OPEN ACCESS

Research Article

Challenges and opportunities in maternal healthcare for refugee women – professionals' perspectives

Die geburtshilfliche Betreuung von Frauen mit Fluchterfahrung – Perspektiven geburtshilflicher Akteur*innen

Abstract

Background: The number of refugees has increased worldwide. Pregnant refugee women are considered a vulnerable group, as they experience physical exertion and psychological burden while fleeing their home countries pregnant. Moreover, pregnancy and the postpartum period require specialised care to enable the transition to motherhood without complications.
Aim: The aim of this project is to analyse maternal healthcare services for refugee women and asylumseeking women from the perspective of maternal healthcare professionals (MHCP) in Germany.
Methods: An interview study was conducted. MHCP with experience in caring for refugee women were recruited for the study. Semi-structured interviews were conducted and analysed according to the standards employed in qualitative thematic analysis.
Results: MHCPs face different barriers when providing maternal healthcare to refugee women, e.g. in the field as well as when it comes to ethical principles and ideals. Due to a lack of resources (e.g. translators, time) and other conditions, they react by adjusting their professional practices towards refugee women, including employing modified or reduced general maternal healthcare practices.
Discussion: The identification of challenges and opportunities in maternal healthcare for refugee women can help improve maternal healthcare and, in turn, maternal health. Research findings in the context of refugee care can help further the development of new approaches in maternal healthcare.

Keywords: refugee women, forced migration, maternal health care, maternal health care professionals

Anne Kasper[1]
Petra Kolip[2]

1 University of Applied Sciences and Arts Hildesheim/Holzminden/Goettingen, Hildesheim, Germany

2 Bielefeld University, Bielefeld, Germany

Zusammenfassung

Hintergrund: Die Anzahl der Menschen mit Fluchterfahrung nimmt weltweit zu. Schwangere mit Fluchterfahrung gelten als vulnerable Subpopulation, da sie parallel zur Schwangerschaft auf der Flucht körperlichen und psychischen Belastungen ausgesetzt sind. Die Phase des Mutterwerdens erfordert eine spezielle Betreuung, um einen komplikationslosen Übergang in die Mutterschaft zu ermöglichen.
Ziel: Das Ziel dieses Projekts ist es, die geburtshilfliche Versorgung von Frauen mit Fluchterfahrung aus der Perspektive geburtshilflicher Akteur*innen zu analysieren.
Methoden: Wir haben eine qualitative Studie mit geburtshilflichen Akteur*innen (GA) mit Erfahrung in der Betreuung von Frauen mit Fluchterfahrung durchgeführt. Halbstrukturierte Interviews wurden nach den Standards der qualitativen Inhaltsanalyse ausgewertet.
Ergebnisse: GA stehen in ihrer beruflichen Praxis vor Herausforderungen in der Betreuung von Frauen mit Fluchterfahrung z. B. in Bezug auf ihre ethischen Grundsätze und Ideale. Aufgrund mangelnder Ressourcen (z. B. Sprachmittlung, Zeit) und anderer Bedingungen reagieren sie mit

Anpassungen in ihrem Handeln, die die Modifizierung, Aufrechterhaltung und Reduzierung der allgemeinen Praktiken umfassen.
Diskussion: Die Identifizierung von Herausforderungen und Chancen in der geburtshilflichen Betreuung von Frauen mit Fluchterfahrung kann dazu beitragen, die Gesundheitsversorgung von Müttern und damit die Gesundheit von Müttern zu verbessern. Die Ergebnisse geben Anlass, Versorgungsansätze weiter zu entwickeln.

Schlüsselwörter: Frauen mit Fluchterfahrung, Flucht, maternale Versorgung, geburtshilfliche Akteure

Introduction

According to the United Nations Refugee Agency (UNHCR), almost 80 million people worldwide are currently displaced within their own country or across national borders [26]. About half the refugee population is female [29] and a large number of them are of childbearing age [23]. To the best of the authors' knowledge, there is no data on the number of women who are pregnant or have recently given birth during forced migration. The term refugee women used in this paper is defined as follows: women who leave their country of origin due to a personal emergency or constraint and seek protection elsewhere; the legal status of these women is not taken into account (e.g. status in the asylum seeking process).
International findings have shown increased risks in pregnant refugee women due to the particular physical, psychological and social burdens they suffer, such as pregnancy-related diseases or postpartum depression [4], [6], [11], [15], [25]. It has been observed that many current pregnancies are often preceded by complications, such as short intervals between pregnancies, increased abortion or miscarriage rates [6], [7], [12]. Pregnancy and early motherhood impact women's health and well-being [2]. The stress of forced migration adds to the stresses and strains associated with the transition to motherhood [1], [7], [9], [12]. Refugee women who are about to become mothers can be vulnerable in a number of ways. Traumatic events and experiences before and/or during their flight as well as acculturation stress in the host country, for example, are heightened due to the circumstances of pregnancy, birth and the postpartum period. This may have negative effects on their health condition. Consequently, the maternal health of refugee women has become an increasing concern to maternal healthcare professionals [16], [21], [28], [29]. Maternal healthcare not only includes physical and medical care, but also takes women's psychosocial and emotional needs into account [29], [30]. In their capacity as maternal healthcare professionals, obstetricians and midwives provide support for the processes related to pregnancy and birth in order to facilitate a smooth transition to motherhood. Under the Asylum Seekers' Benefits Act [3], refugee women in Germany are granted maternal healthcare before and after the birth. In formal terms they have the same access and entitlement to maternal healthcare in Germany as German citizens do.

