use professional interpreters who have been trained in gender-based violence and who, to ensure confidentiality and safety, are not part of the same community network. Table 1 shows the advantages and limitations of the range of language support strategies.

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73 Ibid. p19
### Table 1 – Advantages and limitations of the range of language support strategies.

<table>
<thead>
<tr>
<th>Language support</th>
<th>Advantages</th>
<th>Limitations</th>
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<tbody>
<tr>
<td><strong>Bilingual staff</strong>&lt;br&gt;(clinical staff, receptionists)</td>
<td>• Preferred by patients and practitioners&lt;br&gt;• Essential in specialist services&lt;br&gt;• Ease and speed of communication&lt;br&gt;• Cultural competency&lt;br&gt;• Employment opportunities for marginalised communities</td>
<td>• Practitioners not available in more unusual languages&lt;br&gt;• Some may have limited English proficiency&lt;br&gt;• Limited availability of specialist practitioners&lt;br&gt;• Cannot cover the whole range of languages in all services</td>
</tr>
<tr>
<td><strong>Register of bilingual staff to act as interpreters</strong></td>
<td>• Easily available within the organisation&lt;br&gt;• Professional development opportunities</td>
<td>• Compromises staff members’ primary role&lt;br&gt;• Poor continuity of care&lt;br&gt;• Training required to support confidentiality and quality</td>
</tr>
<tr>
<td><strong>Link and support workers</strong></td>
<td>• Support patients’ skills development&lt;br&gt;• Mediators between communities and services&lt;br&gt;• Joint working across agencies&lt;br&gt;• Continuity of care across sectors</td>
<td>• Difficulties for individuals managing boundaries with and expectations of communities</td>
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<tr>
<td><strong>Advocacy workers and agencies</strong></td>
<td>• Patient-centred interpreting promoting patients’ preferences and control over decision-making&lt;br&gt;• Preferred by patients&lt;br&gt;• Improve access to services</td>
<td>• Provider staff can be suspicious of advocacy workers initially</td>
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<tr>
<td><strong>Community volunteers</strong></td>
<td>• Basic immediate interpreting&lt;br&gt;• Pathways to employment&lt;br&gt;• Community and cultural knowledge&lt;br&gt;• Outreach (e.g. Health Trainers)</td>
<td>• Training and support for confidentiality and for managing boundaries and community expectations</td>
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<tr>
<td><strong>Reasonable adjustments</strong></td>
<td>• Essential to meet legislative requirements&lt;br&gt;• Facilitates the development of a wide range of language support options</td>
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<tr>
<td><strong>Face-to-face interpreting</strong></td>
<td>• Preferred over telephone interpreting&lt;br&gt;• Facilitates signing / relay interpreting&lt;br&gt;• Professional, confidential, supports understanding&lt;br&gt;• Locally available</td>
<td>• Some languages not locally available&lt;br&gt;• Travel costs can be prohibitive</td>
</tr>
<tr>
<td><strong>Telephone interpreting</strong></td>
<td>• Available 24 hours per day&lt;br&gt;• Available in an emergency&lt;br&gt;• Can provide for unusual languages</td>
<td>• Misses non-verbal communication cues&lt;br&gt;• Not cost-effective for contacts over 20 minutes&lt;br&gt;• Cost effective for short simple interpreting (e.g. on reception)&lt;br&gt;• Not suitable for complex, sensitive issues or children</td>
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</table>

Example of good practice – local interpreting services

East of England INTRAN partnership

INTRAN is a multi-agency not-for-profit partnership providing language services throughout the Eastern region (Norfolk, Suffolk, Cambridgeshire, Hertfordshire and Essex). It was established in 2000 to meet the interpretation and translation needs of public and voluntary sector organisations. INTRAN operates by commissioning different interpretation and translation agencies to provide their services in either interpretation or translation to the INTRAN partners. The partners include local authorities, health providers, housing associations, police and probation services.

By pooling resources and having greater bargaining power through the Partnership, INTRAN is able to reduce costs and provide locally appropriate services. It maintains quality standards that its partners can depend on and monitors changes in language support requirements as migrant populations change. It provides specifications for its service providers and training for partner organisations on how to use the service and how to work with interpreters.

INTRAN’s acute trust partners have set up a sub group which meets approximately twice yearly. The group analyses levels of and changes in interpreter use and shares best practice to attempt to increase efficiency and make cost savings without increasing risk.

INTRAN’s work has been internationally recognised as good practice and it has received national awards for procurement.


Recommendations to commissioners

• Commissioners should ensure that there are procedures in place for interpreting and translation services to be commissioned at a local level. Changes in the organisation of commissioning may offer new opportunities for collaboration between commissioners and hospital trusts.

• Commissioners should familiarise themselves with different models of language support and understand the advantages and limitations of the range of language support strategies. They should note particularly those strategies preferred by patients and practitioners.

• Commissioners should carry out an equality impact assessment of any language support strategy or initiative, with particular reference to gender as well as race and other issues.

• Commissioners should liaise with local community organisations, specialist professionals, other statutory organisations and interpreting services to identify gaps in existing language services. Such gaps may include a lack of bilingual staff or access to professional interpreters in appropriate languages or dialects, failure of health professionals to employ interpreters, or a lack of skills among health professionals in using interpreters.

• Commissioners should consider establishing or continuing locally based services which work across institutional boundaries and have good links with local community organisations.
Mainstream or specialist GP services

Full GP registration constitutes the 'core' of primary health care and is a condition of full participation in the NHS. However, local conditions will to a considerable extent determine the shape of such provision to vulnerable migrants in a particular locality, particularly whether services are provided within mainstream or specialist practices. Each form of provision has advantages and disadvantages which are summarised in Table 2.

<table>
<thead>
<tr>
<th>Mainstream With or without supplementary provision</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• All practices gain experience.</td>
<td>• May not be cost effective to provide practice-based specialist skills.</td>
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<td></td>
<td>• Less affected by fluctuations in size of migrant population.</td>
<td>• Practice staff may not be sensitive to vulnerable migrants’ needs.</td>
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<td></td>
<td>• Specialist services not always practicable e.g. if migrant populations have wide geographical spread or small numbers of migrants.</td>
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<td></td>
<td>• Can have dedicated additional services outside scheduled clinical sessions. These can be run jointly with other practices and be linked to refugee community organisations.</td>
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<table>
<thead>
<tr>
<th>Specialist</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Relieves pressure of large number of migrants.</td>
<td>• May be resented by local population</td>
</tr>
<tr>
<td></td>
<td>• Avoids risk of temporary registration by mainstream practices.</td>
<td>• Practices may be penalised in QOF (Quality and Outcomes Framework) remuneration because they cannot meet the standard targets.</td>
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<tr>
<td></td>
<td>• Assists vulnerable who experience most barriers to access.</td>
<td>• Need to pass on patients to mainstream at some stage – this can be difficult.</td>
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<td></td>
<td>• Offers more to vulnerable people with most complex needs.</td>
<td>• Other practices don’t acquire knowledge about migrant populations – can reinforce prejudices.</td>
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<tr>
<td></td>
<td>• Staff have wide range of relevant specialist skills for vulnerable groups.</td>
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<tr>
<td></td>
<td>• Typically offers holistic, multi-disciplinary service with more time per patient.</td>
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<tr>
<td></td>
<td>• Staff with knowledge, interest and empathy for vulnerable migrants.</td>
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<td></td>
<td>• Greater knowledge of other services to which patients can be signposted.</td>
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<td></td>
<td>• Smaller practices with better continuity of care.</td>
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</table>


