

When maternity doesn't matter

Dispersing
pregnant women
seeking asylum



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challenging inequality: promoting wellbeing



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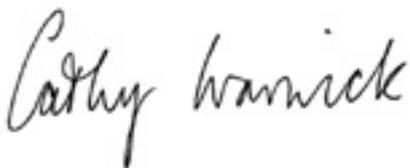
Foreword

This is an extremely important and eye opening piece of research. Much of the discussion that is entered into about maternity services focuses on the need for us to improve services from good to excellent. This report however shows very clearly that there are groups of women who are receiving care that is way below even minimum expected standards. The sad truth is that, as in other areas of health care, disadvantaged women experience the worst outcomes in pregnancy and childbirth. In this paper, the women who have provided their stories for the researchers are from the most vulnerable groups in pregnancy who actually need the highest standards of care if they are to experience good outcomes. Midwives and other health care workers know this and are doing their best to improve the care that vulnerable women receive but this report highlights that the system is working against them and failing to heed their advice or recognise their knowledge and expertise. It is shocking that in a country which, arguably, has one of the best maternity services in the world more is not being done to prevent such vulnerable women being denied high quality care.

High quality care in maternity services is about far far more than recognising major complications of pregnancy. Of course this is important but it is also about recognising the emotional component of pregnancy. Women need support in pregnancy. They need to be surrounded by a network of friends and family. They need stable and adequate housing. They need good nutrition, rest and exercise. Not only does stress and isolation impact negatively on the mother herself but it is now well known that it impacts firstly on the developing brain of the baby and secondly on the health of the baby after birth. A woman's mental health impacts on her child's future life chances. Our society has, I believe, a duty to both the mother and her baby to reduce the stress and anxiety caused by frequent dispersal of asylum seekers. This tears the woman away not only from her social network but from midwives with whom she needs to build a trusting and compassionate relationship.

All of these vulnerable women have social problems and many of them also have medical problems, such as HIV or other serious infections, complicating their pregnancy. When it comes to such disorders women need skilled input from multidisciplinary teams. It puts women at serious risk if they do not know who to turn to for care or if having started their treatment they find themselves having to form a new relationship with a new team. It is hard enough for those of us who understand the system well and are confident to negotiate these sorts of changes. Many of this group of women have little idea how services work and often will not speak English. If these women or their babies are not to suffer serious consequences we must offer them the chance of continuity of care throughout pregnancy and childbirth from a team who understands their needs.

I very much hope that this important report will be taken very seriously. Our society is failing these women and their babies. This is not acceptable particularly when the solutions are so obvious.



Cathy Warwick

**General Secretary
Royal College of Midwives**

Acronyms

ARC	Application Registration Card
CCTV	Close Circuit Television
CEMACH	Confidential Enquiry into Maternal and Child Health
CMACE	Centre for Maternal and Child Enquiries
CPAG	Child Poverty Action Group
EDD	Expected Date of Delivery
FGM	Female Genital Mutilation
GP	General Practitioner
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IDVA	Independent Domestic Violence Adviser
MW	Midwife
NASS	National Asylum Support Service
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NSF	National Service Framework
PND	Postnatal Depression
PTSD	Post Traumatic Stress Disorder
RCM	Royal College of Midwives
TB	Tuberculosis
UK	United Kingdom
UKBA	United Kingdom Border Agency

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Executive Summary

The study

This report is a collaboration between Maternity Action and the Refugee Council to investigate the health impact of dispersal and relocation on pregnant women seeking asylum and new mothers. The study reviewed UKBA asylum dispersal policy relating to pregnant women, and maternity policy and good practice on the care of vulnerable women. Qualitative interviews were carried out with twenty women who had been dispersed and/or relocated by the UKBA while pregnant.

The women interviewed had been in receipt of either section 95 support (support during an ongoing asylum claim) or section 4 support (support for asylum seekers whose claim has been refused). Recipients of both types of support are normally dispersed to 'no-choice' accommodation away from London. Financial support on section 95 is provided in cash, and in cashless form on section 4.

Seventeen midwives were interviewed by phone about their experiences of working with asylum seeking women either before or after they were dispersed.

Maternity care policy and asylum seekers

Refugees and asylum seekers are an especially vulnerable group in relation to maternity care and pregnancy outcomes. National Institute for Health and Clinical Excellence (NICE) Guidance and other policy documents draw attention to the need for special efforts and service provision for disadvantaged and vulnerable pregnant women in order to reduce levels of maternal and infant mortality.

Despite the complex social and health needs of pregnant women seeking asylum being clearly recognised in NICE guidance, the UK Border Agency (UKBA) has only acknowledged pregnancy as representing a very limited health need unless there is a major pregnancy complication. Its dispersal policies made very little allowance for the healthcare and social needs of pregnant women. Its guidance, until recently, specified no time limit for dispersal during pregnancy and expected women to be able to be dispersed within two weeks of giving birth.

The UKBA introduced new guidance on pregnancy and dispersal in 2012 in response to concerns about the impact of dispersal on pregnant women. This study provides an opportunity to explore how adequately the new policy responds to the expressed concerns of asylum seekers and midwives, and to determine the compatibility of UKBA policies on dispersal of pregnant women with mainstream maternity care policy for women with complex social factors.

Physical and mental health during pregnancy

Most women interviewed reported feeling unwell during their pregnancy. Midwives and women reported serious underlying health conditions including HIV, diabetes, other sexually transmitted diseases, female genital mutilation (FGM), as well as particular problems of pregnancy, such as severe headaches, elevated blood pressure, repeated urinary tract infections. Two thirds of the women had their first contact with a midwife later than recommended in NICE guidance, which increased risks for their pregnancies.

Over half the women described suffering from mental health conditions such as depression, anxiety and flashbacks, and very high levels of stress. Two had attempted suicide during the pregnancy under discussion. Midwives reported a disturbingly high incidence of mental health problems among the dispersed or pre-dispersal women they had looked after.

The social impact of dispersal

All the women interviewed had been dispersed or relocated during their pregnancy though only two of them were moved away from London and South East England. Fourteen women experienced multiple moves during pregnancy or immediately after the birth, including one woman, who was moved six times during her pregnancy and once after delivery before she found settled accommodation.

Women were very distressed about being dispersed away from areas in which they had strong social networks and established healthcare provision. In several cases dispersal separated women from the father of their baby.

Initial accommodation

Over half the women spent time in Initial Accommodation before being moved on. Women's feelings about Initial Accommodation were generally very adverse. They complained about dirty bathrooms and toilets, bad or inedible food, being forced to sterilise bottles in the toilets, safety issues, rooms on upper floors without lifts, and being assigned top bunks.

One woman was sent to Initial Accommodation within London and had to stay there for the 'protected period' in accordance with new UKBA guidance. However, it provided no improvement over dispersal to other areas in terms of social support, access to healthcare, suitable accommodation or even the experience of travel.

Timing of dispersal

Fourteen women were in their final trimester of pregnancy and eight were in their last month when they were moved. Two women were dispersed one day before they gave birth and another woman gave birth two days after dispersal. Women reported being moved despite their treating clinicians advising against travel.

Travel to the dispersal areas

The journeys were often very distressing. Women were often moved at very short notice, without being informed of their destination or the distance to be travelled until the last minute, or when they would be picked up. Several women reported not being able to eat during the journey, inadequate toilet breaks, and lack of assistance with luggage.

Conditions on arrival

Some women received little help to register with a GP in their new location. Women with other children faced problems enrolling their existing children into school or nursery.

Accommodation for pregnant women or those who had recently given birth was often inappropriate. There was rudimentary equipment for the baby but little effort was made to ensure adequate hygiene and sanitary facilities for newborns. Women often had to climb several flights of stairs to their rooms.

Managing financially

Women found that they had insufficient money for essential needs. The worst affected were those receiving cashless support, either on section 4 or because they were based in full-board hostels and also received no cash except a minimal pregnancy payment of £3, or £5 per week once their baby was born. One woman's support was stopped while she was in hospital having her baby, because her asylum claim had been refused, and it took two weeks to get section 4 support during which time she had no money.

The impact of dispersal on women's health and maternity care

Midwives attached great importance to regular antenatal contact with vulnerable women, emphasising especially continuity of care and of carer in order to build up trust where there were evident health and social care issues. However, most women's antenatal care was interrupted as a result of dispersal, often with breaks of several weeks before they could again receive maternity care in the new area, mainly due to difficulties in registering with GPs. Two women interviewed had been booked into three different maternity units because of multiple moves.

The interruption of care could have serious consequences for conditions such as diabetes or hepatitis, which required regular monitoring or where treatment needed to be sustained during pregnancy. It also prevented the implementation of multi-agency care packages which were particularly important if children were deemed to be at risk.

Although nearly all women who had booked into maternity services before they were dispersed, had handheld records, nevertheless, booking appointments, tests and scans often had to be repeated in the new unit to ensure that results were accurate and referred to the right woman. Information on sensitive issues such as domestic violence was not normally stored on handheld records.

Dispersal had an extremely adverse impact on women's mental health. At least five women had clinically diagnosed postnatal depression (PND). Many women found themselves in the dispersal area with no social support. They therefore had to make their own arrangements to go into hospital when they went into labour, and in some cases were frightened to call ambulances. They also had anxieties about who would look after their children, and in some cases arranged very *ad hoc* childcare.

None of the midwives interviewed were informed by UKBA of when women were being moved, or whether they were fit to travel. This wasted valuable time and public resources looking for them, and prevented planning or information sharing between maternity units. Midwives often asked women due to be dispersed to contact them on arrival at their dispersal destination, so that they could alert the maternity service in the new area, but this left the responsibility for doing this with the woman.

Where there were anxieties about a woman's or baby's welfare, midwives often tried to get a dispersal deferred or stopped, but letters to UKBA were rarely acknowledged or responded to. Midwives frequently spent a great deal of time trying to liaise with UKBA on behalf of a woman about whom they were concerned.

Women's experience of labour and the postnatal period

Eight women interviewed were in labour without any birth companion present. None of the women had an interpreter present during labour, and four had no one with them who could help interpret. While the provision of an interpreter is not the responsibility of UKBA, the lack of continuity of maternity care makes it less likely that appropriate interpreting services would be provided.

Almost all women found the postnatal period very stressful. Some felt completely unsupported because they had been moved from family and friends. Accommodation on upper floors was unsuitable for women who were in pain and weak after giving birth. Financial provision was inadequate to meet their needs, and many women had problems obtaining UKBA Maternity Payments. Women on section 4 support were unable to use public transport even though they were in pain after surgical interventions in delivery because their support was cashless.

Addressing complex social factors among pregnant women seeking asylum

In spite of some improvement, the UKBA's 2012 *Healthcare and Pregnancy Dispersal Guidance* falls far short of addressing the issues identified in the interviews with the women and midwives or in the NICE Guidelines on *Pregnancy and Complex Social Factors*. The most important recommendation of the UKBA 2012 guidance is for dispersal to be deferred during a 'protected period' of four weeks either side of delivery. However, this fails to recognise the importance of postnatal care and tests for at least six weeks postnatally.

The UKBA 2012 guidance makes no mention of mental health issues, or other health needs arising in pregnancy, nor of many underlying health problems that may affect women during their pregnancies. It does not address women's need for social support throughout pregnancy and labour. Loss of social support, not only on dispersal, but also for women kept in Initial Accommodation for at least eight weeks during the 'protected period', is very damaging to women's wellbeing.

The study shows that Initial Accommodation is wholly inappropriate for women in advanced pregnancy. In opting for women in the 'protected period' to be accommodated in Initial Accommodation, the UKBA is continuing to regard pregnancy and birth as a logistic rather than as a healthcare issue.

While formally recognising some aspects of antenatal care such as the need not to delay tests or to disrupt a programme of tests, the 2012 guidance does not indicate how its policy can contribute to avoiding such disruption earlier than four weeks before the expected date of delivery.

The policy of maintaining very low levels of cashless support forces women into poverty and limits the uses to which the support may be put, especially by denying them cash for public transport or preferred types of food from small shops rather than supermarkets.

Dispersal of women in pregnancy, especially late in pregnancy, inevitably disrupts maternity care which is a continuous and cumulative process. Maternity care costs are increased by wasting valuable resources in searching for women who have been moved without the service being informed, and by generating a need for repeat tests and scans.

The way forward

This study demonstrates a need for the UKBA to reconsider its policy of dispersing pregnant women, and for new guidance to be developed in conjunction with experts in the maternity care of vulnerable women. We urge it to take seriously the recommendations stemming from this study.

Recommendations

1. Recognise complex needs in pregnancy

UKBA should recognise pregnancy in women seeking asylum as involving complex needs, including mental health, family and social circumstances, experience of trauma and violence, pregnancy-related conditions, and underlying health conditions and reflect this in its policies and processes.

2. Maintain women's residence where they can access existing support

Pregnant women should not normally be dispersed. Case owners should ensure that pregnant women are accommodated in an area where they can continue to access existing GP and maternity care. This should mean that they are also within reach of existing social and family support.

3. Women pregnant on arrival in the UK

In order to avoid lengthy stays in Initial Accommodation women asylum seekers who arrive in the UK already pregnant, should be prioritised for dispersal and moved quickly, if they are in the early stages of pregnancy. If they are in a later stage of pregnancy they should be offered suitable accommodation near the port of entry.

4. Women applying for support late in pregnancy

- No woman should be dispersed after 34 weeks gestation, or sooner than 6 weeks postnatally. This means extending the 'protected period' from at least 6 weeks before the expected date of delivery to at least 6 weeks after. No woman should be dispersed after delivery until she has been discharged from postnatal care and a full medical report is available on her and her baby.
- If women apply for support late in pregnancy and support is granted while they are within the 'protected period' and they cannot be accommodated where they were formerly living, their accommodation needs should be met in safe, suitable accommodation *outside* Initial Accommodation. Women at this late stage of their pregnancy should not be moved out of their area and suitable private accommodation should be commissioned if necessary.

5. Full risk assessment before unavoidable dispersal

If a dispersal is unavoidable, before any dispersal takes place there must be a full assessment of needs and risk associated with dispersal, to be carried out by the woman's current treating midwife/obstetrician and other clinician (if she is receiving care for another long-term condition). If the woman is not receiving maternity or other healthcare this assessment should be carried out by a midwife with expertise in the care of vulnerable women.

- Such an assessment should specify any accommodation requirements that need to be met.
- Such an assessment should certify the woman's fitness to travel.
- No dispersal of a pregnant woman should take place before such an assessment has been carried out.
- Responsibility for ensuring such an assessment takes place lies with UKBA, not with the woman seeking asylum.

6. Transfer arrangements before unavoidable dispersal

If a pregnant woman has unavoidably to be dispersed to another area, case owners should notify both her current treating midwife/obstetrician and other clinician (if she is receiving care for another long-term condition) and a named contact in the Healthcare team at the dispersal destination. No pregnant woman who has booked into maternity care should be dispersed without arrangements having been made for her to be received into maternity care in the dispersal area. The receiving midwife/obstetrician and other relevant clinician should have received a full medical report and detailed medical records as well as the woman having her handheld notes.

7. Ensure adequate financial support throughout pregnancy

- Given the particular health risks facing asylum seeking women during pregnancy and after birth, asylum support levels for pregnant women on both section 95 and section 4 support should never fall below the equivalent of 70% of Income Support.
- Financial support should always be provided in cash during pregnancy and until the end of the postnatal period for women on section 4 support.
- Sufficient financial support should be provided to pregnant women and new mothers in full-board hostels in recognition that full-board does not adequately meet their needs.
- No pregnant woman's asylum support payments and accommodation should be stopped until after completion of all antenatal and postnatal care, regardless of any decision on her asylum case.
- In view of the health problems for both pregnant women and their unborn babies caused by destitution, UKBA should provide support to all pregnant women seeking asylum whose asylum claim has been refused.
- The timeframes for application for Maternity Payments should be eleven weeks before the expected date of delivery until three months after the birth (thereby matching those of the Sure Start Maternity Grants). Section 4 Maternity Payment levels should be raised to section 95 levels.

8. Monitor negative impacts of dispersal on maternity care

The Department of Health should facilitate data collection by NHS Trusts of incidents in which UKBA dispersal and relocation practices have prevented delivery of effective maternity care. The Department of Health should also facilitate communication of the data to the UKBA.

9. Develop improved support guidance for pregnant women seeking asylum

The UKBA should, as a matter of urgency, engage in discussions with representatives of midwives, obstetricians, general practitioners, and relevant voluntary organisations to develop dispersal policies for pregnant women and women who have recently delivered, which are compatible with NICE guidance on the maternity care of women with complex social factors.

Chapter I Introduction

This study was carried out as a collaboration between Maternity Action and the Refugee Council to investigate the health impact of dispersal and relocation on pregnant women and new mothers seeking asylum.¹ It reviewed asylum dispersal policy in relation to pregnancy and relevant parts of UK-wide maternity policy. It also collected experiences from women who had been dispersed in pregnancy and from midwives who have cared for such women.

This chapter outlines the rationale of the study, and explains the current rules and entitlements in asylum support policy, especially as they affect pregnant women and new mothers. It then reviews studies and debates on the health needs of pregnant asylum seeking women and how current maternity policies and best practice approach the care of asylum seekers as a sub-group of women with 'complex social factors'. UKBA policies on the dispersal of pregnant women are then explored. The chapter concludes with a description of the study methodology.

Rationale for the study

Most pregnant women seeking asylum are likely to have been dispersed. Anecdotal reports by current or former asylum seeking women and midwives, and interviews with midwives in an earlier study have indicated that a substantial number of pregnant women seeking asylum were dispersed during pregnancy, often very late in pregnancy and sometimes very soon after delivery.² Such reports suggest that dispersal has a severe impact on women's mental and physical health and on their maternity care.

However, until now there has been no study which specifically addresses the experiences of asylum seeking women dispersed during pregnancy, or of midwives who have looked after such women before and after dispersal. This study attempts to fill this gap.

In the first half of 2011 we estimate that there were approximately 500 pregnant women seeking asylum and receiving support in the UK, and about 125 pregnant women whose claim for asylum had been refused, also receiving support.³ Both destitute asylum seekers awaiting a decision and refused asylum seekers who qualify for support are normally dispersed to a number of locations in the UK away from London and South East England "in which there is a ready supply of accommodation".⁴ They may also be relocated elsewhere after an initial dispersal.

1 Throughout this report we include refused asylum seekers who are pregnant and on section 4 support under this designation.

2 H. Beecher Bryant, 2011, *Improving Care for Refugees and Asylum Seekers: The Experiences of Midwives*, London, Maternity Action, available at <http://www.maternityaction.org.uk/sitebuildercontent/sitebuilderfiles/experiencesofmidwivesreport2011.pdf>

3 These figures are based on responses to a Freedom of Information Request made by the Refugee Council. 491 s95 and 126 s4 maternity payments were made during the first 6 months of 2011. The UKBA keeps no separate record of the numbers of pregnant women receiving asylum support, so the number of maternity payments is used here as a proxy for numbers of pregnant women. It therefore can provide only a rough estimate as it excludes any supported asylum seekers or refused asylum seekers who did not receive a maternity grant.

4 UK Border Agency, 2009, *Dispersal Guidelines*, Asylum Support Policy Bulletin 31, p2, available at <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/asylum-supportbulletins/dispersal/pb31?view=Binary>

Asylum support: rules and entitlements⁵

Since the implementation of the Immigration and Asylum Act 1999, support for asylum seekers has been separated from mainstream benefits. It was initially provided by the National Asylum Support Service (NASS) and is still commonly referred to as NASS support although it is now provided by the UK Border Agency (UKBA) through contracts with private companies. This section describes current entitlements for support as they affect pregnant women. (Technical terms relating to asylum and maternity care are explained in the *Glossary* at the end of this report).

Asylum seekers may be granted asylum support under section 95 or section 4 of the Immigration and Asylum Act 1999. Both types of support are commonly referred to as 'section 95' or 'section 4'.

Section 95 support

Asylum seekers are excluded from mainstream state benefits and are normally not allowed to work. Asylum seekers who are destitute, or are likely to become destitute within 14 days, may apply for support under section 95 of the Immigration and Asylum Act 1999, commonly known as section 95 support. The act deems a person to be destitute if "(a) he does not have adequate accommodation or any means of obtaining it (whether or not his other essential living needs are met); or (b) he has adequate accommodation or the means of obtaining it, but cannot meet his other essential living needs."⁶

To qualify for section 95 support, asylum seekers must have claimed asylum as soon as practicable after they entered the UK (normally within three days). However, support must still be granted if they have children under 18 who are part of their household, or if they would be destitute and street homeless without such support. Refused asylum seekers with dependent children born before their asylum claim was refused (or up to 21 days after this) can continue to receive section 95 support while the child is under 18 and they and the child remain in the United Kingdom.⁷

Section 95 support consists of either 'subsistence only' support or both subsistence and accommodation. Subsistence support is paid in cash but does not cover rent, so in this situation, the asylum seeker will need to be housed at the expense of family or friends. Support with accommodation includes the costs of electricity and gas as well as rent, so the cash element in both kinds of support is the same.

Where accommodation is needed, it is provided by UKBA on a 'no-choice' basis and will normally be located outside London. The process of moving and accommodating asylum seekers in various parts of the UK is known as dispersal. Asylum seekers who are dispersed are sent notification of travel and provided with transport to their new accommodation by housing providers contracted to UKBA.

Prior to dispersal, asylum seekers will usually be placed in hostels known as Initial Accommodation before they are moved to a final destination where they will be given shared, self-catering accommodation, or if a family, sometimes self-contained accommodation.

5 This section draws on Rights of Women, 2012, *Seeking Refuge? A handbook for asylum-seeking women*, London, Rights of women, available at www.rightsofwomen.org.uk/pdfs/ROW-Seeking-Refuge-May12.pdf; Asylum Support Appeals Project, 2011, Factsheets 1,2,14, available at http://asaproject.org/web/index.php?option=com_content&view=category&id=39&Itemid=102; and UKBA, 2012, *Allocating section 95 support*, available at <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/modernised/asylum-support/section-95/allocating-section95?view=Binary>

6 Immigration and Asylum Act, 1999, section 95 (3) available at http://www.legislation.gov.uk/ukpga/1999/33/pdfs/ukpga_19990033_en.pdf; UKBA, 2011, *Assessing Destitution*, available at <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/asylumprocessguidance/asylum-support/guidance/assessing-destitution?view=Binary>

7 Immigration and Asylum Act 1999, Section 94 (5) http://www.legislation.gov.uk/ukpga/1999/33/pdfs/ukpga_19990033_en.pdf

However, people are sometimes sent to another Initial Accommodation hostel in a dispersal area after they have already spent a short time in such accommodation in London before getting longer term housing in that area. Initial Accommodation is usually full-board, so whilst there, asylum seekers normally receive no cash unless they are pregnant or have children under three years old.

Pregnant women receive an additional £3 per week for the duration of their pregnancy, after sending UKBA a MAT B1 form or a letter from their midwife or their GP confirming their pregnancy. They are also entitled to a maternity payment of £300 which they can apply for from 8 weeks before the expected date of delivery until up to 6 weeks after delivery. To obtain this payment they need to enclose formal evidence of the pregnancy or the birth such as a MAT B1 form or a birth certificate. Recent asylum claimants living in Initial Accommodation will normally receive this payment in the form of (smart card) tokens which can be cashed at a Post Office until their regular payments are sorted out. Additional payments are made for any other children under 3 years, at £5 per week for babies under 12 months, and £3 per week for children from 1 to 3 years. Thus, after giving birth, a woman will receive an additional £5 for her newborn baby.

Section 95 payments are significantly less than income support levels.⁸ At the time of writing single adults receive £36.62 per week. The payments are made at a local Post Office on production of the asylum seeker's Application Registration Card (ARC). Dispersed asylum seekers also receive an initial payment of £90 each for essential expenses if they are placed in self-catering accommodation. Those placed in full-board accommodation are given £30 per person.

