Practice Guide for Perinatal Health Care of Migrant, Asylum- seeking & Refugee Women (D4.1.)

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Operational Refugee And Migrant Maternal Approach

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Contents

Executive Summary 10
1 INTRODUCTION TO THIS DOCUMENT 10
1.1 Background 11
1.1.1 Migration effect 11
1.1.2 Challenges related to the perinatal care of migrant or other refugee women 12
1.1.3 Aim 13
2 METHODOLOGY 14
3 OVERARCHING STANDARDS OF CARE AND RECOMMENDATIONS FOR MIGRANT OR OTHER REFUGEE WOMEN 17
4 PERINATAL CARE OF MIGRANT OR OTHER REFUGEE WOMEN 21
4.1 Antenatal Period 21
4.1.1 Gestational age assessment 21
4.1.2 Maternal and fetal assessment 23
4.1.3 Diet and Lifestyle Considerations 31
4.1.4 Mental Health 35
4.1.5 Female Genital Mutilation (FGM) 37
4.1.6 Sexual and gender based violence 39
4.2 Intrapartum Period 41
4.2.1 Mode of birth 41
4.2.2 Maternal Morbidity 42
4.2.3 Birth Weight and prematurity 43
4.2.4 Female Genital Mutilation 44
4.2.5 Pain Management 45
4.3 Postpartum Period 46
4.3.1 Maternal assessment 46
4.3.2 Newborn assessment 47
4.3.3 Maternal mental health 48
4.3.4 Gestational Diabetes 49
5 MULTIDISCIPLINARY TEAM WORKING 50
5.1 Members of the multidisciplinary team 50
5.1.1 The Midwife 50
5.1.2 The Social Care Provider 60
5.1.3 The General Practitioner and other medical doctors/ obstetricians 65
5.2 Training needs 68
REFERENCES 69
Appendix 1 80

Acronyms and abbreviations

ANC	Antenatal care
BMI	Body mass index
CS	Caesarean section
GDM	Gestational diabetes mellitus
GP	General Practitioner
Hb	Haemoglobin
HCP	Health care professional
HIV	Human immunodeficiency virus
LMP	Last menstrual period
MAR	Migrant, asylum seeker or refugee
NGO	Non-governmental organisation
NICU	Neonate intensive care unit
NTD	Neural tube defects
PITC	Provider- initiated testing and counseling
PRH	Pregnancy- related hypertension
PTD	Preterm delivery
RFM	Reduced fetal movements
SCP	Social care provider
SGBV	Sexual and gender based violence
Td	Diphtheria
Tdap	Tetanus, diphtheria and pertussis

Executive Summary

The “PRACTICE GUIDE” compiles evidence and good practices to apply to the antenatal, intrapartum and postnatal care of new migrant, asylum seeker or refugee women. This has been developed through various rigorous approaches including systematic reviews of evidence, consultation and consensus among an interdisciplinary team of experts in the field.

Highlighting specific issues experienced by migrant women during perinatal period, this provides supporting evidence; good practice and quality standard recommendations to enable the delivery of sensitive and equitable perinatal care for these vulnerable women.

1 INTRODUCTION TO THIS DOCUMENT

The “PRACTICE GUIDE FOR PERINATAL CARE OF MIGRANT, ASYLUM-SEEKING AND REFUGEE WOMEN” aims to provide guidance on the antenatal, intrapartum and postnatal care of new migrant, asylum seeker or refugee (MAR) women (arrived within the last 5 years), including women who are seeking asylum or have refugee status. Within the text that follows this group of women are referred to more broadly as "migrants". This document summarizes evidence and relevant recommendations to address the health risks associated with asylum-seeker, refugee and other migrant status during pregnancy and the postpartum period, as well as suggesting approaches to support these women during the perinatal period to meet their needs. It addresses health system and service provider organizations, individual health care professionals and other professionals working with MARs. It is important that any professional who has direct contact with MAR women, and identifies that a woman is pregnant, is aware of issues that may impact on the woman's health and wellbeing and is able to make appropriate and timely referrals if needed.

Several well-established evidence-based guidelines (e.g. WHO, NICE) exist that are applicable to the clinical care of all pregnant women; however, this document addresses issues pertinent to childbearing MAR women. This document aims to support practice and to be used as an informative tool for all stakeholders involved in health assessment of MAR women and other related services in the perinatal period. This emphasizes the importance of effective communication, building trust and nurturing a friendly relationship with women, ensuring that women are listened to and that there is an efficient interdisciplinary team providing holistic woman-centred care throughout all stages of pregnancy, birth and the postpartum period.

1.1 Background

1.1.1 Migration effect

Migration can have consequences for people's physical and mental health and wellbeing. In general, although often healthy when leaving their country of origin, the health of MARs deteriorates over time, and in general, they rate themselves to have poorer health compared to the native population of their host countries [1]. Poor health is influenced by chronic stress related to migration and precarious socio-economic living conditions, unhealthy lifestyle, low health literacy, and healthcare that is not tailored to the needs of the MARs. Linguistic and cultural differences as well as socioeconomic barriers hamper access to and the quality of healthcare [2].

There is wide heterogeneity between studies that have investigated pregnancy outcomes amongst MAR women, relevant to: (a) study design view, (b) definition of what a migrant is and (c) the outcomes. This reflects the heterogeneity of the women themselves in terms of country of origin, reason for migration and the host countries in which they gave birth. Being a migrant is not a consistent marker of risk for poor pregnancy outcomes, and the effects of migration can differ [3]. Refugees and asylum-seekers and those who have lived in camps or come from war-torn regions may be at risk of poorer health because of gender-based violence, post-traumatic stress, poor nutritional status and infectious diseases [4]. Economic migrants, by contrast, may be of a higher socioeconomic group and in better health than the native population of their host country, the so-called "healthy migrant effect" [4]. Generally, studies have shown that MARs are more likely to suffer from chronic diseases such as diabetes, cardiovascular diseases and mental health problems as well as reproductive health problems [5].

Due to the limitations of existing statistical data and audit, it is not possible to determine the exact differences between maternal mortality and morbidity between MAR women and the host population across Europe. However, there is some evidence from the UK that maternal mortality and morbidity is higher amongst women from specific geographical regions; with significantly higher risk of maternal death in women born in Bangladesh, Pakistan, Jamaica, Nigeria and Poland [6], and higher rates of preterm birth, low birthweight, preterm birth and congenital malformations amongst MAR women [6,7].

Depending on the country of origin, MAR women are more likely to be subject to sexual violence, to have unmet contraceptive needs and unwanted pregnancies, and experience a higher incidence of induced abortions [8,9] and have higher rates of perinatal morbidity and mortality [10]. In a Swedish study, African MARs had 18 times higher risk of neonatal deaths compared with Swedish mothers [11]. One study however, indicated that recent immigrants were more likely to have better outcomes in terms of low-birth-weight babies and preterm births than women born in the receiving country [12] while another study found no such correlation [13]. Other authors have observed an increased preterm delivery (PTD) rate in MAR women [14-16] that varied with ethnic group; for example, an odds ratio of 3.54 in African

women in Italy and a 1.8 percentage point increased risk in African women compared with host women in Portugal [14,17]. In Norway, the risk of pre-eclampsia was lower in MARs related to Norwegian women but increased by length of residence in Norway [18], other studies demonstrate that risk of pre-eclampsia differs by MAR group, generation and host country [19,20].

1.1.2 Challenges related to the perinatal care of migrant or other refugee women

Conditions during migration, low socioeconomic position and irregular status may all have a negative impact on maternal health. Poorer maternal health in migrants compared with non-migrant women is often related to risk factors that precede a woman becoming pregnant, such as availability of family planning, health-seeking behaviours, gender-based violence and migration-related procedures, as well as the risks of the perinatal period [21].

Quality of prenatal, intrapartum and postnatal care is affected by poor communication [22]. In some cases, interpretation services are used to meet the needs of HCPs, like conveying information or obtaining informed consent, rather than being used routinely to develop a genuine dialogue with MAR pregnant women [22].

Migrant and refugee women are at higher risk of incorrect diagnosis due to communication difficulties compared to non-migrant women [23]. There is evidence that MAR mothers have difficulties communicating symptoms that could be indicative of pregnancy problems and also that some women stopped attending follow-ups, because of poor communication [24]. They were also found to express a poor understanding of the purpose of prenatal monitoring [25].

The expectations of women about examinations may differ from the host care system's recommended examinations. Some procedures may be unacceptable in the context of various cultures and religions (e.g., amniocentesis, fetal malformation screening), or the necessity of each screening test may not be well understood [26]. If medical recommendations are not compatible with individuals' health beliefs, dietary practices, views and perceptions about health and illness, the care plan is less likely to be followed [27].

Studies show that health service providers have an over-reliance on ad hoc, 'informal' interpretation from family, friends, other patients and non-medical personnel, raising issues about quality of interpretation and confidentiality [28]. Midwives and other HCPs should consider that some of these women may experience domestic violence and controlling relationships from family members that are used as mediators for communication. This has been identified as preventing women from getting the care they need and impacting on their and the fetus's health. HCPs should not involve relatives or husbands for interpretation because of confidentiality issues that may have a negative impact on the women [29]. Furthermore, the lack of knowledge of medical terminology by informal interpreters may lead women to undergo medical interventions that they had not consented to, without the procedures being explained or understood [24,30].

Lack of understanding of different traditions surrounding pregnancy and childbirth can also exacerbate communication difficulties. Misunderstanding can also occur if some traditions are at odds with the routine practices and recommendations from maternity care providers [28].

Culturally appropriate services may be helpful to motivate women's utilization of maternity care [29,31]. MAR women have expressed difficulties with integration of their cultural beliefs with the recommended health care practices during the intrapartum period, and lack of understanding of the informed consent process for procedures during delivery [25]. Others have mentioned that their language and communication needs were not met [29]. Many women have expressed a preference for a female physician during the labor and delivery process [25].

MAR women during the postpartum period may also experience problems related to expectations within their family and community norms regarding motherhood that may impede women's attendance to healthcare services or follow ups [25]. For example, breastfeeding initiation may be delayed due to cultural beliefs which deprives babies from colostrum intake [32].

Cultural diversity is sometimes challenging for midwives, general practitioners (GPs) and other healthcare providers, in their duty to act as advocates for MARs [30]. In some cases, MAR women evaluate the midwife- based antenatal care (ANC) as rushed and merely a physiological check, rather than being orientated to women's needs [23].

Racism is a very real issue within the health and maternity services, which can have tangible effects, but is rarely explored. Several studies conducted within maternity services showed that ethnic minority women encountered racism [28].

Pregnant women with complex social factors are known to book later, on average, than other women and late booking is known to be associated with poor obstetric and neonatal outcomes [33]. There is evidence of underutilization of prenatal visits among MARs, which translates into a delayed first prenatal visit [22,34], usually classified as presenting for ANC at over 20 weeks' gestation [28].

1.1.3 Aim

In line with the World Health Organization (WHO)'s vision, this document aims to provide practice guidance to enhance quality of care and reduce health inequalities for pregnant mothers from MAR background. WHO defines quality of care as 'the extent to which health care services provided to individuals and patient populations improve desired health outcomes. WHO states that in order to achieve this health care must be safe, effective, timely, efficient, equitable, and people-centred [35].

2 METHODOLOGY

In addition to background information, this document consists of two major sections:

- Overarching quality care standards and recommendations to enhance the care of MAR women
- Highlights of perinatal care aspects focused on specific conditions experienced more commonly by MAR women during pregnancy, intrapartum and the postpartum period

To enable sensitive and equitable perinatal care for MAR women, the above sections were developed through various rigorous approaches including systematic reviews of evidence, consultation and consensus. These are explained below:

a. **Systematic reviews contributed to identifying specific conditions which were then confirmed and expanded by the views of a multidisciplinary expert team**
    i. to identify MAR women's and health care professionals' experiences of perinatal care in Europe
    ii. to identify MAR specific conditions related to perinatal care

The systematic reviews were particularly used to formulate background information for the "overarching standards of care and recommendations for MAR". Two systematic reviews were carried out with a focus on "Migrant women's experiences of perinatal care in European countries" and "health care professional's experiences of perinatal care in European countries" [Appendix 1].

The review into migrant women's experiences of maternity care included a systematic search of the databases CINAHL, MEDLINE, PUBMED, PSYCHINFO and SCOPUS. Specific search terms were identified around the themes of 'migrant', 'maternity' and 'experiences' and were combined using Boolean operators. Full search terms can be seen in Appendix 1. A random subset of papers was double screened against inclusion criteria (e.g. articles published from 2007) and standardised data extraction tables and quality appraisal tools were used. A thematic synthesis of qualitative data was undertaken using Nvivo and AltasTi.

The findings revealed several overarching themes relating to migrant women's experiences of perinatal care; access to care, communication, information needs, self-esteem, attitudes and psychological issues, socioeconomic and living conditions, quality of care, and specific conditions in the perinatal period [36]

The systematic review of healthcare professional's experiences included a systematic search of two databases, to identify qualitative, quantitative and mixed methods studies published since 2007 and related to health professionals' experiences of care provision to MAR women during perinatal period. The following databases were searched PUBMED and SCOPUS. Search terms were identified around the themes of "health professionals", "maternity" and "experiences", and combined algorithms.

A meta- synthesis of the studies' findings revealed five themes as the main barriers for

optimal perinatal care offered to MAR pregnant women. These include: “Maternal socio-demographic characteristics”, “Professionals’ Cultural Competence”, Professionals’ Interpersonal and Communication Skills”, “Maternity Services” and “Leadership- Policy”. These themes were further organized into sub- themes.

b. Interdisciplinary team consultation and consensus

i. confirmed priority areas and MAR conditions for further good practice recommendations and additional support specific to the needs of MAR
ii. discussed and agreed "Overarching quality care standards" based on the above systematic review findings and expert opinion within the interdisciplinary team and advisory committee members
iii. identified condition specific guidelines and authoritative practice sources

In summary, the areas of focus for perinatal care of migrant women and the relevant quality improvement suggestions were identified through the systematic reviews. The results were then discussed among an interdisciplinary team of experts (e.g. midwives, general practitioners, social care providers, primary care providers). Through a consensus process, the team prioritised and formulated the over-arching quality standard of care. For perinatal care conditions specific to the needs of MAR women (e.g. gestational diabetes), robust evidence from authoritative sources such as WHO, NICE and other EU and NL national sources were scoped and presented along with summary quality standard recommendations by the advisory and multidisciplinary team of experts.

