University Hospitals Dorset
NHS Foundation Trust

Maternity Service care for refugees (including care for the Afghan Resettlement Programme)

If this document is printed – please check in the Policies, Procedures and Guidelines section of the intranet to ensure this is the most up to date version.

Out of date policy documents must not be relied upon

A) SUMMARY POINTS
• This guideline is to support staff caring for women who are refugees and require maternity services care- antenatally, intrapartum and postnatally
• Refugees may require care from multiple care providers as they may be subject to resettlement throughout the country so this outlines responsibilities to ensure they understand the maternity services in the United Kingdom and support them to access care
B) ASSOCIATED DOCUMENTS
• Bookings and the Antenatal Care pathway (Poole) Antenatal Care pathway (RBH- awaiting merged version)
• Postnatal care guideline
• Female Genital Mutilation Policy
• Care of women with complex social factors
• Safeguarding Children
• Adults safeguarding policy
• SARS-COV-2 in pregnancy and the immediate postnatal period
• Diabetes in pregnancy
• Care outside of the maternity unit for pregnant women/ care outside the maternity unit for newly delivered women and their babies
• NIPE (newborn initial physical examination) guideline
• Preterm Birth guideline

C) DOCUMENT DETAILS	
Author:	Lisa Relton
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Directorate:	Maternity- Specialities
Version no:	1.0
Equality impact assessment date:	21/09/2021
Target audience:	All providers of maternity care- midwifery, maternity support workers, obstetricians, primary care staff, neonatologists, anaesthetics
Approving committee / group:	Maternity Policies and Procedures group, Policies and Procedures
Chairperson:	Nicola McCord, Louisa Way
Review Date:	September 2024

D) VERSION CONTROL

Date of Issue	Version No.	Date of Review	Nature of Change	Approval Date	Approval Committee	Author
09/2021	1.0	09/2024	New policy		MPPG, PPG	L Relton

E) CONSULTATION PROCESS

Version	Review Date	Author	Level of Consultation

No.			
1.0	09/2024	L Relton	MPPG Group, PPG group

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Appendices

- **Antenatal/ Intrapartum, Postnatal care guidance**
- **Languages spoken**
- **Considerations for care for women that are refugees from Afghanistan**

1. Introduction

This guidance is to support maternity staff to provide the best care for those women arriving from other countries as refugees. This guidance aims to ensure staff are aware of how to refer on and ensure all care needs are met, including clear lines of communication to other health professionals or care providers.

2. Purpose

NHSE/I have provided principles of care checklist for maternity services. While this relates to those refugees from Afghanistan Maternity services may care for refugees from other countries and therefore this guideline reflects any woman with refugee status. Arrivals are initially cared for by the Managed Quarantine Service, they will then be relocated to bridging hotels where they may stay for some time following this, local authorities will then lead on resettlement throughout the country. While many of their healthcare needs are being addressed on arrival they may present to local health care facilities.

Once the maternity service is notified of pregnancy or a newly delivered woman (either through self-referral, the CCG or via the Managed Quarantine service or Managed Quarantine Service health care worker) then a full antenatal, neonatal assessment should be completed. This will require an individual triage to assess urgency of this- antenatally we would aim to review face to face within 72 hours and postnatally arrange a visit within 24 hours.

Local contact details: resettlementplacements @bcpcouncil.gov.uk

If hospital attendance is required, all women should be treated in accordance with the agreed SARS-COV-2 in pregnancy and the immediate postnatal period guidance. Any refugee may have to isolate for 10 days after arrival in the country and therefore any hospital admissions in this time would have to follow requirements set out in the SARS-COV-2 in pregnancy and the immediate postnatal period guidance.

If the woman is pregnant she should be offered antenatal care as per RCOG/ NICE guidance. Appendix one details the flowcharts of care through antenatal care, intrapartum care and postnatal care alongside considerations for refugee women. Successive MBRRACE reports have noted the disparity in outcomes for black or minority ethnic women with a higher maternal death rate than white women, alongside an increased risk of neonatal mortality or stillbirth rate.

This guideline aims to enable sensitive and equitable maternity care for those accessing care through UHD.