Asylum seekers are entitled to full NHS services including free prescriptions, and their children are required to receive full-time education until the age of 16.

b) Section 4 support

Section 4 of the Immigration and Asylum Act 1999 provides support to some groups of asylum seekers whose claim has been refused, if they are destitute or likely to become destitute within 14 days. They must also meet *one* of five additional conditions. These are that they

- are taking all reasonable steps to leave the UK
- are unable to leave the UK because of a physical impediment to travel or for some other medical reason
- have no viable route of return
- have applied for judicial review of the decision on their asylum claim and have been granted permission to proceed or
- that the provision of accommodation is necessary to avoid breaching their human rights.⁹

Of these, the criterion usually most relevant to pregnant women is that relating to medical impediments to travel. Refused asylum seekers may be eligible for section 4 support if they are "destitute and unable to leave the United Kingdom by reason of a physical impediment to travel or for some other medical reason."

A pregnant woman who applies for section 4 support on medical grounds must submit a MAT B1 form confirming her pregnancy. UKBA guidelines specify that section 4 support should not normally be granted to a pregnant woman on the basis of physical impediment to travel until 6 weeks before her expected date of delivery, or the 34th week of pregnancy unless there are

⁸ The Children's Society, 2012, Highlighting the gap between asylum support and mainstream benefits, London, The Children's Society, available at http://www.childrenssociety.org.uk/sites/default/files/tcs/a_briefing_from_the_childrens_society_on_asylum_support.pdf

⁹ UKBA, 2005, *The Immigration and Asylum (Provision of Accommodation to Failed Asylum-Seekers) Regulations 2005*, Regulation 3(2) (a-e), available at www.tinyurl.com/9o9q4tx

complications with the pregnancy that may put the mother and baby at risk.¹⁰ However section 4 support can be difficult to obtain if the woman is at less than 34 weeks gestation, even when a woman's midwife or doctor has written to UKBA on her behalf to state that there are complications with the pregnancy that may put the mother or baby at risk.¹¹

Section 4 support consists of no-choice accommodation in a dispersal area. No cash is provided, instead money is credited to a smart 'Azure' card which can be spent in a limited number of shops. Single people can only save and carry over £5 per week on their card, though families can carry over an unlimited amount. Additional payments for pregnant women are the same as those for pregnant women on section 95 support, an extra £3 per week for the duration of the pregnancy, £5 per week for every child under 12 months, and £3 for children between 1 and 3 years. However, for section 4 recipients, such payments are also cashless and are added to the Azure card. Pregnant women on section 4 support are also eligible for a maternity payment of £250, also paid onto the Azure card. There are also further payments for pregnant women and new mothers to meet travel costs for medical treatment, costs of a long birth certificate, and a clothing allowance for children under 16. The latter payment is given in addition to the extra payments for children under 3.

People receiving section 4 support are entitled to full NHS care, but in England, refused asylum seekers not in receipt of section 4 may be charged for hospital care.¹² This includes pregnant women. A pregnant woman may not be refused NHS maternity care on the basis of inability to pay at the time, but she may be billed for the care she receives. Under current guidelines the hospital is entitled to pursue her to recoup the costs of care.¹³ Because section 4 support is only available for most pregnant refused asylum seekers from the 34th week of pregnancy, some women access maternity services very late, because of fears of being charged and having no ability to pay.

While all section 4 support is cashless, pregnant asylum seekers on section 95 support can also find themselves receiving very little cash if they are staying in full-board Initial Accommodation, since during this time they only receive £3 per week during the pregnancy. Often the maternity payment is only received after the birth of the baby. This means that pregnant asylum seekers on section 4 support, or those on section 95 support in Initial Accommodation are unable to travel except to medical appointments for which they have claimed additional payments. They have no money for maternity clothes, including underwear, and do not have the means to buy food if, as this study shows, they miss meals or cannot eat the food provided in the accommodation.

10 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>

11 Personal communication from the Asylum Support Appeals Project.

12 In Scotland and Wales all refused asylum seekers can receive free NHS care. See NHS Scotland, 2012, *Health Care for asylum seekers and refugees in Scotland*, Health Rights Information Scotland, available at <http://www.hris.org.uk/patient-information/information-about-health-rights/health-care-for-overseas-visitors/health-care-for-asylum-seekers-and-refugees/> and NHS (Charges to Overseas Visitors) (Amendment) (Wales)(Regulations 2009) <http://www.legislation.gov.uk/wsi/2009/1512/contents/made>

13 Department of Health, 2012, *Implementing the Overseas Visitors Hospital Charging Regulations*, London: Department of Health, available at <http://www.dh.gov.uk/health/2012/10/overseas-visitors/>

Health needs of pregnant asylum seeking women

There have been growing concerns among health professionals and advocacy organisations about both the impact of dispersal on maternal and child health and the absence of adequate procedures within UKBA to safeguard the health of pregnant asylum seeking women being dispersed under section 95 and section 4 of the Immigration and Asylum Act 1999.

Refugees and asylum seekers have been identified as an especially vulnerable group in relation to maternity care and pregnancy outcomes. The Seventh Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom (CEMACH) found that “Black African women, including asylum seekers and newly-arrived refugees have a mortality rate nearly six times higher than White women.¹⁴ The CEMACH report outlines a number of health or social problems that disproportionately affect newly arrived migrants, refugees and asylum seeking women, placing them at greater health risk and posing new challenges for maternity services. These include poor overall health status including underlying and possibly unrecognised medical conditions which have resulted in maternal deaths, including notably congenital cardiac disease, HIV/AIDS and TB.

Other issues creating health risks for pregnant women discussed in the CEMACH report include traumatic experiences undergone in conflict and war zones including rape, trafficking for sexual exploitation, and reluctance to seek maternity care because of fears about immigration status or shame relating to the pregnancy or for other reasons. The report also notes risks to pregnant women in this category from domestic violence, and other studies have drawn attention to the high levels of physical and/or sexual violence experienced by women asylum seekers.¹⁵ Women who have undergone female genital mutilation (FGM) may also be at risk especially if they only disclose this condition very late in pregnancy. In addition, the CEMACH report found most of the women who died and who did not speak English had not had access to translation services, so that vital information about their health or medical history may not have been conveyed.¹⁶

As well as risks to maternal health, reports on perinatal mortality continue to show significantly higher stillbirth and neonatal mortality rates for black women. Data on selected mothers' countries of birth has shown that women born in Pakistan, parts of Africa and the Caribbean had approximately double the risk of infant mortality rates of the UK as a whole. Factors associated with these poor birth outcomes include late booking for maternity care, FGM, and lack of social support.¹⁷ The most recent report by the Centre for Maternal and Child Enquiries (CMACE), which has replaced CEMACH, showed that black and Asian women were up to 2.4 times as likely to have a stillbirth or a neonatal death than white mothers. However, this report did not explore mothers' country of birth.¹⁸

14 G. Lewis (ed.), 2007, *Saving mothers' lives: reviewing maternal deaths to make motherhood safer – 2003–2005*, Seventh Confidential Enquiry into Maternal and Child Health, London, CEMACH, available at <http://www.publichealth.hscni.net/publications/saving-mothers-lives-2003-2005>

15 C. Zimmerman, M. Hossain, L. Kiss, J. Hoey, K. Weneden and C. Watts, 2009, *Asylum-Seeking Women, Violence & Health: Results from a Pilot Study in Scotland and Belgium*, London: London School of Hygiene and Tropical Medicine and Scottish Refugee Council, available at <http://genderviolence.lshtm.ac.uk/files/2009/10/Asylum-seeking-Women-Violence-and-Health.pdf>

16 *Ibid.* pp32-35

17 B. Taylor and D. Newall, 2008, *Maternity, mortality and migration: the impact of new communities*, Birmingham, Heart of Birmingham Teaching NHS and West Midlands Strategic Migration Partnership <http://www.wmcouncils.gov.uk/migration-documents>; Department of Health, 2007, *Review of the Health Inequalities Infant Mortality PSA Target*, London Department of Health, available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_065544

18 Centre for Maternal and Child Enquiries (CMACE), 2011, *Perinatal Mortality 2009: United Kingdom*, London: CMACE, available at <http://www.hqip.org.uk/assets/NCAPOP-Library/CMACE-Reports/35.-March-2011-Perinatal-Mortality-2009.pdf>

In response to an earlier CEMACH report, in evidence to the House of Commons Health Committee, the Department of Health acknowledged that “pregnant asylum applicants may be in a particularly vulnerable condition”.¹⁹ The Committee commented that “several of the reasons given by the Department for this vulnerability also represent factors which prevent asylum seekers from making contact with maternity services: their future in the UK will not be certain, they are unlikely to have family or friends around them for support, and they may not be able to speak English.”²⁰

The Committee also recognised the importance of good communication between accommodation providers and health services to meet the needs of dispersed pregnant women so that records can be transferred in good time. In their recommendations they particularly stressed “the support needs of pregnant women and new mothers since separating them from any support network at this time could be especially detrimental to families.”²¹ The National Institute for Health and Clinical Excellence (NICE) has drawn on the 2007 CEMACH report for their Clinical Guidelines for the service needs of particularly vulnerable groups. Pregnant women who are recent migrants, asylum seekers or refugees, and women who have difficulty reading or speaking English are one of four distinctive groups whose needs are addressed by NICE.²²

Further evidence of the needs of women asylum seekers and problems in their care, especially of those who have been dispersed, has been published since the dispersal policy was introduced. McLeish’s study of pregnant women seeking asylum documented barriers in access to GPs, underlying mental and physical health problems of women asylum seekers, inadequate food in accommodation centres, and emphasised such women’s special needs in maternity care, particularly the importance of continuity of carer.²³

Yet disruption to continuity of care and carer as a result of dispersal is highlighted as a problem in several studies of asylum seeking women, even where women were found to have been satisfied with their care.²⁴ In a report for the Home Office on healthcare issues in dispersal, Johnson noted that there were sometimes health problems for pregnant women who travelled long distances, and that it was sometimes difficult for dispersed asylum seekers to register with GPs.²⁵ Similar findings emerge from a study of pregnant women seeking asylum in Leeds, some of whom had difficulties accessing maternity care after dispersal.²⁶

A serious case review into the death of a child whose mother was a refused asylum seeker who had died earlier, took the view that the loss of continuity in medical care was the major factor in the mother’s death which indirectly led to the subsequent death of her child. It highlighted the mother’s frequent moves to different parts of the country as part of the dispersal policy and commented that the circumstances of the woman in question – facing removal, having a life threatening illness, caring for a young child with few support networks

19 House of Commons Health Committee, 2003, *Inequalities in Access to Maternity Services: Eighth Report of Session 2002–03*, available at <http://www.parliament.the-stationery-office.co.uk/pa/cm200203/cmselect/cmhealth/696/696.pdf>

20 *Ibid.* p19

21 *Ibid.* p21

22 National Institute for Health and Clinical Excellence, 2010, *Clinical guideline 110 – Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors*, London, available at <http://publications.nice.org.uk/pregnancy-and-complex-social-factors-cg110>

23 J. McLeish, 200s, *Mothers in Exile*, London, Maternity Alliance. Available at <http://www.maternityaction.org.uk/sitebuildercontent/sitebuilderfiles/mothersinexile.pdf>

24 See, for example, H. Beecher Bryant, 2011, *op.cit.*; A. Gaudion and P. Allotey, 2008, *Maternity Care for Refugees and Asylum Seekers in Hillingdon: A Needs Assessment*; J. Nabb, 2006, “Pregnant asylum-seekers: perceptions of maternity service provision”, *Evidence Based Midwifery*, 4:3 pp89-95

25 M. Johnson, 2003, *Asylum seekers in dispersal – healthcare issues*, Home Office Online Report 13/03, available at <http://library.npia.police.uk/docs/hordsolr/rdsolr1303.pdf>

26 M. Waugh, 2010, *The mothers in exile project: Women asylum seekers’ and refugees’ experiences of pregnancy and childbirth in Leeds*, Leeds, Women’s Health Matters

– “would challenge any individual’s coping strategies and the need for high levels of support for someone with such vulnerabilities was clear but not picked up due to multiple errors in information sharing.”²⁷ The review also underlined the findings of a research study of 40 serious case reviews which found that almost half of the families were highly mobile and living in poor conditions.

Like the CEMACH report, both the House of Commons Health Committee and the NICE guidelines also make reference to homeless women and women who live in poverty as being vulnerable. Although NICE recognise that “vulnerable women may experience a number of complex social factors at the same time,”²⁸ homelessness or poverty is rarely referred to as an integral part of the health needs of vulnerable women migrants, including asylum seekers and refugees.²⁹ However, these issues are central to the problems of pregnant asylum seeking women. This is because asylum seekers requesting section 95 support, and refused asylum seekers requesting section 4 support are only entitled to UKBA support if they can be deemed destitute according to the provisions of the Immigration and Asylum Act 1999 and guidance on section 4 support.³⁰

People applying for asylum support with accommodation are often sofa surfing, living in precarious housing, facing imminent eviction, and in some cases, street homeless.³¹ Many of the problems faced by homeless pregnant women reported ten years ago, are similar to those faced by the women interviewed in this study who were destitute before they obtained asylum support. For example, both groups of women found it difficult to find out about local services, and continuity of maternity care was disrupted.³²

In addition to experiencing destitution before they receive asylum support, even asylum seekers who are supported by UKBA are in poverty. Rates of asylum support were deliberately set at lower levels than Income Support rates. A lone parent with a baby under 1 year in 2011-12 on section 95 support would receive £101.90 per week, 69% of the equivalent payment on Income Support. This has been justified on the grounds that utility costs are paid for people in receipt of asylum support. However, a lone parent and baby on section 4 support would receive £80.78, less than 55% of Income Support rates.³³ Yet costs for a lone parent on section 4 are no lower than those for someone on section 95. The level of section 4 support is 48% of the poverty line level (after the deduction of housing costs) used by the Child Poverty Action Group, and section 95 support stands at 61% of this level.³⁴

27 Croydon Safeguarding Children Board, 2010, *Serious Case Review: Executive summary Child Z*, available at <http://www.croydon.gov.uk/contents/departments/healthsocial/pdf/1028604/scr-execsummary>

28 National Collaborating Centre for Women’s and Children’s Health, 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 (NICE) available at <http://www.nice.org.uk/nicemedia/live/13167/50861/50861.pdf>

29 See for example National Institute for Health and Clinical Excellence, 2010, *op.cit.*; S. Haroon, 2008, *The health needs of asylum seekers, Briefing Statement*, Faculty of Public Health, available at http://www.fph.org.uk/policy_reports;

30 See above – section on financial support.

31 H. Crawley, J. Hemmings and N.Price, 2011, *Coping with Destitution: Survival and livelihood strategies of refused asylum seekers living in the UK*, Swansea University, Centre for Migration Policy Research (CMPR), available at http://stillhumanstillhere.files.wordpress.com/2009/01/oxfam_coping_with_destitution.pdf

32 See Select Committee on Health, 2003, *Minutes of Evidence: Memorandum by the Maternity Alliance (MA 3) – Lives on Hold: Homeless Families in Temporary Accommodation* <http://www.parliament.the-stationery-office.co.uk/pa/cm200203/cmselect/cmhealth/696/3051304.htm>

33 The Children’s Society, 2012, *Highlighting the gap between asylum support and mainstream benefits*, London, The Children’s Society, available at http://www.childrenssociety.org.uk/sites/default/files/tcs/a_briefing_from_the_childrens_society_on_asylum_support.pdf

34 Child Poverty Action Group, 2012, *The UK poverty line*, available at <http://www.cpag.org.uk/content/uk-poverty-line>

Maternity care of vulnerable and disadvantaged women

All asylum seekers supported by UKBA are entitled to full NHS care.³⁵ This means that principles of maternity care developed for NHS patients apply as much to UKBA supported asylum seekers in England (and in Scotland and Wales to all asylum seekers regardless of the status of their claim) as to any other patients. Ethnic inequalities in maternal mortality were highlighted in *Why Mothers Die*, the 2004 CEMACH report into maternal mortality, and its next report addressed the disproportionate numbers of maternal deaths among migrant women more specifically.³⁶

The statistics produced by CEMACH and their analysis of the factors leading to inequalities in maternal mortality are part of a revived concern with health inequalities. The goal of reducing inequalities in health has been repeatedly re-stated in NHS policy, particularly since the end of the twentieth century, including in the Health and Social Care Act 2012 (England) of the Coalition Government.³⁷ The Marmot review also highlighted the importance of maternity services in reducing social inequalities in pregnancy outcomes³⁸, and this theme was taken up earlier in the Department of Health's *National Service Framework for Children, Young People and Maternity Services* (NSF), and in *Maternity Matters*, and subsequently in guidance developed by the National Institute for Health and Clinical Excellence.³⁹

All these documents drew attention to the need for special efforts and/or service provision for disadvantaged and vulnerable pregnant women in order to reduce levels of maternal and infant mortality. In addressing the maternity care needs of such women, the policies which they set out focused on services for women with more complex pregnancies who may require multidisciplinary or multi-agency care. The NICE Guidelines used the terminology of 'pregnant women with complex social factors', "that is, women whose social situation may impact adversely on the outcomes of pregnancy for them and their baby," clearly distinguishing social problems or disadvantage from additional health problems which could complicate a pregnancy.⁴⁰

Fundamental principles for maternity care generally had already been developed in *Changing Childbirth*, involving women as the focus of maternity care, emphasising choices in antenatal and postnatal care, and continuity of care.⁴¹ What later policy documents added was to advocate explicitly for inclusivity and to set out mechanisms to ensure that the same standards of care should apply to socially disadvantaged or excluded women. "As a minimum, all migrant women should be able to fully access the standard antenatal care package as outlined in the NICE Clinical Guideline 62 *Antenatal care* (2008)."⁴² This meant that special measures needed

35 Department of Health, 2012, *op.cit.*

36 G. Lewis (ed.), 2004, *Why Mothers Die 2000-2002*, The Sixth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom, London, CEMACH available at <http://www.hqip.org.uk/assets/NCAPOP-Library/CMACE-Reports/33.-2004-Why-Mothers-Die-2000-2002-The-Sixth-Report-of-the-Confidential-Enquiries-into-Maternal-Deaths-in-the-UK.pdf>; G. Lewis (ed.), 2007, *op.cit.*

37 Department of Health, 2000, *The NHS Plan*, Norwich, TSO, Cm 4818-I, available at http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_5207943; Health and Social Care Act 2012, Norwich TSO available at http://www.legislation.gov.uk/ukpga/2012/7/pdfs/ukpga_20120007_en.pdf

38 M. Marmot, 2010, *Fair Society, Healthy Lives, The Marmot Review – Strategic Review of Health Inequalities in England Post-2010*, available at <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review>;

39 Department of Health, 2004, *National Service Framework for Children, Young People and Maternity Services: Standard 11 Maternity Services*, London, Department of Health, available at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4090523.pdf; Department of Health, 2007, *Maternity Matters*, London, Department of Health, available at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_074199.pdf; National Collaborating Centre for Women's and Children's Health, 2010, *op.cit.*; National Institute for Health and Clinical Excellence, 2010, *op.cit.* It should be noted that NICE Clinical Guidelines do not apply in Scotland. The Scottish Government's approach/guidance to implementing the NICE Guidelines to care for vulnerable women can be found at <http://www.scotland.gov.uk/Publications/2011/03/22145900/4>

40 National Collaborating Centre for Women's and Children's Health, 2010, *op.cit.* pp25-26.

41 Expert Maternity Group, 1993, *Changing Childbirth*, London: HMSO

42 National Collaborating Centre for Women's and Children's Health, 2010, *op.cit.* p97

to be put in place *additional* to the standards for routine care for women with complex social factors to enable them to access the same level of care as other women and move towards achieving improved pregnancy outcomes.

Proposals for strategies to achieve this have consistently emphasised identifying and reaching disadvantaged women early in order to facilitate early booking, continuity of midwifery care throughout pregnancy, birth and postnatally, inter-professional and inter-agency collaboration, and provision of language and translation services, including extra time at antenatal appointments. NICE Guidance specifically emphasised working with local agencies providing housing and other services for asylum seekers and for handheld maternity records with detailed and comprehensive information to be kept by the woman. It also noted that there was a need for individual and continuing risk assessments for pregnant asylum seekers, refugees and recent migrants and for specific health, legal and social issues to be considered, including residential mobility.⁴³

There is much less attention in policy reports paid to routine postnatal as opposed to antenatal care, and even less about postnatal care for vulnerable women. However, NICE has issued clinical guidelines on routine postnatal care which sets out the core care which women and their babies should receive in the first 6 to 8 weeks after giving birth.⁴⁴ The National Service Framework for Children and Young People (NSF) on Maternity Services commented that “routine discharge from maternity care at six to eight weeks, now appears too short for a full assessment of health needs, given the long term nature of many post-delivery health problems.” The NSF proposed that midwifery services “should provide for a mother and her baby for at least a month after birth or discharge from hospital, and up to three months or longer depending on individual need”.⁴⁵ Even without particular postnatal care guidelines for vulnerable women and families, it is clear that a universal standard of at least 6-8 weeks planned postnatal care has implications for the time at which an asylum seeking woman can safely be dispersed after delivering her baby.

UKBA policies on healthcare for dispersed pregnant women seeking asylum

Although the vulnerability and concomitant complex social and health needs of pregnant women seeking asylum is clearly recognised in policies on maternity care across the UK, the UKBA has only acknowledged pregnancy as representing a very limited health need unless there is a major pregnancy complication. It has not in any way acknowledged or recognised the concept of pregnancies with complex social factors.

Between 2001 and 2012, NASS Policy Bulletin (Policy Bulletin) 61 on Pregnancy, with some modifications, was used to provide “instructions for dealing with queries relating to pregnancy from persons supported by the UK Border Agency.”⁴⁶ The focus of Policy Bulletin 61 was on the third trimester of pregnancy, and the accommodation needs for the child, once it is born, which would need to be addressed during the third trimester. It contained nothing on any issues which might arise in antenatal care.

The bulletin stipulated that if medical advice was given that dispersal should be delayed until after the birth of the child, “this must be adhered to,” and that “unless we intend to have the applicant examined we will have to take the GP’s word of inability to travel.”⁴⁷ However, it did not specify how such medical advice would be obtained, and this requirement appears to

43 *Ibid.*

44 National Institute for Health and Clinical Excellence, 2006, *Routine postnatal care of women and their babies NICE clinical guideline 37*, available at <http://www.nice.org.uk/Guidance/CG37> London: NICE

45 Department of Health, 2004, *op.cit.* p33

46 NASS Casework Instructions, 2001, *Pregnancy: Policy Bulletin 61* (no longer available online)

47 *Ibid.* p4

contradict a further instruction that it is caseworkers who must consider a pregnant woman's fitness to travel. It provided no criteria for caseworkers to make this decision, nor did it suggest that caseworkers consult with clinicians to arrive at this conclusion. The bulletin took the view that "in general, women do not need to restrict travel during pregnancy" though it advised a limit of four hours on the journey time in "the last few weeks of the third trimester."⁴⁸ It contained no other special considerations about transporting pregnant women such as the need for frequent toilet breaks, regular food, assistance with luggage, or addressing feelings of nausea.

The *Pregnancy Policy Bulletin* gave almost no other attention to the medical needs of pregnant women except to state that caseworkers should assess "whether it is reasonable to disperse applicants to an area if specialist medical treatment is required. They will need to ensure with Accommodation Providers that specialist care is available for the (asylum) applicant in the dispersal area."⁴⁹ Again, it was not specified how caseworkers were to make such an assessment, nor how accommodation providers were competent to know what specialist medical care was available in their area.

Policy Bulletin 61 made no reference to the vulnerability or complex needs of the women seeking asylum it was referring to, or to any of the complexities of maternity care before, during, or after delivery. This can be clearly seen from its instructions about birth complications, reproduced here in full:

"After the birth of her child a woman should receive essential clinical care for 14 days and this should not be disrupted without good reason. In addition, women often feel unwell during this period, particularly if they have had a caesarean section. Women who have experienced birth complications, caesarean section or whose child is requiring specialist baby care, should not be expected to move within two weeks of the birth."⁵⁰

It is not clear from this instruction whether women who had not experienced the above problems could be expected to move within two weeks of the birth. In any case, there is no elaboration, beyond specification of caesarean section, of what constitutes birth complications. The Royal College of Midwives, in their response to a UKBA consultation on the revision of their healthcare and pregnancy guidance in 2010, noted that

"the UKBA appears to be unclear about normal delivery and what constitutes the postnatal period. ... A normal delivery is where the woman has had no interventions or drugs for the duration of labour and birth; this excludes caesarean section, ventouse and forceps deliveries."⁵¹

In this context it is hard to see how caseworkers would know what kind of birth complications a woman had experienced without clear guidance from a medical professional.