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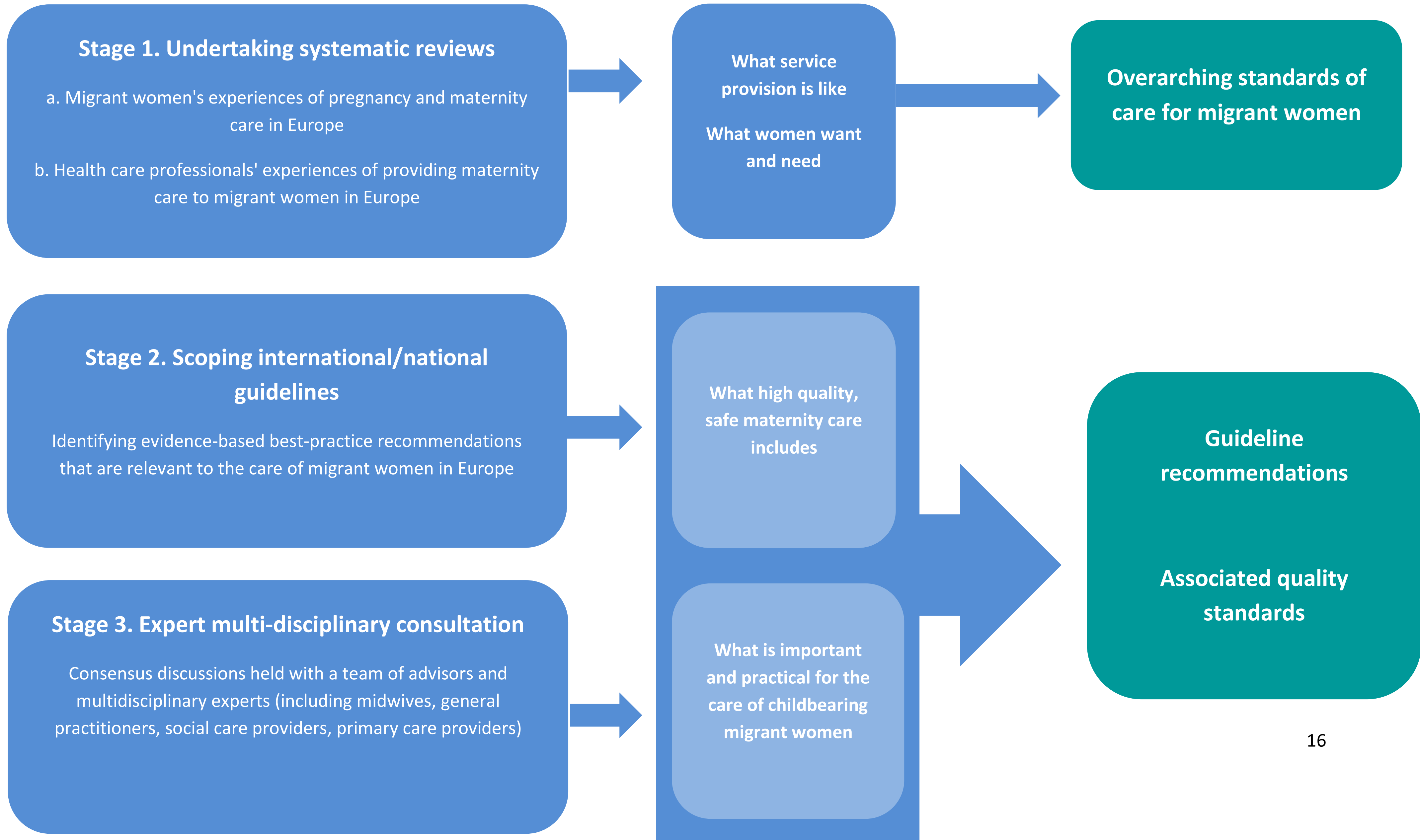
Figure 1. Process of developing the overarching standards of care for migrant women, guideline recommendations and associated quality standards



3 OVERARCHING STANDARDS OF CARE AND RECOMMENDATIONS FOR MIGRANT OR OTHER REFUGEE WOMEN

Access and Follow up
Maternity services should be accessible to all pregnant and postpartum MAR women.
• MAR women should be made aware of their entitlement to maternity healthcare. • Midwives and other HCPs should discuss with MAR women the importance of timely booking and of attending all the suggested appointments. • Potential barriers to accessing care should be discussed and addressed; these may include transport or financial difficulties, language barriers and fear of being reported to the police. • MAR women should be made aware of the pattern of maternity healthcare provision in the specific country and women's expectations of care should be discussed. • Care should be provided in flexible locations and at flexible times. • MAR women should be asked about their preference regarding the gender of the HCPs and as much as possible these preferences should be met. This means that female HCPs should be available. • MAR women should not be denied access to maternity healthcare on any prohibited grounds of discrimination. • Maternity care should be available at detention centers. • Midwives and other professionals must engage and support women to maintain contact with the health care system during the postpartum period.

Communication
Heath care professionals should always maintain effective and respectful communication.
• Excellent interpersonal and communication skills, active listening skills and self-awareness among HCPs is necessary for promoting focused care in maternity services. • Training should focus on developing sufficient self-awareness to allow for effective communication where HCPs are fully attentive to women's beliefs, fears, and goals, and are respectful of these. • HCPs should identify women's preferred language, and ask women if they have any communication issues, including ability in reading and speaking in their preferred language as well as in the local language. • Language barriers can be largely overcome by offering well-trained professional interpreters to non-native speakers at each appointment/care encounter. • It is not appropriate to use family members or friends as interpreters given that the use of family members or friends can compromise confidentiality or cover up circumstances such as domestic abuse. • Access to multiple methods of communication, such as use of posters, leaflets, drawings/diagrams, video clips, DVDs in a variety of languages, as well as access to

Communication

interpreters as a mean of improving communication with MAR women is recommended.

- Care should be taken to ensure that non-verbal communication is fully understood by regularly checking mutual understanding using questions like: "Am I understanding you correctly that ….".
- HCPs should ensure that they do not use overly medicalised vocabulary or jargon.
- Communication should always be warm and respectful; for instance, by asking about the woman's family, respecting the way she wants to greet and avoiding comments like "I thought everybody would know this"; "I cannot understand why you did not come to see me earlier".
- HCPs should show the woman they have listened to her by summarizing regularly during the consultation what the woman has said using the words the woman used. HCPs should apply the "teach-back" method to make sure what the woman has understood. A suitable question at the end of the consultation is "Please, could you tell me what we have discussed? Then I will know if I have explained things clearly to you."

Information needs

Women's information needs should be met.

- HCPs should identify and fulfil women's information needs.
- These information needs may include, but are not limited to: nutrition and diet, exercise, labour, available resources, coping after the birth, breastfeeding and care of the infant as well as information on entitlements, possible care facilities, mental health support, and available social support and social care facilities.
- Women should have access to information in various forms; verbal, written and electronic preferably in their own language and adjusted to their levels of health literacy.
- Educational programs should be offered to MAR women related to services and various support systems available to them

Self-esteem, attitude and psychological issues

MAR women may have experienced significant trauma. They often feel lonely, powerless and isolated. It is important that all care providers understand women's circumstances to provide high quality compassionate care.

- A positive attitude and reassurance of the woman's capacities is essential.
- HCPs should ask women in an appropriate manner about their mental health and be aware of the possible impact of previous trauma on the perinatal period.
- HCPs should signpost women to support or advocacy services as required.

Socio-economic and living conditions

MAR women face a number of psychosocial and economic challenges. It is important that healthcare providers are aware of these and are able to signpost women to support as required.

- HCPs should ask women about any financial/ housing concerns or problems and should be aware of the issues surrounding dispersal.
- HCPs should ask women, in a sensitive way, about any concerns surrounding their legal rights or entitlements and should signpost women to support or advocacy services as required.
- Midwives and other professionals should be trained about the complex wider health and social needs of pregnant asylum-seeking women.

Continuity of care and compassionate care

Health professionals/care providers should ensure that MAR women do not experience inequities in quality of care.

- Continuity of care needs specific attention in MAR women. Personal continuity of care is highly recommended as it facilitates a trusting relationship.
- Continuity in philosophy of care provision can be achieved by providing appropriate training for HCPs on high quality care as well as providing consistent information which is understandable to women in their own language.
- HCPs should demonstrate cultural competence, and should identify, acknowledge and accommodate as appropriate traditional or cultural practices that are relevant to the perinatal period.
- HCPs should identify the impact of cultural factors or traditions on maternal and newborn health and support mothers with evidence based advice.
- Extra time should be allocated for appointments and services provided to MAR women, to address complex issue and communication barriers.
- Maternity peer supporters (MPSs) can provide health mediation and provide increased opportunities for culturally appropriate care. They also support provision of continuity in care.
- All care providers should ensure care is always dignified, respectful and compassionate.

Building Cultural Competence

- MAR pregnant women should not be typified based on their ethnicity but as individuals.
- Specific training sessions delivered to HCPs about how to deal and interact with patients from different cultural and religious backgrounds are recommended.
- Since many of HCPs' stereotypical beliefs are unconsciously activated, cultural awareness and cultural competence should be part of HCPs' education curriculum. HCPs should be supported to identify their own unconscious stereotypes about MAR women, their babies and their wider families and communities.

The cultural competence training should not be restricted to knowledge of facts about other cultures that can result in further objectification and stigmatization. Rather the focus should be on developing an understanding of diversity, recognition of the multiplicity of issues that contribute to our understanding of culture and responsiveness to the cultural needs.

Leadership- Policy Reform

Development of a viable community-based maternity service is crucial to providing high quality continuity of care for childbearing MAR women.

- Hospitals and communities should collaborate in capacity building and arrange regular joint courses on pregnancy and maternity care themes for MAR women.
- To ensure continuity and a trusting relationship, it is necessary to adopt flexible models that support women's health. These models should be responsive to women's diverse support needs and based on equity and diversity.
- Individualized outreach programs and gateway services should be developed to increase access to services, help new MARs learn how to navigate health services, and provide training in cultural competence for HCPs.
- Revision of the government policy of forced dispersal for women in the asylum process who are pregnant or in the early postpartum period is urgently needed.
- Women who have ongoing health issues or who have infants requiring specialist follow-up should also be exempt from forced dispersal.

4 PERINATAL CARE OF MIGRANT OR OTHER REFUGEE WOMEN

Migrant or other refugee (MAR) women need the same general antenatal, intrapartum and postnatal care as non- migrant women, therefore for the basic care plans well-established, evidence-based national and international clinical guidelines should be followed. However, there are certain complications and issues in the migrant population which need extra attention. These are highlighted below with the source of evidence and quality standard recommendations specific to the needs of MAR women.

4.1 Antenatal Period

4.1.1 Gestational age assessment

Several studies have reported a shorter average gestational length in Black women, such as in an American study that found a difference of 5 days compared with White women. Furthermore, the results showed that the most common gestational week of delivery at term was the 39th week among Black women and the 40th week among White women [37]. However, this pattern is not uniformly observed. Among Somali-born MAR women to Scandinavia, the average gestational length, as well as the PTD rate, was found to be comparable to the native-born, mostly White, population [38,39]. Among nulliparous women progressing to spontaneous labour in the United Kingdom, Black (of both African and Caribbean descent) and Asian (Indian, Pakistani and Bangladeshi descent) women had a shorter mean duration of pregnancy (39 weeks) compared with women of European origin (40 weeks) [40]. Among women living in eight South American countries, women reporting Latin American ancestry had on average a 2-4 days shorter duration of pregnancy than among women reporting European ancestry, who may be the descendants of more recent migration waves [41]. Despite much debate, there is no consensus as to the clinical significance and potential implications of these disparities in the average duration of pregnancy [37].

Ultrasonography before 20 weeks of gestation is often considered the ‘gold standard’ for gestational dating as it is more accurate (±3-5 days) than any other prenatal or postnatal estimate of pregnancy dating, particularly if conducted earlier in pregnancy. Ultrasound assessment assumes that below a certain gestational age, differences in fetal size are related to gestational age, which can lead to underestimation of the gestational age of small but normal fetuses by approximately 1-2 days. However, this systematic error is considered minor compared with the large errors inherent in last menstrual period (LMP). Newer studies often use the ‘best obstetric/clinical estimate’, which is thought to improve accuracy by combining ultrasound and clinical information [37].

There is a possibility of pregnancy dating bias contributing to the ethnic/racial disparities seen in gestational length and PTD. A recent study, comparing gestational age estimates based on LMP with first trimester ultrasound assessment, found important discrepancies (average differences, in days) among women of young maternal age, lower education, non-Hispanic Black race/ethnicity and maternal obesity [42]. For most characteristics, this study

indicated on average, consistently longer gestational lengths when the LMP was used compared with ultrasound. A notable exception was by race/ethnicity; non-Hispanic Black women exhibited a gestational length of 0.5 days shorter on average when LMP was used as compared with ultrasound, whereas the gestational length among non- Hispanic White women was 1.2 days longer using LMP compared with ultrasound. The authors suggest that such measurement biases may exacerbate the racial disparity in PTD, and that this should be verified in a more representative sample. This suggestion is consistent with findings from another study, where compared with White women, Black women had an 80% increased risk of PTD when gestational length was calculated from LMP, but only a 50% increased risk when calculated from ultrasound measurements [43].

Guideline Recommendations	Source
Gestational age should be assessed early in pregnancy by ultrasound scan between 10 and 14 weeks.	NICE [44]
Quality Standard Recommendations	
All information regarding the gestational age assessment and examination process should be provided for MAR women in their own language verbally and/or in written format as required.	

4.1.2 Maternal and fetal assessment

4.1.2.1 Fetal anomaly screening

Immigrant women suffer from poorer pregnancy outcomes in comparison to native women, including risk of low birth weight, perinatal mortality [45,46], PTD, and congenital malformations, especially in countries with weak integration policies [7].

Recent studies have shown that Muslim women are less likely to choose to have fetal anomaly screening tests and that their views on life, disabled life and termination based on their religious beliefs are a key factor in their decision-making on whether to have anomaly screening done [47].

Thus, awareness of religious and ethical values is essential among health professionals counseling individuals faced with a prenatal diagnosis. Clinicians should explicitly ask about religiosity and what consequences it may have in this situation, rather than assuming either a certain set of values based on ethnic origin or one's own ethical stance [48].

Guideline Recommendations	Source
Ultrasound screening for fetal anomalies should be offered between 18 weeks and 20 weeks, 6 days. Women should be offered the choice of screening for Down's Syndrome.	NICE [44]
Quality Standard Recommendations	
HCPs should explore women's attitudes and be aware that these may be influenced by religious or cultural factors or traditions. Women should be given sufficient information for informed decision-making.	
HCPs should not stereotype women and avoid predicting women's choices regarding their care and screening options, based on perceived cultural or religious backgrounds.	

