May 2015

advice briefing

Housing and financial support for pregnant women who have been refused asylum

Who is this briefing for?

This briefing is for anyone who is providing support and advice to a pregnant woman who has been refused asylum and who is in need of accommodation and financial support. It is particularly relevant to midwives and other health professionals.

What is it about?

It provides information about pregnancy and birth risks associated with the pregnancies of refused asylum seeking women who are applying for housing and financial support (commonly known as section 4 support) from the Home Office. It outlines basic current medical understanding and best practice relating to pregnancy care, and highlights additional pregnancy risks facing refused asylum seekers.

How is it going to help me to help my client?

The information in this briefing will help you to complete stronger applications for section 4 support and/or to write letters to support section 4 applications by your patients or clients.

What is section 4 support?

Accommodation and financial support can be granted by the Home Office under section 4 of the Immigration and Asylum Act 1999 to destitute asylum seekers whose application for asylum has been refused. Refused asylum seekers are eligible for section 4 support under certain conditions, including on the basis of their inability to travel back to their country of origin. At present this applies to pregnant women if they are 34 weeks+ gestation or if they are recognised to have a high risk pregnancy which makes long distance travel inadvisable. Section 4 support consists of no-choice accommodation, normally outside London, and weekly vouchers.

Can all pregnant women who have been refused asylum get section 4 support?

No. The Home Office guidelines specify that section 4 support should not normally be granted to a pregnant woman on medical grounds until the 34th week of pregnancy unless there are complications with the pregnancy that may put the mother and baby at risk.[1]

Section 4 support can be difficult to obtain if the woman is at less than 34 weeks gestation.

This is why it is important that applications for support contain as much information as possible about a woman's pregnancy risk. The information below sets out issues and information which you can submit to the Home Office on behalf of your patient or client to demonstrate that there are complications in her pregnancy which make it inadvisable for her to undertake a journey back to her country of origin.

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Summary of expert report

The summary below is based on an expert report by consultant obstetrician Dr. Daghni Rajasingham who has drawn on an extensive literature.

What are high risk pregnancies?

High risk or complex pregnancies can stem from **medical complications** or **social risk factors** or a **combination of both**. All such pregnancies are at **high risk of adverse outcomes** which include pre-term births, low birthweight births, maternal infection, thrombosis, haemorrhage, hypertension and difficulty establishing breastfeeding. They also include the worsening of any existing mental health condition of the mother, and a lack of bonding between mother and baby. Infant death or miscarriage would also be an adverse pregnancy outcome, as would any health condition of the baby such as respiratory distress requiring respiratory support on a neonatal unit.

Medical complications

Medical complications can arise at any time in pregnancy and require additional care for women who suffer from them. Existing medical conditions which affect the course of a pregnancy and risk further complications are considered medical complications.

Commonly occurring medical complications in pregnancy:

- cardiac disease
- high blood pressure
- renal disease
- endocrine disorders
- haematological disorders
- autoimmune disorders
- epilepsy requiring anticonvulsant drugs
- malignant disease
- HIV or hepatitis infection
- gestational diabetes
- type 1 and type 2 diabetes
- pre-eclampsia

In addition, previous poor obstetric histories may also denote medical complications in the current pregnancy.

Conditions in previous pregnancies deemed to create obstetric medical complications in the current pregnancy:

- recurrent miscarriage (three or more consecutive pregnancy losses or a mid-trimester loss)
- preterm birth
- severe pre-eclampsia
- low platelets (HELLP syndrome)
- eclampsia
- rhesus isoimmunisation
- uterine surgery including caesarean section
- myomectomy or cone biopsy

Mental health is particularly important in pregnancy. Women with previous psychiatric disorders including depression, need to continue their treatments. Depression may increase in severity during pregnancy and afterwards, so needs to be carefully monitored

Social risk factors

Social risk factors[2] in pregnancy are social circumstances which contribute to complex health and social care needs, and which, if not addressed, can lead to poorer child and maternal health outcomes. Social risk factors should be treated as seriously as medical complications in assessing the risk of adverse pregnancy outcomes.

Social risk factors in pregnancy include:

- poverty
- homelessness or precarious housing
- domestic abuse
- asylum seekers, refugees, recent migrants and/or poor command of English
- substance misuse
- teenage pregnancies

Women with social risk factors in pregnancy often suffer from poor mental health. Such women are often extremely vulnerable and frequently find it more difficult to access maternity care early, or to attend follow-up appointments regularly due, for example, to frequent moves, language difficulties or poor mental health.

