Training Handbook for Health Care Professionals (D5.2.)

Oramma
Operational Refugee And Migrant Maternal Approach

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Editors

Victoria Vivilaki
RM, PGCert, MMedSc, PhD
Assistant Professor of Community Midwifery Practice & Postnatal Care
Midwifery Department
University of West Attica, GREECE

Hora Soltani
RM, BSc, PGDip, PGCert, MMedSc, PhD
Professor of Maternal and Infant Health
Faculty of Health and Wellbeing
Sheffield Hallam University, UK

Maria van den Muijsenbergh
MD, PhD
General Practitioner
Professor of Health Disparities and person centred integrated primary care.
Department of Primary and Community Care
Radboud University Medical Center, Nijmegen, THE NETHERLANDS

Authors

Eirini Sioti RM, MSc
Midwifery Department
University of West Attica
GREECE

Frankie Fair RM, BSc, BMedSci, MSc
Faculty of Health and Wellbeing
Sheffield Hallam University, UK

Helen Watson RM, MSc
Faculty of Health and Wellbeing Sheffield Hallam University, UK

Liselotte Raben MD, MSc
Department of Primary &Community Care
Radboud University Medical Center, THE NETHERLANDS

Maria Papadakaki BSW, MPH, PhD
Department of Social Work
TEI of Crete, GREECE

Acknowledgments

Mervi Jokinen
Practice and Standards Professional Advisor, The Royal College of Midwives
President of European Midwives Association (EMA)
Vice Chair European Forum for National Nurses and Midwives Associations (EFNNMA)

Eleanor Shaw
European Midwives Association (EMA)

Diederik Aarendonk
Coordinator of European Forum for Primary Care (EFPC)

Diana Castro Sandoval
Junior Coordinator of European Forum for Primary Care (EFPC)

Anastasios Mastroyiannakis
CMT Proopriki

Artemis Markatou
CMT Prooptiki

External Reviewers

Billie Hunter
WHO Collaborating Centre for Midwifery Development, School of Healthcare Sciences, Cardiff University, UK

Diane Nurse
National Social Inclusion Office, Primary Care Division, Health Service Executive, Ireland

Nia Georges
Department of Anthropology, Rice University, USA


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ΠΑΝΕΠΙΣΤΗΜΙΟ ΔΥΤΙΚΗΣ ΑΤΤΙΚΗΣ
UNIVERSITY OF WEST ATTICA


Sheffield
Hallam
University


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Radboudumc
university medical center


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ASSOCIATION


european forum
for primary care


CMT Prooptiki
CONSULTING MANAGEMENT TRAINING


TEI of Crete
Technological Educational Institute of Crete

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Acronyms and abbreviations

GP	General Practitioner
HSCP	Health and Social Care Provider
ICU	Intensive Care Unit
MAR	Migrant, Asylum seeker or Refugee
NGO	Non-Governmental Organisation
NICU	Neonate Intensive Care Unit
SCP	Social Care Provider
SGBV	Sexual and Gender-Based Violence

Symbols

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 Lecture

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 Summary

 Case scenarios

 Simulation, exercises or activity

 Role play

 Story telling

 Video

Foreword

Pregnant women with a history of recent migration face a mix of socio-economic problems and barriers to accessing good quality, affordable care in the host country, which can lead to poorer pregnancy outcomes and poorer satisfaction with maternity care. The EU/CHAFEA funded project ORAMMA aims to support these women and to help improve the outcomes of pregnancies by developing the ORAMMA approach, based on systematic reviews of the needs of these women and the current experiences of healthcare providers.

The ORAMMA model is an integrated, woman-centred, culturally sensitive and evidence-based approach to perinatal healthcare for migrant and refugee women, including the detection of pregnancy, care during pregnancy and birth and support after the birth. This approach is facilitated by a multidisciplinary team including Midwives, Social Support Workers, Medical Practitioners (as and when required) and Maternity Peer Supporters (MPSs), with the active collaboration of migrant women, to enable a safe journey to motherhood.

Introduction

What is this document?

This handbook presents a training plan for Health and Social Care Providers (HSCPs), involved in the care for and support of migrant women during pregnancy, birth and the postnatal period.

It is intended that this document be understood in the context of and used alongside three other documents: the ORAMMA Approach, the ORAMMA Practice Guide and the ORAMMA Personal Operational Plan (POP). Furthermore, it is intertwined with the ORAMMA e- course for HSCPs [Figure 1].

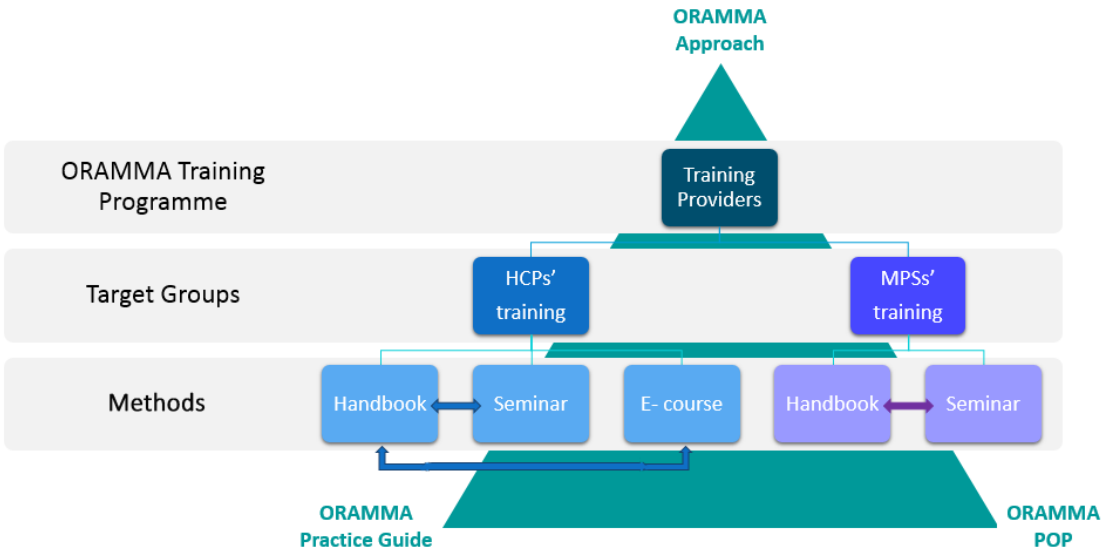


Figure 1: ORAMMA training programme

Who is this document for?

This document is intended to be used by training programme facilitators. It may also be a source of information for HSCPs or service commissioners who want to enrich their knowledge on healthcare professional skills in delivering perinatal healthcare for migrant and refugee women.

HSCPs may include midwives, medical practitioners (e.g. general practitioners, obstetricians) and social support workers.

How should this document be used?

This document should be used to guide the delivery of the training for HSCPs. The content of the training is designed to be delivered over one three-hour workshop, however the duration of the training sessions should be adapted to the local context. HSCPs may want to access the included supplementary reading following the workshop.

This document details the specific learning and teaching activities to be undertaken and timings for each of these. Learning materials referred in the modules outlines, including case scenarios, worksheets etc, can be found in the appendixes of the handbook. Additional learning materials can be found in the additional resources at the end of each module description.

Each module is organized as follows:

- brief introduction to the issues covered
- the general objectives
- suggested teaching methods.

The module descriptions include the following information:

- information on the issues covered that a trainer can read in order to be familiarized with the sections
- teaching aids and reference materials.

How was this document developed?

The content of the training was developed using:

1. Three systematic reviews which identified the experiences and needs of childbearing migrant women in Europe as well as the learning needs and challenges in daily practices as identified by HSCP.
2. Cultural Competent Healthcare provision, as described and tested by Seeleman et al (2014).
3. A previous model of culturally competent care training, the MEM -tp project.
4. Expert practice knowledge and experience of the ORAMMA project partners

The training was piloted and evaluated in the Greece, the Netherlands and UK and adjustments were made accordingly [Appendix 3].

Methodology

Construction

After introductory sections on background and methodology and general reflections on the outline of the training, five modules are described in more detail that can be used as complete courses during in-service education, or to be integrated into different courses. Module 2 “Maternity Care for Migrant Women”, module 3 “Taking Action: The ORAMMA project” and module 4 “Communication and Culturally Sensitive Practice” are the core of the ORAMMA training programme for HSCPs. The main training modules are supported by Module 1 “Introduction to Migration”, which provides background information on migrants and migration [Figure 2]. This module can be used as additional material.

Which of the complementary modules will be used, is at the discretion of the trainers/ providers and should be in accordance with the specific features of trainees’ groups.

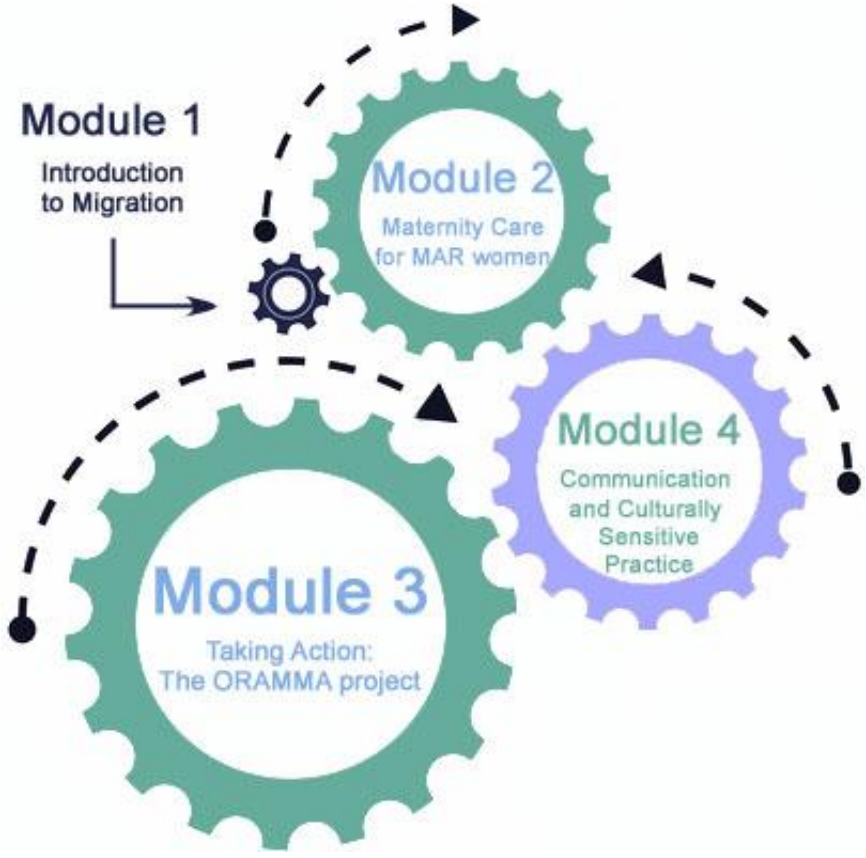


Figure 2: ORAMMA training programme's modules

Training process

Trainers are advised to:

- Use this training handbook in conjunction with the ORAMMA's "Approach to integrated perinatal healthcare for migrant women", the "Practice Guide" and the "Personal Operational Plan".
- Use the suggested time allocations, session contents, teaching and learning activities and resources as guidelines and adapt them to suit the local context.
- Use case studies drawn from real life locally where possible, or those provided in the handbook
- Make use of appropriate reference materials and teaching resources that are available locally.
- Incorporate practical exercises, including role-play with training-actresses, and cultural awareness exercises.
- Give ample opportunity to the participants to share their own experiences in daily practice
- Organise a booster training after 3-4 months, after this time the HSCPs have had the opportunity to practice what they have been taught and will have encountered new experiences and possible challenges that can be addressed in the booster training.