The *Pregnancy Policy Bulletin* is important in the history of the healthcare of pregnant women seeking asylum in the UK because it was the reference point for decisions about dispersal long after general health guidance was revised in 2005. This followed a review, commissioned by NASS, of "dispersal policies and practices where the (asylum) applicant's health presents as a particular issue".⁵² The review found that assessments of healthcare requirements were often made by staff not equipped for the tasks involved. For example, "some do not appreciate the

48 *Ibid.* p5

49 *Ibid.* p4

50 *Ibid.* p6

51 Royal College of Midwives, 2010, *Response to UKBA Health AI Consultation and Azure section 4 payment cards* (unpublished)

52 H. Scott (for National Asylum Support Service), 2004, *Meeting the health care needs of people seeking asylum – a review*

implications of some diagnoses (and may, for example, regard depression as always a routine and minor matter)."⁵³

It found that NASS processes also failed to take account of the NHS' own well-established systems of transferring patient care between clinicians, nor were there any criteria to guide clinicians who wrote to support deferrals of dispersal or to advise against dispersal. It advocated the production of a comprehensive policy bulletin on healthcare issues including the needs of pregnant women and those who had recently given birth. This led to the publication of a new policy bulletin in December 2005 on dispersing asylum seekers with healthcare needs (Policy Bulletin 85).⁵⁴

The new bulletin covered pregnancy and a number of conditions and situations such as HIV/AIDS, TB, mental health problems, support for torture victims, people undergoing surgery, people with ongoing complex medical treatment and infectious diseases. It also responded to changes in asylum support policy which meant that asylum seekers were to be moved as quickly as possible from Initial Accommodation to dispersal areas, rather than an earlier system of long stays in 'Emergency Accommodation'. The assumption was that most health needs specified in applications for asylum support would be long-term, and that treatment would start after dispersal.

Policy Bulletin 85 did bring about clarification of processes and procedures in relation to a number of conditions, notably HIV/AIDS. As far as pregnant women and women who had just given birth were concerned, however, virtually all issues were referred to the earlier and unrevised *Pregnancy Policy Bulletin 61*, discussed above. For example, Policy Bulletin 85 sets out detailed new instructions with regard to HIV/AIDS, TB and mental health, but simply refers caseworkers to an unchanged Policy Bulletin 61 in connection with pregnancy.⁵⁵

It also repeated Policy Bulletin 61's lack of clarity about 'pregnancy complications' by excluding pregnant women "without any other complication" from instructions relating to continuity of care for people not in Initial Accommodation.⁵⁶ Yet virtually all studies of vulnerable pregnant asylum seekers have emphasised the importance of continuity of care and the potentially negative effect both on them and on their healthcare when they are dispersed.⁵⁷ Furthermore, it too, failed to mention the complex needs of pregnant asylum seeking women. Because the *Pregnancy Policy Bulletin 61* remained unchanged, there was therefore virtually no improvement to policies on the care of pregnant women seeking asylum despite the publication of Policy Bulletin 85 until wholly new guidance, *Healthcare needs and pregnancy dispersal guidance* was published in 2012.⁵⁸

This guidance has now replaced Policy Bulletin 61 and Policy Bulletin 85. A consultation on a draft of the guidance produced responses about the health needs of women in pregnancy from the Royal Colleges of Midwives and Obstetricians, Maternity Action and other advocacy organisations, and led to substantial changes in the final document. This includes important improvements on the previous policy bulletins, notably the provision of a 'protected period' of four weeks either side of delivery during which a woman should not be dispersed. Other issues in the care of pregnant women seeking asylum recognised in the new guidance include some

53 *Ibid.* p4

54 National Asylum Support Service (NASS), 2005, *Dispersing Asylum Seekers with Health care needs: Asylum Support Policy Bulletin 85* (No longer available online)

55 *Ibid.* p6

56 *Ibid.*

57 H. Beecher Bryant, 2011, *op.cit.*; A. Gaudion and P. Allotey, 2008, *Maternity Care for Refugees and Asylum Seekers in Hillingdon: A Needs Assessment*; J. Nabb, 2006, "Pregnant asylum-seekers: perceptions of maternity service provision", *Evidence Based Midwifery*, 4:3 pp89-95

58 UK Border Agency, 2012, *Healthcare needs and pregnancy dispersal guidance*, available at <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/asylumprocessguidance/asylumsupport/guidance/healthcare-guidance-.pdf?view=Binary>

procedures to enable continuity of care, especially in 'high-risk' pregnancies, and to protect imminent pre-booked appointments, and an acknowledgment of the need to minimise stress to women during pregnancy. The guidance also recognises some issues affecting fitness to travel of either the pregnant woman or a newborn baby and sets out basic information about routine care in pregnancy and the postnatal period.

The new guidance was not in place to impact on the maternity care of almost all the women interviewed in this study or on any of the cases described in interviews with midwives. In that sense this study reflects on policy that is now superseded. However, the study provides a good opportunity to explore how the new policy responds to the expressed concerns both of women seeking asylum who have been dispersed in pregnancy, and of midwives who have looked after such women in recent years. Furthermore, by juxtaposing mainstream maternity care policy for women with complex social factors with UKBA policy on dispersal of pregnant asylum seeking women, the study also enables us to see whether or how far the two approaches are compatible, and to make recommendations to bring UKBA policy more in line with current best practice in maternity care.

Study design and methodology

The study involved a review of asylum dispersal policy in relation to pregnancy and maternity policy and good practice towards pregnant women seeking asylum. Midwives were interviewed as well as women who had been dispersed in pregnancy. A reference group of professionals with expertise on maternity, and asylum health policy was set up to comment on the research strategy and methodology, and on drafts of the report.

The interviews

Face to face structured qualitative interviews were conducted with 20 women. Most of them were women who had been dispersed or relocated by UKBA under section 95 or section 4 support during a pregnancy in the previous three years. The sample also included two women on section 95 or section 4 support whose dispersal was stopped on medical grounds, and one woman who was not dispersed but was being kept in Initial Accommodation under the 'protected period' established by the UKBA *Healthcare needs and pregnancy dispersal guidance 2012*. Women were invited to participate via publicity in local refugee support organisations in London and in dispersal areas with links to the Refugee Council. Twelve of the women were supported under section 95 and six under section 4 during their pregnancies. Two women moved between types of support – one from section 95 to section 4 support, and the other from section 4 to section 95 – during the course of their pregnancies.

The twenty women interviewed had been dispersed as shown in Table 1.1

Dispersal region	Number of women
London*	3
South of England	5
Midlands and East of England	4
North West	2
North East	5
Wales	1
Total	20

* Two women were moved within London and one remained in Initial Accommodation in London under new Healthcare and Pregnancy Guidelines

Interviews with current or former asylum seeking women aimed to explore their experiences of pregnancy and childbirth before and after dispersal, and the impact on them of dispersal during pregnancy or soon after birth. The interviews were conducted by Refugee Council staff and volunteer researchers. Participants were given information sheets about the nature of the interview, and signed consent forms agreeing to be interviewed and for the interview to be recorded. They were also assured that the interviews were confidential. In some cases the researchers actively advocated on behalf of the women where there were opportunities to improve their circumstances, such as helping them apply for maternity grants, or accessing maternity care.

Interpreters were used in interviews with eight women. Interpreters were briefed and provided with the interview questions beforehand. One interview was conducted in Spanish and translated into English by the bilingual researcher. The interviews took place at sites where the women felt comfortable such as their homes or the offices of organisations that were supporting them.

Five women were interviewed while they were still pregnant, and interviewers were able to contact three of them by phone after they had given birth to obtain information about what had happened to them. This information was added to the original interview transcript.

Midwives included in the study were interviewed by telephone by a researcher at Maternity Action. The interviews were designed to explore the midwives' experiences of looking after women seeking asylum *before* they were dispersed or relocated (sending areas) or *after* they were dispersed or relocated (dispersal areas). They asked midwives to give examples of pregnant women seeking asylum who had been in their care, and focused particularly on how they viewed the case or cases they described in terms of their professional expectations and ethos.

Midwives known to Maternity Action who specialised in working with refugees and asylum seekers or who worked with vulnerable women were invited to participate in the study. Those invited had indicated in an earlier study by Maternity Action that they had experience of working with women who had been dispersed. Midwives were included who were able to provide case examples, from their professional experience, of women who had been dispersed or relocated by UKBA in the course of a pregnancy, or whose dispersal had been stopped for medical reasons. Any case examples of women who were dispersed *before* they were pregnant, or who moved for reasons other than dispersal under asylum support policy, were excluded. This led to interviews with 17 midwives being used for the study. These midwives contributed 23 case examples which were subsequently included in the analysis. One interview with a consultant midwife which did not contain any recent case examples was used in the analysis as it provided a general overview of the impact of dispersal on pregnant women.

Of the midwives interviewed, seven were Consultant Midwives, and the remainder were either specialists or worked within teams specialising in the care of vulnerable or migrant women. Midwives were asked to consent verbally to their interviews being recorded. Where requested, permission was sought from the line managers of midwives before an interview was conducted.

Table 1.2 – Regions of work of the midwives interviewed

Region	Number of midwives
London and South of England	5
South East	2
Midlands	3
North West	1
North East	4
Wales	2
Total	17

Confidentiality

All the names of the women interviewed have been anonymised to protect their confidentiality. No names were recorded in any interviews. Pseudonyms have been used where individual stories of women interviewed are given in the text. Women's dispersal locations have also not been revealed, to protect confidentiality. Women whose cases were described in the midwife interviews were not named, and midwives' case examples in the text are referred to by single initials. Midwives are not named or their locations given in order to protect their anonymity, though where cases refer to London, this is acknowledged. The interviews were recorded and transcribed by the interviewers. Recordings of the interviews have been deleted.

Data from both midwife interviews and interviews with women were analysed thematically by the author of this report. Most data are qualitative and have been presented in this report as narrative accounts which have both given rise to and illustrated the themes of the report. Some basic demographic data and other factual data regarding health or healthcare or particular dispersal patterns have been tabulated.

Study limitations

Where a woman interviewed could not speak English, professionally qualified interpreters were used which may mean that the women's exact words were not communicated.

Telephone interviews provided a quick and efficient means of speaking to busy midwives, but were carried out at midwives' workplaces and liable to interruption and consequent loss of continuity.

Midwives' case examples were drawn from memory and hence some details of the cases may have been lost.

Structure of the report

The remainder of the report contains the findings and analysis of the interviews with dispersed women and midwives which is presented in Chapters 2 and 3. Chapter 2 focuses on the health and circumstances of the women when they were dispersed and their experiences of the dispersal process as a whole. Chapter 3 explores the impact of dispersal on the maternity care and health of the women during their pregnancies, their experiences of giving birth and the postnatal period. Chapter 4 evaluates the UKBA's 2012 *Healthcare and Pregnancy Dispersal Guidelines* in the light of the study's findings.

Chapter 2 Women's experience of dispersal

This chapter explores the circumstances of the women interviewed before they were dispersed and discusses their underlying health conditions, especially in relation to their pregnancies. It then follows their experiences of the dispersal process including life in Initial Accommodation, the number of times they were moved, the journeys to their new areas, and the notice they were given before leaving. Further sections explore how they settled in after arrival, focusing particularly on housing, accessing health services, and how they managed financially. Finally, the chapter presents a case study of one woman who was kept in Initial Accommodation until four weeks after she gave birth, under the 2012 UKBA *Healthcare and Pregnancy Dispersal Guidance*.

Women's circumstances before dispersal

The women interviewed came from a wide range of personal situations and had very different migration histories which are not reflected in the simple categories of *asylum seekers* or *refused asylum seekers*. Many of them lived in very difficult and precarious circumstances which prompted their requests for asylum support, and in some cases were barriers to them seeking healthcare early in pregnancy. In almost all cases, dispersal added to the anxieties and difficulties which had led to their requests for support

Seven women were pregnant when they arrived in the UK while the remainder had been living in the UK when they became pregnant, either as asylum seekers or with irregular immigration status.⁵⁹ Homelessness because of the pregnancy was the most important reason for applying for asylum support, even when women had been settled in an area for some time and had strong links there. Twelve women applied for asylum support during their pregnancy because they were homeless or at risk of homelessness after they became pregnant; of these, six obtained section 4 support, five obtained section 95 support following initial or fresh asylum claims, and one because she had other children from the time of her original claim.⁶⁰

Frieda was a refused asylum seeker from southern Africa, living with HIV. She had lived in the UK since 2000 and in a northern city since 2001. Her partner lived in the same city with his family, and he and the family helped her financially. She was being treated for HIV at the local hospital, and also received strong practical and social support from an HIV charity in the city, and had many friends nearby. She was receiving antenatal care at her local GP surgery and antenatal classes from the National Childbirth Trust. When she became pregnant, the friend with whom she was living said she would not be able to continue to stay there with a new baby, so she applied for section 4 support.

Seven women had ongoing relationships with partners who were the fathers of their babies but only three were living with them during their pregnancies. This was not through choice; one woman's partner worked away from home, one lived with his parents, two were employed or lived in another town. One woman who was pregnant on arrival seems to have come to the UK separately from her partner, and was initially detained and later dispersed separately

59 'Irregular immigration status' refers to migrants who do not have settled status or a valid UK visa.

60 Families with children born before they reach the end of the asylum process can continue to receive section 95 support even after their asylum claim has been refused. (See Chapter 1, section on asylum support).

from him. Four women separated from their partners during the pregnancy, in some cases becoming destitute as a result.

Irene is a 37 year old woman from east Africa who fled her country after being raped and to avoid FGM and a forced marriage. She was brought to the UK by her boyfriend on a false passport and lived with him in London for over three years, supported by him. He became abusive when she tried to legalise her status as his partner – he had told her he had status in an EU country but had kept her a virtual prisoner ostensibly to avoid her lack of valid immigration documents becoming known. After she became pregnant the abuse increased and when she refused to have an abortion he threw her out. She was a church member and a woman friend from the church encouraged her to apply for asylum and asylum support. She was offered section 95 support at about 3 months gestation and dispersed to a northern city despite requesting to stay in London where she had friends and other support.

Both Frieda and Irene spoke good English and had established lives in the areas from which they were dispersed before they claimed asylum support from UKBA. For Frieda, dispersal was a major disruption to the stability she had achieved over time in her personal life, and to the well-established healthcare she was receiving to control her HIV, and which she felt would protect the health of her unborn baby. Irene's life had already become destabilised as a result of her partner's violence and she only had her church and local friends to hang on to, desperately fearing being returned to her country.

Newly-arrived pregnant women seeking asylum faced different kinds of problems. Some had fled horrific situations in their home countries, endured arduous journeys alone, arriving pregnant in a strange country without knowing a word of English. Two women who arrived alone from Afghanistan and Iran respectively did not say in what circumstances they had fled from their home countries, but one young woman from West Africa had been gang-raped in prison several times before fleeing. (MW)⁶¹ Women are often ashamed to give details of their experiences in their screening interviews, and many arrive in a traumatised state.⁶²

Dana arrived from Afghanistan 8 months pregnant, in such bad shape that she was admitted to hospital. She said of her journey: "We were treated like animals – no food, no clothes, sometimes they put us in a container for maybe three or four days, we don't eat, just dirty water dripping in the side. When I come here the doctor thought my baby was dead because it had stopped moving. So I stayed in hospital for three days." After the hospital she was placed in Initial Accommodation where she tried to kill herself. She was then taken to a psychiatric hospital where she was left in a room with fellow patients whom she perceived as aggressive. She discharged herself with the help of an interpreter and was taken back to the Initial Accommodation. After this she was dispersed very soon to UKBA accommodation in the south of England, as it was thought she would be 'fine' in her own accommodation.

61 Information based on case studies by midwives is indicated by (MW)

62 D. Bögner, J. Herlihy and C. Brewin, 2007, "Impact of sexual violence on disclosure during Home Office interviews", *The British Journal of Psychiatry*, 191: 75-81

Underlying health conditions and health in pregnancy

All but two of the women interviewed reported feeling unwell during their pregnancies. Some women described serious health problems including thyroid disorder, anaemia, severe headaches, elevated or fluctuating blood pressure, serious pains and mobility problems. Several said that they had sometimes repeated urinary tract infections. They also suffered from particular problems of pregnancy including back pain, low lying placenta, or swollen feet, some of which could indicate high risk for themselves or their baby. Many felt sick and were vomiting for much of their pregnancy. Two women described how they could not eat and lost weight while in Initial Accommodation.

Dana (see above) was in very poor health after a long journey in a lorry from Afghanistan. She was one of four women interviewed who was hospitalised in the course of their pregnancies. In at least one case, described in the following example, such hospitalisation was a result of lack of access to healthcare and misinformation about healthcare in Initial Accommodation resulting in a costly health emergency.

Estella was pregnant when she arrived in the UK but was detained for five weeks immediately on arrival. She had her pregnancy confirmed whilst in detention and was diagnosed with a urine infection but she did not see a midwife while she was there. On release from detention she was taken to Initial Accommodation in a city in the north west, where she became ill with high fever, vomiting, and bleeding, and was afraid that she would lose the baby. The hostel manager gave her some paracetamol, after telling her she could not see a GP because she was only staying there temporarily.⁶³ It was only after she fainted a few hours later that they called an ambulance for her. She was diagnosed with an infection and kept in hospital for three days after which she was moved to her final dispersal destination. The hospital doctor had contacted the accommodation provider and told them that she could not return to the hostel.

Some women also had underlying health problems, or problematic general medical or pregnancy histories. One woman had HIV, two were sickle cell carriers, one had experienced FGM, one had hepatitis B, one had had a previous ectopic pregnancy, and one had had a fibroid removed which affected how she would deliver.

Over half (13) the women described experiencing mental health issues on top of physical health problems during their pregnancy. All of these suffered from stress or depression, and some linked these feelings directly to a history of rape, other trauma such as war experiences, domestic violence, imprisonment in their home country or by a partner in connection with abuse or trafficking. In every case depression and stress were additional to physical problems. Two of the women had attempted suicide during the pregnancy under discussion. Both the women and the midwives interviewed saw the threat or experience of dispersal as a major factor increasing their stress.

⁶³ This was wholly inaccurate information.

One midwife reporting on a woman who booked at 28 weeks gestation said:

“Most certainly she was absolutely distraught. Her mental health was suffering because of the stress of the situation she was in (the imminent dispersal) ..When I was with her she was absolutely distraught. She was heavily pregnant and extremely distressed. She didn't have any knowledge of the (new) area, her English wasn't particularly good, she wouldn't have any family support in that area. She had another young child. She definitely asked not to be dispersed.”

MW – sending area

As in the self-reported pregnancy histories of the women, most midwives identified similar and other health issues in the cases they described. Mental health was mentioned even more commonly in the midwife reported cases, and they described several women highly traumatised by past experiences, including rape and torture, domestic violence, trafficking, and loss of close family including children. In some cases the women were so depressed or traumatised that the midwives had concerns over the welfare of their babies. Several felt that the woman in their care needed specialist psychological help.

Midwives also reported frequent physical health problems among the women they looked after before or after dispersal. These included a woman with uncontrolled diabetes, two with gestational diabetes, and cases of women with HIV, hepatitis, TB or sexually transmitted infections such as chlamydia, or who had been subjected to FGM. One woman had severe pelvic pain and required crutches.

The process of dispersal

Dispersal locations

Since 1999, it has been government policy to house people in receipt of asylum support “in areas in which there is a ready supply of accommodation”. This generally means moving people away from London and the south of England. However, of the twenty women in this study, only two were actually dispersed away from London and the south, even though all were moved at least once during the pregnancy. Instead, people were moved between other regions or within the same region, including within London and the south.

Table 2.1 UKBA region where women lived when first pregnant and their final destination after dispersals (including dispersal within a single region)

Region moved from	Region moved to	Number of women (n=19) *
Port of entry	London and South of England	1
	North West	2
	Wales	1
London and South of England	London and South of England	6
	North East, Yorkshire and Humber	1
	Midlands and East of England	1
North East, Yorkshire and Humber	North East, Yorkshire and Humber	3
North West	Midlands and East of England	1
	North East, Yorkshire and Humber	1
Midlands and East of England	Midlands and East of England	2
Total		19

*Excludes 1 woman who stayed in Initial Accommodation on section 4 until after delivery

Dispersal during their pregnancies away from areas with which they were familiar, and in which they had already established healthcare and support networks caused women considerable distress. Even women who had strong connections with a particular area were forced to leave it when they claimed asylum support. In several cases dispersal separated them from their partner who was the father of their unborn baby because people are not allowed to have guests stay with them in their supported accommodation. It also forced a change in maternity care even when women were dispersed within the same region. Table 2.1 shows that over half (11 women) were moved *within* the region where they became pregnant. Nevertheless, only one of them lived near enough to the same maternity unit to continue antenatal care and give birth there without any disruption.

Multiple moves

It is to be expected that women who were pregnant on arrival and claimed asylum and asylum support at the port of entry would be accommodated somewhere determined by UKBA. What was difficult for them, as for women who claimed asylum in-country, was being moved several times.

Table 2.2 Number of times women were moved by UKBA during pregnancy or immediately after birth

Number of moves	Number of women (n=20)
1	6
2	7
3	3
4-6	4

Afya had had a miscarriage the previous year and arrived in the UK at about three months pregnant. She experienced six moves during her pregnancy and one after delivery before she was able to find settled accommodation with her partner.

“When I arrived I was put into prison for one day and on the next day I was taken to Yarl’s Wood Detention Centre in Bedford, where I stayed for about two months. After that, they took me to a UKBA hostel, and I stayed there for one month and two weeks and then I was put into another accommodation for one night. I had a signing appointment the next day and when I went to sign they took me back to Yarl’s Wood. I spent about one month in Yarl’s Wood.

“Then they took me to a hostel in Wales and I lived there for about a month. Then they brought me to a shared house (about 100 miles distance). And then I went to hospital to give birth. When I came out of hospital I went back to the shared accommodation for one week and after that they put me in a hostel. I stayed three weeks in that hostel and then my partner (the father of my child) was granted refugee status and applied for accommodation. He was given this house and so I moved in.”

Afya was very distressed by these moves. She said, “It would have been better if I could have stayed in one place. Moving around made me sad, tired and unhappy.”

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“It would have been better if I could have stayed in one place. Moving around made me sad, tired and unhappy.”

Estella was pregnant on arrival in the UK and was moved four times – from detention to Initial Accommodation centres in two different cities, and then finally to UKBA accommodation in the North West. For her the moves added to her anxiety about what would happen to her. “When I was in the detention centre I was ... torturing myself because I was ... wondering what was going to happen to me, but I didn’t expect all those stressful journeys to add to it.”

Frequent moves not only impact on the wellbeing of the women concerned but also create additional healthcare costs. They can give rise to repeated booking appointments, scans, blood tests, and midwives’ time spent trying to obtain accurate records from previous units.

Initial accommodation

Twelve of the women spent time in Initial Accommodation before being moved on. All but one of them received section 95 asylum support. The other woman was on section 4 support but was staying in Initial Accommodation until four weeks after the birth of her child, in accordance with new guidance.⁶⁴

Table 2.3 – Time spent in Initial Accommodation

Overall time spent in Initial Accommodation	Number of women
1 day	1
2 – 21 days	3
22 - 28 days	1
More than 28 days	7

64 UK Border Agency, 2012, *Healthcare needs and pregnancy dispersal guidance*, available at <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/asylumprocessguidance/asylumsupport/guidance/healthcare-guidance-.pdf?view=Binary>

Three women spent one or two nights in a first Initial Accommodation centre before moving to another one for a longer period. The length of time the other women spent in Initial Accommodation ranged from one night before dispersal to several periods of one month or more in different Initial Accommodation hostels, as in Afya's case above. Two women were returned to hostel accommodation after they delivered in hospital. One woman arrived in Initial Accommodation one day before she gave birth and then spent six weeks in the same hostel postnatally. We do not know why women stayed in Initial Accommodation for so long.