In the context of recent migration movements, maternal healthcare professionals are also caring for refugee women on an everyday basis. The current evidence on maternal healthcare practices for refugee women who resettle in high-income host countries has been compiled in a systematic qualitative review analysing the literature on maternal healthcare provision and services for refugee women [18]. Despite the heterogeneity of the studies included, the synthesis states challenges on the micro level, namely in regard to interactions in maternal healthcare for refugee (and migrant) women. Accordingly, the following questions arise: How do maternal healthcare professionals perform maternal healthcare for refugee women and what typical practices are employed when providing care for refugee women? The aim of this project was to analyse maternal healthcare provision and services for refugee women from the perspective of maternal healthcare professionals in Germany, the focus being on micro level and influencing factors which refugee women and maternal healthcare professionals encounter on a personal level.

Methods

For this research project, a qualitative interview study was conducted among maternal healthcare professionals who have cared for refugee women during pregnancy, childbirth and the postpartum period. Interview data was collected through semi-structured interviews with obstetricians and midwives. Various sampling strategies were applied to ensure that the data collection process yielded indepth data from heterogeneous sources, including criteria sampling, maximum variation sampling, opportunistic sampling and snowball sampling [24].
The use of criteria sampling helped limit the research field. The inclusion criteria were specified in advance. Eligible interview partners

1. were qualified obstetricians or midwives,
2. offered care during pregnancy and/or childbirth and/or the postpartum period, and
3. had experience in caring for refugee women.

The aim was to ensure a high degree of variation in the range of characteristics and attributes of the interview partners (maximum variation sampling). To achieve the desired sample heterogeneity, MHCP characteristics were followed where possible:

- Setting: clinical/inpatient sector, outpatient sector
- Range of services: antenatal care, birth attendance, postpartum care
- Place of action: working contexts, e.g. federal state, municipality, urban or rural area

Opportunistic sampling was used in unforeseen, yet advantageous situations which occurred during fieldwork and the recruitment of interview partners, while snowball sampling was used in cases where interview partners referred the researcher to further contacts and potential interview partners.
Access to the field was achieved through different channels (e.g. maternity clinics and relevant professional associations and organisations), drawing the attention of as many maternal healthcare professionals as possible to the research project. Interview partners were recruited directly through personal contacts or were approached through relevant institutions/organisations, which were asked to disseminate the study information to maternal healthcare professionals that met the inclusion criteria.

Sample characteristics

A total of 31 maternal healthcare professionals were interviewed between November 2017 and April 2018. With no new information and insights identified during the interviews, no further recruitment took place. The individual interviews were conducted face-to-face. A total of 22 midwives and nine obstetricians were interviewed. The majority of the maternal healthcare professionals interviewed worked as freelancers (self-employed) (n=22) and all of them had looked after women during pregnancy (n=31). Nineteen midwives also offered postpartum care. A total of 11 maternal healthcare professionals in this study population provided birth attendance. The average professional work experience among the interview partners was 15 years (range: five to 42 years). Maternal healthcare professionals from various Federal States in Germany were interviewed. The study population's characteristics are summarised in Figure 1.
The semi-structured face-to-face interviews were based on a thematic guide and were conducted in German. Following the qualitative interview, a standardized questionnaire was used to collect additional demographic data. Oral interviews were recorded and transcribed verbatim. The transcripts were anonymised, and the audio files were destroyed after transcription. Approval from an ethics commission was obtained.
The analysis of the interviews included an examination of the contextual knowledge and practical experience of maternal healthcare professionals during their care of refugee women [22], including:

- representative problems and challenges,
- action-based knowledge and expertise,
- established solutions,
- features of decision-making structures, and
- orientation and guidance in conduct and practices.

The interviews were evaluated in terms of a theoretical perspective – the theory of professional practice. Owing to the extensive open data material collected, the material was examined in German using qualitative content analysis.
This systematic analysis method was used to condense the abundance of available material and reduce the data to relevant and interesting themes and categories.
The regulated procedure was based on Kuckartz's method of qualitative content analysis [19]. Throughout the entire analysis process, various readings by interdisciplinary researchers from the health sciences, but also from other disciplines (e.g. philosophy, law or religious studies) were incorporated into the interpretation. In research workshops, interpretations were shared and discussed in an open format. The workshops also served as a forum for validating and discussing any available (interim) analysis results.

Results

Context and field of practice

The impression held by the majority of maternal healthcare professionals was that the number of refugee women has increased significantly since 2015. At the same time, they also suggested that no systematic census nor statistical data existed. Furthermore, they reported that this initial large increase was not permanent but has decreased over time.