Recommendation to commissioners

- The decision as to the most appropriate form of delivering primary care services to vulnerable migrant women will depend on local circumstances. Commissioners should inform themselves of alternative models of care, and the strengths and limitations of these models in relation to the needs of their migrant populations, with particular attention to the needs of vulnerable migrant women.
7. Clinical services

Many clinical services recommended for vulnerable migrant women are the same as those for the general population. The services mentioned here are those which indicate additional or special provision for this group, some of which may need to be commissioned additionally to services in the clinical areas mentioned. For example, initial health checks will be longer than those for other new patients and deal with more issues, and additional services for sexual and reproductive health, mental health, chronic disease management, and health promotion may need to be commissioned in partnership with organisations working closely with the migrant populations in the locality. Close collaboration between commissioners and others working with migrant populations should enable commissioners to identify organisations that can provide services to enable better use of mainstream services and to help vulnerable migrant women maintain better health.

In particular this section highlights specialist services for vulnerable migrant women. There has been a tendency to subsume or replace specialist services by generic services for issues such as domestic violence or mental health under the misapprehension that this means mainstreaming BAMER issues. However losing specialist services can have a detrimental impact on the health of the particular population which that service served, with a loss of expertise in language, cultural understanding, and understanding of the distinctive circumstances of particular groups. It also risks undermining the relationship between a specialist health or social care service and other services serving a particular community.74

Initial assessment, immunisation and patient records

Registration of patients who are vulnerable migrants may require further inputs when the new patient is a migrant. These include additional elements in the initial health assessment, and special consideration to immunisations, as well as providing or continuing patient held records if the patient is likely to be mobile. Burnett and Fassil suggest that the initial health check should include:

- Ethnic origin
- Language needs – whether interpreter is required and, if so, which language/dialect
- Social history – accommodation/family/whether separated, how travelled to the UK
- Experience and identification of torture and violence including current or past sexual violence
- Disability/special needs
- If bowel symptoms are present, check stool for ova, cysts and parasites
- Diet/nutrition
- Vitamin D deficiency
- Immunisation as appropriate
- Screening as appropriate – breast and cervical for women, testicular for men
- Sexual health advice and screening /family planning – as appropriate
- TB screening
- HIV and Hepatitis screening as appropriate
- Sickle cell/thalassaemia
- Assessment of psychological well-being
- Oral health75

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75 A. Burnett and Y. Fassil, 2011, Meeting the health needs of refugees and asylum seekers: A resource for health workers, “Health assessment, including registration checks and screening”, Online resource: http://www.migranthealthse.co.uk/dhnhs-specialist-support/health-services/health-assessment
It is desirable that initial health checks should be carried out by an experienced nurse with expertise in migrant health issues, and interpreters should always be used during such checks. In some cases initial health assessments are carried out in “gateway” services, or in specialist clinics in mainstream practices.

The HPA Migrant Health Guide recommends that “primary care practitioners should always ask new migrants about their vaccine history” (emphasis in original). They give advice on immunisation for migrants whose immunisation status is uncertain or incomplete.76

Hand-held records have been used for some time in maternity and diabetes care to promote better communication between patients and healthcare staff with the aim of improving outcomes. They were introduced for asylum seekers in response to new policies of dispersal and are “intended to facilitate information sharing by health professionals during the asylum application process.”77 They are particularly important for asylum seekers at any stage in the process, as they may be moved at short notice, or if destitute, may be living in temporary or vulnerable accommodation. If people are fully registered on a long-term basis, patient-held records may be less important.

Performance indicators for primary care for migrants

Eling has suggested a set of performance indicators for primary care in addressing screening, initial health assessments, hand-held records and immunisations. These are:

- The service makes an appointment for an initial health assessment within x days of an asylum seeker/refugee/vulnerable migrant registering
- The service follows NICE guidelines or other locally agreed guidelines for the detection of TB in new entrants
- The service has a record of the % of patients who have been screened for TB as per guidelines
- All patients are offered blood borne virus screening; the service records the % of patients who have been offered this, % who have been tested/declined
- The service has a policy on pneumococcal and influenza vaccination in patients who are HIV positive and records this as being offered and taken up/declined
- The service has a protocol (following local guidelines) for investigation of Hepatitis B if found to be positive
- The service has a register of patients who are Hepatitis B sAg positive
- All patients are offered sexual health screening
- The service has a register of patients who have undergone FGM
- Adults of reproductive age are offered contraceptive advice and % who have received this is recorded
- The service has a policy for catch-up immunisations for all patients (e.g. Health Protection Agency schedule) and records the percentage who have been offered catch-up immunisations
- The service has a policy for screening for/treating/preventing vitamin D deficiency and records the proportion of patients who have been screened and if the protocol has been followed
- The service provides a hand-held record for patients or provides copies of medical notes to patients78

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78 Eling, 2010, op.cit.
Mental health

Psychological distress following migration, especially forced migration, is well documented, as is the complexity of diagnosing and addressing it and of distinguishing mental illness from ‘normal’ reactions to stress. Mental ill-health and mental distress is likely to be much more common among vulnerable migrants than among the general population.

How people experience psychological distress can vary and is dependent on many factors including gender, the circumstances people have come from, their reasons for migration, and the conditions in which they find themselves in the UK. For example, asylum seekers may have experienced trauma in their countries of origin, as well as very difficult circumstances in the UK, including detention, destitution or poverty, forced dispersal and fear of removal back to their country of origin. Some of them may have been sexually abused. Refugees may have been through similar stresses, and although their asylum claims have been recognised, their initial leave for only five years, can leave them in a state of anxiety. “I’m going through counselling at the moment, therapy, because I am severely depressed and...one of the reasons why I’m severely depressed is because I don’t feel settled. I’m anxious as to what is going to happen in two years’ time.” Other migrants may experience mental ill-health in response to poverty and stressful living circumstances.

