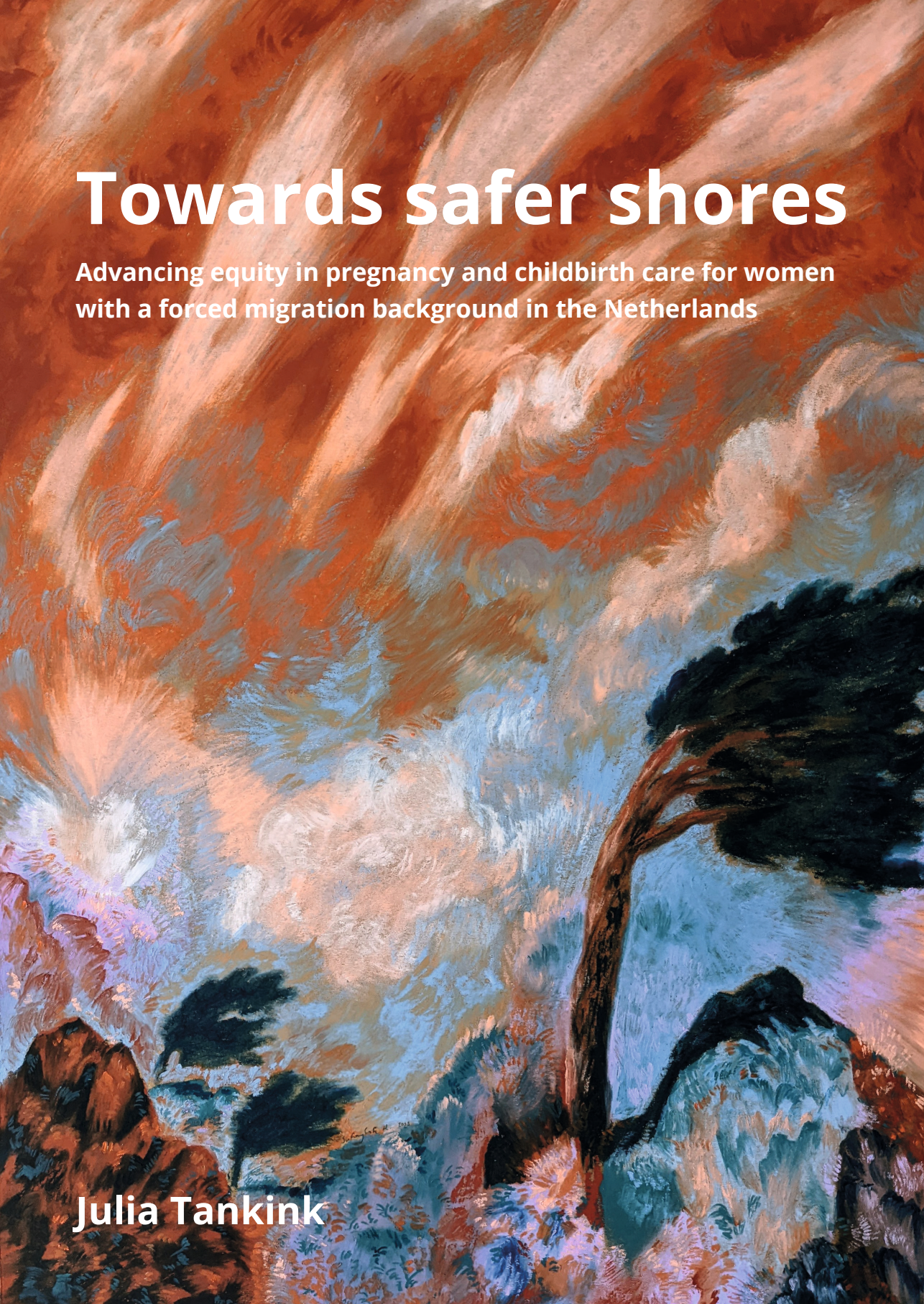
Towards safer shores

Advancing equity in pregnancy and childbirth care for women with a forced migration background in the Netherlands



Julia Tankink

Towards safer shores

Advancing equity in pregnancy and childbirth care for women with a forced migration background in the Netherlands

Julia Bieneke Tankink

Copyright 2024 © Julia Bieneke Tankink

All rights reserved. No parts of this thesis may be reproduced, stored in a retrieval system or transmitted in any form or by any means without permission of the author.

Provided by thesis specialist Ridderprint, ridderprint.nl
Printing: Ridderprint
Cover artwork: Suhaylah H. 'The End of Days' (2023)
Layout and design: Katie McGonigal, persoonlijkproefschrift.nl
ISBN: 978-94-6506-698-1

Towards Safer Shores:

Advancing equity in pregnancy and childbirth care for women
with a forced migration background in the Netherlands

Op weg naar veiliger havens:
Gezondheidsrechtvaardigheid in de zorg rondom zwangerschap en
geboorte voor vrouwen met een vluchtachtergrond in Nederland

Proefschrift

ter verkrijging van de graad van doctor aan de
Erasmus Universiteit Rotterdam
op gezag van de
rector magnificus

Prof.dr.ir. A.J. Schuit

en volgens besluit van het College voor Promoties.
De openbare verdediging zal plaatsvinden op

donderdag 9 januari 2025 om 10.30 uur

door

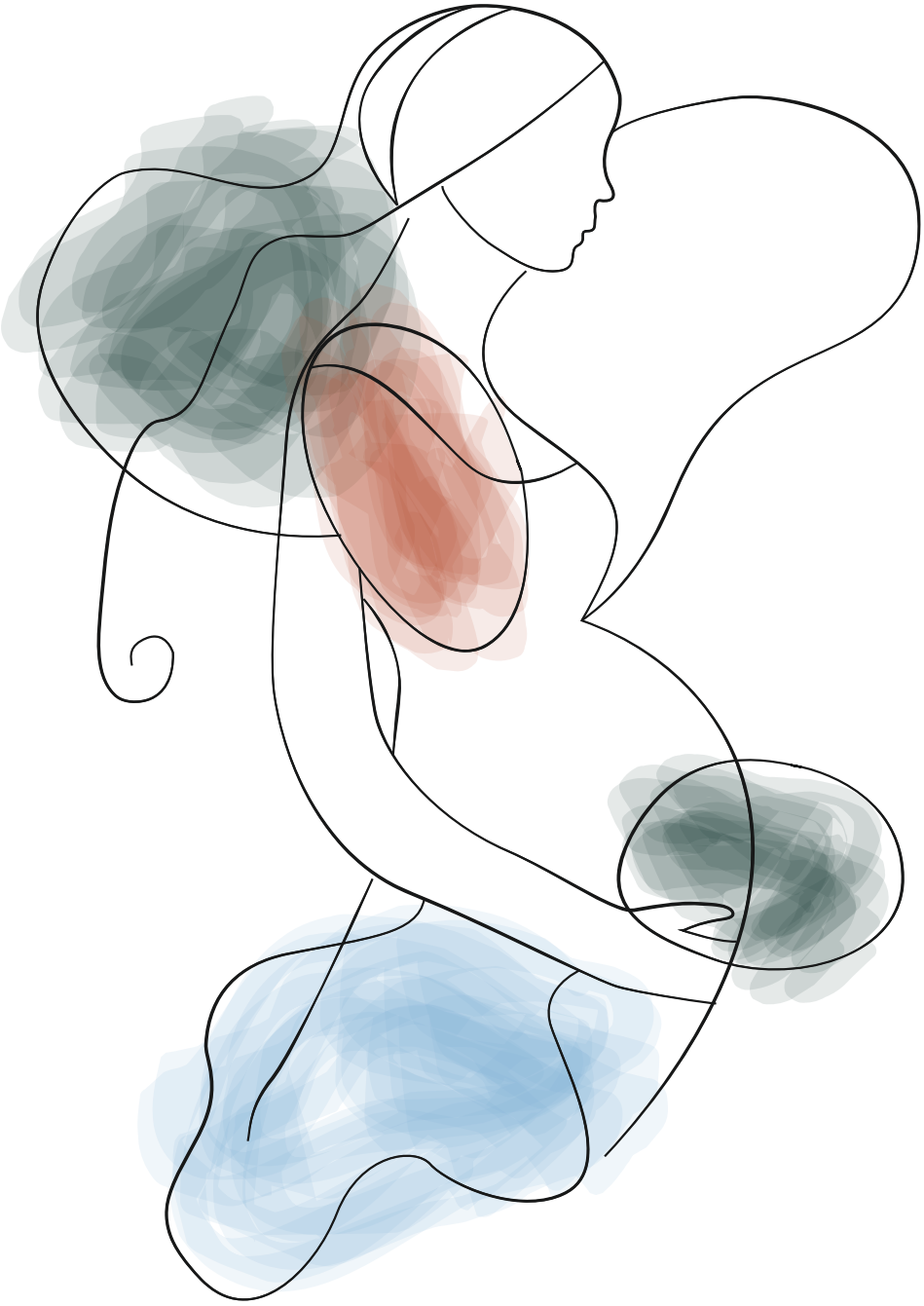
Julia Bieneke Tankink
geboren te Peize.

Erasmus University Rotterdam

Promotiecommissie:

Promotoren:	Prof. dr. A. Franx Prof. dr. M. E. T. C. van den Muijsenbergh
Overige leden:	Prof. dr. A. Burdorf Prof. dr. I. Hutter Prof. dr. C. O. Agyemang
Copromotoren:	Dr. J. P. de Graaf Dr. B. Goodarzi

Table of contents



Duha Khalal (12 jaar)

Part I

Pregnancy and childbirth outcomes of women with a forced migration background

Chapter one

General introduction

When people are forced to flee their homes in search of safer shores, securing a safe future for their current or unborn children is often one of their main concerns. In this context, pregnancy and childbirth care emerges as a critical arena to ensure physical, emotional and cultural safety surrounding the start of new life. Achieving this requires a healthcare system that is equitably attuned to the diverse needs of each individual, regardless of their social position, (migration) background or legal status.

This thesis examines the state of health equity within the Dutch system of pregnancy and childbirth care for women with a forced migration background. Specifically, we aimed to shed light on their maternal and perinatal health, evaluate the pregnancy and childbirth care they receive in the Netherlands, and derive recommendations for the advancement of equity in this area. The studies included in this thesis have been conducted in the context of the EGALITE project (2020-2024), which was supported by a grant from the Netherlands Organization for Health Research and Development (ZonMw; grant number 543003112).

The chapters of this thesis are structured into three parts. The first part examines the characteristics, maternal, and perinatal health outcomes of populations affected by forced migration in the Netherlands and Europe. The second part addresses the quality, experiences and challenges of pregnancy and childbirth care for these populations in the Netherlands. Part three of this thesis integrates these findings and unpublished data from the EGALITE project, and offers critical reflections and recommendations to enhance equity in pregnancy and childbirth care in a forced migration context.

In this introduction, I will first define and contextualize the key terminology used throughout the thesis. I will then provide a brief overview of the global and Dutch contexts of forced migration, summarizing existing knowledge, and research gaps that have shaped the design of this thesis. I will also delineate the research setting of pregnancy and childbirth care for women with a forced migration background in the Netherlands. Finally, I will outline the research questions and objectives addressed in each subsequent chapter.

Use of terminology

This thesis focuses on pregnant women affected by what is referred to as 'forced migration'. Following the definition of the International Organization for Migration, forced migration represents the extreme end of a continuum of migratory motives.[2] At one end, individuals willingly leave their country and meet the entry requirements of their destination country. At the opposite end, forced migration refers to '*a migratory movement which, although the drivers can be diverse, involves force, compulsion, or coercion*'.[3] The legal understanding of

forced migration is closely related to the United Nations Refugee Convention of 1951, which articulates the principle of non-refoulement, stating that '*a refugee should not be returned to a country where they face serious threats to their life or freedom*'.[4] This convention, ratified by the Netherlands among 145 countries, entitles people to protection in other countries when they are legally recognized as refugees. An 'asylum seeker' is someone whose request for legal recognition as a refugee is pending.[3] In this thesis, the term 'undocumented migrant' describes individuals without legal residency status, either because their asylum request for recognition as a refugee was rejected or they never filed one.

Navigating the terminology of migration in health research requires balancing precise definitions for research clarity against the risk of reinforcing harmful stereotypes or oversimplifying the complex realities of (forced) migration. Public discourse often leans towards dichotomizing categories, labeling people either as 'real' refugees' or as 'fortune hunters'.[5] In reality, people rarely migrate based on a single motive, and their reasons might be neither completely voluntary nor totally forced.[6] Moreover, seemingly specific terms still signify imprecise classifications: for instance, not all asylum seekers are necessarily forced migrants, and not all forced migrants obtain a formal refugee status.[1] Therefore, the lack of fully consistent terminology in this thesis reflects methodological challenges, ethical considerations, as well as the multi-layered nature of migration experiences.

In each of the following chapters, the study populations will be defined and delineated as specifically as possible. Most chapters include the terms 'asylum seekers' and 'refugees' ('statushouders' in Dutch) to denote women who hold these specific legal statuses. Meanwhile, more inclusive terms such as 'forcibly displaced people', 'people with a forced migration background' or 'forced migrants' indicate broader populations where applicable.

The terminology used to refer to populations without a migration background also varies between studies, often including terms such as 'host population' or 'local population'. This raises questions regarding who is considered 'native' or 'local'. To maintain precise terminology, this thesis predominantly uses 'non-migrants' to refer specifically to people who have never migrated, and 'general population' to describe the entire population.

When discussing 'pregnancy and childbirth care', we refer to comprehensive healthcare during pregnancy, childbirth, and the postpartum period. It involves prenatal visits, support and interventions during childbirth, and postnatal care for both the mother and newborn. In addition to pregnancy and childbirth care, the terms 'perinatal care' and 'maternity care' are also used in subsequent chapters to describe this continuum of care. Similarly, the terms 'pregnancy (and childbirth)

outcomes' and 'maternal and perinatal outcomes' are used interchangeably. These outcomes are specified where applicable, though generally encompass all health results for both the mother and baby during pregnancy, childbirth, and the immediate postnatal period. Last, where the term 'women' is used in this thesis, we acknowledge and intend to include all individuals with a uterus, including those with a different gender identity.

Research context

Forced migration and the Dutch situation

In 2022, the global population affected by forced migration increased to an unprecedented number of 108.4 million people.[4] A significant part of this population concerns internally displaced people that remain within country borders. Among externally displaced people, 76% are hosted in low and middle-income countries, while 70% reside in neighboring countries, such as Iran, Pakistan, and Uganda.[4] The International Organization for Migration has identified the journey to Europe as the most dangerous of all migration routes, with over 28.000 fatalities and missing people since 2014 on the Central Mediterranean route only.[7]

In the Netherlands, asylum seekers constitute a minority of approximately 10% of the total number of immigrants per year. Specifically, in 2023, the country received 38.377 initial asylum requests, while another 10.125 individuals arrived through family reunification, according to Statistics Netherlands.[8] These figures do not include over 108.000 Ukrainians who were granted residence under a European Union (EU) temporary protection directive, thereby bypassing the asylum system.[9]

The number and origin of asylum seekers in the Netherlands has fluctuated markedly in the past decades, indicative of larger global patterns of conflict and displacement. The most significant influx occurred in 1994, following the war in Yugoslavia, and more recently in 2015 due to the Syrian crisis. By 2023, the primary countries of origin among asylum seekers in the Netherlands were Syria (36%), followed by Afghanistan and Turkey (both 8%).

When applying for asylum in the Netherlands, people are first required to report to an intake center of the Immigration and Naturalization Service (IND). Typically, the following general asylum procedure consists of two interviews with the IND. By the end of 2023, the waiting time prior to the initial interview was 14 weeks on average, and 37 weeks for the follow-up. The average processing time of asylum applications increased to one year.[10] The approval rates for residence permits have shown variability, ranging from 34-85% from 2014 through 2022.[8] The majority of first asylum applications in the Netherlands are submitted by men,

while women more often receive residence permits based on family reunification. In 2023, approximately 20% of the asylum-seeking population concerned women of reproductive age.[8]

Forced migration and health in pregnancy and childbirth

Migration influences health outcomes through complex mechanisms that unfold before, during and after displacement; in the countries of origin, transit, and destination; and on the levels of the (healthcare) system, socioeconomic forces, and the individual characteristics of migrants.[11-13] Epidemiological research into the health impacts of migration illustrates this complexity, as findings diverge into different directions. A longstanding body of evidence has documented health disadvantages of migrants relative to native populations, encompassing a wide spectrum of outcomes ranging from cardiovascular events and psychiatric conditions to infectious diseases.[14-16] Many of these studies have linked the 'pathogenic' health effects of migration to social stratification, through determinants including socioeconomic disadvantage, discrimination and psychosocial stress.[17,18] Conversely, numerous studies have described the 'healthy migrant paradox', where migrant populations initially exhibit better health outcomes than the resident population in certain contexts.[11] This effect is typically attributed to selection bias, with healthier individuals being more likely to migrate, and to the healthier lifestyles of migrants compared to those prevalent in the country of resettlement.[19]

In the field of pregnancy and childbirth, research comparing outcomes between migrants and resident populations in the Global North has begun to take shape from the 1990s. Early systematic reviews did not consistently identify migrant status as a risk indicator for adverse maternal or perinatal outcomes.[11,12] While some studies indicated increased risks, such as higher rates of caesarean sections, pregnancy complications, perinatal mortality, and postpartum depression, others reported lower odds of adverse outcomes, including preterm birth and low birthweight.[20-23]

The observed discrepancies in pregnancy and childbirth outcomes have commonly been attributed to the heterogeneity across migrant study populations, varying by ethnic background, socioeconomic status and migration-related characteristics such as length of residence and legal status in the host country.[24,25] Differences in the specific outcomes examined and the study settings across different countries also contribute to the inconsistencies in findings. In particular, multiple studies have highlighted the crucial role of migration policies as key determinants of maternal and perinatal health.[27,28] Collectively, the available evidence implies that different outcomes among migrant and general populations should not be ascribed to genetics or other biological differences. Instead, it is increasingly

recognized that these health differences represent *'tangible manifestations of persistent inequities in global health and socioeconomic development'*.[26]

Within this landscape of social and structural or '*superdeterminants'* of health, a growing body of research identified women with a forced migration background as a specifically disadvantaged migrant population in pregnancy and childbirth.[26] While a 2002 review found *'extremely little evidence'* available, more recent systematic reviews have consistently reported higher risks of perinatal mortality, mental health disorders, and other adverse outcomes among these women compared to the general population of the study country, as well as other migrant cohorts.[29-33] Additional negative health determinants associated with forced migration include armed conflict, sexual and gender-based violence, and limited access to care.[29] However, targeted research addressing the added risks of women with a forced migration background remains highly limited.[34-36]

In the Netherlands, the percentage of newborns with mothers who were not born in the country themselves increased from 25% to 32% between 2010 and 2020.[37] Approximately 21% of these mothers are classified as having a 'non-Western' origin, a category that traditionally mostly included Morocco, the Dutch Caribbean, Turkey, and Suriname. Various Dutch studies have consistently shown that rates of adverse outcomes, in particular perinatal mortality, are elevated among non-Western migrants.[38-40] In 2016, the rate of perinatal mortality in the non-Western group was more than 50% higher than the national average for pregnancies between 32 and 37 weeks, and 30% higher for full-term births.[37] Notably, between 2004 and 2016, the proportion of perinatal deaths with a maternal background classified as '*other* non-Western' – thus excluding Morocco, the Dutch Caribbean, Turkey, or Suriname – increased from 7% to 12%. This group likely includes a significant number of women from world regions with high rates of forced migration, yet more precise data were lacking at the time of designing our studies.

Pregnancy and childbirth care for women with a forced migration background

Studies have demonstrated barriers in accessing and receiving the right care at the right time across migrant populations.[41] Most migrant groups enter prenatal care later in pregnancy than the general population, a trend also observed in the Netherlands.[40,42] In addition, care provision does not always meet the needs of women with migration backgrounds.[43,44] Commonly reported challenges in this regard include communication barriers and clients' limited understanding of the care system in the host country.[46,47] In the Dutch context, one study reported that substandard care—such as delayed responses to women's pregnancy-related

complaints—contributed to severe maternal morbidity in a broad migrant population.[45]

Although research indicates that individuals with a forced migration background face unique complexities and a high risk of receiving substandard or suboptimal care, limited research has focused on the specific needs of this population. Studies from outside the Netherlands reported distinct barriers to accessing and receiving timely and adequate care, such as restricted healthcare rights and frequent relocations of asylum seekers. The experiences of care among women with a forced migration background vary in the literature, influenced by factors such as the continuity of care, cultural appropriateness and care providers' attitudes.[53] However, prior to the design of this thesis however, no previous research had specifically examined the accessibility, experience or quality of care among this population in the Netherlands.[44,50-52]

Another research gap in the Dutch context concerns the optimal organization of care and the role of guidelines in care for women with a forced migration background. Internationally, the World Health Organization provides technical guidance for pregnancy and childbirth care tailored to migrant populations.[48] In the Netherlands, the 'Multidisciplinary Guideline Birth Care for Asylum Seekers' has been developed in 2010. This effort was prompted by the Dutch Health Inspectorate's call for standardized care practices following critical incidents, including the death of a pregnant asylum seeker. Despite its importance, the effectiveness of this guideline for the quality of care and structured collaboration among care providers and professionals at asylum reception centers remains uncertain. The adherence to recommended practices, such as involving professional interpreters in care and avoiding relocations of pregnant asylum seekers during the twelve weeks surrounding childbirth, has not been formally evaluated. Furthermore, the organization of care for recognized refugees who have recently exited the asylum system has not been studied, and it is unknown whether specific guidelines are needed to address care for his group.

Given these gaps, there is an urgent need for precise data concerning the maternal and perinatal health outcomes of women with a forced migration background in the Netherlands. In addition, there is a dearth of knowledge regarding the organization, experiences, and quality of pregnancy and childbirth care for these women.

Research setting

Housing of asylum seekers and refugees in the Netherlands

Asylum seekers in the Netherlands are entitled to accommodation in reception centers managed by the Central Agency for the Reception of Asylum Seekers

(COA), a governmental agency under the Ministry of Justice and Security. Initially, accommodation is provided in one of the two Central Reception Locations (COL) in Ter Apel or Budel. Once their asylum procedure formally starts, people are relocated to Process Reception Locations (POL), and subsequently to asylum reception centers (AZC in Dutch). However, by the end of 2023, over half of all asylum seekers in the Netherlands were accommodated in emergency or crisis reception locations managed by the COA or local municipalities. In 2022 and 2023, the shortage of available accommodation led to multiple instances where people were forced to spend the night in the open air.

When asylum seekers are formally recognized as refugees and receive a residence permit, they become eligible for regular social housing in Dutch municipalities. Due to a backlog in social housing available to this population, more than 16.000 recognized refugees were still accommodated in the asylum reception system by the end of 2023.

Organization of healthcare for asylum seekers and refugees
The COA is mandated with the organization and financing of healthcare for asylum seekers, which is not covered by regular Dutch health insurance. Since 2007, the provision of primary healthcare within asylum reception centers has been outsourced to private agencies. Currently, GZA Healthcare is the main contracted party for primary care, which includes medical screening of newly arrived asylum seekers. In the first two months after arrival, asylum seekers are only entitled to medically necessary and non-deferrable care, which always includes pregnancy and childbirth care. After this period, medical doctors at GZA may refer asylum seekers to the regular Dutch healthcare system for healthcare that is covered by the 'Regulation Medical care Asylum Seekers (RMA)'. The RMA insurance scheme largely aligns with basic healthcare covered by the Dutch Health Insurance Act, although several services such as fertility and transgender care are largely exempted.

Refugees with a residence permit who have left the asylum reception centers have access to healthcare through the regular Dutch system and insurance.

Pregnancy and childbirth care in the Dutch setting
Unlike primary healthcare, pregnancy and childbirth care for women in asylum reception centers are organized through the regular Dutch system. In case of pregnancy, women in asylum reception centers are referred to a midwifery practice or hospital by COA or GZA. In the Dutch system, independent community care midwives collaborate with obstetric care providers in hospitals to offer integrated care throughout pregnancy and childbirth. Most pregnant women start care with a midwife, who may refer to the hospital when complications arise that

necessitate obstetrician-led care. While midwives can also oversee uncomplicated births at home, in birth centers, or in hospital settings, more than 70 percent of all pregnant women in the Netherlands ultimately gives birth in hospitals under the responsibility of obstetricians (ref). After childbirth, postpartum care continues to be provided by midwives as well as by specialized postpartum care nurses (also referred to as 'maternity care assistants').

Professional (telephone) interpreter services for healthcare are offered by several agencies in the Netherlands. The costs for interpreters in healthcare are reimbursed by the RMA insurance for asylum seekers. For refugees with a residence permit, the costs for interpreters in pregnancy and childbirth care were only covered by governmental insurance after January 1st, 2023.

The EGALITE project

The EGALITE project (2020-2024) was funded by ZonMw (grant number 543003112) and carried out by a research group in the Erasmus Medical Center, in collaboration with nine midwifery practices in the Netherlands, and the stakeholders represented in the collective that developed the national guideline for pregnancy and childbirth care to asylum seekers. The project was initiated to evaluate the implementation of this guideline, with the overarching objective to develop recommendations for pregnancy and childbirth care for asylum seekers and refugees in the Netherlands. The following section will delineate the specific aims and outline of the consequent chapters in this thesis.

Aims and outline of this thesis

Part I of this thesis provides an overview of the characteristics and maternal and perinatal health outcomes of women with a forced migration background. In **chapter two**, we aimed to systematically review these outcomes in the specific populations of asylum seekers and undocumented migrants in European countries. **Chapter three** serves to map the maternal characteristics and prevalence of risk factors for adverse birth outcomes among all live births registered in Dutch asylum reception centers. In **chapter four**, we aimed to examine the rate of adverse maternal and perinatal outcomes among women with a forced migration background on a nationwide scale, and compare these to other migrant women and the non-migrant Dutch population.

Part II of this thesis shifts the focus to the experiences behind these clinical outcomes, and the challenges and quality of pregnancy and childbirth care for women with a forced migration background in the Netherlands. In **chapter five**, the objective was to identify specific suboptimal care factors in cases of adverse

maternal and perinatal health outcomes among refugees and asylum seekers in the Dutch national perinatal audit registry. In **chapter six**, we explored the organization of care provision including the implementation of the national guideline for care to asylum seekers, as well as midwives' perspectives regarding the main challenges and target areas for improvement. In **chapter seven**, we conducted in-depth interviews with midwives, to identify specific barriers and understand how these are managed in current care practices, aiming to extract insights for the development of targeted recommendations.

Part III of this thesis offers a comprehensive reflection and future perspectives based on all previous findings and additional data. **Chapter eight** presents a preliminary version of the final report from the EGALITE project, aimed at developing recommendations for policy and practice through a participatory action approach. This chapter synthesizes the findings from the previous studies, and includes results from focus group discussions with all stakeholders conducted in the last phase of the project. In addition, we incorporated preliminary data regarding the quality of care and the experiences of women who have received pregnancy and childbirth care as asylum seekers or refugees themselves.

In **chapter nine**, the **general discussion**, I will contextualize our research within the broader field of literature, reflect on key lessons and methodological considerations, and outline future research directions. The discussion will conclude with key recommendations for policy and practice.

References

1. Wenner J, Namer Y, Razum O. Migrants, refugees, asylum seekers: Use and misuse of labels in public health research. In: Krämer, A., Fischer, F. (eds). *Refugee migration and health: challenges for Germany and Europe*. Cham: Springer; 2019: 49-62.
2. International Organization of Migration. The Global Context of International Migration. 2023. https://emm.iom.int/handbooks/global-context-international-migration.
3. International Migration Law No. 34 - Glossary on Migration. Geneva: International Organization of Migration, 2019.
4. UNHCR. Global Trends: Forced Displacement in 2022. Copenhagen: UNHCR Global Data Service, Statistics and Demographics Section; 2023.
5. Schoor C, Viola L. Asylum Seekers or Fortune Seekers? In: Fábián A, ed. *The Representation of Refugees and Migrants in European National Media Discourses from 2015 to 2017: A Contrastive Approach (Corpus Linguistics)*. Berlin, Heidelberg: Springer Berlin Heidelberg; 2023: 195-223.
6. De Haas H, Czaika M, Flahaux ML, et al. International migration: Trends, determinants, and policy effects. *Population and Development review* 2019; **45**(4): 885-922.
7. International Organization of Migration (IOM). Missing Migrants Project. 2024. Available from: https://missingmigrants.iom.int/data (accessed 26 Jan 2024).
8. Statistics Netherlands. Asielverzoeken en nareizigers; nationaliteit, geslacht en leeftijd. 2024.
9. Rijksoverheid. Cijfers opvang vluchtelingen uit Oekraïne in Nederland. 2024. Available from: https://www.rijksoverheid.nl/onderwerpen/opvang-vluchtelingen-uit-oekraine/cijfers-opvang-vluchtelingen-uit-oekraine-in-nederland (accessed 26 Jan 2024).
10. Immigratie- en Naturalisatiedienst (IND). Asiel: laatste ontwikkelingen. Available from: https://ind.nl/nl/asiel-laatste-ontwikkelingen#:~:text=Beslistermijn%20van%20uw%20asielaanvraag,te%20verlengen%20met%209%20maanden (accessed 26 Jan 2024).
11. Zeeb, H., Stronks, K., Agyemang, C., Spallek, J. (2023). Epidemiological Studies on Migrant Health. In: Ahrens, W., Pigeot, I. (eds) *Handbook of Epidemiology*. Springer, New York, NY.
12. Abubakar I, Aldridge RW, Devakumar D, et al. The UCL–Lancet Commission on Migration and Health: the health of a world on the move. *The Lancet* 2018; **392**(10164): 2606-54.
13. Wickramage K, Vearey J, Zwi AB, Robinson C, Knipper M. Migration and health: a global public health research priority. *BMC public health* 2018; **18**: 1-9.
14. Cantor-Graae E, Pedersen CB. Full spectrum of psychiatric disorders related to foreign migration: a Danish population-based cohort study. *JAMA psychiatry* 2013; **70**(4): 427-35.
15. Bustamante LH, Cerqueira RO, Leclerc E, Brietzke E. Stress, trauma, and posttraumatic stress disorder in migrants: a comprehensive review. *Brazilian Journal of Psychiatry* 2017; **40**: 220-5.
16. Castelli F, Sulis G. Migration and infectious diseases. *Clinical Microbiology and Infection* 2017; **23**(5): 283-9.
17. De Maio FG. Immigration as pathogenic: a systematic review of the health of immigrants to Canada. *International Journal for Equity in Health* 2010; **9**: 1-20.
18. Chilunga FP, Boateng D, Henneman P, et al. Perceived discrimination and stressful life events are associated with cardiovascular risk score in migrant and non-migrant populations: The RODAM study. *International Journal of Cardiology* 2019; **286**: 169-74.
19. Agyemang C. Comfy zone hypotheses in migrant health research: time for a paradigm shift. *Public Health* 2019; **172**: 108-15.

20. Vangen S, Stoltenberg C, Stray-Pedersen B. Complaints and complications in pregnancy: a study of ethnic Norwegian and ethnic Pakistani women in Oslo. *Ethnicity and Health* 1999; **4**(1/2): 19.
21. Essén B, Hanson BS, Östergren Po, Lindquist PG, Gudmundsson S. Increased perinatal mortality among sub-Saharan immigrants in a city-population in Sweden. *Acta Obstetricia et Gynecologica Scandinavica* 2000; **79**(9): 737-43.
22. Stewart DE, Gagnon A, Saucier J-F, Wahoush O, Dougherty G. Postpartum depression symptoms in newcomers. *The Canadian Journal of Psychiatry* 2008; **53**(2): 121-4.
23. Guendelman S, Buekens P, Blondel B, Kaminski M, Notzon FC, Masuy-Stroobant G. Birth outcomes of immigrant women in the United States, France, and Belgium. *Maternal and Child health Journal* 1999; **3**: 177-87.
24. Sørbye IK, Daltveit AK, Sundby J, Vangen S. Preterm subtypes by immigrants' length of residence in Norway: a population-based study. *BMC Pregnancy and Childbirth* 2014; **14**(1): 1-14.
25. Sow M, Schoenborn C, De Spiegelaere M, Racape J. Influence of time since naturalisation on socioeconomic status and low birth weight among immigrants in Belgium. A population-based study. *PLOS ONE* 2019; **14**(8): e0220856.
26. Souza JP, Day LT, Rezende-Gomes AC, et al. A global analysis of the determinants of maternal health and transitions in maternal mortality. *The Lancet Global Health* 2023.
27. Bollini P, Pampallona S, Wanner P, Kupelnick B. Pregnancy outcome of migrant women and integration policy: a systematic review of the international literature. *Social Science & Medicine* 2009; **68**(3): 452-61.
28. Juárez SP, Honkaniemi H, Dunlavy AC, et al. Effects of non-health-targeted policies on migrant health: a systematic review and meta-analysis. *The Lancet Global Health* 2019; **7**(4): e420-e35.
29. Gagnon AJ, Merry L, Robinson C. A Systemic Review of Refugee Women's Reproductive Health. *Refuge* 2002; **21**: 6.
30. Heslehurst N, Brown H, Pemu A, Coleman H, Rankin J. Perinatal health outcomes and care among asylum seekers and refugees: a systematic review of systematic reviews. *BMC Medicine* 2018; **16**(1): 1-25.
31. Hadgkiss EJ, Renzaho AM. The physical health status, service utilisation and barriers to accessing care for asylum seekers residing in the community: a systematic review of the literature. *Australian Health Review* 2014; **38**(2): 142-59.
32. Fellmeth G, Fazel M, Plugge E. Migration and perinatal mental health in women from low-and middle-income countries: a systematic review and meta-analysis. *BJOG: An International Journal of Obstetrics & Gynaecology* 2017; **124**(5): 742-52.
33. Gissler M, Alexander S, MacFarlane A, et al. Stillbirths and infant deaths among migrants in industrialized countries. *Acta Obstetricia et Gynecologica Scandinavica* 2009; **88**(2): 134-48.
34. Behboudi-Gandevani S, Bidhendi-Yarandi R, Panahi MH, Mardani A, Prinds C, Vaismoradi M. Perinatal and Neonatal Outcomes in Immigrants From Conflict-Zone Countries: A Systematic Review and Meta-Analysis of Observational Studies. *Frontiers in Public Health* 2022; **10**.
35. Sturrock S, Williams E, Greenough A. Antenatal and perinatal outcomes of refugees in high income countries. *Journal of Perinatal Medicine* 2021; **49**(1): 80-93.
36. Harakow HI, Hvidman L, Wejse C, Eiset AH. Pregnancy complications among refugee women: a systematic review. *Acta Obstetricia et Gynecologica Scandinavica* 2021; **100**(4): 649-57.
37. Achterberg P, Harbers M, Post N, Visscher K. Beter weten: Een beter begin: Samen sneller naar een betere zorg rond de zwangerschap. Bilthoven: Rijksinstituut voor Volksgezondheid en Milieu (RIVM); 2020.

38. Troe EJW, Bos V, Deerenberg IM, Mackenbach JP, Joung IM. Ethnic differences in total and cause-specific infant mortality in the Netherlands. *Paediatric and Perinatal Epidemiology* 2006; **20**(2): 140-7.
39. Ravelli AC, Tromp M, Eskes M, et al. Ethnic differences in stillbirth and early neonatal mortality in The Netherlands. *Journal of Epidemiology & Community Health* 2010.
40. Posthumus AG, Schölmerich VL, Steegers EA, Kawachi I, Denktaş S. The association of ethnic minority density with late entry into antenatal care in the Netherlands. *PLOS ONE* 2015; **10**(4): e0122720.
41. Fair F, Raben L, Watson H, et al. Migrant women's experiences of pregnancy, childbirth and maternity care in European countries: A systematic review. *PLOS ONE* 2020; **15**(2): e0228378.
42. Choté AA, De Groot CJ, Bruijnzeels MA, et al. Ethnic differences in antenatal care use in a large multi-ethnic urban population in the Netherlands. *Midwifery* 2011; **27**(1): 36-41.
43. Saastad E, Vangen S, Frederik Frøen J. Suboptimal care in stillbirths–a retrospective audit study. *Acta Obstetricia et Gynecologica Scandinavica* 2007; **86**(4): 444-50.
44. Asif S, Baugh A, Jones NW. The obstetric care of asylum seekers and refugee women in the UK. *The Obstetrician & Gynaecologist* 2015; **17**(4): 223-31.
45. Jonkers M, Richters A, Zwart J, Öry F, van Roosmalen J. Severe maternal morbidity among immigrant women in the Netherlands: patients' perspectives. *Reproductive Health Matters* 2011; **19**(37): 144-53.
46. Boerleider AW, Francke AL, Manniën J, Wiegers TA, Devillé WL. "A mixture of positive and negative feelings": A qualitative study of primary care midwives' experiences with non-western clients living in the Netherlands. *International Journal of Nursing Studies* 2013; **50**(12): 1658-66.
47. Robertshaw L, Dhesi S, Jones LL. Challenges and facilitators for health professionals providing primary healthcare for refugees and asylum seekers in high-income countries: a systematic review and thematic synthesis of qualitative research. *BMJ open* 2017; **7**(8): e015981.
48. World Health Organization. Improving the health care of pregnant refugee and migrant women and newborn children: Technical guidance. Copenhagen: WHO Regional Office for Europe; 2018.
49. Bo Brancheorganisatie Geboortezorg; Asylum Seeker Healthcare ('GZA'); Central Agency for the Reception of Asylum Seekers ('COA'); Royal Dutch Organisation of Midwives (KNOV); RMA Healthcare. Dutch Guideline Perinatal Care for Asylum Seekers ('Ketenrichtlijn Geboortezorg Asielzoeksters'). 2020. https://www.kennisnetgeboortezorg.nl/nieuws/actualisatie-ketenrichtlijn-geboortezorg-asielzoekers/ (accessed March 13 2022).
50. Leppälä S, Lamminpää R, Gissler M, Vehviläinen-Julkunen K. Hindrances and facilitators in humanitarian migrants' maternity care in Finland: qualitative study applying the three delays model framework. *Scandinavian Journal of Caring Sciences* 2020; **34**(1): 148-56.
51. Feldman R. When maternity doesn't matter: dispersing pregnant women seeking asylum. *Reproductive Health Matters* 2013; **21**(42): 212-7.
52. Feldman R, Musgrave A. "Dispersal" of asylum seeking women in UK during pregnancy. *BMJ* 2015; **351**.
53. Kasper A, Mohwinkel L-M, Nowak AC, Kolip P. Maternal health care for refugee women-A qualitative review. *Midwifery* 2022; **104**: 103157.
54. GGD GHOR, GZA. Gezondheidszorg voor asielzoekers in Nederland (Factsheet). 2019.
55. GGD GHOR. Factsheet Pasgeboren kinderen en hun moeders in de COA-opvang 2016 tot en met 2020: feiten en achtergronden. 2022. Available from: https://www.venvn.nl/media/z40hwapj/factsheet-ggdghor-geboortes-coa-opvang_2022-1.pdf.

Chapter two

Maternal and perinatal outcomes of asylum seekers and undocumented migrants in Europe: a systematic review

N.C. Gieles* & J.B. Tankink*, M. van Midde, J. Düker, P.J.A. van der Lans, C.M. Wessels, K.W.M. Bloemenkamp, G. Bonsel, T. van den Akker, S. Goosen, M.J. Rijken, J.L. Browne

*Shared first authorship

Published in: *European Journal of Public Health* (2019), 29(4), 714-723.

Abstract

Background
Asylum seekers (AS) and undocumented migrants (UM) are at risk of adverse pregnancy outcomes due to adverse health determinants and compromised maternal healthcare access and service quality. Considering recent migratory patterns and the absence of a robust overview, a systematic review was conducted on maternal and perinatal outcomes in AS and UM in Europe.

Methods
Systematic literature searches were performed in PubMed/MEDLINE and EMBASE (until[1] May[2017]), complemented by a grey literature search (until[1] June[2017]). Primary research articles reporting on any maternal or perinatal outcome, published between[2007] and[2017] in English/Dutch were eligible for inclusion. Review protocols were registered on Prospero: CRD42017062375 and CRD42017062477. Due to heterogeneity in study populations and outcomes, results were synthesized narratively.

Results
Of[4652] peer-reviewed articles and[145] grey literature sources screened,[11] were included from[4] European countries. Several studies reported adverse outcomes including higher maternal mortality (AS), severe acute maternal morbidity (AS), preterm birth (UM) and low birthweight (UM). Risk of bias was generally acceptable, although the limited number and quality of some studies preclude definite conclusions.

Conclusion
Limited evidence is available on pregnancy outcomes in AS and UM in Europe. The adverse outcomes reported imply that removing barriers to high-quality maternal care should be a priority. More research focussing on migrant subpopulations, considering potential risk factors such as ethnicity and legal status, is needed to guide policy and optimize care.

Key points
- Asylum seekers and undocumented migrants are subpopulations of migrants who face specific negative health determinants that put them at risk of adverse maternal and perinatal outcomes.
- This review identified a lack of research on asylum seekers and undocumented migrants. The available studies often have methodological limitations.

- Adverse outcomes reported for asylum seekers include a higher maternal mortality and severe acute maternal morbidity compared with the host country's population.
- Adverse outcomes reported for undocumented migrants include more preterm birth and low birth weight in babies from undocumented migrants compared with documented migrants.
- Clinical registration of migration-related health determinants and studies that disaggregate data for migrant subpopulations could provide insight into risk factors for adverse outcomes and how to address these in policy and practice.

Introduction

As migration into Europe has increased in the past decade, understanding the relation between migration and health outcomes can guide appropriate policy responses including improved healthcare provision.[1,2] The high number of women and children among migrant populations requires a specific evaluation of maternal and perinatal health outcomes.[3] Compared with host-country populations (HP), poorer as well as better pregnancy outcomes have been reported in migrants, the latter often being referred to as the 'healthy migrant effect'.[4–10] These divergent outcomes are a result of an interplay of determinants before migration, *en route* and after reaching the resettlement country.[11–13] Disaggregating data on subpopulations of migrants may reveal why some migrant women have worse pregnancy outcomes than others.[14–16] One way to differentiate migrants is by legal status, which determines many of their rights, social opportunities and access to healthcare.[17] Through these factors, asylum seekers (AS) and undocumented migrants (UM) may face particular risks during pregnancy.[16,18–20] Reviews on pregnancy outcomes in these groups are scarce and inconclusive, possibly as a result of heterogeneous study populations.[21–23] This systematic review aims to provide an overview of maternal and perinatal outcomes in AS and UM in the past decade in Europe.

Methods

Protocol and registration

A protocol for each study population was initially registered with the international prospective register of systematic reviews: PROSPERO (AS: CRD42017062477 and UM: CRD42017062375). These protocols were based on PRISMA guidelines and merged after registration. To allow for a concise review focussed on health

outcomes, we decided to deviate from the original registered protocols by only including quantitative studies into this review.

Study populations were defined according to the International Organization of Migration (IOM, box 1):[24]

Box 1. Definition of study populations

Asylum seeker: 'A person who seeks safety from persecution or serious harm in a country other than his or her own and awaits a decision on the application for refugee status under relevant international and national instruments'.
Undocumented migrant: (…) 'people whose entry, stay or work in a country is without the necessary authorization or documentation under immigration regulations'.

Eligibility criteria
All studies reporting maternal, perinatal or neonatal outcomes (from22 weeks of gestation up to28 days postpartum) in AS or UM, available in English or Dutch, were eligible for inclusion. To study the effect of recent migration streams and policies in the European context, only studies from European countries published betwee n2007 and 2017 were included. As this review focussed on pregnancy outcomes, pregnancy-related findings such as induced abortion, unintended pregnancy and maternal infection during pregnancy were excluded. Study populations were defined according to the International Organization of Migration:.

Information sources and search
The systematic literature search was conducted in two electronic databases: / MEDLINE and EMBASE (date last search: 1 May 2017). Peer-reviewed articles were identified using pre-defined search (Title/Abstract) and indexing terms (MeSH/Emtree) (search syntax: Supplementary file S1). Bibliographies of relevant studies were screened for additional references that fitted eligibility criteria. As (non-)governmental organizations may publish reports on the study populations of interest, an extensive grey literature search was conducted (date last search: 1 June 2017; for search syntax: Supplementary file S2). Moreover, (non-)governmental organizations, research and policy experts in the field of AS and UM were approached with a request for grey literature (organizations contacted: Supplementary file S3; request for grey literature: Supplementary file S4).

Study selection
Titles and abstracts of the two searches were screened by two researchers independently (AS: J.B.T. & J.L.B., UM: N.C.G. & C.M.W.) using the online screening programme for systematic reviews Rayyan.[25] Potentially eligible studies

were assessed in full-text. If full-text was not available, the corresponding author of the paper was contacted once by e-mail to request the full-text version or translation. Authors were also contacted in cases where the legal status of the study population was uncertain. Any disagreement over eligibility of studies was resolved through discussion among the researchers until consensus was reached.

Data collection process and data items
Data were extracted using a piloted extraction form. Data extraction was performed by one review author (AS: J.B.T. and UM: N.C.G.). None of the review authors was blinded for journal or author details. In case of missing data, the corresponding authors were approached once by e-mail. Extracted data included setting, design, data source, study period, study population (including sample size and nationalities), reference population and maternal/perinatal outcomes.

Risk of bias assessment
Studies were assessed for risk of bias using the Newcastle-Ottawa Scale (NOS) for risk of bias in cohort studies, based on three criteria (selection, comparability and outcome).[26] The NOS was adapted to color-coding where orange and red refer to one and multiple negative scores on a sub-question, respectively.

Summary measures
Where available, the odds ratio (OR) or risk ratio (RR) including a 95% confidence interval (95% CI) of an outcome was reported. Alternatively, when these outcome measures were not provided, the sample size, percentages and corresponding *P*-value were reported. If no statistical analysis had been conducted over results, only sample size and percentages were reported.

Synthesis of results
Extracted data were evaluated to determine whether meta-analysis with pooled data was possible, as originally intended. However, given the heterogeneity of outcomes reported and the differences in study populations regarding nationality, sample size and setting, results could not be pooled into a meta-analysis. Data synthesis therefore provides a narrative review of maternal and perinatal outcomes.

Results

Study selection
The literature search generated 3682 unique results for AS and 857 for UM, of which 68 (AS) and 77 (UM) were grey literature sources. After screening on title/abstract,115 (AS) and 71 (UM) manuscripts were screened in full-text. Full-text

screening resulted in inclusion of 11 articles (AS: 5, all peer-reviewed, UM: 6, of which one grey literature source) (figure 1).

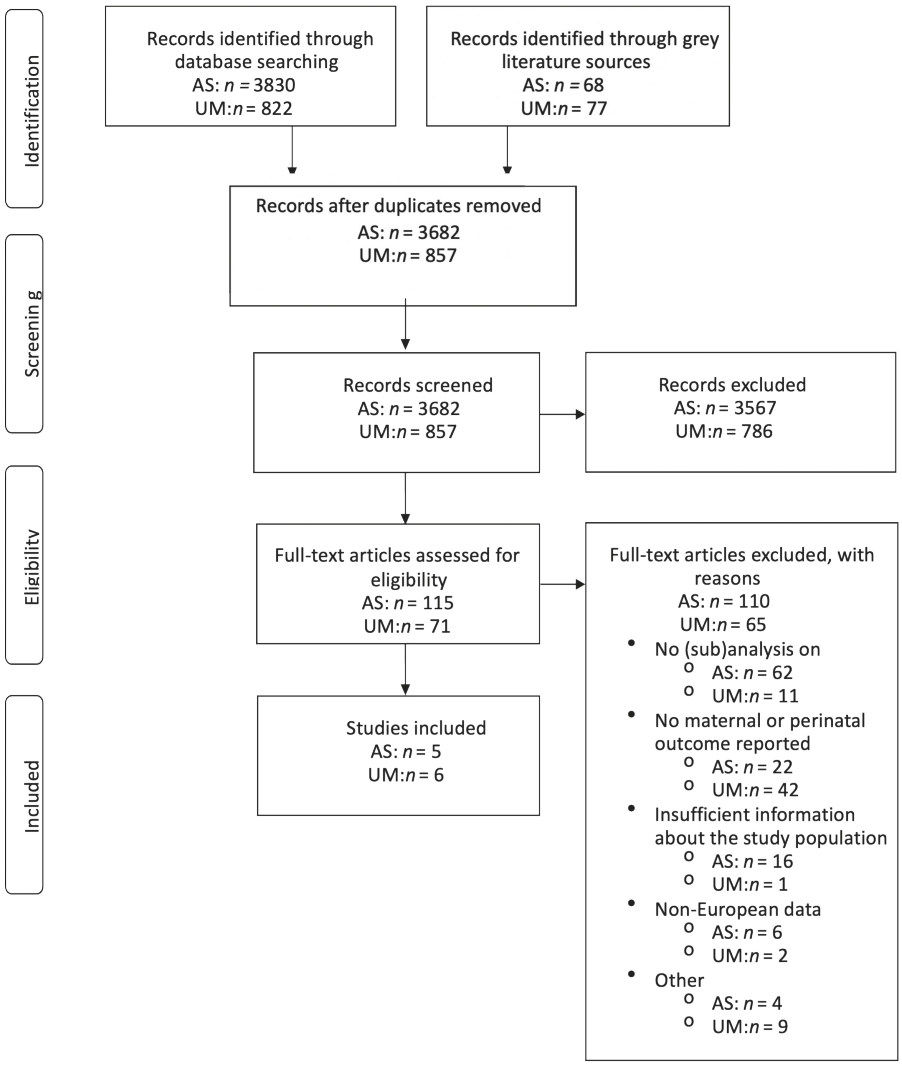


Figure 1 Flow diagram of study selection process in asylum seekers (AS) and undocumented migrants (UM)

Study characteristics

An overview of study characteristics is presented in table 1. Two included studies had prospective cohort designs, six were retrospective cohorts and three were

cross-sectional studies. Studies were conducted in The Netherlands (AS: three, UM: two), Switzerland (AS: two, UM: one), Italy (UM: two) and the UK (UM: one).

Table 1. Study characteristics of studies reporting maternal or perinatal outcomes in asylum seekers and undocumented migrants (n = 11)

Author(s) (year)	Region/country	Setting	Research methods	Period	Study population (size)	Nationalities of study population (%)	Reference population (size)
Asylum seekers							
Kurth et al. (2010)[29]	Basel, Switzerland	University Hospital of Basel	Design: retrospective cohort, mixed-methods (qualitative and quantitative) Data source: 1. hospital demographic database 2. semi-structured interviews 3. medical records	2000–03	AS attending women's clinic (80; deliveries among them: 48)	Former Yugoslavia (50%), Africa (19%), Asia (16%), E-Europe (9%), other countries (6%)	Total patient population (6396)
Van Oostrum et al. (2011)[28]	The Netherlands	Community health services for AS	Design: retrospective cohort Data source: national mortality and birth registers	2002–05	AS (4327 deliveries)	W-, C- and S-Africa (22.5%), N-, E- and Horn of Africa (11.1%), C-, E- and S-Europe (26.8%), Middle East and S-W-Asia (31.1%), C-, E- and S-Asia (5.4%), other (3.2%)	Dutch population in 2002–05

Author(s) (year)	Region/country	Setting	Research methods	Period	Study population (size)	Nationalities of study population (%)	Reference population (size)
Van Hanegem et al. (2011)[27]	The Netherlands	Maternity wards of all public hospitals	Design: retrospective cohort Data source: 1. national registry data on maternal morbidity 2. birth registration by the Central Agency for the Reception of Asylum Seekers	2004–06	Pregnant AS with SAMM (40)	Africa (47.5%), Middle East (15.0%), Turkey (10.0%), Asia (12.5%), S-America (5.0%), Former USSR (5.0%), other non-Western (5.0%)	Non-Western migrants with SAMM (517) General Dutch population with SAMM (2512)
Goosen et al. (2015)[31]	The Netherlands	Community health services for AS	Design: cross-sectional Data source: electronic medical records from the community health services for AS	2000–08	HIV-positive AS who delivered (80)	Sub-Saharan Africa (98.8%)	HIV-negative AS who delivered (4774)
Ratcliff et al. (2015)[30]	Geneva, Switzerland	Midwifery practice	Design: cross-sectional Data source: 1. questionnaires 2. Edinburgh Postnatal Depression Scale 3. midwives' observations and participants' self-report	2006–14	Migrant women with precarious legal status attending antenatal education programme (118)	AS and refugees: Africa (37%), Asia (13%), the Middle East (17%), C- or E-Europe (7%), N-Africa (3%), other (14%) Undocumented: Latin America (19%)	Migrant women with non-precarious legal status attending antenatal education programme (110)

Author(s) (year)	Region/country	Setting	Research methods	Period	Study population (size)	Nationalities of study population (%)	Reference population (size)
Undocumented migrants							
Wolff et al. (2008)[34]	Geneva, Switzerland	Midwifery healthcare unit in collaboration with the Geneva University Hospital	Design: prospective cohort Data source: 1. questionnaires 2. blood tests 3. medical records	2005–06	Pregnant UM (161)	Bolivia (34.8%), Brazil (23%), Columbia (8.7%), Ecuador (6.2%), Peru (5.6%), Philippines (3.7%)	Pregnant women with legal residence permit (both migrants and locals) (233)
Schoevers et al. (2009)[32]	The Netherlands	Support organizations, community networks and healthcare providers	• Design: cross-sectional • Data source: interviews	Unknown	Pregnant UM and undocumented migrant mothers (31 pregnancies, 22 deliveries in 27 women)	• E-Europe (30%), Sub-Saharan Africa (21%), Turkey/Middle E-/N-Africa (12%), • China/ Mongolia (12%), Afghanistan/Iran (11%), • Middle and S-America/ Philippines (8%), • Surinam (6%)	None
Fedeli et al. (2010)[36]	Veneto, Italy	Obstetric wards of acute care hospitals	• Design: retrospective cohort • Data source: hospital discharge records	2006–07	UM and a minority of migrants with a short-term residence (1870)	Unknown	Veneto residents with 1. Italian citizenship (73 098) 2. foreign citizenship (18 462)

Author(s) (year)	Region/country	Setting	Research methods	Period	Study population (size)	Nationalities of study population (%)	Reference population (size)
de Jonge et al. (2011)[33]	Amsterdam and Rotterdam, The Netherlands	Primary care midwifery practices	Design: retrospective cohort Data source: medical records	2005–06	Pregnant UM (141)	All from non-Western European countries	Pregnant DM (141)
Shortall et al. (2015)[35]	London, UK	Drop-in healthcare unit, Doctors of the World	Design: prospective cohort study Data source: 1. medical records 2. semi-structured (telephone) questionnaires	2013–14	Pregnant migrants visiting the Doctors of the World drop-in clinic, the majority being UM (35)	Unknown	NA
Salmasi et al. (2015)[37]	Italy	All deliveries nation-wide	• Design: retrospective cohort • Data source: birth sample surveys from 2001 and 2003	2002–05	Newborns from UM (2344)	Worldwide, please refer to the appendix of Salmasi et al. (2015) for a full overview	1. DM with Italian nationality (4189) 2. Women born in Italy (90 578)

Notes: Under 'Nationalities of study population': N, north(ern); E, east(ern); S, south(ern); W, west(ern); C, central; AS, asylum seekers; DM, documented migrants; UM, undocumented migrants.

Studies on AS mostly (n = 3) compared AS to HP.[27–29] One study compared the HIV mother-to-child transmission rate in AS over time. UM and AS were compared with a group of migrants with long-term or permanent residence permits in another study.[30] In studies on UM, two studies included the HP as a comparison group. In two other studies, UM were compared with documented migrants (DM; i.e. migrants with legal residence permit) alone. Two studies did not have a control group. One study with a control group did not apply statistical analysis to their data.

An overview of all maternal and perinatal outcomes in AS and UM is presented in table 2. In Supplementary file S5, the relative (dis)advantage of AS and UM per outcome is shown. Other than perinatal outcomes (up to 7 days postpartum), no neonatal outcomes were reported in included studies.

Table 2. Overview of maternal and perinatal outcomes in asylum seekers and undocumented migrants for each of the included studies

Author(s) (year)	Maternal outcomes	Perinatal outcomes
Asylum seekers		
Kurth et al. (2010)[29]	• Mode of birth: no difference • Spontaneous abortions: 8%* • Premature labour: 15%* • Prenatal bleeding: 11%* • Gestational diabetes: 9%* • Anaemia: 7%*	• Preterm birth (35–37 weeks): 6% (n = 3/48)* • Mean birthweight (SD): 3470 g (556)* • Low birthweight (<2500 g): 2% (n = 1/48)* • Congenital malformations: 2% (n = 1/48)* • Intrauterine growth restriction: 7%*
Van Oostrum et al. (2011)[28]	• Maternal mortality ratio (deaths per 100 000 births): higher [AS vs. HP: rate ratio (95% CI) = 10.08 (8.02, 12.83)] • Maternal mortality ratio (deaths per 100 000 births): higher [AS vs. Surinams/Antillians (ethnic group with highest maternal mortality ratio in The Netherlands): 69.33 vs. 35]	• Perinatal mortality: no difference
Van Hanegem et al. (2011)[27]	• Maternal deaths: none • Incidence of SAMM (per 1000 births): higher [n = 369 711, AS vs. HP: 31.0 vs 6.8, RR (95% CI) = 4.5 (3.3, 6.1); AS vs. non-western DM: 31.0 vs 8.5, RR (95% CI) = 3.6 (2.6, 5.0)] • SAMM (per 1000 births): higher [AS vs. non-Western migrants: 31.0 vs. 8.5, RR (95% CI) = 3.6 (2.6, 5.0)] • –Inclusion categories for SAMM: ICU admission, uterine rupture, eclampsia/HELLP, major obstetric haemorrhage, miscellaneous (other types of SAMM)	NA

Author(s) (year)	Maternal outcomes	Perinatal outcomes
Goosen et al. (2015)[31]	NA	Mother-to-child transmission of HIV: 9.8% (n = 6/62)
Ratcliff et al. (2015)[30]	Antenatal depression (EPDS score): no difference (AS & UM vs. DM)	• Obstetric complications: no difference • –Complications considered: e.g. premature birth, infection, gestational diabetes, hypertension or pre-eclampsia, haemorrhage
Undocumented migrants		
Wolff et al. (2008)[34]	• Mode of birth: no difference • Complications during pregnancy, vaginal birth or postpartum: no difference • –Pregnancy and vaginal birth complications considered: urinary infection, anaemia, risk of preterm birth, vaginal tear, retention of the placenta, pre-eclampsia, fever	• Mean gestational age in weeks (SD): lower (n = 335, UM vs. DM: 38.9 (1.9) vs. 39.4 (1.4), P = 0.02) • Preterm births (<37 weeks): no difference (n = 335, UM vs. DM: 9% vs. 4%, P = 0.09) • Born in good health, born dead, transfer to the neonatology for serious health hazard, birth weight, low birth weight, APGAR scores and neonatal complications: no difference
Schoevers et al. (2009)[32]	• Hypertension/toxemia during pregnancy: 6% (n = 2/31)* • Kidney problems during pregnancy: 3% (n = 2/31)* • Cervix insufficiency: 3% (n = 1/31)*	• Preterm birth: 9% (n = 2/22)* • Caesarean section: 9% (n = 2/22)* • Prolonged labour: 5% (n = 1/22)* • Multiple handicapped foetus: 5% (n = 1/22)* • Embryoma spine neonate: 5% (n = 1/22)* • Low birth weight (<2500 g): 14% (n = 3/22)* • Foetal distress 5% (n = 1/22)* • Birth trauma: 5% (n = 1/22)*
Fedeli et al. (2010)[36]	• Birth via caesarean section: (n = 93 430, UM vs. DM vs. HP: 19.5% vs. 26.9% vs. 29.5%)* • Antepartum hospitalizations per birth: (n = 93 430, UM vs. DM vs. HP: 0.24 vs. 0.21 vs. 0.1)* • Miscarriages per birth: (n = 93 430, UM vs. DM vs. HP: 0.35 vs. 0.15 vs. 0.1)*	NA

Author(s) (year)	Maternal outcomes	Perinatal outcomes
de Jonge et al. (2011)[33]	• Intervention during labour: no difference. Intervention during labour: no difference. –Interventions considered: induction, augmentation, vacuum, forceps, caesarean section • Referral for failure to progress in labour: lower [*n* = 226, UM vs. DM: 7% vs. 24%, OR (95% CI) = 0.40 (0.16, 0.98)] • Anaemia: no difference • Neonatal admission at maternal indication: no difference	• Perinatal mortality (>22 weeks): no difference • Gestational age at birth in weeks: no difference • Preterm birth (<37 weeks): higher [*n* = 226, UM vs. DM: 12.6% vs. 3.1%, OR (95% CI) = 4.59 (1.43, 14.72)] • Foetal distress: no difference • Weight of babies born at term: no difference • Low birth weight (<2500 g): higher [*n* = 226, UM vs. DM: 14% vs. 6%, OR (CI 95%) = 3.51 (1.30, 9.52)] • Neonatal admissions for prematurity/ SGA: higher [*n* = 226, UM vs. DM: 12% vs. 3%, OR (95% CI) = 6.17 (1.69, 22.52)] • Neonatal admissions for poor neonatal condition: no difference
Shortall et al. (2015)[35]	Mode of birth: elective caesarean section: 2.9% (*n* = 1/35) emergency caesarean section: 29.4% (*n* = 10/35) instrumental birth: 5.9% (*n* = 2/35) spontaneous vaginal birth: 58.8% (*n* = 20/35)*	• Birth at term: 43%* • Postterm birth: 37%* • Preterm birth: 14%* • Perinatal mortality: 5.5%; (*n* = 2/35)*
Salmasi et al. (2015)[37]	NA	Low birth weight decreased with 1.2–2.7% (*P* < 0.05) when UM had become DM

No difference: AS/UM have been compared with HP/DM, no statistical differences found.
Higher/lower: significantly higher/lower results reported for study population (AS/UM) as compared with control population (HP/DM) on this outcome.
**No statistical analysis available on this outcome.*
Notes: APGAR, Appearance, Pulse, Grimace, Activity, Respiration; AS, asylum seekers; DM, documented migrants; EPDS, Edinburgh Postnatal Depression Scale; HELLP, haemolysis, elevated liver enzymes, low platelet count; HP, host-country population(s); ICU, intensive care unit; SAMM, Severe Acute Maternal Morbidity; SGA, Small for Gestational Age; UM, undocumented migrants.

Narrative summary of results

Asylum seekers

Maternal outcomes

Maternal mortality ratio was reported 10-fold higher for AS compared with the Dutch population [RR (95% CI) = 10.08 (8.02–12.83)].[28] In another Dutch study, severe acute maternal morbidity (SAMM; defined as ICU admission, uterine rupture, eclampsia/HELLP syndrome, major obstetric haemorrhage or miscellaneous) occurred at a rate 4.5 times higher in AS compared with the HP [RR (95%CI) = 4.5(3.3–6.1)], and 3.6 times higher compared with other non-Western DM [RR (95%CI) = 3.6 (2.6–5.0)].[27] In Switzerland, no differences were found for a composite of obstetric complications—including pre-eclampsia and

postpartum haemorrhage—between undocumented or refugee women with a temporary residence permit and women with long-term or permanent residence permits. The same study found high overall antenatal depression scores but found no significant difference between the study groups.[30]

With regards to mode of birth, no differences were found for vaginal and instrumental birth and caesarean section rates in a small Swiss study (n = 48 deliveries).[29] In The Netherlands, no differences were reported in induction of labour or caesarean section rates among AS, non-Western DM and native Dutch women who experienced SAMM (n = 3087 cases).

Perinatal outcomes

Perinatal outcomes were reported in some studies, but these did not compare AS to a reference group. In one of these studies, mother-to-child transmission rate of HIV was 9.8% among AS in The Netherlands (n = 80 births to HIV-positive asylum seeking women). All children who were HIV-positive at birth were born before the implementation of universal HIV screening in 2004.[31]

Undocumented migrants

Maternal outcomes

Several studies reported maternal outcomes in UM.[32–36] A study from Italy found a higher ratio of spontaneous abortions/miscarriages to births compared with DM and to Italian residents in a large study from Italy, although no statistical analysis was performed in this study (n = 93430, UM vs. DM vs. HP: 0.35 vs. 0.15 vs. 0.16).[36] The same study reported higher ratios of antepartum hospitalizations per birth for UM (n = 93430, UM vs. DM vs. HP: 0.24 vs. 0.21 vs. 0.18). A study from Switzerland showed no significant differences compared with DM in pre-eclampsia, gestational diabetes, anaemia, prenatal bleeding, urinary tract infection and risk of preterm birth.[34] A study from The Netherlands reported rates of pre-eclampsia, cervix insufficiency and kidney problems during pregnancy but did not include a control group.[32]

Five studies reported findings regarding mode of birth and had conflicting results.[32–36] Rates of vaginal birth and interventions during labour (including induction, vacuum/forceps and caesarean section) were similar for UM and DM in The Netherlands.[33] This was confirmed in the Swiss study, where spontaneous birth, forceps, vacuum and caesarean sections were similar among UM and DM.[34] A lower caesarean section rate was reported in Italy [UM: 19.5% (n = 365/1870) vs. DM: 26.9% (n = 4966/18462) vs. HP: 29.5% (n = 21564/73098)], whereas a high rate of emergency caesarean sections was reported by a small study published by Doctors of the World in the UK [29% (n = 10/35)].[35,36]

Perinatal outcomes

Regarding perinatal outcomes, UM were more likely to give birth prematurely compared with DM in The Netherlands [n = 226, UM vs. DM: 12.6% vs. 3.1%, OR (95% CI) = 4.59 (1.43,14.72)].[33] The Swiss study showed no significant differences but reported a trend of higher preterm birth rate as well (n =[335], UM vs. DM:[9]% vs.[4]%, P =[0].09).[34] Regarding birthweight, a higher rate of low birthweight (<2500 g) was found in The Netherlands [n = 226, UM vs. DM: 15% vs. 5%, OR (CI95%) = 3.51 (1.30,9.52)], although birthweight for babies born at term was not significantly different.[33] The Swiss study reported a higher rate of low birthweight in UM, but this difference was not significant (n = 335, UM vs. DM: 4.7% vs. 2.6%, P = 0.24).[34] Finally, a large-scale study (n = 2344 newborns) in Italy showed that the number of babies born with low birthweight decreased when UM became documented as a result of a change in law (1.2% vs. 2.7%, P <0.05).[37]

The overall health of the neonate, including being born in good health, stillbirth, APGAR scores and transfer to the neonatology ward for serious health hazard was not different between UM and DM in the Swiss study.[34] In the same study, neonatal complications (not further defined) showed a trend towards worse outcomes in UM vs DM: (n = 335, UM vs. DM: 2.8% vs. 6.6%, P =0.07).[34] The number of newborns admitted to the hospital for poor neonatal condition was similar for UM and DM in The Netherlands.[33]

Risk of bias of individual studies

The risk of bias assessment for individual studies was conducted using the NOS for cohort and cross-sectional studies (risk of bias: Supplementary file S6). Risk of bias was low in the majority of studies (n =6/11) included. Four studies had moderate, and one had high risk of bias. Risk of bias emerged from diverse sources, such as selective facility-based sampling methods, small sample sizes and the lack of a control group in two studies on UM. A number of other studies had control groups that were not adequately described or that differed from the study population in important population characteristics such as age, ethnicity or time spent in the country (n =4/11). One study reported data on mother-to-child transmission rate of HIV in AS but did not include a reference group for this outcome.[31] Most studies used hospital or registry data (n = 9/11), while some depended (partially) on self-reported outcomes (n = 4/11).

Discussion

This review systematically assessed the literature on maternal and perinatal outcomes in AS and UM in Europe published in the past decade. An overall lack

of high-quality quantitative research was identified, and available studies only covered four European countries (Italy, The Netherlands, Switzerland and the UK). The studies showed no consistent pattern of adverse outcomes, although none of the studies reported a healthy migrant effect (i.e. more favourable outcomes) in AS or UM compared with host-country populations. Some well-designed studies reported adverse findings, including a higher maternal mortality and severe maternal morbidity rates among AS in The Netherlands compared with host-country populations.[27,28] In UM, higher preterm birth and low birth weight rates were reported compared with documented migrants.[33,37]

The heterogeneity of maternal and perinatal health findings of this review suggests that legal status (asylum seeking or undocumented) is part of a complex interplay of potential risk and resilience factors.[12,38] Among AS and UM, women with a refugee background may be particularly at risk of adverse outcomes.[6,16,20,39,40] Additional risk factors for AS include short length of residence, low socio-economic status and language barriers.[27] UM face increased risk as a result of precarious material and social conditions, such as poor housing and fear of deportation as well as stringent regulations limiting employment opportunities and healthcare access.[17,18] Maternal country of origin is another key characteristic considered a potential risk factor for adverse maternal and perinatal health outcomes.[16,30,41] Conversely, positive integration policies, becoming documented and adopting host-country nationality can improve maternal and perinatal health outcomes.[4,37,42,43]

The rather low number of studies included in this review illustrates general issues in research on 'migrants'—a poorly demarcated group of which variables such as ethnicity, length of residence and legal status are not standardly registered or reported.[6,16] The aim of this review was to strictly consider migrants with temporary or uncertain residence permits (AS) or no residence permits at all (UM). Although these stringent inclusion criteria allowed us to specifically explore the role of legal status as a determinant in maternal/perinatal health care, it also resulted in the exclusion of high-quality studies if insufficient information was available about the legal status of the study populations. Some of these studies included women from war-affected countries or with short length of residence in the destination country, who could in fact be AS or UM. Among these, Bakken et al. (2015) reported increased risk of adverse obstetric outcomes in Somalians but not in women from other conflict-zone countries.[44] Liu et al. (2014) showed that war refugees (with unknown legal status) had increased risk of preterm birth in their first year in Sweden, compared with the following year.[45] Other studies included AS or UM as part of the study population, but did not present a sub-analysis on these groups, hence did not meet inclusion criteria.[45] The lack of such

analyses reflects legal, social and administrative barriers to clinical registration of migration-related determinants in national databases.

Several limitations should be considered in interpreting the findings of this review. Meta-analysis could not be performed due to heterogeneity across studies in design and methods. Narrative synthesis of results relied on studies with several methodological limitations, such as the lack of a control group in some studies.[29,32,35] Caution is warranted when interpreting non-significant results from studies whose sample size was not powered to detect differences for specific outcomes. Particularly in studies on UM, study and control populations often differed in important characteristics such as ethnicity, nationality and length of residence. Findings were not always controlled for confounding factors, such as low birthweight for prematurity. Moreover, as UM were mostly compared with documented migrants, differences to host-country population(s) may be underestimated. Bias may also arise from the comparison of migrant groups across different destination countries. Studies comparing AS to UM do, to the best of our knowledge, not exist. Finally, countries with a high recent influx of migrants (such as Greece and the Balkan countries) as well as ethnicities most prevalent in these migrant groups (such as Syrian, Afghan and Iraqi) were not covered in included studies.[2]

In parallel, this review has important strengths. The systematic search involved academic and grey literature sources, including a search through experts in the field. This strategy recognized the substantial expertise of non-governmental and other support organizations that may not publish their findings through academic channels. The extensive search guaranteed the inclusion of a wide range of pregnancy outcomes. The focus on European studies published between 2007 and 2017 allowed for the consideration of migratory movements in a specific geographical context and time-frame.

The findings and limitations of available studies translate into several recommendations for future research and policy. To address or compare findings in specific migrant subgroups, a list of indicators to be included in standardized perinatal data collection was developed in a Delphi study by the Reproductive Outcomes and Migration (ROAM) collaboration.[46] ROAM recommended characteristics to be collected include country of origin and length of residence. Legal status was also considered to be important, yet less feasible for clinical registration.

Furthermore, several outcomes that were not considered in the current review deserve future research attention, such as the prevalence of maternal infections during pregnancy, unintended pregnancy and induced abortions.[47–49] As higher

adverse maternal mental health outcomes have been reported for AS outside of Europe, there is a need for such enquiries in Europe.[39] Similarly, barriers in access to maternal and reproductive healthcare services, for contraceptives and antenatal care, exist and require further evaluation.[32,50] The impact of European migration policies on maternal and perinatal outcomes could provide critical insights, e.g. by using the MIPEX-index, which assesses migrant integration policies across all EU Member States.[52] Beyond quantitative assessments, qualitative studies and collaboration with support organizations can provide insight into the specific needs and experiences of AS and UM, and guide culturally sensitive care provision.[51,53] Audit studies are an important tool in the prevention of maternal and perinatal mortality or severe morbidity.[54,55] Finally, as emphasized by the recent report of the Guttmacher-Lancet Commission, policy should protect maternal and neonatal health by ensuring access to sexual and reproductive health and rights for all, including vulnerable groups such as AS and UM.[56]

Conclusion

In conclusion, this systematic review highlights the need for standardized high-quality quantitative research on maternal and perinatal outcomes in AS and UM in Europe. Available studies are limited in number, heterogeneous in design and have several methodological limitations. Higher rates of maternal mortality and severe morbidity among AS have been reported, as well as higher rates of preterm birth and low birthweight among UM. These adverse findings necessitate further evaluation of the role of legal status and other factors affecting the health of migrant women and their newborns in European countries. In future clinical registration and research into maternal and perinatal health, disaggregating data for migrant subpopulations facing different health determinants would help to disentangle the mechanisms underlying adverse outcomes or a healthy migrant effect. To guarantee safe motherhood for coming generations of people entering or remaining in Europe, reducing the barriers to optimal maternity care should be a priority in migrant health research, policy and practice.

Conflicts of interest

None declared.

Acknowledgements

We received the generous support of the Van Walree grant by the Royal Netherlands Academy of Arts and Sciences (KNAW) to present at the1st World Congress on Migration, Ethnicity, Race and Health (Edinburgh, 17–19 May 2018).

We would like to acknowledge the contribution of the organizations which sent in recommendations to the call for grey literature: Gezondheidszorg Illegalen Leiden, Defence for Children, Pharos, Doctors of the World UK and Médecins du Monde France. We would also like to extend our appreciation to those who distributed the call for articles: Iva Jovovic and Sylvia Mennink. We are thankful to the librarians of the University Medical Center Utrecht who supported us in the strategy for the literature searches.

Lastly, we would like to express our gratitude to three anonymous reviewers for the *European Journal of Public Health*, who provided excellent and constructive feedback.