Care needs of women with high risk pregnancies

Early booking into antenatal care and continuity of care are recognised as the cornerstone of high quality care in low risk pregnancies. These practices are even more important in high risk pregnancies. Identifying and caring for women with, or at risk of, medical complications or social risk factors requires:

- good history taking at first booking
- more frequent antenatal appointments to enable careful monitoring and coordination of care throughout the pregnancy, during delivery, and postnatally
- continuity of care to enable women to form a trusting relationship with a midwife.

Why do refused asylum seekers often have high risk pregnancies?

As a general rule, **all refused asylum seekers can be deemed to have high risk pregnancies from early in the pregnancy** due to:

Destitution and homelessness

- Low birth weight infants are significantly more likely to be born to homeless women.
- Women in extreme poverty are less able to obtain healthy diets or to access medical care.
- Low birth weight babies have a significantly higher risk of morbidity and mortality.

Sub-optimal antenatal care

- The aim of antenatal care is to monitor and respond to risk factors, signs or symptoms that may affect the health of the mother and baby. Late entry to maternity care or moves between health providers can compromise the standard of vigilance expected in normal antenatal care.
- Late entry or interrupted care prevents the development of trust between the midwife and pregnant woman which enables appropriate care to be provided.

Stress

- There is evidence of a physiological link between stress and mechanisms triggering labour. Stress increases the risk of preterm delivery, and chronic stress may be an important component of some preterm births. Preterm babies have a significantly higher risk of morbidity and mortality.
- Domestic abuse and post-traumatic stress disorder (PTSD) are also linked to preterm births. Asylum seeking women are at higher risk of PTSD than the general population.
- They also have a significantly increased risk of mental health problems during pregnancy and may find it difficult to engage with healthcare services and to attend appointments. Continuity of care is critical for women with these problems because the delivery and postnatal period will predispose such women to further mental health problems.

Specific migrant and Black, Asian and Minority Ethnic health risks

- Pregnant asylum seekers are significantly more likely than the general population to have untreated or undiagnosed medical complications which give rise to adverse pregnancy outcomes.
- Health outcomes for BAME groups are also significantly worse than for the general population with maternal mortality rates up to six times higher than those of White women.
- BAME women are also at higher risk of early pregnancy complications including maternal mortality resulting from ectopic pregnancy.
- The Confidential Enquiry into Maternal and Child Health 2007[3] recommended that all pregnant women from less developed countries should have a full medical assessment and history at antenatal booking or soon after.

Maternity care for refused asylum seekers

The above risk factors are often interlinked. Maternity care for **all** refused asylum seekers should therefore include all the recommendations for care of women with high risk pregnancies. As a group likely to have high risk pregnancies, they should also be advised against any long distance travel during pregnancy.

Endnotes

1 UKBA, 2007, *Section 4 Support* (updated 2012) available at http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/asylumprocessguidance/asylumsupport/guidance/section-4-support-inst.pdf?view=Binary

2 The National Institute for Health and Care Excellence (NICE) refers to social risk factors as 'complex social factors'. See NICE Clinical Guideline 110, 2010, *Pregnancy and complex social factors*

3 Lewis, G (ed) 2007, *The Confidential Enquiry into Maternal and Child Health (CEMACH). Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer – 2003-2005. The Seventh Report on Confidential Enquiries into Maternal Deaths in the United Kingdom.* London: CEMACH.p225

Maternity Action Advice Line 0845 600 8533

If you need further information about the maternity rights of refused asylum seekers please contact Maternity Action's advice line which offers free, confidential telephone support and advice.

Our advice line is open:

- Wednesday 3pm – 7pm
- Thursday 3pm – 7pm
- Friday 10am – 2pm

Calls cost 5p per minute, plus your phone company's access charge.

Maternity Action resources

- You can download our full report *When Maternity Doesn't Matter* or the report *Summary* which describes social, physical and mental health issues faced by pregnant asylum seeking women who have been dispersed.
- Our information sheet on *Maternity rights and benefits: refused (failed) asylum seekers* sets out the entitlements of refused asylum seekers to maternity care and asylum support.

ASAP Advice Line 020 3716 0283

If you still have questions or need further information and advice, please contact our advice line on **020 3716 0283**.

It is open:

- Monday 2pm - 4pm
- Wednesday 2pm – 4pm
- Friday 2pm – 4pm

Please note that this is a 'second tier' advice line. This means that we can give advice to other professionals but not to individual clients.

ASAP factsheets

ASAP has written a number of factsheets on asylum support issues. You can find them *here*.

They include a *general introduction about asylum support for pregnant, refused asylum seekers*

And a factsheet about what sort of information you need to think about if you are *supporting a pregnant woman to **appeal*** a Home Office decision to refuse asylum support.

Please contact Maternity Action or ASAP if you would like further information about this briefing:

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ASAP ASYLUM SUPPORT APPEALS PROJECT

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