Mental health problems of men and women may arise for different reasons and be linked to patterns of gender relations in countries of origin and how these are affected by the experience of migration. Common factors affecting women’s mental health may be experiences of sexual violence and abuse, including trafficking, especially among young women, domestic violence, feelings of loneliness, isolation, and despair when women feel trapped at home either with sole care of children or because of prohibitions by male relatives.

Practitioners trying to steer a path between viewing mental distress as mental illness and wishing to avoid pathologizing anxiety and depression can leave vulnerable migrants failing to receive the care and support they need. There is also a serious dearth of mental health services which are able to work in a culturally sensitive way, and which are able to address social as well as psychological problems. A report by MIND found that there were significant barriers to accessing mental health services among asylum seekers and refugees and these are likely to similarly affect other migrant groups. These barriers include:

- inadequate availability and use of language services.
- lack of cultural awareness among healthcare and voluntary sector staff.
- limited provision of culturally appropriate mental health services.
- major gaps in services to address intermediate mental health needs or specialist services for torture survivors.
- lack of coordination and collaboration between community organisations and both statutory and voluntary mental health services.

There are a few organisations which provide counselling and mental health services in clients’ own languages. Some provide more holistic services that combine counselling or psychotherapy with casework, while others focus on ‘pure’ psychotherapeutic services with no other casework.

Case study – Inflexibility in commissioning appropriate services for vulnerable individuals

**Roma Support Group and PROMO project**

The Roma Support Group based in Newham in east London has worked with East European Roma asylum seekers, refugees and migrants since 1998. Its wide range of projects and services are based on principles of community development and empowerment. This has been achieved by means of work with individuals and groups. The RSG runs a variety of projects including welfare, housing, debt and employment advice and support, education advocacy, cultural and recreational, activities for children and young people, as well as general health advocacy and mental health projects. The organisation also works with members of the Roma community to promote a better understanding of Roma culture and challenge prejudice and discrimination.

Roma have for centuries been among the most excluded and discriminated against groups in the world, as a result of which they commonly mistrust public services. RSG’s community development approach means engaging with issues and concerns expressed by the people with whom they come into contact and building on these. Their current mental health project recognises the stigma of mental illness among the Roma, and women’s huge fear of losing their children if they access mental health services.

A worker from the Roma Support Group accompanied a Kosovan Roma woman to her GP, who diagnosed her with PTSD. The woman was living in east London. On the recommendation of a researcher on the Promo Project, (a project working with socially marginalised groups throughout Europe), she was referred to a specialist PTSD therapist who spoke her language, but who worked in a different PCT. After an initial assessment and establishing good rapport with the woman, the therapist recommended that she attend a few sessions for therapy. However, the original PCT refused to commission this service in another Trust and the woman was consequently referred to counselling in her own area. Her English was too limited for counselling, so she was provided with an interpreter. However, because she had some understanding of English, during counselling she was aware that the (non-Roma) interpreter was misunderstanding and misinterpreting the issues she was raising. She came to the Roma Support Group and explained her problems to the mental health worker who then sent a letter to the counsellor explaining the issues raised by the woman. After this, the therapy improved.

Not all mental health needs require clinical services. There are examples of services, mainly, but not exclusively, within the voluntary sector, which try to reduce social isolation and provide meaningful activities as a means of improving migrants’ mental wellbeing. However many of these projects are time-limited because they are dependent on short-term funding.

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Models of mental health services for vulnerable migrants

Services within specialist GP practices
Meridian Practice for refugees and asylum seekers in Coventry has a mental health clinic, a counsellor and offers art therapy.
Whitehouse practice for refugees and asylum seekers and homeless people in Huddersfield has a part-time in house psychologist

Statutory sector services
Refugee Support Service – NELMHT (Waltham Forest Psychology Service)
This service provides counselling to refugees and asylum seekers, and works with migrant community groups to improve awareness of mental health issues and to develop their capacity. It also provides information, consultation and support for professionals working with this population.

Lambeth, Southwark and Lewisham (LSL) Refugee Health Team
Mental health is integrated into the overall remit of the Refugee Health Team LSL. A Community Psychiatric Nurse (CPN) works alongside caseworkers, community workers, nurses and a team of part-time GPs and a complementary therapist. The CPN assesses clients, makes short-term interventions and refers patients on to other services. Complementary therapy aims to help individuals and groups to recognise and manage their own stress.

Most services are provided at non-NHS venues in partnership with the voluntary sector. The service is designed to address users’ multiple complex needs, provided nearer to where people live in venues such as day centres, community organisations, GP Practices or NHS centres, and/or in another environment that is convenient and comfortable for them. The team aims to improve access to the NHS for refugees and asylum seekers and provides relevant health interventions.85

Voluntary sector specialist services for women
Women’s Therapy Centre
The Women’s Therapy Centre provides low cost psychotherapy services to BME women. The service was designed for women who traditionally cannot access psychotherapy. They provide individual counselling and group-work. They can see clients for up to two years on an individual basis, and groups can run for up to three to five years. They have a specialised service for asylum seeking and refugee (ASR) women whatever their immigration status, with a dedicated link worker for asylum seekers and refugees. The ASR counselling service is relatively new. Therapists may determine at assessment that the client is unsuitable for psychotherapy (e.g. their situation is too dire to risk delving into trauma). The Women’s Therapy Centre has produced a very helpful Toolkit providing guidelines and models of good practice to assist women refugees and asylum seekers experiencing mental health problems, and to provide information to agencies working with them.86

Refugee Council Vulnerable Women’s Project

This project is part of a specialist team which provides counselling and advocacy for refugees and asylum seekers with mental health support needs, and a women’s worker, whose role is to provide gender sensitive support to vulnerable women. The women’s worker for the Vulnerable Women’s Project, runs a women’s group and advice services. The team uses a concept of ‘therapeutic casework’, in which bilingual therapists combine counselling, advocacy and practical crisis intervention.87

Recommendation for commissioners

1. Commissioners should ensure that mental health services take account of the specific needs of vulnerable migrants. This requires a holistic approach where dealing with practical needs through casework or good signposting occurs alongside therapeutic interventions. They should have regard to the recommendations in the MIND report, A civilised society: Mental health provision for refugees and asylum-seekers in England and Wales88 adapted to include all vulnerable migrants, as a basis for commissioning services. Partnership work with voluntary sector services is essential to identify needs and gaps in services.

2. Commissioners should ensure that there are services in place to provide gender and culturally sensitive support to vulnerable migrant women.

3. Commissioners should be flexible in commissioning specialist services in circumstances where existing services are inappropriate.