4.1.2.2 Fetal movement assessment

Reduced fetal movements (RFM), defined as a subjective perception of significantly reduced or absent fetal activity, is emerging as an important clinical marker to identify women with high risk of stillbirth and fetal growth restriction due to placental dysfunction. RFM are an important and frequently seen problem in maternity care, with 6-15% of women reporting at least 1 episode of RFM during the third trimester of pregnancy [49].

Although awareness of fetal movements is associated with improved perinatal outcomes, the quest to define a quantitative "alarm limit" to define decreased fetal movements has so far been unsuccessful, and the use of most such limits developed for fetal movement counting should be discouraged [50].

Guideline Recommendations	Source
Routine formal fetal-movement counting should not be offered.	NICE [44]
Healthy pregnant women should be made aware of the importance of fetal movements in the third trimester and of reporting RFM.	WHO [51]
Quality Standard Recommendations	
It is important to provide clear and language appropriate information for women in a way that is not causing anxiety and yet encourage them to be vigilant about signs of fetal wellbeing.	

4.1.2.3 Hypertensive disorders

Hypertensive disorders are a common cause of maternal mortality and morbidity [6]. The likelihood of developing pre-eclampsia during pregnancy is increased in women who are nulliparous, age 40 years or older, have a family or prior history of pre-eclampsia, have a BMI at or above 30 kg/m^2 and have a multiple pregnancy or pre-existing vascular disease (for example, hypertension or GDM) [44]. MARs from western- or southern Africa descent are also more at risk of severe hypertension that needs specific treatment [52].

Lower incidence of pregnancy related hypertension (PRH) has been reported among immigrants when compared to women native to the hosting country [18,53]. Even women emigrating from impoverished countries or regions with high prevalence of PRH tend to experience a lower risk of PRH when compared to women native to the country to which they have immigrated [18,53].

A meta-analysis of epidemiological studies for PRH and immigrant status, concluded a 26% average risk increase for immigrants, emphasizing that immigration status may be an important risk factor or proxy for PRH, with a risk magnitude similar to other perinatal conditions such as a one centimeter increase in waist circumference, a one-point increase in body mass index (BMI), and type 1 diabetes [54]. Thus, immigrant women from Sub-Saharan Africa and Latin America and the Caribbean require increased surveillance due to a consistently high risk of pre-eclampsia and eclampsia [55].

Guideline Recommendations	Source
At each appointment the MAR women should have their blood pressure measured and urinalysis to detect proteinuria.	NICE [44]
Pregnant women should be informed of the symptoms of advanced pre-eclampsia because these may be associated with poorer pregnancy outcomes for the mother or baby. Symptoms include severe headache, problems with vision, such as blurring or flashing before the eyes, bad pain just below the ribs, vomiting, and sudden swelling of face, hands or feet.	NICE [44]
Quality Standard Recommendations	
Women should be informed of the warning signs of serious illness during the perinatal period, how to access emergency care and appropriate medical interventions in a culturally appropriate way, using an interpreter if required and ensuring the information has been understood.	
Extra vigilance should be applied for MAR pregnant women to screen for elevated blood pressure and pre-eclampsia.	

4.1.2.4 Anaemia

Iron deficiency anaemia is common in pregnant women due to an increase in maternal and fetal requirement for iron. Anaemia is the world's second leading cause of disability, and one of the most serious global public health problems, with the global prevalence of anaemia among pregnant women at about 38% [51]. MARs from regions in the developing world with a high prevalence of hookworm and malaria [56], high parity, and genetic predisposition for red blood cell disorders are at increased risk for anaemia. Poverty, circumstances, culture, custom, and education can affect the choice and availability of iron-rich foods [57].

Guideline Recommendations	Source
Pregnant women should be offered screening for anaemia in early pregnancy (at the booking appointment) and at 28 weeks. Haemoglobin (Hb) levels outside the normal range should be investigated and treated with iron supplementation if indicated.	NICE [44]
Quality Standard Recommendations	
Screening for anaemia is essential for all MAR women.	

4.1.2.5 Haemoglobinopathies

Hemoglobinopathy (predominantly thalassemia and sickle-cell anemia) is more common among newly arrived women from certain regions of the world, such as Africa, the Mediterranean basin, the Middle East, the Indian subcontinent, southeast Asia, and southern China [58] and can lead to serious maternal complications, severe anemia in infants, and painful vaso-occlusive crises [59]. These cases are common in those whose ancestors came from areas where malaria is endemic, including Africa, the Mediterranean basin, the Middle East, the Indian subcontinent, south-east Asia, and southern China [59].

Guideline Recommendations	Source
Information about screening for sickle cell diseases and thalassemia, including carrier status and the implications of these, should be given to pregnant women at the first contact with a HCP.	NICE [44]
Screening for haemoglobinopathies should be offered to all women ideally before 10 weeks gestation.	NICE [44]
MAR pregnant women coming from Africa, South Asia and Mediterranean descent are at increased risk for being carriers of hemoglobinopathies and should be offered carrier screening and, if both parents are determined to be carriers, genetic counselling.	ACOG [60] NICE [44]
Quality Standard Recommendations	
In case of anaemia in MAR women, additional testing for haemoglobinopathies is mandatory.	
Language appropriate information should be provided for MAR women to allow full understanding of the risks and benefits of the treatment options.	

4.1.2.6 Gestational Diabetes Mellitus

Gestational Diabetes Mellitus (GDM) is more common in immigrant and minority populations [61,62] than the host country population. The prevalence of GDM appears to be particularly high among women from South Asia and South-East Asia, compared to Caucasian, African-American and Hispanic communities [63]. High BMI is a risk factor for the development of GDM.

Limited studies have shown that women who live in an English-speaking country but predominantly speak a language other than English, have lower rates of dietary understanding compared with their English-speaking counterparts, and this may affect compliance to therapy. Insulin therapy also plays an important role and there appears to be variation as to the progression of women who progress to requiring insulin among different ethnicities [63].

Guideline Recommendations	Source
Identify risk factors of GDM at the booking appointment, including family ethnic origin with a high prevalence of diabetes.	NICE [64]
Risk factors for GDM include: BMI above 30 kg/m², previous baby weighing 4.5 kg or above, previous GDM, family history of diabetes (first-degree relative with diabetes), family origin with a high prevalence of diabetes: South Asian (specifically women whose country of family origin is India, Pakistan or Bangladesh), black Caribbean, Middle Eastern (specifically women whose country of family origin is Saudi Arabia, United Arab Emirates, Iraq, Jordan, Syria, Oman, Qatar, Kuwait, Lebanon or Egypt). Women with any one of these risk factors should be offered testing for GDM.	NICE [44]
To make an informed decision about screening and testing for GDM, women should be informed that: • In most women, GDM will respond to changes in diet and exercise. • Some women (between 10% and 20%) will need oral hypoglycaemic agents or insulin therapy if diet and exercise are not effective in controlling GDM. • If GDM is not detected and controlled there is a small risk of birth complications such as shoulder dystocia.	NICE [44]
Quality Standard Recommendations	
In terms of treatment, nutrition and exercise can play a key role in the management of GDM and the prescription of appropriate diet and physical activity should be culturally sensitive.	
Accessible culturally and language-appropriate community based programs should be offered to support MAR women for prevention and management of GDM.	
HCPs should explore women's attitudes, information needs, and social context with regard diet modification and ongoing risk of diabetes post-pregnancy.	

4.1.2.7 Human Immunodeficiency Virus (HIV)

The epidemiological data available indicates higher rates of human immunodeficiency virus (HIV) infection among MARs, compared to national populations [65-68]. Women appear to be at a greater risk than men for HIV due to biological, social and cultural factors. Furthermore, immigration-related factors place MAR women at greater risk than other women for sexually transmitted infections, including HIV [69,70].

Studies have indicated that often MARs have late HIV screening in pregnancy [71]. A study by Jasseron et al [72] showed African women were more likely to present later for ANC and to start prenatal care in the third trimester; they were also more likely to discover their HIV infection during pregnancy, and to start antiretroviral therapy after 32 weeks of gestation.

Guideline Recommendations	Source
In high-prevalence settings, provider-initiated testing and counseling (PITC) for HIV should be considered a routine component of the package of care for pregnant women.	WHO [51]
In low-prevalence settings, PITC can be considered for pregnant women in ANC settings as a key component of the effort to eliminate mother-to-child transmission of HIV, and to integrate HIV testing with syphilis, viral or other key tests, and to strengthen the underlying maternal and child health systems.	WHO [51]
Quality Standard Recommendations	
Testing and culturally and language-appropriate counseling for HIV should be considered a routine component of the package of care for MAR pregnant women in all ANC settings.	
HCPs should discuss with women the impact of HIV on breastfeeding and offer advice/ support on this.	

4.1.2.8 Immunization

Many immigrants are susceptible to vaccine-preventable diseases upon arrival in host countries. To promote patients' safety and adherence to therapy, patients must be informed of the risks and benefits of treatment in a culturally and linguistically appropriate manner [26,73,74].

Rubella immunity was found to be the lowest among women from North Africa, Middle East, China and the South Pacific [25].

Guideline Recommendations	Source
Hepatitis A: in women at high risk of exposure to Hepatitis A, the risk of hepatitis A should be weighed against the risk associated with vaccination.	CDC [75]
Hepatitis B: vaccination is recommended for pregnant women who are identified as being at risk of Hepatitis B infection during pregnancy.	CDC [76]
Influenza: it is recommended that all women who are or will be pregnant during the influenza season should receive inactivated influenza vaccination.	CDC [77] GACVS[78]
Polio: vaccination can be administered to pregnant women, if they are at increased risk of infection and require immediate protection against polio.	CDC [79] GACVS[78]
Tetanus, Diphtheria, and Pertussis (Tdap)/ Tetanus and Diphtheria (Td): A dose of Tdap during each pregnancy (preferably between 27 and 36 weeks of gestation) should be administered to all pregnant women irrespective of their prior history of receiving Tdap. If a Td booster is indicated for a pregnant woman in case of wound management, healthcare providers should administer Tdap. In cases of unknown or incomplete tetanus vaccination, pregnant women should receive three vaccinations containing tetanus and reduced diphtheria toxoids with Tdap replacing 1 dose of Td, preferably between 27 and 36 weeks' gestation.	CDC [80]
Quality Standard Recommendations	
The immunization of MAR women should be recorded and audited thoroughly e.g. for varicella, rubella, since we cannot know the immunization protocols followed in the origin countries.	
Culturally and language appropriate information should be given to MAR women regarding the risks and benefits of treatment of vaccine-preventable diseases.	

4.1.3 Diet and Lifestyle Considerations

4.1.3.1 Nutrition & Obesity

Immigrant women may continue to eat culturally preferred foods despite healthcare advice [25,81]. Mothers, mothers-in-law, and husbands frequently have critical influences on the food practices of perinatal women [82]. As a result, influencing dietary behavior change may be particularly difficult in these groups, particularly when the changes are perceived to clash with one's own customs that provide emotional connections to home [82].

Obese women have a higher risk of complications during pregnancy and delivery - which increases with a rising BMI. Women who migrated from low- and middle-income to high-income countries often have even higher prevalence of overweight and obesity than women from the majority populations and thus experience higher pregnancy-related risks [83].

Guideline Recommendations	Source
Counseling about healthy eating and keeping physically active (30 min/day of moderate intensity) during pregnancy is recommended for pregnant women to stay healthy and to prevent excessive weight gain during pregnancy.	WHO [51] NICE [84]
Maternal weight and height should be measured at the first antenatal appointment, and the woman's BMI calculated (weight [kg]/height[m]^2).	NICE [44]
At the earliest opportunity, for example, during a pregnant woman's first visit to a health professional, discuss her eating habits and how physically active she is. Find out if she has any concerns about diet and the amount of physical activity she does and try to address them.	NICE [85]
Women, who book with a BMI ≥30 kg/m^2, should receive personalized advice from an appropriately trained professional on healthy eating and physical activity.	NICE [85]
Quality Standard Recommendations	
Pregnant women should be encouraged to receive adequate nutrition through consumption of a healthy, balanced diet.	
To ensure optimal education for MAR women about good nutrition and dietary practices during the perinatal period, midwives and other HCPs must address the cultural traditions and eating practices of these women, e.g. cravings management, fasting practices that affect glucose metabolism and hydration etc., in favor of their wellbeing.	
Midwives and other HCPs, should be aware of the diverse backgrounds and situations of the women and how their individual and sociocultural contexts can affect their health and dietary practices.	
Local immigrant support agencies can play a role in helping immigrant women make healthy choices that incorporate their cultural beliefs while simultaneously navigating their new environment.	
Those offering training in nutrition should have an appropriate qualification, for example, as a dietitian or a registered public health nutritionist. They must also recognize the importance of communication and inter-personal skills to be able to raise and convey important sensitive messages about weight and health.	

4.1.3.2 Nutritional supplementation

3.1.3.2.1 Iron and folic acid supplements

Although routine iron supplementation is not recommended, screening for anemia and discussion around healthy diet and iron rich sources of food is important. MAR women are at higher risk of anaemia as they are more likely to not have a balanced diet [26] and to suffer from parasitic infections that may cause anemia. They are also more commonly from low or middle-income countries and disadvantaged populations [51,86]. However, as anemia in MARs also can be caused by hemoglobinopathies, these conditions must be screened for when providing iron supplementation.

Folic acid supplements reduce the risk to the fetus of Neural Tube Defects (NTD). There have been reports of a high prevalence of NTDs in countries of Sub-Saharan Africa, which may largely be attributed to suboptimal preconception intake of folic acid [87]. Furthermore, obesity increases the risk of NTDs which is particularly relevant to this population group [88,89]. Counselling on preconception use of folic acid should be a critical focus for NTD prevention among immigrant women. Dietary advice could also be utilized to increase the dietary intake of folate [89].

Guideline Recommendations	Source
Iron supplementation should not be offered routinely to all pregnant women. It does not benefit the mother's or the fetus's health and may have unpleasant maternal side effects.	NICE [44]
Women should be informed that dietary supplementation with folic acid, before conception and up to 12 weeks of gestation, reduces the risk of having a baby with neural tube defects (anencephaly, spina bifida).	NICE [44]
Quality Standard Recommendations	
Midwives and other HCPs must explain the importance of folic acid and check the understanding as well as possible barriers to taking folic acid in MAR women.	
Midwives and other HCPs may need to consider ways of explaining and reminding pregnant MAR women of the need for taking supplements, and explore reasons why women do not take them; costs could be an important barrier.	

3.1.3.2.2 Vitamin D

Dietary sources of vitamin D are limited and achieving optimal vitamin D status is largely dependent upon adequate exposure of the skin to sunlight. It is also dependent upon skin pigmentation, with darker skin requiring greater exposure than fair skin [90].

Vitamin D deficiency is of public health concern, particularly for south Asian, African, Afro–Caribbean and other darker-skinned ethnic minority communities [40,44,89].