> *"There are definitely fewer of them [refugee women] now; there was quite a peak in the number of pregnant women in '15, '16. So that has dropped." (MID_20: 741-743)*[1]

According to the maternal healthcare professionals interviewed, the needs and demands for maternal care did not differ considerably between women with and without refugee experience. Refugee women also needed care and support in pregnancy, during birth and in the postpartum period.

> *"[Refugee women come with] all kinds of things, as do German women, too. Because of pulling and pinching pain in the 20th week of pregnancy. Because of bleeding. So there are all kinds of indications or pregnancy complications. I don't have the feeling that they are very different from other women." (OB_27: 235-239)*

On the other hand, in the opinion of the maternal healthcare professionals, there were refugee women who were traumatised or who had at the very minimum had potentially traumatizing experiences, meaning psychosocial care was needed.

> *"I always have to expect trauma [in refugee women]. I really have to try and I do always try, but I also know that sometimes I don't succeed in approaching it in an entirely trauma-sensitive way." (MID_14: 302-304)*

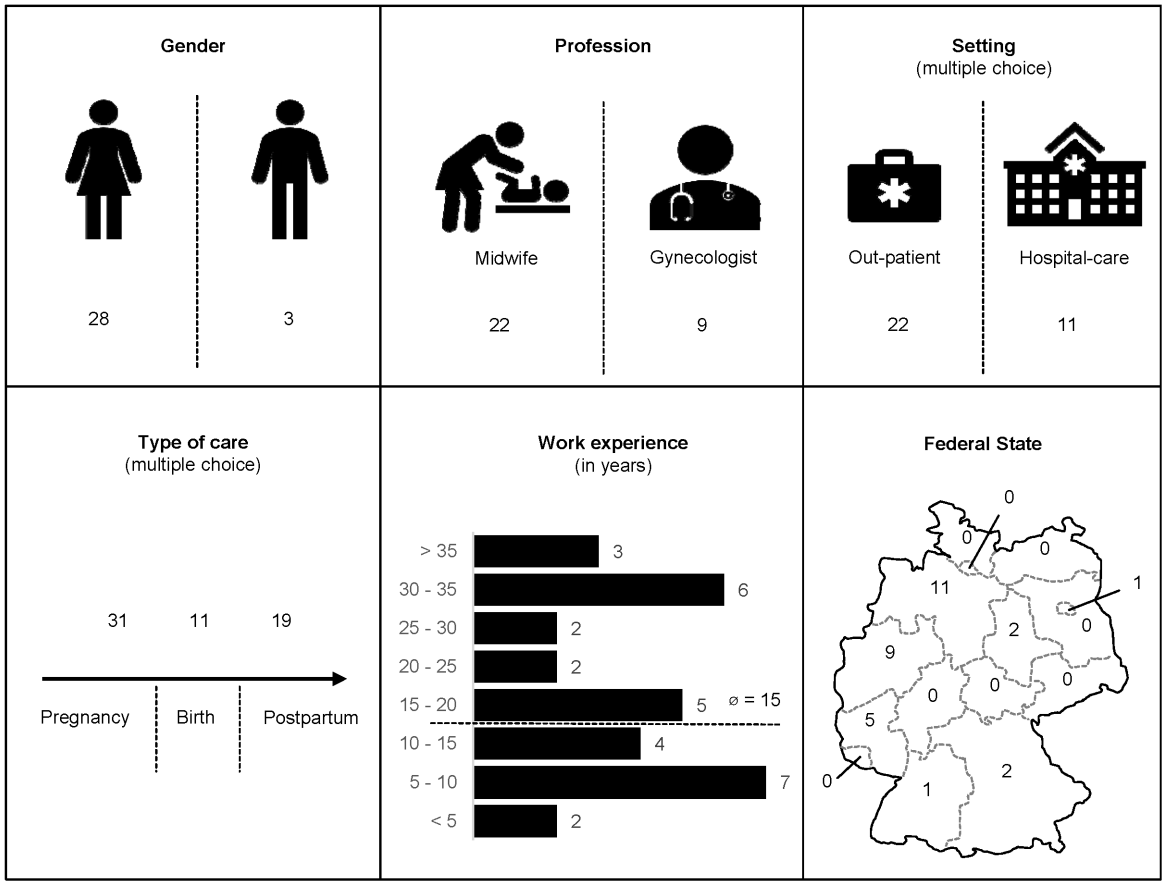

Figure 1: Study population characteristics

Maternal healthcare professionals stated that when caring for refugee women, they felt unprepared. For example, they expected differences in behaviour and attitudes among refugee women due to their different religious or cultural background. In order to address these uncertainties, they tried to expand their knowledge and drew on various sources of knowledge and skills across the following areas and fields:

- organisation and forms of maternal healthcare in the women's country of origin, including religious and cultural practices
- the expected specific disease spectrum seen in refugee women which might have an impact on pregnancy (e.g. HIV, malaria or tuberculosis)
- women's mental health (e.g. trauma), and
- intrapartum procedures required in cases of female genital mutilation.

