Approach To Integrated Perinatal Healthcare for Migrant And Refugee Women (D4.2.)

Oramma
Operational Refugee And Migrant Maternal Approach

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Table of contents

1. FOREWORD 9
2. EXECUTIVE SUMMARY 10
3. INTRODUCTION 11
   3.1. What is this document? 11
   3.2. Who is this plan for? 11
   3.3. How should I use this approach? 11
4. OUR VISION “MIGRANT MOTHERS MATTER TOO”: CALL TO ACTION 12
5. ORAMMA APPROACH 14
   5.1. Phases for integrated perinatal care of MAR women 15
      a. Assessment Flowchart 15
      b. Perinatal Personal Operational plan 17
6. TAKING ACTION 18
   6.1. Focus on continuity of care 18
   6.2. Focus on primary care 18
   6.3. Focus on multidisciplinary team 20
   6.4. Focus on facilitators and barriers 22
   6.5. Focus on knowledge and skills 23
   6.6. Focus on “Propagating Keys” in the MAR community 23
   6.7. Focus on MAR mothers and their families 26
7. KEY PRIORITIES FOR IMPLEMENTATION 27
   7.1. Service organization 27
   7.2. Care provision 27
   7.3. Information and support 28
   7.4. Training for the healthcare professionals 28
   7.5. Supporting referrals 29
8. REFERENCES 30

Acronyms and abbreviations

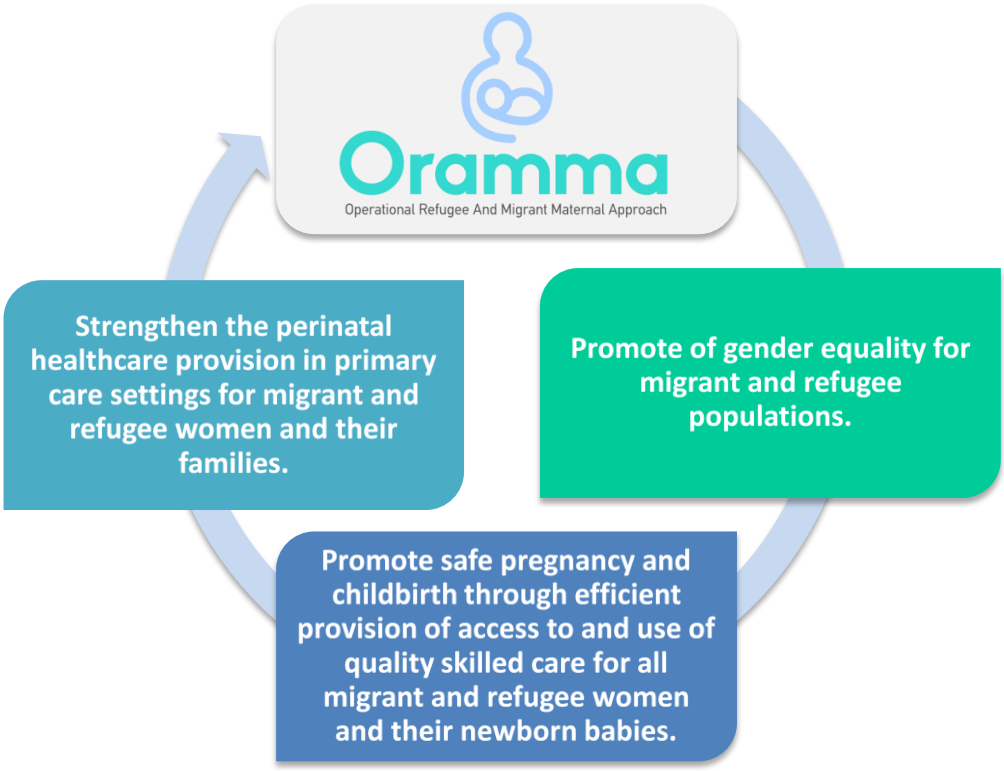
GP	General practitioner
HCP	Health care professional
HIV	Human immunodeficiency virus
MAR	Migrant, asylum seeker or refugee
MPS	Maternity peer supporter
NGO	Non- governmental organisation
SCP	Social care provider

1. FOREWORD

ORAMMA is an integrated, woman centered, culturally sensitive, and evidence based approach to perinatal health care for migrant, asylum seeking or refugee (MAR) women. This approach includes detection of pregnancy, care during pregnancy and birth, and support after birth. It is facilitated by multidisciplinary teams including midwives, social care providers (SCPs), General Practitioners (GPs) and Maternity Peer Supporters (MPSs), with the active participation of women from the MAR communities, to ensure a safe journey to motherhood.

ORAMMA aims to a) strengthen the perinatal healthcare provision in primary care settings for MAR women and their families, b) promote community- based health care models for MAR populations and c) promote safe pregnancy and childbirth through efficient access to quality maternity care for all MAR women and their newborn babies **[figure1]**.

