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Review

The obstetric care of asylum seekers and refugee women in the UK

Sonia Asif MBChB MRCOG,[a,*] **Amy Baugh** MBChB BSc(Hon) MRCP Dip GUM DipHIV,[b] **Nia Wyn Jones** MBBCh MRCOG PhD[c]

[a]ST7 in Obstetrics and Gynaecology, Department of Obstetrics and Gynaecology, Nottingham University Hospitals NHS Trust, Queens Medical Centre, University Road, Nottingham NG7 2UH, UK
[b]Consultant in Genitourinary Medicine, Department of Genitourinary Medicine, Sherwood Hospitals NHS Foundation Trust, Kings Mill Hospital, Mansfield Road, Sutton in Ashfield, Nottinghamshire NG17 4JL, UK
[c]Associate Professor of Obstetrics and Gynaecology, Division of Child Health, Obstetrics and Gynaecology, University of Nottingham, D floor East Block, Queens Medical Centre, University Road, Nottingham NG7 2UH, UK
*Correspondence: Sonia Asif. Email: Mda99sa@yahoo.co.uk

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Key content

- Asylum seekers and refugees are a vulnerable group with regards to pregnancy outcomes and accessing maternity care.
- Asylum seekers and refugees who are pregnant and living in the UK face medical, sexual and psychosocial challenges, including dispersal late in pregnancy.
- The health needs of asylum seekers and refugees are complex but similar to other deprived and ethnic minority communities in the UK.
- Asylum-seeking women are three times more likely to die in childbirth and up to four times more likely to experience postnatal depression than the general population because of a complex combination of physical, psychological, educational, monetary and language problems.
- Healthcare professionals may not be aware of the legal issues surrounding asylum seekers, and therefore may not provide adequate help and support.

Learning objectives

- To gain knowledge of how to provide good antenatal care for this group of vulnerable women.
- To be able to describe the medical, sexual and psychosocial issues that face pregnant asylum seekers and refugee women in the UK.
- To gain awareness of the legal aspects of seeking asylum in the UK and its impact on accessing health care, especially in pregnancy.

Ethical issues

- Should the NHS provide free health care to failed asylum seekers?
- Is it justified to disperse pregnant women late in the third trimester (up to 36 weeks of gestation) to prevent destitution with consequent fragmentation of care and isolation of the women?

Keywords: antenatal care / asylum seeker / complex psychosocial needs / dispersal / refugee health

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Introduction

Recent migration into the UK has meant that healthcare professionals are coming into contact with a changing multi-ethnic population with its differing medical, economic and psychosocial needs. Most migrants come to the UK seeking economic and professional opportunities, however, there are some individuals that view the UK as a place of safety, fleeing from persecution and instability in their home country.[1]

Over the last 10 years there has been an increase in both voluntary and forced global migration. By 2013, more than 2.5 million people had been forced to leave their homes and seek protection outside their home countries.[2] Although refugees and asylum seekers make up only a small minority of UK society, they are a potentially vulnerable social group; their complex health needs may be underestimated.

The asylum-seeking population is dynamic and there is frequent relocation around the host country. For pregnant women, there may be fear regarding disclosure of a pregnancy. This, along with upheaval to a new place, leads to late booking and disruption in antenatal care. The Centre for Maternal and Child Enquiries report continues to highlight that disadvantaged and vulnerable women, including asylum seekers, have poor pregnancy and birth outcomes, with women of Black African ethnicity at an almost four-fold increased risk of maternal mortality.[3] The report also highlights that a lack of interpreting services has been implicated in several cases.

The women at greatest risk of poor obstetric outcomes are those that are newly arrived in the host country in the advanced stages of pregnancy, possibly related to language issues and unfamiliarity with accessing healthcare services.

Midwives have identified the poverty and destitution experienced by pregnant asylum seekers as significant barriers to providing effective care, citing that appointments are missed because the women do not have money for transport.[4] Following delivery, women may struggle as single parents in poverty and isolation. This is often a trigger for postnatal depression and further disengagement with healthcare services.