"I know about HIV and tuberculosis, but I realise that most professionals here don't know that much about it." (MID_14: 508-509)

"You feel less secure in your role [as a midwife], [...] because you don't really know who you have in front of me, so to speak." (MID_30: 287-292)

"Then I also think it's important to look at what is different in the countries of origin or in the religion and such, and to take that into consideration. Of course you can't look at everything in detail, but there are a few things you can learn, [...]." (MID_30: 402-408)

In addition, the maternal healthcare professionals stated that in many cases they relied on their recollection of experiences and intuition, which included observing and examining the women. They also reported that they let refugee women talk and learned from their stories and experiences. Combining their own knowledge and expertise with the refugee women's knowledge was found to be something of a balancing act. In the "grey areas" (MID_10: 760) of insufficient knowledge (in new areas of practice), the maternal healthcare professionals provided women with the best possible information and maternal healthcare services.

" [...] So I just trust in my professional experience, and I think I will hopefully get it right." (OB_22: 320-321)

"I think there is this grey area in every profession where some [maternal healthcare professionals] think they know what they are doing, but often they don't at all. And different cultures do it differently, so I then simply go along [with the refugee woman's way], see what I can deal with, sometimes from knowledge, mostly intuitively, [...]." (MID_10: 759-764)

Maternal healthcare professionals working in clinics reported a shift in their responsibilities and scope of practice. They were confronted with routine prenatal care for pregnant women – a typical task of the outpatient sector in Germany.

"We have emergencies in the clinic or women who think they are an emergency. [...] Now we provide

prenatal care, which is actually daily bread for registered gynaecologists." (OB_29: 55-65)

The maternal healthcare professionals in the outpatient sector described how they were taking on additional medical tasks within the framework of basic maternal healthcare for refugee women, such as vaccinations or extra assistance with family planning. Besides this, there were other, supposedly minor details and tasks. One thing that was emphasised in particular was help with logistic tasks across a wide range of areas, from clarifying the accommodation situation for the women and organizing language mediation to coordinating (further) maternal care or arranging appointments with other health or social institutions. This involved management on a case-by-case basis rather than general organisation of appropriate structures.

"In summary, a lot of logistics and conversations and organising and relatively little actual midwifery work. But always with the ulterior motive that everything has an effect on the mother's and child's health. In other words when she [refugee woman] is stressed, when she is afraid, when she doesn't know where she is being sent, when she doesn't have proper food, when she is cold at night because the heating isn't working. All this can have an effect on the pregnancy, worst case scenario being premature birth and so on. In other words, there is always an ulterior motive, which is many different things. That was the main issue in the refugee reception centre." (MID_1: 327-337)

This often led to an unclear distinction between professional and voluntary work. In addition, the maternal healthcare professionals often saw themselves in the role of bridge builder in their care for refugee women. They provided refugee women with orientation and helped them settle in Germany and navigate the German healthcare system. They compared their additional tasks with those of social workers, because they were giving practical help and advice on everyday issues.

"I have the feeling that I am a midwife, but also a lot like a social worker." (MID_23: 375-377)

They also described how refugee women and their families entrusted them with administrative tasks. These included issuing certificates or providing help and support understanding letters and filling in application forms (e.g. from the job centre, health insurance companies, financial institutions).

"They [refugee women] also bring their mail and they get a lot of mail from the local authority, from the job centre, from kindergarten, and they don't understand anything, but they bring it with them, and we go through it with them." (MID_10: 458-460)

Care for refugee women meant additional workload for maternal healthcare professionals. Communication and language mediation were often associated with an above average demand on their time. As a result, maternal healthcare professionals would adapt their typical organisation, work and daily routine in regard to maternal care.

"We also arranged things such that we could cooperate in this way. They [refugee reception centre] would send the refugee women at lunchtime, and we made longer consultation hours for them, because by this point what we were doing really is beyond the normal scope. Their [prenatal] care always takes twice as long as with other women." (OB_22: 98-102)

Maternal healthcare professionals stated that there was a lack of structures in maternal care for refugee women. The relevant institutions were not properly prepared and were consequently overstretched, meaning maternal healthcare was suboptimal. Some maternal healthcare professionals even spoke of "chaos" and an "uncoordinated mess" (OB_09: 51, 86; MID_10: 686). Over time, however, they saw a development towards more stable structures, although there is still room for improvement here.

"And we somehow thought, they just didn't realise that medical help is necessary here [for refugee women]. We'll tell the authorities and then they'll organise it. That was our idea. And we'll just help out for a week or so. At that time nobody thought that it would somehow become, I think, almost a year and a half of established work on the premises [of the reception centre for asylum seekers]." (MID_20: 89-94)

Ethical principles and ideals

Maternal healthcare professionals, particularly in the outpatient sector, were intrinsically motivated and tried altruistically to follow their own ideals when caring for refugee women. In some cases, they proactively contacted institutions for refugees, such as accommodation facilities, and offered their help and cooperation in the area of maternal healthcare. Their intrinsic motivation, they said, was that "feeling in their heart" (MID_3: 130) for women in special situations as well as the "need to help" (MID_20: 842), both of which drives them to make a meaningful contribution. They also stated that they were interested in women with migration experience and welcomed this change in their professional work. Thus, most maternal healthcare professionals had already worked and cared for women in a "multicultural context" (MID_20: 9) before the migration influx in 2015-2016.

