



RCOG Position Statement:

Equitable access to maternity care for refugee, asylum seeking and undocumented migrant women

Access to timely, safe and appropriate maternity care should not depend on a woman's immigration status or ability to pay. Addressing additional barriers to a safe pregnancy experienced by migrant women is a vital part of ending the UK's persistent inequities in maternal and perinatal outcomes.

Key recommendations

- The UK Government must immediately and permanently suspend NHS charging regulations for maternity care due to the harm this system causes to the health of women and their babies during the perinatal period.
- Until charging for maternity care is suspended or abolished, NHS Trusts in England must review and improve practices relating to charging pregnant women to ensure that women are not deterred from accessing perinatal and maternity care, or have care refused or delayed. The RCOG supports the recommendations set out in Maternity Action's *Breach of Trust* report,¹ including that all NHS Trusts adopt and commit to implementing the Maternity Action and Royal College of Midwives guidance *Improving access to maternity care for women affected by charging*.²
- NHS organisations and commissioners must ensure the consistent implementation of national standards for interpreting and translation services in maternity care, including access to appropriately qualified interpreters for planned, urgent and emergency care. The availability, quality and timeliness of interpretation services should be routinely monitored to ensure equitable access to safe maternity care.
- An urgent review is required into how the UK Government cares for pregnant women within the asylum system. This review should consider the creation of a centralised team responsible for safeguarding care and accommodation standards for pregnant women and co-ordinating the data collection vital to understanding how the system can better support safe pregnancy.

Background

Existing policies and practices relating to the care of refugee, asylum seeking and undocumented migrant women – particularly in England – disrupt antenatal, intrapartum and postnatal care, prevent women from accessing services and ultimately influence maternal and perinatal outcomes. This contradicts ongoing UK Government and NHS commitments to improve maternity safety, reduce inequalities in maternal and perinatal outcomes, and ensure access to high-quality maternity care for all women and babies.³

Migrant pregnant women are a diverse group at risk of disproportionately worse maternal and perinatal outcomes. They often face multiple barriers to care and are more likely to experience poverty or destitution, a higher burden of disease or poorer healthcare in their country of origin or transit, trauma, experiences of conflict, limited English proficiency, barriers to accessing support services, and limited social support network.⁴ They are more likely to access antenatal care later than the recommended first 10 weeks,⁵ and the National Institute for Health and Care Excellence (NICE) identifies recent migrants, refugees and asylum seekers, and women who speak or read little or no English, as a group with 'complex social factors' requiring special efforts to improve access and engagement with maternity services.⁶ These inequalities are reflected in poorer maternity outcomes.

Research has found that pregnant migrants in the UK have up to a 74% higher risk of emergency caesarean birth, a 49% higher risk of severe maternal complications requiring intensive care or blood transfusion, and a 53% higher risk of babies being born in poor health.⁷

Reproductive justice demands that women can exercise bodily autonomy in their decisions to not have children and to have and parent their children in safe, sustainable environments.⁸ The hostile environment created by UK Government policy in relation to pregnant refugee, asylum seeking, and undocumented migrant women is an example of reproductive injustice and an affront to the human rights of vulnerable pregnant women and their families.

NHS charging for maternity care

Under the NHS visitor and migrant cost recovery programme (NHS charging) in England, and sometimes in Wales, Scotland and Northern Ireland, people may be charged for hospital-based NHS care, including maternity care, if they have been refused asylum, are living in the UK without official immigration status, or have no recourse to public funds.⁹ These charges apply to some of the most vulnerable women living in the UK today, who are not able to work or claim benefits.¹⁰ The true impact of this programme extends far beyond those eligible for charging, due to limited understanding of eligibility amongst both health services and patients, and fears of associated data sharing.

Under this system, maternity services – including all antenatal, labour and delivery, and postnatal services – are deemed ‘immediately necessary’ care and must not be denied or delayed due to charging issues.¹¹ However, women are charged for their care following birth, with the average bill being around £9,000.¹² The charges also apply to women who experience a miscarriage or a stillbirth. In addition, NHS bodies can report unpaid debts of £500 or more to the Home Office, which can threaten future immigration applications to enter or remain in the UK.¹³

Fear of receiving unaffordable bills for healthcare, and of data sharing between the NHS and immigration authorities, deters women from seeking and accessing essential and time-critical antenatal care, contributing to poorer outcomes for these women and their babies.¹⁴ Despite the ‘immediately necessary’ classification of all maternity care, pregnant women have also had healthcare delayed or denied outright due to the current charging regulations.¹⁵