Guideline Recommendations	Source
The importance of good nutrition and having adequate intake of Vitamin D should be explained to women in early pregnancy (e.g. booking visit)	NICE [44]
Quality Standard Recommendations	
Pregnant women who originate from South Asian, African, Caribbean or Middle Eastern, and those who remain covered when outside for cultural reasons, are at greatest risk of vitamin D deficiency. Particular care should be taken to enquire as to whether women at greatest risk are following advice to take a daily supplement of vitamin D.	
The importance of taking vitamin D has to be explained to facilitate the understanding of such nutritional needs as well as barriers to regularly taking relevant supplementations should be explored.	
Dietary health promotion materials adjusted to the needs of women should be available.	

3.1.3.2.3 Vitamin A

Vitamin A deficiency affects about 19 million pregnant women, mostly in Africa and South-East Asia, causing night blindness [91]. There is evidence that vitamin A deficiency is a public health problem among communities from Sudan, who were displaced from their homelands because of drought, famine conditions and civil unrest. The deficiency may be due to insufficient intake of food of animal origin and repeated malarial and other parasitic diseases that are common among this population [92].

Guideline Recommendations	Source
Pregnant women should be informed that vitamin A supplementation (intake greater than 700 micrograms) might be teratogenic and therefore it should be avoided.	NICE [44]
Vitamin A supplementation is only recommended for pregnant women in areas where vitamin A deficiency is a severe public health problem, to prevent night-blindness.	WHO [51]
Quality Standard Recommendations	
Risks of both Vitamin A deficiency and excessive amount of vitamin A intake should be considered, and appropriate treatment considered according to woman's condition.	

4.1.3.3 Tobacco, alcohol and substance use

Tobacco and alcohol use in pregnancy are important modifiable risk factors of poor perinatal outcomes and children's cognitive and behavioral difficulties [93]. Migrant women generally have lower substance use levels than native women [94]. Alcohol use in migrant women may be associated with social or psychological vulnerability [93], while tobacco use may reflect a less advanced stage of the tobacco epidemic in their country of origin and more traditional gender roles [95], instead following a socioeconomic gradient [93].

Guideline Recommendations	Source
Healthcare providers should ask all pregnant women about their use of alcohol and other substances (past and present) as early as possible in the pregnancy and at every ANC visit.	WHO [51]
At the first contact: • Pregnant women should be advised to eliminate alcohol intake through pregnancy as it may be associated with an increased risk of miscarriage or harm to the baby. • Discuss smoking status, provide information about the risks of smoking to the unborn child and the hazards of exposure to secondhand smoke.	NICE [44]
Address any concerns that the woman and her partner or family may have about stopping smoking and provide personalised information, advice and support on how to stop smoking.	NICE [44] WHO [51]
Quality Standard Recommendations	
Culturally and language-appropriate advice and interventions for substance use should be offered to all MAR pregnant women who are identified as using alcohol and/or drugs; past and present.	
Culturally and language-appropriate advice and psychological interventions for tobacco cessation should be offered to all MAR pregnant women who are either current tobacco users or recent tobacco quitters.	

4.1.4 Mental Health

In this state of super-diversity and heterogeneity of migration, it is difficult to ascertain the exact prevalence of mental health issues among MAR pregnant women, particularly those who have recently arrived at the host country [96]. However due to a higher total fertility rate [97] and because of socioeconomic difficulties, cultural issues and stigmatization, language barrier and isolation, lack of certainty about future, lack of family or social support, and trauma which they may have experienced through migration or in their home country [98], there is a higher likelihood of maternal mental health service requirements by MAR women.

Guideline Recommendations	Source
At a woman's first contact with services HCPs (including midwives, obstetricians, health visitors and GPs) should ask about: past or present severe mental illness including schizophrenia, bipolar disorder, psychosis in the postnatal period and severe depression, previous treatment by a psychiatrist/specialist mental health team, and a family history of perinatal mental illness.	NICE [99]
Other specific predictors, such as poor partner relationship, should not be used for the routine prediction of the development of a mental disorder.	NICE [99]
At the first contact, these specific questions should also be asked: • During the past month, have you often been bothered by feeling down, depressed or hopeless? • During the past month, have you often been bothered by having little interest or pleasure in doing things? If the answer to either of these questions is 'yes', the following question should be considered: • Is this something you feel you need or want help with?	NICE [99]
After identifying a possible mental disorder: • If the HCP or the woman has significant concerns, the woman should normally be referred for further assessment to her GP. • If the woman has, or is suspected to have, a severe mental illness (for example, bipolar disorder or schizophrenia), she should be referred to a specialist mental health service, including, if appropriate, a specialist perinatal mental health service. This should be discussed with the woman and preferably with her GP. • The woman's GP should be informed in all cases in which a possible current mental disorder or a history of significant mental disorder is detected, even if no further assessment or referral is made. • Exercise can provide mental health benefits during pregnancy. • Routine perinatal health data collection should include information concerning immigration indicators (duration of residence in the host country, language fluency, legal status as a proxy of socioeconomic condition and difficulties, religion and ethnicity)	RCOG [100] CMA [101]

Quality Standard Recommendations
Midwives and other HCPs should ask women in a sensitive way about their mental health and be aware of the possible impact of previous trauma on the perinatal period.
In case of indications of mental health problems in MAR women, they should be referred to cultural sensitive mental HCPs, preferably in their own language.
Midwives and other HCPs must provide extra support to MAR pregnant women who lack social/family/marital support.
Midwives and other HCPs should take culturally and language appropriate preventive measures to help MAR pregnant women to cease taking psychoactive substances like alcohol, tobacco, illicit and OTC drugs.
Peer support groups or physical activity groups for MAR women could empower them and help in reducing the risk of isolation and mental health disorders.
Determining the prevalence of depression, anxiety, or stress in MAR pregnant women is vital for establishing and expanding appropriate mental health services.

4.1.5 Female Genital Mutilation (FGM)

Female genital mutilation (FGM) is a traditional practice that has no medical benefit and severe health consequences for girls and women. It is a common practice in Egypt, Eritrea, Somalia, Sudan, Sierra Leona, northern Iraq, and occurs sometimes in other African and Middle Eastern countries. FGM affects more than 125 million girls and women worldwide and is reportedly practiced in 29 countries in sub-Saharan Africa and the Middle East [102]. Recent estimates revealed that 137 000 girls and women are living with FGM in England and Wales, although their country of origin was not reported [103]. In Somalia, a reported 98% of 15–49-year old females have been affected, mostly by type III (63%) [102].

WHO FGM classification	
Type I	Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).
Type II	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).
Type III	Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).
Type IV	All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.
World Health Organization. Eliminating female genital mutilation: an interagency statement. Geneva: World Health Organization; 2008.	

The most severe form of FGM is type III (infibulation), which involves the removal and apposition of the inner and outer labia, with or without excision of the clitoris, leading to the creation of a covering seal and narrowing of the vaginal orifice [104]. Mismanagement of women with FGM during pregnancy and labor may lead to problems at birth, patient dissatisfaction or promote barriers to accessing services in the future [105-107]. The risks to patients who are pregnant and have had FGM includes urinary tract infections and the difficulty in vaginal examinations that can be caused by FGM can delay diagnosis and treatment of several situations related to pregnancy. Female genital mutilation also doubles the risk of maternal deaths during child birth owing to difficulty during labour [108]. The physical impact of FGM during pregnancy includes exacerbations of pre-existing psychological issues, such as a fear of giving birth [109]; factors that tend to make the overall experience of labor more negative [110].

Women with history of FGM have reported feeling left out of decision making regarding their care and undergoing more medical interventions than they expected [25]. The women reported experiencing hurtful comments, apparent disgust, and lack of privacy during procedures, inadequate pain management and cultural insensitivity by the healthcare

providers. Women expressed the importance of cultural sensitivity and awareness [25,111].

A midwife's awareness and knowledge of FGM is an important factor in providing adequate care to affected women [109]. Midwives are central to MAR women's experiences of antenatal and intrapartum services, with better relationships resulting in more positive experiences. Most women are comfortable discussing FGM and have previously reported higher satisfaction levels when treated by health workers with prior knowledge of it [106]. From their point of view, midwifes and other health care professionals, should explore this further and identify areas of improvement, as mismanagement of FGM during the antenatal period may increase the risk of birth problems [107] or cause psychological harm [109].

Guideline Recommendations	Source
Pregnant women who have had female genital mutilation should be identified early in ANC through sensitive enquiry. Antenatal examination will then allow planning of intrapartum care.	NICE [44]
Antepartum or intrapartum de-infibulation should be offered, the decision about the timing of the procedure should be based on the following contextual factors: • preference of the woman • access to healthcare facilities • place of delivery • healthcare provider's skill level.	WHO [112]
Quality Standard Recommendations	
Midwives and other HCPs need to be competent to evaluate women's needs with a history of genital mutilation and interview women in a caring, respectful and culturally sensitive way.	
Women should be asked about whether they have undergone FGM and any ongoing complications, and their attitudes towards pregnancy and de-infibulation should be explored.	
Midwives and other HCPs should know where to refer women who have undergone FGM for support and medical help.	

4.1.6 Sexual and gender based violence

Sexual and gender-based violence (SGBV) is generally defined as 'any act, or threat of acts, of physical, sexual and psychological violence that is directed against a person on the basis of her/his gender or sex, and which occurs in the family, the community, or is perpetrated or condoned by the State and/or institutions' [113]. In the context of forced migration, the United Nations High Commissioner on Refugees (UNHCR) applies a definition that comprises five types of violence, namely, physical, psychological, sexual, socio-economic violence and harmful cultural practices [114].

There is evidence of vulnerability to SGBV of people with restricted residence permits such as MARs [115]. Violence against women is a major public health problem and violates women's human rights [116]. MAR women are more likely to experience emotional violence and experience sexual victimization [117], which frequently prevents them from getting the help they need, or impacts the health of both woman and unborn child, either because they are not permitted (by their partner) to attend appointments, or because they are concerned that medical staff would see their injuries [29]. Abused immigrant women face significant social, cultural, structural, and political barriers to patient-provider communication and help-seeking behaviors [118], while women who report SGBV situations may end up isolated and alone [29].

In addition to important negative effects on the victim's well-being and participation in society, SGBV may have significant consequences on sexual, reproductive, physical and psychological health [115]. Systematic reviews on health effects have shown that SGBV can lead to short-term and long-term health consequences, particularly mental health disorders, such as depression, anxiety, and alcohol abuse [116]. Health consequences can be broadly grouped into more immediate effects directly stemming from the incident, whereas medium- to long-term consequences occur in the period after the incident [108], and include: (a) physical and psychological stress levels, (b) isolation and adequate access to antenatal healthcare, (c) negative maternal coping behaviors (e.g. smoking, alcohol/ illicit drug use, etc.), (d) inadequate maternal nutrition. These may work through different pathways and result in adverse pregnancy outcomes [119].

Guideline Recommendations	Source
HCPs need to be alert to the symptoms or signs of domestic violence and women should be given the opportunity to disclose domestic violence in an environment in which they feel secure.	NICE [44]
Women who experience domestic abuse should be supported in their use of ANC services by: • training HCPs in the identification and care of these women • making available information and support tailored to these women • providing a more flexible series of appointments if needed • addressing women's fears about the involvement of children's services by providing information tailored to their needs.	NICE [120]

Oramma
Operational Refugee And Migrant Maternal Approach

Quality Standard Recommendations
Midwives and other HCPs must be able to detect signs and symptoms of sexual violence.
The establishment of routine screening for abuse in the maternity services settings, as well as tested, culturally sensitive referral systems are needed.
Midwives and other HCPS must be competent to manage pregnancies complicated by sexual violence issues.
Midwives and other HCPs should be aware that attitudes to domestic violence may be influenced by cultural factors or traditions.
Women should be supported by offering additional appointments and informed of available social support services for domestic violence. Obtaining women's telephone numbers for additional support is a good practice.

4.2 Intrapartum Period

4.2.1 Mode of birth

The rate of Caesarean Section (CS) varies widely across the globe, with countries in Latin America and the Middle East having high rates of CS while African countries have very low rates [121]. MAR women will therefore often originate from countries with different levels of medicalisation to the host country and their personal preferences and expectations may be based on the care provided in their country of origin. For example, Somali women often have a fear of medical intervention particularly CS [122,123] which may understandably arise from having lived in a country with a high maternal mortality rate [124]. On the other hand, women from the Middle East, Latin America or Poland stated they would prefer more interventions and doctor rather than midwife care [125-127].

Therefore, women's beliefs regarding safe birth and the mode of birth need to be explored and addressed early in their ANC.

Guideline Recommendations	Source
Women should not be offered or advised to have clinical interventions if labour is progressing normally and the woman and baby are well.	NICE [128]
Encourage the women to adopt whatever position she finds comfortable throughout labour.	NICE [128]
Pregnant women should be offered evidence based information and support to enable them to make informed choices about mode of birth. Addressing women's views and concerns should be integral to the decision-making process.	NICE [129]
CS is not necessary to prevent mother-child transmission of HIV for women on highly active anti-retroviral therapy with a viral load <400 copies/ml or on any anti-retroviral therapy with a viral load <50 copies/ml.	NICE [129]
Quality Standard Recommendations	
Provide information on medical interventions in a culturally and language appropriate way.	
HCPs should explore women's attitudes and be aware that these may be influenced by religious or cultural factors or traditions. Women should be given sufficient information for informed decision-making.	
Women should be given the opportunity to create a birth plan prior to labour. HCPs should ensure that women are involved and retain control in all decision-making during labour.	

4.2.2 Maternal Morbidity

MAR women do not exhibit higher rates of severe morbidity; however, disparities in severe maternal morbidity have been identified for refugee women [25]. There is evidence of a higher risk of severe maternal mortality among women originating from Sub-Saharan Africa and the Caribbean [6,55].

Female genital mutilation also doubles the risk of maternal deaths during child birth owing to difficulty during labour [108], and could cause one to two extra perinatal deaths per 100 deliveries to African women [104], with the lifetime risk of maternal death ranging from one in 35 in Ghana to one in 12 in Burkina Faso [130].

Similarly, immigrant women from sub-Saharan Africa are consistently found to be at higher risk of severe maternal morbidity with the most common diagnosis being eclampsia, followed by uterine rupture [25]. Moreover, women may die from uterine rupture with subsequent pregnancies following a CS, as there may be no access to appropriate obstetric care [124].

Guideline Recommendations	Source
During labour blood pressure should be monitored hourly in women with mild to moderate hypertension and continually in women with severe hypertension.	NICE [131]
Risk factors for postpartum hemorrhage include maternal Hb< 85g/litre, parity of 4 or more, BMI> 35kg/m².	NICE [128]
Quality Standard Recommendations	
Midwives attending women during the intrapartum period should be alerted for increased risk of eclampsia and uterine rupture in some MAR women.	
Midwives should be aware that some MAR groups can fall into a high-risk category for postpartum haemorrhage.	