Asylum and refugee status: demographics

During 2013 just over one million individual applications for asylum or refugee status were submitted to the United Nations High Commissioner for Refugees in 167 countries or territories. The UK received 23 507 applications which comprise 0.23% of the population.[2] Figure 1[5] highlights the country of origin of these claims. Women make up one-third of all asylum seekers in the UK; this has remained constant since 2003.[6]

Currently, the UK Home Office does not have a well-defined method for recording how many asylum seekers are pregnant, therefore the prevalence remains unknown. A report looking at the care of pregnant asylum seekers in 2011 estimated that there were 500 pregnant women seeking asylum and 125 who had had their application refused.[7]

There are many reasons why an individual may claim asylum, including political and social unrest in their home country, war or exploitation. However, there is very little evidence to indicate the reasons as to why pregnant women claim asylum and the circumstances surrounding their pregnancies. Most women present with their partner, with a small proportion applying individually. Occasionally, the pregnancy may be a result of sexual abuse/exploitation either in the home or host country. Irrespective of their circumstances, 2012 National Institute for Health and Care Excellence guidelines[8] highlighted the need for health professionals to be aware of the sensitive nature and complex psychosocial factors when caring for these women.

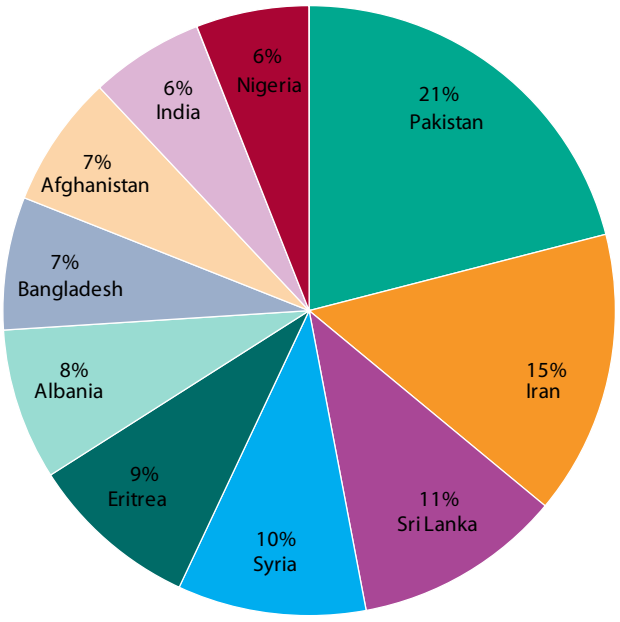

Figure 1. The country of origin of asylum seekers in the UK. Information taken from Home Office Asylum Data Tables, January–March 2014.[5]

Immigration status and legal rights

The highly publicised trends of immigration by the media have led to the terms refugee and asylum seeker becoming familiar to most individuals living in the UK. These terms are often used interchangeably. However, they are different and are used to describe an individual's immigration status once they apply for asylum. Table 1 highlights the difference between each immigration status and the legal entitlements.[9]

Although refugee women have the same legal rights as British citizens, often there is a delay acclimatising into UK society. There are feelings of isolation and, despite better financial prospects, their needs are still very similar to those in the asylum process.

Legal aspects of claiming asylum

The 1951 UN Convention on Refugees[9] states that an individual claiming asylum should present themselves to the authorities on arrival. This may be to the Immigration Services at an airport, port, or at the asylum screening units based in Liverpool or Croydon. Once an individual declares their need for asylum they are entered into a complex legal process and subject to various biometric and health screening. Figure 2 outlines the process of seeking asylum in the UK.[10]

The process of seeking asylum in the UK

Health assessment

On application for asylum, a basic interview will be conducted and security screening will be performed, including photographs and fingerprints. During this process the applicant will be asked about pregnancy and pre-existing or recent medical conditions. Referral to emergency health care or antenatal services is arranged if deemed appropriate.