Violence against women and girls

Domestic violence is recognised as a major public health concern and as a risk factor for chronic ill health and premature death in women. The government definition of domestic violence is “any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality.” 89 Physical health problems of domestic violence include gynaecological problems, chronic pain, neurological symptoms, and gastrointestinal disorders. Mental health can be especially affected, with high prevalence of depression, anxiety and PTSD in women who have experienced it, lasting long after the violence has ceased.90 Violence often occurs during pregnancy, affecting an estimated 4%-8% of pregnancies.91

Though figures of prevalence are not always comparable because of differences in criteria and definitions of domestic violence, how data is gathered and the types of samples used, recent careful estimates suggest that among women attending GP clinics, physical or sexual abuse perpetrated by intimate partners in the previous year, ranges from 6% to 23% while lifetime prevalence ranges from 21% to 55%.92

88 MIND, 2009, op. cit.
90 A. Gregory et al. 2010, “Primary care Identification and Referral to Improve Safety of women experiencing domestic violence (IRIS): protocol for a pragmatic cluster randomised controlled trial”, BMC Public Health 10:54,
92 A. Gregory et al. 2010, op. cit.
Violence experienced by migrant women may be much broader than domestic violence if forced marriage, ‘honour’ based violence, trafficking and female genital mutilation (FGM) are added to narrower definitions of intimate partner violence. A small-scale study by the Scottish Refugee Council reported that 70% (32/46) of asylum seeking women interviewed reported having experienced physical and/or sexual violence in their lifetime. 38% had experienced physical or sexual violence from an intimate partner in their lifetime and 19% had experienced such violence in the past 12 months. 50% of women had experienced physical or sexual violence by an individual other than an intimate partner in their lifetime.93

Primary healthcare services are likely to be the first and even the only professional contact of many women suffering domestic abuse, and vulnerable migrant women may have very little idea where else to turn. However, GPs often do not know where to refer women to for specialist support or how to provide women with opportunities to disclose their problems.

There are also additional implications of domestic violence for migrant women compared to the settled population. These are:

- Vulnerable migrant women may find it more difficult to leave situations of violence and abuse than settled women because of problems of language, social isolation, patriarchal cultural expectations, fear of repercussions from family members and the wider community, and inappropriate responses and/or racism from mainstream agencies. The ‘no recourse to public funds’ rule means that many women in the UK as spouses or students or overstayers lack cannot access refuges, and so continue to lack access to safe housing. This means that they are likely to be forced to return to the perpetrator or face destitution.94

- Women who are in the UK on a spouse or partner visa may fear that they cannot leave a violent relationship without jeopardising their leave to remain here during the two year ‘probationary’ period. However the domestic violence rule allows women experiencing domestic violence, including forced marriage, to apply for indefinite leave to remain (ILR) provided that they can provide evidence of violence (including psychological injury or the psychological impact of forced marriage). Useful evidence for such an application includes a medical report from a hospital doctor or a GP who must confirm the dates when domestic violence was reported.

- Women are often reluctant to disclose experiences of gender-based violence at asylum interviews. Despite the introduction of Gender Guidelines which recognises the impact of gender-based violence on how a woman might respond during an asylum interview, or the importance of gender-sensitive interview procedures to enable women to disclose their experiences,95 there is evidence that such guidelines are often ignored.96 Where women have not disclosed experiences of gender-based violence initially, any such later claims may be disbelieved. In such cases, evidence from clinicians becomes even more important.

Rapid identification of domestic violence in this population and early intervention is therefore necessary to limit the effects of its adverse health and social consequences on the women concerned and their children, and concomitant additional healthcare costs. It can also underpin women’s legal entitlements in claims for asylum or for the right to remain in the UK.

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95 UKBA, 2010, Gender issues in the asylum claim, UKBA Asylum Policy Instructions (updated) http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/asylumpolicyinstructions/

However patients are rarely asked about domestic violence and health workers have little or no training in how to respond to disclosures about it. If women are accompanied by family members they may not feel able to disclose domestic or other forms of gender based violence. It is therefore important to try to see women alone or with neutral interpreters. Although consideration of experiences of gender-based violence is advocated as an important element in initial health assessments for refugee and asylum seeking women, there is little in-service guidance for professionals on how to interact with a woman so as to enable her to disclose her experience of gender-based violence.

Examples of services

**Bevan House, Bradford** PMS practice has integrated a rape crisis and domestic violence service within its specialist service for homeless, asylum seekers and hard to reach groups. Its services include health checks, longer GP consultations, contraception and sexual health, rape crisis and domestic violence, and mental health. The team consists of GPs, nurses, a psychologist, community mental health worker and therapeutic resource team, midwife, a Health Visitor.

**The IRIS (Identification and Referral to Improve Safety) programme** has been developed to test the effectiveness and cost-effectiveness of training and support targeted at general practice teams to overcome barriers to asking women about domestic violence, to encourage appropriate responses to disclosure, and to enable referral to specialist domestic violence agencies. Intervention practices have a prompt to ask about abuse integrated in the electronic medical record system. The IRIS programme now has 12 PCTs targeted for service implementation. It has no special focus on vulnerable women migrants but could be extended and adapted to incorporate special features appropriate for migrant women.

Recommendations to commissioners

- Commissioners should be prepared to fund services to meet the mental health as well as physical health needs of migrant women who have experienced various forms of gender-based violence, such as advocacy and advice, outreach, counselling and other forms of therapeutic intervention.
- Commissioners should work with specialist organisations to develop performance indicators for recognising gender-based violence in initial health checks.
- Commissioners should develop clear referral pathways to appropriate services for women with current or past experience of gender-based violence with recognition of the need for specialist services for vulnerable migrant women.

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98 A. Burnett and Y. Fassil, 2009, Meeting the health needs of refugees and asylum seekers: A resource for health workers http://www.migranthealthse.co.uk/dhnhs-specialist-support


100 Ibid.

• Commissioners should incorporate training about domestic violence and immigration in in-service training programmes.
• Commissioners could use an electronic prompt for asking about domestic or sexual violence integrated into the record system as a performance indicator for services for vulnerable migrant women.

Reproductive and sexual health

Maternity

The 2007 CEMACH Report Saving Mothers’ Lives found that 10% of all maternal deaths between 2003 and 2005 were in women who could not speak English, and of these, nearly a quarter had either booked late or missed more than four antenatal visits. 12% had received no antenatal care at all. The report states that black African women, including asylum seekers and newly arrived refugees have a mortality rate nearly six times higher than White women. Thirty six out of 295 maternal deaths during this period were to refugee and asylum seeking women.