4.2.3 Birth Weight and prematurity

Conflicting data exists for the incidence of preterm birth among immigrant women. Some studies found no difference in preterm birth for immigrant mothers or uninsured refugee or undocumented women [25]. Some studies found that MAR women from Asia and sub-Saharan Africa as well as Haiti were at a greater risk of preterm birth [3]. Undocumented MARs and asylum seekers were also found to have an increased likelihood of preterm birth [25].

Recent immigrants have been found to be at a higher risk of having low birth weight (below the 10th percentile) infants [132]. This is especially true for immigrant women of East or South Asian descent; however, a number of researchers have discovered that when region-specific birth weight curves from the mothers' country of origin were used, this higher risk disappeared [25].

Guideline Recommendations	Source
Women in preterm labour or with preterm rupture of membranes should give birth in an obstetric unit.	NICE [128]
Give both oral and written information to women in preterm labour.	NICE [133]
HCPs must support families who experience pregnancy loss or stillbirth in a culturally sensitive way.	RCOG [134]
Babies< 2500g require special consideration around feeding, fluid balance and body temperature maintenance.	WHO [135]
Quality Standard Recommendations	
Midwives must be alert to potential poor birth outcomes regarding low birth weight and premature neonates or stillbirths.	
Midwifes and other HCPs should offer culturally and language appropriate information to women in PTD.	

4.2.4 Female Genital Mutilation

Type III FGM causes a mechanical barrier to delivery. Types I, II and IV can also produce severe vulval and vaginal scarring that may obstruct delivery. Types II and III are associated with greater risks of CS, postpartum hemorrhage, extended hospital stays, infant resuscitation, and stillbirth or early neonatal death [26].

De-infibulation is a vertical incision made along the anterior surface of the infibulated scar until the urethral meatus, and eventually the clitoris, are visible. The cut edges are then sutured, which allows the introitus to remain open. It may be performed during the antepartum period [136], at the onset of labor just before a vaginal delivery, or unrelated to pregnancy [137]. Removal of obstruction due to scar tissue should allow vaginal delivery with fewer short-and long-term risks of maternal and fetal complications from prolonged labor, obstructed labor, and perineal lacerations [137].

If the pregnant woman is sure to deliver at a health facility, de-infibulation can be done during delivery. This prevents the woman from undergoing two surgical procedures [109]. Another factor to consider is the timing of antenatal booking. Early antenatal booking would perhaps favor antenatal de-infibulation while late antenatal booking would foreclose the opportunity of having antenatal de-infibulation and so pregnant women would be restricted to intrapartum de-infibulation. It would also be important to evaluate women's preferences between antepartum and intrapartum de-infibulation [137].

Women with FGM issues report being provided with inadequate pain management, treated with cultural insensitivity (hurtful comments, apparent disgust, lack of privacy), feeling left out of decision making regarding their care and undergoing more medical interventions than they expected [25]. Therefore, the impact of FGM on labour and delivery should be sensitively discussed, and a plan of care agreed [138].

Guideline Recommendations	Source
Antenatal or intrapartum de-infibulation is recommended to facilitate childbirth in women living with type III FGM.	WHO [112]
Quality Standard Recommendations	
Midwives must be aware of FGM issue's and management during labor and birth.	
Midwives and other HCPs should provide care in a compassionate and nonjudgmental manner to infibulated women.	

4.2.5 Pain Management

MAR women felt their needs were not met, including attendance and sufficient pain relief during labor and birth [29]. It has previously been reported, for MAR mothers, to be less likely to use analgesia during labour than resettlement country-born women [139].

A meta-analysis of Somali women in six receiving countries showed that they were more likely to labour without any analgesia or epidural [139], while women from Middle and East African humanitarian source countries were less likely to use analgesia in labour than women from non-humanitarian source countries, perhaps reflecting cultural perceptions of childbirth or perhaps communication barriers with the greater need for interpreters. A smaller proportion of Sudanese women had induced labour and this may have contributed to the lower proportion of analgesia use in this group [140].

Guideline Recommendations	Source
HCPs should think about how their own values and beliefs inform their attitude to coping with pain in labour and ensure their care supports the woman's choice.	NICE [128]
If a woman is contemplating regional analgesia, talk with her about the risks and benefits and the implications for her labour.	NICE [128]
Quality Standard Recommendations	
Midwives and other HCPs must be competent to evaluate the need for pain medication during labor and birth, acknowledging that women’s expression of pain is culturally determined.	
Midwives and other HCPs should be aware of different cultural attitudes to epidural analgesia and the impact this may have on women's consideration of pain relief in labour.	

4.3 Postpartum Period

4.3.1 Maternal assessment

Studies in general indicate inadequate quality of care for MAR women during the perinatal period [139] and less assessment of maternal mental well-being after childbirth among MAR women [125].

There is evidence that communication difficulties emerged as the biggest issue in relation to ethnic minority women in the maternity services. Research shows that ethnic minority mothers, who have language difficulties, are given less information than other women, are unable to ask questions or have their worries explained [28].

Postpartum period's practices are also culturally determined. The provision of culturally appropriate social support is critical in the care of MAR childbearing women. There is evidence of sub-standard postpartum care for MAR women. As they frequently do not follow-up referrals, they could be at increased health risk. Inhibitors that prevent MAR women from following up care referrals included language 'barriers', absence of husband, lack of childcare, perceived inappropriate referrals, and cultural differences [141].

Guideline Recommendations	Source
Women should be advised of potential life-threatening conditions at the first postnatal contact.	NICE [142]
At each postnatal contact, women should be asked about common concerns e.g. perineal discomfort, dyspareunia, headache, fatigue, backache, constipation, haemorrhoids and incontinence.	NICE [142]
Methods of contraception should be discussed within the first week and customized and individualized contraception counseling provided.	NICE [142] RCOG [134]
Quality Standard Recommendations	
Midwives and other HCPs must be competent to make a postnatal risk and needs assessment of mothers. They must assess women's traditional customs and beliefs regarding the mother's care, maternal nutrition and bathing, to provide appropriate advice and support.	
Information on life threatening conditions should be provided in a culturally and language appropriate way.	
Midwives and other HCPs must assess women's religious/cultural norms and personal needs regarding contraception.	

4.3.2 Newborn assessment

Infant mortality rates are increased among MARs and especially asylum seekers [29]. Risk factors impacting upon infant mortality rates include late access to services, lack of advice about support services available and healthy lifestyles, and lack of funds impacting upon maternal diet and possibly intrauterine growth [143]. These mothers experienced problems that may exacerbate infant mortality like poor housing and overcrowded conditions. Lack of funds also meant women were unable to access health care, basic equipment needed to look after their babies, or to eat a healthy diet [29].

Despite ethnic disparities in health, which are usually associated with other health inequality determinants such as income, ethnicity tends to be positively associated with breastfeeding initiation [144]. However, moving from a culture of high breastfeeding to low breastfeeding is likely to have a negative effect on feeding practices rather than immigrant practices influencing local culture, which is reflected in decreased breastfeeding with increased acculturation [145].

Guideline Recommendations	Source
Parents should be offered information to enable them to assess their baby's general condition, identify signs and symptoms of common health problems in neonates and how to contact HCPs if required.	NICE [142]
Breastfeeding support should be available regardless of place of care.	NICE [142]
Women should be given information on the benefits of breastfeeding and colostrum and the timing of the first breastfeed in a culturally appropriate way.	NICE [142]
Quality Standard Recommendations	
Midwives and other HCPs must be competent to make a postnatal risk and needs assessment of newborns.	
Midwives and other HCPs should explore women's attitudes to infant feeding and neonatal care and be aware that these may be influenced by religious or cultural factors or traditions. Women should be given sufficient information for informed decision-making in a culturally and language appropriate way.	
Women should be provided with support for breastfeeding from a midwife or peer-supporter/peer support group.	

4.3.3 Maternal mental health

MAR women's incidence of postpartum depression is reported to be at least twice as high as the rate of non-immigrant women due to higher psychological stress, isolation and discrimination. Consequently, these women have been reported to exhibit lower rates of breastfeeding [25]. Clinical attention should be given to the dimensions that impact mental and emotional processes regarding motherhood. Socioeconomic and subjective individual experiences must be urgently integrated into medical care to re-establish social equity [146].

Access to maternal mental health services by MAR women and especially by asylum seeking and refugee women may be limited due to practical barriers and cultural factors. These practical barriers and cultural factors include language difficulties, not knowing where to seek help, pejorative attitudes towards mental health in MAR communities and medical tools which are not sensitive to detecting maternal mental health illnesses in some MAR women. Greater focus should be given to eliminate practical barriers and to better understand the mechanism by which cultural factors interfere with access to service provision [96].

Guideline Recommendations	Source
At each postnatal contact, women should be asked about their emotional wellbeing and what family and social support they have. Women should be encouraged to report any changes in mood or emotional state.	NICE [142]
Midwives and other HCPs must be able to distinguish women's normal changes after birth from significant mental health problems and refer for support.	RCOG [134]
Quality Standard Recommendations	
Sensitive medical tools should be used to detect maternal mental health illness in MAR women.	
Midwives and other HCPs should provide a personal plan, to meet the individual needs of MAR mothers.	

4.3.4 Gestational Diabetes

Among the problems caused by GDM, infants of GDM mothers who are born prematurely are more likely to develop respiratory distress syndrome and other problems of prematurity. Hyperinsulinemic babies are prone to hypoglycemia during the early neonatal period, when they are suddenly isolated from the maternal source of glucose and still have high concentrations of circulating insulin. Other problems encountered by such infants include hypocalcemia, hyperbilirubinemia, and plethora. Such problems may require close monitoring in the neonate intensive care unit (NICU) [147].

The initial postpartum management of women with GDM should focus on maternal-infant well-being. Encouragement and training for healthy nutrition, planned physical activity, and weight reduction as needed, continued cessation of smoking, facilitation of breastfeeding, and effective planning for the next or no more pregnancies are of high importance for all GDM mothers after delivery [148].

Guideline Recommendations	Source
All maternity units should have a written policy for the prevention, detection and management of hypoglycaemia in babies of women with diabetes.	NICE [64]
Test blood glucose in women diagnosed with GDM prior to discharge to community care and a further fasting glucose test at 6-13 weeks after the birth.	NICE [64]
Quality Standard Recommendations	
Midwives and other HCPs should provide culturally and language appropriate advice and clear information on the importance of breastfeeding and weight management for ethnic minorities with a high prevalence of diabetes.	

5 MULTIDISCIPLINARY TEAM WORKING

To respond to the increasing social and ethnic diversity within European countries, a multifaceted and multiagency approach to maternity care is needed [149]. Effective multidisciplinary team working enables continuity of philosophy of care which promotes quality woman-centred care, and involves collaboration between professionals built on mutual respect and trust, and incorporates flexible competency-based definitions of roles and responsibilities [150].

Relational continuity, flexibility, and adaptation to each woman's needs and coordination of the healthcare system are important actions on the part of midwives, GPs and other care providers. To ensure continuity and a trusting relationship, it is necessary to organize leadership and adopt flexible models that support women's health. The health of minority groups must constitute a part of health education [30].

5.1 Members of the multidisciplinary team

5.1.1 The Midwife

For the ORAMMA approach, midwives are essential care-providers and care coordinators for all women throughout pregnancy and the postnatal period. Working as part of the multidisciplinary team, midwives should be aware of non-clinical issues that affect pregnancy management and pregnancy outcome that relate to MAR status, as well as clinical factors that warrant referral to medical colleagues or social and support services [149].

Migrant and refugee women's maternity care is a multiagency issue. Midwives along with other HCPs must manage antenatal, perinatal and postnatal period considering all the factors that relate to women's health such as her origin, her culture and her specific individual needs. Health providers need not know about all cultural or religious practices, rather they should support pregnancy in diverse contexts through open communication strategies, refugee and migrant "friendly" approaches, respect for all women and evidence-based knowledge and practices. This may mean that midwives give "that bit extra" to MAR women in correspondence to their needs.

Midwives are the key care providers throughout pregnancy, intrapartum and post-partum. Working within a multidisciplinary team, midwives can undertake the role of lead professional for low risk pregnant women and the role of coordinator professional for high risk pregnant women [151,152]. A Cochrane review involving 12276 women who received **midwife-led care** in comparison to other models of care showed lower rates of intervention, similar clinical outcomes, higher level of maternal satisfaction and improved continuity of care throughout antenatal, intrapartum and postnatal period [152,153].

For quality maternity care provision for MAR women, midwives are recommended to:

a. Promote migrant and refuge pregnant women's access to care

To remove barriers and improve women's access to maternity care midwives should be aware of existing barriers to care. Barriers to utilization of services put women at greater risk of untreated diseases, late interventions, high rates of complications and poor outcomes. Midwives roles must be visible, clear and proximate to women's communities in order to promote women's access to care [154].

b. Provide quality communication and interaction

MAR women report poor connection with their care providers or receiving disrespectful or hostile treatment [155]. MAR's women expectations of care are less often fulfilled [23]. The quality of prenatal, perinatal and postnatal care seems to be affected by poor communication [22]. Quality communication and interaction helps MAR women to trust midwives, engage with care, and feel integrated. Midwives should ensure that women receive quality communication during care.

c. Provide evidence-based care practices within national standards and guidelines

To provide quality maternity care midwives should rely on evidence-based knowledge and practices within the national standards and guidelines regarding maternity care for MAR women. Midwives must provide women with evidence based and unbiased information in order to support women to make informed decisions [156].

d. Provide individualized and woman-centred care

Midwives must ensure that women receive quality care that meets their needs. To provide quality maternity care, midwives should focus on women's needs. Refugee and migrant women mention that they sometimes receive inadequate, time constrained care, unhelpful or threatening advice [155]. Eliciting woman's needs and expectations, midwives can form an individualized care plan that fits them and assures woman's satisfaction.

e. Following culturally appropriate practices

Midwives must reconsider their practices in the light of non-clinical, social factors by being aware of cultural diversity [155]. Women are not a homogenous group and each one has a different cultural, ethnic, religious, identity, family, and educational background and life experiences [154]. Midwives should be trained in culturally sensitive approaches and practices or be assisted by cultural mediators such as MPSs [23]. When midwives' practices are culturally appropriate to women's cultural background, women are more likely to consent to the care plan and be more satisfied with the pregnancy, delivery and parenting experience. Women who are treated in a culturally sensitive way feel welcomed, supported and feel their needs are met [157]. Midwives should acknowledge the need to be flexible in order to adapt to new challenges [152].