Key points for initial assessment (See Appendix one)

- Ascertain if already received antenatal/postnatal care since arrival in the UK
- Arrange booking for antenatal care. All care to be recorded and given with the maternity handheld notes in case rapid transfer required
- Midwife then to undertake antenatal care as per the normal care pathway (liaise with primary care if support required with non- obstetric issue- TB, cardiac assessment etc)

- Any urgent maternity care will follow normal maternity care processes- The handheld notes include all contact details which should be highlighted to women
- If newly postnatal a NIPE will be required. Clarification should be sought from primary care as to whether the newborn is registered for NHS care. Midwife will identify postnatal care requirements (ask if mother has any concerns regarding her or baby's wellbeing at each point of contact)

3. Definitions

ARAP scheme- Afghan relocations and Assistance Policy

FGM- Female Genital Mutilation

NIPE- Newborn initial physical examination

RCOG- Royal College of Obstetricians and Gynaecologists

Refugee- A refugee is a person who has fled their own country because they are at risk of serious human rights violations and persecution there. They have the right to international protection and are protected by law (The 1951 Refugee Convention). Refugee Status is a legal status endowed on them.

The guideline uses the terms 'woman' or 'mother' throughout. These should be taken to include people who do not identify as women but who are pregnant. Similarly, where the term 'parents' is used, this should be taken to include anyone who has main responsibility for caring for a baby.

4.Consultation

This policy will go through the Maternity Policies and Procedures group (MPPG) and then to the policies and procedures group for trust oversight

5. Procedures/ Document Content

NHSE/I have detailed considerations for those caring for refugees in maternity services (NHSE/I 2021):

- Impacts of culture, religion and gender on health
- Explain to women their entitlement to maternity care. Women arriving as part of the ARAP scheme are entitled to the same free NHS services as UK residents
- Access to antenatal care in Afghanistan is often limited. Pregnant women and women of childbearing age from Afghanistan may not be aware of the importance of antenatal care and how antenatal services work in the UK.
- Leaving their home country and being brought to the UK may also have an impact on women's mental and physical health.
- Think about their specific vulnerabilities to communicable diseases (refer to letter on Afghanistan relocations and assistance policy to COVID-19, TB, hepatitis B and C and HIV. Refer to the Afghan relocation schemes: advice for primary care for guidance on screening and referrals.
- They may have experienced war, conflict or torture; some will have witnessed the death of close family members and children. Therefore, consider trauma-informed approaches to care.

- Women may be separated from family, living in temporary accommodation and be socially isolated.
- Women and girls are particularly at risk of sexual and gender-based violence before, during and following migration. Refer to the women's health page of the Migrant Health Guide for further information about violence against women and girls and addressing their sexual and reproductive health needs.

Further consideration is required in terms of mental and physical wellbeing due to:

- Deterioration of health over time linked to chronic stress, precarious socio-economic living conditions, low health literacy, untailored healthcare
- Language barriers impairing the quality of care received by expectant mothers
- Disrupted maternity care and multi-agency care packages due to transient living conditions

Safeguarding: Interpreting best practice advises the interpreter to be neutral and therefore the use or children, family members, friends and other accompanying persons as interpreters is not recommended. Appendix two details list of languages that may be spoken.

Women may also be subject to honour based abuse, child abuse or forced marriage. Therefore local safeguarding policies should be followed regardless of their refugee status.

The first point of contact should address a robust and enhanced health assessment- this may be conducted alongside other teams from primary care such as a local GP or Health visitor. There may be consideration of a two stage approach- initial urgent care triage assessment followed by a more in- depth booking appointment.

Given the health needs of this vulnerable population and the potentially traumatic circumstances surrounding their arrival appendix one includes care to be provided to ensure a robust approach to identifying health care needs of mother and baby is provided.

In addition to the Antenatal and Newborn Screening programme, consider the specific vulnerabilities of these patient groups to communicable diseases as above. COVID-19, TB, hepatitis B and C, and other infections including HIV. Refer to the Afghan relocation schemes: advice for primary care for guidance on screening and referrals. The usual refugee pre-entry health assessment and screening process has not taken place for the majority of individuals. Appendix three notes further considerations for care.

5.1 Antenatal Care

Consider the length of stay in the local area maybe short and therefore ensure women are provided with their maternity handheld notes containing all the necessary documentation, results and scan reports. Emphasise to women that the notes need to always be carried. Help ensure women know to contact maternity services and register with a GP on arrival to a new area.

