

STUDY

Requested by the FEMM committee



Access to maternal health and midwifery for vulnerable groups in the EU

WOMEN'S RIGHTS & GENDER EQUALITY



Policy Department for Citizens' Rights and Constitutional Affairs
Directorate General for Internal Policies of the Union
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Access to maternal health and midwifery for vulnerable groups in the EU

STUDY

Abstract

This study, commissioned by the European Parliament's Policy Department for Citizens' Rights and Constitutional Affairs at the request of the FEMM Committee examines issues related to access of vulnerable social groups to maternal health care services and midwifery in the EU. As the study points out, this access is affected by the interplay of health systems, law, policies, socio-economic factors and attitudes of health professionals and users which leads to barriers to access and consequently to worse health outcomes for those women, as evidence demonstrates. This study critically discusses the issues, analyses the causes, surveys the literature for best practices and makes policy recommendations, aiming at improving the situation for vulnerable women and contributing to reduction of health inequalities.

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LIST OF ABBREVIATIONS

CEE	Central and Eastern Europe
EIGE	European Institute for Gender Equality
EASO	European Asylum Support Office
EU	European Union
FGM	Female Genital Mutilation
FRA	EU Agency for Fundamental Rights
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
ICESCR	International Covenant of Economic, Social and Cultural Rights
ICM	International Confederation of Midwives
IHRL	International Human Rights Law
IOM	International Organisation for Migration
MIPEX	Migrant Integration Policy Index
NGO	Non-Governmental Organisation
PHAME	Public Health Aspects of Migration in Europe
SRH	Sexual and reproductive health
TFEU	Treaty on the Functioning of the European Union
UNHCR	United Nations High Commissioner for Refugees
UN	United Nations
WHO	World Health Organisation
WWID	Women Who Inject Drugs

BACKGROUND

The demographic landscape in the European Union has been changing. Among the main factors contributing to this change are migration and free movement. Inhabitants of urban and rural areas vary in terms of class, race, ethnicity, status, religion, socio-economic and educational level and sexual orientation. Consequently, they have different health needs and some live on the margins of society, due to different forms of discrimination.

Migrants but also EU nationals who belong to certain vulnerable social groups (migrants, refugees, asylum seekers, women with disabilities, prisoners, sex workers among others) often experience poor maternal health outcomes, limited or lack of access to maternal health services. Despite the scarce, inconsistent and non-generalizable data, evidence suggests clearly that maternal morbidity and mortality rates of such groups are higher. These can be attributed to different risk profiles, but also to lower standards of care and barriers to access for those vulnerable categories. Female refugees, undocumented migrants but also marginalised autochthonous women are more likely to have complex health needs, due to their difficult circumstances, which might adversely affect their pregnancy.

The global and EU policy frameworks have established the right to health as a fundamental human right. Maternal health services which, in theory, should be provided universally and be accessible to all across the EU. None the less, the reality is different, as national health systems often render that impossible for those women due to various barriers to maternal health care access.

Migrants and refugees across Europe avoid seeking care, including during pregnancy, due to fear of being reported to authorities, absence of clear policies and information regarding their entitlement to health care and various administrative and legal barriers. Native vulnerable women similarly share this fear of being reported or having state intervention in their personal life act as deterrents. Other barriers are associated with reduced knowledge of the health care system, language and communication obstacles, limited or no financial capacity (e.g. when there are fees to pay), and lack of knowledge about cultural issues and expectations on the part of health professionals. These are compounded by the reluctance by vulnerable groups to resort to the health mechanisms owing to social and cultural reasons and the fear of social stigma. Self-care and resort to accident and emergency treatment is often their chosen way.

Serving the needs of a diverse population poses challenges to policy-makers and service providers but also requires changes in attitudes, as diversity is often blamed for inefficiency of health systems and growing inequalities. Vulnerable women must have access not just to maternity services but to overall sexual and reproductive health care, as the latter can detect, diagnose and treat conditions which may lead to severe complications during pregnancy. Improvement in maternal care is urgently needed, including better family planning, antenatal and postnatal services, as well as research into maternal morbidity and mortality.

Aims

This study attempts:

- To highlight the need for raising of the standards of care, reduction in maternal morbidity and improvement of the sexual and reproductive health of women who belong to vulnerable social groups.
- To provide a picture of the reality of maternal health and maternal health outcomes of vulnerable groups, drawing on the scarce statistics available and highlighting the relevant methodological problems.
- To give an account of the global and EU policy evolution on health and maternal health as a human right, as well as its interpretation in the national context of selected Member States.
- To provide a critical overview of the existing literature highlighting the complexity of maternal health access and delivery, analysing the barriers that vulnerable groups of women face and the causes behind inequalities in maternal care in the EU context.
- To present selected best practices adopted by EU Member States to promote and deliver maternal health care of adequate standard.
- To make policy recommendations to all stakeholders and policy-makers, on both the national and the EU levels, for an inter-sectoral and co-ordinated approach towards the provision of universal and person-centred maternal health.

The study concludes that maternal health for vulnerable women needs urgent improvement and that co-ordination of the different actors and organisations is required to this end. It provides a detailed list of recommendations along the following lines: legal provision for full health coverage of all pregnant women; co-ordinated and holistic policy actions involving multiple stakeholders and representatives of all marginalised groups; improvement of research into the needs of such groups in order to design effective and gender-sensitive policies; better provision of maternal health services, antenatal, postnatal and family planning through a person-centred, culturally-sensitive and continuous approach to care; appropriate communication mechanisms and investment in facilities, resources and personnel to adequately provide and deliver maternal health according to needs.

SETTING THE SCENE

In the constantly diversifying population profile of the EU, there is a growing realisation that health care provision has to address the needs of all social groups, including the most vulnerable. Welfare states define what is (and should be) public health care and shape the role of the family, the market and the voluntary sector accordingly.¹

Access to sexual and reproductive health services is a fundamental right. Nonetheless, many women in the EU come up against a harsh reality of unequal and limited access to proper treatment and information about the resources available, their entitlements and the relevant procedures to access them. As a result, an estimated 500,000 women in the EU will go through their first months of pregnancy with no access to health services resulting in higher maternal health rates. Women belonging to vulnerable social groups are particularly affected by these gaps in availability, access and use of resources and adequate services.²

Migrant women are particularly disadvantaged, as they suffer intersectional discrimination³ because of their secondary status in many of their countries of origin, which goes together with lack of financial means, less education and very often traumatic experiences necessitating access to mental health services. Moreover, native women belonging to other vulnerable social groups, such as women with disabilities, sex workers, women with addiction to substances or communicable diseases (e.g. HIV, HBV or HCV), or simply poor women unable to cover the cost of services are de facto excluded and are faced with similar difficulties in accessing sexual and reproductive health (SRH) care. What renders the situation more complex, is that those women are subject to intersectional discrimination, as they often inhabit more than one of the above categories.

Mechanisms of exclusion are in operation in the EU of open borders. Differences in health systems, systemic and administrative failures, cultural barriers, lack of resources, inadequate education, information and communication, and fear are but some of the reasons behind this reality. However, data are limited and this fact obscures certain dimensions and causes of the problem. There are different kinds of inequalities between social categories which are related to political, historical, social and cultural intersections⁴.

Civil society, national authorities and EU organisations and structures have come together to address these issues through a number of relevant initiatives, networks and research. We have reached a point in which priority has to be given to research into the needs of the excluded so that these are identified

¹ Zadoroznyj, M, Benoit, C, Berry, S. (2012) Motherhoods, medicine and markets: the changing politics of postnatal health provision. *Sociological Research Online* 17(3) 24.

² Recent global data show that one in five women who inject drugs (WWID), a proportion of 10-30% of all people who inject drugs, are HIV positive, one in two are infected with Hepatitis C (HCV) and one in 10 with Hepatitis B (HBV) viruses. Often HCV and HIV coincide. Also among the approximately 3.5 million WWID in the world, one third are sex workers and very often subject to violence. Not enough research has been done to date with regard to the needs of WWID. See Iversen J, Page K, Madden A, Maher L. (2015) HIV, HCV and health-related harms among women who inject drugs: implications for prevention and treatment. *Journal of acquired immune deficiency syndromes* 2015 Jun 1:69 (01), 176-181.

³ An intersectionality approach argues that forms of oppression (e.g. racism, sexism, disablism) overlap, defining unique social groups, and thus posits that the consequences of disability, race/ethnicity and gender cannot be understood sufficiently by studying these phenomena separately; their overall effects need to be examined by looking into how disability, gender and race/ethnicity structurally interrelate to establish access to resources (both material and relational) or lead to risks for the groups in question (see European Parliament (2013) *Discrimination Generated by the Intersection of Gender and Disability. A Study*, Directorate General for Internal Policies, Policies Department C: Citizens' Rights and Constitutional Affairs, Gender Equality, European Parliament, Brussels).

⁴ Verloo, M. (2006) Multiple inequalities, intersectionality and the European Union. *European Journal of Women's Studies*.13: 211.

and understood before attempting to address them through adequate, specialist and appropriate services⁵.

This study examines access to maternal health and midwifery for vulnerable groups in the EU. Chapter 1 clarifies the concepts which will be used, presents and discusses the scarce data available, to offer an overview of the issues involved in SRH care access and delivery in selected Member States. Chapter 2 presents the international and EU legislation that establish health as an international human right. The second part of this presents evidence and research findings which shows the great variety in coverage across the EU in access to SRH care. Chapter 3 focuses on the barriers faced by marginalised women in exercising their entitlements, which are the result of the interaction of national laws, policies, socio-economic factors, attitudes and practices. Positive measures and best practices from various Member States are highlighted in the first section of Chapter 4, while the second part is dedicated to the vital role of midwifery and its potential in future actions and policies aiming at the reduction of health inequalities. Finally, Chapter 5 comprises a number of recommendations to inform policy-making and co-ordinated initiatives and practices towards overcoming these barriers. The study concludes that the only way to reach the policy objective of equal access to sexual and reproductive health care is to argue within the International Human Rights framework for the universality of this right and for a person-based delivery of services to all according to their needs.

⁵ Phillimore, J, (2015) Delivering maternity services in an era of superdiversity: the challenges of novelty and newness. *Ethnic and Racial Studies* 38:4, 568-582.

1. THE EVIDENCE – CONCEPTS, FIGURES AND ISSUES

KEY FINDINGS

- A number of definitional and methodological issues in the identification of categories of vulnerable women do not allow for accurate measurements and collection of information. Consequently, there is dearth of systematic, consistent and generalizable data with regard to their maternal morbidity and mortality.
- Different vulnerable groups, including marginalised native women, as well as various categories of migrant women, are exposed to different risk factors. This heterogeneity accounts for their diverse health needs, which so far have not received sufficient attention.
- The inability of health care systems and policies to respond to their needs, due to barriers to access to SRH services has led to very poor maternal health outcomes, which vary across different groups. The category of undocumented migrant women is represented in all vulnerable groups and focusing on addressing their needs would lead to policies which will benefit all.

1.1. Definitions and methodological issues

The present study examines issues of access to maternal health and midwifery services for vulnerable women in the EU.

Maternity/maternal health care comprises all formal health care related to pregnancy, prenatal care, childbirth and postnatal care.

Maternal mortality is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, regardless of the place of death, from any cause related to or aggravated by the pregnancy, or its management, but not from accidental or incidental causes.⁶

Maternal morbidity refers to the state of health of a mother and the presence of certain physical or mental illnesses related to pregnancy and/or childbirth. It includes eclampsia and pre-eclampsia, major obstetric haemorrhage, sepsis and severe infection and obstructed labour.⁷

Access of socially marginalised women to maternal health and midwifery services has been the topic of numerous studies, both European and international. Most of the studies have dealt with migrant health, as migration has been highly topical for years and a priority for politicians, policy-makers and researchers. Disentangling categories is ever so challenging when accounting for the complexity and fluidity of people's status and the resulting differences in entitlements to services. For clarity purposes, the main concepts will be defined from the beginning.⁸

⁶ WHO definitions, taken from Van den Akker, T, van Roosmalen, J. (2016) Maternal mortality and severe morbidity in a migration perspective. *Best Practice and Research Clinical Obstetrics and Gynaecology* 32: 26-38.

⁷ Van den Akker, T, van Roosmalen, J. (2016) Maternal mortality and severe morbidity in a migration perspective. *Best Practice and Research Clinical Obstetrics and Gynaecology* 32: 26-38.

⁸ Adapted from WHO (2016) Strategy and action plan for refugee and migrant health in the WHO European Region. Copenhagen: WHO Europe.

Vulnerable women include all categories of migrants but also categories of native women such as ethnic minorities (Roma, Gypsies and travellers), poor and homeless women, sex workers, disabled women, female victims of violence, addicts to drugs, HIV positive women and female prisoners.

Migrant: An individual who moves from their initial country of settlement to a different one. The move can be the result of a voluntary decision (e.g. to find gainful employment) or the result of adverse social, economic and political conditions in the country of origin. This category includes subgroups such as refugees, settlers, circular migrants or transit migrants. Migrants may remain in the host country ('settlers'), or reside provisionally in a country aiming to move to another country ('transit migrants'), or move back and forth between countries ('circular migrants', such as seasonal workers).

Refugee: An individual who, owing to war, natural disaster, or fear of persecution for reasons of race, religion, nationality, or political beliefs, has been forced to leave the country of initial settlement and is unable or unwilling to return there.

Asylum seeker: An individual who is seeking international protection and sanctuary in a country other than the one of their usual settlement. In countries with formal institutional procedures, an asylum seeker puts a formal application for protection and their claim is granted or rejected.

Undocumented migrant: An individual who lives in a foreign country without the legal right to stay (valid residence permit or visa) and who can be faced with deportation. This category includes asylum seekers whose claim has been rejected, people who overstayed their expired visa and those who entered the country by illegal means.

Definitional issues include whether a 'migrant' is defined through recent cross-border movement, or through their reported ethnicity. Vaguely defined notions, such as 'nationality', 'ethnicity', 'foreigner', 'immigrant status', 'refugee' further obscure results. Some studies control for factors such as socio-economic status, which is lower in migrants and affect health outcomes; however, others do not control for such factors and may arrive at different results.⁹

Further methodological problems have to do with:

- the frequent conflation in studies of the terms 'refugee' and 'migrant'
- the diversity of health care organisation within national and regional boundaries, which makes the quality of health care for migrants, asylum seekers and refugees difficult to assess
- the lack of agreed definition on how much time is needed for a migrant to be considered a member of an ethnically distinct group.¹⁰

Undocumented migrant women epitomise the experience of intersectional discrimination. They are faced with most barriers to access to maternal and reproductive health services and are represented in all the vulnerable groups. Therefore, the focus will be on them, as addressing their need will benefit all the vulnerable groups.

⁹ Gagnon, AJ and Redden, KL. (2016) Reproductive health research of women migrants to Western countries: a systematic review for refining the clinical lens. *Best Practice and Research Clinical Obstetrics* 32:3-14.

¹⁰ In national data in some Member States there is reference to 'ethnic minorities' and this may group together vulnerable migrants and refugees but also well-established nationals of second or third generation. Mladovsky, P, Rechel, B, Ingleby, D, McKee, M. (2012) Responding to diversity: an exploratory study of migrant health policies in Europe. *Health Policy* 105:1-9.

Furthermore, even though the topic is 'access to maternal health', women's sexual and reproductive health will also be discussed, as it is a broader category which includes maternal health. From a human rights perspective, all women are entitled to sexual and reproductive health services and from a gender-equality point of view women are not just mothers. Finally, as far as health policy is concerned, SRH is linked with morbidity, which will have a subsequent impact on maternal health. As a result, early diagnosis of diseases leads to the prevention of chronic conditions and reduction in morbidity, with significant financial gains for the health system.

1.2. Problems with the available statistical data

The available statistical data are scarce and problematic. Data on migrant health care are not easy to gather, as migrants often live, in poor social conditions and those that are undocumented are particularly difficult to find and contact for research purposes. Data, as a result, tend to underestimate the size of the problem.¹¹ Moreover, as recent the WHO Health Evidence Network highlights, in addition to non-consistent use of definitions throughout the WHO European Region, their meaning is constantly shifting, according to political and administrative objectives, with the resulting impact on access to health care.¹² Another reason why recent numbers of migrants are not easy to estimate is that undocumented migrants are recorded in ten-year national censuses and, due to their status, some are not visible.¹³

In light of the above, the quality of maternal health care is hard to disaggregate out of statistics that refer to overall health care of migrants (men and women), or to health care of refugees (men and women), or to female populations without indicating whether they belong to vulnerable groups (e.g. general minorities of women in a country). Data on other marginalised groups present similar issues.

Extensive use of **tools** and **indicators** is made in health care services research. Donabedian's categorisation of health care indicators includes: *structure indicators*, which represent the necessary conditions/resources (physical, human, financial etc.) for the delivery of care; *process indicators*, which represent the activities that take place and their performance, i.e. how health care is provided and *outcome indicators*, which are attributed to the health care provided, e.g. mortality rates, health status, patient satisfaction with services.¹⁴

A **tool** can be defined as a collection of indicators used as an instrument to obtain information about a particular aspect of the performance of maternity care.¹⁵

Both the OECD and Eurostat databases use maternal care related indicators. Out of the 388 total indicators found in a survey of a large number of sources (including the two databases of OECD and Eurostat), a total of 297 focused on process and outcomes in maternity care, with structure indicators

¹¹ Almeida, LM, Caldas, J, Ayres-de-Campos, D, et al. (2013) Maternal health care in migrants: a systematic review. *Maternal and Child Health Journal* 17: 1346-1354.

¹² These inconsistencies and changes contribute to the increased complexity in defining the refugee population, which can comprise those who have been successful in claiming asylum, those in the process of doing so, and those who have failed to do so. The result is that asylum seekers and refugees are a heterogeneous group with widely differing experiences, backgrounds, as well as health needs and access to health mechanisms.

¹³ Flegar, V, Dallí, M, Toebes, B. (2016): Access to Preventive Health Care for Undocumented Migrants: A Comparative Study of Germany, the Netherlands and Spain from a Human Rights Perspective, in: *Laws* 5 (2016), 9, doi:10.3390/laws5010009.

¹⁴ Donabedian, A. (2003) *An Introduction to quality assurance in health care*. Oxford: Oxford University Press.

¹⁵ Escuriet, R, White, J, Beeckman, K et al. (2015) Assessing the performance of maternity care in Europe: a critical exploration of tools and indicators. *BMC Health Services Research* 15:491. EU COST Action IS0907.

less represented. Intrapartum care was the aspect of maternal care most assessed through these process and outcome indicators, while the postnatal and neonatal aspects were the least evaluated. Caesarean section rate was the most commonly measured event, followed by the type of instrument employed and postnatal maternal complications. Maternal morbidity was the most common indicator regarding undesirable outcomes.¹⁶

An analysis of the indicators threw into relief the following limitations:

- a focus on the clinical aspects of intrapartum care with much less emphasis on the postnatal care of mothers
- limited measurement of non-intervention in delivery –which might suggest focus of the current health system on technical and clinical interventions
- influence on the indicators used by professional context and national/local maternal health care models
- lack of consensus about what criteria should be used to measure good or optimal care
- absence of links between care processes and the complex inter-relationship between different elements of care in measurement indicators and tools.¹⁷

On this basis, the present study will draw on aggregate statistics with a considerable degree of reservation. It will put its emphasis more on issues emerging out of studies that can possibly be targeted to the populations of interest (vulnerable groups). It is beyond its scope to dwell on methodological issues related to the available statistical data. In this section the figures, collected from different sources, aim to give an idea of the magnitude of the problem and shed light on the gaps and inefficiencies in service provision and delivery.

1.3. Data and emanating issues

Childbirth services are complex and intra- and postpartum care can reduce maternal but also foetal deaths.¹⁸ Home births are generally low in the EU (less than 5%), with the exception of the Netherlands (15% in 2013). In most cases, they take place in the presence of skilled birth attendants and have uncomplicated outcomes (though the evidence is not ample).¹⁹ Data from 1990-2013 show that global coverage of births with skilled birth attendants rose from 57% to 74%, one or more antenatal visits from 65% to 83% and four or more antenatal visits from 37% to 64%.²⁰

1.3.1. Data on maternal deaths

The global number of women and girls who died from complications of pregnancy and childbirth were 303,000 in 2015. Though this constitutes an improvement in the last 25 years, over 800 women are dying every day from complications in pregnancy and childbirth.²¹

¹⁶ Ibid.