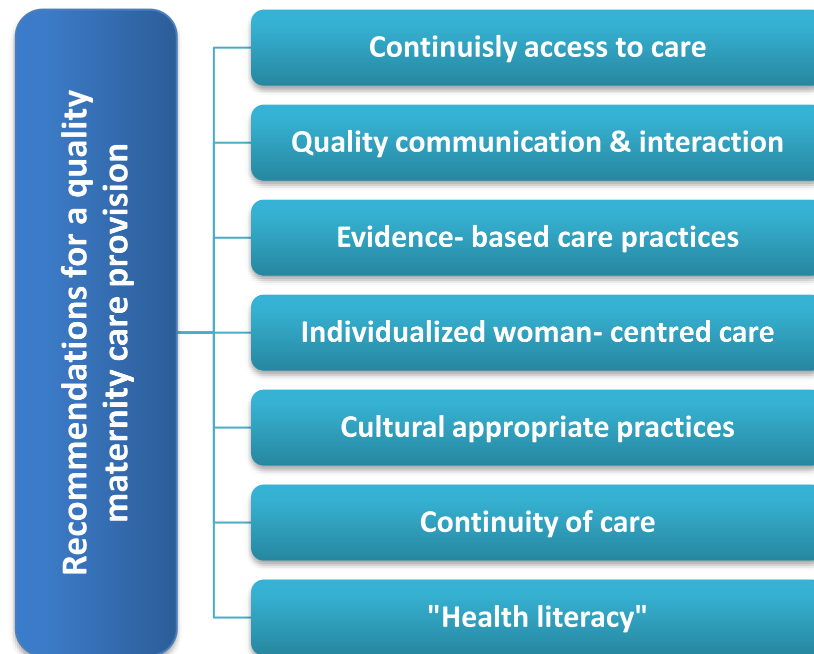
f. Promote continuity of care

Continuity of care promotes quality maternity care [155]. Women should receive most of their care from the same midwife [134,152,155]. Having the same or a known midwife during pregnancy, delivery and postnatal stages contributes to higher levels of satisfaction amongst

women; and midwives may have better management of the care plan [51,134,153,158].

g. Promote "health literacy"

Health cultural capital" or "health literacy" helps women advance their knowledge, perceptions, capacities and coping strategies on managing their own and their children's health, and maximize their opportunities for better health outcomes. Midwives must be able to support women to reduce inequalities which impede quality care provision [155].



5.1.1.1 Antenatal period

The role of the midwife in antenatal period can be divided into five basic steps:

Step 1: Needs and risks assessment

Midwives must assess the MAR women's needs [134]. During appointments for assessing the needs and risks of each woman, midwives should focus specifically on some key issues: attitude towards women, time provided, communication provided, detection of all potential risks and barriers, conditions related to MAR status or ethnic origin etc. These issues can affect pregnancy and birth and women's and children's wellbeing.

i. Attitude

In some cases, MAR women evaluate the midwife-based ANC as rushed and merely a physiological check rather than orientated to women's needs [23]. Midwives must welcome women with a caring and respectful attitude [152], establish a trusting relationship with women during the booking process and focus on quality interactions.

ii. Communication

MAR women are at higher risk of incorrect diagnoses due to communication difficulties compared to non- migrants [23]. The quality of prenatal, perinatal and postnatal care is affected by poor communication [22]. In some cases, Interpretation Services are used to meet the needs of HCPs (conveying information or obtaining informed consent), rather than being used routinely to develop a genuine dialogue with MAR pregnant women [22]. Midwives must ensure that quality communication is established between care providers and women. They must engage women in genuine dialogue to give them opportunities to express their cultural and religious or other needs. Midwives should approach women as individuals rather than speaking to husbands or relatives as some women may be in abusive or controlling relationship. Domestic violence and controlling relationships may prevent women from getting the help they need or impact on their and their unborn child's health. Midwives should not involve relatives or husbands for interpretation also because of confidentiality issues that may have a negative impact on women [29].

iii. Time

Additional appointment time should be allocated to women with complex issues when there are communication barriers [29]. Midwives must give enough time to interact with women in order to listen to and record woman's needs [159].

Step 2: Develop a care plan

According to need and risk assessments midwives should be competent to develop an individualized, realistic and woman-centred care plan. Consideration of barriers to realization of the plan is essential.

Midwives must ensure that the care plan provided is culturally appropriated and meets women's needs. Culturally appropriate services motivate women's utilization of maternity care [29,31]. Midwives must ensure that the care plan enhances the women's capacities [134]. The care plan should enable women to be active participants in their own care, to be in control of their own body and to enhance resilience and woman's capacity to manage her pregnancy and giving birth through a holistic approach [153,155]. Midwives must open a genuine dialogue with the woman and give her motivation to follow the plan. Midwives should emphasise the benefits of adequate prenatal care utilization through community organisations, and appropriate websites and leaflets [160]. Quality communication, educational interventions, promotion campaigns, antenatal classes all support "health literacy" and may support midwives to motivate and encourage women to follow their care plan [161]. Midwives must encourage women to maintain contact with the care system before and after birth. Midwives must ensure that the care plan is evaluated in three periods (pregnancy, intrapartum and postnatal) to ensure the care plan is up to date and appropriate.

Birth plans have been shown to inform and empower women and lead to higher satisfaction with their birth experiences [162]. As a component of childbirth preparation, a birth plan can improve patient-provider communication regarding a desired labor and birth experience and improve satisfaction with care [163,164]. Providing the pregnant woman with detailed and reliable information in suitable mediums can support informed choice. A formal birth plan developed prior to labor is useful in outlining the woman's expectations and helping her care providers do their best to meet them [164].

There is evidence that a majority of MAR women, mostly from Africa and Middle East countries, report not having had a birth plan and that many women didn't know what to expect and did not feel that their needs were met during birth. To have a positive birth experience it is important to have a birth plan, to know what to expect at birth, to be well informed during birth, and to meet women's needs [29].

Guideline Recommendations	Source
Structured maternity records should be used for ANC. Maternity services should have a system in place whereby women carry their own case notes.	NICE [44]
When giving information and options midwives should give women enough time between receiving information and making choices to reflect upon the information, and to seek additional information and advice.	RCOG [134] NICE [120]
When giving verbal information midwives should ask women to repeat information to ensure they understood correctly.	NICE [120]
Midwives should help support these women's uptake of ANC services, having first learned the most recent government policies on access and entitlement to care for recent migrants, asylum seekers and refugees.	NICE [120]
Midwives should use a variety of means to communicate with women, informing women about ANC services and how to use them and undertaking training in the specific needs of women in these groups.	NICE [120]
Design behaviour change interventions to include techniques that have been shown to be effective at changing behavior and include: • Goals and planning. Work with the client to: agree goals for pregnancy and the resulting outcomes, • Develop action plans and prioritise actions, • Develop coping plans to prevent and manage relapses, • Consider achievement of outcomes and further goals and plans.	NICE [165] NICE [166]
Quality Standard Recommendations	
According to needs and risk assessments midwives should be competent to develop an individualised, woman-centred and culturally appropriate care plan that meet the woman's needs.	
Midwives should take into consideration that some women will not follow the plan for various reasons. They must be aware of the potential barriers women face to access or attend care. Midwives must give women clear and unbiased information to motivate and support them in health-seeking behaviors and engage women in their own care.	
Midwives must ensure that the care plan is re-evaluated at intervals throughout pregnancy to ensure it is up to date and still meets the woman's needs.	

Step 3: Follow referral protocols

Midwives must provide the right balance between primary level care and access to appropriate levels of medical expertise as clinically required [31]. They must refer and collaborate with other agencies, services, specialists or HCPs in order to address women's needs [152]. The referral management systems must not be time- consuming and not to impede timely interventions. Referral protocols should be agreed between care providers for when and how acute pregnant women will be referred or transferred (Smith et al, 2010). Midwives must refer women in case of abuse, trauma, misuse of substances, domestic violence, trafficking or rape according to protocols and after obtaining women's consent [134,154]. Midwives must refer unaccompanied minors (e.g. pregnant adolescent girls) and must be able to distinguish women's normal changes after birth from significant mental health problems in order to refer them [134]. They must refer women and babies for a range of maternity and associated services minimizing the risk for women and families, facilitating the earliest possible intervention for those presenting with medical, obstetric or social complications [152].

Step 4: Ensure optimal utilization of maternity care services

In order to maximize the utilization of maternity care services midwives must be aware of MAR women's barriers (perceptions and beliefs about ANC, knowledge about the health services provided, communication issues etc. [154]. Quality maternity care services have no impact if the women do not use them.

Midwives at the first contact must provide women with informative material e.g. a simple leaflet explaining to women what to expect at different stages of pregnancy and an information booklet about available maternity care services. [29]**.** Midwives must inform women about the national health system, the maternity entitlements and the services provided [29]**.** They must also support women to navigate within the health system [167]. Midwives must encourage women to maintain contact with the care services. Raising women's awareness of health and social services [160,161], providing culturally appropriate care [29] and propagating the benefits of adequate prenatal care utilization through community, organizations, websites, leaflets are recommended to improve women's utilization of services [160]. Ensuring that MAR women know how to navigate in the health care system can reduce delays in health care seeking and appropriate treatment [23].

Step 5: Promote "health literacy"

Midwives must ensure that refugee and migrant women develop a healthy lifestyle during pregnancy and postpartum period [134].

Health literacy is a key to fighting inequalities. Health literacy refers to the skills and the ability of people to obtain, understand and use information to make optimal informed decision regarding treatments, instructions and the management of their health. While delivering education interventions midwives must be aware of cultural diversity and context and shape the intervention to meet different women's needs. Midwives must use verbal strategies as well as cultural and age appropriate illustrations to communicate with women

[168]. They must timely offer information about: how the baby develops during pregnancy, nutrition and diet, supplements, exercise and work, antenatal screening, risks and benefits of the screening tests, the pregnancy care pathway, planning place of birth, breastfeeding, workshops, antenatal classes, and maternity benefits [134]. Midwives can train community supporters such mothers, to help or support women in the community during antenatal, perinatal and postnatal period [154]. Midwives must develop innovative and easy to use material promoting women's health literacy.

5.1.1.2 Intrapartum period

During the intrapartum period, MAR women have expressed difficulties with: communication and integration of their cultural beliefs with recommended health care practices, lack of support from healthcare providers and lack of understanding of the informed consent process for procedures during delivery [25]. Midwives must ensure optimal communication with the woman during labor and delivery. Midwives must ensure that all women have the chance to communicate their needs and be treated in a respectful and caring way. Midwives must ensure the promotion of normality by enhancing the physiological capacity of most women to give birth through a holistic approach [152]. Midwives must ensure that all women receive the appropriate information about the process of labor and delivery and support during the process. Midwives must reconsider their practices during labor and delivery, in the light of social factors, [155] ensuring that maternity services and care are provided in a culturally appropriate and responsive manner according to the individual needs of each woman [31].

5.1.1.3 Postnatal period

MAR women are found to have poorer postnatal outcomes including higher rates of postpartum depression and consequently lower rates of breastfeeding. Isolation and discrimination increase experiences of psychological stress. MAR women also experience complex gender related problems. Gender based expectations within their family, community norms, new gender roles and conflicts may impede women's ability to attend healthcare services or follow ups [25]. Midwives must ensure the wellbeing of mother and children. They must be able to directly refer women and babies for additional services in order to minimize potential risks by facilitating timely interventions [152]. Midwives must be able to distinguish between women's normal changes after birth from significant mental health problems and refer for support [134]. They must support optimal infant feeding and provide contraception counseling within 2 weeks of birth, considering women's cultural and religious needs [134]. They must also ask women about the gender and cultural norms regarding reproductive health issues [169].

5.1.1.4 The role of midwife in a multidisciplinary team

Midwives must be competent to plan and provide the majority of the woman's ANC with support from the interdisciplinary team as required and continue providing care postnatal care in the community [152].

Midwives can take the role of lead professional for low risk pregnant women throughout pregnancy, labor and the postnatal period [151,152] and the role of coordinator of care for complex pregnancies. This model is applied within a multidisciplinary network in which consultation and referral to other care providers occurs when necessary [51]. In high risk pregnancies the lead professional is the obstetrician throughout the woman's pregnancy, coordination and continuity of care is provided by midwives and a range of other professionals. The coordinator role ensures that the women are referred to care services and receive appropriate, quality and holistic care. Both the role of lead professional and coordinator of care require a multiagency approach and must be distinct and developed in a way that promotes normality, safety and continuity of care [152].

Collaboration with other agencies, services or specialists is important, in order to meet each woman's needs following the referral protocols [152]. They must establish optimal communication with GPs or obstetricians, and agree protocols for when and how MAR women will be referred or transferred. If a woman's condition gives rise to concern, midwives must refer to a GP or obstetrician (by phone, fax or email etc.) [170]. They should also ensure that there is optimal collaboration and quality inter-professional communication between care providers (GPs, maternity peer supporters, interpreters, SCPs, obstetrics etc.). Quality collaboration can promote a positive experience and a safe outcome, provide all women with an appropriate individualized care plan and reduces the possibilities of receiving conflicting advice [134,152].

The core responsibilities of midwives and other HCPs must be defined for optimal coordination of care [134]. A midwife's potential can be maximized through a well-designed coordinated interdisciplinary approach that ensures the right balance between primary level care and access to appropriate levels of medical expertise as clinically required [31]. They also have to ensure that the interdisciplinary team they work with have quality collaboration principles such as [168]:

- team focus,
- clarity of responsibilities,
- acceptable case load for each one,
- aim to maximize continuity of care,
- frequent communication,
- good documentation,
- evidence-based practices,
- high efficiency and excellence in education.

Midwives must cooperate with other professionals to promote health literacy and undertake education interventions by meeting with other care providers on a regular basis to review women's histories and develop and elaborate the care plan to ensure optimal co-ordination [170]. Cooperation with interpreters at all appointments and stages of maternity care is also crucial for ensuring quality communication with women [152]. Finally, the development of a personal care plan for each woman, in collaboration with the other members of the maternity team, will ensure the optimal coordination of care [170].

Such practices fight against health inequalities and promote refugee and migrant women's and infants' health.

5.1.2 The Social Care Provider

5.1.2.1 Social support

Provision of appropriate social support and care during the antenatal and postnatal period, particularly for recent female migrants and refugees, is paramount to achieve a healthy pregnancy and birth outcome. Pregnant women who are recent migrants, asylum seekers or refugees are considered to have complex social factors [120].

The main goals of social care for refugees and other migrant groups are:

a. Promotion of their economic self-sufficiency and quality of life,
b. Promotion of adjustment, orientation to the new community and self-determination,
c. Facilitation the recovery from traumas and distress.

The International Federation of Social Workers [171] emphasizes that the ideal long-term goal for refugees should be durable solutions to their problems; the achievement of self-sufficiency, economic independence, spiritual and intellectual fulfillment.