References

1. Hanefeld J, Vearey J, Lunt N, et al. A global research agenda on migration, mobility, and health. Lancet 2017;389:2358–9.
2. EUROSTAT. Asylum Statistics—Statistics Explained [Internet], 2017. Available at: http://ec.europa.eu/eurostat/statistics-explained/index.php/Asylum_statistics, (2 February 2018, date last accessed).
3. UNICEF. More Children and Women Seek Safety in Europe [Internet], 2016. Available at: https://www.unicef.org/media/media_90000.html, (26 August 2017, date last accessed).
4. Bollini P, Pampallona S, Wanner P, Kupelnick B. Pregnancy outcome of migrant women and integration policy: a systematic review of the international literature. Soc Sci Med 2009;68:452–61.
5. Villalonga-Olives E, Kawachi I, von Steinbüchel N. Pregnancy and birth outcomes among immigrant women in the US and Europe: a systematic review. J Immigr Minor Heal 2017;19:1469–87.
6. Gissler M, Alexander S, Macfarlane A, et al. Stillbirths and infant deaths among migrants in industrialized countries. Acta Obstet Gynecol 2009;88:134–48.
7. Gagnon AJ, Zimbeck M, Zeitlin J, et al. Migration to western industrialised countries and perinatal health: a systematic review. Soc Sci Med 2009;69:934–46.
8. Nybo Andersen AM, Gundlund A, Villadsen SF. Stillbirth and congenital anomalies in migrants in Europe. Best Pract Res Clin Obstet Gynaecol 2016;32:50–9.
9. Racape J, Schoenborn C, Sow M, et al. Are all immigrant mothers really at risk of low birth weight and perinatal mortality? The crucial role of socio-economic status. BMC Pregnancy Childbirth 2016;16:1–10.
10. McDonald JT, Kennedy S. Insights into the "healthy immigrant effect": health status and health service use of immigrants to Canada. Soc Sci Med 2004;59:1613–27.
11. Gushulak B, MacPherson D. Population mobility and health: an overview of the relationships Between movement and population health. J Travel Med 2006;11:171–8.
12. Urquia ML, O'Campo PJ, Heaman MI. Revisiting the immigrant paradox in reproductive health: the roles of duration of residence and ethnicity. Soc Sci Med 2012;74:1610–21.
13. Binder P, Johnsdotter S, Essén B. Conceptualising the prevention of adverse obstetric outcomes among immigrants using the "three delays" framework in a high-income context. Soc Sci Med 2012;75:2028–36.
14. Wanigaratne S, Cole DC, Bassil K, et al. Severe neonatal morbidity among births to refugee women. Matern Child Health J 2016;20:2189–98.
15. Gagnon AJ, Dougherty G, Wahoush O, et al. International migration to Canada: the post-birth health of mothers and infants by immigration class. Soc Sci Med 2013;76:197–207.
16. Van Den Akker T, Van Roosmalen J. Maternal mortality and severe morbidity in a migration perspective. Best Pract Res Clin Obstet Gynaecol 2016;32:26–38.
17. Woodward A, Howard N, Wolffers I. Health and access to care for undocumented migrants living in the European Union: a scoping review. Health Policy Plan 2014;29:818–30.
18. Hacker K, Anies M, Folb BL, Zallman L. Barriers to health care for undocumented immigrants: a literature review. Risk Manag Healthc Policy 2015;8:175–83.
19. Haelterman E, Qvist R, Barlow P, Alexander S. Social deprivation and poor access to care as risk factors for severe pre-eclampsia. Eur J Obstet Gynecol Reprod Biol 2003;111:25–32.
20. Khanlou N, Haque N, Skinner A, et al. Scoping review on maternal health among immigrant and refugee women in Canada: prenatal, intrapartum, and postnatal care. J Pregnancy 2017;2017: 1–14, doi: 10.1155/2017/8783294.

21. De Jong L, Pavlova M, Winters M, Rechel B. A systematic literature review on the use and outcomes of maternal and child healthcare services by undocumented migrants in Europe. Eur J Public Health 2018;27:1–8.
22. Munro K, Jarvis C, Munoz M, et al. Undocumented pregnant women: what does the literature tell us? J Immigr Minor Heal 2013;15:281–91.
23. Asif S, Baugh A, Jones NW. The obstetric care of asylum seekers and refugee women in the UK. Obstet Gynaecol 2015;17:223–31.
24. International Organization for Migration. Key Migration Terms [Internet]. Glossary on Migration, International Migration Law Series No. 25, 2011. Available at: https://www.iom.int/key-migration-terms#Irregular-migration, (20 August 2017, date last accessed).
25. Ouzzani M, Hammady H, Fedorowicz Z, Elmagarmid A. Rayyan—a web and mobile app for systematic reviews. Syst Rev 2016;5:210.
26. Wells GA, Shea B, O'Connell D, et al. The Newcastle-Ottawa Scale (NOS) for Assessing the Quality of Nonrandomised Studies in Meta-Analyses. Ottawa: Ottawa Hospital Research Institute, 2016.
27. Van Hanegem N, Miltenburg AS, Zwart JJ, et al. Severe acute maternal morbidity in asylum seekers: a two-year nationwide cohort study in the Netherlands. Acta Obstet Gynecol Scand 2011;90:1010–6.
28. Van Oostrum IE, Goosen S, Uitenbroek DG, et al. Mortality and causes of death among asylum seekers in the Netherlands, 2002–2005. J Epidemiol Community Health 2011;65:376–83.
29. Kurth E, Jaeger FN, Zemp E, et al. Reproductive health care for asylum-seeking women—a challenge for health professionals. BMC Public Health 2010;10:659.
30. Ratcliff BG, Sharapova A, Suardi F, Borel F. Factors associated with antenatal depression and obstetric complications in immigrant women in Geneva. Midwifery 2015;31:871–8.
31. Goosen S, Hoebe C, Waldhober Q, Kunst AE. High HIV prevalence among asylum seekers who gave birth in the Netherlands: a nationwide study based on antenatal HIV tests. PLoS One 2015;10:1–12.
32. Schoevers MA, van den Muijsenbergh M, Lagro-Janssen A. Self-rated health and health problems of undocumented immigrant women in the Netherlands: a descriptive study. J Public Health Policy 2009;30:409–22.
33. De Jonge A, Rijnders M, Agyemang C, et al. Limited midwifery care for undocumented women in the Netherlands. J Psychosom Obstet Gynaecol 2011;32:182–8.
34. Wolff H, Epiney M, Lourenco AP, et al. Undocumented migrants lack access to pregnancy care and prevention. BMC Public Health 2008;8:93.
35. Shortall C, McMorran J, Taylor K, et al. Experiences of Pregnant Migrant Women receiving Ante/Peri and Postnatal Care in the UK: A Longitudinal Follow-up Study of Doctors of the World's London Drop-In Clinic Attendees. London: Doctors of the World, 2015.
36. Fedeli U, Alba N, Lisiero M, et al. Obstetric hospitalizations among Italian women, regular and irregular immigrants in North-Eastern Italy. Acta Obstet Gynecol Scand 2010;89:1432–7.
37. Salmasi L, Pieroni L. Immigration policy and birth weight: positive externalities in Italian law. J Health Econ 2015;43:128–39.
38. Urquia ML, Glazier RH, Blondel B, et al. International migration and adverse birth outcomes: role of ethnicity, region of origin and destination. J Epidemiol Community Heal 2010;64:243–52.
39. Collins CH, Zimmerman C, Howard LM. Refugee, asylum seeker, immigrant women and postnatal depression: rates and risk factors. Arch Womens Ment Health 2011;14:3–11.
40. Carolan M. Pregnancy health status of sub-Saharan refugee women who have resettled in developed countries: a review of the literature. Midwifery 2010;26:407–14.
41. Reference numbers 41–56 are available in Supplementary file 7.

42. Bakken K, Skjeldal O, Stray-Pedersen B. Higher risk for adverse obstetric outcomes among immigrants of African and Asian descent: a comparison study at a low-risk maternity hospital in Norway. Birth. 2015;42(2):132–40.
43. Minsart A, Englert Y, Buekens P. Naturalization of immigrants and perinatal mortality. Eur J Public Health. 2010;23(2):269–74.
44. Racape J, De Spiegelaere M, Dramaix M, Haelterman E, Alexander S. Effect of adopting host-country nationality on perinatal mortality rates and causes among immigrants in Brussels. Eur J Obstet Gynecol Reprod Biol. 2013;168(2):145–50.
45. Bakken K, Skjeldal O, Stray-Pedersen B. Immigrants from conflict-zone countries: an observational comparison study of obstetric outcomes in a low-risk maternity ward in Norway. BMC Pregnancy Childbirth. 2015;15:163.
46. Liu C, Urquia M, Cnattingius S, Hjern A. Migration and preterm birth in war refugees: A Swedish cohort study. Eur J Epidemiol. 2014;29(2):141–3.
47. Gagnon AJ, Zimbeck M, Zeitlin J. Migration and perinatal health surveillance: An international Delphi survey. Eur J Obstet Gynecol Reprod Biol. 2010;149(1):37–43.
48. Goosen S, Uitenbroek D, Wijsen C, Stronks K. Induced abortions and teenage births among asylum seekers in The Netherlands: analysis of national surveillance data. J Epidemiol Community Health. 2009;63(7):528–33.
49. Wolff H, Lourenço A, Bodenmann P, Epiney M, Uny M, Andreoli N, et al. Chlamydia trachomatis prevalence in undocumented migrants undergoing voluntary termination of pregnancy: a prospective cohort study. BMC Public Health. 2008;8(391):1–7.
50. Casillas A, Bodenmann P, Epiney M, Gétaz L, Irion O, Gaspoz JM, et al. The border of reproductive control: undocumented immigration as a risk factor for unintended pregnancy in Switzerland. J Immigr Minor Heal. 2015;17(2):527–34.
51. Sebo P, Jackson Y, Haller DM, Gaspoz J-M, Wolff H. Sexual and Reproductive Health Behaviors of Undocumented Migrants in Geneva: A Cross Sectional Study. J Immigr Minor Heal. 2011;13(3):510–7.
52. Gagnon AJ, DeBruyn R, Essén B, Gissler M, Heaman M, Jeambey Z, et al. Development of the Migrant Friendly Maternity Care Questionnaire (MFMCQ) for migrants to Western societies: an international Delphi consensus process. BMC Pregnancy Childbirth. 2014;14(1):200.
53. Ingleby D, Petrova-benedict R, Huddleston T, Sanchez E. The MIPEX Health strand : a longitudinal , mixed-methods survey of policies on migrant health in 38 countries. Eur J Public Health. 2018;0(0):1–5.
54. Keygnaert I, Vettenburg N, Roelens K, Temmerman M. Sexual health is dead in my body: participatory assessment of sexual health determinants by refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands. BMC Public Health. 2014;14(416):1–13.
55. Esscher A, Binder-Finnema P, Bødker B, Högberg U, Mulic-Lutvica A, Essén B. Suboptimal care and maternal mortality among foreign-born women in Sweden: maternal death audit with application of the “migration three delays” model. BMC Pregnancy Childbirth. 2014;14(141):1–11.
56. Draper ES, Kurinczuk JJ, Kenyor S. MBRRACE-UK 2015 Perinatal Confidential Enquiry: Term, singleton, normally formed, antepartum stillbirth. The Infant Mortality and Morbidity Studies. Leicester; 2015.
57. Starrs AM, Ezeh AC, Barker G, Basu A, Bertrand JT, Blum R, et al. The Lancet Commissions Accelerate progress — sexual and reproductive health and rights for all : report of the Guttmacher – Lancet Commission. 2018;391.

Supplementary files

Table of contents

File 1. Search syntax asylum seekers and undocumented migrants

Asylum seekers

Search Pubmed/MEDLINE (25th of April 2017) (search syntax was adapted to Embase database)
#1 AND #2 AND (#3 OR #4)
#1
Asylum[Title/Abstract] OR refugee*[Title/Abstract] OR migrant*[Title/Abstract] OR immigrant*[Title/Abstract] OR immigration[Title/Abstract] OR migration[Title/Abstract] OR transients and migrants[MeSH Terms] OR refugees[MeSH Terms]
#2
Europe[MeSH Terms] OR Albania*[Title/Abstract] OR Andorra*[Title/Abstract] OR Austria*[Title/Abstract] OR Belarus*[Title/Abstract] OR Belgium[Title/Abstract] OR Bosnia[Title/Abstract] OR Bulgaria*[Title/Abstract] OR Croatia*[Title/Abstract] OR Cyprus[Title/Abstract] OR Czech*[Title/Abstract] OR Denmark[Title/Abstract] OR England[Title/Abstract] OR Estonia*[Title/Abstract] OR Faroe*[Title/Abstract] OR Faeroe*[Title/Abstract] OR Finland[Title/Abstract] OR France[Title/Abstract] OR Germany[Title/Abstract] OR Gibraltar*[Title/Abstract] OR Greece[Title/Abstract] OR Great-Britain[Title/Abstract] OR Great Britain[Title/Abstract] OR Holland[Title/Abstract] OR Hungary[Title/Abstract] OR Iceland*[Title/Abstract] OR Ireland[Title/Abstract] OR Northern Ireland[Title/Abstract] OR Italy[Title/Abstract] OR Kosovo*[Title/Abstract] OR Latvia*[Title/Abstract] OR Liechtenstein*[Title/Abstract] OR Lithuania*[Title/Abstract] OR Luxembourg*[Title/Abstract] OR Luxemborg*[Title/Abstract] OR Macedonia*[Title/Abstract] OR Malta*[Title/Abstract] OR Moldavia*[Title/Abstract] OR Monaco[Title/Abstract] OR Montenegro[Title/Abstract] OR Netherlands[Title/Abstract] OR Norway[Title/Abstract] OR Poland[Title/Abstract] OR Portugal[Title/Abstract] OR Romania*[Title/Abstract] OR San Marino[Title/Abstract] OR Scotland[Title/Abstract] OR Serbia*[Title/Abstract] OR Slovenia*[Title/Abstract] OR Slovakia*[Title/Abstract] OR Spain[Title/Abstract] OR Sweden[Title/Abstract] OR Switzerland[Title/Abstract] OR United Kingdom[Title/Abstract] OR UK[Title/Abstract] OR Ukraine[Title/Abstract] OR Vatican*[Title/Abstract] OR Wales[Title/Abstract] OR Belgian[Title/Abstract] OR Bosnian[Title/Abstract] OR British[Title/Abstract] OR Cypriot[Title/Abstract] OR Danish[Title/Abstract] OR Dutch[Title/Abstract] OR English[Title/Abstract] OR Finnish[Title/Abstract] OR French[Title/Abstract] OR German[Title/Abstract] OR Greek[Title/Abstract] OR Hungarian[Title/Abstract] OR Irish[Title/Abstract] OR Italian[Title/Abstract] OR Kosovar*[Title/Abstract] OR Maltese[Title/Abstract] OR Monacan[Title/Abstract] OR Norwegian[Title/Abstract] OR Polish[Title/

Abstract] OR Portuguese[Title/Abstract] OR Scottish[Title/Abstract] OR Spanish[Title/Abstract] OR Swedish[Title/Abstract] OR Swiss[Title/Abstract] OR Ukrainian[Title/Abstract] OR Welsh[Title/Abstract] OR Europe*[Title/Abstract] OR EU[Title/Abstract] OR Benelux[Title/Abstract] OR Western-Europe*[Title/Abstract] OR Western Europe*[Title/Abstract] OR Eastern-Europe*[Title/Abstract] OR Eastern Europe*[Title/Abstract] OR Scandinavia*[Title/Abstract] OR Balkan[Title/Abstract] OR Nordic[Title/Abstract] OR Baltic States[Title/Abstract] OR Mediterranean[Title/Abstract] OR Western countr*[Title/Abstract] OR Destination countr*[Title/Abstract] OR High-income countr*[Title/Abstract] OR High-immigration setting*[Title/Abstract] OR Host countr*[Title/Abstract] OR Immigrant-receiving countr*[Title/Abstract] OR migrant-receiving countr*[Title/Abstract]

#3

Pregnanc*[Title/Abstract] OR pregnant[Title/Abstract] OR mother*[Title/Abstract] OR matern*[Title/Abstract] OR conception[Title/Abstract] OR delivery[Title/Abstract] OR partus[Title/Abstract] OR labor[Title/Abstract] OR labour[Title/Abstract] OR childbirth[Title/Abstract] OR cesarean[Title/Abstract] OR caesarean[Title/Abstract] OR section[Title/Abstract] OR puerper*[Title/Abstract] OR breastfeeding[Title/Abstract] OR lactation[Title/Abstract] OR reproductive[Title/Abstract] OR sexual health[Title/Abstract] OR antenatal[Title/Abstract] OR prenatal[Title/Abstract] OR postnatal[Title/Abstract] OR perinatal[Title/Abstract] OR antepartum[Title/Abstract] OR peripartum[Title/Abstract] OR intrapartum[Title/Abstract] OR postpartum[Title/Abstract] OR post-partum[Title/Abstract] OR post birth[Title/Abstract] OR after birth[Title/Abstract] OR obstetric*[Title/Abstract] OR maternal health[MeSH Terms] OR maternal health services[MeSH Terms] OR obstetrics[MeSH Terms] OR maternal child nursing[MeSH Terms] OR pregnancy[MeSH Terms] OR postnatal care[MeSH Terms] OR prenatal care[MeSH Terms] OR perinatal care[MeSH Terms] OR Maternal-child nursing[MeSH Terms] OR reproductive health[MeSH Terms] OR Neonat*[Title/Abstract] OR newborn[Title/Abstract] OR infant*[Title/Abstract] OR baby[Title/Abstract] OR babies[Title/Abstract] OR congenital[Title/Abstract] OR fetus[Title/Abstract] OR fetal[Title/Abstract] OR Infant[MeSH Terms] OR Infant Health[MeSH Terms]

#4

SAMM[Title/Abstract] OR near miss[Title/Abstract] OR near-miss[Title/Abstract] OR abortion[Title/Abstract] OR miscarriage[Title/Abstract] OR ectopic OR preeclampsia[Title/Abstract] OR eclampsia[Title/Abstract] OR HELLP[Title/Abstract] OR placenta*[Title/Abstract] OR gestation*[Title/Abstract] OR hyperemesis gravidarum[Title/Abstract] OR PPH[Title/Abstract] OR haemorrhage[Title/Abstract] OR hemorrhage[Title/Abstract] OR hypovolem*[Title/Abstract] OR hysterectomy[Title/Abstract] OR sepsis[Title/Abstract] OR septic[Title/Abstract] OR malpresentation[Title/Abstract] OR

breech[Title/Abstract] OR dystocia[Title/Abstract] OR chorioamnionitis[Title/Abstract] OR amniotic[Title/Abstract] OR endometritis[Title/Abstract] OR umbilical cord[Title/Abstract] OR birth weight[Title/Abstract] OR ICU admission[Title/Abstract] OR NICU admission[Title/Abstract] OR vaginal[Title/Abstract] OR genital[Title/Abstract] OR uterine[Title/Abstract] OR uterus[Title/Abstract] OR prematur*[Title/Abstract] OR preterm[Title/Abstract] OR pre-term[Title/Abstract] OR postterm[Title/Abstract] OR post-term[Title/Abstract] OR stillbirth[Title/Abstract] OR asphyxia[Title/Abstract] OR birth injur*[Title/Abstract] OR birth defect*[Title/Abstract] OR birth complication*[Title/Abstract] OR Congenital, Hereditary, and Neonatal Diseases and Abnormalities[MeSH Terms]

Filters: publication date 01-01-2007/01-03-2017, languages: Dutch, English

Undocumented migrants

Search Pubmed/MEDLINE (25th of April 2017) (search syntax was adapted to Embase database)
#1 AND #2
#1
undocumented immigrants[MeSH Terms] OR undocumented[Title/Abstract] OR stateless[Title/Abstract] OR non-citizen[Title/Abstract] OR ((illegal[Title/Abstract] OR unauthorized[Title/Abstract] OR irregular[Title/Abstract]) AND (immigrant*[Title/Abstract] OR migrant*[Title/Abstract] OR women[Title/Abstract] OR mother*[Title/Abstract] OR alien*[Title/Abstract] OR pregnan*[Title/Abstract]))
#2
Europe[MeSH Terms] OR Albania*[Title/Abstract] OR Andorra*[Title/Abstract] OR Austria*[Title/Abstract] OR Belarus*[Title/Abstract] OR Belgium[Title/Abstract] OR Bosnia[Title/Abstract] OR Bulgaria*[Title/Abstract] OR Croatia*[Title/Abstract] OR Cyprus[Title/Abstract] OR Czech*[Title/Abstract] OR Denmark[Title/Abstract] OR England[Title/Abstract] OR Estonia*[Title/Abstract] OR Faroe*[Title/Abstract] OR Faeroe*[Title/Abstract] OR Finland[Title/Abstract] OR France[Title/Abstract] OR Germany[Title/Abstract] OR Gibraltar*[Title/Abstract] OR Greece[Title/Abstract] OR Great-Britain[Title/Abstract] OR Great Britain[Title/Abstract] OR Holland[Title/Abstract] OR Hungary[Title/Abstract] OR Iceland*[Title/Abstract] OR Ireland[Title/Abstract] OR Northern Ireland[Title/Abstract] OR Italy[Title/Abstract] OR Kosovo*[Title/Abstract] OR Latvia*[Title/Abstract] OR Liechtenstein*[Title/Abstract] OR Lithuania*[Title/Abstract] OR Luxembourg*[Title/Abstract] OR Luxemborg*[Title/Abstract] OR Macedonia*[Title/Abstract] OR Malta*[Title/Abstract] OR Moldavia*[Title/Abstract] OR Monaco[Title/Abstract] OR Montenegro[Title/Abstract] OR Netherlands[Title/Abstract] OR Norway[Title/Abstract] OR Poland[Title/

Abstract] OR Portugal[Title/Abstract] OR Romania*[Title/Abstract] OR San Marino[Title/Abstract] OR Scotland[Title/Abstract] OR Serbia*[Title/Abstract] OR Slovenia*[Title/Abstract] OR Slovakia*[Title/Abstract] OR Spain[Title/Abstract] OR Sweden[Title/Abstract] OR Switzerland[Title/Abstract] OR United Kingdom[Title/Abstract] OR UK[Title/Abstract] OR Ukraine[Title/Abstract] OR Vatican*[Title/Abstract] OR Wales[Title/Abstract] OR Belgian[Title/Abstract] OR Bosnian[Title/Abstract] OR British[Title/Abstract] OR Cypriot[Title/Abstract] OR Danish[Title/Abstract] OR Dutch[Title/Abstract] OR English[Title/Abstract] OR Finnish[Title/Abstract] OR French[Title/Abstract] OR German[Title/Abstract] OR Greek[Title/Abstract] OR Hungarian[Title/Abstract] OR Irish[Title/Abstract] OR Italian[Title/Abstract] OR Kosovar[Title/Abstract] OR Maltese[Title/Abstract] OR Monacan[Title/Abstract] OR Norwegian[Title/Abstract] OR Polish[Title/Abstract] OR Portuguese[Title/Abstract] OR Scottish[Title/Abstract] OR Spanish[Title/Abstract] OR Swedish[Title/Abstract] OR Swiss[Title/Abstract] OR Ukrainian[Title/Abstract] OR Welsh[Title/Abstract] OR Geneva[Title/Abstract] OR Europe*[Title/Abstract] OR EU[Title/Abstract] OR Benelux[Title/Abstract] OR Western Europe*[Title/Abstract] OR Eastern Europe*[Title/Abstract] OR Scandinavia*[Title/Abstract] OR Nordic[Title/Abstract] OR Baltic States[Title/Abstract] OR Balkan[Title/Abstract] OR Mediterranean[Title/Abstract] OR Western countr*[Title/Abstract] OR Destination countr*[Title/Abstract] OR High-income countr*[Title/Abstract] OR High-immigration setting*[Title/Abstract] OR Host countr*[Title/Abstract] OR Immigrant-receiving countr*[Title/Abstract] OR migrant-receiving countr*[Title/Abstract]

Filter: publication date: 2007-2017

File 2. Grey literature search strategy

Asylum seekers

- **Google search**
  For each country/region we searched the first 5 pages:
  - Keywords: asyl pregnant OR pregnancy OR matern "country" filetype:pdf
  - Time frame: 01/01/2007 – 25/06/2017
- **Countries/regions searched via Google:**
  Europe, Albania, Andorra, Austria, Bosnia, Belarus, Belgium, Croatia, Cyprus, Czech Republic, Denmark, England, Estonia, Faroe Islands, Finland, France, Germany, Gibraltar, Greece, Great-Britain, Holland, Hungary, Iceland, Ireland, Northern-Ireland, Italy, Kosovo, Latvia, Liechtenstein, Lithuania, Luxembourg, Macedonia, Malta, Moldavia, Monaco, Netherlands, Norway, San Marino, Scotland, Serbia, Slovenia, Slovakia, Spain, Sweden, Switzerland, United Kingdom, Ukraine, Vatican, Wales, European Union, Benelux, Western Europe, Eastern Europe, Scandinavia, Nordic countries, Baltic countries, Mediterranean countries, destination countries, high income countries, high immigration setting, host countries, migrant-receiving countries

Undocumented migrants

- **Google search**
  For each country/region we searched the first 5 pages:
  - Undocumented pregnan outcomes + country/region
  - Undocumented matern outcomes + country/region
- **Countries/regions searched via Google:**
  Europe, Albania, Andorra, Austria, Bosnia, Belarus, Belgium, Croatia, Cyprus, Czech Republic, Denmark, England, Estonia, Faroe Islands, Finland, France, Germany, Gibraltar, Greece, Great-Britain, Holland, Hungary, Iceland, Ireland, Northern-Ireland, Italy, Kosovo, Latvia, Liechtenstein, Lithuania, Luxembourg, Macedonia, Malta, Moldavia, Monaco, Netherlands, Norway, San Marino, Scotland, Serbia, Slovenia, Slovakia, Spain, Sweden, Switzerland, United Kingdom, Ukraine, Vatican, Wales, European Union, Benelux, Western Europe, Eastern Europe, Scandinavia, Nordic countries, Baltic countries, Mediterranean countries, destination countries, high income countries, high immigration setting, host countries, migrant-receiving countries

File 3. Organisations contacted with request for grey literature

Individual names of persons contacted are not provided out of privacy considerations

Organisation	City, Country	Region of Focus
Landelijk Ongedocumenteerden Steunpunt	NL	NL
OKIA	The Hague, NL	NL
NIVEL	NL	NL
Pharos	NL	NL
Stg Lampion (Pharos)	NL	NL
GGD	The Hague, NL	NL
GGD	Amsterdam, NL	NL
Johannes Wier Stichting	NL	NL
Wereldhuis	Amsterdam, NL	NL
Casa Migrante	Amsterdam. NL	NL
INLIA	Groningen, NL	NL
Fabel van de Illegaal	Zeist, NL	NL
Huize Agnes	Utrecht, NL	NL
Wereldvrouwenhuis	Nijmegen, NL	NL
Harriet Tubmanhuis	Amsterdam, NL	NL
SVZV	Amsterdam, NL	NL
KNOV - Tijdschrift voor Verloskundigen	NL	NL
Verlokundigenpraktijk Bijlmermeer	Amsterdam, NL	NL
Kruispost	Amsterdam, NL	NL
Rotterdams Ongedocumenteerden Steunpunt	Rotterdam, NL	NL
Pauluskerk	Rotterdam, NL	NL
VLOT	Heerlen, NL	NL
Moeders van Rotterdam	Rotterdam, NL	NL
Defense for Children International	NL	NL
Vluchteling onder Dak	Wageningen, NL	NL
SNOV	Nijmegen, NL	NL
Médecins du Monde	International	EU
Médecins du Monde	Austria	EU

Organisation	City, Country	Region of Focus
Médecins du Monde	Belgium	EU
Médecins du Monde	Bulgaria	EU
Médecins du Monde	Croatia	EU
Médecins du Monde	Czech Republic	EU
Médecins du Monde	France	EU
Médecins du Monde	Germany	EU
Médecins du Monde	Greece	EU
Médecins du Monde	Hungary	EU
Médecins du Monde	Ireland	EU
Médecins du Monde	Italy	EU
Médecins du Monde	Luxembourg	EU
Médecins du Monde	Norway	EU
Médecins du Monde	Poland	EU
Médecins du Monde	Romania	EU
Médecins du Monde	Spain	EU
Médecins du Monde	Sweden	EU
Médecins du Monde	Swiss	EU
Médecins du Monde	Slovenia	EU
Médecins du Monde	UK	EU

File 4. Request for grey literature

Dear Sir/Madam,

We are currently conducting systematic literature reviews on mother and infant health among asylum seekers, asylum status holders, and undocumented immigrant women in Europe. These reviews are carried out by a team of researchers from i.a. University Medical Center Utrecht, Dutch Association of Community Health Services & Regional Medical Emergency Preparedness and Planning offices (GGD GHOR) and Médicins du Monde.

Because various actors are active in this field who do not necessarily publish their experiences or studies in peer reviewed journals, we aim to also include 'grey literature', such as reports, articles and guidelines.

We are reaching out to you because of your or your organization's affinity and/or expertise in health(care) for asylum seekers, asylum status holders, and undocumented migrant women.

In case you have or know of documents we kindly ask you to share this information with us via the forms below. If you happen to know of other organizations or persons we should approach - please let us know using the same form.

For sources regarding health of mothers and infants (maternal or perinatal outcomes) among **undocumented migrants** in Europe, please use this form [form link]

For sources concerning health of mothers and infants (maternal or perinatal outcomes) among **asylum seekers and asylum status holders** in Europe, please use this form [form link]

We would like to ask you to share your information by April[30], to allow us for sufficient time to analyze the results. In case you have questions or comments, please contact:

- Undocumented migrants review: (email)
- Asylum seeker review and asylum status holders: (email)

Thank you very much in advance for your cooperation.

File 5.

Table 3: Overview of reported outcomes and the direction of findings in each study

	Asylum seekers (AS) vs. host-country population (HP) (unless stated differently)					Undocumented migrants (UM) vs. documented migrants (DM) (unless stated differently)				
Mortality-related outcomes	**N=**	**Higher**	**No difference**	**Lower**	**No comparison**	**N=**	**Higher**	**No difference**	**Lower**	**No comparison**
Maternal mortality	2	Van Oostrum et al. (2011)			Van Hanegem et al. (2011)	0				
Perinatal mortality	1		Van Oostrum et al. (2011)			3		Wolff et al. (2008); De Jonge et al. (2011)		Shortall et al. (2014)
Spontaneous abortion/ miscarriage	1				Kurth et al. (2010)	1	Fedeli et al. (2010) *compared to host population and documented migrants* ◊			
Maternal morbidity (pre-birth)	**N=**	**Higher**	**No difference**	**Lower**	**No comparison**	**N=**	**Higher**	**No difference**	**Lower**	**No comparison**
Pre-eclampsia/hypertensive disorders	0					2		Wolff et al. (2008)		Schoevers et al. (2009)

Table 3: Overview of reported outcomes and the direction of findings in each study **(continued)**

	Asylum seekers (AS) vs. host-country population (HP) (unless stated differently)			**Undocumented migrants (UM) vs. documented migrants (DM) (unless stated differently)**		
Antenatal depression	1	Ratcliff et al. (2015) *compared to migrants with non-precarious legal status*	Ratcliff et al. (2015)€	0		
Gestational diabetes	1		Kurth et al. (2010)	1	Wolff et al. (2008)	
Anemia during pregnancy	1		Kurth et al. (2010)	1	Wolff et al. (2008)	
Cervix insufficiency	0			1		Schoevers et al. (2009)
Prenatal bleeding	1		Kurth et al. (2010)	1	Wolff et al. (2008); De Jonge et al. (2011)	
Urinary tract infection	0			1	Wolff et al. (2008)	
Kidney problems during pregnancy	0			1		Schoevers et al. (2009)
Risk of preterm birth (unspecified)	0			1	Wolff et al. (2008)	

Table 3: Overview of reported outcomes and the direction of findings in each study **(continued)**

	Asylum seekers (AS) vs. host-country population (HP) (unless stated differently)					**Undocumented migrants (UM) vs. documented migrants (DM) (unless stated differently)**				
Antepartum hospitalisations (unspecified)	0					1	Fedeli et al. (2010) *compared to host population and documented migrants* ◊			
Complications during pregnancy (unspecified)	0					1		Wolff et al. (2008)		
Maternal morbidity (birth-related)	**N=**	**Higher**	**No difference**	**Lower**	**No comparison**	**N=**	**Higher**	**No difference**	**Lower**	**No comparison**
Severe acute maternal morbidity	1	Van Hanegem et al. (2011)				0				
Vaginal tear	0					1		Wolff et al. (2008)		
Retention of the placenta	0					1		Wolff et al. (2008)		
Obstetric complications (unspecified)	1		Ratcliff et al. (2015)			1		Wolff et al. (2008)		
Maternal morbidity (post-partum)	**N=**	**Higher**	**No difference**	**Lower**	**No comparison**	**N=**	**Higher**	**No difference**	**Lower**	**No comparison**
Complications post-partum (unspecified)	0					1		Wolff et al. (2008)		

Table 3: Overview of reported outcomes and the direction of findings in each study **(continued)**

	Asylum seekers (AS) vs. host-country population (HP) (unless stated differently)					Undocumented migrants (UM) vs. documented migrants (DM) (unless stated differently)				
Timing of birth	**N=**	**Higher**	**No difference**	**Lower**	**No comparison**	**N=**	**Higher**	**No difference**	**Lower**	**No comparison**
Preterm birth	1				Kurth et al. (2010)€	4	De Jonge et al. (2011)	Wolff et al. (2008)		Shortall et al. (2014); Schoevers et al. (2009)
Post-term birth	0					2		Wolff et al. (2008)		Shortall et al. (2014)
Gestational age	0					2		De Jonge et al. (2011)	Wolff et al. (2008)	
Mode of birth	**N=**	**Higher**	**No difference**	**Lower**	**No comparison**	**N=**	**Higher**	**No difference**	**Lower**	**No comparison**
Vaginal birth (spontaneous)	1		Kurth et al. (2010)			2		Wolff et al. (2008)		Wolff et al. (2008); Shortall et al. (2014)
Prolonged labor	0					1				Schoevers et al. (2014)
Referral for failure to progress in labor	0					1		De Jonge et al. (2011)		

Table 3: Overview of reported outcomes and the direction of findings in each study **(continued)**

	Asylum seekers (AS) vs. host-country population (HP) (unless stated differently)		**Undocumented migrants (UM) vs. documented migrants (DM) (unless stated differently)**		
Induction of labor	1	Van Hanegem et al. (2011) *compared to non-Western immigrants and Dutch women with severe acute maternal morbidity*	1	Jonge et al. (2011)	
Instrumental birth (unspecified)	0	Kurth et al. (2010)	1		Shortall et al.(2014)
Forceps	0		2	De Jonge et al. (2011)	Wolff et al. (2008)
Vacuum	0		2	De Jonge et al. (2011)	Wolff et al. (2008)
Episiotomy	0		1	Wolff et al. (2008)	

Table 3: Overview of reported outcomes and the direction of findings in each study **(continued)**

	Asylum seekers (AS) vs. host-country population (HP) (unless stated differently)					**Undocumented migrants (UM) vs. documented migrants (DM) (unless stated differently)**				
Caesarean section (unspecified)	1		Van Hanegem et al. (2011) *compared to non-Western immigrants and Dutch women with severe acute maternal morbidity*			3		De Jonge et al. (2011)	Fedeli et al. (2010) *compared to host population and documented migrants*	Wolff et al. (2008); Schoevers et al. (2009)
Elective caesarian section	1		Kurth et al. (2010)			1				Shortall et al. (2014)
Unplanned/emergency caesarian section	1		Kurth et al. (2010)			1				Shortall et al. (2014)
Neonatal outcomes	**N=**	**Higher**	**No difference**	**Lower**	**No comparison**	**N=**	**Higher**	**No difference**	**Lower**	**No comparison**
Low birthweight (<2500 grams)	1				Kurth et al. (2010)	4	De Jonge et al. (2011); Salmasi et al. (2015) *compared before and after acquisition of documented status*	Wolff et al. (2008)		Schoevers et al. (2009)

Table 3: Overview of reported outcomes and the direction of findings in each study **(continued)**

	Asylum seekers (AS) vs. host-country population (HP) (unless stated differently)		**Undocumented migrants (UM) vs. documented migrants (DM) (unless stated differently)**		
Macrosomia	0		1	De Jonge et al. (2011)	
Retardation of intrauterine growth	1	Kurth et al. (2010)	0		
Born in good health	0		1	Wolff et al. (2008)	
Apgar score	0		1	Wolff et al. (2008)	
Admission to neonatal intensive care unit	0		1	Wolff et al. (2008)	
Neonatal admission at maternal indication	0		1	De Jonge et al. (2011)	
Neonatal admission for prematurity/being small-for-gestational age	0		1	De Jonge et al. (2011)	
Neonatal admission for poor neonatal condition	0		1	De Jonge et al. (2011)	
Foetal distress	0		2	De Jonge et al. (2011)	Schoevers et al. (2009)
Difficulties in adaptation to extra-uterine life	1	Kurth et al. (2010)			
Birth trauma	0		1		Schoevers et al. (2009)

Table 3: Overview of reported outcomes and the direction of findings in each study **(continued)**

	Asylum seekers (AS) vs. host-country population (HP) (unless stated differently)		**Undocumented migrants (UM) vs. documented migrants (DM) (unless stated differently)**		
Mother to child transmission of HIV	1	Goosen et al. (2015)			
Congenital malformations	1	Kurth et al. (2010)	2		Schoevers et al. (2009); Shortall et al. (2014)
Neonatal complications (unspecified)	0		1	Wolff et al. (2008)	

Note. All studies were classified as reporting results either higher, lower or similar (no differences) for target populations as compared to host populations/ documented migrants¸ or as not comparing those two.
◊ Percentages/rates reported only, no statistical analysis conducted
€ No control group; national rates are mentioned as a reference (without statistical analysis)

File 6. Risk of bias assessment according to the Newcastle-Ottawa Scale (NOS)

Author(s)	Selection (max. 4 stars)	Comparability (max. 2 stars)	Outcome (max 3 stars)	Overall risk of bias
Asylum seekers				
Van Oostrum et al. (2009)	****	**	***	Low
Kurth et al. (2010)	**-*	--	***	Moderate
Van Hanegem et al. (2011)	****	**	***	Low
Goosen et al. (2015)	-***	**	***	Low
Ratcliff et al. (2015)	-***	**	**-	Moderate
Undocumented migrants				
Wolff et al. (2008)	****	**	**-	Low
Schoevers et al. (2009)	****	--	-*-	Moderate
Fedeli et al. (2010)	***-	--	**-	Moderate
De Jonge et al. (2011)	****	**	***	Low
Shortall et al. (2014)	--**	--	-*-	High
Salmasi et al. (2015)	****	**	***	Low

Chapter three

Childbirths and the prevalence of potential risk factors for adverse perinatal outcomes among asylum seekers in the Netherlands: a five-year cross-sectional study

J.B. Tankink* & A.E.H. Verschuuren*, I.R. Postma, P.J.A. van der Lans, J.P. de Graaf, J. Stekelenburg, A.W. Mesman

* Joint first authorship.

Published in: *International Journal of Environmental Research and Public Health* (2021), 18(24), 12933.

Abstract

This five-year cross-sectional study mapped the prevalence of several known risk factors for adverse perinatal outcomes in asylum-seeking women in The Netherlands. Characteristics of 2831 registered childbirths among residents of asylum seekers centers (ASCs) in The Netherlands from 2016 to 2020 were included. Results showed a high general and teenage birthrate (2.15 and 6.77 times higher compared to the Dutch, respectively). Most mothers were pregnant upon arrival, and the number of births was highest in the second month of stay in ASCs. Another peak in births between 9 and 12 months after arrival suggested that many women became pregnant shortly after arrival in The Netherlands. Furthermore, 69.5 percent of all asylum-seeking women were relocated between ASCs at least once during pregnancy, which compromises continuity of care. The high prevalence of these risk factors in our study population might explain the increased rate of adverse pregnancy outcomes in asylum seekers compared to native women found in earlier studies. Incorporating migration-related indicators in perinatal health registration is key to support future interventions, policies, and research. Ultimately, our findings call for tailored and timely reproductive and perinatal healthcare for refugee women who simultaneously face the challenges of resettlement and pregnancy.

Introduction

Health equity among women and their babies during pregnancy, childbirth and the postnatal period is under serious pressure in a migration context.[1,2] Asylum seekers represent a specific migrant population who may face higher rates of several adverse maternal health outcomes, such as postnatal complications and postpartum depression, as well as adverse perinatal outcomes, such as stillbirth and low birthweight, compared to native populations.[3,6]

In The Netherlands, a recent study demonstrated a 7 times higher risk of perinatal mortality (defined as death between 22 weeks of pregnancy and 7 days postpartum) among asylum seekers as compared to Dutch women in a regional hospital.[6] Another Dutch study reported a maternal mortality ratio (MMR) of 69.33 per 100,000 births among asylum seekers, which was 10.08 times that of the native population (95% CI 8.02 to 12.83).[7] In addition, asylum seekers had a 4.5 times greater risk of severe acute maternal morbidity (RR 4.5; 95% CI 3.3–6.1) compared to the general population. This risk remained 3.6 times higher when comparing asylum seekers to other non-Western immigrant groups (RR 3.6; 95% CI 2.6–5.0).[8]

A complex interplay of social, medical, and migration-related determinants places asylum seekers in a particularly vulnerable situation as expectant mothers.[3-5,9] In the process of forced migration, women may be exposed to gender-based violence, other types of potential trauma and perilous living conditions in refugee camps or on the streets.[10,11] Healthcare, including antenatal care, does not always come timely, and continuity of care is often compromised while women relocate to or within the country of resettle-ment.[9,12] Once seeking or receiving care, cultural differences and language barriers can hamper effective communication and understanding between care providers and pregnant women.[13,14]

Previous research identified risk factors for severe acute maternal morbidity in asylum seekers, including single motherhood, low socio-economic status, short duration of stay in The Netherlands and a major language barrier.[8] In addition, pregnancies may be complicated by preexistent disease, such as HIV infection or perinatal mental health disorders.[15-17] The stress associated with an uncertain residence status, lengthy asylum procedures or financial hardship may further explain why asylum seekers are disadvantaged in perinatal health.[12]

Given the strong indication of health disparities between asylum-seeking and native women, there is ample reason to monitor asylum seekers' perinatal health status and pregnancy outcomes. However, asylum seekers remain a relatively

understudied population, as hospital records and national perinatal registries in most countries lack migration-related indicators.[18,19] Therefore, the possibilities to identify and study different migrant populations are limited. In The Netherlands, asylum seekers with a length of stay shorter than six months will generally not have a social security number and therefore cannot easily be traced in national perinatal registry data.

To develop focused interventions and target perinatal health inequities, more insight into the population and reproductive health needs of residents in asylum seekers centers (ASCs) is key. With the use of a unique database, this study aimed to present an overview of childbirths among women in Dutch ASCs and assess the prevalence of several previously described risk factors for adverse perinatal outcomes.

Materials and methods

This was a five-year cross-sectional study which used data from the Dutch Central Agency for the Reception of Asylum Seekers (in Dutch "Centraal Orgaan opvang Asielzoekers; COA").

Setting

In The Netherlands, the COA is the governmental organization which is nationally responsible for the accommodation and assistance of asylum seekers. The COA provides asylum seekers with housing while the immigration services process their asylum request. COA locations include 2 central reception centers and around 60 asylum seeking centers (ASC). After first registration and short-term stay in a central reception center, asylum seekers will be relocated to an ASC. Subsequent relocations between ASCs may occur in the context of the asylum procedure or for a variety of other reasons, such as limited capacity or closure of centers, family reunification or special care needs. At present, the Dutch guideline of perinatal healthcare for asylum seekers advises against relocation of pregnant asylum seekers between 34 weeks of gestation and 6 weeks postpartum.[20] Hereafter, all COA locations will be referred to as ASCs.

Healthcare and perinatal care for asylum seekers

In The Netherlands, healthcare is covered by governmental insurance for asylum seekers. Asylum seekers receive primary healthcare from a contracted organization (GZA Healthcare) which has health centers in most ASCs, while perinatal care is provided by midwifery practices located near ASCs. In the Dutch system, all pregnant women, including asylum seekers, receive midwife-led care unless they are referred to gynecolo- gists/obstetricians in case of (threatening)

complications or "high-risk" pregnancy. In case of the relocation of asylum seekers during pregnancy, all medical care and patient history is transferred to new care providers at the next GZA, midwifery practice and/or hospital (see Figure 1). The specific pathways and responsibilities in birth care for asylum seekers have been documented in a national guideline for all stakeholders involved.[20]

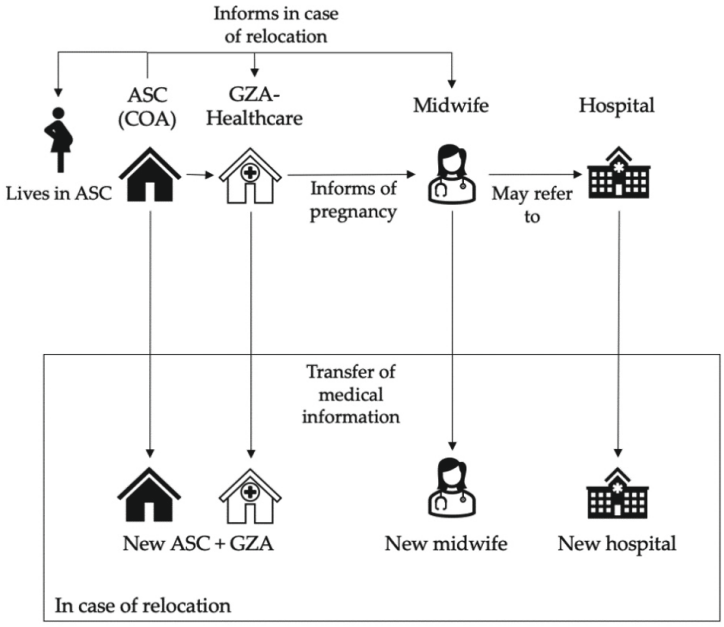


Figure 1. Organization of antenatal care and relocations of pregnant asylum seekers in The Netherlands. ASC = asylum seekers center; COA = Central Agency for the reception of Asylum seekers; GZA = GZA Healthcare (health care center of contracted primary care provider for asylum seekers).

Study population

Our study population included all women accommodated in an ASC at the time of childbirth between 1 January 2016 and 1 January 2021. Mothers were included regardless of the status of their request for asylum (in process, approved or denied). As undocumented women are legally entitled to housing in ASCs from six weeks before the due date to at least six weeks after childbirth, these women were also included in the sample. In this study we will further refer to our study population as asylum seekers.

Data collection

The administrative system of the COA contained demographic information, housing details and information about childbirths of women in ASCs. Childbirths included all babies born alive after 22 weeks of gestation. Multiple pregnancies were considered as one birth in this study; if one mother gave birth more than

once during the study period, births and maternal characteristics were included separately. The COA anonymized data and provided the following data for each birth: maternal age in years (calculated at the time of birth); date of registration at an ASC; country of origin; number of relocations between COA locations within nine months prior to birth and registration with a husband or partner (yes/no). Lack of partner registration in an ASC did not necessarily mean a partner was not involved, for example, because partners could have stayed behind in the country of origin. In order to calculate birthrates, the COA provided the total number of asylum seekers in ASCs by sex, age, and country of origin on every first day of the month during the study period.

Data on the Dutch population were derived from Statistics Netherlands (in Dutch: Centraal Bureau voor de Statistiek, CBS).[21]

Data processing

From the COA dataset, we derived our main study outcomes, including birthrate, teenage birthrate, number of relocations during pregnancy, length of stay and registered with partner (yes/no). We calculated birthrates per 1000 person years in female asylum seekers of fertile age, as previously described by Goosen et al.[22] These person years were estimated through the total number of female asylum seekers aged 15–49 accommodated in ASCs each month. Birthrates were compared to Dutch population birthrates, which were defined as the number of livebirths per 1000 women aged 15–49. Using the date of registration at an ASC, we calculated length of stay at the time of birth. Categories of 0–9, 9–12 and 12+ months of stay at childbirth were chosen to estimate the number of women who were pregnant upon arrival in The Netherlands. Teenage births were defined as births among mothers aged below 20 years on the day of birth. We grouped countries of origin in accordance with UNHCR worldwide operations.[23]

Statistical analysis

Descriptive statistics were applied to report all outcomes. As our study included the entire population of women who gave birth while registered in an ASC in The Netherlands during the study period (instead of a sample), inferential statistics were not considered appropriate.

Ethical considerations

This study was approved by an acknowledged medical ethical committee (MEC-2021- 0552, Erasmus MC Rotterdam) and was not subject to the Medical Research Involving Human Subjects Act in The Netherlands. Regarding privacy issues, all data were retrieved and handled anonymously.

Results

The total number of registered newborns in the study period was 2933. Of all births, we excluded 11 because the registration date of the mother was after the date of birth. Thus, 2922 births were included in the birthrate calculations. From 2016 to 2020, 170 mothers gave birth to 2 children and 4 mothers gave birth to 3 children. After deduplication of 41 twin births, a total of 2881 births remained. Maternal characteristics were considered for 2831 childbirths (among 2694 unique mothers), as an additional 50 births were excluded due to missing information of the mother.

Childbirths and maternal characteristics

The number of births varied between years, with 778 births in 2016, 452 in 2017, 427 in 2018, 652 in 2019 and 572 in 2020 (see Appendix A). Of all 2831 births for which maternal characteristics were available, 319 births (11.3 percent) were registered among undocumented women residing in an ASC at the time of childbirth. The age of women ranged from 15 to 51 years old at the time of birth, and most women originated from different African regions (33.8 percent from Middle East/North Africa, 18.7 percent from East/Horn of Africa and 16.2 percent from West/Central Africa) (see Table 1). The most common countries of origin included Syria, Nigeria, Eritrea, Iraq, Iran, and Afghanistan (see Appendix B).

Table 1. Childbirths and maternal characteristics among asylum seekers.

	***n* (%)**
Age	
15–19	(2.5)
20–29	(54.4)
30–39	(38.1)
40–49	(4.9)
50+	(0.1)
Regions of origin	
America	(1.1)
Asia and Pacific	(14.7)
Europe	(12.8)
Middle East/North Africa	(33.8)
East/Horn of Africa	(18.7)
West/Central Africa	(16.2)

Table 1. Childbirths and maternal characteristics among asylum seekers. **(continued)**

	n **(%)**
Southern Africa	(1.8)
Unknown/stateless	(1.1)
Registered with partner	
Yes	(55.1)
No	(44.9)
Length of stay	
0–9 months	(52.0)
9–12 months	(14.4)
12+ months	(33.6)
Number of relocations during pregnancy	
0	(30.5)
1	(41.3)
2	(15.5)
3	(8.3)
or more	(4.4)
Subgroups	
Unaccompanied minors	(1.7)
Undocumented women	(11.3)

Length of stay and number of relocations

Most asylum-seeking women (52.0 percent) gave birth within 9 months after arrival in an ASC; 14.4 percent of women gave birth between 9 and 12 months after arrival and 33.6 percent stayed in ASCs for more than 12 months before giving birth (see Table 1). Overall, the largest number of women gave birth in the second month after arrival. From the second month onwards, the number of births showed a downward trend up until 24 months after arrival. Between 9 and 12 months, there was a deviation from the trend due to a peak in births (see Figure 2).

The number of relocations during pregnancy varied between 0 and 7 times. Of all asylum-seeking women, 69.5 percent were relocated once or more, and 28.2 percent were relocated two times or more during pregnancy (See Table 1). Of all relocations, 40.1 percent took place between a central reception center and an ASC. Of the women who were relocated more than 3 times during pregnancy,

104 women were relocated 4 times, 20 women 5 times, 3 women 6 times and 1 woman 7 times.

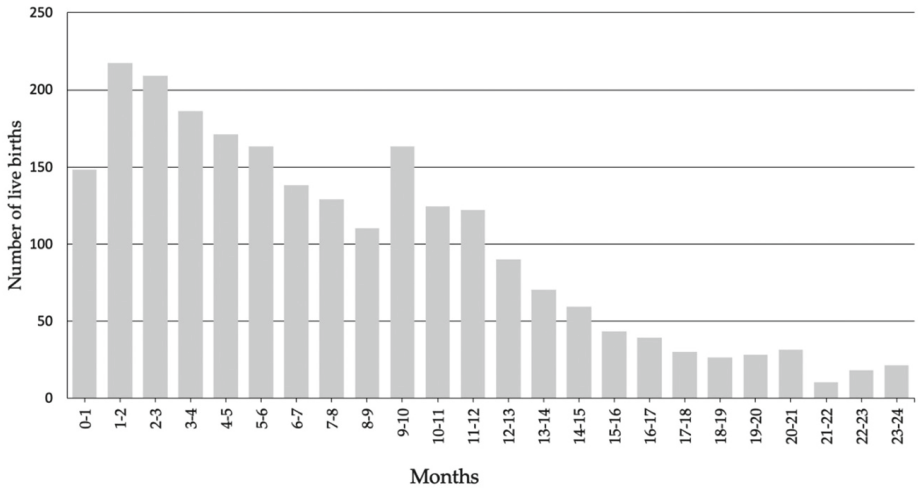


Figure 2. Distribution of live births by the mothers' length of stay in an ASC before giving birth (from 0–24 months).

Birthrates and region of origin

The average birthrate in the asylum-seeking population was 96.77 births per 1000 women of fertile age. This rate was 2.15 times higher compared to the Dutch population, which had 44.99 live births per 1000 women of fertile age (95% CI 44.90–45.09).[22] Birthrates varied between different regions of origin. Women from West/Central Africa and Southern Africa had a relatively high birthrate (234.82 [95% CI 213.45–256.18] and 119.82 [95% CI 87.25–152.38] per 1000, respectively), especially compared to women who originated from America and Asia and the Pacific (51.99 [95% CI 33.39–70.60] and 64.88 [95% CI 58.68–71.08] per 1000, respectively) (see Table 2).

Table 2. Variation in (teenage) birthrates among asylum seekers between different regions of origin compared to the Dutch population.

	Women of fertile age (15-49)						Women aged 15-19					
Region of origin of the mother	Women per 5 years [1,2]	Births in 5 years	Birthrate per 1000 [3]	95% CI birthrate per 1000		Birth ratio vs. NL	Women per 5 years	Teenage births in 5 years	Teenage birthrate per 1000 [3]	95% CI teenage birthrate per 1000		Teenage pregnancy ratio vs. NL
				Lower	Upper					Lower	Upper	
Netherlands	18,874,506	849,242	44.99	44.90	45.09	N/A	2,539,944	6678	2.63	2.57	2.69	N/A
Asylum seekers	30,194	2,922	96.77	91.93	98.90	2.15	4,045	72	17.80	13.69	21.91	6.77
America	577	30	51.99	33.39	70.60	1.16	62	0	0.00	0	0	0.00
Asia and Pacific	6,489	421	64.88	58.68	71.08	1.44	699	7	10.01	2.60	17.43	3.81
Europe	3,756	368	97.98	87.97	107.99	2.18	397	6	15.11	3.02	27.21	5.75
Middle East/ North Africa	10,757	971	90.27	84.59	95.94	2.01	1479	28	18.93	11.92	25.94	7.20
East/Horn of Africa	5,891	536	90.99	83.28	98.69	2.02	1043	21	20.13	11.52	28.75	7.66
West/Central Africa	1,976	464	234.82	213.45	256.18	5.22	114	8	70.18	21.55	118.80	26.69
Southern Africa	434	52	119.82	87.25	152.38	2.66	42	0	0.00	0	0	0.00
Unknown/ stateless	314	30	95.54	61.35	129.73	2.12	209	2	9.57	-3.69	22.83	3.64

[1] *The total population of asylum-seeking women of fertile age in the Dutch ASCs (2016-2020): Sum of estimated person years 2016-2020.*
[2] *The total population of women of fertile age in the Netherlands (2016-2020): Sum of women per year 2016-2020 (source: CBS).*
[3] *Birthrates for the Dutch population were calculated per 1000 women aged 15-49. For asylum seekers, birthrates were expressed per 1000 person years of women aged 15-49.*

Teenage pregnancies

During the study period, 72 teenage mothers gave birth while they lived in ASCs. Of these teenage mothers, 49 (68.1 percent) were unaccompanied minors. Compared to the Dutch population, the teenage birthrate among asylum-seeking women was 6.77 times higher (see Table 2).[22] Most of these teenage mothers originated from Middle East/North Africa and East/Horn of Africa (28 and 21 respectively). The teenage birthrate was the highest among women from West/Central Africa and East/Horn of Africa (70.18 and 20.13 per 1000, respectively).

Compared to non-teenage mothers, teenage mothers were less often registered with a partner (45.8 vs 55.3 percent), and a short length of stay in The Netherlands at birth was relatively more common (66.7 vs 51.6 percent). Specifically, 66.7 percent of teenage mothers gave birth within 9 months of their stay in an ASC, compared to 51.6 percent of non-teenage mothers (see Table 3).

Table 3. Registration with partner and length of stay in teenage and non-teenage mothers.

	n (%)	**Teenage mothers** *n* (%)	**Non-teenage mothers** *n* (%)
Asylum Seekers	(100)	(100)	(100)
Registered with Partner			
Yes	(55.1)	(45.8)	(55.3)
Unknown	(44.9)	(54.2)	(44.7)
Length of Stay in ASC at Childbirth			
0–9 months	(52.0)	(66.7)	(51.6)
9–12 months	(14.4)	(6.9)	(14.6)
>12 months	(33.6)	(26.4)	(33.8)

Discussion

This study presented an overview of childbirths in Dutch ASCs from 2016 to 2020, including maternal characteristics and the prevalence of previously described risk factors for adverse perinatal outcomes. We found that asylum seekers had a 2.15 times higher birthrate and a 6.77 times higher teenage birthrate compared to the Dutch population. Almost 70 percent of teenage mothers were unaccompanied minors, and 11.3 percent of all women were undocumented at the time of childbirth. Notably, more than half of all mothers and 66.7 percent of teenage mothers in this study were pregnant upon arrival in an ASC, with the highest number of total births in the second month after arrival. Only 55.1 percent of all mothers and 45.8 percent of teenage mothers were registered with a partner, and

69.5 percent of all women were relocated at least once during pregnancy. These findings offer important reflections into the origin of perinatal health inequities between asylum seekers, other migrants, and native populations.

The relatively high birthrate among asylum seekers in this study was likely related to limited access to and availability of sexual and reproductive health services throughout the process of forced migration.[24–2] In absolute numbers, most children in this study were born to mothers from the Middle East/North Africa, a region which includes common countries of origin among asylum seekers such as Syria and Iraq.[28] The highest birthrate was found among women from different African regions, which is in line with the UN estimate of 4.7 births per woman in sub-Saharan Africa, more than twice the level of any other world region.[29,30]

Most women who gave birth during the study period were pregnant on arrival at an ASC. The peak in births in the second month after arrival indicated that most of these women were already in their third trimester at the date of registration. The arrival of pregnant women with a refugee background has been addressed by two recent Italian studies. In one study, 11 percent of all migrants arrived pregnant; in another study, 45 percent of pregnant women living in reception centers were pregnant on arrival.[31,32] In non-academic reports, humanitarian organizations raised concerns over the number and dire circumstances of pregnant women in refugee camps and documented a minimum of 27 deaths of pregnant migrants at European borders in the last decade.[33–35] To our knowledge, no research has studied the percentage of women that became pregnant before leaving their homelands or along the way. As women on the move are prone to gender- based violence, a substantial part of their pregnancies may be due to rape .[10,11,32,36] Regardless of how, when and where women became pregnant, antenatal care will mostly start late or get disrupted for women arriving pregnant in ASCs.

Overall, the number of childbirths decreased with increasing length of stay, which could be partially attributed to asylum seekers leaving ASCs. However, we found that a relatively high number of women became pregnant in the first 3 months after arrival in ASCs. Refugees' hope that pregnancy may help to receive a residence permit may be one explanation for this relative peak in births between 9 and 12 months of stay.[21] Although the background and motives of having a baby shortly after reaching a destination country need to be further explored, these results stress the need for access to reproductive health services immediately after arrival.

A substantial part of the women who gave birth shortly after arrival most likely concerned undocumented women, who are legally entitled to shelter from 6 weeks prior to their due date to 6 weeks after birth in The Netherlands. As

not all women use this option, for instance because they are unaware of the right to shelter or fear deportation, the 319 women in our study probably represent an underestimation of the number of undocumented women giving birth in The Netherlands. Compared to different European populations, poor perinatal health outcomes have been reported in undocumented migrants.[37–39] Although few studies have compared perinatal outcomes between documented and undocumented migrants, the intersection of a precarious legal status, jeopardized access to healthcare and systemic and social exclusion likely renders undocumented migrants a particularly vulnerable group of pregnant women in ASCs. [3,38–41]

Considering the increased risks of sexual abuse and exploitation among young girls, the high percentage (66.7 percent) of teenage mothers in our study who arrived pregnant in ASCs was especially alarming.[36,42] Teenage pregnancy and childbirth have been linked to poor perinatal health outcomes and may have long-term negative socioeconomic consequences.[43] In line with earlier research, this study demonstrated a relatively high teenage birthrate among asylum seekers (17.80/1000).[21] The high teenage birthrate in women from sub-Saharan Africa (SSA) corresponds to literature estimating that one in four adolescent girls in SSA gives birth before reaching 18 years old.[43] Young asylum seekers may be at increased risk of early and unintended pregnancies because of discontinued education, disrupted family structures or a lack of financial means and contraceptives.[21,44]

Over half of the teenage mothers, and 44.9 percent of all mothers in this study were registered without a partner at the time of childbirth in an ASC. Moreover, 68.1 percent of all teenage mothers were unaccompanied minors. While social connectedness is not limited to (registered) civil status or having a guardian, these numbers suggested that social isolation may be significant among mothers in ASCs. Asylum seekers are often separated from family and friends, which adds to the complex reality of new parenthood simultaneously with resettlement in a new country. A lack of social support has consistently been shown to increase the risk of perinatal mental health disorders across general, but also refugee, populations.[45,46] For asylum seekers, single motherhood was identified as a specific risk factor for severe acute maternal morbidity.[8] A recent systematic review concluded that community building and a stimulating social network are key protective factors across interventions for refugee mothers.[47]

Another finding in our study concerned the frequent relocations of pregnant women between ASCs. In our population, 69.5 percent of women were relocated at least once, and 28.2 percent were relocated two times or more during pregnancy. No conclusions can be drawn regarding the reasons for relocations, or how

relocations may have affected the health or wellbeing of the pregnant women in our study. However, in a previous systematic review of qualitative evidence, the effects of relocations included discontinuity of care, repeated interventions and missed treatment leading to potentially dangerous medical situations.[48] Moreover, frequent or late relocations caused feelings of powerlessness, stress and anxiety among pregnant asylum seekers in multiple studies. Care providers reported how relocations frustrated the care process and interfered with the ability to form trusting relationships with their clients.[12,48–51]

Strengths and limitations

An important strength of this study regarded the unique source of data as provided by the COA. As such, we were able to consider all childbirths registered in ASCs, including multiple maternal, demographic, and social factors that appear relevant to perinatal health. To our knowledge, no previous studies have quantified relocations of asylum seekers during pregnancy. Since migrant perinatal health research has long failed to acknowledge the heterogeneity within migrant populations, our focus on residents of ASCs (including undocumented women and minors) represents another important strength of this study.

Several limitations should be considered in the interpretation of our results. Firstly, the available data only included maternal characteristics and no clinical outcomes of childbirths among residents of ASCs. Although a detailed population profile proves an important first step in recognizing risk factors and reproductive health needs, further research is needed to consider associations between maternal characteristics of asylum seekers and pregnancy outcomes. As abortive outcomes and stillbirths could not be included in this study, our study population represented an underestimation of the total population of pregnant women in ASCs.

No general health, lifestyle or obstetric care parameters could be included in this study besides maternal age, and only limited information related to the asylum process was available. Details on the length or status of the procedure, migration motives and language barriers could provide more insight into the situation of women who are pregnant while seeking asylum. The understudied subpopulation of undocumented migrants was part of our sample, but we could not disaggregate other characteristics of these women. Lastly, length of stay in ASCs may not represent the true duration of residence in The Netherlands for all women in this study, as only the latest date of registration in an ASC was available.

Policy and research recommendations

The high percentage of women pregnant on arrival in this study urges rapid referral pathways and support in navigating the maternity care system for women

in ASCs. Healthcare professionals attending to asylum seekers should be aware that pregnancy may be unplanned and/or unwanted and be equipped to offer trauma-informed care. Education and empowerment with regards to sexual and reproductive health and rights should be facilitated for (teenage) asylum seekers and especially unattended minors. In addition, the relatively large percentage of (expectant) single mothers calls for programs and policy focused on social support. Given the psychosocial effects and discontinued care associated with relocations of pregnant asylum seekers, these should be kept to a minimum.[50]

Future research should provide more insight into the prevalence of migration-related risk factors and their association with adverse pregnancy outcomes in refugee women. Studies should focus specifically on the effects of migration policies, housing, and integration of refugees on different maternal and perinatal health outcomes. Ultimately, to advance research and monitoring of otherwise invisible subpopulations, quality registration of migration indicators in care and the possibility to link these to pregnancy outcomes is key.

Conclusions

In conclusion, this study showed a high birthrate and a high prevalence of previously described risk factors associated with adverse pregnancy outcomes in the asylum-seeking population in The Netherlands. These risk factors include a high rate of teenage pregnancies, single motherhood, frequent relocations, and a short length of stay. We identified a substantial number of unaccompanied minors and undocumented women, who face additional barriers to perinatal care. The relationship between included characteristics and perinatal outcomes could not be determined in our study, since the latter were lacking from the data, and linkage to other datasets was not possible. This limitation stresses the importance of including migration-related indicators in perinatal health registration to support future interventions, policies, and research. Ultimately, our findings call for tailored and timely reproductive and perinatal healthcare for refugee women who simultaneously face the challenges of resettlement and pregnancy.

Author contributions

Conceptualization, J.B.T., A.E.H.V., I.R.P., P.J.A.v.d.L., J.P.d.G., J.S. and A.W.M.; data curation, A.W.M.; formal analysis, J.B.T. and A.E.H.V.; investigation, J.B.T. and A.E.H.V.; methodology, J.B.T., A.E.H.V., I.R.P., P.J.A.v.d.L., J.P.d.G., J.S. and A.W.M.; project administration, J.B.T. and A.E.H.V.; supervision, I.R.P., P.J.A.v.d.L., J.P.d.G., J.S. and A.W.M.; writing—original draft, J.B.T. and A.E.H.V.;

writing—review & editing, I.R.P., P.J.A.v.d.L., J.P.d.G., J.S. and A.W.M. All authors have read and agreed to the published version of the manuscript.

Funding
This study was partially supported by The Netherlands Organization for Health Research and Development (ZonMw), project number 543003112.

Institutional review board statement
The study was conducted according to the guidelines of the Declaration of Helsinki and approved by the Institutional Ethics Committee of Erasmus medical center Rotterdam (MEC-2021-0552, approved on 26 August 2021).

Informed consent statement
Not applicable.

Data availability statement
Restrictions apply to the availability of these data. Data were obtained from the Dutch Central Agency for the Reception of Asylum Seekers (in Dutch "Centraal Orgaan opvang Asielzoekers; COA") and are available upon reasonable request from the authors with the permission of the COA.

Acknowledgments
First, we would like to thank the COA for sharing their data for the purpose of this publication. Specifically, we thank M. Mars for providing the data and B. Belic´ and J. Kooren for their valuable comments on the manuscript. In addition, we would like to acknowledge L. Bertens, A. Meerdink and K. Tamasi for sharing their thoughts on our data analysis and data presentation as experts in epidemiology and statistics. Lastly, we acknowledge the project members of the EGALITE project (Erasmus Medical Center) for their contribution to the setup of a larger research project, to which this study is related.

Conflicts of interest
The authors declare no conflict of interest. The sponsors had no role in the design, execution, interpretation, or writing of the study.

References

1. Gagnon, A.; Zimbeck, M.; Zeitlin, J. Migration to western industrialised countries and perinatal health: A systematic review. Soc. Sci. Med. 2009, 69, 934–946.
2. Akker, T.V.D.; Roosmalen, J.v. Maternal mortality and severe morbidity in a migration perspective. Best Pract. Res. Clin. Obstet. Gynaecol. 2016, 32, 26–38.
3. Gieles, N.C.; Tankink, J.B.; Van Midde, M.; Düker, J.; Van Der Lans, P.; Wessels, C.M.; Bloemenkamp, K.W.M.; Bonsel, G.; Akker, T.V.D.; Goosen, S.; et al. Maternal and perinatal outcomes of asylum seekers and undocumented migrants in Europe: A systematic review. Eur. J. Public Health 2019, 29, 714–723.
4. Heslehurst, N.; Brown, H.; Pemu, A.; Coleman, H.; Rankin, J. Perinatal health outcomes and care among asylum seekers and refugees: A systematic review of systematic reviews. BMC Med. 2018, 16, 89.
5. Bozorgmehr, K.; Biddle, L.; Preussler, S.; Mueller, A.; Szecsenyi, J. Differences in pregnancy outcomes and obstetric care between asylum seeking and resident women: A cross-sectional study in a German federal state, 2010–2016. BMC Pregnancy Childbirth 2018, 18, 417.
6. Verschuuren, A.E.H.; Postma, I.R.; Riksen, Z.M.; Nott, R.L.; Jong, E.I.F.-D.; Stekelenburg, J. Pregnancy outcomes in asylum seekers in the North of the Netherlands: A retrospective documentary analysis. BMC Pregnancy Childbirth 2020, 20, 320.
7. Van Oostrum, I.E.A.; Goosen, S.; Uitenbroek, D.G.; Koppenaal, H.; Stronks, K. Mortality and causes of death among asylum seekers in the Netherlands, 2002-2005. J. Epidemiol. Community Health 2010, 65, 376–383.
8. Hanegem, N.v.; Miltenburg, A.S.; Zwart, J.J.; Bloemenkamp, K.W.; Roosmalen, J.v. Severe acute maternal morbidity in asylum seekers: A two-year nationwide cohort study in the Netherlands. Acta Obstet. Gynecol. Scand. 2011, 90, 1010–1016.
9. Sturrock, S.; Williams, E.; Dassios, T.; Greenough, A. Antenatal care and perinatal outcomes of asylum seeking women and their infants. J. Perinat. Med. 2021, 49, 619–623.
10. Vu, A.; Adam, A.; Wirtz, A.; Pham, K.; Rubenstein, L.; Glass, N.; Beyrer, C.; Singh, S. The Prevalence of Sexual Violence among Female Refugees in Complex Humanitarian Emergencies: A Systematic Review and Meta-analysis. PLoS Curr. 2014, 6.
11. Keygnaert, I.; Vettenburg, N.; Temmerman, M. Hidden violence is silent rape: Sexual and gender-based violence in refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands. Cult. Health Sex. 2012, 14, 505–520.
12. Asif, S.; Baugh, A.; Jones, N.W. The obstetric care of asylum seekers and refugee women in the UK. Obstet. Gynaecol. 2015, 17, 223–231.
13. Briscoe, L.; Lavender, T. Exploring Maternity care for asylum seekers and refugees. Br. J. Midwifery 2009, 17, 17–23.
14. Fair, F.; Raben, L.; Watson, H.; Vivilaki, V.; Muijsenbergh, M.V.D.; Soltani, H. Migrant women's experiences of pregnancy, childbirth and maternity care in European countries: A systematic review. PLoS ONE 2020, 15, e0228378.
15. Goosen, S.; Hoebe, C.J.P.A.; Waldhober, Q.; Kunst, A.E. High HIV Prevalence among Asylum Seekers Who Gave Birth in the Netherlands: A Nationwide Study Based on Antenatal HIV Tests. PLoS ONE 2015, 10, e0134724.
16. Castaner, M.M.; Villadsen, S.F.; Petersen, J.H.; Norredam, M. First perinatal psychiatric episode among refugee and family- reunified immigrant women compared to Danish-born women: A register-based study. Psychiatry Psychiatr Epidemiol. 2021, 56, 2239–2250.

17. Fellmeth, G.; Fazel, M.; Plugge, E. Migration and perinatal mental health in women from low- and middle-income countries: A systematic review and meta-analysis. BJOG Int. J. Obstet. Gynaecol. 2017, 124, 742–752.
18. Racapé, J.; Schoenborn, C.; Sow, M.; Alexander, S.; De Spiegelaere, M. Are all immigrant mothers really at risk of low birth weight and perinatal mortality? The crucial role of socio-economic status. BMC Pregnancy Childbirth 2016, 16, 75.
19. Gagnon, A.J.; Zimbeck, M.; Zeitlin, J. Migration and perinatal health surveillance: An international Delphi survey. Eur. J. Obstet. Gynecol. Reprod. Biol. 2010, 149, 37–43.
20. Bo Brancheorganisatie Geboortezorg; Asylum Seeker Healthcare ('GZA'); Central Agency for the Reception of Asylum Seekers ('COA'); Royal Dutch Organisation of Midwives (KNOV); RMA Healthcare, Dutch Society of Obstetrics and Gynaecology ('NVOG'); Netherlands Association for Community Health Services (GGD GHOR Nederland). Dutch Guideline Perinatal Care for Asylum Seekers ('Ketenrichtlijn Geboortezorg Asielzoeksters'). Available online: https://www.kennisnetgeboortezorg.nl/ nieuws/actualisatie-ketenrichtlijn-geboortezorg-asielzoekers/ (accessed on 19 July 2021).
21. Statistics Netherlands. "StatLine". Open Data. 2021. Available online: https://opendata.cbs.nl/#/CBS/nl/ (accessed on 4 September 2021).
22. Goosen, S.; Uitenbroek, D.; Wijsen, C.; Stronks, K. Induced abortions and teenage births among asylum seekers in The Netherlands: Analysis of national surveillance data. J. Epidemiol. Community Health 2009, 63, 528–533.
23. United Nations Refugee Agency. UNHCR Operations Worldwide. Available online: https://reporting.unhcr.org/operations#:~{}:text=UNHCRWorksin134Countries,ReportingInformationfor40Operations (accessed on 13 July 2021).
24. Inci, M.G.; Kutschke, N.; Nasser, S.; Alavi, S.; Abels, I.; Kurmeyer, C.; Sehouli, J. Unmet family planning needs among female refugees and asylum seekers in Germany—Is free access to family planning services enough? Results of a cross-sectional study. Reprod. Health 2020, 17, 1–9.
25. Ivanova, O.; Rai, M.; Kemigisha, E. A Systematic Review of Sexual and Reproductive Health Knowledge, Experiences and Access to Services among Refugee, Migrant and Displaced Girls and Young Women in Africa. Int. J. Environ. Res. Public Health 2018, 15, 1583.
26. Raben, L.A.D.; Muijsenbergh, M.E.T.C.V.D. Inequity in contraceptive care between refugees and other migrant women?: A retrospective study in Dutch general practice. Fam. Pract. 2018, 35, 468–474.
27. Tanabe, M.; Myers, A.; Bhandari, P.; Cornier, N.; Doraiswamy, S.; Krause, S. Family planning in refugee settings: Findings and actions from a multi-country study. Confl. Health 2017, 11, 1–12.
28. Immigration and Naturalisation Service (IND). Asylum Trends. Asylum Trends. 2021. Available online: https://ind.nl/en/about- ind/figures-and-publications/Pages/Asylum-Trends.aspx (accessed on 4 September 2021).
29. United Nations Population Division. World Population Prospects 2019; United Nations: New York, NY, USA, 2019.
30. Bongaarts, J. Trends in fertility and fertility preferences in sub-Saharan Africa: The roles of education and family planning programs. Genus 2020, 76, 32.
31. Sulekova, L.F.; Spaziante, M.; Vita, S.; Zuccalà, P.; Mazzocato, V.; Spagnolello, O.; Lopalco, M.; Pacifici, L.E.; Bello, L.; Borrazzo, C.; et al. The Pregnancy Outcomes Among Newly Arrived Asylum-Seekers in Italy: Implications of Public Health. J. Immigr. Minor. Health 2020, 23, 232–239.