¹⁷ Escuriet, R, White, J, Beeckman, K et al. (2015) Assessing the performance of maternity care in Europe: a critical exploration of tools and indicators. *BMC Health Services Research* 15:491. EU COST Action IS0907.

¹⁸ Campbell, O, Calvert, C et al. (2016) The scale, scope, coverage and capability of childbirth care. *Lancet* 388: 2193-2208.

¹⁹ Ibid.

²⁰ Ibid.

²¹ <https://data.unicef.org/topic/maternal-health/maternal-mortality/>

Nearly 1,800 **maternal deaths** occurred in Europe in 2015. Every year 8 out of 100,000 women in the EU die giving birth (compared to a global average of 216). The maternal mortality ratio in 2015 was 50 times higher in low income countries than in high income ones (496 vs. 10 in 100,000 live births).²²

Although in the EU the average maternal mortality rate is low it would be misleading to not acknowledge that some Member States present a different picture. In Latvia for instance the percentage ranges, according to the sources of data, between 18 and 31.3 per 100,000 live births, which placed maternal health as priority of the Latvian health system.²³ Similar percentages are reported for Hungary and Romania.²⁴

While progress has been made in reducing maternal mortality, **indirect maternal deaths** are seen as being either stable or on the rise both in the developed and in the less developed countries.²⁵ **Indirect maternal death** is defined as 'maternal death resulting from a previous disease or disease that developed during pregnancy and was not due to direct obstetric causes, but which was aggravated by physiologic effects of pregnancy'.²⁶ In 2013 there were 33,128 reported indirect maternal deaths globally.²⁷ It has been estimated that 27.5% of maternal deaths in the period 2003-2009 were due to indirect causes.²⁸ 15% of maternal deaths occurring within six weeks after the end of pregnancy are estimated to result from pre-existing medical conditions²⁹, while a significant proportion will happen after the six weeks but are not included in the statistics.

Undocumented migrant women appear to have the highest number of unintended pregnancies, are more exposed to violence, have delays in accessing care and are more at risk for adverse pregnancy outcomes. Research shows that the social determinants of health are very important in the case of undocumented migrant women, as their living conditions, fear and constant stress, as well as lack of funds, all contribute to physical and mental health problems and failed asylum seekers tend to rate their health as very poor.³⁰

Under-reporting is a serious issue, particularly in less developed countries, due to poor diagnosis by medical professionals. Conditions such as obesity create higher pregnancy-related risks, both direct (e.g. cardiac) and indirect (haemorrhage, eclampsia).³¹ As a result, distinguishing between direct and indirect deaths is increasingly unhelpful, not least because the emphasis is on direct deaths. This is more so, if one considers definitional differences across countries, as, for instance, a case of anaemia-related fatal bleeding during pregnancy can be classified as direct maternal death in the UK but indirect in India, where anaemia is common. Additionally, autopsies are often not adequate, which means that many maternal deaths are consequently not identified or not classified correctly.³²

²² WPL (2018) Improving Maternal Healthcare for Vulnerable Women in EU28. What can you do? Women Political Leaders Global Forum, p.23.

²³ Miteniece, E, Pavlova, M, Rechel, B et al. (2019) Barriers to accessing adequate maternal care in Latvia: A mixed method study among women, providers and decision-makers. *Health Policy*, 123:87-95.

²⁴ Ibid.

²⁵ Nair, M, Nelson-Piercy, C, Knight, M. (2017) Indirect maternal deaths: UK and global perspectives. *Obstetric Medicine* 10(1): 10-15.

²⁶ WHO (2012) *The WHO application of ICD-10 to deaths during pregnancy, childbirth and the puerperium: ICD-MM*. Geneva: World Health Organisation.

²⁷ Kassenbaum, NJ, Bertozzi-Villa, A, Coggeshall MS et al. Global, regional and national levels and causes of maternal mortality during 1990-2013: a systematic analysis for the global burden of disease study 2013. *Lancet* 384: 980-1004.

²⁸ Say, L, Ghou, D, Gemmill, A et al. (2014) Global causes of maternal death: a WHO systematic analysis. *Lancet Global Health* 2014 (2): e323-e333.

²⁹ Ibid.

³⁰ Kvamme, E, and Ytrefhus, S, (2015) Barriers to health care among undocumented migrant women in Norway. *Society, Health & Vulnerability*. 2015;6(1):28668.

³¹ Van den Akker, T, Nair, M, Goedhart, M et al. (2017) Maternal mortality: direct or indirect has become irrelevant. *Lancet* 5: e1181-e1182.

³² Ibid.

The causes of indirect maternal deaths in less developed countries are communicable diseases (e.g. HIV in Africa), non-communicable diseases (e.g. anaemia in India) and nutritional disorders (e.g. obesity), while in the developed countries they are primarily non-communicable diseases. In 2011-2013, 68% of UK maternal deaths resulted from indirect causes, cardiac arrest being the most significant one, followed by sepsis resulting from various causes. Research has also shown that pre-existing conditions were also contributory in many cases of death because of direct pregnancy complications.³³ A study comparing a population of women with BMI>50 kg/m² with one with BMI<50 kg/m² has shown that the former is associated with poor perinatal and maternal outcomes. In particular, they had higher risk of hypertensive disorder and preeclampsia, while 12 of their infants died in the early neonatal period or were stillborn, while their infants had eight more times higher chances for macrosomia.³⁴

In the UK, for instance, the mortality rate from direct or indirect causes for 2013-15 was 202 women (8.8 per 100,000 maternities). The UK Confidential Enquiries into Maternal Deaths have shown that more than two thirds of these deaths (over the period of up to six weeks postpartum) were due to mental and medical causes and less than one third from obstetric causes. **Cardiac disease** is the leading cause, with thrombosis and thromboembolism the main direct factors.³⁵ **Sepsis** is of equal significance as a cause of direct deaths in the UK and studies from maternity units have shown that the risk to it is quite high.³⁶ **Maternal suicide** is the third cause of direct maternal deaths for the six-week postpartum period but also the leading cause during pregnancy or over the period from six weeks to a year after pregnancy.³⁷ Suicides can frequently be attributed to postpartum psychosis or to previous underlying psychiatric conditions. The matter is both serious and intricate, as a number of interlinked factors can increase pregnancy risks and complications for women with pre-existing medical and mental health conditions.

Based on data from Doctors of the World at clinics in nine European countries, 54% of pregnant women lack **access to maternal healthcare** and are living in poverty. Additionally, despite the progress made, 1 in 10 women in the EU still have no access to maternal health services in the first months of pregnancy, while the percentage of vulnerable women increases due to influx of refugees and migrants.³⁸

Prenatal care is vital in reducing perinatal mortality, as it allows for an early diagnosis of conditions and can lead to treatment and prevention of possibly life-threatening complications later on. Research involving 37,000 women in Italy has shown that low socio-economic and educational levels, immigrant status, young maternal age, cultural factors, single mother status, unemployment inhibit early use of

³³ Nair, M, Nelson-Piercy, C, Knight, M. (2017) Indirect maternal deaths: UK and global perspectives. *Obstetric Medicine* 10(1): 10-15.

³⁴ McCall, SJ, Li, Z, Kurinczuk, JJ, Sullivan, E, Knight, M (2019) Maternal and perinatal outcomes in pregnant women with BMI>50: An international collaborative study. *PLoS ONE* 14(2): e0211278.

³⁵ Knight, M. (2018) The findings of the MBRACE-UK confidential enquiry into maternal deaths and morbidity. *Obstetrics, Gynaecology and Reproductive Medicine* 29(1): 21-23.

³⁶ A national cohort study using representative data has found that severe sepsis and septic shock are common among pregnant women with pneumonia or respiratory infection, as the source of it in 40% of the cases. Significantly, the study exposed a clear association between increasing risk to sepsis and decreasing socioeconomic status. It also highlighted the fact that women from deprived geographical areas had poorer health care and outcomes and called for the need to disentangle the social determinants that participate in pre- and post-partum mortality due to maternal sepsis. In Acosta, CD, Harrison, DA, Rowan, K et al. (2016) Maternal morbidity and mortality from severe sepsis: a national cohort study. *BMJ Open* 6: e012323.

³⁷ In the period 2013-15, 13 women died from epilepsy during or the year after their pregnancy. Few of them seem to have received any pre-conception advice or had access to good care during their pregnancy. Fifty-four women (2.3 per 100,000 maternities) died during or up to six weeks after pregnancy from cardiac disease. Neither had they received pre-pregnancy counselling nor were the cardiovascular symptoms (e.g. a raised respiratory rate, or chest pain) correctly interpreted during pregnancy. A lack of proper communication across teams was observed. Similar lack of counselling on risk factors during labour (e.g. thromboembolism) was observed. With regard to the post-pregnancy period, women with mental health incidents received no advice on future pregnancy risks. In Knight, M. (2018) The findings of the MBRACE-UK confidential enquiry into maternal deaths and morbidity. *Obstetrics, Gynaecology and Reproductive Medicine* 29(1): 21-23.

³⁸ WPL (2018) Improving Maternal Healthcare for Vulnerable Women in EU28. What can you do? Women Political Leaders Global Forum, p.13.

prenatal care services.³⁹ Married women made better and more adequate use of prenatal services, as opposed to single mothers.

Postnatal care is a form of social care shaped by welfare state policies but also by cultural norms. These formulate the assumptions about whether the need for care exists, how it is provided, whether it is formal or informal, its duration and geographical location, as well as how it is financed.⁴⁰

From hospital stays of 11-14 days in the 1950s we have moved to two days or less in the 2000s, which means that women's experience in the period after birth has changed and care takes place more at home and within the community. Early discharge of women after birth fails to recognise their need for health and social care.⁴¹ The focus of interventions has hitherto been on improving obstetric care through skilled and emergency personnel for and during the delivery. However, such interventions have not had any impact on reducing indirect deaths.

At the same time, it is essential to properly monitor and adequately design customised follow-up for the later (after six weeks) postnatal period for women with medical and mental health comorbidities. This is crucial, as in the UK, for instance, an enquiry has shown that three out of four indirect maternal deaths have occurred after the period of six weeks postpartum.⁴²

As a result, it is highly significant to examine and understand the risk factors involved in medical and mental health comorbidities and take them into consideration in the provision of health care to reduce indirect maternal deaths. Evidence-based multidisciplinary care is seen as necessary to address the problem.⁴³ The conviction is that there is ample opportunity to reduce the risk by early and forward planning, for example involving senior obstetric and cardiology personnel.⁴⁴

1.3.2. Migrant women

According to UNHCR, an estimated 362,000 refugees and migrants risked their lives crossing the Mediterranean Sea in 2016, with 181,400 people arriving in Italy and 173,450 in Greece. In the first half of 2017, over 105,000 refugees and migrants entered Europe.⁴⁵ In that year, there were 728,470 applications for asylum in Europe, representing a decrease of 44 % compared to 2016, but remaining at a higher level than prior to the refugee crisis, which started in 2015.⁴⁶

The percentage of migrants in the EU population has increased substantially in the last two or three decades. In Ireland, there was a 300% increase between 1990-2010, while in Greece the equivalent was 250%. Among these migrants there are also vulnerable categories, such as undocumented ones and asylum seekers.⁴⁷ According to data by UNHCR, the EU Member States received 2.6 asylum seekers per

³⁹ Chiavarini, M, Lanari, D, Minelli, L. and Salmasi, L. (2014) Socio-demographic determinants and access to prenatal care in Italy, *BMC Health Services Research* 14:174.

⁴⁰ Zadoroznyj, M, Benoit, C, Berry, S. (2012) Motherhoods, medicine and markets: the changing politics of postnatal health provision. *Sociological Research Online* 17(3) 24.

⁴¹ Ibid.

⁴² Nair, M, Nelson-Piercy, C, Knight, M. (2017) Indirect maternal deaths: UK and global perspectives. *Obstetric Medicine* 10(1): 10-15.

⁴³ Ibid.

⁴⁴ Knight, M. (2018) The findings of the MBRRACE-UK confidential enquiry into maternal deaths and morbidity. *Obstetrics, Gynaecology and Reproductive Medicine* 29(1): 21-23.

⁴⁵ <https://www.unhcr.org/europe-emergency.html>.

⁴⁶ EASO (2018) Annual Report on the Situation of Asylum in the European Union 2017. Luxembourg: European Asylum Support Office, p.8.

⁴⁷ O'Donnell, CA, Burns, N, Mair, FS et al. (2016) Reducing the health care burden for marginalised migrants: The potential role for primary care in Europe. *Health Policy* 120: 495-508.

1,000 inhabitants between 2008 and 2012; in 2012 there were 296,700 new asylum claims, an increase of 7% from 2011.⁴⁸ By the end of 2013, Western nations received more than 130 million international migrants.⁴⁹ On 1 January 2014 there were 19.6 million third-country nationals living in the EU28, while 14.3 million were citizens of one EU country living in a different Member State.

Health care coverage of migrants is among the most important challenges in the EU. Maternal care coverage is part of this and presents its own challenges if we take into consideration that about **55% of migrants and refugees are women and children.**⁵⁰

Health inequalities between migrants and natives involve disparities in perinatal health outcomes, as well as other reproductive health outcomes.⁵¹ A key issue is that maternal mortality is a higher risk for migrant women. Other studies, for example for France and the UK, showed that certain groups of migrant women were at a risk comparable to that for native women.⁵² However, migrant women are not a homogeneous category. In France, for example, women from sub-Saharan Africa were at a higher risk, while in the UK it was women from African and Caribbean Commonwealth countries.⁵³

This general paucity of data with respect to maternal mortality and morbidity of migrant women suggests that such populations are not the prime object of interest for research and policy-making.⁵⁴ Research into migrant health has limitations, as designs of studies vary making generalisation difficult.

Depending on policies of the host country they may experience a fall in socio-economic status. Compared to the general EU population regarding their SRH, migrant women are less often screened for cervical and breast cancer, have less access to family planning, receive less gynaecological and antenatal care, have poorer pregnancy outcomes and higher infant and maternal mortality.⁵⁵ A recent report by the WHO Health Evidence Network, shows poor antenatal outcomes and poorer perinatal outcomes for certain categories of women refugees and asylum seekers, which, however, are not consistent across all groups. This suggests that there are needs yet to be covered, but also that the evidence cannot be generalised due to the aforementioned limitations of data.⁵⁶

Migrant women face both the stress inherent in the migration process, as well as the evidenced increased vulnerability that all women face during pregnancy and the postpartum period. Negative social and physical environmental circumstances have been associated with poor pregnancy outcomes, such as prematurity, low-birth weight and infant mortality.⁵⁷

⁴⁸ Mentioned in Keygnaert, I, Guieu, A, Ooms, G et al. (2013) Sexual and reproductive health of migrants: does the EU care? *Health Policy* 114: 215-225.

⁴⁹ Gagnon, AJ, Redden, KL (2016) Reproductive health research of women migrants to Western countries: a systematic review for refining the clinical lens. *Best Practice and Research Clinical Obstetrics* 32:3-14.

⁵⁰ <http://oramma.eu/wp-content/uploads/2018/12/ORAMMA-e-newsletter-no1.pdf>.

⁵¹ Gagnon, AJ, Redden, KL. (2016) Reproductive health research of women migrants to Western countries: a systematic review for refining the clinical lens. *Best Practice and Research Clinical Obstetrics* 32:3-14.

⁵² Van den Akker, T, van Roosmalen, J. (2016) Maternal mortality and severe morbidity in a migration perspective. *Best Practice and Research Clinical Obstetrics and Gynaecology* 32: 26-38.

⁵³ Ibid.

⁵⁴ Ibid.

⁵⁵ Keygnaert, I, Guieu, A, Ooms, G et al. (2013) Sexual and reproductive health of migrants: does the EU care? *Health Policy* 114: 215-225.

⁵⁶ Bradby H, Humphris R, Newall D, Phillimore J. (2015) Public health aspects of migrant health: a review of the evidence on health status for refugees and asylum seekers in the European Region. Health Evidence Network synthesis report 44. Copenhagen: WHO Regional Office for Europe.

⁵⁷ Almeida, LM, Caldas, J, Ayres-de-Campos, D et al. (2013) Maternal health care in migrants: a systematic review. *Maternal and Child Health Journal* 17: 1346-1354.

Increased rates of mortality and morbidity in migrant women can be explained either through the originally different profiles of the migrants from that of the home population, or the quality of the health care they receive in the host countries. The first set of factors (profile) include both medical (e.g. HIV prevalence among categories of migrant women) and socio-economic (e.g. lower education levels, single motherhood, language issues, short stay in the country) ones. However, again, such data are not systematic and cannot be generalised, as exceptions are often more important than the rule.⁵⁸ By contrast some migrants may demonstrate the *healthy migrant effect*, i.e. their health upon arrival may be better compared to the health of that of the native population.

When it comes to the second set of factors (health care in the host country), studies in **Sweden, France** and the **Netherlands** have shown stronger links between maternal deaths and inferior care for migrant women.⁵⁹ It seems that emergency treatment (e.g. provided by civil society organisations in refugee camps) often leads to better pregnancy outcomes than the standard health care provided by the system.

The group of migrants is heterogeneous and their health care coverage also differentiated. Moreover, not all of them are exposed to the same risks in the same ways. Refugees and asylum seekers often have poorer maternal health outcomes because of a history of gender-based violence or post-traumatic stress disorder. Economic migrants are much better-off and they are linked with the idea of the 'healthy migrant'.⁶⁰ Migrants who have recently migrated in the host country (and may not have residence permit) are generally most vulnerable and present higher health risks. A study of deliveries in Denmark, for instance, showed that sub-Saharan African women were at higher risk of maternal morbidity. Asylum seekers in the Netherlands had an incidence of 'severe acute maternal morbidity' of 31 per 1,000 women, which was 3.6 higher than non-Western immigrant women with a residence permit and 4.5 times higher than Dutch women.⁶¹

A systematic review found that there was a higher health risk in immigrants, increased comorbidity, lower rates of obstetrical interventions, increased risk of maternal death, and higher rates of postpartum depression.⁶² Women of refugee background from Africa are reported to be at increased risk of perinatal mortality compared with native women in European countries. Less is known about women from Asian background, but evidence suggests that migrant women from Afghanistan, Iraq and Iran have higher risks of neonatal outcomes than those born in the countries of settlement.⁶³

Early pregnancy health care is a way to address the complex needs of migrant women, particularly if it targets their identified risk factors.⁶⁴ Research into Afghan refugee women has shown that information provision, staff attitudes, staff cultural training and awareness, and participative decision-making have a strong impact on the maternity care provided.⁶⁵

⁵⁸ Van den Akker, T, van Roosmalen, J. (2016) Maternal mortality and severe morbidity in a migration perspective. *Best Practice and Research Clinical Obstetrics and Gynaecology* 32: 26-38.

⁵⁹ Ibid.

⁶⁰ Gagnon, AJ, Redden, KL. (2016) Reproductive health research of women migrants to Western countries: a systematic review for refining the clinical lens. *Best Practice and Research Clinical Obstetrics* 32:3-14.

⁶¹ Van den Akker, T, van Roosmalen, J. (2016) Maternal mortality and severe morbidity in a migration perspective. *Best Practice and Research Clinical Obstetrics and Gynaecology* 32: 26-38.

⁶² Almeida, LM, Caldas, J, Ayres-de-Campos, D et al. (2013) Maternal health care in migrants: a systematic review. *Maternal and Child Health Journal* 17: 1346-1354.

⁶³ Gibson-Helm, M, Boyle, J, Cheng, IH et al. (2015) Maternal health outcomes among women of refugee background from Asian countries. *International Journal of Gynecology and Obstetrics* 129: 146-151.

⁶⁴ Ibid.

⁶⁵ Ibid.