Women's feelings about Initial Accommodation were generally very adverse. Women in the final weeks of pregnancy or postnatally found the conditions particularly difficult, and several complained of dirty bathrooms and toilets, bad or inedible food, or having to walk up several flights of stairs. Afya said,

“When I gave birth the manager (of her pre-natal shared housing) came and said he would take me to a hostel, but I was scared to go there and I cried and begged him to take me back to the shared accommodation. In a hostel there are so many people and the hygiene is not that good. It's not right for a baby.”

Nevertheless she was returned to the hostel but found herself neglected and without appropriate healthcare.

“In the hostel I had my own room, but I think I was forgotten when I was there because nobody really came to check with me. The midwife from the shared accommodation said she couldn't help me any more because I had moved out of her area. She said I had to ask somebody at the hostel. So I asked them and they kept on asking me to wait, saying 'next time...next time'. I even had to take my baby to hospital as an emergency by ambulance because she had a cold and a cough. After I went to the hospital someone came to visit me one time because my baby had sores on her body so he gave me a little ointment. I was very very unhappy about being there with a baby for three weeks. First of all, the baby was not getting enough milk from me and the only place I could use the bottle steriliser was in the toilet, and I was worried because there were so many people coming in and out. Secondly, I was worried about the hygiene.”

Patience arrived in Initial Accommodation in the Midlands a day before giving birth even though the refugee support organisation which was helping her with her asylum support application had notified the UKBA that she was unfit to travel because she was heavily pregnant. Her midwife had already called the UKBA to tell them Patience could not travel to Croydon for her asylum interview because of her pregnancy and also gave her a note to take to the support organisation to explain why she could not travel. She then stayed in Initial Accommodation for five weeks postnatally. Patience said of the hostel,

“It was a bad experience because there was no bath for my baby. I had to put my baby in the sink to wash him... The hostel is the same thing as prison. The only difference is that you can go out. You're the only one there, no-one asks you how you and your baby are, no space for the baby to play. The bathroom was dirty. You have six or seven people using the same bathroom, separate for men and women. But the accommodation is shared. The first floor is for women with children; the second floor is for single people; the top floor is for men who are very huge, from prison. They always warn women that they should not go there.”

Safety issues were raised by several women. Irene, who was in Initial Accommodation for three weeks in her pregnancy, told of the following incident in a shared bathroom.

“It was horrible. We shared toilets, men and women. Once I went to shower and this man followed me and he went into the next cubicle and he climbed on the thing to put your towel and he was peeping on me while I was showering. I looked up and saw this head looking down on me. I was in the hands of the UK Border Agency and this is what was happening to me. I was shattered. I screamed and reported it. But they didn't take any action (against the man who had done it). They put it in writing, it's recorded. That's when they changed everything. They set up toilets and bathrooms for women.”

Several women also found it very difficult to stay in a shared room with a stranger with no common language. Haleh was about 35 weeks pregnant when she arrived in the UK and spent over three weeks in Initial Accommodation. She asked for a single room because her roommate disturbed her by coming in late at night, switching on the light and speaking on the phone, but her request was refused. Dana, who was taken to hospital immediately on arrival after days in a container, described how she felt after she was placed in Initial Accommodation when she was discharged from hospital.

“I was staying on the top floor. I was too tired. I can't speak English. I was sharing with a young girl, sixteen. She brought her boyfriend, friends who were men. So I couldn't sleep in there while they were sleeping here. It was not a good thing for me. The food was very bad. So I tried to kill myself.”

Women who were not well during their pregnancies found conditions in Initial Accommodation centres especially harsh. It was difficult for them to deal with inflexible mealtimes or having a room on an upper floor without lifts. One woman was given a top bunk when she first arrived in Initial Accommodation. Mimi, who remained there for the last three weeks of pregnancy and the postnatal period under the new healthcare and pregnancy guidance (see below), said:

“I don't like it really because of the food. Every day they cook the same thing, rice and this. I have gastric pain in my stomach when I eat things like rice or beans, and that is what we get every day. The lift is often broken and I am on the third floor. If you want to eat you have to go downstairs. They only do breakfast until 9.30 and if you are too tired or weak you might not get food and then you have to wait until the next meal at 13.00.”

However, Rita, who was very underweight, said that the hostel staff where she stayed did try to accommodate to her needs when they discovered that she was pregnant.

“The food in Initial Accommodation was difficult. As we are Hindu, we are vegetarian and the food was made for Muslim people, loads of beef. My midwife told me to eat fish but they would not provide it either in the hostel. I would have eaten it but it was not made available. They gave us beans and some vegetables and samosas. Once they heard I was pregnant they tried to make more special food, they would keep a separate plate for me.”

Moving to the dispersal area

The dispersal policy is about moving people receiving UKBA support to another location, not of their own choosing. This is a traumatic experience for anyone, and especially so if the person concerned is a pregnant woman in the later stages of pregnancy. Fourteen women interviewed were in their final trimester of pregnancy and eight were in their last month when they were dispersed. Two women were dispersed one day before they gave birth, and another woman gave birth two days after dispersal.

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“I was staying on the top floor. I was too tired. I can't speak English. I was sharing with a young girl, sixteen. She brought her boyfriend, friends who were men. So I couldn't sleep in there while they were sleeping here. It was not a good thing for me. The food was very bad. So I tried to kill myself.”

Even where, and perhaps especially because the women concerned were completely destitute (an already difficult situation, practically and emotionally) and knew that they had no choice as to where they could live, they clung to what they knew, and in most cases wanted to stay in the areas in which they had been living, where they felt they had friends, support for giving birth, partners, churches, temples and mosques, children established at school, GPs and midwives.

Only one woman was happy to have been dispersed after she and her husband applied for asylum because they were given a house to themselves. However, although the family had had to stay in Initial Accommodation for one month, they ended up housed near where they had lived before, and her healthcare was not interrupted by their stay in Initial Accommodation.

Three women who were pregnant on arrival all accepted that they would be sent somewhere chosen by UKBA. However, even for them, the process was extremely destabilising. One woman was upset at constantly moving, another at not knowing where she was going or what was going to happen to her, and the third was desperate to move out of Initial Accommodation because she was so unhappy there. All the other women interviewed wanted to stay either where they had been living because of the ties they had established, or to move somewhere where they had other connections. None of them were able to do so.

Estella (see above) was taken from Yarl's Wood Detention Centre to Initial Accommodation in the north west. While there, she became seriously ill and was admitted to hospital. She said that she asked to stay in that town "because the doctor there was very nice to me.. and I made friends there." Nevertheless, she was moved to permanent accommodation in another city.

The prospect of dispersal was alarming for women, in many cases, late in their pregnancies. Not knowing where they might be sent, afraid of what they would find in the new area, not feeling well and frequently depressed, how a move is carried out can have a further impact on women's levels of anxiety. In general the women interviewed were given very little notice before the move took place. Fifteen women of the 20 interviewed were given less than one week's notice of travel, and seven received less than 24 hours' notice.

Although most journeys were short, the process of being moved was often very distressing, especially where requests had been made by asylum agencies and medical staff had advised against travel.

Clara was eight months pregnant and living in South London when she applied for section 4 support with the help of a local support group. Both the support group and the GP asked UKBA not to disperse her and the GP wrote that because of her pregnancy she was not fit to travel. However, the request was turned down but Clara only heard about this after her support group called UKBA. UKBA then sent her a letter stating that she would be sent to Liverpool or Manchester but did not give her a date for the move. The support group called them again and they said she would be moved the following day. In the event, instead of taking her to the north west Clara was taken to a town in the south. Clara prepared everything that night but no-one came in the morning, and eventually it was she who had to phone again. She was only then told that someone would come at 2pm.

Although the journey was much shorter than she had initially been led to expect, Clara was very upset about the move. "I was crying all the way in the car. I don't even know why I was crying. I was thinking, 'I'm going to a new place, I'm pregnant, I don't know the hospital, I've left it behind. So all those things were going through my mind. I couldn't cope and I was on my own."

Clara gave birth just one month after the move.

Clara's story is typical of the peremptory way in which many of the dispersed women were treated by the accommodation providers and the UKBA, and how the move affected them. A reasonable request supported by a GP to delay dispersal on account of her advanced pregnancy was refused, in spite of clear UKBA guidance that such advice should be accepted.⁶⁵ She was only given the dispersal date one day beforehand, and only because the support agency rang the accommodation provider. She was not given a collection time until she herself rang the accommodation provider to find out what was going on. The result was a woman alone, in despair and weeping as she travelled to her new life.

Women often feel very unwell during the first trimester of pregnancy. One woman travelled from London to Birmingham by coach with her three year old daughter in early pregnancy and was sick the whole time. The following case shows how stressful a long journey can be for a woman even in early pregnancy, and how no special consideration appeared to have been taken of this woman's health or welfare before or during the journey.

Irene claimed asylum after leaving her abusive partner when she was about three months pregnant, destitute, and feeling very unwell (see above). After her screening interview which took all day and during which she felt ill and was unable to eat, she was taken to Initial Accommodation in London to be dispersed with other people the following day. She was initially told that she was being sent to Scotland but at 8.30 in the evening was informed that they would be taken to a northern city in England the next morning. The group travelled in a minibus, and the journey took seven hours including three breaks. Irene said that they were given crisps but no other food and no water.

"I asked for help (to carry her bags) but he said 'no we're not paid to do this'. I was still very unwell and the driver couldn't even put my luggage in the van, which was quite heavy. I said I was pregnant. He just walked away and had a cigarette. I cried. Who am I? I thought, I'm just an asylum seeker.

Another thing about the journey was that, when I was in the early stages of my pregnancy I used to get hungry, hungry. I asked the driver if I could have something in the minibus. He said 'no, you're not allowed to eat'. I said 'I'm pregnant'. He said I'm not allowed to. You feel dizzy when you're pregnant, you can't understand your body. He said 'you are not going to eat in this bus'. You wait until we have a break somewhere'."

Other women also spoke about not being allowed to eat during the journey, and told of inadequate toilet breaks, particularly difficult for pregnant women. The now superseded *Pregnancy Policy Bulletin 61* which was operative during the period our interviewees were discussing, only made reference to the *length* of dispersal journeys and advised that they should not exceed 4 hours.⁶⁶ With a few exceptions most women's journeys were within this timeframe, but women's accounts of the need for toilet breaks, of lack of access to food and water on the journey, of delays in being picked up, of lack of assistance with baggage and restrictions on the number of bags allowed, of late notification of time of travel and the destination, and of lack of information about the distance to be travelled, indicate that many other issues also affect pregnant women's wellbeing on these stressful journeys to places unknown to them.

⁶⁵ UKBA, 2009, *Pregnancy: Asylum Support Policy Bulletin 61* "If the UK Border Agency is advised, by those providing medical care that dispersal should be delayed until after the birth of the child this must be adhered to. Unless we intend to have the applicant examined we will have to take the GP's word of inability to travel. – p4. (No longer available online)

⁶⁶ *Ibid.*

Estella, travelling from London to the north west when she was 28 weeks pregnant, described her journey:

“They picked us up in a bus from London at 8 in the morning. There were 10 or so of us. They were going to different places and picking more people up on the way. It was a very long bus. The car was very very squeezed up. I wanted to ease myself, the driver said he can't stop, even when I was very hungry throughout the day. I didn't know the journey would be very far so I did not take breakfast.

“We left at 8 in the morning and arrived around midnight. My god it was really really bad. The man was picking people up from different places, stopping, waiting for people to come out, checking their papers. And even though when we stopped I could see somewhere to buy food, because I was very very hungry...I asked and the man said I was not allowed to get out of the bus. Before I left London I had food in my bag but we'd had to put our bags in the hold of the bus. So I said okay just let me get my bag and eat, I have some biscuits in there. He said there's no eating in the bus. And the lady who was sitting next to me said: This lady's pregnant, you can see that she's pregnant, how can she stay a full day without eating. He said it's not his fault, it's the law. There's no eating in the car, you should read the sign, there's even a sign to say that.”

Current policy guidance does now recognise the need for “frequent comfort breaks” in the journey to be agreed with the provider but still does not address the other issues about travel raised by the women interviewed in this study.⁶⁷

Reception in dispersal area

Most women were very anxious about what would happen to them in the new place. Some women described how bewildered they were because they did not know or understand anything about what was happening to them. For example, Dana, who had already attempted suicide in Initial Accommodation, had no idea what was happening to her.

“I don't know where I'm going because there is no-one to talk to us. I just received a letter and showed it to the African lady (roommate in Initial Accommodation). She said, they will send you to another house (miming the shape of a building)... When I came here (to the dispersal area) I didn't know how long I would stay here, where is the Post Office, where is things, I didn't know nothing.

“They could show us these things because this is a totally new area for me. I don't know. That night (the night she gave birth) I was thinking that if I didn't call the ambulance maybe I would die alone in this room. I was shouting and shouting. I didn't call the ambulance because I was scared because the ambulance man had shouted at me and saying you have to call a taxi but I didn't have money to call a taxi.”

Haleh, who also spoke no English, said that she was very stressed because she had no idea where she was going to. Other women who did know at least vaguely where they were going were largely, as we have seen, at best reluctant and at worst desperate not to go.

In these circumstances their experience of the journey and how they were received on arrival in the dispersal area, in many cases in very advanced stages of pregnancy, made a big difference to women's capacity to deal with their new circumstances. Above all, the interviews show how important it was for the women to have information about where to access essential services, such as the GP in the new area.

“

That night (the night she gave birth) I was thinking that if I didn't call the ambulance maybe I would die alone in this room. I was shouting and shouting. I didn't call the ambulance because I was scared because the ambulance man had shouted at me and saying you have to call a taxi but I didn't have money to call a taxi.”

67 UKBA, 2012, *op.cit.*

Accessing health services

Women were understandably concerned to access healthcare as soon as possible and the UKBA's *Asylum Support Policy Bulletin 85*, stated that pregnancy is one of the "pre-existing medical conditions and other instances that will require a (accommodation) provider to register a dispersed asylum seeker with a GP within 5 working days of the asylum seeker's arrival at the dispersal address" or within 1 working day if there is a need for a new supply of prescribed medication.⁶⁸ It is not clear from this instruction what steps the accommodation provider needed to take to get a woman registered and not all women felt they were helped by their provider. For example, Beatrice, moved at 35 weeks gestation, described the casual way in which she was given this information as she was driven to her new accommodation.

"I asked her how to register with the GP because I needed to have a scan at 37 weeks (because of a low lying placenta). ... So she said to me there is one there but I should go to the hospital and waved her hand in the direction of the hospital, while driving through town to drop me off at the accommodation. But the next day when I went to look for it I couldn't find it so I had to ask people in the street, but I still couldn't find it. When I saw her about a week later, I told her I couldn't find the hospital and she described that if I go down I will see a restaurant and beside it is the hospital."

In some areas there seemed to be close collaboration between the NHS and the accommodation providers, or between them and national or local voluntary organisations which helped women register with GPs. For example Irene, dispersed from a city in the North West to the North East, was taken straight to a specialist GP practice by a support worker for the accommodation provider. She was also helped to get some money on her first day there. Where there was no such help it could take several weeks to register even if women know where to go. This caused delays and interruptions to some women's maternity care as GPs are the main route to accessing such care.

Settling in

Some women also faced other problems such as enrolling their other children into school or nursery, and obtaining money. Grace was dispersed just one day before she gave birth, which had been her due date. In her case the accommodation provider did inform the health visitor as soon as she arrived. But Grace did not know the area, and had no food to cook and did not know where to buy clothes for her child. She spoke no English and did not know that baby equipment left in her room was for her use. Eventually her friend told her that the cot, bottle and other equipment was for her. Two women had difficulty enrolling their children into local schools which caused them great anxiety, and some had delays or problems with receiving financial support.

These practical difficulties added to women's stress on moving, and exacerbated the distress experienced by half the women on finding their new accommodation unpleasant and/or unsuitable. Eighteen of the twenty women interviewed were moved to private accommodation run by accommodation providers contracted by UKBA at some point in the dispersal process. Seven women were satisfied with or accepted their new accommodation, but eleven were very unhappy with theirs.

Many women complained that the houses assigned to them were very dirty and smelled bad. One woman who moved at 8 months gestation said that the fridge was so dirty that it smelled but she did not have the energy to clean it. Several women felt unsafe in their new accommodation. In one case, this was because of the other people there, in another because the woman was alone there, or because they thought the house itself had dangerous features

⁶⁸ UKBA, 2009, *Dispersing Asylum Seekers with Healthcare needs*, Asylum Support Policy Bulletin 85 Paras. 16.7-16.9. (No longer available online).

such as an unsafe boiler or difficult stairs. Some women were unhappy with the size or location of their rooms. A few had tiny rooms with poor ventilation, noisy boilers, or were at the top of a house where they had difficulty climbing the stairs.

Financial problems

Women often faced considerable hardship before they became eligible for UKBA support. Those who had been refused asylum were entirely dependent on the charity of friends or support organisations before they were granted section 4 support, and often experienced real poverty during their pregnancy. Because UKBA only recognises pregnancy as a criterion for section 4 support after 34 weeks gestation, some women could find themselves totally destitute for several weeks or months during pregnancy, even if, like Martha, they have complex social and health problems which could affect their pregnancy.

Martha had twice undergone FGM as a child and, several years ago, fled to the UK to avoid a forced marriage, but was refused asylum. Subsequently she lived precariously for some years, living from domestic work and selling sex after escaping from an abusive relationship. She also had a child during this time (now aged 3) but avoided any contact with UKBA until she was pregnant again. Martha was very depressed and fearful of being returned to her country. "I did not want them to find me. I was really scared. Whenever I hear police sirens I wee in my pants. I still have nightmares, and have to have painkillers to sleep."

She had been living with a friend in east London for the last year, but could no longer stay there, and finally decided to request section 4 support. She became homeless at only three months pregnant so at that stage was not eligible for support on the basis of her pregnancy. UKBA refused to prioritise her application after she was evicted from the house, even though a worker at the Refugee Council told them about her circumstances. Her local Social Service department was reluctant to help her and tried to push her back to UKBA for support. For a while Martha did get social services support of £30 a week and was provided with temporary accommodation in another area.⁶⁹ Martha said, "I used to take my daughter to school every day as she would keep crying otherwise. I managed to get some money for a bus pass from ___ (a refugee charity) and I would take her to school and then sit in the gardens waiting until it was time to pick her up."

Martha was helped by a refugee agency, which referred her to a specialist counselling service. She was eventually granted section 4 support but allowed to stay in London in order to continue her trauma counselling. She also submitted a fresh claim for asylum.

Once dispersed, on top of the social upheaval which they went through, the women interviewed found it very hard to make ends meet. On being dispersed from where they had been living, many of them had lost the support of partners, friends, or familiar charities which had sustained them with food or money. Now they not only had no money but also had new expenses for the pregnancy and to prepare for their babies, and found themselves in strange places without their previous support, however limited and tenuous that had been. Some of them actually went hungry while others were unable to buy clothes before they gave birth.

69 This was probably under the Children Act, 1989, section 17.

Estella stayed in a hostel for three weeks before travelling on to her final dispersal area.⁷⁰ “When I was there... they were giving us five pounds a day so I was trying to save it up. I just went hungry so I could buy things for my baby.” Lara was receiving section 4 support and complained that it took two months after her baby was born before his allowance was added to her Azure card, so she had to survive on £35 per week. “For two months it was extremely difficult as I had to survive on only £35 of vouchers, which meant that I could not eat so I could get transport and feed my child. They gave me the money all in one go – and what is the point of that after you have suffered all of that time?”

Inflexibility in the administration of support sometimes meant that women could be left with no money at all, or with much less than their entitlement. As Lara said, what is the point of giving the money all in one go, when you have gone hungry beforehand? Most women interviewed did not report problems with receiving their regular support payments but it was extremely stressful for those who did not receive payments on time as their income was so low. Such delays or non-payments could be because of inefficiencies within UKBA in processing information about the birth, poor advice about applying for their Maternity Payment, or changes to their asylum status during their pregnancy. Delays are also often a result of UKBA issuing ‘Further Information Requests’ before payments are granted.⁷¹

Dana (see above) did not have enough money before she gave birth to buy clothes and necessities for the baby. She had received an initial payment of £90 when she first claimed asylum on arrival in the UK, but she used this money to pay for travel from outside London for her asylum interview and for fares to see her solicitor. Her next payment of £35 was due on the day she delivered, and she thought she would lose it if she did not collect it immediately. So, straight after giving birth, she left her baby in the hospital to go to the post office to collect her money to buy clothes for her baby.

“It was freezing (December 29th) but if I didn’t go I would lose my money. For £35 I left my baby. Two hours after I gave birth I left the hospital to go to the post office. The nurses said, ‘No you are not allowed to take the baby with you because you are not fine.’ I said, ‘No I have to go because she doesn’t have clothes. I have to buy clothes.’ So when she was born for two hours she didn’t have any clothes so they covered her with towels.”

Dana spoke no English and had arrived in the UK in a very poor state of mental and physical health. Adequate arrangements to provide enough money for her had not been made, and she was obviously overwhelmed by anxiety about how to clothe and feed her baby or herself. Dana only received her maternity grant two months after the birth.

Many women interviewed complained of having no or insufficient money for essential needs. The worst affected were those receiving cashless support, either on section 4 or because they were based in full-board hostels and only received minimal cash payments for pregnancy (£3 per week).

Clara, on section 4 support, said, “They give you a card to buy food but you can’t survive with that. Sometimes you need buses to go places, your taxi to the hospital, which cost £7 because it’s far away.” Irene’s case illustrates the difficulties faced by women on section 4

⁷⁰ This appears to have been a self-catering hostel.

⁷¹ See Refugee Council, 2012, *Submission to the inquiry into asylum support for children and young people* (Unpublished)

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“It was freezing (December 29th) but if I didn’t go I would lose my money. For £35 I left my baby. Two hours after I gave birth I left the hospital to go to the post office. The nurses said, ‘No you are not allowed to take the baby with you because you are not fine.’ I said, ‘No I have to go because she doesn’t have clothes. I have to buy clothes.’ So when she was born for two hours she didn’t have any clothes so they covered her with towels.”

cashless support who have no money to pay for public transport for medical appointments or who, like her, have difficulties walking before or after delivery.⁷²

Irene had her section 95 support stopped while she was in hospital giving birth as her asylum claim was refused. She had had complications in labour and was delivered by emergency caesarean section. As a result she found it painful to walk and even to climb the stairs carrying her baby (see Chapter 3). She had no money for two weeks until the local refugee support agency helped her apply for section 4 support. She said, “I’m getting section 4 support now, but it isn’t any money so I can’t get the bus anywhere. I have to walk, which is hard, especially earlier on because I’d had such an intrusive surgery it really hurt to walk...I used my last coins to get a cab to the registry office (to register the birth) but I didn’t have any money left to get home so I walked, which was really painful.”

We do not know whether Irene’s baby was born within the ‘grace’ period of 21 days after her asylum request was refused, and whether she should have been entitled to continue section 95 support.⁷³ It is, however, disturbing that a newly delivered woman with birth complications should have had her support stopped at this time.

Even women receiving cash on section 95 support found that their lives were constrained by lack of money. Ofilia, who was on section 95 support only, took her son to the Sure Start centre every one or two weeks when she was pregnant because each session cost £1.50. Yet the service meant a lot to her as she got to know other mothers, learned English, and met some women who spoke her language. If they were on section 95 support but in full-board hostels, women were as badly off as those on section 4. This could mean that they could not buy food on the journey to the dispersal area, could not arrange transport back to their hostel after delivery, and had no money for travel either to get to appointments or to visit friends.

Women who are required to stay for at least eight weeks in Initial Accommodation as set out in the UKBA *Healthcare needs and pregnancy dispersal guidance* 2012 are unlikely to have any cash throughout this period. Mimi was destitute throughout her pregnancy until the Red Cross helped her obtain section 4 support at 37 weeks pregnant. Until then Mimi was sofa surfing with various friends, getting food parcels from charities, and occasional cash from the Red Cross. In the hostel she was provided with nappies, baby wipes and milk, and given £5 in cash per week (since delivery) for other things. She used this money to pay for transport for her hospital appointments but was unable to buy many other essentials.

All pregnant women supported by UKBA were also entitled to Maternity Payments. In general women received help to obtain these payments while they were in Initial Accommodation or from the refugee support organisations which helped them claim asylum support. However, getting the Maternity Payment was not always straightforward.