In the UK, late booking or fewer antenatal appointments than recommended have been independently associated with poorer pregnancy outcomes, including maternal death.¹⁶ The 2019 MBRRACE-UK confidential enquiry into maternal deaths found that between 2015 and 2017 three women who died may have been reluctant to access care because of concerns over the costs of care and the impact of their immigration status.¹⁷

NHS charging also leaves women at increased vulnerability to domestic abuse and exploitative relationships,¹⁸ and increases stress and anxiety throughout the perinatal period, itself linked to poorer birth outcomes such as low birth weight.¹⁹

The UK Government must immediately and permanently suspend NHS charging regulations for maternity care due to the harm this system causes to the health of women and their babies during the perinatal period.

Pre-conception health contributes directly to pregnancy outcomes for both mother and baby, and so it is very likely that this wider NHS charging system has a detrimental impact on pregnancy outcomes, as well as on women’s health more widely. **We support the Academy of Medical Royal Colleges position that all NHS charging regulations should be suspended pending a full and independent review of the impact on both individual and public health.**²⁰

To enforce NHS charging ethnicity, name, country of origin and accent may be used as markers to differentiate between and discriminate against patients.²¹ As it is not routine to enquire about the immigration status of all women who present to NHS maternity care, the existence of NHS charging encourages NHS staff to actively stereotype women and their families. In effect, this system promotes routine discrimination and racial profiling of patients to identify who may be chargeable.

Historical and ongoing implicit bias, discrimination, and racism have a negative impact on the health and wellbeing of women and their babies.²² When medicine and healthcare are used as tools of surveillance, they contribute to the persistence of mistrust between vulnerable and marginalised communities and health care workers. Such mistrust acts as a further barrier to accessing care for recent migrants, refugees, and asylum seekers.

The UK Government must more clearly separate the roles of the healthcare sector and immigration authorities, including ending the referral of patients who have incurred a debt of £500 or more to the Home Office.

It is impossible to understand the full impact of NHS charging policies on maternal and perinatal outcomes without the routine collection of quantitative data relating to the care and outcomes of those affected.

The Department of Health and Social Care must collect consistent data on the impact of NHS charging for maternity care, including the number of women who have been charged, when fear of charging may have delayed presentation (regardless of actual NHS entitlements), maternal and perinatal outcomes, and when NHS charging has influenced decisions to access abortion care rather than continue with pregnancy. This data should be regularly published and accompanied by a plan for action on how to address any inequities found in the care of these women and their babies.

Charging practices of NHS Trusts in England

Some NHS Trusts in England have been found to be implementing NHS charging regulations in a way that is harmful to pregnant or postpartum women, including aggressively pursuing payments while women are still pregnant, and incorrectly charging exempt women who are victims of trafficking or are seeking asylum.²³ Trusts may also refuse to write off debt for women who are manifestly destitute, despite government guidance supporting this.²⁴ This can contribute to high levels of stress and anxiety for the women affected, as well as again deterring women from seeking care.²⁵

Until charging for maternity care is suspended or abolished, NHS Trusts in England must review and improve practices relating to charging pregnant women to ensure that women are not deterred from accessing perinatal and maternity care, or have care refused or delayed. The RCOG supports the recommendations set out in Maternity Action's *Breach of Trust* report,²⁶ including that all NHS Trusts adopt and commit to implementing the Maternity Action and Royal College of Midwives guidance *Improving access to maternity care for women affected by charging*.²⁷

Maternity commissioners should ensure Maternity Voices Partnerships and similar local and regional NHS maternity care service user and working groups ensure representation from women with experience of NHS charging for maternity care and receive sufficient funding to do so.

Addressing other barriers to care within the healthcare system

Language barriers and interpretation services

Access to a high quality interpretation service is a vital part of the provision of safe, consensual and personalised care for all women who have difficulty reading or speaking English. Healthcare

professionals rely on the provision of these services to ensure women are able to make informed choices about their care and can give informed consent to treatment and procedures.²⁸

MBRRACE-UK confidential enquiries into maternal deaths have found inadequate translation provision to have delayed care and hindered women's ability to follow treatment plans, and frequently highlight the need for appropriate interpreting services.²⁹ The 2024 MBRRACE-UK perinatal confidential enquiry reviewed the care of 25 women whose baby was stillborn or died within seven days of birth, all of whom had come to the UK less than two years previously and had a preferred language other than English.³⁰ In almost three quarters (73%) of all contacts between pregnant women and healthcare services, there was no formal record of professional interpretation, and in 50% of all contacts no interpreter provision was documented.³¹

