Destitution in pregnancy: Forced migrant women's lived experience.

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Abstract

Background Forced migrant women are increasingly becoming destitute whilst pregnant. Destitution may exacerbate their poor underlying physical and mental health. Little published research examines this to ensure midwifery care addresses their specific needs.

Aim To explore vulnerable migrant women's lived experience of being pregnant and destitute.

Methods Six in-depth individual interviews with forced migrant women who had been destitute during their pregnancy.

Findings: A lack of food and being homeless impacted on women's physical and mental health. Women relied on support from the voluntary sector to fill the gaps in services not provided by their local authorities. Although midwives were generally kind and helpful, there was a limit to how they could support the women.

Conclusions:

There is a gap in support provided by local authorities working to Government policies and destitute migrant pregnant women should not have to wait until 34 weeks gestation before they can apply for support.

Key words: forced migrant women; pregnancy; destitution; poverty; homelessness

Key points:

- Increasingly, forced migrant women are becoming destitute at some point in their pregnancy.
- A dearth of published midwifery research exists which examines migrant women's lived experiences of destitution and the impact on their health and wellbeing.
- This study found that pregnant destitute women do not have enough food, can be homeless and have poor physical and mental health.

- There is a gap in support provided by the local authorities before 34 weeks gestation and midwives need to be active in calling for a change in policy to avoid women becoming destitute.

Reflective questions:

- Reflecting on a recent experience when you have cared for a forced migrant woman, how did you consider her holistic needs in your care plan?
- How could you tailor your advice about healthy eating when you care for a forced migrant woman?
- How much emphasis do you place on a woman's home environment when you provide care?
- What do you think are some of the risk factors and wider social and political causes of destitution in pregnancy experienced by forced migrant women?
- What voluntary sector services exist in your area to support forced migrant women who are destitute and how would you work with them?

Introduction and background

Evidence suggests that across the United Kingdom (UK), forced pregnant migrant women are increasingly becoming destitute (Carter, 2017, Petch et al., 2015). Forced migrants are people who have been coerced or forced to leave their home country for reasons including, but not limited to: a threat to life or livelihood such as war; conflict; and natural disaster. Forced migrants include persons seeking asylum, refugees and people who have been trafficked (European Commission, 2020). Pregnant migrant women who are destitute are not able to work, legally, and do not receive financial support from Government, (Dudhia, 2020). Forced migrants are sometimes living in poverty so acute that they cannot provide for themselves (Carter,

2017). Consequently, they often rely on charities, faith-based organisations or the good will of friends to offer them support. In extreme cases they may become street homeless. Many are also at risk of exploitation by traffickers or unscrupulous employers, including in the sex industry (Petch et al., 2015, Ukoko, 2007).

In the UK, pregnant forced migrant women can become destitute for a number of reasons. It is common, for example, that asylum seekers entitled to welfare benefits experience administrative errors or delays leading to a pause on their financial support (Petch et al., 2015). Even women who have been granted refugee status and thus have a legal right to remain in the UK are at risk of destitution due to administrative delays: asylum support ceases 28 days after being granted refugee status but a delay in receiving welfare benefits can mean an individual still fails to receives financial support or accommodation (Carter, 2017, Allsopp et al., 2014b). If a woman's application for asylum is refused or they come to the end of their asylum they are not entitled to financial support, however they may still be unable to return to their home country. (Ukoko, 2007, Allsopp et al., 2014b, Dudhia, 2020). Pregnant forced migrant women who have been denied a right to remain in the UK are considered undocumented migrants and therefore have no recourse to public funds. Arguably, forced migrant women fit within the NICE (2010) definition of women with complex social factors requiring enhanced maternity care. However, they are often charged to use the NHS.

Pregnant forced migrant women in the UK can have underlying poor mental and physical health leading to more complex pregnancies (Aspinall and Watters, 2010, Asif et al., 2015). They have a higher rate of maternal and perinatal mortality than the general population (Knight et al., 2019) thus it is essential that the underlying

causes of this disparity including poor access to services, social and economic disadvantage and lifestyle factors are addressed to maximise the chances of their pregnancy resulting in a positive outcome (Aspinall and Watters, 2010, Higginbottom et al., 2019, Shortall et al., 2015). Ukoko (2007) discusses the potential negative impact of destitution on pregnant women's health. It is important to understand women's experiences of pregnancy and destitution including their specific needs to maintain their health in order to provide midwifery care which meet these needs.