Undocumented migrants often experience worse health outcomes: An Italian study demonstrated that they are at a higher risk of teenage delivery, pregnancy complications, as well as miscarriages and induced abortions.⁶⁶ Other studies showed excessive bleeding, higher rates of anaemia and foetal distress.⁶⁷

Lower rates of obstetrical interventions are observed in migrant populations, such as planned caesareans and epidural analgesia in labour, as a German study has shown.⁶⁸ Research in the Netherlands indicates that immigrant women received inadequate health care more often than native women, for example, and they were less frequently operated upon and received insufficient treatment of complications.⁶⁹

In addition, according to evidence from France, that the risk for postpartum maternal death was twice as high for foreign women. The quality of care received was often less optimal in immigrants (9.1% of immigrant women received optimal maternal care compared to 28.8% of French women).⁷⁰

As far as more specific conditions are concerned, studies on pre-eclampsia tend to give different results. In a study of about 440 thousand single mothers in Lower Saxony, for example, no increased risk was found among migrant women. In Greece, a study of 7,000 pregnancies between 2003 and 2009 found a lower pre-eclampsia rate for migrant women. Other studies showed higher post-partum haemorrhage in migrants and higher rates of anaemia in several migrant groups. Variations among migrant groups were found in other types of morbidity, such as hysterectomies.⁷¹

Immigrants bring their own background, which includes their cultural beliefs and practices related to illness and health. There is a need for additional qualitative research to obtain a better insight into the perceptions of migrant women of the individual, community and health system barriers.⁷²

A systematic review of 228 reports on reproductive health, which selected 51 of acceptable quality for analysis demonstrated a number of neglected issues related to migrant women's reproductive health: menopause, contraceptive counselling, abortion care, HIV and sexually transmitted diseases, infection during pregnancy.⁷³

1.3.3. Women with disabilities

A growing body of evidence suggests that disabled women are at increased risk of domestic abuse⁷⁴. A study on the health impact of disabled women who are victims of violence has summarised the available evidence:

⁶⁶ Fedeli, U, Alba, N, Lisiero, M et al. (2010) Obstetric hospitalisations among Italian women, regular and irregular immigrants in North-Eastern Italy. *Acta Obstetrica et Gynecologica Scandinavica* 89: 1432-1437.

⁶⁷ Geltman, PL, Meyers AF. (1999) Immigration legal status and use of public programs and prenatal care. *Journal of Immigrant Health* 1: 91-97.

⁶⁸ David, M, Pachaly, J, Vetter, K. (2006) Perinatal outcome in Berlin (Germany) among immigrants from Turkey. *Archives of Gynaecology and Obstetrics* 274: 271-278.

⁶⁹ Schutte, JM, Steegers, EA, Schuitemaker, NW et al. (2010) Rise in maternal mortality in the Netherlands *BJOG* 117: 399-406.

⁷⁰ Philibert, M, Deneux-Tharoux, C, Bouvier-Colle, MH. (2008) Can express maternal mortality among women of foreign nationality be explained by suboptimal obstetric care? *BJOG* 115: 1411-1418.

⁷¹ Van den Akker, T, van Roosmalen, J. (2016) Maternal mortality and severe morbidity in a migration perspective. *Best Practice and Research Clinical Obstetrics and Gynaecology* 32: 26-38.

⁷² Almeida, LM, Caldas, J, Ayres-de-Campos, D et al. (2013) Maternal health care in migrants: a systematic review. *Maternal and Child Health Journal* 17: 1346-1354.

⁷³ Gagnon, AJ, Redden, KL. (2016) Reproductive health research of women migrants to Western countries: a systematic review for refining the clinical lens. *Best Practice and Research Clinical Obstetrics* 32:3-14.

⁷⁴ We adopt the definition of domestic abuse as 'the infliction of physical, sexual or mental harm, including coercion or arbitrary deprivation of liberty as in Bradbury-Jones, C, Breckenridge, JP, Devaney, J et al. (2015) Priorities and strategies for improving disabled women's access to

- Between 15 and 71 % of women have experienced physical or sexual violence by their husband or partner, according to a 10-country study on women's health and domestic abuse.
- 22% of all women have experienced physical and/or sexual violence by a partner since the age of 15, according to a 28-country European study.
- Physical and sexual abuse are associated with emotional harm and abused women are almost twice as likely to experience depression than non-abused women.
- An estimated 30% of domestic abuse begins during the perinatal period.⁷⁵

Despite evidence of some progress, disabled women (those with physical disabilities, mental health issues, learning disabilities) generally have poor access to maternity care.⁷⁶ Disabled women who experience domestic abuse face additional barriers to accessing high-quality maternal care.

It is significant that many abused women delay accessing maternal health care (not earlier than the third semester), with obvious risks of complications. Disabled women are more vulnerable to pregnancy-related domestic abuse and it is important to examine how domestic abuse impacts on their accessing maternal health services.⁷⁷

There is a lack of a sufficient number of studies. A systematic review identified only eleven relevant studies and unravelled the barriers to maternity care that women experiencing domestic abuse have faced, such as mental health problems, poor relationships with health professionals and environmental barriers.⁷⁸

Staff has reported a **lack of awareness** of disability and domestic abuse which made them less confident in handling and responding to disclosure appropriately. They have mentioned that much of their knowledge derived from experience, rather than training. Some held rather stereotypical views of abused women. **Fear of disclosure** on the part of users was seen as the most significant barrier to good maternity care, as they are apprehensive of both the stigma attached to abuse and health professionals' misconceptions about disability.

Some **environmental barriers**, included limited freedom from their partners and inability to access services on their own.⁷⁹

1.3.4. Imprisoned women

Prison policies and practices lack gender sensitivity and overlook the different health care needs women have, including reproductive health issues, as well as their frequent status as mothers and carers for their children.⁸⁰

maternity services when they are affected by domestic abuse: a multi-method study using concept maps. *BMC Pregnancy and Childbirth* 15:350.

⁷⁵ Bradbury-Jones, C, Breckenridge, JP, Devaney, J et al. (2015) Priorities and strategies for improving disabled women's access to maternity services when they are affected by domestic abuse: a multi-method study using concept maps. *BMC Pregnancy and Childbirth* 15:350.

⁷⁶ Redshaw, M, Malouf, R, Gao, H, Gray, R (2013) Women with disability: the experience of maternity care during pregnancy, labour and birth and the postnatal period. *BMC Pregnancy and Childbirth* 13: 1-14.

⁷⁷ Bradbury-Jones, C, Breckenridge, JP, Devaney, J et al. (2015) Priorities and strategies for improving disabled women's access to maternity services when they are affected by domestic abuse: a multi-method study using concept maps. *BMC Pregnancy and Childbirth* 15:350.

⁷⁸ Breckenridge, JP, Devaney, J, Kroll, T et al. (2014) Access and utilisation of maternity care for disabled women who experience domestic abuse. *BMC Pregnancy and Childbirth* 14: 234-247.

⁷⁹ Bradbury-Jones, C, Breckenridge, JP, Devaney, J et al. (2015) Priorities and strategies for improving disabled women's access to maternity services when they are affected by domestic abuse: a multi-method study using concept maps. *BMC Pregnancy and Childbirth* 15:350.

⁸⁰ Van den Bergh, BJ, Gatherer, A, Fraser, A, Moller, L. (2011) Imprisonment and women's health: concerns about gender sensitivity, human rights and public health. *Bulletin of the World Health Organisation*. Copenhagen: WHO Regional Office for Europe.

The proportion of women prisoners in 80% of prisons worldwide in 2006 varied from 2% to 9%. Women in prison often come from disadvantaged backgrounds and have histories of violence, physical and sexual abuse. In the UK the prison population has doubled since 1990. The number of imprisoned women has increased more than 200% in England and Wales in the period 2000-2010, compared to 50% increase in male prisoners.⁸¹

There has been inadequate attention to women's needs and neglect of their human rights in prison, something which reflects the societal gender disparities, including in the field of health.⁸² Addressing health in prisons is part of addressing public health more generally, as the WHO Regional Office for Europe has acknowledged in its Health in Prisons Project since 1995 and its Declaration on Women's Health in Prison.⁸³

EU evidence has shown that women are at greater risk than men to enter prison with sexually transmitted diseases such as chlamydia, gonorrhoea, syphilis and HIV/AIDS, due to past high-risk sexual activity, including sex work, or being victims of sexual abuse. They also have specific health issues, not least related to reproductive health, such as menstruation, menopause, pregnancy and breastfeeding.⁸⁴

Health care provision for women in prisons presents variation among countries, but special support services are rare. Reproductive needs are not properly met, hygiene is inadequate, health care and feeding for pregnant women is below the community standard, breastfeeding is not particularly encouraged, while support for victims of sexual abuse is missing.⁸⁵

1.3.5. Roma women

A comprehensive review of access to health services by the Roma population, drawing on three published qualitative studies and seven sources of non-research literature, has found that:

- Romani women encounter barriers to accessing maternity care and they tend to be uninsured.
- When they are able to access care, they are discriminated against on the basis of their ethnicity, economic status, place of residence or language and are mistreated.
- Some health professionals are prejudiced against Romani women.
- There are no published research studies examining the effectiveness of interventions to address discrimination against Romani women and their infants in Europe.⁸⁶

A study of four vulnerable groups, namely migrants, Gypsies and Travellers, homeless people and sex workers has shown that Gypsies and Travellers have the poorest birth outcomes and maternal health,

⁸¹ Ibid.

⁸² Sen, G, Östlin, P, George, A. (2007) *Unequal, unfair, ineffective and inefficient: Gender inequity in health. Why it exists and how we can change it.* Women and Gender Equity Knowledge Network. Geneva: WHO Europe.

⁸³ WHO (2009) *Women's health in prison: Correcting gender equity in prison.* World Health Organisation. Regional Office for Europe.

⁸⁴ Van den Bergh, BJ, Gatherer, A, Fraser, A, Moller, L. (2011) *Imprisonment and women's health: concerns about gender sensitivity, human rights and public health.* *Bulletin of the World Health Organisation.* Copenhagen: WHO Regional Office for Europe.

⁸⁵ Ibid.

⁸⁶ Watson, H, Downe, S. (2017) *Discrimination against childbearing Romani women in maternity care in Europe: a mixed-methods systematic review.* *Reproductive Health* 14:1.

with possibly the highest maternal death rate among all ethnic groups and suggested collection of better data and monitoring for this group.⁸⁷

It becomes evident from the above facts that there are clear disparities in maternal health outcomes for women in vulnerable social groups, attributed to lack of or inadequate provision of health and reproductive care, which is in conflict with the universal right to maternal care. The next chapter focuses on the existing legislation on global, European and national levels which should constitute the basis of entitlements to SRH care services.

⁸⁷ Aspinall, P.J. (2014) *Hidden needs. Identifying key vulnerable groups in data collections: vulnerable migrants, gypsies and travellers, homeless people, and sex workers*. Brighton: Centre for Health Services Studies, University of Kent.

2. ENTITLEMENTS TO MATERNAL HEALTH SERVICES ON INTERNATIONAL AND EU LEVELS

KEY FINDINGS

- Health as a universal human right, regardless of background and status, is a key feature of global health policy, as expressed in the UN Sustainable Development Goals and related actions. It includes women's and children's health and the aim is to guarantee maternal health.
- The EU has also subscribed to achieving universal health coverage through access to essential health services, including maternal health. A number of health programmes and actions seek to create health capacities to meet the needs of diverse populations (including migrants and ethnic minorities) in non-discriminatory ways.
- Member States and their welfare systems still retain the authority of implementation of a rights-based approach to universal health provision. The variety of social protection across national contexts, particularly for vulnerable groups, and the waves of migrant influx pose big challenges in organising care for all, not least for vulnerable women.

2.1. The Global Context

The legislation stipulated under International Human Rights Law (IHRL), the International Covenant on Economic, Social and Cultural Rights (ICESCR) and Article 12,⁸⁸ in particular, can be used to argue undocumented migrants' rights to preventive health care, which includes four essential indicators: the right to education and information on health, immunisation, regular screening programmes and the promotion of the underlying determinants of health, i.e. socio-economic factors which are behind the causes of diseases. These comprise access to housing, potable water, sanitation, safe food, environmental safety, occupational health and education and information on health issues, including sexual and reproductive health. All EU Member States have signed the ICESCR and this guarantees the 'right to the highest attainable state of health'.⁸⁹ As a result, IHRL comes to remedy the gap in certain national legislations by not denying access to health to any member of the most vulnerable social groups. However, some authors have argued that there is an inherent paradox in the rationale of IHRL, namely that rights are conferred on persons, as human beings, who enjoy some degree of membership in the nation-state.⁹⁰ This immediately excludes undocumented migrants.

The UN Committee on Economic, Social and Cultural Rights (CESCR), issued in 2000 an explanation of the Article 12.1 on the right to health of the International Covenant on Economic, Social and Cultural Rights (ICESCR). According to it, governments have legal obligations to ensure that 'health facilities, goods and services are accessible to all, especially the most vulnerable of marginalised sections of the population, in law and in fact, without discrimination on any of the prohibited grounds',⁹¹ which include race, colour, sex, language, religion, political or other opinion, national or social origin,

⁸⁸ UN CESCR (2000) *General comment No14. The right to the highest attainable standard of health*. United Nations Doc E/C12/2000/4.

⁸⁹ Flegar, V, Dalll, M, Toebes, B. (2016) Access to Preventive Health Care for Undocumented Migrants: A Comparative Study of Germany, the Netherlands and Spain from a Human Rights Perspective, in: *Laws 5* (2016), 9.

⁹⁰ *Ibid.*

⁹¹ UN CESCR (2000) *General comment No14. The right to the highest attainable standard of health*. United Nations Doc E/C12/2000/4.

property, birth, physical/mental disability, health status, sexual orientation and civil/political/social status. In addition, the CESCR specifies that states should not deny or limit equal access to anyone (including asylum seekers and illegal immigrants) when it comes to preventive, curative, and rehabilitative health services. All 27 EU Member States ratified the 'International Bill of Human Rights', which includes the ICESCR.⁹² Universal health coverage also entails the removal of user fees for health care at the point of use. Sexual and reproductive health are at the forefront of the universal health coverage agenda, with 179 nations committed to protecting reproductive and health rights of girls and women at the International Conference on Population and Development (ICPD) in Cairo in 1994.⁹³

On the global stage, **two trends** can be discerned that both present opportunities and pose challenges for maternal health. Firstly, after the transition from the Millennium Goals (which expired in 2015) to the **Sustainable Development Goals**; maternal health has moved from being a standalone goal to being part of the bigger goals of ensuring health and wellbeing for all at all ages. Secondly, the **fragmentation of governance and financing** for maternal health into a number of complementary plans for the newborn, family planning and nutrition.⁹⁴ Universal health coverage is included in the Sustainable Development Goals as a principle that ensures that people obtain essential health services without incurring financial burdens and suffering hardship as a result. However, this is not an automatic process; it rather requires political will and civil society advocacy.⁹⁵

A human rights-based approach to health is a key feature of emerging global health policy and includes the Sustainable Development Goals and the Global Strategy for Women's and Children's Health. The UN Secretary-General's Global Strategy for Women's, Children's and Adolescents' Health (2016–2030), launched in September 2015, is a plan aiming at ending preventable deaths and improving the health and well-being of women, children, and adolescents globally by 2030.⁹⁶ It was produced through a consultation with 7,000 organisations and its goals are:

- to end preventable maternal, newborn, child and adolescent deaths and stillbirths
- to ensure at least a 10-fold return on investments in the health and nutrition of women, children and adolescents through better educational attainments, workforce participation and social contributions
- to ensure at least US\$100 billion in demographic dividends from investments in early childhood and adolescent health and development
- to give all women, children and adolescents an equal chance to survive and thrive.⁹⁷

Increasing international attention is paid to migrant health, as shown by the Council of Europe 2007 Bratislava Declaration on Health, Human Rights and Migration and the 2008 World Health Assembly resolution on the Health of Migrants⁹⁸ which urged governments to design policies that will respond to the migrants' needs and the diversity of the population.⁹⁹ The 2016 New York Declaration for

⁹² Keygnaert, I, Guieu, A, Ooms, G et al. (2013) Sexual and reproductive health of migrants: does the EU care? *Health Policy* 114: 215-225.

⁹³ McPake, B, Witter, S, Ensor, T et al. (2013) Removing financial barriers to access reproductive, maternal and newborn health services: the challenges and policy implications for human resources for health. *Human Resources for Health* 11:46.

⁹⁴ Kruk, ME, Kujawski, S et al. (2016) Next generation maternal health: external shocks and health-system innovations *Lancet* 388: 2296-2306.

⁹⁵ Ibid.

⁹⁶ United Nations (2015) *The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030)*. New York: Every Woman Every Child.

⁹⁷ Ibid.

⁹⁸ Mladovsky, P, Rechel, B, Ingleby, D, McKee, M. (2012) Responding to diversity: an exploratory study of migrant health policies in Europe. *Health Policy* 105:1-9.

⁹⁹ World Health Assembly (2008) Health of migrants. Executive Health Resolution. World Health Assembly. Geneva.

Refugees and Migrants also makes a number of references to health issues, in agreement with the EU Member States.¹⁰⁰

The Global Strategy intends to address the needs of the population regarding sexual, reproductive, maternal and newborns' health (SRMNH). This requires better data collection and mutual accountability from all stakeholders (and led to the creation of the Expert Review Group for Women's and Children's Health); life-saving commodities and delivery strategies (remit of the Commission on Life-Saving Commodities) and health, social and economic benefits assessment (related to the Global Investment Framework for Women's and Children's Health).

A human rights approach is particularly useful to argue for health care entitlements of vulnerable social groups in many ways: as an evaluation tool of state practices which goes beyond the interpretation of national law, as an advocacy framework which leads to state accountability for lack of protection and finally as a moral principle which permits a broader protection of the more marginalised segments of the population.¹⁰¹

2.2. European legislation and initiatives

The EU has an obligation to safeguard human health according to the Article 168 of the Treaty on the Functioning of the European Union (TFEU) and Article 35 of its Charter of Fundamental Rights in 2000. However, Article 35 states that 'everyone has the right to access preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices'.¹⁰² This allows for national modification of the right to health. However, Member States should not discriminate based on national origin, migration, or residence status.¹⁰³ The Right to Health is not limited to health care but also includes the conditions for a healthy life, such as food, access to safe water, housing and a safe and healthy working environment.¹⁰⁴

The EU has dealt with the issues of health inequalities in the first and second Health Programmes, including those involving 'vulnerable groups'.¹⁰⁵ These included migrants and ethnic minorities, as well as certain other high-risk social groups, such as sex workers and people who use drugs. During the Portuguese and Spanish Presidencies, migrant health was given high priority. Recommendations and pledges by governments and other stakeholders were put forward and led to relevant Council conclusions in 2007 and 2010. In the same year, WHO produced a report in consultation with IOM on improving migrant health as a collaborative and inter-sectoral effort between multiple stakeholders (governments, academics, civil society).¹⁰⁶

¹⁰⁰ PICUM (2017) *Framing document*. EU Health Policy Platform. Thematic network on "Migration and Health". Platform for International Cooperation on Undocumented Migrants.

¹⁰¹ Flegar, V, Dallí, M, Toebes, B. (2016) Access to Preventive Health Care for Undocumented Migrants: A Comparative Study of Germany, the Netherlands and Spain from a Human Rights Perspective, in: *Laws 5* (2016), 9.

¹⁰² European Parliament. (2000). *Charter of fundamental rights of the European Union*. Luxembourg: Office for Official Publications of the European Communities.

¹⁰³ PICUM (2017) *Framing document*. EU Health Policy Platform. Thematic network on "Migration and Health". Platform for International Cooperation on Undocumented Migrants.

¹⁰⁴ Ibid.

¹⁰⁵ CHAFAE (2014) *Action on health inequalities in the European Union. The EU Health Programme's contribution to fostering solidarity in health and reducing health inequalities in the European Union 2003–13*. Luxembourg: Consumers, Health and Food Executive Agency.

