Briefing on section 4 (asylum support) pregnancy appeals October 2014

This is a briefing for advice workers who are helping pregnant women to appeal against refusals of section 4 asylum support. The aim of the briefing is to provide guidance that will help you to fill in the grounds of the appeal form and to think about any extra evidence that may be helpful in the appeal hearing.

Please also see *'ASAP Factsheet 14: Section 4 support for pregnant refused asylum seekers'* (available on our website) for more background information on this issue, including the legal and policy framework that applies**. If you are not already aware of this framework, you should read Factsheet 14 before going any further with this document.**

1) What sort of evidence should I be submitting with the appeal form?

Individuated (i.e specific to the appellant) medical evidence. This is likely to be the most persuasive to the judge:

- Opinion from woman's medical advisors on her fitness to travel
- Medical evidence from a midwife or other medical professional which outlines any issues in relation to health of mother and foetus and any complications in current or previous pregnancies
- Any additional evidence that you may have researched on the impact of a particular medical condition on pregnancy and flying.
- Be aware that potential TB infection has been accepted (in a previous appeal hearing) as a condition that precludes travel. This is not a binding decision.

General evidence for this group:

- General medical evidence on the risks associated with flying when pregnant and under particular conditions
- General medical evidence on the risks associated with certain groups (i.e BME women, migrants, refused asylum seekers) in pregnancy
- Airline guidance

- Remember to check for any opinion from the Home Office Medical Officer

2) What sort of arguments should I consider making on the appeals form?

2.1 The risk that a pregnant woman, at any stage in the pregnancy, may suffer a miscarriage, obstetric emergency or preterm birth. Your client may be at increased risk of this due to the medical evidence you have highlighted above (if available) and due to her membership of a group with higher general risk of poor maternal outcomes – see more info on these risks below.

2.2 If the evidence points to a risk of a poor maternal outcome (e.g. obstetric emergency or pre term birth), you may be able to argue that this could prove fatal to mother and/or baby if it occurred on a flight because of a lack of emergency obstetric and neonatal treatment. So, even if the likelihood of the emergency occurring appears comparatively low, you can argue that it is not a reasonable risk to expect a woman to take, bearing in mind the severity of the possible consequences.

Obviously, the higher the likelihood of a poor maternal outcome, the higher risk that this would occur and potentially prove fatal on a flight.

2.3 Foetal viability outside the womb is currently about 24 weeks in the UK. A baby born at this stage could receive neonatal resuscitation and support. This is clearly not available on an aeroplane.

2.4 Would the airline allow her to get on the flight? If she is post 28 weeks, most airlines require a certificate of 'fitness to fly' from a relevant medical professional. If the medical evidence suggests that a midwife/doctor would not sign such a certificate, argue that, on the balance of probabilities, it is unlikely that an airline would allow a woman to board a plane.

2.5 You may be able to argue that a woman would not be able to go through a process of re-documentation in order to take a flight within a timescale that would still allow her to fly. This will depend on the stage of her pregnancy and her preterm birth risk, as well as her country of origin. This argument has been successful, used in conjunction with other medical evidence of complications.

2.6 The evidence may show poor general health but not include individuated medical evidence of a high risk pregnancy or risk of flying. Look for evidence of general clinical and social risk factors (see below) and argue that there is little likelihood that a woman with a combination of poor general health and general risk factors would obtain a 'fit to fly' certificate.

3) What if there is no individuated medical evidence of complications in the pregnancy?

3.1 **Higher risk of pre-term birth (PTB)**: Research has shown that only around 4% of women have their baby on the estimated date of delivery (EDD) and only 70% deliver within 10 days of their EDD[1]. In addition to this significant disparity, research shows that women of ethnic minorities (i.e. the vast majority of refused asylum seeking women) can expect a reduced gestational term. PTB occurs before 37 weeks gestation. This has an overall incidence of 5% in developed countries as opposed to 25% in developing countries[2]. Studies have demonstrated that black and Asian women have a greater risk of delivering preterm compared to white women[3].

3.2 This disparity between estimated delivery dates (EDD) should allow for a more cogent argument for early support applications. Home Office policy accepts that women should not fly within 6 weeks of the due date and that support should be given in this window. If evidence (either

1 A.M. Jukic, D.D. Baird, C.R. Weinberg, D.R. McConnaughey, A.J. Wilcox. Length of human pregnancy and contributors to its natural variation. Human Reproduction, 2013 DOI: 10.1093/humrep/det297

2 Steer P: The epidemiology of preterm labour.BJOG. 2005 Mar;112 Suppl 1:1-3.

3 Menon R: Spontaneous preterm birth, a clinical dilemma: etiologic, pathophysiologic and genetic heterogeneities and racial disparity.
Acta Obstet Gynecol Scand 2008, 87(6):590-600.
Patel R, Steer P, Doyle P, Little M, Elliott P: Does gestation vary by ethnic group? A London-based study of over 122 000 pregnancies with spontaneous onset of labour.
International Journal of Epidemiology 2003;33:107–113

individuated or general) indicates a risk that a woman may have a preterm birth, argue that support should be brought forward to accommodate this increased risk. Argue that the HO policy is guidance only and that it does not define 'late stages of pregnancy'. A woman at risk of preterm birth is arguably in the late stages of pregnancy before 34 weeks.

3.3 **Poor general health**: There is evidence that asylum seeking women commonly have poor general health when they arrive in the UK and that their health declines in the years following their arrival[4]. It is well established that asylum seeking women and refugees are at a greater risk of complications in pregnancy due to conditions that are undiagnosed or untreated[5].