The scope of social care with refugees and asylum seekers includes [172]:

- Strengths-based comprehensive psychosocial assessments.
- Strengths-based community assessments.
- Building empathic relationships and working with refugees and asylum seekers in an ethical, respectful, client-centred and strengths-focused manner.
- Working with groups, organisations and communities to respond to shared goals; linking individuals and families to community networks.
- Facilitating coordination and cooperation across health, welfare and other systems to ensure good outcomes and assist client aspirations.
- Advocacy for services and education within the national welfare and health systems.
- Socio-legal and ethical decision making within complex legal frameworks.
- Advocacy in relation to the rights of refugees and asylum seekers.
- Specialist culturally sensitive counselling with regard to loss and grief.
- Torture and trauma, and in suicide prevention.
- Educating other service providers and professionals about the cultural, ethnic, and faith-based gender issues specific to the individual or group.

Social care seeks to ensure that refugees and asylum seekers are afforded the highest level of protection possible under the law of the host country. Social care providers (SCPs) are particularly alert to those with little support, such as unaccompanied minors. Ongoing assistance involves a combination of practical assistance within a culturally responsive and inclusive practice framework that acknowledges the impact of previous trauma. It also acknowledges the importance of family and seeks to utilise the strengths of individuals, families and communities and the supportive networks that already exist [172].

Social care for recent MARs can be provided through various settings and care providers. In the UK, there are over 200 non-governmental organisations (NGOs), listed in the Refugee Council-published directory in the UK (Refugee Council, UK, www.refugeecouncil.org.uk/), providing counselling to address distress as a result of torture and trauma, education, advocacy with employment, health and social care, housing and emergency aid [173]. There are also mental health care services provided by local Community Mental Health Teams (CMHT's), which aim to offer an integrated, joined-up approach to health care in which social and practical problems are considered in relation to mental and physical ones [174]. In Greece, social care is offered by community social services and a variety of NGOs, which are staffed primarily by social workers and they engage with matters more directly concerned with practical problems and integration (housing, training and employment). In the Netherlands, social work is embedded in primary care as well as local welfare, working together in social neighbourhood teams. In many cities these teams are trained in migrant care, or collaborate with special support organisations for refugees and other migrants. To improve the healthy integration of newly settled refugees into Dutch society, the Dutch government has emphasized the need for participation in society by encouraging language classes, finding appropriate housing, education and jobs for refugees. Pharos, the Dutch centre of expertise on health disparities, and the organization of Dutch local cities Platform 31 support local government and healthcare and social work / welfare professionals in adjusting their services to the needs of MARs. Although access to social work is for free and accessible without referral, MARs usually are referred to social work by their GP, youth health organization, or other HCP like midwives, or by school or local welfare organization. In the Netherlands, social workers provide little mental health support; this is mainly a task for the POH-GGZ – a mental HCP working in a General Practice, or for mental healthcare services, some of those specifically targeting MARs. Although all health professionals are expected to be aware and support women with complex social factors, the role description among different disciplines offering social care, may vary significantly among different countries. In countries such as the UK, social workers are assigned to child protection services and other social care responsibilities are allocated to social support workers. In Greece, social workers are the key professionals in charge of social care for vulnerable groups including refugees and asylum seekers, and may offer services within a variety of health, mental health and social care settings[1].

Regarding the antenatal and postnatal care of MAR women, social care should consider the following aspects which are emphasized throughout the literature:

- Assessment, recording and management of individual practical needs of daily living with particular emphasis on factors which may impact on the outcome of the pregnancy (e.g. family development, migration experience, disability, stressful life events, social network, housing, language acquisition, job training and placement, financial situation).
- Assessment, recording and management of high risk cases of women, babies and other family members presenting psychosocial situations, which may impact on the outcome of

[1] Due to this difference between countries, instead of "social worker", the term "social care provider" will be used for the needs of ORAMMA.

the pregnancy, whether in the community or a clinical unit (e.g. domestic violence, child abuse, mental health problems and substance abuse).

- Administration/counselling in early pregnancy to facilitate access to culturally and linguistically appropriate information for women and family members (e.g. maternity benefits/entitlements, childcare opportunities, employment rights/benefits).
- Mental health promotion in the migrant community i.e. competence in managing practical matters of daily living and positive adaptation matters including interpersonal relationships, childcare issues, informal social support.
- Capacity building through community education and community organizing (i.e. empowering indigenous leadership and community organization in consistency with social work's ethical value of self-determination).

5.1.2.2 Illegality, job insecurity and lack of formal/informal support

Unemployment is common among newly arrived refugees, and those who do attain employment are often employed in low paying jobs or casual employment [175]. MAR women are more likely to accept employment in hazardous occupations and also less inclined to take time off work to access healthcare for the fear of income loss or threat of dismissal [176]. When their citizenship is illegal, they do not have any employment rights, and therefore have no maternity leave, no possibility of reduced working hours, or even permission to leave work to breastfeed [177,178]. In these cases, they mostly have an illegal employment status with fear of losing their job and being dependent on the goodwill of their employers to take a few days off to access healthcare (with the possibility of not being paid for their time off). Illegality is associated with a variety of risks including political, economic and psychosocial complications which leave unauthorized MARs and their families vulnerable to health adversity [179-183].

Other obstacles preventing women from accessing adequate healthcare may include a lack of institutional support and the shortage of places in public nurseries and in some countries a lack of access to infant schools [184].

5.1.2.3 Poor socioeconomic status

Socioeconomic factors have been shown to explain the 33% of inadequate prenatal care utilization of MAR women, while sociocultural factors explain 43% [160]. Those who are refused asylum are often entirely dependent on the charity of friends or support organisations before they are granted formal support, and often experience real poverty during their pregnancy. Stress resulting from living in poverty can impact on physical and psychological health and also increase a woman's risk of experiencing domestic abuse [185,186]. Often pregnancy is recognized as a criterion for formal support at a late period of gestation and many women find themselves totally destitute for several weeks or months during pregnancy, even if they have complex social and health problems which could affect their pregnancy. The realities of socio-economic disadvantage (low income, financial pressure, low education levels) mean that women do not prioritise their health and are less likely to

use preventive and curative sexual and reproductive health services than women from wealthier households [178]. Less educated women are more likely to have poor maternal health literacy than more-educated women[51]. Women with compromised socio-economic status are also particularly at risk of perinatal mental health disorders [187].

5.1.2.4 Conflicting cultural beliefs and female roles

The conflicting cultural practices of childrearing also act as a deterrent from utilizing childcare services because families may fear that their culture and language will be lost. As a result, immigrant and refugee women may engage in shift work so they can work around their child care needs, or decide to stay at home until the child is of school age, resulting in economic hardship for the family. For the asylum-seeking woman living with her family, it is important to consider her role within the family unit. Some MAR women appear to define health in the context of their family. Ill health may be considered the inability to undertake normal family roles rather than considering the individual's symptoms [188]. Gender based expectations within their family, community norms, new gender roles and conflicts may also impede women's ability to attend healthcare services or follow ups [25].

Guideline Recommendations	Source
Commissioners should monitor emergent local needs and plan and adjust services accordingly.	NICE [120]
Practical services, before settlement or resettlement, should include: • housing provision, based on a policy which allows for reasonable proximity to people of the same ethnic group to maintain cultural identity, • language training, • career counselling, • vocational training, • social and recreational facilities to reduce any sense of social isolation, • facilitation of self-help groups, • health care, • income maintenance, • provision for unaccompanied minors, based on child care policy which recognises the importance of maintaining culture as an important aspect of self-identity, • use of para-professionals drawn from the same ethnic group, including from the refugee population, • interpreter services, • specific mental health programmes, • counselling services, • provision for relatives who join refugees under Family Reunion policies, • public education programmes.	IFSW [171]

Quality Standard Recommendations
Access to multidisciplinary and multi-agency support team ((MAST) e.g. social support workers) should be provided for vulnerable women (e.g. new MAR women with complex factors).
Building a friendly, respectful, nonjudgmental and trusting relationship between all care providers and women is essential. SCPs, in particular, should ensure such relationships are in place. Confidentiality should be broken only in case of a child protection concern. Skills of active listening are very important to achieve this goal.
The impact of life stressors on women's well-being (e.g. reasons for leaving home country, family members left behind or gone missing), should be assessed. Depending on the local health care infrastructures, this may be assessed by midwives, health visitors and social support workers (e.g. UK) or by SCPs (e.g. Greece).
All care providers including SCPs should be aware of religious and other socially determined taboos and how these may shape the consultation or contribute to the reluctance a refugee might have of disclosing sensitive personal information.
All careers including SCPs should be vigilant about women's emotional well-being, what family and social support they have and their coping strategies for dealing with day-to-day matters.
All carers including social support providers should support women in their roles as new mothers, empower them and celebrate small wins, offer them choice and control over how they will use the support. They should make new mothers feel safe and supported.
SCPs should facilitate women's in-group community bonding; associate them with community leaders and members of their specific ethnic group. They should also arrange availability and access to religious and spiritual advisors upon women's request.
Appropriate referral to services/agencies which are specialized in serving women's needs in the community particularly on psychological and psychiatric issues should be provided; this may be facilitated by midwives' health visitors or SCPs.
Attention should be given to the residency and labor status of the women and ensure access to linguistically and culturally appropriate information regarding the procedures involved in gaining legal citizenship and labour permits as well as access to brief education regarding labor rights and entitlements are provided. This is within the remit of all care providers' roles and responsibilities including SCPs.
SCPs should offer information and facilitate access to available childcare programs for refugee/migrant mothers to reconcile motherhood and employment.
SCPs should organize awareness raising interventions in collaboration with other primary care professionals to improve refugee and other migrant women's maternal health literacy and therefore increase the ability of disadvantaged women to access, understand and use educational materials.
SCPs should inform women about the organizational structure of the national health and welfare system of the host country as well as about their health and welfare entitlements that apply to their residency status and their individual needs. They should also inform women how to navigate within the health system and how to apply for social welfare payments and other legal entitlements.

5.1.3 The General Practitioner and other medical doctors/ obstetricians

Along with midwives, GPs are the primary care providers who focus on the physiology of pregnancy and childbirth and they are the professionals of first choice to provide maternity care for women at low risk of complications [189].

The role of the GPs during perinatal period mainly concerns health promotion and includes the following actions [190]:

- Offering accurate and engaging information.
- Directing to credible resources and support services.
- Addressing disease prevention by targeting modifiable lifestyle risks.
- Managing chronic health concerns in the optimisation of pregnancy care.
- Offering the opportunity to develop important skills to cope with challenges women may face across the perinatal period and into early parenting.

GPs have an important role in maternity care, and those who wish to provide the care must maintain competence. In all other circumstances collaboration and communication between all members of the maternity team is crucial in delivering woman-centred care [191]. As a consequence, GPs should:

- Provide pre-conception care, especially for women with complex medical or social needs in collaboration with other specialists.
- Provide counselling and health promotion in early pregnancy. This would include competence in management and appropriate referral for conditions such as bleeding and hyperemesis, obesity and smoking cessation management.
- Provide information about screening in pregnancy and initiate or refer promptly for the tests.
- Provide an early pregnancy consultation to check the woman's general health, including a review of medical history from the medical records and an examination of the heart. The GP should then formally communicate, with the woman and members of the maternity team, any issues of medical, psychiatric or social significance for the pregnancy.
- Signpost childbearing women with emergency conditions directly to hospital. For less urgent conditions face to face assessment by the GP may be appropriate. GPs need to be competent to recognise, manage and refer conditions such as pre-eclampsia, sepsis, headache and breathlessness in pregnancy.
- Provide postnatal care including contraception advice and a postnatal examination.
- Provide follow up care for GDM, PRH, anaemia, sepsis, mental health or conditions which may have complicated pregnancy.

In terms of GP responsibilities, the most notable of these standards is pre-pregnancy care for women with existing medical conditions or significant family or obstetric history. The standard suggests that GPs should provide pre-pregnancy counselling and support for women of childbearing age with existing serious medical or mental health conditions that

may be aggravated by pregnancy (specifically epilepsy, GDM, congenital or known acquired cardiac disease, autoimmune disorders, obesity or a history of severe mental illness) [170].

5.1.3.1 The role of the GP in antenatal period

GPs can play an important role in ANC, by ensuring that all relevant information about a woman's medical history is shared with others, subject to the woman's consent, and by providing continuity of care – especially in the management of any ongoing medical conditions [170,192].

The first visit presents an ideal time for the GP to refer for any gestation-critical early antenatal testing. For instance, thalassaemia screening needs to be carried out by 8-to-10 weeks' gestation. If the woman is not booked with a midwife until 10–12 weeks, this time period is likely to be missed [170].

5.1.3.2 The role of the GP in postnatal period

Postnatally, GPs could play a role in advising about physical issues such as incontinence or back pain, assessing mental health and contraception. Generally, it is a GP who performs the six-week postnatal check, and this would be an opportunity to discuss a variety of issues, including contraception, back pain, incontinence, dyspareunia, mental health and preparation for any subsequent pregnancies [170].

Guideline Recommendations	Source
Midwife and GP led models of care should be offered to women with an uncomplicated pregnancy. Routine involvement of obstetricians in the care of women with an uncomplicated pregnancy at scheduled times does not appear to improve perinatal outcomes compared with involving obstetricians when complications arise.	NICE [44]
Quality Standard Recommendations	
GPs should ensure they undertake a careful risk assessment during telephone consultations with, or concerning, women who are or who may be pregnant. If they are in any doubt they should see the woman or arrange an appropriate referral for her. In case of MARs women, the mediation of an interpreter is considered necessary.	
Whenever possible, the GP should give the woman's named midwife confidential access to her full written and electronic records and should ensure that any significant letters are copied into the woman's hand-held personal maternity plan.	
A GP should make fast-track referrals directly to appropriate physicians if a woman has a serious medical condition and should not rely only on conventional referral pathways to an obstetrician or midwife, as this introduces delays that may compromise the woman's health.	

GPs should take detailed histories from pregnant women about any previous psychiatric illness and its severity, should enquire directly about substance misuse or addiction, and should check their previous records if there is any doubt. They should communicate details of their patient's previous psychiatric history, including that of alcohol and drug misuse, not only with obstetricians but also with midwives – preferably with the woman's consent. In any case, they should consider the cultural background of the women.
A GP should refer a pregnant woman with a significant mental health history to a psychiatric service – preferably a specialist perinatal service – during pregnancy, so that a management plan can be developed.
GPs should not work beyond their level of expertise in managing drug-using women. They should refer or seek advice from specialists in drug misuse. Women who misuse drugs and alcohol should be managed by multidisciplinary teams comprising GPs, specialists in substance misuse (who may be GPs), specialist obstetricians and midwives, health visitors and social care providers. Each woman must have a lead professional, and a lead agency, to take responsibility for the overall management and co-ordination of her care, in a culturally appropriate way.
GPs should record the BMI of pregnant women and those contemplating pregnancy, and should counsel obese women before and during pregnancy regarding weight loss or healthy eating. Women with obesity are not suitable for GP midwifery-led care, because their pregnancies are higher risk. These women should be referred for specialist care because of possible co-morbidity.
Close multidisciplinary and multi-agency support must continue to be provided for women who have had their baby removed into care by social services. This reflects the risk that removal of a child by social services is a high risk for suicide in women.