As repetition of teaching, and experiential learning are known to have the best results in changing behaviour in HSCPs, it is strongly advised:

1. To incorporate in each training as much as possible, practical exercises like role-play with training-actors and awareness exercises for cultural awareness
2. To give ample opportunity to the participants to share their own experiences in daily practice, like in presenting case stories.
3. To organise a booster training after 3-4 months. In between, the HSCPs have had the opportunity to practice what they have been taught and will have encountered new experiences and possible challenges that can be addressed in the booster training.

Teaching/ learning activities

It is important for the trainees to have the opportunity to share their own experiences, ideas, beliefs and cultural values as much as possible. Besides being an effective method of learning, this helps to reduce anxieties. The teaching methods proposed in this handbook are therefore designed to be participatory. Suggestions for teaching/learning activities include:

The lecture – A brief talk, used to introduce a session or topic or provide new information. Such talks by teachers are kept to a minimum to allow trainees as much time as possible to participate and share their own ideas.

Small group discussions – These are exercises in which trainees divide up into groups of three to five people to discuss an issue between themselves. Trainees should be given a specific task to work on, time to complete it, and time to feedback to the whole group. After the groups have presented their work, the teacher/ facilitator should summarise. Small group discussions are particularly good for teaching about sensitive issues.

Whole group discussions – These are sessions in which the facilitator engages the whole class in brainstorming about an issue, or in discussing the feedback from small group work. Large group discussion can be used to evaluate the trainees' understanding of the session. They can also be used as forums for debating controversial issues.

The summary – This is a very important activity. At the end of every session, the teacher should summarise what has been taught, and relate this to the stated objectives of the session. The teacher may ask the class to do the summary or answer questions on the session they have just completed to check that they have understood everything.

Case scenarios– For this exercise, trainees are given the opportunity to share real-life case studies from the community or clinic with others in the classroom. Where this is not feasible, fictional cases provided in the handbook, can be used for classroom discussion. They are asked to decide how such cases or situations should be managed and are asked to justify their decisions. Trainees may work singly or in groups on these assignments, but a crucial part of the exercise is sharing their analysis with the class.

Simulation, exercises or activity – These are make-believe situations in which the teacher asks a trainee to perform a procedure, activity or quiz. These exercises are particularly effective at teaching skills. It is important that the teacher makes it clear exactly what skill is being taught.

Role play – For these activities, trainees are given a range of roles to play in mini dramas in order to give them insights into different people's situations and points of view regarding maternal care of MAR women. They may, for example, be asked to play the role of a midwife counselling clients in a clinic or discussing family planning options with an excised woman. After acting they should be given time to share their feelings and perceptions before their fellow trainees give their comments. Besides allocating roles directly, trainers may wish to work together

with trainees on translating stories or actual case studies into role-plays they can act out.

Story telling – This is used to explore attitudes and values. The modules include stories that illustrate many different aspects of migration and maternity care. which the trainer/ provider or trainee can tell the class.

Videos – A video containing educational material, particularly of women talking about their experiences of maternity care and being a migrant to enable trainees to understand the topic from women's point of view.

Evaluation

For the evaluation of the impact of the training, an evaluation questionnaire has been developed, based on existing evidence-based assessment-tools of cultural competence. (Seeleman et al., 2014). This should be undertaken pre- and post-training [Appendix 2].

However, evaluation should be a continuous process, and the teacher should organize time for questions and answers at regular intervals, to check the understanding of students.

MODULE 1. Introduction to migration

This module is intended to introduce the trainees to the topic of migration, by describing the situation in the EU, as well as the laws and policies in force.

General objectives

At the end of this module, trainees are expected to be able to:

- Understand the difference between a migrant, a refugee and an asylum seeker.
- Understand identifying vulnerable populations
- Know what they are obligated by the law to do regarding the healthcare and social welfare provision to MAR women

Suggested teaching activities

- Lectures
- Whole group discussion
- Story telling
- Video

Background

Europe is currently experiencing an unprecedented influx of refugees, asylum seekers and other migrants. Over the past two decades, the global population of forcibly displaced people has grown substantially from 33.9 million in 1997 to 65.6 million in 2016, and it remains at a record high. Most of this increase was concentrated between 2012 and 2015, driven mainly by the Syrian conflict. But this rise also was due to other conflicts in the region such as in Iraq and Yemen, as well as in sub-Saharan Africa including Burundi, the Central African Republic, the Democratic Republic of the Congo, South Sudan, and Sudan. The increase of recent years has led to a major increase in displacement: from about 1 in 160 people a decade ago to 1 in 113 today (UNHCR, updated 20 Dec 2017).

An estimated 362,000 refugees and migrants risked their lives crossing the Mediterranean Sea in 2016, with 181,400 people arriving in Italy and 173,450 in Greece. In the first half of 2017, over 105,000 refugees and migrants entered Europe (UNHCR, updated 20 Dec 2017).

Section 1: Migration status

Migrant is defined as any person who is moving or has moved across an international border or within a State away from his/her habitual place of residence, regardless of (1) the person's legal status; (2) whether the movement is voluntary or involuntary; (3) what the causes for the movement are; or (4) what the length of the stay is (IOM, 2011).

Refugee is defined as a person who, "owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinions, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country. (*Art. 1(A)(2), Convention relating to the Status of Refugees, Art. 1A (2), 1951 as modified by the 1967 Protocol*). In addition to the refugee definition in the 1951 Refugee Convention, Art. 1(2), 1969 Organization of African Unity (OAU) Convention defines a refugee as any person compelled to leave his or her country "owing to external aggression, occupation, foreign domination or events seriously disturbing public order in either part or the whole of his country or origin or nationality" (IOM, 2011).

Asylum seeker is defined as a person who seeks safety from persecution or serious harm in a country other than his or her own and awaits a decision on the application for refugee status (IOM, 2011). Under EU law, asylum seekers are defined as "applicants for international protection". EU law prohibits removal of an asylum seeker until a decision on the asylum application is taken. Article 9 (1) of the Asylum Procedures Directive (2013/32/EU), provides that the asylum seeker's presence in the territory of an EU Member State is lawful. It states that asylum seekers are "allowed to remain in the Member State" for the purpose of the procedure until a decision by the responsible authority has been made, although some exceptions exist, notably for subsequent applications (FRA, 2014).

Undocumented migrant is defined as a migrant who has not obtained a permit to stay in the host country, e.g. a rejected asylum seeker. In most countries, undocumented migrants have no or less entitlements to receive healthcare – or have to pay for all care themselves. However, maternity care should be exempted in all countries and be accessible and affordable to all women, including undocumented. In different countries, different legislation exists on the (reimbursement of) healthcare for undocumented migrants. As legislation changes frequently, one is advised to look for local resources or supporting NGO's like doctors of the world.
(http://mighealth.net/eu/index.php/Undocumented_migrants_Entitlement,_accessibility_and_quality_of_care).

Vulnerable person, as defined in Article 21 Directive 2013/33/EU, includes minors, unaccompanied minors, disabled people, elderly people, pregnant women, single parents with minor children, victims of human trafficking, persons with serious illnesses, persons with mental disorders and persons who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence, such as victims of female genital mutilation (AIDA, 2017).

Migration status definitions

"Seeking asylum in the EU"
URL: www.europarltv.europa.eu/en/programme/others/seeking-asylum-in-the-eu

"Walk in the park" [Appendix 1]

Refugees - who they are and where they come from
URL:www.moh.govt.nz/notebook/nbbooks.nsf/0/70BF0D88EFA0AB6CCC256BC70087DA82/$file/Section1.pdf

Section 2: Migration policy and access to Health Care and Social Welfare

Everyone has a fundamental right to health and to access health care, legally enshrined in both international and European instruments, such as the European Charter of Fundamental Rights. However, while such rights maybe set down in legal documents, in practice the picture is very different, particularly for migrants in vulnerable situations. For example, depending on migration status, migrants may have limited entitlements to health care due to national laws and policies. The structure and organisation of health systems, as determined by government policy, can have a profound influence on the ability of particular groups to access health care. Availability of services, the need for health care insurance, the extent of health care coverage and out-of-pocket payments can all impact on populations' and individuals' ability to access health care. This is particularly true for individuals with low health literacy, different cultural backgrounds, or language barriers which will lessen their capacity to cope with such demands (O'Donnell et al., 2016).

Directive 2013/33/EU[1] of the European Parliament and of the Council of 26 June 2013 requires EU Members to provide "material reception conditions" (i.e., housing, food, clothing) and health care to ensure an adequate standard of living and to guarantee the physical and mental welfare of applicants for international protection. Member States must ensure that applicants receive necessary health care, which must include as a minimum emergency care and the essential treatment of illnesses and serious mental disorders.

EU Members have the discretion to make the availability of material reception conditions and health care conditional on the lack of sufficient means by the applicants to secure for themselves an adequate standard of living. The material reception conditions may be provided in kind, in the form of vouchers, or via financial allowances, or by a combination of the three, including a daily expenses allowance. They also have the freedom to require that applicants cover or contribute to the material conditions and health care costs, if applicants are financially able to do so. Where housing is provided, it could be in the form of accommodation centres or premises used for the examination of applicants during border procedures, or even apartments, houses, or hotels converted to house applicants. When housing applicants, Member States must take into consideration applicants' age and gender, and the needs of vulnerable people.

Refugee phenomena overview and main trends. Facts, figures, policies and legislation. IENE 6 KNOWLEDGE HUB. URL: ienerefugeehub.eu/information

[1] Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 Laying Down Standards for the Reception of Applicants for International Protection, 2013 O.J. (L 180) 96, http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex%3A32013L0033, archived at https://perma.cc/H6EY-BE5B.

Section 3: Refugee country of origin information on language and religion

According to UNHCR, almost 60 per cent of those arriving in Europe in 2017 come from the world's top 10 refugee-producing countries, primarily from the Syrian Arab Republic (Syria), Afghanistan, Nigeria and Iraq [Figure 3].

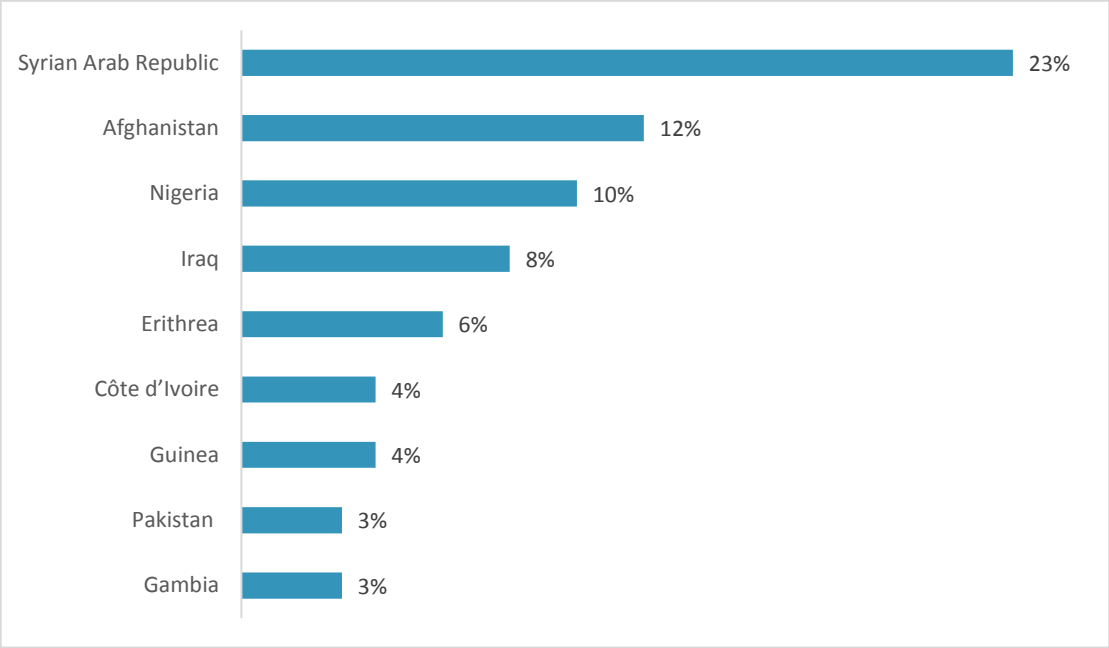


Figure 3: Main countries of refugee population's origin in EU. UNHCR REGIONAL REFUGEE AND MIGRANT RESPONSE PLAN FOR EUROPE, January-December 2017

Refugee intakes to EU, show a huge diversity of religion, language, as Table 1 indicates.

