ΠΑΝΕΠΙΣΤΗΜΙΟ ΔΥΤΙΚΗΣ ΑΤΤΙΚΗΣ

Department of Midwifery

Τίτλος εργασίας

Οι εμπειρίες και η ικανοποίηση μεταναστριών, προσφύγων και αιτούντων άσυλο γυναικών από την παροχή περιγεννητικής φροντίδας στα πλαίσια του προγράμματος ORAMMA.

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ΒΙΚΤΩΡΙΑ ΒΙΒΙΛΑΚΗ

Αθήνα, ΣΕΠΤΕΜΒΡΙΟΣ 2021

UNIVERSITY OF WEST

ATTICA SCHOOL

DEPARTMENT

Diploma Thesis

Title

“Perinatal care experiences and satisfaction among female migrant, refugees and asylum seekers in the context of the ORAMMA project.”

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Athens, SEPTEMBER 2021

ΠΑΝΕΠΙΣΤΗΜΙΟ ΔΥΤΙΚΗΣ

ΑΤΤΙΚΗΣ ΣΧΟΛΗ

ΤΜΗΜΑ

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Μέλη Εξεταστικής Επιτροπής συμπεριλαμβανομένου και του Εισηγητή

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ΔΗΛΩΣΗ ΣΥΓΓΡΑΦΕΑ ΠΤΥΧΙΑΚΗΣ/ΔΙΠΛΩΜΑΤΙΚΗΣ ΕΡΓΑΣΙΑΣ

Ο/η κάτωθι υπογεγραμμένος/η Κομποθανάση Ελένη του Στεφάνου, με αριθμό μητρώου 18017 φοιτητής/τρια του Πανεπιστημίου Δυτικής Αττικής της Σχολής ΣΕΥΠ του Τμήματος Μαιευτικής., δηλώνω υπεύθυνα ότι:

«Είμαι συγγραφέας αυτής της μεταπτυχιακής εργασίας και ότι κάθε βοήθεια την οποία είχα για την προετοιμασία της είναι πλήρως αναγνωρισμένη και αναφέρεται στην εργασία.

Επίσης, οι όποιες πηγές από τις οποίες έκανα χρήση δεδομένων, ιδεών ή λέξεων, είτε ακριβώς είτε παραφρασμένες, αναφέρονται στο σύνολό τους, με πλήρη αναφορά στους συγγραφείς, τον εκδοτικό οίκο ή το περιοδικό, συμπεριλαμβανομένων και των πηγών που ενδεχομένως χρησιμοποιήθηκαν από το διαδίκτυο.

Επίσης, βεβαιώνω ότι αυτή η εργασία έχει συγγραφεί από εμένα αποκλειστικά και αποτελεί προϊόν πνευματικής ιδιοκτησίας τόσο δικής μου, όσο και του Ιδρύματος.

Παράβαση της ανωτέρω ακαδημαϊκής μου ευθύνης αποτελεί ουσιώδη λόγο για την ανάκληση του πτυχίου μου».

** Επιθυμώ την απαγόρευση πρόσβασης στο πλήρες κείμενο της εργασίας μου μέχρι 6 μήνες και έπειτα από αίτηση μου στη Βιβλιοθήκη και έγκριση του επιβλέποντα καθηγητή*

Η Δηλούσα

* **Ονοματεπώνυμο /Ιδιότητα**
(Υπογραφή)

Ψηφιακή Υπογραφή Επιβλέποντα

VIKTORIA VIVILAKI

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**** Σε εξαιρετικές περιπτώσεις και μετά από αιτιολόγηση και έγκριση του επιβλέποντα, προβλέπεται χρονικός περιορισμός πρόσβασης (embargo) 6-12 μήνες. Στην περίπτωση αυτή θα πρέπει να υπογράψει ψηφιακά ο/η επιβλέπων/ουσα καθηγητής/τρια, για να γνωστοποιεί ότι είναι ενημερωμένος/η και συναινεί. Οι λόγοι χρονικού αποκλεισμού πρόσβασης περιγράφονται αναλυτικά στις πολιτικές του Ι.Α. (σελ. 6):***

https://www.uniwa.gr/wp-content/uploads/2021/01/%CE%A0%CE%BF%CE%BB%CE%B9%CF%84%CE%B9%CE%BA%CE%B5%CC%81%CF%82_%CE%99%CE%B4%CF%81%CF%85%CE%BC%CE%B1%CF%84%CE%B9%CE%BA%CE%BF%CF%85%CC%81_%CE%91%CF%80%CE%BF%CE%B8%CE%B5%CF%84%CE%B7%CF%81%CE%B9%CC%81%CE%BF%CF%85_final.pdf).

Abstract

Background: Inadequate understanding of medical terminology, poor communication and lack of information affect women's ability to receive adequate care and to establish a relationship with the care provider.

Objective: The purpose of the qualitative study was to demonstrate the effectiveness of the implementation of ORAMMA program and satisfaction of women who participated in it, but also to highlight the problems faced during pregnancy and childbirth.

Methods: The sample consists of five immigrants and refugees who lived in a shelter and participated in the ORAMMA program during their pregnancy, in March 2018. In-person interviews were conducted with the participation of an intercultural mediator with an open-ended exploratory questionnaire.

Results: The women who received care under the ORAMMA program were very satisfied with the provision of prenatal care, they felt very comfortable with the providers talking, communicating, and building a relationship, asking clarifying questions and understanding the reason for their care. Women also felt intimacy, respect, friendship, empathy and confidence to share problems and feelings.
Finally, empowering them to familiarize themselves with the health care system has proven to be useful enough for women to be able to care for themselves.

Conclusion: The provision of prenatal and perinatal care to refugee and migrant women offers significant benefits to pregnancy. Therefore, the provision of the ORAMMA program to migrant and refugee women is vital.

Keywords: Operational Refugee and Migrant Maternal Approach" (ORAMMA)**,** Perinatal care, Migrant, Refugees

Introduction:

Those who believe that the peak of human history was the conquest of the moon, they forget the date of July 25th, 1978, when the man conquered the secrets of life and birth, as the young Louise Brown saw the light of life in an unprecedented way. It was the apotheosis of the late Nobel laureate Edwards who, together with the gynecologist Dr. Septoe, were involved in devising the method of IVF by opening up new research and technological fields. At the same time, a host of ethical and scientific doubts were born, which in some cases reached the subtle irony of the new generation of "tube kids" (De Grande et al., 2014).

In the past decades, the significant improvements have been made in many areas of perinatal care, and the advances in medical science have shaped and adapted to the evolution of human societies. The old values and concepts are shattered and questioned for some as likely to be redeemed for individual-centric utility regards centuries of knowledge and wisdom, while medical knowledge and technology. For example, despite reports that planned cesarean section is associated with a series of medical conditions in offspring, the birth method tends to be considered "via naturalis", while milk substitutes have occasionally arrived to replace female nature and breastfeeding.

Based on the above, it should be defined that *perinatal care* is, according to the international organizations, the care needed, to provide medical and social services to the pregnant and neonatal during the perinatal period. The start-up period of care changes over time, but according to the World Association of Perinatal Medicine and the 2007 guidelines, it starts from the 22nd week of pregnancy (day 157) to childbirth (fetal period) and continues until day 7 (early postnatal period) or on the 28th day (late postnatal period) after childbirth (Arcaya, 2015).

The provision of assisted reproductive services does not belong to the perinatal period, with strict adherence to changing definitions over time. The widely used term "perinatal mortality rate" (PMR) was adopted by the American Academy of Pediatrics Committee on Fetus and Newborn and the Committee on Midwifery.In daily practice, two different definitions are also used, depending on the time of death of the newborn, that is, whether it occurred until the 7th or 28th day of life. In particular, the first definition defines perinatal mortality as the sum of fetal (≥20th week of gestation) and neonatal (first 28 days of life) deaths occurring in a country over a year by the sum of the living and the dead infants during the same year. The index is expressed per 1,000 live births and late dead infants. According to the second definition, the perinatal mortality is defined as the sum of fetal deaths (≥20 weeks gestation) and early neonatal (first 7 days of life) deaths over a year by the sum of live births and dead embryos during of the same year per 1,000 live births and late dead infants (Urquia et al., 2015).

The perinatal mortality is an international indicator of the quality of perinatal and neonatal care. Indirectly it can be considered to provide a measure of the expected social burden of newborns with acquired disabilities and to shape the overall quality of life of a country. In Greece, in particular, perinatal mortality is estimated at fewer than 6 deaths / 1,000 births in the EU, ranging from 4.2 to 9.5 / 1,000 births and in the US 6.5 / 1,000 births, while in developing countries it can exceed 50 deaths per 1,000 births (ORAMMA, 2017).

In 1/3 of fetal deaths, the cause remains unclear. The perinatal mortality is mainly shaped by socioeconomic variables such as nationality and socioeconomic class, duration and multiparty of pregnancy. Confirmed aggravating factors are also assisted reproduction, fetal disease states (anatomical abnormalities, arrhythmias, syndromes, and abnormalities of normal development),

placenta, (chorioamnionitis, chondrocyte ablation, and placenta part of the mother (obesity, hypertension, diabetes mellitus, preeclampsia, autoimmune diseases, and intrahepatic gestational cholestasis). Guidelines for planned pregnancy monitoring, development of pregnancy, and selection of the appropriate type of childbirth are considered to contribute significantly to the reduction of maternal and perinatal mortality and morbidity. It goes without saying that these directives must be adapted to the socio-economic and development conditions of each country (Lionis et al., 2018).