Jung was badly advised about applying for the Maternity Payment. Her accommodation provider brought her the form and she took it to a local advice drop-in for refugees and asylum seekers. The advisor phoned the Home Office to check what was needed and was told that Jung did not need to fill in the form. Later, when she had not received any money, she went back to the drop-in where another advisor told her that it was because she had not filled in the form, and helped her do so. But by this time the deadline had passed and she was refused the payment.

“

“I’m getting Section 4 support now, but it isn’t any money so I can’t get the bus anywhere. I have to walk, which is hard, especially earlier on because I’d had such an intrusive surgery it really hurt to walk... I used my last coins to get a cab to the registry office (to register the birth) but I didn’t have any money left to get home so I walked, which was really painful.”

⁷² See also S. Reynolds, 2010, *Your inflexible friend: The cost of living without cash*, London: Refugee Council, available at <http://www.refugeecouncil.org.uk/Resources/Refugee%20Council/downloads/researchreports/ASP%20-%20azurecard-v4.pdf>

⁷³ For an explanation of the ‘grace period’ see Glossary

Very few, if any, women would have known how to claim the Maternity Payment without assistance. Jung was receiving section 95 support, so she was not able to receive £300 through no fault of her own. This is one of many examples in this study of misinformation, or failure to follow proper procedures by the UKBA or accommodation providers, resulting in hardship and distress for the women affected.

Pregnant women who are not dispersed

Because dispersal is usually viewed as dispersal away from London and the south east, keeping women in London is presented as not dispersing them. The new *Healthcare and Pregnancy Guidance* which stipulates that women must not be dispersed during a protected period, but kept in Initial Accommodation, also implies that accommodating a woman in this way means that she has not been dispersed.⁷⁴ We interviewed one woman whose pregnancy fell under the new guidance, allowing us to see what difference it might be making, and to give an initial idea of the impact of an eight week or more stay in Initial Accommodation during pregnancy and the postnatal period.

In 2011 Mimi (see above) became pregnant, and applied for section 4 support when she became eligible at 7 months of pregnancy. Mimi asked the UKBA to allow her to stay where she was living because of her pregnancy and the fact that she was receiving therapy at a specialist counselling service. She had a GP in north London and had seen a midwife regularly throughout her pregnancy. Her midwife wrote a letter to UKBA requesting that she be allowed to stay in north London. Mimi waited one month before receiving a response from UKBA. They refused her request to remain in the same area, and, following the new guidance, required her to stay in Initial Accommodation in London for the remainder of her pregnancy and the first four weeks postnatally.

Mimi travelled by bus from north London to the Initial Accommodation with the help of a friend three weeks before her due date, a journey involving several changes that would have taken at least three hours. Although she was given money by the Red Cross for travel, she was not given food. She found no baby equipment ready for her and found living conditions in the hostel very uncomfortable (see above).

It had taken Mimi 10 days to see a GP after arriving at the Initial Accommodation. At the time of the interview (two days before her due date), she had still not seen a midwife there, even though she had informed the new GP that traces of e-coli had been found in her stomach which had to be monitored. She did not know the number of the hospital where she would have been expected to give birth or where it was. She was simply told by the refugee support agency in the Initial Accommodation Centre that she could call an ambulance when she needed to go there for her labour.

In spite of not being dispersed to another city, Mimi had to give birth in an unfamiliar hospital despite having had maternity care until 37 weeks in another hospital which had all her records, and where she felt secure.

74 UKBA, 2012, *op.cit.*

Mimi's experience shows that moving from one side of London to another is, for the woman concerned, as much a dispersal out of one's area as moving to another city. In Mimi's case, despite the very long journey, she was not even provided with transport to the Initial Accommodation. Mimi's story, and those of two other women who remained in London, give us an insight into the implications of women being moved within London from one area to another in advanced pregnancy.

The two women were not dispersed from London for health reasons, but were moved by UKBA to other boroughs far from where they had been living and were accessing services. They found the experience of moving just as traumatic as women who were moved from city to city in the north of England. Like women dispersed to other towns, they knew no-one and had to establish new connections including school and healthcare.

Martha, (see above) was six months pregnant at the time and was given practically no notice before the accommodation provider came to collect her. In the new area she could not find a nursery place for her daughter and was lonely and depressed. Helen was two weeks from her due date when she was moved to another borough, but she gave birth the next day, after travelling back alone by train with all her bags to stay with friends as she could not face moving into the new accommodation. Helen had been supported by social services before they passed her on to UKBA, so it was known that she was exceptionally vulnerable. This was why she was not moved out of London, yet her move to a distant borough was both far too late in her pregnancy, and much too far to enable her to access the services she needed.

All three women described in this section were receiving section 4 support and so could only claim it after 34 weeks of pregnancy. This inevitably resulted in moving at very advanced stages of pregnancy.

Conclusion

All the women interviewed were either entitled to support while their asylum claim was being considered or, if their claim had been refused, met the stringent conditions for section 4 support.⁷⁵ Almost all of them had physical health problems, including mobility problems connected with, or in addition to their pregnancy; thirteen women also suffered from stress or depression or other mental health problems; two women had tried to kill themselves during their pregnancies before they were dispersed.

Nearly all of them moved to the dispersal areas reluctantly and in a state of distress. Two thirds were in the final trimester of pregnancy. This made the situation they faced on arrival, which may have followed moves to several places, including other harsh conditions such as prison, immigration detention or lengthy stays in Initial Accommodation, much more difficult than for a fit and healthy person. Some had lost family members, and almost all were being separated from partners or friends or both. For them dispersal was yet a further loss of control over lives in which they already had little autonomy.

The evidence from the woman moved late in pregnancy to Initial Accommodation in London showed that, in her case, it provided no improvement over dispersal to other areas in terms of social support, access to healthcare, suitable accommodation or even the journey and experience of travel. The other women who were permitted to stay in London, were dispersed in all but name as they were placed in new areas where they needed to establish themselves with no money or prior social networks. All of them were deeply distressed by these moves across London.

⁷⁵ 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>

All the women interviewed presented with 'complex social factors' as designated by NICE.⁷⁶ They had either not yet initiated maternity care, or their established maternity care had been interrupted, either of which situations could increase risks to their health. However, despite their high risk pregnancies, the conditions of dispersal often made it extremely difficult for them not only to access healthcare, but also to deal with practical difficulties arising from their pregnancies and from living in a new and unknown area.

The women's stories about their experiences of the dispersal process which we have examined in this section, focus on the strain of moving when pregnant, especially when that move separates them from safe and familiar surroundings. The next section discusses how dispersal affected their experience of pregnancy and healthcare, and draws both on the interviews with the dispersed women and with midwives involved with women before and after dispersal.

⁷⁶ National Institute for Health and Clinical Excellence, 2010, Clinical guideline 110 – *Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors*, London, available at <http://publications.nice.org.uk/pregnancy-and-complex-social-factors-cg110>

Chapter 3 The impact of dispersal on women's health and maternity care

This chapter discusses how the women interviewed first engaged in maternity care, and the effect on them of the interruption of care as a result of dispersal. Using accounts from the women and midwives, the chapter explores the health and social implications of losing continuity of care, and the obstacles faced by midwives planning women's care when they were dispersed. Particular attention is given to the impact of dispersal on women's mental health. The chapter examines what happens when women and their midwives challenged a woman's dispersal, and the difficulties women faced if they tried to stay with the same maternity unit after dispersal. Women's experiences of giving birth and how they felt in the postnatal period are also discussed.

Current health guidelines have identified additional inputs required to provide women such as these with 'woman centred care'. These include providing interpreters, flexibility in the number and length of antenatal appointments, providing women with information about how to access antenatal services, and sensitive and culturally appropriate care.⁷⁷ The Guideline Development Group for the NICE Guidelines notes that there are "particular issues with residential mobility, particularly among women who are asylum seekers or refugees."⁷⁸ However, the guidelines themselves do not address the additional problems of women who are dispersed by UKBA in the course of their pregnancies, and for whom, whatever attention is paid to their special needs by trained midwives, the process of maternity care is disrupted. This chapter shows the effect of such disruption on the health and maternity care of the women interviewed.

Initiating maternity care before dispersal

As women's pregnancies were an important part of their circumstances at the time they were dispersed or relocated by the UKBA, we investigated their engagement with maternity services before dispersal. This included their first contact with maternity services and the frequency of contact, and tests and scans that followed, until their dispersal or relocation. They were also asked about any health problems during the pregnancy.

According to NICE guidelines the antenatal 'booking appointment' follows confirmation of a pregnancy, and involves a long interview with the woman during which a midwife can ascertain any need for additional care. At the booking appointment, screening and tests are offered, risks are identified, and a plan is developed with the woman for her care during the pregnancy.⁷⁹ Clinical staff are advised to 'be alert to any factors, clinical and/or social, that may affect the health of the woman and baby.'⁸⁰ Current policy is for the booking appointment to take place by 12 weeks, and NICE guidelines advocate first booking at 10 weeks.⁸¹

77 National Collaborating Centre for Women's and Children's Health, 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 (NICE) available at <http://www.nice.org.uk/nicemedia/live/13167/50861/50861.pdf>

78 *Ibid.* p93

79 See S. Bennett, 2010, *Integrated Maternity Care Pathway for women seeking asylum in Leeds*

80 National Institute for Health and Clinical Excellence, 2008, 'Antenatal care: routine care for the healthy pregnant woman' (*NICE clinical guideline 62*): quick reference guide

81 National Institute for Health and Clinical Excellence, 2010 *Clinical guideline 110 – Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors*, London, <http://publications.nice.org.uk/pregnancy-and-complex-social-factors-cg110>

Because the women interviewed may not have known what 'booking appointment' meant, they were asked about their stage of their pregnancy when they first had *any* contact with a midwife. Table 3.1 shows the self reported stages of pregnancy at first contact with midwives by the women interviewed. Only six women in our sample (30%) had first contact with a midwife before 12 weeks pregnancy.⁸² This proportion remains the same even after excluding the seven women who arrived in the UK already pregnant. Of the six women reporting first contact with a midwife after 20 weeks or more, four had arrived in the UK already pregnant, two arriving at eight months gestation.

Period of gestation at first contact with a midwife/ maternity services	Number of women (n=20)	Women pregnant on arrival (n=7)
<10 weeks	2	
10-12 weeks	4	2
13-16 weeks	5	1
16-19 weeks	3	
20-23 weeks	1	1
24-29 weeks	2	
30-35 weeks	2	2
> 36 weeks	1	1

* Where women gave the stage in months, we have calculated 1 month as 4.4 weeks

Delays in obtaining maternity care resulted from women arriving in the UK late in pregnancy, their fears of accessing health services because of their own or their partner's or family's immigration status, and barriers to accessing GP services. The latter are particularly important as GPs are by far the most common referral route to maternity services. A midwife interviewed for this study said that most asylum seekers come early to maternity services if they make contact through the GP. However, several women reported that they had been refused registration by GPs. For example, Grace had lived undocumented in the UK for nine years and had been refused registration with a GP because of her immigration status.⁸³ Eventually, when she was six months pregnant, a friend helped her to register. "Because she speaks English she told the receptionist that I was six months pregnant and I hadn't seen anyone."

Some women were unaware of their entitlements and were afraid to make contact with the NHS or other agencies for fear of being reported to the Home Office. As a result, their initial contact with maternity services was delayed.

82 Compare Raleigh et al., 2010, "Ethnic and social inequalities in women's experience of maternity care in England: results of a national survey", *Journal of the Royal Society of Medicine*, 103, 188-98.

83 Everyone, whatever their immigration status is eligible for full GP registration. GP practices throughout the UK have the discretion to accept *all* overseas visitors as registered NHS patients including refused asylum seekers. See Department of Health, 2011, *Guidance on Implementing the Overseas Visitors Hospital Charging Regulations*, London, Department of Health, available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127393; BMA Ethics, 2012, *Access to healthcare for asylum seekers and refused asylum seekers- guidance for doctors*, London, British Medical Association, available at <http://www.hpa.org.uk/MigrantHealthGuide/GeneralInformation/MigrantsAndTheNHS/EntitlementsToNHSCare/>

Katerina said:

“I was scared that if I registered with the doctor or at the school they would find out and deport me. When I was 12 weeks pregnant I was told at ____ (a local refugee charity) that there was a doctor for the homeless and that if you went there they would not give your details to the Home Office. So I went there to register, but they told me that I had to find a GP as they could not see pregnant women there at the Homeless team. Once they told me that they would not send the information to the Home Office, I went and registered at a GP practice near the house where we were living at the moment.” Katerina was in fact referred to the maternity services by the Homeless team.

In another case, lack of understanding of NHS procedures, and a concern to do ‘the right thing’ also delayed access to maternity services. While Rita and her husband were awaiting their initial asylum interview, Rita’s pregnancy was confirmed by her GP who referred her to a local maternity unit. However, under the misapprehension that you had to stay with the same hospital throughout your pregnancy, she declined an appointment there because “I was worried that when we went to Croydon (for the asylum interview) they would take us somewhere else and then there would be a problem with having attended that hospital.” She was already about 3 months pregnant and severely underweight when she finally had a booking appointment after she and her family were sent to Initial Accommodation away from London.

Three women did not establish any antenatal care before dispersal. Two were pregnant when they arrived in the UK. They were Dana and Estella whose stories are told in the last chapter. Although both of them were hospitalised in a maternity unit during their pregnancies, neither had any routine antenatal care until after they were dispersed at 37 weeks and 32 weeks gestation respectively. The third woman, Nerissa, claimed asylum in-country in early pregnancy and was taken to Initial Accommodation in the Midlands, where she stayed for four weeks. While there, she had an appointment to see a midwife, but was dispersed further before that took place. She eventually booked into antenatal care in her second dispersal area at about 14 weeks gestation. These cases show how even if dispersal does not interrupt existing antenatal care, it can delay its start.

Continuity of care

Initial contact, of course, is not the same as regular antenatal care, and those women who booked early and were then dispersed may not have been able to establish regular contact in the unit they first booked in. Two women who were pregnant and claimed asylum on arrival had their first contact with maternity services through the healthcare units of detention centres or Initial Accommodation.

Interviews with midwives in maternity units in the sending areas show the importance they attached to regular antenatal contact with vulnerable women. Very often the care was interrupted by dispersal even though in some cases the midwives and other healthcare professionals wrote to the UKBA requesting that the woman remain where she was for health or social support reasons. The midwife interviews indicate how much they considered continuity of care and of carer to contribute to the health of the woman, her baby, and the welfare of other children, particularly where there were evident health and social issues. The following cases describe antenatal care before dispersal to show how both clinical and multi-agency work is involved in the care of these vulnerable women. They also demonstrate midwives’ perception that time is needed to build a relationship with the women in order to understand their needs and organise appropriate care.

MW Case 1 (North)

C had booked late (after 12 weeks) and was also under specialist treatment for hepatitis. She was referred to the community and FGM midwife with responsibility for asylum seekers. The baby required immunisation at birth because of the hepatitis and C's mental health was deteriorating rapidly.

The midwife put in a request to the UKBA for C not to be dispersed as her partner lived in the same town, support services had been set up for her there, and she also had support from her own community. Her health also required careful monitoring.

At the same time the midwife also put in numerous requests to the housing provider to say that conditions in the house C was living in were unacceptable. This became worse after the baby was born. C was unable to go to the toilet after her caesarean section as it was down two flights of stairs. "There were days that she couldn't walk up and down the stairs because she was in so much pain." The midwife was very concerned about a newborn in a shared house with strangers and raised child protection and safety issues with the housing provider.

Although the dispersal was successfully delayed until just two weeks after delivery, C finally agreed to move as it was the only way for her to get better accommodation. However, the midwife remained concerned about the baby's immunisation and C continued to come back to her original hospital for all her appointments and follow-ups. C was very depressed postnatally and her midwife was sure that her postnatal depression adversely affected her bonding with the baby.

C's story shows the level of involvement of the midwife throughout a woman's pregnancy both in ensuring appropriate healthcare for both C herself and the baby, and also in recognising and attempting to address the social and housing issues, including the threat of dispersal to another city, which were affecting C's mental health. In this case the midwife had close contact with both the case-owner (the person responsible for an asylum seeker in UKBA) and the caseworker for the housing provider.

MW Case 2 (London)

D had been in the UK for about four years and had a young daughter. She applied for asylum after escaping violence and effective imprisonment by her partner and booked for antenatal care in a maternity unit after she was hospitalised with severe abdominal pain, directly from the Initial Accommodation centre. At this stage she was in the third trimester of pregnancy. The maternity unit offered her individualised care with a named midwife. It was also engaged in a wide range of multi-agency work on behalf of D including referrals to the Haven, a specialist centre for people who have experienced sexual violence, and a referral to the Child and Adolescent Mental Health Service, as there were concerns about her daughter's safety and welfare. The maternity service worked with others to delay the woman's dispersal, but she was finally dispersed without anyone being notified of where she was going, so that no continuing support by health visitors or others could be arranged.

In D's case, efforts were made to build a relationship with the woman who was very vulnerable and complex multi-agency work had been developed. All this was wasted with the woman's sudden dispersal. All the midwives emphasised that establishing trust and rapport with women was an essential basis of good midwifery. However, it took time to build relationships that would make women feel secure enough to disclose personal details which might be important to their maternity care, especially if they had experienced trauma or abuse or had other mental health problems.⁸⁴

One midwife looked after a woman who had flashbacks after being raped in her country and who was dispersed in late pregnancy. She said, "She needed some stability and care because she felt confident with the people who were looking after her and felt she could trust them. The best outcome would have been for her not to be transferred especially at that late stage." Another midwife said, "Women get settled – they have a care-giver whom they trust and a service provider whom they are familiar with."

For the women, the lack of continuity could be felt as a loss of confidence in their carers.

Clara received antenatal care in the hospital where she had previously had a fibroid operation. She was told that because of that operation she would need to have a caesarean section. She attended another hospital in the dispersal area where the midwives said she should have a normal delivery in spite of the notes in her handheld record. She persisted to challenge this, and eventually did have a caesarean section, though with some complications. She felt that the change of hospital had affected the way the caesarean was carried out. "If the hospital staff had known about my operation maybe they wouldn't have done the caesarean in the same place. I don't think they had the time to read the handheld notes. Because it's a big file maybe they're not looking for information about past operations, maybe they're just looking for your blood group and things like that."

Clara's experience tells us less about whether or not her birth would have been handled differently in the hospital with which she was familiar than about the trust and confidence that women need in order to feel safe when they give birth, which, in her case, was broken by the dispersal. Many midwives interviewed felt that interrupting care destroys the rapport between a midwife and the woman she is looking after. Such a relationship cannot be recreated quickly, and there is not enough time if the first contact takes place late in her pregnancy. Moving or even the fear of moving can create stress and distrust, which is difficult to overcome even if services are being offered sympathetically.

One midwife commented about one of the women she looked after who had very complex family circumstances:

"It had taken a long time to build up trust. It had taken me, having known her from 10 weeks to 34 weeks, to begin to have an idea of what was really going on. (In dispersal) that relationship-building has to start again. It's very difficult for people to help when it's late pregnancy so it very much becomes crisis management."

⁸⁴ Compare the emphasis on trust in the summary of the work of Imperial College Healthcare NHS Trust One to One Midwifery teams in National Collaborating Centre for Women's and Children's Health, 2010, *op.cit.* p47

Interruption of antenatal care

Only four women had unbroken antenatal care and delivered their babies in the same maternity unit, though for three of them, as will be seen below, this was problematic both for them and for the maternity service. Three women received no antenatal care before they were dispersed so attended only one unit after being moved. Thirteen women attended at least two maternity units during their pregnancy having booked into antenatal care which was interrupted by dispersal. Two of them were seen in three or more units because they had been moved several times between towns or to and from detention centres.

Table 3.2 Antenatal care of women dispersed in pregnancy (n=20)

Antenatal care before dispersal	Number of women	Notes and explanations
Stayed with one maternity unit in antenatal care and for delivery	4	2 women refused to engage with antenatal care in the dispersal area and returned to the sending area for antenatal appointments and in labour. 1 woman was dispersed just before delivery but was told to come back to the hospital where she had received antenatal care. 1 woman was moved within the catchment area where she was receiving antenatal care and so did not change units.
No antenatal care before dispersal	3	2 women arrived in the UK in mid or late pregnancy, and were detained or placed in Initial Accommodation before antenatal care was established. 1 woman stayed in Initial Accommodation during the first trimester, but antenatal care was delayed until she was dispersed at 14 weeks.
Interrupted care because of dispersal	13	2 women were booked into 3 units because of multiple moves. 11 women were booked into 2 units, 1 before and 1 after dispersal.

Midwives described two cases of women dispersed in pregnancy who came back from their dispersal areas because they could not cope with the isolation and loneliness they experienced there. This also interrupted any care which had been established for them in those areas and gave rise to similar problems of re-starting care to those created by the original dispersal. Such drastic action by women who are likely to lose their asylum support by leaving their allocated accommodation, also indicates their desperation at being dispersed at such a vulnerable time.

Women's interview accounts suggest that they saw the interruption to antenatal care as just part of the total disruption to their lives created by the dispersal. They had no expectation of continuity of care although they were all anxious to receive maternity care as quickly as possible in the new area. However, it was often not easy to enrol in a new maternity unit because of the difficulties of finding a GP with whom to register, as GPs were still their main means of access to antenatal care.⁸⁵ One woman said that it took over a month to register with a GP in her new area, so meanwhile she went back to an appointment in her former practice several miles away. She was already 5 months pregnant.

Women sometimes tried to access maternity services via Accident and Emergency departments if they could not register quickly with a GP, or they sought help from the Red Cross or other agencies. In some cases women with children had to juggle organising new antenatal care with getting their children into school or finding someone who would look after

⁸⁵ Whatever the limitations of housing providers in helping women register with a GP, it is clear that not all dispersal destinations had services in place to ensure speedy uptake of antenatal services as advised in National Institute for Health and Clinical Excellence, 2010, *op.cit.* p15

their children when they were giving birth. All this was difficult in a new area where women did not know the local geography or anyone who could help them, especially if they were in advanced stages of pregnancy and had young children with them.

Transfer of records

Once back in antenatal care, handheld notes did not provide a seamless move from one unit to another because tests might still be repeated or different decisions made in the new unit, creating anxiety for the woman concerned. Sarah was booked into three maternity units during her pregnancy. By the time she reached her third dispersal she said,

"I first saw the midwife about one month after I arrived in the north east. I had by then a record from one town in the north west, another from a town in the north east, and in another town in the north east, I was given yet another one. They would not consider the previous ones, and said that they had to use their own so they discarded them. I had to start my records all over again."

Lack of liaison and repeat tests also concerned the midwives. They needed to ensure that results were accurate, that they referred to the right woman, and that nothing had been missed. As a result tests might need to be repeated even though this was very invasive for the women as well as expensive. A midwife in a dispersal area said, "I've had three this month coming past 36 weeks, and nobody ever liaised... Such a lot of work and they're repeating all the bloods and all the screening. So unfair to the women."(MW North).

Another explained, "(In the handheld notes) there was the bare bones of the information. Sometimes tests are done but we don't always have the results in the notes. That's quite common. They tick that they are done. Then you have to try and contact the other hospital. Sometimes that's a nightmare trying to get the results of blood tests from another hospital. Sometimes it's even quicker to repeat the whole thing in your own unit which is not always cost effective." (MW North)

One midwife also commented that although there is some information in the handheld record, they do not usually document issues such as a history of domestic violence as that is better communicated personally.

MW Case 3 (London)

K booked at about 30 weeks gestation. Despite the late stage in pregnancy, the midwife felt that she was developing rapport with K which enabled her to disclose her experience of domestic violence. This enabled the maternity service to work closely with the Independent Domestic Violence Adviser (IDVA) and other local agencies to support K and help her after she gave birth. However K was moved, and the unit was not informed where she had gone. The midwife who looked after K was worried that she would not disclose her history elsewhere and that it would therefore not be possible to put protection plans and support in place for her in the new area.

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MW - "I've had three this month coming past 36 weeks, and nobody ever liaised... Such a lot of work and they're repeating all the bloods and all the screening. So unfair to the women."

Health and social consequences of interrupted care

Interruption to continuity of care on dispersal had a wider impact beyond the midwives' relationships with the women they looked after. Every midwife gave examples of concerns about the impact of interruption of antenatal care on the health and wellbeing of the women and their babies. Scans, tests, specialist referrals or other medical or social investigations for mental health or child protection would be disrupted and delayed. One midwife said that even if you send a direct referral to another hospital you might lose two weeks just because of administrative processes involved in booking and appointments.

