Covid 19 Vaccine in Pregnancy: Don't forget Pregnant Women and People Seeking Asylum

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Summary

Pregnant women and people are at an increased risk of severe disease and pregnancy complications if they contract severe acute respiratory syndrome coronavirus 2. In April the Joint Committee on Vaccination and Immunisation (JCVI) advised this group to take the Pfizer/BioNTech or Moderna COVID-19 vaccines; however, recent data from Public Health England (PHE) indicate that this population are vaccine hesitant. As midwives urge this cohort to get vaccinated, consideration should be given to pregnant women and people seeking asylum so that they are not left out. This population experience significant health and social inequities which place them at a higher risk of developing serious illness from COVID- 19. This article considers the risk factors for infection and the barriers and facilitators for COVID- 19 vaccines in pregnancy. This article uses the term 'pregnant women and people seeking asylum' as it focuses on the people seeking asylum and not their status.

Risk Factors

Pregnant women and people are vulnerable to infectious pathogens due to changes in immune, respiratory, and cardiovascular physiology that occur during pregnancy.[1] Data from the UK Obstetric Surveillance System (UKOSS) show that this population are more likely to be admitted to an Intensive Care Unit, require ventilation and have an increased risk of caesarean section and iatrogenic pre-term birth.[2]

Why do pregnant women and people seeking asylum have an increased risk of developing severe illness from COVID-19 infection?

Pregnant women and people seeking asylum are a marginalised group outside of 'mainstream society'[3] making them highly vulnerable. They experience significant health and social inequalities which along with difficulties and delays in accessing healthcare puts them at high risk of becoming infected and severely ill with COVID-19.[4] They may have or be unaware of pre-existing congenital heart disease, hypertension and diabetes and/or untreated infectious diseases such as malaria and tuberculosis which are common to this group.[5] These conditions as well as being from a non-white ethnicity are risk factors for severe COVID- 19 in pregnancy.[6] Furthermore, data show that childbearing women and people from black and minority groups are more likely to die from causes directly related to COVID- 19 than their white counterparts.[7]

People seeking asylum are housed in overcrowded Initial Accommodation centres with shared amenities.[8] This has implications for social distancing especially if they are living with non-believers of COVID- 19 or, if they have been identified as 'extremely vulnerable'. Whilst their claim for asylum is being considered they are excluded from receiving benefits and are not permitted to work. Under the Immigration and Asylum Act 1999[9] they receive a basic level of financial support which is insufficient to support their most basic needs. Buying food and toiletries involves shopping around to make their budget stretch thereby increasing their exposure to the virus.[6] With limited access to open spaces and a meagre

subsistence, they may be unable to carry out simple yet effective public health measures of social distancing and handwashing leaving them unable to protect themselves from becoming infected. This is concerning, where in the absence of COVID- 19 it is already known that they have worse outcomes in pregnancy[10] including death.[11]

Barriers

People from this group are likely to face significant barriers accessing the vaccines.

> What factors might prevent pregnant women and people seeking asylum from accessing the vaccines?

Firstly, they are living below the poverty line, they do not have long-term security and are at risk of being deported. Day to day survival and their application for asylum or appeals may take precedent over getting vaccinated. Secondly, beliefs about health, ill-health and how to prevent illness and disease can be influenced by culture and religion. For example, some individuals may have a belief that receiving a vaccine interferes with God's will. Other significant barriers include access to and accurate information about the vaccines.

Harsh policies emanating from the Immigration Acts of 2014 and 2016 have embedded immigration controls into the NHS.[12] Policies such as charges to overseas visitors, routine immigration checks and data sharing of addresses with the Home Office are often perceived to be implemented by healthcare workers. Consequently, this creates a 'hostile environment' and prevents people without appropriate immigration status from accessing healthcare.[12] People who have been

refused asylum and are unable or afraid to return to their country become undocumented migrants and are amongst those affected. At the start of the pandemic, the UK Government introduced a temporary armistice whereby anyone seeking a test or treatment for COVID- 19 infection would not be subjected to any charges or checks on their immigration status. In February this was also extended to include the vaccines. There is also no requirement to have an NHS number or to be registered with a General Practitioner.[13] Unfortunately, evidence shows that many people are unaware of this information with tragic accounts of people dying at home from COVID-19 infection because they were too afraid to seek medical assistance.[14] A lack of knowledge, a fear of being charged and a mistrust of public institutions may therefore prevent access.

Financial barriers such as the cost of public transport may deter individuals even though the costs are reimbursed as they are forced to choose between buying food or paying for transport. Crucially, previous bad experiences of contact with healthcare workers may also be a barrier. The UK Border Agency policy of dispersal[15] disrupts continuity of care and hence relationship building with midwives. The negative reporting of people seeking asylum in the media influences wider society and exacerbates stigma. Regrettably, in the maternity setting there is evidence of individuals experiencing discrimination, racist abuse, hostility and receiving different treatment to that of the host population.[8] Hence, previous experiences of discrimination by healthcare workers can prevent access to the vaccines.

