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**Article Title:** Access to Maternity Care for 'Failed' Asylum Seekers

**Year of publication:** 2006

**Citation:** Gaudion, A., McLeish, J., Homeyard, C. (2006) 'Access to Maternity Care for 'Failed' Asylum Seekers' International Journal of Migration, Health and Social Care 2 (2) 15-19

**Link to published version:**

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**DOI:** (not stated)

**Publisher statement:**

[http://www.pavpub.com/pavpub/journals/guidelines/HCS\\_guidelines.pdf](http://www.pavpub.com/pavpub/journals/guidelines/HCS_guidelines.pdf)

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# Access to Maternity Care for 'Failed' Asylum Seekers

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peer-reviewed

## Abstract

This article analyses provision of health and social care for pregnant women and new families who have been unsuccessful in their asylum claims in the United Kingdom. It identifies the contribution of maternity care to child health, and examines the implications of the legislation that excludes 'failed' asylum seekers from free NHS secondary health care and denies them housing and financial support. Finally, the article examines the impact on pregnant women and their babies of being held in removal (detention) centres.

## Introduction

Article 25 of the Universal Declaration of Human Rights, 1948 asserts that:

*Everyone has the right to a standard of living adequate for... health and well-being... including... medical care and necessary social services... Motherhood and childhood are entitled to special care and assistance. All children... shall enjoy the same social protection (UNHCHR, 1948 p7).*

However, the United Kingdom (UK) is one of the European Union countries that increasingly restrict 'failed' asylum seekers' access to health and social care. This article explores how recent health and immigration legislation has profound and detrimental implications for marginalised women and their children who have not been successful in their claim for asylum.

## The importance of maternity care for child health

What happens during pregnancy and the early months of life can have long-term consequences for a child, and in some cases can mean the difference between life and death, or between health and illness/disability. For example, a baby who is born at a low birthweight (below 2,500g) is at increased risk of neonatal death, disabilities,

hospitalisations, brain damage, poor language development, special educational needs and, in later life, coronary heart disease and diabetes (British Medical Association, 1999; Macfarlane & Mugford, 2000; Kempley *et al*, 1995). Lack of timely and appropriate maternity care can contribute to the avoidable death of a baby (CESDI, 2001). Maternity care is also crucial in prevention of vertical (maternal to child) transmission of the HIV virus. In the UK HIV testing is offered as part of routine antenatal screening to pregnant women. In an untreated HIV positive pregnant woman in the developed world, the risk of passing the HIV virus to her baby is between 15% and 30%, but with appropriate antiretroviral treatment during pregnancy, caesarean delivery and formula feeding the risk drops to below two per cent (Merchant & Lala, 2005). Sub-Saharan born women living in the UK (many of whom are asylum seekers) are disproportionately likely to be HIV positive.

The Department of Health has issued best practice guidance in the form of a National Service Framework for Children, Young People and Maternity Services (DoH, 2004a), which emphasises the needs of vulnerable and disadvantaged women. This explicitly recognises that:

*the care and support provided for mothers and babies during pregnancy, childbirth and the post-natal period have a significant effect on*

*children's healthy development and their resilience to problems encountered later in life (DoH, 2004 p6).*

The National Service Framework also recognises that asylum-seeking women and refugees may have multiple social problems and may find it difficult to access and maintain contact with maternity services. It therefore:

*seeks to improve equity of access to maternity services, which will increase the survival rates and life chances of children from disadvantaged backgrounds. It also aims to ensure that all mothers and babies receive high quality clinical services (DoH, 2004a p6).*

## **Barriers to accessing care for asylum seekers and refugees**

The National Service Framework is in part a response to evidence of the poor access to maternity care and worse health outcomes experienced by asylum-seeking and refugee mothers and babies. The latest Confidential Enquiry into Maternal and Child Health (CEMACH, 2004) found that black African women, including asylum seekers and refugees, had a maternal mortality rate that was seven times as high as that of white women, and that this group had major problems in accessing maternity care.