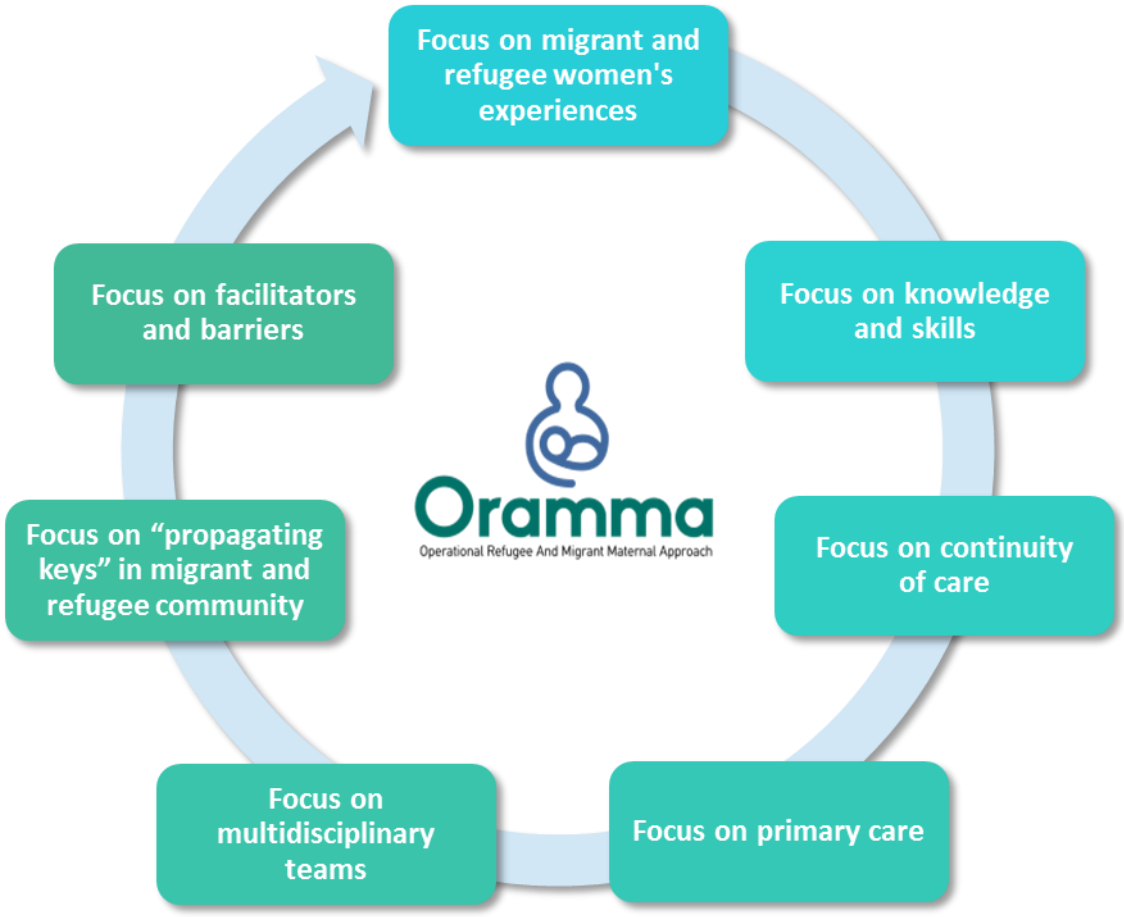
Figure 1. ORAMMA's aims



2. EXECUTIVE SUMMARY

This document is a detailed plan setting out our vision for establishing an approach to perinatal health services and applying practices that ensure safe motherhood for MAR women in European Union countries. We have structured our plan around seven key drivers for providing and delivering quality maternity care. The approach focuses on continuity of care, primary care, multidisciplinary teams, knowledge and skills, MAR women's experiences, "propagating keys" and facilitators and barriers **[figure 2]**. Through the implementation of the action plans and their continuous improvement and evaluation we aim to achieve safer motherhood for MAR women.

Figure 2. Key drivers for maternity care provision



3. INTRODUCTION

3.1. What is this document?

This document is a plan of action including a framework with all the characteristics of the perinatal healthcare approach, the role of the multidisciplinary team, the specifications of perinatal care phases, and directions for the implementation of this approach.

This document will help care providers and stakeholders to understand and promote safety and quality of perinatal healthcare services for MAR women.

It should be used alongside two other documents, the Practice Guide for care providers and the Perinatal Personal Operational Plan for women and for healthcare professionals. In these documents, care providers can find information about how to assess MAR women's needs and guidance of how to provide quality maternity care to them. Information, recommendations and tools included in these documents, are orientated to culturally sensitive care, promoting facilitators for optimal maternity care provision and delivery of woman centered care.

3.2. Who is this plan for?

This plan is for all members of the team involved in perinatal healthcare for MAR women (GPs, Midwives, SCPs, MPSs etc.). It could be also for anyone interested in MAR women's perinatal care that could spread the messages of this approach and wish to contribute to safer motherhood for these women.

3.3. How should I use this approach?

This approach guidance should be used additionally and alongside the National and International Protocols and Guidelines (e.g. WHO and NICE recommendations for maternity care, ICM guidelines, MISP etch).

The awareness of this approach is a prerequisite for using the ORAMMA Practice Guide and the Perinatal Personal Operational Plan. These documents should be used together.

4. OUR VISION "MIGRANT MOTHERS MATTER TOO": CALL TO ACTION

Migration increases MAR's vulnerability and puts women's physical and mental well-being at risk. Generally, studies have shown that MAR women are more likely to suffer from chronic diseases such as Diabetes Mellitus, cardiovascular diseases, mental health problems [1] and reproductive health problems such as sexual transmitted infections, including HIV and hepatitis B etc. [2].

In general, although often healthy when leaving their country of origin, the health of migrants deteriorates over time, and in general, they rate themselves to have poorer health compared to the native population of the host countries [3-7]. The background for this deterioration is formed by poor living conditions and limited access to health and social care.

Generally poor health and outcomes are influenced by factors such as chronic stress related to migration and precarious socio-economic living, unhealthy lifestyles, SGBV and lack of healthcare tailored to the needs of the migrants' conditions [2,8,9]. Specifically, refugees and asylum-seekers and those who have lived in camps or come from war-torn regions are at risk of poorer health due to the effects of post-traumatic stress, poor nutritional status and infectious diseases [10].

Additionally, MARs' health is to a large extent determined by the availability, affordability, acceptability, accessibility and quality of services in the host country [7,11,12]. The lack of entitlements related to migration status is also a factor that decreases access to maternity and SRH services [11]. Due to the limitations of existing statistical data and audit, it is not possible to determine the exact differences in access to perinatal health services and maternal mortality and morbidity between migrant women and the host population across Europe.

However, there is evidence that MAR women's access to perinatal healthcare services is influenced by financial constraints, administrative problems, coverage issues, lack of information, low levels of health literacy, language barriers, fear of authorities and previous bad experience [13-17]. Furthermore, cultural differences and incompatibilities also hamper access to and delivery of quality healthcare or result in delayed referral to the services [7,18-23].

Regarding pregnancy outcomes, there is a wide heterogeneity of evidence from studies amongst migrant women. This reflects the heterogeneity of the women themselves in terms of country of origin, pre-migration risk factors, 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 may differ [20,24]. Thus, some studies have shown disparities in maternal mortality and morbidity, which are higher amongst migrant women. Poorer perinatal outcomes (such as miscarriages, stillbirths, complications etch) are higher amongst migrant women and the rates of preterm birth, low birth weight and congenital malformations are higher amongst migrant women's babies [5,22,25-32].

Combating the preventable mortality and morbidity of MAR women and newborns is essential in order to promote social equity and sustainable development, considering the critical role of healthy people in economies, societies, and in the development of future generations and communities [33]. According to WHO [34,35], all women have the right to access to appropriate maternity care services and the governments should ensure their access to sexual and reproductive health and maternity care services. Ensuring MAR women's and newborn's health is a matter of equity, human rights, and is a way of achieving the Sustainable Development Goals while offering quality of life for all. In this era of diversity, to ensure maternal and infant health we need to go beyond the provision of homogenous services to women. We must ensure that well- designed healthcare services meet the heterogeneous needs of all MAR women. For these reasons ORAMMA approach aims to respond to MAR women's complex needs by providing individualized and culturally sensitive maternity care.