Recently arrived migrant women may have poor overall health, underlying and possibly unrecognised medical conditions, including congenital heart disease, HIV/AIDS or tuberculosis. They may been subject to female genital cutting or mutilation (FGM), or suffering psychological or physical sequelae of living in and fleeing from conflict zones. They may have fears about their immigration status and their entitlements to health care.102

There is also evidence of much higher rates of infant mortality in babies born to women who were born abroad and/ or who belong to settled BAME communities. 2001 census data showed that 7% of people in the ‘Routine and Manual’ group were from black and minority ethnic groups. However, in the 43 areas with highest numbers of ‘Routine and Manual’ infant deaths, this proportion increases to 14%.103 Data on selected mothers’ countries of birth showed that babies of women born in Pakistan, parts of Africa and the Caribbean had approximately double the infant mortality rates of the UK as a whole.104

The NICE Guideline used the categories of “recent migrants (arrived within the past year), refugees and asylum seekers and women who have difficulty reading or speaking English” as one group of women with “complex social factors”, to reflect migrant women particularly at risk of adverse birth outcomes. Studies reviewed for the guideline showed that these groups faced numerous barriers in accessing maternity services, of which language and lack of information about the healthcare system were the most significant.105 A summary of barriers identified is shown in Table 3.

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Table 3 – Barriers reported for recent migrants, refugees, asylum seekers and women with little or no English*  

<table>
<thead>
<tr>
<th>Service barriers reported by women</th>
<th>Personal reasons which act as barriers reported by women</th>
<th>Barriers reported by providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Language – lack of interpreters, use of colloquialisms (17)</td>
<td>Not understanding the healthcare system and how to access it (9)</td>
<td>Language (4)</td>
</tr>
<tr>
<td>Discrimination, racism towards immigrants and non-English speakers (6)</td>
<td>Lack of social network (4)</td>
<td>Lack of availability of suitable interpreters especially for emergencies, out-of-hours and unbooked appointments (1)</td>
</tr>
<tr>
<td>Lack of continuity of carer (3)</td>
<td>Misunderstanding dates and times of appointments (1)</td>
<td>Unfamiliarity of healthcare system, what to expect, how to use it (3)</td>
</tr>
<tr>
<td>Not told about antenatal education (2)</td>
<td>Not understanding the purpose of antenatal classes, diagnostic tests (1)</td>
<td>Ethnic minority women do not conform to rules – use emergency services instead of clinics, can be demanding expecting health care to live up to standards of care in their home country (1)</td>
</tr>
<tr>
<td>Refused registration with a GP (1)</td>
<td>Depression/ fear/anxiety/other personal (5)</td>
<td>Lack of knowledge of cultural and religious differences (1)</td>
</tr>
<tr>
<td>Lack of transport (6)</td>
<td>Financial (6)</td>
<td>Negative attitude towards women from ethnic minorities (2)</td>
</tr>
<tr>
<td>Inconvenient time of antenatal clinic (8)</td>
<td>Lack of childcare (3)</td>
<td>Lack of continuity of carer (1) Pressures and difficulties arising from immigration status (1)</td>
</tr>
<tr>
<td>No directing agencies (1)</td>
<td>Fear of immigration services (4)</td>
<td></td>
</tr>
<tr>
<td>Lack of cultural sensitivity among providers (2)</td>
<td>Dispersement policies for women with asylum seeker/refugee status (1)</td>
<td></td>
</tr>
<tr>
<td>Negative attitude of healthcare professionals (2)</td>
<td>Lack of assertiveness in dealing with the healthcare system (1)</td>
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</table>

* Brackets refer to the number of studies reporting a particular barrier
Language particularly affects the probability of attending antenatal visits and antenatal classes, lack of knowledge of what is available or expected is linked both to language difficulties and to perceived discrimination by healthcare staff and a lack of familiarity by healthcare staff of cultural and religious factors.

NICE Guidelines on routine care for healthy pregnant women recommend that booking appointments should ideally be before 10 weeks gestation.\textsuperscript{106} The guidelines relating to women with complex social factors stress that such women have “may have additional needs” and set out “what healthcare professionals as individuals, and antenatal services as a whole, can do to address these needs and improve pregnancy outcomes in this group of women.”\textsuperscript{107} Thus the key issue for services for vulnerable migrant women is to enable them to access the same standards of care regarded as standard for all women. This involves commissioning services to address and attempt to overcome the barriers they face. These should include:\textsuperscript{108}

- identifying the most appropriate settings for maternity provision.
- making language services available.
- providing information about pregnancy and antenatal services, registering with a GP and the organisation of the NHS in a variety of formats, settings and languages.
- offering referral to sexual health services if she is considering termination of the pregnancy.
- considering initiating a multi-agency needs assessment including safeguarding issues so that the woman has a coordinated care plan.
- providing women with a one-to-one consultation without her partner, a family member or a legal guardian present, at least once to enable her to discuss sensitive issues such as domestic abuse, previous experiences of sexual violence, previous pregnancies, and FGM.
- respecting the woman’s right to confidentiality and sensitively discussing her fears in a non-judgmental manner.
- offering flexibility in the both the number and length of antenatal appointments
- making special efforts to ensure continuity of care
- providing guidance on the woman’s NHS entitlements throughout pregnancy including access to maternity grants and milk supplements for asylum seeking women. This is to ensure that at no stage during pregnancy or birth can treatment be refused if a woman is unable to pay.
- identifying women with financial problems and providing information on local charities to support women during pregnancy.
- taking account of women’s emotional and social needs during pregnancy, labour and postnatally

Reaching the women most at risk of late booking requires a multi-faceted approach, and will require close partnership working with voluntary sector organisations.

\textsuperscript{106} National Institute for Clinical Excellence, 2010, Antenatal care: Routine care for the healthy pregnant woman, NICE clinical guideline 62 Developed by the National Collaborating Centre for Women’s and Children’s Health http://guidance.nice.org.uk/CG62/NICEGuidance/pdf/English

\textsuperscript{107} National Institute for Clinical Excellence, 2010, Pregnancy and complex social factors: full guideline, CG110, op.cit.

\textsuperscript{108} These issues are drawn from National Institute for Clinical Excellence, 2010, Pregnancy and complex social factors: full guideline, CG110, op.cit.; and from H.Sharpe, 2010, Migrant Friendly Maternity Services: Toolkit For Improving Local Service Provision, West Midlands Strategic Migration Partnership and Department of Health http://www.wmcountcils.gov.uk/migration-documents
Meeting the maternity care needs of vulnerable women migrants

South Staffordshire PCT
A project team of midwives from Staffordshire and Burton hospitals and representatives from South Staffordshire PCT was set up to develop a maternity care pathway for non-English speaking women.

The pathway outlines how language needs should be identified at registration and then passed on to professionals throughout ante-natal, intra partum and post natal care. The pathway ensures that all those who come into contact with the women during her pregnancy and birth, for example the ultrasound department, are able to provide information in the women’s first language, either through language line or translated leaflets. It also highlights the need to discuss the women’s expectations of maternity care in England and to explain how the model of care in the UK may differ from that in the women’s home country.