32. Trovato, A.; Reid, A.; Takarinda, K.C.; Montaldo, C.; Decroo, T.; Owiti, P.; Bongiorno, F.; Di Carlo, S. Dangerous crossing: Demographic and clinical features of rescued sea migrants seen in 2014 at an outpatient clinic at Augusta Harbor, Italy. Confl. Health 2016, 10, 14.
33. UNITED for Intercultural Action. UNITED List of Refugee Deaths; UNITED for Intercultural Action: Amsterdam, The Netherlands, 2021. Available online: http://unitedagainstrefugeedeaths.eu/wp-content/uploads/2014/06/ListofDeathsActual.pdf (accessed on 19 July 2021).
34. Médecins Sans Frontières. Vulnerable Refugees Evicted and Left to Sleep on Streets. Available online: https://www.msf.org/ greece-evicts-vulnerable-refugees-leaves-them-streets (accessed on 13 July 2021).
35. International Organization for Migration. Fatal Journeys: Tracking Lives Lost during Migration; International Organization for Migration: Geneva, Switzerland, 2014.
36. Mason-Jones, A.; Nicholson, P. Structural violence and marginalisation. The sexual and reproductive health experiences of separated young people on the move. A rapid review with relevance to the European humanitarian crisis. Public Health 2018, 158, 156–162.
37. De Jong, L.; Pavlova, M.; Winters, M.; Rechel, B. A systematic literature review on the use and outcomes of maternal and child healthcare services by undocumented migrants in Europe. Eur. J. Public Health 2018, 27, 990–997.
38. Haelterman, E.; Qvist, R.; Barlow, P.; Alexander, S. Social deprivation and poor access to care as risk factors for severe pre- eclampsia. Eur. J. Obstet. Gynecol. Reprod. Biol. 2003, 111, 25–32.
39. Tasa, J.; Holmberg, V.; Sainio, S.; Kankkunen, P.; Vehviläinen-Julkunen, K. Maternal health care utilization and the obstetric outcomes of undocumented women in Finland—A retrospective register-based study. BMC Pregnancy Childbirth 2021, 21, 191.
40. Liu, C.; Ahlberg, M.; Hjern, A.; Stephansson, O. Perinatal health of refugee and asylum-seeking women in Sweden 2014–17: A register-based cohort study. Eur. J. Public Health 2019, 29, 1048–1055.
41. Munro, K.; Jarvis, C.; Munoz, M.; D'Souza, V.; Graves, L. Undocumented pregnant women: What does the literature tell us? J. Immigr. Minor. Health 2013, 15, 281–291.
42. Urindwanayo, D.; Richter, S. Teenage Pregnancy in Refugee Camps: A Narrative Synthesis. J. Int. Womens. Stud. 2020, 21, 255–270.
43. Carvajal, L.; Wilson, E.; Requejo, J.H.; Newby, H.; Eriksson, C.d.C.; Liang, M.; Dennis, M.; Gohar, F.; Simon-Kapeu, A.; Idele, P.; et al. Basic maternal health care coverage among adolescents in 22 sub-Saharan African countries with high adolescent birthrate. J. Glob. Health 2020, 10, 021401.
44. Amjad, S.; Macdonald, I.; Chambers, T.; Osornio-Vargas, A.; Chandra, S.; Voaklander, D.; Ospina, M.B. Social determinants of health and adverse maternal and birth outcomes in adolescent pregnancies: A systematic review and meta-analysis. Paediatr. Perinat. Epidemiol. 2019, 33, 88–99.
45. Iliadou, M.; Papadakaki, M.; Sioti, E.; Giaxi, P.; Leontitsi, E.; Petelos, E.; Muijsenbergh, M.V.D.; Tziaferi, S.; Mastroyiannakis, A.; Vivilaki, V.G. Addressing mental health issues among migrant and refugee pregnant women: A call for action. Eur. J. Midwifery 2019, 3, 9.
46. Collins, C.H.; Zimmerman, C.; Howard, L.M. Refugee, asylum seeker, immigrant women and postnatal depression: Rates and risk factors. Arch. Women's Ment. Health 2011, 14, 3–11.
47. Balaam, M.-C.; Kingdon, C.; Haith-Cooper, M. A Systematic Review of Perinatal Social Support Interventions for Asylum-seeking and Refugee Women Residing in Europe. J. Immigr. Minor. Health 2021, 1–18.
48. McKnight, P.; Goodwin, L.; Kenyon, S. A systematic review of asylum-seeking women's views and experiences of UK maternity care. Midwifery 2019, 77, 16–23.

49. Feldman, R. When maternity doesn't matter: Dispersing pregnant women seeking asylum. Br. J. Midwifery 2014, 22, 23–28.
50. Harris, M.; Humphries, K.; Nabb, J. Delivering care for women seeking refuge. RCM Midwives 2006, 9, 190–192.
51. Reynolds, B.; White, J. Seeking asylum and motherhood: Health and wellbeing needs. Community Pract. 2010, 83, 20–23.

Supplementary materials

Appendix A

Table A1. Number of births and person years per year from 2016 to 2020.

Year	Number of births	Person years of women aged 15–49 in ASCs
2016	778	7708
2017	452	5412
2018	427	5052
2019	652	5824
2020	572	6198
Total	2881	30,194

Appendix B

Table A2. Number of births per country of origin.

Regions of origin	Countries	Number of births
America $n = 30$	Brazil	1
	Colombia	4
	Cuba	5
	El Salvador	3
	Honduras	2
	Nicaragua	1
	Suriname	3
	Venezuela	10
	United States of America	1
Asia and Pacific $n = 417$	Kazakhstan	2
	Kyrgyzstan	1
	Uzbekistan	2
	China	32
	North Korea	1
	India	1
	Nepal	1
	Sri Lanka	7
	Bangladesh	1
	Indonesia	1
	Mongolia	9
	Myanmar	2
	Thailand	1
	Viet Nam	2
	Afghanistan	147
	Islamic Republic of Iran	165
	Pakistan	42

Table A2. Number of births per country of origin. **(continued)**

Regions of origin	Countries	Number of births
Europe $n = 361$	Armenia	23
	Azerbaijan	24
	Belarus	3
	Georgia	19
	Russian Federation	38
	Turkey	108
	Ukraine	19
	Austria	1
	Germany	1
	Italy	1
	Latvia	1
	Republic of Moldova (the)	16
	Romania	1
	Albania	32
	Bosnia and Herzegovina	7
	North Macedonia	17
	Serbia	11
	Kosovo	6
	Yugoslavia	25
	Soviet Union	8

Table A2. Number of births per country of origin. **(continued)**

Regions of origin	Countries	Number of births
Middle East/North Africa *n* = 957	Iraq	182
	Israel	4
	State of Palestine	1
	Jordan	9
	Kuwait	4
	Lebanon	13
	Saudi Arabia	7
	Syrian Arab Republic	620
	United Arab Emirates	6
	Yemen	29
	Algeria	4
	Egypt	24
	Libya	26
	Mauritania	1
	Morocco	23
	Tunisia	4
East/Horn of Africa *n* = 528	Burundi	11
	Djibouti	1
	Eritrea	236
	Ethiopia	111
	Kenya	6
	Rwanda	3
	Somalia	70
	Sudan	22
	United Republic of Tanzania	5
	Uganda	63

Table A2. Number of births per country of origin. **(continued)**

Regions of origin	Countries	Number of births
West/Central Africa *n* = 458	Burkina Faso	1
	Cameroon	6
	Côte d'Ivoire	18
	Ghana	7
	Liberia	4
	Guinea	80
	Gambia	20
	Togo	1
	Benin	6
	Mali	1
	Niger	2
	Nigeria	272
	Senegal	4
	Sierra Leone	36
Southern Africa *n* = 50	Angola	13
	Democratic Republic of the Congo	32
	Madagascar	2
	Malawi	1
	Zimbabwe	2
Unknown/stateless *n* = 3	Unknown	28
	Stateless	2

Chapter four

Pregnancy outcomes of forced migrants in the Netherlands: a national registry-based study.

J.B. Tankink, L.C.M. Bertens, J.P. de Graaf, M.E.T.C. van den Muijsenbergh, J.N. Struijs, B. Goodarzi, A. Franx

Accepted for publication in *Journal of Migration and Health* (2024).

Abstract

Background
The rise of global forced migration urges healthcare systems to respond to the needs of forced migrants (FM) during pregnancy and childbirth. Yet, comprehensive data on the health outcomes of pregnant FM in destination countries remain scarce. This study aimed to describe the characteristics and maternal and perinatal outcomes of pregnancy in this specific migrant population on a national scale in the Netherlands and to explore differences from other populations.

Methods
The Dutch perinatal registry was linked to national migration data to analyze pregnancy outcomes in FM (2014-2019), using non-migrants (NM) and resident migrants (RM) as reference populations. We reported outcome rates (% [95% CI]) for a range of primary and secondary pregnancy outcomes. Primary outcomes included perinatal mortality, small for gestational age infants (SGA), preterm birth, and emergency cesarean section (CS), for which we also calculated the crude relative risk (RR [95% CI]) of FM compared to NM and RM. In addition, we conducted binary logistic regression analyses on primary outcomes to report adjusted odds ratios (aORs [95% CIs]) while controlling for multiple births, maternal age and parity.

Findings
Compared to the NM group, the FM group had increased risks of perinatal mortality (RR 1.50 [95% CI 1.20 – 1.88]), SGA (1.65 [1.59 – 1.71], and emergency CS (1.19 [1.13 – 1.25]). Compared to RM, FM still had elevated risks of SGA (1.17 [1.13 – 1.22]). In contrast, the risk of preterm birth was lower in FM than in NM (0.81 [0.76 – 0.86]) and RM (0.83 [0.77 – 0.88]). These differences were confirmed in the adjusted analysis. Differences in secondary outcomes included higher rates of late antenatal care in FM (29.4% [28.5 – 30.3]) than in NM (6.7% [6.6 – 6.9]) and RM (15.5% [15.1 – 15.9]). Rates of planned CS were similarly elevated (14.3% [95% CI 13.7 – 14.8] versus 7.8% [7.7 – 7.8] and 9.6% [9.5 – 9.7]), while FM had lower rates of postpartum hemorrhage (3.9% [3.6 – 4.2]) versus 6.8% [6.8 – 6.9] and 5.7% [5.6 – 5.9]).

Conclusion
This first Dutch registry-based study demonstrated increased risks of multiple, though not all, adverse pregnancy outcomes in forced migrants. Our results emphasize the imperative to further unravel and address migration-related disparities, dismantle structural barriers to health among forced migrants, and

improve the inclusivity of data systems. Collaborative policy, clinical practice, and research efforts are essential to ensure equitable care for every individual, regardless of migration status.

Introduction

The global population of refugees, asylum seekers, and others in need of international protection reached an unprecedented number of 45 million people under the mandate of the UNHCR in 2022.[1] Women* forced to cross borders due to threats to life or livelihood may be exposed to a multitude of negative health determinants, including gender-based violence, socioeconomic marginalization, and suboptimal healthcare.[2] As a consequence, forced migrants face higher risks of a wide range of adverse outcomes of pregnancy and childbirth compared to other populations in destination countries.[2,3]

The Netherlands receives approximately 45,000 asylum applications annually, and several hundred women give birth while living in a reception center for asylum seekers. A recent study showed that these women face a sevenfold greater risk of perinatal mortality than other women in the same hospital.[4] However, national population-based studies on maternal and perinatal health outcomes among forced migrants have not yet been conducted.

The scarcity of population-based studies in the Netherlands and internationally is partially attributable to the limited availability of data, as specific indicators of forced migration, such as asylum seeking status, are rarely recorded in clinical practice and national registries.[5] Consequently, migrant populations are often poorly defined in research, which impedes further insights into the complex interactions between migration and pregnancy.[6] Moreover, subpopulations that face specific health disadvantages, such as forced migrants, remain understudied and underserved.

In response to these gaps, our study aimed to elucidate the characteristics and maternal and perinatal outcomes of forced migrant women in the Netherlands. We present a linkage method to identify these women in nationwide registry data and compare their pregnancy outcomes to those of non-migrant women, as well as a more heterogeneous population of migrants. In addition, we explore outcome variations between forced migrants with different migration characteristics. The resulting overview will be used to set the stage for future research and provide recommendations for current policy and practice.

*When referring to 'women' in this study, we also refer to people with a uterus who may not identify as women, such as trans men and nonbinary persons.

Methods

Study design and participants

In this retrospective registry-based cohort study, we linked individual-level birth records to routinely collected population and migration data. The study population consisted of women with a high likelihood of recent forced migration, defined as *"a migratory movement in which an element of coercion exists, including threats to life and livelihood, whether arising from natural or man-made causes"*.[7] We operationalized these criteria by including all asylum seekers who either arrived or obtained a residence permit as a legally recognized refugee in the Netherlands during the study period between 2014 and 2019.

To explore differences, we compared forced migrants (FM) with two reference populations: women born in the Netherlands with two native Dutch parents, referred to as non-migrants (NM), and all first-generation migrants not included in the FM population, referred to as resident migrants (RM).

The RM population comprised people with diverse migration motives, such as study or work, as well as former asylum seekers who already received a residence permit before the start of the study period (01-01-2014).

Births were eligible for inclusion if the pregnancy duration was known and above 22 weeks and if maternal age fell within the WHO reproductive range of 15 to 49 years. Multiple births were treated as separate records. Women giving birth more than once during the study period were included multiple times.

Data sources and linkage

We obtained birth records from the Netherlands Perinatal Registry (Perined, www.perined.nl). Perined contains maternal and perinatal data of more than 97% of all pregnancies in the country. Birth records were linked to non-public, pseudo-anonymized microdata from Statistics Netherlands (Dutch abbreviation: CBS). We first linked to the municipal personal records database for information on maternal country of birth. To identify births in FM, we then linked Perined to the asylum migration microdata of CBS. Starting in 2014, these microdata cover monthly information on asylum seekers in reception centers, recipients of a refugee residence permit, children of these groups born in the Netherlands, and reunified family members from abroad. The microdata are provided to CBS by the Immigration and Naturalization Services, the Central Agency for the Reception

of Asylum seekers, and Dutch municipalities. Linkage between registries was performed through a unique personal identification key, the Record Identification Number (RIN). The RIN is a meaningless and dimensionless number assigned by CBS as a pseudonymized version of the national citizen service number. At the time of this study, asylum seekers could request a citizen service number (Dutch abbreviation: BSN) after receiving a residence permit or after approximately six months of residence in the Netherlands. Women who did not have a BSN at the time of birth and did not receive it until the end of the study period could therefore not be included.

Data access and processing

All data sources were accessed within a data infrastructure (DIAPER; Data-InfrAstructure for ParEnts and ChildRen) managed by the National Institute for Public Health and the Environment (RIVM).[8] Permission for the use of data for this study was obtained from CBS (project number 8552) and Perined (data request number 19.39). All data were handled in accordance with the EU General Data Protection Regulation and were accessed only in the secured remote-access environment of CBS.

Variables

Population characteristics

From the perinatal registry, we obtained maternal parity (categorized as none, one, two or more than two previous live births), age (mean and categorized as <20, 20-24, 25-29, 30-34 or >35 years), singleton birth (yes/no), start of care (community or hospital care), transfer from community to hospital care (no transfer/unknown, during pregnancy, during birth, postpartum or with unclear timing), and birth setting (homebirth, midwife-led hospital birth, obstetrician-led hospital birth or other/unknown).

From the municipal personal records database, we obtained maternal country of birth and categorized these into world regions as defined by the WHO, i.e., the African Region, Region of the Americas, South-East Asian Region, European Region, and West Pacific Region. The five most common countries of birth were reported separately.

From the asylum microdata, we obtained the type of FM as categorized by the immigration services (family reunification applicant or regular asylum seeker). After linkage to the perinatal registry, we derived the status of the asylum procedure during pregnancy (residence permit received prior to pregnancy, during pregnancy, or not received before birth) and the official place of residence at the time of birth (categorized as the asylum reception center, regular housing, or unknown). In addition, we calculated the number of relocations between

reception centers in the period between one year prior to birth and two months postpartum (none, one, two, or more than two relocations).

Pregnancy outcomes
All pregnancy outcomes were obtained from the perinatal registry. Primary outcomes included maternal mortality (any maternal death during pregnancy or within 42 days after birth), perinatal mortality (defined as fetal or neonatal death between 22 weeks of pregnancy and seven days after birth), small for gestational age infants (SGA; birthweight below <p10 of national reference curves adjusted for gestational age and sex), preterm birth (<37 weeks of pregnancy), and emergency cesarean section (CS).

Secondary outcomes were categorized into maternal and perinatal outcomes. Secondary maternal outcomes included a late start of antenatal care (first antenatal consultation after 12 weeks of pregnancy in line with WHO recommendations), start of birth (spontaneous, induction of labor, or by planned CS), end of birth (spontaneous, instrumental, or by emergency CS), the use of intrapartum analgesics for hospital births (none, epidural analgesia from the onset of dilation, general anesthesia for CS or 'other'), the use of general anesthesia in cases of emergency CS, postpartum hemorrhage (PPH; defined as blood loss of 1000 ml or more), and obstetric anal sphincter injury (OASI; perineal laceration grade III or IV).

Secondary perinatal outcomes included postterm birth (>42 weeks of pregnancy), low Apgar score (< seven at five minutes after birth), and admission to a neonatal intensive care unit (NICU) after birth.

Statistical analyses

All outcomes were reported as rates (proportions) with corresponding 95% confidence intervals (95% CI) using IBM SPSS 22. Missing values were not included in the analyses; the proportion of missing data was only reported if it was higher than 1.5% for any variable. Since the aim of the study was to describe the maternal and perinatal health profile of FM during pregnancy and childbirth, we reported the outcome rates of NM and RM as reference populations for interpretation. To estimate the differences between FM and the reference populations, we calculated crude relative risks (RR) with 95% CI for the primary outcomes. In addition, we conducted binary logistic regression analyses to report adjusted odds ratios (aORs) with 95% CI, controlling for multiple births, maternal age and parity.

We performed a sensitivity analysis including only singleton births, to address the potential bias caused by the overrepresentation of mothers with multiple

births among the adverse outcomes in the main analysis. In case of multiple births of the same mother in the study period, we only included the first-born in the sensitivity analysis.

In additional analyses, we explored the relevance of specific migration characteristics among FMs. Specifically, we compared rates of primary outcome between regular asylum seekers and women registered as family reunification applicants. Furthermore, we compared women from the top five countries of birth in FM to women from the same country of birth in the RM group. For example, Syrian FM were compared to Syrian RM.

Ethical approval

The study was submitted to the Medical Ethical Committee of the Erasmus Medical Center in Rotterdam, which determined that formal ethical review was not required under the Dutch Medical Research Involving Human Subjects Act (registration number MEC-2021-0101).

Role of the funding source

This study was part of the EGALITE research project funded by The Netherlands Organization for Health Research and Development (ZonMw, grant number 54300311). The funder had no role in the study design, data collection, data analysis, data interpretation, or writing of the report.

Results

Study populations and characteristics

The asylum microdata contained 249 802 records of FM; 61 414 of those did not have a RIN required for linkage, and 106 451 records concerned men. Of the remaining 81 936 records, 16 491 could be linked to the perinatal registry, of which 16 442 met the inclusion criteria. Following the same criteria, births in FM could be compared to 667 862 births in NM and 178 371 births in RM.

Table 1 presents the maternal characteristics of FM, NM, and RM, as well as the specific migration characteristics of FM. All characteristics contained less than 0.5% missing data. Overall, FM were younger (M 28.0, SD 5.5 years) compared to NM (M 30.7, SD 4.5) and RM (31.6, SD 5.2), and FM had higher rates of teenage pregnancies (4.5% vs. 0.7% and 0.8% respectively), and parity above two (19.5% vs. 4.7% and 10.3% respectively). Compared to RM, FM more commonly originated from the East-Mediterranean (64.0%, vs. 23.3%) and the African region (31.5% vs. 6.1%). The five most common maternal countries of birth in FM were Syria (48.6%), Eritrea (22.9%), Somalia (5.5%), Iraq (3.4%), and

Afghanistan (2.2%). During pregnancy, FM were transferred from community midwifery care to hospital care relatively often (45.4% of FM, vs. 37.3% of NM and 39.6% of RM), and mostly gave birth under supervision of an obstetric specialist in the hospital (80.4% vs. 70.0% and 78.6% respectively).

Regarding migration characteristics, 60.3% of FM were registered as regular asylum seekers, and 39.7% were registered as family reunification applicants. Overall, most women (68.8%) already received a residence permit as a refugee before pregnancy, 13.0% received it during pregnancy, and 18.1% did not have a residence permit when giving birth. Of the 15.7% of FM who resided in an asylum reception center at the time of birth, approximately half (54.3%) were not relocated between centers in the perinatal period (defined as one year before until two months after birth), while 26.9% were relocated once, 11.4% were relocated twice, and 7.4% were relocated more than twice.

Table 1. Maternal characteristics of all study populations and migration characteristics of forced migrants

		Forced migrants (N=16 442)	Non-migrants (N=667 862)	Resident migrants (N=178 371)
Age at child-birth (years)	M (SD)	28.0 (5.5)	30.7 (4.5)	31.6 (5.2)
	<20	4.5	0.7	0.8
	20-24	24.8	7.4	8.3
	25-29	33.1	31.3	25.2
	30-35	27.0	46.1	42.3
	>35	10.6	14.5	23.3
Parity	0	31.7	45.3	40.9
	1	28.7	37.3	33.1
	2	20.2	12.7	15.7
	>2	19.4	4.7	10.3
World region of birth	African Region	31.5	.	6.1
	Region of the Americas	0.2	.	14.9
	South-East Asian Region	0.7	.	5.6
	European Region	2.7	100.0	43.7
	East-Mediterranean Region	64.0	.	23.3
	West-Pacific Region	0.8	.	6.5
Country of birth	Syria	46.9	.	0.6
	Eritrea	22.9	.	0.2
	Somalia	5.5	.	2.7
	Iraq	3.4	.	2.4
	Afghanistan	2.2	.	2.4
	Netherlands	.	100.0	.
	Other	19.0	.	91.7
Multiple births		2.4	3.1	3.0
Start of care	Community care	89.4	89.7	85.4
	Hospital care	10.1	10.0	14.1
	Unknown/NA	0.5	0.3	0.5

Table 1. Maternal characteristics of all study populations and migration characteristics of forced migrants **(continued)**

		Forced migrants (N=16 442)	Non-migrants (N=667 862)	Resident migrants (N=178 371)
Transfer of community to hospital care	None/unknown	27.7	37.0	33.1
	During pregnancy	45.4	37.3	39.6
	During birth	23.9	22.3	24.5
	Postpartum	1.6	2.8	1.9
	Unclear when	1.4	0.6	0.9
Birth setting	Homebirth	5.4	15.9	5.7
	Hospital (midwife-led)	13.9	13.9	15.3
	Hospital (obstetrician-led)	80.4	70.0	78.6
	Other/unknown	0.2	0.2	0.3
Type of asylum applicant upon entry in the Netherlands	Regular applicant	60.3	NA	NA
	Family reunification applicant	39.9	NA	NA
Status of residence permit	Received before pregnancy	68.8	NA	NA
	Received during pregnancy	13.0	NA	NA
	Not received before birth	18.1	NA	NA
Official place of residence at birth	Asylum reception center	15.7	NA	NA
	Regular housing	82.9	NA	NA
	Unclear/missing	1.3	NA	NA
Relocations between asylum reception centers *	None	54.3	NA	NA
	relocation	26.9	NA	NA
	relocations	11.4	NA	NA
	>2 relocations	7.4	NA	NA

All data are presented as proportions (%) unless otherwise indicated.
NA = Not applicable.
** Sum of relocations between three months before conception and two months postpartum among women residing in asylum reception centers at the time of childbirth (n=2 581).*

Pregnancy outcomes

Primary outcomes

Table 2 presents the rates, crude relative risks, odd ratios and adjusted odds ratios of primary outcomes in FM compared to those in NM and RM. No maternal deaths were registered in FM in the study period (results not in table; excluded from further analysis). The crude relative risk of perinatal mortality in FM was higher than that in NM (RR 1.50 [95% CI 1.20 – 1.88]. Compared to RM, the risk of perinatal mortality in FM was 1.23 [0.98 – 1.55]. The relative risk of SGA was elevated in FM compared to NM (1.65 [1.59 – 1.71] and to RM (1.17 [1.13 – 1.22]). In contrast, the risk of preterm birth was lower in FM than in NM (0.81 [0.76 – 0.86]) and RM (0.83 [0.77 – 0.88]). Finally, the risk of emergency CS was again higher in FM than in NM (1.19 [1.13 – 1.25]), although not in RM (0.95 [0.91 – 1.00]). Figure 1 presents the rates of primary outcomes in FM, NM and RM with the total population as a reference.

After adjusting for multiple births, maternal age and parity, the odds of perinatal mortality remained higher in FM than in NM (aOR 1.43 [1.14–1.79]). Compared to the reference populations, the risk of FM increased for SGA (aOR 1.96 [1.87 – 2.05] and 1.30 [1.24 – 1.36]) and emergency CS [aOR 1.71 [1.62 – 1.81] and 1.28 [1.21 – 1.36]) in the adjusted analyses. The risk of preterm birth remained lower for FM compared to NM and RM (aOR 0.84 [0.78 – 0.91] and 0.86 [0.80 – 0.92]).

Table 2. Rates, crude relative risks (RR), odds ratios (OR) and adjusted odds ratios (aOR) of primary outcomes in forced migrants (FM) compared to non-migrants (NM) and resident migrants (RM)

Outcome	Group	Rate		RR (FM vs. reference group)		OR (FM vs. reference group)		aOR (FM vs. reference group)*	
		%	95% CI		95% CI		95% CI		95% CI
Perinatal mortality	FM	0.49	0.38 – 0.59	-	-	-	-	-	-
	NM	0.32	0.31 – 0.33	1.50	1.20 – 1.88	1.51	1.20 – 1.88	1.43	1.14 – 1.79
	RM	0.40	0.36 – 0.42	1.23	0.98 – 1.55	1.23	0.98 – 1.55	1.22	0.96 – 1.54
SGA	FM	14.9	14.3 – 15.4	-	-	-	-	-	-
	NM	9.0	9.0 – 9.1	1.65	1.59 – 1.71	1.77	1.69 - 1.85	1.96	1.87 – 2.05
	RM	12.8	12.6 - 12.9	1.17	1.13 – 1.22	1.20	1.15 – 1.26	1.30	1.24 – 1.36
Preterm birth	FM	5.5	5.2 – 5.9	-	-	-	-	-	-
	NM	6.8	6.8 – 6.9	0.81	0.76 – 0.86	0.80	0.74 – 0.86	0.84	0.78 – 0.91
	RM	6.7	6.6 – 6.8	0.83	0.77 – 0.88	0.81	0.76 – 0.87	0.86	0.80 – 0.92
Emergency CS	FM	9.3	8.9 – 9.8	-	-				
	NM	7.9	7.8 – 8.0	1.19	1.13 – 1.25	1.21	1.14 – 1.27	1.71	1.62 – 1.81
	RM	9.8	9.7 – 10.0	0.95	0.91 – 1.00	0.95	0.90 – 1.00	1.28	1.21 – 1.36

**Adjusted for multiple births, maternal age and parity*
SGA = Small for gestational age infant.
CS = Cesarean section.

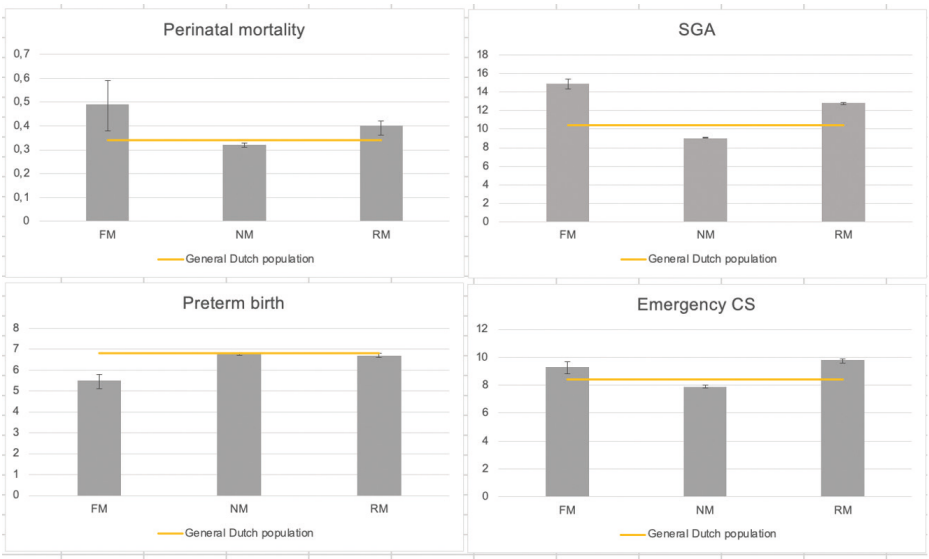


Figure 1. Bar charts of primary outcome rates (%) in forced migrants (FM), non-migrants (NM), and resident migrants (RM)

SGA: Small for gestational age infants.
CS: Cesarean section.
Y-axis represents rates (%), with 95% confidence intervals represented in error bars.
The reference line (general Dutch population) represents the outcome rates for all registered births in the Netherlands in the study period (2014-2019).

Secondary outcomes

Table 3 presents the rates of secondary maternal and perinatal outcomes in FM, NM, and RM. Only the outcomes 'start of antenatal care' and 'intrapartum analgesics' contained more than 1.5% missing data (8.4% and 17.5% on average, respectively).

Notable differences in maternal outcomes included a higher rate of late antenatal care in FM (29.4% [28.5 – 30.3]) than in NM (6.7% [6.6 – 6.9]) and RM (15.5% [15.1 – 15.9]). We also observed higher rates of planned CS in FM than in NM and RM (14.3% [13.7 – 14.8] vs. 7.8% [7.7 – 7.8] and 9.6% [9.5 – 9.7]). Furthermore, the rate of hospital births without any intrapartum analgesics was higher in FM (28.9% [28.3 – 29.6]) than in NM (26.9% [26.7 – 27.0]) and RM (26.0% [25.7 – 26.3]). In particular, the use of general anesthesia was higher in FM than in both other groups, particularly in cases of emergency CS (11.2% [9.7 – 12.9] vs. 6.3% [6.1 – 6.5] in NM and 6.8% [6.5 – 7.2] in RM). In contrast, the incidence of PPH was notably lower in FM (3.9% [3.6 – 4.2]) than in both NM (6.8% [6.8 – 6.9]) and RM (5.7% [5.6 – 5.9]).

Notable differences in perinatal outcomes included a higher rate of postterm births in FM than in both NM and RM (1.0% [0.9 – 1.2] vs. 0.5% [0.5 – 0.5] and 0.6% [0.6 – 0.6]), as well as a higher rate of low Apgar scores (2.6% [2.4 – 2.9] vs. 1.7% [1.7 – 1.7] and 2.1% [2.0 – 2.1]). The rate of NICU admissions was similar in FM compared to NM (3.7% [3.4 – 4.0 vs. 3.8% [3.7 - 3.8]) and lower compared to RM (4.3% [4.2 - 4.4]).

Table 3. Rates of secondary outcomes in forced migrants (FM), non-migrants (NM), and resident migrants (RM)

Group		FM		NM		RM	
		%	95% CI	%	95% CI	%	95%CI
Maternal outcomes							
Late start of antenatal care		29.4	28.5 – 30.3	6.7	6.6 – 6.9	15.5	15.1 – 15.9
Mode of birth (start)	Spontaneous	64.1	63.4 – 64.9	69.9	69.8 – 70.0	68.0	67.8 – 68.2
	Induction of birth	20.2	19.6 – 20.8	21.8	21.7 – 21.9	21.8	21.6 – 22.0
	Planned CS	14.3	13.7 – 14.8	7.8	7.7 – 7.8	9.6	9.5 – 9.7
Mode of birth (end)	Spontaneous	69.1	68.4 – 69.8	76.2	76.1 – 76.3	73.2	73.0 – 73.4
	Instrumental birth	5.9	5.5 – 6.3	7.6	7.5 – 7.6	6.7	6.6 – 6.8
	Emergency CS	9.3	8.9 – 9.8	7.9	7.8 – 8.0	9.8	9.7 – 10.0
Intrapartum analgesics	None	28.9	28.3 – 29.6	26.9	26.7 – 27.0	26.0	25.7 – 26.3
	Epidural anesthesia*	17.4	16.8 – 18.0	18.8	18.7 – 18.9	22.3	22.1 – 22.5
	General anesthesia	2.2	2.0 – 2.5	0.8	0.8 – 0.9	1.2	1.1 – 1.2
Analgesics in emergency CS	General anesthesia	11.2	9.7 – 13.0	6.3	6.1 – 6.5	6.8	6.5 – 7.2
	Other	88.8	88.3 – 89.3	93.7	93.5 – 93.9	93.2	89.9 – 93.4
Postpartum hemorrhage		3.9	3.6 – 4.2	6.8	6.8 – 6.9	5.8	5.7 – 5.9
Obstetric anal sphincter injury		1.8	1.6 – 2.0	2.1	2.0 – 2.1	1.8	1.8 - 1.9
Perinatal outcomes							
Postterm birth		1.0	0.9 – 1.2	0.5	0.5 – 0.5	0.6	0.6 – 0.6

Table 3. Rates of secondary outcomes in forced migrants (FM), non-migrants (NM), and resident migrants (RM) **(continued)**

Group	FM		NM		RM	
Low Apgar score	2.6	2.4 – 2.9	1.7	1.7 – 1.7	2.1	2.0 – 2.1
NICU admissions	3.7	3.4 – 4.0	3.8	3.7 – 3.8	4.3	4.2 – 4.4

All data are reported as proportions (%, [95% confidence intervals]).
**Only the use of epidural anesthesia in labor (excluding CS) is reported.*
CS = Cesarean section.
NICU = Neonatal Intensive Care Unit.

Sensitivity analyses and subanalyses

A sensitivity analysis, including only first-born singleton births in the dataset, revealed differences similar to those of the main analyses. Analyses of subgroups within the FM population revealed that in comparison to regular asylum seekers, family reunification applicants had lower rates of preterm birth (4.7% [4.2 – 5.3] vs. 6.0% [5.6 – 5.5]) and emergency CS (7.0% [6.4 – 7.7] vs. 10.8% [10.2 – 11.4]) (see supplementary materials, table 1).

Comparison of perinatal mortality rates between the FM and RM groups with the same country of birth was not possible due to unreportable data resulting from low sample sizes. No differences were observed in the other primary outcomes between these groups (see supplementary materials, table 2).

Discussion

This registry-based cohort study confirms that recently arrived forced migrants in the Netherlands are more likely to experience several adverse pregnancy outcomes, compared to both non-migrants and migrants with a different profile (resident migrants). In particular, compared with both reference populations, forced migrants had higher risks of multiple adverse outcomes in adjusted and unadjusted analysis, including perinatal mortality and small for gestational age (SGA) infants. Forced migrants also had higher risks of emergency CS than non-migrants, whereas their risk of preterm birth was lower than non-migrants and resident migrants. Rates of secondary outcomes were mostly elevated in forced migrants, including the rate of late start of antenatal care, planned cesarean sections, postterm birth and low Apgar scores, while postpartum hemorrhage rates were lower in forced migrants than in non-migrants and resident migrants.

Our nationwide findings support the evidence that women affected by forced migration face specific inequities in pregnancy and childbirth and underscore the need to address structural health barriers for this population.[2,9-12] In the Netherlands, these may include lengthy asylum procedures, limited socioeconomic opportunities, and substandard or unstable living conditions in asylum reception centers.[13,14] Nearly half (45.7%) of the women in asylum reception centers at the time of birth in this study were relocated at least once in the perinatal period, which likely reduced continuity and quality of care and exacerbated maternal stress.[15,16] In addition, the high rates of late antenatal care, cesarean sections, and the use of general anesthesia in emergency cesareans may reflect barriers to seeking, accessing and receiving high-quality care.[2,17-19] Suboptimal care can result from women's lack of trust and information, unresolved language barriers, or a lack of culturally appropriate care, including professionals' implicit bias or

racism.[20-22] Measures to facilitate equitable care should therefore target both the conditions for a healthy pregnancy, such as safe and stable housing for asylum seekers, and care responsiveness, for instance, by advancing guidelines and professional training.[16,23]

The observed perinatal mortality rate of 0.5% in our national forced migrant cohort contrasts with the 3.2% rate reported in a recent study from the Netherlands' primary reception center for asylum seekers.[4] This difference may be related to the added stress and limited access to healthcare faced by women arriving pregnant at the primary reception center, while our larger cohort also included women in later stages of the asylum procedure and recognized refugees.[24] In addition, the primary reception center accommodates more recently arrived asylum seekers and undocumented women, who may face the highest risk of adverse outcomes.[25,26] Undocumented women only have the right to stay in a reception center in the weeks around childbirth, and lack a citizen service number needed for data linkage. We thereby inadvertently excluded at least one maternal death, which was reported to us by a midwife after the study.

Other remarkable findings, such as the reduced risk of preterm birth, and lower rate of PPH in forced migrants compared to non-migrants and resident migrants also underscore the complexity of the relationship between different pregnancy outcomes and forced migration. Lower preterm birth rates have previously been reported in forced migrant populations, though remain poorly understood.[14,27] Explanations for the lower preterm birth rates in forced migrants could include bias in pregnancy dating or a higher rate of early miscarriages.[18,28,29] In addition, although maternal stress is associated with increased preterm birth rates in other populations, an adaptive response to the specific stress of forced migration might delay labor until the mother reaches safer circumstances, resulting in longer fetal survival under suboptimal uterine conditions. This could also explain the observed higher rates of postterm birth and SGA in forced migrants, as well as fewer preterm births.

Further research should address the heterogeneity within the forced migrant population to understand the mechanisms driving migration-related disparities. In this study, we refrained from adjusting for a wide range of individual characteristics to describe a general profile of the maternal and perinatal health status of women with a background of recent forced migration. However, variations in legal status, length of residence, and exposure to relocation policies within the forced migration population, which may also correlate with the geographic origin of women, likely influence outcome patterns. For instance, family reunification applicants, which mostly concern Syrian women in the Dutch context, generally spend less time in the asylum procedure, which might

contribute to the reduced rates of preterm birth and emergency CS observed in the exploratory subanalyses.

The strengths of this study include the successful strategy of registry data linkage to identify a specific, often invisible population of migrants, in line with recent recommendations for advancing equity amidst fragmented healthcare and information systems.[30] Other strengths of our approach include the multiyear, nationwide cohort of births and the comparison of forced migrants to multiple reference populations, including a more heterogeneous migrant population. The main limitation concerns the missing data of an unknown number of women who never received a citizen service number, as their birth records could not be linked. This likely led to an underestimation of adverse outcomes, including maternal mortality, among forced migrants in our study. This limitation reflects the inherent inequity caused by data invisibility of already marginalized populations and underscores the need for registration and ethical use of relevant migration indicators in clinical practice and perinatal databases.[31] The issuance of unique personal identification numbers needed for the linkage of health records to other registries should not depend on migrants' legal status or length of residence.

In conclusion, this first Dutch national registry-based study on pregnancy outcomes in forced migrants demonstrated higher risks of several outcomes, including perinatal mortality and small for gestational age infants, compared to both non-migrants and resident migrants in the Netherlands. Our unadjusted and exploratory analyses also highlight the complexity of disparities and the need for further research to take heterogeneity in migrants' characteristics and policy exposures into account. The relative invisibility of the most marginalized groups of migrants posed limitations to our study and calls for improved monitoring and registration of forced migrants in healthcare. Furthermore, our findings call for critical reflection and dismantling of structural health barriers among women in asylum reception centers and recognized refugees in the Netherlands. This will require a collaborative approach in policy, clinical practices, and research to ensure equitable care for every individual, irrespective of migration status, throughout their pregnancy journey.

Contributors

AF, HdG, MvdM, BG, LB, and JT were involved in conceptualization. JS facilitated data access and advised on data curation and analysis. JT conducted the formal analysis, with supervision by LB and AF. All authors were involved in the interpretation of the findings. JT wrote the first draft of the article, with substantial contributions from AF and LB. All authors provided input on several versions of the article, read and approved the final version, and had final responsibility for the decision to submit for publication.

Data sharing

The results in this manuscript are based on calculations by Erasmus MC, using non-public microdata from Statistics Netherlands. Under certain conditions, these microdata are accessible for statistical and scientific research. For further information: microdata@cbs.nl.

Upon reasonable request, the authors are willing to provide the statistical syntax used for data linkage and analysis. Interested investigators are encouraged to contact the corresponding author.

Declaration of interest

None to declare.

Acknowledgments

We are thankful to all the researchers and data managers at Statistics Netherlands (Dutch abbreviation: CBS) and the National Institute for Public Health and Environment (Dutch abbreviation: RIVM) who provided advice in the initial phase of the study, in particular regarding the registry linkage.

References

1. UNHCR. Global Trends: Forced Displacement in 2022. Copenhagen, Denmark: UNHCR Global Data Service, Statistics and Demographics Section, 2023.
2. Heslehurst N, Brown H, Pemu A, Coleman H, Rankin J. Perinatal health outcomes and care among asylum seekers and refugees: a systematic review of systematic reviews. BMC medicine 2018; 16(1): 1-25.
3. Gieles NC, Tankink JB, van Midde M, et al. Maternal and perinatal outcomes of asylum seekers and undocumented migrants in Europe: a systematic review. European journal of public health 2019; 29(4): 714-23.
4. Verschuuren A, Postma I, Riksen Z, Nott R, Feijen-de Jong E, Stekelenburg J. Pregnancy outcomes in asylum seekers in the North of the Netherlands: a retrospective documentary analysis. BMC pregnancy and childbirth 2020; 20(1): 1-10.
5. Eslier M, Azria E, Chatzistergiou K, Stewart Z, Dechartres A, Deneux-Tharaux C. Association between migration and severe maternal outcomes in high-income countries: Systematic review and meta-analysis. PLoS medicine 2023; 20(6): e1004257.
6. Villalonga-Olives E, Kawachi I, Von Steinbüchel N. Pregnancy and birth outcomes among immigrant women in the US and Europe: a systematic review. Journal of Immigrant and Minority Health 2017; 19: 1469-87.
7. Office EUP. European Migration Network (EMN) Glossary. 2019. https://home-affairs.ec.europa.eu/networks/european-migration-network-emn/emn-asylum-and-migration-glossary_en (accessed November 1, 2023 2023).
8. Scheefhals ZTM, de Vries, E.F., Molenaar, J.M., Numans, M.E., Struijs, J.N. . Observational data for understanding maternity care and early life: experiences with a data-infrastructure for parents and children in the Netherlands. Under review 2023.
9. Juárez S, Mussino E, Hjern A. Being a refugee or having a refugee status? Birthweight and gestational age outcomes among offspring of immigrant mothers in Sweden. Scandinavian Journal of Public Health 2019; 47(7): 730-4.
10. Sturrock S, Williams E, Greenough A. Antenatal and perinatal outcomes of refugees in high income countries. Journal of Perinatal Medicine 2021; 49(1): 80-93.
11. Liu C, Ahlberg M, Hjern A, Stephansson O. Perinatal health of refugee and asylum-seeking women in Sweden 2014–17: a register-based cohort study. European journal of public health 2019; 29(6): 1048-55.
12. Gibson-Helm ME, Teede HJ, Cheng IH, et al. Maternal health and pregnancy outcomes comparing migrant women born in humanitarian and nonhumanitarian source countries: a retrospective, observational study. Birth 2015; 42(2): 116-24.
13. Bollini P, Pampallona S, Wanner P, Kupelnick B. Pregnancy outcome of migrant women and integration policy: a systematic review of the international literature. Social science & medicine 2009; 68(3): 452-61.
14. Harakow HI, Hvidman L, Wejse C, Eiset AH. Pregnancy complications among refugee women: a systematic review. Acta Obstetricia et Gynecologica Scandinavica 2021; 100(4): 649-57.
15. Tankink JB, Verschuuren AE, Postma IR, et al. Childbirths and the Prevalence of Potential Risk Factors for Adverse Perinatal Outcomes among Asylum Seekers in The Netherlands: A Five-Year Cross-Sectional Study. International Journal of Environmental Research and Public Health 2021; 18(24): 12933.
16. Verschuuren A, Tankink J, Franx A, et al. Community midwives' perspectives on perinatal care for asylum seekers and refugees in the Netherlands: A survey study. Birth 2023.

17. Esscher A, Binder-Finnema P, Bødker B, Högberg U, Mulic-Lutvica A, Essén B. Suboptimal care and maternal mortality among foreign-born women in Sweden: maternal death audit with application of the 'migration three delays' model. BMC pregnancy and childbirth 2014; 14(1): 1-11.
18. Bozorgmehr K, Biddle L, Preussler S, Mueller A, Szecsenyi J. Differences in pregnancy outcomes and obstetric care between asylum seeking and resident women: a cross-sectional study in a German federal state, 2010–2016. BMC pregnancy and childbirth 2018; 18(1): 1-8.
19. Schrot-Sanyan S, Kolanska K, Haimeur Y, et al. Language barrier as a risk factor for obstetric anal sphincter injury–A case-control study. Journal of Gynecology Obstetrics and Human Reproduction 2021; 50(8): 102138.
20. Royce CS, Morgan HK, Baecher-Lind L, et al. The time is now: addressing implicit bias and in obstetrics and gynecology education. American Journal of Obstetrics and Gynecology 2022.
21. Koopmanschap I, Martin L, Gitsels-van der Wal JT, Suurmond J. Counselling for prenatal anomaly screening to migrant women in the Netherlands: An interview study of primary care midwives' perceived barriers with client–midwife communication. European journal of midwifery 2022; 6.
22. Sheikh J, Allotey J, Kew T, et al. Effects of race and ethnicity on perinatal outcomes in high-income and upper-middle-income countries: an individual participant data meta-analysis of 2 198 655 pregnancies. The Lancet 2022; 400(10368): 2049-62.
23. Balaam M-C, Kingdon C, Haith-Cooper M. A Systematic Review of Perinatal Social Support Interventions for Asylum-seeking and Refugee Women Residing in Europe. Journal of Immigrant and Minority Health 2021: 1-18.
24. Van Loenen T, Van Den Muijsenbergh M, Hofmeester M, et al. Primary care for refugees and newly arrived migrants in Europe: a qualitative study on health needs, barriers and wishes. The European Journal of Public Health 2018; 28(1): 82-7.
25. de Jonge A, Rijnders M, Agyemang C, et al. Limited midwifery care for undocumented women in the Netherlands. Journal of Psychosomatic Obstetrics & Gynecology 2011; 32(4): 182-8.
26. Eslier M, Deneux-Tharaux C, Sauvegrain P, et al. Severe maternal morbidity among undocumented migrant women in the PreCARE prospective cohort study. BJOG: An International Journal of Obstetrics & Gynaecology 2022; 129(10): 1762-71.
27. Sørbye IK, Daltveit AK, Sundby J, Vangen S. Preterm subtypes by immigrants' length of residence in Norway: a population-based study. BMC Pregnancy and Childbirth 2014; 14(1): 1-14.
28. Khadra MM, Suradi HH, Amarin JZ, et al. Risk factors for miscarriage in Syrian refugee women living in non-camp settings in Jordan: results from the Women ASPIRE cross-sectional study. Conflict and Health 2022; 16(1): 1-10.
29. Juárez SP, Urquia ML, Mussino E, Liu C, Qiao Y, Hjern A. Preterm disparities between foreign and Swedish born mothers depend on the method used to estimate gestational age. A Swedish population-based register study. Plos one 2021; 16(2): e0247138.
30. Bozorgmehr K, McKee M, Azzopardi-Muscat N, et al. Integration of migrant and refugee data in health information systems in Europe: advancing evidence, policy and practice. The Lancet Regional Health–Europe 2023; 34.
31. Gagnon AJ, Zimbeck M, Zeitlin J. Migration and perinatal health surveillance: an international Delphi survey. European Journal of Obstetrics & Gynecology and Reproductive Biology 2010; 149(1): 37-43.

Supplementary materials

Table 1. Rates of primary outcomes in regular asylum seekers and family reunification applicants

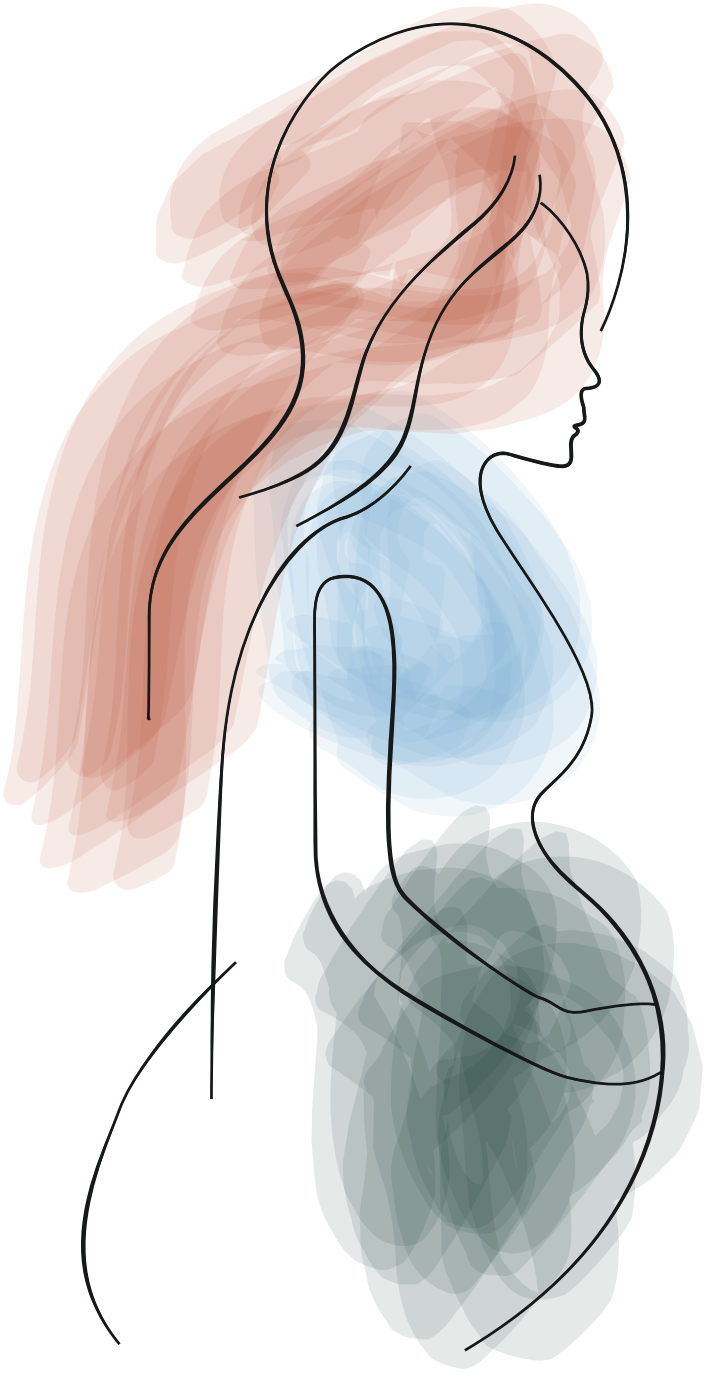
	Regular asylum seekers (N=9918)	**Family reunification applicants (N=6524)**
Perinatal mortality	0.5 [0.4 – 0.7]	0.5 [0.3 – 0.7]
Preterm birth	6.0 [5.6 – 6.5]	4.7 [4.2 – 5.3]
SGA	15.0 [14.3 – 15.7]	14.7 [13.8 – 15.6]
Emergency CS	10.8 [10.2 – 11.4]	7.0 [6.4 – 7.7]

Data are reported as proportions (%, [95% confidence interval]).
SGA = Small for gestational age infants.
CS = Caesarean section.

Table 2. Rates of primary outcomes in women from Syria, Eritrea, Somalia, Iraq and Afghanistan among forced migrants (FM) and resident migrants (RM)

Country of birth	Syria		Eritrea		Somalia		Iraq		Afghanistan	
	FM (n=7704)	RM (n=1060)	FM (n=3763)	RM (n=318)	FM (n=909)	RM (n=4851)	FM (n=557)	RM (n=4279)	FM (n=369)	RM (n=4271)
Perinatal mortality	0.5 [0.00 – 1.57]	NR*	0.6 [0.41 – 0.91]	NR*	NR*	0.8 [0.06 – 0.11]	NR*	0.3 [0.17 – 0.51]	NR*	0.5 [0.30 – 0.72]
Preterm birth	5.4 [4.4 – 6.4]	5.6 [4.3 – 7.1]	4.9 [4.2 – 5.6]	6.0 [3.7 – 9.1]	5.3 [4.0 – 6.9]	5.1 [4.5 – 5.7]	6.3 [4.6 – 8.6]	5.5 [4.9 – 6.2]	4.1 [2.5 – 6.6]	6.2 [5.5 – 6.9]
SGA	13.6 [12.5 – 14.7]	13.2 [11.2 – 15.4]	17.8 [16.2 – 19.3]	17.0 [13.4 – 21.0]	18.7 [16.3 – 21.4]	18.3 [17.3 – 19.4]	12.7 [10.2 – 15.8]	11.9 [11.0 – 13.0]	8.9 [6.4 – 12.3]	12.0 [11.1 – 13.0]
Emergency CS	7.0 [5.9 – 8.1]	6.4 [5.0 – 7.8]	10.6 [9.6 – 11.6]	12.3 [9.0 – 16.3]	11.7 [9.7 – 13.9]	10.5 [9.7 – 11.4]	7.7 [5.8 – 10.2]	9.6 [8.7 – 10.5]	10.6 [7.8 – 14.1]	10.7 [9.9 – 11.7]

Data are reported as proportions (%, [95% confidence interval]).
SGA = Small for gestational age infants.
CS = Caesarean section.
**NR = Not reportable due to data privacy regulations (n<10).*



Duha Khalal (12 jaar)

Part II

Pregnancy and childbirth care for women with a forced migration background

Chapter five

Suboptimal factors in maternal and newborn care for refugees: lessons learned from perinatal audits in the Netherlands.

A.E.H. Verschuuren, J.B. Tankink, I.R. Postma, K.A. Bergman, B. Goodarzi, E.I. Feijen-de Jong, J.J.H.M. Erwich

Published in *PLOS ONE* (2024). *Suboptimal factors in maternal and newborn care for refugees: Lessons learned from perinatal audits in the Netherlands*. DOI:10.1371/journal.pone.0305764

Abstract

Introduction
Refugees and their healthcare providers face numerous challenges in receiving and providing maternal and newborn care. Research exploring how these challenges are related to adverse perinatal and maternal outcomes is scarce. Therefore, this study aims to identify suboptimal factors in maternal and newborn care for asylum-seeking and refugee women and assess to what extent these factors may contribute to adverse pregnancy outcomes in the Netherlands.

Methods
We conducted a retrospective analysis of national perinatal audit data from 2017 to 2019. Our analysis encompassed cases with adverse perinatal and maternal outcomes in women with a refugee background (n=53). Suboptimal factors in care were identified and categorized according to Binder et al.'s Three Delays Model, and the extent to which they contributed to the adverse outcome was evaluated.

Results
We identified 29 suboptimal factors, of which seven were related to care-seeking, six to the accessibility of services, and 16 to the quality of care. All 53 cases contained suboptimal factors, and in 67.9% of cases, at least one of these factors most likely or probably contributed to the adverse perinatal or maternal outcome.

Conclusion
The number of suboptimal factors identified in this study and the extent to which they contributed to adverse perinatal and maternal outcomes among refugee women is alarming. The wide range of suboptimal factors identified provides considerable scope for improvement of maternal and newborn care for refugee populations. These findings also highlight the importance of including refugee women in perinatal audits as it is essential for healthcare providers to better understand the factors associated with adverse outcomes to improve the quality of care. Adjustments to improve care for refugees could include culturally sensitive education for healthcare providers, increased workforce diversity, minimizing the relocation of asylum seekers, and permanent reimbursement of professional interpreter costs.

Introduction

The rise of forced migration worldwide urges maternal and newborn care providers to respond to the needs of pregnant refugees[1] and their children.[1] In the Netherlands, approximately 600 babies are born annually to women living in asylum seeker centers. The number of babies born to refugee women[2] with a residence permit is likely higher, but the exact number remains unknown.[2] A substantial body of international literature has demonstrated that asylum seekers and refugee women with residence permits more often experience adverse perinatal and maternal outcomes compared to non-migrant populations, including higher rates of perinatal and maternal mortality and morbidity.[2–6] In the Netherlands, one study showed a seven times higher perinatal mortality among recently arrived asylum seekers compared to the local Dutch population.[4]

Given these inequities, access to high-quality maternal and newborn care is essential to promote the health and well-being of pregnant refugees. However, these women face many challenges in accessing maternal and newborn care, such as linguistic differences, disadvantaged socio-economic status, racial, ethnic, and cultural discrimination, limited knowledge of the host country's healthcare system, and the stress of resettlement in a new country.[7–9] Maternal and newborn care providers also face numerous challenges in providing care to refugees.[10,11] A previous study on maternal and newborn care for refugees in the Netherlands identified five themes of challenges community care midwives face while providing care for refugee women: interdisciplinary collaboration, communication with clients, continuity of care, psychosocial care, and the vulnerable context of clients.[12]

The effect these challenges have on the quality of maternal and newborn care and their direct or indirect association with adverse perinatal and maternal outcomes remain poorly studied in refugee populations. Our study aims to fill this gap by identifying suboptimal care factors and evaluating to what extent these factors contribute to adverse perinatal and maternal outcomes among refugee women in the Netherlands. Based on the identified suboptimal care factors, we will formulate recommendations for policy and practice in maternal and newborn care for refugee women.

1 When we use the term 'refugee' without further specification we refer to both refugees with a residence permit, asylum seekers whose claim for asylum is still pending, and undocumented migrants.

2 In this study, the term 'woman', also refers to individuals with a uterus who are not woman identified, including trans and non-binary individuals.

Research question: Which suboptimal factors play a role in maternal and newborn care for refugees, and to what extent do they contribute to adverse perinatal and maternal outcomes?

Methods

Design

We conducted a retrospective audit of cases from the Dutch National Perinatal Audit registry, which concerned adverse perinatal and maternal outcomes in refugee women over three years (2017-2019).

The Perinatal Audit Registry

Local perinatal audits in the Netherlands are confidential enquiries of severe maternal or perinatal morbidity or mortality cases. These audits take place in all maternal and newborn care centers in the Netherlands. During an audit meeting, healthcare professionals systematically review case reports and identify improvement and action points to enhance practice. For every case reviewed, a detailed case report is stored, documenting case characteristics and details about the perinatal care provided. The selection of cases reviewed depends on the submissions from healthcare providers and whether the cases align with one of the four audit themes. During the course of this study, the audit themes, chosen on a national level as focal points, encompassed late premature mortality (occurring between 32+0 and 36+6 weeks of pregnancy), perinatal asphyxia (occurring above 37+0 weeks of pregnancy), hyperbilirubinemia, and uterine rupture. The Dutch National Perinatal Audit registry is a comprehensive database containing all cases reviewed in regional perinatal audits in the Netherlands.[13] A more detailed explanation of the Perinatal Audit registry is included in Appendix 1.

Theoretical framework: The Three Delays Model

In 1994, Thaddeus and Maine proposed the Three Delays Model to facilitate the identification of factors that cause a delay in care and might therefore contribute to adverse outcomes. [14] The model identifies three phases of possible delay (see Figure 1).

Figure 1: The Three Delays Model (15,16)

The model was originally designed for low-resource settings but was modified by Binder et al. to evaluate maternal and newborn care for migrant populations in high-income settings.[16] In this study, we employ the modified version of the model to categorize suboptimal factors of care.

Study population

We included all cases that concerned women with a refugee background included in the Dutch National Perinatal Audit registry. Women with a refugee background were defined as asylum-seeking women, women with recently obtained residence permits, and undocumented women, altogether referred to as 'refugees' in this study.

To identify refugee women in the Perinatal Audit registry, the first author hand-searched all case reports between March and May 2021 as migration history and legal status are not routinely included in the Perinatal Audit registry's administration. Women's cases were deemed eligible for inclusion if either the country of origin or terminology in the case report indicated a refugee background (see box 1). The determination of which countries of origin rendered women eligible for inclusion depended on both the number of asylum applications and the percentage of immigrants that applied for asylum from these countries, as reported by Statistics Netherlands. [17]) Cases were excluded if women had lived in the Netherlands for more than ten years, if there was uncertainty about a woman's migration background, or if there was no record of the provided care.

Box 1: Words, phrases, and countries of origin encountered in reports, which made women's cases eligible for inclusion
Words or phrases encountered in case reports which made them eligible for inclusion:
Asylum seeker; Asylum seekers center; Refugee camp; Refugee status; Residence permit; Fled from; Dutch Council for Refugees; GCA/GZA*; Temporary residence in the Netherlands due to political tensions back home.
Countries of origin encountered in case reports which made them eligible for inclusion:
Syria; Somalia; Iran; Eritrea; Afghanistan; Pakistan; Middle East; Congo; Ethiopia; Turkey**; Ghana; Nigeria.

** Organization that provides primary healthcare for asylum seekers in the Netherlands.*
*** Only eligible for inclusion in combination with another factor such as a short stay in the Netherlands*

Identification and classification of suboptimal factors

After case selection, we identified suboptimal factors by independently reviewing all case reports. This was done by the first two authors in collaboration with an expert team, that consisted of a midwife (EF-dJ), an obstetrician (JE), an obstetrician in training (IP), and a neonatologist (KB). The experts considered care suboptimal for patient-related factors (phases one and two of the Three Delays Model) if they negatively affected the care refugee women received with a possible negative effect on the outcome. Quality-related factors (phase three of the Three Delays Model) were considered suboptimal if care deviated from the professional requirements of standard care, national guidelines, or local protocols. Cases in which there was no consensus on suboptimal factors were discussed in a meeting with the entire team and conflicts were resolved. After the identification of suboptimal factors, we classified them according to Binder et al.'s Three Delays Model.[16]

We conducted this analysis in addition to the data available from the original audit as our objective was to also identify patient-related suboptimal factors that were not included in original audits. During all stages of the analysis, the research team was blinded to the suboptimal factors identified in original audits. Additional suboptimal factors identified by the original audits were included after classification. We conducted descriptive statistics on suboptimal factors using SPSS version 28.0.0.0.

Minor/Major analysis

After the identification of suboptimal care factors, we assessed the likelihood that a suboptimal factor contributed to the adverse outcome, by labeling factors either 'minor' or major'. Factors were considered 'minor' if any contribution to the adverse outcome was unlikely or uncertain. Factors were considered 'major' if they most likely or probably contributed to the adverse outcome. These decisions were made by the expert team and based on their professional judgment.

Ethics

This study was assessed by the medical ethical committee of the University Medical Centre Groningen (METc 2021/375) and was not subject to the Medical Research Involving Human Subjects Act in the Netherlands. With regards to privacy, the researchers exclusively accessed anonymized data contained within a secured file. So all data were retrieved and handled anonymously. Perined, the organization responsible for administering and maintaining the National perinatal audit, provided authorization for this research, and conducted a thorough review of the manuscript, approving the final version for publication.

Results

Selection of cases

Of all 1117 cases stored in the national Perinatal Audit, in 53 (4.7%) cases women were identified as refugees. Most cases (n=33, 62.3%) were included because women originated from countries that suggested a forced migration background. The other 20 cases (37.7%) were included because the terminology in the case report suggested that the women had a refugee background (see box 1).

The audit processes

During the audit process, we discussed seventeen cases with all members of the research team due to doubt from a team member whether a factor should be classified as suboptimal. In a three-hour-long meeting, all members of the team discussed the cases and two general issues, which included the definition of an untimely start of antenatal care and how to handle missing data in case reports. During this meeting, all discrepancies and unclarities between experts were resolved. After the team reached a consensus, suboptimal factors were finalized. A detailed description of the suboptimal factors is included in Appendix 2.

After completing our analysis, we added the descriptions of suboptimal care recorded in the national perinatal audit database from the original audits. These original audits described 119 suboptimal care factors, divided over 43 cases. Ten cases contained no suboptimal factors in the Perinatal Audit Registry. Of the suboptimal factors identified in the original audits, 45.4% (n=54) addressed the same suboptimal care identified by the research team, while 45.4% (n=54) were not identified by the research team's analysis. All additional factors corresponded to our framework and were grouped into 29 suboptimal factor categories. Of the suboptimal factors identified by original audits 8.4% (n=10) were not included because they concerned team evaluations or peer support for healthcare providers (n=4), it was unclear what specific suboptimal factor they targeted (n=3) or it was unclear what was meant (n=3).

Characteristics of included cases

Table 1 shows the characteristics of the included cases. Women were born in Asia, Africa, or Europe. At the start of pregnancy care, 24.5% of women were asylum seekers and 22.6% were refugees with a residence permit. In the rest of the cases (50.9%), women's residence status was missing from the perinatal audit data.

Table 1: Case characteristics

Case characteristics	Total (N=53)
Origin of the mother	
Asia*	(49.1)
Africa†	(37.7)
Europe‡	(5.7)
Unknown	(7.5)
Residence status at the start of pregnancy care	
Asylum seeker	(24.5)
Refugee with a residence permit	(22.6)
Unknown	(52.8)
Duration of stay in the Netherlands (years)	
< 1 year	(34.0)
< 2 years	(11.3)
3 - 4 years	(17.0)
4 - 10 years	(11.3)
Unknown	(26.4)
Age	
< 20	(7.5)
20 - 29	(37.7)
30 - 39	(49.1)
40+	(5.7)
Parity	
Nulliparous	(28.3)
Multiparous (1,2,3)	(60.4)
Grand multipara (≥4)	(11.3)

Data are presented as: Number of cases (%)
** Asian countries included: Syria, Iran, Iraq, Afghanistan, Pakistan, and Turkey*
† African countries included: Somalia, Eritrea, Nigeria, Ethiopia, Congo, Ghana, Sudan, and Gambia
‡ European countries included: Bosnia, Belarus, and Moldavia

Adverse outcomes

Adverse outcomes from cases were divided into five categories: fetal death (n=14), perinatal asphyxia (n=15), severe neonatal hyperbilirubinemia (n=12), uterine rupture (n=7), and other (n=7). The category 'other' included neonatal mortality (n=2), postpartum hemorrhage (n=2), pre-eclampsia (n=1), meconium aspiration syndrome (n=1), GBS-sepsis (n=1) and one case in which a woman suffered from pre-eclampsia, placental rupture, and postpartum hemorrhage (n=1). The number of suboptimal factors per adverse outcome is included in Appendix 3.

Suboptimal factors

We identified 29 suboptimal factor categories, which are grouped according to the Three Delays Model in Table 2. Seven suboptimal factors were related to care-seeking (first delay), six to the accessibility of services (second delay), and sixteen to the quality of care (third delay). In 67.9% of cases (n=36) at least one suboptimal factor most likely or probably contributed to the adverse outcome. Most of these major suboptimal factors occurred in phase three of the three delays model, followed by phase one and phase two. The number of cases with major suboptimal factors in phase three is especially high in cases of severe neonatal hyperbilirubinemia (11 out of 12 cases, 91.7%).

Phase one: care seeking

Suboptimal factors with a possible effect on care seeking occurred in 43 cases (81.1%), and in fourteen cases (26.4%) at least one of these factors most likely or probably contributed to the adverse outcome (labeled as major)The most common suboptimal factors were an untimely start of antenatal care (n=22), missed or late arrival at appointments (n=22), and non-compliance (n=20) (see Table 2). Of all suboptimal factors in phase one, delayed care seeking most often contributed to the adverse outcomes (n=7, 13.2%). Case A presents an example, in which major contributing factors in phase 1 were missed appointments and delayed care seeking. In phase two, a language barrier and inadequate involvement of an official interpreter were major suboptimal factors. The major factor identified in phase three was missed or late diagnostic tests.

Case A:

A young multiparous mother from the Middle East, who had been in the Netherlands as an asylum seeker for less than a year, frequently missed appointments throughout her pregnancy. Due to miscommunication, the patient missed blood glucose measurements and didn't go to a lab appointment her midwife had scheduled her for. Healthcare providers mentioned a language barrier as the reason for miscommunication and the patient's missed appointments. At 32 weeks of pregnancy, the patient was referred to the hospital because her community care midwife suspected fetal growth restriction. Due to another

miscommunication, the patient did not show up at the ultrasound appointment in the hospital. After three weeks, her midwife arranged a new appointment, and fetal growth restriction was diagnosed. The obstetrician decided that the fetal growth ultrasound must be repeated after two weeks, even though an additional ultrasound for doppler-flow measurements after one week would have been indicated according to Dutch care guidelines. More than two weeks later, with no record of a new fetal growth ultrasound, the patient's partner phoned the hospital with signs of labor. After arrival at the hospital, healthcare providers found no fetal heartbeat and fetal death was diagnosed. When asked, the patient reported that she hadn't felt any fetal movements in the two days before the hospital visit.

Table 2: Suboptimal factors and their association with adverse outcomes (number of major factors) grouped by phase of delay.

Suboptimal factors	**Number of cases in which suboptimal care was present, n(%)**	**Number of times factors were labeled major**
Total	**53**	
Phase 1: Care seeking	**(81.1)**	**14**
Untimely start of antenatal care	(41.5)	1
Missed appointments/late arrival	(41.5)	3
Non-compliance	(37.7)	3
Misunderstanding	10	0
Patient's choice	2	1
Unclear	10	2
Delayed care seeking in case of alarm symptoms	(34.0)	7
Vulnerable context	(28.3)	1
Partially unmonitored pregnancy	(9.4)	0
Lack of trust in healthcare provider	(3.8)	1
Phase 2: Accessibility of services	**(94.3)**	**8**
Language barrier	(84.9)	7
Inadequate involvement of an official interpreter	(58.5)	7
Transportation difficulties	(22.6)	1
Transfer of care	(18.9)	0
Financial barriers	(5.7)	0
Uncertainty or stress surrounding the asylum procedure	(5.7)	0

Table 2: Suboptimal factors and their association with adverse outcomes (number of major factors) grouped by phase of delay. **(continued)**

Suboptimal factors	Number of cases in which suboptimal care was present, n(%)	Number of times factors were labeled major
Phase 3: Quality of care	**(100)**	**29**
Communication issues between care providers	(62.3)	4
Missed or late diagnostic tests	(62.3)	13
Other inadequate care	(47.2)	4
No or late start of treatment	(45.3)	14
Incomplete history taking or counseling	(45.3)	7
Issues concerning documentation	(35.8)	0
Missed or late diagnosis	(34.0)	13
Logistic or technical issues	(30.2)	2
Delay in consultation or referral	(30.2)	7
Insufficient or inadequate psychosocial care	(26.4)	0
Inadequate action in case of no-show	(15.1)	0
Healthcare providers' negative attitude	(15.1)	0
Insufficient monitoring during labor	(13.2)	2
Issues with postnatal maternity care	(11.3)	2
Inadequate risk assessment	(7.5)	1
No placental pathology while indicated	(7.5)	0

A detailed description of suboptimal factors can be found in Appendix 2

Phase two: accessibility of care

Suboptimal factors with a possible effect on the accessibility of care occurred in 50 cases (94.3%). In eight cases (15.1%) at least one of these factors most likely or probably contributed to the adverse outcome (labeled as major). The most common suboptimal factors for refugee women while accessing perinatal care were language barriers (n=45) and inadequate involvement of an official interpreter (n=31) (see Table 2). In seven cases (13.2%), these factors most likely or probably contributed to an adverse outcome. Case B presents an example, in which the major contributing factor for phase one concerned missed

appointments. The major contributing factors in phase two were a language barrier and inadequate involvement of an official interpreter and in phase three this was an issue with postnatal maternity care.

Case B:
A primiparous woman from Africa, who had been in the Netherlands for a little over a year, had an uncomplicated pregnancy when labor started after 41 weeks of gestation. The patient did not speak any Dutch or English. Her partner served as an interpreter, but his Dutch language skills were limited. After a difficult labor, complicated by shoulder dystocia, the patient gave birth to a child with a suboptimal start who recovered quickly (Apgar score of 8 after 1 minute, and 9 after 5 minutes). That same evening at nine pm, the family was discharged from the hospital, and maternity care services were called for a home visit. As the concept of maternity care services was not sufficiently explained to the woman and her partner, they were asleep and had their phones turned off when the maternity care assistant rang the door of their home that evening and the next morning. When the community midwife arrived later that day, she discovered that the newborn's temperature had not been monitored, there were no hot water bottles in the baby's bed, and breastfeeding had not yet succeeded. Moreover, the baby looked yellow. The midwife immediately arranged hospital admission, where healthcare providers started treatment with phototherapy for hyperbilirubinemia.