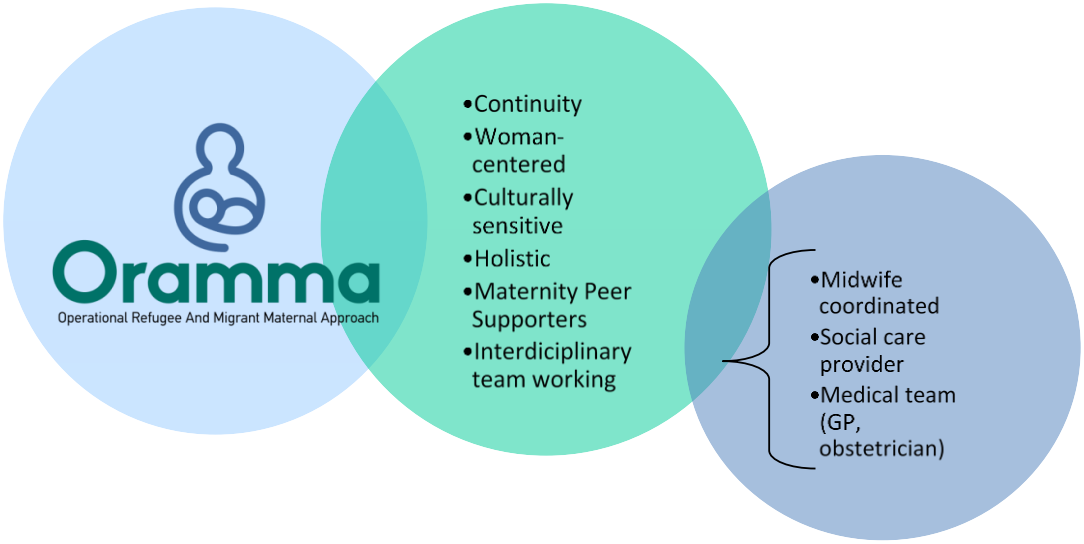
5. ORAMMA APPROACH

The characteristics of ORAMMA care approach are described in **figure 3**. Continuity of care is at the heart of the approach encompassing both the ORAMMA philosophy of care and the ORAMMA provision of care plan. According to ICM [36], continuity of midwifery care is the "provision of midwifery services for a woman and her infant by a known midwife and backup colleagues or a known group of midwives across the continuum of pregnancy, birth and the postnatal period". Continuity of care is supported by having robust training about the importance of a friendly and trustworthy relationship, respectful, dignified and autonomous care as well as a deep understanding of principles of natural birth and providing consistent information and harmonious care.

Within the ORAMMA approach continuity of care is also supported by accordingly trained MPSs that provide consistent support and information throughout pregnancy, birth and the postpartum period. For ORAMMA, MPSs will be women recruited from MAR women's communities or language groups and their role will be to ensure and facilitate better understanding between the Healthcare professionals (HCPs) and the women. They will act as translators, supporters, facilitators, mediators and they will advocate women's rights throughout the whole process.

The care is holistic and envisaged to meet the needs of women beyond their clinical requirements. In addition to health and clinical care, the interdisciplinary team is orchestrated to address women's socioeconomic complexities by appropriate referrals and signposting. The interdisciplinary working is coordinated by a midwife supported by MPSs in a close working relationship with medical doctors and SCPs.

Figure 3. Characteristics of ORAMMA approach for perinatal care of MAR women



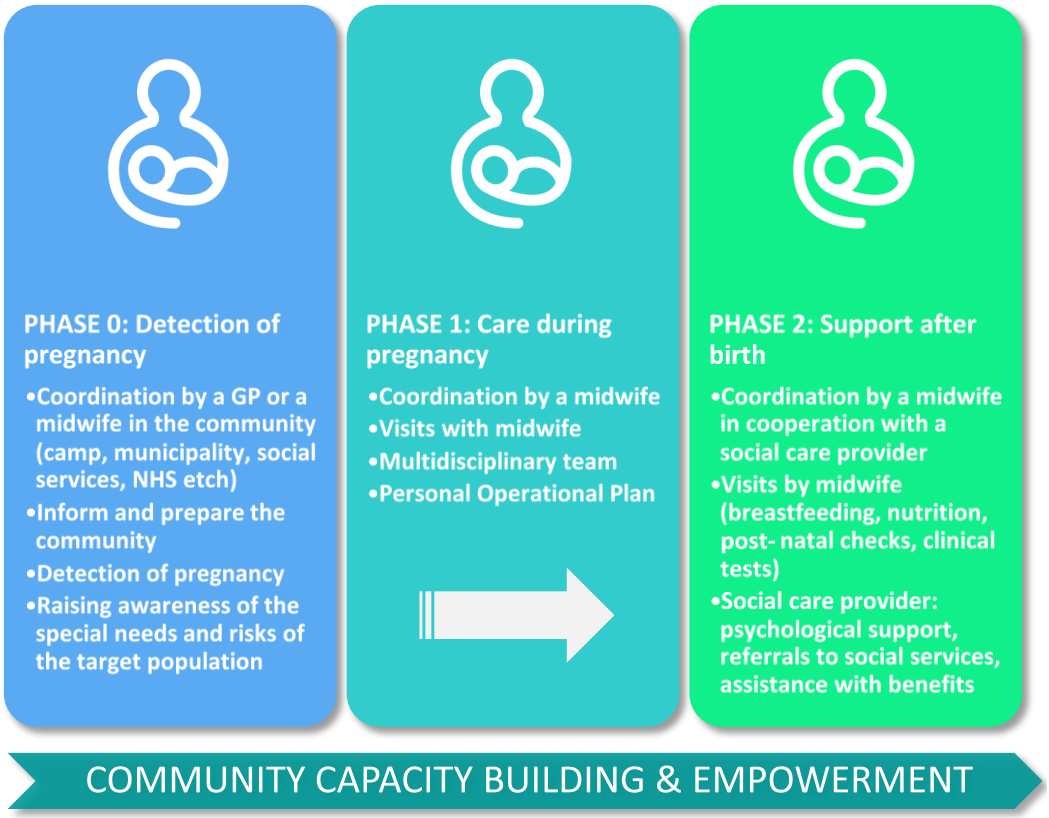
5.1. Phases for integrated perinatal care of MAR women

The proposed integrated approach will be a coordinated, culturally-appropriate, and mother-centered approach to healthcare provision for migrant, asylum seeking and refugee women with the aim of being transferable to different healthcare settings in Europe.

a. Assessment Flowchart

The assessment of care provided is divided in three phases a) detection of pregnancy, b) care during pregnancy and c) support after birth **[figure 4**].