To treat many of the factors that are critical to the outcome of pregnancy, it is necessary to treat the neonate in Neonatal Intensive Care Units (NICUs) with physicians of different specialties with specialized knowledge. It is important in cases of high-risk pregnancies to schedule a timely transfer of the pregnant woman to a tertiary care hospital that has a NICU. Otherwise, timely and safe transfer of the neonate from the maternity hospital to NICU is required, which must be carried out within an organized transport system staffed by properly trained nursing staff, especially in the case of newborns born in remote and inaccessible areas. This issue has important dimensions for our country due to its geographical configuration (Pedersen et al., 2014).

Screening for all newborns was first introduced half a century ago in the US and adopted by most countries around the world as an important tool for prevention, early diagnosis, early treatment and genetic counseling to reduce their endogenous metabolic diseases and complications. Consequently, it contributed to the decline the disabilities that accompany controlled diseases and the improvement of the quality of life of patients and their families. Top issues in today's socio-economic context are the quality control of the programs being implemented and the assessment of social cost-effectiveness by implementing an expanded screening test for the most frequent endogenous metabolic diseases in Greece.

Based on the above-mentioned facts, it has to be said that the ORAMMA project develops an integrated, mother and woman centered, culturally oriented and evidence based approach for all phases of the migrant and refugee women perinatal healthcare, including detection of pregnancy, care during pregnancy and birth, as well as support after birth. This approach implemented by multidisciplinary teams of experts, namely midwives, social workers, and general practitioners, with the active participation of women from migrant and refugee communities, ensures a safe journey to motherhood (ORAMMA, 2017).

The ORAMMA was a 2-year project, funded through the European Union's Health Programme, to develop an approach to maternal healthcare for migrant and refugee women. ORAMMA is now into its second year, and the partners have been busy. The first part of the project - exploring the current situation for pregnant migrant women and creating recommendations for improvements based on the evidence - is now completed and we are about to begin to pilot the ORAMMA approach (Arcaya, 2015).

The teams in Greece, the Netherlands and the UK have recruited pregnant migrant women to the pilot and guided them through the ORAMMA approach. Part of the ORAMMA approach was to train Midwives and other health professionals who engaged with pregnant migrant women in developing cultural competence. For migrant women to receive the care they need, it is critical that healthcare professionals can recognize the way their own views are influenced by their culture, can be open and receptive to those of other cultures, and have the skills they need to have effective and respectful communication with migrant women. The health professionals engaged in the ORAMMA project were trained in each country over two sessions, and the ORAMMA project has created an e-learning course, which made the training available across Europe (ORAMMA, 2017)..

In order to be more specific, the employees and the members of the ORAMMA project in European countries, took care of the following aspects among female migrant, refugees and asylum seekers. As to the pregnant Care among female migrant, refugees, and asylum seekers, at an individual level, it seems that the Greek pregnant woman has a high standard of care. The maternal mortality rate in Greece is extremely low, as even unplanned pregnancy is monitored almost exclusively by doctors (Obstetricians Gynecologists) and frequently (> 50%) on a private basis. However, the collective control system with national guidelines is significantly lagging behind and consequently no follow-up mechanisms are in place to monitor pregnancy (ORAMMA, 2017).

According to the ORAMMA approach, the monitoring begins early in the majority of cases where there are gaps (<10th EC), which require centralized improvement interventions. Carrying out laboratory tests even in low-risk pregnancies is rather uncontrollable, resulting in the financial burden of the funds and the family budget. In particular, ultrasound screening, according to a presidential decree, is done only by specialized obstetricians and radiologists, but without any morals in the frequency and the reason for the test.

Consequently, when systemic administration of folic acid began in Greece and whether it has contributed to the reduction of open lesions in the neural tube of the fetus, as indicated. There are also shortcomings in the approach to issues related to the mental sphere of the pregnant woman or the health treatment for smoking cessation, despite the known burden of the substance on the offspring's health, even in a country such as Greece with extremely high rates of obesity. The absence of a collective system for dealing with cases of poor pregnancy outcomes, such as in cases of perinatal mortality, is recognized as an important problem that needs immediate response and support for human parenting needs (Lionis et al., 2018).

As to the high-risk newborns among female migrant, refugees, and asylum seekers, despite the significant contribution of perinatal medicine to the survival and quality of life of high-risk premature and newborns, their reservoir in Greece of low birth rate appears to be increasing. Timely data on high-risk pregnancies and newborns are not available nationwide (De Grande, et al., 2014).

However, it seems that one of the causes leading to increased risk pregnancies is the fact that the age of first childbearing has been postponed. The Greek mother is forced or decides to delay the first childbearing age (> 35 years). Increased incidence of assisted reproductive methods, such as IVF and spermatogenesis, is also being sought (ORAMMA, 2017).

Consequently, the incidence of conditions such as premature birth (the incidence of prematurity in Greece has more than doubled in the last 30 years) is more common, multiple pregnancy, gestational diabetes, hypertension, eclampsia, pre-eclampsia, thyroid disease, and increased incidence be shorter or longer for the duration of pregnancy birth weight or have an intrauterine growth retardation. In addition, the uneven geographical and socioeconomic distribution of services for pregnant and newborns, increased risk behaviors such as smoking in pregnancy and discontinuation of care appear to play their own aggravating role which is not satisfactorily fulfilled. be studied and evaluated.

Infections in Neonatal Intensive Care Units: Infections are a serious cause of morbidity and mortality in MENNs and are overly expensive for the health system. In particular, congenital infections are due to transplacental transmission from the affected mother during pregnancy, perinatal transmission to the vertical shortly before or

during parturition, usually with bacteria and the main representative of streptococci group B, while intra-hospital infections (usually urinary tract infections and lower respiratory infections) are transmitted to the neonate from person to person during hospitalization or transport. In many developed countries, efforts are being made to unify the registration of the most easily preventable intra-hospital neonatal infections to allow their strategies to be restricted (Pedersen et al., 2014).

The monitoring programs start with the planning of the newborn's exit according to his / her medical and social needs and provide for regular monitoring by a team of experts with parallel control even of their academic performance. In our country, efforts to establish timely monitoring by public and private NICU commensurate with the capabilities of each space are commendable. However, the way the surveillance programs work is fragmentary and does not allow for the evaluation of the inpatient care cost of each follow-up program per se or the evaluation of neurodevelopmental outcomes by type of problem. and allocate limited resources (ORAMMA, 2017).

Nevertheless, there is an awareness of the need to coordinate NICU's efforts and cooperation to optimize the outcome of interim monitoring programs. The individual proposals include:

(1) Formalizing the follow-up programs as a natural continuum of care after leaving NICU.
(2) Establishment and monitoring by an official body of the implementation of Greek guidelines with clear age-groups for each monitoring area and minimum monitoring age for NICU graduates.
(3) Concentrating programs or finding ways to support those with significant or delayed meninges, in implementing a single program of compliance with minimum criteria for the timely follow-up of high-risk

neonates regarding inclusion, age ratings, minimal infrastructure and use of commonly accepted diagnostic tests and therapeutic protocols.
(4) Developing a program development schedule or decentralization of activities to larger centers providing school-based surveillance programs.
(5) Use integrated monitoring software over time to evaluate the collective experience over time and calculate the outcome indicators of monitoring over time to identify the needs of qualified personnel, evaluate the monitoring programs over time and further organization of intervention programs in all age groups.
(6) Further training of neonatologists in time monitoring programs and weighted diagnostic tests.
(7) Raising the awareness of pediatricians and other health care providers about the particularities of monitoring high-risk infants with continuing education seminars.
(8) Improving the decisive cooperation of the pediatrician following the child with the NICU team with the aim of continuing the monitoring by primary health care providers over time.
(9) Educating teachers about early childhood health problems, learning and behavioral disorders that may occur in the early school years.
(10) Empowering the family in the complex role of parenting with a NICU child and using new technologies in support of therapeutic / educational programs.

Finally, as to the High Risk Pregnancy and Premature Pregnancy Transfer Network through the ORAMMA approach, it is mentioned that with the aim of early recognition and referral of an increased risk of pregnancy to an intrauterine or, if failed, extracurricular wave transfer to a tertiary perinatal center, there is a well-established routine - the school he decorates and the one he receives. On extracurricular transport, the main objective is to ensure the stabilization and safe transport of premature and problematic neonates (ORAMMA, 2017).

The geographical peculiarity of the country with its extensive archipelago and central massif, the uneven distribution of population and movements during the year due to tourist needs, as well as the current economic conditions, require caution; prudence and flexibility in designing an effective and cost-effective delivery system for high-risk pregnant and premature or problematic neonates. In our country, the official transport system relates exclusively to newborns and not high-risk pregnancies, is usually accelerated, and the periphery usually finds it difficult to stabilize the neonate prior to transfer to the central unit.

