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ΣΧΟΛΗ ΕΠΙΣΤΗΜΩΝ ΥΓΕΙΑΣ &
ΠΡΟΝΟΙΑΣ
ΤΜΗΜΑ ΜΑΙΕΥΤΙΚΗΣ

ΤΙΤΛΟΣ ΠΡΟΓΡΑΜΜΑΤΟΣ ΜΕΤΑΠΤΥΧΙΑΚΩΝ ΣΠΟΥΔΩΝ
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Μεταπτυχιακή Διπλωματική Εργασία

Health care policies for antenatal and postpartum migrant, asylum-seeking and refugee women: a systematic review

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Health care policies for antenatal and postpartum migrant, asylum-seeking and refugee women: a systematic review

Μέλη Εξεταστικής Επιτροπής συμπεριλαμβανομένου και του Εισηγητή

Η μεταπτυχιακή διπλωματική εργασία εξετάστηκε επιτυχώς από την κάτωθι Εξεταστική Επιτροπή:

Α/α	ΟΝΟΜΑ ΕΠΩΝΥΜΟ	ΒΑΘΜΙΔΑ/ΙΔΙΟΤΗΤΑ	ΨΗΦΙΑΚΗ ΥΠΟΓΡΑΦΗ
1	Βιβιλάκη Βικτωρία	Αναπληρώτρια Καθηγήτρια του τμήματος Μαιευτικής του Πανεπιστημίου Δυτικής Αττικής	Viktoria Vivilaki Digitally signed by Viktoria Vivilaki Date: 2023.06.27 16:12:18 +03'00'
2	Διαμαντή Αθηνά	Επίκουρη Καθηγήτρια του τμήματος Μαιευτικής του Πανεπιστημίου Δυτικής Αττικής	Athina Diamanti Athina Diamanti 2023.06.27 16:27:37 +03'00'
3	Ηλιάδου Μαρία	Επίκουρη Καθηγήτρια του τμήματος Μαιευτικής του Πανεπιστημίου Δυτικής Αττικής	Maria Iliadou Digitally signed by Maria Iliadou Date: 2023.07.03 09:25:45 +03'00'

ΔΗΛΩΣΗ ΣΥΓΓΡΑΦΕΑ ΜΕΤΑΠΤΥΧΙΑΚΗΣ ΕΡΓΑΣΙΑΣ

Η κάτωθι υπογεγραμμένη Φουρτουνίδου Βασιλική του Αντωνίου, με αριθμό μητρώου 20071 φοιτήτρια του Προγράμματος Μεταπτυχιακών Σπουδών Προηγμένη και Τεκμηριωμένη Μαιευτική Φροντίδα του Τμήματος Μαιευτικής της Σχολής Επιστημών Υγείας & Πρόνοιας του Πανεπιστημίου Δυτικής Αττικής, δηλώνω ότι:

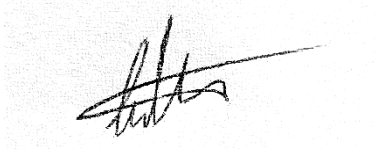
«Είμαι συγγραφέας αυτής της μεταπτυχιακής εργασίας και ότι κάθε βοήθεια την οποία είχα για την προετοιμασία της, είναι πλήρως αναγνωρισμένη και αναφέρεται στην εργασία. Επίσης, οι όποιες πηγές από τις οποίες έκανα χρήση δεδομένων, ιδεών ή λέξεων, είτε ακριβώς είτε παραφρασμένες, αναφέρονται στο σύνολό 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 μένα 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* …… *και έπειτα από αίτηση μου στη Βιβλιοθήκη και έγκριση του επιβλέποντα καθηγητή.*

Η Δηλούσα

Φουρτουνίδου Βασιλική



*** Ονοματεπώνυμο /Ιδιότητα**

Βιβιλάκη Βικτωρία, Αναπληρώτρια Καθηγήτρια του τμήματος Μαιευτικής Πανεπιστημίου Δυτικής Αττικής