Figure 4. Assessment flowchart: integrated approach on perinatal healthcare for MAR women



The detection of pregnancy is coordinated by a GP or midwife (depending on each country's setting) and is followed by a risk and needs assessment of each woman. The first activity for the health professionals is to identify those women who are MARs from the pregnant population. The midwife or GP will be responsible for detecting the pregnancies, performing all the necessary screening of the health of the women and making the referral to the coordinator.

Care during pregnancy is coordinated by a midwife in cooperation with the multidisciplinary team using ORAMMA's Perinatal Personal Operational Plan and the "My Maternity Plan". The midwives will perform all the necessary visits with the mothers either individually or in groups.

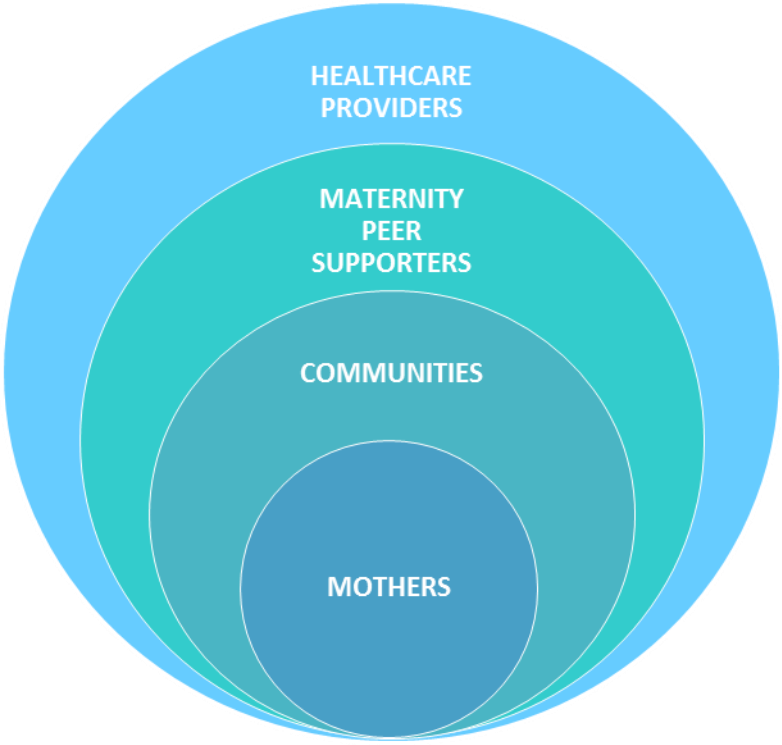
During this phase the MPSs will play an important role as both mediators and as supporters for the mother during the clinical care pathway and supporting the mother's decisions for her birth plan.

Support after birth is coordinated by a SCP in cooperation with a midwife. The SCP will provide psychosocial support to the mothers and useful information about social benefits and other important issues for the family. In this phase, the midwives will also perform the post-natal check for the mother and the newborns.

The process of implementing this community-based health care model for MAR women will also be facilitated by a process of empowering the communities through partnerships, collaborative planning, community actions and overall community capacity building.

Community Capacity Building strategies are required to work effectively with MAR women, their families and their communities to increase their understanding of maternal and newborn health needs and to engage them as partners in improving their health. Activities will aim to prepare and empower communities to enhance their participation in their own healthcare.

Figure 5. ORAMMA approach on Community Capacity Building



Community Capacity Building **[figure 5]** refers to promoting the capacities of communities to develop, implement and support their own management of health issues [37]. Women and their families will be empowered to be active partners of their healthcare through health educational interventions and support [38]. On the other hand, HCPs will also be trained and supported to assist MAR women and their families. Community Capacity Building will include a) training for MPSs for the MAR community, b) training for healthcare providers, c)

educational interventions to raise health literacy of MAR women and their families and e) antenatal and postnatal group sessions. By enhancing communities' knowledge, skills and experiences ORAMMA model offers them better opportunities to improve their health status and motherhood experience.

b. Perinatal Personal Operational plan

In order for women to receive quality maternity care and have a positive birth experience it is essential to know what to expect at birth, to be well informed and have their needs (cultural, religious, personal etc.) met [39]. Women should have a maternity plan and share it with HCPs. The existence of health records enhances continuity of care and subsequently has impact on the quality of overall care especially for women in movement from one country to another [40].

The ORAMMA project provides a Perinatal Personal Operational Plan -PPOP- (general health, psychosocial, perinatal assessment and plan) to enhance the assessment, planning, management and monitoring of women's and fetus/ infant's health. This has been designed according to the evidence regarding refugee/migrant maternity care and assists care providers to improve maternity clinical practice and service delivery, quality of care and safety. Two interrelated documents have been produced, one for the mother and one for the HCPs treating her.

The booklet called "My Maternity Plan" is a woman hand- held note that includes her individualized healthcare plan. It provides all the necessary information for the woman: (a) personal information and contact details, (b) brief medical history related to pregnancy and childbirth as well as chronic and communicable diseases, (c) the perinatal care plan (conditions, medicines, preferences for birth, etc.), (d) the assessment of the professionals of the multidisciplinary team and (e) useful information for the women, such as the benefits and impact of the PPOP for her and her family.

The document for healthcare professionals includes all the necessary detailed maternal notes.

6. TAKING ACTION

6.1. Focus on continuity of care

Community based services delivered in primary care setting involving GPs, cultural mediators, midwifes etc., can enhance continuity of care [41]. Continuity of care is an indicator for quality of care [12], is the best option for providing care to childbearing women, mothers and their children, and occurs when women receive their care from a continuous group of the same providers [42].

Continuity of care refers to relationships and management [43]. Relationship continuity implies that MAR women benefit from having a long-term relationship with a primary care provider that goes beyond specific appointments during the perinatal period. The quality of the longitudinal relationship between primary care providers and women, in terms of accommodation of women's needs and preferences, such as communication and respect for women, determine relationship continuity [44]. Regarding maternity care, WHO [42], in order to promote the utilization and quality of perinatal care, recommends a midwife- led continuity of care model in which women are cared for by a small group of known midwives. Women cared for by a few known care providers are more likely to get satisfaction from their care since they have the opportunity to build a trusting relation with the care givers [42].

Management continuity also refers to vertically integrated systems of care by means of continuous healthcare provision through integration and sharing of information while including coordination and teamwork between caregivers, different providers and across organizational boundaries [45].

The provision of continuous and accessible care is a challenge since it is related to the legal and residential status of the women [2]. MAR women may not stay for the length of their perinatal period at the same place or within the same country. Some MAR women may be on the move or legally lack access to health systems. This affects the continuity of care since information about medical records should be shared between states and between agencies and services [17].

For these reasons, ORAMMA aims to ensure continuity of care for these vulnerable populations.