The schedule of care should follow the schedules detailed in the UHD antenatal care pathway (RBH) and booking and the antenatal care pathway guideline (Poole). Booking should identify immediate care needs and whether Obstetric Led care is required. At the point of booking referral should be made for scans- timing of which will be dependent on individual risk assessment and gestation. Consideration should be made for urgent referral

for childcare (via social care) for siblings if presents to antenatal or labour care setting (see safeguarding policies).

All pregnant women should be offered regular urinalysis (as per routine care) with particular attention to ketones. Referral for diabetes testing should be completed where indicated.

5.1.1 Handheld notes

Consider that the length of stay in your area may be short and therefore ensure that comprehensive Maternity Handheld notes are given to the woman and contain all necessary documentation, results and scan reports. Emphasise to the women that the notes always need to be carried. It will be increasingly difficult to track women through the system as they move on. Help ensure women know to contact maternity services and register with a GP on arrival in a new area.

5.2 Intrapartum Care

All births must be entered onto the maternity information system as per routine care. If they present unbooked in labour then a booking will be required and all booking bloods to be offered and performed if consent gained. Appendix one details the flowchart for care for these women.

Interpretation should be used throughout labour either via language line or our electronic language line. All advice on skin to skin, safe sleeping, neonatal care, feeding and hygiene should be given via interpretation service.

5.2.1- NHS Number

If the woman has not registered with the GP she may not have an NHS number: therefore an NHS number cannot be immediately created for baby.

Baby should be labelled as normal with name, date of birth, hospital number and admissions can review creation of an NHS number.

5.3 Postnatal Women

Admission and discharge information should be given to the woman, the GP (once identified) and health visitor detailing the date they will return to their accommodation. Essential postnatal care (including neonatal screening) may require visits to attend the bridging hotel (with interpretation support).

6. Roles and Responsibilities

Appendix three details specific roles and responsibilities for specific conditions

Administration staff will contact the community midwifery team leaders once women have presented for maternity care.

The community team leaders will be responsible for allocating midwifery care (both antenatal and postnatal)

7. Training

It is every midwives/obstetricians/ neonatal staff/ anaesthetists responsibility to ensure they are updated with the current guidance by accessing guidelines relevant to the care they are providing.

8. Monitoring Compliance and Effectiveness of the Document

In order to provide Maternity Services with assurance of implementation of the guideline and the provision of safe clinical care the following process of monitoring will be utilised

Audit Method	Lead responsible for audit and report submission	Frequency of audit
10% of notes	Community Matron/ Safeguarding lead midwife	Yearly

Report findings on compliance to guideline to both Directorate quality Risk meeting and Safeguarding as appropriate

9 Supporting Documents/ References

Feldman, R., (2013) *When maternity doesn't matter: Dispersing pregnant women seeking asylum.* London: Maternity Action

NHSE/I (2021) Maternity Services principles checklist for the care of pregnant women arriving from Afghanistan. London: NHSEI https://www.england.nhs.uk/wpcontent/uploads/2021/09/B0967_Maternity-services principles-checklist-for-the-care-of-pregnant-women-arriving-from-Afghanistan_Sept21.pdf (accessed 21/09/2021)

Psarros, A., (2018) *Mother's voices. Exploring experiences of maternity and health in low income women and children from diverse ethnic backgrounds.* London: Maternity Action

10. Dissemination

Once the policy has been approved via the Maternity Policies and Procedures group and the policies and procedures group staff will be notified that it will be uploaded to the maternity intranet policies pages.

11. Approval and Ratification

As above the policy will go through consultation with Maternity Policies and procedures group, Drugs and therapeutics group and trust oversight through the policies and procedures group

12 Review

All documents to be reviewed 3 yearly or earlier if appropriate.