The development of the pathway has highlighted additional areas for improvement, for example the need for a clear policy on Female Genital Mutilation (FGM). The challenge now is to embed the pathway within the other maternity policies and guidelines to ensure it is appropriately implemented and to ensure it is part of a wider programme of improvements in maternity services.

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Bilingual Maternity Support Workers – London Borough of Hackney

Bilingual Maternity Support Workers (BMSW) were established as part of a multi-disciplinary and multi-intervention project to reduce infant mortality in Hackney from 2007-2009. This included a midwifery group practice in a deprived area, midwives in Children’s Centres, a specialist midwifery service in a dedicated practice for refugees and asylum seekers, a peer education support project (‘bump buddies’) and labour support volunteer programme (‘birth buddies’).

The BMSW role, which still continues, was created to support women who find it difficult to engage with maternity services because English is not their first language. Of particular concern are those identified as ‘vulnerable’, and women who have recently arrived in the UK. A key aim of the programme is to enhance their antenatal and postnatal health, social care, and parenting support. BMSWs are trained on the job by midwives, and also receive classroom training.

BMSWs are allocated to the different community midwifery teams working across Hackney and are managed day-to-day by the team leader or midwife in charge. The BMSW role consists of language and interpretation with a wide range of teams and agencies in the borough with which women come into contact. They work in partnership with other strands of the Reducing Infant Mortality Programme, signposting women to other local services. They offer clinical support to mothers and babies during pregnancy and after birth, including supporting the midwives in antenatal and postnatal clinics within Children’s Centres and, following training, carrying out some clinical tasks such as weighing babies or measuring blood pressure. In some cases they have also supported specialist sessions such as baby massage.

Sheffield Community Midwifery Service

This post started in 2005 with recognition that growing numbers of dispersed asylum seeking women in Sheffield were receiving inappropriate care or not accessing care until the last minute. Often women are dispersed late in pregnancy.

New arrivals were targeted and the specialist midwife set up a weekly all-day drop-in for women at the dedicated GP practice for asylum seekers to which she is attached. The drop-in has Farsi and Somali bilingual support workers and is visited on a regular basis by many asylum seeking women and other vulnerable migrant women whether or not they need ante-natal services. It provides a “safe space” for these women, as well as an opportunity for longer consultations. The specialist midwife says that each asylum seeker needs four times as much time as other women because there are many issues that need to be addressed and a great deal of information to be given. Some women are HIV positive; family planning and safer sex advice is given during pregnancy; women might want information about termination of pregnancy. Nowadays the client population also includes migrant women facing other issues than asylum, for example, some have been trafficked into the sex industry and are afraid to return home. The service works closely with Health Visitors, social services and family support workers at a Children’s Centre to address child protection issues. Women are encouraged to go to mainstream parenting classes as well as being signposted to other groups for material and social support. These links have developed as a result of a specialist service. The specialist midwife is also responsible for ongoing training of all maternity and support staff on migrant issues.

“This service avoids costs to the individuals, families and NHS incurred by premature birth, neonatal and maternal complications, and death. This service model is recognised as an excellent way of engaging potentially highly vulnerable women and their babies in health services – as a result of this in 2008 the post-holder received the Addressing Health Inequalities Award from the Royal College of Midwives.”

dot.smith@sth.nhs.uk Dorothy Smith, Specialist Midwife

Training for midwives – Maternity Action

In response to consultations with midwives and asylum seeking women to identify and try to overcome barriers to providing the best possible care, Maternity Action initiated a training programme for midwives to improve maternity care for refugees and asylum seekers. An introductory course provides an overview of issues relevant to refugee and asylum seeking women and offers information and tools which can be used to support these groups more effectively. The advanced course aims to provide midwives with a more in-depth understanding of these issues and suggests methods to help promote these groups’ early engagement with services and to enable them to receive appropriate women-centred care. Additional resources to support midwives working with refugees and asylum seekers have been developed and are available on Maternity Action’s dedicated training website.

It is intended to provide over 40 courses to an average of 12 midwives in each course, resulting in the training of about 500 midwives. Of these about 200 are expected to also take the advanced course.

http://www.maternityactiontraining.org.uk/about_the_training.html

Recommendations to commissioners

- All commissioners should implement a policy on maternity care for vulnerable migrants. This would address all elements of the QIPP agenda as well as helping maternity services to enable vulnerable migrant women to achieve the same standards of care as recommended by NICE for all pregnant women. This involves ensuring that the same elements for migrants are in place for maternity services as for other primary care services i.e. facilitating access to enable early booking, provision of core services, and additional services.

- Early access by vulnerable migrant women can be enhanced by partnership with voluntary sector organisations, providing information about services in a variety of formats and languages and locating clinics conveniently for the target population.

- Every maternity service should have in place a comprehensive referral pathway, linking with specialist providers and voluntary sector support organisations, to meet the needs of vulnerable migrant women in pregnancy and childbirth. Such a pathway can be integrated with existing local strategies to improve pregnancy outcomes, and to reduce infant and maternal mortality and morbidity. It should include social risk assessment mechanisms, and routes to address problems such as FGM, domestic violence, history of sexual violence, pre-existing medical conditions.

- Training should be commissioned for maternity staff to enhance their awareness of migrant women’s financial and social vulnerabilities, and of the entitlements to maternity care and to financial support from UKBA or social services of refused asylum seekers or women with no recourse to public funds. Such training should complement existing equalities training for healthcare professionals working with pregnant women.

Sexual health

The National Strategy for sexual health aimed to:

- reduce the transmission of HIV and STIs
- reduce the prevalence of undiagnosed HIV and STIs
- reduce unintended pregnancy rates
- improve the health and social care for people living with HIV
- reduce the stigma associated with HIV and STIs.113

The strategy also considered the need for specialist services to address sexual and psychological problems and to meet the needs of women who had had FGM. Other than these, the strategy broadly characterised sexual health services as consisting of two key elements, fertility control, and the control and treatment of sexually transmitted infections (STIs) and HIV.

Since the publication of the national strategy in 2001, there have been major improvements in sexual health provision nationally, and a shift towards a more integrated and holistic approach to sexual health. Nevertheless, there are significant continuing problems and inequalities within sexual health, notably, in relation to vulnerable migrant women, the association of teenage pregnancies with poverty and deprivation, the negative impact of sexual violence and abuse on the sexual health of survivors, high rates of abortion within some minority communities, and high rates of STIs among black African and black Caribbean populations.114 There may also be particular local inequalities, for instance, sex worker outreach projects have reported that migrant sex workers find it difficult to


access timely and free termination of pregnancies. The Open Doors clinic in Hackney reported cases of undocumented women who had attempted to undertake their own medical termination coming to clinics with retained products of conception. These women have required follow-up gynaecological procedures as a result.  