A review of the literature revealed very little published research around the experiences of forced migrant pregnant women who are destitute. Much of the literature is unpublished reports found on voluntary sector websites. Nyiri and Eling (2012) undertook a survey of 112 attendees to a specialist GP London based clinic for destitute refugees and asylum seekers. The sample included 10 pregnant women in the second and third trimesters of their pregnancies. The participants received no formal antenatal care and generally had poor physical and mental health. It is estimated that around 20% of maternal deaths in high income countries are due to women not receiving adequate antenatal care (Downe et al., 2009) and being destitute could influence the decision on whether to attend. It is important to understand women's experiences of accessing midwifery care in order that their needs can be met. In particular, we need to understand how midwives, other health professionals and voluntary sector services can best support women in this position. In addition, evidence is needed to change national and local policy to ensure women and their babies avoid destitution and remain safe and healthy. We report on a phenomenological study undertaken with the aims of exploring forced migrant women's lived experience of being pregnant and destitute and understanding the

gaps in support for these women in order to influence local and national policy and address these gaps.

Methodology:

A hermeneutic phenomenological approach was undertaken to seek to understand how forced migrant women interpret and find meaning from their lived experience of destitution during pregnancy (Jacobsen, 2017). Women were purposefully recruited via local voluntary sector groups, word-of-mouth, and through friends and peers. An element of 'snowballing' was important to access women who may be hard to reach but fit the study inclusion criteria (see table 1). A pilot interview was undertaken with a refugee woman to test the wording and cultural acceptability of the questions. In depth interviews were then undertaken with six women who had experienced destitution at some time whilst pregnant. Six participants are considered the minimum number to obtain rich data in phenomenological studies (Todres & Holloway, 2011) and due to difficulties finding women to participate, six interviews were considered a pragmatic approach to ensure contemporary data is presented. The interview questions were framed in a way to encourage participants to explore their lived experiences of being pregnant and destitute. Women were asked to broadly discuss their experiences, and the interviewer followed up with additional prompts (see table 2). Interviews were audio recorded and data were transcribed verbatim by the researchers. The interviews were undertaken in a location convenient to the woman either in a voluntary sector office space or her home. The interviewers were two experienced voluntary sector workers (first and second authors) who were known to the women. Although this helped to build trust during the interviews, the interviewers were not migrant women. To ensure the authenticity

of the findings, the research team agreed the themes and direct quotes to include within the article.

Ethical issues

Ethical approval was granted by the Chair of the Humanities, Social and Health Sciences Research Ethics Panel at the local University ref E640. Women who expressed an interest received an information sheet and were phoned by the researchers to arrange an interview. English language ability was assessed by an experienced voluntary sector worker familiar to them and an interpreter identified if required.

Prior to the interview, verbal consent was obtained via the audio recorder. A signature was not requested because of the possible fear of it being acquired by the Home Office, influencing their migration status. Anonymity and confidentiality were assured; it was stressed that the researchers had no link with the Home Office and that the data would only be used for research purposes. Audio recordings were destroyed once transcribed and the transcripts were stored in a password protected computer file accessible only to the researchers. To enhance anonymity, minimal demographic data were obtained. No quotes were included where a participant could be identified.

Due to the nature of the subject, the researchers were aware that participants may be describing some difficult experiences. If participants appeared uneasy or distressed the researcher offered to pause and wait until the participant felt able to continue or discontinue the interview. In either case, the participant was de-briefed

and signposted to counselling services if required. Participants were informed that they could withdraw their consent within four weeks of the interviews and their data would be destroyed.

Data analysis

Thematic analysis was undertaken guided by Braun and Clarke (2006). Using Microsoft word, codes were identified from the data then grouped together to form working categories. Similar categories were then merged together to create the final themes. All the research team approved the final themes to ensure rigour in the process.

Findings

All the women who participated in this study originated from different countries in the African subcontinent. They had lived in the UK for between one to ten years and four of the women required an interpreter (see table 3).

From the data, four themes emerged which represented the women's lived experiences of destitution in pregnancy; having nothing, a place to call home, suffering mental and physical health issues; and searching for support. The themes are discussed below, with the participant number identified.