Within the initial accommodation centre, another preliminary health assessment is carried out to assess any

Table 1. Definition and legal rights according to immigration status[9]

Immigration status	Definition and role	Legal rights
Asylum seeker	A person who flees from perceived risk, enters a host country and informs the authorities that they wish to claim asylum (under the 1951 UN Convention and its 1967 Protocol).	• The individual can remain in the country while awaiting the outcome of their claim. • They have no legal rights to work, study or claim benefits in the UK. • They may be entitled to limited financial help from the authorities. • They are entitled to free NHS treatment.
Refugee	A person who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his or her nationality, and is unable to or unwilling to avail him or herself of the protection of that country.	• The individual has proven to the authorities that their asylum claim is valid. • They have the same legal rights as British citizens. • They can work, study and claim state benefits. • They are entitled to free NHS treatment.
Failed asylum seeker	A person whose asylum claim has been refused by the Home Office and therefore must return to their home country.	• They have the right to appeal against the decision but if unsuccessful must leave the UK. • They have no legal rights to work, study or claim benefits in the UK while awaiting a decision. • They are entitled to limited NHS treatment.
Economic migrant	A person who enters the host country legally or illegally to improve their financial status. Some may have submitted an asylum claim that has been refused.	• They may have no legal right to work, study or claim benefits in the UK. • They are not entitled to free NHS treatment. • They are liable to be deported to their home country if they are here illegally and found by the authorities.

immediate healthcare needs, as well as to provide a more detailed medical history so that registration with a general practitioner (GP) can be completed. Other aspects of health are also addressed including:

- Documentation of the patient's immunisation and vaccination history.
- Documentation of the woman's obstetric history. A pregnancy test is offered if indicated and contraception advice is offered to both men and (non-pregnant) women.
- A sexual health risk assessment is carried out and investigations/treatment initiated if deemed appropriate.
- Screening for tuberculosis (TB), hepatitis A, B and C, and Human immunodeficiency virus (HIV) if there are risk factors identified or the individual is concerned.
- A mental health assessment is conducted to screen for psychiatric conditions and to assess mood.

Financial support and access to services

Asylum seekers can apply to the UK Border Agency for financial support under the Immigration and Asylum Act 1999. This process is facilitated through the National Asylum Support Service and applicants are entitled to 70% of the funding a UK citizen receives on income support (100% for those under 16 years of age).

Although access to both primary and secondary health care is free to all asylum seekers, they are not allowed to work. They cannot claim any other financial benefits, nor can they study until they have been given leave to remain in the UK. Most refused asylum seekers are not entitled to any form of financial support leaving many women at high risk of destitution, violence and exploitation.[11]

Dispersal in pregnancy

Initial accommodation centres have limited capacity and therefore most asylum seekers are relocated to various areas around the UK. This process is known as dispersal and individuals can be moved several times during the asylum application. The quality of accommodation is varied and often there is a high level of self-neglect and isolation, which can lead to poor obstetric outcomes.

The Border Agency endeavours to keep dispersal of pregnant women to a minimum, citing that they should not be moved from 36 weeks of gestation to 4 weeks postpartum. A 2012 report from the British Refugee Council[7] highlighted that in reality this is not the case, with most women being moved in the third trimester with a highly negative impact on their obstetric care and mental health. Many women have reported dispersal being highly detrimental to their wellbeing, feeling scared and unsupported in labour and the postpartum period.[12]