Table 1: Summary of religious, linguistic groups of most common refugee populations resettled in EU

Country	Religious and ethnic groups	Languages
Afghanistan	Mainly Sunni Muslims, with Shiite minority, also some Hindus, Sikhs and Jews; ethnic groups include Pashtun, Tajik, Hazaras, Uzbek and others	Pashtu, Dari, Turkic, and other minority languages
Eritrea	Coptic Christian; Islam; Catholic and Protestant minorities; some traditional religions	Mainly Tigrinya or Tigray; also, Arabic and local languages; some English and Italian
Ethiopia	Ethiopian Orthodox; Islam; some traditional African religions	Amharic, Oromo, Tigrinya, and local languages; some English and Italian
Iran	Mainly Islamic (Shias predominating), other Muslim groups including Kurdish groups, Bahá'í, Catholics, Jews, Zoroastrians	Farsi (Persian), ethnic minority languages including Kurdish

Iraq	Arab and Kurdish groups, mainly Islamic (Sunnis in north and Shias in south), also Christian Assyrians	Arabic, Kurdish, Assyrian
Nigeria	Predominantly Islam; minority Christian; some traditional religions	English (official) and other major African languages like Hausa, Igbo, Yoruba, Urhobo, Ibibio, Edo, Fulfulde and Kanuri
Somalia	Predominantly Islam; some Christians	Somali and Arabic; some English and Italian
Sudan	Predominantly Islam; minority Christian; some traditional religions	Arabic, including Creole Arabic in the south, and many local languages; also some English
Syria	Mainly Islamic (Sunni predominating); Alawite, Ismaili or Twelver Imami sects; Christians; Druze; Jews	Arabic, Kurdish, Armenian, Aramaic, Circassian, French, English

Refugee country of origin information on language and religion

Cultural Knowledge. Bitesized Online Learning. IENE 6 KNOWLEDGE HUB. URL: ienerefugeehub.eu/training/bitesizes-online-learning/cultural-knowledge/

Summary of the module

MODULE 2. Maternity care of migrant women

This module is intended to explain to healthcare professionals the needs of MAR women in the perinatal period, by focusing on the barriers that they seem to face. Furthermore, it intends to explain the barriers that HSCPs seem to face when they provide care to MAR women. The content of this module is based on two systematic reviews[2] carried out for the ORAMMA project, which identified the experiences and needs of childbearing MAR women in Europe.

General objectives

At the end of this module, trainees are expected to be able to:

- Understand the needs of childbearing MAR women.
- Understand the barriers to access healthcare.
- Recognize these barriers in their practice and give feedback.

Suggested teaching activities

- Small groups discussions
- Whole group discussions

Background

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. 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] Systematic reviews are available upon request

Section 1: Migrant women's experiences

From the systematic review, conducted with the aim of evaluating the state of current evidence on migrant women's experiences of pregnancy, childbirth and maternity care in their destination country within Europe, the following overarching themes relating to migrant women's experiences of perinatal care were revealed:

Access to care	Access to care was compromised for migrant women by their lack of awareness of their entitlement to maternity care and the importance of it.
Communication & information needs	Examples of communication and information needs identified were the need for professional interpreters, the need to be listened to, to be involved in decision-making and to receive more information on specific issues with regards to their pregnancy as well as coping after birth. These communication and information needs were noted by many migrant women to leave them unable to establish a positive relationship with their health professionals or to communicate their needs.
Self-esteem & psychological issues	Low self-esteem and psychological issues due to previous trauma and social isolation could impact upon migrant women's mental health.
Socioeconomic & living condition	Poor socioeconomic and living conditions became the primary focus of many migrants, over and above their health. Lack of finances and precarious work situations also meant attending maternity care appointments was difficult.
Quality of care	Quality of care was essential for migrant women due to the complexity of their needs. Continuity of care was seen as particularly beneficial to migrant women as it enabled them to develop trust in their healthcare professional. Migrant women appreciated culturally competent care that acknowledged and accommodated their traditional beliefs and practices.
Specific conditions in the perinatal period	Many specific perinatal conditions were noted to be more prevalent within the migrant community such as gestational diabetes, female genital mutilation and HIV.

In conclusion, migrant women need culturally-competent, trauma-aware, compassionate health professionals who listen to them and provide respectful, dignified and equitable perinatal care. Models of perinatal care for migrant women should facilitate multidisciplinary team-working and continuity-of-care and should go beyond clinical care needs to address women's social and economic challenges.

Let the trainees to discuss in small groups for 10 minutes about what needs they think MAR women may have and how they could handle them. Ask to give feedback to the rest of team.

Videos of women's experiences, URL: https://maternity.cityofsanctuary.org/films

Section 2: Health Care Professionals' experiences

Five themes were emerged as the main barriers faced by HSCPs, for optimal perinatal care offered to MAR pregnant women. These themes were further organized into subthemes as below:

Maternal socio-demographic characteristics	Immigrants' low socioeconomic status, precarious working conditions and language difficulties were listed among them and were related to lower standards of care or less choice.
Professionals' Cultural Competence	This theme included lack of cultural awareness and lack of equity and diversity programs. Indeed, 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.
Professionals' Interpersonal and Communication Skills	Lack of active listening and self- awareness among healthcare professionals hinder medical providers from delivering optimal maternal healthcare.
Maternity Services	Maternal lack of knowledge of maternity services use, NHS structure was found to impact on the time healthcare providers needed to be dedicated 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.
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.

Let the trainees to reflect and write down a few barriers that had faced while providing care to MAR women and how they could have be overcame. Ask to give feedback to the rest of team.

Summary of the module

MODULE 3. Taking Action: The ORAMMA project

This module is intended to explain to healthcare professionals what the aim of the ORAMMA project's deliverables are and how they can use them, when they provide healthcare to MAR women during the perinatal period. The module consists of knowledge and examples relevant to these tasks, as well as case studies [Appendix 1] that can be used as teaching aids.

General objectives

At the end of this module, trainees are expected to be able to:

- Understand ORAMMA's approach to integrated perinatal healthcare for MAR women.
- Provide a healthcare plan, based on the specific perinatal needs of MAR women, according to ORAMMA's recommendations included in the practice guide.
- Understand the importance of the Personal Operational Plan and My Maternity Plan and how to use them.
- Understand the importance of working as a member of a multidisciplinary team.

Suggested teaching activities

- Lectures
- Whole group discussion
- Case scenarios

Background

ORAMMA is an integrated, woman centred, culturally sensitive, and evidence-based approach to perinatal healthcare for migrant, asylum seeking or refugee (MAR) women. This approach extends from 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 gender equality for MAR populations and (c) promote safe pregnancy and childbirth through efficient access to quality maternity care for all MAR women and their new-born babies [Figure 4].

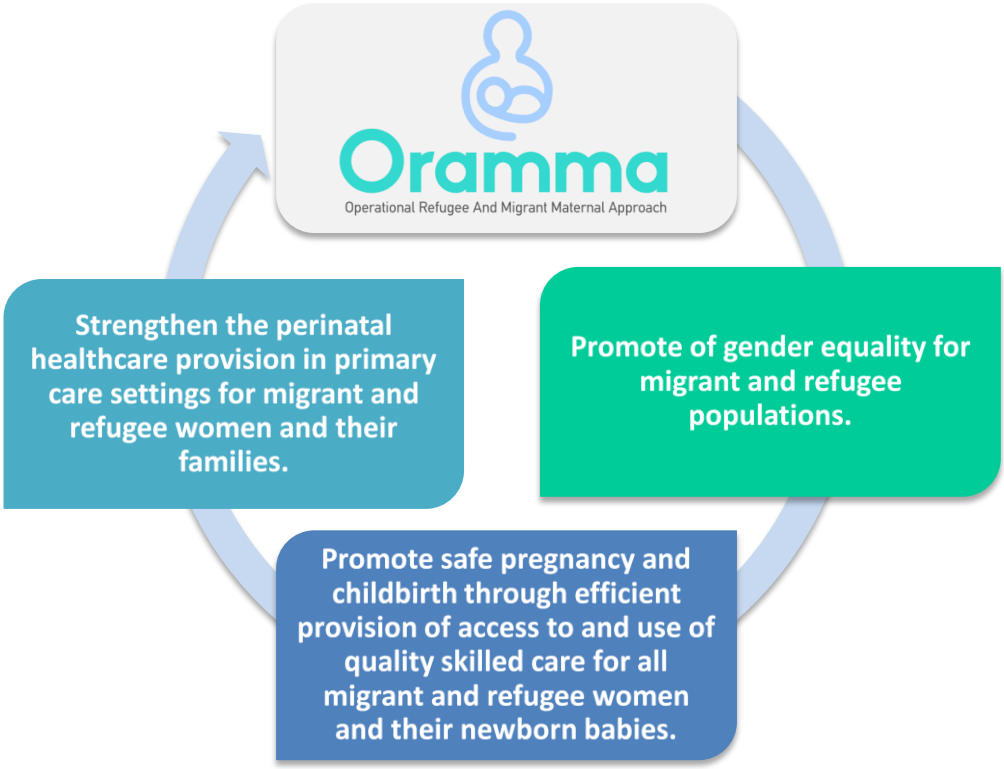


Figure 4: ORAMMA's aims

Section 1: The ORAMMA Approach to integrated perinatal healthcare for migrant, asylum- seeking & refugee women

The "ORAMMA Approach to integrated perinatal healthcare for migrant, asylum- seeking & refugee women" is a detailed plan setting out an approach to perinatal health services and applying practices that ensure safe motherhood for MAR women in European Union countries. The ORAMMA approach aims to respond to MAR women's complex needs by providing individualized and culturally sensitive maternity care. It contains all the characteristics of the approach, a description and role of multidisciplinary team, as well as description of phases and specifications on each phase of the perinatal healthcare provision.

Case I [Appendix 1]

ORAMMA Approach to integrated perinatal healthcare for migrant, asylum-seeking & refugee women

Section 2: The ORAMMA Practice Guide for perinatal healthcare of migrant, asylum- seeking & refugee women

The **"ORAMMA Practice Guide for perinatal healthcare of migrant, asylum- seeking & refugee women"** is a document that summarizes evidence and good practice to address the health risks associated with asylum-seeker, refugee and other migrant status women during the antenatal, intrapartum and postpartum period, as well as suggesting approaches to support these women during the perinatal period to meet their needs.

It is based on a literature review of scientific papers and reports from major health organization (such as WHO and NICE) and medical journals on perinatal healthcare of MAR women (special risks, best practices, case studies, implementing tools, social issues etc).

The aim is to provide practice guidance to enhance quality of care and reduce health inequalities for pregnant mothers from MAR backgrounds.

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

1. Overarching quality care standards and recommendations to enhance the care of MAR women (📖 Practice Guide, Chapter 3).
2. Highlights of perinatal care aspects focused on specific conditions experienced more commonly by MAR women during pregnancy, intrapartum and the postpartum period (📖 Practice Guide, Chapter 4).
3. Description of the role of each HSCP of the ORAMMA's multidisciplinary team (Midwife, GP or other medical doctor/ obstetrician, SCP) in the perinatal healthcare provision of MAR women (📖 Practice Guide, Chapter 5).