1. Having nothing

All the women discussed their experiences of scarcity during their period of destitution. Four women were destitute when their pregnancy was confirmed and the

remaining two women became destitute in early pregnancy. In both cases , the women's partner forced them to leave home due to the pregnancy. One of these women described her experience of domestic violence which led to her destitution:

'the relationship with my partner was not working, a bit of violence, and then he broke up with me…and then... I was destitute' w2

Every participant interviewed was refused financial support from the Home Office or their local authority. One woman who was seeking asylum was accused of working illegally in a salon and her application for support was refused. Other women had been refused asylum and were appealing the decision. One woman was refused support when she applied for asylum because she told the Home Office she had somewhere to live. In reality, she was only allowed to stay with a friend for two weeks, after which she became destitute until the end of her pregnancy. She was not informed that she could apply for accommodation or financial support once she became homeless. One woman remained destitute until she was six months pregnant, whereas the remaining women were destitute until they were term or in the early postnatal period.

Despite having nothing, many of the women discussed their fear of being charged for maternity care due to having no recourse to public funds. One woman who had gestational diabetes described how being billed for her care deterred her from attending future appointments:

'…£519, £900, the other one was £1,000 something….visit for maternity, visit for the Diabetic Clinic…I was shocked and I was disturbed and I was frightened. I was thinking

how, I don't think I'm going to give birth in the hospital. Where am I going to get the money?…'w5

For each of the women interviewed, the central impact of having nothing was hunger. During their destitution, women went without eating for prolonged periods of time:

'Sometimes I would live for the whole day I didn't eat' w2

This feeling of hunger was exacerbated for women who were exposed to food in different contexts but couldn't eat due to a lack of money:

'..when she was wanting to eat something, or she will smell it, but she can't get to it because she's got no money.'W6

This was also the case for women who were offered food but could not eat it:

'I vomit a lot, I can't like.....keep down…and then because I don't want to disturb people…so whatever they cook I try… I tried to push myself' w3

Some of the women accessed small amounts of food through charities, though one woman described how this made her ill because the food was out of date:

'I eat some of the food, and I was poorly, I got a runny tummy, I had a fever, I was really poorly. I had no option, that's the only food I have…'W2

2. A place to call home

All of the women discussed their negative experience of living in poor and precarious conditions while they were pregnant and destitute. None of the women interviewed had a permanent living arrangement until they received Section 4 support from the Home Office after their 34th week of pregnancy. In the meantime, they moved around different types of accommodation. One woman had to leave her home when she separated from her partner and became destitute at this point. She slept in the internal stairwell at the entrance to the block of flats in which she had lived. She ensured she was not seen by vacating the flats in the daytime:

'I wait till people go in, late, a little bit later because you know the fire exits, the stairs, people don't use them that much. They use the lifts before they come in the morning to clean, the council cleaners come and I'm out' W2

All the women 'sofa surfed', moving around between different friends' houses. This involved living in cramped conditions and sleeping on a settee or even the floor. Despite this, many women described feeling grateful for having somewhere to stay:

'I can sleep on the floor, it is better for me than to stay in the street' w1

However, women also described feeling deeply uncomfortable for intruding on their friends' lives and privacy. One woman told researchers that she tried to spend most of the daytime outside:

'Because one of my friends she's night shift working and she sleep in the daytime, and then her house very tiny, and then I don't want to disturb her…and then when I go to

toilet her toilet…I am scared to flush because I don't want to disturb her, so I want to stay outside, better for me, I go outside every time' W3

As previously stated, all women were eventually provided with accommodation by the Home Office. Their experience of Home Office accommodation varied, and some women told researchers that they did not always feel safe. One woman told the interviewer about her experiences of racism from other residents in temporary accommodation:

'The lady..she was staying in the opposite room…if I come out the room..she start calling me names…I was shaking like this..and, that's the only entrance…I was so scared, she did it once, she did twice, she did it three times, it was what she was screaming, she stands on the stairs blocking me not to pass, not to go down. And then I said 'what have I done to you... you don't know me, I don't know you' w2

and then she said responded with a profane racist remark.