The reasons are mainly related to his lack of special education pediatrician and the nurse who are called upon to deal with the care and lack of infrastructure. Of course, there is a lack of overall log data that could be the key to assessing the quality of the system's operation, as the transport system is not open: in Attica transport is served by the neonatal EKAB, in Thessaloniki by the EKAB in collaboration with the "Smile of the Child" offering ambulances, while the inpatient hospital is staffed by medical personnel and in the rest of the country exclusively from the inpatient hospital facilities. In Attica, EKAB neonates are staffed by ICU Attica physicians while in other areas medical and paramedical coverage is provided by a variety of trained staff, such as pediatricians, specialists, agricultural doctors, midwives. The region usually uses a simple transport ambulance, while the islands are transported by helicopter or military C130 from the islands (Lionis et al., 2018).

In order to ensure the best outcome of pregnancy and newborn increased risk that is served and in line with international standards of reciprocity, it is necessary to:

(1) focus on ensuring the procedures for timely transfer of increased risk pregnancy to 32 EC; center to reduce urgent and more infertile

extracurricular transport. Emergency situations will need to be transported to the nearest perinatal center first.

(2) In the case of outpatient transfers, the KESY Committee on Perinatal Care submitted a detailed proposal for the organization of a network co-ordinating the regions by the competent peripheral centers, training of all staff in resuscitation and transport under the responsibility of the perinatal center. (pediatricians, midwives, anesthesiologists), transport from the district to the center exclusively by a transfer incubator, and medical staff from the admission hospital. For transfers from island Greece within the Basin from the respective airport it is suggested to use the EKAB ambulance and the air medical attendant.
(3) Mandatory recording, collection and analysis of the data of each carrier; A pregnant or newborn child throughout the country with a central body responsible for analyzing the results and redefining needs.
(4) Annually check the effectiveness of the system.
(5) Announcing data online to all stakeholders and the general public.

Neonatal Mortality Factors

- Low Birth Weight

Birth weight is the weight of the newborn that is measured within the first hour of life before significant weight loss occurs after birth. All newborns, live and dead, should be weighed to the nearest gram in the delivery room, preferably with an electronic balance (Costalos et al. 1996). Infants and newborns should be classified according to birth weight per group of 250 g. This classification serves to determine mortality by birth weight group (Ahmad et al. 2000).

The low-birth-weight newborn is the newborn weighing less than 2500 grams, up to 2,499 grams. The group of low-birth-weight

newborns includes two completely different groups of premature newborns and low birth weight newborns (Bang et al. 2002). This proportion applies only to developed countries where the birth rate of low-birth-weight babies does not exceed 6 - 7%. In developing countries this proportion varies considerably. The newborn "very low birth weight" is the newborn weighing less than 1,500 g. up to 1,499 g. In developed countries where the birth rate of low birth weight babies has now reached a very low level, the birth rate of "very low birth weight" babies is a measure and indicator of the effectiveness of measures taken to protect maternity (De Jesus et al, 2010).

The newborn 'extremely low birth weight' is the newborn with a birth weight of less than 1,000 g, up to 999 g. The lower birth weight limit, 500 g, adopted by WHO. for national birth statistics and the separation between birth and miscarriage, on average, corresponds to 22 - 23 weeks of gestation. This definition does not define sustainability thresholds and therefore "the 500 g threshold" and the term "sustainability" are not identical concepts (Black et al. 2003).

Regardless of the strategy followed by neonates after birth, everyone now agrees that in all cases of threatened 'early' childbirth, perinatal care should be optimal and infertility conditions best to avoid deaths (Yasmin et al. 2001). It follows from this that when neonatal mortality in this group is used as an indicator to evaluate and compare the level of care provided, other factors such as obstetricians and neonatal strategy, place of birth, should be considered, and hospitalization (perinatal center, children's hospital or obstetric center not provided by NICU) and the age of the newborn at admission to MENN. (Lawn et al. 2004).

In order to discuss a problem, one must first determine it. A baby who, because of his size or maturity is on the viability threshold, is a candidate to die despite the means provided by modern technology. It is very difficult to tell if this limit is 26, 25, 24 weeks or 23 weeks'

gestation, 700 or 500 g birth weight. It is this newborn that lies beyond the capabilities of medicine and whose various systems cannot meet the demands of extracurricular life, for which the neonatal is called upon to make a decision (Costalos et al. 1996).

- The Duration of the Pregnancy

The duration of pregnancy is measured from the first day of the last normal menstrual period and is expressed in completed weeks. For example, the birth of a newborn at 280 days of gestation up to 286 days of gestation is assumed to occur at 40 completed weeks (280: 7 = 40 wk, 286: 7 = 40 wk plus 6 days). It is now well known and proven that the calculation of gestational age from the date of the last menstrual period is incorrect in more than 20% of cases. For this reason, and not only, it is necessary to calculate the gestational age systematically with the help of ultrasound at 16-18 weeks' gestation or earlier. As a factor in infant mortality, it has been observed that the highest proportion of infants dying is observed in those age groups of women over 35 years. The increased age of women is an important factor in neonatal mortality as concomitant abnormalities increase (Costalos et al. 1996).

- Intrauterine Growth Retardation

The infants upon delayed intrauterine growth are embryos that are less birth weight than they were genetically determined at birth. The delay in intrauterine growth is always due to a pathological process that modifies the innate growth potential of the fetus, reducing the rate of growth. To Mr daily clinical practice, embryos with delayed intrauterine growth are considered embryos that are found to have a reduced growth rate, as determined by sequential measurements of various somatic parameters of the fetus, and if such findings are associated with pathologic and somatic syndromes. mainly mitroplastic failure (Costalos 1996).

Many of the delayed growth embryos, sometimes with intrauterine weight loss, are not lightweight embryos for gestational age but are at high risk for endometrial death, asphyxia at birth, hypoxic brain injury (hypoxic ischemia) morbidity. Epidemiologic studies have linked many clinical situations to low birth weight infants, but the precise role of specific factors has not been elucidated. Of course, such correlations do not confirm a causal relationship. The incidence of intrauterine growth retardation ranges from 3 to 8% of pregnancies worldwide (Costalos et al. 1996).

Direct Causes of Newborn's Death

In less than 3% of neonatal deaths, immediate causes are found to be causative. Estimates from 2000 on the distribution of immediate causes of death show that preterm birth accounts for 28%, serious infections 36% including neonatal pneumonia, 7% tetanus and 23% asphyxiation complications. Of the remaining 7%, it is related to congenital abnormalities (Bang et al. 2002). The distribution of neonatal causes of death varies across countries, correlated with neonatal mortality rates. At a very high mortality rate, almost 50% of deaths are due to severe infection, tetanus and diarrhea while at low levels pneumonia accounts for less than 20% of deaths while tetanus and diarrhea are almost non-existent as causes of neonatal death. The risk of death from suffocation is about eight times higher for infants in countries with very high infant mortality. The proportion of premature deaths decreases with the increase in infant mortality.

Maternal Health and Complications in Childbirth

Maternal health and complications in childbirth are key factors in the survival of newborns. The ultimate mortality or not of the newborn is largely determined by the state of the mother's health and the

potential complications that may occur during childbirth (Bacci et al. 1993).

Early childbirth

Early infants have a much greater risk of death and disability than infants (Baterman & Simpson 2006). In 2006, the infant mortality rate for very early infants (less than 32 weeks' gestation) was 175 infant deaths per 1,000 live births (Hamilton et al. 2010). Although mortality decreases with increasing gestational age, even infants born just a few weeks earlier have a significantly increased risk of death (Huang et al. 2008). The infant mortality rate for preterm infants (34 - 36 weeks gestation) was 3 times higher than for infants (| Chu et al. 2008). The mortality rate for infants born between 37 - 38 weeks' gestation was 47% higher than for infants born between 39 - 41 weeks' gestation (Reddy & Willinger 2006). 29% of US births occur at 37 - 38 weeks' gestation (Martin et al. 2007).

Due to the much higher risk of death, infants born at much lower gestational age have a major impact on overall infant mortality (Hogberg & Cnattingius 2007). In 2006, more than two thirds of all infant deaths in the United States occurred in 13% of premature infants, and more than half (54%) occurred in infants born prematurely (Salihu et al. 2007).

- **Maternal Medical Disorders (diabetes, chronic hypertension, antiphospholipid syndrome, hereditary thrombophilia) which are Concerned to the Care and Treatment by the ORAMMA Project**

The mother's various chronic medical disorders are associated with an increased risk of stillbirth. About 10% of all births are related to maternal medical disorders. Chronic hypertension is associated with an

increase in the infant mortality rate (ACOG 2009). To a large extent, this is due to an increased risk of preeclampsia in women with chronic hypertension (Allen et al. 2004; Ray et al. 2001). The diabetes is also an important issue as a risk factor for stillbirth, accounting for approximately 3% of cases (Simpson 2002).

In the past, the mortality rate in women with diabetes was 2.1%, approximately 4 times higher than in the general population (Persson et al. 2009). The degree of maternal glycemic control during pregnancy greatly affects the risk of infant mortality, while improvement in the rate is associated with better outcomes. Any newborn born with high birth weight is suspected and should be screened for the possibility of a diabetic mother (Antoniadis 2000).

The Antiphospholipid Syndrome (APS) occurs when individuals have specific levels of antiphospholipid antibodies, thrombosis or obstetric complications. If left untreated, the rate of fetal death can be as high as 90% in women with APS. It is estimated that 2% -3% of infant mortality is associated with APS (Miyiakis et al. 2006). Hereditary thrombophilia is a group of heterogeneous diseases associated with an increased risk for thrombosis. It has been linked to infant mortality, but there is not a large body of research to fully confirm this conclusion (Rey et al. 2003).