To enable sensitive and equitable perinatal care for MAR women, the above sections were developed through various rigorous approaches, including systematic reviews which were conducted to identify:

- MAR women's and HSCPs' experiences of perinatal care in Europe
- MAR specific conditions related to perinatal care
- the role of MPSs in perinatal healthcare of MAR women

How to use

📖 **ORAMMA Practice Guide, Chapter 3: "Overarching standards of care and recommendations for migrant or other refugee women"**

In this chapter, the reader can find recommendations regarding quality care standards and recommendations, derived from a systematic review regarding the provision of care during the perinatal period to MAR women. The topics included, concern:

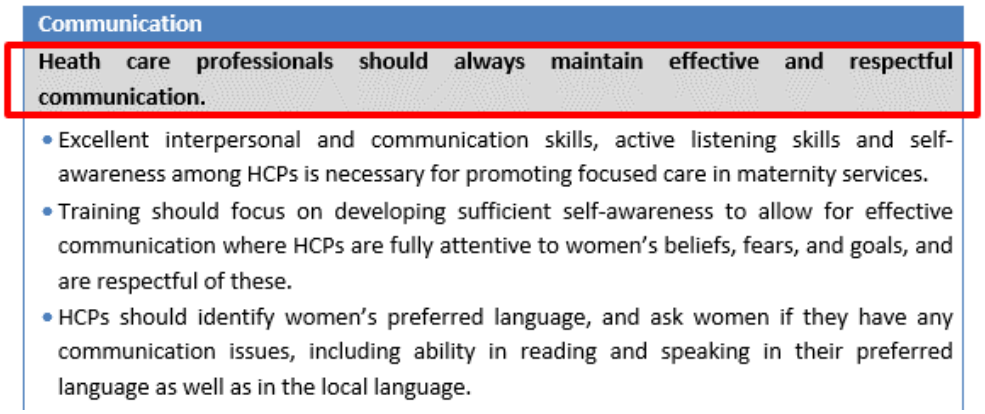
- access and follow up
- communication
- information needs
- self-esteem, attitude and psychological issues
- socio-economic and living conditions

- continuity of care and compassionate care
- building cultural competence
- leadership- policy reform

Example:

You are taking care of an MAR pregnant woman, who is able to speak your language. You are wondering which the evidenced based communication method is, when counselling her.

In the topic that refers to communication, you can find all the recommendations for effective communication with MAR woman. In the beginning of the table is the recommendation resulting from the literature review and is based on the ORAMMA approach [Figure 5, red frame]. Below this, are listed all the recommendations that have been identified by other authors.



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.

Figure 5: Example of how to use the Practice Guide

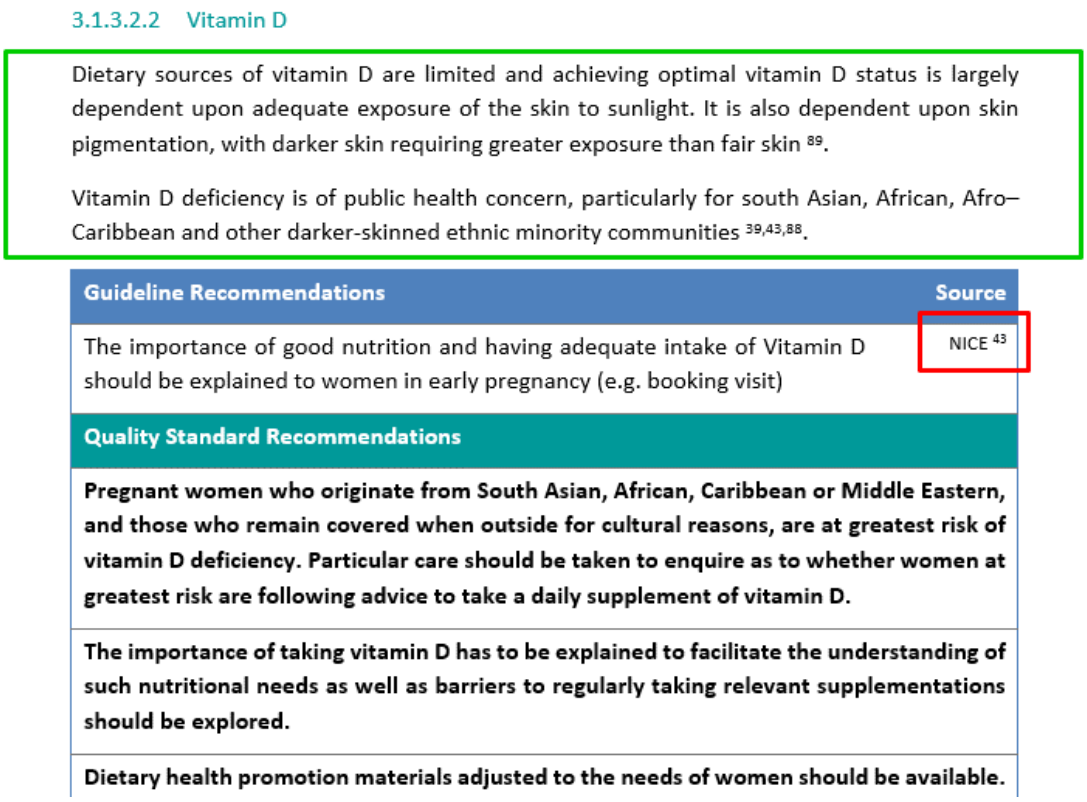
📖 **ORAMMA Practice Guide, Chapter 4: "Perinatal care of migrant or other refugee women"**

In this chapter, the reader can find the main perinatal care aspects, focused on specific conditions experienced most commonly by MAR women during the perinatal period. It is divided into three subsections, referring to the antenatal, intrapartum and postpartum period. Each subsection includes evidence on specific conditions experienced most commonly by MAR women and recommendations on their assessment. The 'Guideline Recommendations' are based on reports from major health organization (such as WHO, NICE, etc), while 'Quality Standard Recommendations' resulting from the literature review and are based on the ORAMMA approach, considering the specific characteristics and needs of MAR women.

Example:

You are taking care of a MAR pregnant woman and you are wondering which steps you should follow regarding the supplementation assessment.

In the subsection of Chapter 4, 'Nutritional supplementation' you can find some useful information and relevant references on this subject. Each paragraph contains literature evidence [Figure 6, green frame], references from major health organizations [Figure 6, red frame], as well as 'Quality Standard Recommendations' resulting from the literature review and are based on the ORAMMA approach, considering the specific characteristics and needs of MAR women on nutritional supplementation.



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 [89].

Vitamin D deficiency is of public health concern, particularly for south Asian, African, Afro–Caribbean and other darker-skinned ethnic minority communities [39,43,88].

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 [43]
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.	

Figure 6: Example of how to use the subsections of Practice Guide

🕮 ORAMMA Practice Guide, Chapter 5: "Multidisciplinary team working"

According to the ORAMMA approach, the healthcare professionals that constitute the multidisciplinary team are (a) midwives, (b) GPs or other medical doctors/ obstetricians and (c) SCPs. In this chapter, the reader can find the role of each member, as well as their fields of work and tasks during the perinatal period.

Each subsection of the chapter includes evidence on the role of each healthcare professional and recommendations on their tasks during the perinatal period. The 'Guideline Recommendations' are based on reports from major health organization (such as WHO, NICE,

etc), while 'Quality Standard Recommendations' result from the literature review and are based on the ORAMMA approach, considering the specific characteristics and needs of MAR women.

Practice Guide's recommendations on perinatal care of MAR women

Case II [Appendix 1]

ORAMMA Practice Guide for perinatal healthcare of migrant, asylum- seeking & refugee women

Section 3: The Perinatal Personal Operational Plan & My Maternity Plan

The **"Perinatal Personal Operational Plan"** is a tool that can be used by health professionals as an individualized healthcare plan for each woman for whom they provide care. It includes all the necessary information for the team of health professionals that provide care to MAR women during the perinatal period, like personal information, interpretation needs and contact details, as well as medical history related to pregnancy and childbirth. It is divided in three subsections: (a) 'Pregnancy', (b) 'Postpartum period' and (c) 'Maternal & infant outcomes'.

The **"My Maternity Plan"** is a tool that intends to empower the MAR mother to make decisions about her care during the perinatal period. It includes contact details, lists with the perinatal appointments, useful information for the women, such as the benefits and impact of the MMP for her and her family, symptoms that if she notices she should immediately call her midwife or doctor, etc. Furthermore, it includes a clinical summary, with basic information of the MAR mother's health condition, tables for recording and assessing the mother's needs during the perinatal period and checklists with topics that should be discussed within the counselling. The 'My Maternity Plan' is bilingual (English and the mother language of the MAR woman) and has the form of a booklet, so the MAR mother could have it with her in all her perinatal appointments.

The aim of the **Perinatal Personal Operational Plan & My Maternity Plan** is to provide all the useful information regarding the health and social needs of the MAR mother, to every professional who is taking care of her.

How to use

ORAMMA Perinatal Personal Operational Plan

Listed below are the parts of "Perinatal Personal Operational Plan" that HSCPs should fill out during MAR mothers' perinatal appointments. In case the national health system's records include thess information, skip this part.

1st antenatal visit	• Personal information and contact details • Estimated date of delivery and BMI calculation • Health history • Family medical history • Obstetric history • Immunization record • Substance use • Mental health history
1st & other antenatal visit	**Subsection: 'Pregnancy'** • Rhesus factor blood type and 'anti-D' injection dose administration • Tests during pregnancy • Ultrasound scans • Special features during pregnancy • Medications during pregnancy • Antenatal appointments (tests' results) • Antenatal assessments/admissions, multi-professional assessment
Early postpartum period	**Subsection: 'Postpartum period'** - at discharged from the maternity ward • Postnatal discharge summary • Postnatal care information • Information on infant feeding • Mental health assessment- EPDS
Postpartum follow- up	**Subsection: 'Maternal & infant outcomes'** It includes long term outcomes for mother and infant (e.g. ICU/ NICU, etc).

🕮 ORAMMA My Maternity Plan

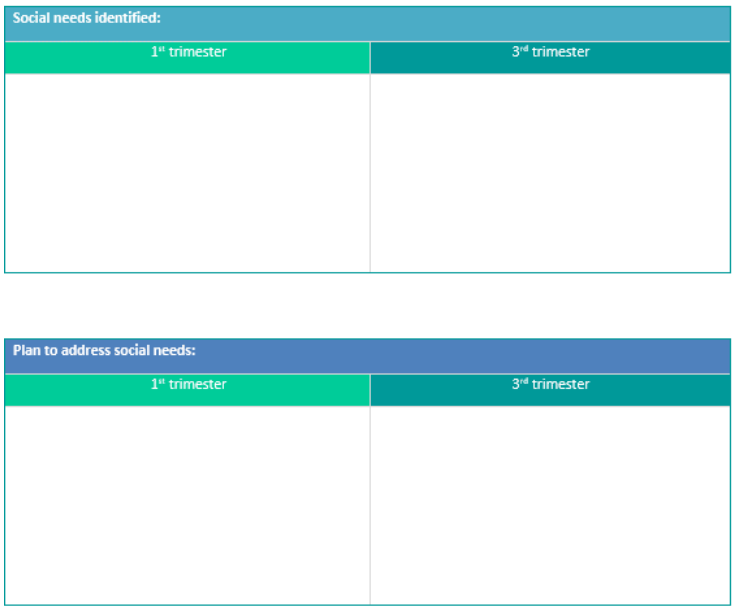
In each phase of the perinatal period (pregnancy, labour, postpartum), the MAR woman - with the help of the MPS- can note down her goals, the steps that she can follow in order to achieve them, as well as the people that can support her. This aims to empower her to make decisions about her care during the perinatal period.