Women also discussed how the Home Office accommodation they were provided with was not suitable for a pregnant woman or a woman with a new baby:

'It was bad, the conditions…the living room, it was smelly…the sofas they were dirty, they stink, they smell, believe me as soon as you enter it was so dirty, the carpet was full of stain' W2

3. Suffering mental and physical health

All of the women who participated in this study reported a deterioration in their mental health. They described feeling scared, lonely, helpless, traumatised, sad, vulnerable, ashamed and angry. One woman described how she felt confused by the situation she was in:

'I imagine how can I survive with a baby, like more scary, and then at the same time happiest, because I feel, oh I have a baby, and then in the future like you are going to be mum like that I feel, two confusing feelings' W3

Other women described feeling very depressed, with thoughts of giving up and committing suicide:

'I feel weak. I feel tired, I feel hopeless. I feel like there is no hope for me, there is no life. I nearly give up.' W2

Despite the danger posed back home, one woman described how she was so desperate in her current situation that she wanted to be at home with her parents:

'*I want to go back to my country because there is not anywhere to stay here, there is no house for us, I am crying all the time because I know I don't like to be here*...'W4

One woman was granted section 4 support by the Home Office at the end of her pregnancy and was subsequently dispersed to a new city where she did not know anyone and gave birth alone. She described how this impacted her mental health:

'..It broke me a lot because I was lonely, I had no-one to talk to, I had no-one to say, no-one just to give me just 5 minutes break, "can I just hold the baby for you?" Just for 5 minutes'…W5

Once their period of destitution ended and their baby was born, most women described an improvement in their mental health:

'…when she gave birth, she was so happy…she didn't forget everything, but she started forgetting some things and that's because she was in a better place, she had just giving birth to a healthy baby and she was healthy….she had a baby and that was hers ….' W6

However, one woman developed postnatal depression which she felt was a result of the social isolation and loss of health care due to being dispersed to a new city:

'I thought I was a strong woman…I could face anything…But now considering the dispersal to (new city)…it broke me a lot because I was lonely, I had no-one to talk to..' W5

It is noteworthy that multiple women described being 'broken' by their precarious and isolated experiences. Another concern for women throughout their period of destitution was their physical health. Weight loss due to a lack of food, insomnia and headaches were commonly experienced. One woman described how she developed pelvic pain in pregnancy that affected her mobility, to the point that shehad to crawl to move around. Another woman developed gestational diabetes which was poorly controlled due to not having the money to eat properly. She described an occasion in

the early postnatal period where she had to walk alone with her newborn baby to her GP when she became unwell:

'…I was going to the GP, my diabetes was high by then just after giving birth and I was shaking' W5

4. Searching for support

Women discussed their experiences of trying to get support from different places to help them meet their basic needs. Most of the women interviewed understood the Home Office and their local authority to be the main sources of support, however, they were all informed they were not entitled to receive any help until 34 weeks into their pregnancy. One woman visited her local authority on a daily basis begging for somewhere to live:

'Sometimes she take her luggage and everything and they tell her go away straight away and they didn't give her any house and (she) even (had) her bags with her' W1

Another woman applied for section 4 support at 34 weeks gestation but did not receive anything until the baby had been born and she was discharged from hospital to new accommodation:

'…till she has her baby…two days only they give her this house and they didn't have anything, there is no bed, no anything' W4

One woman described feeling intimidated by social workers, who had previously stated that they could not help her due to her immigration status.

'…that's the time they start calling me, they start coming around, they start pushing themselves to me they start saying that if I see my ex, they were going to take my baby from me at that time I was pregnant… The time I needed you guys, you said I'm not entitled to, you can't help me. They said at that time you were not entitled to public funds' W2

Another woman described how she was left destitute until 37 weeks gestation when Home Office section 4 support started. She was dispersed to a new city where she knew no-one and lost her social support, midwife and doula:

*'…It was a strange city. I haven't been in ***. I didn't know anything and what they did was just give me a couple of papers to look, to find my way through to the new GP, to the hospital….I didn't have a midwife' W5*

All the women interviewed relied on the voluntary sector to get support when they were destitute. They were signposted to sources of support for food and other basic necessities. Some women were also housed in temporary accommodation. However, the voluntary sector could not always help:

'They didn't want to host me, that shelter, because I didn't have my UK residency...'W2

Women discussed how voluntary sector workers as well as independent members of the community went out of their way to support them. Some helpful individuals wrote to the Home Office about women's circumstances. They also helped one woman by

sourcing her and her new born baby furniture for their new empty house, going to buy the food, and picking up medicines:

'She (voluntary worker) has to go and get me paracetamol. I was not able to go out. She has to go shopping for me and bring food. There was a lady who used to work with her they used to come pick me up and go and help me for shopping' w2

The women discussed how they relied on the kindness of friends and neighbours to help them out with food and somewhere to stay:

'A gentleman called B who used to bring the shopping round every week…that really touched her heart…she classes him as a grandad. He was so nice and he would come round and give her 20 pounds, just so that, you know, it would be a help toward her transportation, because she had no money obviously..and yeah, she thinks very highly of him…' W6

Some women also relied on the local church:

'I am going to church, and then I meet my other, my country people, and then they help me sometimes because they know I am (have) not nothing..they give me like £5, like that, for bus…'W3

However, one woman discussed how she avoided relying on friends who were the same ethnic background due to the fear of gossip:

'there is something, with the African people, you don't want people to know about you, because they gossip. So, there's a point in time I prefer to just struggle on my own, then I go and meet someone who is from the same country or the same colour I was scared of what they would say behind my back'. W2

Some women described how they attended a specialist antenatal support group run by the voluntary sector which provided them the opportunity to gain support from their peers:

'…they help her and she said she sometime talking to them it make her happy as well… W1

The classes included socialising but also learning about pregnancy and childbirth:

'…chatting and each one themselves they are pregnant…massage, everything, it was very wonderful, and as well..I learn a lot about pregnant, how it will happen, the step…'W3

Women discussed the support they received from midwifery services. Some women had been referred to specialist migrant women midwives and found the midwives really understood their needs beyond the pregnancy:

'Because when a person gets pregnant, you're an asylum seeker, if you're a refugee and you get pregnant, you're in a certain country, new laws, new policies, new things, no-one, you have no-one. It's like in middle of nowhere in your life but you are with, someone (midwife) comes to you, to your rescue, listens to whatever rubbish you're saying, crying whatever, talking whatever but listens to them, gives you advice.' W5

However, despite this, midwives could not always help the women overcome their experiences of destitution:

'my midwife, her name is P, she was very kind and lovely and she tried to help us because every month she came to see me in new house, yeah. And, she tried, but

you know that the council say... we can't give you a home now... in the beginning of my pregnancy... where can I stay?. W4

Experiences of midwifery care in hospital varied with some women describing a lack of continuity of care in hospital as a negative experience:

'Yeah, and then I will tell them, because I, my feeling like vomiting, and then they refer me in hospital, and then they have midwife, but every day different midwife, not like the same one.' W3

Another woman (who was homeless and alone) was advised to return home when her membranes spontaneously ruptured until her contractions became more established:

"Ah, we don't have bed, you have to go back house," she said she can't go back, and then she stay downstairs in the...(hospital) coffee shop So painful. Yeah, everyone seeing me. W3

However, other women described positive experiences, one woman explaining how a midwife acted as an advocate for her:

'The midwife in the hospital where I gave birth, they had to tell the social worker to leave me alone, I just went through caesarean, I am not strong enough, they should stay away for the moment. The midwife had to intervene…'W2

Discussion

This study confirms that migrant women who are destitute in pregnancy face many difficulties which impacts on their mental and physical health. These difficulties relate to having no money for food, being homeless and having to move around frequently. For the majority of their pregnancies, women could not access support they needed from the Home Office or their local authority. Midwives were generally seen to be kind and helpful. However, the extent to which they could help women in this context was limited. The findings add to the evidence around pregnant migrant women and destitution. It supports previous studies around the impact of destitution on people more generally (Fitzpatrick et al., 2016, Dudhia, 2020, Allsopp et al., 2014a). It also supports previously published research which includes some discussion of destitution in pregnancy (Lephard and Haith-Cooper, 2016), although this study was small and therefore limited in its transferability.

Hunger was the prevailing difficulty for women who didn't have the funds to buy food and relied on charity and friends to feed them. Often the women could not eat the food due to pregnancy nausea and one woman described how eating food past its sell by date made her ill. This reflects previous research around the experiences of destitute people (Fitzpatrick et al., 2016, Allsopp et al., 2014a) where hunger was found to be the biggest issue and food they received from sources such as charities and friends was sometimes inadequate. For instance, dried pasta or rice is not appropriate as a donation for those with no access to kitchen facilities. It is well documented that the nutritional status of women in pregnancy, especially in the first trimester impacts on embryonic development and can lead to small for gestational age and preterm babies (Ramakrishnan et al., 2012). It is essential therefore that migrant women who are destitute have access to a well-balanced diet.