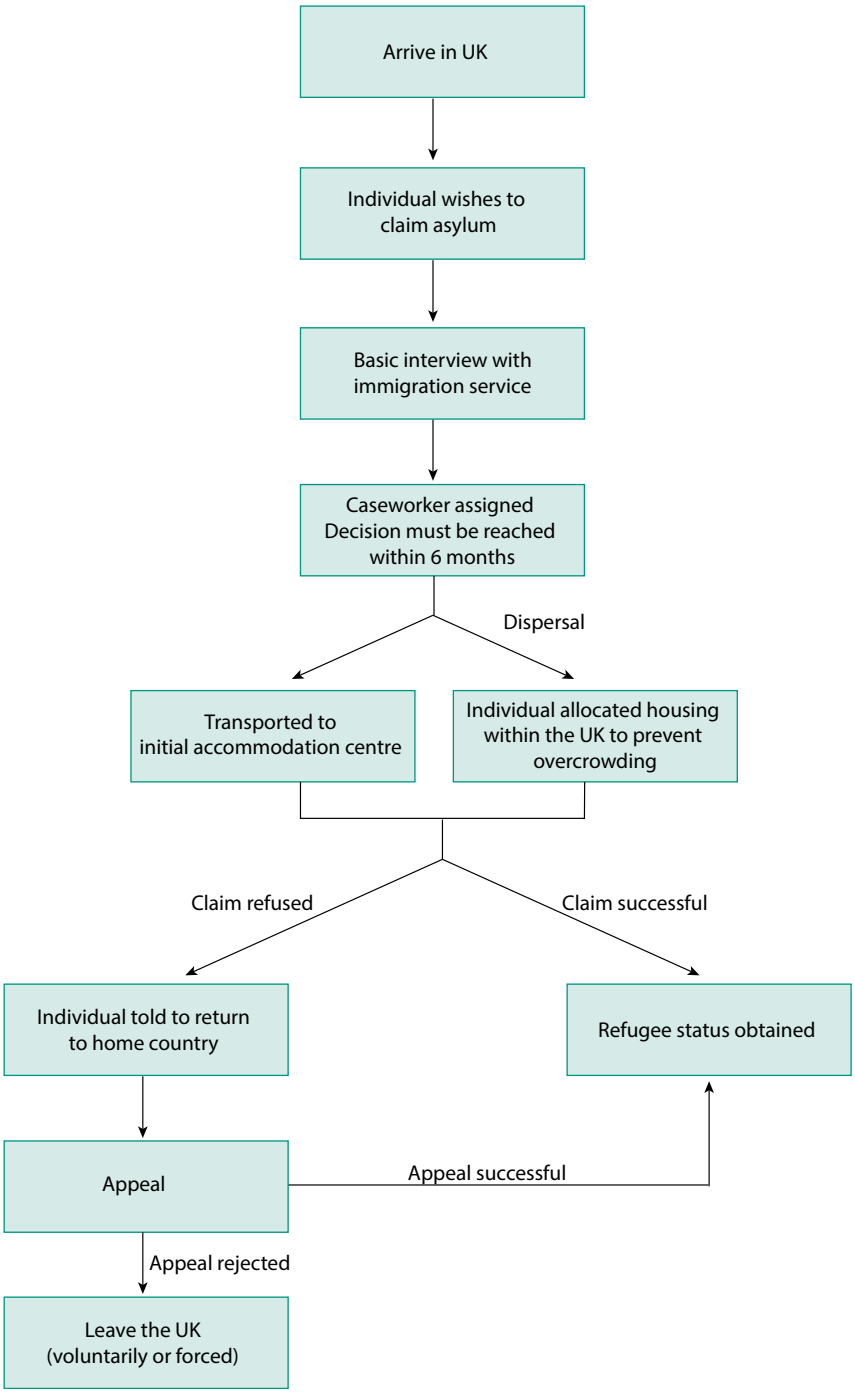

Figure 2. The process of seeking asylum in the UK.

The challenges of accessing care, building rapport and establishing a social network are exacerbated by dispersal. In a UK-based study, midwifery staff and obstetricians highlighted the extra time and resources spent trying to contact women with complex pregnancies to ensure that the next hospital was aware of recent investigations and care.[13] This was particularly evident in women with medical conditions such as HIV, TB and diabetes.