¹⁰⁶ WHO (2010) *Health of migrants – the way forward. Report of a global consultation*. Madrid.

The EU has also subscribed to the UN Sustainable Development Goals, specifically Goal 3.8, which aims at 'achieving universal health coverage, including risk protecting, access to quality essential health care services and access to safe effective, quality and affordable essential medicines and vaccines for all'.¹⁰⁷

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The WHO Regional Office for Europe established the Public Health Aspects of Migration in Europe (PHAME) project in 2012 with the financial support of the Ministry of Health of Italy. This was subsequently developed into a programme to strengthen health capacities and thereby meet the health needs of mixed populations of refugees and migrants through timely, quality and migrant-sensitive health policies. Its aims are to:

- provide ad hoc technical assistance to Member States of the WHO European Region
- strengthen health information and available evidence
- promote advocacy and sharing of information among Member States and partners
- support migration-sensitive health policy development.¹⁰⁹

In February 2013, the European Commission issued the Communication Social Investment Package recognising the role of the health care system in enabling the inclusive growth objectives in the Europe 2020 Strategy.

In the third Health Programme (2014-2020), 'reducing health inequalities' is a general, rather than specific, objective, and several projects have focused on migrants.¹¹⁰

In 2016 the WHO regional office in Europe adopted (with agreement by its Member States) a strategy and action plan for the health of refugees and migrants in Europe and made explicit the commitment of the Member States to universality, solidarity and equal access in the organisation of their health systems.

The European Institute for Gender Equality (EIGE) recognises health as an area of significant inequalities between men and women in the EU. Drawing on the Beijing Platform for Action, it outlines the following strategic objectives:

- to increase women's access, throughout their lifecycle, to appropriate, affordable and quality healthcare, information and related services
- to strengthen preventive programmes that promote women's health
- to undertake gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS, and sexual and reproductive health issues

¹⁰⁷ <https://www.who.int/sdg/targets/en/>

¹⁰⁸ <https://www.who.int/sdg/targets/en/>

¹⁰⁹ Keygnaert I, Ivanova, O, Guieu A, et al. (2016) *What is the evidence on the reduction of inequalities in accessibility and quality of maternal health care delivery for migrants? A review of the existing evidence in the WHO European Region*. Health Evidence Network synthesis report 45. Copenhagen: WHO Regional Office for Europe.

¹¹⁰ WHO (2010) *Health of migrants – the way forward. Report of a global consultation*. Madrid.

- to promote research and disseminate information on women's health
- to increase resources and monitor follow-up for women's health.¹¹¹

The EU migration policy includes the 'Common European Asylum System', various migration programmes and agreements and partnerships with neighbouring countries.¹¹²

The European Commission has used relevant directives to enforce standards of health care entitlements for EU migrants (Directive on Cross-border Healthcare)¹¹³, refugees (Qualification Directive)¹¹⁴ and asylum seekers (Reception Conditions Directive)¹¹⁵. However, entitlements for documented or undocumented third-country nationals are not regulated and cannot be enforced. This can possibly be counteracted by EU anti-discrimination legislation, such as the Race Equality Directive, adopted in 2000, which prohibits discrimination on grounds of race and ethnic origin, and covers the area of health care.¹¹⁶

The legal and policy documents governing migration do not ensure a rights-based approach of sexual and reproductive health for migrants. While there is an international recognition of specific migrants' needs, at the national and subnational levels, there are measures that restrict their right to health and diverse strategies to address the paradox between serving human rights principles and controlling migrant flows.¹¹⁷

In 2010 only five out of the 27 EU Member States (France, Italy, the Netherlands, Portugal and Spain) gave undocumented migrants access to virtually the same services as the native population.¹¹⁸

Additionally, the application of a rights-based approach is superseded by national welfare systems, which are traditionally based on citizenship and universality. Some co-ordination between the two exists, for example in the case of HIV transmission, which however has 'migrants as health threats' undertones.¹¹⁹

More generally, applying the 'health in all policies' principle to the social and environmental determinants of migrant health and health inequalities is a 'soft' way of influencing policies of Member States. Arguably, more work needs to be done in that direction, as, for instance, the adoption by the EU of the Pillar of Social Rights has hitherto failed to address the cases of migrants in an irregular situation. Interestingly, the EU Agency for Fundamental Rights (FRA) has conducted studies showing also the financial impact on health systems from excluding irregular situation migrants.¹²⁰

¹¹¹ Available at <https://eige.europa.eu/gender-mainstreaming/policy-areas/health>.

¹¹² Keygnaert, I, Guieu, A, Ooms, G et al. (2013) Sexual and reproductive health of migrants: does the EU care? *Health Policy* 114: 215-225.

¹¹³ Directive 2011/24/EU

¹¹⁴ Directive 2011/95/EU

¹¹⁵ Council Directive 2003/9/EC

¹¹⁶ http://europa.eu/rapid/press-release_MEMO-07-257_en.htm?locale=en.

¹¹⁷ Keygnaert, I, Guieu, A, Ooms, G et al. (2013) Sexual and reproductive health of migrants: does the EU care? *Health Policy* 114: 215-225.

¹¹⁸ Mladovsky, P, Rechel, B, Ingleby, D, McKee, M. (2012) Responding to diversity: an exploratory study of migrant health policies in Europe. *Health Policy* 105:1-9.

¹¹⁹ Keygnaert, I, Guieu, A, Ooms, G et al. (2013) Sexual and reproductive health of migrants: does the EU care? *Health Policy* 114: 215-225.

¹²⁰ FRA (2015) *Cost of exclusion from healthcare: the case of migrants in an irregular situation*.

2.3. A view of maternal care services in EU Member States

Access to sexual and reproductive health care of undocumented migrants and other vulnerable social groups varies considerably between Member States. The type of national health systems (insurance-based or universal coverage) plays a crucial role. Moreover, legislation and policies must be viewed in their interrelation and complementarity, so that policy gaps are filled and access of women who belong to these categories can be facilitated and inequalities can be reduced. This endeavour involves organisations, services of health and social care, attitudes, and beliefs. In this section reference to some systems will be made to give an idea of the situation. While the list cannot be considered exhaustive, a conscious attempt has been made to include information from as many Member States as possible.

Germany's health system is insurance-based. All women who have the right to live in the country, including asylum seekers who have been resident for 15 months, have access to maternal care, screening, midwifery services and curative measures. This excludes undocumented migrants. There is a way for health care providers to be reimbursed by the Social Security Office for treating undocumented migrants but the latter is under the obligation to report them to the Immigration Office. In practice this deters undocumented migrants or other vulnerable women from accessing services out of fear of deportation or social stigma.¹²¹

The Netherlands also has a health system in which there is a single and compulsory insurance scheme. Private insurers compete and the government only safeguards and controls the quality of services. Since 1998 access to health care services depends on the administrative status of people, so undocumented migrants are excluded from services which do not fall into the category of 'necessary care'. Public health has been the joint responsibility of the government and the local authorities since 2008, when the Public Health Act was introduced to implement the WHO International Health Regulations. The contribution of NGOs in the Netherlands in offering information and liaising with health care providers to ensure access of undocumented migrants to services is crucial. HIV and hepatitis screening and treatments are free to all and the same applies to prenatal screening.¹²²

Spain's health system used to offer universal coverage financed by general taxation to natives and migrants who had registered with local authorities. Everything changed in 2012 with the Royal Decree Law 16/2012 which restricted coverage only to those who were insured and their dependants. The universal right to health care and the need for services to address diversity (over 12% of Spain's population are foreigners) are dispersed in policy and legal documents, inequalities exist and there is a degree of vagueness and differences between the regions, with Andalusia and Catalonia making efforts to become more inclusive¹²³. Nationals, EU citizens and documented migrants whose annual income is below 100,000 Euros are considered 'insured'. However, health care services for children under 18, pre- and postnatal care and emergency care are offered to all. In theory there is the possibility for undocumented migrants to be entitled to the full health care package, if they pay monthly, which in practice renders coverage impossible for the vast majority of them.¹²⁴ Doctors of the World and other NGOs offer information, psychological and social care but there is a limit to what they can achieve, as it is the law which presents numerous irregularities.

¹²¹ Flegar, V, Dallí, M, Toebes, B. (2016): Access to Preventive Health Care for Undocumented Migrants: A Comparative Study of Germany, the Netherlands and Spain from a Human Rights Perspective, in: *Laws 5* (2016), 9.

¹²² Ibid.

¹²³ Vázquez, M.L, Terraza-Núñez, R, S-Hernández, S et al. (2013) Are migrants' health policies aimed at improving access to quality healthcare? An analysis of Spanish policies. *Health Policy* 113: 236-246.

¹²⁴ Flegar, V, Dallí, M, Toebes, B. (2016): Access to Preventive Health Care for Undocumented Migrants: A Comparative Study of Germany, the Netherlands and Spain from a Human Rights Perspective, in: *Laws 5* (2016), 9.

Research in the **UK** also pinpoints that health outcomes are differentiated due to cultural inequalities. In 2012-14 the risk of maternal death was much higher for black and minority ethnic background women compared to white women. The stillbirth rate for white women in the UK was 4.5, while for black women 9.2 and for Asian 7 (per 1,000 maternities).¹²⁵ Some of these differences can be explained by the different medical profiles of the various ethnic groups; for example, the prevalence of endometrial cancer among black and South-Asian women.¹²⁶

In **Latvia**, all women are entitled to maternity services free of charge in shared rooms with out-of-pocket payments only for extra screening or comfort costs (i.e. private room). Only 18 out of the 70 hospitals in a country with a population of 2 million people have maternity units and there are considerable disparities between rural and urban areas.¹²⁷ The system is highly medicalised and run by obstetricians/gynaecologists. However, there is out-of-pocket co-payment of 75% for medication and a very strong private sector. Women who choose a doctor in the private sector must deliver in a private maternity hospital.

In **Poland**, social health insurance coverage is 98% with a comprehensive package of benefits. Maternity health care is free but anaesthesia and epidurals are paid out-of-pocket.¹²⁸ Poland is a good example in terms of the anti-corruption measures introduced during the transition period, which have improved the situation and made it the least corrupted system among the former communist countries. Historical and cultural issues together with the desire to join the EU drove such initiatives¹²⁹.

In **Lithuania**, the vast majority of the population is covered by the health insurance system which is based on the contributions of the economically active section of the population. There are charges for non-vital health care services for non-residents, uninsured or users non-registered with a general practitioner. Before joining the EU, a rationalisation of services took place and transparency and anti-corruption measures were taken.¹³⁰

Both Poland and Lithuania have improved considerably primary care services and reduced informal payments. None the less, recent research shows that 7% of Poles and 20% of Lithuanians still pay informally.¹³¹ Although attitudes have changed, respondents see the perpetuation of such practices as related to the very low pay of health professionals with gynaecology, surgery and dentistry attracting the most informal payments. A salary increase is not the only solution, as proven in the case of Lithuania to curb informal payments. It must be coupled with performance-related pay mechanisms.

Roma women in **Bulgaria** and other non-EU countries in the Balkan region do not have health professionals in their settlements, which makes availability an issue, but still the main challenges in the Central and Eastern European countries remain affordability and approachability. Roma women must

¹²⁵ Walker, KF, Gribbin, C, Siddiqui, F (2018) Cultural aspects of care in obstetrics and gynaecology. *Obstetrics Gynaecology and Reproductive Medicine* 28:11-12.

¹²⁶ Ibid.

¹²⁷ Miteniece, E, Pavlova, M, Rechel, B et al. (2019) Barriers to accessing adequate maternal care in Latvia: A mixed method study among women, providers and decision-makers. *Health Policy* 123:87-95.

¹²⁸ Miteniece, E, Pavlova, M, Rechel, B et al. (2019) Barriers to accessing adequate maternal care in Latvia: A mixed method study among women, providers and decision-makers. *Health Policy* 123:87-95.

¹²⁹ Stepurko, T, Pavlova, M, Gryga, I, Murauskiene, L, Groot, W (2015) Informal payments for healthcare services: The cases of Lithuania, Poland and Ukraine. *Journal of Eurasian Studies* 6:46-58.

¹³⁰ Ibid.

¹³¹ Ibid.p.53.

bring their consumables to maternity hospitals and have to give birth in rooms with poor conditions, called 'Gipsy rooms'.¹³²

Discrimination on the basis of ethnicity, legal or socio-economic status leads to vulnerable women's reluctance to access services. Research shows substantial underutilisation of prenatal services in **Romania** by women with such demographic profiles.¹³³

Similar findings in **Portugal** show that vulnerable women have higher rates of unintended pregnancies, pregnancy complications or miscarriages.¹³⁴ However, such data are not systematic and not particularly generalizable.

Some evidence demonstrates that the use of antenatal care is lower among migrant women. Foreign-born single women and women from Eastern Europe and Mediterranean countries appear as not having access to adequate antenatal services in various European health care systems, while the quality of antenatal care received by those who make use of the existing services is very low.¹³⁵ Norredam et al. provide evidence that migrants were less likely to access cervical screening and mammography services.¹³⁶

¹³² Miteniece, E, Pavlova, M, Rechel, B, and Groot, V. (2017) Barriers to accessing adequate maternal care in Central and Eastern European countries: A systematic literature review. *Social Science and Medicine* 17:1-8.

¹³³ Ibid.

¹³⁴ De Vito, E, de Waure, C, Specchia, ML, Ricciardi, W. (2015) *Public health aspects of migrant health: a review of the evidence on health status for undocumented migrants in the European Region*. Health Evidence Network synthesis report 42. Copenhagen: WHO Regional Office for Europe.

¹³⁵ Rechel, B, Mladovsky, P, Ingleby, D, Mackenbach, JP, McKee, M (2013) Migration and health in an increasingly diverse Europe. *Lancet* 381: 1235-45.

¹³⁶ Norredam, M, Nielsen, SS, Krasnik, A. (2010) Migrants' utilisation of somatic health care services in Europe – a systematic review. *European Journal of Public Health* 20: 555-563.

3. BARRIERS TO ACCESS

KEY FINDINGS

- Maternal health provision is affected by social determinants and the health system, which interacts with the profiles of vulnerable women to perpetuate inequalities.
- Availability of services, the extent of health care coverage, the need for health care insurance and the demand for out-of-pocket payment affect accessibility for vulnerable groups.
- The vulnerability of migrants and other groups is enhanced by means of other barriers, such as legal status, economic obstacles, language and cultural issues, as well as attitudes of health service providers.

It has become clear that vulnerable women have worse birth outcomes in comparison with the general population and are faced with obstacles that prevent access to health care. These barriers can be institutional, namely the legal frameworks governing the rights of refugees and asylum seekers and the ways in which migration processes are managed, together with the inadequate guidance on entitlements.¹³⁷ Moreover, organisational obstacles, such as the way services are provided in terms of accessibility and availability, training of health professionals to deal with diversity, culture, religion and attitudes of professionals and users are contributory factors. Obstacles to migrants' accessing health care also include discrimination by health care providers on the basis of gender, race and ethnicity, as well as moral attitudes on sex work in the case of migrant sex workers and cost.¹³⁸

There is a discrepancy between the stated principle of health care as a human right and the de facto obstacles confronting migrants and other vulnerable social groups when it comes to their SRH. Additionally, there is uncertainty regarding entitlements of migrants which makes health professionals indecisive as to the level of services they should provide. Strategies that do address migrant health, are limited to perinatal care and HIV screening, leaving out other areas of SRH.¹³⁹

Undocumented migrants, in particular, face significant barriers to accessing health care due to their legal status.¹⁴⁰ They only do so, if they feel severely ill, as their main concern is to survive.¹⁴¹ Their original conditions have in many cases shaped a vulnerable health profile, with sexual, reproductive, maternal and child problems. Moreover, they often lack information about their entitlements and frequently avoid access out of fear of the consequences of being discovered.¹⁴²

The numerous barriers to access can be active or passive. Active are those which directly deny access to maternal health care, for instance asking users to pay for services or deny them care despite their

¹³⁷ Bradby H, Humphris R, Newall D, Phillimore J. (2015) Public health aspects of migrant health: a review of the evidence on health status for refugees and asylum seekers in the European Region. Health Evidence Network synthesis report 44. Copenhagen: WHO Regional Office for Europe.

¹³⁸ Keygnaert, I, Guieu, A, Ooms, G et al. (2013) Sexual and reproductive health of migrants: does the EU care? *Health Policy* 114: 215-225.

¹³⁹ Ibid.

¹⁴⁰ De Vito, E, de Waure, C, Specchia, ML, Ricciardi, W. (2015) *Public health aspects of migrant health: a review of the evidence on health status for undocumented migrants in the European Region*. Health Evidence Network synthesis report 42. Copenhagen: WHO Regional Office for Europe.

¹⁴¹ Flegar, V, Dallí, M, Toebes, B. (2016) Access to Preventive Health Care for Undocumented Migrants: A Comparative Study of Germany, the Netherlands and Spain from a Human Rights Perspective, in: *Laws* 5 (2016), 9.

¹⁴² De Vito, E et al (2016) Are undocumented migrants' entitlements and barriers to healthcare a public health challenge for the European Union? *Public Health Reviews* 37:13.

entitlement to it. Passive barriers can be expressed through omission of obligations on the part of providers, for instance lack of information regarding users' rights, which leads to underutilisation of services.¹⁴³

A recent survey of 14,000 women refugees carried out by Doctors of the World in Greece from May 2016 to September 2017 has revealed the significant challenges refugee and migrant women across Europe face in accessing maternal healthcare. In addition, it has demonstrated that providing equal access to quality care for refugees (as opposed to only emergency care) will have a positive impact on national health care systems in Europe in the long-term.¹⁴⁴

3.1. The '5As Framework': Approachability, Acceptability, Availability, Affordability, Appropriateness

A very useful framework to analyse access to health care services is what will be called for the purpose of brevity, the '5 As' framework, comprising five dimensions: approachability, acceptability, availability, affordability and appropriateness¹⁴⁵ in supply and demand for services, as well as the five dimensions of abilities on the side of users: ability to perceive; ability to seek; ability to reach; ability to pay; and ability to engage. This framework is deployed in this study, as it encompasses most issues and helps to categorise the plethora of barriers.

Approachability denotes communication and attitudes of providers, information available and transparency. Information about entitlements and use of maternal health care may be available to the public and accessible. However, vulnerable pregnant women are not aware or knowledgeable about the use of such services, with undocumented migrants and the poor/homeless much less exposed to information.

Acceptability refers to the sphere of culture and tradition, acceptance of maternal health care, gender norms, personal values and health literacy. It also reflects the readiness of users to demand the available care services. There is evidence that the EU28 performs inadequately with respect to the cultural sensitivity of maternal health care, while vulnerable pregnant women are asked for identification to access health services. In countries with a strong private sector in maternity care, there is the assumption that lower-paid public sector health professionals' attitudes, attention and communication during childbirth are not as good as those of their counterparts in the private sector. Women feel more secure when, for instance, they hire midwives privately to be present during labour.¹⁴⁶

Availability refers to the existence of services, their geographic distribution, health care professionals' numbers and specialties, the range of services and more administrative elements such as waiting lists and opening hours. The existing evidence is inconclusive, e.g. with regard to suitability and waiting times for antenatal appointments for vulnerable pregnant women.

¹⁴³ Kvamme, E and Ytrehus, S, (2015) Barriers to health care among undocumented migrant women in Norway. *Society, Health & Vulnerability*. 6(1):28668.

¹⁴⁴ <https://mdmgreece.gr/en/equal-access-vital-maternal-healthcare-vulnerable-refugee-women-across-europe-remains-challenge/>

¹⁴⁵ Levesque J, Harris MF, Russell G. (2013) Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *Int J Equity Health* 12:18.

¹⁴⁶ Miteniece, E, Pavlova, M, Rechel, B et al. (2019) Barriers to accessing adequate maternal care in Latvia: A mixed method study among women, providers and decision-makers. *Health Policy* 123:87-95.