6.2. Focus on primary care

Primary care is the basis for and an essential component of national health systems. It represents the first level of contact with the health system where most of the people's curative and preventive health needs can be fulfilled near to their communities. Primary Care is the ideal setting to provide initial health

care, assess the needs of women and their families, offer continuing care, assist the transition to other levels of care and services or refer clients when needed and collaborate with other agencies, Non-Governmental Organizations (NGOs) and the MAR communities [40,46]. Primary

Care services located near MAR communities are potentially the most competent to assess and manage women's and their families' health. Access to primary healthcare for all is an indicator of health equity [47]. For this reason, ORAMMA relies on the pre- existing structure and promotes the development of primary care maternity services.

An essential component of primary care is providing access to services for all who need them, irrespective of personal characteristics, socioeconomic status or health status. The structure of primary care, access to, coordination and comprehensiveness are all critical aspects that reduce unnecessary hospitalizations and costs, duplication of services and higher risk of medical errors [44].

Primary care providers play an important role in coordinating the health care of pregnant women and newly mothers, including coordination within primary care, coordination of input from medical specialists, and coordination with public health to address broader public health issues. These professionals often play a gate- keeping role in accessing other services, which makes this a crucial site for addressing their complex health and social needs, often in cross-cultural interactions, and operate within health systems that may not be structurally configured or politically favorable towards this group [48].

It has been widely recognized that population health is better in countries with relatively stronger primary care compared to countries with relatively weaker one [44]. In general, Primary Healthcare teams are on the frontline of healthcare provision for refugees and asylum seekers that arrive in high-income countries [49]. These teams may include a variety of professional backgrounds, clinical and non-clinical, but typically include a core of GPs, community-based nurses and midwives [50].

According to preceding European funded projects, EUR-HUMAN and SH-CAPAC, primary care for refugees and other migrants should be women-centered, comprehensive, goal-oriented, minimally disruptive, compassionate, outreaching, integrated within the existing primary health system and other services, and provided by a multidisciplinary team. In all circumstances, the health needs and preferences of MAR women should guide the healthcare process. However, all care providers need to be culturally competent, compassionate and women- centered. Primary care providers need to be aware of refugees' background (country of origin, culture etc.), need to have knowledge of the healthcare system, asylum process and entitlements for different immigration status' of women, as well as of specific tasks in triage, assessment, initial treatment and health promotion. In addition, primary care providers need to collaborate in a multidisciplinary team (including volunteers) as well coping with task shifting.

Even if primary care professionals face significant challenges when caring for refugees and asylum seekers, it seems realistic to say that primary care is the ideal level of care to provide integrated perinatal healthcare services to MAR women. It is a cost-effective level of care to provide initial healthcare, assess the needs of women and their families, offer continuing care, assist the transition to other levels of care and services or refer women and their children when it is clinically required, collaborate with other agencies, NGOs and the MAR communities organizations [46].

Primary care services located near MAR communities are potentially most able to assess and manage refugee and migrant women's and their families' health. For this reason, ORAMMA relies on the pre-existing primary care structures wherever available and promotes the development of primary care maternity services wherever they are needed.

Clear treatment pathways, as well as structures in healthcare for refugees are to some extent lacking and often unclear responsibilities challenge the healthcare provision for refugees. For instance, there is no standardized initial health assessment in many countries and documentation and monitoring structures are often missing. Furthermore, the lack of specific guidelines for vulnerable refugees, such as pregnant women, unaccompanied minors, refugees and migrants subjected to torture and violence, is challenging for healthcare provision.

6.3. Focus on multidisciplinary team

MAR women have multifaceted holistic needs, influenced by socioeconomic and cultural issues. These women may suffer consequences of trauma, mental health problems, and untreated non-communicable or infectious diseases, nutritional deficiencies and also may face poverty, isolation, exploitation, violence, abuse and discrimination [51]. A multidisciplinary and holistic approach is needed to manage the complexity of their health needs.

Multidisciplinary primary care teams ideally consist of GPs, midwives, SCPs, cultural mediators and other allied health professionals. These teams have the capacity to adapt to the trans-cultural setting and needs, wishes, and expectations of MAR women.

Multidisciplinary teams that cooperate effectively, share the same principles, focus on team work, share workload and information, respect the distinct roles of each one, maximize capacity, promote innovations, and develop a joined-up strategy of maternity care can be a competent working group. Their duty is to develop, elaborate, review and share a personal operational plan for each woman and this requires regular communication [52].

The ORAMMA multidisciplinary team of experts will consist of (a) a midwife, (b) a GP or other medical doctor, (c) a SCP and (d) the MPSs. The team will act in a collaborative way to provide coordinated care for the MAR pregnant woman. Each professional will provide a separate assessment of the mother, but all together will plan and treat the mothers synergistically. According to each country's settings, will be recruited according to who is required to provide perinatal health care and social care.

The medical doctor, or other HCPs, will provide assessment and clinical actions on health issues related to chronic and communicable diseases; the midwife will care and support the mother during pregnancy and mother and new-born after birth [36]; and the SCP will provide counseling mainly after birth to the mother and the whole family.

Within this approach midwives will coordinate and provide the majority of the MAR woman's antenatal care, intrapartum and postnatal care with support from the multidisciplinary team as required [42]. They will undertake the role of lead professional for low risk pregnant women and the coordinator of care for complicated pregnancies [42,53]. They will also provide group