Such delays could have serious consequences for conditions which require regular monitoring during pregnancy. A midwife described how the diabetes of one dispersed woman who was not seen promptly had become uncontrolled by the time she accessed the unit. She had been given a routine appointment because the unit was not informed that she was diabetic. One woman was dispersed while waiting for a scan to see if her low lying placenta would mean she had to have a caesarean, and experienced difficulties accessing maternity care in the new area. Midwives were worried about vaccinations for babies born to women with hepatitis, or postnatal follow up for women with multiple complications. Other concerns raised included women being moved before the unit received the results of screening tests and scans and could establish appropriate treatment, care of women with gestational diabetes, and risks of delayed treatment for sexually transmitted diseases.

Mental health

Above all, both midwives and the women themselves stressed the impact of dispersal on women's mental health. Almost all the cases described by the midwives involved women suffering mental distress. Many women's mental health problems stemmed from prior trauma including rape, torture, imprisonment, loss, and domestic violence and included flashbacks, depression, fear, and anxiety. One woman became hysterical at the end of her booking appointment when she suddenly disclosed to the midwife the loss of her husband and other children in her own country. Midwives described women as being in "acute distress", "very frightened", "very sad", "distracted", "depressed" and "stressed". Some women were unable to sleep.

In their interviews nearly all the women talked about feeling depressed and stressed.⁸⁶ Some linked this to their experiences in their home countries but mostly they referred to what happened to them when they were dispersed and how the dispersal had affected them emotionally. Two women had attempted suicide during their pregnancies and five explicitly said that they had postnatal depression. Three women cried during their interview as they talked about particular experiences, as in the following example.

"I was always very anxious about this new baby. As I had two other children that needed looking after, I was getting worried about what was going to happen to them when I had to give birth. As I had nobody to help, I worried.

86 This study made no attempt to establish formal diagnoses for depression but acknowledges women's self-reporting and midwives' reporting of depression as likely to represent at least "symptoms of depression and/or anxiety that do not meet the threshold for a formal diagnosis." National Institute for Health and Clinical Excellence, 2007, *Clinical Guideline 45 – Antenatal And Postnatal Mental Health: clinical management and service guidance*, London, National Institute for Health and Clinical Excellence, available at <http://publications.nice.org.uk/antenatal-and-postnatal-mental-health-cg45>

“

I was always very anxious about this new baby. As I had two other children that needed looking after, I was getting worried about what was going to happen to them when I had to give birth. As I had nobody to help, I worried.

"When the midwife would ask me who would stay with me during the birth, I said that my husband couldn't come with me as I had two other children to look after. She then said that I could ask someone to look after the children so that he could be there, but I didn't know anybody that could have looked after them. I therefore had to give birth on my own, my husband was looking after the children." (Rita)

Some women just talked about feeling sad when they arrived in the dispersal area, about giving birth alone, or after the birth. Grace, who moved a day before she gave birth said:

"The first month I cried a lot because I moved down here and there's no family, no friends and I don't know anyone. My husband only stayed one night because there is a rule that your partner cannot stay overnight. My friends couldn't visit me because it was a long journey." Her interpreter added that in their culture a new mother doesn't go out at all. "You stay inside and the whole family around you takes care of the baby and the mum literally does nothing but lying in bed, and then people cook for you and carry it to the bed for you."

The women interviewed described these kinds of feelings as part of their everyday experiences. The midwives on the other hand, talked about women's distress with sympathy, but more particularly, as professionals worried about how the loneliness and isolation engendered by dispersal might exacerbate existing psychological problems, or how poor mental health would affect them once they had their babies. In the dispersal areas midwives often tried hard to put services in place to help such women, and to stop further moves.

MW Case 6 (Dispersed woman)

"This was a very young woman (aged 20), separated from her family, but she had health problems commonly seen with older people. Most of them might be attributed to stress. She was suffering from flashbacks from her experiences which were horrific. She was still experiencing a lot of fear in her day to day life, because of her fear of being sent back to her country. She had very many psychological problems and was referred to the consultant midwife. We were very limited in how we could help her through local support because of where she was based. That meant she fell out of the area of some support because some charitable organisations work in particular postcodes.

"There was concern about her mental health and her ability to cope with that and with a newborn baby. But because we were able to medicate and to keep an eye on her that was important. And it was important that when she did give birth she was in a position to know that she could be looked after postnatally as well. That continuity was really important." (MW Midlands)

The midwives' attention to women's mental health reflects their understanding of both the risk factors for postnatal depression (PND) before birth and the risks of PND on infant development. NICE Guidelines draw attention to the impact of a pregnant woman's mental state "on obstetric and maternity outcomes, the development of the foetus or child, and her partner and family", and note that "routine contact with healthcare professionals during pregnancy and the postnatal period provides an opportunity to identify women who have, or are at risk of developing, a mental disorder."⁸⁷

A review of the literature on PND rates and risk factors among migrant women shows that PND rates among immigrant women in developed countries may be up to three times higher than among native-born women.⁸⁸ The studies reviewed found that the main risk factors for PND among migrant women were stressful life events prior to or during pregnancy both pre- and post-migration, and lack of social support. Stressful life events for migrant women considered in the studies reviewed include experiences of war, conflict, and persecution, and violence, rape, torture, loss and death associated with these situations. Whatever the circumstances of their leaving their countries, migrant women “may struggle to cope with leaving family and friends, the insecurity of an uncertain future, difficulties adapting to new value systems and lifestyles, and potential social marginalisation resulting from language difficulties and discrimination.”⁸⁹ Several women in our study, interviewed directly, or in cases described by midwives, experienced gender-based violence not only in their own countries but also since arrival in the UK. Rape and sexual violence are recognised particularly as established risk factors for depression and PTSD.⁹⁰

Lack of social support discussed in the review confirms other studies which show that asylum seekers and refugees “are frequently separated from family and friends or dispersed in unfamiliar areas of the host country, apart from their community, which adds to feelings of isolation and loneliness.”⁹¹ Isolation and loneliness were widely highlighted by both the women and midwives interviewed as significant reasons for the depression and stress they experienced.

NICE guidelines on the mental health of pregnant women assume that women who have or are at risk of developing mental disorders in pregnancy or postnatally will normally be identified through routine contact.⁹² At the same time, as noted above, its guidelines on care of women with complex social factors, recommend the need for strategies to engage such women into maternity services.⁹³ Evidence from this study suggests that dispersal not only exacerbates problems of mental health of pregnant asylum seeking women, but also, at worst prevents, and at best, impedes the provision of appropriate care that could mitigate such problems and reduce their effects on the woman, her family and development of the foetus or child.

Planning and information sharing

Continuity of care was also compromised by the absence of any system for planning or information sharing and frequently by women simply disappearing. Some midwives used valuable time searching for women who did not attend antenatal appointments as the maternity unit was not informed that they had been dispersed. In some cases police and social services were used to try to trace a woman who was only ‘missing’ because she had been dispersed. In one case, contact between a maternity unit and UKBA was established, and a woman’s dispersal was delayed because of her poor mental health and child protection concerns in relation to her other child. Nevertheless, she was later dispersed, while still pregnant, without the unit being informed or any risk assessment having taken place.

88 C. Collins, C. Zimmerman & L. Howard, 2010, “Refugee, asylum seeker, immigrant women and postnatal depression: rates and risk factors”, *Archives of Women's Mental Health* DOI 10.1007/s00737-010-0198-7

89 *Ibid.*

90 See for example, R. Campbell, E. Dworkin, and G. Cabral, 2009, “An ecological model of the impact of sexual assault on women’s mental health, *Trauma, Violence, and Abuse*, 10, pp. 225–246. D. Kilpatrick, K. Ruggiero, R. Acerno, B. Saunders, H. Resnick, and C. Best, 2003, “Violence and Risk of PTSD, Major Depression, Substance Abuse/Dependence, and Comorbidity: Results From the National Survey of Adolescents”, *Journal of Consulting and Clinical Psychology* 71:4, pp692–700

91 C. Collins, C. Zimmerman & L. Howard, 2010, *op.cit.*

92 National Institute for Health and Clinical Excellence, 2007, *op.cit.*

93 National Institute for Health and Clinical Excellence, 2010, *op.cit.*

One midwife said of a woman who had been in her care, "We should really be sharing what we've done for women, especially when they're so vulnerable, so that when she goes into the next borough they know what sort of support she's had and what sort of further care she needs. That information wasn't forthcoming (in this case)." (MW sending area) It would take time in a new area to establish the knowledge base that could inform a suitable support package for a woman with complex needs, and more time still to make the multi-agency links that would be required to put a package in place.

Overall, the flow of information between maternity units and UKBA was very poor. Midwives were never informed by UKBA when women in their care were being moved, nor did UKBA ask them whether these women were fit to travel or had other health needs. The lack of information about where and when women would be dispersed affected communication between maternity units, as no planning could be done in advance of the dispersal. On the contrary, midwives' hands are tied as neither they nor the woman are given a forwarding address until the dispersal takes place, so there is no way of arranging for services in the dispersal area to prepare in advance for the new arrival or be ready to visit a vulnerable woman.

Midwives who were aware that women in their care would be dispersed asked them to text or get someone to contact them so they would know what had happened to them, and then they could alert the maternity service in the new area. But the responsibility for this rested with the woman alone, and depended on her getting in touch. Instead, if this could have been done in advance of the move, without adding to the pressure on the women themselves and depending on them for the information, arrangements could be made more quickly and efficiently.

Staying with the same maternity unit after dispersal

Three women interviewed continued antenatal care and gave birth at the unit where they had been receiving care throughout the pregnancy in spite of their having been moved to another town. This caused enormous administrative and logistic problems and was not without great stress for both them and the midwives. Their stories indicate how problematic it was to continue maternity care where they were living before being dispersed.

Patience (see Chapter 2) had been living with a friend in the Midlands. She obtained asylum support only a month before her baby was due. Five days before her due date, and two days before her baby was actually born, she was dispersed to another town in the Midlands (about 15 miles away) and placed in an Initial Accommodation hostel. She had been receiving regular antenatal care in her original area and her midwife arranged for her to go back there to give birth, so when she went into labour the hostel called an ambulance to take her to the hospital there.

However, Patience said that after giving birth she spent a week in hospital because the hostel refused to collect her. They said that she had to make her own way back even though she had no money. She was finally discharged and the hospital arranged for a charity to help her travel as she had no money for a taxi. A charity volunteer took her to the station and bought her a train ticket. "She dropped me at the train station with my baby, my bags, no buggy, no car seat." When she arrived in the dispersal area, Patience took a cab and told the driver that the hostel would pay the fare, but when she arrived, the hostel worker shouted at her and refused to pay, saying it was her decision to go to hospital in the other town. Finally, he saw CCTV footage that she had been taken there by ambulance and only then agreed to pay the driver.

Although there appeared to be an understanding between the health workers and the hostel to allow Patience to give birth in the hospital where she had received antenatal care and which had all her pregnancy records, there was no mechanism to make sure that proper arrangements were made for her return home. Because support in Initial Accommodation is full-board, Patience would only have received £3 cash per week as a supplement for pregnant women, and this lack of cash made her entirely dependent on the hostel workers' decisions. Her story is another example of the difficulties faced by pregnant women receiving cashless support. Patience was clearly very distressed by how she was treated by the hostel worker on her return. These experiences may have contributed to the postnatal depression she experienced.

In two other cases where the women gave birth in the maternity unit where they had received antenatal care, the women themselves chose to return to it, giving rise to further health or other problems. The stories show how badly affected they were by their dispersal during pregnancy.

Frieda (see Chapter 2) continued all her antenatal and HIV care in her original town after she was dispersed. UKBA had initially wanted to send Frieda to a city 18 miles away from where she was living, but her HIV consultant, her midwives, her antenatal teacher, and the HIV charity which was helping her had all asked for her not to be dispersed, so that she could continue her treatment and care with them. This delayed her dispersal but in spite of this she was sent, at 36 weeks gestation, to another town, 50 miles away. Her partner was not allowed to travel with her in the minibus which took her alone to the new area. Frieda said she was scared to go out in the dispersal town as she faced racist abuse.

Despite the distance, Frieda continued to travel regularly from the dispersal area to see her midwife and HIV consultant in her original town. She also refused to register with a GP in the new area. At her last routine appointment her midwife told her that her labour had started, but she should go back home to wait for it to develop, so she returned to the dispersal area. The next day she came back to the hospital, but they sent her 'home' as she was not dilating. This time she stayed with her partner and his family near the hospital until her waters broke and she was admitted.

The hospital midwife probably had no idea that Frieda could not just 'go home' like an ordinary woman in early labour. After the birth, in spite of being kept in hospital because of birth complications, Frieda was pressurised by the housing provider in the dispersal area to return to her accommodation or lose it. As a result, she asked to be discharged despite still having a catheter inserted. However, she became very ill when she got back to the dispersal area, and had to have an emergency admission there to treat urine and blood infections. She stayed in hospital for 10 days. The hospital in the dispersal area did not allow her to have her baby with her as she had not given birth there, but fortunately her partner came to stay for some time and looked after the baby.

Frieda's story is particularly disturbing because of the apparently punitive decision to disperse her to another dispersal area, over 30 miles further than the first one proposed, despite UKBA's knowledge of her pregnancy and HIV condition. The UKBA guidelines on dispersing asylum seekers with healthcare needs acknowledged that additional care was required if a woman was pregnant and HIV positive, and also that "dispersal should normally only take place if (an HIV positive) asylum seeker is medically stable and does not have any other active complication."⁹⁴ Furthermore, the general Dispersal Guidelines also explicitly permit

94 National Asylum Support Service (NASS), 2005, *Dispersing Asylum Seekers with Healthcare needs: Asylum Support Policy Bulletin 85* (No longer available online)

caseworkers to exercise discretion “where compelling or exceptional circumstances exist.”⁹⁵ The guidelines do not specify what circumstances are exceptional but it is hard to imagine what more compelling or exceptional circumstances than Frieda’s would be needed for UKBA to agree not to disperse a pregnant woman living with HIV.

Frieda was not unique in refusing to give up everything in the area with which she was familiar when she was dispersed, but this increased the risks she faced during labour and postnatally, and may well have contributed to the postnatal depression she suffered. Katerina’s story showed how forced dispersal created stress for her, and serious concerns over her and her children’s welfare on the part of health workers.

Katerina had been living with her husband and two children but her husband was refused asylum and moved away. She obtained section 95 support and was due to be dispersed to a town 27 miles away. Katerina’s pregnancy was very difficult: she was very depressed, suffered from headaches and vomiting, and had recurrent urinary tract infections. She had been in frequent contact with the maternity services since about 12 weeks of pregnancy, and also with other support agencies where she was living. Several health workers wrote letters on her behalf to try to stop the dispersal but she was moved at over 7 months gestation. Katerina refused to engage with any services in the dispersal area and was determined to give birth where she had been living and where she had friends with whom she could leave her children. She kept coming back there as she found it difficult to stay in the dispersal area. She felt that the move had made her very stressed.

After the interview, which took place before Katerina had given birth, she was helped by a solicitor who persuaded UKBA to allow her to return to her original town where she later gave birth. However, uncertainty about where she had been staying, and concerns about her and her family meant that midwives and health visitors in two towns had been spending time trying to locate her. The midwife who had been looking after her for over 5 months had won her trust but felt that the move had made their relationship much more difficult.⁹⁶

Challenging dispersal

As some of the above accounts show, both women and midwives did try to challenge or influence dispersal decisions by the UKBA, although one midwife was worried whether challenging the UKBA could have a negative impact on the dispersal decision. Over half the women interviewed requested not to be dispersed but only two had their requests accepted.⁹⁷ Social services had been involved in both these cases.

Some midwives were also in touch with accommodation providers when they had concerns about the quality of a woman’s housing. As has been seen in MW Case 1 above, a midwife managed to help delay a woman’s dispersal but was unsuccessful in getting her rehoused in the same town, so that eventually the dispersal did take place postnatally. One midwife wrote to the UKBA after a woman in her care was dispersed without her having been asked if she was fit to travel, as she was so concerned about her mental state. Several midwives said that they wrote official letters asking for women not to be dispersed for health reasons.

95 UKBA, 2009, *Dispersal Guidelines: Asylum Support Policy Bulletin 31*, available at <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/asylum-support-bulletins/dispersal/pb31?view=Binary>

96 One of the midwives interviewed for this study described Katerina’s case and corroborated her account without the interviewer or the midwife knowing that Katerina had been interviewed independently. We have used this coincidence to amplify Katerina’s story.

97 It is not clear how their requests were submitted, or what, if any, supporting evidence they provided.

Both earlier and current UKBA guidance required medical evidence to support a request to defer or stop a dispersal, and also required all representations from health professionals to be “acknowledged with the name of the caseworker dealing with the case and be signed, dated and contain a telephone number for the clinician to contact.”⁹⁸ However such acknowledgments were often not forthcoming.

One midwife received a reply from UKBA one month after a woman had been dispersed at 39 weeks gestation despite requests to keep her in the original area because of particular health needs affecting mother and baby. This woman was, in fact, brought back less than a week after delivery; this may have been due to the midwife's intervention. But even so, it meant the woman was moved unnecessarily one week before and a few days after delivery.

In another case there was no reply at all from UKBA. Some midwives had difficulties even getting through to an appropriate person at UKBA with whom to discuss the needs of the woman. Even though she had a known contact at UKBA whom she could ring, one midwife was unable to speak to anyone else if this person was not on duty. Several midwives interviewed were very keen to improve the liaison between themselves and UKBA.

In two cases, efforts by midwives and other health workers did result in successful challenges to women's dispersal. The following case illustrates how the criteria used by UKBA for dispersal may fail to take into account the health needs of a woman or her newborn baby.

MW case 4 (London)

J left her accommodation in Wales where she had been dispersed when she was already pregnant, and returned to London. She was suffering from post-traumatic stress and was described as “very, very lonely”, which her midwife commented “wouldn't help her mental health.” She had been booked at a maternity unit in the dispersal area, but contacted a London maternity unit at about 24 weeks gestation. Her waters broke very prematurely, at about 26 weeks. UKBA wanted to send her back to Wales, but the midwife insisted this was not possible as it was not safe to send her on a long journey with ruptured membranes. UKBA finally found J somewhere to stay within reach of the hospital in London. She delivered very prematurely at 28 weeks and UKBA said they would have to disperse her again after delivery. Again the midwife explained that this could not take place soon but would take four to five months because of the baby's prematurity and need for special care which was not available in the dispersal area. Eventually J was allowed to stay in London indefinitely.

The following case is an example of the effort some midwives and other health professionals made when they thought that a woman in their care could be at risk of being dispersed.

98 National Asylum Support Service (NASS), 2005, *Dispersing Asylum Seekers with Healthcare needs: Asylum Support Policy Bulletin 85* (No longer available online); UK Border Agency, 2012, *Healthcare needs and pregnancy dispersal guidance*, available at <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/asylumprocessguidance/asylumsupport/guidance/healthcare-guidance-.pdf?view=Binary>

MW Case 5 (specialist HIV midwife London)

S had been imprisoned, tortured and raped in her country. She was diagnosed with HIV in pregnancy, but also suffered from post-traumatic stress and flashbacks. Her mental health was very poor as a result of her new HIV diagnosis and her history of torture. She was receiving HIV treatment and psychiatric care at the same hospital where she had antenatal care. The hospital was also in touch with voluntary sector organisations which help people living with HIV. All the people with whom she felt safe lived in the borough where she was receiving treatment.

In mid-pregnancy S received a letter saying that she was going to be dispersed to Scotland; she was about 30 weeks pregnant by then, and became very distressed. The midwife contacted the head of the dispersal team at UKBA to try to keep S where she was. She reported that she told him: “we had never had anyone so mentally unwell in terms of adjusting to diagnosis. I told him of the significant harm this could do her because her support network was in London and my fears about her long-term treatment with HIV and how she would engage with care somewhere else. He listened to me but said that they had already looked at the medical records and the aim was still to disperse her.”

After this S's HIV consultant also telephoned the Head of Dispersal and told him that “this is the worst case case we've ever had.” Following that call he agreed to review the case, and S was finally allowed to stay in London.

Whether intervention by midwives is successful or not, it requires considerable time on the part not only of a midwife, but often of other health or social care professionals too, explaining the needs of a patient to a UKBA official.

Giving birth in the dispersal area

To understand the implications of giving birth after being dispersed during pregnancy, especially in late pregnancy, we have explored how dispersal exacerbated the known difficulties asylum seeking women have in dealing with labour. The women interviewed found getting to hospital, support during labour, care of other children, communication during labour, and postnatal health and care particularly problematic. These issues have also been raised in other studies of maternity care for asylum seekers.⁹⁹ Waugh's study, in particular, includes both women who were dispersed during pregnancy and others who lived in Leeds before they became pregnant, and highlights similar problems following dispersal to those found in the current study.

Asylum support provides minimal income in cash for those still in the asylum process, and only cashless vouchers or Azure cards for refused asylum seekers. Housing provision for those on asylum support is known to be rudimentary, and the dispersal policy can separate people from prior support networks whether or not they are pregnant.

Asylum seeking women in general can be distressed, anxious, poor, and have very little control over their lives. Many of them have also suffered loss and prior trauma. Thus, as we have seen throughout this report, such women are already highly vulnerable and their pregnancies can almost always be classified as high risk. There is also often inadequate provision of interpreting

99 M. Waugh, 2010, *The Mothers In Exile Project: Women asylum seekers' and refugees' experiences of pregnancy and childbirth in Leeds*, Leeds, Women's Health Matters, available at <http://www.womenshealthmatters.org.uk/downloads.html>; A. Gaudion and P. Allotey, 2008, *Maternity care for refugees and asylum seekers in Hillingdon: a needs assessment*, Centre for Public Health Research, Brunel University, Uxbridge; J. McLeish, 2002, *Mothers in Exile: Maternity Experiences of Asylum Seekers in England*, London, Maternity Alliance, available at <http://www.maternityaction.org.uk/sitebuildercontent/sitebuilderfiles/mothersinexile.pdf>

services or social and family support for such women giving birth. It is in this context that we examine the additional problems in giving birth faced by asylum seeking women dispersed during their pregnancy.

Going into labour and getting to the hospital

Afya (see Chapter 2) arrived at Initial Accommodation in a dispersal area at over eight months pregnant. She had endured labour pains all night but did not want to disturb her housemates so waited until they woke up before calling an ambulance. "I went to the hospital at 9.00 in the morning and gave birth at 10.00. I was in labour all night but I didn't know it was labour." Afya's husband was not allowed to stay with her in the hostel, and she did not know the other residents well. So, without any support, and having her first child, Afya suffered on her own, afraid to make a fuss with other hostel residents.

Dana (see Chapter 2), who had a history of attempted suicide during her pregnancy and had arrived at eight months gestation in very poor health, was also in labour in her shared accommodation for a long time because she had no money to pay for a taxi to go to the hospital and was afraid to call an ambulance. "Because I'd called an ambulance three or four times, when the ambulance came they told me no, if you have pain you have to call a taxi. He was shouting at me. So I did not say I don't have money I said okay. Next time I had a pain that was when the baby was really coming. So I did not go to the hospital. My pain started at 4am. Until 12 o'clock I was in pain. But I didn't want to call the ambulance because I thought they would shout or they would think the baby isn't coming. When I knew the baby was definitely coming I called an ambulance and went to the hospital." Despite Dana's extreme vulnerability, no special provision was made for her to get a taxi to the hospital.

Most other women went to hospital by ambulance or taxi and did not report similar hostility from ambulance workers. However, Frieda, (see above) had to twice make an hour long train journey before she was admitted to the labour ward. Frieda's understandable determination to sustain her support network in her previous location enabled her to have her partner with her at the birth, but made getting to the hospital exceptionally stressful for her. Similarly, Patience had to undergo a long ambulance journey from her dispersal accommodation back to the hospital in her previous location – at the request of the midwives – rather than being allowed to stay in her original location until after delivery. In both these cases forced dispersal created additional problems for them.