In this study, all the women were homeless for the majority of their pregnancy and had to 'sofa surf', moving around different homes which often included sleeping on the settee or floor. In the daytime, many women felt obliged to leave the house so as not to become a burden on the residents. In addition, when women were provided temporary and permanent

housing, this was frequently considered inappropriate and unsafe for a pregnant woman or new mother. Poor living conditions are unlikely to support good health in pregnancy due to poor quality sleep, increased stress and a lack of shelter in the day time. In this study, unstable living conditions also led to an interruption of maternity care, when the opportunity of accommodation involved moving cities. This reflects findings from previous studies which focused on the impact of dispersal in pregnancy and the impact on women especially related to social isolation and interruptions to health care (Lephard and Haith-Cooper, 2016, Feldman, 2014). The woman in our study who was moved to a new city had gestational diabetes and the interruption to her care could have been life threatening.

All the women reported that destitution had a negative impact on their mental health, reflecting previous research (Fitzpatrick et al., 2016, Allsopp et al., 2014a). Forced migrant women can have poor underlying mental health due to their experiences of violence and conflict back home, losing their family and support networks and the hostile environment they may face in their host country (Zimmerman et al., 2009, Merry et al., 2017). Poor mental health in pregnancy can lead to preterm birth and low birthweight babies (Stanevaa et al., 2015). Antenatal depression is a risk factor for postnatal depression (Gaillard et al., 2014) and an exacerbation of mental health symptoms due to destitution can only increase the likelihood of women developing severe postnatal depression.

Women in this study sought much of their support from the voluntary sector, reflecting previous work. A Joseph Rowntree Association report found that people who were destitute had positive experiences of the voluntary sector in accessing food, clothes and toiletries (Fitzpatrick et al., 2016). In this study, women reflected on experiences of voluntary sector workers going above and beyond their role to support women in difficult situations. The Home Office and local authority were criticised by the women interviewed in this study as being unhelpful and rigid until they reached 34 weeks gestation. Even then, support should take five days to process. In contrast, women were often left waiting until the early postnatal

period until any support began. It is essential that women are healthy in early pregnancy to promote embryonic development however there is no system in place to support destitute women at this stage in their pregnancy. In addition, support should not include dispersing women to a new city during the Home Office defined protected period of 36-42 weeks gestation (UK Visas and Immigration, 2016). In this study, for one woman it led to a loss of her midwifery care and she gave birth alone having lost her doula support. She became socially isolated and developed postnatal depression. Although this study found numerous positive examples of voluntary agencies, religious groups and individuals helping forced migrant women, this help is a poor substitute for the core provisions women need from their local authorities.

This study is limited, with a small sample of women who all originated from the African subcontinent. This was likely because the study was advertised through word of mouth and these women may have been in a similar social network. However, the women had lived in the UK for 0-10 years. More than half the women interviewed required an interpreter which may have provided an insight into a group of women who are seldom heard because of language barriers. Data were not collected relating to the NHS Trusts in which the women received their midwifery care and it became apparent that some women had experienced good quality care from specialist midwives but not always from hospital midwives. No other published midwifery research could be found related to destitution in pregnancy therefore these findings provide an insight to a phenomenon not previously explored.

Implications for midwifery practice

Although we found examples of positive midwifery care, some women felt that the midwives were limited in what they could do to help. A recent systematic review found that migrant women described positive health care professionals as ‘caring, confidential and openly communicative in meeting their medical, emotional, psychological and social needs’ (Higginbottom et al., 2019, pg 1). In this study, women described experiences where

specialist midwives were clearly knowledgeable and caring. Examples include midwives offering to write letters of support for women to the Home Office. However, midwives were not always able to meet women's social needs including the need for a home and funds for food. Further, our evidence suggests that women did not always experience appropriate care from hospital midwives. Clearly, when advising forced migrant women about their care, midwives need to consider the implications of this from a holistic perspective: advice to return home in early labour if the woman does not have a home is not an appropriate response. A way of considering forced migrant women's holistic needs is by referring to the 'pregnant woman within the global context model, placing the woman at the centre of her care and considering her wider holistic needs within a local, macro and global context' (Haith-Cooper and Bradshaw, 2013). In thinking of the women in their care within their wider global context, midwives can better visualise the social and political challenges forced migrant women face, such as destitution. Although midwives are not in a position to change these material outcomes, a greater acknowledgment of forced migrant women's experiences can lead to more sensitive care and support.