- **Factors During Pregnancy (multiple pregnancy, placental abruption, preeclampsia, obstetric interventions) which are Concerned to the Care and Treatment by the ORAMMA Project**

Multiple pregnancies, placental abruption, preeclampsia, and obstetric interventions are important factors in infant mortality that occur during pregnancy. In multiple pregnancies, there is an increased mortality rate. In a national birth survey (1995 - 1998), rates were increased by waves (one, two, or three) (Salihu et al. 2004). The

etiology of multiple pregnancy is unknown, but it appears that there is some association with racial or other factors. Black breed is more common than white, while Asian breed is less common. In addition to race, other factors are involved, such as gonadotropins for induction of ovulation, the age of the pregnant woman, the origin of parents from multiple pregnancies, etc. (Stergiopoulos 2002).

There are also opinions that argue that placental abruption may be largely responsible for infant mortality. Its detachment Placenta is responsible for 15 - 25% of perinatal fetal mortality as it leads to premature birth. Importantly, it is also a major cause of serious damage to live embryos, which may present with neurological debris in the first year after birth (Yang et al. 2006).

Preeclampsia is another obstetric complication associated with infant mortality. It is often associated with chronic hypertension and at percentage levels it is associated with 5% - 10% of total deaths. This factor can be reduced by appropriate medical interventions. Pregnant blood pressure should be monitored regularly and kept low. Increased blood pressure, especially above 170mmHg during pregnancy, can result in a higher rate of miscarriage or premature birth (Stergiopoulos 2002). Lastly, wrong maternity interventions are an important factor in infant mortality during pregnancy. Minimizing the risk of mortality and morbidity can be achieved by implementing appropriate interventions on the part of midwives, which can even lead to infant mortality if proper techniques are not followed.

- **Congenital Abnormalities, Infections and Suffocation which are Concerned to the Care and Treatment by the ORAMMA Project**

The main causes of mortality include perinatal problems and congenital and chromosomal abnormalities. These two categories

account for 85% of the underlying causes of infant mortality. Perinatal conditions and congenital abnormalities remain the two leading causes of infant mortality over time. Developments in the treatment of infections have resulted in a gradual reduction in infant mortality, to be reduced to less than 6% by 2001 in EU member states and to 6.8% in the US, while still high in developing countries. (64%). In developing countries, the most common causes of postnatal mortality are infections and nutritional deficiencies. These data set out future goals, which are to improve the supply of health services in pregnant and newborns, while developing countries also need to take measures to prevent and combat infections and improve nutrition of pregnant and infants (Lawn et al. 2005).

Many women come into contact during pregnancy and are infected by various infectious agents. Although most of these infections do not affect the outbreak pregnancy and fetal smooth development (Stergiopoulos 2002). Perinatal asphyxia remains a serious problem with serious implications for mortality as well as immediate and long-term morbidity, despite the great advances made in neonatology in recent years. Embryos usually show some degree of suffocation during childbirth due to uterine contractions (Das 2004).

- **Poverty**

Poverty is a major cause of many neonatal deaths, either by increasing the prevalence of risk factors such as maternal infection, or by reducing access to effective inpatient care. However, poverty is not just a problem in poor countries. The results of a Canadian study (Datta et al. 1988) report a difference in neonatal deaths between the richest and poorest countries. The data show consistently higher infant mortality rates in poorer countries than for those with higher household consumption. Addressing inequalities should be a priority for all strategies to improve the survival of newborn babies.

- **Health care inaccessibility**

The relative importance of the various causes of death in infants varies. Another factor in infant mortality is the inability to access health care. Worldwide, the largest proportion of women during pregnancy have access to health care. However, data from studies in countries with high infant mortality rates showed that there was a direct correlation with women's inability to access health care. In sub-Saharan Africa, less than 40% of women have health care while in South Asia this is less than 30%. In forty (40) countries between 1995 and 2003, it was found that more than 50% of neonatal deaths occurred after childbirth at home without specialized assistance (Lawn et al. 2005).

- **Effect of Medicines**

Drug administration to the pregnant woman can have effects that are completely unknown in other situations. This is because during pregnancy the drug affects two organisms, which may react differently. Medications are usually used to treat disorders present in the pregnant woman. However, due to the normal coexistence of pregnant - fetus both are affected. The mechanisms of action of the various harmful factors on the fetus are basically the following (Costalos et al. 1996):

- ✓ Immediate action on the fetus.
- ✓ Indirect action through placental function and hematopoiesis, through some more general effect on the parent organism and through the parental factor.

- **Ethical Reflections of Modern Neonatal Intensive Care Units**

With the introduction of intensive care for newborns, more and more premature babies are surviving with a lower birth weight. Newborns with multiple congenital abnormalities who formerly died shortly after birth, today with immediate resuscitation, surgical treatment, are surviving in ever-increasing numbers. For some newborns, intensive care fails, and its consequences remain. For newborns who survive despite severe congenital anomalies, the future is bleak for them and for their parents. For a pregnant woman, high-risk pregnancy means moving away from her family for extended periods of time, even in times of need, and introducing her to a specialist center capable of dealing with any difficult pregnancy and childbirth (Costalos 1996).

Early childbirth also means prolonged bedtime, monitor connection, complicated examinations, and frequent cesarean section that may prevent premature birth from complications, but can cause problems for subsequent pregnancies. So, after the first "failures" the initial reactions began both from parents' organizations with children with disabilities and medical and nursing staff to establish more stringent criteria for the selection of neonates who are in respiratory care or undergoing other intensive care. It is exceedingly difficult, especially for the physician, to decide whether or not to stop providing intensive care. Because this decision is not only medical, but it has moral and legal implications and requires special training that doctors have not been taught. For many, the decision to let a newborn die is contrary to their religious beliefs. Others are again fearful of parents' lawsuits against them trying to avoid the responsibility of a serious decision. The blame is also on the legislation, which is very unclear on these issues (Costalos 1996).

Another problem that makes it difficult for the doctor to make a decision There is also uncertainty about the prognosis. Despite the introduction to the medical diagnostics of CT, ultrasound and so many

other miracles of technology, there are still no precise clinical and laboratory tools available today to fully evaluate the neurological consequences of a disease, except in extreme cases.

So while for the newborn with severe perinatal apnea that has apnea and has permanent murmurs of the daughters, the decision to discontinue intensive care is relatively easy, for other less gloomy situations based on personal experience of doctors, some thresholds are set below which, no mechanical support or other intensive care is applied, at least until the problem is discussed with the child's parents, who will ultimately bear the consequences of any such decision (Costalos 1996). These thresholds must necessarily be accepted by both neonatal and obstetricians as they are called upon to deal with the problem of preterm birth and their correct or not actions will greatly depend on the further development of the newborn.

This limit should not be absolute but take into account some other factors such as the presence of other aggravating factors or complications, the newborn's marital status, and of course the means available to each unit (both inhaled and inhaled). Discontinuation or failure of intensive care does not mean abandoning the infant. He will continue to be provided with warmth, parenteral fluids, oxygen. This approach has the following advantages (Costalos 1996):

- ✓ Reduces the complications of intensive care.
- ✓ Allows the physician and nursing staff to drop her weight of their efforts to the rest of the infants in the unit.

- **Challenges Related to the Perinatal Care of Migrant or Other Refugee Women**

Conditions during migration, low socioeconomic position and irregular status may all have a negative impact on maternal health. Poorer maternal health in migrants compared with non- migrant

women is often related to risk factors that precede a woman becoming pregnant, such as availability of family planning, health-seeking behaviors, gender-based violence and migration-related procedures, as well as the risks of the perinatal period (De Grande, et al., 2014).

Quality of prenatal, intrapartum and postnatal care is affected by poor communication. In some cases, interpretation services are used to meet the needs of HCPs, like conveying information or obtaining informed consent, rather than being used routinely to develop a genuine dialogue with MAR pregnant women (ORAMMA, 2017). Migrant and refugee women are at higher risk of incorrect diagnosis due to communication difficulties compared to non-migrant women. There is evidence that MAR mothers have difficulties communicating symptoms that could be indicative of pregnancy problems and also that some women stopped attending follow-ups, because of poor communication. They were also found to express a poor understanding of the purpose of prenatal monitoring (ORAMMA, 2017).

The expectations of women about examinations may differ from the host care system's recommended examinations. Some procedures may be unacceptable in the context of various cultures and religions (e.g., amniocentesis, fetal malformation screening), or the necessity of each screening test may not be well understood. If medical recommendations are not compatible with individuals' health beliefs, dietary practices, views and perceptions about health and illness, the care plan is less likely to be followed (Arcaya, Arcaya, 2015).

Studies show that health service providers have an over-reliance on ad hoc, 'informal' interpretation from family, friends, other patients and non-medical personnel, raising issues about quality of interpretation and confidentiality. Midwives and other HCPs should consider that some of these women may experience domestic violence and controlling relationships from family members that are used as mediators for communication. This has been identified as preventing

women from getting the care they need and impacting on their and the fetus's health. HCPs should not involve relatives or husbands for interpretation because of confidentiality issues that may have a negative impact on the women. 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 (ORAMMA, 2017).