*Fourteen women were recently arrived in the UK, of whom ten could be classified as refugees or asylum seekers... four of these women did not access antenatal care at all. (CEMACH, 2004 p46)*

*Two women who delivered at home died of postpartum haemorrhage. In both cases they had not sought any care during pregnancy, had delivered and died on their own, and were found later by relatives. One baby survived. Another woman who died... had not sought any antenatal care and delivered at home on the toilet: the baby drowned. (CEMACH, 2004 p37)*

Research on the experiences of asylum seekers and refugees in the UK has identified some key obstacles to accessing health care, including maternity care: lack of language support, lack of accessible health information, cultural differences and racism. It also highlighted lack of

awareness of refugee issues and rights among health professionals, and the difficulty asylum seekers have in gaining registration with a general practitioner (GP), the primary care doctors who are the gatekeepers to most other NHS services (Aldous *et al*, 1999; McLeish, 2002; Kennedy & Murphy-Lawless, 2001; Woodhead, 2000; Norredam *et al*, 2005). Asylum seekers and refugees living in marginal and insecure situations may give their health lower priority than the need to secure accommodation, education and money (Clinton-Davis & Fassil, 1992). Some asylum seekers and refugees do not understand how the NHS functions, and are unaware that they can access maternity care through a midwife instead of a GP or a hospital (Burnett & Fassil, 2002). Asylum seekers' access to health services may also be obstructed by other barriers, such as confinement in removal (detention) centres (Keller *et al*, 2003).

## **Exclusion of 'failed' asylum seekers from free NHS care**

A recent change in legislation constitutes yet another barrier to accessing maternity services for a particularly vulnerable group - asylum seekers whose claim for asylum has been rejected. The amendments were intended to tackle a perceived problem of people coming to the UK with a primary purpose of making use of free NHS services (so-called 'health tourism'). NHS trusts are required to establish whether people using their hospital services are ordinarily and lawfully resident in the United Kingdom, and to charge those who are not ordinarily or lawfully resident for the services if they are liable to pay. Legislation in force since April 2004 has added 'failed' asylum seekers to the categories of people who should be charged for NHS health care in hospitals, even though they will usually have been in the UK for long periods at the time the asylum claim is rejected, and cannot be supposed to be 'health tourists' (NHS, 2004). 'Failed' asylum seekers include women and children who cannot return to their countries of origin because those countries are considered unsafe by UNHCR (Hargreaves *et al*, 2005), and women accepted by the UK immigration authorities as being unable to leave the UK because they are at an advanced stage of pregnancy.

Because all maternity care is classed as 'immediately necessary treatment', it cannot lawfully be withheld by the hospital if the service user is unable to pay (as will

generally be the case for 'failed' asylum seekers, since asylum seekers are barred from working in the UK and receive minimal subsistence support). In these cases there is a procedure for the hospital to record and then write off the debt (DoH, 2004b). However, case studies collected by the charities, the Refugee Council and Medact, and examples from the authors' experience, indicate that the hospital overseas managers who assess liability to pay do not always appreciate the importance of explaining this procedure to pregnant women, and in some cases effectively turn women away from the hospital by making assertive demands for 'up front' payments which the women cannot meet. There is no safety net to ensure that pregnant women without resources to pay for private care can access services (McColl *et al.*, 2006).

As well as directly deterring 'failed' asylum seekers from accessing essential maternity care, this legislation is affecting the wider black and minority ethnic communities in the UK who are entitled to free NHS care. These communities often rely on word of mouth recommendations to access services, and they are discouraged from seeking maternity care in a climate where some members of the community are told they will have to pay, and where all black and minority ethnic women can expect to have to prove their immigration status before receiving any hospital care. Furthermore, in some cases women who are entitled to free care have been wrongly denied it by confused staff. For example, a recent investigation into the maternity services of North West London Hospitals NHS Trust, following the occurrence of nine maternal deaths in three years, reported that staff were unsure about the entitlement to maternity care of overseas visitors, including asylum seekers.