"[...] my heart is always drawn to people who have it harder than others and who are in greater need." (MID_03: 372-373)

"However, I have also enjoyed looking after migrants in the past." (MID_16: 89-90)

The provision of maternal care for refugee women allowed many maternal healthcare professionals to reflect on their professional practices and thinking. On the one hand, they thought about the stereotypical "pigeonhole thinking" (OB_29: 93) about refugee women, a thought pattern that was not confirmed in any personal encounters.

"So, of course, one is very quick to put a label on someone, a refugee is a refugee and all that. And it's difficult to define. People also think in boxes, as stupid

as it is; they put everyone who doesn't know German and doesn't look like they fit here into a box, some of whom don't belong there." (OB_29: 90-95)

On the other hand, caring for refugee women led maternal healthcare professionals to reflect on their actions, especially in encounters where maternal healthcare professionals perceived the care being provided as suboptimal. Such encounters led them to seek to improve care for every woman (with and without refugee experience) in future. Most importantly, respect for women and their families was found to be indispensable in maternal healthcare. According to the maternal healthcare professionals interviewed, by reflecting on the way they provide care, they were expressing a sincere interest in and understanding for women and in adhering to nondiscriminatory practices.

"[Good care is] interest. If the woman doesn't interest me, then I can't take good care of her. That means always keeping the interest alive, really wanting to know—How are you? Or how do you feel? Or what can I do for you?" (MID_14: 700-703)

"That was, I think, the most important thing to date, that I just go in there with an understanding of what I don't know, instead of educating myself upfront and still putting my foot in it just as much [...]." (MID_10: 330-334)

Maternal healthcare professionals also described how they wished to free themselves from assumptions and stereotypes about refugee women and to approach them openly and without bias. To be able to provide proper maternal healthcare, the maternal healthcare professionals interviewed considered patience, calmness and attentiveness to be essential. Providing care without time pressure and disturbances was essential, particularly when caring for refugee women.

"I think this calls for even greater awareness. Taking your time and (...), just letting it happen, [...]." (MID_26: 514-515)

"Sometimes I try to do that [explaining] even more with these women [refugee women], because I feel that they simply have to know what is happening [...] so that the women are also informed and I hope that they always have a say as well, because that also makes it easier for me. If I now look at the time component, it takes much, much longer to inform refugee women. And I always check whether they have understood, is it clear what is going to happen? So I always check again. But that takes time." (MID_17: 661-667)

The maternal healthcare professionals emphasised that the practices they employ in caring for refugee women are not fundamentally different to how they care for other women. Their approach to caring for refugee women is therefore based on the desire to treat everyone equally. Some of them, however, did identify a difference between what they desired and what they had actually done for refugee women, acknowledging that they could not always do justice to refugee women in maternal healthcare.

"I think families [with refugee experience] really do get a different standard of care. And the standard will sometimes accidentally be lower [...]. Sometimes it's unintentional, but sometimes it's intentional and I think we can do more to make people more aware that we have this unfairness, that it's unfair, so to speak. [...]" (MID_1: 905-913)

Dilemmas and contradictions

The maternal healthcare professionals reacted to the challenges by adjusting their professional practices towards refugee women, including employing modified or reduced general maternal healthcare practices.

"[...] We had to modify and customise many, many things [...]." (OB_02: 13-14)

"The care they get is always a slimmed down version [...]." (OB_02: 500-501)

For example, they adapted care procedures or changed indications for interventions.

"And an actual problem we have now, which is almost absurd, is that the anaesthetists say: "Well, when I give a local anaesthetic, when I give a spinal, I have to/or would like to talk to the woman afterwards. I would like to know if she has noticed any neurological deficits or anything like that. And if I can't do that, then my professional society says: Do a general anaesthetic." So that we end up doing things that pose a greater medical risk, so a general anaesthetic for difficult caesarean sections, or a general anaesthetic for nothing. Because communication is not possible. So they are treated worse, simply because they don't know German." (OB_29: 249-258)

Maternal healthcare professionals maintained their scope of practice where medically necessary or where routine examinations were recommended in accordance with the guidelines and standards of maternal healthcare.

"And medical care according to standards. She [refugee woman] will have a CTG, an ultrasound examination. I would inform the doctor, take a blood sample, in other words everything that medically has to be done." (MID_17: 344-347)

By way of contrast, maternal healthcare professionals reduced their scope of practice when it came to providing general information or explaining procedures and informed consent, especially in the case of urgent medical treatments.