Health professionals must therefore ensure that they work closely with their safeguarding teams and Border Agency dispersal staff, so that if relocation is necessary it happens as early as possible and without compromising antenatal care.

The health needs of pregnant asylum seekers

Women seeking asylum may be physically and psychosocially vulnerable as a result of their previous experiences. They present with a range of health and social care needs including poor nutrition, infectious diseases, mental health issues and a significantly higher maternal mortality rate than white British women.[14] There is also evidence that for asylum seekers health deteriorates in the first 2–3 years following arrival in the UK.[15] Table 2 highlights the basic needs of all pregnant women and the challenges faced by asylum seekers.

Common health problems

The most common health problems affecting pregnant asylum seekers include chronic disease, infectious diseases, poor oral hygiene, mental health needs, and consequences of rape, injury or torture.

Chronic disease

Congenital heart disease, diabetes and hypertension are examples of conditions that may have gone undiagnosed in the woman's home country because of poor access to health services.

Table 2. The challenge to basic needs faced by pregnant asylum seekers and refugees

The needs of pregnant women	The challenges faced by pregnant asylum seekers and refugees
Shelter and housing	Housing may be overcrowded, squalid and dispersal at short notice is common.
Good nutrition	Poor living conditions and financial constraints may lead to poor diet. Anxiety and depression may contribute to poor appetite.
Good physical and mental health	Women may have multiple comorbidities, e.g. congenital heart disease, TB and HIV. There may be very little screening for HIV, rubella and hepatitis. There may be feelings of isolation, poor self-esteem and racism. Access to maternity services may be limited due to language difficulties and unfamiliarity with the system. The consequences of past trauma, rape and forced migration may lead to high levels of depression and psychosomatic illness. Dealing with living conditions in the host country and challenges of integration/ hostility lead to additional psychosocial stressors. Lack of family support and isolation may cause deterioration in mental health.

Infectious diseases

Often immunisation programmes or treatment may not be widely available for asylum seekers from countries where health care is lacking and women may have infectious diseases such as TB, HIV or malaria.

Poor oral hygiene

Dental problems are commonly reported among refugees and asylum seekers due to lack of resources and poor nutritional status in their home countries.

Mental health needs

Asylum-seeking women have complex mental health needs related to previous experiences and breakdown in their support mechanisms. Isolation and hostility in the host country may exacerbate this further.

Consequences of rape, injury and torture

Over half of pregnant asylum seekers have experienced some violation of human rights leading to further mental health problems.[6] Women from Africa may also have experienced female genital mutilation (FGM), which leads to increased risk of obstructed labour and postpartum haemorrhage.

Obstetric and perinatal outcomes

There are many studies that have investigated pregnancy outcomes in migrant populations. A systematic review[16] comparing the pregnancy outcome of native and migrant pregnant women across 12 European countries found that immigrant women were disadvantaged and more likely to experience adverse obstetric outcomes. This trend is irrespective of immigration status, with similar outcomes seen in newly arrived migrant women, those seeking asylum and fully integrated ethnic minorities.[17] The same adverse outcomes are seen in native women of low socioeconomic status. The aetiological factors for this observation are complex and entwined with language difficulties, the cultural differences in how health care is accessed, the wider family support network. They are less dependent on physical health and pre-existing disease.

Conversely, some studies state that on arrival to the host country, some migrant women display good health outcomes termed as the 'healthy migrant effect'.[18] This may be because only healthy motivated individuals seek refuge outside their countries and hence may have good pre-existing health. Once in the host country they are able to access health care more widely than in their home countries and are screened extensively at the point of entry. There is evidence that this positive effect does decline shortly after arrival, highlighting the importance of the interplay of social factors on health status.