In the 'Clinical Summary', the midwife or the doctor, assess the possible risks during pregnancy and writes down basic information regarding her health condition [Figure 7]

RISK ASSESSMENT	Y / N	OUTCOME	INVESTIGATIONS	DATE	OUTCOME
Medical conditions			MSU		
Obstetric issues			Hb		
Venous thromboembolism			Blood group		
Aspirin required?			Antibodies		
BMI			HBV		

Figure 7: The 'Clinical Summary' of the 'My Maternity Plan'

In the 'Needs' Assessment Tables', the MAR mother should be motivated to identify her needs (medical, social, nutritional, etc.) at the beginning of her pregnancy and with the support of the MPS and the HSCP, to create a plan to meet those needs. Towards the end of her pregnancy, the plan should be re-evaluated [Figure 8]



Social needs identified:	
1st trimester	3rd trimester

Plan to address social needs:	
1st trimester	3rd trimester

Figure 8: 'Needs' Assessment Tables' example

The 'Discussion Topics Checklists' are lists of topics that should be discussed with the MAR mother during her perinatal appointments with the midwife. With the assistance of the MPSs, midwives should provide counselling to MAR mothers on topics such as healthy eating, smoking, breastfeeding, etc. and check each of the topics that they have discussed, while noting down comments, when it is necessary [Figure 9].

Topics	Discussed-information provided/ Date	Comments
Health in pregnancy		
Maternity Benefits		
Place of birth		
Common symptoms		
Healthy eating *Folic acid* *Vitamin D* *Alcohol* *Drugs*		
Smoking *Effects in baby* *Effects in mother* *Smoking cessation*		
Travel safety		
Emotion wellbeing in pregnancy		
Support in camp or community		
Sex in pregnancy		
Preparation for birth		
Skin to skin contact		
Breastfeeding		

Figure 9:'Discussion Topics checklist' example

POP and MMP's aim and 'how to use'

ORAMMA Perinatal Personal Operational Plan & My Maternity Plan

Summary of the module

MODULE 4. Communication and Culturally Sensitive Practice

This module is intended to present to healthcare professionals good practices that they can adopt while taking care of MAR mothers, in order to ensure the best perinatal care of MAR mothers.

General objectives

At the end of this module, trainees are expected to be able to:

- Understand how they can communicate effectively with MAR mothers.
- Understand how they can provide culturally sensitive care to MAR mothers.
- Assess a MAR mother appropriately for post traumatic experiences.

Suggested teaching activities

- Lectures
- Activities
- Small group discussion
- Whole group discussion
- Role play

Section 1: Communicating effectively with migrant, asylum- seeking & refugee mothers

4.1.1. Five steps for an effective perinatal appointment

Step 1 — **Consider the possible barriers before starting the consultation**

MAR mothers may:

- Have experienced trauma and violence producing physical and psychological effects.
- Prefer a female practitioner
- Not understand the health system and how to access services
- Be reminded of past trauma during the consultation

Step 2 — **Consider the special needs of the MAR mothers**

- Consider the background of the mother and the community in which she lives
- Use MPSs as mediators to facilitate the communication
- Check whether other family members (e.g. father) need to be involved before scheduling the appointment
- Keep in mind before scheduling an appointment, that religious practices may affect the everyday life of MAR mothers, so for example, avoid scheduling an early morning appointment during Ramadan, because sleeping hours may differ during that period
- Allow extra time for the appointment, to accommodate communication, built a trusting relationship, give careful explanations, etc.
- Keep in mind that the mother may be late due to lack of experience with appointment systems, unfamiliarity with the transport system or with the location of the clinic, etc.

- Take a flexible approach to the timing and location of appointments to suit the unique requirements of MAR mothers.

Step 3	**Check whether the MAR mother has had prior health and pregnancy screening** If the MAR mother has been screened, she should be asked to bring her records to the appointment. For newly arrived refugees or asylum-seeking mothers, difficult immigration conditions may result in lack prior records, either because she lost them during the journey or due to difficulty in accessing healthcare services.
Step 4	**Engaging a Maternity Peer Supporter** MPSs are women with MAR background themselves, who speak a common language with the MAR mothers, but they also speak the language of the hosting county fluently and they are trained in some basic information about perinatal care. Since they have the same cultural background with the MAR mothers, they also have the role of a cultural mediator. Furthermore, one MPS accompanies one mother during all her perinatal appointments, so is easier for a trusting relationship to be developed between HSCPs, MAR mothers and MPSs. It is not appropriate to use family members or friends as interpreters, given the sensitivity and confidentiality of some of the issues such as domestic violence, mental health conditions and lack of partiality of involved parties. 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 (📖 Practice Guide, Chapter 3: Communication).
Step 5	**Consult in an appropriate way** • Speak slowly and clearly, using one or two sentences at a time. Pause to allow time for interpreting. • Make sure the mother is the focus of attention, not the interpreter. • Use simple language. Try to avoid medical terms and colloquialisms. • Avoid conversation with the MPS in front of the mother. If this cannot be avoided, try to include the mother or explain what is happening. • Explain your role carefully to MAR mothers. • Give reassurance about confidentiality, consent, choice and control. Conditions under which confidentiality cannot be maintained (for clinical safety) can also be explained at this time. • Make sure the MAR mother knows that everything that is said during the appointment will be interpreted. It is your responsibility to direct the interview. It is a prerequisite that any side conversations must be interpreted.

4.1.2. Enhance an effective communication

Establishing a trustworthy relationship with MAR mothers and communicating effectively during perinatal appointments, are crucial factors in providing safe, effective and appropriate care.

While consulting during a perinatal appointment, some basic principles should be considered [Figure 10]. For example, generalizations about ethnic groups should be avoided, since people from one group may 'look' similar, but there might be significant differences (e.g. some may be from rural backgrounds, others from urban or some may be religious, while others not). Furthermore, assumptions related to ethnicity or religion of MAR mothers should be avoided, for example a Muslim mother may not necessarily abstain from alcohol.

Figure 10: Principles to enhance an effective communication

Activity on effective communication [Appendix 1]

Office guide to communicating with limited English proficient patients. URL: www.multiculturalmentalhealth.ca/wp-content/uploads/2013/10/lep_booklet.pdf

Section 2: Providing care in a culturally sensitive way

Communication with MAR mothers may be affected by cultural and religious differences in (Goodwin et al., 2018, Withers et al., 2018, Camplin-Welch, 2007):

- Patterns of communication
- Views about pregnancy, childbirth, postpartum and new-born care
- Views about causes of illness and disability
- Views about ways in which illness and disability should be managed
- Views about the relationship with service providers
- Views about the role of western-style medicine in the management and prevention of pregnancy and postpartum ailments
- Individual versus collective approaches to illness and health
- Views about gender roles
- Cultural and religious customs and practices.

Considering the MAR mother's cultural and religious beliefs and practices, will help promote culturally and religiously responsive care for the mother and their family. The following steps encourage cultural competence in HSCPs(Foundation House, 2007):

Step 1	Take opportunities to familiarise yourself with the cultural and religious beliefs and practices of the MAR mothers with whom you work. This does not mean you have to know about all cultural/religious practices, other than respecting women's choices and beliefs.
Step 2	Acknowledge that you understand that MAR mothers may have different perspectives and experiences of illness and health, as far as the perinatal period is concerned.
Step 3	Ask MAR mothers if there are any special requirements or information that they would like you to take into consideration when providing care.
Step 4	Avoid making generalisations about individual mothers based on your experience of other MAR women from that cultural, ethnic or religious group: there are significant differences within groups.
Step 5	Avoid making assumptions based on a MAR mother's adherence to cultural or religious practices. For instance, a Muslim woman may not wear the traditional veil, nor be devout in other respects. Do not generalise or assume all adhere to practices that you know of that religion.
Step 6	When working with individual MAR mothers, check any impressions you have formed directly; for example, you can ask 'I understand that many Muslim women prefer to see a woman doctor. Do you prefer the same?'
Step 7	Beware of attributing too much to culture and religion backgrounds, since there are a range of factors affecting MAR mothers (such as SGBV, experiences in country of origin, educational level and settlement stressors).
Step 8	Be aware of the impact of your own culture and religion on the way you relate to MAR mothers. For example, your confidence in a western healthcare approach may lead you to overlook or dismiss a MAR mother's traditional health beliefs.
Step 9	In some cultures, it is common for family members to be involved in decision-making in healthcare matters. Additional time may be required for explanation and discussion with family members.
Step 10	If a MAR mother is unfamiliar with western approaches to healthcare, consider asking straightforward questions about their views in perinatal care, how they feel at present, what their biggest worries are about their pregnancy and what they believe will help.

10 steps to encourage cultural competence in HSCPs

Enhancing Cultural Competency: A Resource Kit for Health Care Professionals
URL: www.multiculturalmentalhealth.ca/wp-content/uploads/2013/10/Enhancing_Cultural_Competency_Resource_Kit1.pdf

CALD Cross Cultural Resource [e-Toolkit]. URL: www.ecald.com/resources/cross-cultural-resources/cross-cultural-resource-e-toolkit/

Section 3: Providing compassionate care

Compassion implies a sense of recognising the other as a being of worth, of a depth of care that goes beyond a simple professional relationship. Compassionate care is empathetic and loving (Hall, 2013). Culturally competent compassion is the human quality of understanding the suffering of others and wanting to do something about it, using culturally appropriate and acceptable healthcare interventions, which take into consideration both the mothers'- when it comes to MAR mothers' perinatal care - and the carers' cultural backgrounds as well as the context in which care is given (Papadopoulos and Pezzella, 2015). In midwifery, compassion is recognised as a quality that is wanted by women (Hall, 2013). The characteristics of compassionate care are described in Figure 11 (Danielsen and Cawley, 2007).

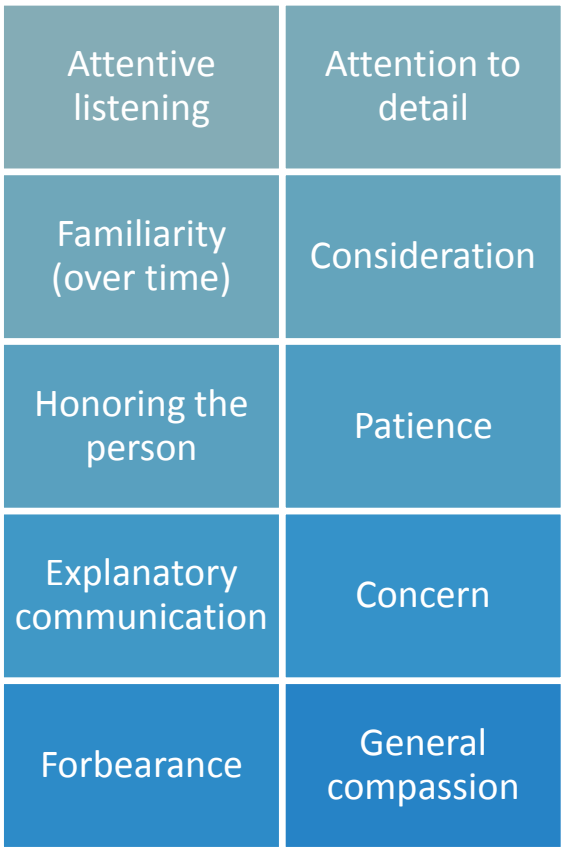


Figure 11: Characteristics of compassionate care

The steps that a HSCP should follow in order to be compassionate while providing psycho-emotional support to MAR mothers, are listed below:

Step 1	Giving the MAR mothers time and a safe space to speak to you and tell you about their problems or what is on their mind.
Step 2	Listening in an active way: sometimes just the act of listening can be very beneficial to a mother who is distressed
Step 3	Acknowledging and being aware that recalling traumatic events in itself can be distressing and evoke strong emotions
Step 4	Being aware of the MAR mother's culture and individual characteristics
Step 5	Being non-judgemental and non-critical whilst trying your best to advocate and find acceptable solutions
Step 6	Letting the MAR mothers show their emotions; letting them know that being sad, angry, distressed and shocked are human ways of responding to traumatic and stressful life events and situations
Step 7	Building a therapeutic relationship with the MAR mother, that is based on respect, acceptance and a genuine desire to help.