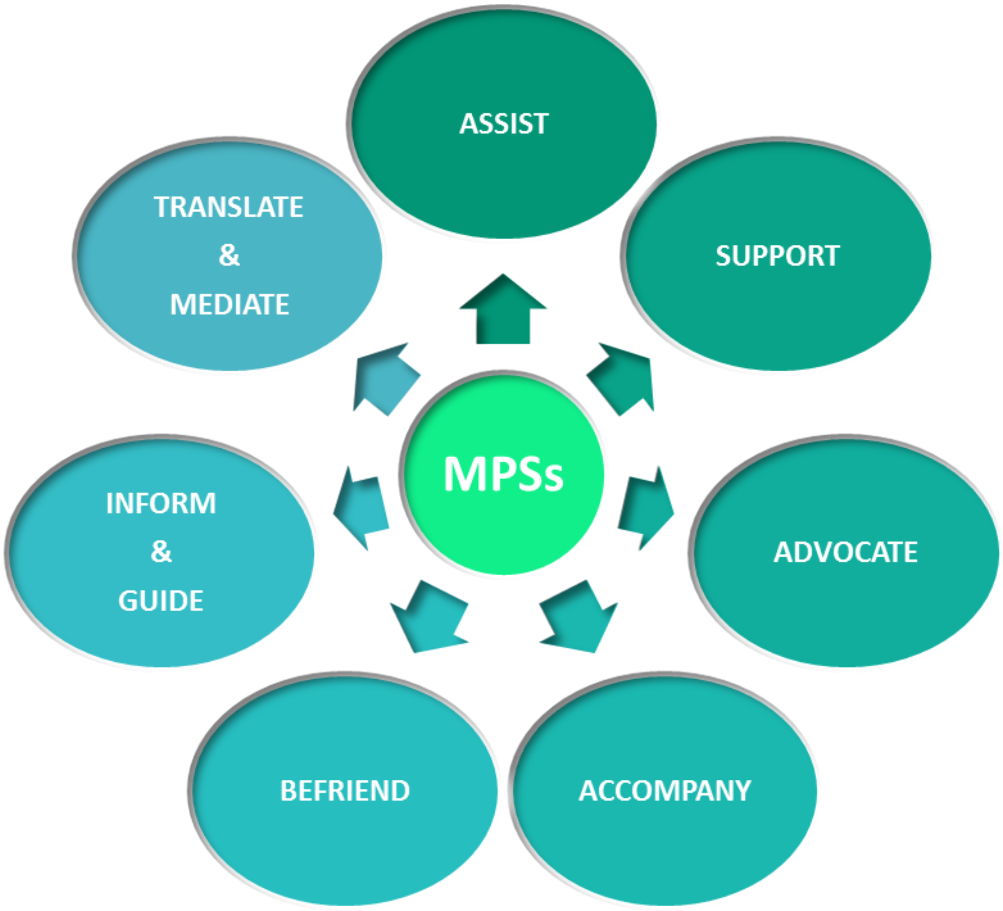
sessions and contribute to community capacity building through community education [36]. Consultation and reference to other care providers must occur when necessary, following the appropriate local referral protocols [42].

SCPs are needed to ensure that refugees and asylum seekers are afforded the highest level of protection possible under the law of the host country. Their assistance involves a combination of practical assistance within a culturally responsive and inclusive practice framework that acknowledges the impact of potential previous trauma. It also acknowledges the importance of family and seeks to utilize the strengths of individuals, families and communities and the supportive networks that already exist [54]. For ORAMMA the SCP will make the assessment and management of individual needs of daily living and psychosocial situations which may impact on the outcome of the pregnancy and motherhood. They will provide appropriate information and support on accessing social benefits. SCPs will be responsible for ensuring that all MAR women receive protection services, refugee resettlement services, services for the treatment and rehabilitation of torture and trauma survivors, advocacy services for refugees and asylum seekers, health services, education, legal and family support services, etc.

MAR pregnant women are a highly vulnerable target group that is in need not only of translation but also mediation assistance and emotional and social support. It has been shown that peer support during all perinatal stages gives to the women a feeling of security and trust, improves the level of communication with the care givers, increases their confidence, enhances the provision of information and the continuity of care [55] and can have positive impact on their emotional health and well- being and their relationship with their partners [56]. Additionally, providing support, advocacy, guidance and empowerment to disadvantaged women in a culturally appropriate way maximizes their satisfaction, communication and collaboration level with the care providers [55].

The team will also be gender-sensitive, meaning consisting of female professionals, to address the potential religious needs of the target group and moreover to ensure that all the women will feel comfortable and safe (considering the special risks of the target group to gender based violence or abuse).

Figure 6. The role of Maternity Peer Supporters during all perinatal stages



6.4. Focus on facilitators and barriers

Pregnancy and childbirth are special moments in women's and family's lives. Experiencing pregnancy and birth in a country where you are unaware of the language, culture, and medical practices while facing additional stressful conditions, is a hard situation to cope with without support. Lack of information about health entitlements and the health services pathways and low health literacy are additional barriers to accessing or maintaining contact with healthcare services [17,46,57-60].

ORAMMA aims to combat these barriers in various ways. The support pathways will include a) strategies to promote effective communication and interaction with the assistance of competent bilingual MPSs or bilingual HCPs, b) recruiting empathic, compassionate, culturally competent HCPs, c) establishing flexible and responsive services, following culturally sensitive medical and healthcare practices and d) promoting women's and their families' awareness and health literacy.

6.5. Focus on knowledge and skills

HCPs with poor knowledge of legislation and poor understanding of MAR's complex needs are considered to be a barrier to providing quality and responsive maternity care [17]. For these reasons ORAMMA's approach on Community Capacity Building also includes the HCPs. HCP's should be empowered with knowledge and understanding of MAR mothers' needs and issues, and should be aware of local and regional services for MAR and of how to access further information. They should understand the boundaries of their own skills and knowledge, and have strong communication skills, diplomacy and sensitivity, to establish a successful and trusting relationship with MAR mothers and their families and to empower the mothers to make decisions including challenging them when appropriate. They should understand the implications of the mother's assessment in relation to risks and protective factors, and have good awareness of safeguarding issues and responsibilities. HCPs should also be culturally competent, and be able to support and enable the mothers to achieve their potential, understand information sharing, consent and issues around confidentiality and ensure continuity and quality of care provided. They must be competent to ensure essential standards of quality maternity care provision according to the ORAMMA approach.

6.6. Focus on "Propagating Keys" in the MAR community

"Propagating Keys" are an alternative strategy in health education for social change. The goal of this approach is to transform members of the community from passive recipients of a Health Education Message to active participants in a process of community change, to involve people in collective action and to create health promoting environments and life-styles [61]. Interventions using members of the community as "Propagating Keys" and gate- keepers are considered to be cost effective in achieving social empowerment by MAR women in their communities [62].