By **affordability**, issues of costs to users are described, whether those are formal or informal, direct or indirect. Although some vulnerable pregnant women are covered by certain health care systems, vulnerable undocumented pregnant women are in a less secure financial situation and are required to pay in many EU regions. High maternal mortality rates seem to go along with a lack of financial means for young women. Bureaucratic barriers endemic in the national social insurance systems, which often require refugees to pay a fee, are a significant disincentive for receiving health care.¹⁴⁷ The disparity between salaries of health professionals in the public and private sector is one of the reasons which drive professionals to the private sector. As a result, women of undocumented status and those with limited or no financial means are affected disproportionately¹⁴⁸. Informal payments to doctors is a 'plague' in several Member States and very hard to monitor or regulate. Their cost to women is hard to estimate.

Finally, **appropriateness** includes the availability of equipment, infrastructure and skills of professionals, in other words what services are offered and how. A national standard has been recommended that governments should adhere to in relation to the provision of SRH services to vulnerable pregnant women.¹⁴⁹ Proper information on medical history can be a concern for some women, especially migrants, who lack the education or language skills to communicate this to health professionals¹⁵⁰.

The most common barriers and examples from different Member States are presented in categories and discussed in the next section.

3.2. Categories of barriers

3.2.1. Language and communication with health professionals

Unlike previous waves of migration which were much more homogeneous, currently migrants come from many different countries and speak many different languages. This makes provision of interpreters and planning of such services particularly difficult, particularly when knowledge of medical terminology is required, as research¹⁵¹ has shown.

The EASO Annual Report highlights various problems in terms of access of refugees in the receiving countries. France, Poland, Malta and Italy, for example, have reported insufficient interpretation services, non-standard operating procedures, a lack of qualified staff for the identification and treatment of vulnerabilities. Cyprus and Greece have highlighted some administrative matters related to the issuance of the relevant certificates at local hospitals on the islands (Greece).¹⁵²

A study of pregnant asylum-seeking and refugee women in Ireland demonstrated inadequate antenatal care to which they were entitled, due to factors such as lack of language support, transport

¹⁴⁷ Bradby H, Humphris R, Newall D, Phillimore J. (2015) Public health aspects of migrant health: a review of the evidence on health status for refugees and asylum seekers in the European Region. Health Evidence Network synthesis report 44. Copenhagen: WHO Regional Office for Europe.

¹⁴⁸ Miteniece, E, Pavlova, M, Rechel, B et al. (2019) Barriers to accessing adequate maternal care in Latvia: A mixed method study among women, providers and decision-makers. *Health Policy* 123:87-95.

¹⁴⁹ WPL (2018) *Improving maternal healthcare for vulnerable women in EU28. What can you do?* Women Political Leaders Global Forum.

¹⁵⁰ Miteniece, E, Pavlova, M, Rechel, B et al. (2019) Barriers to accessing adequate maternal care in Latvia: A mixed method study among women, providers and decision-makers. *Health Policy* 123:87-95.

¹⁵¹ Phillimore, J, (2015) Delivering maternity services in an era of superdiversity: the challenges of novelty and newness. *Ethnic and Racial Studies*, 38:4.

¹⁵² EASO (2018) *Annual report on the situation of asylum in the European Union 2017*. Luxembourg: European Asylum Support Office.

difficulties, childcare problems, as well as poor health, exhaustion and stress.¹⁵³

Likewise, in the 2002-2005 Confidential Enquiry into maternal deaths in the UK, 10 out of 14 recently arrived women who died were classified as refugees or asylum seekers: more than half of them could not speak English and were not supported by interpreting and translation services. It is generally found that the needs of such categories for language support is often underestimated.¹⁵⁴

A study of 40 asylum seekers with severe acute maternal morbidity in the Netherlands demonstrated communication barriers for 90% of them. Other studies in the Netherlands and Canada reported that the complaints of the women were not taken into proper consideration.¹⁵⁵

Information material is available usually in the languages of the most established migrant communities. In its absence, research has shown that women skip antenatal classes, miss medical appointments and do not receive necessary nutritional and prenatal information. The lack of permanent address in some cases aggravates the situation.¹⁵⁶

Another dimension worth noting is the use of appropriate terms by health, local and national authorities which calls for abandoning terms such as 'illegal' to characterise migrants, as this makes them feel undeserving.¹⁵⁷ Language is a mechanism for stigmatising, either deliberately or accidentally.¹⁵⁸

3.2.2. Health professionals' lack of experience in dealing with 'difference'

Literature highlights a clear deficit when it comes to the ability of health professionals to deal with difference. Often health professionals see migrant women as responsible for missed appointments and delays, stereotype them as 'a problem'. They treat them according to their previous experiences with representatives of their ethnic groups, often making estimates in relation to issues such as pain threshold or time in labour, while ignoring their actual problems and needs.¹⁵⁹

Health professionals report lack of support by the state, when it comes to dealing with the needs of women who have for instance undergone genital mutilation and the appropriate antenatal care those women must receive.

From the point of view of users, what becomes evident from the few studies on migrant women's needs in relation to access to maternity services is that women feel intimidated or ashamed about being different, miss the support of their female network and lack the confidence to express their fears and

¹⁵³ Kennedy, P, Murphy-Lawless, J. (2003) The maternity care needs of refugee and asylum seeking women in Ireland. *Feminist Review* 73: 39-53.

¹⁵⁴ Walker, KF, Gribbin, C, Siddiqui, F (2018) Cultural aspects of care in obstetrics and gynaecology. *Obstetrics Gynaecology and Reproductive Medicine* 28:11-12.

¹⁵⁵ Van den Akker, T, van Roosmalen, J. (2016) Maternal mortality and severe morbidity in a migration perspective. *Best Practice and Research Clinical Obstetrics and Gynaecology* 32: 26-38.

¹⁵⁶ Vázquez ML, Vargas I, Jaramillo DL, Porthé V, et al. (2016) Was access to health care easy for immigrants in Spain? The perspectives of health personnel in Catalonia and Andalusia. *Health Policy*. 2016;120(4):396-405; Balaam, M.C, Akerjordet, K, Lyberg, A, Kaiser, B. et al (2013) A qualitative review of migrant women's perception of their needs and experiences related to pregnancy and childbirth. *Journal of Advanced Nursing* 69(9): 1919-1930.

¹⁵⁷ Kvamme, E, and Ytrehus, S, (2015) Barriers to health care among undocumented migrant women in Norway. *Society, Health & Vulnerability*. 2015;6(1):28668.

¹⁵⁸ Cook, R and Dickens, BM. (2014) Reducing stigma in reproductive health. *International Journal of Gynecology and Obstetrics* 125(1): 89-92.

¹⁵⁹ Phillimore, J, (2015) Delivering maternity services in an era of superdiversity: the challenges of novelty and newness. *Ethnic and Racial Studies* 38:4, 568-582.

concerns about discrimination, isolation and difficulties in adapting to a new and harsh reality. These impediments are enhanced by common mental health issues such as depression, which are aggravated by pregnancy and their precarious living conditions.¹⁶⁰

Women and health professionals have to overcome the barriers of lack of familiarity with each other's experiences when it comes to health provision. Health systems and needs vary from country to country. The training of health professionals is required to enable them to provide services efficiently. From the point of view of care recipients, access to information in their language and to interpreters is vital for them to be able to understand their entitlements and treatments.

3.2.3. Structural inequalities

Even though in many countries maternity care is free, there are co-payments which women of vulnerable social groups cannot afford. These may be legal or illegal, as in some cases legislation is vague, but they aggravate social inequalities.¹⁶¹

'Envelope payments', 'under-the-table payments', 'gratitude money' are all referring to informal payments to health care professionals, endemic in countries of Eastern and Southern Europe (Greece). This culture deepens existing inequalities and particularly affects maternity services users.¹⁶² Blaming professionals for unethical behaviour is the obvious reaction but it hides chronic underfunding of services and low remuneration of health providers. Such practices seriously undermine the effectiveness of health care delivery, as the cost deters the financially weaker women from seeking care and also allows medical professionals to choose whom to give priority to. Low-income women are disproportionately affected when they need sexual or reproductive care. Maternal care is particularly susceptible to informal payments.¹⁶³

Tax-based universal coverage health systems can more easily accommodate migrant health care than insurance-based ones. Still, most of the EU countries with the latter type of health system have created statutory mechanisms that link entitlement with residence status, regardless of the ability to pay contributions, in effect providing coverage only to migrants with a permanent residence status.¹⁶⁴

User fees are often quoted as one of the main obstacles that women seeking maternal care are faced with. Policies for universal health coverage will increase utilisation and this poses the question of how to ensure quality provision under conditions of increased utilisation, i.e. how to balance demand with supply. Evidence from low- and middle-income countries has shown that fee removal policies have increased the workload for staff, have led to less smooth functioning of hospitals and contributed to staff layoffs.¹⁶⁵

¹⁶⁰ Balaam, M.C, Akerjordet, K, Lyberg, A, Kaiser, B. et al (2013) A qualitative review of migrant women's perception of their needs and experiences related to pregnancy and childbirth. *Journal of Advanced Nursing* 69(9): 1919-1930.

¹⁶¹ Vázquez ML, Vargas I, Jaramillo DL, Porthe V, et al. (2016) Was access to health care easy for immigrants in Spain? The perspectives of health personnel in Catalonia and Andalusia. *Health Policy* 120(4):396-405.

¹⁶² Stepurko, T, Pavlova, M, Gryga, I, Murauskiene, L, Groot, W (2015) Informal payments for healthcare services: The cases of Lithuania, Poland and Ukraine. *Journal of Eurasian Studies* 6:46-58.

¹⁶³ Miteniece, E, Pavlova, M, Rechel, B, and Groot, V. (2017) Barriers to accessing adequate maternal care in Central and Eastern European countries: A systematic literature review. *Social Science and Medicine* 17:1-8.

¹⁶⁴ Mladovsky, P, Rechel, B, Ingleby, D, McKee, M. (2012) Responding to diversity: an exploratory study of migrant health policies in Europe. *Health Policy* 105:1-9.

¹⁶⁵ McPake, B, Witter, S, Ensor, T et al. (2013) Removing financial barriers to access reproductive, maternal and newborn health services: the challenges and policy implications for human resources for health. *Human Resources for Health* 11:46.

Lack of financial means can be a problem for both migrant and native mothers in countries in which maternity services require out of pocket payments. Homelessness, poverty, addiction to substances, disabilities, history of mental health issues for mothers with young children and legal status, or a combination of more than one of these, may reduce their ability to access services they are entitled to. Poverty and addiction often drive women into sex work) and sexually transmitted diseases. An estimated 12% are HIV positive, which varies substantially geographically.¹⁶⁶ In general, financial difficulties can make continuity of care from difficult to impossible.

3.2.4. Organisational barriers

A common complaint in many studies refers to the geographic concentration of health care facilities, both primary and secondary in urban centres which makes punctual access to services dependent on the availability of affordable public transport. The opening hours of health care facilities may still be an issue for some women who either because of culture or because of mobility impairments need to be escorted. This may also pose a problem for mothers who have children at school or for women working in the informal sector and in precarious occupations.

Delay in receiving care is considered an important factor in death from pregnancy complications, therefore faster ways of communication and transport are seen as essential in improving access to emergency obstetric treatment.¹⁶⁷

Transport can be a problem for many categories of women in terms of cost, which in many EU Member States is too high, but also for women with mobility issues and those who live in very remote areas. Moreover, for migrants who live in camps and have children and fixed meal times, finding transport and being punctual for medical appointments can be particularly challenging.¹⁶⁸

3.2.5. Culture and faith

Cultural and religious diversity is a major factor which underlies disparities in access and use of health care services and more importantly SRH services. When familiarity with different values and faith is missing, health professionals cannot effectively deal with diversity.

There is a growing volume of research in various Member States focusing on Muslims and how their religious practices shape their attitudes to sexual and reproductive health. More specifically, their negative attitude to contraception, the effect of Ramadan fasting on the weight of newborns, patriarchal values and control exerted by male and older family members over young Muslim girls and women, when it comes to their sexuality and sexual activity, are some issues researchers have factored in their studies. Some interesting findings from the US and the UK show that Islamophobia influences the way Muslim patients are depicted in MEDLINE¹⁶⁹ and health literature, whereas many differences that exist in different branches of Islam are completely overlooked. Therefore, maternity care policies

¹⁶⁶ Iversen J, Page K, Madden A, Maher L. (2015) HIV, HCV and health-related harms among women who inject drugs: implications for prevention and treatment. *Journal of acquired immune deficiency syndromes* Jun 1:69 (01), 176-181.

¹⁶⁷ Noordam, AC, Kuepper, BM, Stekelenburg, J et al. (2011) Improvement of maternal health services through the use of mobile phones. *Tropical Medicine and International Health* 16(5): 622-626.

¹⁶⁸ Balaam, M.C, Akerjordet, K, Lyberg, A, et al (2013) A qualitative review of migrant women's perception of their needs and experiences related to pregnancy and childbirth. *Journal of Advanced Nursing* 69(9): 1919-1930.

¹⁶⁹ Laird, L.D, de Marrais, J, & Barnes, LL (2007). Portraying Islam and Muslims in MEDLINE: A content analysis. *Social Science & Medicine* 65: 2425-2439.

tend to be 'faith-blind'.¹⁷⁰ Termination of pregnancy according to Islam can take place up to the 120th day of pregnancy and not later. Screening procedures must be planned before that day instead of later, as is the case in many countries. Additionally, in vitro fertilisation is permitted by both Sunni and Shia Islam, but the former rules out sperm or egg donation, while the latter is more flexible.

Studies of young Muslim women's attitudes to sexual and reproductive health indicate that devotion to the Muslim faith and ideas about women's purity may be challenging and requiring self-regulation.¹⁷¹ Cultural sensitiveness, namely health professionals' attempts to work within the cultural framework of patients, has been recommended but there are risks of professionals treating different ethnic or religious groups as homogeneous or projecting their own assumptions and assign them characteristics they may not have. A person-centred approach to avoid generalisation, would be more appropriate.

Migrant women report their reluctance to discuss their struggle to preserve 'bodily integrity' whatever that means according to their values and culture during childbirth in a foreign health system with health professionals who often use methods and terminology unfamiliar to them or exhibit hostile and disrespectful behaviour¹⁷².

3.2.6. Mental health

Depression is very common among marginalised social groups and is aggravated by pregnancy. According to research, women who are drug-dependent are more likely to suffer from psychological problems such as depression, anxiety, panic attacks and are more reluctant to seek help. These conditions lead to further social isolation.¹⁷³ Their decision-making and cognitive abilities are affected and this may lead to abstention from accessing the available services in case of pregnancy or other sexual and reproductive health issues. As a result, chronic communicable diseases remain untreated during pregnancy and can infect babies during childbirth.

3.2.7. Fear and social stigma

All marginalised women the study addresses are governed by fear. Their precarious circumstances cause constant worrying and insecurity as to their status and survival. For undocumented women it is fear of deportation. For sex workers, victims of violence and abuse, women with addictions, HIV positive, sex workers, it is fear of being reported to the police. Exposure to the media and social media is also a risk. A recent example was the 2013 media exposure of a number of HIV positive female sex workers in Greece¹⁷⁴.

Stigma (which can be taken to mean disgrace or discredit) has often been associated with recipients of sexual and reproductive health services, e.g. those who have contracted HIV, or mothers who have undergone an abortion.¹⁷⁵ Stigmatisation can create dislike, hatred, ridicule, contempt and isolation

¹⁷⁰ Arousell, A, and Carlbom, A. (2015) Culture and religious beliefs in relation to reproductive health. *Best Practice and Research Clinical Obstetrics and Gynaecology* 32:77-87.

¹⁷¹ Arousell, A, and Carlbom, A. (2015) Culture and religious beliefs in relation to reproductive health. *Best Practice and Research Clinical Obstetrics and Gynaecology* 32:77-87.

¹⁷² Balaam, M.C, Akerjordet, K, Lyberg, A. et al. (2013) A qualitative review of migrant women's perception of their needs and experiences related to pregnancy and childbirth. *Journal of Advanced Nursing* 69(9): 1919-1930. doi:10.1111/jan.12139.

¹⁷³ Iversen J, Page K, Madden A, Maher L. (2015) HIV, HCV and health-related harms among women who inject drugs: implications for prevention and treatment. *Journal of acquired immune deficiency syndromes* 2015 Jun 1:69 (01), 176-181.

¹⁷⁴ Insipidus, P and Boucas, D. (2015) *Media policy and independent journalism in Greece London*: Open Society Foundations.

¹⁷⁵ Cook, R and Dickens, BM. (2014) Reducing stigma in reproductive health. *International Journal of Gynecology and Obstetrics* 125(1): 89-92.

from the community. The social, psychological and health impact of stigmatisation need to be researched and initiatives for its reduction and possibly elimination ought to be undertaken.¹⁷⁶

People who fear stigmatisation (e.g. HIV positive patients) may avoid seeking health care or resort to covert practices, something which renders social responses (to disease or a social problem) ineffective. Women who are afraid of the stigma of abortion may resort to unsafe and unregistered providers. There are risks in such decisions and the links between stigmatisation and risky behaviour need to be examined. In the case of abortion, restrictive laws can be challenged on human rights grounds, not least because a continuation of pregnancy may endanger a woman's life or health. Laws prohibiting or impeding necessary health treatment for women constitute sex discrimination.¹⁷⁷

Stigma in health care provision can be related to conditions such as obesity or disability, whereby, for example, medically assisted reproduction might be denied on grounds of health or ineffectiveness. Such situations can be seen as a violation of human rights under the UN Convention on the Rights of Persons with Disabilities.¹⁷⁸

Fear of being reported to the police which will trigger intervention of other state mechanisms can act as a deterrent to accessing health services. Moreover, in many countries, the law considers addiction to substances a criterion for removing children from parents' care, a crime or a reason for coerced sterilisation. Similar problems are faced by women prisoners, very often addicted, who have more health needs than male prisoners and the relevant treatments are not provided to them¹⁷⁹.

For WWID in some countries access to services means discrimination by health professionals in addition to societal prejudice. Poor mental and/or physical health enhances the stigma and obstacle for them to access services. As the vast majority of drug users are male, there are not gender-disaggregated data to inform effective, gender-specific service delivery.¹⁸⁰

Finally, for undocumented migrant women, the sensitive issue of reporting to the legal authorities is the most important impediment. In some countries, reporting is required of health professionals (e.g. Sweden, Slovenia, the UK, Croatia and Germany), while in others it is prohibited (e.g. Portugal, Spain, France, Italy, the Netherlands, the Czech Republic, Denmark and Norway). Legal action can be taken against health professionals who provide care to undocumented migrants in certain countries, while, in others, providing such health services is at the discretion of the health staff.¹⁸¹

¹⁷⁶ Ibid.

¹⁷⁷ Cook, R and Dickens, BM. (2014) Reducing stigma in reproductive health. *International Journal of Gynecology and Obstetrics* 125(1): 89-92.

¹⁷⁸ Ibid.

¹⁷⁹ Iversen J, Page K, Madden A, Maher L. (2015) HIV, HCV and health-related harms among women who inject drugs: implications for prevention and treatment. *Journal of acquired immune deficiency syndromes* Jun 1:69 (01), 176-181.

¹⁸⁰ Ibid.

¹⁸¹ De Vito, E, de Waure, C, Specchia, ML, Ricciardi, W. (2015) *Public health aspects of migrant health: a review of the evidence on health status for undocumented migrants in the European Region*. Health Evidence Network synthesis report 42. Copenhagen: WHO Regional Office for Europe.

4. BEST PRACTICES AND THE ROLE OF MIDWIFERY

KEY FINDINGS

- A number of EU Member States have in recent years adopted good practices regarding migrant health care, while practices to improve maternal care of other vulnerable groups are less visible.
- More research is required to understand the needs of vulnerable women and inform good practices.
- Midwives can play a crucial role in improving maternal care for vulnerable women, as they provide holistic care which better serves their needs. They can function in both formal and informal settings and offer continuous and personalised care.

Very little research has been done into the perceived health needs of vulnerable women. It is imperative to have such data for effective policies to be designed and introduced. A number of countries have since 2015 adopted good practices regarding migrant healthcare or are in the process of doing so.¹⁸² In the meantime, some good practices can be shared across the EU territory. Certain best practices are presented in the first section of this chapter, while the second is dedicated to the crucial role of midwives in the provision of SRH care and in enhancing women's birthing experience.