13 Equality Impact Assessment

1. Title of document	Maternity Service care for refugees
2. Date of EIA	21/09/2021
3. Date for review	21/09/2024
4. Directorate/Specialty	Maternity- specialities

5. Does the document/service affect one group less or more favorably than another on the basis of:

	Yes/No	Rationale
• Age – where this is referred to, it refers to a person belonging to a particular age or range of ages.	No	
• Disability – a person has a disability if they have a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal daily activities.	No	
• Gender reassignment – the process of transitioning from one gender to another.	No	
• Marriage and civil partnership – marriage can include a union between a man and a woman and a marriage between a same-sex couple.	No	
• Pregnancy and maternity – pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavorably because she is breastfeeding.	No	
• Race – refers to the protected characteristic of Race. It refers to a group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins.	No	
• Religion and belief – religion has the meaning usually given to it but belief includes religious and philosophical beliefs including lack of belief (such as Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.	No	
• Sex – a man or a woman.	No	
• Sexual orientation – whether a person's sexual attraction is towards their own sex,	No	

the opposite sex or to both sexes.		
7. If you have identified potential discrimination, are the exceptions valid, legal and/or justified?	No	
8. If the answers to any of the above questions is 'yes' then:	**Yes**	**Rationale**
Demonstrate that such a disadvantage or advantage can be justified or is valid.		
Adjust the policy to remove disadvantage identified or better promote equality.		

Name of guideline Maternity service care for refugees
Version: 1.0 Date: September 2021

Appendix One- Care flowcharts

Follow routine care from the Bookings and the Antenatal Care pathway (Poole) Antenatal Care Pathway (RBH)

Antenatal Pathway for refugees

Booking (within 72 hours of referral if over 12/40)

Ascertain if had antenatal care elsewhere in UK since arrival

Inform of benefits of attending antenatal care in the UK

Ask if she has had a full medical examination since entering the UK

Identify language for future translation services need and document this in handheld notes and on maternity information system

Ensure has phone numbers for local points maternity services

Referral to Obstetric team / other specialists as required

If 12/40 liaise with ANC for urgent USS (may need to be at Poole site if specialist scanning required)

Complete Health visitor liaison for information sharing

Refer to GP if not had recent medical examination

Antenatal care

Allow for longer community visits if required

Check Address/ Contact details at every appointment (if moving advise how to access local maternity care). Advise to notify community team if moving out of area between visits

Encourage to access early help if concerned about their health (including symptoms of COVID-19)

Follow advice from Booking and antenatal guidance on mental wellbeing and support

Complete Mat B1 to obtain maternity payment

When discussing birth place consider support for other children- liaising with social care as required

Reduced fetal movements

Advise women what to look for as per local policy

If reports reduced fetal movements should be seen as ANDA can allow- a taxi may be required to facilitate this which should be organised by the Maternity boardholder

Contact details:

Labour Line:

03003690388 for urgent queries including labour

Poole community team (non urgent queries) 0300 0192692

Bournemouth community team (non urgent queries) 0300 0194434

Advise women for non obstetric concerns they may be asked to **call 111**

For health issues that require immediate treatment they may be advised to **call 999** (such as bleeding, seizures, sepsis, chest pain, respiratory difficulties, psychotic episodes)

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Intrapartum and Postnatal Pathway for refugees

Labour Care

Use interpretation services where possible to ensure informed decision making on all aspects of care. Discussions may be held in advance of/ in case routine procedures or emergency procedures if limited access to interpreters. Use either the mobile language line I-Pad or telephone language line.

Consider admission in early labour if transport or financial issues/ concerns, or language difficulties where the woman cannot be reassured or offered advice over the telephone.

Access social care support if attends with children and no support to care for them.

If unbooked:

Complete booking (including screening bloods)

Full risk assessment by obstetric team (including cardiac assessment) and alert Neonatal team of admission

Contact GP (if registered) to gain further medical background

Sensitive enquiry to understand no reasons for no antenatal care

Admissions should generate hospital number

Awareness may not be able to generate NHS number- admissions to liaise on this

Unbooked only

Identify safeguarding concerns and refer any concerns as per safeguarding guidance

Postnatal care

Check maternity electronic notes for any recommendations of care from antenatal period (including neonatal alerts)

Do NOT advise early discharge unless good support network at home/ bridging hotel

Support with establishing feeding and newborn baby care

NIPE where possible to be completed in hospital

Verbal handover of care to community midwifery team, health visitors and any other specialists (including if discharged out of area)

Additional postnatal visits where specified as necessary

Give safety netting advice on all aspects of postnatal care (including safe sleeping, hygiene, PV loss, where to contact if unwell) as well as advice if unwell for non-obstetric reasons (inc COVID-19) and who to contact

If given birth elsewhere ensure NIPE complete and any referrals required are in place (as per NIPE guidance)

Complete midwifery/ health visitor liaison form for information sharing

Appendix two – Languages and interpretation

NHSE/I (see reference list) have provided guidance on Afghanistan refugees and advised:

It is highly likely that many women will not speak or understand English. The main languages in Afghanistan are: Afghan Persian or Dari [majority], Pashto, Uzbek, Turkmen, Urdu, Pashayi, Nuristani, Arabic and Balochi. They may also not read or write well even in their own language. Always use Interpreting Services, as commissioned by the CCG/NHS England- Language line.