Pregnant asylum seekers have a significantly higher risk of congenital malformations possibly due to consanguinity (odds ratio [OR] = 1.61, 95% CI 1.57–1.65), low fetal birthweight (OR = 1.43, 95% CI 1.42–1.44), preterm delivery (OR = 1.24, 95% CI 1.22–1.26) and overall perinatal mortality (OR = 1.50, 95% CI 1.47–1.53).[16] This same review also demonstrated that these risks were reduced in maternity units where women had frequent antenatal surveillance and felt integrated into society. A further meta-analysis supports the finding of increased risk of stillbirth and infant mortality. This was greatest in Asian, North African and Sub-Saharan refugee women who have migrated to developed countries.[19] This trend is not race-specific but is dependent on psychosocial factors, pre-existing risk factors such as HIV/TB, and accessing health care appropriately.

During labour both migrant women and asylum seekers have higher rates of surgical intervention and poor birth experiences. A meta-analysis looking at the obstetric outcomes of 10 000 migrant Somali women found higher rates of caesarean section in both primiparous and multiparous women.[20] In their study of low-risk migrant women giving birth, Dahlen et al.[17] found that the rates of caesarean section, instrumental delivery and episiotomy were highest in migrant south Asian women. In a Dutch study, migrant women were three times more likely to experience life-threatening haemorrhage at the time of delivery.[21]

In their UK-based study, Newall et al.[22] found that 51% of refugees and asylum seekers stated their needs had been unmet during labour. The failure of health professionals to acknowledge the language and cultural differences were cited as reasons for poor birth experiences. Women with limited English presenting in labour without a birth partner are especially vulnerable to feeling a lack of personal control and having a poor understanding of the birth experience. The reasons for these trends are multifactorial and dependent on differences in patients' demographics such as language proficiency, socioeconomic status and health-seeking behaviours. Failure to provide culturally sensitive communication and lack of professional interpreters are also influential in the discrepancies seen in health outcomes.

Sexual and reproductive health

Sexually transmitted infections

Unfortunately data are not collected in sexual health clinics about the country of origin and immigration status of the clients attending, so estimating the prevalence of sexually transmitted infections in this population is limited. One British study examining the issues faced by healthcare professionals when dealing with asylum seekers' sexual health, found access to services was limited by stigma and language barriers.[23] It also revealed a lack of confidence among health professionals in discussing sexual health issues.

HIV

There were estimated to be around 100 000 people living with HIV in the UK in 2012, of whom 20% were unaware of their infection. This information is gathered from HIV clinics across the UK and unlinked anonymous data collected from antenatal blood samples, genitourinary medicine clinic attendees and drug clinics. In the UK, Black African men and women are the second largest group affected by HIV after men who have sex with men.[24]

Many asylum seekers entering the UK are from countries where HIV is highly prevalent. This has led to increased numbers living with HIV, being diagnosed and accessing care throughout the UK.

Testing for HIV is offered on request or where a medical or sexual history indicates the asylum seeker has been at risk. Testing with patient consent can be done by any healthcare professional or through referral to a genitourinary medicine clinic. Success has been seen with the antenatal screening for HIV and other blood-borne viruses in the UK, leading to increased diagnoses of HIV and retention in care. In 2012, 98% of all pregnant women accepted a HIV test thus showing acceptability for testing. In England in 2013 0.25% of pregnant women screened positive or were reported already known to have HIV.[25] This has enabled joint HIV/obstetric care to reduce HIV transmission from mother to child to less than 0.1%.[26]

Access to health care for asylum seekers living with HIV is free of charge. Health professionals are also allowed to treat failed asylum seekers for HIV-related problems. If asylum is refused and applicants are sent back to their home countries, it is imperative that they have sufficient medication for their journey and information regarding how to access HIV treatment and support once home.[24]

Female genital mutilation

FGM is a range of procedures that involve partial or total removal of female genital organs for cultural reasons. There are no health benefits for women following this tradition but it can lead to health, reproductive and sexual problems. Internationally, FGM is recognised as a violation of the human rights of the individual and potentially a child protection issue for an unborn female infant. Although the World Health Organization (WHO) differentiates between four different types of FGM,[27] some cases are difficult to define. The four recognised types of FGM are:

- ***Type 1.*** Partial or full excision of the clitoris prepuce.
- ***Type 2.*** Excision of the clitoris prepuce, the clitoris and/or labia minora.