Adapted from*: Ali S, Papadopoulos I. Bitesized Learning Tool No2: Culturally Competent Compassion. IENE 6 KNOWLEDGE HUB. Middlesex University 2017*

7 steps for providing compassionate psychological support

Activity on compassionate care [Appendix 1]

Culturally Competent Psychological Compassion. Bitesized Online Learning. IENE 6 KNOWLEDGE HUB. URL: ienerefugeehub.eu/training/bitesizes-online-learning/culturally-competent-psychological-compassion/

4.3.1. Assessing trauma

Many MAR people believe they have been permanently physically damaged by their experiences. History taking, physical examination and procedures may trigger traumatic memories. A sensitive and gentle physical examination with careful repeated explanation of investigation results may be immensely reassuring. A MAR mother is more likely to disclose a trauma history if the HSCP has displayed empathy, interest, and allowed adequate time (Gardiner and Walker, 2010).

If a traumatic experience is suspected, the screening must be done in a very sensitive and culturally appropriate way, through questions that may enable the MAR mothers to reveal some of their story in a 'safe' way if they choose [Table 2]. Further helpful questions include genogram construction, migration history and current household composition and functioning, resettlement difficulties and the plight of family overseas. Enquiry into sleep, energy levels, daily tasks, appetite, concentration, memory and 'worries' are an appropriate and culturally acceptable mental health screen (Gardiner and Walker, 2010).

Table 2. Culturally appropriate screening for trauma (Kuwert et al., 2009)
'Are there any health problems for you/your children that you are very worried about today?'
'Has anything happened to you/your family in the past, that you think may be causing this problem you have today?'
'What was happening to you/your family when this problem started?'
'Many people in your situation have experienced… I do not need to know the details, but has anything like this happened to you?'
'Sometimes people's health problems are due to things which have happened in the past, such as violence or detention…' [or specify the difficult circumstances if you know them] … 'do you have any injuries or pain (from those experiences) which may need attention?'
'In your culture, is this problem considered serious? What is the worst problem it could cause you? What is usually done to make the problem better?'

Table 3. A framework for management of MAR mother survivors of trauma			
	ENVIRONMENTAL	**PHYSICAL**	**PSYCHOLOGICAL**
Short term	Engage with the MAR mother Use MPSs Allow for adequate time Reassure the MAR mother about confidentiality Encourage familiarity with local services (eg. pharmacy, emergency, settlement service, transport)	Focus on the MAR mother's concerns first Perform a comprehensive need assessment and develop a problem list Take time to explain examinations, investigations and results	Avoid premature recall of the trauma; let the MAR mother lead A genogram and current household composition may enable the MAR mother to talk about who is missing or in trouble overseas Allow the MAR mothers to ventilate and validate their experience
Medium term	Review regularly Assess and assist with housing, educational and financial concerns and liaise with local agencies if needed Encourage participation in culturally and gender appropriate groups and hobbies Encourage spirituality and observance of the mother's preferred religious practices to assist with the feeling of connection with the community	Refer to allied health and alternative therapies if needed and acceptable to the MAR mother For chronic pain and somatic symptoms investigate physical pathology adequately. Careful and repeated explanation of results may be required	Medication may be required for distressing symptoms and contribute to a sense of safety Suggest relaxation strategies: progressive muscle relaxation, breathing exercises, sleep hygiene Chronic pain may be a reminder of torture and trauma. Consider the effect of intercurrent stressors, early childhood experiences and family separation: 'What was happening when this problem started?'
Long term	Parenting/family strengthening may be needed Offer to assist with migration and sponsorship issues via referral to appropriate agencies	Specialist review if needed for persistent and distressing symptoms Encourage and promote healthy lifestyle choices (eg. smoking cessation, physical activity)	Use CBT techniques in a limited way, eg. cognitive reframing, reality checking, problem solving, activity scheduling Reinforce the mother's own resources and strengths. Do not attempt trauma exposure Assist with grief and bereavement counselling (losses may be multiple including property, status and vocation)
Adapted from: ***Gardiner J, Walker K (2010) Compassionate listening. Managing psychological trauma in refugees. Australian Family Physician Vol. 39, No. 4***			

"Culturally appropriate screening for trauma" [Appendix 1]

Summary of the module

Summary of sections

Welcome & Introduction - 30 min

General Objectives	Sections	Topics	Teaching/ learning activities (with suggested time)	Suggested facilitators/ resources
• To let trainees to know each other • To familiarize themselves with the content of the training • Evaluate the cultural competence of trainees before the sessions	1. Icebreaker exercise	• Participants introducing themselves • Sharing their experiences with migrant mothers, and expectations	Icebreaker exercise (10 min)	• Ball or soft toy
			Whole group discussion (10 min)	
	Pre-test cultural competence		(10 min)	• Cultural Competence Questionnaire (pre-test)

Module 1. Introduction to migration - 1 hour

General Objectives	Sections	Topics	Teaching/ learning activities (with suggested time)	Suggested facilitators/ resources
• Understand the difference between a migrant, a refugee and an asylum seeker • Identifying vulnerable populations • Know the obligations by the law, regarding the healthcare and social welfare provision to MAR women	1. Migration status	• Definitions on migration status	Story telling: "Walk in the park" & Whole group discussion (10 min)	
			Lecture (10 min)	• Projector and screen • Power point presentation
			Video: "Seeking asylum in the EU" (5 min)	• Projector and screen
	2. Migration policy and access to Health Care and Social Welfare	• EU migration policy • Migrants' rights to access healthcare and social welfare	Small or whole group discussion (15 min)	• Flip chart white board at front for leader to write on as groups feedback
			Lecture (10 min)	• Projector and screen • Power point presentation
	3. Refugee country of origin information on language and religion	• Religious and linguistic characteristics of most common refugee populations resettled in EU	Lecture (10 min)	• Projector and screen • Power point presentation

Module 2. Maternity care of migrant women - 1 hour

General Objectives	Sections	Topics	Teaching/ learning activities (with suggested time)	Suggested facilitators/ resources
• Understand the needs of childbearing MAR women. • Understand the barriers to access healthcare. • Recognize these barriers in their practice and give feedback.	1. Migrant women's experiences	• Experiences of pregnancy, childbirth and maternity care in MAR women destination country within Europe	Small & whole group discussion (20 min)	• Papers & pens • Flip chart white board at front for leader to write on as groups feedback
			Videos (10 min)	• Projector and screen
	2. Health care professionals' experiences	• Barriers faced by HSCPs, for optimal perinatal care offered to MAR pregnant women.	Small & whole group discussion (30 min)	• Papers & pens • Flip chart white board at front for leader to write on as groups feedback

Module 3. Taking Action: The ORAMMA project - 1 h 30 min

General Objectives	Sections	Topics	Teaching/ learning activities (with suggested time)	Suggested facilitators/ resources
• Understand ORAMMA's approach to integrated perinatal healthcare for MAR women. • Provide a healthcare plan, based on the specific perinatal needs of MAR women, according to ORAMMA's recommendations included in the practice guide. • Understand the importance of the Personal Operational Plan and My Maternity Plan and how to use them. • Understand the importance of working as a member of a multidisciplinary team.	1. The ORAMMA Approach to integrated perinatal healthcare for migrant, asylum- seeking & refugee women	• Description of the approach	Case study (30 min)	• Papers & Pens • Flip chart white board at front for leader to write on as groups feedback
				• Handout: The ORAMMA Approach
	2. The ORAMMA Practice Guide for perinatal healthcare of migrant, asylum- seeking & refugee women	• Description of the structure • How to use the Practice Guide	Lecture on Practice Guide's guidelines (20 min)	• Projector and screen • Power point presentation
				• Handout: The ORAMMA Practice Guide
			Case study (20 min)	• Papers & Pens • Flip chart white board at front for leader to write on as groups feedback
	3. The Perinatal Personal Operational Plan & My Maternity Plan	• Description of the structure • How to use the Practice Guide	Lecture on POP/ MMP content (20 min)	• Projector and screen • Power point presentation
				• Handout: The ORAMMA POP/ MMP

Module 4. Best Practices for Health Care Professionals - 1 h 30 min

General Objectives	Sections	Topics	Teaching/ learning activities (with suggested time)	Suggested facilitators/ resources
• Understand how they can communicate effectively with MAR mothers. • Understand how they can provide cultural sensitive care to MAR mothers. • Assess properly a MAR mother with post traumatic experiences.	1. Communicating effectively with migrant, asylum- seeking & refugee mothers	• Communication techniques • Steps for an effective appointment with MAR women	Lecture (10 min)	• Projector and screen • Power point presentation
			Activity & Whole group discussion (20 min)	• Communication errors' list • Pens
	2. Providing care in a cultural sensitive way	• Steps for enhancing cultural competence	Lecture (10 min)	• Projector and screen • Power point presentation
			Whole group discussion (10 min)	• Flip chart white board at front for leader to write on as groups feedback
	3. Providing compassionate care	• Steps for establish compassionate care • Grief assessment techniques • Trauma assessment techniques	Lecture (10 min)	• Projector and screen • Power point presentation
			Activity & Small group discussion (30 min)	• Papers & Pens • Flip chart white board at front for leader to write on as groups feedback

Summary & Conclusion - 30 min

General Objectives	Sections	Topics	Teaching/ learning activities (with suggested time)	Suggested facilitators/ resources
• To summarise the training • To take feedback from trainees • Evaluate the cultural competence of trainees after the sessions	Feedback on training, feelings or questions		Whole group discussion (20 min)	
	Pre-test cultural competence		(10 min)	Cultural Competence Questionnaire (post- test)

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Appendix 1

Icebreaker exercise

This exercise is supposed to be performed before the beginning of the train sessions.

Purpose:

- To help trainees get to know each other.
- To give trainee some practice with communication.

Materials:

- Ball or soft toy

Preparation:
The trainees will stand in a circle. If there are more than 20 trainees, they should be divided into two or more groups.

Activity:
Explain that this exercise is all about getting to know each other. Start by tossing the ball to someone and asking them a question. They will answer the question and then toss the ball to someone else and ask a different question. If trainees are not familiar with each other, they may want to state their name, too.

When the game has been going for about a minute, challenge the participants to repeat a fact about another participant before they ask a question.

If someone is not comfortable answering a question, he/ she may pass.

Case Studies

Case I

Haifa, is a 26- year- old pregnant woman from Syria. She fled her country after terrorists attacked her village. As she mentions *"…there was nothing else to do but flee. With kids in arm and 4 months pregnant, we fled for our lives, literally, running on foot out of the village"*. During the attack, her son, her niece and her father were killed in front of her eyes, so she had to travel alone, because her husband had to stay back in Syria.

She travelled across her country through conflict and check points and arrived in Greece, through the sea, in January 2016. She lived in Lesvos for 2 months and finally arrived in Athens, where she lived in Piraeus port hotspot. Her goal was to resettle in Germany and live with her sister's family.

She doesn't speak or understand English or any language other than her mother language. She reports a severe cough, exhaustion and not sleeping well because of nightmares.