However, the Department of Health’s Equality Impact Assessment for Sexual Health Policy found that other than targeted funding on HIV prevention, race inequalities in sexual health were not addressed at national level, and depended on local commissioning. It recommended that “further consideration should be given to this issue in any future sexual health strategy development.”

It also highlighted the health needs of survivors of sexual violence and abuse. Commissioning for sexual health for vulnerable migrant women should clearly form part of addressing race and gender inequalities in sexual health.

There are few reports of how effectively the sexual health needs of vulnerable migrant women, including contraception, abortion and STI and HIV prevention and care, are currently being met. While government policy focuses on young people for contraception and STI prevention, young migrants may not have the same access to sex education and sexual health advice as the settled population. Teachers and youth workers voiced concern over young migrant women getting pregnant, and saw sex education and access to contraception as an important unmet need of young refugees and asylum seekers in south London. Similar issues were identified in a further education college in Hounslow where a dedicated welfare officer is able to discuss some sexual health issues. However, a report for the Family Planning Association commented that:

> Talks on sexual health are arranged with some of the classes, but the classes are mixed, and some young women feel reluctant to talk about such issues in this setting. The students face many of the same issues as British teenagers, but because many are without family in the UK, they have a greater need for advice and guidance.

> Many of the students carry physical and psychological scars of FGM. As a result, many girls suffer from urinary tract infections, and the duration of menstruation is longer and extremely painful. This often affects their studies.
Example of good practice

Newham Asian Women’s Project Sexual health project, Health to Happiness

Newham Asian Women’s Project (NAWP) was established in 1987, initially as a service for south Asian women fleeing domestic violence. Its work in this area had revealed the impact on women’s sexual and reproductive health of domestic violence and sexual abuse. It already had a young women’s project providing specialist support services for young women vulnerable to self-harm and suicide, with youth workers and mental health advocates who helped young women access mainstream sexual health services.

NAWP’s sexual health project, Health to Happiness, was set up in 2006, in response to increasing teenage pregnancy rates, and a growing incidence of STIs, including HIV. NAWP believes that the taboo on talking about sex in south Asian communities has resulted in an under-representation of south Asian women at sexual health facilities, a lack of information about sexual and reproductive health and consequently higher risks of sexual and reproductive health problems. It also works with lesbian and bisexual south Asian women on issues of sexual orientation.

The project was funded by Newham PCT and ran from 2006 to 2010. It worked with women and girls of all ages as well as with frontline health professionals in and around the London Borough of Newham. The project’s activities included:

• regular outreach and drop-in slots to young women and girls providing essential information on sexual health.
• discussions with young girls and women on women’s physical, sexual and emotional health.
• individual support to women including counselling, information, guidance and ongoing support.
• training of trainers and frontline professionals providing services to vulnerable young people.

As a result of the sexual health project NAWP now provides a counselling service for young Asian women aged 11-25 who have experienced domestic or sexual violence or sexual abuse. Some of them have been trafficked for sexual exploitation.

Recommendations for commissioners

• Commissioners should be aware of and endeavour to respond to the broad range of sexual health service needs of all women in the consortium area, including vulnerable migrant women.
• Commissioners should check local service needs and provision against known national inequalities in sexual health, for example, over-representation of some BAMER groups in abortion statistics, with a view to commissioning appropriate services for prevention and to ensure current need is met.
• Commissioners should acknowledge the need for specialist services in sensitive areas such as sexual health, both to provide an entry point to mainstream services and to meet needs where specialist expertise is not available in mainstream services.

• Whilst most STI prevention and testing is part of primary care, and STI treatment is exempt from charging in secondary care, HIV treatment may be chargeable in secondary care settings. Commissioners should ensure that clear protocols are in place as part of overall performance indicators for HIV care, to ascertain who is chargeable, so that vulnerable migrants who are entitled to free care are not wrongly charged for their HIV care. This is particularly important for pregnant women who may avoid attending antenatal care because of fears of being charged, and who, if HIV positive, risk vertical transmission of the virus, as well as damaging their own health.121 There should also be specific consideration of when HIV treatment should be provided as “immediately necessary” treatment to prevent the condition becoming life-threatening.

Health promotion

The prevention of ill health has been recognised as a key element in reducing health inequalities.122 Since the 1990s, much primary care has been concerned with primary and secondary disease prevention including cancer screening, flu immunisations, long term management of chronic diseases such as diabetes, and prevention and management of cardiovascular diseases through diet and exercise. Performance management systems such as QOF have also encouraged early intervention, improved coverage of screening programmes, better management of diabetes and other chronic diseases in order to save costs and to indicate good practice.

However, health promotion interventions are particularly complex where the target population has overwhelming immediate priorities such as poverty, poor housing, immigration concerns, childcare, language difficulties, and discrimination. Ethnic inequalities have been reported in prevalence and awareness of identifiable risk of serious diseases, affecting take up of screening or other preventative interventions. For example, a Cancer Research survey found that nearly a third of non-white women compared with a fifth of white women, were unsure about their risk of developing cervical cancer compared to other women of their age.123 The diagnosed population with diabetes in the UK has now reached 2.8 million.124 Type 2 diabetes is strongly associated with ethnicity, social deprivation and age. Women of Pakistani origin are over five times more likely than the general population to have Type 2 diabetes and those of Bangladeshi and Black Caribbean populations over three times more likely.125

Ethnic inequalities in the reach of health promotion interventions are often attributed to a ‘deficit’ model about the groups concerned, where culture and beliefs, “ethnicity”, or lack of information are seen as reasons for poor uptake of screening or other health promotion initiatives. However, lack of uptake could rather be due to poor communication between professionals and minority ethnic women leading to a lack of understanding of the purpose or procedures of the screening programme, with implications both for regular uptake and for informed consent and informed choice.126

Such problems can be exacerbated among vulnerable migrant women who may have other overwhelming immediate priorities such as poverty, poor housing, immigration concerns, childcare,
Examples of good practice

Social Action for Health (SAfH) – Hackney Cancer Screening Project

Social Action for Health Hackney Cancer Screening Project, funded by NHS City and Hackney Public Health, has been delivered with support from GPs in Hackney and the Central and East London Breast Screening Service. The project involves peer encouragement to attend routine breast screening appointments for local women who do not normally attend screening because of barriers such as fear, problems of access and work/family commitments. Social Action for Health’s local knowledge of communities enables these barriers to be identified and overcome.

SAfH employs ACE (Active Communities Engage) workers to go into GP surgeries and call patients who have previously not attended breast screening appointments. The ACE workers are local people who speak to women in their first language, thus building a rapport which is seen as key to overcoming barriers. The ACE workers are trained by healthcare professionals about the importance of screening and they then pass on this message. Women are offered the opportunity to choose appointment times, offering group appointments and also providing transport to and from screening appointments.