- ***Type 3.*** Excision of part, or all, of the external genitals with the remaining parts of the labia majora stitched together leaving a small hole for urine and menstrual flow. The scar is usually opened before intercourse or giving birth.
- ***Type 4.*** This involves pricking, piercing, cutting or stretching of the clitoris and labia.

FGM is primarily practised in Africa, with the highest prevalence in Egypt, Sudan, Eritrea and Somalia. However, it also takes place in the Middle East and South-East Asia. It is estimated that 125 million women are affected by FGM worldwide.[28] In the UK, the number of girls and women having undergone FGM amounts to approximately 137 000 individuals.[29] FGM is usually performed by circumcisers with little surgical training, under inadequate hygiene practices.

Health professionals in the UK need to be aware that asylum seekers have a high probability of FGM. There have been cases of women claiming asylum on the grounds of FGM. There is often shame and stigma associated with this procedure and, therefore, medical and midwifery staff should be competent in discussing mode of delivery and the associated obstetric risks with these women. There are several obstetric risks associated with FGM, including perineal tears, postpartum haemorrhage and the need for caesarean section in cases of obstructed labour. Women with FGM may present unbooked in advanced labour, leading staff to feel unprepared in techniques to aid vaginal delivery.[30]

Mental health

The circumstances that lead many asylum seekers to seek refuge in the UK are in themselves detrimental to mental health. Some women will have been subjected to torture or rape, as well as witnessing the breakdown of their support mechanisms and society. This can lead to psychotic or depressive episodes in the host country. Bracken et al.[31] also cited cultural differences in the way that asylum seekers manifest psychological symptoms and access help. Somatic symptoms such as headaches, and non-specific chest and abdominal pain are common presentations for underlying emotional distress. Post-traumatic stress disorder is underdiagnosed in this group, with clinicians focusing on identifying medical conditions. There may also be stigma in diagnosing mental health issues and western psychological concepts may not be relevant to some individuals.[32] Significant barriers to seeking help include language difficulties, reluctance to share personal information with an unknown clinician and fear that disclosure will lead to deportation.

Studies have shown that poor mental health, depression and anxiety are over-represented in migrant women in the perinatal period. Migrant women are twice as likely to develop postnatal depression as native women.[33] Risk factors include social isolation, language barriers and poor family support. Postnatal depression is seen more commonly in women who undergo dispersal later in pregnancy and are physically or culturally removed from their support systems. Diagnosis is often delayed because of feelings of personal shame, stigmatisation and reluctance to disclose emotional problems to an outsider.

Health professionals also express a lack of experience in dealing with these mental health issues, which are complicated by language and cultural differences. Performing a detailed mental health assessment in collaboration with perinatal psychiatric teams and trained interpreters at the start of antenatal care will highlight complex issues and guide early intervention.

Language barriers and interpreting services

Failure to communicate in the same language has been cited as one of the biggest barriers to providing care for asylum-seeking women.[34] Patients who have language difficulties have poorer health outcomes and do not access services appropriately, leading to dissatisfaction and financial burdens amongst healthcare providers.[35] Interestingly, migrant women encounter language barriers for longer than their male counterparts. This is still evident even after years of integration into the host country and is due to underexposure to the native culture: traditional gender roles may restrict them to their home environment.

The use of relatives and other staff members acting as interpreters can lead to medical terminology being lost in translation. The use of partners in particular may cause some women to avoid discussion of sensitive issues such as domestic violence and sexual history. Health professionals should therefore ensure that they use professional interpretation services to overcome the language difficulties in their consultations. If a professional interpreter is not available, then a telephone interpreting service (preferably using dual handsets) should be accessed to facilitate communication rather than relying on accompanying partners, friends or children.