Because of the symptoms, Haifa was referred to a primary health care center, where the health providers were not able to communicate with her, as they didn't speak a foreign language other than English, and interpreter services were not available. The consultation was made via non- verbal means (signs, drawings, etc.) She resisted when she went to be examined by a male GP.

She felt dizzy and almost fainted while she was waiting in the reception room, because she had not eaten a proper meal for days. She didn't have an antenatal check after she left her country.

Questions:

1. What is Haifa's immigration status?
2. What are her healthcare needs?
3. What are the barriers in the provision of healthcare?
4. Which healthcare professionals can collaborate so that Haifa can get the care she needs?
5. What is the healthcare plan in this case, according to the ORAMMA approach?

Case II

Amad is a 32-year-old woman from Iraq, who has lived in an apartment during the last year, with her husband and their two children. She is pregnant, and she is visiting, for the first time, a midwife for antenatal assessment. She is weighting 88 kg (194 lbs) and her height is 1,63 m (64,17 inch). She reports that before getting pregnant, her weight was approximately 75 kg (165,34 lbs). The gestational age, according to her last menstrual period is 20+3 weeks and the fetal heart beats are positive.

Her children are a girl who is 4 years old and a boy who is 16 months old. Both, were born in Iraq, with birth weight 3,320g (7,32 lbs) and 4,450g (9,81 lbs). She reports that she had at least three miscarriages in the past.

She has not had any pregnancy screening until now and her family history shows that her mother died during labour “because the baby was very big, and she couldn’t give birth”.

Questions:

1. Are there any concerns regarding the pregnancy outcome in this case?
2. What are the next steps in Amad’s health care provision?
3. What recommendations should be made?
4. Where should we pay attention when providing care, regarding the cultural and religious background of Amad and her family?
5. Does Amad need to be referred to a specialist health professional?
6. If you have the opportunity to see Amad on her next prenatal visits, how would you plan to provide care?

Story telling

A Walk in the Park

Materials:

- Pictures of parklands/trees (optional)
- Sheets of paper
- Pens

Preparation:
This is a guided imagination 'A walk in the park'. Let the trainees to choose a picture of a park that appeals to them. Guide the trainees through the exercise step-by-step: "Just relax into it and close your eyes - imagine you are entering a park that looks just like the picture you have chosen. Enjoy your walk through the park. Notice everything!"

Activity:
«Imagine you are standing at the entrance to a park. You really like this park. It is an interesting place, filled with winding paths and intriguing sights and sounds. You are looking forward to your walk and what you will discover here.

You can feel a light warm breeze across your face and you can hear leaves rustling on the trees – you can also hear children laughing and people talking in the distance. You like these sounds, they make you smile.

You walk slowly along the path and it takes you from the entrance deeper into the park. All around you, there are interesting plants and trees, and you can smell freshly-cut grass. You can see and hear people in the distance.

You continue walking and you hear laughter close by. To your right, **a couple are eating ice-cream**, lying on the grass, talking happily together. You smile and walk on.

A little further on, under the trees, the path winds past a park bench. **Someone** is sitting on the bench alone, stroking their dog. You nod at them as you pass by and continue on the path.

Now you are walking beneath some large old trees - you see **a group of people** coming toward you – they are chatting, and they obviously know each other very well, they are joking and teasing one another. You look at them, they say hello in a friendly way and you nod back at them.

As you continue along the path, you see **another couple sitting on the grass having a picnic**. One of them is organising the food, laying things out on a rug, while the other is sitting cross-legged, working on a laptop computer. They are chatting to each other while they organise the food and work on the laptop.

Now you can hear the sound of splashing and wonder where the sound is coming from – you look around and see a pool, very shallow, and some children and adults playing in the water. The path takes you slowly towards the pool and you stand and watch for a while. **One couple is playing ball with two small children**; **another couple is wandering slowly along the edge of the pool, hand-in-hand**. On the far side, in the distance, you can see **a nurse** in a white uniform **helping someone** to walk along - now they stop to watch some children playing at the centre of the pool, floating plastic toys on the surface of the water and chattering loudly. The children are really enjoying themselves and they sound happy. You walk on past the pool

and continue to follow the path as it slopes downhill.

As you reach the bottom of the slope, you notice **some people** coming towards you; they seem to be engrossed in conversation and they pass you by. The sounds of the children laughing are fading into the background.

In the distance you see an old gate that leads into another part of the park, into a walled garden. Slowly, you walk towards the gate, and moving through it, you see an old wooden bench by the wall. You walk towards the bench and sit on it.

Feel the seat beneath you. Feel the breeze on your face. This is the end of your walk in the park. When you are ready, open your eyes.

Return to the room. »

A. Debriefing and feedback questions

1. Were there any people not of your ethnicity in your park?
2. Were any of the people you saw and watched in the park using a wheelchair? Did any of them have any type of visible disability?
3. The person on the first bench stroking a dog, was it an elderly person? Male or female? Ethnicity?
4. Were any of the couples (the ice-cream eaters, the picnic couple, the couple playing ball with children, the couple wandering by the edge of the pool hand-in-hand) a same-sex couple?
5. The couple who were having a picnic – what sex was the person laying out the food? Female or male? And the person working on the laptop - man or woman? Ethnicity?
6. Were the children and adults playing in the shallow water representative of a range of ethnicities? Or all of the same ethnic origin?
7. Was the nurse in the white uniform male or female? Ethnicity?
8. Was the person being assisted by the nurse young or old? Ethnicity?
9. Towards the end of your walk in the park, a group of people came towards you engrossed in their conversation -
   a) what age range were they?
   b) gender?
   c) accents?
   d) ethnicity?
   e) ability/disability?
   f) type of dress?
   g) did you unconsciously ascribe a potential religious affiliation to them, or any of them?

B. Reflection questions

1. Surprised by anything?
2. What- if anything- does this exercise highlight for you?
3. Does this exercise reveal anything to you about unconscious biases you may have?
4. Does this exercise reveal anything to you about your attitude/s?
5. Does this exercise reveal anything to you about norms and expectations you operate with?

Activities

Activity on effective communication

Purpose:
By the end of this activity trainees will are expected to:

- understand the importance of an effective communication
- understand the pitfalls to avoid while communicating

Materials:

- Communication errors' list (see below)
- Pens

Preparation:
Divide the trainees into groups of 3 and gave them the role of HSCP, MAR woman and observer. Give to each observer a list of communication errors.

Activity:
Ask trainees who have the role of HSCP and MAR woman to start a short dialogue. Ask from the observer to note the communication errors including in the list, during the dialogue. A whole group discussion can follow upon completion of the dialogue on feelings as well as pitfalls during communication.

Communication error list

☐ Avoid using the following:
☐ Command: "Stop doing this"
☐ Threating/ warning: "If you don't do that, then…"
☐ Ethical style: "You have to respect the elderlies"
☐ Direct advice: "Why don't you…"
☐ Criticism: "Don't you think what you did was wrong?"
☐ Reassuring tone: "Don't worry, everything is going to be fine"
☐ Neglection of the problem/ feeling: "Everyone feels the same"
☐ Comment instead of feedback: "I don't like this behavior"
☐ Barriers:
☐ Stereotypes- "labeling"- low expectations
☐ Wrong message hypothesis- no use of feedback
☐ Communication barriers related to: personality, age, etc.
☐ Authoritarian communication style
☐ Frequent interruptions
☐ Provider's coping strategies/ values - not accepting specific behaviors/ people, etc.
☐ Noise or room set up that does not facilitate an effective communication
☐ Different perceptions
☐ Linguistic, cultural or religious differences
☐ Different educational level/ low- literate attentant
☐ Provider's vocabulary is inconsistent with that of attendant
☐ Non- verbal communication is not taken into account

Activity on compassionate care

Purpose:
By the end of this activity trainees will are expected to:

- be aware of the characteristics of compassionate care
- understand how they can provide care with compassion

Materials:

- Handout: characteristics of compassionate care [Module 4, Section 3, Figure 11]
- Papers and pens

Preparation:
First the trainees are divided into small groups. Read aloud the following story:
"A refugee woman has arrived from Syria on a boat. She is carrying her baby who has died during the boat journey. The woman is in shock and very distressed. You are supposed to take care of her."

Activity:
Ask from the trainees to work in groups and write a small dialogue between the care provider and the woman (10 minutes), based on how they would provide care as HSCPs. After that, ask from groups to read their dialogues to the rest of team.

In the second phase of the activity, handle the handout with the characteristics of compassionate care and ask the groups to give feedback:

1. Have they used any of these characteristics while writing the dialogues? Would they change anything?
2. Do they use any of these characteristics in their work as HSCPs?

Role Plays

Purpose:

After this activity the trainees are supposed to:

- be aware of the culturally appropriate screening for trauma
- understand how they can screen for trauma in a culturally appropriate way

Preparation:

After a presentation of culturally appropriate screening for trauma [Module 4, Section 3, Paragraph 4.3.1., Table 4], read aloud the following story:

"Farousha, is a pregnant woman from Syria, who has nutritional disorders and intense mood swings. You suspect she has been victim of sexual violence."

Activity:

You (or an actor) become the HSCP, who will perform a **non-culturally appropriate** screening for trauma and one of the trainees will be the woman. After the performance of a small role play, ask the trainee to say what he/ she felt during the process and ask the rest of the team for feedback.

Repeat the role play, performing a culturally appropriate screening for trauma and ask the team for feedback.

Appendix 2

Evaluation Test: Cultural Competence Questionnaire

Post- evaluation test (correct answers are marked)
(NOTE: for pre-evaluation test, exclude questions 12 - 17)

You are receiving this questionnaire because you are taking part in the training which is in the framework of the ORAMMA project about perinatal care MAR woman. It will take about 10 minutes to complete. The questionnaire is anonymous, and all data will be treated confidentially.

This questionnaire has been developed by the department of Primary and Community Care at Radboud University Medical Centre, Nijmegen, the Netherlands in collaboration with the Faculty of Health and Wellbeing at Sheffield Hallam University, the Athens School of Midwifery and the Department of Social Work, TEI of Crete. It is based on the example of the questionnaire on cultural competent palliative care that was developed by the department of Social Medicine of the University of Amsterdam, the Netherlands together with Pharos, the Dutch center of expertise on health disparities.

Participation code: _____

1. To what extent do you feel capable to provide adequate perinatal care to migrant women who have recently migrated (less than 5 years ago) to your country?

1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Not capable at all Extremely capable

2. Case study

Farousha is pregnant, she is 24 years old and originally from Northern Iraq. As undocumented migrant she does not possess a legal residence permit and lives in a house with other recently arrived migrants. She does irregular, illegal work such as cooking and cleaning for families. She speaks very little English. She does not have a partner and it is not clear who the father of her unborn child is. She mentions that she hopes by being pregnant will help her to leave to remain.

When she visited your practice for the first time she was over 4 months pregnant. She does not know much about her own medical history or her family's medical history, or about normal pregnancy. Today is the second time she has not arrived for her appointment.