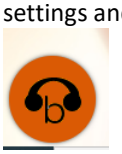
However we may have refuges from other countries and Amnesty.org have provided a table on other refugees and languages spoken (Summary of reasons for fleeing and languages spoken for the most common refugee populations resettled in EU (source: https://www.amnesty.org/en/countries/)

Country	Reasons for fleeing	Languages
Afghanistan	Persecution of minority religions. Inter-ethnic conflict. Sexual violence & denial of human rights to women. Persecution for perceived political affiliation. Organised child abuse.	Pashtu, Dari, Turkic, and other minority languages
Albania	Blood feuds within families that follow codified rules called Kanun. High risk of trafficking. High risk of domestic abuse with no protection.	Albanian, also Italian, Greek, French, German, English
Bangladesh	Honour based violence. Persecution against minority faith groups, LGBT people. Acid attacks against women who reject sex. Domestic abuse with no protection.	Bengali (Bangla); also, Bishnupriya, Chakma, Chittagonian, Hajong, Rohingya, Sylheti, Rangpuri and other minority languages. English
Eritrea	Persecution of minority religions (Pentecostal Christian). Oppression of political opposition or expression. Military conscription of all, slavery and abuse within military.	Mainly Tigrinya or Tigray; also, Arabic and local languages; some English and Italian
Ethiopia	Ethnic violence. Security forces involved in violence rather than protecting people. Previous suppression of the right to freedom of expression & association. Oppression of political opposition.	Amharic, Oromo, Tigrinya, and local languages; some English and Italian
Iran	Persecution of religious converts to minority religions. Oppression of ethnic minorities. Corporal / capital punishment for adultery (including homosexuality). Political repression.	Farsi (Persian), ethnic minority languages including Kurdish
Iraq	Inter-religious & inter-ethnic conflict. Violence from ISIS / Daesh. Persecution of gay men, those linked to current government, opposition or American forces.	Arabic, Kurdish, Assyrian
Nigeria	Attacks by Boko Haram. Torture & ill-treatment to detainees by army, police & state security service. Communal violence. Lawful assembly banned. Suppression of right to freedom of expression & association. Violence against women & children (physical & sexual). Suppression of right to housing. Corporal punishment for homosexuality.	English (official) and other major African languages like Hausa, Igbo, Yoruba, Urhobo, Ibibio, Edo, Fulfulde and Kanuri
Pakistan	Persecution of Ahmadis, Christians and other minorities. Honour based violence. Fear of extremist militant groups.	Urdu, English, Punjabi, Pashto,

	Little protection for women. No protection against domestic abuse.	Sindhi, Saraiki, Balochi
Somalia	Ongoing conflict. Sexual violence against women & girls. Indiscriminate attacks from Al-Shabaab on civilians, infrastructure and those believed to be linked to government. Suppression of right to freedom of expression & opinion.	Somali and Arabic; some English and Italian
Sudan	Inter-ethnic conflict. Persecution of perceived political activists and dissenters of (suspected) members of rebel groups. Fear of 'Janjaweed' militia. FGM.	Arabic, including Creole Arabic in the south, and many local languages; also some English
Syria	Civil war. Conflict created from peaceful student protests on the Bashar al-Assad government. Increasing violence between government forces and protesters. Collapsed infrastructure.	Arabic, Kurdish, Armenian, Aramaic, Circassian, French, English