Lack of understanding of different traditions surrounding pregnancy and childbirth can also exacerbate communication difficulties. Misunderstanding can also occur if some traditions are at odds with the routine practices and recommendations from maternity care providers (Pedersen et al., 2014). Culturally appropriate services may be helpful to motivate women's utilization of maternity care. MAR women have expressed difficulties with integration of their cultural beliefs with the recommended health care practices during the intrapartum period, and lack of understanding of the informed consent process for procedures during delivery. Others have mentioned that their language and communication needs were not met. Many women have expressed a preference for a female physician during the labor and delivery process (ORAMMA, 2017).

MAR women during the postpartum period may also experience problems related to expectations within their family and community norms regarding motherhood that may impede women's attendance to healthcare services or follow ups [25]. For example, breastfeeding initiation may be delayed due to cultural beliefs which deprives babies from colostrum intake. Cultural diversity is sometimes challenging for midwives, general practitioners (GPs) and other healthcare providers, in their duty to act as advocates for MARs. In some cases, MAR women evaluate the midwife- based antenatal care (ANC) as rushed and merely a physiological check, rather than being orientated to women's needs (Lionis et al., 2018).

Racism is a very real issue within the health and maternity services, which can have tangible effects, but is rarely explored. Several studies conducted within maternity services showed that ethnic minority women encountered racism. Pregnant women with complex social factors are known to book later, on average, than other women and late booking is known to be associated with poor obstetric and neonatal outcomes. There is evidence of underutilization of prenatal visits among MARs, which translates into a delayed first prenatal visit, usually classified as presenting for ANC at over 20 weeks' gestation.

- **The Social Care Provider - Social support**

Provision of appropriate social support and care during the antenatal and postnatal period, particularly for recent female migrants and refugees, is paramount to achieve a healthy pregnancy and birth outcome. Pregnant women who are recent migrants, asylum seekers or refugees are considered to have complex social factors (Urquia et al., 2015). The main goals of social care for refugees and other migrant groups are:

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

The International Federation of Social Workers emphasizes that the ideal long-term goal for refugees should be durable solutions to their problems; the achievement of self- sufficiency, economic independence, spiritual and intellectual fulfillment. The scope of social care with refugees and asylum seekers includes (ORAMMA, 2017):

✓ Strengths-based comprehensive psychosocial assessments.
✓ Strengths-based community assessments.

✓ Building empathic relationships and working with refugees and asylum seekers in an ethical, respectful, client-centred and strengths-focused manner.

✓ Working with groups, organisations and communities to respond to shared goals; linking individuals and families to community networks.

✓ Facilitating coordination and cooperation across health, welfare and other systems to ensure good outcomes and assist client aspirations.

✓ Advocacy for services and education within the national welfare and health systems.

✓ Socio-legal and ethical decision making within complex legal frameworks.

✓ Advocacy in relation to the rights of refugees and asylum seekers.

✓ Specialist culturally sensitive counselling with regard to loss and grief.

✓ Torture and trauma, and in suicide prevention.

✓ Educating other service providers and professionals about the cultural, ethnic, and faith-based gender issues specific to the individual or group.

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

Social care for recent MARs can be provided through various settings and care providers. In the UK, there are over 200 non-

governmental organisations (NGOs), listed in the Refugee Council-published directory in the UK (Refugee Council, UK, www.refugeecouncil.org.uk/), providing counselling to address distress as a result of torture and trauma, education, advocacy with employment, health and social care, housing and emergency aid.

There are also mental health care services provided by local Community Mental Health Teams (CMHT's), which aim to offer an integrated, joined-up approach to health care in which social and practical problems are considered in relation to mental and physical ones. In Greece, social care is offered by community social services and a variety of NGOs, which are staffed primarily by social workers and they engage with matters more directly concerned with practical problems and integration (housing, training and employment). In the Netherlands, social work is embedded in primary care as well as local welfare, working together in social neighborhood teams (ORAMMA, 2017).

Continuity of care is at the heart of the approach encompassing both the ORAMMA philosophy of care and the ORAMMA provision of care plan. According to ICM, continuity of midwifery care is the "provision of midwifery services for a woman and her infant by a known midwife and backup colleagues or a known group of midwives across the continuum of pregnancy, birth and the postnatal period". Continuity of care is supported by having robust training about the importance of a friendly and trustworthy relationship, respectful, dignified and autonomous care as well as a deep understanding of principles of natural birth and providing consistent information and harmonious care (Urquia et al., 2015).

Within the ORAMMA approach continuity of care is also supported by accordingly trained MPSs that provide consistent support and information throughout pregnancy, birth and the postpartum period. For ORAMMA, MPSs will be women recruited from MAR

women's communities or language groups and their role will be to ensure and facilitate better understanding between the Healthcare professionals (HCPs) and the women. They will act as translators, supporters, facilitators, mediators and they will advocate women's rights throughout the whole process.

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

- **Phases for Integrated Perinatal Care of MAR Women**

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

Assessment Flowchart

The assessment of care provided is divided in three phases a) detection of pregnancy, b) care during pregnancy and c) support after birth. The detection of pregnancy is coordinated by a GP or midwife (depending on each country's setting) and is followed by a risk and needs assessment of each woman. The first activity for the health professionals is to identify those women who are MARs from the pregnant population. The midwife or GP will be responsible for detecting the pregnancies, performing all the necessary screening of the health of the women and making the referral to the coordinator (Arcaya, Arcaya, 2015).

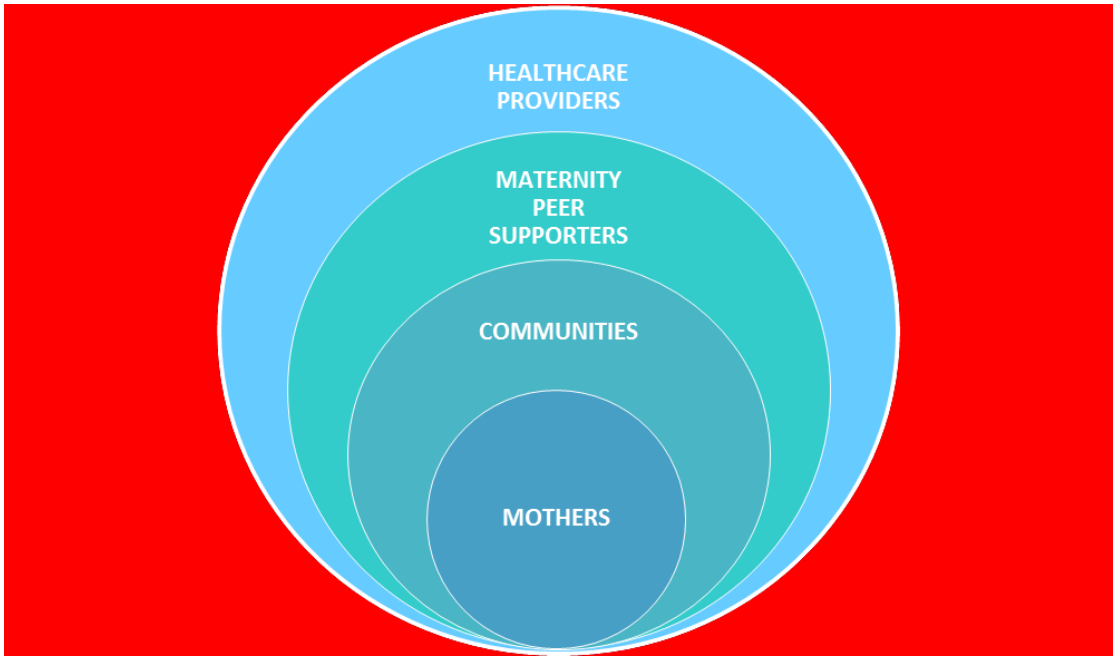
Care during pregnancy is coordinated by a midwife in cooperation with the multidisciplinary team using ORAMMA's Perinatal Personal

Operational Plan and the "My Maternity Plan". The midwives will perform all the necessary visits with the mothers either individually or in groups. During this phase the MPSs will play an important role as both mediators and as supporters for the mother during the clinical care pathway and supporting the mother's decisions for her birth plan.

Support after birth is coordinated by a SCP in cooperation with a midwife. The SCP will provide psychosocial support to the mothers and useful information about social benefits and other important issues for the family. In this phase, the midwives will also perform the post-natal check for the mother and the newborns. The process of implementing this community-based health care model for MAR women will also be facilitated by a process of empowering the communities through partnerships, collaborative planning, community actions and overall community capacity building.

Community Capacity Building strategies are required to work effectively with MAR women, their families and their communities to increase their understanding of maternal and newborn health needs and to engage them as partners in improving their health. Activities will aim to prepare and empower communities to enhance their participation in their own healthcare (ORAMMA, 2017).

Figure No.1 ORAMMA approach on Community Capacity Building



Community Capacity Building refers to promoting the capacities of communities to develop, implement and support their own management of health issues [37]. Women and their families will be empowered to be active partners of their healthcare through health educational interventions and support. On the other hand, HCPs will also be trained and supported to assist MAR women and their families. Community Capacity Building will include a) training for MPSs for the MAR community, b) training for healthcare providers, c) educational interventions to raise health literacy of MAR women and their families and e) antenatal and postnatal group sessions. By enhancing communities' knowledge, skills and experiences ORAMMA model offers them better opportunities to improve their health status and motherhood experience.