This project currently works with twelve GP Practices in Hackney and books up to 30 women a week to attend the screening site at St Bartholomew’s Hospital. SAfH provide a minibus service to the screening unit from the various surgeries, so women can travel together.

SAfH’s initial involvement with breast screening began in Tower Hamlets where local engagement with groups of women highlighted the many barriers that women face when sent a postal invitation to attend a mammography appointment. This enabled SAfH to develop a model, where a screening unit would block off a day of appointments for women who had previously not attended. SAfH would then engage with these women to address barriers which they may face. This resulted in a minibus service being provided so women could travel together, providing them with a sense of security and reassurance, helping them to overcome barriers. It also helped them reach the screening centre easily and made the experience far more pleasant for them. The result of women having a positive mammography experience has also provided a trickle-down effect where women can pass the message on, and in turn increase women’s uptake of screening.

SAfH’s success over the previous two years in increasing the awareness and uptake of the breast, cervical and bowel cancer screening programmes amongst the local Bengali community in Tower Hamlets led to similar work being funded in the neighbouring borough of Hackney.129

Managing chronic conditions

Women’s Health and Family Services (WHFS) Somali diabetes project – Tower Hamlets

Both the prevalence of and risks of complications from diabetes are related to ethnicity and economic deprivation, and Tower Hamlets scores high on indices of multiple deprivation and also has a large ethnic minority population.

The WHFS Somali Diabetes Project was set up in 2003 with three year funding from the King’s Fund within this context and in response to growing local concerns about the rapid increase of diabetes among Somalis and the huge and unmet demand for improved diabetes provision to this community. Diabetes is three times more prevalent among Somalis than the national average.

The project used mixed activities and a multi-site approach including individual case work, providing a comprehensive advocacy service, advice and information and a variety of group educational and support sessions. In its later stages, project also delivered “Self-management of chronic disease” training to Somali groups for the first time, as part of the Expert Patient Programme, delivered with another local voluntary organisation.

The project also sought to improve users’ links to health care providers by working closely with statutory health services at implementation and policy levels. Close collaboration with local health providers was key to providing better services to Somalis with diabetes. Between 2003 and 2006, the project had contact with over a 1300 Somali women and men in Tower Hamlets. At the end of the first year of its functioning, the local Diabetes Services reported a notable improvement in outpatient attendance among Somali patients and in their diabetes control. For many Somalis, contact with the project meant the first time ever they had routine diabetes checks, learnt to do their own monitoring and increased their self-care.

Currently WHFS continues to run a diabetes education and befriending programmes for Somalis.130

Healthier Lifestyles

Women’s Health and Family Services Tower Hamlets – Older Somali Women’s Project

For more than eight years WHFS has been working with older Somali women enabling them to develop healthier lifestyles and increase their feelings of independence whilst reducing their isolation in the community. Over 120 older Somali women have benefited from the project and a small representative group of women have been trained and supported to become a user forum.

The women want to feel more integrated into life around them so mother tongue classes and English for Speaker of Other Languages (ESOL) have been very successful. They also want to

be able to use services in the borough in order to stay healthy and active. Keep fit sessions are popular and the regular slots for health promotion sessions and other agencies coming to introduce new initiatives or consult with the women. There are also regular trips and cultural events organised and planned with the women. The four venues across the borough attract a different group of Somali women living locally in the neighbourhood and are much valued by each group of women.

“I am a severely disabled person, I had a stroke 10 years ago and I can hardly walk. This is the only place I come to meet my friends. And have a laugh, all other days apart from Fridays I am just sitting on my chair staring out the window”. (Older Somali woman)131

Generic health awareness

Roma Support group – Pacesetters Programme Gypsy, Roma and Traveller core strand

As part of the Pacesetters Programme, launched in 2008, projects were developed with Gypsy, Roma and Traveller communities in 18 participating Trusts and six Strategic Health Authorities “to deliver equality and diversity improvements and innovations which aimed to enhance patient and public involvement in the design and delivery of services.” In Newham in east London, the project worked with the Roma Support group which had identified a need for a health event for Roma to raise their awareness of health services. The health event was organised as part of the Roma Support Group AGM, and well-advertised. Speakers from NHS Newham spoke about a number of health topics including heart disease, smoking cessation and child immunisation. Roma volunteers advised the presenters on how to make their presentations culturally acceptable and relevant to the community, for example to avoid using depictions of the body, and to promote exercise in the form of dance or walking rather than jogging.

Participants were able to visit stalls at which PCT staff were present to gain individual advice on smoking cessation and other issues. 23 people had MOT health checks, including weight and BMI measurement, blood pressure and blood glucose measurement, provided by Community Care Navigators (people working in the community with people who are at risk of or who have long term conditions to help them to navigate services that are available to them and to offer them support in management of their conditions). Although all the people who had health checks were already registered with GPs, six were taken on as clients by the Community Care Navigators. All six had already diagnosed chronic conditions including chronic heart disease, hypertension, previous stroke, angina and arthritis. Others without a previously diagnosed condition but with abnormal results were referred to their GPs, while people with borderline scores were given advice about lifestyles.

The event was very well received and was filmed for a DVD to be made available in community languages.132

131 Women’s health and Family Services http://www.whfs.org.uk/health.html
Recommendations to Commissioners

- Commissioners need to familiarise themselves with community-based methods of increasing awareness of health risks and methods of disease prevention such as cancer screening or better chronic disease management among vulnerable migrant women. Many of these can be carried out by existing community organisations which are well trusted by vulnerable women with a history of expertise in this area.

- Commissioners should actively discourage opportunistic screening of minority ethnic women without information and explanation and ensure that health promotion interventions allow vulnerable migrant women opportunities to develop informed consent and to make choices.\(^{133}\) This may require commissioning distinctive screening strategies for this population.

- Commissioners should ensure that GPs and other health professionals are trained to understand cultural beliefs and customs, language needs, racial awareness and communication skills.

- Where new services of this kind need to be developed, commissioners should allow for adequate lead times for outcome measurement.

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133 L. F. Chiu, 2004, \emph{op.cit.}
**Women’s Health and Equality Consortium**

The Women’s Health and Equality Consortium (WHEC) aims to tackle health inequalities and advance policies and practices to improve the health of all women and girls.

WHEC partners are: FORWARD, Imkaan, Maternity Action, Positively UK, Platform 51, Rape Crisis (England and Wales) and Women’s Resource Centre.

[www.whec.org.uk](http://www.whec.org.uk)

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**Maternity Action**

Maternity Action is a national charity working to challenge inequality and promote the health and wellbeing of all pregnant women, new mothers and their families.

[www.maternityaction.org.uk](http://www.maternityaction.org.uk)

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