Another recent systematic review found that midwives need to provide care underpinned by team work across multiple agencies (Fair et al., 2020). Our study demonstrates how midwives need to work in collaboration with the voluntary sector, the Home Office and local authorities to ensure destitute migrant women do not fall between the gaps in support. To work with a holistic approach, midwives may benefit from increasing their knowledge of migrant-specific voluntary services to direct women towards. In addition, midwives who are aware of some of the legal issues surrounding migrant women's access to support can be more helpful to vulnerable women, as our study shows, because they can engage with the Home Office to push for support.

There are specialist midwives in areas of the UK who have been trained to understand the wider holistic needs of forced migrant women. Increasing the provision of specialist midwives

could improve support for women in other areas. In addition, the voluntary sector antenatal groups run for forced migrant women is an example of good practice where women feel well supported, make friends, are signposted to other services such as mental health support and learn about pregnancy and childbirth. In the context of this study, an antenatal group was run by the National Childbirth Trust (NCT) and similar voluntary sector models could be implemented across the UK to ensure women have the same opportunities.

Conclusions

Being destitute while pregnant is an important issue that can affect forced migrant women's mental health and also the physical health of the mother and baby. There is very little research focusing specifically on pregnancy, forced migrant women and destitution. This study found that women were hungry, had nowhere to live and relied on support from friends and the voluntary sector until they could apply for section four support from the Home office at 34 weeks gestation. It is important that midwives are able to identify specific risk factors in pregnancy experienced by forced migrant women who may be destitute. Also, that all midwives are knowledgeable about destitution and how they can help, which could be achieved by training more specialist midwives. Destitution in pregnancy is a real issue for forced migrant women and their need to be changes to policy to ensure women do not have to wait until 34 weeks gestation before they can apply for Home Office support.

References

ALLSOPP, J., SIGONA, N. & PHILLIMORE, J. 2014a. Poverty among refugees and asylum seekers in the UK An evidence and policy review. *IRIS Working paper series.* Birmingham: University of Birmingham

ALLSOPP, J., SOGONA, N. & PHILLIMORE, J. 2014b. Poverty among refugees and asylum seekers in the UK. An evidence and policy review. Birmingham: University of Birmingham.
ASIF, S., BAUGH, A. & JONES, N. 2015. The obstetric care of asylum seekers and refugee women in the UK. *The Obstetrician & Gynaecologist,* 17**,** 223-231.
ASPINALL, P. & WATTERS, C. 2010. Refugees and Asylum Seekers. A Review From an Equality and Human Rights Perspective. Manchester: Equality and Human Rights Commission.
BRAUN, V. & CLARKE, V. 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology,* 3**,** 77-101.
CARTER, M. 2017. *Red Cross figures reveal new mums and pregnant women left destitute by admin delays* [Online]. The Red Cross. Available: http://blogs.redcross.org.uk/refugeesservices/2017/05/red-cross-figures-reveal-new-mums-pregnant-women-left-destitute-admin-delays/ [Accessed 30th March 2018].
DOWNE, S., FINLAYSON, K., WALSH, D. & LAVENDER, T. 2009. "Weighing up and balancing out": a meta-synthesis of barriers to antenatal care for marginalised women in high-income countries. *British Journal of Obstetrics and Gynaecology,* 116**,** 518-529.
DUDHIA, P. 2020. Will I ever be safe? Asylum seeking made destitute in the UK. London: Women for Refugee Women.
EUROPEAN COMMISSION. 2020. *Migration and Home Affairs* [Online]. Available: https://ec.europa.eu/home-affairs/what-we-do/networks/european_migration_network/glossary_search/forced-migrant_en [Accessed 28th March 2020].
FAIR, F., RABEN, L., WATSON, H., VIVILAKI, V., VAN DEN MUIJSENBERGH, M. & SOLTANI, H. E. A. 2020. Migrant women's experiences of pregnancy, childbirth and maternity care in European countries: A systematic review. *Plos ONE,* 15**,** e0228378.
FELDMAN, R. 2014. When maternity doesn't matter: Dispersing pregnant women seeking asylum. *British Journal of Midwifery,* 22**,** 22-28.
FITZPATRICK, S., BRAMLEY, G., SOSENKO, F., BLENKINSOPP, J., JOHNSEN, S., LITTLEWOOD, M., NETTO, G. & WATTS, B. 2016. Destitution in the UK. Joseph Rowntree Foundation.
GAILLARD, A., LE STRAT, Y., MANDELBROT, L., KEÏTA, H. & DUBERTRET, C. 2014. Predictors of postpartum depression: Prospective study of 264 women followed during pregnancy and postpartum. *Psychiatry Research,* 215**,** 341-346.
HAITH-COOPER, M. & BRADSHAW, G. 2013. Meeting the health and social care needs of pregnant asylum seekers; midwifery students' perspectives: Part 3; "The pregnant woman within the global context"; an inclusive model for midwifery education to address the needs of asylum seeking women in the UK *Nurse Education Today,* 33**,** 1045-1050.
HIGGINBOTTOM, G., EVANS, C., MORGAN, M., BHARJ, K., ELDRIDGE, A. & HUSSAIN, B. 2019. Experience of and access to maternity care in the UK by immigrant women: a narrative synthesis. *BMJ open,* 9.
JACOBSEN, K. 2017. *Health Research Methods, a Practical Guide,* USA, Jones and Bartlett.
KNIGHT, M., BUNCH, K., TUFFNELL, D., SHAKESPEARE, J., KOTNIS, R., KENYON, S. & KURINCZUK, J. 2019. Saving Lives, Improving Mothers' Care. Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015-17. Oxford: National Perinatal Epidemiology Unit.