Support during labour and with childcare

Besides the consequences of interrupting maternity care during the course of pregnancy, the most striking effect of dispersal during pregnancy is the loss of local social and family support. This becomes particularly poignant when women go into hospital to give birth when they need support from friends and family both as birth partners and to look after their children.

Eighteen women interviewed had given birth and were able to give details of their experience of labour. Eight women delivered alone, six had a friend or roommate with them, and four had their husband or partner. Women who delivered without anyone to help them found the experience very depressing.

Clara gave birth alone. When asked if anyone would have been with her if she had been in London, she said, “Yes of course, my friend was ready to come and my ex was willing to come, in fact he came but he was too late and missed the birth” After the birth Clara worried about not having support at home. “The move definitely had an effect. I have to go out to look for things. I don’t know where I’m going. I have to take my baby everywhere with me. If I was back in London I’d be able to leave her with friends sometimes, not all the time. But at least I’d know what to do and where to go.”

Four women needed help with looking after their other children and a friend or roommate looked after the children. Beatrice was very worried about who would look after her children. She was advised by the housing provider to go to the Red Cross for assistance but as she did not know when she would give birth she thought she could not ask them. Instead she asked the people who ran a nearby African shop if she could leave her children with them.

“When they called me (to go into hospital for a membrane sweep), I went to the other woman living in the same UKBA accommodation and said I will ask the African shop people to pick my children up in the morning but she said, it’s okay she will look after them. Without her I would have left them at the African shop because they’d already said I could. I didn’t know them (the people in the shop). I just went there to buy things and I didn’t know who else to turn to.”

Beatrice eventually left her children with the woman in her shared accommodation. Wherever or whoever she left them with, there was no professional assistance to ensure their safety while she was in hospital. For Beatrice, like so many other recently dispersed pregnant women, the absence of appropriate information or help with forward planning, not surprising given that she only moved four weeks before her due date, exacerbated the lack of support available from family or friends. It left her worried and her children potentially vulnerable.

Language and communication during labour

Nine women interviewed (half of those who had given birth) did not speak English well enough to communicate effectively but none of them had an interpreter present during labour. Five of them had friends or their partner to help them but the other four had no means of interpreting. Rita’s husband would have been able to translate for her, but he was looking after the children outside the delivery room. She said,

“They did not have an interpreter and it was difficult for me as sometimes I could not understand what was happening. The midwife did ask me to send my husband alone, but as the children were outside I had to manage.”

Grace said, “They didn’t have any interpreter. I couldn’t understand them, I couldn’t talk to them, I couldn’t ask questions. It was very sad.” Dana had never had a conversation with any healthcare professional in the UK about what to expect during the birth, but her physical and mental condition on arrival and before dispersal should have triggered exceptional care services rather than the experience of labour she described.

“

I needed (an interpreter) but I didn't have one. I needed one because in my country they never teach the girl what will happen because they think it is a shame. So I didn't know what was happening to me. I was crying. I had a lot of questions but I couldn't ask them.

“I needed (an interpreter) but I didn't have one. I needed one because in my country they never teach the girl what will happen because they think it is a shame. So I didn't know what was happening to me. I was crying. I had a lot of questions but I couldn't ask them. And also in my country when a woman shouts or cries the nurse beats them or says stop. They say bad bad words. I was not shouting, I was doing like this (bites her hand). When the nurse came she said why are you doing this, hold my hand. I tried to explain and she said no, you can shout. Then I started shouting.”

Interestingly, it was only after Dana had left the hospital two hours after giving birth to get her UKBA payment from the Post Office in order to buy clothes for her baby that social workers were called and an interpreter involved.

“When the interpreter came with the social workers she said, ‘Do you want to drink a cup of coffee?’ I said, ‘No’, because I thought that it cost money. She said, ‘No, these are free.’ She said, ‘When did you last eat?’ I said, ‘Last night.’ She said, ‘Oh my god.’ She went and brought me food and showed me where to get it from. I told her that this lady was shouting at me. She said, ‘No, in here no-one is allowed to shout at you, if you want I will tell the Social Worker.’ I said, ‘No, leave it,’ because I thought if I asked a question like how to change the nappy or anything they would be angry with me, upset. So then the interpreter helped me and showed me how to change the nappy.”

Failure to use interpreters during labour is not a direct consequence of dispersal, nor an immediate responsibility of UKBA. It does, however, add further burdens and anxieties to women already weighed down by bewilderment, stress and depression exacerbated by the dispersal process. Dana's report of her conversation with the interpreter highlights the extreme level of misunderstanding and need that women in her situation may face.

An interpreter or bilingual advocate has a crucial role in labour, helping to prevent the birth and hospital experience become yet another traumatic event for a vulnerable woman. Women who have survived rape, sexual assault or other trauma may also experience flashbacks or other psychological responses during labour, which it would be impossible to respond to without an interpreter.¹⁰⁰ One midwife interviewed for this study said, “We're aware that women who are raped can have massive flashbacks especially at delivery.” Where women have had continuity of maternity care and understanding of their complex needs it is more likely that appropriate interpreting services would be provided.

Postnatal health and care

We have already noted the high incidence of depression among the women interviewed for this study. It is striking that not a single woman interviewed spoke of her joy or happiness at having given birth. On the contrary, women described their feelings after the birth as sadness, depression, stress, pain and weakness and their dominant concerns were practical, to do with housing or money, or dealing with physical pain. There is a palpable sense of despair in women's accounts of dealing with pain, their own or their babies' or other children's ill health, immigration problems and trying to manage financially.

100 D. James-Hanman, 1999, “Inter-Agency Work with Children and Young People”, in: N. Harwin, G. Hague, and E. Malos (eds.) *The Multi-Agency Approach to Domestic Violence. New Opportunities, Old Challenges?* London: Whiting and Birch; National Institute for Health and Clinical Excellence, 2010 *Clinical guideline 110, op.cit.*; J. Dunkley-Bent, 2005, “Healthcare provision for pregnant asylum seekers and refugees”, Chapter 6 in C. Momoh (ed.) *Female Genital Mutilation*, Oxford, Radcliffe Publishing

“Physically I was weak. Mentally...I was worrying that I don't have support at home and I have a little baby to look after and I've got to look after myself. Friends came to visit me once, and my ex came once or twice. The rest of them keep promising but its too far. The night I was discharged I was in so so much pain that I had to call the emergency services.” (Clara)

Several women also experienced delays in getting Maternity Payments which seriously affected their capacity to cope with everyday life.

One woman struggled with the stairs at her house because of severe knee pain but despite repeated requests her housing provider would not offer her alternative accommodation. Another woman was in hostel accommodation with no support when her baby got ill. Beatrice's oldest son was hospitalised for three days after she had given birth by caesarean section and she had to visit him while having to care for another child and her new baby.

Many accounts of the postnatal period reveal that this was an even more stressful time than that of arrival in the dispersal area. Although most women were helped by health workers or charities to get money, to register the birth or to buy baby equipment that they needed, a few felt completely unsupported. The overwhelming impression from the women interviewed is that the need to deal with immediate practical problems on their own completely dominated their lives in the period after giving birth.

Conclusion

It is clear from the evidence in this chapter that dispersal had an adverse impact on the health and wellbeing of the asylum seeking women interviewed who were dispersed in pregnancy. Almost all of them felt alone and unsupported in the new area, at a time when continuity of care and social and family support is absolutely essential to maintaining a healthy pregnancy and a good experience of giving birth. For the women, dispersal created additional stress and unhappiness and required extra effort in accessing health and other services. Where women resisted dispersal in order to try to maintain continuity and support in their lives, yet further stresses were created.

Women were moved, sometimes many times during their pregnancies, including in advanced stages, and without prior notification to ongoing health providers. The new 'protected period' can provide no solution to the disruption to maternity care created by dispersal if women are moved out of the area served by their regular hospital.

The midwives interviewed expressed concerns about the quality of the maternity care that the women were able to receive in such disrupted circumstances, and of the effect on women of loss of trust in a known midwife. They were anxious about the risks of error involved in the fragmentation of information as women were moved from one unit to another. Moreover, the lack of information or communication by UKBA with health providers before dispersal often made the handover of health information difficult or impossible. There were cases when midwives were able to establish good communications with officials from UKBA, but there was no formalised or universally followed procedure for the transfer of information.

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“Physically I was weak. Mentally...I was worrying that I don't have support at home and I have a little baby to look after and I've got to look after myself. Friends came to visit me once, and my ex came once or twice. The rest of them keep promising but it's too far.

Underlying the problem faced by the women interviewed for this study was a failure on the part of UKBA to acknowledge that pregnant women seeking asylum have complex social and health needs which it is critical to take into account in making decisions about where and how to accommodate them. Numerous cases from both women and midwives show that UKBA was rarely prepared to acknowledge social or mental health needs relating to pregnancy as a basis for delaying dispersal, or to consider flexible ways of keeping pregnant asylum seeking women in areas in which they had been living. Failure to acknowledge such needs meant that no risk assessments were undertaken before dispersal, including a consideration of the journey to the dispersal area.

Midwives and other health professionals often made great efforts to minimise disruption for women with very complex needs, but mostly these requests were ignored. This also applied to requests for more appropriate accommodation for pregnant women or those who had recently given birth. Apart from the provision of rudimentary equipment for the baby, there seems to have been little effort on the part of UKBA's accommodation providers to ensure that there were adequate hygiene and sanitary facilities for newborns. Even where requests were made to provide more suitable housing for the pregnant women or women with newborns, they were ignored.

Chapter 4 Conclusion: looking ahead

This chapter explores whether, in the light of the findings of this study, current dispersal policy adequately addresses the complex health and social needs of pregnant asylum seeking women. It revisits the concept of 'complex social factors' in relation to asylum seeking women, and identifies the ways in which earlier guidance failed to address the issues identified in the interviews carried out in this study. It then evaluates whether the UKBA's 2012 *Healthcare and Pregnancy Guidance* is likely to remedy the deficiencies of earlier policies, and concludes that, in spite of some attempts at improvement, a radically new approach needs to be taken to support for pregnant asylum seekers.

Pregnancy and complex social factors

This study explored the pregnancy and birth experiences of asylum seeking women who were dispersed during pregnancy, alongside those of midwives who had looked after such women in the course of their practice. It has both a narrower and broader focus than previous reports of the pregnancy experiences of asylum seeking women. It is narrower in that it has concentrated on women dispersed *during* pregnancy, but broader in that we have addressed the maternity care of these women from the perspective of both UKBA dispersal policy and of mainstream best practice standards. It is for this reason that midwives as well as dispersed women themselves have been included in the study, and why attention has been paid to Department of Health and NICE standards of maternity care for vulnerable women.

The evidence of the study leaves no doubt that pregnant women seeking asylum fall within any health service definition of a vulnerable or disadvantaged group. NICE has described refugees, asylum seekers, recent migrants and women who have difficulty reading or speaking English as a group of women with 'complex social factors' which create additional challenges for maternity services. It is known that women in this group are at greater risk of perinatal death, and are likely to book late into maternity services. Complex social factors for this group of women include:

- arriving in poor health
- suffering from underlying and possibly unrecognized medical conditions
- experience of sexual or physical violence and trauma both in the country of origin and since arrival
- consequences of female genital mutilation
- psychological and medical effects of fleeing war torn countries
- fears about immigration status
- language difficulties and unfamiliarity with British society and culture.

Poverty and homelessness exacerbate the effect of these problems and increase these women's vulnerability and the risks to their pregnancies.¹⁰¹ The women interviewed experienced poverty in their pregnancies both as a result of prior destitution and because of inadequate support on both section 4 and section 95, at less than 70% of Income Support levels, which made it difficult for them to meet essential living needs. Women in full-board accommodation or on section 4 support who had to manage with no cash at all were even

¹⁰¹ Both poverty and homelessness are separately identified by NICE as additional 'complex social factors'. See National Institute for Health and Clinical Excellence, 2010 *Clinical guideline 110 – Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors*, London, <http://publications.nice.org.uk/pregnancy-and-complex-social-factors-cg110>

more disadvantaged, and their accounts testify to the stress created by having to choose between food or the needs of their babies, or having to walk everywhere, even when in great pain.

Several women were homeless before receiving asylum support, but with the multiplicity of moves that they endured, many more felt homeless and suffered from typical effects of homelessness in pregnancy, such as having their maternity care interrupted and not knowing how to access local services. On top of all these problems women found themselves isolated and without any support from friends and family. Nearly half the women interviewed who had given birth did so without any friend or family member with them during labour.

The accounts given in this study by both the women and the midwives interviewed confirm that all of them had at least one, and most several, of the factors mentioned in NICE Guidelines on Antenatal Care for Women with Complex Social Factors. They all therefore fell into a category in which *additional*, rather than less attention needed to be paid to their antenatal care in order to ensure safe and healthy pregnancy outcomes.

Addressing complex social factors among pregnant women asylum seekers

Previous pregnancy and dispersal guidance

The former UKBA guidance on pregnancy and dispersal did not acknowledge or recognise that there could be any complexity in pregnancy except acute 'pregnancy complications' and so failed to recognise the vulnerability of the dispersed women for whom it was responsible.¹⁰² Most importantly it did not acknowledge that they all fell into a high risk category as defined in CEMACH reports.

It thus failed to consider a wide range of health issues affecting women in pregnancy, notably mental health, underlying health conditions and specific pregnancy related health problems such as gestational diabetes, urinary tract infections, or mobility problems. It also ignored how factors like social and family support, anxiety about immigration, and poverty before and after dispersal can affect the mental health of a pregnant woman, and create risks for her future capacity to bond with and care for her baby.

The study shows that there is in the dispersal process virtually no recognition by UKBA of the mental health needs of pregnant asylum seeking women who are likely to have experienced trauma, violence, loss and dislocation in their country, in the course of their journey to the UK, and for many in the UK itself. Such experiences predispose women to anxiety and depression in pregnancy and postnatally, and may have long term harmful effects on their children.

Moreover, although the UKBA stated that it "aims to ensure that all asylum seekers it supports with healthcare needs are able to access appropriate medical care and any special facilities they may need and, where appropriate, that continuity of treatment is arranged on dispersal,"¹⁰³ it actually showed no appreciation of maternity care standards and procedures for antenatal or postnatal care, especially for vulnerable women. Facilitating early booking and continuity of carer were not mentioned, nor was it deemed necessary for maternity care professionals to know where women were going or had gone to. Indeed the dispersal policy actively prevented women accessing appropriate continuing maternity care. Tests could not be carried out at the correct times, referrals for the woman's health and support or for child protection could not be followed up, and women's social support needs were ignored.

102 NASS Casework Instructions, 2001, *Pregnancy: Policy Bulletin 61* (no longer available online)

103 National Asylum Support Service (NASS), 2005, *Dispersing Asylum Seekers with Healthcare needs: Asylum Support Policy Bulletin 85* (No longer available online).

There was virtually no consideration in the guidance of the implications of dispersing women in late pregnancy, except to limit length of travel. There was also no requirement or procedure to obtain medical assessments about women's fitness to travel, even though fitness to travel was one of the main issues it considered. It also left it entirely up to the woman to raise any medical problems with the caseworker, rather than for the UKBA to take responsibility for that. This study has shown examples of women such as Dana who were not in a position to influence dispersal decisions. The guidance required any special needs requests by women to be supported in writing by medical practitioners. In practice, however, our study showed that even when practitioners did make recommendations or requests regarding a woman's dispersal, they were almost always ignored or over-ruled.

The guidance offered no procedures to ensure the transfer of medical records or pre-dispersal medical reports. Although there were requirements in the *Healthcare Guidance* for accommodation providers to help asylum seekers with pre-existing medical conditions to register speedily with GPs in dispersal areas, the experiences of many women interviewed suggested that these were not well enforced, so that continuity of care was further impeded. As far as postnatal care was concerned the *Pregnancy* guidance only recognised caesarean sections, unspecified birth complications, and specialist baby care as bases for delaying travel until two weeks after birth.¹⁰⁴ (Our emphasis).

All but one of the women interviewed for this study, and all the cases described by the midwives fell under the former *Pregnancy* guidance which the UKBA has itself now replaced. The evidence that we have gathered suggests that despite some improvements, the new *Healthcare Needs and Pregnancy Dispersal Guidance* also falls far short of addressing the major issues that have been identified in the interviews, or in NICE guidelines. Although it takes a significant step forward in providing guidance on continuity of care of people with 'severe or complex healthcare needs' it still fails to recognise that all pregnancies of asylum seeking women should be regarded as complex.¹⁰⁵

New pregnancy and dispersal guidance

The *Healthcare needs and pregnancy dispersal guidance, 2012*, makes no mention of the range of issues known to affect vulnerable women in pregnancy and soon after birth, especially mental health, including anxiety, stress, women suffering from PTSD, and their increased risk of postnatal depression. It therefore ignores the need for emotional and practical support in pregnancy and in delivery, and the need for a supported and undisrupted post partum period. While women living with HIV or pregnancy related disorders such as pre-eclampsia are identified as requiring special dispersal conditions, it still assumes that other pregnancies are wholly unproblematic.

The guidance also fails to address women's need for social support throughout pregnancy and labour. This study shows that the loss of social support, not only on dispersal, but also for women kept in Initial Accommodation for at least eight weeks during the 'protected period', is very damaging to women's wellbeing.

While this guidance, for the first time, makes some concessions to the needs of pregnant women in early as well as later pregnancy, such as the importance of the first antenatal visit and antenatal care tests, its own advice often contradicts the needs it describes. For example, it points out that tests should not be delayed, and that caseworkers should not disrupt the programme of tests, but it does not show how disruption can be avoided. It provides no guidance for case owners to know and understand which tests are being conducted, which could be different for each pregnant woman.

¹⁰⁴ NASS Casework Instructions, 2009, *Pregnancy: Policy Bulletin 61* (no longer available online).

¹⁰⁵ UK Border Agency, 2012, *Healthcare needs and pregnancy dispersal guidance*, available at <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/asylumprocessguidance/asylumsupport/guidance/healthcare-guidance-.pdf?view=Binary>

The guidance requires dispersal to be deferred during a protected period of four weeks either side of delivery, to avoid disruption around delivery and for women to stay in Initial Accommodation during this time. Yet the appropriateness of the timing of the protected period is contradicted in its own mention of the importance of care and tests until six weeks postnatally, and in the recognition that asylum seeking women may have an earlier than the UK average delivery date than the standard expected date of delivery (EDD). So four weeks before the EDD could in practice mean only three weeks before delivery, and possibly even earlier. Dispersal four weeks after delivery means interruption to postnatal care which should continue for 6 to 8 weeks.

The assumption that Initial Accommodation is appropriate for women in advanced pregnancy also runs counter to the reports in our interviews with women who have stayed in such hostels, often for some time. They describe serious problems of privacy, safety, hygiene, the inappropriateness of the food for pregnant women, as well as struggling to live in this situation without cash. In opting for women in the protected period to be accommodated in Initial Accommodation, the UKBA is continuing to regard pregnancy and birth as a logistic rather than as a healthcare issue.

The UKBA's disregard for the real welfare of pregnant asylum seeking women and their children is also evident from its policy of maintaining extremely low levels of cashless support for pregnant women receiving section 4 support. This not only forces them into poverty, but also limits the uses to which the support may be put, by denying them cash for transport or preferred types of food from small shops rather than supermarkets. Our study shows how women struggled without money for public transport when in advanced pregnancy or following a caesarean section.

This study has outlined the adverse impact on women who have been dispersed, and the sometimes desperate measures they have taken to avoid dispersal. Midwives have emphasised the importance of continuity of carer to enable trust between them and the women in their care. This can help women to disclose problematic and sensitive issues, thus enabling midwives to take appropriate action. Such action can include specialist referrals for mental or physical health, for safeguarding children, or developing multi-agency plans for support or protection.

Dispersal of women in pregnancy, especially late in pregnancy, cuts a swathe through the best intentioned work carried out for vulnerable women by midwives and contradicts any notion of 'joined up' state services. It inevitably disrupts maternity care which is a continuous and cumulative process. Maternity care costs are increased by wasting valuable resources searching for women who have been moved without the service being informed. It wastes time and effort by 'receiving' units in dispersal areas who often have to repeat tests in spite of the woman having a handheld record, or to carry out tests or scans at sub-optimal times. Women's distress is noticeably increased, creating higher risks of postnatal depression and concomitant problems for their relationship with their babies.

Looking ahead

This study has taken careful account of the efforts made by the UKBA to improve its guidance on healthcare and dispersal, and to improve practice to address the needs of pregnant asylum seeking women. However, on the basis of the evidence of this report, we believe that the new guidance marks only a very limited step towards addressing those needs appropriately or adequately. We urge the UKBA to urgently reconsider its policy of dispersing pregnant woman in conjunction with experts in the maternity care of vulnerable women, and taking seriously the recommendations below.

Recommendations

1. Recognise complex needs in pregnancy

UKBA should recognise pregnancy in women seeking asylum as involving complex needs, including mental health, family and social circumstances, experience of trauma and violence, pregnancy-related conditions, and underlying health conditions and reflect this in its policies and processes.

2. Maintain women's residence where they can access existing support

Pregnant women should not normally be dispersed. Case owners should ensure that pregnant women are accommodated in an area where they can continue to access existing GP and maternity care. This should mean that they are also within reach of existing social and family support.

3. Women pregnant on arrival in the UK

In order to avoid lengthy stays in Initial Accommodation women asylum seekers who arrive in the UK already pregnant, should be prioritised for dispersal and moved quickly, if they are in the early stages of pregnancy. If they are in a later stage of pregnancy they should be offered suitable accommodation near the port of entry.

4. Women applying for support late in pregnancy

- No woman should be dispersed after 34 weeks gestation, or sooner than 6 weeks postnatally. This means extending the 'protected period' from at least 6 weeks before the expected date of delivery to at least 6 weeks after. No woman should be dispersed after delivery until she has been discharged from postnatal care and a full medical report is available on her and her baby.
- If women apply for support late in pregnancy and support is granted while they are within the 'protected period' and they cannot be accommodated where they were formerly living, their accommodation needs should be met in safe, suitable accommodation *outside* Initial Accommodation. Women at this late stage of their pregnancy should not be moved out of their area and suitable private accommodation should be commissioned if necessary.

5. Full risk assessment before unavoidable dispersal

If a dispersal is unavoidable, before any dispersal takes place there must be a full assessment of needs and risk associated with dispersal, to be carried out by the woman's current treating midwife/obstetrician and other clinician (if she is receiving care for another long-term condition). If the woman is not receiving maternity or other healthcare this assessment should be carried out by a midwife with expertise in the care of vulnerable women.

- Such an assessment should specify any accommodation requirements that need to be met.
- Such an assessment should certify the woman's fitness to travel.
- No dispersal of a pregnant woman should take place before such an assessment has been carried out.
- Responsibility for ensuring such an assessment takes place lies with UKBA, not with the woman seeking asylum.

6. Transfer arrangements before unavoidable dispersal

If a pregnant woman has unavoidably to be dispersed to another area, case owners should notify both her current treating midwife/obstetrician and other clinician (if she is receiving care for another long-term condition) and a named contact in the Healthcare team at the dispersal destination. No pregnant woman who has booked into maternity care should be dispersed without arrangements having been made for her to be received into maternity care in the dispersal area. The receiving midwife/obstetrician and other relevant clinician should have received a full medical report and detailed medical records as well as the woman having her handheld notes.

7. Ensure adequate financial support throughout pregnancy

- Given the particular health risks facing asylum seeking women during pregnancy and after birth, asylum support levels for pregnant women on both section 95 and section 4 support should never fall below the equivalent of 70% of Income Support.
- Financial support should always be provided in cash during pregnancy and until the end of the postnatal period for women on section 4 support.
- Sufficient financial support should be provided to pregnant women and new mothers in full-board hostels in recognition that full-board does not adequately meet their needs.
- No pregnant woman's asylum support payments and accommodation should be stopped until after completion of all antenatal and postnatal care, regardless of any decision on her asylum case.
- In view of the health problems for both pregnant women and their unborn babies caused by destitution, UKBA should provide support to all pregnant women seeking asylum whose asylum claim has been refused.
- The timeframes for application for Maternity Payments should be eleven weeks before the expected date of delivery until three months after the birth (thereby matching those of the Sure Start Maternity Grants). Section 4 Maternity Payment levels should be raised to section 95 levels.