Appendix Three- further considerations for care and responsibilities

Challenge/background	Testing/management	Responsibility
COVID-19 Afghanistan is currently a 'red' list country for COVID-19 risk. Individuals should have completed at least 10 days in a managed quarantine hotel and been tested for COVID-19 at days 2 and 8	COVID 19 pathways must be used for all women from this group, unless confirmed COVID negative. Recent arrivals from Afghanistan with a cough should also be considered as at risk of TB and managed in respiratory isolation while under investigation. Ensure individuals are offered COVID-19 vaccination as appropriate. First dose may have been given in quarantine hotels; arrangements will be needed for second dose.	All maternity staff Triage women and if require inpatient care follow SARS-COV-2 for pregnant women guidance Counsel for vaccination as per RCOG guidance Primary care to provide vaccination
Hep B x10 more common	Offer test to all pregnant women and ensure post-exposure prophylaxis is provided to infants of hepatitis B-positive mothers. Greenbook_chapter__18.pdf	Booking midwife to offer testing as per antenatal care pathway
Hep C more common	As incidence in Afghanistan is higher than in the UK, consider screening for hepatitis C if other risk factors apply. Test babies of infected women or women of unknown Hep C status.	Consider screening with booking
Tuberculosis (TB) is more prevalent in Afghanistan than the UK with higher rates of multi drug resistant TB. The urgency of the current situation means that most of those arriving will not have been screened for TB; therefore, it is important that this happens after arrival.	All women should be offered testing for active pulmonary TB as soon as possible after arrival: usually a chest X-ray with shielding or sputum test (the latter may take longer). Women should be screened for latent TB once registered in primary care as per NICE guidance (Tuberculosis and the national latent TB infection (LTBI) testing and treatment programme.	Primary care
Typhoid/enteric fever Typhoid fever is highly contagious. An infected person can pass the bacteria out of their body in their poo (stools) or, less commonly, in their pee (urine).	Enteric fever should be considered in the differential diagnosis of any illness following arrival. The main symptoms of typhoid fever are: a high temperature that can reach 39 to 40oC, headache, aches and pains, cough, constipation. Diagnosis is possible through testing of faeces. Typhoid fever requires prompt treatment with antibiotics.	Primary care will be first point of contact If fever- advise to contact 111/ 999 dependant on severity of symptoms If admitted follow care outside maternity unit guidance for pregnant (or newly delivered) women for daily obstetric review
HIV Testing	Offer testing to all women at booking/arrival. Point of care testing should be carried out if not yet tested but in labour.	Maternity staff
STI screening	Take a sexual history and: • screen for STIs and HIV according to risk as specified in the UK national standards and guidelines • test all sexually active patients under the age of 25 for chlamydia	Primary Care (Including GU medicine)

MMR/polio Polio is endemic in Afghanistan and measles is common.	Professionals need to consider a wider differential diagnosis for individuals who have recently arrived from Afghanistan and investigate as appropriate. This includes vaccine preventable diseases (including measles and polio), typhoid and malaria. All new entrants should be brought up to date with the UK immunisation schedule as soon as possible, including flu and pertussis. Consider offering postnatal MMR vaccination at discharge. For advice about signs and symptoms of measles and/or polio and pictures of measles rash (link for further information)	All heath care providers
Anaemia and vitamin deficiency	There is a moderate prevalence of anaemia in adults from Afghanistan and a high risk of vitamin A deficiency. Vitamin D deficiency may also be possible, particularly for individuals who cover their body for cultural or religious reasons or have darker skin. Testing for anaemia should be done at booking/arrival and as clinically indicated. If vitamin A deficiency is suspected, seek advice on diagnosis and treatment from local endocrinology/medical team. Refer to NICE guidelines on vitamin D to determine which individuals should be tested. Advise women of the importance of taking vitamin D supplements	Maternity Staff Maternity Matters includes information on Vitamin D so direct to www.maternitymattersdorset.nhs.uk (this has link to translate in top tool bar- click on earphone sign and then settings and can choose language) 
Multidrug resistance infections The widespread use of antibiotics in Afghanistan, results in a high prevalence of multidrugresistant organisms (MDROs).	All Afghanistan women who have recently travelled to the UK and are admitted to hospital should have a risk assessment to determine the requirement for pathogen screening. Consider sending microbiological specimens early before initiating antimicrobial treatment (eg for urinary tract infections), particularly where first-line empiric treatment has already been given and failed. Microbiologists should be involved in antibiotic prescribing if required to enable adequate cover for infections	Obstetric/ other teams in charge of care on admission If UTI noted on Booking MSU then midwifery team to seek obstetric advice
Female genital mutilation (FGM) Prevalence varies, but is high in some parts of Afghanistan.	Enquiry should happen at booking/arrival and be recorded on the national system. Deinfibulation should be offered antenatally, where possible, via specialist clinics (see RCOG green top guideline) Management of delivery – plans to be put in place. Women should be assessed for deinfibulation and repair, with access to clinicians with relevant skills. Mandatory reporting still applies if FGM is discovered or disclosed for a woman/child under the age of 18. Link Female genital mutilation (rcgp.org.uk) Information Migrant Health Guide FGM guidance link	Maternity staff (including questioning at booking) If identified as FGM- Obstetric led care and referral as per Antenatal Guideline to OASIS team