4.1. Categories of Best Practices

4.1.1. Facilitating access to services

Some Member States have taken initiatives to include marginalised groups and improve their use of SRH services.

A good step in the right direction is that of the Federal State of Berlin in Germany that has introduced anonymised health insurance vouchers which undocumented migrant women can use without being reported. However, the range of services provided is up to the discretion of providers¹⁸³.

In a similar vein, the *Malteser Migrantenmedizin* is another positive attempt in Germany to facilitate access. The Catholic association Malteser runs contact points which sick or pregnant migrants can access to receive care.¹⁸⁴

Italy has introduced the *Stranieri Temporaneamente Presenti* code, which enables equal access for all to urgent and essential care. Using it, the patient can gain anonymous and free access to all health services. One can apply for it at any time and the code is valid for six months initially but can be renewed. It guarantees entitlement for undocumented migrants and their families.¹⁸⁵

¹⁸² <https://ec.europa.eu/migrant-integration/feature/migrant-health-across-europe>.

¹⁸³ Flegar, V, Dallí, M, Toebes, B. (2016) Access to Preventive Health Care for Undocumented Migrants: A Comparative Study of Germany, the Netherlands and Spain from a Human Rights Perspective, in: *Laws 5* (2016), 9.

¹⁸⁴ Flegar, V, Dallí, M, Toebes, B. (2016) Access to Preventive Health Care for Undocumented Migrants: A Comparative Study of Germany, the Netherlands and Spain from a Human Rights Perspective, in: *Laws 5* (2016), 9.

¹⁸⁵ De Vito, E, de Waure, C, Specchia, ML, Ricciardi, W. (2015) *Public health aspects of migrant health: a review of the evidence on health status for undocumented migrants in the European Region*. Health Evidence Network synthesis report 42. Copenhagen: WHO Regional Office for Europe.

4.1.2. Improving information provision and communication

The cultural aspects of communication with migrants have been emphasised and training programmes for improving the cultural competence of health care professionals have been introduced.¹⁸⁶

Austria has established a training programme for improving intercultural competence of health practitioners and hospital staff. Portugal has also training and communication programmes in place to inform health staff about the legal rights of migrants. Ireland also promotes culturally competent, non-discriminatory service provision and has developed guidelines for translated material. On the demand side, France provides information on major diseases affecting migrants and ways to access the health system. The Netherlands had for long offered migrants health information in their native languages but subsequently this service was withdrawn. Currently only the local authorities that can finance such services are in a position to provide them. Germany provides leaflets and telephone services in the migrants' languages. Spain has a national plan and a number of regional plans, which include provision of information.¹⁸⁷

A number of countries, such as Austria and Netherlands, have also addressed the intersection of migration and LGBTIQ identity, through the provision of information on the available services and (in the second case) a mobile app on LGBTIQ refugee rights (available in Arabic, English, Farsi and French). It is important to note, as an example of practice involving the interested party themselves, that ten refugees contributed actively to the development of the application.¹⁸⁸

The Finnish *PALOMA programme* is an online training programme disseminating information about refugees and ways to support their well-being.¹⁸⁹ In the UK, the Children's Society's *Refugee Toolkit* supports all relevant agencies to stay informed on the care needs, rights and entitlements of young refugees and asylum seekers, as well as their families.¹⁹⁰ In Italy, the *Common Approach to **REfugee** and other migrants' health programme* (CARE) aims at increasing the health literacy of refugees and migrants through the dissemination of information material on what health care services are offered and how they can be accessed. The material is produced for Italy, Malta, Greece, Croatia and Slovenia, is translated into languages such as Arabic, Farsi, Tigrinya and is distributed to migrants and refugee centres and health access points.¹⁹¹ In Scotland, the ***Fair for All initiative*** provides free interpreting/translation services, spiritual services in hospitals for every religion, food options to suit cultural differences, training for staff and support for community organisations to provide services.¹⁹²

The Belgian *ETHEALTH* (Ethnicity and Health) Expert Group made recommendations for reducing ethnic and migrant health inequalities: urgent medical aid reimbursement, provision of vouchers entitling undocumented migrants to receive assistance, extension of the medical card to undocumented migrants to ensure urgent medical care delivery and provision of a temporary residence permit to those affected by infectious diseases for receiving treatment.¹⁹³

¹⁸⁶ O'Donnell, CA, Burns, N, Mair, FS et al. (2016) Reducing the health care burden for marginalised migrants: The potential role for primary care in Europe. *Health Policy* 120: 495-508.

¹⁸⁷ Mladovsky, P, Rechel, B, Ingleby, D, McKee, M. (2012) Responding to diversity: an exploratory study of migrant health policies in Europe. *Health Policy* 105:1-9.

¹⁸⁸ EASO (2018) *Annual report on the situation of asylum in the European Union 2017*. Luxembourg: European Asylum Support Office.

¹⁸⁹ <https://thl.fi/en/web/immigrants-and-multiculturalism>.

¹⁹⁰ <https://www.childrensociety.org.uk/youngcarer/refugee-toolkit?file=health.htm>

¹⁹¹ <https://www.inmp.it/eng/content/view/full/15369>.

¹⁹² De Vito, E, de Waure, C, Specchia, ML, Ricciardi, W. (2015) *Public health aspects of migrant health: a review of the evidence on health status for undocumented migrants in the European Region*. Health Evidence Network synthesis report 42. Copenhagen: WHO Regional Office for Europe.

¹⁹³ Ibid.

The cross-country project *RESTORE* (Research into implementation strategies to support patients of different origins and language background) aimed at the implementation of guidelines and training for cross-cultural communication in European practice for vulnerable migrants, asylum seekers, refugees, migrants in low-paid employment and undocumented ones. It involved empirical work conducted in Austria, Greece, England, Ireland, and the Netherlands.¹⁹⁴

Finally, all attempts at inclusion can be strengthened by good social support networks which facilitate access to health services.¹⁹⁵

4.1.3. Data collection and evaluation

The importance of the collection of information and monitoring of service delivery to vulnerable social groups cannot be stressed enough. Confusion caused by the use of different terms interchangeably is at the root of the problems with data and the inability to have a more accurate picture of the situation.

Most national policies use the term ‘migrant’ – but, in general, national policies focus on either migrants or ethnic minorities but not both. However, the Irish National Intercultural Health Strategy (2007-2012) covers migrants (including asylum seekers, refugees, undocumented) together with travellers, other ethnic minorities, as well as children of migrants born in Ireland. Likewise, the Netherlands address both established ethnic minorities and migrants under the term “cultural difference”.¹⁹⁶

The *Migrant Integration Policy Index (MIPEX)*, a tool that measures policies to integrate migrants is a good example. Developing further and refining such tools could lead to more efficient and adequate SRH service provision to marginalised women. According to MIPEX, Italy is the leading example in ensuring that undocumented migrants are entitled to healthcare.¹⁹⁷ Italy registers to its national health system foreigners with a residence permit. The *Commission for the Health of Migrants* was established to monitor the quality of health services provided to all categories of migrants. Ireland aims to improve its data collection with specific ethnic identification variables and a database on the health of ethnic minorities.¹⁹⁸

4.1.4. Inter-sectoral Interventions

Portugal’s *Plan for Integration of Immigrants 2007-2009* promoted inter-sectoral collaborations to improve quality and change in organisational culture. Ireland has supported a strategy of collaboration with NGOs and has sought the input of minority communities in implementation of its primary care plan. Switzerland, with its *Migration and Public Health Strategy*, seeks to remove access barriers through migrant-friendly hospitals.¹⁹⁹

In January 2017, the Swedish Association of Local Authorities and Regions was instructed to implement the national programme *Health in Sweden* which included training for health professionals to enable

¹⁹⁴ O’Donnell, CA, Burns, N, Mair, FS et al. (2016) Reducing the health care burden for marginalised migrants: The potential role for primary care in Europe. *Health Policy* 120: 495-508.

¹⁹⁵ Agudelo-Suarez, A, Gil-Gonzalez D, Vives-Cases, L et al. (2012) A metasynthesis of qualitative studies regarding opinions and perceptions about barriers and determinants of health services’ accessibility in economic migrants. *BMC Health Services Research* 12:461.

¹⁹⁶ Mladovsky, P, Rechel, B, Ingleby, D, McKee, M. (2012) Responding to diversity: an exploratory study of migrant health policies in Europe. *Health Policy* 105:1-9.

¹⁹⁷ De Vito, E et al (2016) Are undocumented migrants’ entitlements and barriers to healthcare a public health challenge for the European Union? *Public Health Reviews* 37:13, <https://doi.org/10.1186/s40985-016-0026-3>.

¹⁹⁸ Mladovsky, P, Rechel, B, Ingleby, D, McKee, M. (2012) Responding to diversity: an exploratory study of migrant health policies in Europe. *Health Policy* 105:1-9.

¹⁹⁹ Ibid.

them to better meet the needs of asylum seekers and newcomer immigrants showing signs of mental illness. In Greece, the Ministry of Health launched the programme *PHILOS*, funded by EU's Asylum, Migration and Integration Fund to address the sanitary and psychosocial needs of refugees living in camps.²⁰⁰ In Cyprus, the *Strategy on the Rights of the Child in Health 2017-2025* has included health care for migrant children as a central pillar.

There are examples of successful inter-sectoral interventions that promote communication and integration between medical agencies, and draw on migrants' self-assessment of needs. A UK study, for example, shows that access to primary care for asylum seekers and refugees can be promoted by collaboration between multidisciplinary staff and patient advocacy.²⁰¹

The *ORAMMA* project was developed by the EU authorities to address the maternal health needs of migrant women during the increasing influx of migrant population, which reached its height of 1,015,000 people in 2015. It responded to evidence that migrant women showed poor health outcomes during the perinatal period by developing an innovative inter-professional approach, which included the recruitment of volunteer maternity assistants to help migrant pregnant women.²⁰²

4.1.5. The Dutch system – a more holistic approach to maternal health care

The Dutch system of maternity care provision is renowned for a number of features, such as low rates of medical intervention during labour and delivery, safe birth outcomes for mothers and newborns, substantial percentages of births at home, autonomous roles for professional midwives, as well as cost-effectiveness.²⁰³

It also offers long-standing home-based postnatal care provision for several hours per day for up to ten days following the birth of their infant through a specialised occupational group of postpartum caregivers. These trained caregivers work in the homes of new parents and provide a broad range of social care and support, from practical day-to-day help to information about issues such as breastfeeding. They report to the midwives and other health care providers who supervise the care.²⁰⁴ This form of free care provision constitutes the official recognition of the need and importance of care for new mothers and crosses the boundary between the health sector and the home and community care sector. Crucially, it is accessible to all, as it does not incur any out-of-pocket payments.²⁰⁵ For these reasons, the Dutch system presents the features of a 'warm modern' system.²⁰⁶

²⁰⁰ <https://philosgreece.eu/en/>

²⁰¹ Eling J. (2010) *Asylum seeker, refugee and vulnerable migrant services. Mapping and best practice report and recommendations*. London: Maternity Action.

²⁰² ORAMMA (2017) *Approach to Integrated Perinatal Healthcare for Migrant and Refugee Women*. Operational Refugee and Migrant Maternal Approach., deliverable D4.2.

²⁰³ Zadoroznyj, M, Benoit, C, Berry, S. (2012) Motherhoods, medicine and markets: the changing politics of postnatal health provision. *Sociological Research Online* 17(3) 24. <http://www.socresonline.org.uk/17/3/24.html>.

²⁰⁴ De Vries, R. (2004) *A pleasing birth: midwives and maternity care in the Netherlands*. Philadelphia: Temple University Press.

²⁰⁵ Zadoroznyj, M, Benoit, C, Berry, S. (2012) Motherhoods, medicine and markets: the changing politics of postnatal health provision. *Sociological Research Online* 17(3) 24. <http://www.socresonline.org.uk/17/3/24.html>.

²⁰⁶ Hochschild, A. (1995) The culture of politics: traditional, postmodern, cold-modern and warm-modern ideals of care. *Social Politics* 2(3):331-346.

4.2. Midwifery: Role and Potential

Midwifery is a key element of sexual, reproductive, maternal and neonatal health care and has been around since time immemorial, long before child birth became medicalised. The increasing hospitalisation of childbirth has led to a reduced status for midwives in certain parts of the world, a trend which is gradually being reversed.

A recent global report by UN and WHO defines midwifery as: ‘the health services and health workforce needed to support and care for women and newborns, including sexual and reproductive health and especially pregnancy, labour and postnatal care’.²⁰⁷ The report finds that midwifery is delivered by a great variety of health care and associate professionals in diverse ways.

Midwifery is crucial to the survival and wellbeing of mothers and newborn infants in all countries and settings but also to improving clinical and psychological outcomes. Midwives’ contribution to achieving the Millennium Development Goals and the drastic reduction in maternal morbidity and mortality has been acknowledged.²⁰⁸ Midwives can be central in the delivery of emergency services, particularly in contexts of lower and middle income countries where facilities might be unavailable or of lower quality.²⁰⁹ Strengthening their role is imperative in a global context of increasing inequalities of all kinds and in a demographic landscape which constantly becomes more complex.

Among the positive developments in this direction was the Bologna Declaration of 2005 which obliged the EU countries to offer university degree-level education to midwives. However, national standards and practices still vary, as does the emphasis placed on midwifery’s practice across Member States.²¹⁰ Whereas in the Nordic countries it is very strong, in other Member States the dominant model is hospital birth. In the Netherlands, as shown in the previous section, midwives are pivotal, whereas in the Central and Eastern European countries, they play the least important role. In the UK midwives are regulated and can work as independent professionals in different settings. Research that over-medicalisation leads to unnecessary interventions and deprives women and children of skilled professional midwives who can offer a much broader spectrum of advice and work together with women toward the promotion of a healthy and more natural approach to pregnancy and childbirth, breastfeeding and antenatal and postnatal care.²¹¹

Midwives provide care to women at important moments of their life, such as birth and pregnancy, when apart from real health risks and complications, women can also be emotionally vulnerable and often require compassionate and sensitive practitioners to take care of them. Midwives operate in different cultural and socio-economic settings and they must take care of women’s physical, mental and spiritual needs, as all three are relevant in such situations. Research from different countries involving midwifery students has shown that they feel less equipped and want more training in dealing with women’s spiritual needs and suggest personal spirituality as an important criterion for student selection for midwifery.²¹²

²⁰⁷ United Nations (2014) *A universal pathway - A woman’s right to health. The state of the world’s midwifery 2014*. United Nations Population Fund.

²⁰⁸ Luyben, A, Barger, M, Avery, et al. (2017). Exploring global recognition of quality midwifery education: Vision or Fiction? *Women and Birth* 30: 164-192.

²⁰⁹ Campbell, O, Calvert, C et al. (2016) The scale, scope, coverage and capability of childbirth care. *Lancet* 388: 2193-2208.

²¹⁰ Renfrew, MJ, Burns, E, Gross, MM, Symon, A. (2015) Pathways to strengthening midwifery in Europe. *Entre nous*. digitalcollection.zhaw.ch.

²¹¹ Ibid.

²¹² Ross, L., McSherry, W, Giske, T, et al. (2018) Nursing and midwifery students’ perceptions of spirituality, spiritual care, and spiritual care competency: A prospective, longitudinal, correlational European study. *Nurse Education Today*, 67: 64–71.

In order to enhance the presence of midwives in all the EU Member States and to reinforce their role, all stakeholders (health professionals, policy planners, politicians, civil servants and civil society organisations) must be involved and ensure that midwifery services are available to all women and newborns.

In Germany midwives have to be present at every birth and are employed mainly in the public sector but also in the private sector, while in parallel they can offer services in women's homes, although childbirths in Germany take place in hospitals. Their training is either a three-year basic vocational education or since 2009 a four-year degree from Universities of Applied Sciences (Fachhochschulen) that have a more applied orientation²¹³. They can continue to postgraduate level as well. The new generation of midwives and their involvement in research will lead to a much more substantial contribution and increasing influence on the childbirth experience.

A similar situation is encountered in Austria where the presence of a midwife at every childbirth is mandatory. Midwives' contribution lies in pre- and postnatal care and their attendance at birth, because obstetricians are in charge of intrapartum and routine antenatal care. In terms of postnatal care, although there are community midwifery services, such as courses on breastfeeding and exercises, they are not used as much as postnatal clinics at hospitals²¹⁴. Nevertheless, lately the role of midwives is strengthened and they offer courses at hospital postnatal clinics, too. Their education is also at university level.

Midwifery has been subject to regulation by the Dutch state since the late 19th century and the professional title is officially protected. **The Netherlands** have a two-level system of primary and secondary maternity care and midwives work in both settings. Access to secondary care is permitted through midwives who act as gatekeepers and refer complex cases to the second tier (approximately 20%).²¹⁵ Their number has increased drastically, especially in hospitals and they have been working alongside obstetricians for a very long time. They can also work as independent professionals assisting women at home births which used to be the rule in the Netherlands in the 1950s and still represent around 25%.²¹⁶ Midwives and women have a long relationship which ends six weeks after childbirth. As far as quality assurance is concerned, global recognition and accreditation have stimulated debate for some time. Although the International Confederation of Midwives (ICM) has established international standards and benchmarks, the question that remains is how to promote their acceptance. The need for a higher number of midwives and higher quality in midwifery services has also been highlighted²¹⁷.

Accreditation is the formalised process of evaluation of an institution or programme of study in terms of meeting the minimal criteria of quality in the education and training it offers to students and whether it provides the competences required. Accreditation bodies have to be independent and the process transparent and based on pre-determined criteria. There is considerable variation in accreditation procedures and independence from the state which result in different competences among graduates

²¹³ Luyben, A, Wijnen, H.A.A, Oblasser, C, et al. (2012) The current state of midwifery and development of midwifery research in four European countries. *Midwifery* (2013). dx.doi.org/10.1016/j.midw.2012.10.008.

²¹⁴ Midwives' contribution lies in pre- and post-natal care and their presence at birth.

²¹⁵ Luyben, A, Wijnen, H.A.A, Oblasser, C, et al. (2012) The current state of midwifery and development of midwifery research in four European countries. *Midwifery* (2013). dx.doi.org/10.1016/j.midw.2012.10.008.

²¹⁶ Ibid.

²¹⁷ Luyben, A, Barger, M, Avery, M, et al. (2017). Exploring global recognition of quality midwifery education: Vision or Fiction? *Women and Birth* 30: 164-192.

of different countries. Recognition is a similar process with the difference that it sets higher standards than the minimal ones set by accreditation but, unlike the latter, it lacks penalising power.²¹⁸ From student selection criteria, to high standard education, accreditation and strong regulation of practice, involvement of women advocacy groups and research by midwives themselves, a lot remains to be done on the EU level.²¹⁹

Nevertheless, as research has shown²²⁰, a global recognition process will not be able to replace national accreditation procedures, as the local and national configuration of factors matters. Accreditation bodies review the legitimacy and appropriateness of education programmes and sometimes countries opt for short-term training programmes to alleviate need, while aiming at the long-term improvement of education standards.

Availability of high-quality evaluators and collaboration between professional associations and government bodies are indispensable and even more so in order to ensure political and financial investment without which none of the above goals can be reached. In the same vein, midwives' participation in leadership and decision-making is essential.

Research led by midwives is relatively recent. It started in the USA and the UK in the 1970s when a call from health care professionals and consumers challenged midwives to do research to improve maternity care. Subsequently, the International Confederation of Midwives (ICM) organised workshops in non-English speaking countries to promote research in other parts of Europe and WHO supported those efforts aiming at developing a body of evidence in order to improve maternity services.²²¹

Priorities in different countries varied. In the UK midwives aimed at enhancing their role and minimising the intervention of obstetricians in their work by reducing practices such as episiotomies and then joined forces with researchers from the Pregnancy and Childbirth Database to systematically evaluate the effectiveness of maternity care with the aim to contain perinatal mortality and morbidity.²²² Dutch midwives are very active when it comes to research. As home birth is still an option, midwives' experiences feed into research together with financial support by the Royal Dutch Midwifery Association. There are also three MSc programmes which contribute to strengthening midwifery as a profession and an academic discipline.²²³

Research on the needs of marginalised women shows that they crave for female solidarity and understanding during pregnancy. They need a caring relationship with a midwife who is going to introduce them smoothly to a new system.²²⁴ This is precisely the gap which lay health workers can fill. **Lay health workers** perform work in the context of maternal and child health (ranging from support and counselling to treatment and diagnosis and the provision of supplements and other products).