Obstetricians role is to focus on the pathology of pregnancy and childbirth, and to the special care for women with obstetrical risks or complications that may lead to adverse outcomes for them or their baby [189].

5.2 Training needs

There is evidence that HCPs want to give appropriate information and advice to women but sometimes they don't feel suitably trained to do so [51].

HCPs should be given training on the specific health needs of women who are recent migrants, asylum seekers or refugees; the specific social, cultural and psychological needs of women in these groups, the most recent government policies on access and entitlement to care for them [120]. It is important that the training of perinatal HCPs encourages the development of cultural sensitivity and competence. It is important that all HCPs involved in caring for MAR pregnant women, to ensure that they identify their own training needs and be accountable for keeping their training up to date.

Guideline Recommendations	Source
There should be effective partnership working across communities, including local authorities and the voluntary sector, providing pathways of care with access to social care agencies.	RCOG [193]
There should be formal communication and referral pathways for midwives and obstetricians with GPs, Health Visitors, laboratory services, emergency services, acute and primary care services and other health and social care networks.	RCOG [193]
A system of clear referral pathways should be established so that women who require additional care because of pre-existing medical conditions or because of complications during their pregnancy are cared for and treated by the appropriate multidisciplinary or specialist teams, including anaesthetic assessment when problems are identified.	RCOG [193]
Quality Standard Recommendations	
The lead professional should be clearly documented and kept up to date throughout the pregnancy, birth and postnatal period.	
Women with additional medical needs/risk factors should be referred to an obstetrician or other appropriate consultant.	
Assessment of social needs should determine the pattern of referral and the intensity of care needed, by other disciplinary team members, such as midwives, SCPs, MPSs, GPs and other medical team members.	
There should be systematic pathways of communication between members of the multidisciplinary team.	
Professionals engaged in caring for MS women, require adequate training that encompasses awareness of their health and social needs and the provision of culturally competent woman-centred care.	

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Operational Refugee And Migrant Maternal Approach

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Operational Refugee And Migrant Maternal Approach

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Appendix 1

Systematic reviews

a. Migrant women's experiences of perinatal care

Review question

What are migrant women's experiences of pregnancy, childbirth and maternity care in their destination country within Europe?

Brief overview of method

A systematic search of 5 databases was undertaken to identify qualitative, quantitative and mixed methods studies published since 2007 and related to migrant women's experiences of pregnancy and maternity care in their destination country. The following databases were searched between 24th April and 22nd May 2017; CINAHL, MEDLINE, PUBMED, PSYCHINFO and SCOPUS. Search terms were identified around the themes of "migrant", "maternity" and "experiences", and combined using Boolean operators. (See table below).

Migrant	Maternity	Experiences
migrant	Pregnancy	experience
refugee	Pregnant	belief
immigrant	Maternity	believe
asylum	Maternal	attitude
trafficked	Midwifery	view
	Birth	perspective
	Perinatal	story
	Intrapartum	stories
	Antenatal	narrative*
	prenatal	account
	postnatal	accessib*
	Childbearing	availab*
	motherhood	acceptab*
		quality
		help seeking
		help-seeking
		access
		need

Electronic search results were initially screened by title and abstract and then full text versions against the inclusion and exclusion criteria by 2 researchers and any uncertainties over inclusion were discussed with team members. A total of 48 studies were eligible for inclusion, study characteristics of all included studies were extracted and managed in Microsoft Excel and all included studies were quality appraised using the NICE critique tool. Data were analysed using a thematic synthesis approach and the CERQual approach was adopted to determine confidence in the findings.

Brief overview of findings

The following were identified as areas of need or importance to childbearing migrant women;

Access
• Entitlement to maternity healthcare • Awareness of the importance of maternity healthcare • Discrimination • Women's expectations of care • Flexibility of care provision • Barriers to accessing care including transport or financial difficulties, language barriers and fear of being reported to the police • Maternity care provision at detention centres

Communication
• Communication issues and ability in reading and speaking in the local language • Provision of interpreting services • Misunderstanding non-verbal communication • The use overly medicalised vocabulary or jargon by health professionals • Listening skills of professionals • Professionals failing to ensure that explanations are understood and sufficient

Information needs
• Information needs including nutrition and diet, exercise, labour, available resources, coping after the birth and care of the infant • Access to information in various forms; verbal, written and electronic

Psychosocial & economic factors
• Financial concerns or problems • Housing concerns or problems • Issues surrounding dispersal • Concerns surrounding their legal rights or entitlements • Mental health and the impact of previous trauma on the perinatal period • Need for support or advocacy services as required

Quality of care
• Cleanliness of facilities • Privacy • Desire for continuity of care • Respect and non-discriminatory care • Care by professionals who demonstrate positive professional behaviours, cultural competence, and should identify, acknowledge and accommodate as appropriate traditional or cultural practices that are relevant to the perinatal period • Experiences of poor care

Specific conditions and issues
• Medical interventions and screening programmes - Women's attitudes may be influenced by religious or cultural factors or traditions. Women need sufficient information for informed decision-making. • Breastfeeding - women's attitudes may be influenced by religious or cultural factors or traditions. Women need sufficient information for informed decision-making, and support with breastfeeding from a HCP or peer-supporter/peer support group. • Domestic violence (DV) - attitudes to DV may be influenced by cultural factors or traditions. Women need information about the health and social consequences of DV. • Female Genital Mutilation (FGM) - some women have undergone FGM and may have ongoing complications, and this may affect their attitudes to being pregnant and to de-infibulation. • Gestational Diabetes Mellitus (GDM) - women have unmet information needs, particularly in regard to diet modification and ongoing risk of diabetes post-pregnancy. • HIV - women need information about the impact of HIV on breastfeeding • Illness in the perinatal period - women need to be informed of the warning signs of serious illness during the perinatal period and how to access emergency care. • Labour - women need an opportunity to create a birth plan prior to labour and HCP who ensure they are involved and retain control in all decision-making during labour.

b. Healthcare professionals' experiences

Review questions

What are the barriers and facilitators for care provision to migrants/refugee women during perinatal period?

Brief overview of method

A systematic search of 2 databases was undertaken to identify qualitative, quantitative and mixed methods studies published since 2007 and related to health professionals' experiences of care provision to migrants/refugee women during perinatal period. The following databases were searched PUBMED and SCOPUS. Search terms were identified around the themes of "health professionals", "maternity" and "experiences", and combined algorithms.
In particular, a step-wised search strategy -including six individual steps- was used to ensure that all information relevant to the topic of interest would be captured in the final portfolio. At the first step, all documents identified through the initial electronic search, went through an initial screening in titles and abstracts by two individual researchers. Discrepancies in judgements on eligibility were solved by discussion in the review team. At the second step, those documents that were retained after the initial screening in titles and abstracts, went through an additional screening in their full text by two individual researchers, following the same procedures. At the third step, references of the selected documents were reviewed. At the fourth step, the documents that fulfilled the eligibility criteria were reviewed and certain information was extracted and put into a data extraction form (Template A) including the following items: a) generic bibliographic information (author, date of publication), b) study characteristics (location, research method), c) study objectives (and research questions), d) population and context characteristics, e) most relevant findings (e.g. main outcomes in quantitative studies, f) major themes/minor themes in qualitative studies), g) results of the critical appraisal (Template B). At the firth step, a meta-synthesis of evidence was carried out through which, findings of the retrieved studies were synthesized and organized into themes and sub- themes. Finally, drawn from the findings presented, the authors proceed to key recommendations for migrants' perinatal care which were organised into themes and classified as follows: Level A (High Quality of Evidence), Level B (Moderate Quality of Evidence), Level C (Low Quality of Evidence), Level D (Very Low Quality of Evidence).

Search strategy

Inclusion Criteria

i. Type of Population: health care providers/professionals (including midwives, general practitioners, general practitioners or volunteers, informal carers, cultural doulas, etc), serving female migrants/immigrants or refugees or asylum seekers.
ii. Types of Studies: Qualitative and quantitative studies and mixed-method studies.
iii. Types of documents: Original articles
iv. Outcome measure: All aspects of health care provision (accessibility, availability, and quality of healthcare) Geographical area: Studies conducted in Europe Date of publication: 2007 - today (last 10 years) Languages: No restriction

Exclusion Criteria

i. Type of Population: non-clear reference to migrant status/asylum seeker status/refugee status
ii. Types of documents: reviews, commentaries, editorials, notes, policy analysis, evaluation reports, books, conference proceedings, study protocols, descriptive studies.
iii. Outcome measure: Studies assessing social situation without clear link to health understood as physical, mental and social well-being.
iv. Geographical area: Studies conducted outside Europe

Sources/Databases

Pubmed/MEDLINE SCOPUS

Search algorithm

i. PUBMED search (((((migrant OR refugee OR immigrant OR asylum seeker)) AND (maternal OR perinatal OR prenatal OR postnatal OR antenatal OR pregnant)) AND (provider OR professional OR volunteer OR worker OR carer OR midwife OR practitioner))) AND Europe (Filters: Journal Article; published in the last 10 years).
ii. SCOPUS search (TITLE-ABS-KEY (maternal OR perinatal OR postnatal OR prenatal OR antenatal OR pregnant) AND TITLE-ABS-KEY (migrant OR refugee OR immigrant OR asylum AND seeker) AND TITLE-ABS- KEY (provider OR professional OR volunteer OR worker OR carer OR midwife OR practitioner)) (Filters: published in the last 10 years).

Brief overview of findings - *A meta- synthesis of the studies' findings*

Five themes were emerged as the main barriers for optimal perinatal care offered to migrants/ refugees' pregnant women. These include: "Maternal socio- demographic characteristics", "Professionals' Cultural Competence", Professionals' Interpersonal and Communication Skills", "Maternity Services" and "Leadership- Policy". These themes were further organized into sub- themes as below:

1. "Maternal socio- demographic characteristics": Immigrants' low socio- economic status, precarious working conditions and language difficulties were listed among them and were related to lower standards of care or less choice.
2. "Professionals' Cultural Competence": This theme included lack of cultural awareness and lack of equity and diversity programs. Lack of understanding of cultural differences which includes lack of understanding and insight, differences in childbirth practices, and caring for women was also identified as a key barrier to effective care.
3. Professionals' Interpersonal and Communication Skills": Lack of active listening and self- awareness among healthcare professionals hinder medical providers from delivering optimal maternal healthcare.
4. "Maternity Services": Maternal lack of knowledge of maternity services use, NHS structure was found to impact on the time healthcare providers needed to dedicate to these women which resulted to extra workload for them. Furthermore, increased workload and associated time constraints strongly impacted the quality of care provision for migrants/ refugees. Finally, lack of culturally adopted medical interpreter services had a negative impact on the delivery of optimal maternal healthcare while the use of informal interpreters introduced issues of confidentiality and accuracy of the interpretation.
5. "Leadership- Policy": Findings revealed the need of governmental policy and law revision. In addition, the lack of community-based services, outreach programs and gateways services were found to contribute to the provision of low-quality service to pregnant women. Finally, effective leadership was stressed as an urgent need for the delivery of high standards care for migrants/ refugees.

Key recommendations derived from the body of evidence

Building Cultural Competence Recommendations
• Migrant pregnant women should not be typified based on their ethnicity but as individuals. • Since many of healthcare professionals' stereotypical beliefs are unconsciously activated, cultural competence programs designed for healthcare professionals are needed. • Specific training sessions delivered to healthcare professionals about how to deal and interact with patients from different cultural and religious backgrounds are recommended. • Cultural awareness and cultural competence should be part of health education curriculum. • Healthcare professionals' education should include programs regarding cultural issues, equity and diversity. • The cultural competence training should not be restricted to knowledge of facts about other cultures that can result in further objectification and stigmatization, but rather that the focus is on developing an understanding of diversity and recognition of the multiplicity of issues that contribute to our understanding of culture.

Improving Interpersonal and Communication Skills Recommendations
• Improved interpersonal and communication skills, active listening skills and self-awareness among professionals is necessary for promoting greater- focused care in maternity services. • Training should focus on developing sufficient self-awareness to allow for effective communication where providers are fully attentive to women's beliefs, fears, and goals, and are respectful of these. • Access to multiple methods of communication, such as use of posters, leaflets, drawings/diagrams, video clips, DVDs in a variety of languages, as well as access to interpreters as a mean of improving communication with migrant women is recommended. • Language barrier can be largely overcome by well-trained professional interpreters who should be available when needed.

Improving Maternity Services Recommendations
• The provision of culturally appropriate interpreter services all time in maternity services given that the use of family members or friends can compromise confidentiality or cover up circumstances is crucial. • Extra time allocation for appointments and services provided to ethnic minority pregnant women is needed. • Educational programs offered to migrant women related to services, structure, etc. should be delivered. • Doulas could act as facilitators for midwives and provide increased opportunities for transcultural care. • The employment of bilingual and bicultural staff, especially in obstetric services, is recommended for creating transcultural care.

Leadership- Policy Reform Recommendations
• Hospitals and communities should collaborate in capacity building and arrange regular joint courses on pregnancy and maternity care themes. • Managers must strive to establish high-quality relationships by means of leadership. One way of organizing care is by implementing supervision built on a relationship and aimed at achieving trust. Supervision and leadership also have an impact on the quality of maternal care. • Relational continuity, flexibility, adaptation to each woman’ s needs and coordination of the health-care system are important actions on the part of health-care managers. In order to ensure continuity and a trusting relationship, it is necessary to organize leadership and adopt flexible models that support women’ s health. These models should be responsive to women diverse support needs and based on equity and diversity. • Individualized outreach programs and gateway services tailored to increasing access to services, helping new migrants learn how to navigate health services, and providing training in cultural competence for midwives and other health providers are needed. • Development of a viable community-based maternity service that is crucial to providing continuity of care for childbearing women. • For women in the asylum process, having access to dedicated community-based services would begin to address the problems of access, late booking, and development of midwife/client relationships which in turn would help to decrease fear and anxiety for both the women themselves and the midwives who care for them. • Revision of the government policy of forced dispersal for women in the asylum process who are pregnant or in the early postpartum period is urgently needed. • Women who have ongoing health issues or who have infants requiring specialist follow-up should also be exempt from forced dispersal.

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