The RCOG has previously called for national guidance to define minimum standards for interpreting services supporting NHS maternity care,³² and has supported greater access to English for Speakers of Other Languages (ESOL) provision for pregnant and postpartum women. **In 2025, the RCOG published its updated Maternity Service Standards Framework, alongside the Cross-Cultural Communication and Language Support: Standards for Maternity Care and Women's Health.**³³ Together, these set out expectations for culturally responsive communication, equitable access to professional interpreting and translation services, and person-centred maternity care.³⁴

We therefore welcome the interpreting service standards guidance published in England in 2025,³⁵ and similar frameworks in Wales,³⁶ Scotland³⁷ and Northern Ireland.³⁸ These guidance frameworks set out expectations for the provision of high-quality interpreting and translation services, including minimum qualification standards for interpreters and guidance on their use in maternity care settings. We also welcome the Department for Education's ongoing review of the ESOL programme,³⁹ which provides an opportunity to better consider the needs of pregnant and postpartum women.

However, implementation of interpreting standards must be consistent across services to ensure equitable access to safe maternity care. NHS organisations should ensure full implementation of relevant guidance, frameworks and standards, and monitor the availability, quality and timeliness of interpretation in maternity settings, including during emergencies. Commissioners and health leaders must also ensure that antenatal services can offer flexibility in the number and length of appointments to accommodate the use of interpreting services, as recommended by NICE.

NHS Trusts and Health Boards must also ensure healthcare professionals receive training on the roles of different types of interpreters working in maternity care, how to work with them effectively, how to recognise poor interpretation and how to work with people with different levels of health literacy.

Navigating the maternity system

Healthcare staff, including obstetricians, midwives and administration and reception teams, play an important role in supporting migrant women to access maternity care. Migrant women may be unfamiliar with the maternity system and models of care in the UK,⁴⁰ and may encounter stigma or judgement from healthcare staff.⁴¹

All healthcare staff must receive training on migrant women's entitlements to care, where to find information on the charging system, and the additional barriers to care faced by migrant women.

Advocacy and support from the voluntary sector and community based organisations

Voluntary sector organisations across the UK provide vital support and community for migrant women during the perinatal period. They are able to work across traditional health and social care boundaries and may continue to support women following dispersal, enabling further continuity of care, as well as connecting women to more sustainable communities of support beyond their perinatal care.

For example, professional birth companion support, delivered by community group Happy Baby Community, has been found to significantly improve the labour and birth experiences of pregnant women housed in initial asylum accommodation.⁴² Similar findings were made by independent evaluations of the 'community link' service and combined care models offered by the charity Birth Companions.⁴³

The NHS and governments of the UK should commit to ongoing, sustainable funding for projects that support migrant women and demonstrate improvements in women's experiences of pregnancy care. This should include the expansion of successful local projects and the extension of pilots to other areas, to ensure that support is available to everyone who needs it.

All NHS Trusts and Health Boards should have an up-to-date, easily accessible and searchable list of local voluntary sector and community-based organisations offering support to migrant women to ensure healthcare professionals can easily connect women with these important sources of support. In England, this should follow NHS England's *Equity and equality: Guidance for local maternity systems* recommendation for asset mapping, with migrant women an inclusion group considered.⁴⁴

Dispersal policies and appropriate accommodation for pregnant women seeking asylum

The Home Office may move people seeking asylum and living in asylum accommodation to different accommodation in another part of the UK, often at short notice and sometimes several times, while their application is being processed.⁴⁵ Dispersal of pregnant women is a factor in late booking for antenatal care,⁴⁶ and can disrupt continuity of care – a stated NHS England priority to improve clinical outcomes for vulnerable pregnant women.⁴⁷ Dispersal practices were found to have exposed mother and baby to risk in the case of a baby who died in 2017.⁴⁸

UK Government guidance sets out a protected period in which pregnant women should only be moved at the request of the applicant or her treating medical practitioners.⁴⁹ This period currently runs from six weeks before the estimated date of delivery until a clinician has signed off on the postnatal checks, usually around six weeks after birth unless there have been complications. Importantly, this guidance states that the aim of dispersal during pregnancy should be to settle women into accommodation where they will be able to access services throughout their pregnancy and into new motherhood.⁵⁰