*On at least two occasions, this lack of clarity resulted in women leaving an antenatal clinic without receiving care and treatment. For example, one of the trust's documents stated that a female asylum seeker was told by the finance department that she would have to pay £2,300 to have her baby. The woman was in the advanced stages of her pregnancy and said that she had no money and could not pay, so would have her baby at home. (Commission for Healthcare Audit and Inspection, 2005 p42)*

The impact of this legislation is directly contrary to the intention, set out in the National Service Framework quoted above, to increase marginalised women's access to maternity services. It is also open to criticism on the grounds of cost-effectiveness, as the cost to the health service of caring for a baby born with a health condition that might have been prevented by antenatal care (for example HIV) is likely to outweigh any cost savings from denying care to 'failed' asylum seekers. A recent government consultation has proposed extending the exclusion of 'failed' asylum seekers - which currently applies only to hospital care - to primary NHS care. If taken forward, this would have even more damaging consequences for 'failed' asylum seekers and their children, as it would exclude them from free community-based antenatal care and child health services.

### **Denial of accommodation and support to 'failed' asylum seekers**

A recent development in immigration policy has created an additional obstacle to engagement with vulnerable families of 'failed' asylum seekers. Under a pilot scheme, if the immigration authorities take the view that the family is not taking reasonable steps to leave the UK, then their accommodation and subsistence welfare support can be withdrawn. Local authorities are then obliged to offer to accommodate the destitute children, but are specifically not allowed to support or accommodate the destitute parents with the children. This raises the prospect of young children being taken into local authority care, of mothers being unable to breastfeed their babies (even though they may have no other safe means to feed them when they leave the UK), and of grave damage to mother-infant attachment.

The coercive use of destitution and the threat of forcible family separation as tools of immigration policy have been strongly condemned by refugee charities, which have pointed out that the scheme has created intense hardship and fear while failing in its objective of persuading 'failed' asylum seekers to leave the UK (Refugee Council and Refugee Action, 2006). Only one family of the 116 in the pilot has left the UK as a result of the policy, while more than a quarter of families have gone into hiding.

## Mothers and babies in removal (detention) centres

Children of all ages who belong to asylum-seeking families, or 'failed' asylum-seeking families, can be detained with their parents in removal (detention) centres, which are effectively dedicated prisons run on behalf of the immigration authorities. Pregnant women and newborn babies are among those detained. In a small qualitative study (McLeish *et al*, 2002), pregnant asylum seekers described receiving limited maternity care in removal (detention) centres, good care being obstructed by the centres' failure to provide interpreters for medical consultations, failure to take a woman to an important hospital appointment for an antenatal scan, and failure to forward important blood test results when detainees were released or transferred. Detainees who were pregnant or new mothers described feelings of acute depression, loneliness and stress.

Detention can also have a direct impact on infant health. McLeish and colleagues (2002) cite the case of a four-week-old premature baby taken into detention with his mother in circumstances which abruptly broke off contact with the health professionals who had been caring for mother and child. The removal (detention) centres withheld the baby's medical treatment, and refused to arrange or provide the baby's first three sets of immunisations. This mother and child were eventually released from detention after eight months, when the mother's allegedly 'failed' asylum claim was found to have been wrongly decided.

## Conclusion

*The Children Act 1989*, and international obligations such as the United Nations Convention on the Rights of the Child (1989), place 'the best interests of the child' at the heart of decision-making. However, legislation affecting 'failed' asylum seekers and their children has the potential to harm young children by deterring pregnant women from accessing essential maternity care, forcing vulnerable families with young children to 'disappear' into communities and detaining pregnant women and babies in conditions inimical to health.

Government policy on children is co-ordinated under the framework of a strategy called Every Child Matters (Treasury, 2003). The legislation discussed in this article

indicates that, in fact, the strategic objective of controlling immigration takes precedence over the welfare of some of the most vulnerable children in the UK (Cunningham & Tomlinson, 2005; Refugee Children's Consortium, 2003). It appears that in the UK in 2006, some children matter less than others.

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