- **Perinatal Personal Operational plan**

In order for women to receive quality maternity care and have a positive birth experience it is essential to know what to expect at birth, to be well informed and have their needs (cultural, religious, personal etc.) met. Women should have a maternity plan and share it with HCPs. The existence of health records enhances continuity of care and

subsequently has impact on the quality of overall care especially for women in movement from one country to another.

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

The booklet called "My Maternity Plan" is a woman hand-held note that includes her individualized healthcare plan. It provides all the necessary information for the woman: (a) personal information and contact details, (b) brief medical history related to pregnancy and childbirth as well as chronic and communicable diseases, (c) the perinatal care plan (conditions, medicines, preferences for birth, etc.), (d) the assessment of the professionals of the multidisciplinary team and (e) useful information for the women, such as the benefits and impact of the PPOP for her and her family (ORAMMA, 2017).

In summary, in 2017 more than 90 million international migrants were residing in the World Health Organization (WHO) European region and more than half of these migrants were women, many of childbearing age (De Grande, et al., 2014). There are no

universally accepted definitions for a migrant at an international level and this heterogeneous group includes individuals who vary by length of stay in a country, documentation and residency status, movement being voluntary or forced, and reasons for migration (Lionis et al., 2018). Health needs and outcomes in this heterogeneous group is a complex topic, as these are influenced by the interaction of the process of migration and exposure to risks and access to the determinants of health in the country of origin, during transit and in the destination country (Pedersen et al., 2014).

On average the fertility rate in the migration population is higher than the native population. Among women living in the United Kingdom, birth data from 2015 show a total fertility rate (the average number of children a woman has in her lifetime) of 2.06 for non-UK born women versus 1.75 for UK born women (ORAMMA, 2017).

Pregnancy is a period of increased vulnerability for migrant women. There is a consistent trend for poorer pregnancy outcomes amongst migrant women who are at greater risk of maternal and neonatal morbidity and mortality when compared to native born women (Arcaya, 2015). This is a result of the complex interplay of multiple factors including substandard healthcare in the country of origin and issues around accessing care and the quality of care in the new country (De Grande, et al., 2014).

Moreover, migration itself can have significant negative consequences for people's physical and mental health and their wellbeing due to migration-related social problems, like poor socio-economic status, discrimination and social exclusion, multiple losses, and the chronic stress caused by these (Pedersen et al., 2014) (Heslehurst et al, 2018). It is often observed that migrants leaving their country of origin are healthier than comparable native populations. This phenomenon has been called the “healthy migrant effect” and is usually explained through the positive self-selection of

immigrants and the positive selection, screening and discrimination applied by host countries. But, although often healthy when arriving in the country, the health of migrants deteriorates over time, and in general, they rate themselves to have poorer health compared to the native population of their host countries (Urquia et al., 2015).

Across the WHO European region there is consensus and commitment to ensure the availability, accessibility, affordability, and quality of essential health services for migrants in transit and host environments (Lionis et al., 2018). Hence European countries have a common responsibility to tackle inequalities and provide high quality healthcare that meets the needs of childbearing migrant women. However, across European Union (EU) member states, the services provided for migrants and how they are administered, financed and delivered differs between countries; with some providing care free of charge, some requiring health insurance and some available to those making national insurance contributions through a place of work (Arcaya, 2015).

A previous qualitative evidence synthesis has explored both migrant women's care experiences and their perceived care needs for data published prior to June 2010. However, an updated review was deemed important with the acknowledgement that changing global, political, and economic climates have led to increased migration into Europe (ORAMMA, 2017). This includes recent political unrest and conflict in many Middle Eastern and Sub-Saharan countries, the updated rights of free movement of citizens and their families within the European Economic Area laid down in a Directive in 2004 and an increased recognition of the need to integrate the health needs of migrants and refugees into national health strategies (Urquia et al., 2015). This review therefore aimed to provide up-to-date systematic evidence on migrant women's experiences of pregnancy, childbirth, and maternity care in their destination country within Europe.

Material and Methods

The aim of qualitative research is to "discover the views of the researched population, focusing on the perspectives from which individuals experience and feel the events".

In the interview, the researcher needs to have the ability to build trust relationships and create a climate of trust that will enable participants to relax, open up and give honest and complete answers. To listen to his interlocutor with interest, to observe and react to what is being said in such a way as to urge him to reveal more information, without losing his mind or escaping the matter or drifting in the direction he wishes the researcher.

The purpose of the interview is to reveal the respondent's views, perceptions, behaviors, attitudes, experiences, interpretations and experiences. The interview process, therefore, is designed to enable the respondent to move across the spectrum of possible answers, rather than limiting or trapping him in a series of specific answers in the direction the researcher desires.

The methodology of this quality study based on the experiences and satisfaction of migrants, refugees and asylum seekers women by providing perinatal care.

- **Sample of the Interview Respondents**

The participants are five (5) women, all Arab speaking, living in Skaramagas camp and it was conducted in March 2018. The interviews were conducted during (1) or a few weeks after (4) the 6-weeks-postpartum appointment. Five (5) individual interviews conducted by a female midwifery researcher. All the interviews were carried out with

the help of a female mediator, not related to the MPSs (Maternity Peer Supporters), so that women's answers to be objective. The questions were made in Greek. The answers were given in Arabic and translated in Greek by the mediator. All interviews lasted between 30-40 minutes. Finally an informed consent was obtained for all women, including permission for audio recording and participants were informed about the type and purpose of the interview.

The interviews ranged in four themes. As to the theme 1 about their overall experience with the care according to the ORAMMA approach. As to the theme 2 about their experience with the midwifery-led continuity. As to the theme 3 about their experience with MPSs. As to the theme 4 about their empowerment for health seeking- assessing to maternity services, care model.

The data of each interview were studied and analyzed in order to draw conclusions regarding the recording of women's views and experiences regarding the provision of perinatal care.

Results

- **Theme 1: Overall experience with the care according to the ORAMMA approach**

1. How satisfied were you with your care overall?
2. Could you tell me about any parts you particularly liked during perinatal care? Why did you like those parts/ how were they beneficial?
3. Could you tell me about any parts you did not liked during perinatal care? Why didn't you like those parts?

“I was very happy every time I had an appointment. [...] The MPS was waiting for me at the hospital and we went together to the midwives.” (1803)

“The people there made me feel very comfortable. Sometimes they were trying to speak Arabic and they had a lot of fun!” (1801)

“I was very satisfied! [...] They did all my examinations in 1 day while they could send me to another center every day. [...] They explained me every time what these examinations were about, and they were let me be the one who will decide if I will do them or not!” (1805)

“For me it was very difficult to move in the town. There, they (the multidisciplinary team) were in all in the same place, the same date, so I had to take the bus only for that day.” (1805)

“...I didn’t want to do the ultrasound in the second trimester, because if there was an anomaly to the baby, we couldn’t do anything because of our religion. (Midwives) respect our choice. [...] (The MPS) had a lot of patience and helped me understand a lot about this situation.” (1802)

“I did not feel fear, I felt great security. The environment was friendly, and they were all pleasant.” (1804)

“I am generally satisfied. The only thing that bothered me was the long wait to know the baby's sex and that I had to go to many appointments throughout pregnancy. [...] In Syria, if we feel well, we usually go 2 or 3 times to the doctor.” (1801)

- **Theme 2: Experience with the midwifery- led continuity care model**

1. What was your experience of the care you received by midwives?

2. Can you tell us two things you liked about the care by your midwife?

3. Can you tell us two things that could have been improved in the care you received by your midwife?

“I was feeling very comfortable because (the midwives) were women. [...] My husband was feeling safe also and was waiting for me outside the examination room with our daughter.” (1801)

“It was very important that all they were all women because I could ask questions that I was shy to ask in front of a male doctor.” (1803)

“When I was about to have an ultrasound scan, (the midwife) gave me an apron to cover myself and closed the door of the examination room. [...] We were only me, the midwife and the MPS, all women! [...] I felt very relieved, because in the other hospital they were men in the room, and I was too embarrassed...” (1805)

“I felt like I was talking to a friend” (1804)

“...(the midwives) made me feel very comfortable and safe because I was very anxious due to diabetes. They showed the baby in the monitor and they told me that he (the baby) is fine. I felt very relieved!” (1802)

“They paid a lot of attention to me. I had a problem with my blood, and I had to make injections every day. [...] (Referring to the name of midwife) and (referring to the name of MPS) explained me very carefully how to do the injection to myself, like teachers!” (1803)

“It is my first time I became a mother. [...] My husband and I were very anxious with the baby care because (the baby) had to stay in hospital after birth. The midwives explained us everything and the social worker helped us to find an apartment. We are moving next week!” (1802)

“I loved that they gave a lot of attention to pregnant women and taking care of them more than they should.” (1801)

- **Theme 3: Experience with MPSs**

1. What was your experience of having a maternity peer supporter involved in your care?
2. Did the maternity peer supporter increase your knowledge and confidence around pregnancy, childbirth and looking after your child?
3. Was the maternity peer supporter the same ethnicity as you? What are your thoughts about this?
4. Overall do you think there was a benefit in having a maternity peer supporter?
5. What if anything do you think could be improved in the services you were offered during pregnancy, birth or after having our baby?
6. Prior to this current baby had you previously accessed maternity services in Greece?