LEPHARD, E. & HAITH-COOPER, M. 2016. Pregnant and seeking asylum; exploring experiences 'from booking to baby'. *British Journal of Midwifery,* 24**,** 130-136.
MERRY, L., PELAEZ, S. & EDWARDS, N. 2017. Refugees, asylum-seekers and undocumented migrants and the experience of parenthood: a synthesis of the qualitative literature. *Globalization and Health,* 13.
NICE 2010. Pregnancy and complex social factors. A model for service provision for pregnant women with complex social factors. London: National Institute for Health and Clinical Excellence.
NYIRI, P. & ELING, J. 2012. A specialist clinic for destitute asylum seekers and refugees in London. *British Journal of General Practice,* 62**,** 599-600.
PETCH, H., PERRY, J. & LUKES, S. 2015. How to improve support and services for destitute migrants. London: Joseph Rowntree Foundation.
RAMAKRISHNAN, U., GRANT, F., GOLDENBERG, T., ZONGRONE, A. & MARTORELL, R. 2012. Effect of Women's Nutrition before and during Early Pregnancy on Maternal and Infant Outcomes: A Systematic Review. *Paediatric and Perinatal Epidemiology,* 26**,** 285–301.
SHORTALL, C., MCMORRAN, J., TAYLOR, K., TRAIANOU, A., GRACIA DE FRUTOS, M., JONES, L. & MUR-WILL, P. 2015. Experiences of Pregnant Migrant Women receiving Ante/Peri and Postnatal care in the UK. A Doctors of the World Report on the Experiences of Attendees at their London Drop in Clinic. London: Doctors of the World.
STANEVAA, A., BOGOSSIAN, F., PRITCHARD, M. & WITTKOWSKID, A. 2015. The effects of maternal depression, anxiety, and perceived stress during pregnancy on preterm birth: A systematic review. *Women and Birth,* 28**,** 179-193.
UK VISAS AND IMMIGRATION 2016. Healthcare Needs and Pregnancy Dispersal Policy. 3 ed. London: Home Office,.
UKOKO, F. 2007. Childbearing women with no recourse to public funds: the health and social implications. *MIDIRS Midwifery Digest,* 17**,** 585-587.
ZIMMERMAN, C., HOSSAIN, M., KISS, L., HOEY, J., WENEDEN, K., BHATTI, S. & CHRISTIE, G. 2009. Asylum-Seeking Women , Violence & Health : Results from a Pilot Study in Scotland and Belgium. London: London
School of Hygiene & Tropical Medicine and Scottish Refugee Council.