"Precisely the scope of action. We are not able to care for refugee women in the way that general postpartum care would require. [...] I have to say that it is better than no care at all, but it is not what I would actually describe as an adequate level of care." (MID_08: 1813-1819)

"What is ignored completely is any kind of information about prenatal diagnostics. Discussing in advance [with refugee women] whether they want to have any choice in deciding what to do/that the women themselves have a say in the decision, that falls completely by the wayside." (OB_22: 234-239)

This adaptation of practices sometimes led to contradictions or dilemmas with regard to the ethical principles in maternal healthcare. Maternal healthcare professionals were not able to fully comply with their principles of fair treatment or respectful and need-oriented care when caring for refugee women. Their encounters with refugee women in maternal healthcare were more a compromise between ideals and reality.

Discussion

This research project involved an analysis of practices employed by maternal healthcare professionals when caring for refugee women in Germany. Maternal healthcare professionals were found to adapt their practices when caring for refugee women. When the maternal healthcare professionals interviewed encountered migrant women, they initially expected noteworthy differences in behaviour and attitudes owing to their different religious or cultural backgrounds. This assumption sometimes made them feel uncertain. Some tried to counter this uncertainty with more knowledge and sought to acquire what is known as culturebound knowledge. Haith-Cooper & Bradshaw recommend acquiring knowledge on the background these women come from (e.g. through textbooks or training) in order to be able to make assumptions about potential care needs [14]. Correa-Velez & Ryan have also suggested training in the form of inservice training on religious or cultural backgrounds [8]. As a result, maternal healthcare professionals have acted with the good intention of providing need-oriented care for refugee women, although sometimes they may actually act on the basis of stereotypes. The expectation and consideration of stereotypes neglects the individual preferences of the woman and her family, as refugee women's needs are diverse and vary from one woman to the next [10]. In light of this, Briscoe & Lavender advise maternal healthcare professionals to provide holistic and individualised care for women with refugee experience. With respect for and interest in the views, attitudes and questions of the individual woman, origin, ethnicity and religion can be set aside in the process of getting to know each other and the development of the relationship [5]. Some of the maternal healthcare professionals interviewed also approached refugee women without preconceptions in order to identify their personal attitudes and be able to provide them with individual care.

Maternal healthcare for refugee women was found to differ from the care provided for women without refugee experience. The differences become apparent on closer examination and analysis of specific and complex problem constellations. These problem constellations included distinct contexts which in some cases rendered appropriate maternal healthcare more difficult, e.g. housing conditions or inadequate structures in asylum procedures. This resulted in the need for a broader scope of practice and meant extra responsibility for maternal healthcare professionals, for example when guiding the patients through the healthcare system and/or carrying out additional or more extensive tasks. These circumstances with regard to maternal healthcare for refugee women led to the need for modifications to care practices. Maternal healthcare professionals altered practices such as procedures for or indications of maternal intervention, focusing on medical treatments (following standards and guidelines) and reducing the scope of care (e.g. number of postpartum visits) or providing shortened explanations of procedures or examinations for refugee women. Nevertheless, maternal healthcare professionals were for the most part motivated to care for refugee women because of their ideals and personal commitment.

Maternal healthcare professionals base their practices on ethical principles. Obstetricians comply with the Geneva Declaration [27] while midwives follow the International Code of Ethics for Midwives [17]. Both groups agreed to exercise their profession for the benefit of women by treating all women with dignity, humanity and with respect. The maternal healthcare professionals interviewed also justified their practices in terms of the ethical principles of their respective profession. Kurth et al. have shown there to be contradictory demands on the care practices used for refugee women, a fact that can lead to conflicts. In addition to maternal healthcare, they are also obliged to cooperate with governmental institutions (e.g. issuing certificates in the asylum process) and must also ensure costefficient care. These mandates conflict with their professional code of conduct, which requires them to support women in all situations and circumstances and to provide them with the best possible care [20]. The maternal healthcare professionals interviewed in this research project seldom addressed these kinds of contradictions. By way of contrast, there was a degree of ambivalence towards intended practices (akin to ethical codes and principals) and the actual practices provided for refugee women when decisions were made for women and they were not asked about their wishes, especially when interpreters were not available. This corresponds less to a need-oriented care approach for refugee women and once again revealed the challenges encountered by the maternal healthcare professionals interviewed, who strove to find a compromise between ideals and reality in maternal care for refugee women.

Strengths and limitations

The use of a combination of different sampling strategies enabled the views of a heterogeneous study population to be collected, providing a comprehensive picture of maternal healthcare for refugee women in Germany. The statements made in this research project, however, cannot necessarily be applied to all maternal healthcare professionals in Germany, as the findings are based on the subjective views of maternal healthcare professionals who have a special interest in changing care provision and structures.

The interviews were conducted between November 2017 to April 2018, some two years after a significant increase

in the number of refugees seeking asylum in Germany. The maternal healthcare professionals interviewed were thus able to remember the challenges in maternal care at the time and to share the strategies and solutions that had been developed as well as established routines. Nevertheless, recall bias cannot be ruled out entirely.
The interviews were analysed from a theoretical perspective – the theory of professional practice. As a result, the analysis was carried out with a focus on the following topics:

- Problem constellation and case description: Who are refugee women and what are their needs?
- Problem solving: How are refugee women cared for?
- Value orientation (habitus): How do maternal healthcare professionals build relationships with refugee women? How do they conduct their practices?