Phase three: quality of care
Suboptimal factors with a possible effect on quality of care occurred in 53 cases (100%), and in 29 cases (54.7%) at least one of these factors most likely or probably contributed to the adverse outcome (labeled as major). Suboptimal factors that most often contributed to adverse outcomes were no or late start of treatment (n=14, 26.4%), missed or late diagnosis (n=13, 24.5%), and missed or late diagnostic tests (n=13, 24.5%). As a part of missed or late diagnostic tests, late diagnostics after detecting neonatal jaundice occurred in seven cases and always most likely or probably contributed to the adverse outcome (labeled as 'major' factors). Communication issues between care providers were the most common suboptimal factor (n=33, 62.3%), although its contribution to the adverse outcome was often unlikely or uncertain (n=29, 54.7%). A negative attitude by healthcare providers in case reports was observed in eight cases and included describing patients as 'incapable of following instructions', 'unreasonable', 'uncooperative', and 'unmanageable'. In all these cases communication issues had been described during pregnancy. Case C presents an example in which all suboptimal factors in phases one and two were deemed minor. Phase three was assessed major for incomplete history taking, late diagnostic tests, missed diagnosis, and a delay in referral.

Case C:
A primiparous woman from the Middle East had been in the Netherlands as an asylum seeker for around 6 months. She experiences an uncomplicated pregnancy and childbirth. During pregnancy, healthcare providers did not assess risk factors for neonatal hyperbilirubinemia while family history would have revealed a high risk. Two days postpartum, the newborn's skin and eyes appeared yellow, and the child had lost 9% of its birth weight. Two days later, even though the newborn's weight had increased 80 grams, the skin was still yellow, and the maternity care assistant discovered urate crystals in the urine. No action was undertaken by any of the care providers. Seven days postpartum, the mother expressed worry because her baby hadn't defecated for three days and seemed less alert. The midwife immediately referred the family to the hospital where the baby was diagnosed with severe hyperbilirubinemia (bilirubin: 389 umol/l) and treated with phototherapy.

Discussion

The aim of this study was to identify suboptimal factors in maternal and newborn care for refugee women and assess to what extent these factors contribute to adverse pregnancy outcomes in the Netherlands. Our results indicate that in 67.9% of cases, at least one suboptimal factor most likely or probably contributed to the adverse perinatal or maternal outcome. We identified 29 suboptimal factor categories, which were categorized according to the Three Delays Model. Seven factors were related to care-seeking (1st delay), six to the accessibility of services (2nd delay), and sixteen to the quality of care (3rd delay). Most of the suboptimal factors in maternal and newborn care identified in this study have been previously reported in refugee populations.[4,5,10,12,18–30] Previous studies show that suboptimal maternity care is more prevalent among refugee women compared to non-migrant populations.[19,20] In our study, we explicitly demonstrate that suboptimal factors in maternal and newborn care contributed to adverse perinatal and maternal outcomes among refugees. Our findings in this context thus imply that suboptimal factors in maternal and newborn care play a role in perinatal health inequities between refugee and non-migrant populations, highlighting the need for targeted interventions in this area.

The wide variety of suboptimal factors identified in this study and their association with adverse outcomes challenge the Dutch healthcare system's fundamental principles of access to care, equity, and high-quality services for all.[31] Moreover, forced migration into the Netherlands has a long-standing history, and health inequities have disadvantaged various migrant populations for decades.[6,32,33] The subsequent paragraphs will discuss suboptimal factors identified in this study

per phase of delay in care and provide recommendations on how to address these factors to improve maternal and newborn care for refugees.

Phase 1: Care-seeking

The suboptimal factors related to care seeking in this study, emphasize the importance of promoting and facilitating care-seeking behavior among refugee women. However, it is important to recognize that limited care-seeking and perceived non-compliance are not solely attributable to refugees, but frequently stem from structural barriers on the individual, healthcare service, and migration policy levels. [34–36] To improve refugee women's access to care, it is crucial to acknowledge that addressing individual behaviors alone is insufficient and that interventions must also target underlying structural barriers, such as socio-economic disadvantage, women's educational attainment, unwelcoming attitudes towards refugees, and healthcare providers' lack of cultural competence. [5,27,34–38] Further research should explore the extent to which different structural barriers affect refugee women's access to care and identify best practices in this regard. In addition, Policy maker and healthcare providers should collaborate with refugees to develop and implement future interventions and research. [39–42]

Phase 2: Accessibility of services

The most common suboptimal factor in phase 2, which also most frequently contributed to the adverse outcomes in this phase, was a language barrier. These results add to a large body of evidence demonstrating the harmful impact of unaddressed language barriers in healthcare. [5,26,27] In many of the audited cases, official interpreters were not routinely involved, and care providers commonly relied on women's language skills, nonverbal communication, or informal interpreters. These alternative communication strategies limit women's ability to understand medical information and compromise the safety, confidentiality, and accuracy of translations. [43,44] Barriers to language support can be a direct consequence of political choices. For instance, during our study period community care midwives in the Netherlands were unable to claim the costs of professional interpreter services for refugees with a residence permit while before 2012 these services were freely available for healthcare providers. This stresses the need for the permanent reimbursement of interpreter costs in all refugee receiving countries, which the Dutch government reinstalled in maternal and newborn care as of January 2023. [45] Although studies show that the presence of professional interpreters improves clinical outcomes and patient satisfaction with care, professional interpreters alone do not resolve all communication barriers. [43,46,47] Other factors, such as cultural differences, women's educational attainment and experiences of discrimination or stigma, also influence communication in maternal and newborn care for refugees. [5,12,38] Thus, to overcome communication barriers, efforts towards an inclusive healthcare system should be made,

which encompasses culturally sensitive care that considers the widely diverse backgrounds of refugees. [48] One of the initial steps in realizing this objective is to train both current and aspiring healthcare professionals in cultural humility. [49–52]

Other factors leading to phase 2 delays, such as transfer of care and stress surrounding the asylum procedure, illustrate how migration policy and the asylum seeker context compromise women's ability to access care. [4,12,35,53] Transfer of care often occurs due to the relocation of asylum seekers and leads to partially uncontrolled pregnancies, missed appointments, and missed or repeated diagnostic tests. These findings add to a growing body of evidence on the negative effects of relocations on the well-being of pregnant asylum seekers as well as the continuity and quality of care. [4,12,18,28–30] This calls for an adjustment to the Dutch refugee system which limits the number of relocations for all asylum seekers, especially during pregnancy.

Phase 3: Quality of care

While several suboptimal factors observed in phase 3 have been reported in non-refugee populations, we also identified factors that appear more specific to refugees. These concern incomplete history taking or inadequate counseling, particularly regarding prenatal diagnostics, and issues with post-partum care, such as delayed arrangement. [10,19–24,54,55] Furthermore, in contrast with previous audit studies that did not focus on refugees specifically, our findings present evidence for negative attitudes among healthcare providers in care for refugee women. [10,19–24] Previous research on refugee women's experiences and healthcare staff's attitudes shows that racial and ethnic discrimination in care is common. [5,56–58] This is concerning, as racism adversely affects the quality of care refugee women receive and is associated with a lack of trust and delayed care seeking. [59–68] In many cases, healthcare providers may be unaware of their discriminatory behavior, as it may result from unconscious bias, prejudices, or stereotyping. [69] Further research is necessary to better understand how implicit bias and discrimination affect the quality of maternity care provided to refugee populations in the Netherlands. In addition, efforts should be made to increase workforce diversity, as cohorts of both current and training healthcare providers are often not representative of the populations they serve. [70,71] This is of fundamental importance as workforce diversity improves the cultural sensitivity of care and is associated with improved patient satisfaction, better communication between patients and their healthcare providers and a reduced risk of severe maternal outcomes. [50,51,70–74]

Strengths and limitations

This study adds to the existing literature by providing a more in-depth presentation of suboptimal factors in maternal and newborn care for refugees and

examining which suboptimal factors contribute to adverse perinatal and maternal outcomes. The unique database which allowed us to describe suboptimal factors in great detail and assess to what extent they contribute to adverse outcomes poses a major strength of this study. Additionally, the Three Delays Model offers a comprehensive framework for understanding how delays in care can contribute to adverse outcomes and provides valuable insights for developing targeted interventions. The involvement of experts from all care professions involved in maternal and newborn care for refugees and the unanimous consensus reached on suboptimal factors by these experts strengthen the validity of our conclusions.

The main limitation is that the Perinatal Audit registry only includes cases discussed in local audits and therefore presented a selection of cases with only adverse pregnancy outcomes. Due to the explorative scope of the study, we decided not to compare suboptimal factors between refugee and non-refugee populations, which limits conclusions on population-specific factors that influence care. In addition, reports stored in the Perinatal Audit registry contain summaries of patient records, which can make it challenging to distinguish inadequate documentation from actual instances of suboptimal care. To tackle this problem, we did not assign a suboptimal factor if there was any unclarity on whether or how care was provided. This probably explains why 45.4% of the suboptimal factors identified in the original local audits were not identified by our research team. Our outcomes therefore most likely reflect an underrepresentation of suboptimal factors in the study population.

Conclusion

The number of suboptimal factors identified in this study and the extent to which they contributed to adverse perinatal and maternal outcomes among refugee women is alarming. The wide range of suboptimal factors identified provides considerable scope for improvement of maternal and newborn care for refugee populations. These findings also highlight the importance of including refugee women in perinatal audits as it is essential for healthcare providers to better understand the factors associated with adverse outcomes to improve the quality of care. To improve care for refugees initiatives such as culturally sensitive education for healthcare providers, increased workforce diversity, minimizing the relocation of asylum seekers, and permanent reimbursement of professional interpreter costs are necessary.

Declarations

Acknowledgments
The authors wish to thank A. Schonewille-Rosman from Perined, who enabled the audit database search and approved the final manuscript for publication.

Conflicts of interest
The authors declare no conflict of interest. The sponsors had no role in the design, execution, interpretation, or writing of the study.

Data availability
Restrictions apply to the availability of these data. Data was obtained from Perined, which is a Dutch organization that facilitates the national perinatal registry and audit databases. Therefore, upon reasonable request the authors can provide data on the suboptimal factors they identified in the audit cases with Perined's permission, but they cannot share the actual audit reports.

Ethical approval
This study was reviewed by the acknowledged medical ethical committee of the University Medical Center Groningen (METc 2021/375) and was not subject to the Medical Research Involving Human Subjects Act in the Netherlands.

References

1. United Nations High Commissioner for Refugees (UNHCR). Global trends: forced displacement in 2021. 2022.
2. Tankink JB, Verschuuren AEH, Postma IR, van der Lans PJA, de Graaf JP, Stekelenburg J, et al. Childbirths and the Prevalence of Potential Risk Factors for Adverse Perinatal Outcomes among Asylum Seekers in The Netherlands: A Five-Year Cross-Sectional Study. Int J Environ Res Public Health. 2021 Dec 8;18(24):12933.
3. Gieles NC & Tankink JB, Midde M van, Duker J, Lans P Van Der, Wessels CM, et al. Maternal and perinatal outcomes of asylum seekers and undocumented migrants in Europe: a systematic review. Eur J Public Health. 2019 Aug 1;29(4):714–23.
4. Verschuuren AEH, Postma IR, Riksen ZM, Nott RL, Feijen-de Jong EI, Stekelenburg J. Pregnancy outcomes in asylum seekers in the North of the Netherlands: a retrospective documentary analysis. BMC Pregnancy Childbirth. 2020 Dec 25;20(1):320.
5. Heslehurst N, Brown H, Pemu A, Coleman H, Rankin J. Perinatal health outcomes and care among asylum seekers and refugees: a systematic review of systematic reviews. BMC Med. 2018 Jun;16(1):89.
6. van Oostrum IEA, Goosen S, Uitenbroek DG, Koppenaal H, Stronks K. Mortality and causes of death among asylum seekers in the Netherlands, 2002-2005. J Epidemiol Community Heal. 2011;65(4):376–83.
7. McKnight P, Goodwin L, Kenyon S. A systematic review of asylum-seeking women's views and experiences of UK maternity care. Midwifery. 2019 Oct;77:16–23.
8. Machado MC, Fernandes A, Padilla B, Dias S, Gomes I, Dias A, et al. Maternal and child healthcare for immigrant populations. International Organization for Migration (IOM). Geneva, Switserland; 2009.
9. Khanlou N, Haque N, Skinner A, Mantini A, Kurtz Landy C. Scoping Review on Maternal Health among Immigrant and Refugee Women in Canada: Prenatal, Intrapartum, and Postnatal Care. J Pregnancy. 2017;2017:1–14.
10. Esscher A, Binder-Finnema P, Bødker B, Högberg U, Mulic-Lutvica A, Essén B. Suboptimal care and maternal mortality among foreign-born women in Sweden: maternal death audit with application of the 'migration three delays' model. BMC Pregnancy Childbirth. 2014 Dec 12;14(1):141.
11. Balaam MC, Kingdon C, Thomson G, Finlayson K, Downe S. "We make them feel special": The experiences of voluntary sector workers supporting asylum seeking and refugee women during pregnancy and early motherhood. Midwifery. 2016;34:133–40.
12. Verschuuren AE, Tankink JB, Franx A, van der Lans PJ, Erwich JJ, Jong EF, de Graaf JP. Community midwives' perspectives on perinatal care for asylum seekers and refugees in the Netherlands: A survey study. Birth. 2023 Dec;50(4):815-26.
13. Eskes M, Waelput AJM, Erwich JJHM, Brouwers HAA, Ravelli ACJ, Achterberg PW, et al. Term perinatal mortality audit in the Netherlands 2010–2012: a population-based cohort study. BMJ Open. 2014 Oct 14;4(10):e005652.
14. Thaddeus S, Maine D. Too far to walk: maternal mortality in context. Soc Sci Med. 1994 Apr;38(8):1091–110.
15. Greenspan JA, Chebet JJ, Mpembeni R, Mosha I, Mpunga M, Winch PJ, et al. Men's roles in care seeking for maternal and newborn health: a qualitative study applying the three delays model to male involvement in Morogoro Region, Tanzania. BMC Pregnancy Childbirth. 2019 Dec 13;19(1):293.

16. Binder P, Johnsdotter S, Essén B. Conceptualising the prevention of adverse obstetric outcomes among immigrants using the 'three delays' framework in a high-income context. Soc Sci Med. 2012 Dec;75(11):2028–36.
17. Statistics Netherlands. Asielverzoeken en nareizigers; nationaliteit, geslacht en leeftijd [Internet]. 30 november 2022. 2018 [cited 2019 May 7]. Available from: https://opendata.cbs.nl/statline/#/CBS/nl/dataset/83102NED/table?ts=1529128026717
18. Fair F, Raben L, Watson H, Vivilaki V, van den Muijsenbergh M, Soltani H. Migrant women's experiences of pregnancy, childbirth and maternity care in European countries: A systematic review. Daoud N, editor. PLoS One. 2020 Feb 11;15(2):e0228378.
19. Improving the health care of pregnant refugee and migrant women and newborn children. Copenhagen: WHO Regional Office for Europe; 2018.
20. Sheikh J, Allotey J, Kew T, Fernández-Félix BM, Zamora J, Khalil A, et al. Effects of race and ethnicity on perinatal outcomes in high-income and upper-middle-income countries: an individual participant data meta-analysis of 2 198 655 pregnancies. Lancet. 2022 Dec;400(10368):2049–62.
21. Rosman AN, van Dillen J, Zwart J, Overtoom E, Schaap T, Bloemenkamp K, et al. Lessons learned from the perinatal audit of uterine rupture in the Netherlands: A mixed-method study. Heal Sci Reports. 2022 Sep 4;5(5).
22. van der Geest BAM, Rosman AN, Bergman KA, Smit BJ, Dijk PH, Been J V, et al. Severe neonatal hyperbilirubinaemia: lessons learnt from a national perinatal audit. Arch Dis Child - Fetal Neonatal Ed. 2022 Sep;107(5):527–32.
23. de Reu P, Diem M Van, Eskes M, Oosterbaan H, Smits L, Merkus H, et al. The Dutch Perinatal Audit Project: a feasibility study for nationwide perinatal audit in the Netherlands. Acta Obstet Gynecol Scand. 2009 Nov;88(11):1201–8.
24. Wolleswinkel-Van Den Bosch JH, Vredevoogd CB, Borkent-Polet M, Van Eyck J, Fetter WPF, Largo-Janssen TLM, et al. Substandard factors in perinatal care in The Netherlands: Acta Obstet Gynecol Scand. 2002 Jan;81(1):17–24.
25. Till SR, Everetts D, Haas DM. Incentives for increasing prenatal care use by women in order to improve maternal and neonatal outcomes. Cochrane Database Syst Rev. 2015 Dec 15;2015(12).
26. Bains S, Sundby J, Lindskog B V., Vangen S, Diep LM, Owe KM, et al. Satisfaction with maternity care among recent migrants: an interview questionnaire-based study. BMJ Open. 2021 Jul 16;11(7):e048077.
27. Cheng I-H, Drillich A, Schattner P. Refugee experiences of general practice in countries of resettlement: a literature review. Br J Gen Pract. 2015 Mar;65(632):e171–6.
28. Tobin C, Murphy-Lawless. Irish midwives' experiences of providing maternity care to non-Irish women seeking asylum. Int J Womens Health. 2014 Jan;159.
29. Feldman R, Action M, Council R. When maternity doesn't matter: dispersing pregnant women seeking asylum. Reprod Health Matters. 2013;21(42):212–7.
30. Chitongo S, Pezaro S, Fyle J, Suthers F, Allan H. Midwives' insights in relation to the common barriers in providing effective perinatal care to women from ethnic minority groups with 'high risk' pregnancies: A qualitative study. Women and Birth. 2022 Mar;35(2):152–9.
31. Ministery of Health Welfare and Sport. Healthcare in the Netherlands. 2016.
32. UNHCR's Refugee Population Statistics Database [Internet]. [cited 2023 Mar 4]. Available from: https://www.unhcr.org/refugee-statistics/
33. Carballo M, Grocutt M, Hadzihasanovic A. Women and migration: a public health issue. World Health Stat Q. 1996;49(2):158–64.
34. Parajuli J, Horey D. Barriers to and facilitators of health services utilisation by refugees in resettlement countries: an overview of systematic reviews. Aust Heal Rev. 2020;44(1):132.

35. Asif Z, Kienzler H. Structural barriers to refugee, asylum seeker and undocumented migrant healthcare access. Perceptions of Doctors of the World caseworkers in the UK. SSM - Ment Heal. 2022 Dec;2:100088.
36. Bains S, Skråning S, Sundby J, Vangen S, Sørbye IK, Lindskog B V. Challenges and barriers to optimal maternity care for recently migrated women - a mixed-method study in Norway. BMC Pregnancy Childbirth. 2021 Dec 7;21(1):686.
37. Zeidan A, Khatri U, Munyikwa M, Barden A, Samuels-Kalow M. Barriers to Accessing Acute Care for Newly Arrived Refugees. West J Emerg Med. 2019 Oct 16;20(6):842–50.
38. Binder P. The Maternal Migration Effect: Exploring Maternal Healthcare in Diaspora Using Qualitative Proxies for Medical Anthropology. Uppsala university; 2012.
39. Sandoval JA, Lucero J, Oetzel J, Avila M, Belone L, Mau M, et al. Process and outcome constructs for evaluating community-based participatory research projects: a matrix of existing measures. Health Educ Res. 2012 Aug 1;27(4):680–90.
40. Baum F. Participatory action research. J Epidemiol Community Heal. 2006 Oct 1;60(10):854–7.
41. Minkler M, Baden CA. Community-Based Participatory Research for Health: From Process to Outcomes. 2nd ed. John Wiley & Sons, Inc.; 2008. 243–261 p.
42. Israel BA, , Eng E, Schulz A, Parker EA. Methods in Community-Based Participatory Research for Health. John Wiley & Sons, Inc.; 2013. 4–37 p.
43. Patel P, Bernays S, Dolan H, Muscat DM, Trevena L. Communication Experiences in Primary Healthcare with Refugees and Asylum Seekers: A Literature Review and Narrative Synthesis. Int J Environ Res Public Health. 2021 Feb 4;18(4):1469.
44. Kasper A, Mohwinkel L-M, Nowak AC, Kolip P. Maternal health care for refugee women - A qualitative review. Midwifery. 2022 Jan;104:103157.
45. The Dutch Healthcare Authority (Nederlandse zorg autoriteit). Reimbursement of interpreters now possible in community midwifery care (Dutch: Declaratie talentolk nu mogelijk in eerstelijns geboortezorg) [Internet]. [cited 2023 Apr 7]. Available from: https://www.nza.nl/actueel/nieuws/2022/10/04/declaratie-talentolk-nu-mogelijk-in-eerstelijns-geboortezorg
46. MacFarlane A, Huschke S, Pottie K, Hauck FR, Griswold K, Harris MF. Barriers to the use of trained interpreters in consultations with refugees in four resettlement countries: a qualitative analysis using normalisation process theory. BMC Fam Pract. 2020 Dec 5;21(1):259.
47. Karliner LS, Jacobs EA, Chen AH, Mutha S. Do Professional Interpreters Improve Clinical Care for Patients with Limited English Proficiency? A Systematic Review of the Literature. Health Serv Res. 2007 Apr;42(2):727–54.
48. Lau LS, Rodgers G. Cultural Competence in Refugee Service Settings: A Scoping Review. Heal Equity. 2021 Mar 1;5(1):124–34.
49. Lee A, Padilla C. Causes of health inequities. Curr Opin Anaesthesiol. 2022 Jun;35(3):278–84.
50. Vance AJ, Bell T. Becoming an Antiracist Neonatal Community. Adv Neonatal Care. 2021 Feb;21(1):9–15.
51. Smith DG. Building Institutional Capacity for Diversity and Inclusion in Academic Medicine. Acad Med. 2012 Nov;87(11):1511–5.
52. Vella E, White VM, Livingston P. Does cultural competence training for health professionals impact culturally and linguistically diverse patient outcomes? A systematic review of the literature. Nurse Educ Today. 2022 Nov;118:105500.
53. Villalonga-Olives E, Kawachi I, von Steinbüchel N. Pregnancy and Birth Outcomes Among Immigrant Women in the US and Europe: A Systematic Review. J Immigr Minor Heal. 2017 Dec 24;19(6):1469–87.

54. Koopmanschap I, Martin L, Gitsels - van der Wal J, Suurmond J. Counselling for prenatal anomaly screening to migrant women in the Netherlands: An interview study of primary care midwives' perceived barriers with client–midwife communication. Eur J Midwifery. 2022 May 19;6(May):1–9.
55. Posthumus AG, Peters IA, Borsboom GJ, Knapen MFCM, Bonsel GJ. Inequalities in uptake of prenatal screening according to ethnicity and socio-economic status in the four largest cities of the Netherlands (2011-2013). Prenat Diagn. 2017 Oct;37(10):959–67.
56. Ajjarapu A, Story WT, Haugsdal M. Addressing Obstetric Health Disparities among Refugee Populations: Training the Next Generation of Culturally Humble OB/GYN Medical Providers. Teach Learn Med. 2021 May 27;33(3):326–33.
57. Hamed S, Bradby H, Ahlberg BM, Thapar-Björkert S. Racism in healthcare: a scoping review. BMC Public Health. 2022 May 16;22(1):988.
58. Zemouri C. Discriminatie maakt ziek. Hoe patiënten met een migratieachtergrond door zorgdiscriminatie verslechterde zorg ontvangen. Wetenschappelijk instituut Statera; 2022.
59. Giurgescu C, McFarlin BL, Lomax J, Craddock C, Albrecht A. Racial Discrimination and the Black-White Gap in Adverse Birth Outcomes: A Review. J Midwifery Womens Health. 2011 Jul 6;56(4):362–70.
60. Alhusen JL, Bower KM, Epstein E, Sharps P. Racial Discrimination and Adverse Birth Outcomes: An Integrative Review. J Midwifery Womens Health. 2016 Nov 13;61(6):707–20.
61. Daniels KP, Valdez Z, Chae DH, Allen AM. Direct and Vicarious Racial Discrimination at Three Life Stages and Preterm Labor: Results from the African American Women's Heart & Health Study. Matern Child Health J. 2020 Nov 12;24(11):1387–95.
62. Attanasio L, Kozhimannil KB. Patient-reported Communication Quality and Perceived Discrimination in Maternity Care. Med Care. 2015 Oct;53(10):863–71.
63. Headen IE, Elovitz MA, Battarbee AN, Lo JO, Debbink MP. Racism and perinatal health inequities research: where we have been and where we should go. Am J Obstet Gynecol. 2022 Oct;227(4):560–70.
64. Pabayo R, Ehntholt A, Davis K, Liu SY, Muennig P, Cook DM. Structural Racism and Odds for Infant Mortality Among Infants Born in the United States 2010. J Racial Ethn Heal Disparities. 2019 Dec 15;6(6):1095–106.
65. Liu SY, Fiorentini C, Bailey Z, Huynh M, McVeigh K, Kaplan D. Structural Racism and Severe Maternal Morbidity in New York State. Clin Med Insights Women's Heal. 2019 Jan 14;12:1179562X1985477.
66. Debbink MP, Bader MDM. Racial Residential Segregation and Low Birth Weight in Michigan's Metropolitan Areas. Am J Public Health. 2011 Sep;101(9):1714–20.
67. Salow AD, Pool LR, Grobman WA, Kershaw KN. Associations of neighborhood-level racial residential segregation with adverse pregnancy outcomes. Am J Obstet Gynecol. 2018 Mar;218(3):351.e1-351.e7.
68. Willey S, Desmyth K, Truong M. Racism, healthcare access and health equity for people seeking asylum. Nurs Inq. 2022 Jan 26;29(1).
69. FitzGerald C, Hurst S. Implicit bias in healthcare professionals: a systematic review. BMC Med Ethics. 2017 Dec 1;18(1):19.
70. Mulder L, Wouters A, Twisk JWR, Koster AS, Akwiwu EU, Ravesloot JH, et al. Selection for health professions education leads to increased inequality of opportunity and decreased student diversity in The Netherlands, but lottery is no solution: A retrospective multi-cohort study. Med Teach. 2022 Jul 3;44(7):790–9.
71. Clayborne EP, Martin DR, Goett RR, Chandrasekaran EB, McGreevy J. Diversity pipelines: The rationale to recruit and support minority physicians. J Am Coll Emerg Physicians Open. 2021 Feb 2;2(1).

72. Cohen JJ, Gabriel BA, Terrell C. The Case For Diversity In The Health Care Workforce. Health Aff. 2002 Sep;21(5):90–102.
73. Parker RB, Stack SJ, Schneider SM, Bowman SH, Broderick KB, Brown NA, et al. Why Diversity and Inclusion Are Critical to the American College of Emergency Physicians' Future Success. Ann Emerg Med. 2017 Jun;69(6):714–7.
74. Guglielminotti J, Samari G, Friedman AM, Lee A, Landau R, Li G. Nurse workforce diversity and reduced risk of severe adverse maternal outcomes. Am J Obstet Gynecol MFM. 2022 Sep;4(5):100689.

Supplementary files

Appendix 1: National Perinatal Audit Registry in the Netherlands

This appendix is partially based on previous descriptions of the Dutch national perinatal audit by van der Geest et al. and Rosman et al. (21,22).

During perinatal audit meetings, healthcare providers evaluate the provided care in cases with adverse perinatal or maternal outcomes. Audit meetings take place biannually at most hospitals in the Netherlands. Each audit meeting is prepared by a local team and chaired by an independent supervisor. All perinatal healthcare professionals within a region are invited to audit meetings, including obstetricians, community midwives, clinical midwives, pediatricians, and obstetric nurses. Cases are discussed anonymously and involved healthcare providers can stay anonymous if they wish.

Which cases are discussed depends on the cases healthcare providers submit and whether these cases fall within one of the four audit themes. These themes change every two to three years and are determined by Perined in collaboration with experts in the field. During this study, the audit themes included late premature mortality (between 32+0 and 36+6 weeks), perinatal asphyxia (above 37+0 weeks), hyperbilirubinemia, and uterine rupture. Most cases discussed in perinatal audits fall within these themes although exceptions to this rule exist.

During an audit meeting, suboptimal factors and improvement points are constructed based on healthcare providers' evaluation of the cases. After reaching a consensus on the formulation of suboptimal factors and action points, these are registered in the National Perinatal Audit Registry. The local audit team also constructs a chronological report of each discussed case, which includes maternal characteristics, obstetric history, relevant prenatal consultations, a delivery report, and a summary of postpartum care, including maternal and neonatal follow-up. As this report is based on medical records, its completeness depends on the accuracy and thoroughness of the involved healthcare professionals' documentation.

Chronological reports and their corresponding suboptimal factors and action points are stored in the national Perinatal Audit registry. This registry facilitates the confidential and anonymous registration of the cases, the audit process, and its outcomes. As most local teams only discuss two cases per audit meeting, the National Perinatal Audit registry doesn't contain all cases with adverse outcomes, but only the selection of cases discussed in local audits.

Appendix 2: Detailed description of suboptimal factors

Table A: Detailed description of suboptimal factors

Suboptimal factor	Description in case report:	Specification or issues/consequences described
Phase 1: Care seeking		
Untimely start of antenatal care	First antenatal care appointment after 12 weeks of gestation.	Average start of antenatal care in weeks + days of pregnancy: 18+1 (range 12+4 - 33+4).
Missed appointments/ late arrival	One or more missed appointments with the midwife or in the hospital, or late arrival with consequences for care.	
Non-compliance	Clients' non-compliance with healthcare providers' advice.	Most important consequences: • Missed or delayed diagnostics tests. • Medication not used according to prescription. • Refused induction of labor.
Delayed care seeking in case of alarm symptoms	More than two days delay in consulting healthcare provider or no consultation at all in the case of alarm symptoms or symptoms of labor.	Most common alarm symptoms with delay in care: • Reduced fetal movements. • Stomach-aches. • Vaginal blood or fluid loss.
Vulnerable context	Factors in woman's social situation that significantly impacted care-seeking behavior according to the care provider.	Most common factors: • Teenage pregnancy. • Domestic violence. • Undocumented status.
Partially uncontrolled pregnancy	Interruption of antenatal care	N = 5 cases: • Four cases of interrupted care for 10, 6, 4, and 7 weeks at the gestational age of 27, 32, 27, and 20 weeks respectively. • In one case with an unknown number of weeks of interrupted care, return to care at 36+6 weeks.
Lack of trust in healthcare providers	Cases in which patients' lack of trust was explicitly mentioned by the care provider	

Table A: Detailed description of suboptimal factors **(continued)**

Suboptimal factor	Description in case report:	Specification or issues/consequences described
Phase 2: Accessibility of services		
Language barrier	Language barrier with mention of consequences leading to suboptimal care	Consequences described: • Inadequate/insufficient counseling for prenatal diagnostics and/or mode of birth. • Inadequate/insufficient coaching during labor. • Difficulties in interpreting patients' symptoms. • Incomplete patient histories. • Unnecessary hospital admission. • Use of general anesthesia during an emergency cesarean. • No follow-up care postpartum provided. • Missed appointments. • Missed psychological screening.
Inadequate involvement of professional interpreters	At least one prenatal or post-partum consultation where: 1. Healthcare providers described insufficient involvement of a professional interpreter in the case report. 2. Negative consequences of a language barrier were described, but a professional interpreter was not involved. 3. No involvement of an interpreter was described in situations considered crucial for communication according to the research group, while it was described during other consultations.	Most mentioned informal interpreters, as a consequence of not working with professional interpreters: • Clients' partner. • Family member. • Friend. • Neighbor. • Underaged child. • An unknown man from the waiting room.

Table A: Detailed description of suboptimal factors **(continued)**

Suboptimal factor	Description in case report:	Specification or issues/consequences described
Transportation difficulties	Any description of problems related to the transportation of clients to care facilities.	Problems mentioned: • No transportation available/accessible for women to reach the midwifery practice or hospital for consultations. • No transportation available/accessible during labor. • Taxi service for asylum seekers hard to reach, delayed service, or taxi divider's refusal to transport asylum seekers during labor. Consequences of transportation difficulties: • More home consultations. • Midwives take clients in their own cars. • Missed appointments. • Continued antenatal care with a community midwife while hospital care was indicated. • Delay in arrival at the hospital in a case with potentially life-threatening complications.
Transfer of care	Transfer of care between care facilities during pregnancy for reasons other than medical indication.	Reasons described: • Relocations between asylum centers. • Women moving house. • Threatening deportation. • Living with different family members because of undocumented status. • Transfer of care on clients' request. Consequences of a transfer of care during pregnancy: • Partially uncontrolled pregnancies. • Missed hospital appointments. • Missed or repeated diagnostic tests due to the incomplete or late transfer of medical records.

Table A: Detailed description of suboptimal factors **(continued)**

Suboptimal factor	Description in case report:	Specification or issues/consequences described
Financial barriers	Explicit mention of financial barriers to care	Consequences: • No use of folic acid. • No uptake of postpartum care. • Not coming to appointments because of fear of costs.
The stress of the asylum procedure	Description of uncertainty or stress surrounding the asylum procedure	Examples: • Asylum-seeking women with threat of deportation. • Fear of losing residence permit.
Phase 3: Quality of care		
Missed or late diagnostic tests	Diagnostic tests should have been performed, however these opportunities were missed or carried out with a delay.	Most common diagnostics missed: • Bilirubin testing after detection of neonatal jaundice. • Doppler and growth ultrasounds in case of IUGR. • Blood pressure measurements. • Fetal growth ultrasounds or CTGs in case of reduced fetal movements. • Fetal scalp blood sampling during labor. • Thompson scores and temperature management in case of perinatal asphyxia. • MRSA screening. • Diagnostics for persistent anemia.

Table A: Detailed description of suboptimal factors **(continued)**

Suboptimal factor	Description in case report:	Specification or issues/consequences described
Communication issues between care providers	Description or mention of communication issues between care providers or organizations involved in care for asylum seekers	Most common issues described: • Incomplete or absent transfer of medical information between midwives and hospitals, different midwifery practices, different hospitals, midwives and general practitioners, and among staff within hospitals. • Late or absent communication from the Dutch Central Agency for the Reception of asylum seekers with regards to the deportation or relocation of asylum seekers. • Ultrasound centers or laboratories not communicating results with midwives. • Delay in consulting a university hospital in complex cases. • The lack of a case manager who keeps track of a client's care process.
No or late start of treatment	Treatment would have been indicated but was carried out late or not at all.	Most common examples: • Delayed intervention during labor (most often in the form of an emergency cesarean). • Delayed phototherapy treatment of a neonate after detecting hyperbilirubinemia. • Missed opportunity for prophylactic treatment with acetylsalicylic acid, tranexamic acid, and/or calcium. • Delayed start of antibiotics in neonates with infection.
Other inadequate care	Inadequate care provided, not fitting into a different suboptimal factor	Most common issues described: • Incorrect medication or incorrect dose of medication given. • Type of treatment obsolete/not evidence-based. • Care not according to a specific protocol for the condition.

Table A: Detailed description of suboptimal factors **(continued)**

Suboptimal factor	Description in case report:	Specification or issues/consequences described
Issues concerning documentation	Case report reflects issues such as incompleteness, inconsistency, or complete absence of documentation with a possible effect on care.	Most common examples: • Inconsistent notes on case details or treatment provided. • Lack of notes on the treatment plan or care providers' considerations. • Lack of documentation regarding diagnostic examinations performed.
Incomplete history taking or counseling	Case report reflects incomplete history taking or counseling of the patient	Most common examples: • No risk assessment of patient history for hyperbilirubinemia. • Incomplete medical history obtained. • No counseling concerning the mode of birth, risks of post-term birth, and induction of labor. • Insufficient counseling to ensure patients' understanding and trust.
Logistic or technical issues	Issues in logistics or availability of technical support	Most common issues: • Staff short on time/high work pressure. • Shortage of staff, e.g., no gynecologist available to perform an emergency cesarean section. • No operation or labor room available. • No NICU availability. • Lab results unavailable. • Malfunctioning of CTG device.
Missed or late diagnosis	Medical conditions that were either missed or diagnosed late.	Missed diagnoses: • Hyperbilirubinemia. • Uterus rupture. • IUGR. • Pre-eclampsia. • Neonatal coarctation aortae. • Anemia requiring blood transfusion. • Maternal acute fatty liver syndrome.

Table A: Detailed description of suboptimal factors **(continued)**

Suboptimal factor	Description in case report:	Specification or issues/consequences described
Delay in consultation or referral	The patient should have been referred or invited for an appointment after a referral	Most common issues: • Delay between the registration of a patient at the midwifery clinic and intake consultation. • No referral for neonatal icterus on the first day after birth. • No referral to emergency care in case of alarm symptoms, such as severe vomiting in the third trimester, lack of fetal movements, and thrombocytopenia.
Insufficient or inadequate psychosocial care	Insufficient or inadequate care offered to clients with known psychological health problems	Most common examples include women for whom no referral to specialist care was made despite healthcare providers' awareness of one of the following: • Unsafe home situation due to domestic violence. • Mental health symptoms such as stress, depression, or anxiety. • Unwanted pregnancy. • Traumatic birth.
Inadequate action in case of no-show	Insufficient or inadequate action from the healthcare provider after multiple missed appointments without notice from the client	In all cases, this concerned missed appointments without action from healthcare providers, or actions were not as recommended by national guidelines on birth care for asylum seekers.
Insufficient monitoring during labor	Insufficient monitoring of a woman in labor or the fetal condition during labor	Most common examples: • CTG not monitored regularly by a care provider. • Technical failure of CTG equipment. • No registration of maternal contractions.
Issues with postnatal maternity care	Insufficient attention of healthcare providers to counsel patients and/or make arrangements concerning postnatal maternity care	• Postnatal maternity care was arranged very late in pregnancy or not arranged at all. • Maternity care assistants not accepted by patients due to misunderstandings about the concept of maternity care.

Table A: Detailed description of suboptimal factors **(continued)**

Suboptimal factor	Description in case report:	Specification or issues/consequences described
Healthcare providers' negative attitude	Negative attitudes towards clients reflected by the negative framing of patients in cases where other issues, such as communication difficulties, presumably played a role.	Examples of terms used to refer to patients by healthcare providers: • 'Uncooperative' • 'Incapable of following instructions' • 'Unreasonable' • 'Unmanageable' In all cases, communication difficulties had been previously described, whereas no professional interpreters were involved.
Inadequate risk assessment	The responsible care provider should have been different based on the patient's known obstetric risk status	Most common issues: • Care by a community midwife while hospital care was indicated. • Care in a regular hospital while care in a university hospital for complex conditions would have been indicated.
No placental pathology while indicated	Lack of diagnostics on placental pathology while indicated	

Appendix 3: Suboptimal factors per adverse outcome

Table A: Suboptimal factors per adverse outcome

Suboptimal factors	Number of cases with suboptimal factors					
	Total	Intrauterine fetal death	Perinatal asphyxia above 37 weeks	Severe neonatal hyperbilirubinemia	Uterine Rupture	Other
Total	53	14	15	12	7	7
Phase 1: Care seeking	(29+14)	(7+6)	(6+4)	(7+3)	(5+1)	(6+0)
Untimely start of antenatal care	(21+1)	(7+1)	(6+0)	(4+0)	(4+0)	(2+0)
Missed appointments/ late arrival	(19+3)	(4+1)	(9+1)	(4+1)	(2+0)	(1+0)
Non-compliance	(17+3)	(4+1)	(6+1)	(3+1)	(2+0)	(3+0)
Misunderstanding	(10+0)	(0+0)	(4+0)	(1+0)	(2+0)	(0+0)
Patient's choice	(1+1)	(0+0)	(1+1)	(0+0)	(0+0)	(0+0)
Unclear	(8+2)	(1+1)	(2+0)	(2+1)	(0+0)	(3+0)
Delayed care seeking in case of alarm symptoms	(11+7)	(2+4)	(2+2)	(4+0)	(2+1)	(2+0)
Vulnerable context	(14+1)	(5+0)	(3+0)	(3+1)	(3+0)	(2+0)
Partially uncontrolled pregnancy	(5+0)	(0+0)	(2+0)	(1+0)	(1+0)	(1+0)
Lack of trust in healthcare provider	(1+1)	(1+0)	(0+1)	(0+0)	(0+0)	(0+0)
Phase 2: Accessibility of services	(42+8)	(12+1)	(13+2)	(7+3)	(4+3)	(7+0)
Language barrier	(38+7)	(8+1)	(13+2)	(7+2)	(4+3)	(7+0)
Inadequate involvement of an official interpreter	(24+7)	(6+1)	(8+2)	(3+2)	(3+3)	(5+0)

Table A: Suboptimal factors per adverse outcome **(continued)**

Suboptimal factors	Number of cases with suboptimal factors					
	Total	Intrauterine fetal death	Perinatal asphyxia above 37 weeks	Severe neonatal hyperbilirubinemia	Uterine Rupture	Other
Transportation difficulties	(11+1)	(5+0)	(1+0)	(4+1)	(0+0)	(1+0)
Transfer of care	(10+0)	(2+0)	(5+0)	(2+0)	(1+0)	(1+0)
Financial barriers	(3+0)	(0+0)	(0+0)	(1+0)	(1+0)	(1+0)
Uncertainty or stress surrounding the asylum procedure	(3+0)	(2+0)	(0+0)	(1+0)	(0+0)	(0+0)
Phase 3: Quality of care	(24+29)	(7+7)	(9+6)	(1+11)	(2+5)	(5+2)
Communication issues between care providers	(29+4)	(7+1)	(11+0)	(4+2)	(5+0)	(3+1)
Missed, late, or incomplete diagnostic tests	(20+12)	(7+3)	(6+1)	(0+7)	(5+1)	(2+0)
Late diagnostics after detecting neonatal jaundice	(0+7)	NA	NA	(0+7)	NA	NA
Other inadequate care	(21+5)	(7+1)	(4+0)	(3+3)	(4+2)	(4+0)
No or late start of treatment	(10+14)	(3+3)	(3+5)	(1+3)	(1+3)	(2+1)
Incomplete history taking or counseling	(17+7)	(4+0)	(3+1)	(6+6)	(4+0)	(1+0)
Issues concerning documentation	(19+0)	(8+0)	(5+0)	(2+0)	(3+0)	(2+0)
Missed or late diagnosis	(5+13)	(2+4)	(1+1)	(1+5)	(2+3)	(0+1)
Logistic or technical issues	(14+2)	(1+1)	(5+1)	(5+0)	(3+0)	(1+0)
Delay in consultation or referral	(9+7)	(4+1)	(2+0)	(2+5)	(2+0)	(1+1)

Table A: Suboptimal factors per adverse outcome **(continued)**

Suboptimal factors	Number of cases with suboptimal factors					
	Total	Intrauterine fetal death	Perinatal asphyxia above 37 weeks	Severe neonatal hyperbilirubinemia	Uterine Rupture	Other
Insufficient or inadequate psychosocial care	(14+0)	(5+0)	(3+0)	(3+0)	(3+0)	(1+0)
Inadequate action in case of no-show	(8+0)	(2+0)	(2+0)	(4+0)	(0+0)	(0+0)
Healthcare providers' negative attitude	(8+0)	(2+0)	(4+0)	(0+0)	(3+0)	(0+0)
Insufficient monitoring during labor	(5+2)	(1+0)	(3+2)	(0+0)	(2+0)	(1+0)
Issues with postnatal maternity care	(4+2)	(0+0)	(1+0)	(3+2)	(0+0)	(0+0)
Inadequate risk assessment	(3+1)	(1+1)	(1+0)	(0+0)	(0+0)	(1+0)
No placental pathology while indicated	(4+0)	(0+0)	(2+0)	(0+0)	(1+0)	(1+0)

Numbers are presented as: Number of cases (minor+major)

Chapter six

Community midwives' perspectives on perinatal care for asylum seekers and refugees in the Netherlands: a survey study

A.E.H. Verschuuren* & J.B. Tankink*, A. Franx, P.J.A. van der Lans, J.J.H.M. Erwich, E.I. Feijen-de Jong, J.P. de Graaf

*Shared first authors

Published in: *Birth* (2023), 50(4), 815-826.

Abstract

Background

The rise of forced migration worldwide compels birth care systems and professionals to respond to the needs of women giving birth in these vulnerable situations. However, little is known about the perspective of midwifery professionals on providing perinatal care for forcibly displaced women. This study aimed to identify challenges and target areas for improvement of community midwifery care for asylum seekers (AS) and refugees with a residence permit (RRP) in the Netherlands.

Methods

For this cross-sectional study, data were collected through a survey aimed at community care midwives who currently work or who have worked with AS and RRP. We evaluated challenges identified through an inductive thematic analysis of respondents' responses to open-ended questions. Quantitative data from close-ended questions were analyzed descriptively and included aspects related to the quality and organization of perinatal care for these groups.

Results

Respondents generally considered care for AS and RRP to be of lower quality, or at best, equal quality compared to care for the Dutch population, while the workload for midwives caring for these groups was considered higher. The challenges identified were categorized into five main themes, including: 1) interdisciplinary collaboration; 2) communication with clients; 3) continuity of care; 4) psychosocial care; and 5) vulnerabilities among AS and RRP.

Conclusions

Findings suggest that there is considerable opportunity for improvement in perinatal care for AS and RRP, while also providing direction for future research and interventions. Several concerns raised, especially the availability of professional interpreters and relocations of AS during pregnancy, require urgent consideration at legislative, policy, and practice levels.

Introduction

The rise of forced migration worldwide requires birth care systems and professionals to respond to the needs of women giving birth in vulnerable situations. In the Netherlands alone, approximately 600 babies per year are born to mothers living in asylum seekers centers (ASC).[33] Severe inequities in maternal and perinatal mortality and morbidity continue to be reported between refugee and majority populations in Europe.[15,16,36] In the process and aftermath of forced migration, women may be exposed to a range of factors associated with maternal and perinatal health risks such as trauma, socioeconomic disadvantage, and a precarious legal status.[2]

Moreover, a substantial portion of the disparities in perinatal and maternal outcomes can be explained by the availability, accessibility, acceptability, and quality of perinatal care.[9,35] Asylum seekers and refugees must navigate a mostly unfamiliar healthcare system and may experience barriers to care ranging from limited financial resources to a lack of trust in care providers.[2,12] These barriers may cause significant delays in seeking and receiving perinatal care, even in high-income settings such as the Netherlands.[1,8,28] Once care has been found, suboptimal care factors such as misdiagnosis and insufficient monitoring may contribute to poor outcomes, including stillbirth and maternal death.[10,29]

Considering the role of suboptimal care factors in perinatal health inequities, there is a need to understand how the organization and provision of perinatal care can meet the needs of disadvantaged migrant populations. Little research has been done to explore the experiences of care professionals and their perspective on perinatal care for forcibly displaced women.[4,19,20,34] In the Netherlands, community care midwives play a crucial role as the primary obstetric care provider throughout most women's pregnancies and births.[26] As such, this study aimed to answer the following research questions:

1. What are the main challenges community midwives in the Netherlands experience when providing perinatal care for asylum seekers and refugees with a residence permit?
2. What do midwives consider opportunities for the improvement of perinatal care for asylum seekers and refugees with a residence permit?

Methods

Population
Our survey was distributed to community care midwives who currently work or have worked with pregnant asylum seekers (AS) or refugees with a residence permit (RRP). For the purposes of this, AS were defined as women living in a Dutch asylum-seeking center (ASC) while awaiting their request for asylum. RRP were defined as women whose asylum request had been granted (i.e. with a legal residence status in the Netherlands).

Setting
In midwife-led birth care in the Netherlands, pregnant women receive community midwifery care during their pregnancy, childbirth and postpartum period. In case of high-risk pregnancies or complications, women will be referred to obstetricians in a hospital. Most AS and RRP also start their antenatal care with midwives. In 2012 a collective of care organizations including obstetricians, general practitioners, maternity care nurses, and the Central Agency for the Reception of Asylum Seekers (COA) developed a national guideline on birth care for AS. The guideline describes how tasks and responsibilities should be divided and coordinated between different organizations and professionals involved in their care.[5] There are no specific protocols or guidelines for perinatal care for refugees with a residence permit in regular housing. Professional interpreter services in medical facilities are financed by the national government for AS, but not for RRP.

Study design
For this cross-sectional study data were collected through an online survey.

Survey development
The survey was developed by researchers from the EGALITE project (Erasmus MC Rotterdam) in collaboration with the University Medical Center Groningen in LimeSurvey (version 2.06LTS). Questions were based on previous studies on midwives' experiences caring for refugee populations, interviews with midwives, and the Dutch guideline on perinatal care for pregnant AS.5,12,24,25,34 The survey was tested by obstetric care professionals and discussed with an implementation scientist and adapted based on their feedback.

The 50–item survey comprised five sections of questions: characteristics of respondents and midwifery practices caring for AS and/or RRP (1), organization of care for AS (2), organization of care for RRP (3), evaluation of care provided for AS/RRP (4) and respondents' perspectives on opportunities for improvement of

care for AS/RRP (5). The total survey comprised of 37 close-ended and 13 open-ended questions. Respondents were asked to fill in questions on either AS, RRP or both, depending on which of these groups they had worked with. Formats for close-ended questions included multiple choice, yes/no/do not know statements, and 4- or 5-point Likert scale answer options. The open-ended questions had free text answer formats.

Data collection

Data collection took place between March and June 2021. The invitation to the digital survey was sent to midwifery practices known to work with AS or RRP and to all Dutch midwifery practices that claimed expenses from the national insurance fund for AS (n = 320). Further recruitment took place through snowballing, several news outlets, online platforms, and social media networks frequented by midwives. Duplicate responses were excluded as were survey responses that only included the "characteristics" section.

Outcomes and analysis

Qualitative outcomes included respondents' views concerning the main challenges in birth care for AS and/or RRP. Participants' answers to the open-ended questions were analyzed with an inductive thematic approach which resulted in the themes described. For the analysis, ATLAS.ti software was used.

Quantitative outcomes for both AS and RRP included:

- respondents' perception of the quality of care;
- satisfaction with interdisciplinary collaboration;
- ease of communication with other care professionals;
- the frequency of multidisciplinary meetings;
- the use of protocols and guidelines;
- deployment of professional interpreters;
- frequency of missed appointments among AS and RRP;
- the frequency of screening for psychosocial problems;
- referral to psychosocial care; and
- the extent to which respondents believed interventions would improve care.

For RRP specifically, the perceived intensity of care and additional tasks for obstetric care professionals were added to the survey. For AS these topics were not included in the survey since additional tasks are described in the national guideline. Quantitative data mostly originated from close-ended questions. These questions were analyzed in SPSS using descriptive statistics. For some open-ended questions data were grouped and counted.

Ethical considerations

This study was submitted to an acknowledged medical ethical committee (MEC-2021-0155), Erasmus MC Rotterdam) and was not subject to the Medical Research Involving Human Subjects Act in the Netherlands. Data were collected anonymously and stored in accordance with national privacy regulations. Data contained no personal information, unless respondents consented to be updated on study results and provided their name and e-mail addresses. In this case, results were processed separately from contact details.

Results

Response rate

From the 320 invitations sent out to midwives directly, 134 responses were collected. Of these, 70 responses were included and 64 were excluded because responses were duplicate, or because respondents only filled in the characteristics section (total response rate: 22%). Through an open link to the survey distributed online, 32 additional responses were collected.

Characteristics of respondents

All 102 respondents worked as community care midwives with AS and/or RRP. For respondents' characteristics, see Table 1.

Table 1: Characteristics of respondents (N = 102)

Characteristics	Number of respondents
Age	
25 - 30	23 (22.5)
31 - 40	36 (35.3)
41 - 50	20 (19.6)
51 - 60	15 (14.7)
61 - 68	8 (7.8)
Migration background of the midwife	
No migration background	94 (92.2)
First or second-generation migrant	8 (7.8)
Number of midwives in practice	
Solo practice	6 (5.9)
Duo practice	23 (22.5)
Group practice (>2)	73 (71.6)
Experience with care for AS (in years) *	

Table 1: Characteristics of respondents (N = 102) **(continued)**

Characteristics	Number of respondents
1 - 5	28 (38.9)
6 - 10	16 (22.2)
11-15	11 (15.3)
>15	17 (23.6)
Total	72 (100)
Experience with care for RRP (in years) **	
1 - 5	21 (23.3)
6 - 10	22 (24.4)
11-15	23 (25.6)
>15	24 (26.7)
Total	90 (100)
Average number of AS in care, per year *	
0	4 (5.6)
1 - 10	29 (40.2)
11 - 20	17 (23.6)
21 - 30	15 (20.8)
31 - 40	4 (5.6)
> 40	3 (4.2)
Average number of RRP in care, per year **	
0	0 (0.0)
1 - 10	51 (56.7)
11 - 20	21 (23.3)
21 - 30	8 (8.9)
31 - 40	2 (2.8)
> 40	8 (11.1)

Respondents' perspectives on quality and intensity of care

Most respondents considered the quality of obstetric care for AS and RRP to be either poorer or equivalent compared to care for the Dutch population (Table 2). In addition, 94.4% of respondents considered the intensity of caring for RRP to be higher when compared to caring for non-migrant women.

Table 2: Perceived quality of care

	Much poorer quality	Somewhat poorer quality	Equal quality	Somewhat higher quality	Much higher quality	I don't know
Quality of care AS	0 (0)	30 (47.6)	28 (32.6)	3 (3.5)	1 (1.6)	1 (1.6)
Quality of care RRP	1 (1.2)	34 (39.5)	43 (50.0)	6 (7.0)	0 (0)	2 (2.3)

Data are presented as number of respondents (%)
**N=63*
***N=86*

Challenges in midwifery care for AS and RRP

Thematic analysis of respondents' perspectives on perinatal care for AS and RRP resulted in a series of challenges, including: interdisciplinary collaboration, communication with clients, continuity of care, psychosocial care and vulnerabilities among AS and RRP (Figure 1).

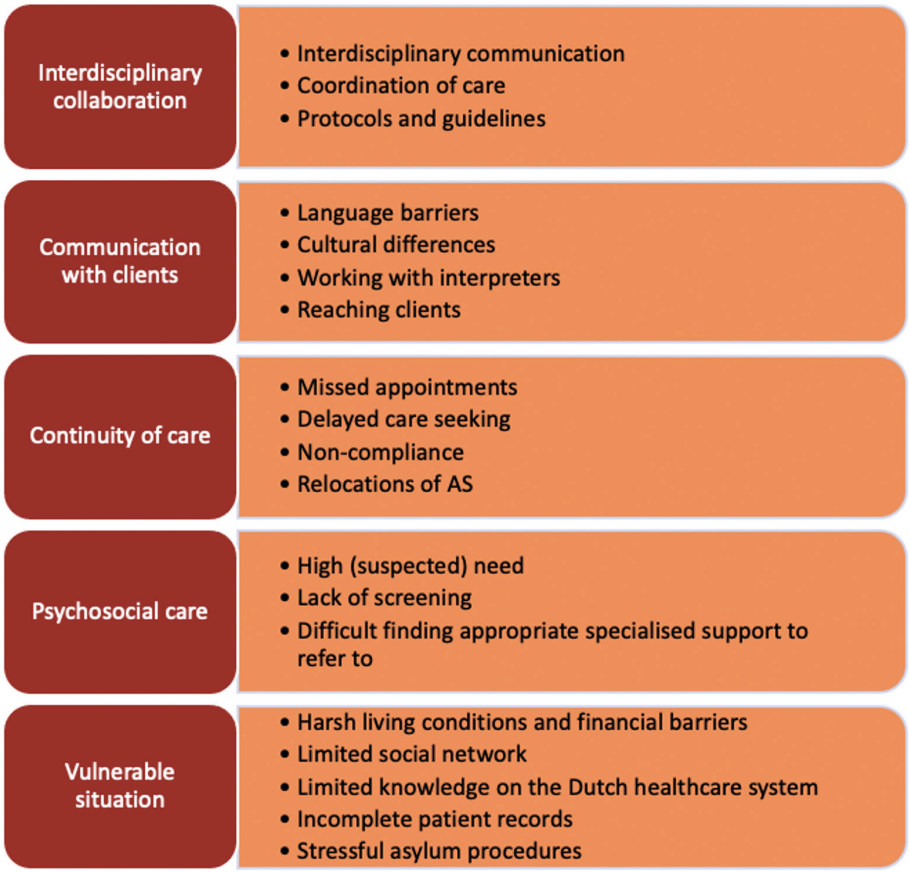


Figure 1: Main challenges in perinatal care for AS and RRP

Interdisciplinary collaboration

Most respondents (54.1% AS vs 55.6% RRP) stated that they were either fairly satisfied or very satisfied with interdisciplinary collaboration in the medical and social domain of care (Table 3).

However, satisfaction varied between different care disciplines (Figure 2). Respondents were most satisfied with communication between their own midwifery practice and maternity care organizations, the hospital, and youth health services. Nevertheless, some respondents felt that maternity care

organizations and hospital specialists did not always understand or respond adequately to the complex needs of AS and RPP clients.

In care for AS, respondents considered communication with COA, GZA and social work to be more difficult. Problems included identifying and reaching responsible professionals at these organizations. Additionally, some respondents reported that AS received insufficient support from the COA/GZA.

> *"Collaboration with the GZA and the COA [is the most important challenge in perinatal care for AS]. The last couple of years, the general opinion of GZA and COA has been: people are autonomous and should take care of their own business. Being involved [with the client] is labelled as 'unprofessional'."* **- Participant 33**

Coordination of care
Respondents struggled with a lack of coordination of care and several respondents reported that they spend more time coordinating care as a case manager for their AS and RPP clients compared to non-migrant clients. Of all respondents, only 15.3% and 7.8% (AS vs RPP) reported having regional, multidisciplinary meetings specifically for AS or RRP, whilst many expressed a need for these meetings and for more intensive collaboration overall.

Although mentioned for both groups, the lack of coordination of care, including the absence of an overview of organizations involved and referral pathways, was specifically mentioned as a challenge in care for RRP.

Protocols and guidelines
Only 16.7% of respondents reported having a protocolized regional care pathway for RRP. Some respondents mentioned the lack of a national guideline as a challenge for the coordination of care. 18.1% of respondents reported that they were fully familiar with the Dutch perinatal guideline for AS women; 23.6% stated they had good knowledge of the content, 19.4% were somewhat familiar, and 38.9% were not familiar with the content of the guideline at all.

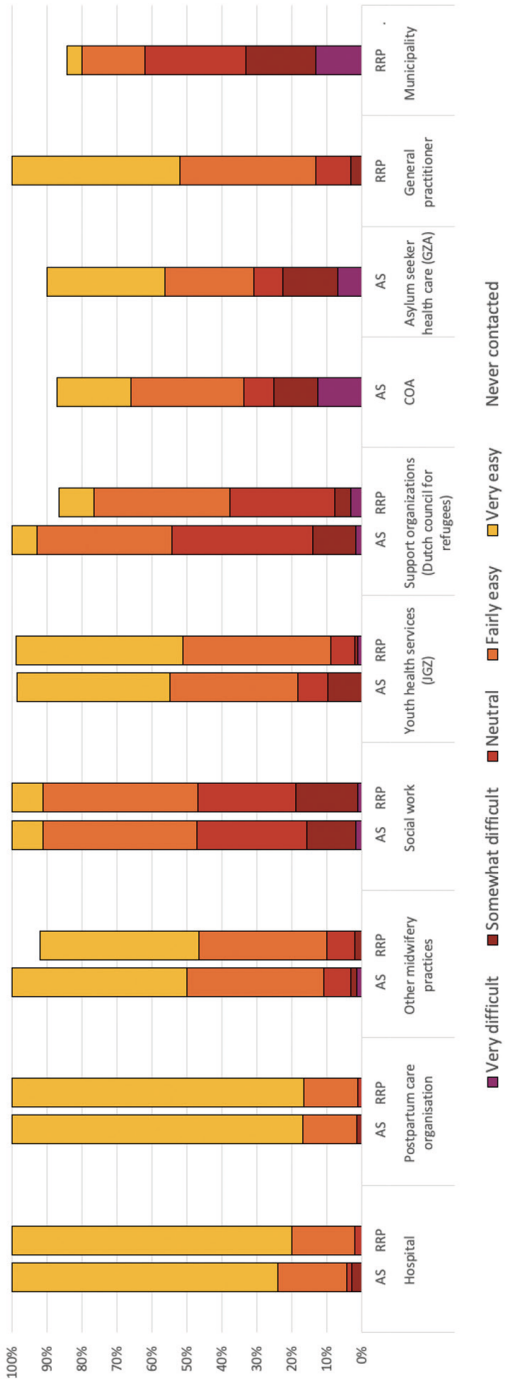


Figure 2: Interdisciplinary communication

Table 3: Overall satisfaction with interdisciplinary communication.

	Very dissatisfied	Somewhat dissatisfied	Neutral	Fairly satisfied	Very satisfied	I don't know
Satisfaction with interdisciplinary communication in care for AS	3 (4.2)	9 (12.5)	10 (13.9)	24 (33.3)	15 (20.8)	2 (2.8)
Satisfaction with interdisciplinary communication in care for RRP	3 (3.3)	9 (10.0)	21 (23.3)	35 (38.9)	15 (16.7)	3 (3.3)

Data are presented as Number of respondents (%)
**N=63*
***N=86*

Communication with clients

The main communication challenges mentioned were language barriers, cultural differences, working with interpreters, contacting clients by phone, and clients' limited trust in care providers and in the Dutch healthcare system.

Language barriers & cultural differences

Respondents described several negative consequences of language barriers, including problems with providing information to the client, clients who are unable to understand the midwife, miscommunications in care, missed appointments and difficulties in building a relationship with the client. Cultural differences were also considered to be challenging, for example, when clients had different expectations of care. Several respondents reported that they had limited knowledge on other cultures' customs and beliefs regarding pregnancy and childbirth.

Interpreters

In cases of insufficient language compatibility between the midwife and an AS client, 87.5% of respondents indicated that they often or always work with professional interpreter services. In the case of RPP clients, only 31.1% of respondents often or always work with interpreters (Table 4).

Reasons for not using official interpreters differed. The cost of interpreter services was spontaneously mentioned as one of the main barriers to working with these services by 60.2% of respondents caring for RRP, while only 17.1% of respondents mentioned this barrier in care for AS. Other reasons for not using official interpreters were similar between both groups and included the presence of informal interpreters, sufficient (Dutch or alternative) language proficiency of clients or midwives, time constraints and technical difficulties with interpreter services by phone. Some respondents preferred communication

through Google Translate or with hand gestures, as telephone services were considered impersonal, undesirable, or only necessary in certain consultations.

> *"The costs of using telephone interpreter services [for RRP] are such, that we decided to not use these any longer. Most of the time people know someone who speaks their language and who also knows English or sometimes Dutch. Then we call through them. Or we use Google Translate."* **– Participant 101**

Contacting clients

Respondents also expressed difficulties in contacting AS and RRP women by telephone or e-mail. Several respondents explained that the limited opportunities to communicate with their clients by these means intensified care due to the necessity for more home visits.

Continuity of care

Continuity of care was considered a major challenge as a result of missed appointments, delays in seeking care in case of symptoms, non-compliance, and relocation of AS. Among respondents, 73.6% of those caring for AS versus 62.2% of those caring for RRP agreed that these clients miss more antenatal visits without notice than do non-migrant women.

Relocation of AS

Respondents expressed major concerns about continuity of care for AS women specifically because of frequent relocation between ASCs and in some cases pending deportation. Potential problems included missed or delayed care, extra costs due to repeated care and setbacks in the relationship with pregnant AS due to alternating care providers. Additionally, respondents stated that the transfer of medical records was often delayed in case of relocation of AS (Table 4).

> *"Sometimes COA forgets to inform us when a pregnant woman is going to be relocated to another center or sent back to her country of origin. In that case we only find out when she does not turn up for her consultation. That cannot be right."* **– Participant 37**

Table 4: Interpreters, relocations, and aspects of psychosocial care

	Never	Sometimes	Often	Always	I don't know
Respondents work with interpreters for AS*	0 (0.0)	9 (12.5)	24 (33.3)	39 (54.2)	0 (0.0)
Respondents work with interpreters for RRP**	16 (17.8)	46 (51.1)	19 (21.1)	9 (10.0)	0 (0.0)
Respondents are informed by COA in case of relocation of AS*	10 (13.9)	20 (27.8)	27 (37.5)	9 (12.5)	6 (8.3)
Respondents receive relevant client history from GZA in case of a new pregnant AS client*	10 (13.9)	28 (38.9)	15 (20.8)	17 (23.6)	2 (2.8)
Respondents inquire about migration history of AS client*	0 (0.0)	16 (22.2)	22 (30.6)	34 (47.2)	0 (0.0)
Respondents inquire about migration history of RRP client**	2 (2.2)	18 (20.0)	35 (38.9)	34 (37.8)	1 (1.1)

Data are presented as number of respondents (%)
**N=72*
***N=90*

Psychosocial care

Another major challenge in providing perinatal care for AS and RRP concerned the identification, support, and referral of women in need of psychosocial care. Respondents reported the process of finding appropriate support for AS and RPP to be difficult, including long waiting times and a lack of referral options that meet these women's complex needs. This was even more concerning because respondents suspected a high incidence of psychological conditions and social problems among pregnant AS and RRP. A minority of 47.2% and 37.8% of respondents (AS vs RPP, respectively) reported that they always inquire about the personal history of the client, including the reason for migration, family circumstances and trauma exposure. Although prescribed by the national guidelines, 52.8% of respondents indicated that they never or only occasionally received information regarding the psychosocial situation of their AS clients from the GZA (Table 4). In addition, only 17% and 21% of respondents used a specific screening instrument to assess the psychosocial status of their AS or RRP clients.

Table 5 shows the most common referral pathways for psychosocial care as indicated by respondents. Almost 20 percent of the respondents reported that they never made a referral to psychosocial care.

Table 5: Most common referral pathways for psychosocial care

	GZA/COA	Hospital	General physician/ family doctor	Psychologist	Other***/ unknown	Never/ almost never
AS*	26 (34.2)	25 (32.8)	11 (14.4)	N/A	13 (17.1)	14 (18.4)
RRP**	N/A	35 (38.4)	45 (49.4)	9	28	18 (19.7)

Data is presented as Number of respondents (%)
**N=76*
***N=91*
****Other, including Municipal Health Services/Youth Health Services, mental healthcare institution, social work, Dutch refugee council, municipality, Veilig Thuis (Safe at Home).*

Vulnerable situation of AS and RRP

The last major challenge in providing perinatal care expressed by respondents was the vulnerable situation of pregnant AS and RRP. Harsh living conditions, financial precarity, limited health literacy, lack of information on the Dutch healthcare system, limited social networks, incomplete patient records and, for AS specifically, stressful asylum procedures were described by participants. Financial precarity was considered a factor for both groups, though more prominently for RRP. Respondents reported how financial barriers resulted in limited uptake of postpartum care by this group, insufficient baby products, and problems with transport to medical facilities.

For RRP, respondents reported additional aspects of vulnerability, such as care providers' limited awareness of women's refugee status. Moreover, RRP were considered to face more difficulties navigating the health care system as they are expected to be responsible for their own care process and receive little guidance after receiving a residence permit.

Additional tasks

The vulnerable situation of AS and RRP clients resulted in additional tasks and greater care responsibilities for respondents. When asked about the nature of tasks performed in addition to "care as usual", respondents caring for RRP commonly mentioned practical and material support, spending more time with the client, postpartum care, booking appointments, intensive multidisciplinary collaboration, and more psychosocial/extra care (Table 6). To bridge transportation problems, multiple respondents indicated that they had used their private cars to drive clients to the hospital during labor.

Besides the practical burdens, some respondents also reported that the vulnerable situations of AS and RRP clients caused an emotional burden which contributed to

the intensity of care. This was reflected in statements on how they felt powerless or as if they were "falling short" in caring for these clients.

> *"I oftentimes feel like I fall short, especially on a social and emotional level."* **– Participant 69**

Table 6: Most common additional tasks in care for RRP

Domain	Example(s) of additional tasks	Number of respondents
Practical & material support	Organising donations of birth or baby products	68
	Support transportation	
	Support filling out forms	
Spending more time with clients	More home visits	46
	Offering additional explanation	
Postpartum care	Admission to postpartum care	41
Booking appointments	Booking appointments with other care professionals	34
	Follow-up after missed appointments	
Intensive multidisciplinary collaboration	Arranging hospital birth at social indication	24
	More frequent contact and sharing information with other professionals	
More psychosocial/ extra care	Referrals to psychosocial support	9
	Support in finding "buddies"	

Opportunities for improvement

Respondents spontaneously mentioned several facilitators to good care. The most common facilitators included: involvement of a limited number of health care professionals per organization, clear agreements on the allocation of tasks and responsibilities, awareness of AS' situations, consultations at or close to the ASC, and having a positive attitude and interest in caring for this population. Specifically for AS, the availability of professional, on-demand telephone interpreter services was seen as a facilitator for optimal care delivery. As these services were not covered by government funds for RRP, the availability of informal interpreters and financial compensation by local governments were considered facilitators.

Respondents also spontaneously described initiatives that strengthen care. Some examples included strong community networks, local or church initiatives that offer social or material support, and having former clients donate baby products or act as "buddies" during consultations. When asked to score eight

initiatives for AS, respondents considered ending relocation of pregnant women to be the best idea for improving care, followed by matching pregnant AS to a buddy from a similar cultural background, prenatal care in a group setting and having a national shared electronic record for pregnant AS. For RRP, financial compensation for using interpreter services was considered extremely beneficial by almost 75% of respondents, followed by prenatal group care, a buddy project and having a specific protocol/guideline for RRP. For both groups, cultural training programs for midwives and more doula involvement were expected to be slightly less beneficial, but still moderately to extremely beneficial to care by most respondents (Figure 3).

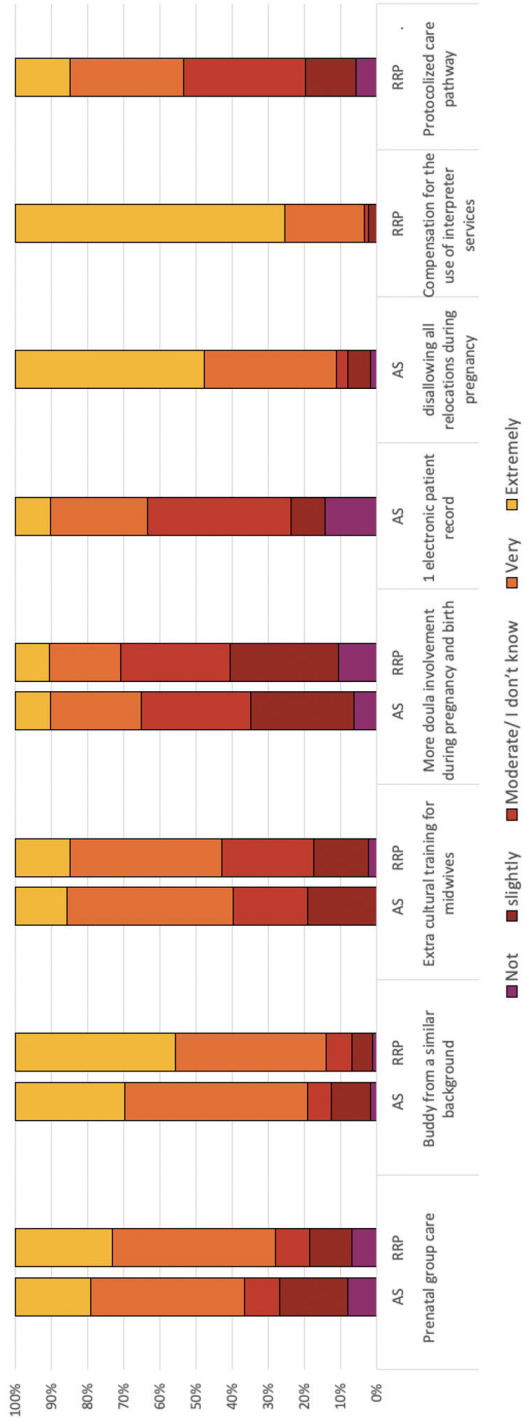


Figure 3: Respondents view on possible initiatives to improve care for AS and RRP

Discussion

This study aimed to identify challenges that community care midwives experience when providing perinatal care for AS and RRP in the Netherlands. Midwives' perspectives on target areas for improvement of care for these specific migrant groups were also explored. While perceived as more intensive and demanding, midwives in this study still considered the overall quality of perinatal care for AS and RRP clients to be lower compared to the quality of care for Dutch women. Major challenges in providing adequate care included interdisciplinary collaboration, communication with clients, continuity of care, psychosocial care, and the vulnerable situation of AS and RPP.

To our knowledge, this study was the first in which midwives reported interdisciplinary collaboration as a major challenge in care for AS and RRP. A possible reason might be the lack of a national guideline with a focus on interdisciplinary collaboration for RPP. With respect to the guideline for AS, our study showed a low awareness rate of the guideline's contents among midwives and a low adherence grade to several recommended practices, such as yearly multidisciplinary team meetings and the exchange of information between disciplines. Based on these findings, efforts are needed to improve the implementation of the national guideline for AS among midwives and to develop a new guideline or local care pathways with a clear task allocation for RRP.

Apart from interdisciplinary collaboration, all other challenges resonate with previous findings on the experiences of midwives who provide care for women with a forced migration background.[4,6,12,13,19,25,34] With respect to communication difficulties, this study demonstrated a clear difference between AS, for whom the costs of interpreter services are covered by basic government health care insurance, and RRP, for whom interpreters are not covered. The resulting financial costs for midwives seemed to be the most important reason for the low rate of interpreter use in the RRP client group as compared to AS. Moreover, our findings indicate that midwives often work with women's personal contacts, Google Translate, or hand gestures for intercultural communication. Such alternatives to formal interpreters may come with serious ethical and medical risks, including risks to informed consent for obstetric procedures, the quality of counseling on birth choices and the wellbeing of underaged children when asked to interpret.[24,31] Generally studies have shown direct and indirect associations between communication difficulties, suboptimal care and adverse birth outcomes, including obstetric trauma and maternal death.[18,21,30,31] Our findings, therefore, add to a body of evidence that calls for increased efforts to ensure obstetric

care providers are made aware of and facilitated to work with intercultural interpreters, in line with ethical and legal standards of care.