"When there was my MPS with me I felt I knew everything. In the previous pregnancy, this was not the case and I had many questions" (1801)

"I was very happy that (the MPS) waited for me at the hospital every time I had an appointment." (1802)

"...it is very important for us (the refugees) to have someone to translate in every service we go. We rely on him like he's king. Otherwise we are lost. [...] The MPS was better than anyone else; she knew all the things about pregnancy and where I had to go to do the medical test. [...] In every appointment was the same person; we knew her, and this made us (referring to her husband) fell comfortable to discuss about our questions" (1805)

"...it is easier to talk about female issues and have a woman to translate to you." (1804)

"(name of MPS) was a nurse in her country. She had also said that has made seminars about maternity care. [...] I am sure that she

understands exactly what the doctors are talking about and explains me everything in details. I feel safe that way." (1803)

"She inspires confidence because she knows exactly what the doctor is talking about and explains it very well" (1802)

"Here (in Greece) everything is different than Syria. The pregnant woman must do a lot of medical test and ultrasound in specific dates. [...] I had to go to different places for different reasons and I usually got lost. [...] It was helpful to have someone to help you. (The MPS) spoke Greek too, so she understood everything." (1805)

"Sometimes I called her to her mobile phone. For example, I had pain in my belly, but it was not the time to give birth. I call (name of MPS) and she called the midwife. [...] I went directly to the emergency..." (1804)

"I had someone who understood me, standing next to me all the time. [...] I could share all my thoughts. She was a mother too and knew a lot about baby care. We were discussing altogether (with the midwives) like friends about our babies and how to take care of my baby. [...] They helped me a lot!" (1802)

"The MPS was not from Syria. She was from Libya. Does this matter? No! We are talking the same language, we are Arabs. All I care about is to understand each other." (1805)

"Yes, the MPS was from a nearby village. But she had left Syria for a long time. [...] I felt even better that we were from the same place." (1801).

- **Theme 4: Empowerment for health seeking- assessing to maternity services**

1. What were your experiences of accessing maternity services? If you got pregnant again would you know how to access maternity services?

2. Did you shared any of the information you learned about perinatal care and how to handle the maternity services in Greece with other pregnant women (eg friends, relatives, etc.)
3. Do you have any further comments you would like to make about your maternity care or the ORAMMA project?

“I think I will be able. Although… I don’t want to get pregnant again. I already have 3 children and now I have a boy too.” (1801)

“Yes, I have understood very well; so much that I think I can visit the hospital alone!” (1802)

“Yes, I'm talking to everyone. I explain them, I help them understand how important it is… They may have some trouble with all the services and medical test, but it is more important to give birth to a healthy baby and be well themselves too.” (1805)

“Sometimes I go together with my sister to the hospital. She will give birth to the same hospital as me. I know the place there and I help her to understand how the system works. […] Yes, I am able to help her because they helped me too much when I was pregnant to understood how things work” (1801)

“I want to get pregnant again! I had a wonderful time with you! I really miss (name of the midwife) and (name of the MPS)…” (1803)

Discussion

As to the results of the interviews to the five (5) women, according to the themes that they were analyzed, these are mentioned as follows.

As to the **theme 1 about their overall experience with the care according to the ORAMMA approach,** the women said that the MPS was waiting for them at the hospital and they went together to the

midwives. The people there made them feel very comfortable. Sometimes they were trying to speak Arabic and they had a lot of fun. They did all their examinations in 1 day while they could send them to another center every day as also, they explained them every time what these examinations were about, and they were let them be the one who will decide if they will do them or not. The environment was friendly, and they were all pleasant.

As to the **theme 2 about their experience with the midwifery-led continuity care model,** the women said that they were feeling very comfortable because (the midwives) were women. It was very important that all they were all women because they could ask questions that they were shy to ask in front of a male doctor. When they were about to have an ultrasound scan, (the midwife) gave them an apron to cover their selves and closed the door of the examination room. They felt like they talking to a friend. They paid a lot of attention to them. Finally, they loved that they gave a lot of attention to pregnant women and taking care of them more than they should.

As to the **theme 3 about their experience with MPSs,** the women said that they were very happy that (the MPS) waited for them at the hospital every time they had an appointment. Moreover, that it is very important for them (the refugees) to have someone to translate in every service they go. They rely on him like he's king. Otherwise they are lost. The MPS was better than anyone else; she knew all the things about pregnancy and where they had to go to do the medical test. In every appointment was the same person; they knew her, and this made them (referring to their husbands) fell comfortable to discuss about our questions. Here (in Greece) everything is different than Syria. The pregnant woman must do a lot of medical test and ultrasound in specific dates.

Finally, they said that they had someone who understood them, standing next to them all the time. They could also share all their

thoughts. They were discussing altogether (with the midwives) like friends about our babies and how to take care of their baby.

As to the **theme 4 about their empowerment for health seeking-assessing to maternity services,** the women said that they have understood very well; so much that they think they can visit the hospital alone. They are talking to everyone. They explain them, they help them understand how important it is. They may have some trouble with all the services and medical test, but it is more important to give birth to a healthy baby and be well themselves too. Sometimes they go together with their sister to the hospital. They give birth to the same hospital as them. They know the place there and they help her to understand how the system works. Finally, they say that they had a wonderful time with the midwife.

Based on the literature review mentioned above as also the results from the interviews, the main findings of this study, there are mentioned as follows. Migrant women's struggles with communication and language barriers are recurrent themes within this and previous reviews. Migrant women report a poor understanding of medical terminology and yet there is inadequate use of interpreters within the healthcare system (Lionis et al 2018, Fair et al 2020).

Poor communication and the provision of insufficient information impact on women's ability to choose appropriate care options and provide informed consent. An inability to converse in the local language also means women find it difficult to establish a relationship with their care provider and this impacts upon women accessing care. HCPs can help women to overcome language barriers by providing appropriate information, engaging professional interpreters more frequently and ensuring they give women the opportunity to ask the questions that they have.

In line with other studies, a lack of understanding between migrants and HCPs in terms of their traditional customs and their

expectations of maternity care was found to impact upon their access of services. The issues clearly point to a need for HCPs to receive education and training in culturally competent care to better identify women's expectations of care and how to understand and appropriately respond to women's needs related to their cultural background, to ensure effective maternity care and reduce barriers to accessing care (ORAMMA, 2017).

Women's fear of deportation impacting upon use of services identified within this review is in line with previous literature as is lack of awareness of entitlements to maternity care. The United Nations, to which all European countries belong, has developed the Convention on the Elimination of all Forms of Discrimination Against Women which states that all maternity services, including routine antenatal treatment, must be treated as being immediately necessary; *'No woman must ever be denied, or have delayed, maternity services due to charging issues'*. Healthcare providers need to ensure the provision of adequate support and timely advice for migrant mothers on their entitlements to care to allay fears and improve access to care, with the ultimate aim of reducing pregnancy complications.

While the healthy migrant phenomenon may mean that some migrants are healthier than the native population; a theme which emerged particularly strongly within this review is that to meet the unique needs of many migrant women there is a necessity for care which goes beyond traditional models. Other academic studies and reports have highlighted migrant women's unstable or inappropriate living conditions, their financial struggles and the enormous burden of loneliness and the lack of a family network around them (Heslehurst et al, 2018).

As the wider determinants of health are well recognized, including intimate partner violence, low health literacy, limited social support; addressing social and mental wellbeing alongside physical

wellbeing is seen as important for the overall health of mothers and their infants. Addressing the wider determinants of health which impact on migrant women requires closer cross-agency working with effective collaboration between healthcare, social care, the voluntary sector and communities (Lionis et al., 2018).

This current review also highlighted that many migrant women have experienced trauma prior to and during migration, which is widely recognized to impact on mental health and wellbeing in the destination country. Maternity services should develop trauma-informed care to promote a culture of safety and avoid re-traumatization through staff training and reviewing policies and procedures through a trauma lens and developing pathways of support to meet the needs of these vulnerable women.

Some migrant women described exemplary care, receiving treatment that was empathetic, caring, culturally sensitive and compassionate. However other migrants reported discrimination prevalent in the HCPs that they encountered. Care is seen to be impacted where women do not feel well treated or where they feel discriminated against, while unrushed, kind, empathetic HCPs are appreciated. Our findings suggest that continuity of care increases migrant women's satisfaction with maternity care. This is in line with the Cochrane review into continuity of midwife care models which has found increased satisfaction reported by women receiving continuity by a known midwife, as well as reduced rates of preterm birth and perinatal death (Pedersen et al., 2014).

To address the social determinants of health and avoid discriminating against migrant women, it calls for person-centred, high-quality, continuity of care that incorporates aspects of cultural competency and trauma aware care. The evidence within this review, alongside other evidence, led to the development of the ORAMMA integrated perinatal care model (ORAMMA, 2017). This model has been

feasibility tested and will be reported in further articles currently under development. Other known integrated healthcare models include Community Orientated Primary Care, as well as the integrated approach developed within the European Refugees-Human Movement and Advisory Network (EUR-Human) project (ORAMMA, 2017).