This approach can be expected to be instrumental in the development of more advanced theories in the health sciences and can initiate subsequent research projects on (further) theory development. Furthermore, additional and more indepth interpretations such as reconstructive analysis may reveal more profound insights into the professional behaviour of maternal healthcare professionals. This research project illuminates the perspective of maternal healthcare professionals who care for refugee women. The inclusion of the views of refugee women can broaden the picture of maternal healthcare for refugee women and would be an important and necessary addition to the healthcare professionals' perspective. When investigating refugee women's perspectives, it is important to work closely with language mediators and involve multilingual researchers in the data collection and analysis processes in order to achieve high quality results. Further, these findings have to be transferred to the practical field of maternal healthcare professionals. In particular, they can be disseminated through professional associations, journals, conferences and further training courses for maternal healthcare professionals. In addition, it is important to present the key takeaways to politicians and relevant stakeholders. This may lead to the creation of structures which, for example, provide an appropriate time frame for the maternal healthcare for refugee women, enable continuity in care provision, facilitate networking and ensure language mediation. As a result, maternal healthcare professionals would be able to return to their original and essential maternal health practices.

Conclusion

Maternal healthcare professionals face different obstacles when providing maternal healthcare for refugee women, e.g. in the field of medical practice as well as in relation to ethical principles and ideals. Due to a lack of resources (e.g. translators, time) as well as other conditions, they react by adjusting their professional practices towards refugee women, including employing modified or reduced general maternal healthcare practices. As challenges and opportunities in maternal healthcare for refugee women are identified, they may facilitate and contribute to improvements and the development of further care approaches in maternal healthcare which will positively impact overall maternal health.

Note

[1] This and the following interview statements are provided for illustration purpose and were translated from German into English for this publication only. Back translation verification was not carried out.

Competing interests

The authors declare that they have no competing interests.

References

1. Afflerback S, Anthony AK, Carter SK, Grauerholz L. Consumption Rituals in the Transition to Motherhood. Gender Issues. 2014;31(1):1-20. DOI: 10.1007/s12147-014-9115-0
2. Aspinall P, Watters C. Refugees and Asylum Seekers. A Review From an Equality and Human Rights Perspective. Manchester: Equality and Human Rights Commission; 2010.
3. Asylbewerberleistungsgesetz in der Fassung der Bekanntmachung vom 5. August 1997 Nr. 57 (BGBl I, S. 2022), das durch Artikel 4 des Gesetzes vom 17. Juli 2017 (BGBl , S. 2541) und zuletzt am 13. August 2019 geaendert worden ist. Bundesgesetzblatt Teil I. 2019;(31):1290-3.
4. 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(1):4-11. DOI: 10.1186/s12884-018-2053-1
5. Briscoe L, Lavender T. Exploring maternity care for asylum seekers and refugees. Br J Midwifery. 2009;17(1):17-23. DOI:10.12968/bjom.2009.17.1.37649
6. Brown-Bowers A, McShane K, Wilson-Mitchell K, Gurevich M. Postpartum depression in refugee and asylum-seeking women in Canada: A critical health psychology perspective. Health. 2015;19(3):318-35. DOI: 10.1177/1363459314554315
7. Carolan M. Pregnancy health status of sub-Saharan refugee women who have resettled in developed countries: a review of the literature. Midwifery. 2010;26(4):407-14. DOI: 10.1016/j.midw.2008.11.002
8. Correa-Velez I, Ryan J. Developing a best practice model of refugee maternity care. Women Birth. 2012;25(1):13-22. DOI: 10.1016/j.wombi.2011.01.002
9. Coutinho E, Rocha A, Pereira C, Silva A, Duarte J, Parreira V. Experiences of motherhood: Unmet expectations of immigrant and native mothers, about the Portuguese health system. Atencion Primaria. 2014;46(S5):140-4. DOI: 10.1016/S0212-6567(14)70081-2
10. Domenig D. Das Konzept der transkulturellen Kompetenz. In: Domenig D, editor. Transkulturelle Kompetenz Lehrbuch fuer Pfege-, Gesundheits- und Sozialberufe. 2nd ed. Bern: Hans Huber Verlag; 2007. p.165-89.

11. Fellmeth G, Plugge E, Paw KM, Charunwatthana P, Nosten F, McGready R. Pregnant migrant and refugee women's perceptions of mental illness on the Thai-Myanmar border: a qualitative study. BMC Pregnancy Childbirth. 2015;15(1):1-11. DOI: 10.1186/s12884-015-0517-0

12. Gibson-Helm M, Teede H, Block A, Knight M, East C, Wallace EM, Boyle J. Maternal health and pregnancy outcomes among women of refugee background from African countries: A retrospective, observational study in Australia. BMC Pregnancy Childbirth. 2014;14(1):392. DOI: 10.1016/j.ijgo.2014.10.036

13. 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. DOI: 10.1136/jech.2008.079368