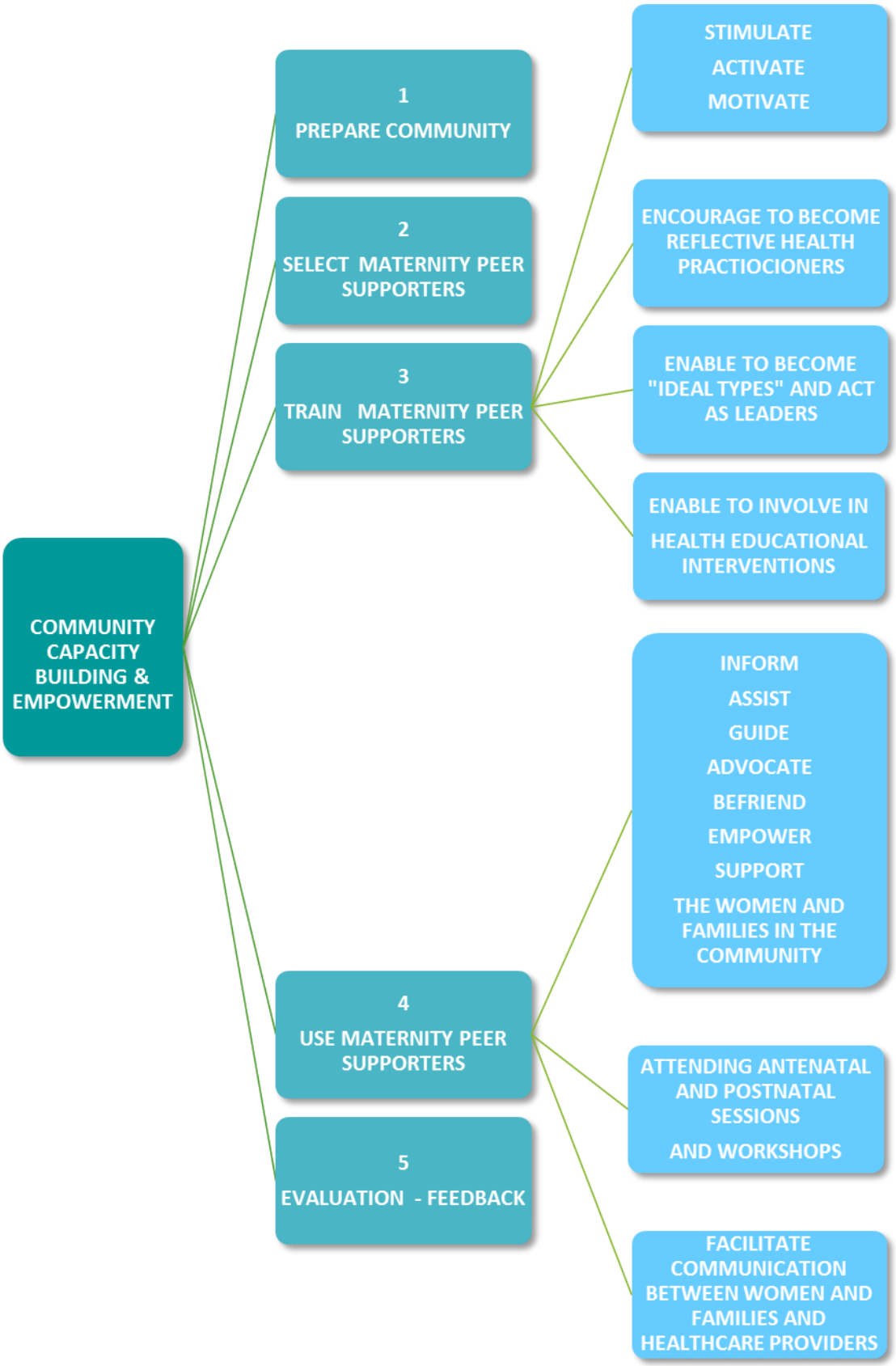
Distinguished women (those of a higher social capital or social skills and/or with higher education or being a healthcare professional) within the migrant's communities, will be recruited and educated according to ORAMMA's standards in order to motivate other women and the whole community and disseminate the messages that will impact on women's health behaviors for a better pregnancy, birth and parenting outcome **[figure 7]** [62].

The development of Propagating Keys able to fulfill the roles of animator (stimulating women and their families to think critically and to reflect on Health Education Message) and facilitator (providing a process through which the women and their families can express its own content regarding the Health Education Message) is crucial to the effectiveness of healthcare interventions [63].

This kind of intervention, through "social learning", influences, orientates and motivates women and their families to undertake healthy behaviors and promotes health literacy by stimulating intrapersonal relations and bonds, as well as community's norms and functions [64], while contributing to community capacity building and empowerment **[figure 8]**.

Figure 7. Criteria for recruiting “Propagating keys” for ORAMMA approach

Figure 8. Community Capacity Building and Empowerment using “Propagating keys”



6.7. Focus on MAR mothers and their families

MAR women report that they would like more culturally sensitive care, and culturally competent professionals, who attend to their individual needs with respect and kindness. They require more assistance with communication and language difficulties and more information about the healthcare system. In some cases, migrant women have encountered unacceptable discriminatory attitudes or behaviors or prejudice. They also wish they had better recognition of their needs and being able to actively participate in decisions about their care [65].

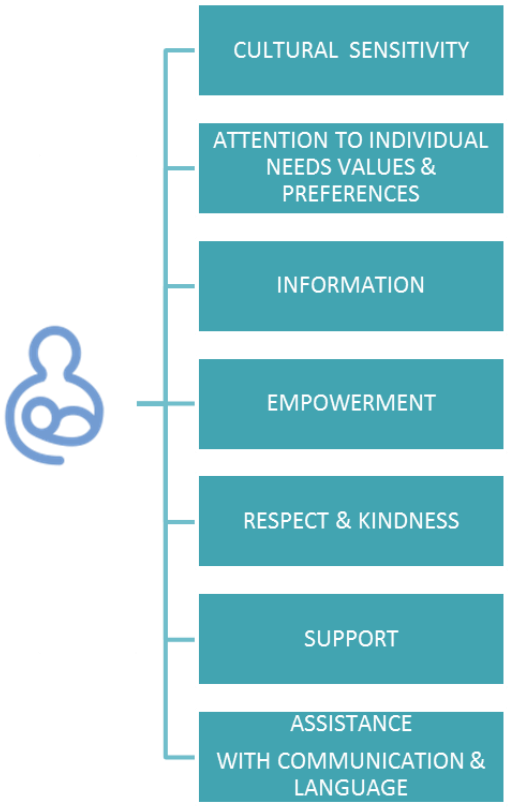


Figure 9. Characteristics of ORAMMA's approach on woman- centered care

ORAMMA aims to offer woman-centered, family-centered, and consequently culturally sensitive perinatal care. The content of the care plan will be based on the best available evidence, while considering each woman's values and preferences and incorporating her culturally-derived expectations, where possible. The provided care will be the outcome of genuine interaction between the multidisciplinary team, women and their families. Within this woman-centered perinatal health service, women will be able to express their fears and worries, and personal, linguistic, cultural or religious needs and expectations. They will be empowered to be active participants in their healthcare and give informed consent only for appropriate and needed interventions, and they will feel respected and that they have been heard. Also, husbands, partners and families must be enabled and assisted to support the mothers.

7. KEY PRIORITIES FOR IMPLEMENTATION

7.1. Service organization

In most European countries all women have access to a GP in a health centre but MAR women's access to care differs regarding to their status and entitlements. Considering that access to primary care and entitlements of MAR women may vary from country to country [11,29,66], innovative actions and policy changes are a prerequisite to ensure free perinatal health access for all women and to avoid poor maternal and infant outcomes. The financing and the healthcare structure are two essential issues to be addressed to facilitate the ORAMMA approach.