²¹⁸ Ibid.

²¹⁹ Renfrew, MJ, Burns, E, Gross, MM, Symon, A. (2015) Pathways to strengthening midwifery in Europe. *Entre nous*. digitalcollection.zhaw.ch.

²²⁰ Luyben, A, Barger, M, Avery, M, et al. (2017) Exploring global recognition of quality midwifery education: Vision or Fiction? *Women and Birth* 30: 164-192.

²²¹ Luyben, A, Wijnen, H.A.A, Oblasser, C, et al. (2012) The current state of midwifery and development of midwifery research in four European countries. *Midwifery* (2013). dx.doi.org/10.1016/j.midw.2012.10.008.

²²² Robinson, S, and Thomson A.M (1989) Research and Midwifery in Robinson, S, and Thomson A.M. (eds) *Midwives Research and Childbirth*, 1:1-7. Chapman and Hall. London.

²²³ Luyben, A, Wijnen, H.A.A, Oblasser, C, et al. (2012) The current state of midwifery and development of midwifery research in four European countries. *Midwifery* (2013). dx.doi.org/10.1016/j.midw.2012.10.008.

²²⁴ Balaam, M.C, Akerjordet, K, Lyberg, A, Kaiser, B. et al (2013) A qualitative review of migrant women's perception of their needs and experiences related to pregnancy and childbirth. *Journal of Advanced Nursing* 69(9): 1919-1930.

However, though they receive training, they do not have a tertiary education degree, nor a professional or paraprofessional certificate.²²⁵

A review of qualitative evidence (53 studies) on the experiences of lay health workers, the recipients of their services and other health workers identified trust, kindness, respect and empathy as very strong factors in those programmes. The motivations of lay workers included altruism, social recognition but also knowledge and career development. However, there were challenges for lay health workers, notably the management of emotional relationships, as well as the risk that their services may not be appreciated. Lay workers thought that low pay and inadequate and poor training were serious deficiencies and called for more training in communication, counselling and health issues. Health professionals often appreciated the support of lay health workers, their communication skills and commitment, but sometimes they feared their authority was being undermined. Some mothers expressed concerns and uncertainty about the issue of confidentiality.²²⁶

²²⁵ Glenton, C, Colvin, CJ, Carlsden, B, Swartz, A, Lewin, S, Noyes, J, Rashidian, A. (2013) Barriers and facilitators to the implementation of lay health worker programmes to improve access to maternal and child health: qualitative evidence synthesis. *Cochrane Systematic Review*.

²²⁶ *Ibid.*

5. POLICY RECOMMENDATIONS AND CONCLUDING REMARKS

KEY FINDINGS

- Systemic policies and co-ordinated services are needed to promote the ideal of health as a human right universal and free at the point of use.
- Provision of SRH care services must be person-centred to mitigate exclusion of women in vulnerable social groups on the basis of biological, ethnic, socio-economic, cultural or other discriminatory factors.
- Investment in relevant resources and improved accessibility and availability of maternal health services are essential to address the needs of a diverse population.
- Policy innovations, behavioural economics and technological evolution create new circumstances and potential and raise expectations for high quality care provision. These can be harnessed to benefit maternal health and improve current and constantly deepening inequalities among women on the margins of society.

5.1. Recommendations

The EU needs to show cross-section policy co-ordination and action, so that health policy is seen as a **shared responsibility**. An inter-sectoral approach and cross-border cooperation will be necessary for universal health coverage.²²⁷ The immediate and harmonised action by all EU Member States is required to ensure **special protection of minors and pregnant women**, so that they may have access to adequate medical care throughout an illness or during pregnancy. Systemic policies are needed to promote the ideal of health as a human right, universal, free and person-centred.²²⁸

Health as a Universal Human Right in practice

A recent report by the WHO Health Evidence Network suggests improved access to services by the **removal of legal restrictions and provision of full health coverage for all pregnant women and for children regardless of immigration status**.²²⁹ The Committee on the Rights of Persons with Disabilities points to the same direction. It states that the EU has failed to keep up with a human rights approach when it comes to migrants with disabilities and suggests that guidelines be issued to EU agencies and Member States to rule out restrictive detention of disabled migrants of any status, as such practices are not in line with the Convention.²³⁰

²²⁷ De Vito, E, de Waure, C, Specchia, ML, Ricciardi, W. (2015) *Public health aspects of migrant health: a review of the evidence on health status for undocumented migrants in the European Region*. Health Evidence Network synthesis report 42. Copenhagen: WHO Regional Office for Europe.

²²⁸ O'Donnell, CA, Burns, N, Mair, FS et al. (2016) Reducing the health care burden for marginalised migrants: The potential role for primary care in Europe. *Health Policy* 120: 495-508.

²²⁹ Bradby H, Humphris R, Newall D, Phillimore J. (2015) *Public health aspects of migrant health: a review of the evidence on health status for refugees and asylum seekers in the European Region*. Health Evidence Network synthesis report 44. Copenhagen: WHO Regional Office for Europe.

²³⁰ PICUM (2017) *Framing document*. EU Health Policy Platform. Thematic network on "Migration and Health". Platform for International Cooperation on Undocumented Migrants.

In the case of women and girls, a multi-level awareness and policy dialogue of vulnerable women's health needs on both the national and the EU levels is a priority. The relevant stakeholders ought to reconsider the entitlements of undocumented migrants on the basis of human rights and the national contexts. A **review of the existing national legal frameworks** is indispensable to identify barriers to access to healthcare for documented and undocumented migrants and refugees, as well as other categories of native marginalised women.

Emphasis on **public sector provision** is important, not least to ensure that maternal health is free. As most health systems in the EU-28 are insurance-based, certain vulnerable women (e.g. undocumented migrants) are left unprotected, as SRH services are not affordable. A **free benefits package for vulnerable women** has been suggested in various consultations. This should include access to contraception, antenatal, delivery and postnatal care.²³¹ Universal access to maternal health care and promotion of family planning will reduce undesirable outcomes, such as expensive emergency care and unwanted pregnancies and will have a cost-saving impact on the health systems.²³² In addition, **further research into informal payments** is necessary in order to increase transparency and reduce inequalities among service users, while guaranteeing that maternal health remains free for all.

Stakeholders' collaboration toward a holistic policy design

Policies should address sexual and reproductive health holistically.²³³ Complementing hospitalisation with decent housing, for example, will create circumstances for migrants to escape poor accommodation, which often leaves them with no choice but to return to hospital after they have been discharged.²³⁴

Building institutional and organisational cultural competencies that are sensitive to the maternal health/SRH needs of vulnerable women is essential. Holistic organisational approaches need to be implemented to improve access to services. More research is needed to understand how migrant health policies can be developed within different political, economic and socio-cultural national contexts, as the one-size-fits-all approach has not been effective.²³⁵ Monitoring of maternal morbidity and mortality must be systematic, linking the health centre/hospital with the broader local, regional and national levels.

Most current policies are gender-, culture- and religion-blind and consequently lead to deepening of disparities in access to services. Policy should include all vulnerable and marginalised groups of women, namely native, established ethnic minorities and migrant. **Involvement of representatives of all these groups in policy-design** will allow their voices to be heard and their needs to become known. This can only be achieved in a tolerant, non-prejudiced, non-stigmatising and non-punitive social environment.

²³¹ WPL (2018) *Improving maternal healthcare for vulnerable women in EU28. What can you do?* Women Political Leaders Global Forum.

²³² Keygnaert I, Ivanova, O, Guieu A, et al. (2016) *What is the evidence on the reduction of inequalities in accessibility and quality of maternal health care delivery for migrants? A review of the existing evidence in the WHO European Region.* Health Evidence Network synthesis report 45. Copenhagen: WHO Regional Office for Europe.

²³³ Ibid.

²³⁴ PICUM (2017) *Framing document.* EU Health Policy Platform. Thematic network on "Migration and Health". Platform for International Cooperation on Undocumented Migrants.

²³⁵ Mladovsky, P, Rechel, B, Ingleby, D, McKee, M. (2012) Responding to diversity: an exploratory study of migrant health policies in Europe. *Health Policy* 105:1-9.

Midwives are essential to building a more responsive and efficient system of delivering SRH services to socially disadvantaged women. They offer a more bespoke type of care, which allows for the building of trust with vulnerable women and continuity. Lay health workers can also be involved in the provision of information. The cultural and ethnic diversity of health professionals can play an important role to overcoming communication barriers.

Data collection and indicators

Multiple stakeholders (international organisations, national governments, health donors, civil society) must work together to improve data collection and analysis. A variety of **indicators**, ranging from GDP and health expenditure to the content of antenatal care, caesarean rates, postnatal coverage, family planning, as well as their links with health indicators such as obesity, HIV rates, maternal mortality, need to be developed and refined to enhance understanding of needs and inform relevant policies.²³⁶ New quality indicators assessing the care processes and providing an insight into the overall system of health care will be instrumental.²³⁷ Post-partum care indicators should also be included to evaluate continuity of care for mothers and children. The development of such indicators calls for a wide-ranging co-operation involving health care professionals, researchers, midwives and users.

The **improvement of data on women's and girls' reproductive needs** and the **creation of a supranational funding mechanism** to provide information and free maternal health care resources has been suggested. Such an initiative will make funding independent of financial constraints on the level of Member States, due to austerity or lack of political will by the national governments.

The needs of immigrant women, women with disabilities, sex workers, prisoners and other vulnerable groups when it comes to their access to sexual and reproductive health remain under-researched. There is an urgent call for **disaggregated data collection** to capture the variety of needs of different vulnerable women and design effective and person-centred policies. The combination of economic and political analysis with participatory studies on migrants' sexual and reproductive health can become the basis of concerted attempts across the EU to adopt common definitions and indicators and subsequently lead to comparable and disaggregated data.

Communication, information and health literacy

Sexual and reproductive health services should be provided according to individual needs. This should include efforts for health promotion among women of vulnerable social groups together with a more individualised/customised antenatal care for all, taking into account particularities of health conditions, which often emanate from different cultural backgrounds (e.g. anaemia, HIV, or FGM practices).

Access to good quality antenatal care for vulnerable groups requires improvement. Family planning should be encouraged in culturally acceptable ways. Maternal health services combined with neonatal strategies and community services can provide a **continuum of care**.²³⁸ The generalisation of the use of an **Electronic Health Record**, for refugees and other vulnerable women will facilitate follow-up and continuity of care.

²³⁶ Campbell, O, Calvert, C et al. (2016) The scale, scope, coverage and capability of childbirth care. *Lancet* 388: 2193-2208.

²³⁷ Escuriet, R, White, J, Beeckman, K et al. (2015) Assessing the performance of maternity care in Europe: a critical exploration of tools and indicators. *BMC Health Services Research* 15:491. EU COST Action IS0907.

²³⁸ Campbell, O, Calvert, C et al. (2016) The scale, scope, coverage and capability of childbirth care. *Lancet* 388: 2193-2208.

Lack of trust in the health system is a factor which impedes migrant women from seeking care and contributes to their high maternal morbidity rates. Health systems should be able to respond to needs in ways that can build this trust.²³⁹ Strengthening the role of midwives and involving lay health workers can contribute to this end.

The recognition of the **special health care requirements** (including mental health) of the refugee population and consequently the provision of adequate and specialist training for health care workers are priorities.

Improved understanding of cultural issues involved in health care is paramount. The case of FGM, a culturally sensitive issue, is indicative. Three million girls annually undergo FGM on a global level. Migrants continue to practice it in their host countries and therefore FGM services and clinics should be in place to address its medical and psychological consequences.

Similar initiatives to raise awareness of health needs of particular groups of vulnerable women are required for staff of prisons. International standards that account for the specificities of women prisoners also must be developed, as the current ones, such as the European Prison Rules, are not specifically designed for women prisoners' needs and rights. Women's preferences with regard to health care in prison should be taken into account.²⁴⁰

In order to deal with super-diversity, cultural sensitiveness in health care has been proposed. The growing literature on this matter has to be treated with caution, as it obscures at times the nuances and differences within the same groups. A more suitable way would be to base treatment on each individual's medical history, a **person-centred approach** to care which spans ethnicity, socio-economic status, religion and legal status.²⁴¹

Advocacy and integration programmes on undocumented migrants' issues to increase public awareness have been proposed. Public health education policies should target both migrant women and their community to increase health literacy. Culturally sensitive practices are required to increase the awareness of the support services available in the community. Involving local communities is also considered of essence to overcome suspicion on the part of migrant women and concerns about the implications.²⁴²

Improvement in communication, including the provision of interpreters and better documentation materials for patients and practitioners are necessary initial steps. Studies have suggested more detailed measures for improved interpreting and translating services (e.g. communication aids, laminated information in many languages, large fonts, telephone vs. face to face interpretation).²⁴³ The recruitment of **bilingual health workers**, medical and care providers who would be aware of the language and the culture of refugee women and the use of interpreter services can complement such initiatives.

²³⁹ Kruk, ME, Kujawski, S et al. (2016) Next generation maternal health: external shocks and health-system innovations *Lancet* 388: 2296-2306.

²⁴⁰ Van den Bergh, BJ, Gatherer, A, Fraser, A, Moller, L. (2011) Imprisonment and women's health: concerns about gender sensitivity, human rights and public health. *Bulletin of the World Health Organisation*. Copenhagen: WHO Regional Office for Europe.

²⁴¹ Arousell, A, and Carlbom, A. (2015) Culture and religious beliefs in relation to reproductive health. *Best Practice and Research Clinical Obstetrics and Gynaecology* 32:77-87.

²⁴² Walker, KF, Gribbin, C, Siddiqui, F. (2018) Cultural aspects of care in obstetrics and gynaecology. *Obstetrics Gynaecology and Reproductive Medicine* 28:11-12.

²⁴³ Ibid.

Acknowledging **heterogeneity between and within categories** of marginalised women and the right of every member of such groups to carve their own niche within their ethnic, religious or cultural setting, is the best way for health care professionals to improve outcomes in sexual and reproductive health.

Facilities, resources and personnel

Women should be encouraged to give birth in places with adequate capacities, skilled personnel, through formal referral mechanisms and where there are adequate monitoring control mechanisms. **Boosting service utilisation** by adopting practical measures such as longer appointment times, or the provision of transport means towards treatment is a necessary move to this end.²⁴⁴

To **improve geographical access**, particularly for women in rural or remote areas, governments should upgrade lower-level facilities which might be available nearby, establish maternity waiting homes, or set up regular transport routes to emergency facilities that can provide obstetric health care.²⁴⁵ The numbers of facilities and skilled birth attendants are increasing, which should result in a decrease in maternal and perinatal mortality. However, in reality, results are lower than expected and skilled providers and timely access to health care should be pursued further. Provision of **midwifery-led facilities** can resolve problems, such as lack of emergency facilities with medical professionals or inter-facility emergency transfer. To ensure that urgent intrapartum services are delivered in a timely manner, transport services or relocation spaces, such as maternity waiting homes, must be introduced.

In the case of women who are victims of abuse or prone social stigmatisation, the creation of safe spaces and ways which will encourage disclosure, the introduction of one-stop service stations to reduce multiple trips for women with mobility issues.²⁴⁶

More **investment in health professionals' remuneration** is a priority, as under-skilled, overburdened and under-appreciated health workers are less likely to provide quality health care, or respond to emergencies and shocks. Governments should consider that, given international human capital mobility, the salaries set for national and local health workers have to be comparable to international salary levels. Health financing has to be co-ordinated with human resources policies in regard to pay and recruitment, retention and distribution of health staff.²⁴⁷ Moreover, the contribution of health workers should be properly acknowledged, not least because they are responsible also for interpersonal relations in care provision, as well as for availability of drugs and other supplies.²⁴⁸

Innovative communication technologies, such as mHealth, which entails the use of mobile phones to access health services, have the potential to improve maternal health services, especially in rural and remote areas and can empower women by enabling easier communication and timely information access.²⁴⁹

²⁴⁴ Bradby H, Humphris R, Newall D, Phillimore J. (2015) *Public health aspects of migrant health: a review of the evidence on health status for refugees and asylum seekers in the European Region*. Health Evidence Network synthesis report 44. Copenhagen: WHO Regional Office for Europe.

²⁴⁵ Campbell, O, Calvert, C et al. (2016) The scale, scope, coverage and capability of childbirth care. *Lancet* 388: 2193-2208.

²⁴⁶ Bradbury-Jones, C, Breckenridge, JP, Devaney, J et al. (2015) Priorities and strategies for improving disabled women's access to maternity services when they are affected by domestic abuse: a multi-method study using concept maps. *BMC Pregnancy and Childbirth* 15:350.

²⁴⁷ McPake, B, Witter, S, Ensor, T et al. (2013) Removing financial barriers to access reproductive, maternal and newborn health services: the challenges and policy implications for human resources for health. *Human Resources for Health* 11:46.

²⁴⁸ Ibid.

²⁴⁹ Noordam, AC, Kuepper, BM, Stekelenburg, J et al. (2011) Improvement of maternal health services through the use of mobile phones. *Tropical Medicine and International Health* 16(5): 622-626.

5.2. Concluding remarks

Maternity services, as currently organised in the health systems of EU countries, were designed with more homogeneous and less mobile populations in mind. As Phillimore²⁵⁰ puts it, health professionals are challenged by 'newness' and must offer services to very diverse and constantly transient groups of people, which can be daunting and overwhelming, as their numbers are increasing.

The technocratic model of care of the developed world is contrasted with alternative approaches that target health care provision for mothers of diverse backgrounds and needs over sustained periods of time. In low and middle income countries, indeed, new mothers and their babies receive care from female relatives, are excused from chores and recuperate for periods of around 40 days. The cultural re-framing of a reduced level of support of postpartum care shifts the care responsibility to the individual (new mother).²⁵¹

In addition to training for health care professionals to better communicate and understand the needs of marginalised women, creating a more personal and supportive environment, through the involvement of midwives and trained lay health workers in more remote areas, is vital. In this way, women will know that, when they access the services, they will be examined and treated by the same person and will thus feel more confident and secure. Ideally, hiring health professionals of different ethnic groups and with fluency in foreign languages could contribute to a more culturally diverse and welcoming environment. Good resettlement circumstances such as employment, family reunion, protection from discrimination and support mechanisms for integration relate to better health outcomes for migrant women.²⁵²

Urbanisation is a significant trend: it is estimated that by 2030, 52% of births will be in urban areas (from 39% in 2000).²⁵³ This development will entail a reconsideration of the provision of maternal health care. It can lead to improvement due to reduction of geographical barriers but it can also backfire if, for instance, migrants are concentrated in slums and ghettos. At the same time, decentralisation in health provision provides opportunities for greater accountability and responsiveness to local needs. The role of communities will be important in lobbying for increased health care spending and accountability.

Marginalised women seem to be receiving lower-quality SRH services compared to the average of indigenous women. Undocumented migrants are those who use the available health services the least.²⁵⁴ and present intricate cases of conflict and negotiation between international and national law. On the one hand they should have access to healthcare according to the international and EU legislation, as a basic human right regardless of their legal status. On the other, most countries have yet to implement this and may provide undocumented migrants only with emergency care, or maternal health care for specific groups.

²⁵⁰ Phillimore, J. (2015) Delivering maternity services in an era of superdiversity: the challenges of novelty and newness. *Ethnic and Racial Studies* 38:4, 568-582.

²⁵¹ Zadoroznyj, M, Benoit, C, Berry, S. (2012) Motherhoods, medicine and markets: the changing politics of postnatal health provision. *Sociological Research Online* 17(3).