Furthermore, results indicate that caring for AS and RPP populations comes with an increased emotional and practical burden for midwives, which is in line with previous studies in the field.[4,7,24,25,34] This burden may partially reflect the vulnerable situation of AS and RPP, which appears to push midwives beyond the boundaries of their role as strictly obstetric care providers, for example, when offering support for practical, financial, and transportation issues.[7] Midwives in this study also struggled with a lack of referral options to psychological care for AS and RPP, while perceiving a high need for such care and for psychosocial support programs. These needs are confirmed by the high rates of perinatal mental health disorders found in forcibly displaced populations in high-income settings (48.2% for PTSD, 41.8% for anxiety and 42.0% for depression).[14] Previous studies also highlighted the lack of adequate screening instruments to assess migrant women's psychosocial situations.[27,32]

Offering continuity of care was another major challenge for midwives in this study and appeared to be mostly hampered by relocations of AS. Midwives described how relocations could cause a setback in the relationship with clients as well as, a delay in care due to the need to transfer medical records while not always being informed of relocations in time. Almost all midwives in this study agreed that ending the relocation of pregnant AS would greatly benefit quality of care. Many studies have highlighted the importance of the patient-care provider relationship in migrant populations and therefore consider continuity of care to be of key importance.[7,23,25] Our study adds to a growing body of evidence on the negative effects of relocations on continuity of care and the wellbeing of clients.[7,11,13,34] There is an urgent need for policy revisions related to relocation of AS women during pregnancy and early motherhood.

Besides stronger interdisciplinary collaboration and policy revisions that would improve continuity of care and communication with clients, this study demonstrated that midwives see potential in a range of interventions aimed at perinatal care for AS/RPP. Most of these, such as antenatal group care, training in intercultural care provision for midwives, peer-support, and doula-support programs, have been or are currently being developed and evaluated and show promising results.[3,12,17,22] More evaluation and implementation research is needed to draw conclusions on these and other potential improvements in care, which should explicitly involve the perspective of pregnant and postpartum AS and RPP women, diverse care-providers, and policy makers.

As a next step, our research teams are further exploring challenges in perinatal care for AS and RRP by interviewing care providers and women with lived experience and reviewing perinatal death audit cases. In addition, a national registry study on pregnancy outcomes and risk factors such as relocation is being conducted within the EGALITE project, while research from the University Medical Center of Groningen focuses on antenatal group care, as well as psychosocial screening tools for pregnant AS and RRP populations.

Strengths and limitations

Important strengths of this study include the large sample size and the combination of quantitative and qualitative aspects, since most studies that focus on challenges in perinatal care for AS and RRP are solely qualitative and have very small sample sizes. In addition, by defining two subpopulations of migrants, the design of this study responds to the need for recognizing the heterogeneity of migrants in perinatal health research. The survey was developed in collaboration with the target group but was not formally validated prior to its use in this study. The methods of sample recruitment and data collection could have led to some degree of inclusion bias as midwives who participated in the survey might have had an above-average motivation to provide optimal care for AS and RRP.

Conclusion

The main challenges that community care midwives face while providing care for AS and RRP include interdisciplinary collaboration, communication with clients, continuity of care, psychosocial care, and the vulnerable situation of these populations. These findings suggest that there is considerable opportunity for improvement in perinatal care for AS and RRP; results also provide direction for future research and interventions. Several concerns raised, especially the availability of professional interpreters and relocation of AS during pregnancy, require urgent reconsideration at legislative, policy, and practice levels.

Acknowledgments

The authors wish to thank N. de Gast (medical student) for her help in distributing the survey and F. Santegoets (database manager) for LimeSurvey technical support. Furthermore, J. Koomans, C. Wilhelm, M. Haverkate (midwives/nurses) and R. van der Kleij (implementation scientist) provided valuable feedback on survey drafts. For their contribution to the full language review of the paper we also wish to acknowledge F. Joziasse and E. Joziasse-Fitzpatrick.

Funding information

This study was partially supported by the Netherlands Organization for Health Research and Development (ZonMw), grant number 543003112.

Conflict of interest

The authors declare no conflict of interest. The sponsors had no role in the design, execution, interpretation, or writing of the study.

Data availability statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

References

1. Alderliesten M, Vrijkotte TGM, van der Wal M, Bonsel GJ. Late start of antenatal care among ethnic minorities in a large cohort of pregnant women. BJOG. 2007;114(10):1232-1239.
2. Asif S, Baugh A, Jones NW. The obstetric care of asylum seekers and refugee women in the UK. The Obstetrician & Gynaecologist. 2015;17(4):223-231.
3. Balaam M-C, Kingdon C, Haith-Cooper M. A systematic review of perinatal social support interventions for asylum-seeking and refugee women residing in Europe. J Immigr Minor Health. 2021;24:1-18.
4. Bennett S, Scammell J. Midwives caring for asylum-seeking women: research findings. Pract Midwife. 2014;17(1):9-12.
5. Bo Brancheorganisatie Geboortezorg; Asylum Seeker Healthcare ('GZA'); Central Agency for the Reception of Asylum Seekers ('COA'); Royal Dutch Organisation of Midwives (KNOV); RMA Healthcare. Dutch Guideline Perinatal Care for Asylum Seekers ('Ketenrichtlijn Geboortezorg Asielzoeksters'). 2020 [cited March 13, 2022]; Available from: https://www.kennisnetgeboortezorg.nl/nieuws/actualisatie-ketenrichtlijn- geboortezorg-asielzoekers/.
6. Boerleider AW, Francke AL, Manniën J, Wiegers TA, Devillé WLJM. "A mixture of positive and negative feelings": a qualitative study of primary care midwives' experiences with non-western clients living in The Netherlands. Int J Nurs Stud. 2013;50(12):1658-1666.
7. Chitongo S, Pezaro S, Fyle J, Suthers F, Allan H. Midwives' insights in relation to the common barriers in providing effective perinatal care to women from ethnic minority groups with 'high risk'pregnancies: a qualitative study. Women Birth. 2022;35(2):152-159.
8. Choté AA, de Groot CJM, Bruijnzeels MA, et al. Ethnic differences in antenatal care use in a large multi-ethnic urban population in The Netherlands. Midwifery. 2011;27(1):36-41.
9. de Graaf JP, Steegers EA, Bonsel GJ. Inequalities in perinatal and maternal health. Current Opinion in Obstetrics and Gynecology. 2013;25(2):98-108.
10. Esscher A, Binder-Finnema P, Bødker B, Högberg U, Mulic-Lutvica A, Essén B. Suboptimal care and maternal mortality among foreign-born women in Sweden: maternal death audit with application of the 'migration three delays' model. BMC Pregnancy Childbirth. 2014;14(1):1-11.
11. Fair F, Raben L, Watson H, et al. Migrant women's experiences of pregnancy, childbirth and maternity care in European countries: a systematic review. PloS One. 2020;15(2):e0228378.
12. Fair F, Soltani H, Raben L, et al. Midwives' experiences of cultural competency training and providing perinatal care for migrant women a mixed methods study: operational refugee and migrant maternal approach (ORAMMA) project. BMC Pregnancy Childbirth. 2021;21(1):1-13.
13. Feldman R. When maternity doesn't matter: dispersing pregnant women seeking asylum. Reprod Health Matters. 2013;21(42):212-217.
14. Fellmeth G, Fazel M, Plugge E. Migration and perinatal mental health in women from low-and middle-income countries: a systematic review and meta-analysis. BJOG. 2017;124(5):742-752.
15. Gieles NC, Tankink JB, van Midde M, et al. Maternal and perinatal outcomes of asylum seekers and undocumented migrants in Europe: a systematic review. Eur J Public Health. 2019;29(4):714-723.
16. Heslehurst N, Brown H, Pemu A, Coleman H, Rankin J. Perinatal health outcomes and care among asylum seekers and refugees: a systematic review of systematic reviews. BMC Med. 2018;16(1):1-25.
17. Johnsen H, Ghavami Kivi N, Morrison CH, Juhl M, Christensen U, Villadsen SF. Addressing ethnic disparity in antenatal care: a qualitative evaluation of midwives' experiences with the MAMAACT intervention. BMC Pregnancy Childbirth. 2020;20(1):1-10.

18. Kallianidis, A, Schutte, J, Schuringa, L et al., Confidential Enquiry into Maternal Deaths in The Netherlands, 2006–2018: a Retrospective Cohort Study. 2021.
19. Kasper A, Mohwinkel LM, Nowak AC, Kolip P. Maternal health care for refugee women-a qualitative review. Midwifery. 2022;104:103157.
20. Kurth E, Jaeger FN, Zemp E, Tschudin S, Bischoff A. Reproductive health care for asylum-seeking women-a challenge for health professionals. BMC Public Health. 2010;10(1):1-11.
21. Martijn L, Jacobs A, Amelink-Verburg M, Wentzel R, Buitendijk S, Wensing M. Adverse outcomes in maternity care for women with a low risk profile in The Netherlands: a case series analysis. BMC Pregnancy Childbirth. 2013;13(1):1-6.
22. Mendel WE, Sperlich M, Finucane A. The doulas of the Priscilla project: understanding the experience of refugee women navigating the US maternity-care system. Journal of Refugee Studies. 2021;34(2):2275-2290.
23. O'Mahony JM, Donnelly TT. Health care providers'perspective of the gender influences on immigrant women's mental health care experiences. Issues Ment Health Nurs. 2007;28(10):1171-1188.
24. Origlia Ikhilor P, Hasenberg G, Kurth E, Asefaw F, Pehlke-Milde J, Cignacco E. Communication barriers in maternity care of allophone migrants: experiences of women, healthcare professionals, and intercultural interpreters. J Adv Nurs. 2019;75(10):2200-2210.
25. Oscarsson MG, Stevenson-Ågren J. Midwives experiences of caring for immigrant women at antenatal care. Sex Reprod Healthc. 2020;24:100505.
26. Perined. Kerncijfers Nederlandse Geboortezorg 2020. 2021 [cited May 5, 2022]; Available from: https://www.perined.nl/ onderwerpen/publicaties-perined/kerncijfers-2020.
27. Playfair RL, Salami B, Hegadoren K. Detecting antepartum and postpartum depression and anxiety symptoms and disorders in immigrant women: a scoping review of the literature. Int J Ment Health Nurs. 2017;26(4):314-325.
28. Posthumus AG, Schölmerich VLN, Steegers EAP, Kawachi I, Denktaş S. The association of ethnic minority density with late entry into antenatal care in The Netherlands. Plos One. 2015;10(4):e0122720.
29. Saastad E, Vangen S, Frederik Frøen J. Suboptimal care in stillbirths–a retrospective audit study. Acta Obstet Gynecol Scand. 2007;86(4):444-450.
30. Schrot-Sanyan S, Kolanska K, Haimeur Y, et al. Language barrier as a risk factor for obstetric anal sphincter injury–a case-control study. Journal of Gynecology Obstetrics and Human Reproduction. 2021;50(8):102138.
31. Sentell T, Chang A, Ahn HJ, Miyamura J. Maternal language and adverse birth outcomes in a statewide analysis. Women Health. 2016;56(3):257-280.
32. Soldati E.V.A., Postma IR, Veling W, Stekelenburg J, Feijen-De Jong EI, Pregnant asylum seekers' perspective on mental health screening: a qualitative study. Manuscript submitted for publication, 2022.
33. Tankink JB, Verschuuren AEH, Postma IR, et al. Childbirths and the prevalence of potential risk factors for adverse perinatal outcomes among asylum seekers in The Netherlands: a five-year cross-sectional study. Int J Environ Res Public Health. 2021;18(24):12933.
34. Tobin CL, Murphy-Lawless J. Irish midwives' experiences of providing maternity care to non-Irish women seeking asylum. Int J Womens Health. 2014;6:159.
35. van den Akker T, van Roosmalen J. Maternal mortality and severe morbidity in a migration perspective. Best Pract Res Clin Obstet Gynaecol. 2016;32:26-38.
36. Verschuuren AEH, Postma IR, Riksen ZM et al. Pregnancy outcomes in asylum seekers in the north of The Netherlands: a retrospective documentary analysis. BMC Pregnancy Childbirth. 2020;20(1):1-10.

Chapter seven

Let this be a safe place: a qualitative study into midwifery care for forcibly displaced women in the Netherlands

---

J.B. Tankink, A.E.H. Verschuuren, J.P. de Graaf, E.I. Feijen-de Jong, P.J.A. van der Lans, M.E.T.C. van den Muijsenbergh, A. Franx, B. Goodarzi

Accepted for publication in *BMC Health Services Research* (2024).

Abstract

Background

Forcibly displaced women in the Netherlands face increased chances of perinatal mortality and other adverse pregnancy and childbirth outcomes compared to the resident country population, which has been linked to suboptimal care. This study was conducted to gain insights from the experiences of Dutch midwives to inform and enhance the provision of tailored and equitable care for forcibly displaced women.

Methods

We conducted a qualitative study using semistructured interviews with community midwives who provide care for forcibly displaced women (asylum seekers and recognized refugees) in the Netherlands. Through thematic analysis, we identified the barriers midwives encounter in providing care and explored their strategies for navigating these barriers, aiming to inform recommendations that advance equitable care provision.

Results

Interviews with eleven midwives revealed barriers across three thematic levels: 1) the interactional level, where barriers related to language and interpreters, cultural differences, and building trust impeded positive interactions between midwives and forcibly displaced women; 2) the organizational level, where barriers concerning relocations of asylum seekers, delays in accessing care, and interdisciplinary collaboration impeded optimal care; and 3) the contextual level, where barriers related to women's housing conditions, the resettlement process and the mental health of forcibly displaced women impeded midwives' to respond to clients' needs. These levels of barriers culminated in a core theme of imbalance between midwives' expanded responsibilities and the limited resources and strategies available to them in care for forcibly displaced women. This imbalance forced midwives into multiple roles, increased both the practical and emotional burden on them, and undermined their ability to provide optimal, equitable care.

Conclusions

To enhance the provision of equitable pregnancy and childbirth care for forcibly displaced women in the Netherlands, it is crucial to target the imbalance between the responsibilities that midwives bear and the resources available to them. This requires dismantling barriers at the interactional, organizational and contextual level of care through targeted policy interventions. Structural determinants that perpetuate the imbalance in midwives' work and restrict their scope of influence, such as restrictive migration policies that contribute to socioeconomic

marginalization and poor housing conditions, need to be addressed. Ultimately, midwives themselves require more support and education to recognize and combat injustices in pregnancy and childbirth care for forcibly displaced women.

Introduction

An increasing number of people of reproductive age are forcibly displaced from their home country due to threats to their lives or livelihood, seeking safer residence elsewhere. In many of their destination countries, however, forcibly displaced people face reduced chances of a positive outcome of pregnancy and childbirth compared to local populations.[2-4] In the Netherlands, recent studies showed a two- to sevenfold increased risk of perinatal mortality in women* with a forced migration background compared to resident women.[5,6] These findings add to a body of evidence demonstrating maternal and perinatal health inequities in the context of forced migration.[7,8]

Suboptimal healthcare significantly contributes to increased rates of adverse outcomes of pregnancy and childbirth in forcibly displaced populations. Several studies demonstrated specific suboptimal care factors, such as unresolved language barriers, inadequate responses to complaints, and culturally insensitive care.[9,10] A recent Dutch study confirmed that suboptimal care factors delay care seeking and access and receipt of quality care among forcibly displaced women, which ultimately may result in adverse outcomes.[10,11] To prevent this, a national guideline outlines responsibilities and recommendations for pregnancy and childbirth care for asylum seekers in the Netherlands, although its scope and practical implementation remain limited.[12,13]

In the Netherlands, community care midwives provide comprehensive care throughout pregnancy and childbirth and often represent primary healthcare contacts for pregnant women who have recently undergone forced migration. A previous exploratory study revealed that Dutch midwives encounter a multitude of challenges, including issues related to communication with clients, continuity of care, and psychosocial care.[13] These findings indicate the need for a more detailed understanding of these challenges to unravel the mechanisms underlying suboptimal care and ultimately strengthen midwives' position in combating health inequities.

The overarching aim of this study is to generate insights from midwives' experiences that will inform and enhance the provision of tailored and equitable care for forcibly displaced women. Guided by two key research questions—what specific barriers do midwives face when caring for these women, and how

do they manage these barriers to meet women's needs?—this study aims to deepen our understanding of current care practices. The findings will facilitate critical reflection on these practices and guide the formulation of targeted recommendations to support midwives in their roles, and ultimately improve pregnancy and childbirth outcomes for forcibly displaced women.

* While we use the term "woman" in this article, it is intended inclusively to encompass all gender identities who give birth.

Methods

Design and study populations

This qualitative study was part of a larger research project on pregnancy and childbirth care for forcibly displaced populations in the Netherlands (the EGALITE project). We collected data through semistructured interviews with Dutch community care midwives who provide care to forcibly displaced women. Throughout the study, we use the term "forcibly displaced women" or the specific terms "asylum seekers" and "recognized refugees/refugees with a residence permit" to distinguish between women living in reception centers and women with a residence permit in regular housing. While acknowledging the limitations of these labels in capturing the diversity of experiences and identities within forced migration, these choices reflect the terminology most commonly used in clinical practice while distinguishing between different legal statuses in the Dutch setting.

Setting

In the Netherlands, asylum seekers are accommodated in government-run reception centers managed by the Dutch Central Agency for the Reception of Asylum Seekers (abbreviated to the 'COA' in Dutch). These centers provide temporary housing and access to basic services such as food and healthcare while asylum requests are processed. The COA contracts different organizations to provide primary healthcare services in reception centers. During the period of this study, the main contracted provider was HealthCare Asylum Seekers (abbreviated to GZA in Dutch). Upon receiving a residence permit, recognized refugees are eligible for social housing and Dutch health insurance, thereby gaining access to the regular healthcare system.

Pregnant women living in asylum reception centers are referred by COA or GZA to a nearby community midwifery practice or hospital. In the Dutch pregnancy and childbirth care system, community midwives provide comprehensive care and consult medical specialists or refer women to hospitals when necessary.

After birth, postpartum care assistants offer support in hospitals, women's homes, or asylum reception centers, although they receive no specific training for this setting. During this study, governmental insurance covered the costs of professional telephone interpreter services for pregnancy and childbirth care for asylum seekers, but not for recognized refugees.

Participant recruitment

We used purposive sampling to recruit midwives from nine midwifery practices that participated in the EGALITE project. These were regular community midwifery practices across different regions of the Netherlands, where a portion of the client population consisted of asylum seekers and recognized refugees. The midwives in this study were not exclusively specialized, but provided care to both the general population and forcibly displaced women. Besides geographical distribution, we approached midwives who varied in ages, years of experience, and cultural backgrounds to achieve a diverse sample. Midwives were invited to participate in the study via e-mail.

Data collection

The first author (JT) conducted all the interviews in the presence of a student (SE). We used a semistructured topic guide for the interviews, which was developed through a literature review and field visits to three midwifery practices prior to the study. The field visits consisted of observations of antenatal consultations with forcibly displaced women and informal conversations with midwives. The first version of the topic guide included midwives' general experiences with care and more specific questions regarding the barriers they encountered, their strategies to navigate these barriers, and the needs they indicated to improve tailored care to forcibly displaced women. As the interviews progressed from March to April 2021, emerging experiences and challenges were dynamically integrated into the topic guide. The most up-to-date version of the topic guide is included as supplementary material (Appendix 1).

The interviews ranged from 48 to 64 minutes, with one session including two midwives from the same practice by their request. One interview was conducted at the midwife's workplace. Due to COVID-19, eight interviews were conducted via Microsoft Teams, and one interview took place outdoors. After completing interviews with eleven midwives, data saturation was reached.

Data processing and analysis

The audio-recorded interviews were transcribed verbatim and were accessible only to the first two authors on a secured server of the Erasmus University Medical Center. We conducted a member check by inviting all midwives to review

their transcripts for feedback or additional comments; five midwives agreed to receive their interview transcripts and confirmed the accuracy of the content.

We combined deductive and inductive approaches in thematic analysis, facilitated by ATLAS.ti software (version number 22.2.3).[14,15] Initially, two researchers (JT and AV) independently coded the first interview transcript. Codes were categorized into the domains of challenges identified in a previous survey study conducted among Dutch community midwives.[13] These domains included interdisciplinary collaboration, communication with clients, continuity of care, psychosocial support and addressing the needs of women in a vulnerable situation. As midwives shared barriers beyond the scope of these domains during the interviews, we proceeded with inductive coding and categorizing to identify new emerging themes. This iterative process of developing and adjusting themes was guided by reflective discussions within the research team to critically assess our analysis and interpretation.[16]

No specific theoretical framework guided the analysis of this study. However, we applied an equity perspective as a lens for reflecting on and interpreting our results in the discussion section. Specifically, the concept of reproductive justice – which refers to the right to make autonomous decisions about parenthood in safe and supportive environments—was used to contextualize the barriers midwives encountered within the broader sociopolitical landscape of care.

Positionality

The research team comprised PhD-level and senior researchers, midwives, a gynecologist and a general physician. All team members possess diverse academic, clinical and personal experiences in healthcare for forcibly displaced women. The first author and primary interviewer (JT) is a medical doctor and PhD candidate. Several shared social identity traits, such as gender, age and cultural background, likely facilitated rapport with the majority of midwives during the interviews. To mitigate biases linked to her "insider" status within the Dutch healthcare system, JT deliberately avoided making assumptions and actively invited participants to discuss practices and experiences they might consider self-evident. Nevertheless, the study's focus on improving care for forcibly displaced women could have influenced midwives to provide socially desirable responses. While the topic guide was informed by the literature and field visits, we acknowledge that our team's limited personal experience with forced migration might have narrowed our perspective and the breadth of data interpretation.

Results

We approached nine midwifery practices, resulting in eleven individual midwives who agreed to participate in the study. Nine midwives were born in the Netherlands, while two midwives had a different country of birth, although none identified as refugees. The midwives' ages ranged from 25 to 51 (M 34.7), with 2.5 to 17 years of experience with forcibly displaced populations (M 7.0).

Thematic analysis revealed that the barriers that midwives encountered in care manifested at three thematic levels: 1) the interactions between midwives and clients, 2) the organization of care, and 3) the context and living circumstances of forcibly displaced women. As a result of midwives' experiences with these barriers, we identified an imbalance between increased responsibilities and limited resources in care for forcibly displaced women. The code tree is presented in Appendix 2.

Barriers at the level of midwife-client interactions

The first level of barriers affected the individual interactions between midwives and their forcibly displaced clients. These barriers were mostly related to language and interpreters in care, cultural differences, and building trust.

Language and interpreters

Almost all midwives described how language barriers affect the autonomy, access to information, and freedom of expression of refugee clients throughout pregnancy care, particularly during childbirth:

> *"I notice how language plays an enormous role, because often people actually have an opinion, but well yeah—if you cannot express it, I'd also rather keep quiet. Otherwise, I might end up in a difficult situation where you keep asking questions that I can't answer."* **(Midwife 5)**

All midwives identified the absence of government-funded professional (telephone) interpreters for refugees with residence permits as a major barrier. In practice, midwives frequently relied on hand gestures or on the clients' friends or relatives, including minors, to bridge language gaps, while interpreters were considered to be *"a luxury"*:

> *"And I'm thinking about what you [the interviewer] just said, 'don't you find it difficult with an interpreter?' But for us – I often talk to someone else, a sister or a friend or a child, so a [professional] interpreter can truly be a luxury, that what I am saying gets translated at least. Because with someone else – I say ten*

sentences and then they translate one thing, and then the lady says 'yes'. Well, that was it (laughs). So I truly think the [professional] interpreter is a luxury!"
(Midwife 6)

Apart from financial barriers, midwives indicated that telephone interpreter services posed additional barriers because the required language was not always available, the quality of the interpreters varied, and the services were perceived as time-consuming. Even when interpreters were engaged in consultations, most midwives still reported barriers, such as miscommunication and difficulty conveying emotions.

To overcome communication barriers, several midwives felt that working with women-identifying interpreters often helped to make women with a background of forced migration feel more comfortable. They also mentioned the value of multilingual educational materials and the importance of reserving extra time for appointments.

Cultural differences
The majority of midwives described accommodating the diverse cultural backgrounds of their clients as a challenge in care provision. In particular, midwives noted that clients' expectations and preferences regarding aspects such as the frequency of antenatal consultations or birthing methods often deviated from the norm in Dutch healthcare practices. In addition, a number of midwives observed that forcibly displaced women expressed their questions less openly than other clients. In addition to language barriers, midwives attributed this pattern to cultural differences, such as norms of respect for medical professionals. Furthermore, midwives often perceived forcibly displaced women as less demanding and more content with care. Several midwives mentioned being motivated by their clients' gratitude.

Although only a few midwives mentioned having limited competence in handling cultural differences, most interviews contained examples of cultural stereotyping:

"Usually, people from Syria are very motivated; they try to learn Dutch by themselves; they are well informed about everything, always on time. Well, from Eritrea, not everyone is like that, of course. There are also people who arrive on time and show up consistently, so not everyone – but there is a difference..."
(Midwife 8)

To manage cultural differences in care, midwives described having respectful dialogues regarding cultural values and habits as a way to connect with women. Several midwives emphasized that care for forcibly displaced women did not

fundamentally differ from care for other women, who shared similar worries, wishes, and physiological aspects of pregnancy, *"which is conceived and progresses in the same way"* (**Midwife 7**).

Building trust

Midwives noted several barriers related to building a relationship of trust with forcibly displaced women. Besides language barriers and cultural differences, limited continuity of care was identified as a key barrier to trust. Continuity of care was most commonly hindered by relocations of asylum seekers or by transfer of pregnancy care from midwives to hospitals. Additionally, clients' shame and fear, particularly regarding the immigration authorities, were mentioned as barriers.

To navigate these barriers, several midwives emphasized the value of becoming a familiar presence in locations near asylum reception centers. One midwife shared that having the same religious background as her clients was an asset with regard to building trust. Like other participating midwives, she highlighted the importance of patience and sensitivity to potential trauma when interacting with women:

> *"And if someone truly does not want to share anything, then it is just done, then I always say, 'I know you have been through something rough, I know it's a process that can be painful but also beautiful. Know that I'm here for you, the moment you do want to talk about it. I'm here for you.' And then – often that is just enough to open up a story."* **(Midwife 5)**

Barriers in the organization of care

The second level of barriers concerned the organization of care for forcibly displaced women. These barriers were mostly related to the relocation of asylum seekers, delays in access to care, and interdisciplinary collaboration.

Relocations of asylum seekers

Midwives unanimously identified relocations between reception centers as a challenge that compromises the overall quality of care for asylum seekers. Almost all midwives experienced fragmented care due to the absence or delay of the transfer of medical information to subsequent care providers following relocations, which were often not communicated timely by the COA. In addition, relocations were considered physically burdensome and distressing for clients. They also diminished some midwives' own sense of control:

And as a result [of relocations], you simply lose control from time to time. And that is where I struggle most, thinking 'oh, so now you are gone and going somewhere else, is it going to be handled in the right way?' (**Midwife 1**)

Midwives appreciated the national guideline for asylum seekers, particularly the recommendation against relocating women between the 34th week of pregnancy and the 6th week postpartum. However, multiple midwives had experienced relocations occurring outside this period without their consultation. To mitigate information loss during relocations, midwives tried to provide detailed handovers to the next care providers and, in some cases, provided printed pregnancy records to the women to carry with them.

Delays in access to care

Most midwives reported frequent delays in antenatal care initiation among forcibly displaced women, complicating risk assessment during pregnancy, especially when women arrived without any registered medical history. Missed antenatal appointments were also common, which midwives attributed to several barriers delaying care seeking and access. Besides relocations of asylum seekers, these included clients' lack of transportation options and insufficient knowledge of the health system. Several midwives resorted to using their personal cars to transport clients from asylum reception centers to the hospital, due to unreliability of the taxi services that women are entitled to around childbirth. In addition, critical care was sometimes postponed due to delayed care seeking for alarm symptoms, regularly caused by unresolved language barriers, as one midwife described:

> *"I once experienced a situation where a woman had a lot of blood loss, but she only spoke – well, I don't know which language, but let's say Tigrinya, and there was no one around her at that moment who could speak English. So it took about two hours until someone was able to call me on her behalf. By the time I arrived, it was already too late because there was indeed something wrong with the baby, causing her excessive bleeding. But because she simply didn't know how to reach us due to a language barrier, she just didn't call. And things went wrong."* **(Midwife 11)**

Midwives tried to improve timely access to care by organizing consultation hours at or near asylum reception centers, providing antenatal care in a group format, and actively contacting women after missed appointments, at times in collaboration with COA and GZA.

Interdisciplinary collaboration

Barriers to interdisciplinary collaboration in pregnancy care for asylum seekers commonly included difficult communication with COA and GZA, as well as

limited dissemination and implementation of the national guidelines in all involved organizations. In addition, several midwives voiced concerns regarding the inconsistent quality of care when they referred clients to care providers who had less experience with forcibly displaced women. Specifically, multiple midwives observed a lack of time and compassion for these clients during consultations in the hospital:

> *"Actually, it sounds very rough, but a part of the humane – is lacking there [in the hospital], and that truly breaks my heart, when someone just says afterwards: 'but that was no discussed with me at all, I didn't want that, and I had put it in a plan with you.' It just breaks me when I see that, and the communication as well – not much effort is made to guide them [the clients] in a proper and correct way. And that puts them – that is a very vulnerable position as a birthing woman."* **(Midwife 5)**

In regions where the national guideline for care for asylum seekers was more widely implemented, midwives highlighted its benefits for interdisiciplinary collaboration, citing specific aspects such as regular meetings with all parties involved in care. Implementation of was mostly achieved through the development of local protocols, based on the national guideline:

> *"We initially ran into the issue that everything was just poorly organized. And then I thought: 'I can either sit and complain, or I can just say: hey, hello, I'm (first name), shall we create a protocol together with the AZC [asylum reception center]. (…) And at that time, a new [national] guideline had just come out on care for asylum seekers, and we turned that into a protocol. We then presented it to the collaborative network with the hospitals, and they approved it, and now it's in place at the AZC, yes, with the COA."* **(Midwife 6)**

In addition, several midwives indicated the necessity of having designated contact persons and dedicated staff at COA, GZA, the hospital, and postpartum care organizations to facilitate efficient interdisciplinary collaboration.

Barriers in the context of forcibly displaced women

The third level of barriers included the broader context that affected the lived realities of forcibly displaced women under midwives' care. Specifically, these barriers were related to the housing conditions, the resettlement process, and the prevalent mental health issues of this population.

Housing conditions

Most midwives were concerned about the housing conditions in reception centers for asylum seekers, which they deemed unsuitable for pregnant women in terms

of hygiene, food options, space, and privacy. The majority of midwives described feelings of compassion and powerlessness in relation to women's living conditions, frequent relocations, and the stress of asylum procedures:

> *"If you see someone saying that she feels depressed because of the burden from COA, that she may be deported, that she will be relocated to another center and that she feels unsafe, that she cannot return to her country of origin because she would be threatened with death. When you witness that happening right in front of you, you think, 'Oh my God, that woman truly cannot go back because she will simply be killed. (…) Yeah, it truly moves you'"* **(Midwife 3)**

Several midwives expressed their efforts to advocate for clients' needs, such as requesting improved living conditions from COA or writing letters to clients' lawyers. Others considered such efforts to fall beyond their professional responsibilities. For women with a residence permit, midwives often requested hospital birthing beds via 'social indication' to prevent suboptimal homebirths.

Resettlement after forced migration

Many midwives encountered barriers in supporting clients in the process of resettlement after forced migration. These included the lack of social support networks, unfamiliarity with the healthcare system and other institutions, and clients' vulnerable socioeconomic position. Midwives also highlighted the lack of adequate guidance for women who recently transitioned out of the asylum system with a residence permit:

> *"As soon as they [forcibly displaced women] leave the asylum center, they are suddenly assumed to be normal people. They are still the same individuals who don't understand certain things, and there are still things that need to be arranged."* **(Midwife 6)**

To tailor care to women in the process of resettlement, midwives organized practical, material, and social support for their clients. This included collecting donations from former clients or coordinating informal peer support within their practice. Two midwives also implemented formal antenatal group care for forcibly displaced clients.

Mental health

The majority of midwives highlighted the gap between the mental health needs of forcibly displaced clients and the services available. In the Netherlands, the waiting periods for psychological treatments are generally lengthy, and while hospitals provide specialized perinatal mental healthcare, midwives reported barriers in access for forcibly displaced women due to language barriers or

the physical distance of the hospital. Midwives described that women would regularly share "*horrifying*" experiences (**midwife 1**0), while most midwives felt unprepared to offer appropriate psychological support:

> *"Of course, that is not our profession. And it's also too intense, you know, sometimes the tears are almost in your eyes when you hear what they have been through."* **(Midwife 2)**

Nevertheless, many midwives outlined their strategies and dedication to positively influencing women's mental well-being and pregnancy experience, mostly by fostering a safe and supportive environment:

> *"Because I feel they are vulnerable and have been through so much, leaving so much behind, that I think: I truly want this to be place of comfort for you, where you feel safe. (…) Because then, I think they can give birth in a good way as well, and the child can have a good start."* **(Midwife 2)**

Core theme: imbalance between midwives' responsibilities and resources

The numerous barriers across different levels of care for forcibly displaced women ultimately culminated in a core theme of imbalance between midwives' responsibilities and resources. Almost all midwives described taking on additional responsibilities and workloads to navigate barriers, often extending beyond their typical role in "*regular care*" (**midwife 7**):

> *"[When caring for forcibly displaced women] you feel like a social worker, you feel like a planner, you feel like someone's buddy, you feel like a psychologist – you just have a lot more roles than only your profession."* **(Midwife 3)**

Juggling roles, midwives stretched their boundaries to meet their clients' needs in different ways, as one mentioned, "*not always strictly following the rules*" (**midwife 1**). The impression of forcibly displaced clients as "*drowning in an enormous system*" (**midwife 1**), "*disoriented*," (**midwife 3**) or "*not capable enough [to be responsible for organizing their own care]*" (**midwife 2**) strengthened midwives' sense of duty to adopt an increased level of responsibility.

However, midwives simultaneously reported a shortage of the resources required to apply supportive strategies for meeting their clients' needs. These resources included extra time, financial compensation and supportive services, as well as more intangible aspects such as power and influence, related to their ability to advocate for their clients and navigate the healthcare system on their behalf.

The resulting imbalance was frequently experienced as an increased emotional burden:

> *"You only experience that sense of peace and satisfaction when someone has given birth, and you see them safe, with a child, after a good birth. (…) Only then can you really let go of the pressure of providing support. As long as someone is still pregnant, and you have to manage a lot of things, and you get stressed when someone calls with complaints that are related to stress but you can't do anything about it – it really does provide extra satisfaction when it's all over. But as long as you're busy, it can be quite a burden."* **(Midwife 4)**

Discussion

This qualitative study sheds light on the experiences of midwives caring for forcibly displaced women in the Netherlands. From these experiences, we identified barriers to equitable care at the levels of midwife-client interactions, the organization of care, and the wider context of forcibly displaced women. As a result, midwives were burdened with additional responsibilities and roles, while they had limited resources and capacity to fully respond to women's needs. Our results provide insights into the underlying dynamics and potential solutions to address this imbalance, and ultimately enhance midwives' influence on the wellbeing of forcibly displaced women in pregnancy and childbirth care.

The barriers identified in this study echo previous research in different settings of care for migrant populations.[17-20] In particular, our findings add to the evidence of the detrimental impact of issues such as unresolved language barriers and frequent relocations of asylum seekers on care quality.[21-23] As observed in other studies, midwives developed different strategies and frequently adopted more responsibilities in reaction to these multi-level barriers.[18]

However, our results also confirmed that these strategies did not always result in optimal, equitable care. For instance, barriers regarding interpreter services left midwives relying on communication strategies that compromised legal and clinical standards. Through such practices, care may inadvertently further marginalize forcibly displaced women by silencing their voices and endangering maternal safety.[24,25] In our study, midwives also inadvertently engaged in cultural stereotyping, in line with previous studies in other countries.[17,26,27] Among stereotypical notions, midwives' perception of forcibly displaced women as easily grateful clients may mask social desirability or lowered expectations of care among this population.[28] This illustrates how implicit bias or cultural "othering" may lead midwives to misinterpret or generalize the diverse needs of forcibly

displaced women.[29] Consequently, this can discourage women from seeking care and lead to incomplete provision of information.[26,29]

Most barriers that midwives encountered in our study are deeply rooted in the broader social, political, and economic structures that shape the circumstances of forcibly displaced pregnant women. These structures include current migration policies, while entangled with historical legacies of colonization, xenophobia and gendered racism, which continue to drive forced displacement today. Thereby, our study elucidated a critical dynamic in care: while midwives were often overwhelmed by immediate client needs, they often fight an uphill battle against systemic barriers that impede equitable care. For instance, midwives' efforts to create a safe and trusting environment were undermined by the stress and uncertainty caused by lengthy asylum procedures. In other cases, midwives resorted to using their own car to transport women to the hospital, while persistent issues with the taxi services contracted at the asylum reception centers remained unresolved.

Pushed toward temporary solutions and assuming additional roles, midwives may face an increased risk of demoralization and burnout.[30] To address the imbalance in current midwifery care for forcibly displaced women, midwives therefore need to be supported by additional resources, such as funding for doulas or antenatal group care. However, midwives must also gain the knowledge, tools and critical consciousness to recognize and address the structural inequities that affect the women they care for, but also place a heavy burden on midwives themselves. Recently, the field of "Critical Midwifery Studies" was launched to promote concepts such as reproductive justice in midwifery education and practice, empowering midwives to offer equitable care and advocate for structural changes.[31]

The specific levels of barriers we identified provide several directions for supporting midwives in providing more equitable care. On the interactional level, the reimplementation of state-funded professional interpreter services in the Netherlands, which was realized after this study following their initial abolition, represents a crucial step forwards. However, our results emphasize that enhancing the quality and availability of these services, along with training midwives' to work with interpreters and offer culturally sensitive care, remains necessary.[32] In addition, the introduction of cultural mediators or peer support programs could help to bridge communication barriers beyond language. Unfortunately, recent Dutch research highlighted significant admission biases in midwifery education, disadvantaging applicants with migration backgrounds.[33] Efforts to promote a more representative professional workforce and facilitate cultural concordance in care are thus essential.[34]

On the organizational level of care, policy reforms should urgently minimize relocations of pregnant women within asylum reception centers, given how issues such as unstable housing and transportation affect women's wellbeing and the quality of midwifery care. Wider implementation of the existing guideline for women in asylum reception centers can help boost collaboration and quality across all care disciplines involved. In addition, further professional standards for care for women transitioning out of the asylum system is imperative as standardized practices are now largely absent for this group. To improve care organization, additional barriers that may explain suboptimal care, such as frequently changing contracts for primary care in asylum reception centers and the geographical isolation of these centers, should also be explored and addressed.

On the contextual level, our study implies that improving the living conditions of women in asylum reception centers is a prerequisite for meeting basic health and safety needs.[35,36] In addition, the socioeconomic vulnerability that often accompanies forced migration could be structurally improved through quicker access to formal language education, labor participation, regular housing and naturalization.[37,38] Previous research showed how positive integration policies can improve the birth outcomes of different migrant populations, as well as their mental health.[39] Regarding the substantial unmet mental health needs among forcibly displaced women that midwives in this study encountered, access to mental health screening and services are priorities.[40,41] Although midwives cannot replace specialized mental healthcare providers, our findings indicate that principles of trauma-informed care can be implemented, concentrating on women's emotional safety. Specific training in such approaches could help reduce the risk of retraumatization and make the midwifery practice a safer space forcibly displaced women.[42]

Strengths and limitations

To the best of our knowledge, this was the first qualitative study that centered the experiences of Dutch community midwives with two specific populations of forcibly displaced women. We included a diverse sample of midwives from various Dutch regions and with different degrees of working experience with women in asylum reception centers and those with a refugee residence permit. However, our findings may still reflect a limited range of perspectives, assuming that midwifery practices that agreed to participate in the EGALITE project are specifically motivated to improve care for forcibly displaced populations. Furthermore, future research should aim to include a wider array of voices, particularly those of forcibly displaced women themselves, to enrich the understanding of priorities for care improvement.[34,43]

Conclusions

This qualitative study shed light on the barriers in midwifery care for forcibly displaced women in the Netherlands, revealing a critical imbalance between responsibilities shouldered by midwives and the resources available to tailor care to women's needs. To address this imbalance, it is crucial to dismantle barriers ranging from the individual encounters in the consultation room to the circumstances of forcibly displaced women during their pregnancy and childbirth. Specific policy priorities should include enhancing the quality and availability of state-funded interpreter services, improving women's living conditions during resettlement, and facilitating access to support such as specialized mental health services. It is also imperative to confront and mitigate the structural determinants that contribute to the imbalance in midwives' work, such as migration and socioeconomic policies that marginalize forcibly displaced women and restrict the scope of midwives' influence on their well-being. Incorporating self-reflective practices and concepts of reproductive justice into midwifery education and practice will be essential to equip midwives to engage more critically with the systemic barriers they face, and advocate for structural change. Ultimately, only through a comprehensive understanding of and engagement with the root causes can we hope to break the cycle of inequity and ensure that midwifery care is equally safe for everyone.

Declarations

Abbreviations

AZC: Asylum reception center.
COA: Dutch Central Agency for the Reception of Asylum Seekers.
GZA: GZA Healthcare (provider currently contracted by COA for primary healthcare at most asylum reception centers).

Ethics approval and consent to participate

Ethical review for this study was requested from the Medical Ethical Committee of the Erasmus University Medical Center Rotterdam (MEC-2021-0155). Formal approval was waived because the Medical Research Involving Human Subjects Act ("WMO" in Dutch) did not apply.

Informed consent was obtained from all participants prior to the interviews using an audio-recorded script. To protect privacy, interview transcripts were pseudonymized by replacing participants' names with numbers and omitting potentially identifying information such as hospital names. All consent recordings

and personal data were securely stored on the Erasmus MC servers and separated from the interview transcripts.

Consent for publication
Not applicable.

Availability of data and materials
The data supporting this study are available upon request, subject to certain conditions. Requests for access can be considered for researchers with similar objectives to those of this study.

Competing Interests
None declared.

Funding
This study was part of the EGALITE research project, funded by The Netherlands Organization for Health Research and Development (ZonMw, grant number 54300311). The funder had no role in the study design, data collection, data analysis, data interpretation, or writing of the report.

Authors' contributions
JT, HdG, PvdL, and AF conceptualized the study design. JT carried out the fieldwork and collected the data. JT and AV performed the data analysis, with supervision of BG and consulting support from EF and MvdM. All authors participated in multiple discussions and reflections during the data analysis. JT drafted the initial manuscript, with significant contributions from AV and BG. All authors reviewed several drafts of the manuscript and approved the final version.

Acknowledgements
We would like to thank student S. van Ede and her supervisor B. de Kok from the University of Amsterdam (Department of Anthropology) for their contributions to the study design, data collection, and interview transcriptions. Additionally, we are thankful for the assistance provided by medical student L. Peene in transcribing interviews.

References

1. UNHCR. Global Trends: Forced Displacement in 2022. Copenhagen, Denmark: UNHCR GlobalData Service, Statistics and Demographics Section; 2023.
2. Heslehurst N, Brown H, Pemu A, Coleman H, Rankin J. Perinatal health outcomes and care among asylum seekers and refugees: a systematic review of systematic reviews. BMC medicine. 2018;16(1):1-25.
3. Gieles NC, Tankink JB, van Midde M, Düker J, van der Lans P, Wessels CM, et al. Maternal and perinatal outcomes of asylum seekers and undocumented migrants in Europe: a systematic review. European journal of public health. 2019;29(4):714-23.
4. Fair F, Raben L, Watson H, Vivilaki V, van den Muijsenbergh M, Soltani H, et al. Migrant women's experiences of pregnancy, childbirth and maternity care in European countries: A systematic review. PloS one. 2020;15(2):e0228378.
5. Tankink JB, Bertens LCM, De Graaf JP, Van den Muijsenbergh METC, Struijs JN, Goodarzi B, Franx A. Pregnancy outcomes of forced migrants in the Netherlands: a national registry-based study. J Migr Health. 2024;10:100261.
6. Verschuuren A, Postma I, Riksen Z, Nott R, Feijen-de Jong E, Stekelenburg J. Pregnancy outcomes in asylum seekers in the North of the Netherlands: a retrospective documentary analysis. BMC pregnancy and childbirth. 2020;20(1):1-10.
7. Malebranche M, Norrie E, Hao S, Brown G, Talavlikar R, Hull A, et al. Antenatal care utilization and obstetric and newborn outcomes among pregnant refugees attending a specialized refugee clinic. Journal of immigrant and minority health. 2020;22:467-75.
8. Sturrock S, Williams E, Greenough A. Antenatal and perinatal outcomes of refugees in high income countries. Journal of Perinatal Medicine. 2021;49(1):80-93.
9. Saastad E, Vangen S, Frederik Frøen J. Suboptimal care in stillbirths–a retrospective audit study. Acta obstetricia et Gynecologica Scandinavica. 2007;86(4):444-50.
10. Esscher A, Binder-Finnema P, Bødker B, Högberg U, Mulic-Lutvica A, Essén B. Suboptimal care and maternal mortality among foreign-born women in Sweden: maternal death audit with application of the 'migration three delays' model. BMC pregnancy and childbirth. 2014;14(1):1-11.
11. Verschuuren AEH, Tankink JB, Postma IR, Bergman KA, Goodarzi B, Feijen-de Jong EI, et al. Suboptimal factors in maternal and newborn care for refugees: Lessons learned from perinatal audits in the Netherlands. PLOS ONE. 2024;19(6):e0305764.
12. Bo Brancheorganisatie Geboortezorg ASHG, Central Agency for the Reception of Asylum Seekers ('COA'), Royal Dutch Organisation of Midwives ('KNOV'); RMA Healthcare, Dutch Society of Obstetrics and Gynaecology ('NVOG'); Netherlands Association for Community Health Services ('GGD GHOR Nederland'), . Dutch Guideline Perinatal Care for Asylum Seekers ('Ketenrichtlijn Geboortezorg Asielzoeksters'). 2020.
13. Verschuuren AE, Tankink JB, Franx A, van der Lans PJ, Erwich JJ, Jong EF, de Graaf JP. Community midwives' perspectives on perinatal care for asylum seekers and refugees in the Netherlands: A survey study. Birth. 2023 Dec;50(4):815-26.
14. Fereday J, Muir-Cochrane E. Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. International journal of qualitative methods. 2006;5(1):80-92.
15. Roberts K, Dowell A, Nie J-B. Attempting rigour and replicability in thematic analysis of qualitative research data; a case study of codebook development. BMC medical research methodology. 2019;19(1):1-8.

16. Olmos-Vega FM, Stalmeijer RE, Varpio L, Kahlke R. A practical guide to reflexivity in qualitative research: AMEE Guide No. 149. Medical teacher. 2023;45(3):241-51.
17. Fair F, Soltani H, Raben L, van Streun Y, Sioti E, Papadakaki M, et al. Midwives' experiences of cultural competency training and providing perinatal care for migrant women a mixed methods study: Operational Refugee and Migrant Maternal Approach (ORAMMA) project. BMC pregnancy and childbirth. 2021;21(1):1-13.
18. Chitongo S, Pezaro S, Fyle J, Suthers F, Allan H. Midwives' insights in relation to the common barriers in providing effective perinatal care to women from ethnic minority groups with 'high risk'pregnancies: A qualitative study. Women and Birth. 2022;35(2):152-9.
19. Yelland J, Riggs E, Szwarc J, Casey S, Duell-Piening P, Chesters D, et al. Compromised communication: a qualitative study exploring Afghan families and health professionals' experience of interpreting support in Australian maternity care. BMJ Qual Saf. 2016;25(4):e1.
20. Hamwi S, Lorthe E, Severo M, Barros H. Migrant and native women's perceptions of prenatal care communication quality: the role of host-country language proficiency. BMC Public Health. 2023;23(1):295.
21. Saunders SL, Sutcliffe KL, McOrist NS, Levett KM. The associations between women who are immigrants, refugees, or asylum seekers, access to universal healthcare, and the timely uptake of antenatal care: A systematic review. Australian and New Zealand Journal of Obstetrics and Gynaecology. 2023;63(2):134-45.
22. Feldman R, Musgrave A. "Dispersal" of asylum seeking women in UK during pregnancy. BMJ. 2015;351:h3896.
23. Asif S, Baugh A, Jones NW. The obstetric care of asylum seekers and refugee women in the UK. The Obstetrician & Gynaecologist. 2015;17(4):223-31.
24. Kirkendall A, Dutt A. Refugee women's pregnancy and childbirth experiences in the US: Examining context through a reproductive justice framework. Feminism & Psychology. 2023:09593535221149166.
25. Schrot-Sanyan S, Kolanska K, Haimeur Y, Varlas V, Parisot-Liance L, Daraï E, et al. Language barrier as a risk factor for obstetric anal sphincter injury–A case-control study. Journal of Gynecology Obstetrics and Human Reproduction. 2021;50(8):102138.
26. Koopmanschap I, Martin L, Gitsels-van der Wal JT, Suurmond J. Counselling for prenatal anomaly screening to migrant women in the Netherlands: an interview study of primary care midwives' perceived barriers with client–midwife communication. Eur J Midwifery. 2022 May 19;6:29. doi:10.18332/ejm/147911.
27. Olcoń K, Rambaldini-Gooding D, Degeling C. Implementation gaps in culturally responsive care for refugee and migrant maternal health in New South Wales, Australia. BMC Health Services Research. 2023;23(1):1-12.
28. Willey SM, Gibson ME, Blackmore R, Goonetilleke L, McBride J, Highet N, Ball N, Gray KM, Melvin G, Boyd LM, East CE. Perinatal mental health screening for women of refugee background: Addressing a major gap in pregnancy care. Birth. 2024 Mar;51(1):229-41.
29. Akbulut N, Razum O. Why Othering should be considered in research on health inequalities: Theoretical perspectives and research needs. SSM-Population Health. 2022;20:101286.
30. Letley K. Midwives' experiences caring for asylum-seeking women in the UK: a systematic review. British Journal of Midwifery. 2022;30(9):490-501.
31. Ashley R, Goodarzi B, Horn A, de Klerk H, Ku SE, Marcus JK, et al. A call for critical midwifery studies: Confronting systemic injustice in sexual, reproductive, maternal, and newborn care: Critical Midwifery Collective Writing Group. Birth (Berkeley, Calif). 2022;49(3):355.

32. Van Loenen T, Van Den Muijsenbergh M, Hofmeester M, Dowrick C, Van Ginneken N, Mechili EA, et al. Primary care for refugees and newly arrived migrants in Europe: a qualitative study on health needs, barriers and wishes. The European Journal of Public Health. 2018;28(1):82-7.
33. Mulder L, Akwiwu EU, Twisk JW, Koster AS, Ravesloot JH, Croiset G, et al. Inequality of opportunity in selection procedures limits diversity in higher education: an intersectional study of Dutch selective higher education programs. Plos one. 2023;18(10):e0292805.
34. Altman MR, McLemore MR, Oseguera T, Lyndon A, Franck LS. Listening to women: recommendations from women of color to improve experiences in pregnancy and birth care. Journal of midwifery & women's health. 2020;65(4):466-73.
35. Gewalt SC, Berger S, Ziegler S, Szecsenyi J, Bozorgmehr K. Psychosocial health of asylum seeking women living in state-provided accommodation in Germany during pregnancy and early motherhood: A case study exploring the role of social determinants of health. PloS one. 2018;13(12):e0208007.
36. Rast E, Hintermeier M, Bozorgmehr K, Biddle L. Housing and health: A multidimensional, qualitative analysis of the experiences of asylum seekers and refugees living in German reception centres. SSM-Qualitative Research in Health. 2024:100407.
37. Sørbye IK, Vangen S, Juarez SP, Bolumar F, Morisaki N, Gissler M, et al. Birthweight of babies born to migrant mothers-What role do integration policies play? SSM-population health. 2019;9:100503.
38. Sow M, Schoenborn C, De Spiegelaere M, Racape J. Influence of time since naturalisation on socioeconomic status and low birth weight among immigrants in Belgium. A population-based study. PLoS One. 2019;14(8):e0220856.
39. Bollini P, Pampallona S, Wanner P, Kupelnick B. Pregnancy outcome of migrant women and integration policy: a systematic review of the international literature. Social science & medicine. 2009;68(3):452-61.
40. Fellmeth G, Fazel M, Plugge E. Migration and perinatal mental health in women from low-and middle-income countries: a systematic review and meta-analysis. BJOG: An International Journal of Obstetrics & Gynaecology. 2017;124(5):742-52.
41. Stevenson K, Fellmeth G, Edwards S, Calvert C, Bennett P, Campbell OM, et al. The global burden of perinatal common mental health disorders and substance use among migrant women: a systematic review and meta-analysis. The Lancet Public Health. 2023;8(3):e203-e16.
42. Sperlich M, Seng JS, Li Y, Taylor J, Bradbury-Jones C. Integrating trauma-informed care into maternity care practice: conceptual and practical issues. Journal of midwifery & women's health. 2017;62(6):661-72.
43. Pangas J, Ogunsiji O, Elmir R, Raman S, Liamputtong P, Burns E, et al. Refugee women's experiences negotiating motherhood and maternity care in a new country: a meta-ethnographic review. International Journal of Nursing Studies. 2019;90:31-45.

Supplementary materials

Appendix 1. Topic guide (final version, English language version)

Category	Topic	Example questions (including possible probes, applied flexibly and depending on question response)
Introduction	Introduction researchers Informed consent procedure Check completion of midwife's information sheet	
Organization of care	General (regional) organization of care Collaboration/coordination Specific organizational aspects	How did you/your midwifery practice become involved with care for asylum seekers and refugees with residence permit? How is care for asylum seekers/refugees organized in your practice and in the region? (What are roles and responsibilities? How would you describe the collaboration with other care providers?) Could you tell me more about specific organizational aspects (e.g., the use of guidelines, collaboration with the hospital or asylum reception center)?
Experiences	General and personal experiences with care for asylum seekers and refugees Workload	Could you describe your experiences with providing care to asylum seekers/refugees? (How do you personally feel about working with asylum seekers and/or refugees?) How do you perceive the workload of care for this population? (What makes it that way (e.g., demanding/rewarding)?)

Category	Topic	Example questions (including possible probes, applied flexibly and depending on question response)
Tailored care	Comparing and adjusting care Relevant differences Health disparities	How would you compare caring for asylum seekers to caring for refugees with a residence permit? And to what extent/in what ways do these populations have different needs than other women in your practice? (What are differences or similarities? What characteristics of women determine different needs among and between groups? How do you adjust your care based on these differences?) Do you always ask about women's migration backgrounds/histories? (Can you give examples of how women's migration backgrounds affect the care provided?) What barriers do you think newly arrived women experience on their way through the Dutch perinatal care system? (How can midwives support them best? To what extent do you feel responsible?) What do you think of the pregnancy outcomes of women with a refugee background? (What possible explanations do you see for differences between them and Dutch women? Would you say refugee women have higher risks/are vulnerable and why (not)?)
Challenges in care	Quality of care General challenges and specific barriers Views on previously identified challenges	How do you view the quality of care to this group, compared to other groups? (In case of suboptimal care, what might be the causes? What best practices or suboptimal care factors do you perceive?) What challenges do you experience in care for asylum seekers/refugees? (What are the most important barriers? What effects do these barriers have?) How do you view challenges we previously identified in care (e.g., in communication with clients, interdisciplinary collaboration, psychosocial care, and the vulnerable situation of asylum seekers/refugees in the Netherlands)?

Category	Topic	Example questions (including possible probes, applied flexibly and depending on question response)
Strategies and best practices	Dealing with challenges Example best practices or solutions Improvements in care	How do you deal with these challenges? (What support or solutions do you have (or miss)?) Do you have positive examples, or recommendations to other midwives? Do you see potential improvements that could be made? (If you could change something tomorrow, what would be the first thing?) What do you think should be different in the care for asylum seekers/refugees in five years? What should we maintain? (How do you think midwives can best be supported/ what do midwives need in the future?) What are your views on possible improvements (e.g., availability of interpreter services, training for midwives, introducing interventions such as group antenatal care or buddy programs)?
Completion	Summarizing/following-up on unclarities, unaddressed field visit observations Check if interviewee would like to receive transcript Thanking interviewee	In the field visit to your practice, we noticed that (…), what is your view on (…) ? Do you feel that we have gained an understanding of your experience with and ideas about the care for asylum seekers and refugees in this interview? Are there any important matters that have not been addressed? (Do you want to add anything? What would you like us to focus on in the research?)

Appendix 2: Code tree

Theme 1: midwife-client interactions (micro-level)

Subtheme	What barriers do midwives encounter in care?	How do midwives manage/adjust care to overcome these barriers?
Language and interpretation	• Limited access to information • Limited expression and (fear of) misunderstandings • Difficult counseling during birth • Empathy/deep connections more difficult with interpreters • Risk of miscommunications with formal and informal interpreters • Limited quality and availability of professional interpreter services • No funding for interpreter services for recognized refugees	• Working with professional interpreters as much as possible • Working with female interpreters • Limiting professional services to essential moments in care (or reserving extra time) • Accepting alternatives to interpreters: body language, multilanguage materials, buddies, speaking different languages
Cultural differences	• FDP have different expectations of care than Dutch clients • FDP do not express their needs and questions as openly as Dutch clients • Midwives' limited competences/ cultural stereotyping	• Positive dialogue/learning from differences • Feeling motivated by grateful clients • Emphasizing similarities instead of differences
Building trust	• Building trust takes more time • FDP more fearful than other clients (e.g. fear of immigration authorities) • Lack of continuity of care	• Continuity of care • Showing patience and genuine interest in client • Offering safe atmosphere • Shared religious background

Theme 2: organization of care (meso-level)

Subtheme	What barriers do midwives encounter in care?	How do midwives manage/adjust care to overcome these barriers?
Delays in care-seeking and access to care	• Late start of care with incomplete patient records • High frequency of missed appointments • Delayed contact for emergency symptoms (e.g. due to language barriers) • Lack of transportation options and unreliable taxi services • Relocations of asylum seekers	• Individual or group antenatal care at the reception center • Active follow-up after missed appointments • Close contact with other professionals (e.g. GZA) • Using personal vehicle to transport clients

Relocations of asylum seekers	• Lack of communication by COA • Incomplete or untimely transfer of information • Losing clients/lack of overview • Physical burden pregnant women • Rule of 34weeks not always adhered to	• No relocations between 34w – 7w postpartum • Requesting a relocation blockade for medical reasons • Ensuring handover of relocated clients to subsequent care provider
Interdisciplinary collaboration	• Concerns about quality of care, especially in the hospital • Difficult communication with COA and/or GZA • Limited guideline awareness and implementation	• Implementing guideline (e.g. multidisciplinary meetings) • Short lines of communication (e.g. contact person at each organization) • Committed colleagues at other midwifery practices/GZA/postpartum care providers/hospital

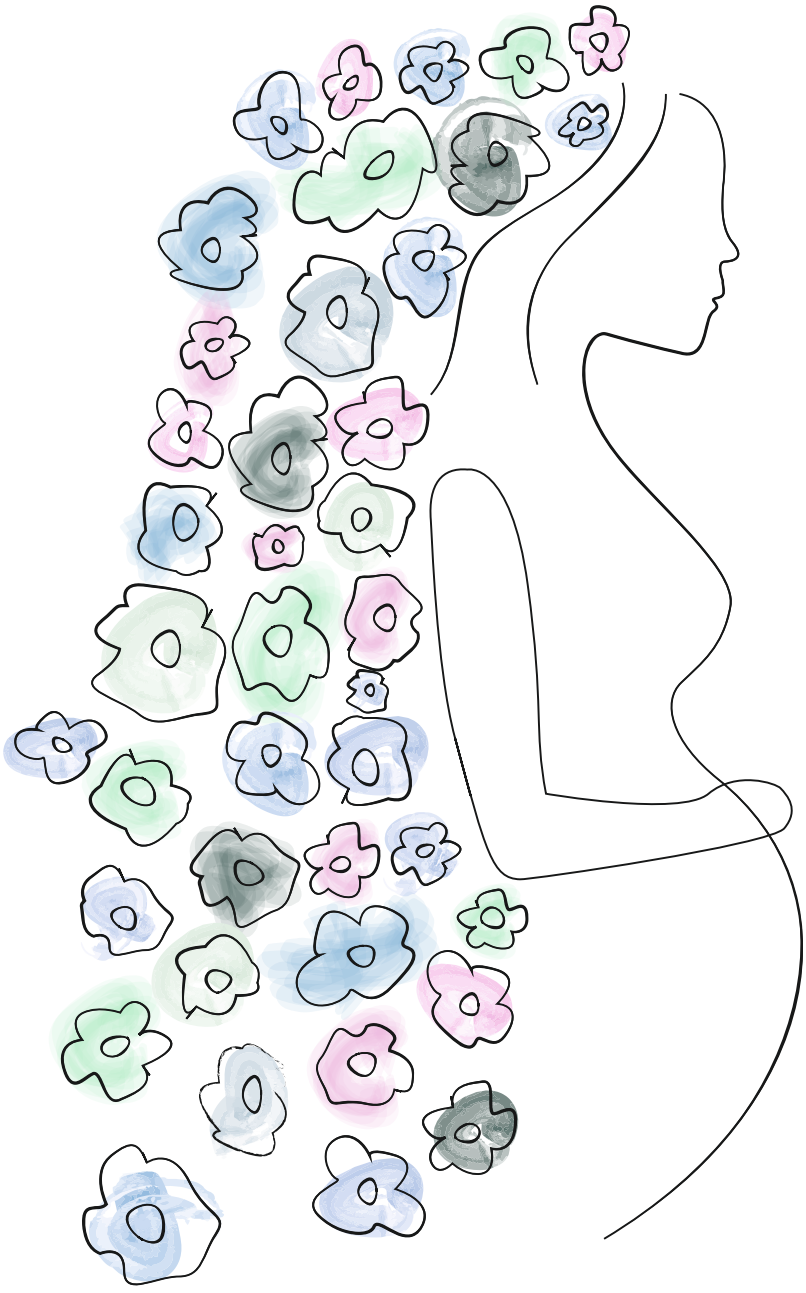
Theme 3: living conditions of forcibly displaced women

Subtheme	What barriers do midwives encounter in care?	How do midwives manage/adjust care to overcome these barriers?
Housing conditions	• Poor hygiene, limited food options, lack of privacy, and other conditions unsuitable for pregnant women in asylum reception centers • Stress of asylum procedures and threat of deportation	• Advocating for better living circumstances in asylum centers • Arranging hospital births
Resettlement after forced migration	• Social isolation • Unfamiliarity with healthcare system • Lack of guidance for refugees with permit • Vulnerable socioeconomic position	• Involving doulas or buddy projects • Providing group care and stimulating peer support • Organizing practical and material support
Mental health	• High burden of trauma-related symptoms and other mental health conditions • Specialized mental healthcare not available/accessible for refugees	• Creating safety for women to discuss mental health

Central theme: imbalance in midwives' work

Subthemes:

- Perceived need to take over responsibility and transcend usual role
- Increased practical and emotional burden
- Limited influence on clients' health and wellbeing
- Limited resources, e.g. time, power, financial compensation, skills/education, supportive services, referral options



Duha Khalal (12 jaar)

Part III

Advancing equity in pregnancy and childbirth for women with a forced migration background

Chapter eight

Recommendations for tailored pregnancy and childbirth care for asylum seekers and refugees in the Netherlands (in Dutch)

Based on the findings of the EGALITE research project (2020 – 2024)

Aanbevelingen voor persoonsgerichte geboortezorg voor asielzoekers en statushouders in Nederland

Gebaseerd op de uitkomsten van het EGALITE onderzoeksproject (2020 – 2024)

J.B. Tankink, J.P. de Graaf, P.J.A. van der Lans, M.E.T.C. van den Muijsenbergh* & A.Franx*

* Shared last authors

Inhoudsopgave

1. Inleiding

Dit hoofdstuk bevat een ingekorte bewerking van de 'Aanbevelingen voor persoonsgerichte geboortezorg voor asielzoekers en statushouders in Nederland', die in het najaar van 2024 worden gepubliceerd. Deze aanbevelingen komen voort uit het EGALITE-onderzoeksproject (2020 – 2024), gefinancierd door ZonMw (projectnummer 543003112).

Het EGALITE project richtte zich op de geboortezorg voor vrouwen met een vluchtachtergrond in of kort na het doorlopen van een asielprocedure in Nederland. De verhoogde cijfers van moeder- en perinatale sterfte onder deze groep migranten, en de noodzaak om de Ketenrichtlijn Geboortezorg Asielzoeksters uit 2010 te evalueren, vormden de aanleiding voor het onderzoek. In het project zijn verschillende studies opgezet en uitgevoerd onder leiding van het Erasmus MC in samenwerking met diverse ketenpartners (waaronder het Universitair Medisch Centrum Groningen), met als doel om de kwaliteit en uitkomsten van geboortezorg voor asielzoekers en statushouders te kunnen verbeteren.

In de laatste fase van het project werden de bevindingen van het eerder verrichte onderzoek vertaald naar concrete aanbevelingen middels een serie focusgroepen met een diverse groep stakeholders. In dit hoofdstuk worden de achtergrond en opzet van het EGALITE project beknopt uiteengezet, waarna we de belangrijkste bevindingen en daaruit volgende aanbevelingen beschrijven per thema: 1) organisatie van zorg, 2) toegankelijkheid en continuïteit van zorg, 3) kwaliteit van persoonsgerichte zorg, en 4) de sociale en politieke context. Het hoofdstuk sluit af met een drietal hoofdaanbevelingen voor de geboortezorg aan asielzoekers en statushouders in Nederland.

2. Achtergrond van het EGALITE project

2.1 Gebruikte begrippen en afkortingen

Het EGALITE project was gericht op de zorg voor twee groepen vrouwen met een vluchtachtergrond in Nederland: vrouwen die nog in de asielopvang verblijven tijdens hun zwangerschap, en vrouwen die grofweg minder dan vijf jaar geleden vanuit de asielopvang naar een reguliere woning zijn verhuisd met een verblijfsvergunning op basis van hun asielaanvraag. Voor het overzicht onderscheiden we deze groepen in dit document als **asielzoekers** en **statushouders**.

Hieronder volgt een beschrijving van de meest voorkomende begrippen en afkortingen in alfabetische volgorde.

Asielzoeker: Een persoon die een asielaanvraag heeft ingediend om erkend te worden als vluchteling in een ander land, wiens aanvraag nog niet definitief is beoordeeld. In dit document verwijst 'asielzoekers' ook naar 'bewoners van een asielopvanglocatie', hoewel dit in sommige gevallen ook statushouders betreft (zie definitie 'Statushouders').

AZC: Asielzoekerscentrum; een faciliteit onder beheer van het COA, waar asielzoekers tijdelijk verblijven terwijl hun asielaanvraag wordt beoordeeld. In de praktijk wordt de term AZC gebruikt voor verschillende soorten opvanglocaties. Formeel worden asielzoekers voor het eerste deel van hun procedure opgevangen in een Centrale Ontvangstlocatie (COL) en Procesopvang-locaties (POL), en verhuizen zij pas bij aanvang van de algemene asielprocedure naar een AZC.

COA: Centraal Orgaan opvang Asielzoekers; de organisatie die landelijk verantwoordelijk is voor de opvang en begeleiding van asielzoekers in Nederlandse opvangcentra (COA-opvanglocaties; vaak ook AZC's genoemd). Het COA is een zelfstandig bestuursorgaan en valt onder de politieke verantwoordelijkheid van het Ministerie van Justitie en Veiligheid.

(C)NO: (Crisis)noodopvanglocatie; een tijdelijke opvanglocatie voor asielzoekers die door de overheid is aangewezen vanwege onvoldoende capaciteit in reguliere opvanglocaties. Vanaf 2024 zal de term CNO worden vervangen voor de afkorting TGO; tijdelijke gemeentelijke opvang. Deze locaties worden beheerd door gemeenten, waarbij het COA een ondersteunende rol vervult.

Geboortezorg: In dit document verwijst de term 'geboortezorg' naar alle zorg en begeleiding die door geboortezorgprofessionals wordt verleend aan zwangere vrouwen en hun ongeboren of pasgeboren kind, vanaf het eerste consult in de zwangerschap, gedurende de bevalling, tot en met de kraamperiode.

GZA: GezondheidsZorg Asielzoekers; de organisatie die sinds 2018 verantwoordelijk is voor de eerstelijns (huisartsen)zorg voor mensen in de asielopvang, in opdracht van het COA. GZA maakt deel uit van de Arts en Zorg Groep.

IND: Immigratie- en Naturalisatiedienst; het overheidsorgaan dat het Nederlandse migratiebeleid uitvoert, waaronder het besluiten over verbijfsaanvragen van asielzoekers.

JGZ: Jeugdgezondheidszorg; de publieke gezondheidszorg voor kinderen op COA-locaties tussen 0 en 18 jaar, waaronder het rijksvaccinatieprogramma, wordt uitgevoerd door de GGD/jeugdzorgorganisaties vanuit een contract tussen COA en GGD Ghor Nederland.

Ketenrichtlijn: Ketenrichtlijn Geboortezorg Asielzoeksters; richtlijn ten aanzien van de begeleiding van zwangeren in de asielopvang, in 2010 ontwikkeld vanuit een werkgroep waarin de landelijke organisaties KNOV, Kenniscentrum Kraamzorg, GZA, RMA, NVOG, COA en GGD GHOR Nederland vertegenwoordigd zijn. In juni 2020 is de richtlijn voor het laatst geactualiseerd; een nieuwe actualisatie staat gepland voor 2024.

Ongedocumenteerde migranten: Mensen die zich in Nederland bevinden zonder verblijfsvergunning of lopende asielaanvraag, bijvoorbeeld omdat hun asielverzoek is afgewezen.

Opvanglocatie(s): In dit hoofdstuk wordt de overkoepelende term opvanglocaties gebruikt voor verschillende opvangcentra voor asielzoekers, zowel COA-locaties (waaronder AZC) en Crisisnoodopvang/TGO.

Perined: fusieorganisatie van PAN (Perinatale Audit Nederland) en PRN (Perinatale Registratie Nederland). In de perinatale registratie leggen de verschillende betrokken beroepsgroepen (o.a. eerstelijns verloskundigen, gynaecologen, neonatologen) hun gegevens over geboortezorg vast. Zie www.perined.nl.

RMA: Regeling Medische zorg Asielzoekers; de zorgverzekeringsmaatschappij waarmee de financiering van de zorg voor asielzoekers georganiseerd is (RMA Healthcare; anno 2024 onderdeel van DSW Zorgverzekeraar). Zie www.rmahealthcare.nl.

Statushouders: Asielzoekers die een verblijfsvergunning hebben gekregen in Nederland, maar (nog) niet de Nederlandse nationaliteit hebben, worden vaak ‘statushouders’ genoemd. In dit document verwijst de term ‘statushouders’ naar mensen die, na het verkrijgen van een verblijfsvergunning, zijn verhuisd vanuit een COA-locatie naar een reguliere woning in de gemeente. In de praktijk verblijven er ook veel statushouders op COA-locaties zo lang zij nog geen

eigen woning toegewezen hebben gekregen. In de zorg vallen zij nog onder de regelingen voor asielzoekers (zie 'RMA').

Vluchteling: In dit document verwijst het begrip 'vluchteling' naar iedereen die zijn of haar thuisland verlaat vanwege gevaren of dreigingen en die zich genoodzaakt ziet elders bescherming te zoeken, ongeacht hun wettelijke status als asielzoekers, statushouders of ongedocumenteerde.

Vrouwen met een vluchtachtergrond: In dit document verwijzen we ook veel naar 'vrouwen met een vluchtachtergrond' om de focus te leggen op de individuele persoon en hun ervaringen, in plaats van op hun (wettelijke) status als asielzoeker, statushouder of vluchteling. Waar we 'vrouw' gebruiken, erkennen we tevens het bestaan van zwangere individuen die zich niet noodzakelijkerwijs als zodanig identificeren.

ZCN: Zorgvervoercentrale Nederland; Bedrijf dat zorgtaxivervoer voor asielzoekers met een medische indicatie regisseert, onder contract van het Medisch Contactcentrum van Arts en Zorg (moederbedrijf van GZA). Zie https://www.zcnvervoer.nl/.

ZIG: Zorgstandaard Integrale Geboortezorg; Richtlijn die de basiszorg die elke zwangere vrouw in Nederland hoort te krijgen voor elke fase van de zwangerschap beschrijft. Zie https://www.zorginzicht.nl/kwaliteitsinstrumenten/integrale-geboortezorg-zorgstandaard.

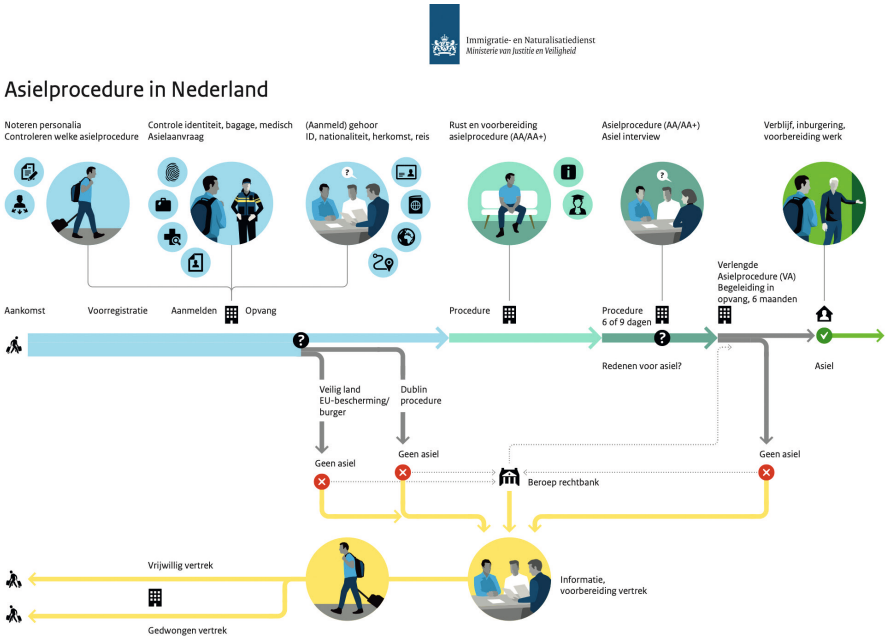
2.2 Asielzoekers en statushouders in Nederland

In 2023 deden ongeveer 38.000 mensen een eerste asielaanvraag in Nederland.[1] Daarnaast zijn er ongeveer 10.000 familieleden van statushouders gekomen voor gezinshereniging. Asielzoekers vormen gemiddeld ongeveer 11% van de totale jaarlijkse immigratie naar Nederland. Hun aantal en herkomst variëren sterk en hangen samen met grote conflicten elders in de wereld, zoals de Syrische burgeroorlog vanaf 2011. Al jaren komt de meerderheid van de asielzoekers in Nederland uit Syrië (in 2023 ongeveer een derde van het totaal). Daarnaast komen relatief veel mensen uit Eritrea, Turkije, Afghanistan, Jemen, en Somalië. In 2023 verbleven er daarnaast ongeveer 95.000 Oekraïense vluchtelingen in Nederlandse gemeenten en opvangcentra. Oekraïners worden echter niet gerekend tot de groep van asielzoekers, omdat zij recht hebben op verblijf op basis van een EU-regeling voor tijdelijke bescherming.