Digital exclusion, limited language and literacy skills can make it difficult for individuals to access accurate information about the vaccines. Limited availability of interpretation services[8,16] and written health information in community languages[8] despite national guidance[17] has been well documented pre- COVID-19. Unfortunately, the pandemic has further compounded these issues. The move to remote working has resulted in many health services being provided on-line. As a consequence, access to official information about the vaccines through this channel will only be accessible to those individuals that can pay for broadband or mobile data, have access to appropriate technology and have the necessary digital skills.[4] Even if digital access were supported, there is a dearth of online COVID- 19 vaccine information in community languages[18] with revisions to the updates trailing behind the English updates.[4] Currently, PHE has made available vaccination information leaflets in 22 community languages representing a small fraction of the different languages spoken by people seeking asylum. Whilst the creation of further translated information may increase the vaccine up-take, it will not benefit individuals with low levels of literacy. Unable to access official information about the vaccines, individuals may be forced to rely on unofficial information or 'word of mouth' which is liable to distortion and embellishment.[18]

Vaccine hesitancy in pregnant women and people is predictable given the mixed messages from the JCVI around its safety. With limited data on the safety and efficacy of the vaccines in pregnancy, only those at high risk of exposure to the virus or with high risk medical conditions were initially advised to get vaccinated. Unsurprisingly, 'fake stories' started to circulate. They ranged from conspiracy theories about the vaccines containing a tracking device to fears that they can cause

miscarriage and infertility[19] even though there is strong evidence to refute these claims.[20] Followers of Islam have also been targeted with incorrect information that the vaccines contain porcine substances which is forbidden. This is worrying as the majority of people seeking asylum are from Muslim Countries.[21] These types of mis-information exacerbates confusion, plants scepticism and jeopardises uptake.

Facilitators

Women and people seeking asylum are a diverse population with distinct cultures, languages, experiences and needs, thus vaccine uptake can be facilitated through the provision of individualised culturally competent midwifery care. This involves midwives having the 'capacity to provide effective healthcare taking into consideration people's cultural (and religious) beliefs, behaviours and needs.[23]

How can culturally competent midwifery care facilitate vaccine uptake?

Within the context of the barriers discussed in this article, cultural differences, a mistrust of public institutions and difficulties with communication may challenge individuals from this group from forming a trusting relationship with midwives. A trusting relationship is key to breaking down barriers, allaying fears and dispelling mis-information. It is enhanced by continuity of relationship, time and interpersonal skills.[18] Whilst dispersal precludes regular contact with a known midwife, making time at appointments, a sound knowledge base about the vaccines with regards to their safety, efficacy and benefits, cultural understanding and meeting

communication needs are important elements that midwives can optimise to build trust rapidly and promote uptake of the vaccines.

Cultural understanding involves midwives being aware of the differences between their own attitudes and beliefs towards the vaccines to that of others. Furthermore, being cognisant of the social context and circumstances in which individuals live such as the discrimination and challenges they face will help to understand what motivates them to refuse or accept the vaccines as well as their sources of information which may be guiding their decision making. Conversations about the vaccines should be approached with sensitivity. An open mind coupled with a willingness to actively listen and understand demonstrates respect for their beliefs. Any corrected mis-information should be given in a respectful non-judgemental way. Discussions should be culturally and religiously tailored to address their fears and anxieties such as those in relation to being tracked, infertility and the constituents of the vaccine. Partnership working with women and people is a basic tenet of midwifery practice that facilitates individual views, preferences and decisions; however, midwives should be mindful that decision-making around many aspects of day to day life may be gender influenced[18] and this is likely to include advice, decisions and permission on taking the vaccine. When midwives have some core understanding about the culture and religion of the people they are caring for, they are more equipped for building trusting relationships which can support uptake of the vaccines.

Effective communication is key to providing a robust understanding of the safety, efficacy and benefits of the vaccines. Interpreters have a central role in facilitating

communication with a reported preference for face to face over remote interpretation.[18] The former is routinely provided by bilingual support workers and professional interpreters in NHS Trusts with large, dispersed populations and Initial Accommodation centres.[8] Their presence however can help or hinder communication. For example, individuals may be more likely to trust the interpreter if their preferences with regards to the age, gender and characteristics of the interpreter are taken into account. Equally, a good midwife-interpreter relationship may discern any vaccine biases that could influence the translation. It is for this reason that using friends and family as interpreters should be avoided wherever possible.

Language appropriate Information about the vaccines can be given in a written format to reinforce the verbal information given. This should be distributed with caution as access will be dependent on levels of literacy. Interestingly, a UK study of official websites with information about COVID- 19 during the first lockdown found that much of the information available was not readable for most of the adult population.[20] This raises questions about the readability of the translated material; furthermore, the effectiveness of using translated written materials during the pandemic is unknown.

What other marginalised pregnant individuals might be forgotten in the campaign to vaccinate the pregnant population?

Conclusion

This article has drawn attention to pregnant women and people seeking asylum as a vulnerable group. They experience challenges with protecting themselves from COVID- 19 infection and barriers to accessing the vaccines. It is crucial that they are not forgotten in the current campaign to increase immunisation within the pregnant population. Midwives can mitigate the barriers through a trusting relationship that is fostered through culturally competent care that takes account of social context, beliefs and communication needs. Whilst this article has underscored pregnant women and people seeking asylum, consideration should also be given to other marginalised groups that are living on the ‘fringes of society.’

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