What are your thoughts and feelings when you imagine this is your patient? Please indicate below (you can choose more than one option):
☑ I respect and understand her choice to become pregnant under these circumstances
☑ I understand why it is hard for her to stick to her scheduled appointment
□ I feel irritated because she fails to show up for the second time
□ I cannot understand why she wants to bring up a child in the world under these conditions
☑ I feel sorry for her
☑ I am worried about her

☑ I am worried about her child
□ I feel desperate because I have no idea how I can help her
☑ I am glad at least I will be able to help her
☑ I am considering informing the child protection organisation about her condition
☑ I feel the need to consult somebody with more experience with these kinds of patients
□ Other, namely: _____

3. Think about your practice over the past 6 months. How many patients have you seen with whom there was a language barrier?
□ none
□ 1- 5
□ 5-10
□ > 10

4. In the case of a language barrier, how often did you make use of one of the following types of help?

	Never	1-5 times	6- 10 times	>10 times
a. Professional interpreter (personally attending the consultation)	□	□	□	□
b. Professional interpreter (by telephone)	□	□	□	□
c. Bilingual colleague	□	□	□	□
d. Adult informal interpreter (family or friend)	□	□	□	□
e. Child younger than 16 years	□	□	□	□

5. Please indicate which of the following types of help are appropriate

	Always appropriate	Most times	Most times not	Never appropriate
a. Professional interpreter (personally attending the consultation)	□	☑	□	□
b. Professional interpreter (by telephone)	□	☑	□	□
c. Bilingual colleague	□	□	☑	□
d. Adult informal interpreter (family or friend)	□	□	☑	□
e. Child younger than 16 years	□	□	□	☑

6. Please indicate if the statements below are right or wrong:

a. Women from Africa and Asia live closer to nature; they do not need much guidance during pregnancy

☐ Right ☑ Wrong ☐ I do not know

b. Pregnant migrant women know enough about the organization of healthcare

☐ Right ☑ Wrong ☐ I do not know

c. Nearly all migrants are Muslim

☐ Right ☑ Wrong ☐ I do not know

d. Pregnant migrants have a theatrical way of showing pain

☐ Right ☑ Wrong ☐ I do not know

e. Many pregnant migrant women feel lonely

☑ Right ☐ Wrong ☐ I do not know

f. Many husbands of pregnant migrants refuse care by a male gynaecologist

☐ Right ☑ Wrong ☐ I do not know

g. African women feel less pain during delivery than European women

☐ Right ☑ Wrong ☐ I do not know

h. Many women prefer female doctors

☑ Right ☐ Wrong ☐ I do not know

7. Case study

After 6 months of pregnancy, Farousha gets permission to move temporarily to a shelter nearby, to await the birth in a secure environment. You are still her perinatal care provider.

Which of the following statements are true?

a. pregnant asylum seekers and undocumented migrants have the right to access healthcare

☑ True ☐False ☐I do not know

b. interpreter services for undocumented migrants are free of charge

☐True ☐False ☐I do not know

c. when the child is born she/he will get the (add country) nationality

☐True ☐False ☐I do not know

d. as Farousha does not possess a residence permit, it is better not to announce the birth of her child to the local authorities

☐True ☑ False ☐I do not know

8. Knowledge medical aspects

How often do the following problems occur in pregnant migrant women compared to non-migrant women?

	Very often	More often	Equally often	Less often
a. premature birth	☐	☑	☐	☐
b. complex delivery	☐	☑	☐	☐
c. breast feeding problems	☐	☐	☑	☐
d. diabetes mellitus	☐	☑	☐	☐
e. anemia	☐	☑	☐	☐
f. financial problems	☐	☑	☐	☐
g. (domestic) violence	☐	☑	☐	☐

h. bonding problems	☐	☑	☐	☐
i. depression	☐	☑	☐	☐
j. low literacy	☐	☑	☐	☐
k. perinatal mortality	☐	☑	☐	☐
l. smoking during pregnancy	☐	☐	☐	☑

9. Case study

Farousha has given birth two day ago to a healthy daughter; the girl is small for age but otherwise they both are well. During the birth Farousha was very anxious and, although she consented to it, a vaginal examination was extremely difficult.

Within a few weeks she has to leave the shelter; she still does not have any financial means nor place of her own. She has been offered a government supported accommodation where she gets care and support, but she does not want to go there because she is afraid they will deport her from there.

What would you do if you were her perinatal care provider? You can choose more than one option:

☐ As I am used to, I end my care after 2 weeks, and give her a letter with all relevant information to hand over to the midwife / GP who will provide somewhere the check-up after 6-weeks
☑ You personally would approach different organizations who support (undocumented) migrants to arrange support and a safe place to stay for Farousha and her child
☑ You discuss with her the pro-and cons of this government accommodation

☐ You write a letter to the government to plead for Farousha to be allowed to stay longer at her current shelter, at least until she has had the regular check-up after 6-weeks by her own GP / midwife
☑ You suspect Farousha has been the victim of (sexual) violence and discuss this with her
☑ You inform the general practitioner and / or health visitor about her because she is at high risk for medical and mental health complications post-partum
☑ You did not think about it before, but now you wonder whether Farousha might have undergone FGM, and discuss this with her

☐ As there is no husband or partner, and communication is difficult, you do not discuss contraception with Farousha
☑ You inform her about all relevant opportunities to get social and other care and support for herself and her child

10. Below are characteristics of learning and functioning in practice. Please indicate for each characteristic to what extent you think this is applicable to yourself (on a scale of 1 to 5)

1 2 3 4 5

Not at all ☐ ☐ ☐ ☐ ☐ Totally applicable

	1	2	3	4	5
a. I can easily imagine how people feel when they are from a different cultural / religious background.	☐	☐	☐	☐	☐
b. I am able to question my own views.	☐	☐	☐	☐	☐
c. I am aware of how my views are culturally influenced.	☐	☐	☐	☐	☐
d. I recognise the influence of stereotypes about patients on my thoughts.	☐	☐	☐	☐	☐
e. I recognise the influence of stereotypes about patients on my behaviour	☐	☐	☐	☐	☐
f. I can easily empathise with the situation of other people.	☐	☐	☐	☐	☐
g. I do not like to question my own views.	☐	☐	☐	☐	☐
h. I am aware of how culture shapes individual's behaviour and thinking	☐	☐	☐	☐	☐
i. I am aware of the social context of certain migrant groups.	☐	☐	☐	☐	☐
j. I can adapt flexibly and creatively to a new situation.	☐	☐	☐	☐	☐

11. Please indicate for each of the following aspects to what extent you feel capable of delivering adequate care to pregnant migrants (on a scale of 1 to 5).

1 2 3 4 5

Not capable at all Very capable

	1	2	3	4	5
a. communication in the case of a language barrier	☐	☐	☐	☐	☐
b. handling cultural differences	☐	☐	☐	☐	☐
c. discussing (sexual) violence	☐	☐	☐	☐	☐
d. asking about FGM	☐	☐	☐	☐	☐
e. managing the consequences of FGM	☐	☐	☐	☐	☐
g. health promotion to migrants	☐	☐	☐	☐	☐
h. legal and procedural aspects related to asylum claims or migration status	☐	☐	☐	☐	☐
i. referring for social care	☐	☐	☐	☐	☐

12. Gender

☐ Female

☐ Male

☐ Other/ do not wish to state

13. Age: _____

14. Were you and / or your parents born in (add country)?

☐ My parents and I were born in (add country)

☐ I was born in (add country), but my parents and family were born outside (add country)

☐ My parents and I were born outside (add country)

15. What is your profession?

☐ Midwife

☐ General Practitioner

☐ Gynaecologist

☐ Other Physician

☐ Maternity Assistant

☐ Social Care Professional

☐ Other, Please Specify: _____

16. How long have you been practising in this profession?

☐ less than 1 year

☐ 1-5 years

☐ 5-10 years

☐ more than 10 years

17. How many pregnant migrant women have you seen as a professional during the past 5 years?

☐ none

☐ 1-10

☐ > 10

Appendix 3

Examples of training implementation

Overall aim of the training

The aim of the training is to prepare the midwives and other healthcare professionals to deliver adequate culturally sensitive maternity care in line with the ORAMMA approach , and to work within their specific local setting with the social workers and maternity peer supporters, using the ORAMMA practice guide and to gather the required data for the project as outlined in various project documents (MMP, MPOP).

Participants

Midwives and other healthcare providers as well as social workers.

Learning objectives:

1. Participants will develop an insight into:
- the difficulties pregnant migrant women face during their pregnancy and in relation to maternity care
- the importance of trauma aware care
- the importance of awareness of one's own cultural beliefs

2. Participants will have knowledge of:
- specific issues related to pregnant migrant women, regarding epidemiology and specific morbidity and to culturally determined aspects of care
- the ORAMMA approach and project, including the different relevant documents and data gathering sets

3. Participants will become able to:
- apply specific communication skills required for culturally sensitive issues with migrants considering language barriers (talking in triads with interpreter and patient) and low literacy in some cases (recognizing low literacy, using plain language and visual aids and applying teach-back method)
- work with the ORAMMA approach and with the maternity peer supporters
- contribute to the data gathering required within the ORAMMA project

Greece

Day 1

Welcome, introduction to ORAMMA project, Pre-test cultural competence	**10 minutes**
Icebreaker exercise	15 minutes
MODULE 1. Introduction to Migration	
Migration status and policies (lecture & video)	15 minutes
MODULE 2. Maternity Care of Migrant Women	
MAR women & HSCPs's experiences (whole group discussion)	30 minutes
Break	**30 minutes**
MODULE 4. Communication & Culturally Sensitive Practice	
Providing compassionate care	
Activity & small group discussion	30 minutes
Lecture on compassionate care	10 minutes
Providing care in a culturally sensitive way	
Lecture on cultural competence & whole group discussion	20 minutes
Summary of the day, feedback	**30 minutes**
Total time (including break)	*3 hours*

Day 2

Welcome, summary of the previous day	**10 minutes**
MODULE 3. Taking Action: The ORAMMA project	
Case study on ORAMMA Approach and MPSs' role	30 minutes
Whole group discussion	20 minutes
Break	**15 minutes**
ORAMMA Practice Guide	
Lecture on antenatal care of MAR women	15 minutes
Case study on antenatal care of MAR women	15 minutes
Lecture on care of MAR women during labour	15 minutes
Case study on care of MAR women during labour	15 minutes
Break	**15 minutes**
Lecture on postnatal care of MAR women	15 minutes
Case study on postnatal care of MAR women	15 minutes
MODULE 4. Communication & Culturally Sensitive Practice	
Communicating effectively with MAR women	
Activity & whole group discussion	20 minutes
Lecture on effective communication techniques	10 minutes
Summary of the day, feedback	**30 minutes**
Total time (including breaks)	*4 hours*

The Netherlands

Pre-workshop reading material:

- The ORAMMA documents
- Pre-test of cultural competence

Facilitators:

- Experienced trainers in cultural sensitive care
- Patient actress

Welcome, introduction to ORAMMA project, Pre-test cultural competence	**10 minutes**
Icebreaker exercise, experiences with migrant patients, and expectations	20 minutes
Interactive role-play communication with (low-literate) migrants	30 minutes
Reflection and discussion	20 minutes
Exercise on cultural awareness 'Walk in the Park'	10 minutes
Break	**30 minutes**
Mini-lecture on migrant experiences and culturally sensitive care	10 minutes
Information on maternity peer supporters (MPSs) role / experiences (preferably by a MPS with experience in supporting migrant women)	20 minutes
ORAMMA approach: short presentation and discussion guided by case stories	20 minutes
Interactive plenary discussion / questions	20 minutes
Speed evaluation	10 minutes
Post – test cultural competence	**10 minutes**
Total time (including break)	***3, 5 hours***

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Welcome, Staff introductions, Pre-training competency questionnaire	**15 minutes**
Introduction to ORAMMA, background, aims and approach Summary of systematic reviews of migrant experiences	25 minutes
Show video clips of women's experiences	10 minutes
Group discussions on experiences of caring for migrant women and their training needs in providing perinatal care for migrant and refugee women Facilitator to guide discussions as required	15 minutes
Summary of systematic review evidence on HCP experiences	10 minutes
Scenario	30 minutes
Break	**15 minutes**
Stereotyping video and then activity	10 minutes
Exercise on cultural awareness 'Walk in the Park'	15 minutes
Trauma aware care presentation and discussion	20 minutes
Cultural competency presentation and group discussion	15 minutes
Role play	20 minutes
Post-test questionnaire	**10 minutes**
Total time (including break)	***3, 5 hours***