We support the Royal College of Midwives' recommendation that the Home Office should extend the protected period to start at 20 weeks of pregnancy, and to settle women into suitable accommodation as early as possible in pregnancy, to allow for continuity of care and to minimise disruption.⁵¹

In the interim, Home Office staff must follow the UK Government's guidance on dispersal of asylum seekers in pregnancy.⁵² As a minimum, women should usually not be moved during the protected period outlined, due to the adverse impact on antenatal care access and continuity of care. If pregnant women or new mothers are dispersed, caseworkers should ensure effective handover of care including referrals to maternity services, before dispersal takes place.⁵³

Concerns have been repeatedly raised that asylum accommodation is frequently unsuitable for pregnant women and young children, with the Chief Inspector of Borders and Immigration finding issues including uncleanliness, lack of sterilisation equipment or facilities to boil water, inappropriate

housing arrangements, lack of space, and poor information sharing inhibiting access to statutory and voluntary local services.⁵⁴ There have also been allegations of sexual harassment within initial accommodation,⁵⁵ and third sector organisations have raised concerns about food provision for pregnant women and families with children in contingency asylum accommodation.⁵⁶ Together, this can further exacerbate stress, anxiety and depression experienced by women residing in asylum accommodation during their pregnancy and the postnatal period, with implications for both maternal wellbeing and infant care.⁵⁷

The Home Office must ensure all pregnant women and new mothers seeking asylum are housed in appropriate accommodation, with access to all necessary amenities and adequate privacy. To achieve this, we recommend that they set out minimum standards for asylum accommodation for pregnant woman and their babies. This may also include the provision of specialised initial accommodation hostels suitable for pregnant women and their babies.

Staff in initial accommodation may not be trained to respond to urgent health needs relating to pregnancy.⁵⁸ **All Home Office staff including third-party providers must receive basic training on the needs of pregnant women, including how and when to refer them to emergency services.**

Although the Home Office records and publishes data on the number of pregnant women detained in the immigration detention estate,⁵⁹ it does not hold readily reportable data on the number of pregnant women in asylum accommodation,⁶⁰ which hinders the understanding and monitoring of women's experiences, access to care and outcomes.

The Home Office must collect data on the number of pregnant women using asylum accommodation and this should be linkable to data on their pregnancy outcomes. This should include a record of how many pregnant women are being dispersed by the Home Office (including within the protected period), how many times they have been moved, and whether dispersal allows women to retain the same GP and maternity service. There should also be a record of risk assessments taken prior to dispersal, including consultation with the woman's clinician.

An urgent review is required into how the UK Government cares for pregnant women within the asylum system. This review should consider the creation of a centralised team responsible for safeguarding care and accommodation standards for pregnant women and co-ordinating the data collection vital to understanding how the system can better support safe pregnancy.

Further reading

Information for clinicians

Royal College of Midwives, [Caring for vulnerable migrant women: RCM pocket guide for midwives and maternity support workers caring for vulnerable migrant women](#)

BMA, [Refugee and asylum seeker patient health toolkit](#)

DHSC, [Migrant health guide](#)

NICE, [Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors \[CG110\]](#)

Information for women

Maternity Action, [I have questions about charging for NHS maternity care](#)

Birthrights, [Your basic birth rights – translated](#)

Further information on NHS charging

Maternity Action and Royal College of Midwives, [Guidance on improving access to maternity care for women affected by charging](#)

Maternity Action, [NHS maternity care for women from abroad \(in England\)](#)

Maternity Action, [Entitlement to free NHS maternity care for women from abroad \(in Scotland/Wales/Northern Ireland\)](#)

¹ Maternity Action, [Breach of Trust](#) (2021)

² Maternity Action, [Guidance on improving access to maternity care for women affected by charging](#)

³ UK Government, [Taskforce set up to deliver urgent action on maternity](#) (2026)

⁴ Healthwatch, [Maternity care for asylum-seeking and migrant women in south east London](#) (2024), RCM, [Caring for vulnerable migrant women](#) (2021), Sonia Asif et al, [The obstetric care of asylum seekers and refugee women in the UK](#) (2015), WHO [Improving the health care of pregnant refugee and migrant women and newborn children](#) (2018), Birth Companions and Revolving Doors Agency, [Making Better Births a reality for women with multiple disadvantages](#) (2019), Birthrights and Birth Companions, [Holding it all together: Understanding how far the human rights of woman facing disadvantage are respected during pregnancy, birth and postnatal care](#) (2019)