Ψηφιακή Υπογραφή Επιβλέποντα
(Υπογραφή)

Viktoria Vivilaki

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**** Εάν κάποιος επιθυμεί απαγόρευση πρόσβασης στην εργασία για χρονικό διάστημα 6-12 μηνών (embargo), 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

Health care policies for antenatal and postpartum migrant, asylum-seeking and refugee women: a systematic review

Abstract

Background: The healthcare policies for migrant mothers is multidimensional and complex issue. Women in perinatal period are vulnerable and need special care, especially migrant pregnant women, since are associated with insufficient prenatal care, financial difficulties, and higher stillbirths or infant death rates. Pregnant women seeking asylum, refugees, or irregular migrants face many barriers to accessing health care, including maternity. Timely access to perinatal care and other barriers needs to be addressed by the health policies. Healthcare policies aimed at supporting antenatal and postpartum refugee women are crucial for ensuring their well-being and the health of their babies. These policies should address the unique needs and challenges faced by refugee women during pregnancy, childbirth, and the postpartum period. It is important to note that healthcare policies should be flexible, responsive, and regularly evaluated to address the evolving needs and challenges faced by antenatal and postpartum refugee women.

Aims: The purpose of this systematic review was to analyze both the barriers which asylum-seeking, migrant and refugee women face during antenatal and postpartum period, and the necessity of healthcare policies to that population.

Methods: Based on The Preferred Reporting Items for Systematic Reviews and Meta-Analyses reporting guidelines (PRISMA, a systematic literature review was conducted from 2009 until 2022 using the following databases: PubMed, MEDLINE, and Scopus. Google Scholar is used to find relevant studies. Titles, abstracts and keywords of studies identified in the search strategies were screened for inclusion criteria.

Results: A total of 16 articles were selected for inclusion. According to the literature, several factors lead to refugee women delaying their search for medical services. Among these factors are instances of racism encountered by refugees from healthcare providers, linguistic barriers, difficulties in integrating into mainstream society, and stress about adapting to host countries. Socioeconomic factors, cultural influences, family status, language, and the quality of social networks can synergistically impact both refugee women's health experiences and their maternal health. In the same time, refugee crisis drives the governments to embrace austerity policies, which effect refugee women’s health condition significantly. Moreover, healthcare policies intersect with laws for migrants and refugees, implying that the health of undocumented women depends on immigration policies. Here are some key healthcare policies that can be implemented:

- Accessible and Culturally Competent Care: Ensure that antenatal and

postpartum healthcare services are accessible to refugee women. This includes providing interpretation services, culturally competent care, and addressing language barriers to facilitate effective communication between healthcare providers and refugee women.

- Comprehensive Antenatal Care: Implement policies that promote early and regular antenatal care for refugee women. This should include routine prenatal check-ups, screenings, immunizations, and access to essential prenatal vitamins and medications. Refugee women should be informed about the importance of antenatal care and the available services.
- Mental Health Support: Recognize the increased risk of mental health issues among refugee women during pregnancy and postpartum. Develop policies that integrate mental health screenings, counselling services, and trauma-informed care into antenatal and postpartum healthcare. Collaborate with mental health professionals and community organizations to provide necessary support.
- Health Education and Literacy: Develop policies that prioritize health education for refugee women, including information on pregnancy, childbirth, breastfeeding, nutrition, and infant care. This should be provided in a culturally sensitive and language-appropriate manner, ensuring that refugee women have access to accurate and understandable health information.
- Collaboration and Coordination: Encourage collaboration and coordination between healthcare providers, refugee support organizations, and government agencies to ensure a holistic approach to healthcare for antenatal and postpartum refugee women.

Conclusions: Pregnant female migrants, asylum seekers, or irregular migrants face more difficulties than the local population. Poor living conditions and nutrition, difficult access to health facilities, and the lack of translators that make communication with medical personnel more difficult affect the health of the pregnant woman during pregnancy, increasing the complications and risks in pregnancy as well as maternal or newborn mortality. These factors also affect the health of the mother and newborn after delivery, increasing the risk of postpartum depression and complications. The above barriers show how important healthcare policies are for migrant, asylum-seeking and refugee women and the quality of taken health care.