3.4 **Mental health:** Several reports suggest a relationship between depression and PTB[6]. Mental health problems are a significant issue for many refused asylum seeking women, with the experiences that many suffered before seeking asylum potentially having huge impacts on their mental health. This is then further compounded by the poverty, discrimination, exploitation, abuse, and uncertainty for the future that they experience as asylum is refused[7]

3.5 **Stress:** Multiple studies have considered both acute and chronic life stressors as a risk factor for PTB. Refused asylum seekers will have experienced high levels of psychological and social stress prior to their exile to the UK, during their asylum application process and their subsequent destitution after a failed application[8].

3.6 **Poor antenatal attendance:** It is recognised that women who have no antenatal care, book late or have poor antenatal attendance are at greater risk of complications[9]. Pregnant women living in disadvantaged situations, including asylum seekers, are less likely to have early access to, or

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[4] British Medical Association. 2002. *Asylum seekers: meeting their healthcare needs.* London: BritishMedical Association

[5] *Lewis G, ed:* The Confidential Enquiry into Maternal and Child Health (CEMACH). Saving mothers' lives: reviewing maternal deaths to make childhood safer—2003-2005*. London: CEMACH,* 2007*.*

[6] Copper RL, Goldenberg RL, Das A, et al: The preterm prediction study: maternal stress is associated with spontaneous preterm birth at less than thirty-fi ve weeks gestation.
Am J Obstet Gynecol 1996; 175: 1286–92.

[7] Reynolds B, White J: Seeking asylum and motherhood: health and wellbeing needs. Community Practitioner; mar 2010; 81.3.
Lewis G, 2007 op.cit.

[8] Sandman CA, Glynn L, Schetter CD, Wadhwa P, Garite T, Chicz-DeMet A, et al., (2006), 'Elevated maternal cortisol early in pregnancy predicts third trimester levels of placental corticotropin releasing hormone(CRH): Priming the placental clock'. *Peptides*, 27:14, pp. 57–63*.*
McGrath S, McLean M, Smith D, Bisits A, Giles W, Smith R. (2002), 'Maternal plasma corticotropin-releasing hormone trajectories vary depending on the cause of preterm delivery',*Am J Obstet Gynecol,* 186, pp. 257–60; Erickson K, Thorsen P, Chrousos G, Grigoriadis DE, Khongsaly O, McGregor J, et al., (2001), 'Preterm birth: Associated neuroendocrine, medical, and behavioral risk factors'. *J Clin Endocrinol Metab,* 86, pp. 2544–52; Herrmann TS, Siega-Riz AM, Hobel CJ, Aurora C, Dunkel-Schetter C., (2001), 'Prolonged periods without food intake during pregnancy increase risk for elevated maternal corticotropin-releasing hormone concentrations', *Am J Obstet Gynecol,* 185, pp. 403–12; Behrman, RE.; Stith Butler, A., (eds) (2007),, *Preterm birth: Causes, consequences, and prevention*, (National Academies Press: Washington, DC) Gennaro & Hennesy, (2003), 'Psychological and physiological stress: impact on preterm birth', *Journal of Obstetric, Gynaecologic and Neonatal Nursing,* 32, 5, pp. 668 – 675

[9] *Lewis G, 2007 op. Cit.*

maintain contact with, services during their pregnancy. A lack of common language, uncertainty of how the health system works and confusion over payment for health care can further compound inadequate antenatal care.

4) What about the impact of destitution on a woman's pregnancy?

Destitution: Adverse social circumstances are significantly associated with PTB[10]; women in the 'most deprived' group having a nearly twofold risk of PTB[11] and homelessness women having nearly a threefold increased risk of PTB[12].

5) What does airline guidance say?

The International Air Transport Association (IATA) recommends[13]:

- Single uncomplicated pregnancies should not travel from 36 weeks gestation and that certification of fit to fly from a doctor is required from 28 weeks.
- Multiple pregnancies should not travel from 32 weeks, and require medical certification from 28 weeks
- Complicated pregnancies require individual assessment to fly at any gestation to determine fitness to fly

Airline policy is dictated by a consideration of the risks of preterm birth (PTB) and emergency complications: 'while the aircraft environment may not be causally related to pregnancy emergencies, the aircraft environment limits the ability for a medical response. In addition, diversion to an alternate airport is expensive and disruptive to other passengers' [14]

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[10] CEMACE, 2011, op.cit. pp50-51; National Institute for Clinical Excellence (2010), Pregnancy and Complex Social Factors: A model for service provision for pregnant women with complex social factors, NICE Clinical Guideline 110 p6
Peacock JL, Bland JM, Anderson HR: Preterm delivery: effects of socioeconomic factors, psychological stress, smoking, alcohol, and caffeine.
BMJ 1995;311:531–35

[11] Smith LK, Draper ES, Manktelow BN, Dorling JS, Field DJ: Socioeconomic inequalities in very preterm birth rates.
Arch Dis Child Fetal Neonatal Ed 2007;92:F11-F14

[12] Little M, Shah R, Vermeulen MJ, Gorman A, Dzendoletas D, Ray JG: Adverse perinatal outcomes associated with homelessness and substance use in pregnancy.
CMAJ • September 13, 2005; 173 (6)

[13] http://www.iata.org/whatwedo/safety/health/Documents/medical-manual-2013.pdfetermine fitness to fly. Pg 54

[14] http://www.asma.org/asma/media/asma/travel-publications/medguid.pdf
Pg A10