²⁵² Bradby H, Humphris R, Newall D, Phillimore J. (2015) Public health aspects of migrant health: a review of the evidence on health status for refugees and asylum seekers in the European Region. Health Evidence Network synthesis report 44. Copenhagen: WHO Regional Office for Europe.

²⁵³ Kruk, ME, Kujawski, S et al. (2016) Next generation maternal health: external shocks and health-system innovations *Lancet* 388: 2296-2306.

²⁵⁴ Kvamme, E, and Ytrehus, S, (2015) Barriers to health care among undocumented migrant women in Norway. *Society, Health & Vulnerability* 6(1):28668.

This points to the significance of broader health care governance issues. National legal decisions which limit entitlements (and impede service provision) or link access with out-of-pocket payments can drastically reduce accessibility/affordability of migrants. Informal payments reflect both the needs of users for higher quality services, as well as the desire of health professionals for higher remuneration. Nevertheless, salary increases do not necessarily lead to a change of attitudes among medical professionals. This, together with increasing privatisation in the health care sector, leaves patients, and most importantly the financially weaker, exposed to exploitation and disproportionate extra costs.

Social stigma enhances the social risk of vulnerable women and compromises their health. Health care practitioners, particularly gynaecologists and obstetricians, carry heavy responsibilities, as their behaviour towards their female patients might be stigmatising and expose them to their family and community.

The current political climate in Europe is increasingly becoming less conducive to social inclusion. Anti-immigration attitudes in certain Member States and the increasing appeal of extreme political parties, which vilify migrants, create xenophobic attitudes. Moreover, cost-containment in welfare is likely to have a negative impact on the provision of auxiliary services (e.g. interpreting services) necessary to reduce barriers to access to SRH services. Such trends can only be reversed through continuous information via all communication and education channels to familiarise the public with different cultures and needs of minorities.

Behavioural economics provides insights into the decision-making processes in maternal health and demonstrates that decisions based on biases and limited information often lead to suboptimal choices, for instance, preventing women from accessing care. Having said that, when structures are absent even good choices cannot result in positive outcomes.²⁵⁵

More attention must be given to needs, utilisation patterns, preferences, quality and outcomes of SRH care, as well as to broader, and hitherto neglected, gynaecological issues and outcomes. Marginalised women's living conditions make them more exposed to sexually transmitted diseases and prone to mental health issues. Their health and wellbeing should be prioritised. Screening and other services which can improve their lives should be accessible and free, regardless of their decision to become mothers or not.

There is an urgent need for policy-makers to reconsider the reality and the disparities between the residents of Europe through a new lens which lacks the restrictive logic of nation states and cultural or ethnic homogeneity. Policies should rise to the new challenges of diversity and counteract the deepening of all types of inequalities. Embracing difference and inclusion, rather than marginalisation and exclusion, will lead to a better use of services, gender- and difference-sensitive policies, with a healthier and happier future for all those who inhabit the EU territory.

²⁵⁵ Kruk, ME, Kujawski, S et al. (2016) Next generation maternal health: external shocks and health-system innovations *Lancet* 388: 2296-2306.

REFERENCES

- Acosta, CD, Harrison, DA, Rowan, K. et al. (2016) Maternal morbidity and mortality from severe sepsis: a national cohort study. *BMJ Open* 6: e012323.
- Agudelo-Suarez, A, Gil-Gonzalez D, Vives-Cases, L et al. (2012) A metasynthesis of qualitative studies regarding opinions and perceptions about barriers and determinants of health services' accessibility in economic migrants. *BMC Health Services Research* 12:461.
- Almeida, LM, Caldas, J, Ayres-de-Campos, D et al. (2013) Maternal health care in migrants: a systematic review. *Maternal and Child Health Journal* 17: 1346-1354.
- Arousell, A, and Carlbom, A. (2015) Culture and religious beliefs in relation to reproductive health. *Best Practice and Research Clinical Obstetrics and Gynaecology* 32:77-87. <http://dx.doi.org/10.1016/j.bpobgyn.2015.08.011>.
- Aspinall, PJ. (2014) *Hidden needs. Identifying key vulnerable groups in data collections: vulnerable migrants, gypsies and travellers, homeless people, and sex workers*. Brighton: Centre for Health Services Studies, University of Kent.
- Balaam, M.C, Akerjordet, K, Lyberg, A, et al. (2013) A qualitative review of migrant women's perception of their needs and experiences related to pregnancy and childbirth. *Journal of Advanced Nursing* 69(9): 1919-1930. doi:10.1111/jan.12139.
- Bradbury-Jones, C, Breckenridge, JP, Devaney, J et al. (2015) Priorities and strategies for improving disabled women's access to maternity services when they are affected by domestic abuse: a multi-method study using concept maps. *BMC Pregnancy and Childbirth* 15:350. doi: 10.1186/s12884-015-0786-7.
- Bradby H, Humphris, R, Newall D, Phillimore J. (2015) *Public health aspects of migrant health: a review of the evidence on health status for refugees and asylum seekers in the European Region*. Health Evidence Network synthesis report 44. Copenhagen: WHO Regional Office for Europe.
- Breckenridge, JP, Devaney, J, Kroll, T, et al. (2014) Access and utilisation of maternity care for disabled women who experience domestic abuse. *BMC Pregnancy and Childbirth* 14: 234-247.
- Campbell, O, Calvert, C, Testa, A, et al. (2016) The scale, scope, coverage and capability of childbirth care. *The Lancet* 388: 2193-2208.
- CHAFAEA (2014) *Action on health inequalities in the European Union. The EU Health Programme's contribution to fostering solidarity in health and reducing health inequalities in the European Union 2003–13*. Luxembourg: Consumers, Health and Food Executive Agency.
- Chiavarini, M, Lanari, D, Minelli, L. and Salmasi, L. (2014) Socio-demographic determinants and access to prenatal care in Italy, *BMC Health Services Research* 14:174.
- Cook, R and Dickens, BM. (2014) Reducing stigma in reproductive health. *International Journal of Gynecology and Obstetrics* 125(1): 89-92.
- David, M, Pachaly, J, Vetter, K. (2006) Perinatal outcome in Berlin (Germany) among immigrants from Turkey. *Archives of Gynaecology and Obstetrics* 274: 271-278.

- De Vito, E, de Waure, C, Specchia, M.L, Ricciardi, W. (2015) *Public health aspects of migrant health: a review of the evidence on health status for undocumented migrants in the European Region*. Health Evidence Network synthesis report 42. Copenhagen: WHO Regional Office for Europe.
- De Vito, E, de Waure, C, Specchia, M.L, et al. (2016) Are undocumented migrants' entitlements and barriers to healthcare a public health challenge for the European Union? *Public Health Reviews* 37:13, <https://doi.org/10.1186/s40985-016-0026-3>.
- De Vries, R. (2004) *A pleasing birth: midwives and maternity care in the Netherlands*. Philadelphia: Temple University Press.
- Donabedian, A. (2003) *An Introduction to quality assurance in health care*. Oxford: Oxford University Press.
- EASO (2018) *Annual report on the situation of asylum in the European Union 2017*. Luxembourg: European Asylum Support Office.
- Eling J. (2010) *Asylum seeker, refugee and vulnerable migrant services. Mapping and best practice report and recommendations*. London: Maternity Action.
- Escuriet, R, White, J, Beeckman, K et al. (2015) Assessing the performance of maternity care in Europe: a critical exploration of tools and indicators. *BMC Health Services Research* 15:491. EU COST Action IS0907. doi: 10.1186/s12913-015-1151-2.
- European Parliament. (2000). *Charter of fundamental rights of the European Union*. Luxembourg: Office for Official Publications of the European Communities.
- European Parliament (2013) *Discrimination Generated by the Intersection of Gender and Disability. A Study*, Directorate General for Internal Policies, Policies Department C: Citizens' Rights and Constitutional Affairs, Gender Equality, European Parliament, Brussels
- Fedeli, U, Alba, N, Lisiero, M et al. (2010) Obstetric hospitalisations among Italian women, regular and irregular immigrants in North-Eastern Italy. *Acta Obstetrica et Gynecologica Scandinavica* 89: 1432-1437.
- Flegar, V, Dallí, M, Toebes, B. (2016) Access to Preventive Health Care for Undocumented Migrants: A Comparative Study of Germany, the Netherlands and Spain from a Human Rights Perspective, in: *Laws* 5 (2016), 9, doi:10.3390/laws5010009.
- Gagnon, A.J, and Redden, K.L. (2016) Reproductive health research of women migrants to Western countries: a systematic review for refining the clinical lens. *Best Practice and Research Clinical Obstetrics* 32:3-14.
- Geltman, PL, and Meyers AF. (1999) Immigration legal status and use of public programs and prenatal care. *Journal of Immigrant Health* 1: 91-97.
- Gibson-Helm, M, Boyle, J, Cheng, I.H et al. (2015) Maternal health outcomes among women of refugee background from Asian countries. *International Journal of Gynecology and Obstetrics* 129: 146-151
- Glenton, C, Colvin, C.J, Carlsden, B. et al. (2013) Barriers and facilitators to the implementation of lay health worker programmes to improve access to maternal and child health: qualitative evidence synthesis. *Cochrane Systematic Review*.
- Hochschild, A. (1995) The culture of politics: traditional, postmodern, cold-modern and warm-modern ideals of care. *Social Politics* 2(3):331-346.

- Iosifidis, P and Boucas, D. (2015) *Media policy and independent journalism in Greece* London: Open Society Foundations.
- Iversen J, Page K, Madden A, Maher L. (2015) HIV, HCV and health-related harms among women who inject drugs: implications for prevention and treatment. *Journal of acquired immune deficiency syndromes* Jun 1:69 (01), 176-181. doi: 10.1097/QAI/0000000000000659.
- Kassenbaum, NJ, Bertozzi-Villa, A, Coggeshall MS et al. (2013) Global, regional and national levels and causes of maternal mortality during 1990-2013: a systematic analysis for the global burden of disease study. *The Lancet* 384: 980-1004.
- Kennedy, P, Murphy-Lawless, J. (2003) The maternity care needs of refugee and asylum seeking women in Ireland. *Feminist Review* 73: 39-53.
- Keygnaert, I, Guieu, A, Ooms, G et al. (2013) Sexual and reproductive health of migrants: does the EU care? *Health Policy* 114: 215-225.
- Keygnaert I, Ivanova, O, Guieu A, Van Parys A.S, et al. (2016) *What is the evidence on the reduction of inequalities in accessibility and quality of maternal health care delivery for migrants? A review of the existing evidence in the WHO European Region*. Health Evidence Network synthesis report 45. Copenhagen: WHO Regional Office for Europe.
- Knight, M. (2018) The findings of the MBRRACE-UK confidential enquiry into maternal deaths and morbidity. *Obstetrics, Gynaecology and Reproductive Medicine* 29(1): 21-23.
- Kringos, D, Boerma, W, Bourgeuil, Y et al. (2013) The strength of primary care in Europe: an international comparative study. *British Journal of General Practice* 63: e742-750.
- Kruk, M.E, Kujawski, S et al. (2016) Next generation maternal health: external shocks and health-system innovations. *The Lancet* 388: 2296-2306.
- Kvamme, E and Ytrehus, S. (2015) Barriers to health care among undocumented migrant women in Norway. *Society, Health & Vulnerability* 6(1):28668. <https://doi.org/10.3402/shv.v6.28668>
- Laird, LD, de Marrais, J, Barnes, LL. (2007) Portraying Islam and Muslims in MEDLINE: A content analysis. *Social Science & Medicine* 65: 2425–2439.
- Levesque J, Harris MF, Russell G. (2013) Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *Int J Equity Health* 12:18. doi: 10.1186/1475-9276-12.
- Luyben, A, Wijnen, HAA, Oblasser, C, et al. (2012) The current state of midwifery and development of midwifery research in four European countries. *Midwifery*. <http://dx.doi.org/10.1016/j.midw.2012.10.008>.
- Luyben, A., Barger, M., Avery, M. et al. (2017) Exploring global recognition of quality midwifery education: Vision or Fiction? *Women and Birth* 30:164-192.
- McCall, S.J, Li, Z, Kurinczuk, JJ, et al. (2019) *Maternal and perinatal outcomes in pregnant women with BMI>50: An international collaborative study*. PloS ONE 14(2): e0211278.
- McPake, B, Witter, S, Ensor, T et al. (2013) Removing financial barriers to access reproductive, maternal and newborn health services: the challenges and policy implications for human resources for health. *Human Resources for Health* 11:46. <https://doi.org/10.1186/1478-4491-11-46>

- Miteniece, E, Pavlova, M, Rechel, B, Groot, V. (2017) Barriers to accessing adequate maternal care in Central and Eastern European countries: A systematic literature review. *Social Science and Medicine* 17:1-8.
- Miteniece, E, Pavlova, M, Rechel, B, et al. (2019) Barriers to accessing adequate maternal care in Latvia: A mixed method study among women, providers and decision-makers. *Health Policy*, 123:87-95.
- Mladovsky, P, Rechel, B, Ingleby, D, McKee, M. (2012) Responding to diversity: an exploratory study of migrant health policies in Europe. *Health Policy* 105:1-9.
- Nair, M, Nelson-Piercy, C, Knight, M. (2017) Indirect maternal deaths: UK and global perspectives. *Obstetric Medicine* 10(1): 10-15.
- Norredam, M, Nielsen, S.S, Krasnik, A. (2010) Migrants' utilisation of somatic health care services in Europe – a systematic review. *European Journal of Public Health* 20: 555-563.
- Noordam, AC, Kuepper, BM, Stekelenburg, J et al. (2011) Improvement of maternal health services through the use of mobile phones. *Tropical Medicine and International Health* 16(5): 622-626.
- O'Donnell, C.A, Burns, N, Mair, F.S et al. (2016) Reducing the health care burden for marginalised migrants: The potential role for primary care in Europe. *Health Policy* 120: 495-508.
- ORAMMA (2017) *Approach to integrated perinatal healthcare for migrant and refugee women*. Operational Refugee and Migrant Maternal Approach, deliverable D4.2.
- Philibert, M, Deneux-Tharoux, C, Bouvier-Colle, MH. (2008) Can express maternal mortality among women of foreign nationality be explained by suboptimal obstetric care? *BJOG* 115: 1411-1418.
- Phillimore, J, (2015) Delivering maternity services in an era of superdiversity: the challenges of novelty and newness. *Ethnic and Racial Studies*, 38:4, 568-582 doi.org/10.1080/01419870.2015.980288.
- PICUM (2017) *Framing document*. EU Health Policy Platform. Thematic network on "Migration and Health". Platform for International Cooperation on Undocumented Migrants.
- Rechel, B, Mladovsky, P, Ingleby, D. et al. (2013) Migration and health in an increasingly diverse Europe. *Lancet* 381: 1235-45.
- Redshaw, M, Malouf, R, Gao, H, Gray, R. (2013) Women with disability: the experience of maternity care during pregnancy, labour and birth and the postnatal period. *BMC Pregnancy and Childbirth* 13: 1-14.
- Renfrew, M.J., Burns, E., Gross, M.M, Symon, A. (2015) Pathways to strengthening midwifery in Europe. *Entre nous*. digitalcollection.zhaw.ch.
- Robinson, S, and Thomson A.M (1989) *Research and Midwifery in Robinson, S, and Thomson A.M. (eds) Midwives Research and Childbirth*, 1:1-7. Chapman and Hall. London.
- Ross, L, McSherry, W, Giske, T, et al. (2018) Nursing and midwifery students' perceptions of spirituality, spiritual care, and spiritual care competency: A prospective, longitudinal, correlational European study. *Nurse Education Today* 67: 64–71.
- Say, L, Ghou, D, Gemmill, A. et al. (2014) Global causes of maternal death: a WHO systematic analysis. *Lancet Global Health* 2014 (2): e323-e333.

- Schutte, JM, Steegers, EA, Schuitemaker, NW et al. (2010) Rise in maternal mortality in the Netherlands *BJOG* 117: 399-406.
- Sen, G, Östlin, P, George, A. (2007) *Unequal, unfair, ineffective and inefficient: Gender inequity in health. Why it exists and how we can change it*. Women and Gender Equity Knowledge Network. Geneva: WHO Europe.
- Smith, L.K, Budd, J.L.S, Field, D.J. and Draper ES (2011) Socioeconomic inequalities in outcome of pregnancy and neonatal mortality associated with congenital anomalies: population based study. *British Medical Journal* 343.
- Stepurko, T, Pavlova, M, Gryga, I, et al. (2015) Informal payments for healthcare services: The cases of Lithuania, Poland and Ukraine. *Journal of Eurasian Studies* 6:46-58.
- UN CESCR (2000) *General comment No14. The right to the highest attainable standard of health*. United Nations Doc E/C12/2000/4.
- Van den Bergh, B.J, Gatherer, A, Fraser, A. and Moller, L. (2011) Imprisonment and women's health: concerns about gender sensitivity, human rights and public health. *Bulletin of the World Health Organisation*. Copenhagen: WHO Regional Office for Europe.
- United Nations (2015) *The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030)*. New York: Every Woman Every Child.
- United Nations (2014) *A universal pathway - A woman's right to health. The state of the world's midwifery 2014*. United Nations Population Fund.
- Van den Akker, T and van Roosmalen, J. (2016) Maternal mortality and severe morbidity in a migration perspective. *Best Practice and Research Clinical Obstetrics and Gynaecology* 32: 26-38.
- Van den Akker, T, Nair, M, Goedhart, M. et al. (2017) Maternal mortality: direct or indirect has become irrelevant. *Lancet* 5: e1181-e1182.
- Vázquez, M.L, Terraza-Núñez, R, S-Hernández, S. et al (2013) Are migrants' health policies aimed at improving access to quality healthcare? An analysis of Spanish policies. *Health Policy* 113: 236-246. <https://doi.org/10.1016/j.healthpol.2013.06.007>.
- Vázquez M.L, Vargas I, Jaramillo D.L, et al. (2016) Was access to health care easy for immigrants in Spain? The perspectives of health personnel in Catalonia and Andalusia. *Health Policy* 120(4):396-405.
- Verloo, M. (2006) Multiple inequalities, intersectionality and the European Union. *European Journal of Women's Studies* 13: 211.
- Walker, KF, Gribbin, C, Siddiqui, F. (2018) Cultural aspects of care in obstetrics and gynaecology. *Obstetrics Gynaecology and Reproductive Medicine* 28:11-12.
- Watson, H, and Downe, S. (2017) Discrimination against childbearing Romani women in maternity care in Europe: a mixed-methods systematic review. *Reproductive Health* 14:1. <https://doi.org/10.1186/s12978-016-0263-4>.
- WHO (2009) *Women's health in prison: Correcting gender equity in prison*. World Health Organisation. Regional Office Europe.
- WHO (2012) *The WHO application of ICD-10 to deaths during pregnancy, childbirth and the puerperium: ICD-MM*. Geneva: World Health Organisation.

- WHO (2016) *Maternal, newborn, child and adolescent health*. Progress Report 2014-15. Geneva: World Health Organisation.
- World Health Assembly (2008) *Health of migrants*. Executive Health Resolution. World Health Assembly. Geneva.
- WPL (2018) *Improving maternal healthcare for vulnerable women in EU28. What can you do?* Women Political Leaders Global Forum.
- Zadoroznyj, M, Benoit, C, Berry, S. (2012) Motherhoods, medicine and markets: the changing politics of postnatal health provision. *Sociological Research Online* 17(3) 24. <http://www.socresonline.org.uk/17/3/24.html>.

NOTES

This study, commissioned by the European Parliament's Policy Department for Citizens' Rights and Constitutional Affairs at the request of the FEMM Committee examines issues related to access of vulnerable social groups to maternal health care services and midwifery in the EU. As the study points out, this access is affected by the interplay of health systems, law, policies, socio-economic factors and attitudes of health professionals and users which leads to barriers to access and consequently to worse health outcomes for those women, as evidence demonstrates. This study critically discusses the issues, analyses the causes, surveys the literature for best practices and makes policy recommendations, aiming at improving the situation for vulnerable women and contributing to reduction of health inequalities.

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