Iedereen die asiel in Nederland aanvraagt moet zich registreren bij de Vreemdelingenpolitie in een aanmeldcentrum van de IND in Ter Apel of op Schiphol. Na registratie hebben asielzoekers recht op opvang door het COA. In

een Centrale Ontvangstlocatie (COL) in Ter Apel of Budel wachten mensen op het eerste aanmeldgehoor bij de IND, waarna zij voor een tweede gehoor bij de IND verhuizen naar een proces-opvanglocatie (POL). Indien mensen volgens deze algemene asielprocedure een verblijfsvergunning krijgen, of als er een verlengde asielprocedure volgt, verhuizen mensen naar een AZC (zie figuur 1). Er zijn speciale opvanglocaties voor bepaalde groepen, bijvoorbeeld alleenstaande minderjarige vluchtelingen.

De wachttijden in het huidige asielsysteem zijn lang: begin 2024 bedroeg de wachttijd voor het eerste aanmeldgehoor gemiddeld 18 weken, en 43 weken voor het tweede gehoor.[2] Vervolgens bedraagt de gemiddelde verwerkingstijd van asielaanvragen nog een jaar. Daarnaast wachtten er begin 2024 ongeveer 16.000 statushouders in een COA-locatie op een woning.



Figuur 1. Infographic van de asielprocedure in Nederland (Bron: IND)

Door gebrek aan duurzame opvanglocaties bij het COA, worden asielzoekers de laatste jaren veel opgevangen in noodopvanglocaties. In januari 2024 waren er in Nederland 86 reguliere COA-locaties, naast 165 noodopvanglocaties.[3] De noodopvanglocaties vallen ook onder beheer van het COA, maar voldoen meestal niet aan de reguliere kwaliteits- en voorzieningenstandaarden. Wanneer ook in de noodopvang onvoldoende capaciteit beschikbaar is, wijkt de opvang van asielzoekers uit naar tijdelijke gemeentelijke opvanglocaties (TGO; voorheen

crisisnoodopvanglocaties), bijvoorbeeld in sporthallen, kantoorpanden of tenten. Deze locaties vallen onder beheer van de gemeenten of Veiligheidsregio. Het huidige beleid is om zwangeren zo min mogelijk op noodopvanglocaties op te vangen, tenzij begeleiding op maat geboden kan worden, en niet in de zes weken voor de uitgerekende bevallingsdatum.

Zwangere vrouwen die ongedocumenteerd in Nederland verblijven kunnen geen zorgverzekering afsluiten, maar hebben recht op medisch noodzakelijke zorg, waaronder geboortezorg. De kosten moet de zwangere vrouw zelf betalen; als zij dat niet kan, kan de zorgverlener deze volledig declareren via de regeling 'Onverzekerbare vreemdelingen' van het Centraal Administratie Kantoor (CAK). Daarnaast hebben ongedocumenteerde zwangere vrouwen op grond van artikel 64 van de Vreemdelingenwet tijdelijk recht op verblijf in een opvanglocatie in de periode tussen zes weken voor de uitgerekende datum en zes weken na de geboorte.

2.3 Gezondheidszorg voor asielzoekers

Het COA is verantwoordelijk voor de organisatie en financiering van gezondheidszorg aan asielzoekers. De Regeling Medische zorg Asielzoekers (RMA) fungeert als zorgverzekering voor asielzoekers. Het zorgpakket vanuit de RMA komt grotendeels overeen met het reguliere basispakket vanuit de Zorgverzekeringswet en de Wet langdurige zorg, met een aantal uitzonderingen (zoals fertiliteitszorg). Er geldt voor asielzoekers geen eigen bijdrage of eigen risico. Statushouders die nog in een COA-locatie verblijven vallen ook onder de RMA. Indien zij een woning in de gemeente toegewezen krijgen, dienen zij zelf een reguliere zorgverzekering af te sluiten.

Voor de publieke gezondheidszorg heeft het COA op dit moment een overeenkomst met GGD GHOR, die onder andere actief is op het gebied van infectieziekten bestrijding, vaccinaties, en gezondheidsvoorlichting. Voor eerstelijns (huisartsen) zorg heeft het COA sinds 2018 een contract met GezondheidsZorg Asielzoekers (GZA). GZA levert huisartsenzorg vanuit gezondheidscentra op de meeste COA-locaties, en is verantwoordelijk voor de medische screening/intake van asielzoekers in de eerste dagen na aankomst in Nederland. Na de medische intake ontvangen asielzoekers een COA-zorgnummer. In de eerste twee maanden in Nederland hebben asielzoekers alleen recht op medisch urgente zorg; daarna kunnen zij met hun COA-zorgnummer worden doorverwezen naar zorgverleners met een contract met RMA Healthcare (www.rmasielzoekers.nl).

2.4 Organisatie van de geboortezorg voor asielzoekers en statushouders

De geboortezorg voor asielzoekers vindt zoveel mogelijk plaats via het reguliere Nederlandse systeem. Zwangeren worden vanuit het COA/GZA doorverwezen voor aanmelding bij een eerstelijns verloskundige praktijk in de buurt van de opvanglocatie. Indien doorverwijzing naar de tweede lijn noodzakelijk is, kunnen asielzoekers terecht bij elk ziekenhuis in Nederland. Asielzoekers bevallen in principe altijd in het ziekenhuis of een geboortecentrum. Statushouders die vanuit opvanglocaties zijn verhuisd naar een reguliere woning hebben toegang tot dezelfde geboortezorg en gezondheidszorg als andere Nederlanders.

Naast de zorgverleners vanuit de reguliere zorg zijn ook GZA en het COA betrokken als ketenpartners in de geboortezorg voor asielzoekers (zie figuur 2). Het COA heeft een 'gidsfunctie' in de gezondheidszorg, hetgeen inhoudt dat het COA asielzoekers wegwijs maakt in het Nederlandse zorgsysteem, en een signalerende rol heeft met betrekking tot sociale en medische problemen. Op de meeste COA-locaties is een woon-of programmabegeleider bij het COA aangewezen als 'aandachtsfunctionaris' geboortezorg. Dit betekent dat deze functionarissen fungeren als contactpersoon voor de zwangeren op hun locatie.

Figuur 2. Ketenpartners in de geboortezorg voor asielzoekers. Bron: GGD GHOR (2021).

2.5 Richtlijnen voor de geboortezorg

De Ketenrichtlijn Geboortezorg Asielzoeksters is in 2010 ontwikkeld door en voor ketenzorgpartners en beschrijft de gewenste werkwijze en de samenwerkingsafspraken binnen de geboortezorg aan asielzoekers.[4] De vertegenwoordigde partijen in de richtlijnwerkgroep betreffen het COA, GZA, de KNOV, de NVOG, de GGD GHOR en Kenniscentrum Kraamzorg. De aanleiding voor het ontwikkelen van de richtlijn waren aanbevelingen van de Inspectie Gezondheidszorg en Jeugd (destijds IGZ) ten aanzien van de geboortezorg voor asielzoekers. De werkgroep rondom de Ketenrichtlijn komt halfjaarlijks bijeen in een samenstelling van ongeveer zeven afgevaardigden van de betrokken ketenpartners (beleidsmakers en clinici), waarbij het COA de bijeenkomsten voorzit. De richtlijn wordt regelmatig geactualiseerd naar aanleiding van veranderingen in de zorg of organisatie. Er is geen wetenschappelijk onderzoek of formele evaluatie beschikbaar ten aanzien van de implementatie of het effect van de ketenrichtlijn. Verspreiding van het document vindt plaats via de eigen communicatiekanalen van de diverse betrokken organisaties en beroepsverenigingen. De beroepsverenigingen dienen mutaties in de richtlijn formeel goed te keuren voor publicatie. De richtlijn en bijbehorende bijlagen

zijn online onder andere te benaderen via de website van het College Perinatale Zorg (CPZ).

De Ketenrichtlijn beschrijft de taken, verantwoordelijkheden en processtappen in de geboortezorg voor asielzoekers, waar die afwijken of meer aandacht vragen ten opzichte van de reguliere zorg. De Zorgstandaard Integrale Geboortezorg (ZIG) beschrijft de basiszorg die elke zwangere vrouw in Nederland hoort te krijgen voor elke fase van de zwangerschap.[5]

3. Overzicht deelstudies EGALITE project

De aanbevelingen in dit document zijn gebaseerd op resultaten van verschillende wetenschappelijke studies die binnen het EGALITE project zijn opgezet. Deze studies en de gebruikte onderzoeksmethoden worden hieronder kort toegelicht. De resultaten van de meeste studies zijn al verwerkt in wetenschappelijke publicaties, waarin een uitgebreidere beschrijving van de toegepaste methoden is te vinden.

3.1 Studies naar kenmerken en uitkomsten van zwangere asielzoekers en statushouders

In **de studie met COA-cijfers** analyseerden we de maternale kenmerken en risicofactoren voor ongunstige zwangerschapsuitkomsten bij moeders in COA-locaties, gebaseerd op alle door het COA geregistreerde geboortes tussen 2016 en 2020.[6] De resultaten zijn tevens samengevat in een factsheet in het Nederlands, uitgegeven in samenwerking met GGD GHOR.[55]

De **registerstudie** onderzocht de geboorte-uitkomsten van asielzoekers en statushouders in Nederland in de periode 2014-2019, aan de hand van landelijke, gekoppelde data van Perined en het Centraal Bureau voor de Statistiek (publicatie in voorbereiding).

3.2 Studies naar ervaringen in de geboortezorg voor asielzoekers en statushouders

De **vragenlijststudie** was gericht op het in kaart brengen van de uitdagingen in de geboortezorg voor asielzoekers en statushouders in Nederland, in eerste instantie onder eerstelijns verloskundigen.[7] De ontwikkelde *EGALITE vragenlijst* is later aangepast voor gebruik onder andere ketenpartners. Hierbij werden algemene ervaringen, knelpunten, 'beste praktijken' (best practices), en de implementatie van de Ketenrichtlijn Geboortezorg Asielzoeksters geëvalueerd. De aangepaste vragenlijsten zijn verspreid onder COA-aandachts-functionarissen, GZA-medewerkers, zorgverleners in het ziekenhuis en kraamverzorgenden, en

onder andere gebruikt als input voor de focusgroepen in de laatste fase van het project.

In de **interviewstudie** zijn knelpunten en beste praktijken in de zorg verder uitgediept in interviews met elf eerstelijns verloskundigen.[8] Daarnaast zijn zestien vrouwen met een vluchtachtergrond geïnterviewd over hun ervaringen in de geboortezorg in Nederland. De eerste reeks interviews (acht vrouwen) richtte zich op hun algemene ervaringen, terwijl later in het project nog eens acht interviews werden afgenomen die specifiek betrekking hadden op de ervaringen van asielzoekers rondom overplaatsingen. De interviews werden deels met de tolkentelefoon, deels met sleutelpersonen van Stichting Nieuw Thuis Rotterdam, en deels door een tweetalige masterstudent afgenomen.

Naast de interviews is de *Photovoice*-methode toegepast om inzicht te verkrijgen in de ervaringen van zwangeren met betrekking tot voeding tijdens hun zwangerschap in een opvanglocatie. Bij *Photovoice* leggen deelnemers hun ervaringen en perspectieven visueel vast via foto's, die als uitgangspunt dienen voor interviews met de onderzoekers.[9]

3.3 Studies naar de kwaliteit van de geboortezorg voor asielzoekers en statushouders

In de **dossierstudie** zijn data verzameld uit 80 verloskundige dossiers van zwangere asielzoekers bij acht deelnemende eerstelijns verloskundigenpraktijken. Hierbij is onderzocht in hoeverre de geboortezorgverlening aansloot bij verschillende relevante richtlijnen, zoals de Ketenrichtlijn Geboortezorg Asielzoeksters en de Zorgstandaard Integrale Geboortezorg. De resultaten uit de dossierstudie worden nog verwerkt in een wetenschappelijk artikel; de voorlopige resultaten die zijn gebruikt in dit document zijn als selectie opgenomen in bijlage 1.

In de **perinatale auditstudie**, die werd uitgevoerd vanuit het UMC Groningen, hebben onderzoekers van het EGALITE team bijgedragen aan de analyse van 53 casus van vrouwen met een vluchtachtergrond uit het register van de Nederlandse Perinatale Audit.10 In deze analyse is onderzocht welke suboptimale zorgfactoren mogelijk bijdragend waren aan de ongunstige uitkomst van de casus.

3.4 Ontwikkeling van aanbevelingen

De aanbevelingen in dit hoofdstuk zijn voornamelijk ontwikkeld in een zestal **focusgroepdiscussies** met een gemengde groep van deelnemers uit het veld (zie details over de specifieke opzet en deelnemersgroepen in kader 1). De focusgroepen werden opgezet vanuit een Participatory Action Research (PAR) benadering, waarbij deelnemers nauw betrokken zijn bij het onderzoeksproces om samen met de onderzoekers tot gedragen inzichten en aanbevelingen te

komen. Hierbij werden ten eerste de eerdere bevindingen over knelpunten en best practices getoetst en aangescherpt. Dit proces van triangulatie bood de kans om eerdere inzichten verder te valideren en vanuit verschillende perspectieven te verrijken. Tijdens latere sessies werkten deelnemers en onderzoekers gezamenlijk aan het formuleren van aanbevelingen, waarbij aanvullende PAR-technieken zoals 'direct ranking' werden toegepast. Zo werd toegewerkt naar een reeks breed gedragen aanbevelingen, gestructureerd rond vier hoofdthema's, die sterk geworteld zijn in de ervaringen van de deelnemers en die inspelen op de gedeelde behoeften binnen het zorgveld.

Kader 1. Inhoud en deelnemers EGALITE focusgroepen (voorjaar 2023)

De eerste sessie betrof een online bijeenkomst voor het COA, waarbij acht aandachts-functionarissen en een COA beleidsmedewerker aanwezig waren. Tijdens deze bijeenkomst werden deelnemers uitgenodigd om te reageren op gepresenteerde onderzoeksbevindingen en hun specifieke ervaringen rondom knelpunten in de geboortezorg voor vrouwen in de asielopvang te delen.

Aan de tweede focusgroep namen acht asielzoekers en statushouders deel, die hun ervaringen met de zorg tijdens hun zwangerschap, bevalling en kraamtijd in Nederland deelden. Positieve voorbeelden en suggesties voor verbetering kwamen in de derde sessie aan bod.

De vierde focusgroep vond plaats met negen geboortezorgprofessionals uit het veld. Hierin stonden knelpunten in de zorgverlening centraal. De vijfde sessie betrok dezelfde professionals als in de voorgaande sessie, samen met enkele deelnemers uit de eerste focusgroep. In deze sessie lag de nadruk op het gezamenlijk opstellen van mogelijke oplossingen. De zesde sessie bracht dezelfde groep professionals en asielzoekers/statushouders nogmaals samen, om middels 'direct ranking' de belangrijkste aanbevelingen en prioriteiten voor het veld vast te stellen.

Deelnemers aan de focusgroepen voor vrouwen met een vluchtachtergrond werden geworven via verschillende kanalen, waaronder het COA, een steungroep voor vrouwen in een opvanglocatie en persoonlijke contacten van de onderzoekers. In de eerste twee sessies met vrouwen namen acht vrouwen deel, waarvan twee op dat moment zwanger waren en in een opvanglocatie verbleven, terwijl de andere vrouwen eerder zwanger waren geweest en inmiddels met een verblijfsvergunning in een eigen huis woonden. Vijf van de deelnemers waren afkomstig uit Syrië, één deelnemer uit Jordanië, één uit Palestina en één uit Somalië.

Deelnemers aan de focusgroepen voor professionals werden geworven via organisaties die deelnamen aan het EGALITE project, waaronder verloskundigenpraktijken, COA, GZA en ziekenhuizen. Deelnemers werkten als beleidsadviseur (bij het COA of GZA), aandachtsfunctionaris (COA), praktijkverpleegkundige/doktersassistent (GZA), kraamverzorgende, eerstelijns verloskundige en gynaecoloog.

De meeste professionals namen deel aan alle sessies, die afwisselend plaatsvonden op een COA-locatie en in het hoofdkantoor van Pharos. In de focusgroepen met een gemengde deelnemersgroep van professionals en asielzoekers/statushouders, namen telkens één tot drie ervaringsdeskundige vrouwen deel.

4. Uitkomsten en aanbevelingen per thema

Hieronder volgt een overzicht van de aanbevelingen die per thema zijn opgesteld. In de toelichting van de thema's verwijzen we naar specifieke bevindingen van het EGALITE project, waarbij de bronstudie *cursief* benoemd wordt. Relevante inzichten uit ander onderzoek worden vermeld met een verwijzing naar de literatuurlijst.

Het overzicht is verrijkt met de perspectieven van zowel professionals als vrouwen met een vluchtachtergrond. Deze ervaringen zijn afkomstig uit de interviews en focusgroepen die binnen EGALITE hebben plaatsgevonden. Waar relevant wordt ook hier de bronstudie vermeld. Uitspraken van deelnemers, tussen aanhalingstekens weergegeven, zijn zo nodig vertaald naar het Nederlands.

Aanbevelingen zijn gericht aan beleidsmakers en bestuurders binnen de geboortezorg voor asielzoekers en statushouders, werkzaam op ministerieel of uitvoerend niveau in de zorg of het asieldomein. Daarnaast is een deel van de aanbevelingen gericht aan de werkgroep Ketenrichtlijn Geboortezorg

Asielzoeksters en aan professionals en zorgverleners die in hun dagelijkse praktijk met zwangeren, moeders en/of pasgeborenen met een vluchtachtergrond te maken hebben.

4.1 Organisatie van de zorg

4.1.1 Ketenrichtlijn Geboortezorg Asielzoeksters

Het EGALITE project heeft de bekendheid en implementatie van en ervaringen met de richtlijn op verschillende niveaus geëvalueerd. Uit de *EGALITE vragenlijst* onder eerstelijns verloskundigen blijkt dat de bekendheid van de Ketenrichtlijn onder deze beroepsgroep beperkt is, zo kent 34% van de meer dan honderd respondenten de richtlijn helemaal niet, en van de respondenten die de richtlijn wel kent, is bijna de helft niet tot maar enigszins bekend met de inhoud (zie tabel 1).

De *EGALITE vragenlijst* is op kleinere schaal ook uitgezet onder tweedelijns zorgverleners, GZA, en COA. Bij deze ketenpartners ligt de bekendheid van de richtlijn nog lager. Zo heeft 45% van de ondervraagde deelnemers in het ziekenhuis nog nooit van de richtlijn gehoord, net als 43% van de zorgverleners van GZA en 30% van de aandachts-functionarissen bij het COA. In de *vragenlijst* werden ook een aantal zorgprocesstappen geëvalueerd. Hieruit bleek dat sommige voorschriften in de praktijk meestal goed verlopen, bijvoorbeeld de dubbele verwijzing voor de 22-weken prik door de verloskundige en GZA (gebeurt vaak tot altijd volgens 54% van de eerstelijns verloskundigen). Een voorschrift dat juist weinig wordt opgevolgd is een verhuisgesprek bij GZA voorafgaand aan overplaatsing (gebeurt nooit of soms volgens 66% van de GZA zorgverleners) en het informeren van COA bij ontslag uit het ziekenhuis (gebeurt nooit of soms volgens 62% van de COA aandachts-functionarissen).

Ook in de *dossierstudie* blijken veel voorschriften uit de Ketenrichtlijn in de praktijk niet uitgevoerd te worden. Zo vindt een multidisciplinair overleg (MDO) tussen alle ketenpartners, een belangrijke aanbeveling uit de richtlijn om de samenwerking te stroomlijnen, slechts bij vier van de acht deelnemende praktijken minimaal eens per jaar plaats (zie bijlage 1, tabel 2).

Voor statushouders bestaat geen specifieke richtlijn. Bijna de helft van alle verloskundigen (47%) in de *EGALITE vragenlijst* geeft aan dat zij wel behoefte hebben aan een dergelijke richtlijn.

Tabel 1a. Bekendheid van het bestaan van de Ketenrichtlijn Geboortezorg Asielzoeksters onder verschillende ketenpartners

Bent u bekend met het bestaan van de Ketenrichtlijn Geboortezorg Asielzoeksters?

	Aantal	Nee	Ja
Eerstelijns verloskundigen	102	34%	66%
Tweedelijns zorgverleners	53	45%	55%
Zorgverleners bij GZA	40	43%	58%
COA aandachts-functionarissen	37	30%	70%

Tabel 1b. Bekendheid van de inhoud van de Ketenrichtlijn Geboortezorg Asielzoeksters onder zorgverleners die 'Ja' antwoordden op vraag 1a

Bent u bekend met de inhoud van de Ketenrichtlijn Geboortezorg Asielzoeksters?

	Aantal	Niet of enigszins bekend	Redelijk of volledig bekend
Eerstelijns verloskundigen	67	48%	52%
Tweedelijns zorgverleners	29	83%	17%
Zorgverleners bij GZA	23	43%	57%
COA aandachts-functionarissen	26	38%	62%

Ervaringen van professionals

In de *interviewstudie* met eerstelijns verloskundigen komt naar voren dat de beperkte bekendheid van de richtlijn bij diverse ketenpartners een belemmering vormt voor de uitvoering van de zorg volgens de richtlijn. In regio's waar de richtlijn gezamenlijk met andere ketenpartners is uitgewerkt in een lokaal zorgpad, zijn verloskundigen positiever over de kwaliteit van de zorg. Dit patroon wordt bevestigd in de *focusgroepen*. De meeste professionals zijn tevreden over het bestaan en de inhoud van de richtlijn, maar ervaren hindernissen in de uitvoering. Met name de communicatie en samenwerking bij de uitvoering van de richtlijn stelt de zorgverlener voor uitdagingen (zie ook *4.1.2. Multidisciplinair samenwerken in de keten*):

> *"De richtlijn zelf is inhoudelijk wel goed, maar we moeten veel beter van elkaar weten wat we doen."* **– Deelnemer focusgroepen (professional)**

Daarnaast komt naar voren dat er behoefte is aan een beter toegankelijk en praktischer format van de Ketenrichtlijn. Bovendien geeft met name het COA aan dat de huidige richtlijn wat betreft (medisch) taalgebruik en leesbaarheid niet voldoende aansluit bij de aandachts-functionarissen die er gebruik van moeten maken.

Ervaringen van vrouwen met een vluchtachtergrond
Hoewel de Ketenrichtlijn niet specifiek aan bod komt tijdens *interviews* met asielzoekers en statushouders, komt uit de *focusgroepen* naar voren dat deze vrouwen wel degelijk graag betrokken zouden worden bij het maken en verbeteren van richtlijnen. Geen van deze vrouwen weet dat de Ketenrichtlijn bestaat, terwijl ze dit wel zouden willen:

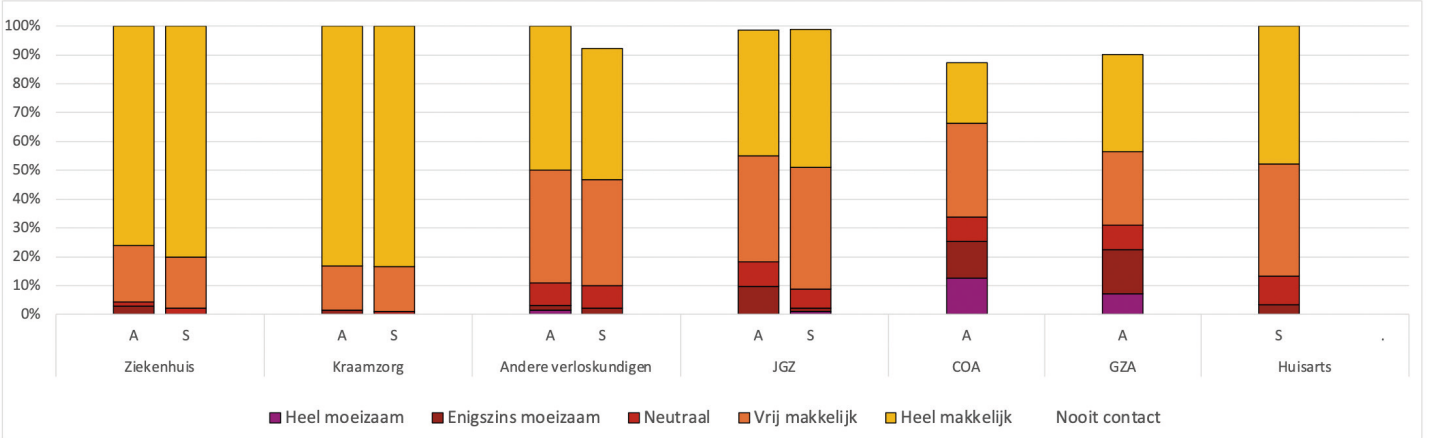
> *"I would like to know about the protocol, so I also know what to ask for."*
> **– Deelnemer focusgroepen (zwangere met vluchtachtergrond)**

Aanbevelingen m.b.t. Ketenrichtlijn Geboortezorg Asielzoeksters
- Neem bij herziening van de huidige Ketenrichtlijn de resultaten ten aanzien van bekendheid en implementatie van specifieke voorschriften, en de aanbevelingen voor inhoudelijke aanpassingen en uitbreidingen in de volgende deelhoofdstukken van dit document mee;
- Verbeter de bruikbaarheid van de Ketenrichtlijn voor de dagelijkse praktijk door ontwikkeling van een gebruikersvriendelijk format, bijvoorbeeld in de vorm van een mobiele applicatie, of een interactief PDF. Zorg dat verschillende gebruikersgroepen makkelijk kunnen navigeren naar de informatie en taakomschrijvingen die voor hen relevant zijn. Zorg daarnaast voor één centrale online locatie van de Ketenrichtlijn om circuleren van verouderde versies te voorkomen;
- Realiseer doorontwikkeling van de Ketenrichtlijn naar een *evidence based* zorgstandaard, bijvoorbeeld ter opname in de Richtlijnendatabase van de FMS (Federatie Medisch Specialisten) en het Kwaliteitsregister van het Zorginstituut, om de professionalisering, bekendheid en implementatiegraad van de richtlijn te vergroten onder alle professionals van de betrokken partners als COA, GZA, geboortezorg-verleners, cliënten, etc.;
- Ontwikkel een aparte richtlijn voor de geboortezorg aan recente statushouders (bijvoorbeeld binnen Kansrijke Startcoalities);
- Betrek asielzoekers en statushouders zelf bij het verbeteren van de zorg door middel van cliëntparticipatie, bijvoorbeeld door het aanstellen van een cliëntvertegenwoordiger in de richtlijnwerkgroep. Betrek ook medewerkers uit de praktijk bij de werkgroep, zoals de aandachts-functionarissen bij het COA;
- Stel een eenduidig format op voor de uitwerking van zorgpaden op lokaal niveau, op basis van de landelijke richtlijn;
- Ontwikkel in samenwerking met alle ketenpartners een lokaal uitgewerkt zorgpad, gebaseerd op de Ketenrichtlijn, ZIG (Zorg- en Informatiegids) en de huidige wet- en regelgeving. Het doel van dit lokale zorgpad is om een praktische handleiding op lokaal niveau op te stellen, voorzien van werkafspraken, contactgegevens en telefoonnummers. Zie ook *4.1.2. Multidisciplinair samenwerken in de keten*;

- Stel binnen een praktijk, organisatie, locatie of afdeling een verantwoordelijke aan voor de implementatie van de Ketenrichtlijn en vaardig deze persoon af naar multidisciplinaire beleidsbijeenkomsten;
- Besteed in het inwerkprogramma voor nieuwe medewerkers aandacht aan de ketenrichtlijn en de bijbehorende regionale afspraken.

4.1.2 Multidisciplinair samenwerken in de keten

In de ketenzorg voor vrouwen met een vluchtachtergrond, en met name voor asielzoekers, werken veel verschillende ketenpartners samen. Uit de *EGALITE vragenlijst* blijkt dat iets meer dan de helft van de ondervraagde eerstelijns verloskundigen redelijk tot zeer tevreden is over de samenwerking in de zorg voor asielzoekers (54%) en statushouders (56%). De samenwerking varieert echter sterk per ketenpartner. Eerstelijns verloskundigen vinden de communicatie zowel in de zorg voor asielzoekers als statushouders het makkelijkst verlopen met het ziekenhuis en kraamzorgorganisaties. In de zorg voor asielzoekers ervaren zij het contact met het COA en GZA als moeizamer (zie Figuur 3). In de *dossierstudie* beschikken niet alle (zes van de acht) verloskundigenpraktijken over contactgegevens van de relevante medewerkers bij het COA en GZA.



Figuur 3. Bereikbaarheid van ketenpartners door eerstelijns verloskundigen in de zorg voor asielzoekers en statushouders. A = Asielzoekers; S = Statushouders.

Ook vanuit het ziekenhuis worden de meeste obstakels ervaren in de communicatie met het COA en GZA; daarnaast geven relatief veel respondenten aan nooit contact te hebben met deze ketenpartners (respectievelijk 36% en 38%), hoewel dit in de Ketenrichtlijn op meerdere punten in het zorgpad wel wordt beschreven.

Ervaringen van professionals
Zowel in de *interviews* met verloskundigen als de *focusgroepen* met alle zorgprofessionals komen knelpunten in de onderlinge communicatie veel aan bod. Elke ketenpartner benoemt dat 'kortere lijnen' de samenwerking goed zouden doen:

> *"Je moet elkaar spreken om elkaars gezicht te kennen en elkaar te kunnen vinden"* **– Deelnemer focusgroepen (professional)**

> *"Ik vind het belangrijk om lokale zorgpaden te maken met duidelijke contactpersonen per organisatie. Wij werken alleen direct samen met de verloskundige, maar voor de rest heb ik geen idee wie ik waarbij moet hebben, dus werken we vaak in cirkeltjes."* **– Deelnemer focusgroepen (professional)**

Het hoge personeelsverloop bij het COA en GZA wordt door andere ketenpartners expliciet als knelpunt in de samenwerking genoemd, naast verschillen in inzicht over optimale zorg en de eigen verantwoordelijkheid van de zwangere:

Vanuit het COA geven aandachts-functionarissen geboortezorg aan dat informatie vanuit de zorg vaak niet met hen wordt gedeeld op basis van het medisch beroepsgeheim en/of in verband met de wet AVG (Algemene Verordening Gegevensbescherming):

"Het COA weet bijvoorbeeld pas dat een vrouw van het ziekenhuis naar huis komt als ze weer op de stoep van de locatie staat. Ook van het GZA krijgen we vaak niet eens te horen dat iemand zwanger is, alleen als ze iets nodig heeft, bijvoorbeeld een babypakket." - Deelnemer focusgroepen (professional)

Ten slotte hebben veel professionals behoefte aan meer kennis(uitwisseling) met betrekking tot de geboortezorg voor asielzoekers en statushouders.

Ervaringen van vrouwen met een vluchtachtergrond
Ook zwangeren hebben soms last van knelpunten in de samenwerking en coördinatie van zorg. Zo beschrijven zwangeren in de *focusgroepen* dat verschillende zorgverleners langs elkaar heen werkten of niet van elkaars adviezen op de hoogte waren.

Aanbevelingen m.b.t. multidisciplinair samenwerken in de keten

- Organiseer op elke locatie waar zorg aan zwangere asielzoekers geboden wordt tenminste tweejaarlijks een beleidsoverleg tussen alle ketenpartners. Organiseer daarnaast een 'zwangeren-bespreking' voor het afstemmen van de zorg voor individuele zwangeren, met een frequentie afhankelijk van het aantal zwangeren op de locatie;
- Zorg voor een toestemmingsverklaring voor het uitwisselen van gegevens van zwangere asielzoekers waarin duidelijk wordt welke informatie COA medewerkers mogen ontvangen die nodig is om optimale begeleiding te bieden. Neem in de Ketenrichtlijn een format op voor een dergelijke toestemmingsverklaring;
- Zorg binnen het COA dat op iedere locatie waar zwangeren verblijven minimaal een (en bij hogere aantallen zwangeren meerdere) aandachts-functionarissen geboortezorg aangesteld is. Vergroot het scholingsaanbod en versterk het netwerk van aandachts-funtionarissen voor onderlinge uitwisseling van kennis, knelpunten en *best practices*;
- Vergroot de mogelijkheden voor verspreiding en uitwisseling van kennis tussen professionals van de verschillende ketenpartners via bestaande kanalen, zoals wwww.kennisnetgeboortezorg.nl (College Perinatale Zorg), het Netwerk Regionale Geboortezorg Consortia en Kennispoort Verloskunde;
- Stel aan het begin van de zwangerschap aan de hand van de individuele behoeften een multidisciplinair, gepersonaliseerd zorgpad vast, en stel voor elke zwangere asielzoeker of statushouder een coördinerend zorgverlener of casemanager namens het multidisciplinaire begeleidingsteam aan;
- Vermeld contactgegevens van ketenpartners in het elektronisch zorgdossier van elke zwangere asielzoeker;
- Neem deel aan lokaal/regionaal ketenoverleg over casuïstiek en/of organisatie en samenwerking in de keten.

4.2 Toegankelijkheid en continuïteit van zorg

4.2.1 Aanvang van de zorg

Tijdige zwangerschapszorg is onder andere van belang voor optimale risicoselectie, prenatale screening, voorlichting, en begeleiding, om daarmee de kans op een goede start voor moeder en kind te vergroten. Evenals in eerder onderzoek naar algemene migrantenpopulaties, blijkt uit het EGALITE project dat asielzoekers en statushouders vaak later starten met prenatale consulten dan wordt aanbevolen in Nederlandse en internationale richtlijnen.[11] In de landelijke *registerstudie* werd bijna 30% van de asielzoekers en statushouders pas na twaalf weken voor het eerste antenatale consult gezien, in vergelijking met 7% van de vrouwen zonder migratieachtergrond. In de *dossierstudie* ligt dit percentage bij asielzoekers zelfs op 48% (zie bijlage 1, tabel 3). Bij minder dan een kwart van deze zwangeren was de reden voor het laat in zorg komen dat zij pas gedurende

de zwangerschap in Nederland arriveerden; bij de andere zwangeren speelde een andere reden of was de reden niet uit het dossier op te maken. Andere barrières, zoals onbekendheid met of weinig vertrouwen in het Nederlandse zorgsysteem, spelen volgens verloskundigen in de *interviewstudie* ook een rol.

In de *studie met COA-cijfers* was meer dan de helft (52%) van de vrouwen die een kind kregen tijdens hun verblijf in de asielopvang al zwanger op het moment van registratie in de opvang.[6] Een deel hiervan betreft echter ongedocumenteerde vrouwen die pas vanaf 34 weken zwangerschap recht hebben op opvang.[55] De omstandigheden waaronder vrouwen voor vertrek of onderweg naar Nederland zwanger werden zijn niet onderzocht, noch is bekend welk deel van de zwangere asielzoekers al zorg heeft gehad in het buitenland.

Mede door vertraging aan de start wordt bepaalde zorg, zoals de termijnecho en het standaard bloedonderzoek inclusief screening op infectieziekten, regelmatig onvolledig of niet tijdig verleend. Ook prenatale diagnostiek wordt volgens de *dossierstudie* niet aan iedere zwangere in de asielopvang aangeboden.

Bij de aanvang van de zorg is ook aandacht voor mogelijk ongewenste zwangerschap een aandachtspunt. Eerder onderzoek toont aan dat seksueel geweld veel voorkomt onder vrouwen die gedwongen zijn te vluchten.[12] Verloskundigen benoemen in de *interviews* dat ongewenste zwangerschappen vaker voorkomen, hoewel dit niet kwantitatief is onderzocht in EGALITE. Een eerdere studie liet wel meer zwangerschapsafbrekingen zien onder asielzoekers in vergelijking met Nederlandse vrouwen.[13]

Ervaringen van professionals

Uit de *vragenlijst- en interviewstudies* met verloskundigen blijkt dat een late start van de zorg veel voorkomt en daarmee een belangrijke belemmering vormt. Verloskundigen wijzen op verschillende gevolgen, zoals een onzekere termijnbepaling, maar ook minder tijd om een vertrouwensband op te bouwen en passende zorg te organiseren, zoals kraamzorg. Het feit dat vrouwen met een vluchtachtergrond meestal zonder medisch dossier in Nederland aankomen beperkt een volledig beeld van de obstetrische voorgeschiedenis.

Professionals signaleren meerdere redenen waarom asielzoekers regelmatig laat in zorg komen, buiten dat een deel van hen al zwanger is bij aankomst in Nederland:

"Afspraken maken is voor veel vrouwen echt ingewikkeld. Dat moet eerst via GZA en dat lukt niet iedereen."
– Deelnemer focusgroepen (professional)

"Eerst op de bus, dan nog met de tram: soms vraagt dat echt te veel."
– Deelnemer focusgroepen (professional)

Professionals benadrukken ook dat de vertraging in de medische screening van asielzoekers bij aankomst in Nederland een negatieve invloed heeft in de jaren 2022/2023. In periodes van hoge opvangtekorten bij het COA worden asielzoekers regelmatig rechtstreeks vanuit Ter Apel overgeplaatst naar crisisnoodopvanglocaties, zonder de registratie en medische intake die normaliter eerst plaatsvinden. Als gevolg hiervan komen zwangere vrouwen op opvanglocaties terecht waar zij niet in beeld zijn bij een verloskundig zorgverlener.

Ervaringen van gevluchte vrouwen
In *interviews* en *focusgroepen* geven de meeste zwangeren aan dat ze het belangrijk vinden om vroeg te kunnen beginnen met zwangerschapszorg. Voor sommigen van hen blijkt de weg naar de zorg echter vol obstakels, bijvoorbeeld doordat ze niet weten waar ze terecht konden voor een zwangerschapstest, lang wachten op een afspraak bij GZA, of na een positieve zwangerschapstest pas veel later een intake krijgen bij de verloskundige. In het algemeen vinden vrouwen de zorg in en vanuit de COA-locatie (ook buiten de zwangerschap) te weinig bereikbaar, en zouden zij meer inloopspreekuren willen.

"Ik was drie maanden in het AZC en ik wist drie maanden lang niet of ik zwanger was of niet. (...) Niemand kon daarmee helpen, ik moest zelf een zwangerschapstest halen, en ik heb zelf ontdekt dat ik zwanger was."
– Deelnemer focusgroepen (zwangere met vluchtachtergrond)

Ook de zorg rondom miskramen en fertiliteit wordt in de *focusgroepen* door meerdere vrouwen onvoldoende toegankelijk genoemd. Vrouwen die een miskraam gehad hebben tijdens hun verblijf op een opvanglocatie voelen zich regelmatig niet serieus genomen; zo missen zij diagnostiek bij herhaalde miskramen.

Aanbevelingen
- Waarborg tijdige medische screening van asielzoekers (op dag twee na aankomst). Pas de inhoud van de screening aan om beter aan te sluiten op de seksuele- en reproductieve zorgbehoeften van de populatie in de asielopvang, zodat zorgvragen niet onopgemerkt blijven. Zorg dat het eerste prenatale

controlebezoek met spoed gepland wordt, wanneer een zwangere wordt aangemeld vanuit de opvanglocatie;
- Realiseer indien mogelijk een verloskundig spreekuur op of vlakbij de locatie van de opvanglocatie, zoals al gedaan wordt op verschillende plekken in het land (bijvoorbeeld in Ter Apel, Leersum en Almere). Indien dit niet mogelijk is, zorg voor goede bewegwijzering en bereikbaarheid van de verloskundig zorgverlener met het OV;
- Houd er rekening mee dat een zwangerschap ongewenst kan zijn; verwijs asielzoekers en statushouders voor afbreking van de zwangerschap naar een van de reguliere abortusklinieken, waar behandeling ook voor asielzoekers vergoed wordt;
- Verbreed de voorlichting vanuit de GGD en/of GZA over zwangerschap- en geboortezorg in Nederland voor vrouwen op opvanglocaties. Neem expliciet in de voorlichtingsinformatie op waar mensen een zwangerschapstest kunnen verkrijgen, maar ook waar vrouwen met een anticonceptieverzoek, onvervulde kinderwens, of ongewenste zwangerschap terecht kunnen;
- Neem deze informatie ook op in de voorlichting die het COA aan statushouders verstrekt wanneer zij naar een woning verhuizen.

4.2.2 Overplaatsingen van asielzoekers

In het huidige Nederlandse asielsysteem verhuizen mensen tijdens de asielprocedure een of meerdere keren. Dit heeft te maken met de organisatie van de procedure, waarbij mensen afhankelijk van de status van hun procedure in een ander type locatie van het COA verblijven. Daarnaast kunnen overplaatsingen het gevolg zijn van capaciteitskwesties, bijvoorbeeld bij sluiting van bepaalde locaties. Asielzoekers kunnen ook zelf een verzoek tot overplaatsing doen, bijvoorbeeld om dichterbij familie of kennissen te wonen.

Uit de *studie met COA-cijfers* blijkt dat 70% van de vrouwen minimaal 1 keer werd overgeplaatst tijdens de zwangerschap, en 28% zelfs twee keer of meer.[9] De overdracht van zorg en medische gegevens loopt bij overplaatsing regelmatig niet goed. Hoewel de Ketenrichtlijn de processtappen en taakverdeling tussen ketenpartners beschrijft, geeft bijna 40% van de verloskundigen in de *EGALITE vragenlijst* aan dat ze nooit of meestal niet tijdig door het COA worden geïnformeerd over een aanstaande overplaatsing van een asielzoeker. Overplaatsingen leiden dan ook vaak tot onderbroken zorg gedurende een langere periode van de zwangerschap, of juist tot onnodig herhaalde zorg.

In de Ketenrichtlijn staat dat zwangere asielzoeksters in principe zes weken voor de uitgerekende datum tot zes weken na de bevalling niet meer verhuizen of overgeplaatst worden. Alleen in overeenstemming met GZA, de verloskundig zorgverlener en de zwangere ter uitsluiting van medisch risico kan van deze

termijn worden afgeweken. Toch geven zorgverleners in de *interviews* aan dat overplaatsingen en uitzettingen naar het buitenland ook in deze periode voorkomen, zonder dat zij geconsulteerd zijn.

De invloed van overplaatsingen op klinische zwangerschapsuitkomsten is op dit moment nog onbekend. Wel blijkt uit veel onderzoek dat stress bij de moeder, ook aan het begin van de zwangerschap, invloed kan hebben op latere geboorte- en gezondheidsuitkomsten.[14,15]

Ervaringen van professionals in de geboortezorg
Uit de *EGALITE vragenlijst* en *interviews* onder verloskundigen komen overplaatsingen naar voren als het belangrijkste knelpunt in de zorg voor zwangere asielzoekers.[7,8] Ook in de *focusgroepen* met een bredere groep zorgverleners en zwangere vrouwen worden overplaatsingen unaniem herkend als belemmerende factor voor optimale zorg. Veel zorgverleners benoemen de risico's die hierdoor in hun ervaring ontstaan:

> *"Het is al zo'n complex iets, de hele zorg voor asielzoekers, ook omdat je gewoon zoveel minder informatie hebt, dus het is sowieso al moeilijk, en het is altijd meer risicovol, en elke overplaatsing creëert weer een moment van overdracht, wat gewoon betekent dat je af en toe de controle verliest."* **– Deelnemer interviews (verloskundige)**

Zorgverleners beschrijven dat de verantwoordelijkheid voor het vervolg van de zorg na een overplaatsing vaak bij de zwangere wordt gelegd, terwijl dit in de praktijk onrealistisch blijkt:

> *"Het wisselen van zorgverleners is elke keer weer spannend. Soms kunnen vrouwen zelf de naam van de verloskundige, de praktijk, of zelfs het vorige AZC niet onthouden."* **– Deelnemer focusgroepen (professional)**

Ervaringen gevluchte vrouwen
Uit interviews met vrouwen met ervaringen met de geboortezorg vanuit opvanglocaties of als statushouder blijkt dat overplaatsingen vaak tot extra stress en onzekerheid in de zwangerschap leiden. Sommige vrouwen vrezen dat verplicht verhuizen tot complicaties, zoals een miskraam kan leiden. In bepaalde gevallen blijken overplaatsingen juist wel gewenst, bijvoorbeeld als het gaat om een verhuizing naar een opvanglocatie met betere leefomstandigheden of kookmogelijkheden.

Aanbevelingen

- Bied als verloskundige professional bij aanvang van de zorg duidelijke uitleg aan de zwangere ten aanzien van de zorg bij overplaatsing. Geef bijvoorbeeld aan hoe de zwangere zelf de verloskundige op de hoogte kan stellen in het geval van een aanstaande overplaatsing. Geef haar na elk contact een afdruk van het medisch dossier (de 'zwangerschapskaart') mee;
- Expliciteer de verantwoordelijkheden van COA, GZA en verloskundig zorgverleners voor het waarborgen van de continuïteit van zorg na overplaatsingen;
- Stel een termijn vast voor de minimale periode tussen het aankondigen van een overplaatsing en de daadwerkelijke overplaatsing, zodat er voldoende tijd is voor een zorgvuldige overdracht van de zorg;
- Informeer vanuit het COA tijdig de betrokken zorgverleners zodat zij de overdracht naar de nieuwe verloskundige praktijk kunnen regelen. Realiseer bijvoorbeeld een automatisch bericht van overplaatsing naar alle betrokken geboortezorgverleners, zoals op dit moment al gebeurt in de digitale communicatie tussen COA en GZA;
- Geef het GZA de bevoegdheid om bij ernstige medische risico's een overplaatsing te blokkeren via een speciale aanvraag bij het COA. Andere zorgverleners kunnen contact opnemen met GZA om deze blokkade aan te vragen;
- Volg bij overplaatsingen het protocol van de Ketenrichtlijn: wanneer een zwangere asielzoekster verhuist, controleert het COA haar afspraken en informeert de betrokken zorgverleners en GZA over de verhuizing. De huidige en nieuwe verloskundige zorgverleners zorgen voor een soepele overdracht van de zorg;
- Volg het project 'HealthEmove', dat de mogelijkheden voor een mobiel dossier voor vrouwen met een vluchtachtergrond onderzoekt;
- Concentreer de zorg voor asielzoekers op een beperkt aantal opvanglocaties en minimaliseer overplaatsingen (Zie ook *5. Overzicht hoofdaanbevelingen*).

4.2.4 Vervoer en vindbaarheid

Naast de overplaatsingen van asielzoekers spelen nog andere knelpunten in de toegankelijkheid en continuïteit van de zorg. In de *vragenlijststudie* onder verloskundigen geeft 74% van hen aan dat asielzoekers vaker geplande afspraken missen dan zwangeren zonder migratieachtergrond; dit geldt volgens 62% van de verloskundigen ook voor statushouders. Dit beeld wordt bevestigd door de *dossierstudie* bij 80 asielzoekers; daaruit blijkt dat 31% een of twee afspraken had gemist; 10% miste zelfs meer dan twee geplande afspraken.

Ervaringen van professionals
Zorgverleners benoemen verschillende verklaringen voor het hoge percentage no-shows onder asielzoekers en statushouders. Ten eerste zijn dit opnieuw de overplaatsingen: vrouwen missen vaak een of meerdere afspraken bij hun verloskundig zorgverlener, voordat duidelijk wordt dat ze zijn overgeplaatst naar een andere opvanglocatie. Daarnaast zien professionals praktische problemen bij vrouwen, zoals moeite om de weg te vinden, en vervoersproblemen. Voor statushouders is het openbaar vervoer vaak prijzig, en de Nederlandstalige afspraakbrieven van zorgverleners zijn soms moeilijk te lezen.

Wat betreft vervoer vormen de taxi's vanuit opvanglocaties een veelgenoemd probleem. Vrouwen hebben recht op vervoer middels een zorgtaxi vanaf 36 weken zwangerschap, of eerder op medische indicatie. Het medisch contactcentrum van het moederbedrijf van GZA (Arts en Zorg) heeft een contract met een vaste aanbieder van zorgvervoer (ZCN, Zorgvervoercentrale Nederland) en regionale onderaannemers. Het is niet mogelijk om een specifiek tijdstip af te spreken voor de zorgtaxi, en de aanrijtijd is volgens verloskundigen regelmatig langer dan een uur, waardoor vrouwen regelmatig te laat op hun afspraak komen. Dit is met name rondom de baring een probleem, waardoor er vaker ambulances worden ingezet en verloskundigen niet zelden besluiten om zwangeren vanuit opvanglocaties in hun eigen auto te vervoeren.

Ervaringen van vrouwen met een vluchtachtergrond
Zwangere vrouwen beamen in de *interviews* en *focusgroepen* dat het moeilijk is om de weg te vinden naar de zorg, zowel letterlijk als wat betreft het begrijpen van het systeem. Een spreekuur van de verloskundige op de opvanglocatie zou een uitkomst kunnen zijn:

> *"Dit zou een goede oplossing zijn voor een belangrijk probleem. Afspraken maken is voor veel vrouwen echt ingewikkeld. Dat moet eerst via GZA en dat lukt niet iedereen. Het zou heel fijn zijn om dingen gelijk te kunnen bespreken bij de verloskundige in het AZC."* **– Deelnemer focusgroepen (zwangere met vluchtachtergrond)**

Ook geven vrouwen aan dat ze zelf niet altijd weten hoe ze hun zorgverlener kunnen bereiken bij alarmsymptomen of als de bevalling zich aandient, en noemen ook zij de problemen met taxivervoer vanuit opvanglocaties. Hierbij beschrijven vrouwen dat er in hun ervaring niet voldoende of niet op tijd naar hen geluisterd wordt:

> *"Er is een vriendin van mij, ze heet [naam], ze was hier zwanger. Ze kreeg weeën en had pijn (...). Ze belde en ze zeiden haar, 'we bellen je terug', terwijl ze weeën*

had! Ze belde nogmaals... En niemand reageerde op haar (...). En toen, na een tijdje, kwam er uiteindelijk een taxi. Maar tegen die tijd was ze al aan het persen, ze was bijna aan het bevallen (…). Er zou een nummer moeten zijn - misschien een apart telefoonnummer voor zwangere vrouwen, voor taxi's die direct kunnen komen." **– Deelnemer interviews (zwangere met vluchtachtergrond)**

Tot slot zijn vrouwen in het land van herkomst niet altijd gewend om op een afgesproken tijd naar antenatale consulten te komen. Ook hebben vrouwen in Opvanglocaties regelmatig veel stress of andere prioriteiten, bijvoorbeeld rondom hun verblijfsvergunning, waardoor afspraken voor de zwangerschap minder belangrijk zijn of makkelijker worden vergeten.

Aanbevelingen

- Verleng de termijn waarbinnen zorgtaxivervoer vanuit COA-locaties geïndiceerd is voor zwangere vrouwen om het aantal gemiste afspraken te verminderen. Buiten deze termijn kunnen COA-locatiemanagers alternatief vervoer voor zwangere vrouwen faciliteren, zoals beschreven in een bijlage van de Ketenrichtlijn;
- Zorg dat de maximale aanrijtijd van 1 uur gewaarborgd is in overeenkomsten met (lokale) vervoerders van zorgtaxivervoer;
- Geef duidelijke belinstructies aan de zwangere en besteed extra aandacht aan uw (telefonische) bereikbaarheid. Maak bij beperkte lees- of gezondheidsvaardigheden bijvoorbeeld gebruik van pictogrammen.

4.3 Kwaliteit van persoonsgerichte zorg

Voor een goede kwaliteit van zorg is het noodzakelijk dat deze gelijkwaardig en persoonsgericht is. Gelijkwaardige zorg betekent dat niet alle individuen precies dezelfde zorg ontvangen, maar juist dat de zorg is afgestemd op relevante verschillen tussen mensen.[20] Persoonsgerichte zorg is door Pharos gedefinieerd als "*Zorg die de persoon van de patiënt centraal zet, niet haar medische toestand. Hierin is aandacht voor het dagelijks leven, de sociale omstandigheden en emoties, waarden en behoeftes van de patiënt.*"[16]

4.3.1 Taal en tolken in de zorg

Het grootste deel van de zwangere asielzoekers komt uit Syrië of Eritrea, maar behalve Arabisch en Tigrinya brengen mensen met een vluchtachtergrond nog honderden andere talen naar de Nederlandse spreekkamers. Zij hebben echter pas na het verkrijgen van een verblijfsvergunning toegang tot formeel taalonderwijs. Slechts 8% van de zorgverleners in Nederland zelf een migratieachtergrond.[17] Taalverschillen tussen zorgverleners en zwangeren komen dus veel voor.

Het overbruggen van taalverschillen is cruciaal voor de kwaliteit van communicatie in de zorg. En die kwaliteit heeft invloed op allerlei aspecten van de geboortezorg, zoals de veiligheid, het vertrouwen van de zwangere in de zorg, voorlichting over complexe onderwerpen zoals prenatale screening, en het proces van 'samen beslissen' over passende zorg. Bij het overbruggen van taalverschillen spelen (telefonische) tolken een belangrijke rol. Voor asielzoekers zijn de tolkdiensten op dit moment door COA gecontracteerd bij Acolad.

In de *EGALITE vragenlijst* onder verloskundigen gaf 88% van hen aan dat zij de tolkentelefoon vaak of altijd inzetten bij asielzoekers; 31% gaf aan dat meestal ook te doen bij statushouders. Het verschil tussen deze percentages hangt samen met de overheidsfinanciering van de tolkentelefoon, die aan het begin van EGALITE alleen beschikbaar was voor asielzoekers met een COA-zorgnummer. Tijdens de onderzoeksperiode (per 1 januari 2023) is er ook weer vergoeding gekomen voor statushouders. Het is niet bekend hoe vaak zorgverleners hier gebruik van maken.

Uit de *dossierstudie* komt naar voren dat verloskundigen bij asielzoekers ondanks de vergoeding lang niet altijd werken met tolken; zo wordt in bijna de helft van de dossiers (47%) nooit notitie gemaakt van inzet van de tolkentelefoon, terwijl in bijna alle dossiers (96%) genoteerd stond dat de zwangere onvoldoende Nederlands sprak voor communicatie zonder tolk (bijlage 1, figuur 1). In een deel (23%) van de dossiers wordt expliciet vermeld dat er bij een of meerdere consulten geen tolk werd ingezet. De belangrijkste redenen die hiervoor worden gegeven zijn een te lange wachttijd bij de tolkentelefoon of een gebrek aan beschikbare tolk in de taal van de zwangere. In plaats van de tolkentelefoon wordt veel gewerkt met vertalende kennissen of familieleden van de zwangere.

In de landelijke *registerstudie* worden ook aanwijzingen gevonden voor mogelijke gevolgen van (onopgeloste) taalbarrières voor de zorg. Zo wordt bij asielzoekers en statushouders vaker een spoedkeizersnede onder algehele anesthesie uitgevoerd dan bij vrouwen zonder migratieachter-grond (namelijk in 11.3% versus 6.3% van de spoed keizersnedes), wat erop zou kunnen wijzen dat zorgverleners geen tijd hebben of nemen om uitleg te geven over de ruggenprik als alternatief.

Zorgverleners geven in de *interviews* en *focusgroepen* aan dat ze blij zijn dat de tolkentelefoon bestaat en (weer) vergoed wordt. Wel zijn er een aantal factoren die het werken met tolken soms belemmeren. Behalve de beperkte beschikbaarheid is ook de kwaliteit van tolken wisselend, en zijn er regelmatig tolken die niet letterlijk vertalen wat er wordt gezegd. Dit leidt nogal eens tot misverstanden. Daarnaast registreren zorgverleners dat vrouwen zich bij sommige – waaronder vaak mannelijke – tolken minder veilig voelen om vrijuit te spreken.

Ervaringen van professionals
Uit de ervaringen van zorgverleners blijkt opnieuw dat taalbarrières ernstige gevolgen kunnen hebben:

> *"Ik heb toevallig zelf een keer meegemaakt dat er een dame heel veel bloedverlies had maar zij sprak - nou ik weet niet welke taal, maar bijvoorbeeld Tigrinya, en er was niemand in haar buurt op dat moment die Engels kon. Dus toen heeft het iets van twee uur geduurd voordat er iemand was die, voor haar, mij kon bellen. En toen kwam ik inmiddels te laat, want toen was er inderdaad iets met het kindje aan de hand waardoor zij zoveel bloedde. Maar omdat ze gewoon niet wist hoe ze ons moest bereiken door een taalbarrière, heeft ze gewoon maar niet gebeld. En toen is dat ook misgegaan."* **– Deelnemer interviews (verloskundige)**

Ervaringen van vrouwen met een vluchtachtergrond
Opvallend is dat zwangeren taalbarrières niet als het belangrijkste probleem in de zorg beoordelen. Het lijkt erop dat de verwachtingen van vrouwen ten aanzien van communicatie laag zijn en niet aansluiten bij hun rechten. Zo weet geen van de vrouwen in de *focusgroepen* dat zij mogen vragen om een tolk, en beschouwen zij het als vanzelfsprekend om hun eigen tolk te regelen bij afspraken. Volgens vrouwen wordt dit met name in het ziekenhuis ook expliciet aan zwangeren gevraagd. Dit leidt tot problemen als zij niemand kunnen vinden, of sensitieve informatie niet willen delen met iemand uit hun eigen netwerk.

> *"In de AZC's is het in theorie geregeld, maar als vriendinnen naar de verloskundige moeten, bellen ze mij alsnog om te tolken omdat de verloskundige vraagt om zelf iemand te regelen."* **– Deelnemer focusgroepen (zwangere met vluchtachtergrond)**

Aanbevelingen
- Neem specifieke aanbevelingen over de inzet van tolken op in alle relevante richtlijnen in de geboortezorg, ook in de Zorgstandaard Integrale Geboortezorg;
- Ontwikkel en integreer onderwijs op het gebied van communicatie met tolken in de opleiding en nascholing van professionals in de zorg en het sociale domein;
- Specificeer in de Ketenrichtlijn op welke momenten in het zorgpad de inzet van een tolk noodzakelijk is; bijvoorbeeld bij de intake, consulten over prenatale screening en diagnostiek, en het bespreken van de bevalling en het geboorteplan. Neem hierbij adviezen over uit de huidig geldende Kwaliteitsnorm tolkgebruik in de zorg, en de toekomstige richtlijnmodule.

- Zorg dat binnen praktijk, afdeling of organisatie alle medewerkers bekend zijn met de procedure voor het reserveren of ad hoc inschakelen van een tolk, inclusief het telefoonnummer en de werkwijze van de tolkentelefoon. Integreer deze informatie in het lokaal uitgewerkte zorgpad voor asielzoekers en statushouders;
- Zorg dat elke individuele zorgverlener een zorgvuldige inschatting van het taalniveau en de gezondheidsvaardigheden van de zwangere maakt, en daarop de communicatiestrategie baseert, inclusief het gebruik van een tolk wanneer nodig;
- Laat in het dossier van elke zwangere een notitie opnemen van het taalniveau en de gewenste strategie m.b.t het omgaan met taalverschillen. Het overbruggen van taalbarrières is de verantwoordelijkheid van de zorgverlener, maar beslissingen over de strategie dienen in samenspraak met de zwangere plaats te vinden;
- Verplicht vrouwen nooit om een naaste mee te nemen om te tolken. Voorkom tevens dat minderjarige kinderen als tolk worden ingezet;
- Zet actief in op het zien van de vrouw zonder de naaste bij vermoedens van afhankelijkheid, geweld, of andere gevoelige onderwerpen die van belang zijn voor de zwangerschaps-begeleiding;
- Overweeg een fysiek aanwezige tolk bij angstige of verwarde zwangeren, slecht-nieuws gesprekken, of consulten waarin beeldvorming wordt besproken.

4.3.2 Cultuursensitiviteit

Culturele verschillen, bijvoorbeeld in normen en waarden, communicatiestijlen, en tradities rondom zwangerschap en geboorte, vormen zowel een verrijking als uitdaging voor zorgverleners.[18] Soms gaan culturele verschillen gepaard met ongelijke machtsverhoudingen, (onbewuste) vooroordelen en stigmatisering in de zorg.19 Discriminatie in de zorg – een ongelijkwaardige behandeling van mensen op basis van hun raciale, etnische of culturele achtergrond of andere identiteitskenmerken – draagt bij aan meer ziekte en sterfte onder gediscrimineerde groepen, en komt ook in de geboortezorg voor.[20-22]

Specifieke aandacht voor de culturele achtergronden van asielzoekers en statushouders is dus cruciaal voor het bieden van gelijkwaardige zorg. Het is van belang daarbij de diversiteit binnen deze groepen te benadrukken en niet te generaliseren op basis van culturele of etnische achtergrond. Zo komen bepaalde problemen als infectieziekten, vrouwenbesnijdenis en anemie in de zwangerschap vaker voor bij sommige – maar zeker niet alle – bevolkingsgroepen. Gebrek aan aandacht voor mogelijke verschillen ten opzichte van vrouwen zonder migratieachtergrond kan leiden tot gemiste zorgbehoeften, en veralgemeniseren van deze verschillen juist tot stigmatisering. Bovendien zijn er problemen die los

van cultuur of achtergrond vaker voorkomen bij asielzoekers en statushouders, zoals stress en trauma, en daarom meer aandacht verdienen.

Ook in EGALITE blijkt de omgang met (culturele) diversiteit soms een barrière voor het realiseren van gelijkwaardige zorg. Zo geven zorgverleners in de *perinatale auditstudie* regelmatig een negatieve beschrijving van vrouwen met een vluchtachtergrond, zoals 'niet coöperatief' of 'onhandelbaar', terwijl er geen tolk wordt ingeschakeld om taal- en cultuurverschillen te overbruggen. Ook treedt er soms vertraging op tussen symptomen die de zwangere aangeeft (zoals pijn), en de behandeling (zoals een spoedkeizersnede bij een uterusruptuur), wat erop kan wijzen dat uitingen van pijn minder serieus worden genomen bij vrouwen met bepaalde culturele achtergronden.[23, 24] In de *registerstudie* ontvangen asielzoekers en statushouders in het algemeen vaker geen pijnstilling bij de baring (28.9%) dan Nederlanders zonder migratieachtergrond (26%). Ook in de *dossierstudie* lijkt bepaalde zorg soms minder te worden aangeboden aan asielzoekers dan richtlijnen voorschrijven. Bij een kwart van de zwangeren is er geen counseling geweest voor de NIPT, of is het onbekend of er counseling heeft plaatsgevonden (bijlage 1, tabel 3). Deze bevinding sluit aan bij eerder onderzoek waarin Nederlandse verloskundigen minder informatie over prenatale diagnostiek aanboden aan vrouwen met een migratieachtergrond. Dit kwam voort uit culturele aannames waardoor verloskundigen ervanuit gingen dat vrouwen geen behoefte hadden aan deze informatie.[25] Hetzelfde geldt mogelijk voor het opstellen van een geboorteplan, waarover slechts in een minderheid (23.8%) van de dossiers van asielzoekers een notitie is gemaakt.

Ervaringen van professionals

In de *EGALITE vragenlijst* en *interviewstudie* benoemen professionals dat sommige cultuurverschillen uitdagingen opleveren voor hun zorgverlening. Dit gaat bijvoorbeeld om andere verwachtingen die vrouwen met een vluchtachtergrond soms hebben ten aanzien van de geboortezorg, bijvoorbeeld met betrekking tot het aantal antenatale consulten en interventies tijdens de bevalling. Bovendien merken veel verloskundigen op dat cliënten met een vluchtachtergrond in hun ervaring minder vragen stellen dan andere cliënten.

Verloskundigen noemen ook positieve aspecten van cultuurverschillen, bijvoorbeeld dat zij deze leerzaam vinden. Daarnaast noemen verloskundigen dat vrouwen met een vluchtachtergrond in het algemeen erg dankbaar zijn en snel tevreden met de zorg vergeleken met andere zwangere vrouwen. Sommige van deze observaties kunnen echter ook duiden op culturele misinterpretaties van zorgverleners, of op angst onder mensen met een vluchtachtergrond om kritisch te zijn op de zorgverlening. Daarnaast kan hun ogenschijnlijke tevredenheid voortkomen uit lage verwachtingen. [26] Een deel van de zorgverleners in de

focusgroepen beschouwt hun eigen beperkte kennis en vaardigheden op het gebied van interculturele zorg als uitdaging.

Ervaringen van vrouwen met een vluchtachtergrond
De meeste zwangeren ervaren dat zij met respect worden behandeld door hun zorgverleners, wat eraan bijdraagt dat zij zich op hun gemak voelen - een gevoel dat veel vrouwen buiten de spreekkamer missen:

> *"Ja, daarbinnen [in de spreekkamer van de verloskundige] voel ik me op mijn gemak (…) omdat ze aardig tegen me praat, net als tegen andere mensen. Maar als ik daar in de wachtkamer wacht, voel ik me niet comfortabel (…) omdat ze me vreemd aankijken. En, ze praten niet met me."* **– Deelnemer interviews (zwangere met vluchtachtergrond)**

Toch benoemen vrouwen ook ervaringen van discriminatie in de zorg, bijvoorbeeld door de houding van zorgverleners ten aanzien van hun status als asielzoeker:

> *"Wanneer ik vraag naar [een extra echo], is het van 'ja, je woont in een AZC dus het is niet gratis voor jou, je moet extra betalen'. En dat wil ik ook wel [extra betalen], maar dan heb ik het gevoel dat je me er steeds aan herinnert dat ik een asielzoeker ben, dat ik in het AZC woon (...)."* **– Deelnemer focusgroepen (zwangere met vluchtachtergrond)**

Daarnaast komt de *focusgroepen* naar voren dat vrouwen vanuit hun land van herkomst andere zorg of een andere houding van artsen gewend zijn, waardoor zij moeten wennen aan de Nederlandse zorgverlening en soms teleurgesteld worden. Dit gaat bijvoorbeeld om aspecten als medicatieverstrekking, doorverwijzing naar specialisten, maar ook het gevoel minder goed gehoord te worden door artsen:

> *"Wij vinden dat Nederlandse artsen meer praten dan dat ze luisteren naar wat het probleem echt is."* **– Deelnemer focusgroepen (zwangere met vluchtachtergrond)**

Ook rondom de baring geven vrouwen aan soms overrompeld te worden door zorgverleners, waarbij niet altijd ruimte is voor hun behoeften, gevoelens of verwachtingen:

> *"Ik had al zeven centimeter ontsluiting, en ik dacht dat de bevalling gewoon doorging, dat ik aan het bevallen was, maar de dokter zei 'nee, de hartslag van de baby is omhoog gegaan, je hebt nog steeds een keizersnede nodig'. En ik vond het helemaal niet nodig. Omdat ik net zo goed had kunnen doorgaan in*

de tijd dat ik van de ene kamer naar de andere werd gebracht." **– Deelnemer focusgroepen (zwangere met vluchtachtergrond)**

Een vrouw die haar ervaringen met zwangerschap als asielzoeker in Nederland deelt in de EGALITE projectvideo, noemt empathisch contact als belangrijk gemis tijdens haar zwangerschap:

"Maar wat ik niet goed vind [aan de zorg] - geen gesprek dat ik een gevoel krijg van 'je bent veilig. Het komt goed.' Dat je gewoon het gevoel geeft van 'Ik ben met jou. Ik ben naast jou. Ik voel het wat jij voelt.'" **– (projectvideo EGALITE, 2021)**

Aanbevelingen

- Ontwikkel, faciliteer en financier meer (na)scholing voor zorgverleners onder alle ketenpartners, om hen te helpen cultureel sensitieve geboortezorg te bieden. Zorg dat cultuursensitiviteit een integraal onderdeel wordt van alle zorgopleidingen en overweeg nascholing verplicht te stellen om gezondheidsuitkomsten te verbeteren;
- Stimuleer en ondersteun meer culturele diversiteit binnen de gezondheidszorgopleidingen en -beroepen. Werk actief aan het bevorderen van etnische en culturele diversiteit onder zorgpersoneel gezien bewezen positieve effecten op de zorgkwaliteit en patiënttevredenheid;
- Streef naar zorg op maat voor elke individuele zwangere asielzoeker en statushouder, zonder algemene aannames over groepen. Ga niet uit van een 'checklist' van feiten over andere culturen, maar van een algemene houding van openheid en respect voor culturele verschillen[27];
- Reflecteer als zorgverlener op eigen zorg en uw waarden, overtuigingen en mogelijke machtsverschillen en vooroordelen. Het bewustzijn van het eigen vertrekpunt en blinde vlekken is een voorwaarde om mensen cultuursensitief te kunnen begeleiden. Stel open vragen om cliënten aan te moedigen om te praten over hun culturele achtergrond en eventuele specifieke tradities of overtuigingen die van invloed kunnen zijn op de zorgbehoefte.

4.3.3 Documentatie en registratie in de zorg

Uit de diverse EGALITE onderzoeken blijkt dat er slechts beperkt aantal gegevens voor onderzoek beschikbaar zijn op het gebied van de kwaliteit van de zorg en de geboorte-uitkomsten van zwangere asielzoekers en statushouders. Door de *dossierstudie* blijkt bijvoorbeeld dat verloskundige informatiesystemen geen duidelijke vermelding bevatten of een zwangere vrouw een asielzoeker of statushouder is. In de *vragenlijststudie* geven slechts 2 (2%) van de verloskundigen aan dat zij de uitkomsten van asielzoekers in hun praktijk specifiek bijhouden; bij statushouders is dit nergens het geval.

In de *registerstudie* wordt duidelijk dat asielzoekers en statushouders moeilijk te identificeren zijn in Perined. Momenteel is in Perined alleen de etniciteit van de moeder beschikbaar, maar deze variabele wordt slecht gedocumenteerd en betreft een verouderde classificatie van etniciteit. Internationaal onderzoek toont aan dat bepaalde indicatoren, zoals geboorteland van de moeder, duur van verblijf in het gastland en wettelijke status, noodzakelijk en bevorderlijk zijn voor onderzoek naar het verminderen van gezondheidsverschillen onder gemarginaliseerde groepen.[28]

In de *registerstudie* zijn geboorte-uitkomsten van asielzoekers en statushouders landelijk in kaart gebracht door middel van koppeling van data van het CBS aan Perined. Toch zijn er aanwijzingen dat deze studie het aantal ernstige uitkomsten onderschat doordat deze onzichtbaar blijven in de huidige registraties. Zo is in ieder geval één geval van maternale sterfte gemist, omdat deze moeder zonder burgerservicenummer (BSN) niet aan Perined kon worden gekoppeld. Mensen krijgen pas een BSN nadat zij een verblijfsvergunning krijgen of minimaal zes maanden in Nederland verblijven.

In de *perinatale auditstudie* zijn casussen van asielzoekers en statushouders handmatig opgezocht in de chronologische verslagen van het auditregister. Het is ook mogelijk dat asielzoekers en statushouders niet besproken worden in de perinatale audit; in de *vragenlijststudie* geeft 13% van de eerstelijns verloskundigen bijvoorbeeld aan dat casuïstiek van asielzoekers niet in de regionale audit wordt besproken.

Er zijn geen verdere ervaringen van zorgprofessionals of zwangere vrouwen verzameld over documentatie en registratie. De volgende aanbevelingen zijn daarom direct gebaseerd op onze bevindingen tijdens het onderzoek.

Aanbevelingen

- Neem in verloskundige informatiesystemen, zoals ChipSoft, Epic, Onatal, Orfeus en Vrumun, invulvelden op voor informatie met betrekking tot de migratieachtergrond van zwangeren. Voeg deze ook als verplichte invulvelden toe aan de landelijke registratie van de geboortezorgketen (Perined). Neem hierin minimaal het geboorteland, de duur van verblijf in Nederland en wettelijke status als asielzoeker, statushouder of ongedocumenteerde migrant op;
- Versnel de inschrijving van statushouders in de Basisregistratie Personen en/of waarborg dat kinderen van ouders zonder BSN toch middels een ander identificatienummer (zoals het V-nummer van asielzoekers) gekoppeld kunnen worden vanuit CBS aan andere databases, zoals Perined;

- Neem alle in Nederland geboren kinderen op in de landelijke CBS-geboortestatistieken, dus ook kinderen van ouders zonder BSN;
- Verbeter de beschikbaarheid van data uit centrale informatiesystemen (zoals gebruikt door GZA) voor onderzoek en monitoring van gezondheidsuitkomsten- en behoeften rondom zwangerschap en geboorte;
- Meld calamiteiten in de geboortezorg voor asielzoekers en statushouders bij de Inspectie voor Gezondheidszorg en Jeugd, en neem casuïstiek mee in regionale perinatale audits. Overweeg om casuïstiek van asielzoekers en statushouders als thema of apart onderdeel van de audit op te nemen, om de specifieke verbeterpunten in de zorg voor deze groepen duidelijker te identificeren;
- Faciliteer geboorteaangifte bij de gemeente voor ouders die zelf (nog) geen BSN hebben.

4.3.4 Psychosociale- en geestelijke gezondheid

Vrouwen met een vluchtachtergrond hebben tijdens de perinatale periode meer kans op psychische klachten dan andere vrouwen.[29] Psychische problemen zoals depressie, angst en posttraumatische stressstoornis komen waarschijnlijk veel vaker voor, terwijl deze lang niet altijd herkend en behandeld worden. Opvallend is dat meer dan de helft (53%) van de verloskundigen in de *vragenlijststudie* zelden of nooit informatie ontvangt over de psychosociale situatie van hun cliënten die verblijven op opvanglocaties, terwijl de Ketenrichtlijn dit wel voorschrijft. Ook geeft een deel van de verloskundigen (23% zowel voor asielzoekers als statushouders) aan meestal geen gesprek te voeren over de psychosociale situatie van hun cliënt. In de *dossierstudie* wordt bij slechts 7% van de asielzoekers een gestandaardiseerde vragenlijst gebruikt om de psychosociale gezondheid in kaart te brengen. Dit betreft altijd een eigen vragenlijst van de verloskundige praktijk; er wordt geen gebruik gemaakt van gevalideerde instrumenten zoals de Mind2Care of R4U. Uit de *EGALITE vragenlijst* blijkt dat bijna 20% van de verloskundigen asielzoekers en statushouders nooit doorverwijst naar geestelijke gezondheidszorg. Wanneer doorverwijzing wel plaatsvindt, is dit voornamelijk naar GZA (34%) of het ziekenhuis (33%) voor asielzoekers en naar de huisarts (49%) voor statushouders. In de *dossierstudie* werd bijna de helft van de vrouwen met een indicatie voor geestelijke gezondheidszorg blijkens hun dossier niet doorverwezen.