The use of professional interpreters has been shown to improve patient care, satisfaction and lower healthcare costs due to less hospitalisation and emergency care use. Studies have also shown that women view professional interpreters as advocates in addition to their translation role.[36]

Perspectives of healthcare professionals

Healthcare staff need to overcome various socioeconomic and language barriers to gain a detailed obstetric and gynaecological history.[37] This is complicated further by most women having little or no antenatal screening/records from their home countries, leading to challenges in

determining expected date of delivery, fetal growth and infectious disease status (HIV, hepatitis, syphilis and rubella). In one study where both health professionals and voluntary sector workers were asked to outline their experience of caring for pregnant asylum seekers, barriers to care included lack of a common language, frequent dispersal and poor quality of life.[13] Health professionals also expressed concern over women arriving late in pregnancy with undiagnosed complications such as pre-eclampsia and placenta praevia. Dispersal of pregnant women leads to disjointed care with health professionals spending time trying to communicate abnormal results to the next hospital or GP. Similarly, a British study highlighted that midwifery staff felt a lack of expertise and support when caring for these women.[38] A similar study conducted in Switzerland found that healthcare professionals often felt frustrated with the lack of information provided, which led to consultations breaking down and negative feelings being projected on to the patient.[39] A 2014 British study identified that some women even experienced racism, rudeness and indifference from midwifery staff, again highlighting the need for staff education and support in this role.[40]

The role of maternity services

Several studies have highlighted that small changes in care can make a big difference to the health outcomes of pregnant asylum seekers.[4,16,19] In addition to addressing the complex medical and mental health needs, obstetricians and midwifery staff must act as advocates for these women so that holistic care is given despite unpredictable circumstances.

The key factors in providing a high standard of care to these women are:

- Ensuring that healthcare professionals are aware of the language, cultural and financial barriers that exist when pregnant asylum seekers access antenatal care.
- Implementing maternity care pathways that highlight at-risk women so that provisions can be made to ensure they do not disengage with services.
- Ensuring continuity of antenatal care with minimal dispersal, ideally from 34 weeks and extending into the postnatal period.
- Healthcare professionals should recognise that asylum-seeking women are a high-risk group for postnatal depression and provide close observation and individualised care.
- Providing good interpretation services for effective communication between patients and health professionals to minimise the challenge posed by a language barrier and empower the individual to take ownership of their healthcare needs.
- Regular and effective communication between UK Border Agency staff and healthcare professionals regarding dispersal and movement of asylum-seeking women so that relocation is an undisruptive process.
- Education of medical and midwifery staff about the legal processes, financial entitlements and social problems affecting asylum-seeking women so that they are equipped to handle these sensitive issues.
- The development of a specialist midwife role in areas with a high prevalence of pregnant asylum-seeking women so that patients can be followed up in between appointments, during dispersal and the postnatal period.
- Multi-agency collaboration involving accommodation centres, maternity safeguarding teams and voluntary services to ensure that accessibility to antenatal care is improved and that women who are dispersed have continuity of care and support.
- Providing emotional support and supervision to all staff working with pregnant asylum seekers so that distressing situations are handled appropriately.

Conclusion

Pregnant asylum seekers are a highly vulnerable and socially excluded group of women. They have complex medical and psychosocial healthcare needs, often booking late, possibly secondary to dispersal. Healthcare professionals may have limited knowledge of the asylum process in the UK and therefore at times risk providing suboptimal care for these women. Studies and government reports have suggested that small yet practical changes can lead to empowerment of these women and improve their health, mental wellbeing and quality of life and that of their babies.

Disclosure of interests

The authors of this article have no conflict of interests to disclose.

Contribution to authorship

SA chose the review topic, performed the literature search and wrote the sections on the asylum process as well as the obstetrics complications. AB wrote the section on sexual health. NJ reviewed and approved the final manuscript.

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