Keywords: Migrant women, Refugee women, Irregular Migrant women, Asylum Seekers, Utilization and quality of care, Perinatal health care, Maternal and child health care, Healthcare policies, Healthcare access, Healthcare Recommendations.

Background

Deprivation of liberty, war, torture, the loss of family and friends, sexual abuse, and slavery are just some of the traumas migrant women carry. (Kalt et al., 2013) They travel for a long time and then live in camps without stable management, living in poverty and misery, with poor nutrition and poor living conditions, which affect their health. (Bradby et al., 2015; Koser, 2000) Migration increases MAR's vulnerability and puts women's physical and mental well-being at risk. (Keygnaert et al., 2014; Keygnaert et al., 2016) According to the literature, refugee women often are healthy when leaving their country of origin, but their health deteriorates over time, and they rate themselves to have poorer health than the indigenous population of the host country. (Almeida et al., 2014; Higginbottom et al., 2013; Poeran et al., 2013; Schaaf et al., 2013; Wahlberg et al., 2013) Generally, studies have shown that MAR women are more likely to suffer from chronic diseases such as Diabetes Mellitus, cardiovascular diseases, mental health problems (Amara & Aljunid, 2014; Keygnaert et al., 2016) and reproductive health problems such as sexual transmitted infections, including HIV, hepatitis B etc. (Keygnaert et al., 2014) In most cases, pregnant women seeking asylum are presented to maternity services in advanced pregnancy with psychological trauma, (Keygnaert et al., 2016) underlying diseases, and even infectious diseases.(Asif et al., 2015) The literature agrees in the fact that poorer prenatal outcomes (such as miscarriages, stillbirths, complications, etc.) are higher amongst migrant women and the rates of preterm birth, low birth weight, and congenital malformations are higher amongst migrant women's babies. (Agency for Fundamental Rights., 2013; Bernd Rechel et al., 2007; Bollini et al., 2009; Gissler et al., 2009; Juárez Sol Pía et al., 2016; Keygnaert et al., 2016; Khanlou et al., 2017; Luque-Fernandez et al., 2013; Schaaf et al., 2013; Sosta et al., 2008) The higher prevalence of physical and/or mental health problems by migrant pregnant women, (Almeida et al., 2013) the delaying the start of prenatal care, the missing appointments due to transportation problems, not recognizing alarm symptoms, not knowing whom to contact, the traveling elsewhere during pregnancy, are factors which affect the perinatal and neonatal mortality. (Almeida et al., 2013; Verschuuren et al., 2020)

Besides health status, several social and cultural aspects aggravate the vulnerability of pregnant migrants. For example, difficulties in accessing obstetric and midwifery care, language barriers, and cultural differences. (Akhavan, 2012; Almeida et al., 2013; Van Loenen et al., 2018; Wolff et al., 2008) According to research in Scotland, the quality of antenatal, intrapartum, and postnatal care is affected by poor communication. (Bray et al., 2010) Refugee pregnant women usually express a poor understanding of the purpose of prenatal monitoring. (Khanlou et al., 2017) Additional, in some cases, interpretation services are used to meet the needs of health care professionals, like conveying information or obtaining informed consent, rather than being used routinely to develop a genuine dialogue with MAR pregnant women. (Bray et al., 2010) Apparently, allophone women were often confused in healthcare systems (Khanlou et al., 2017; Origlia Ikhilor et al., 2019) and sometimes expect help for health issues and other problems as legal or social issues, which healthcare providers do have not the authority to adjust to them. (Origlia Ikhilor et al., 2019) At the same time, limited cultural knowledge and sensitivity discourage them from expressing their needs, thinking that their cultural expectations are unknown to health providers. (Khanlou et al., 2017) Therefore, Misunderstandings can occur when some traditions conflict with the midwife's daily practices and recommendations. (Lyons et al., 2008). The literature

advocate that, language discordance leads to incorrect diagnosis, (Villadsen et al., 2016) more communication errors, worse clinical outcomes, and increasing inequalities in maternal and infant health outcomes. (Origlia Ikhilor et al., 2019; Yelland et al., 2016) According to research relevant to communication barriers, rrefugees need guidance in health care systems and adequate provision of interpreter services. (Origlia Ikhilor et al., 2019).