Er is nog weinig onderzoek gedaan naar de psychische gezondheid van zwangere asielzoekers en statushouders in Nederland. Eerder onderzoek toonde al wel aan dat verschillende factoren het psychisch welzijn van asielzoekers in algemene zin negatief beïnvloeden, waaronder een lange duur van de asielprocedure en het verblijf in opvanglocaties, overplaatsingen, en angst voor uitzetting.[30,31]

Ervaringen zorgprofessionals
Hoewel EGALITE de geestelijke gezondheidstuitkomsten niet onderzocht, noemen veel zorgprofessionals in de *interviews* en *focusgroepen* het gebrek aan passende zorg voor psychische klachten als een belangrijk knelpunt in de geboortezorg voor asielzoekers en statushouders.

> *"Wat denk ik ook echt helemaal tekortschiet: psychische klachten, depressieve klachten. Ik denk dat ze daar nergens mee terecht kunnen eigenlijk, alleen al doordat het niet besproken wordt."* **– Deelnemer interviews (verloskundige)**

Veel verloskundigen voelen zich onvoldoende toegerust om zelf psychologische ondersteuning te bieden:

> *"Want dat is natuurlijk ons vak niet. En ook te intensief, weet je, soms dan staan bijna de tranen in je ogen als je hoort wat ze hebben meegemaakt."* **– Deelnemer interviews (verloskundige)**

De meeste verloskundigen vragen beperkt naar psychische klachten, mede omdat de mogelijkheden om asielzoekers en statushouders door te verwijzen bij psychische klachten beperkt zijn. Hoewel asielzoekers via GZA meestal bij een POH-GGZ terecht kunnen, zijn de wachtlijsten voor geschikte (tweedelijns) psychologische zorg lang. De gespecialiseerde POP-poli's in ziekenhuizen zijn vaak niet toegankelijk voor vrouwen vanwege de taal of de afstand tot de opvanglocatie.

Ervaringen van vrouwen met een vluchtachtergrond
De meeste vrouwen in de *interviews* en *focusgroepen* ervaren het leven als asielzoeker, en in verschillende mate als statushouder, los van hun zwangerschap, als zeer stressvol. Ze beschrijven hoe deze ervaren stress leidt tot complexe emoties tijdens hun zwangerschap:

> *"Ja. Ik voel me blij, maar blij en verdrietig. Ik weet niet hoe mijn leven zal zijn met mijn baby. Omdat hier zijn vandaag, hier willen zijn - het is moeilijk. Voordat ik alleen was, was het moeilijk. En nu met mijn jongen - met mijn baby, denk ik veel na. Het is zwaar en soms slaap ik niet goed. (…) Ja, want ik wil niet dat mijn baby een leven leidt zoals ik hier. Ik wil dat mijn baby een goed leven leidt, een normaal leven."* **- Deelnemer interview (zwangere met vluchtachtergrond)**

Tijdens hun zwangerschap ervaren veel vrouwen juist dat er tijdelijk meer ondersteuning en aandacht is voor hun (psychische) behoeften. Met name de

begeleiding van eerstelijns verloskundigen, maar ook die van andere zorgverleners en COA-aandachts-functionarissen, wordt erg gewaardeerd:

> *"Het geeft echt een warm gevoel hoe de mensen met je omgaan, heel beschermend ook, om je heen de hele tijd. Het neemt een beetje weg van de heimwee dat je moeder niet bij je is."* **– Deelnemer focusgroepen (zwangere met vluchtachtergrond)**

Deze positieve beleving van zorg en aandacht is voor sommige vrouwen zo betekenisvol dat ze om die reden opnieuw zwanger zouden willen worden:

> *"Omdat het zo fijn was de bevalling, soms [heb ik] gewoon alleen al het verlangen om opnieuw te bevallen, om al die aandacht te krijgen."* **– Deelnemer focusgroepen (zwangere met vluchtachtergrond)**

Desondanks komt naar voren dat er bij veel vrouwen achteraf een duidelijke wens is voor meer gespecialiseerde steun op het gebied van geestelijke gezondheid:

> *"Hier zijn zonder familie is echt heel zwaar. En helaas is er niks om je hiermee te helpen. Vooral voor je geestelijke gezondheid, je hebt hulp nodig, maar niemand kan je helpen. Dus ik weet niet waarom er geen geestelijke gezondheidszorg is, voor zwangere vrouwen zoals wij. De eerste baby alleen... Ja, het is echt heel stressvol."* **– Deelnemer focusgroepen (zwangere met vluchtachtergrond)**

Aanbevelingen

- Het (structureel) verbeteren van de mentale gezondheid van asielzoekers en statushouders vereist structurele aanpassingen zoals het verkorten van wachttijden in de asielprocedure, verbeteren van leefomstandigheden en beperken van overplaatsingen, gezien de samenhang tussen deze factoren en psychische problematiek;
- Integreer gestandaardiseerde screening op psychosociale problemen in de reguliere zorg voor zwangere vrouwen met een vluchtachtergrond (bijvoorbeeld middels de Refugee Health Screener-15).[32] Neem hierover tevens aanbevelingen op in de Ketenrichtlijn voor asielzoekers;
- Definieer duidelijke zorgpaden voor doorverwijzing van verloskundige naar zowel laagdrempelige (eerstelijns) als gespecialiseerde geestelijke gezondheidszorg voor vrouwen met een vluchtachtergrond;
- Verbeter de toegankelijkheid van het bestaande aanbod in perinatale geestelijke gezondheidszorg, zoals bij POP-poli's, specifiek voor asielzoekers en statushouders, bijvoorbeeld door meer inzet van tolkdiensten en nauwere samenwerking met de eerstelijnszorg in Opvanglocaties. Overweeg ook het opzetten van gerichte preventieprogramma's voor zwangere vrouwen in

opvanglocaties, vergelijkbaar met het BAMBOO-programma voor de bredere populatie asielzoekers.

4.3.5 Kraamperiode
Meestal is mantelzorg door familie beperkt mogelijk in de kraamperiode van asielzoekers en statushouders, waarmee het belang van passende kraamzorg groot is. Voor asielzoekers wordt kraamzorg conform de reguliere indicatiestelling vergoed door RMA, tot een maximum van 80 uur gespreid over 10 dagen. Aanstaande ouders in de asielopvang hebben recht op een babypakket van het COA, bestaande uit gebruiksartikelen (zoals een ledikant) en een eenmalige verstrekking om verbruiksartikelen (zoals flesjes) aan te schaffen. Op sommige locaties (COL) krijgen asielzoekers alle artikelen in natura.

Volgens de Ketenrichtlijn is het COA verantwoordelijk voor het verstrekken van schriftelijke informatie over kraamzorg en benodigdheden voor het verzorgen van baby en moeder. Vervolgens dient ook de verloskundig zorgverlener de zwangere te informeren over het regelen van kraamzorg en hierbij zo nodig te ondersteunen. In de praktijk bestaat echter vaak verwarring over deze verantwoordelijkheden. Een groot deel (65%) van de COA-aandachts-functionarissen geeft in het *vragenlijstonderzoek* aan doorgaans ondersteuning te bieden bij de aanmelding voor kraamzorg. Desondanks melden kraamverzorgenden dat zij soms pas postpartum worden betrokken. In de *dossierstudie* werd een klein deel (6%) van de asielzoekers na de aanbevolen 32 weken aangemeld bij een kraamzorgorganisatie.

Daarnaast schrijft de Ketenrichtlijn voor dat er tussen de 34e en 36e week een huisbezoek door de verloskundig zorgverlener of de kraamzorg plaatsvindt. Volgens eerstelijns verloskundigen in de vragenlijst vindt dit in de praktijk bij een minderheid vaak of altijd plaats (20% bij statushouders, en 37% bij asielzoekers). Sinds 2022 zijn gemeenten daarnaast verplicht een prenataal huisbezoek door de JGZ aan te bieden aan zwangeren in een kwetsbare situatie. Inmiddels is deze zorg ook door COA ingekocht bij GGD Ghor. In EGALITE is niet onderzocht hoe vaak het PHB-JGZ plaatsvindt bij asielzoekers en statushouders.

Ten slotte noemen COA-aandachts-functionarissen in de *EGALITE vragenlijst* en *focusgroepen* de geboorteaangifte van pasgeborenen bij asielzoekers als knelpunt. De Ketenrichtlijn schrijft voor dat verloskundig zorgverlener toeziet op geboorteaangifte bij de gemeente. De *dossierstudie* suggereert dat dit niet in alle gevallen (43%) daadwerkelijk gebeurt.

Voor statushouders geldt een eigen bijdrage van ongeveer vijf euro per uur voor kraamzorg. Dit bedrag wordt in de *focusgroepen* aangedragen als barrière voor

optimale zorg. Ook zijn veel kraamverzorgenden niet op de hoogte van het feit dat zij sinds 2023 weer de tolkentelefoon kunnen inschakelen.

Uit de studie van het UMC Groningen met gegevens van de *landelijke perinatale audit* blijkt dat onder andere de zorg rondom hyperbilirubinemie bij pasgeboren baby's van asielzoekers en statushouders vaak suboptimaal verloopt.[10]

Ervaringen van professionals in de geboortezorg
Hoewel de ervaringen van kraamverzorgenden beperkt aan bod zijn gekomen, brengen de *EGALITE vragenlijst* en *focusgroepen* verschillende praktische obstakels in opvanglocaties aan het licht. Voorbeelden zijn een incomplete kraamuitzet, gebrek aan kolfapparaat, of de centrale verwarming die niet is aan te passen in het verblijf van de pasgeborene. Daarnaast ervaren kraamverzorgenden uitdagingen in de samenwerking in de zorg voor asielzoekers; zo wordt de kraamzorg bij overplaatsingen lang niet altijd geïnformeerd.

Niet alle kraamverzorgenden voelen zich comfortabel om te werken op opvanglocaties, mede omdat zij onvoldoende weten hoe zij hun zorg kunnen aanpassen aan de omstandigheden en achtergrond van cliënten:

> *"Onbekend maakt onbemind; als we meer scholing krijgen, zouden collega's veel beter kunnen aansluiten bij vrouwen op AZC locaties."* **– Deelnemer focusgroepen (professional)**

Kraamverzorgenden ervaren dat vrouwen met een vluchtachtergrond vaak niet bekend zijn met het concept van kraamzorg:

> *"Vertrouwen winnen [is een uitdaging], ze denken vaak dat we komen controleren en rapporteren aan instanties."* **– Deelnemer EGALITE vragenlijst (kraamverzorgende)**

Terwijl sommige kraamverzorgenden zich afvragen hoe ze het minimale aantal uren moeten invullen op een opvanglocatie, vinden anderen de opdracht minimale zorg (3 uur per dag) waarmee zij meestal aan het werk gaan, juist te beperkt. Bovendien heerst er vaak onduidelijkheid over het toegestane aantal uren kraamzorg voor asielzoekers:

> *"RMA heeft de ruimte om het [aantal uren] uit te breiden op indicatie, al is dat niet overal bekend, want kraamzorg krijgt nu de boodschap dat ze niet langer mogen gaan dan minimale uren."* **– Deelnemer focusgroepen (professional)**

Ervaringen van vrouwen met een vluchtachtergrond
Hoewel de meeste vrouwen vanuit hun land van herkomst niet bekend zijn met kraamzorg zoals deze in Nederland bestaat, waarderen veel van hen de professionele ondersteuning tijdens de kraamperiode:

> *"In [thuisland] krijg je tips van je moeder, je schoonmoeder, je tantes, achterfamilie... En je weet niet – de tips van de een zijn goed en van de ander niet... Dus kraamzorg is dan eigenlijk fijner soms dan al die verschillende meningen. Omdat ze praat vanuit haar deskundigheid en niet zozeer vanuit de ervaring."* **– Deelnemer focusgroepen (zwangere met vluchtachtergrond)**

Toch noemen vrouwen in de *focusgroepen* ook barrières in relatie tot kraamzorg, zoals de financiële bijdrage voor statushouders, en communicatieproblemen doordat tolken niet worden ingeschakeld. Vrouwen die tijdens de zwangerschap al een huisbezoek krijgen van de kraamzorg waarderen dit, maar dit vindt nog lang niet bij iedereen plaats.

Enkele vrouwen ervaren dat de kraamverzorgende voornamelijk het kind controleert en minder oog had voor de hulpvraag van de moeder:

> *"Zij deed eigenlijk niets. Alleen maar aan de tafel zitten, schrijven, schrijven. En na een paar uurtjes weggaan. (…) Niet zoveel voor mij, alleen even baby checken, van koorts, geel en zo. Terwijl ik eigenlijk twee dingen nodig had, kleren opvouwen of schoonmaken."* **– Deelnemer focusgroepen (zwangere met vluchtachtergrond)**

Aanbevelingen
- Verduidelijk de aanbevelingen in de Ketenrichtlijn ten aanzien van de aanmelding en coördinatie van kraamzorg, het aantal kraamzorguren voor asielzoekers, en prenatale huisbezoeken door verloskundige, kraamverzorgende en JGZ. Maak ook duidelijk dat asielzoekers geen eigen bijdrage betalen voor kraamzorg via RMA;
- Investeer in bekwaamheid van kraamverzorgenden om zorg op maat te leveren in locaties waar de zorg voor asielzoekers geconcentreerd is, bijvoorbeeld door ontwikkeling van een specifieke richtlijn voor kraamzorg op opvanglocaties, scholing voor kraamverzorgenden, en kennisverspreiding via het Kenniscentrum Kraamzorg. Neem hierin ook aandachtspunten op vanuit wetenschappelijk onderzoek, bijvoorbeeld over de herkenning van hyperbilirubinemie bij baby's met een donkere huidskleur;
- Overweeg om asielzoekers en statushouders aan te merken als kwetsbare groepen in de vernieuwing van het indicatieprotocol voor de kraamzorg in Nederland (Kraamzorg Landelijke Indicatie Methodiek);

- Zorg voor uniforme en complete kraampakketten en voorlichting ten aanzien van aan te schaffen kraamartikelen op alle opvanglocaties;
- Maak kraamzorg toegankelijker voor statushouders door de eigen bijdrage af te schaffen.
- Verricht als verloskundige en/of kraamverzorgende een prenataal huisbezoek bij asielzoekers en statushouders, eventueel geïntegreerd met een huisbezoek door een jeugdverpleegkundige. Ga bij asielzoekers zorgvuldig na of het kraampakket en de kraamuitzet volledig is, en eventueel of er kolfapparatuur op de opvanglocatie aanwezig is;
- Zorg dat binnen de organisatie verschillende kraamverzorgenden de weg op de opvanglocatie goed kennen en aanspreekpunt voor collega's en andere ketenpartners kunnen zijn;
- Overweeg sterk om een sociaal kraambed in een geboortecentrum aan te vragen voor asielzoekers, of voor statushouders met een suboptimale thuissituatie;
- Maak zoveel mogelijk voorafgaand aan de kraamperiode duidelijk wat kraamzorg precies inhoudt, bijvoorbeeld door aan te sluiten bij het spreekuur van de verloskundige, zodat de kraamverzorgende alvast een bekend gezicht is voor de zwangere;
- Maak ook bij kraamzorg gebruik van tolkentelefoon, en van anderstalige- of beeldmaterialen gericht op de kraamperiode en de zorg voor pasgeborenen;
- Organiseer een bezoek van de kraamzorgorganisatie aan opvanglocaties waar de zorg voor zwangeren is geconcentreerd, bijvoorbeeld met een rondleiding door medewerkers van het COA of GZA;
- Bied conform de ZIG aan iedere asielzoeker en statushouder een postpartum consult (nacontrole) aan, waarin de ervaring van de zwangere en bijvoorbeeld anticonceptiewens aan bod kunnen komen.

4.4 Sociale en politieke context van de zorg

4.4.1 Omstandigheden opvanglocaties

Sociale determinanten van gezondheid, gedefinieerd als de omstandigheden waarin mensen worden geboren, opgroeien, leven, werken en ouder worden hebben een belangrijke invloed op de gezondheid van individuen, en zijn als zodanig grotendeels verantwoordelijk voor gezondheids-ongelijkheden tussen groepen mensen. Zo komen meer gezondheidsproblemen voor in slechtere woonomstandigheden. In eerder onderzoek werd gevonden dat fysieke aspecten van huisvesting, maar ook veiligheid en drukte op opvanglocaties, invloed hebben op de fysieke en mentale gezondheid van zwangeren in Duitsland.[33,34]

De leefomstandigheden binnen opvanglocaties voor asielzoekers in Nederland variëren aanzienlijk. Naast reguliere locaties zijn er de afgelopen jaren tal van

nood- en crisisnoodopvanglocaties opgericht vanwege capaciteitsproblematiek in de asielketen. Hoewel (crisis)noodopvanglocaties bedoeld zijn voor een tijdelijk verblijf van enkele weken, blijkt dat sommige locaties aanzienlijk langer operationeel zijn dan aanvankelijk voorzien. Op deze locaties zijn wisselende partijen verantwoordelijk voor de opvang en de gezondheidszorg. GZA is niet altijd fysiek aanwezig en de eerstelijnszorg wordt er (gedeeltelijk) overgenomen door lokale huisartsen, andere zorgorganisaties (zoals Arts & Specialist).

Specifiek onderzoek naar de gezondheid van zwangere vrouwen in deze noodopvanglocaties ontbreekt nog. Desalniettemin verschenen tijdens de EGALITE onderzoeksperiode verschillende kritische berichten over ontoereikende toegang tot zorg op crisisnoodopvanglocaties. Rapporten van de Inspectie belichten tekortkomingen in onder andere hygiëne, privacy van bewoners en de toegang tot zorg. Bovendien heeft de Europese Commissie bezorgdheid geuit over de schending van de Universele Mensenrechten op bepaalde locaties, zoals in Ter Apel, waar mensen in verschillende perioden (zomer 2022, najaar 2023) buiten overnachtten in verband met plaatsgebrek.

Ervaringen van professionals

De veelal ongunstige omstandigheden in opvanglocaties hebben ook invloed op de verloskundige zorg en op zorgverleners, zo blijkt uit de *vragenlijst-, interview-, en perinatale auditstudies*. Zo staan verloskundigen vaak voor dilemma's wanneer cliënten hen vragen om een betere woonplek of andere voeding te regelen. De stressfactoren die voortvloeien uit het verblijf in een opvanglocatie (zie ook *4.3.4. Psychosociale- en geestelijke gezondheid*) zijn niet alleen belastend voor zwangere vrouwen, maar ook voor hun zorgverleners:

> *"Als je iemand ziet zeggen dat ze zich depressief voelt omdat er zo'n lading vanuit COA op haar ligt, dat ze mogelijk wel uitgezet wordt, dat ze verplaats wordt naar een andere instelling [bedoelt AZC] en dat ze zich onveilig voelt, dat ze niet naar land van herkomst terug kan, omdat ze dan met de dood bedreigd wordt. Dat zie je voor je neus gebeuren en vervolgens, ja, denk je: 'Oh mijn God, die vrouw kan echt niet terug, want die wordt gewoon vermoord. (…) Dat raakt je dan gewoon."* **Deelnemer interviews (verloskundige)**

Ook medewerkers van het COA worstelen ermee dat locaties soms niet voldoen aan de randvoorwaarden voor een gezonde zwangerschap:

> *"Als ik één ding mocht veranderen [in de geboortezorg voor asielzoekers] dan zou het zijn dat er geen ratten en ander ongedierte meer rondloopt in de woonruimtes van zwangeren."* **– Deelnemer focusgroepen (professional)**

Ervaringen van vrouwen met een vluchtachtergrond
In de *focusgroepen* komen veel problemen naar voren die zwangeren in een opvanglocatie ervaren, soms gerelateerd aan de fysieke omgeving van een eerste verblijfplaats in een nieuw land:

> *"Ja het was een beetje moeilijk, want ik wil kleding wassen, ik moet naar een verre plaats toegaan. En ik moet de kleding vasthouden en ik moet naar de - misschien moet ik 10 minuten lopen. Dan moet ik weer terugkomen met deze kleding. Het was moeilijk, het was koud, (…). Alles was nieuw voor ons, nieuwe cultuur, nieuwe taal, alles nieuw, nieuwe regels, nieuwe sociale regels, en heel veel afspraken. Het was moeilijk…"* **– Deelnemer interviews (cliënt)**

Daarnaast ervaren de meeste vrouwen in opvanglocaties verschillende stressfactoren, zoals angst voor uitzetting, tijdens de zwangerschap (zie ook: *4.3.4. Psychosociale- en geestelijke gezondheidszorg*). Op sommige locaties hebben vrouwen zelfs het gevoel vergeten te worden:

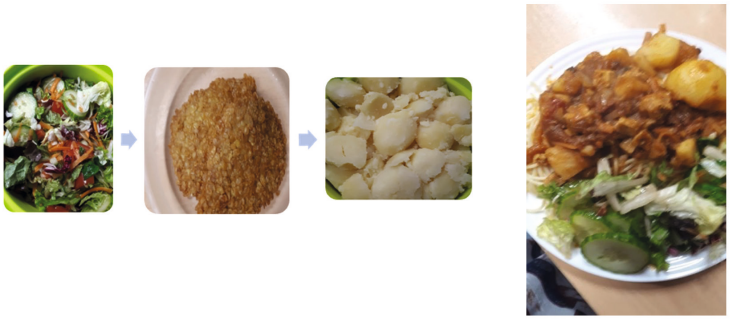
> *"Toen ik in [naam locatie] aankwam, was het eerste wat ik van mensen heb gehoord dat ik nu in het vergeten AZC zit. Wanneer je hier wordt geplaatst vergeet iedereen dat je bestaat. Ik zag ook veel vrouwen die na de bevalling gedeporteerd werden. Ze bleven veertig dagen en direct daarna verdwenen ze uit het AZC. We zagen ze niet meer. Ik was daar ook heel bang voor."* **– Deelnemer interviews (zwangere met vluchtachtergrond)**

De meeste vrouwen ervaren strenge regels vanuit het COA, die een positieve zwangerschapservaring soms belemmeren. Vooral de verstrekte maaltijden op locaties waar niet zelf mag worden gekookt vormen naast de hygiëne een veelgenoemd verbeterpunt:

> *"Betere keukens of kookgelegenheid is nog belangrijker dan dat het schoon is. Je krijgt schoonmaakspullen, dus je kunt vaak zelf schoonmaken. Afhankelijk zijn van de COA catering is erger."* **– Deelnemer focusgroepen (zwangere met vluchtachtergrond)**

In EGALITE zijn de ervaringen van Somalische vrouwen met voeding in opvanglocaties in beeld gebracht middels een *Photovoice* project. Ook hieruit bleek dat vrouwen een grote voorkeur hebben om zelf te kunnen koken:

> *"Sometimes I make my own meals at home of the food I receive from COA. I must do this because I cannot eat the other food. It is not allowed by the rules, but everyone does it (…)."* **– Deelnemer (zwangere met vluchtachtergrond) Photovoice project**



Foto's van deelnemer aan het Photovoice project van Selma Hassan (masterstudent bij EGALITE) tonen hoe vrouwen een traditioneel gerecht bereiden op basis van de maaltijd die zij van het COA krijgen. Officieel is het op locaties waar COA de catering verzorgt niet toegestaan om zelf te koken.

Aanbevelingen

- Neem in de Ketenrichtlijn afspraken op voor medische indicaties ten aanzien van woonomstandigheden, bijvoorbeeld de unit binnen de opvanglocatie, en aangepaste voeding;
- Bij het ontwikkelen van leefstijlzorg dienen zorgverleners, verzekeraars en beleidsmakers speciale aandacht te schenken aan asielzoekers en statushouders. Essentieel is dat opvanglocaties, met name die waar zwangere vrouwen verblijven, een gezonde leefstijl tijdens de zwangerschap niet belemmeren. De voedingsadviezen van Het Voedingscentrum dienen ook in de asielopvang uitvoerbaar te zijn;
- Realiseer kookgelegenheid op alle locaties waar zwangeren verblijven om te kunnen voldoen aan voorgaande voedingsadviezen, afgestemd op persoonlijke en culturele voorkeuren tijdens de zwangerschap.
- Zorg voor voorlichting over gezonde voeding en leefstijl tijdens de zwangerschap, maar wees u ervan bewust dat zwangeren in een opvanglocatie vaak maar beperkte keuzeruimte hebben. Verstrek adviezen die realistisch zijn binnen de gegeven omstandigheden.

4.4.2 Kwetsbare sociaal-economische positie van vrouwen met een vluchtachtergrond

Asielzoekers en statushouders staan vaak voor complexe uitdagingen, zoals het verlies van hun sociale netwerk door gedwongen migratie en het navigeren in een nieuw gezondheidssysteem. Hun sociaaleconomische situatie is extra kwetsbaar door de lange asielprocedures en de beperkte mogelijkheden op het gebied van onderwijs en arbeidsparticipatie. Andere (sociale) risicofactoren voor kwetsbaarheid in de zwangerschap die vaak voorkomen, zijn bijvoorbeeld alleenstaand moederschap op jonge leeftijd. Uit zowel de *studie met COA-*

cijfers en de *landelijke registerstudie* in EGALITE bleek de prevalentie van tienerzwangerschappen onder asielzoekers en statushouders ongeveer zes tot zeven keer hoger dan in de algemene Nederlandse populatie, en een groot deel van de tienerzwangerschappen komen voor bij alleenstaande minderjarige vluchtelingen (AMV).[9] Relatief veel vrouwen die tijdens de opvangperiode een kind krijgen worden door het COA geregistreerd als alleenstaande moeders.

Wanneer statushouders met een verblijfsvergunning naar een eigen woning verhuizen, vervalt de begeleiding vanuit het COA, waardoor de thuissituatie en achtergrond van deze groep vaak minder in beeld zijn bij zorgverleners. In de *EGALITE vragenlijst* vonden bijna alle verloskundigen (94%) de zorg voor statushouders intensiever dan gemiddeld, mede doordat zij de sociale positie van statushouders in het algemeen vaker als kwetsbaar beschouwden.

Uit internationaal onderzoek blijkt dat bepaalde interventies, onder andere gericht op sociale steun, positieve effecten kunnen hebben op zwangerschapsuitkomsten en -ervaringen van vrouwen met een vluchtachtergrond. Hieronder vallen bijvoorbeeld antenatale zorg in groepsverband, intensieve begeleiding van doula's, en programma's gebaseerd op peer-support of waarbij zwangeren juist aan een vrijwilliger uit het gastland worden gekoppeld.[27,35,36] In Nederland is online groepszorg volgens het format van Centering Pregnancy beschikbaar voor Eritrese statushouders; op sommige plekken organiseren verloskundigen zelf groepszorg. De uitdaging voor implementatie van groepszorg in de asielopvang bestaat buiten financiering met name uit de voorwaarde om een stabiele groep te creëren voor een langere periode. In Ter Apel is een protocol voor interactieve groepszorg voor asielzoekers ontwikkeld, dat momenteel nog in studieverband wordt geëvalueerd.

Ervaringen van professionals

De kwetsbare (sociale) situatie van asielzoekers houdt grotendeels verband met de omstandigheden, onzekerheid en isolatie die vrouwen ervaren in Opvanglocaties. Professionals uiten in de *EGALITE vragenlijst*, *interviews* en *focusgroepen* echter ook vaak hun bezorgdheid over de positie van statushouders die nog maar kort in een eigen huis in Nederland wonen als zij zwanger zijn. Veel professionals noemen financiële barrières als belangrijk probleem in de zorg voor statushouders. Verloskundigen vinden de overgang van begeleiding door het COA en zorgverzekering via RMA naar de financiële en praktische zelfredzaamheid die van statushouders wordt verwacht, te plotseling:

In de geboortezorg voor asielzoekers en statushouders zijn veel verloskundigen geneigd om verder te gaan dan hun gebruikelijke rol en competenties, waardoor ze extra tijd en middelen investeren. Extra taken die verloskundigen vaak op

zich namen omvatten bijvoorbeeld het regelen van kraamzorg, het coördineren van afspraken met andere zorgverleners, of het opzetten van initiatieven zoals inzameling van babyartikelen. Verloskundigen waren in zowel de *vragenlijststudie* als de *interviews* positief over een aantal voorbeelden om asielzoekers en statushouders (sociaal) te ondersteunen, zoals antenatale zorg in groepsverband en projecten waarbij zwangeren gekoppeld worden aan een 'buddy'.

Ervaringen van vrouwen met een vluchtachtergrond
Voor veel zwangere vrouwen was de eerste periode in Nederland een moeilijke periode waarin zij zich ook kwetsbaar voelden (zie ook: *4.3.4. Psychosociale- en geestelijke gezondheid*):

> *"Het was in het begin moeilijk [om hier te zijn zonder familie]. Maar daarna, nadat ik een huis had, werd het makkelijker. Een eigen plek hebben."* **– Deelnemer interviews (zwangere met vluchtachtergrond)**

Hoewel het verkrijgen van een verblijfsvergunning en een eigen woning zeker als positieve ontwikkelingen gelden, blijven er voor vrouwen met een vluchtachtergrond uitdagingen bestaan. Toch melden statushouders dat een tweede zwangerschap in Nederland makkelijker verloopt, bijvoorbeeld door uitbreiding van hun sociale netwerk en kennis van het Nederlandse zorgsysteem:

"De eerste zwangerschap was heel erg moeilijk natuurlijk. Ik was me zorgen aan het maken: oké, hoe ga ik hier bevallen? Waar moet ik naartoe? Wat gebeurt er met mijn kinderen thuis? Weet je, dus ik had veel zorgen. (…) De tweede zwangerschap is makkelijker, omdat ik nu langer in Nederland woon, ik heb kennissen, ervaring en nu weet ik zelf hoe ik naar het ziekenhuis moet gaan, naar de verloskundige moet gaan…" – Deelnemer interviews (zwangere met vluchtachtergrond)

Vrouwen geven aan vooral behoefte te hebben aan sociale steun:

> *"Samen praten om ervaringen te delen is het allerbelangrijkst. Zo kun je ook elkaar helpen om bepaalde problemen op te lossen, als iemand bijvoorbeeld te weinig babykleertjes heeft".* **– Deelnemer focusgroepen (zwangere met vluchtachtergrond)**

Aanbevelingen m.b.t. de kwetsbare sociaal-economische positie van vrouwen met een vluchtachtergrond

- Faciliteer het aanbod van (aanvullende)ondersteuning aan zwangere asielzoekers en statushouders, bijvoorbeeld in de vorm van antenatale groepszorg of begeleiding door doula's op opvanglocaties.
- Neem tarieven voor groepszorgprogramma's op locatie en online (zoals Centering Pregnancy) op in de vergoede zorg van RMA, zoals de Nederlandse Zorgautoriteit hierin vanaf 1 januari 2024 ook voor andere groepen in voorziet.
- Bevorder de beschikbaarheid van lokale 'sociale kaarten'. Neem in de Ketenrichtlijn als aanbeveling op dat elke regio een sociale kaart op lokaal niveau uitwerkt;
- Stimuleer uitwisseling van lokale goede voorbeelden in ondersteuning van zwangere asielzoekers en statushouders in regionale samenwerkingsverbanden en via landelijke platformen en beroepsorganisaties.

5. Samenvatting/Overzicht hoofdaanbevelingen

5.1 Concentratie van geboortezorg voor asielzoekers

De eerste hoofdaanbeveling is om specifieke opvanglocaties in te richten voor zwangeren in de asielopvang. Op deze locaties kan maximaal worden ingezet op het optimaliseren van de geboortezorgketen. Hiervoor dienen een beperkt aantal locaties binnen de vier COA-regio's te worden geselecteerd. Bij de uitwerking van deze aanbeveling kunnen de recente ervaringen van de ketenpartners in Ter Apel/Musselkanaal mogelijk handvatten bieden. Naast vrouwen die bij aankomst zwanger zijn, kunnen bepaalde groepen, zoals zwangeren die onder artikel 64 vallen, zwangeren in (crisis)noodopvang en hoog-risico zwangeren, prioriteit krijgen bij de implementatie. In elk scenario vereist het (over)plaatsen van zwangeren in de asielopvang een zorgvuldige afweging waarbij rekening wordt gehouden met de individuele situatie van de zwangere en haar familieleden, in het bijzonder eventuele (schoolgaande) kinderen.

Met behulp van concentratie van zorg kunnen de volgende aspecten worden bereikt:

- *Versnippering van zorg tegengaan*
  Op veel opvanglocaties wordt zorg verleend aan een klein aantal asielzoekers. Tussen 2014 en 2023 werden op meer dan 230 verschillende locaties geboortes geregistreerd door het COA (Bijlage 2, tabel 1 en 2). Vanaf 2021 werden op meer dan de helft van deze locaties minder dan 5 geboortes geregistreerd. Met dergelijke kleine aantallen is het niet mogelijk om expertise en efficiëntie op te bouwen en te onderhouden.

- *Effectievere samenwerking en ontwikkeling van expertise*
  Het verhoogde risico op ongunstige zwangerschapsuitkomsten onder vrouwen in de asielopvang, zoals bevestigd door de registratiestudie in EGALITE, vraagt om een dringende verbetering van de zorg. De organisatie van ketenzorg voor asielzoekers vereist expertise, optimale coördinatie en korte communicatielijnen tussen zorgverleners van diverse organisaties (zoals COA, GZA, en verschillende geboortezorgprofessionals). Concentratie van zorg kan deze aspecten bevorderen, bijvoorbeeld door lokale werkafspraken en een betere implementatie van de ketenrichtlijn.
- *Minder negatieve effecten van overplaatsingen*
  Concentratie van zorg gedurende de zwangerschap zal het gemiddelde aantal overplaatsingen verminderen. Overplaatsingen van zwangeren brengen extra risico's mee voor de zorg en het welzijn van zwangere vrouwen in de opvang.
- *Mogelijkheid voor andere verbeteringen*
  Veel van de eerdergenoemde aanbevelingen zijn niet haalbaar binnen de huidige organisatie van de geboortezorg. Door zorg te concentreren, kan er beter worden ingezet op andere interventies die de kwaliteit van zorg kunnen verbeteren, zoals verloskundige spreekuren op locatie, het aanbieden van antenatale groepszorg, het verbeteren van leefomstandigheden en voeding, en het faciliteren van adequate kraamzorg.

5.2 Doorontwikkeling van richtlijnen

Het is van belang dat de huidige Ketenrichtlijn Geboortezorg Asielzoeksters wordt geformaliseerd tot een wetenschappelijk onderbouwde en gemandateerde richtlijn om een bindend karakter en bredere bekendheid in de praktijk te garanderen. Zorg voor ontwikkeling, beheer en disseminatie volgens de huidige state-of-the-art (bijvoorbeeld middels ondersteuning door het Kennisinstuut van de Federatie Medisch Specialisten en de Richtlijnendatabase).

5.3 Verbeterde registratie en kwaliteitsmonitoring

De huidige situatie, waarin de migratiestatus van zwangeren niet vindbaar is in (medische) kwaliteitsregistraties en (ziekenhuis)informatiesystemen, leidt tot een tekort aan bruikbare gegevens voor de evaluatie en verbetering van de (geboorte) zorg voor asielzoekers en statushouders. Dit is ethisch onaanvaardbaar, omdat hierdoor mogelijke gezondheidsverschillen onzichtbaar blijven en zelfs kunnen toenemen.

6. Slotbeschouwing

Het EGALITE onderzoeksproject heeft belangrijke aandachtspunten en prioriteiten in kaart gebracht voor het verbeteren van de geboortezorg voor asielzoekers

en statushouders in Nederland. De voornaamste uitdagingen betreffen de organisatie van de zorg, de toegankelijkheid en continuïteit, de kwaliteit van persoonsgerichte zorg, en de sociale en politieke context waarbinnen deze zorg wordt verleend. Op basis van de onderzoeksbevindingen binnen deze thema's zijn drie hoofdaanbevelingen opgesteld: het concentreren van de zorg voor zwangeren in de asielopvang, het (verder) ontwikkelen van professionele richtlijnen voor de zorg aan asielzoekers en statushouders, en het verbeteren van de registratie van kwaliteits- en uitkomstindicatoren. Deze laatste aanbeveling is tevens gericht op het verbeteren van de beschikbaarheid van gegevens voor het monitoren en onderzoeken van gezondheidsuitkomsten rondom zwangerschap en geboorte bij mensen met een vluchachtergrond.

Uit het EGALITE project komen verschillende nog onderbelichte onderwerpen en nieuwe onderzoeksvragen naar voren. Er is meer onderzoek nodig naar de invloed van migratiebeleidsfactoren op geboorte-uitkomsten te bepalen, zoals de effecten van overplaatsingen en de verblijfsduur in de asielopvang. Daarnaast zou verder onderzoek de invloed en oorzaken van suboptimale zorg moeten verhelderen, en naar specifieke interventies om zorgverleners in staat te stellen persoonsgerichte geboortezorg te leveren aan vrouwen met een vluchtachtergrond.

Het EGALITE project laat echter ook verbeteringen zien die nu al mogelijk en noodzakelijk zijn. Het realiseren van de aanbevelingen voor gelijkwaardige kansen op een kansrijke start voor mensen met een vluchtachtergrond vereist daadkrachtig optreden binnen het huidige turbulente (politieke) landschap rondom asielmigratie. Het behelst meer dan alleen de inzet van zorgverleners; het vraagt ook om coördinatie, toezicht en een betrokken en verantwoordelijke rol van de overheid. Dit werpt vragen op over de huidige ministeriele verantwoordelijkheid voor de zorg van asielzoekers binnen het Ministerie van Justitie & Veiligheid, waaronder het COA als zelfstandig bestuursorgaan opereert. Een grotere betrokkenheid van het Ministerie van Volksgezondheid, Welzijn en Sport bij deze zorg lijkt logisch en noodzakelijk op basis van de huidige bevindingen. Met het oog op de toekomst, waarin gedwongen migratie een blijvende realiteit zal zijn, is het cruciaal dat onze geboortezorg in staat wordt gebracht om ieder kind een kansrijke start te bieden.

Bijlage 1. Resultaten dossierstudie (selectie voorlopige data)

In onderstaande tabellen wordt een selectie van clientkenmerken en uitkomsten op praktijk- en clientniveau weergegeven. Dit betreffen voorlopige (nog niet wetenschappelijk gepubliceerde) data.

Tabel 1. Cliëntkenmerken (selectie voorlopige data)

Kenmerk/categorie	Aantal (%)
Woonlocatie gedurende zwangerschap	
Asielopvang	(96.3)
Bij familie of kennissen	(3.8)
Leeftijdsgroep	
18-24 jaar	(22.5)
25-34 jaar	(45.0)
≥ 35 jaar	(32.5)
Pariteit	
Nullipara	(37.4)
Multipara	(56.2)
Grande multipara (> para 5)	(6.4)
Graviditeit	
Primigravida	(27.4)
Multigravida	(71.3)
Onbekend	(1.3)
Relationele status	
Alleenstaand	(32.5)
Gehuwd/met partner	(55.0)
Gescheiden	(2.5)
Onbekend	(10.0)
Land van herkomst	
Afghanistan	(2.5)
Eritrea	(15.0)
Iran	(7.5)
Jemen	(7.5)
Nigeria	(17.5)

Tabel 1. Cliëntkenmerken (selectie voorlopige data) **(continued)**

Kenmerk/categorie	**Aantal (%)**
Somalië	(6.3)
Syrië	(16.3)
Overig	(25.0)
Onbekend	(2.5)
Spreektaal zwangere	
Arabisch	(25.0)
Dari/Farsi	(7.5)
Engels	(20.0)
Tigrinya	(10.0)
Somalisch	(5.0)
Overig	(13.7)
Onbekend	(18.8)
Afkomstig uit risicogebied voor vrouwenbesnijdenis	
Ja	(62.5)
Nee	(30.0)
Onbekend	(7.5)
Duur van verblijf in Nederland bij aanvang prenatale zorg	
≤ 1 maand	(12.5)
– 3 maanden	(5)
– 6 maanden	(2.5)
– 12 maanden	(5)
> 1 jaar	(21.3)
Onbekend	(53.8)
Obstetrische voorgeschiedenis in Nederland[a]	
In eerdere zwangerschap onder zorg geweest in Nederland	(30.0)
Niet eerder in Nederland onder zorg geweest	(67.4)
Onbekend	(2.6)

Noot. Deze tabel bevat gegevens uit dossiers van cliënten (N = 80) uit verschillende deelnemende praktijken
a Alleen weergegeven voor multipara zwangeren (N = 50)

Tabel 2. Uitkomsten op praktijkniveau (selectie voorlopige data)

Uitkomst	Aantal praktijken	%
Praktijk werkt volgens Ketenrichtlijn Geboortezorg Asielzoekers		
Ja	7	87.5
Nee	1	12.5
De praktijk neemt jaarlijks deel aan een multidisciplinair overleg met COA		
Ja	4	50
Nee	4	50
De praktijk beschikt over de contactgegevens van COA-personeel		
Ja	6	75
Nee	2	25
De verloskundige praktijk ontvangt aankondiging van overplaatsing van COA		
Ja	2	25
Nee	6	75
De praktijk screent routinematig de geletterdheid van cliënten		
Ja	3	37.5
Nee	5	62.5

Noot. Deze tabel bevat gegevens van acht eerstelijns verloskundige praktijken in Nederland met een wisselende caseload van zwangeren in een asielprocedure.

Tabel 3. Prenatale zorgverlening, uitkomsten op dossierniveau (selectie voorlopige data)

Uitkomst	Categorie	Aantal	%
Aanvang antenatale zorg	Eerste trimester (≤ 12w.)	40	50.0
	Tweede trimester (13 – 27w.)	29	36.3
	Derde trimester (28 – 40w.)	9	11.3
	Onbekend	2	2.5
	Totaal van toepassing[a]	80	100
Reden van start zorg >12 weken	Recente aankomst in Nederland	8	21.1
	Andere bekende reden	3	7.9
	Onbekend	27	71.1
	Totaal van toepassing[a]	38	100
Aantal prenatale consulten[b]	Volgens aanbevelingen	77	96.2
	Minder dan aanbevolen	1	1.3
	Onbekend	2	2.5
	Totaal van toepassing[a]	80	100
Aantal niet verschenen consulten	0	46	57.5
	– 2	25	31.3
	> 2	8	10.0
	Onbekend	1	1.3
	Totaal van toepassing[a]	80	100
Echoscopisch onderzoek	Uitgevoerd in eerste trimester	47	61.8
	Niet uitgevoerd in eerste trimester	24	31.6
	Onbekend	5	6.6
	Totaal van toepassing[a]	76	100
Bloedonderzoek (screening infectieziekten)			
Rubella	Ja	29	39.7
	Nee	41	56.2
	Onbekend	3	4.1
	Totaal van toepassing[a]	73	100
Varicella	Ja	29	39.7
	Nee	41	56.2
	Onbekend	3	4.1
	Totaal van toepassing[a]	73	100
HIV	Ja	66	90.4
	Nee	4	5.5
	Onbekend	3	4.1
	Totaal van toepassing[a]	73	100

Uitkomst	Categorie	Aantal	%
Syfilis	Ja	67	91.8
	Nee	3	4.1
	Onbekend	3	4.1
	Totaal van toepassing[a]	73	100
Hepatitis B	Ja	67	91.8
	Nee	3	4.1
	Onbekend	3	4.1
	Totaal van toepassing[a]	73	100
Bloedonderzoek (overig)			
Bloedgroep en Hb-gehalte)	Ja	70	95.9
	Nee	-	
	Onbekend	3	4.1
	Totaal van toepassing[a]	73	100
Glucose	Ja	69	94.5
	Nee	1	1.4
	Onbekend	3	4.1
	Totaal van toepassing[a]	73	10
Prenatale diagnostiek			
Counseling niet-invasieve prenatale test (NIPT)	Ja	39	75.0
	Nee	6	11.5
	Onbekend	7	13.5
	Totaal van toepassing[a]	52	100
Counseling structureel echoscopisch onderzoek (SEO)	Ja	59	92.2
	Nee	5	7.8
	Onbekend	-	
	Totaal van toepassing[a]	64	100
Prenataal huisbezoek door verloskundige	Ja Nee Onbekend	15	27.5 50.7 21.7
	Totaal van toepassing[a]	69	100
Geboorteplan	Opgesteld, document aanwezig in dossier	1	1.6
	Besproken, notitie in dossier	14	22.2
	Onbekend	48	76.2
	Totaal van toepassing[a]	63	100

Uitkomst	Categorie	Aantal	%
Psychosociale screening	Nee	69	93.2
	Middels eigen vragenlijsten/instrument	5	6.8
	Middels gevalideerd instrument	0	0
	Totaal van toepassing[a]	74	100
Doorverwijzing GGZ (indien bekende indicatie)	Niet doorverwezen	7	38.9
	Ja, rechtstreeks naar GGZ	4	22.2
	Ja, via GZA	3	16.7
	Zwangere wenst geen verwijzing	3	16.7
	Reeds in zorg	1	5.6
	Totaal van toepassing[a]	18	100
Kraamperiode			
Ondersteuning verloskundige bij aanmelding kraamzorg	Ja	36	83.7
	Nee	1	2.3
	Onbekend	6	14.0
	Totaal van toepassing[a]	43	100.0
Tijdige aanmelding kraamzorg	Ja (tot 32 weken)	42	79.3
	Nee (na 32 weken)	3	5.7
	Onbekend	8	15.1
	Totaal van toepassing[a]	53	100.0
Prenataal huisbezoek door verloskundige	Ja	19	27.5
	Nee	35	50.7
	Onbekend	15	21.7
	Totaal van toepassing[a]	69	100
Verloskundige ondersteunt bij geboorteaangifte gemeente	Ja	32	43.2
	Nee	9	12.2
	Onbekend	33	44.6
	Totaal van toepassing[a]	74	100

Noot. Deze tabel bevat gegevens uit dossiers van cliënten (N = 80) uit verschillende deelnemende praktijken.

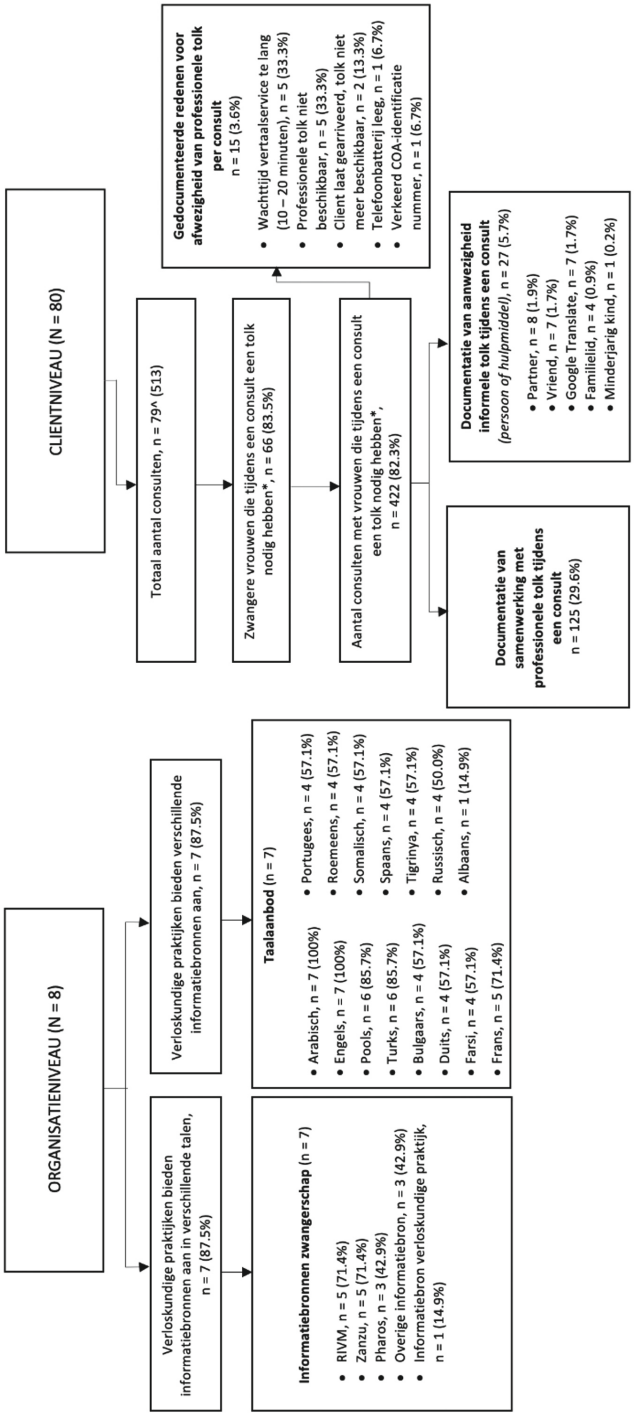
[a] Voor elke uitkomst wordt het totaal aantal cliënten aangegeven waarbij de zorguitkomst van toepassing (relevant) is. Hierbij zijn ontbrekende gegevens, ontstaan doordat het dossier gesloten is vóór de betreffende zorguitkomst relevant werd, uitgesloten van deze uitkomst. Indien de uitkomst wel van toepassing was, maar geen of onvoldoende duidelijke documentatie beschikbaar is, wordt de waarde 'onbekend' toegekend. Bijvoorbeeld: bij vier cliënten was echoscopisch onderzoek in de eerstelijnszorg niet meer van toepassing in verband met een spontane abortus, of omdat zij al waren overgedragen naar de tweede lijn. Bij vijf cliënten is onvoldoende documentatie beschikbaar om vast te stellen of en/of wanneer de echoscopie heeft plaatsgevonden.

[b] Gecorrigeerd voor zwangerschapsduur bij aanvang zorg, waarbij de WHO aanbeveling van ten minste acht consulten in de gehele zwangerschap wordt aangehouden.

Tabel 4. Verhuizingen en overplaatsingen van asielzoekers

Uitkomst	Categorie	Aantal	%
Geregistreerd aantal verhuizingen tijdens perinatale periode*	Niet verhuisd of onbekend	35	43.8
	Verhuizing opvang - eigen woning	4	0.5
	Overplaatsing tussen opvanglocaties	27	34.8
	Meerdere overplaatsingen	12	15.0
	Reden verhuizing onbekend	2	2.5
	Totaal	80	100
Periode overplaatsing(en) per zwangere	Geen binnen perinatale periode[a]	29	74.0
	Minimaal 1 binnen perinatale periode[a]	8	21.0
	Onbekend	2	5.0
	Totaal overgeplaatste zwangeren	39	100

Noot. Deze tabel toont het aantal verhuizingen, waaronder overplaatsingen tussen opvanglocaties, voor zover geregistreerd in de geïncludeerd dossiers. Voor overgeplaatste zwangeren is ook de zwangerschapsduur ten tijde van de overplaatsing weergegeven.
a Perinatale periode: 34 weken zwangerschap tot 6 weken postpartum.



Legenda:
^ = Eén cliënt is geëxcludeerd van deze uitkomst vanwege congenitale doofheid.
* De noodzaak voor een professionele tolk is gebaseerd op de inschatting van de Engelse en Nederlandse taalvaardigheid van de zwangere vrouwen door individuele verloskundigen.

Figuur 1. Meertalig informatieaanbod en inzet van tolken op organisatie- en cliëntniveau

Bijlage 2. Geboortes op COA-locaties

Tabel 1. Aantal geboortes bij vrouwen die verbleven in een COA-locatie in de periode 2014- 2018.

Jaartal	2014	2015	2016	2017	2018	Totaal / %
Geboortes totaal	520	546	793	476	443	2778
Aantal locaties met geboortes	63	75	102	80	70	129
Aantal locaties met <5 geboortes	25	37	43	34	30	44%
Aantal locaties met 5-20 geboortes	33	36	52	44	39	52%
Aantal locaties met >20 geboortes	5	2	7	2	1	4%

Bron: COA. De aantallen betreffen alle geregistreerde geboortes op alle verschillende locaties onder beheer van het COA (AZC, POL, COL, AMV, etc.)

Tabel 2. Aantal geboortes bij vrouwen die verbleven in een COA-locatie in de periode 2019- 2023.

Jaartal	2019	2020	2021	2022	2023	Totaal / %
Geboortes totaal	660	589	449	547	672	2917
Aantal locaties met geboortes	78	95	96	114	132	180
Aantal locaties met <5 geboortes	26	41	59	71	84	55%
Aantal locaties met 5-20 geboortes	49	53	36	41	46	44%
Aantal locaties met >20 geboortes	3	1	1	2	2	2%

Bron: COA. De aantallen betreffen alle geregistreerde geboortes op alle verschillende locaties onder beheer van het COA (AZC, POL, COL, AMV, etc.)

Bronvermelding

1. Centraal Bureau voor de Statistiek (CBS). Asielverzoeken en nareizigers; nationaliteit, geslacht en leeftijd, StatLine, Editor. 2024. Available from: https://opendata.cbs.nl/statline/#/CBS/nl/dataset/83102ned/table?fromstatweb.
2. Immigratie- en Naturalisatiedienst (IND). Asiel: laatste ontwikkelingen. Available from: https://ind.nl/nl/asiel-laatste-ontwikkelingen#:~:text=Beslistermijn%20van%20uw%20asielaanvraag,te%20verlengen%20met%209%20maanden (accessed 26 Jan 2024).
3. Centraal Orgaan opvang Asielzoekers (COA). Capaciteit en bezetting. 2024.Available from: https://www.coa.nl/nl/lijst/capaciteit-en-bezetting.
4. Bo Brancheorganisatie Geboortezorg; Asylum Seeker Healthcare ('GZA'); Central Agency for the Reception of Asylum Seekers ('COA'); National Society for Obstetrics and Gynecology ('NVOG'); Royal Dutch Organisation of Midwives (KNOV) and RMA Healthcare. Dutch Guideline Perinatal Care for Asylum Seekers ('Ketenrichtlijn Geboortezorg Asielzoeksters'). 2020. Available from: https://www.kennisnetgeboortezorg.nl/nieuws/actualisatie-ketenrichtlijn-geboortezorg-asielzoekers.
5. College Perinatale Zorg. Zorgstandaard Integrale Geboortezorg. Utrecht: College Perinatale Zorg; 2020.
6. Tankink, J.B. & Verschuuren, A.E.H. et al., Childbirths and the Prevalence of Potential Risk Factors for Adverse Perinatal Outcomes among Asylum Seekers in The Netherlands: A Five-Year Cross-Sectional Study. International Journal of Environmental Research and Public Health, 2021. 18(24): p. 12933.
7. Verschuuren AE & Tankink JB, Franx A, van der Lans PJ, Erwich JJ, Jong EF, de Graaf JP. Community midwives' perspectives on perinatal care for asylum seekers and refugees in the Netherlands: A survey study. Birth. 2023 Dec;50(4):815-26.
8. Tankink, J.B., Verschuuren, A.E.H., De Graaf, J.P., Feijen-de Jong, E.I., van den Muijsenbergh, M., Franx, A., Goodarzi, B. Let this be a safe place: a qualitative study into midwifery care for forcibly displaced women in the Netherlands. 2024. BMC Health Services research (in press).
9. Sutton-Brown, C.A., Photovoice: A methodological guide. Photography and Culture, 2014. 7(2): p. 169-185.
10. Verschuuren, A., Tankink, JB, et al. , Suboptimal factors in maternal and newborn care for refugees: lessons learned from perinatal audits in the Netherlands. PLOS One (under review). , 2024.
11. Posthumus, A.G., et al., The association of ethnic minority density with late entry into antenatal care in the Netherlands. Plos one, 2015. 10(4): p. e0122720.
12. Freedman, J., Sexual and gender-based violence against refugee women: a hidden aspect of the refugee" crisis". Reproductive health matters, 2016. 24(47): p. 18-26.
13. Goosen, S., et al., Induced abortions and teenage births among asylum seekers in The Netherlands: analysis of national surveillance data. Journal of Epidemiology & Community Health, 2009.
14. Van den Bergh, B.R., et al., Prenatal developmental origins of behavior and mental health: The influence of maternal stress in pregnancy. Neuroscience & Biobehavioral Reviews, 2020. 117: p. 26-64.
15. Bussieres, E.-L., et al., Maternal prenatal stress and infant birth weight and gestational age: A meta-analysis of prospective studies. Developmental Review, 2015. 36: p. 179-199.
16. Pharos. Infosheet Persoonsgerichte zorg en diversiteit 2022 [Available from: https://www.pharos.nl/infosheets/persoonsgerichte-zorg-en-diversiteit/.

17. Intelligence Group. Arbeidsmarkt zorg in cijfers. 2023.
18. Boerleider, A.W., et al., "A mixture of positive and negative feelings": A qualitative study of primary care midwives' experiences with non-western clients living in the Netherlands. International Journal of Nursing Studies, 2013. 50(12): p. 1658-1666.
19. Azria, E., et al., Racial implicit biases among obstetric care providers and associated differential care: The BiP research program. American Journal of Obstetrics & Gynecology, 2023. 228(1): p. S36-S37.
20. Headen, I.E., et al., Racism and perinatal health inequities research: where we have been and where we should go. American Journal of Obstetrics & Gynecology, 2022. 227(4):p. 560-570.
21. Willey, S., K. Desmyth, and M. Truong, Racism, healthcare access and health equity for people seeking asylum. Nursing Inquiry, 2022. 29(1): p. e12440.
22. Goodarzi B, Borrel D. Baren buiten de box: over hoe de geboortezorg niet voor iedereen gelijk is. Nederland: De Arbeiderspers; 2024.
23. Johnson, J.D., et al., Racial and ethnic inequities in postpartum pain evaluation and management. Obstetrics & Gynecology, 2019. 134(6): p. 1155-1162.
24. Kanu, S., Overtoom, E., Goodarzi, B., de Jonge, A. & Bloemenkamp K., You care better for people who look like you": A mixed-methods study of ethnic bias in pain assessment in maternal and newborn care in the Netherlands. Forthcoming, 2024.
25. Koopmanschap I, Martin L, Gitsels-van der Wal JT, Suurmond J. Counselling for prenatal anomaly screening to migrant women in the Netherlands: an interview study of primary care midwives' perceived barriers with client–midwife communication. Eur J Midwifery. 2022 May 19;6:29. doi:10.18332/ejm/147911.
26. Bains, S., et al., Satisfaction with maternity care among recent migrants: an interview questionnaire-based study. BMJ open, 2021. 11(7): p. e048077.
27. Fair, F., et al., Midwives' experiences of cultural competency training and providing perinatal care for migrant women a mixed methods study: Operational Refugee and Migrant Maternal Approach (ORAMMA) project. BMC Pregnancy and Childbirth, 2021. 21(1): p. 1-13.
28. Bozorgmehr, K., et al., Integration of migrant and refugee data in health information systems in Europe: advancing evidence, policy and practice. The Lancet Regional Health–Europe, 2023. 34.
29. Stevenson, K., et al., The global burden of perinatal common mental health disorders and substance use among migrant women: a systematic review and meta-analysis. The Lancet Public Health, 2023. 8(3): p. e203-e216.
30. Laban, C.J., et al., Impact of a long asylum procedure on the prevalence of psychiatric disorders in Iraqi asylum seekers in The Netherlands. The Journal of nervous and mental disease, 2004. 192(12): p. 843-851.
31. Pluck, F., R. Ettema, and E. Vermetten, Threats and interventions on wellbeing in asylum seekers in the Netherlands: a scoping review. Frontiers in Psychiatry, 2022. 13: p. 829522.
32. Soldati, E., et al., Asylum-seeking women's perspectives regarding a mental health screening method during pregnancy: a qualitative study. Tropical Medicine & International Health, 2021. 26: p. 238-239.
33. Gewalt, S.C., et al., "If you can, change this system"-Pregnant asylum seekers 'perceptions on social determinants and material circumstances affecting their health whilst living in state-provided accommodation in Germany-a prospective, qualitative case study. BMC Public Health, 2019. 19(1): p. 1-14.
34. Mohsenpour, A., L. Biddle, and K. Bozorgmehr, Deterioration of housing environment and mental health of asylum seekers–a multi-level analysis. European Journal of Public Health, 2019. 29(Supplement_4): p. ckz185. 323.

35. Mendel, W.E., M. Sperlich, and A. Finucane, The Doulas of the Priscilla Project: Understanding the Experience of Refugee Women Navigating the US Maternity-care System. Journal of Refugee Studies, 2021. 34(2): p. 2275-2290.
36. Balaam, M.-C., C. Kingdon, and M. Haith-Cooper, A Systematic Review of Perinatal Social Support Interventions for Asylum-seeking and Refugee Women Residing in Europe. Journal of Immigrant and Minority Health, 2021: p. 1-18.

Chapter nine

General discussion

General discussion

This thesis examined the state of equity within the Dutch system of pregnancy and childbirth care for women with a forced migration background. The specific objectives were threefold: to provide insights into the maternal and perinatal health of women with a forced migration background, to evaluate the current provision of pregnancy and childbirth care for this group; and to derive recommendations for advancing equity in this area.

This discussion offers a reflection on our findings in context of the literature, articulated through five propositions that I will defend alongside with this thesis. Following methodological considerations, recommendations regarding the necessary steps towards 'safer shores' in pregnancy and childbirth will be synthesized. Opportunities for future research will be highlighted throughout the discussion.

Reflection on findings

Proposition 1: Persistent adverse pregnancy outcomes among women with a forced migration background in the Netherlands are more likely due to structural inequities within and beyond the healthcare system, rather than inherent vulnerability or individual health risks

Our nationwide registry study in **chapter four** demonstrated that women with a forced migration background exhibit higher rates on several pregnancy outcomes compared to other populations in the Netherlands. These findings align with previous evidence from both national and international studies.[1-7] It is also increasingly evident that women who were forced to migrate occupy a particularly disadvantaged position relative to other migrant groups.[3]

These study results are often used to highlight the vulnerability of women with a forced migration background in guidelines and policy documents.[8] Frequently, this vulnerability is attributed to risk factors on the level of the individual, such as biological characteristics, cultural differences or lifestyle choices.[9] However, while prevalent risk factors for adverse outcomes may present individually – such as teenage pregnancy or delayed initiation of antenatal care, they are likely to be part of or result from a more systemic complex of exclusion from access to care, resources, and opportunities.[10] Such systemic or structural causes of vulnerability often represent policy choices, ranging from the lack of legal, safe migration routes that cause women to arrive traumatized, to the lengthy asylum procedures that may ultimately result in a psychiatric disorder during pregnancy

or a different adverse outcome.[11] Focusing on individual vulnerability overlooks the impact of such structural determinants of health and disparity.[10, 11]

The vulnerability narrative can also diminish the potential agency and resilience of women, evidenced by the fact that many women experience clinically healthy pregnancies despite all adversity associated with forced migration.[4,12-14] In **chapter four**, we even found that women had reduced risks of preterm birth compared to the reference groups, and the observed mortality rates were relatively lower compared to previous studies in the Netherlands.[15] These discrepancies are likely partly due to the design, inclusion criteria and data availability across studies, warranting further investigation. However, they also challenge the notion that women with a forced migration background are inherently at risk, which risks subtly accepting adverse outcomes as inevitable.[16]

Still, a woman born and raised in the Netherlands, aside from likely having a more positive pregnancy experience, has substantially better chances of giving birth to a clinically healthy baby compared to her (forcibly) migrated counterparts. **Chapter five** demonstrated that suboptimal care often contributed to adverse outcomes among women with a forced migration background. Other chapters also revealed specific quality impairments, such as inadequate guideline implementation, overburdened and under-resourced midwives, and fragmented care due to relocations of asylum seekers.[17-19]

In a healthcare system that is among the wealthiest in the world, it cannot be stated that we lack the capacity to address this disparity. We must therefore recognize that the health differences presented in this thesis largely represent *inequities*: unjust, unfair, and avoidable differences stemming from power imbalances at social, economic, and political levels. Only through this recognition can we work towards ensuring a Solid Start (Kansrijke Start) for *every* child born in the Netherland, in line with the mission of the Dutch national action campaign launched in 2018.[20]

<u>Proposition 2: Maternal and perinatal health inequities are both concealed and perpetuated through administrative invisibility of marginalized migrant groups</u>
To conduct further studies into migration-related health inequities, researchers partially rely on routinely reported population data by national institutions such as Statistics Netherlands (CBS), which reports yearly numbers of livebirths. However, seemingly precise birth statistics, such as the number of 167.504 livebirths 2022, fail to account for births among several migrant subgroups.[21]Specifically, newborns are excluded when their parents are undocumented migrants or recent asylum seekers, who lack a social security number (BSN in Dutch) because they are not registered in the municipal Personal Records Database (BRP in Dutch).

Without a BSN, these individuals not only lack access to a range of governmental services, formal employment, and education, but the births of their newborns also remain uncounted and statistically invisible.

The lack of a BSN also complicates the study of health outcomes of these populations. Commonly, the BSN is the only unique personal identifier available in health information systems. This limits the possibility to cross-link health records to other databases. In **chapter four**, we introduced a registry data linkage strategy that aligns with recent calls for better integration of migration and health data in research.[22] Despite the nationwide cohort of forcibly displaced migrants that we were able to include through this approach, an unknown number of births to women without a BSN were still missing from our study. This gap was tragically underscored by a maternal death reported to us after the study, involving a woman in an asylum reception center who arrived to the Netherlands late in her pregnancy, and who passed away before obtaining her BSN.

This unintended exclusion of a case of maternal mortality exemplifies the broader issue of the administrative invisibility of marginalized migrant groups, which reflects, obscures and perpetuates health inequities as their needs remain unnoticed and unaddressed.[6,22,23] This particularly affects undocumented women in the Netherlands, who are legally entitled to shelter in asylum reception centers only from six weeks before to six weeks after giving birth. Outside this period, many women remain invisible not only to the asylum authorities, but also to healthcare providers. This likely contributes to the significantly increased risks of adverse outcomes among undocumented women specifically, as documented in **chapter two**, and confirmed by subsequent studies in recent years.[24-27]

However, administrative invisibility is not limited to undocumented migrants and recent asylum seekers, but extends to larger groups. Our systematic review in **chapter two** revealed that only four studies from the past decade addressed the maternal and perinatal health of 'regular' asylum seekers. Moreover, apart from the studies in this thesis and those by Verschuuren and colleagues, no other recent Dutch studies have focused on the perinatal or maternal health outcomes of any study population with a forced migration background.[28,29] This is partially explainable by the absence of migration indicators from health information systems, while the opposite is also true: health outcomes are rarely included in data on migration. In **chapter three**, where we relied on routine data from the COA, we could therefore only include maternal characteristics of asylum seekers, without linking these to pregnancy outcomes. In **chapter five**, we had to manually review all case files in the Dutch perinatal audit to identify asylum seekers or recognized refugees.

As the literature has reported risks to both the non-use and problematic use of data on marginalized, often racialized migrant groups, it is crucial to develop health information systems that facilitate the ethical use of essential migration indicators.[22,30,31] Moreover, policy revisions regarding BRP registration will be necessary to ensure administrative visibility and inclusion in national birth statistics at the very least. For an equitable start of life, we should begin by counting every child born in the Netherlands, regardless of their (parental) migration background or legal status.

Proposition 3. The current management of forced migration fails to provide the conditions for reproductive justice

This thesis must be contextualized within the current political landscape of migration management, i.e. the policies, laws, and practices that regulate the movement and resettlement of people across borders into and. within the EU at large and the Netherlands specifically.[32] This is important as migration policies impact not just migrants' citizenship rights, but also their reproductive rights.[33,34]

The connection between migrants' rights, maternal and perinatal health, is clarified through the framework of reproductive justice, introduced in **chapter seven**. Reproductive justice situates pregnancy and childbirth in a human rights context, emphasizing how people's identity characteristics (such as gender and migration status) impact their ability to enjoy their reproductive rights.[35,36] Specifically, reproductive justice advocates for the fundamental human right of all women to make informed decisions about if, when and how they wish to give birth. This extends to the right to raising children in environments that are safe, dignified and supportive. From a reproductive justice perspective, it is an obligation of the state not just to provide the theoretical right and access to healthcare, but also to create such environments, and support autonomous reproductive decision-making for all.[37]

However, the current policies of the EU at large, and the Dutch government specifically, fall short of meeting these standards. Women fleeing their home countries face their reproductive choices being profoundly restricted, starting with the unsafe conditions at border crossings and in refugee camps across Europe, and the lack of legal migration routes.[9,38,39] After arrival to the Netherlands, lengthy asylum procedures compromise family planning, and complex procedures for family reunification further undermine the opportunities for family life.[37] As core aspects of reproductive justice, family life and community building are also restricted through frequent relocations, which prevent processes of "placemaking".[40]

In addition, several recent studies from Germany reported how the environment of the asylum reception centers and refugee housing negatively impacts women's health during pregnancy and early motherhood.[41-43] **Chapters six** and **seven** demonstrated that adverse conditions, including limited access to nutritious food and poor hygiene, are present in the Netherlands too. The interviews and focus group discussions with women with lived experiences documented in **chapter eight** of this thesis confirmed that relocations and poor housing conditions exacerbated stress on women and their families. After the first phase of arrival and reception, asylum seekers in the Netherlands still face restricted access to education and employment, despite recent judicial rulings.[44] Exclusion from societal participation not only hinders impedes economic independence, but also exacerbates social isolation and negatively impacts birth outcomes, such as birth weight.[45-47] Explicit discriminatory practices, such as the recent childcare benefit scandal in the Netherlands, illustrate how institutional racism can affect the well-being of (forced) migrant families for generations.[48]

With regards to accessing reproductive health services, specific services are financially inaccessible to forcibly displaced migrants in the Netherlands. These include fertility treatments for asylum seekers and abortion care for undocumented migrants. While the right to necessary care during pregnancy and childbirth is protected for all, **chapters three** and **four** demonstrated that delays in reaching care are common, and **chapter five** showed how this factor contributed to adverse outcomes among women with a forced migration background. Furthermore, **chapter seven** highlighted additional barriers that may prevent these women from fully exercising their rights in care, such as not being able to express their wishes without interpreters present. Most of these barriers result from political choices, such as the abolition of governmental funding for interpreter phone services in 2012.

Altogether, these findings elucidate how the policies that regulate access to citizenship are intertwined with policies regarding reproductive health rights. Both sets of policies reflect underlying power dynamics and ideologies that delineate who is considered an insider of the state, deserving of support for their reproductive freedom, and who is seen as an (intended) outsiders, subject to control and exclusion.[35] Future research should therefore address the interconnected policies in the Dutch context, which produce and sustain disadvantages of different migrant groups in the attainment of reproductive health rights and ultimately, justice.[34]

Proposition 4. The gap between evidence and action regarding maternal and perinatal health inequities reflects a lack of (political) accountability, unclear responsibilities and limited critical consciousness among healthcare providers

This thesis provided specific evidence regarding maternal and perinatal health inequities affecting forcibly displaced mothers and newborns. Unfortunately, most of these findings echo previous work, revealing a mismatch between what is known and the changes in practice. This gap may be explained by several factors, including a lack of critical consciousness among healthcare providers, insufficiently defined responsibilities, and the missing of political will and accountability.

Chapters five, six and **seven** highlighted the daily barriers that healthcare care providers face in care to people with a forced migration background. Although most providers recognized a need for knowledge and skills, such as 'cultural competences' to overcome barriers, they showed limited reflection on concepts such as power or privilege in relation to health inequities. This may stem from biomedical education, which tends to "*naturalize*" inequities by attributing them to individual factors such as genetics, culture or lifestyle, as explained under the first proposition.[49,50] This signifies the need for investing in care providers' self-reflection, cultural humility and critical consciousness, defined as "*a reflective awareness of and action upon societal conditions and inequities*".[49,51]

Furthermore, it is unclear who is responsible for improvement of pregnancy and childbirth care for people with a forced migration background. This is exemplified by our findings regarding the national guideline perinatal care for asylum seekers in **chapters six, seven** and **eight.** The guideline was developed outside of standard professional practices, is not included in the Dutch database for medical guidelines, and its dissemination and implementation are limited. However, no specific entity has designated responsibility for improving these guidelines. More generally, the oversight, coordination, and monitoring of healthcare for newly arrived asylum seekers remain ambiguous. This ambiguity extends to the Dutch ministerial level, with fragmented responsibilities between the Ministry of Justice and Security (J&V) and the Ministry of Health, Welfare and Sport (VWS) and its Health Inspectorate.

The absence of dedicated efforts to raise the quality of healthcare for asylum seekers in the Netherlands also illustrates a lack of political accountability. Despite numerous reports and significant media coverage, the conditions in many reception centers continue to threaten basic human rights.[52] During the ongoing 'reception crisis', timely medical screening and basic healthcare provision upon arrival are no longer guaranteed. This is in contrast to the initial reception of Ukrainian refugees in the EU and the Netherlands in recent years, a disparity

that suggests discrimination by racial/ethnic or cultural characteristics and underscores that the issue is not one of capacity, but more likely of political will.[53]

In this vacuum of awareness, responsibility, and political accountability, academic research has a role to generate actionable evidence. To contribute to meaningful and sustainable transformation however, all stakeholders and communities need to be closely involved in the production and application of new knowledge. This aligns with the essence of participatory action research (PAR), which we aimed to exemplify in **chapter eight**. In the section of methodological considerations, several specific directions for future PAR studies in this context will be provided.

Proposition 5. Within a defective asylum system, it is essential to mobilize care providers toward offering more equitable pregnancy and childbirth care

As reflected by the previous sections, the political realm and crisis-state of the Dutch asylum system in the past years cast a shadow over this thesis' findings. Humanitarian actors and academic experts have described the Dutch asylum as 'sickening' for migrants, as well as 'critically ill' itself.[54,55] While care providers are unable to cure systemic flaws, this thesis suggests that equipping them with tools can help make pregnancy and childcare a safe(r) place (**chapter seven**).

Developing targeted recommendations toward this objective presents the challenge of acknowledging the specific needs of women with a forced migration background, while also aiming to integrate these needs into mainstream care that should be inclusive to all.[56] On one hand, creating a parallel system of 'refugee care' could result in segregating and 'othering' the needs of certain groups which are treated as exceptional and complex.[57] This approach also risks generalizing asylum seekers and refugees, reducing these groups to a singular type of mother and overlooking the wide diversity of sociocultural and migration backgrounds. On the other hand, the experiences of forced migration and interacting with the Dutch healthcare system do likely result in distinct needs.[58-60] Fostering specialized expertise among healthcare providers ensures that these particular needs are adequately recognized and addressed.[61,62]

In light of these considerations, we face a dual imperative. First, it is crucial to continue advocating for sustainable transformations towards a migration-responsive health system, as discussed in the opinion piece included as appendix to this thesis. However, the preceding reflections clarify that this transformation is a long-term ambition, which is influenced by the political climate and societal vision of migration. Meanwhile, it appears more pragmatic to pursue achievable, immediate improvements that appear within the reach of healthcare providers and policymakers. A selection of these are outlined in the recommendations section.