14. Haith-Cooper M, Bradshaw G. Meeting the health and social needs of pregnant asylum seekers: Midwifery students' perspectives. Part 2: Dominant discourses and approaches to care. Nurse Educ Today. 2013 Aug;33(8):772-7. DOI: 10.1016/j.nedt.2012.06.014

15. 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;16:89. DOI: 10.1186/s12916-018-1064-0

16. Higginbottom GMA, Morgan M, O'Mahony J, Chiu Y, Kocay D, Alexandre M, Forgeron J, Young M. Immigrant women's experiences of postpartum depression in Canada a protocol for systematic review using a narrative synthesis. Syst Rev. 2013;2(65). DOI: 10.1186/2046-4053-2-65

17. International Confederation of Midwives. International Code of Ethics for Midwives. 2014 [Access 29 May 2020]. Available from: https://www.internationalmidwives.org/assets/files/general-files/2019/10/eng-international-code-of-ethics-for-midwives.pdf

18. Kasper A, Mohwinkel LM, Nowak A, Kolip P. Maternal Health Care for Migrant and Refugee Women - A Qualitative Review. Midwifery. 2021;104:103157. DOI: 10.1016/j.midw.2021.103157

19. Kuckartz U. Qualitative Text Analysis: A Guide to Methods, Practice & Using Software. London: Sage Publications, Ltd.; 2014.

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(659). DOI: 10.1186/1471-2458-10-659

21. Médecins du Monde. Access to health care and human rights of asylum seekers in Malta: Experiences, results and recommendations. Paris: MdM France; 2007.

22. Meuser M, Nagel U. Das Experteninterview - konzeptionelle Grundlagen und methodische Anlage. In: Pickel S, Pickel G, Lauth HJ, Jahn D, editors. Methoden der vergleichenden Politik- und Sozialwissenschaft Neue Entwicklungen und Anwendungen. Wiesbaden: VS Verlag fuer Sozialwissenschaften; 2009. p.465-79.

23. Organisation for Economic Co-operation and Development (OECD); United Nations Department of Economic and Social Affairs (UN-DESA). World Migration in Figures. In: High-Level Dialogue on International Migration and Development; 3-4 October 2013; New York. 2013 [Access: 24 June 2020]. Available from: http://www.oecd.org/els/mig/World-Migration-in-Figures.pdf

24. Patton M. Qualitative Research & Evaluation Methods. 3rd ed. Thousands Oaks: Sage Publications; 2002.

25. Stewart DE, Gagnon AJ, Merry LA, Dennis CL. Risk Factors and Health Profiles of Recent Migrant Women Who Experienced Violence Associated with Pregnancy. J Women's Health. 2012;21(10):1100-6. DOI: 10.1089/jwh.2011.3415

26. United Nations High Commissioner for Refugees (UNHCR). Global Trends. Forced Displacement in 2019. 2020 [Access: 24 November 2022]. Available from: https://www.unhcr.org/statistics/unhcrstats/5ee200e37/unhcr-global-trends-2019.html?query=Global%20Trends.%20Forced%20Displacement%20in%202019

27. Weltaerztebund. Deklaration von Genf. 2006 [Access: 29 May 2020]. Available from: https://www.bundesaerztekammer.de/fileadmin/user_upload/BAEK/Themen/Internationales/Bundesaerztekammer_Deklaration_von_Genf_04.pdf

28. Women Political Leaders (WPL). Taking effective policy action to ensure maternal health for refugee and migrant women [Outcome declaration]. In: WPL Meeting on Maternal Health and Refugee Women; 20-21 March 2017; Malta. 2017 [Access: 24 June 2020]. Available from: https://www.womenpoliticalleaders.org/wp-content/uploads/2017/01/Outcome-Declaration-Meeting-in-Malta-on-Maternal-Health-and-Refugee-Women-FINAL.pdf

29. World Health Organization (WHO). Improving the health care of pregnant refugee and migrant women and newborn children. Copenhagen: WHO Regional Office for Europe; 2018.

30. Yelland J, Riggs E, Szwarc J, Casey S, Dawson W, Vanpraag D, East C, Wallace E, Teale G, Harrison B, Petschel P, Furler F, Goldfeld S, Mensah F, Biro MA, Willey S, Cheng IH, Small R, Brown S. Bridging the Gap: Using an interrupted time series design to evaluate systems reform addressing refugee maternal and child health inequalities. Implementation Science. 2015;10(1):1-13. DOI: 10.1186/s13012-015-0251-z

Corresponding author:
Prof. Dr. Anne Kasper
University of Applied Sciences and Arts Hildesheim/ Holzminden/Goettingen, Hohnsen 4, 31134 Hildesheim, Germany
anne.kasper@hawk.de

Please cite as
Kasper A, Kolip P. Challenges and opportunities in maternal healthcare for refugee women – professionals' perspectives. GMS Z Hebammenwiss. 2023;10:Doc03.
DOI: 10.3205/zhwi000027, URN: urn:nbn:de:0183-zhwi0000279

This article is freely available from
https://doi.org/10.3205/zhwi000027

Received: *2021-12-13*
Accepted: *2022-10-26*
Published: *2023-12-18*