⁵ Gina Marie Awoko Higginbottom et al, [Experience of and access to maternity care in the UK by immigrant women: a narrative synthesis systematic review](#) (2019), Sonia Asif et al, [The obstetric care of asylum seekers and refugee women in the UK](#) (2015)

⁶ NICE, [Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors \[CG110\]](#) (2010)

⁷ King's College, [Pregnant migrants at higher risk of severe life-threatening conditions and ill babies](#) (2026)

⁸ SisterSong, [Reproductive Justice](#)

⁹ UK Government, [Upfront charging operational framework to support identification and charging of overseas visitors](#) (2021)

¹⁰ Maternity Action, [Breach of Trust: A review of implementation of the NHS charging programme in maternity services in England](#) (2021)

¹¹ UK Government, [Overseas NHS visitors: implementing the charging regulations](#) (2021)

¹² Maternity Action, RCOG, [Charging for NHS Care, Guidance for Obstetricians in England](#) (2025)

¹³ Birthrights, [Your right to NHS services: NHS charges](#) (2021), UK Government, [Overseas NHS visitors: implementing the charging regulations](#) (2021), Free Movement, [General grounds for refusal: owing a debt to the NHS](#) (2020)

¹⁴ Lisa Murphy et al, [Healthcare access for children and families on the move and migrants](#) (2020), [Doctors of the World, Deterrence, delay and distress: the impact of charging in NHS hospitals on migrants in vulnerable circumstances](#) (2017), Maternity Action, [What Price Safe Motherhood?](#) (2018)

¹⁵ Lisa Murphy et al, [Healthcare access for children and families on the move and migrants](#) (2020)

¹⁶ M Nair et al, [Factors associated with maternal death from direct pregnancy complications: a UK national case-control study](#) (2015)

¹⁷ MBRRACE-UK, [Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the Error! Bookmark not defined.](#) (2019)

¹⁸ Maternity Action, [A Vicious Circle: The relationship between NHS Charges for Maternity Care, Destitution, and Violence Against Women and Girls](#) (2019)

¹⁹ Lima, Silvana Andréa Molina et al, [Is the risk of low birth weight or preterm labor greater when maternal stress is experienced during pregnancy? A systematic review and meta-analysis of cohort studies](#) (2018), Maternity Action, [Breach of Trust](#) (2021)

²⁰ AoMRC, [NHS charges to overseas visitors regulations: A statement from the Academy of Medical Royal Colleges](#) (2019)

²¹ IPPR, [Towards true universal care: Reforming the NHS charging system](#), (2021)

²² RCOG, [Policy position: Racial and ethnic equality in women's health](#) (2024), Nicola Heslehurst et al, [Perinatal health outcomes and care among asylum seekers and refugees: a systematic review of systematic reviews](#) (2018), Jeeva Reeba John et al, [Exploring ethnic minority women's experiences of maternity care during the SARS-CoV-2 pandemic: a qualitative study](#) (2021), Sarah Chitongo et al, [Midwives' insights in relation to the common barriers in providing effective perinatal care to women from ethnic minority groups with 'high risk' pregnancies: A qualitative study](#) (2021)