8. Monitor negative impacts of dispersal on maternity care

The Department of Health should facilitate data collection by NHS Trusts of incidents in which UKBA dispersal and relocation practices have prevented delivery of effective maternity care. The Department of Health should also facilitate communication of the data to the UKBA.

9. Develop improved support guidance for pregnant women seeking asylum

The UKBA should, as a matter of urgency, engage in discussions with representatives of midwives, obstetricians, general practitioners, and relevant voluntary organisations to develop dispersal policies for pregnant women and women who have recently delivered, which are compatible with NICE guidance on the maternity care of women with complex social factors.

Glossary

Accommodation provider

The UK Border Agency outsources the provision of accommodation to asylum seekers whom it supports. Until 2012 such contracts were directly with companies which were responsible for providing accommodation and associated services in dispersal areas but these are now subcontracted to three firms which each have responsibility for Asylum Support Services divided across a number of UKBA designated regions. Accommodation Providers are responsible for the transport of asylum seekers and the provision of housing to specified standards. They are also required to support their residents' registration with GPs and to signpost them to relevant services.

Asylum seeker

An asylum seeker is a person who has made a claim for international protection under the UN Refugee Convention, 1951 or under Article 3 of the European Convention on Human Rights, 1950 or under Article 15c European Qualification Directive, 2004. Asylum seekers are entitled to support under section 95 of the Immigration and Asylum Act 1999 while their claim is being considered and during any appeal. Asylum support consists of cash and accommodation. Asylum seekers receiving accommodation support are normally required to travel to one of a number of dispersal locations outside London.

Booking appointment

The booking appointment is the first formal antenatal appointment following a woman's first contact with a health professional in her pregnancy, and is where a woman books for maternity care. Ideally it should take place by 10 weeks' pregnancy in order to carry out initial fundamental health checks and to offer and arrange important screening tests. It is regarded as the key opportunity to identify women with particular risk factors such as FGM, domestic violence, previous pregnancy problems, or underlying health or social issues which may require the woman to receive additional care. At the booking appointment women are given information about healthcare during the pregnancy and options for delivery, and have an opportunity to ask questions and discuss issues of concern to them.

Case Owners and Case Workers

The case owner is a UKBA officer assigned to each asylum seeker within a few days of them applying for asylum. Case owners deal with the entire asylum claim, conduct the asylum interview with each applicant and make decisions on individual asylum applications for their caseload. They are also responsible for managing asylum support for the asylum seekers in their caseload. Women asylum seekers can request to have a woman case owner. Case owners are sometimes mistakenly referred to as case workers. Case workers deal with individual issues of asylum support work on behalf of accommodation providers in some areas.

Complex social factors

The National Institute for Health and Clinical Excellence (NICE) has used the terminology of 'pregnant women with complex social factors' to refer to women whose social situation might impact adversely on the outcomes of pregnancy for them and their baby. They thus distinguished social problems or disadvantage from additional health problems which could complicate a pregnancy.

Destitute

The Immigration and Asylum Act 1999 deems a person to be destitute if the person or their dependants do not have adequate accommodation or any means of obtaining it (whether or not their other essential living needs are met); or they have adequate accommodation or the means of obtaining it, but cannot meet their other essential living needs now or within the next 14 days.

Dispersal

Under the Immigration and Asylum Act 1999 and the Nationality and Asylum Act 2002, asylum seekers or refused asylum seekers requiring support and accommodation may be sent to be accommodated anywhere in the UK. This process is known as dispersal.

Female Genital Mutilation

Female genital mutilation (FGM), also known as female genital cutting or female circumcision, comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.

Forceps delivery

Forceps are a surgical instrument that resembles a pair of tongs which can be used to assist the delivery of a baby as an alternative to the ventouse (vacuum extraction) method.

Grace period

Section 95 support may come to an end when an asylum seeker's claim is fully determined with no outstanding appeal. If their claim is refused and the asylum seeker has no dependants (or their child was born after their claim was decided), their support will end after 21 days. This is known as the 'grace period'. They then may be eligible for section 4 support.

High-risk pregnancy

A pregnancy where some condition(s) place the woman, her developing foetus, or both, at higher-than-normal risk for complications during and after the pregnancy and birth.

Initial Accommodation

The provision of Initial Accommodation is a temporary arrangement for asylum seekers who would otherwise be destitute. Initial accommodation consists of mixed sex full-board hostels run by accommodation providers on behalf of the UKBA where asylum seekers requiring UKBA accommodation are housed temporarily before being dispersed elsewhere to more permanent accommodation. Adult residents receive no cash while in Initial Accommodation except for pregnant women who are given £3 per week after their pregnancy is confirmed and £5 a week after the child is born. Sometimes asylum seekers are re-housed in Initial Accommodation in a dispersal area after being moved out of Initial Accommodation in London until self-catering accommodation is found for them.

Heavily pregnant applicants for section 4 support who are street homeless, or imminently street homeless, may also be placed in Initial Accommodation. Under new healthcare guidelines, pregnant women should not be dispersed later than 4 weeks before their expected date of delivery, or sooner than 4 weeks after delivery. This means that pregnant women granted either section 95 or section 4 support who are in Initial Accommodation and who are 36 weeks or more pregnant, will stay there for at least 8 weeks.

Low-lying placenta – also called *placenta praevia*

This is where the placenta is abnormally located in the lower segment of the uterus after 20 weeks of pregnancy and either completely or partially covers the cervix (neck of the womb).

MATB1 form

The Maternity Certificate (MATB1) verifies the fact of pregnancy and confirms the expected date of confinement. It also confirms the actual date of birth in cases where the child is born early. MATB1 forms are issued by doctors or registered midwives to pregnant women in their care.

Perinatal mortality

Perinatal mortality refers to stillbirths and infant deaths at under seven days of life.

Protected period

The UKBA *Healthcare and Pregnancy Dispersal Guidance 2012* states that a woman's dispersal should be delayed during a 'protected period' starting four weeks before the expected date of delivery and ending four weeks after giving birth. If she is in Initial Accommodation she should remain there during this period.

Refused asylum seekers

Refused asylum seekers, also often referred to as 'failed' asylum seekers, are those who have exhausted their appeal rights in the asylum process. They are expected to leave the UK voluntarily, or can be removed if they do not leave of their own accord. Many refused asylum seekers fear that they will be in danger if they return. Refused asylum seekers are more likely to be destitute than other asylum seekers as they often have no access to government support or permission to work. Destitute refused asylum seekers can, under certain conditions, apply to the UKBA for section 4 support.

Screening interview

The first stage of an asylum claim involves a screening interview during which the Home Office tries to find out basic information about the applicant. This will include the applicant's identity, his or her dependants, their date of arrival in the UK, their route into the UK etc. It does not include the substantive reasons for the asylum claim which are presented at the Asylum Interview.

Section 4 support

Section 4 support is the support granted by UKBA under section 4 of the Immigration and Asylum Act 1999 to destitute refused asylum seekers under certain conditions. It is cashless support and includes accommodation on a no-choice basis.

Section 95 support

Section 95 is support granted by UKBA under section 95 of the Immigration and Asylum Act 1999, to asylum seekers in the process of making their asylum claim, including during an appeal process. Support is provided in two ways, on a cash only basis, or with cash and accommodation on a no-choice basis.

United Kingdom Border Agency (UKBA)

The United Kingdom Border Agency (UKBA) is the border control agency of the UK government and an Executive Agency of the Home Office. It is responsible for internal immigration controls including asylum, management of applications for further stay and enforcement. It also has responsibility for asylum support.

Trimester

A period of three months. A human pregnancy comprises three trimesters – first, second and third.

Ventouse

Ventouse is a vacuum device used to assist the delivery of a baby when the second stage of labour has not progressed adequately.

Appendix 1

Women – interview guide

Research project: Dispersal during pregnancy

INTERVIEW TOPIC GUIDE

Section 1: Background of research participants/demographic information

1. What is your country of origin?
2. When did you arrive in the UK?
3. Where have you lived since you arrived in the UK?
4. What was your immigration status when you got pregnant with the pregnancy we are talking about?
5. What is your current immigration status?
6. The pregnancy we're talking about today, was this your first child?
 - a. If no, do you have other children in the UK? How many? What ages?
7. How old are you? (If she does not want to tell us her age, ask if she is between 17-25, 26-35, 36-45)

Section 2: Before dispersal

The questions I am going to ask you now are about your pregnancy and your life before you were dispersed.

Where you lived

8. Where were you living when you found out you were pregnant? (town)
9. Who were you living with? (with partner, children, friends, other family etc.)
10. What sort of accommodation was it? (on your own, partner's house or flat, UKBA accommodation, rented, no accommodation (street homeless, church, homeless shelter etc.))
11. How long had you lived there?
12. Did you live anywhere else while you were pregnant, before you were dispersed?
Prompt – what kind of accommodation was it? (with friends, UKBA, detention)

Income

13. What were you living on at this time?
Prompt: Were you receiving financial support (UKBA (Azure card, cash, vouchers), social services, support from family members, faith groups, paid work, other)

Social support

14. Did you have friends and/or family in the place (or near) where you were living?
15. Were there any organisations helping you before you were dispersed? (e.g. community organisations, faith groups, refugee agencies, schools/pre-schools for other children). If yes, can you explain.

Healthcare (general)

16. Were you registered with a GP when you became pregnant?
- If no:
- Why did you not register?
 - Did you know how to register with a doctor?
 - Did you know that to get care, you needed to register?
17. If yes, was your doctor in the area where you were living when you became pregnant?

Healthcare for this pregnancy

18. How was your health generally when you became pregnant?
Prompt – did you have any specific health problems or conditions such as diabetes, asthma or high blood pressure?
19. How was your health during the pregnancy?
20. Did you have any contact with a midwife or any maternity service *before* you were dispersed? Tell us about your contact with maternity services before you were dispersed.

(note to researcher: be alert to the possibility that the participant may have accessed more than one maternity service – cover the below for all)

- Who put you in touch with a maternity service?
- How many weeks pregnant were you when you first saw a midwife? (approx.)
- How many appointments did you attend with that maternity service? (approx.)
- Were you given a handheld record to keep? (a paper file)
- Did you have any tests or scans carried out?
- Did you have particular health problems during your pregnancy at this time? Tell us about them and what help/ treatment you were getting to deal with them.
- (If it is relevant) Did you have an interpreter for any appointments with the maternity service?

Section 3: Dispersal

The questions I am going to ask you now are about when you were dispersed to a different part of the country.

21. Where were you dispersed to?
22. How did you come to be dispersed?

Prompt for: relocated by UKBA; she or her partner applied for asylum and asylum support (in which case did she know she might be dispersed); she was/ became destitute because e.g. her partner left her; she had to leave temporary accommodation with friends etc.

NB – note whether she was dispersed under S95 or S4 and why (if relevant) she was relocated.

23. Did you (or someone on your behalf e.g. solicitor) ask UKBA not to be dispersed?
 - a. If yes: For what reasons? Did anyone else support this request? (GP, hospital doctor, midwife, legal representative, refugee agency, other)
24. What was UKBA's response?
 - a. Did they give any reasons?
 - b. How did they tell you? (In writing, telephone call, email, via refugee agency)

The following questions are about your pregnancy and your dispersal

25. How much time did you have to get ready to move?
26. How many weeks pregnant were you when you were moved or how soon after birth were you moved?
 - a. Do you remember the date you moved?
 - b. When was the baby due? (date)
 - c. When was the baby born? (date)
27. Did you move on your own or with other members of your family?
28. How did you travel to your new area?
 - a. How long did it take?
 - b. Did you have any breaks?
 - c. Were you provided with food?
 - d. Did you have help in carrying your belongings? If so, by whom?
29. Do you know if your midwife/doctor knew you were being dispersed? Do you know who told them?
30. Did you have your handheld notes with you?
31. Do you know if your midwife or UKBA or a refugee agency spoke to health services in your new area to let them know that you were coming and were pregnant or had just given birth?
32. How did you feel about moving to the new area?

Section 4: Arrival in new area

I am now going to ask you questions about moving to in your new area.

33. Who was living with you in your new accommodation?
34. What did you think of your new accommodation?
(Happy, not happy, practicalities i.e. Ground floor/lifts/sharing)
35. What types of equipment or things were available for taking care of a baby/child?
(cots, high chairs, sterilisation equipment)
36. Did you feel safe in your new accommodation?

Income

37. Did you receive your financial support from UKBA immediately after you arrived?

Social support

38. Did you have friends and/or family in the new area?
39. Were there any organisations you were able to get help and support from in the new area? (e.g. community organisations, faith groups, refugee agencies, schools/pre-schools for other children). If yes, how quickly?

Your pregnancy and healthcare in the new area

40. Did you register with a new GP?
If no:
- a. Why did you not register?
- If yes:
- b. Did anyone help you find the GP?
 - c. How long after you arrived?
 - d. How many weeks pregnant were you?
41. Did you have an appointment with a maternity service in the new area before you gave birth? If yes:
- a. How many weeks pregnant were you?
 - b. How soon after you arrived did you have an appointment?
 - c. How did you contact the service? Or did they contact you?
 - d. How often did you see this maternity service before you gave birth? (approx.)
 - e. Did you see any other service for any other health or other problems in the new area before you gave birth? Tell us about these.
 - f. (If it is relevant) Did you have an interpreter for any appointments with the maternity service?
42. Were you moved any more times before the birth by UKBA? Where?
- a. (If yes, repeat questions from no. 16)

Section 5: Birth

I am now going to ask you questions about the birth.

43. When you went into labour, how did you get to the hospital? Did anybody go with you?
44. (If she has children) Who looked after your other children?
45. Was any friend or family member with you during the birth?
46. Tell us about the delivery of this baby – how long it took, how it was done, any problems for you (e.g. prompt – pain, particular health problems, communicating with midwives, presence of an interpreter etc.)
47. How long did you stay in hospital?
48. How did you get home from hospital?
49. How do you feel about how you were looked after during the birth of your baby?

Section 6: After the birth

I am now going to ask you questions about the first few months after the birth of your baby.

50. How did you feel mentally and physically after the birth?
51. (If the woman talks of problems, ask) Did anyone help you cope with problems during this time? (Friends, family members, partner, members of the community, health workers, refugee agencies)
52. Did you or your baby receive any other health treatment after the birth? Are you happy to tell us about these?
53. Did you get any practical help during this time? (For example, registering the birth of your baby; applying for extra financial support.) Who from? (e.g. refugee agencies, health visitor, friends)
54. Did you receive any extra payments around the time of the birth? (prompt for maternity grant)

Section 7: General thoughts on dispersal and pregnancy and birth

I am now going to ask you some final general questions about your experience of dispersal.

55. Where would you have preferred to have given birth? Why?
56. What do you think the effect of dispersal was on your pregnancy and your first months with a newborn baby?
57. What would you say were the most helpful things that the UKBA did to help you move?
58. Are there things that could have been done differently to improve this experience for you? If yes, what?
59. Do you have anything to add about your experiences of being dispersed while pregnant?

Appendix 2

Sending area midwife interview guide

1. Introduction

Maternity Action and the Refugee Council are currently carrying out a joint study to investigate the effect of dispersal and relocation on pregnant asylum seeking women and new mothers. Our aim is to find out about the health impacts of dispersal and relocation of pregnant women and new mothers. We hope this will lead to improvements in policy and practice by maternity services and the UK Border Agency.

To collect our information we are carrying out telephone interviews with midwives who are or have been involved in the maternity care of asylum seeking women in dispersal areas to learn about your experiences of looking after women dispersed during pregnancy or shortly after giving birth.

- **Have you ever looked after a woman who was dispersed during pregnancy (before or after dispersal)?**

Yes/No (If Yes continue below. If No, ask whether she knows any midwives who have and if she can give us their contact details and stop the interview).

As a midwife, we would like you to tell us about any cases of any women you have looked after who were dispersed or relocated during pregnancy or very soon after delivery. The idea is to get an understanding of each woman's pregnancy and how her care was affected by being dispersed during it, rather than any personal details about her. We will not use any information which could identify any woman whose case is discussed in the interview.

It may sometimes be helpful for the midwives to consult records to be sure that details are accurate.

We would like your permission to record the interview to make sure we have an accurate record of what you tell us. However, all the information you give us is strictly confidential. We will not reveal your name or the name of your service or the identity of any woman whose case you tell us about.

Are you happy for the interview to go ahead?

Are you happy for it to be recorded?

If yes, start recording; if not, ask if the midwife is happy for the interview to go ahead without being recorded.

2. Short personal details of interviewee

- Name
- Trust
- Job title
- Job band
- Length of time in this post
- Responsibilities
- Experience of working with asylum seekers
- Training about asylum

3. Details of cases of women dispersed or relocated away from her unit whom the interviewee has cared for

(Note to interviewer: For each case try to ascertain what her specific concerns were concerning each woman whose case history she is giving with a particular focus on the following issues. Midwives may not be able to answer all questions for each case. If a midwife has seen a large number of such women she should select significant cases as examples)

Contacting the maternity service

- At what stage in her pregnancy did the woman first contact your maternity unit?
- How did she make contact with this maternity service? (e.g. via GP or housing provider or previous maternity unit etc.)
- Was this maternity service the first contact the woman had with maternity services in this pregnancy? If she was booked in elsewhere before contact with this service please give details if you know them.
- If she was booked in elsewhere before, did you have sufficient information on the woman's case from the previous service. Any other comments about the woman's previous maternity care and the transition?

Dealing with the woman's needs in pregnancy

- Did the woman have any additional medical/ social/ mental health needs ? Include any experience of trauma either before or after arrival that affected her experience of pregnancy or any safeguarding children issues? Please specify.
- If there were any additional needs, what had been put in place to address them? Did any of these get interrupted as a result of the dispersal?
- Were any tests carried out in this unit prior to dispersal or was the unit awaiting any further tests, appointments, service input etc.? Did any of these get interrupted as a result of the dispersal?
- Any other issues about this pregnancy.

Liaison between sending maternity services, UKBA, and dispersal maternity service

Information about impending dispersal

- Was your service informed about the woman's dispersal before it took place?
Details – when informed, how informed, by whom etc. Were you told where she was going to go?
- If no, give details of how you knew that the woman had been dispersed.
e.g. Did you spend time trying to locate her? Did you hear from the maternity unit in the dispersal area?

Liaison with receiving unit

- Did you have an opportunity to liaise with the maternity unit in the dispersal area before the dispersal? If yes, give details of how and when you liaised, e.g. letter with details of her pregnancy and (if relevant) of other medical conditions?
- Were sufficient details about the woman's condition included in the woman's handheld records for the unit in the dispersal area to take over her care smoothly?
- Were you able to make contact with the maternity unit in the dispersal area after the dispersal?

Liaison with UKBA

- Had the woman made any requests concerning dispersal e.g. to be dispersed elsewhere, or not to be dispersed? If yes, what happened?
- Were you asked to certify that the woman was fit to travel?
- Did you think there were reasons for the woman to not be dispersed or for the dispersal to be delayed? If so, what were the reasons?
- (If yes to the above) Did you have the opportunity to inform the UK Border Agency about your concerns? If yes, what happened?
- Did you have an opportunity to make recommendations to UKBA about any other concerns about dispersal? e.g. accommodation or medical requirements in the dispersal area
- (If yes to the above) If yes, what happened?

Woman's personal circumstances

- Did the woman have any family or other support where she was living?
- Other relevant details not mentioned previously e.g. knowledge of English, family circumstances etc.

Concluding points

- What overall impact do you think dispersal might have had on the management of the woman's care? Please specify.
- Do you think there are things that would have improved the transfer of care on dispersal? If so, what would have helped?

Appendix 3

Dispersal area midwife interview guide

1. Introductory blurb

Maternity Action and the Refugee Council are currently carrying out a joint study to investigate the effect of dispersal and relocation on pregnant asylum seeking women and new mothers. Our aim is to find out about the health impacts of dispersal and relocation of pregnant women and new mothers. We hope this will lead to improvements in policy and practice by maternity services and the UK Border Agency.

To collect our information we are carrying out telephone interviews with midwives who are or have been involved in the maternity care of asylum seeking women in dispersal areas to learn about their experiences of looking after women dispersed during pregnancy or shortly after giving birth.

- **Have you ever looked after a woman who was dispersed during pregnancy (before or after dispersal)?**

Yes/No (If Yes continue below. If No, ask whether she knows any midwives who have and if she can give us their contact details and stop the interview).

As a midwife, we would like you to tell us about any cases of any women you have looked after who were dispersed or relocated during pregnancy or very soon after delivery. The idea is to get an understanding of each woman's pregnancy and how her care was affected by being dispersed during it, rather than any personal details about her. We will not use any information which could identify any woman whose case is discussed in the interview.

It may sometimes be helpful for the midwives to consult records to be sure that details are accurate.

We would like your permission to record the interview to make sure we have an accurate record of what you tell us. However, all the information you give us is strictly confidential. We will not reveal your name or the name of your service or the identity of any woman whose case you tell us about.

Are you happy for the interview to go ahead?

Are you happy for it to be recorded?

If yes, start recording; if not, ask if the midwife is happy for the interview to go ahead without being recorded.

2. Short personal details of interviewee

- Name
- Trust
- Job title
- Job band
- Length of time in this post
- Responsibilities
- Experience of working with asylum seekers
- Training about asylum

3. Details of cases of women dispersed or relocated during pregnancy the interviewee has cared for.

(Note to interviewer: For each case try to ascertain what her specific concerns were concerning each woman whose case history she is giving with a particular focus on the following issues. Midwives may not be able to answer all questions for each case. If a midwife has seen a large number of such women she should select significant cases as examples)

Previous maternity care

- Had the woman been booked into a maternity service elsewhere before reaching this unit? Yes/No (if no, go to the next section)
- To your knowledge did the previous maternity unit know about the woman's impending dispersal?
- Did the previous maternity unit/ GP liaise with the maternity unit in your area?
- Did the dispersal maternity unit receive results of any tests carried out prior to dispersal?
- Did the dispersal maternity unit receive any letter with details of her pregnancy and (if relevant) of other medical conditions from her previous treating midwife or other clinician?
- Were sufficient details about the woman's condition included in the woman's handheld records for the unit in the dispersal area to take over her care smoothly?
- Any other comments about the woman's previous maternity care?

Contacting the maternity service

- At what stage in her pregnancy did the woman first contact the maternity unit in your area?
- How did she make contact with this maternity service (e.g. via GP or housing provider or previous maternity unit etc.)
- How long after dispersal was she seen?

Dealing with the woman's needs in pregnancy

- Did the woman have any additional medical/ social/ mental health needs? Include any experience of trauma either before or after arrival that affected her experience of pregnancy or any safeguarding children issues? Please specify.
- Do you know if the woman had made any requests concerning dispersal e.g. to be dispersed elsewhere, or not to be dispersed?
- Any other issues about this pregnancy.

Pregnancy experience and outcomes

- Outline any problems for the woman or relating to her care that in your view arose because of the dispersal or how it was managed
e.g. (prompt)
 - Timing of dispersal
 - Fact of dispersal (e.g. woman's reluctance to be dispersed at all or to this area)
 - Lack of availability of crucial medical information, including knowledge about the woman's background that may have been known in her previous maternity unit
 - Issues with communication between previous maternity unit, present maternity unit and UKBA
 - Other

Woman's personal circumstances

- Did the woman have any social or family support in the sending area not available in the dispersal area?
- Other relevant details not mentioned previously e.g. knowledge of English, family circumstances etc.
- Concluding points.
- What overall impact do you think dispersal might have had on the management of the woman's care? Please specify.
- Do you think there are things that would have improved the transfer of care on dispersal? If so, what would have helped?

When maternity doesn't matter

Dispersing pregnant
women seeking asylum

“In the hostel I had my own room, but I think I was forgotten when I was there because nobody really came to check with me. The midwife from the shared accommodation said she couldn't help me any more because I had moved out of her area. She said I had to ask somebody at the hostel. So I asked them and they kept on asking me to wait, saying 'next time...next time'. I even had to take my baby to hospital as an emergency by ambulance because she had a cold and a cough.

“When the interpreter came with the social workers [to see me in hospital] she said, 'Do you want to drink a cup of coffee?' I said, 'No', because I thought that it cost money. She said, 'No, these are free.' She said, 'When did you last eat?' I said, 'Last night.' She said, 'Oh my god.'



www.maternityaction.org.uk



www.refugeecouncil.org.uk