	Male circumcision is highly prevalent in Afghanistan. consider relevance to mothers who give birth to a baby boy. Ensure individuals know how to seek advice and understand the appropriate procedures for men and boys in the UK.	
Cardiac The age-adjusted death rate for rheumatic heart disease is 27.57 per 100,000 people.	Enquiry at booking – possibility of rheumatic heart disease. Cardiac assessment and auscultation should be considered as part of the medical examination in women admitted to maternity units or by GP if registered in the community for primary care.	Primary care will be responsible for auscultation if community care Obstetric team (or accepting clinicians outside maternity) to complete cardiac assessment if in secondary care setting
Liver disease In 2013, almost 30,000 cases of viral hepatitis were diagnosed.	Women should be offered testing for hepatitis B at booking/arrival and for other types of viral hepatitis if clinical concerns	Offer screening as per booking guidance
Mental health Women affected by war and conflict are at higher risk of mental disorders, including PTSD.	Mental health and wellbeing should be assessed. Trauma-informed approaches to care provision should be used. Advice should be sought from specialist mental health services through the IAPT or local voluntary-sector service providers. Professionals should be alert to issues in perinatal mental health and early referral to perinatal mental health services	All maternity staff
Recto-vaginal fistulas/uro-vaginal fistulas	Clinicians should be aware of the possibility and have access to specific surgeons for assessment and repair when required.	Referral from Obstetric team if required
Helminths/treatment of worms	Helminth infection may be particularly detrimental during pregnancy (maternal anaemia and adverse effects on birth outcomes) and should be treated. Consider requesting Strongyloides serology and refer to further guidance for testing. Albendazole in pregnancy has high cure rates for soiltransmitted helminths and is thought to be safe for the mother.	Primary care
TB vaccination for babies – 1 year follow-up responsibilities	Services will need to consider the pathway for following up babies requiring TB vaccination as they may move across the UK and be difficult to track. Early vaccination is recommended to reduce the need for tracking.	If under maternity care- maternity care to refer as per NIPE guidance (section 4.3)
Neonatal services	Capacity in neonatal unit needs to be considered early, as there is a risk of preterm or complex births in asylum groups. Services need to consider a planned neonatal surge capacity plan: region/national. Existing guidelines for asylum seeker communities should be utilised	If admission- link with Neonatal team as per standard practice- referral on using cotline if no cots available. Referral to obstetric team as per preterm birth guidance if requiring preterm birth clinic review
Co-sleeping is likely	Tommy's safe sleeping leaflets for use. (https://www.tommys.org/pregnancy-information/blogs-and stories/im-pregnant/pregnancy-news-and-blogs/safer-	Midwifery team as part of postnatal advice

	sleep babies https://www.lullabytrust.org.uk/safer-sleep-advice/co sleeping/ with an easy read card also in different languages	

Appendix four: Information for bridging hotels:

NHS
University Hospitals Dorset
NHS Foundation Trust

Are you pregnant?

How to contact a midwife (to provide you with antenatal care)

You can do this online:

www.maternitymatersdorset.nhs.uk

Maternity matters dorset includes information that can be interpreted into your own language- press this symbol to enable this:

Maternity Matters in Dorset

<u>Non urgent queries:</u>

Poole community team 0300 0192692

Bournemouth community team 0300 019 4434

<u>Do you need urgent maternity care?</u>

Call labour line on 03003690388

<u>Do you or your baby need emergency care?</u>

999

Wessex Healthier together also has further information on baby's health

Healthier Together
Improving the health of children and young people
what0-18.nhs.uk
NHS