Methodological considerations

Several methodological considerations are relevant for contextualizing our findings and guiding the design of future research.

Participatory Action Research design

The EGALITE project, containing the studies included in this thesis, was initially conceptualized within the framework of Participatory Action Research (PAR). PAR emphasizes participant agency and ownership to generate change for the benefit of involved communities.[63,64] True PAR requires participant involvement in all stages and aspects of research, from setting the study objectives to interpreting results and co-authorship in published articles. Researchers must also commit to disseminating findings in ways that tangibly benefit participants – embodying the 'action' in PAR.[65-67]

By these criteria, the EGALITE project did not fully qualify as a PAR project, although it incorporated PAR elements, most notably in **chapter eight** of this thesis. Here, focus group discussions facilitated interactions and collaboration between the researchers, women with forced migration backgrounds, and field professionals. In these sessions, we not only triangulated earlier findings, but also used participatory techniques such as direct ranking, to develop a prioritized list of recommendations for the improvement of care.[65] Such processes reflect several principles of PAR, such as collaboration, inclusivity, and practical outcomes.

These preliminary experiences with PAR in this context offer several insights for future projects, and underscore the need for an inclusive and context-sensitive approach. For example, we learned the importance of involving trusted contact persons for recruitment of participants and translations during interviews. We also adapted informed consent procedures, such as using audio-recordings, as the length, formal tone and written signatures of conventional informed consent forms appeared unsuitable for women with recent border control and asylum experiences. To accommodate these and other needs of marginalized people in research, Medical Ethical Committees in the Netherlands should also revise their requirements to promote a more inclusive research environment.

Future PAR projects should carefully consider power imbalances and ethical dilemmas, for instance regarding financial compensation – which is currently not allowed for residents of asylum reception centers. Involving disciplines from the humanities and social sciences is highly relevant to navigate challenges and promote researchers' reflexivity and positionality. Practical details, such as transportation to the research location, childcare, planning and catering, also

require (cultural) sensitivity when involving women with recent forced migration backgrounds. As an example, scheduling research activities during Ramadan may or may not be acceptable to all involved participants.

Overall, PAR offers promising ways to promote epistemic justice – i.e. fairness in production, appreciation and dissemination of knowledge – in a field still dominated by positivist, hierarchical research traditions.[68] However, our research also highlights the complexities of meaningful inclusivity and stakeholder involvement, underlining the need for ample time, resources and expertise in future initiatives with women with a forced migration background.

Additional notes on methodologies

Critical notes can also be made with regards to the inclusion of study populations, the availability and use of data, and the limitations of the qualitative methods presented in this thesis. The definition of study populations by legal status posed complexities. For example, the data compiled for **chapter three** revealed individuals oscillating between various legal statuses. We also identified asylum seekers living outside of the reception system, or people with a residence permit still in asylum reception centers. Moreover, there is no consensus on when people should no longer be considered "refugees" in the Netherlands or in the broader literature.

In line with the ambiguities surrounding the study populations, the data landscape concerning the health outcomes of displaced people is inherently fragmented. During migration, health data are lost through the process of border crossings and interactions with multiple health actors, often including non-governmental organizations. Within the Netherlands, frequent relocations of asylum seekers limit the feasibility of prospective data collection, while retrospective study designs are complicated by the lack of identification methods for people with a forced migration background.

As previously described, we therefore relied on alternative data sources in this thesis, including the registries from Statistics Netherlands and Perined. In **chapter four**, we developed a rich dataset through linkage of these registries. However, reliance on existing databases introduced limitations; for instance, not all relevant outcomes, such as early spontaneous abortions, are reliably documented in Perined. This underscores the necessity for researchers to have access to additional data sources, like those from primary care providers in asylum reception centers, which have proven valuable in past research.[69-71] Additionally, we only made limited use of the available data, and our focus was primarily on describing characteristics and outcomes. Future research should employ

more linkage techniques for advanced analyses into associations and causal mechanisms related to, for example, migration policies including relocations.

While **chapters four**, **five** and **six** included partially qualitative studies, women's own voices are still too absent from the research in this thesis and more broadly. Qualitative methods that explore women's experiential knowledge are highly needed, for example through mapping patient journeys within complex migratory contexts to gain insights into how legal statuses affect healthcare responsiveness.[72-74]

Recommendations for policy and practice

Below, I will elucidate four key recommendations that align with the preceding reflections, in which I have already shed light on several necessary steps toward 'safer shores' through equitable care for women with a forced migration background. In this context, equitable care entails that all pregnant women, regardless of their (migration) background or legal status, have access to person-centered care tailored to their specific needs, promoting equal chances of a safe and healthy pregnancy and childbirth. The EGALITE project aimed to formulate concrete recommendations to achieve this. **Chapter eight** outlines the development of recommendations with a group of stakeholders, and summarizes the results of this process.

Key recommendation 1. Increase the registration and monitoring of health outcomes and quality of care among (forced) migrant groups

Efforts to enhance migration-related health equity in the Netherlands should start by counting everyone equally. This means that every child born, regardless of their parents' legal status, should be registered in a way that allows their birth to be counted in national birth statistics. Additionally, all maternal and perinatal outcomes should be identifiable in national health databases like Perined. This might necessitate enabling earlier registration in the national Personal Records Database for asylum seekers to issue a BSN.

As improving equity in care and outcomes requires more equity in data, more comprehensive registration should also be implemented at the level of care provision. Our studies have shown that midwifery information systems currently lack information on characteristics such as legal status, and very few midwives track outcomes specifically among forced migrant groups. Other variables, such as maternal ethnicity is recorded, often contain missing data and use outdated ethnic classifications.

To address this, the national perinatal database (Perined) and health information systems like ChipSoft, Epic, and Onatal should be updated to include mandatory fields for migration background, such as country of birth, length of residence in the Netherlands, and legal status. This aligns with previous studies, the WHO *technical guidance for improving care of pregnant refugee and migrant women and newborn children* and the 2030 Sustainable Development Goals agenda.[31,75]

Since registration alone is insufficient, advanced monitoring systems should be implemented to track the perinatal health of specific migrant populations, similar to the monitoring of several public health outcomes of asylum seekers by the Dutch public health services (GGD). As data for monitoring are now scarce, access to administrative data from the COA and health data from primary care providers in asylum reception centers should be available for research purposes. **Chapter five** suggests that designing dedicated perinatal audits with cases of forced migrants specifically could help to monitor and address the occurrence of suboptimal and inequitable care.

Key recommendation 2. Minimize relocations between asylum centers in all stages of pregnancy

The current Dutch relocation policy is just one of many factors through which migration management infringes upon reproductive justice for women with a forced migration background in the Netherlands. However, the findings presented in this thesis highlight the significant impact of this particular policy. Specifically, the frequency of relocations in **chapter two**, the suboptimal care factors associated with relocations identified in **chapter five**, the adverse effects on midwives' workloads detailed in **chapter six**, and the negative experiences of the women themselves explored in **chapter eight** all underscore that the avoidance of relocations is a top priority.

Avoiding relocations requires that pregnant women and their families are accommodated in a limited number of reception centers nationwide, where expertise and close collaboration between all stakeholders involved in their care can be developed and maintained. Notably, centralizing care would not completely eliminate relocations, as pregnant women and their families, including school-aged children, may need initial relocations to these designated centers. In addition, pausing relocations to centralize care might disrupt some women's asylum procedures, as relocations are typically tied to new phases of the procedure. However, the benefits of stabilized care environments are likely to outweigh these objections, and are crucial for the feasibility of other recommendations outlined in **chapter eight**. These include implementing best practices at asylum reception centers, such as on-site midwife consultations and

antenatal group care, improving living conditions and nutrition for pregnant women, and developing more effective postnatal care practices at asylum reception centers.

The logistic and detailed planning of centralized care for pregnant women in asylum reception centers should be a collective effort by all involved professional organizations, drawing on insights from existing efforts to centralize care, like those in the Ter Apel/Musselkanaal region. While designing the non-relocation policy, some groups may require priority, such as women who are pregnant upon arrival, undocumented women sheltered under Article 64, women in emergency reception centers, and women with high-risk pregnancies. Ultimately, all decisions regarding relocations should be guided by the individual circumstances and preferences of the pregnant woman, her family and care providers. For instance, relocation requests by women seeking proximity to family justifies exceptions to the general non-relocation policy, provided that all necessary care can be assured at the new location.

Key recommendation 3. Warrant the prerequisite conditions, and invest in the resources, knowledge and skills of professionals to provide equitable care

Equitable care and outcomes can never be realized within an asylum system that systematically disadvantages the physical circumstances, opportunities, and livelihood security of pregnant women and their families. Besides minimizing relocations, achieving true equity would require radical revisions of this system, the details of which fall beyond the scope of this thesis. Core elements include realistic planning to prevent capacity issues in reception centers and decommercializing primary healthcare in this sector to address the access to and quality of care within the regular healthcare infrastructure. For these purposes, political accountability for healthcare for asylum seekers should shift to the Ministry of Health from the Ministry of Justice and Security.

While these systemic changes remain distant in the current political landscape, this thesis, particularly in **chapter eight**, presents practical measures for immediate implementation. These include increasing the availability of interpreters and cultural mediators, and addressing language barriers more specifically in healthcare guidelines, as currently being done by the Netherlands Patients Federation. Equipping future care providers with critical consciousness and skills to provide equitable care should be a fundamental priority. This thesis suggests a range of topics for training and education, including cultural sensitivity and implicit bias in medical curricula, awareness of the circumstances faced by women with a forced migration background for hospital staff and postpartum nurses, and specific training for COA staff in their roles as contact persons and

healthcare guides for pregnant women. Additionally, more resources should be allocated to hospitals, midwifery practices, and postpartum care organizations to support local collaboration networks, longer consultations, and specific support programs like doulas or antenatal group care.

Key recommendation 4. Formalize professional guidelines to ensure equitable care and govern the implementation

Guidelines can be instrumental in advancing equity by bridging knowledge gaps, reducing treatment variability, and outlining a legal and ethical framework.[76] Practically, guidelines streamline responsibilities and may improve communication between care providers, highly needed in complex settings such as within the asylum system. However, our research highlighted the need to revise existing guidelines, develop further evidence-based guidelines, and formalize their status in the field.

Current challenges with the national guideline for care to women in asylum reception centers include interdisciplinary collaboration and a lack of familiarity with the guideline among professionals in all sectors. A more user-friendly format and a template for local care pathways with detailed working agreements will enhance practical use and effective coordination of care. Regarding the contents, **chapter eight** has outlined necessary revisions to the national guideline for care to women in asylum reception centers, such as best practices for late entry to care and culturally sensitive psychosocial screening. Separate or integrated guidelines for women with a recent residence permit are also recommended.

To consolidate the position of guidelines for care of pregnant women with a forced migration background, they should be formalized into evidence-based care standards, following the procedure advised by the Dutch national database for medical guidelines. This also requires intensive involvement and formal endorsement from relevant professional organizations, such as the Royal Dutch Organisation of Midwives (KNOV in Dutch) and the Dutch Society for Obstetrics and Gynecology (NVOG in Dutch). Appointing client representatives and a diverse range of professionals in guideline working groups is essential to incorporate the needs of women with a forced migration background and those directly working with them.

The responsibility for developing, governing, and implementing pregnancy and childbirth care guidelines for women with a forced migration background should be a collaborative effort, involving professional organizations, healthcare institutes, and governmental bodies such as the COA. It appears crucial to define more explicit roles and responsibilities in guideline implementation across

settings in the field, including midwifery practices, care organizations, and hospital departments. Entities overseeing healthcare quality in the Netherlands, including the Ministry of Health, the Health and Youth Care Inspectorate, and the National Health Care Institute (Zorginstituut Nederland), should monitor and enforce compliance to these guidelines more intensively. As long as suboptimal care remains a reality for a specific group of people in our country, all involved actors should assume the greatest responsibility. Ultimately, all of us can make a difference to eliminate differences that are unnecessary, unacceptable and unjust.

References

1. Harakow, H.I., et al., Pregnancy complications among refugee women: a systematic review. Acta Obstetricia et Gynecologica Scandinavica, 2021. 100(4): p. 649-657.
2. Bozorgmehr, K., et al., Differences in pregnancy outcomes and obstetric care between asylum seeking and resident women: a cross-sectional study in a German federal state, 2010–2016. BMC pregnancy and childbirth, 2018. 18(1): p. 1-8.
3. Heslehurst, N., et al., Perinatal health outcomes and care among asylum seekers and refugees: a systematic review of systematic reviews. BMC medicine, 2018. 16(1): p. 1-25.
4. Sturrock, S., E. Williams, and A. Greenough, Antenatal and perinatal outcomes of refugees in high income countries. Journal of Perinatal Medicine, 2021. 49(1): p. 80-93.
5. Montagnoli, C. and P. Wanner, Are pregnancy outcomes affected by the lack of legal status? A demographic study based on 850,288 live births in Switzerland. BMC Pregnancy and Childbirth, 2023. 23(1): p. 567.
6. Schoenborn, C., M. De Spiegelaere, and J. Racape, Measuring the invisible: perinatal health outcomes of unregistered women giving birth in Belgium, a population-based study. BMC pregnancy and childbirth, 2021. 21(1): p. 1-13.
7. Behboudi-Gandevani, S., et al., Perinatal and Neonatal Outcomes in Immigrants From Conflict-Zone Countries: A Systematic Review and Meta-Analysis of Observational Studies. Frontiers in public health, 2022. 10.
8. Freedman, J., The uses and abuses of" vulnerability" in EU asylum and refugee protection: Protecting women or reducing autonomy? 2019.
9. Grotti, V., et al., Shifting vulnerabilities: gender and reproductive care on the migrant trail to Europe. Comparative migration studies, 2018. 6(1): p. 1-18.
10. Carruth, L., et al., Structural vulnerability: migration and health in social context. BMJ global health, 2021. 6(Suppl 1): p. e005109.
11. Laban, C.J., et al., Impact of a long asylum procedure on the prevalence of psychiatric disorders in Iraqi asylum seekers in The Netherlands. The Journal of nervous and mental disease, 2004. 192(12): p. 843-851.
12. Wanigaratne, S., et al., Refugee maternal and perinatal health in Ontario, Canada: a retrospective population-based study. BMJ open, 2018. 8(4): p. e018979.
13. Gibson-Helm, M.E., et al., Maternal health and pregnancy outcomes comparing migrant women born in humanitarian and nonhumanitarian source countries: a retrospective, observational study. Birth, 2015. 42(2): p. 116-124.
14. Liu, C., et al., Perinatal health of refugee and asylum-seeking women in Sweden 2014–17: a register-based cohort study. European journal of public health, 2019. 29(6): p. 1048-1055.
15. Verschuuren, A., et al., Pregnancy outcomes in asylum seekers in the North of the Netherlands: a retrospective documentary analysis. BMC pregnancy and childbirth, 2020. 20(1): p. 1-10.
16. Borras, A.M., Toward an intersectional approach to health justice. International Journal of Health Services, 2021. 51(2): p. 206-225.
17. Alderliesten, M., et al., Late start of antenatal care among ethnic minorities in a large cohort of pregnant women. BJOG: An International Journal of Obstetrics & Gynaecology, 2007. 114(10): p. 1232-1239.
18. Posthumus, A.G., et al., The association of ethnic minority density with late entry into antenatal care in the Netherlands. Plos one, 2015. 10(4): p. e0122720.

19. Saunders, S.L., et al., The associations between women who are immigrants, refugees, or asylum seekers, access to universal healthcare, and the timely uptake of antenatal care: A systematic review. Australian and New Zealand Journal of Obstetrics and Gynaecology, 2023. 63(2): p. 134-145.
20. van Meijeren-van Lunteren, A., et al., Monitor Kansrijke Start 2023. RIVM rapport 2023-0463, 2024.
21. CBS. Geboorte. 2022 [cited 2024 May 25]; Available from: https://www.cbs.nl/nl-nl/visualisaties/dashboard-bevolking/bevolkingsgroei/geboren-kinderen.
22. Bozorgmehr, K., et al., Integration of migrant and refugee data in health information systems in Europe: advancing evidence, policy and practice. The Lancet Regional Health–Europe, 2023. 34.
23. Correa-Velez, I. and S. M. Gifford, When the right to be counted doesn't count: the politics and challenges of researching the health of asylum seekers. Critical Public Health, 2007. 17(3): p. 273-281.
24. de Jonge, A., et al., Limited midwifery care for undocumented women in the Netherlands. Journal of Psychosomatic Obstetrics & Gynecology, 2011. 32(4): p. 182-188.
25. Eslier, M., et al., Severe maternal morbidity among undocumented migrant women in the PreCARE prospective cohort study. BJOG: An International Journal of Obstetrics & Gynaecology, 2022. 129(10): p. 1762-1771.
26. Mandroiu, A., M. Pavlova, and W. Groot, Sexual and reproductive health rights and service use among undocumented migrants in the EU: a systematic literature review. 2023.
27. Voldner, N., F. Eick, and S. Vangen, 'Goodbye and good luck'Midwifery care to pregnant undocumented migrants in Norway: A qualitative study. Sexual & Reproductive Healthcare, 2023: p. 100878.
28. Verschuuren, A.E.H., et al., Pregnancy outcomes in asylum seekers in the North of the Netherlands: a retrospective documentary analysis. BMC Pregnancy and Childbirth, 2020. 20: p. 1-10.
29. Soldati E. et al., Pregnant asylum-seekers' perspectives regarding mental health screening: a qualitative study. European Journal of Public Health. 2021 Oct 1;31(Supplement_3):ckab164-861.
30. Gagnon, A.J., M. Zimbeck, and J. Zeitlin, Migration and perinatal health surveillance: an international Delphi survey. European Journal of Obstetrics & Gynecology and Reproductive Biology, 2010. 149(1): p. 37-43.
31. Mosler Vidal, E., Leave No Migrant Behind: The 2030 Agenda and Data Disaggregation. . 2021, International Organization for Migration (IOM): Geneva.
32. Villalonga-Olives, E., I. Kawachi, and N. Von Steinbüchel, Pregnancy and birth outcomes among immigrant women in the US and Europe: a systematic review. Journal of Immigrant and Minority Health, 2017. 19: p. 1469-1487.
33. Juárez, S.P., et al., Effects of non-health-targeted policies on migrant health: a systematic review and meta-analysis. The Lancet Global Health, 2019. 7(4): p. e420-e435.
34. Bozorgmehr, K. and R. Jahn, Adverse health effects of restrictive migration policies: building the evidence base to change practice. The Lancet Global Health, 2019. 7(4): p. e386-e387.
35. Lonergan, G., Reproductive justice and migrant women in Great Britain. Women: A Cultural Review, 2012. 23(1): p. 26-45.
36. Ross, L. and R. Solinger, Reproductive justice: An introduction. Vol. 1. 2017: Univ of California Press.
37. Kirkendall, A. and A. Dutt, Refugee women's pregnancy and childbirth experiences in the US: Examining context through a reproductive justice framework. Feminism & Psychology, 2023: p. 09593535221149166.

38. Belanteri, R.A., et al., Sexual violence against migrants and asylum seekers. The experience of the MSF clinic on Lesvos Island, Greece. PloS one, 2020. 15(9): p. e0239187.
39. Mason-Jones, A.J. and P. Nicholson, Structural violence and marginalisation. The sexual and reproductive health experiences of separated young people on the move. A rapid review with relevance to the European humanitarian crisis. Public health, 2018. 158: p. 156-162.
40. Van Liempt, I. and S. Miellet, Being far away from what you need: the impact of dispersal on resettled refugees' homemaking and place attachment in small to medium-sized towns in the Netherlands. Journal of Ethnic and Migration Studies, 2021. 47(11): p. 2377-2395.
41. Gewalt, S.C., et al., Psychosocial health of asylum seeking women living in state-provided accommodation in Germany during pregnancy and early motherhood: A case study exploring the role of social determinants of health. PloS one, 2018. 13(12): p. e0208007.
42. Gewalt, S.C., et al., "If you can, change this system"-Pregnant asylum seekers 'perceptions on social determinants and material circumstances affecting their health whilst living in state-provided accommodation in Germany-a prospective, qualitative case study. BMC public health, 2019. 19(1): p. 1-14.
43. Rast, E., et al., Housing and health: A multidimensional, qualitative analysis of the experiences of asylum seekers and refugees living in German reception centres. SSM-Qualitative Research in Health, 2024: p. 100407.
44. Raad van State. 24-weken eis is onverbindend [Internet]. Den Haag: Raad van State; 2023 [cited 2023 Nov 12]. Available from: https://www.raadvanstate.nl/actueel/nieuws/november/24-weken-eis-is-onverbindend/
45. Bollini, P., et al., Pregnancy outcome of migrant women and integration policy: a systematic review of the international literature. Social science & medicine, 2009. 68(3): p. 452-461.
46. Sow, M., et al., Influence of time since naturalisation on socioeconomic status and low birth weight among immigrants in Belgium. A population-based study. PLoS One, 2019. 14(8): p. e0220856.
47. Sørbye, I.K., et al., Birthweight of babies born to migrant mothers-What role do integration policies play? SSM-population health, 2019. 9: p. 100503.
48. Hummel, B., M.A. Yerkes, and M. Bal, 'Unprecedented injustice': Digitalisation and the perceived accessibility of childcare benefits. Journal of Social Policy, 2023: p. 1-20.
49. Halman, M., L. Baker, and S. Ng, Using critical consciousness to inform health professions education: A literature review. Perspectives on medical education, 2017. 6: p. 12-20.
50. Ashley, R., et al., A call for critical midwifery studies: Confronting systemic injustice in sexual, reproductive, maternal, and newborn care: Critical Midwifery Collective Writing Group. Birth (Berkeley, Calif.), 2022. 49(3): p. 355.
51. Neff, J., et al., Structural competency: curriculum for medical students, residents, and interprofessional teams on the structural factors that produce health disparities. MedEdPORTAL, 2020. 16: p. 10888.
52. Council of Europe Commissioner for Human Rights. The Netherlands must take urgent measures to improve reception conditions for asylum seekers [Internet]. Strasbourg: Council of Europe; [cited 2023 Nov 12]. Available from: https://www.coe.int/fi/web/commissioner/-/the-netherlands-must-take-urgent-measures-to-improve-reception-conditions-for-asylum-seekers
53. College voor de Rechten van de Mens. Oproep aan de Staatssecretaris van Asiel & Migratie: legitimeer geen discriminerend opvangbeleid van gemeenten [Internet]. 2022 Jul 29 [cited 2023 Nov 12]. Available from: https://www.mensenrechten.nl/actueel/nieuws/2022/07/29/oproep-aan-de-staatssecretaris-van-asiel--migratie-legitimeer-geen-discriminerend-opvangbeleid-van-gemeenten
54. Koopmans R. De Asielloterij. Amsterdam: Prometheus; 2023.

55. VluchtelingenWerk Nederland. Gevangen in een vastgelopen asielsysteem [Internet]. Amsterdam: VluchtelingenWerk Nederland; 2023 [cited 2023 Nov 12]. Available from: https://www.vluchtelingenwerk.nl/sites/default/files/u32926/gevangen_in_een_vastgelopen_asielsysteem.pdf
56. Grove, N.J. and A.B. Zwi, Our health and theirs: Forced migration, othering, and public health. Social science & medicine, 2006. 62(8): p. 1931-1942.
57. Akbulut, N. and O. Razum, Why Othering should be considered in research on health inequalities: Theoretical perspectives and research needs. SSM-Population Health, 2022. 20: p. 101286.
58. Firth, A., Developing effective maternity services for refugee and asylum seeking women with symptoms of perinatal depression: Increasing the visibility of an invisible population. 2021.
59. Van Loenen, T., et al., Primary care for refugees and newly arrived migrants in Europe: a qualitative study on health needs, barriers and wishes. The European Journal of Public Health, 2018. 28(1): p. 82-87.
60. Fair, F., et al., Migrant women's experiences of pregnancy, childbirth and maternity care in European countries: A systematic review. PloS one, 2020. 15(2): p. e0228378.
61. Fair, F., et al., Midwives' experiences of cultural competency training and providing perinatal care for migrant women a mixed methods study: Operational Refugee and Migrant Maternal Approach (ORAMMA) project. BMC pregnancy and childbirth, 2021. 21(1): p. 1-13.
62. P. Iqbal, M., et al., Improving primary health care quality for refugees and asylum seekers: A systematic review of interventional approaches. Health Expectations, 2022. 25(5): p. 2065-2094.
63. van den Muijsenbergh, M.E., et al., Participatory implementation research in the field of migrant health: Sustainable changes and ripple effects over time. Health Expectations, 2020. 23(2): p. 306-317.
64. Cordeiro, L., L. Rittenmeyer, and C.B. Soares, Action research methodology in the health care field: a scoping review protocol. JBI Evidence Synthesis, 2015. 13(8): p. 70-78.
65. O'Reilly-de Brún, M., et al., Material practices for meaningful engagement: an analysis of participatory learning and action research techniques for data generation and analysis in a health research partnership. Health Expectations, 2018. 21(1): p. 159-170.
66. Keygnaert, I., et al., Sexual health is dead in my body: participatory assessment of sexual health determinants by refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands. BMC Public Health, 2014. 14(416): p. 1-13.
67. Markey, K., et al., Fostering collective approaches in supporting perinatal mental healthcare access for migrant women: A participatory health research study. International Journal of Environmental Research and Public Health, 2022. 19(3): p. 1124.
68. Van Den Muijsenbergh, M., et al., Giving voice to the voiceless: how to involve vulnerable migrants in healthcare research. 2016, British Journal of General Practice. p. 284-285.
69. Goosen, S., et al., Induced abortions and teenage births among asylum seekers in The Netherlands: analysis of national surveillance data. Journal of Epidemiology & Community Health, 2009.
70. Goosen, S., et al., High HIV prevalence among asylum seekers who gave birth in the Netherlands: a nationwide study based on antenatal HIV tests. PLoS One, 2015. 10(8): p. e0134724.
71. Zeeb, H., et al., Epidemiological Studies on Migrant Health, in Handbook of Epidemiology. 2023, Springer. p. 1-27.

72. Papadakaki, M., et al., The Perinatal Journey of a Refugee Woman in Greece: A Qualitative Study in the Context of the ORAMMA Project to Elucidate Current Challenges and Future Perspectives. Sexes, 2021. 2(4): p. 452-467.
73. Kuipers, Y.J.F. and E. Mestdagh, The experiential knowledge of migrant women about vulnerability during pregnancy: A woman-centred mixed-methods study. Women and Birth, 2022. 35(1): p. 70-79.
74. Biddle, L., et al., The patient journey of newly arrived asylum seekers and responsiveness of care: A qualitative study in Germany. Plos one, 2022. 17(6): p. e0270419.
75. World Health Organization. WHO recommendations on antenatal care for a positive pregnancy experience. Geneva: World Health Organization; 2016.
76. Welch, V.A., et al., GRADE equity guidelines 1: considering health equity in GRADE guideline development: introduction and rationale. Journal of clinical epidemiology, 2017. 90: p. 59-67.

Appendices (Bijlagen)

Appendix 1. Summary in English and Dutch

Bijlage 1. Engelse en Nederlandse samenvatting

Summary in English

This thesis examined the state of health equity within the Dutch system of pregnancy and childbirth care for women with a forced migration background. Specifically, we aimed to shed light on their maternal and perinatal health, evaluate the pregnancy and childbirth care they receive in the Netherlands, and derive recommendations for the advancement of equity in this area.

In **part one**, we explored the characteristics, maternal, and perinatal health outcomes of populations affected by forced migration in Europe and the Netherlands specifically. **Chapter one** contains the general introduction, including the aims, background and design of this thesis.

In **chapter two**, a systematic literature review was conducted to examine maternal and perinatal health outcomes among asylum seekers and undocumented migrants in Europe from 2007 to 2017. The review utilized databases of peer-reviewed manuscripts such as MEDLINE and EMBASE, as well as grey literature sources. Out of 4652 peer-reviewed articles and 145 grey literature sources screened, 11 studies from 4 European countries were included. Adverse outcomes reported for asylum seekers included higher maternal mortality and severe acute maternal morbidity compared to the host country population. For undocumented migrants, adverse outcomes included higher rates of preterm birth and low birth weight compared to documented migrants. However, the limited number of available studies often had methodological limitations. The review thus underscored the need for more research on specific migrant subpopulations to provide insights into risk factors for adverse outcomes and how to address these in policy and practice.

In **chapter three**, data on registered childbirths from the Central Agency for the Reception of Asylum Seekers (COA) were analyzed to describe characteristics and explore the prevalence of risk factors associated with adverse pregnancy outcomes among mothers in Dutch asylum reception centers. Between 2016 and 2020, 2831 births were registered, with the largest group of mothers (33.8%) originating from the Middle East or North Africa. The teenage birth rate was 6.77 times higher compared to the general Dutch population, and 44.9% of the mothers were registered as single mothers. More than half of all mothers were already pregnant upon registering in the reception center, which may have delayed pregnancy care. Relocations between centers during pregnancy,

which often compromise continuity of care, occurred in 69.5% of the mothers, and 15.5% experienced two or more relocations. In 11.3% of the births, the mother was an undocumented migrant with limited rights to healthcare and accommodation. Although no outcome data were available for this study, the high prevalence of these risk factors likely contributes to the increased rate of adverse pregnancy outcomes in women with forced migration backgrounds as reported in other studies.

In **chapter four,** pregnancy and childbirth outcomes of the national population of women with a forced migration background in the Netherlands were described and compared to those of non-migrants and resident migrants. This overview was obtained by linking birth records from the Netherlands perinatal registry (Perined) with migration data from Statistics Netherlands for the period 2014-2019. The study found that women with a forced migration background had elevated risks of perinatal mortality and small-for-gestational age infants compared to the reference populations of non-migrants and resident migrants. They were also more likely to undergo emergency caesarean sections than non-migrants. The differences were sustained in analyses adjusted for age and parity. Conversely, the risk of preterm birth was lower than in both comparison groups. Most other included adverse outcomes, such as low Apgar scores, showed higher rates among women with a forced migration background, although their rate of postpartum hemorrhage was again lower compared to non-migrants and resident migrants.

In **part two**, studies were focused on the quality, experiences and challenges of pregnancy and childbirth care for women with a forced migration background in the Netherlands.

In **chapter five**, suboptimal care factors were examined in a cohort of 53 women with a forced migration background who experienced adverse outcomes, as recorded in the Dutch perinatal audit registry between 2017 and 2019. An expert panel analyzed these cases using the 'Three Delays Model' of pregnancy and childbirth care. Suboptimal care factors were identified in each case, contributing to adverse outcomes in 67.9% of instances. Further analysis revealed that most of the 29 categories of suboptimal care factors pertained to the third phase of the model, which focuses on the quality of care provision. In this phase, common suboptimal care included missed diagnoses, delayed treatment, and miscommunication between healthcare providers. These were followed by factors from the second phase (accessibility of care), such as unresolved language barriers and transportation issues, and factors from the first phase (care-seeking), including missed appointments and delayed care-seeking for alarm symptoms. The findings indicate that addressing specific suboptimal care factors could

potentially prevent a substantial portion of adverse outcomes among forced migrants in the Netherlands.

In **chapter six**, we explored the perspectives of 102 Dutch community midwives on pregnancy and childbirth care for women with a forced migration background through a survey study. The analysis of survey responses, both quantitative and qualitative, revealed that midwives perceived the quality of this care as inferior to the care for other populations in the Netherlands. Meanwhile, midwives reported a greater practical and emotional burden of care, attributed to challenges across five key domains: interdisciplinary collaboration, communication with clients, continuity of care, psychosocial care, and the vulnerable situation of many asylum seekers and refugees. These findings confirm that there is significant room for improvement of care for these populations, Key priorities should include the availability of professional interpreters and minimizing the relocations of asylum seekers during pregnancy.

In **chapter seven**, we employed a qualitative study design to deepen our understanding of midwives' challenges and gain insight into how equitable pregnancy and childbirth care for women with a forced migration background can be achieved. We conducted a thematic analysis of semi-structured interviews with eleven community midwives, focusing on the specific barriers they encounter in caring for this population. Results revealed barriers at three levels of care. At the micro-level of individual interactions with women with a forced migration background, common barriers included language and interpreter issues, cultural differences, and building trust. At the meso-level of care organization, significant barriers involved the relocations of asylum seekers, delays in accessing care, and difficulties within interdisciplinary collaboration. At the macro-level, within the broader context of clients' lived realities, barriers for midwives were related to housing conditions, the resettlement process, and the mental health of women with a forced migration background. A central theme was the imbalance between the responsibilities and resources of midwives, who are increasingly burdened with additional roles in care, but struggle to address the inequities stemming from structural determinants of health.

Part three focuses on the necessary steps to advance equity in pregnancy and childbirth for women with a forced migration background in the Netherlands.

Chapter eight comprises the development of a comprehensive set of recommendations for Dutch policy and practice through a participatory study in the final phase of the EGALITE project. This chapter extends our research into practical application. We conducted six focus groups with diverse participants, including women with forced migration backgrounds, midwives, postpartum care

nurses, COA and GZA staff, and gynecologists. Initially, we triangulated all earlier findings regarding key barriers and best practices in care across four themes: the organization of care, accessibility and continuity of care, quality of tailored care, and the social and political context of care. In subsequent sessions, these findings were collaboratively translated into comprehensive recommendations for the field by participants and researchers. The key recommendations resulting from this process include centralizing care in select asylum reception centers, enhancing guideline development and implementation, and improving registration needed to monitor health equity.

In the **general discussion**, a reflection on the contributions of this thesis, in the context of existing literature, is articulated through five propositions that highlight necessary steps toward 'safer shores' in pregnancy and childbirth care for women forced to migrate to the Netherlands. Primarily, the integrated evidence underscores that persistent differences in maternal and perinatal health affecting women with a forced migration background should be considered largely preventable inequities. Moreover, these inequities are perpetuated by the administrative invisibility of marginalized migrants and the current management of forced migration, which fails to safeguard reproductive justice. Improvement is currently impeded by a lack of political accountability and a defective asylum system. Therefore, it is essential to invest in the critical consciousness of healthcare providers, who play a crucial role in the attainment of equitable care to pregnant women with a forced migration background.

With regards to future studies, this thesis has marked the potential of Participatory Action Research to incorporate experiential knowledge in efforts to improve care for marginalized migrant groups. Dedicated perinatal audit projects appear useful to address suboptimal care factors in these specific groups. Additionally, large-scale quantitative studies should examine the impact of specific migration policies through an intersectional lens. As long as some children are born in 'administrative invisibility' and the integration of migration and health data registries remains incomplete, other available data sources, such as primary healthcare information systems, should be made accessible for research purposes.

Ultimately, this thesis calls for a paradigm shift to view the heightened rates of adverse pregnancy and childbirth outcomes among women with a forced migration background as largely preventable inequities. This is a necessary step toward 'safer shores' for all pregnant women, mothers and children who seek refuge in the Netherlands.

Summary in Dutch (Nederlandse samenvatting)

Dit proefschrift onderzocht de stand van zaken omtrent gezondheidsrechtvaardigheid binnen het Nederlandse systeem van geboortezorg voor mensen met een achtergrond van gedwongen migratie. Specifiek richtten we ons op het belichten van hun maternale en perinatale gezondheidsuitkomsten, het evalueren van de geboortezorg die zij in Nederland ontvangen, en het opstellen van aanbevelingen voor het bevorderen van gezondheidsrechtvaardigheid op dit gebied.

In **deel één** onderzochten we de kenmerken en maternale en perinatale gezondheidsuitkomsten van gedwongen gemigreerde populaties in Europa en specifiek in Nederland. **Hoofdstuk een** bevat de algemene inleiding, inclusief de doelen, achtergrond en opzet van deze thesis.

In **hoofdstuk twee** werd een systematische literatuurstudie uitgevoerd om maternale en perinatale gezondheidsuitkomsten onder asielzoekers en ongedocumenteerde migranten in Europa tussen 2007 en 2017 te onderzoeken. Voor het literatuuroverzicht werd gezocht in databases met peer-reviewed manuscripten zoals MEDLINE en EMBASE, evenals in grijze literatuurbronnen. Van de 4652 gescreende peer-reviewed artikelen en 145 grijze literatuurbronnen werden 11 studies uit 4 Europese landen opgenomen in de studie. Voor asielzoekers werden ongunstige uitkomsten gerapporteerd, waaronder hogere maternale mortaliteit en ernstige acute maternale morbiditeit in vergelijking met de bevolking van het gastland. Voor ongedocumenteerde migranten omvatten ongunstige uitkomsten hogere percentages vroeggeboorte en laag geboortegewicht vergeleken met gedocumenteerde migranten. De beperkt beschikbare studies vertoonden echter vaak methodologische beperkingen. Deze literatuurstudie onderstreept daarmee de noodzaak voor meer onderzoek naar specifieke migranten subpopulaties om inzicht te krijgen in risicofactoren voor ongunstige uitkomsten en hoe deze in beleid en praktijk kunnen worden aangepakt.

In **hoofdstuk drie** werden gegevens over geregistreerde geboorten van het Centraal Orgaan opvang Asielzoekers (COA) geanalyseerd om de prevalentie van risicofactoren die geassocieerd zijn met ongunstige zwangerschapsuitkomsten onder moeders in Nederlandse asielzoekerscentra in kaart te brengen. Tussen 2016 en 2020 werden 2831 geboorten geregistreerd, waarbij de grootste groep moeders (33,8%) afkomstig was uit het Midden-Oosten of Noord-Afrika. Het tiener geboortecijfer was 6,77 keer hoger vergeleken met de algemene Nederlandse bevolking en 44,9% van de moeders stond geregistreerd als alleenstaande moeder. Meer dan de helft van alle moeders was al zwanger bij registratie in het opvangcentrum, wat mogelijk tot vertraging in de zwangerschapszorg heeft

geleid. Overplaatsingen tussen opvangcentra tijdens de zwangerschap, die vaak de continuïteit van zorg compromitteren, kwamen voor bij 69,5% van de geboortes. Bij 15,5% van de geboortes was de moeder twee keer of vaker overgeplaatst in dezelfde zwangerschap. In 11,3% van de geboortes was de moeder een ongedocumenteerde migrant met beperkte rechten op gezondheidszorg en accommodatie. Hoewel voor deze studie geen uitkomstgegevens beschikbaar waren, dragen de hoge prevalentie van deze risicofactoren waarschijnlijk bij aan ongunstige zwangerschapsuitkomsten bij vrouwen met een gedwongen migratieachtergrond zoals gerapporteerd in andere studies.

In **hoofdstuk vier** worden maternale en perinatale uitkomsten onder de landelijke populatie van vrouwen met een gedwongen migratieachtergrond in Nederland beschreven. De uitkomsten werden vergeleken met uitkomsten onder gevestigde migranten en onder vrouwen zonder migratie-achtergrond. Dit overzicht werd verkregen door geboortegegevens uit de Nederlandse perinatale registratie (Perined) te koppelen aan migratiegegevens van het Centraal Bureau voor de Statistiek voor de periode 2014-2019. Vrouwen met een gedwongen migratieachtergrond hadden verhoogde risico's op perinatale sterfte en te kleine kinderen voor de zwangerschapsduur in vergelijking met de referentiepopulaties van niet-migranten en gevestigde migranten, ook wanneer deze uitkomsten gecorrigeerd werden voor leeftijd en pariteit. Ze ondergingen ook vaker een spoedkeizersnede dan niet-migranten. Daarentegen was het risico op vroeggeboorte lager dan in beide vergelijkingsgroepen. Ook de prevalentie van postpartum bloedingen lag lager vergeleken met niet-migranten en gevestigde migranten, hoewel de prevalentie van de meeste andere ongunstige uitkomsten, zoals lage Apgar-scores, wel degelijk verhoogd was.

In **deel twee** richtten de studies zich op de kwaliteit, ervaringen en knelpunten in de zwangerschap- en geboortezorg voor vrouwen met een achtergrond van gedwongen migratie in Nederland.

In **hoofdstuk vijf** werden suboptimale zorgfactoren onderzocht in een cohort van 53 vrouwen met een gedwongen migratieachtergrond met ongunstige uitkomsten. De data werden verkregen uit de Nederlandse perinatale auditregistratie tussen 2017 en 2019. Een expertpanel analyseerde deze casuïstiek met behulp van het 'Three Delays Model' van geboortezorg. Suboptimale zorgfactoren werden in elke casus geïdentificeerd en droegen in de meerderheid van de gevallen bij aan de ongunstige uitkomst. Verdere analyse onthulde dat de meeste van de 29 categorieën van suboptimale zorgfactoren betrekking hadden op de derde fase van het model, die betrekking heeft op de kwaliteit van zorgverlening. Veelvoorkomende suboptimale zorgfactoren in deze fase waren bijvoorbeeld gemiste diagnoses, vertraagde behandelingen en miscommunicatie tussen zorgverleners. Deze

werden gevolgd door factoren uit de tweede fase (toegankelijkheid van zorg), zoals onopgeloste taalbarrières en vervoersproblemen, en factoren uit de eerste fase (het zoeken van zorg), waaronder gemiste afspraken en te laat zorg zoeken bij alarmsymptomen. De bevindingen van deze studie wijzen erop dat het aanpakken van specifieke suboptimale zorgfactoren mogelijk een aanzienlijk deel van de ongunstige uitkomsten onder gedwongen migranten in Nederland kan voorkomen.

In **hoofdstuk zes** onderzochten we de perspectieven van 102 Nederlandse eerstelijns verloskundigen op zwangerschap- en geboortezorg voor asielzoekers en statushouders, door middel van een vragenlijst. De kwantitatieve en kwalitatieve analyse van de resultaten onthulde dat verloskundigen de kwaliteit van zorg voor asielzoekers en vluchtelingen als inferieur beschouwden in vergelijking met de zorg voor andere populaties in Nederland. Tegelijkertijd was de praktische en emotionele belasting voor verloskundigen juist hoger, toegeschreven aan uitdagingen op vijf belangrijke gebieden: interdisciplinaire samenwerking, communicatie met cliënten, continuïteit van zorg, psychosociale zorg en de kwetsbare situatie van veel asielzoekers en vluchtelingen. Deze bevindingen bevestigen dat er aanzienlijke ruimte is voor verbetering van de zorg voor deze populaties; hierin vormen de beschikbaarheid van professionele tolken en het minimaliseren van overplaatsingen van asielzoekers tijdens de zwangerschap belangrijke prioriteiten.

In **hoofdstuk zes** zetten we een kwalitatieve studie op om ons begrip van de uitdagingen van verloskundigen te verdiepen, zodat hun inzichten gebruikt kunnen worden voor het verbeteren van de geboortezorg voor vrouwen met een achtergrond van gedwongen migratie. We voerden een thematische analyse uit van semigestructureerde interviews met elf eerstelijns verloskundigen, vooral gericht op de specifieke barrières die zij momenteel tegenkomen in de zorg voor deze populatie. De resultaten onthulden barrières op drie zorgniveaus. Op het microniveau van individuele interacties met cliënten omvatten veelvoorkomende barrières taal- en tolkenproblemen, culturele verschillen en het opbouwen van vertrouwen. Op mesoniveau van de zorgorganisatie betroffen de belangrijkste barrières de verplaatsingen van asielzoekers, vertragingen bij het verkrijgen van zorg en moeilijkheden binnen interdisciplinaire samenwerking. Op macroniveau, de bredere context van de leefomstandigheden van cliënten, waren de barrières voor verloskundigen gerelateerd aan huisvestingsomstandigheden, het hervestigingsproces en de geestelijke gezondheid van vrouwen met een gedwongen migratieachtergrond. Een centraal thema was de disbalans tussen de verantwoordelijkheden en middelen van verloskundigen, die steeds meer belast worden met extra taken in de zorg, maar weinig invloed hebben op ongelijkheden die voortvloeien uit structurele determinanten van gezondheid.

Hoofdstuk acht vertaalt ons onderzoek naar praktische toepassingen. Dit hoofdstuk omvat de aanbevelingen die zijn ontwikkeld in een participatieve studie in de laatste fase van het EGALITE project. We voerden zes focusgroepen uit met verschillende deelnemers, waaronder ervaringsdeskundige vrouwen, verloskundigen, kraamverzorgenden, COA- en GZA-medewerkers en gynaecologen. In de eerste focusgroepen trianguleerden we eerdere onderzoeksbevindingen met betrekking tot belangrijke barrières en best practices. In daaropvolgende sessies werden deze bevindingen door deelnemers en onderzoekers samen vertaald in concrete aanbevelingen voor het beleid en de praktijk. De bevindingen en aanbevelingen zijn gestructureerd in vier thema's: de organisatie van zorg, de toegankelijkheid en continuïteit van de zorg, de kwaliteit van zorg op maat voor asielzoekers en statushouders, en de sociale en politieke context van deze zorg. De belangrijkste aanbevelingen die uit dit proces voortkwamen, omvatten de centralisatie van geboortezorg in geselecteerde asielzoekerscentra, het verbeteren van de ontwikkeling en implementatie van richtlijnen, en het verbeteren van dataregistratie die nodig is om migratie-gerelateerde gezondheidsongelijkheid te monitoren.

In de **algemene discussie** reflecteer ik op de bevindingen van dit proefschrift in de context van bestaande kennis, door middel van vijf stellingen die de noodzakelijke stappen belichten om 'veiliger kusten' te creëren voor zwangeren met een gedwongen migratieachtergrond in Nederland. Primair onderstreept het geïntegreerde bewijs dat aanhoudende verschillen in maternale en perinatale gezondheid die vrouwen met een gedwongen migratieachtergrond treffen, grotendeels als vermijdbare ongelijkheden moeten worden beschouwd. Bovendien worden deze ongelijkheden in stand gehouden door de administratieve onzichtbaarheid van gemarginaliseerde migranten en het huidige beheer van gedwongen migratie, dat er niet in slaagt reproductieve rechtvaardigheid te waarborgen. Verbetering wordt momenteel belemmerd door een gebrek aan politieke verantwoordelijkheid en een gebrekkig asielsysteem. Daarom is het essentieel om te investeren in het kritische bewustzijn van zorgverleners, die een cruciale rol spelen bij het bereiken van rechtvaardige en gelijkwaardige zorg voor zwangere vrouwen met een gedwongen migratieachtergrond.

Wat betreft aanbevelingen voor toekomstig onderzoek toont dit proefschrift het potentieel van Participatief Actieonderzoek om ervaringskennis op te nemen in inspanningen om de zorg voor gemarginaliseerde groepen te verbeteren. Toegespitste perinatale auditprojecten blijken nuttig om suboptimale zorgfactoren in deze specifieke groepen aan te pakken, terwijl grootschalige kwantitatieve studies nodig zijn om de impact van structurele factoren, zoals migratiebeleid, verder te onderzoeken, bij voorkeur door een intersectionele lens. Zolang sommige kinderen worden geboren in 'administratieve onzichtbaarheid' en de

integratie van migratie- en gezondheidsdata onvolledig blijft, moeten beschikbare databronnen, zoals eerstelijns gezondheidsinformatiesystemen in opvanglocaties, toegankelijk worden gemaakt voor onderzoek.

Dit proefschrift roept uiteindelijk op tot een paradigmaverschuiving om de verhoogde prevalenties van ongunstige maternale en perinatale uitkomsten onder vrouwen met een achtergrond van gedwongen migratie te beschouwen als grotendeels vermijdbare ongelijkheden. Dit bewustzijn is een cruciale stap richting 'veiligere havens' voor alle zwangere vrouwen, moeders en kinderen die in Nederland een toevlucht zoeken.

Appendix 2. Opinion piece in Dutch media

Bijlage 2. Opiniestuk in Nederlandse media

The first version of this opinion piece was recognized as the top submission in a course organized by Stichting Dokters in Debat and Medisch Contact. It was subsequently published in *Medisch Contact* (February 9, 2023), and a revised version appeared in the weekend edition of *NRC* (February 11, 2023).

De eerste versie van dit opiniestuk werd uitgeroepen tot beste inzending in een cursus van Stichting Dokters in Debat en Medisch Contact. Het werd daarop gepubliceerd in *Medisch Contact* (9 februari 2023). Een bewerking werd gepubliceerd in de weekendeditie van *NRC* (11 februari 2023).

De zorg voor vluchtelingen is ongelijkwaardig en ontoereikend: pleidooi voor een landelijk en uniform beleid

Zodra een vluchteling voet zet in Nederland, is het paspoort dat diegene (al dan niet) bij zich draagt bepalend voor de deuren die opengaan. Dat geldt helaas óók voor de deur van de spreekkamer. De ongelijkheid is zo groot dat de zorg voor huisdieren van Oekraïners op sommige plekken beter geregeld is dan de zorg voor vluchtelingen uit bijvoorbeeld Syrië of Afghanistan. De Inspectie uit zich bezorgd, beroepsverenigingen en hulporganisaties schrijven brandbrieven, maar een reddingsactie voor deze stille ramp in eigen land blijft uit. Het is tijd dat het Ministerie van Volksgezondheid, Welzijn en Sport (VWS) ingrijpt.

Als basisarts werk ik in de Utrechtse Jaarbeurshal, de grootste tijdelijke opvanglocatie voor ontheemde Oekraïners in Nederland. Direct na aankomst vindt er een korte medische triage plaats. De eerstelijnszorg wordt door het medisch team al maanden grotendeels overgenomen van lokale huisartsenpraktijken. Soms valt er overigens weinig over te nemen – het komt regelmatig voor dat ik een halve dienst sta te tafeltennissen in de Jaarbeurshal. Intussen wordt er zelfs aan de huisdieren gedacht: de organisatie “Hulp voor Dieren uit Oekraïne” deelt gratis speeltjes uit, regelt vaccinaties en helpt bij het vinden van vervolgopvang voor mensen samen met hun hond, kat of knaagdier.

Het contrast met vluchtelingen uit andere landen is stuitend. Terwijl veel van de boxsprings én de dierenmanden in de Jaarbeurs onbeslapen bleven deze zomer, brachten honderden mensen *zonder* Oekraïens paspoort de nacht door buiten het aanmeldcentrum in Ter Apel. Capaciteits- en doorstroomproblemen bij het Centraal Orgaan opvang Asielzoekers (COA) en de Immigratie- en Naturalisatiedienst (IND) leidden dit jaar tot niet eerder vertoonde crisisbeelden,

ondanks het feit dat het aantal asielverzoeken niet hoger lag dan bijvoorbeeld in 2000 of 2015.

De historische – want in Nederland allereerste – inzet van Artsen zonder Grenzen in Ter Apel was van korte duur, maar de nood in de zorg duurt voort. De eerste medische screening van asielzoekers laat soms maanden op zich wachten en complexe patiënten raken uit beeld door continue verplaatsingen. Bovendien leiden achterstanden in de registratie van asielzoekers tot 'dossier- en nummerloze' patiënten, voor wie de regelingen over de toegang tot en declaratie van zorg onduidelijk zijn. Het zorglandschap voor vluchtelingen is momenteel een lappendeken waarin chaos, fragmentering en ongelijkheid de boventoon voeren. En dat terwijl juist gevluchte nieuwkomers kwetsbaar zijn voor slechte gezondheidsuitkomsten: zo komt zelfdoding meer voor, is er een hoger risico op diabetes of hart- en vaatproblemen en ligt de sterfte van baby's rond de geboorte zeven keer hoger bij zwangeren uit het asielzoekerscentrum (AZC) in Ter Apel dan bij Nederlanders.

De ongelijkheid berust allereerst op wettelijke status – Oekraïners vallen door politieke keuzes onder de EU Richtlijn Tijdelijke Bescherming en hoeven geen asiel aan te vragen. Totdat zij zich kunnen inschrijven bij reguliere huisartsenpraktijken zijn de Veiligheidsregio's verantwoordelijk voor het organiseren van medische zorg in opvanglocaties.

De organisatie van zorg voor vluchtelingen die wél asiel moeten aanvragen valt onder de verantwoordelijkheid van het COA, als zelfstandig bestuursorgaan ondergebracht bij het Ministerie van Justitie en Veiligheid. Sinds 2008 wordt de curatieve zorg binnen asielzoekerscentra via aanbesteding ondergebracht bij wisselende commerciële partijen; op dit moment bij Gezondheidszorg Asielzoekers (GZA). Maar sinds er naast reguliere AZC's overal in het land noodopvanglocaties en zelfs crisisnoodopvanglocaties worden geopend – die vaak weer onder de verantwoordelijkheid van de gemeenten vallen – schiet de capaciteit van GZA tekort. De zorg wordt daarom sinds dit jaar deels ingekocht bij nieuwe partijen, waaronder Arts en Specialist.

Volgens minister Kuipers zou het betrekken van deze nieuwe spelers naast GZA de druk op de crisisnoodopvanglocaties verlichten. De minister reageerde op een oproep van Artsen zonder Grenzen en Dokters van de Wereld om de zorg op crisisnoodopvanglocaties te ondersteunen. Staatssecretaris Van der Burg noemde de toegang tot zorg voor asielzoekers onlangs 'voldoende geborgd'.

Dat blijkt niet uit de dienst die ik in november draai voor Arts en Specialist op de MS Princess, een oud cruiseschip in Nieuwegein dat is omgedoopt tot

crisisnoodopvanglocatie. De provisorische papieren dossiervoering, Rode Kruisvrijwilligers die wanhopig proberen overzicht te houden en het gebrek aan praktijkruimte of labformulieren doen denken aan taferelen uit de Griekse vluchtelingenkampen waar ik eerder werkte. Bij rondvraag delen collega-artsen soortgelijke ervaringen over andere opvanglocaties.

Ieder parallel systeem dat voor verschillende groepen vluchtelingen wordt opgetuigd brengt problemen met zich mee: ook in de zorg voor Oekraïners bestaan grote regionale verschillen in de toegankelijkheid, kwaliteit en efficiëntie van de zorg. Juist daarom is het van belang dat voor álle vluchtelingen wordt ingezet op snelle toeleiding naar reguliere zorg. Het huidige houtje-touwtje crisismanagement is niet toekomstbestendig. De voorspelling is immers dat (gedwongen) migratie enkel zal toenemen. Het is dan ook essentieel om onze zorgverleners voor te bereiden op hyperdiversiteit als norm, en het systeem duurzaam in te richten op inclusieve zorg aan een dynamische populatie.

En de verantwoordelijkheid voor het inrichten van een dergelijk systeem? Die hoort niet bij een ministerie dat gaat over detentiecentra, maar bij een ministerie dat gaat over zorg. Het is aan minister Kuipers om zich óók de zorg voor nieuwkomers aan te trekken. Vervang commerciële aanbesteding door investering in bestaande zorginfrastructuur om vluchtelingen op te vangen, zonder onderscheid op basis van afkomst of opvanglocatie. Wellicht kan in deze crisistijd gedacht worden aan een grotere rol voor de GGD. Maar laat hoe dan ook de gezondheid van vluchtelingen een zorg voor Volksgezondheid zijn.

Julia Tankink

Promovendus op het gebied van geboortezorg voor asielzoekers en statushouders en als basisarts tot december 2023 werkzaam in het medisch team voor Oekraïners in de Jaarbeurs, Utrecht.

Appendix 3. Curriculum Vitae

Bijlage 3. Curriculum Vitae

Curriculum Vitae | Julia Bieneke Tankink

medical doctor and researcher

Date of birth: 27-06-1993
Address: Waddenweg 97, 1025 PT Amsterdam
Contact: jbtankink@gmail.com – 0031-614329842
Languages: Dutch (native), English (fluent, academic), French (B2 level), Greek (B2 level)

Education

❖ **MD/MSc, Selective Utrecht Medical Master (SUMMA), Utrecht University**
Graduate program in medicine & clinical research (2015 – 2019)
o Senior rotations in gynaecology & obstetrics (Sint Antoniusziekenhuis, Utrecht)
o Elective internship in primary healthcare with NGO DocMobile (Lesvos, Greece)
o Extracurricular courses in Global Health and Medical Humanities (Utrecht University)

❖ **BSc, University College Utrecht, Utrecht University**
Undergraduate honours program in Liberal Arts and Sciences (2012 – 2015)
o Graduated *Cum Laude*
o Exchange to Aristotle University of Thessaloniki, Greece (Jan – July 2014)
o Field course and research internship in East-Africa (Jun – Aug 2015)

❖ **High School: Willem Lodewijk Gymnasium, Groningen** Sep 2005 – Jun 2011
o Graduated *Cum Laude*

Work experience

❖ **Doctors of the World, Amsterdam**
Activity coordinator in Amsterdam, Sexual and Reproductive Health Team – Amsterdam (May 2024 – present)

❖ **Obstetrics & Gynaecology, Erasmus MC, Rotterdam**
Medical doctor/PhD candidate EGALITE project (Sep 2020 – April 2024)

❖ **Abortion Care, Women on Waves, Amsterdam**
Medical doctor in abortion clinic for undocumented migrants (Parttime, Jan 2023 – current)

❖ **General Healthcare, Gezondheidscentrum Lombok (huisartsenpraktijk), Utrecht**
Junior physician / ANIOS (Parttime, Jan – Oct 2022)

❖ **Acute Psychiatry, High-Intensive Care Clinic, Altrecht, Utrecht**
Junior physician/ ANIOS (Fulltime: Jan 2020 – Sep 2020, parttime: Dec 2020 – Aug 2021)

❖ **Utrecht Summerschool, University Medical Center Utrecht**
Organization of Summerschool programs *Global Surgery* and *Reproductive & Maternal Health: a Global Perspective* (Dec 2018 – July 2019)

❖ **Medical and psychosocial work with forcibly displaced people**
o Medical Volunteers International, Greece – *Medical student/doctor in primary healthcare for refugees in Lesvos and Athens* (Sep-Nov 2018, December 2020, May-June 2021)
o Boat Refugee Foundation, Thessaloniki, Greece – *Design and evaluation of psychosocial project* (Nov - Dec 2019)
o Doctors of the World, Amsterdam – *Volunteer in psychosocial clinic for undocumented migrants* (Dec 2018 – Okt 2019)
o KiaThess Solidarity Clinic, Thessaloniki, Greece – *Volunteer at pharmacy for uninsured patients* (Mar – Jun 2014)

Research experience (selection of activities prior to PhD)

❖ **Equator Foundation/Arq Psychotrauma Expert Group, Diemen** Research intern (Nov 2018 – July 2019) o Master's thesis: *"Predicting severity of posttraumatic stress symptoms in a treatment-seeking sample of undocumented migrants: the role of trauma-related guilt"*

❖ **Maryland Health Center, Moshi, Tanzania**
Research intern (Jul – Aug 2015)
o Qualitative study *"Breastfeeding Practices in Moshi Urban District¸ Tanzania: a Perspective of Health Workers"*

Research output (recent)

❖ **Publications**
See list of publications (Appendix 5)

❖ **Conferences (selection)**
o European Congress of Tropical Medicine and International Health (Utrecht, November 2023) – *Oral presentation*
o International Federation of Gynaecology and Obstetrics (Paris, October 2023) – *Session organizer, oral presentation*

❖ **Courses & certificates**
o Harvard University Intensive Summer Course on Refugee & Migration studies (Greece, July 2023) o Trained and certified in Clinician-Administered PTSD Scale for DSM-5 (CAPS)

Appendix 4. PhD Portfolio

Bijlage 4. PhD Portfolio

Courses

Title/Description (year)	Organized by	EC
Participative action research (2021)	School for Participation, Amsterdam UMC	3.0
Qualitative Data Analysis with Grounded Theory (2021)	Erasmus University Rotterdam	2.5
BROK® (Basic course Rules and Organisation for Clinical researchers) (2021)	Erasmus MC	1.5
Regression Analysis (2021)	Erasmus MC Graduate School	1.9
Rookvrije Start (2021)	Trimbos	0.5
Scientific Integrity (2021)	Erasmus MC Graduate School	0.3
Critical Midwifery Studies (2022)	Utrecht Summer School	2.0
Masterclass Intersectionality in Global Health Research (2022)	Amsterdam Public Health, Amsterdam UMC	0.5
De Dokter in de Pen (2022)	Stichting Dokters in Debat	0.70
Refugee & Migration Summerschool (2023)	Harvard FXB Center for Health & Human Rights, National and Kapodistrian University of Athens	4.50
Masterclass Migration & Health (2023)	Joep Lange instituut Amsterdam	0.30
Research meetings attendance (2020-2023)	Department of Obstetrics & Gynecology, Erasmus MC	2.50

Presentations

Title/Description (year)	Organized by	EC
Oral presentation at symposium (Utrecht, 2022)	Safe Motherhood collective	0.30
Oral presentation at symposium (Driebergen, 2022)	Geboortezorg Consortium Midden-Nederland & College Perinatale Zorg	0.30
Oral presentation at conference (Berlin, 2022)	European Public Health Association	0.30
Oral presentation at research symposium (Rotterdam, 2023)	Sophia Research Days, Erasmus MC	0.50
Oral presentation at symposium (Rotterdam, 2023)	SCEM	1.00
Oral presentation at conference (Paris, 2023)	The International Federation of Gynecology and Obstetrics	1.00
Oral presentation at conference (Utrecht, 2023)	European Congress on Tropical Medicine and International Health	1.00
Oral presentation at research meetings (Rottedam, 2022- 2023)	Department of Obstetrics & Gynecology, Erasmus MC	0.50

Teaching and other activities

Title/Description (year)	Occasion/University	EC
Supervising Master students (2021-2024)	Erasmus University Rotterdam / Utrecht University	5.50
Lecture in Global Health course (2021)	University of Groningen	0.60
Lecture in Minor of Medicine (2022)	Erasmus University Rotterdam	0.30
Organization of symposium (2024)	PhD defence Anouk Verschuuren (University of Groningen)	1.00

Total EC obtained: 32,5

Appendix 5. List of publications

Bijlage 5. Publicatielijst

Gieles, N.C. & **Tankink, J.B.**, van Midde, M., Düker, J., van der Lans, P., Wessels, C.M., Bloemenkamp, K.W., Bonsel, G., van den Akker, T., Goosen, S. and Rijken, M.J., 2019. Maternal and perinatal outcomes of asylum seekers and undocumented migrants in Europe: a systematic review. *European Journal of Public Health*, *29*(4), pp.714-723.

Tankink, J.B., Verschuuren, A.E., Postma, I.R., van der Lans, P.J., de Graaf, J.P., Stekelenburg, J. and Mesman, A.W., 2021. Childbirths and the prevalence of potential risk factors for adverse perinatal outcomes among asylum seekers in the Netherlands: a five-year cross-sectional study. *International Journal of Environmental Research and Public Health*, *18*(24), p.12933.

Verschuuren, A.E.H., **Tankink, J.B**., Franx, A., van der Lans, P.J.A., Erwich, J.J.H.M., Jong, E.F.D. and de Graaf, J.P., 2023. Community midwives' perspectives on perinatal care for asylum seekers and refugees in the Netherlands: A survey study. *Birth*, *50*(4), pp.815-826.

Tankink, J. B., 2023. Ongelijkheid in zorg voor vluchtelingen is onhoudbaar. *NRC*, February 10, 2023.

Verschuuren, A.E.H., **Tankink, J.B**., Postma, I.R., Bergman, K.A., Goodarzi, B., Feijen-de Jong, E.I. and Erwich, J.J.H.M., 2024. Suboptimal factors in maternal and newborn care for refugees: Lessons learned from perinatal audits in the Netherlands. *PLOS ONE*, *19*(6), p.e0305764.

Tankink, J.B., Bertens, L., de Graaf, J.P., van den Muijsenbergh, M., Struijs, J.N., Goodarzi, B. and Franx, A., 2024. Pregnancy Outcomes of Forced Migrants in the Netherlands: A National Registry-Based Study. *Journal of Migration & Health*, 10, 100261.

Tankink, J.B., Verschuuren, A.E.H., de Graaf, J.P., Feijen-de Jong, E.I., van den Muijsenbergh, M.E.T.C., Franx, A., van der Lans, P., and Goodarzi, B. Let this be a safe place: a qualitative study into midwifery care for forcibly displaced women in the Netherlands. *BMC Health Services Research (in press)*.

Appendix 6. Acknowledgements

Bijlage 6. Dankwoord

Nu dit onderzoek tot een einde komt, constateer ik helaas dat de situatie voor gevluchte zwangeren in Nederland (nog) nauwelijks is verbeterd. Voor hen blijft de realiteit vaak een harde strijd om toegang tot gelijkwaardige zorg en een kansrijke start. Des te meer ben ik mij bewust van mijn eigen immens bevoorrechte positie, waardoor ik deze PhD-reis kon maken, gesteund door de betrokkenheid van velen. Een aantal van hen wil ik graag persoonlijk bedanken.

Allereerst mijn grote dank aan de mensen die aan het begin van deze reis stonden en het onderzoek mogelijk maakten: prof. dr. Arie Franx, dr. Hanneke de Graaf en Peggy van der Lans. Arie en Hanneke, bedankt voor alle kansen die jullie mij hebben geboden, voor het meebuigen wanneer ik weer eens geen rechte weg wilde bewandelen, en voor jullie inspanningen om mij toch op het pad van dit promotietraject te houden. Arie, jouw scherpe oog voor taal en nuance heeft niet alleen dit proefschrift, maar ook mijn wetenschappelijke vaardigheden naar een hoger niveau getild. Hanneke, je hebt me uitgedaagd om door te zetten bij hobbels onderweg, en hield ons gezamenlijke einddoel in zicht. Peggy, jij stond aan de wieg van EGALITE en bleef de hele reis betrokken, zowel professioneel (vaak in je vrije uren) als persoonlijk: dank daarvoor!

Mijn grote dank gaat ook uit naar prof. dr. Maria van den Muijsenbergh en dr. Bahareh Goodarzi, die mijn promotieteam hebben verrijkt en die op cruciale kruispunten een belangrijke rol speelden. Maria, jouw positieve energie en bevlogen inzet voor rechtvaardige gezondheidszorg waren voelbaar en bemoedigend in elk (digitaal) overleg. Dankzij jou organiseerden we waardevolle focusgroepen, waarin mijn (zelf)vertrouwen en plezier in participatief onderzoek zijn gegroeid. En Bahareh: van jou heb ik zóveel geleerd. Bedankt voor je scherpe blik op mijn werk en op de wereld, je durf om onrecht te benoemen en te bestrijden, het plekje dat je voor me maakte op de VU en natuurlijk voor de eer om onderdeel van je prachtige boek te mogen zijn.

Mijn dank gaat uit naar de leden van de beoordelingscommissie – prof. dr. Burdorf, prof. dr. Hutter en prof. dr. Agyemang – en de opponenten voor hun tijd en inspanning om mijn proefschrift te lezen, beoordelen en bevragen tijdens de verdediging. Het is een grote eer dat u hieraan wilt bijdragen.

Een zeer belangrijke reisgenoot was Anouk Verschuuren, met wie ik vele uren hard werken, kopjes thee, lief en leed heb gedeeld. Dankzij jou werden deadlines gehaald, punten gezet en zijn er nette tabellen in dit proefschrift terechtgekomen. Bovenal ben ik je ontzettend dankbaar voor alle steun, aanmoediging en relativerende *memes* tijdens

dit proces. Onze verschillen hebben ons als duo sterker gemaakt, en ik ben trots op het voorbeeld van samenwerking in de wetenschap dat we samen hebben neergezet. Voor deze samenwerking wil ik ook de gehele UMCG-onderzoeksgroep bedanken, bestaande uit prof. dr. Stekelenburg, prof. dr. Erwich, dr. Postma en dr. Feijen-de Jong.

Zonder studenten had dit werk nooit kunnen worden verzet. Sterre van Ede, Tina Oostrom, Selma Hassan, Insaf Duale, Sabrine Lazaar, Maryam Abdullah en Els Jonkeren: bedankt voor jullie doorzettingsvermogen en enthousiasme om van EGALITE een volledig project te maken met jullie masterscripties en perspectieven. Voor mijn persoonlijke reis was het van grote waarde om van jullie te leren wat goede begeleiding inhoudt. Dank aan Bregje de Kok en Joyce Browne voor de soepele samenwerking en waardevolle voorbeelden – en aan Joyce natuurlijk ook als mijn eigen stagebegeleider bij het artikel dat het startpunt van deze reis bleek!

Mijn collega's in het Erasmus MC maakten de reis naar Rotterdam keer op keer de moeite waard: veel dank aan (oud-)mede-promovendi Sushma, Rachita, Else, Maud, Janna, Jessie, Anne en Silke, en natuurlijk aan mijn lieve 'jaargenoten' Lauren en Kajal, voor alle warmte en herkenning op de 21e verdieping. Loes Bertens, jouw begeleiding en geduld bij de analyses van het meest uitdagende hoofdstuk van dit proefschrift waren absoluut onmisbaar.

Mijn oprechte waardering gaat uit naar alle organisaties en personen die in verschillende fasen hebben bijgedragen aan het onderzoek en aan mijn ontwikkeling als onderzoeker. Het COA, GZA en de deelnemende verloskundigenpraktijken aan het project, verspreid van Ter Apel tot Oisterbeek, hebben een onmisbare rol gespeeld – van de opzet tot de dataverzameling en de vertaling naar de praktijk. Ik zal hier helaas ongetwijfeld onvolledig zijn, maar voor het kritisch meelezen van de aanbevelingen uit dit project wil ik specifiek Joan Kooren, Karin van Pelt, Renske Stuurman, Simone Goosen, Hilde Stolk, Carin Brons en Joanne Koomans bedanken. Ook Bavo Hendriks, Brenda Belić, Lynn Janes-Aben, Olga Moll, Annelies Mesman, Jeroen Struijs, de promovendi van het RIVM en (oud-)projectgroepleden van het EGALITE-project ben ik erg dankbaar voor hun diverse en betekenisvolle bijdragen aan het onderzoek. Muzkin Youssef, bedankt dat je met jouw verhaal in de EGALITE-video menig publiek hebt bewogen om veilige, empathische geboortezorg te verlenen. Simone Goosen, jouw inzichten en onvermoeibare inzet voor tolken in de zorg zijn verweven in dit proefschrift, en veranderen de praktijk. En Jamilah Sherally – van een voorbeeld op afstand tot de leukste congreskamergenoot, dankjewel voor je inspiratie en vriendschap.

Wat ik wellicht het allermeest waardeerde tijdens deze reis waren de onverwachte ontmoetingen, inzichten en verhalen die ik mocht delen met en ontvangen van de deelnemers aan het onderzoek. In het bijzonder wil ik de deelnemers aan de interviews en focusgroepen bedanken dat zij mij voor even deelgenoot maakten van hun ervaringen

als zorgverlener, COA medewerker of zwangere nieuwkomer. Lieve Nirmeen Khalal, dankjewel voor alles wat jij en je gezin mij hebben geleerd over het bouwen van een nieuw thuis – en natuurlijk voor jullie overheerlijke Syrische maaltijden. En Duha, heel veel dank voor de prachtige tekeningen!

Lieve Rebecca, dankjewel dat ik voor Women on Waves mocht werken, precies op het moment dat mijn innerlijke vuur nieuwe vonken nodig had. Jouw warme welkom en de vrouwen in de kliniek gaven mijn dagelijkse werk betekenis en hielpen me om de lange, zware laatste loodjes van dit traject vol te houden. En aan mijn nieuwe collega's bij Dokters van de Wereld en het SRG team: bedankt voor het warme bad waarin ik ben gevallen.

Mijn lieve vrienden, waar was ik zonder jullie? Jullie waren mijn ankers en mijn ontsnapping op deze reis. Dankjewel lieve Noor, dat ik jou haast als vanzelfsprekend kon vragen om me terzijde te staan bij deze promotie - onze vriendschap is een van de meest onwrikbare, gelukzalige en dankbare zekerheden in mijn leven. En als je een keer je telefoon niet opneemt, is Geert een geweldige tweede keuze ♥. Lieve Jori, jouw nabijheid en bijstand bij de errors in SPSS – en in de rest van het bestaan – waren absoluut onmisbaar en maken me een sterker en gelukkiger mens. Floor, lieve vlaggie, onvermoeibare queen of the peptalks, bedankt voor je onuitputtelijke steun, zelfs toen ik midden in de nacht in Taiwan 'nog heel even iets af moest maken'. Sandrine, liefst luisterend oor, dankzij jou ga ik moedig voorwaarts. Ook Frankie (al 31,5 jaar dichtbij!), Tamalone, Anna, Minke, Anne-Rieke, Jennifer, Sander, Lynn, Hanna & Ieva: bedankt, ευχαριστώ, danke schön, köszönöm, ačiū, thank you, voor de manier waarop jullie me doorzien en begrijpen, voor al het lachen met – en soms een beetje om – mij, en voor jullie geloof in een goede afloop op momenten van milde of ernstigere wanhoop. Daniel, dank daarnaast voor je muziek, in het bijzonder onder de EGALITE-video. En Sitsi, je bent een voorbeeld voor mij als activist, arts, en moeder!

Niet te vergeten: dankzij de Scotia-fietsclub weet ik dat ik bergen kan beklimmen (bij voorkeur met jullie) en avonden (of tegenwoordig bruiloften) met de Groningse Randstedelingen blijven een ouderwets goed werkzaam anti-stressrecept. Lieve Patrice, dankjewel voor al je "simpele" eetclub edities en eerste hulp bij dilemma's, en Tobias, bedankt voor het logo-ontwerp in de begindagen van deze reis.

Mijn liefste broertje en zusje, Cas en Josefien, ik ben zo trots op jullie, gelukkig met alles wat wij samen delen, en dankbaar voor onze onverwoestbare band. Lieve oma, dankzij jou draag ik een beschermuiltje op mijn schouder, waar ik ook ga. Bedankt voor alle keren dat ik je saaie huisgenoot mocht zijn, schrijvend in de oude koeienstal terwijl jij je bezighield met minstens zo ingewikkelde zaken, zoals sudoku's.

Mijn ouders, Marcel en Barbara. Lieve papa en mama, jullie zijn mijn veilige thuishaven en allergrootste steun geweest gedurende dit proefschrift en bij vele andere beproevingen. Voor jullie is geen dankwoord groot genoeg.

En tot slot, mijn geliefde Nick: het is een geluk om al heimwee te kunnen voelen als ik de deur van ons thuis voor even achter me dichttrek. Als geen ander heb jij in dit thuis ervaren hoe een promotietraject niet het ideale recept is voor een alle dagen ontspannen en flexibele partner. Bedankt voor je spiegels, je (on)begrip en humor terwijl je naast me liep op deze reis. Jouw liefde is mij meer waard dan 1000 promoties.