Strengths and Limitations

A very important limitation of the qualitative study is that the sample is relatively small. The specific population is very difficult to locate due to the mobility of the population in different parts of Greece and Europe, so it is difficult to be included in the research. Also, these women find it very difficult to easily trust the structures and the purpose of this study.

Through this study, important conclusions and useful benefits emerge from the implementation of the ORAMMA project.

Finally, in the future it would be useful for intercultural mediators to be women with special education in the field of obstetric care. HCPs to be trained and experienced in the culture of the specific population but also to know the obstetric care they have in their country.

Conclusion

As to the conclusion of the above literature review and the results, there are several implications for practice and research from this review, as follows.

- ✓ It is important that migrant women feel understood. Professional interpreters should be provided at each appointment/care encounter to enable HCPs to listen to women and build a friendly, trusting relationship with women.
- ✓ HCPs should avoid stereotyping and respect and accommodate traditional or cultural practices that are relevant in the perinatal period.
- ✓ Migrant women's needs go beyond their pregnancy and include psychosocial-emotional and economic challenges. To address these needs cross-agency working is needed alongside culturally competent and trauma-informed models of maternity care that incorporates continuity.
- ✓ Future research should focus on providing robust evidence on clinical perinatal outcomes for migrant mothers and explore the needs of different migrant populations to facilitate development of tailored interventions.

References

- Allen, V., et al, "The effect of hypertensive disorders in pregnancy on small for gestational age and stillbirth: A population-based study", BMC Pregnancy Childbirth, 2004, 4:1-8.
- Altman, D., Hytten, F., "Intrauterine growth retardation: Let's be clear about it", Brit. J. Obstet. Gynaec., 1989, 96:1127.

- AMERICAN SOCIETY OF HEATING, REFRIGERATING AND AIR CONDITIONING ENGINEERS (ASHRAE), Handbook: Heating, ventilating, and air-conditioning applications: Inch - Pound Edition. Atlanta: American Society of Heating, Refrigerating and Air Conditioning Engineers, 2003, p. 7.
- Arcaya MC, Arcaya AL, Subramanian SV. Inequalities in health: definitions, concepts, and theories. Global Health Action 2015;8(1):27106.
- Bang, A., Reddy, M., Desmuk, M., "Child mortality in Mahararshtra", Economic Political Weekly, 2002, 37:4947–4965.
- Bateman, B., Simpson, L., "Higher rate of stillbirth at the extremes of reproductive age: A large nationwide sample of deliveries in the United States", Am J Obstet Gynecol, 2006, 194:840.
- Black, R., Morris, S., Bryce, J., "Where and why are 10 million children dying every year?", Lancet, 2003, 361: 2226–2234.
- Browne, J., et al., Report of the Seventh Consensus Conference on Newborn ICU Design, Florida, Recommended Standards for Newborn ICU Design, 2007, p. 8-14.
- Chu, S., et al, "Maternal obesity and risk of stillbirth: A metaanalysis", Am J Obstet Gynecol, 2008, 199: e17-e18.
- Das, L., "Low Apgar score and the definition of birth asphyxia", Pediatr Clin North Am, 2004, 51: 737-745.
- De Grande H, Vandenheede H, Gadeyne S, Deboosere P. Health status and mortality rates of adolescents and young adults in the Brussels-Capital Region: differences according to region of origin and migration history. Ethnicity and Health 2014;19(2):122–143.
- DE Jesus, et al, "Risk factors for post - Neonatal Intensive Care Unit Discharge Mortality among Extremely low birth weight infants", The Journal of Pediatrics, 2010, 161(1):70-74.

- Elamin, S., et al., "Classification of perinatal death in a developing country", International Journal of Gynecology & Obstetrics, 2003, 80(3):327-333.
- Fair F, Raben L, Watson H, Vivilaki V, Muijsenbergh M,Soltani H. Migrant women's experiences of pregnancy, childbirth and maternity care in European countries: A systematic review. PLoS One. 2020; 15(2): e0228378.
- Galan – Roosen, A., et al., "Fundamental classification of perinatal death: Validation of a new classification system of perinatal death", European Journal of Obstetrics & Gynecology and Reproductive Biology, 2002, 103(1):30-36.
- Gray, L., Philbin, M., "Effects of the neonatal intensive care unit on auditory attention and distraction", Clin Perinatol, 2004, 31:243-260.
- GUIDELINES INSTITUTE, Health Guidelines Revision Committee: Guidelines for Design and Construction of Health Care Facilities, Dallas, TX, 2010, p. 8.
- Hamilton, B., Martin, J., Ventura, S., "Births: Preliminary Data for 2008: National Vital Statistics Reports;", Hyattsville, MD, National Center for Health Statistics, 2010, 58(16).
- Heslehurst N, Brown H, Pemu A, Coleman H, Rankin J. Perinatal health outcomes and care among asylum seekers and refugees: a systematic review of systematic reviews. BMC Medicine 2018: 89 (2018)
- Holberg, L., "The influence of maternal smoking habits on the risk of subsequent stillbirth: Is there a causal relation?", Br J Obstet Gynaecol, 2007, 114:699-704.
- Huang, L., et al., "Maternal age and risk of stillbirth: A systematic review", CMAJ, 2008, 187:183-184.
- Jolley, A., "The value of surveillance cultures on neonatal intensive care Lancet, 2004, 364: 399–401.
- Lawn, J., Cousens, S., Zupan, J., 4 million neonatal deaths: When? Where? Why?", Lancet, 2005, 365: 891–900.

- Lionis C, Petelos E, Mechili E-, Sifaki-Pistolla D, Chatzea V-, Angelaki A, et al. Assessing refugee healthcare needs in Europe and implementing educational interventions in primary care: a focus on methods. BMC International Health and Human Rights 2018; 18:11.
- Martin, J., et al., "Births, Final Data for National Vital Statistics Reports", Hyattsville, MD, National Center for Health Statistics, 2007, 58(24).
- Miyakis, S., et al., "International consensus statement on an update of the classification criteria for definite antiphospholipid syndrome (APS)", J Thromb Hæmost, 2006, 4:295-306.
- Nielsen SS, Krasnik A. Poorer self-perceived health among migrants and ethnic minorities versus the majority population in Europe: a systematic review. International Journal of Public Health 2010;55(5):357–371. pmid:20437193
- ORAMMA (2017). Practice Guide for Perinatal Health Care of Migrant, Asylum-Seeking & Refugee Women, November (D4.1.)
- ORAMMA (2017). Practice Guide for Perinatal Health Care of Migrant, Asylum-Seeking & Refugee Women, November (D4.2.)
- Persson, M., et al., "Obstetric and perinatal outcomes in type I diabetic pregnancies. A large, population-based study", Diabetes Care, 2009, 32:2005-2009.
- Pedersen GS, Grøntved A, Mortensen LH, Andersen A-N, Rich-Edwards J. Maternal mortality among migrants in western Europe: a meta-analysis. Maternal & Child Health Journal 2014;18(7):1628–1638.
- Phillimore J. Delivering maternity services in an era of superdiversity: The challenges of novelty and newness. Ethnic and Racial Studies 2015;38(4):568–582.
- Ray, J., et al., "MOS HIP: McMaster outcome study of hypertension in pregnancy", Early Hum Dev, 2001, 64:129- 143.
- Rea, M., Lighting handbook, New York, Illuminating Engineering Society of North America, 9th Edition, 2000, p. 25.

- Rea, M., Lighting answers: Light sources and color, Lighting Research Center, 2004, 8(1):41.
- Reddy Y., "Maternal age and the risk of stillbirth throughout pregnancy in the United States", Am J Obstet Gynecol, 2006, 197:114.
- Rey, E., et al., "Thrombophilic disorders and fetal loss: A meta-analysis", Lancet, 2003, 361:901-908.
- Robbins, S., Beker, L., Infant Feedings: Preparation of Formula and Breastmilk in Health Care Facilities, American Dietetic Association, Pediatric Nutrition Practice Group, Chicago, American Dietetic, 2004, p. 19.
- Urquia ML, Glazier RH, Mortensen L, Nybo-Andersen AM, Small R, Davey MA, et al. Severe maternal morbidity associated with maternal birthplace in three high-immigration settings. European Journal of Public Health 2015;25(4):620–625.
- Salhu U, H., et al., "Extreme obesity and risk of stillbirth among black and white gravidas", Obstet Gynecol, 2007, 110: 552-557.
- Salihu, H., et al., "Racial disparity in stillbirth mamong singleton, twin, and triplet gestations in the United States", Obstet Gynecol, 2004, 104:734-740.
- Simpson L., "Maternal medical diseases: Risk of antepartum fetal death", Semin Perinatol, 2002, 26:42-50.
- Tsironi, S., et al., "Factors affecting parental satisfaction in the neonatal intensive care unit", Journal of Neonatal Nursing, 2012, 18(5):183-192.
- Van Oostrum IE, Goosen S, Uitenbroek D, Koppenaal H, Stronks K. Mortality and causes of death among asylum seekers in the Netherlands. Journal of Epidemiology & Community Health 2011;65(4):376–383.
- Yang, Q., Chen, H., Correa, A., et al., "Racial differences in infant mortality attributable to birth defects in the United States, 1989-2002", Birth Defects Res, 2006, 76:706-713.

- Yasmin, S., et al., “Neonatal mortality of lowbirth - weight infants in Bangladesh”, Bull World Health Organ, 2001, 79: 608–614.