-
- ²³ The Guardian, [Asylum seeker billed £10,000 for NHS maternity care ‘could only afford penny a month’](#) (2025), Maternity Action, [Breach of Trust](#) (2021)
- ²⁴ Maternity Action, [Breach of Trust](#) (2021)
- ²⁵ Legal Action Group, [An unfair contribution: charging migrant women for maternity care](#) (2023), Maternity Action, [Breach of Trust](#) (2021)
- ²⁶ Maternity Action, [Breach of Trust](#) (2021)
- ²⁷ Maternity Action, [Guidance on improving access to maternity care for women affected by charging](#)
- ²⁸ Birthrights and Birth Companions, [Holding it all together: Understanding how far the human rights of woman facing disadvantage are respected during pregnancy, birth and postnatal care](#) (2019)
- ²⁹ MBRRACE-UK, [Saving Lives, Improving Mothers’ Care](#), (2025), MBRRACE-UK, [Saving Lives, Improving Mothers’ Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18](#) (2021), Saving Lives, [Improving Mothers’ Care: Rapid report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK](#) (2021)
- ³⁰ MBRRACE-UK perinatal confidential enquiry, [The care of recent migrant women with language barriers who have experienced a stillbirth or neonatal death](#) (2024)
- ³¹ MBRRACE-UK perinatal confidential enquiry, [The care of recent migrant women with language barriers who have experienced a stillbirth or neonatal death](#) (2024)
- ³² The Guardian, [Stop charging migrant women for NHS maternity care, RCOG urges](#) (2022)
- ³³ RCOG, [Cross-Cultural Communication and Language Support: Standards for Maternity Care and Women’s Health](#) (2025), RCOG, [Maternity Service Standards Framework](#) (2025)
- ³⁴ RCOG, [Cross-Cultural Communication and Language Support: Standards for Maternity Care and Women’s Health](#) (2025), RCOG, [Maternity Service Standards Framework](#) (2025)
- ³⁵ NHS England, [Improvement framework: community language translation and interpreting services](#) (2025)
- ³⁶ Welsh Government, [Standard operating procedure: commissioning interpretation and translation services in primary and emergency healthcare](#) (2025)
- ³⁷ Public Health Scotland, [Interpreting, communication support and translation national policy](#) (2020)
- ³⁸ Department for Communities, [Framework for interpretation, translation and transcription services](#) (2022)
- ³⁹ FE Week, [This ESOL review is a rare chance – let’s not waste it](#) (2026), UK Government, [Post-16 Education and Skills](#) (2026)
- ⁴⁰ Birthrights and Birth Companions, [Holding it all together: Understanding how far the human rights of woman facing disadvantage are respected during pregnancy, birth and postnatal care](#) (2019)
- ⁴¹ Gina Marie Awoko Higginbottom et al, [Experience of and access to maternity care in the UK by immigrant women: a narrative synthesis systematic review](#) (2019)
- ⁴² Happy Baby Community, [Birth companion pilot for London initial accommodation for asylum seekers](#) (2020)
- ⁴³ McPin Foundation, [Evaluation of Birth Companions’ Community Link Service](#) (2015), University of Central Lancashire, [Birth Companions Research Project: Experiences and Birth Outcomes of Vulnerable Women](#) (2016)
- ⁴⁴ NHS England, [Equity and equality: Guidance for local maternity systems](#) (2021)
- ⁴⁵ UK Parliament, Women and Equalities Select Committee, [Equality and the UK asylum process](#) (2023)
- ⁴⁶ Gina Marie Awoko Higginbottom et al, [Experience of and access to maternity care in the UK by immigrant women: a narrative synthesis systematic review](#) (2019), Ros Bragg, [Equality and the asylum system: the case of pregnant women](#) (2021)
- ⁴⁷ NHS England, [The Maternal Care Bundle](#) (2026)
- ⁴⁸ Redbridge Local Safeguarding Children Board, [Baby ‘T’ serious case review \(SCR\) report](#) (2020)
- ⁴⁹ UK Government, [Healthcare Needs and Pregnancy Dispersal Policy](#) (2012)
- ⁵⁰ UK Government, [Healthcare Needs and Pregnancy Dispersal Policy](#) (2012)
- ⁵¹ RCM, [Position statement: Caring for migrant women](#) (2022)
- ⁵² UK Government, [Healthcare Needs and Pregnancy Dispersal Policy](#) (2012)
- ⁵³ UK Government, [Healthcare Needs and Pregnancy Dispersal Policy](#) (2012)
- ⁵⁴ Independent Chief Inspector of Borders and Immigration, [An inspection of contingency asylum accommodation](#) (2024), Independent Chief Inspector of Borders and Immigration, [An inspection of the Home Office’s management of asylum accommodation provision](#) (2018)
- ⁵⁵ Women for Refugee Women, [Coercion and Control: The treatment of women seeking asylum in hotel accommodation](#) (2024), The Guardian, [Asylum seekers ‘subjected to sexual harassment’ in government hotels](#) (2021)
- ⁵⁶ Independent Chief Inspector of Borders and Immigration, [An inspection of contingency asylum accommodation](#) (2024)

⁵⁷ Science Direct, Wellbeing, Space and Society, [‘We don’t ask for a luxury life, just basic things’: the experiences of mothers with babies in the UK asylum system](#) (2025)

⁵⁸ DPG, [Claim against Home Office by migrant subjected to dehumanising treatment](#) (2021)

⁵⁹ UK Government, [Migration transparency data](#) (2026)

⁶⁰ Independent Chief Inspector of Borders and Immigration, [An inspection of the Home Office’s management of asylum accommodation provision](#), (2018)