ORAMMA aims to deliver an integrated, targeted, cost effective approach for MAR women's maternity care, transferable to different healthcare systems. Integrated perinatal care refers to a coordinated set of services that are delivered to women across several co-operating professionals and levels of care [67]. ORAMMA's objective is to integrate maternity care components with primary healthcare components, to achieve the very best perinatal care for MAR women. We believe that this project is applicable to primary care services which are the first point of contact of women with healthcare services.

7.2. Care provision

According WHO [68], quality of care is characterized by safety, effectiveness, timely provision of care, equitable delivery of care and people-centered approach. Provision of culturally sensitive care is also considered an indicator of quality [12]. Some studies indicate differences in perinatal outcomes that reflect suboptimal care and differential quality of care for MAR women compared with other women [7,69].

ORAMMA aspires to provide quality maternity care for MAR women. Quality will be enhanced by community capacity building and empowerment interventions including community education and engagement [12].

Care provision is recommended to take place in health centres easily available and accessible to MAR women and their families. The schedule of appointments should be flexible and in accordance with women's needs. Maternity records should be held by the woman during the perinatal period to ensure the very best and continuous care provision.

7.3. Information and support

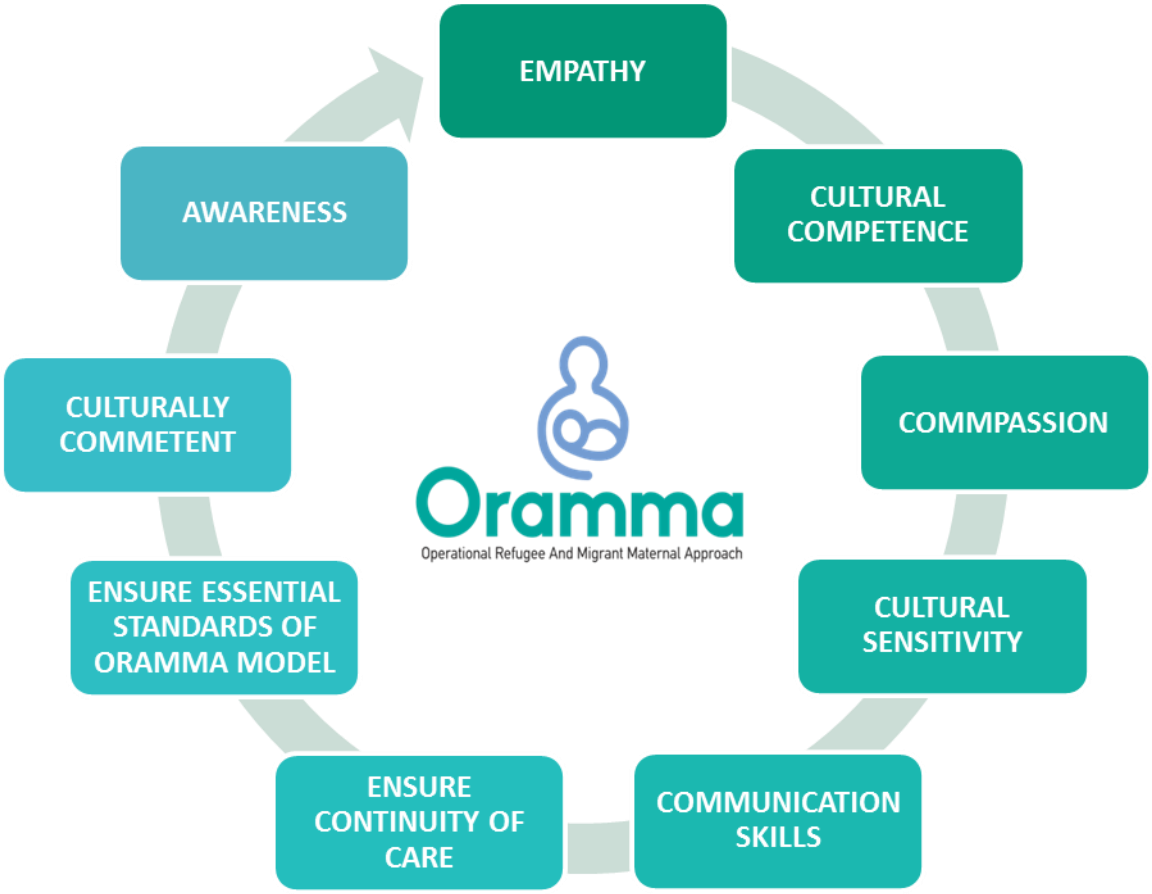
Evidence indicate a positive association between inadequate health literacy and MAR women's adverse perinatal outcomes [70,71]. Health literacy is defined as "social resources required for individuals and communities to access, understand, appraise and use information and services to make decisions about health" [50]. Health literacy is important to ensure effective healthcare education and successful engagement of communities in their own healthcare planning [33]. MAR women should be provided with appropriate, up to date and easily understandable information. They should be aware of the available services and to be given education to be active partners in their own healthcare decision-making processes.

The ORAMMA approach states that MAR women and families will be provided with information and advice on various aspects of pregnancy, birth and motherhood experience that will be supported by discussions with the midwife. A variety of educational materials and information sources (e.g. leaflets, booklets, videos, applications, presentations) will be also provided, according to the women's language, literacy level and cultural background. By raising health literacy (providing knowledge, skills and competencies) ORAMMA aspires to help MAR women and their families to successfully engage in their own healthcare, act upon the factors that affect their health and increase their chance for better perinatal outcomes. Health education will also enable women to understand the necessity of maternity care and the importance of regular check-ups.

7.4. Training for the healthcare professionals

HCPs need adequate preparation to effectively care for MAR women and their families. They should be encouraged to develop cultural sensitivity and competence, empathy and compassion [72]. Cultural competence is a key issue in the ORAMMA training for HCPs. Special training programmes should be organized to prepare, promote efficiency within, and support care providers **[figure 10]**. Within the ORAMMA approach, these training programmes will raise the awareness of specific needs of MAR women in the context of maternity care within a culturally diverse society.

Figure 10. Training healthcare professionals



7.5. Supporting referrals

ORAMMA's approach to care is designed to be delivered during all stages of pregnancy, birth and postpartum period by a small functional team including midwives, medical personnel (e.g. obstetricians, GP), SCPs and MPSs. Women with complicated high-risk pregnancies, births and postpartum issues and their newborns should be referred to other levels of care or experts through appropriate national referral pathways.

A midwife-led continuity care model is recommended within the ORAMMA approach [42]. Where complex care or high-risk cases are identified, national protocols will be followed according to local routine practices. The focus is to adhere to the key characteristics of the approach including continuity, woman-centeredness, holistic care, interdisciplinary team working, and coordinated by a midwife with the support of MPSs.

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