A United Nations report indicates that problems associated with pregnancy are common among migrants across European Union countries and Asia. (Khanlou et al., 2017) Pregnant migrants as patients differ from native populations due to their journey, lack of medical history, and need for comprehensive healthcare. (Crotti et al., 2019) Originally, poorer maternal health in migrant 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 prenatal period. (Ines Keygnaert et al., 2016) In addition, migrant women can suffer from physical diseases that are unknown or poorly understood in their new country of residence. (Esscher et al., 2013; Gagnon et al., 2009; Wolff et al., 2008). These factors present challenges for midwives and doctors working in public hospitals, which are "victims" of austerity policies. (Crotti et al., 2019) In accordance with research in Italy, austerity policies and increased migration flows have impacted the quality of medical services, leading to the gradual adoption and regularization of resolutions or measures often considered urgent, innovative, or ad hoc. (Carney, 2017) Furthermore, numerous health studies have found that if the living conditions of pregnant migrants improve, the likelihood of healthy childbirth and new-born dramatically increases. (Crotti et al., 2019)

Methods

A literature search of relevant articles published between 2009 and 2022, including the electronic PubMed, Medline, Scopus, and Google Scholar. The PRISMA guidelines were utilized in the design and reporting of the study. The main search keywords were combined with the Boolean operators AND and OR to expand and narrow search terms so as to include different versions of the word and search strings. The keywords used included healthcare access, immigrant/migrant/refugee/asylum-seeking women, healthcare policies, EU Member States/European Union/Europe/EU, USA and UK as identified in title and abstract. Abstracts were reviewed according to the following inclusion criteria (EU/USA/UK, migrant, English language) and duplicates were excluded. A full-text review was then conducted for all included papers. However, articles restricted using the search terms shown in Table 1 to those published in the English language and in peer-reviewed journals of research on health outcomes of pregnancy and childbirth and health care access for migrant women. The following inclusion and exclusion criteria were used to answer the research question for the scoping review.

Inclusion Criteria:

i. articles published in English,
ii. with a published date between 2009 and 2022,

iii. all studies in which the sample population was migrant or refugee or asylum-seeking pregnant women and focused on prenatal, perinatal, and postpartum periods and women's healthcare access
iv. studies that migrant women's origin was from Asia and Africa, the Middle East, Sub-Saharan Africa, East Asia, Latin America, and Europe, and especially countries such as Iraq, Iran, Syria, Afghanistan, Eritrea, Somali, Nigeria, etc. unless studies are noted in guidelines, gaps or policies for refugee and migrant population
v. migrants living in Europe, Turkey, the USA, and the UK.

Exclusion Criteria:

i. articles published in non-English languages
ii. thesis, and proposals
iii. internal migrants
iv. articles non-related to the interested population
v. publication date before 2009

This research focused both on the barriers faced by pregnant, asylum-seeking, undocumented migrant women during theirs access to maternal care and health services and the necessity of healthcare policies in antenatal and postpartum period.

Table 1: Search terms used

Immigrant prenatal care	Refugee maternity
Immigrant maternal care	Refugee maternal health
Immigrant antenatal	Refugee antenatal care
Immigrant postnatal care	Refugee prenatal care
Immigrant intrapartum care	Refugee intrapartum care
Immigrant maternal health	Refugee postpartum care
Immigrant healthcare policies	Refugee postnatal care
Asylum-seeker maternal care	Refugee healthcare policies
Asylum-seeker antenatal care	Asylum-seeker healthcare policies
Asylum-seeker postnatal care	Uninsured migrant's healthcare access

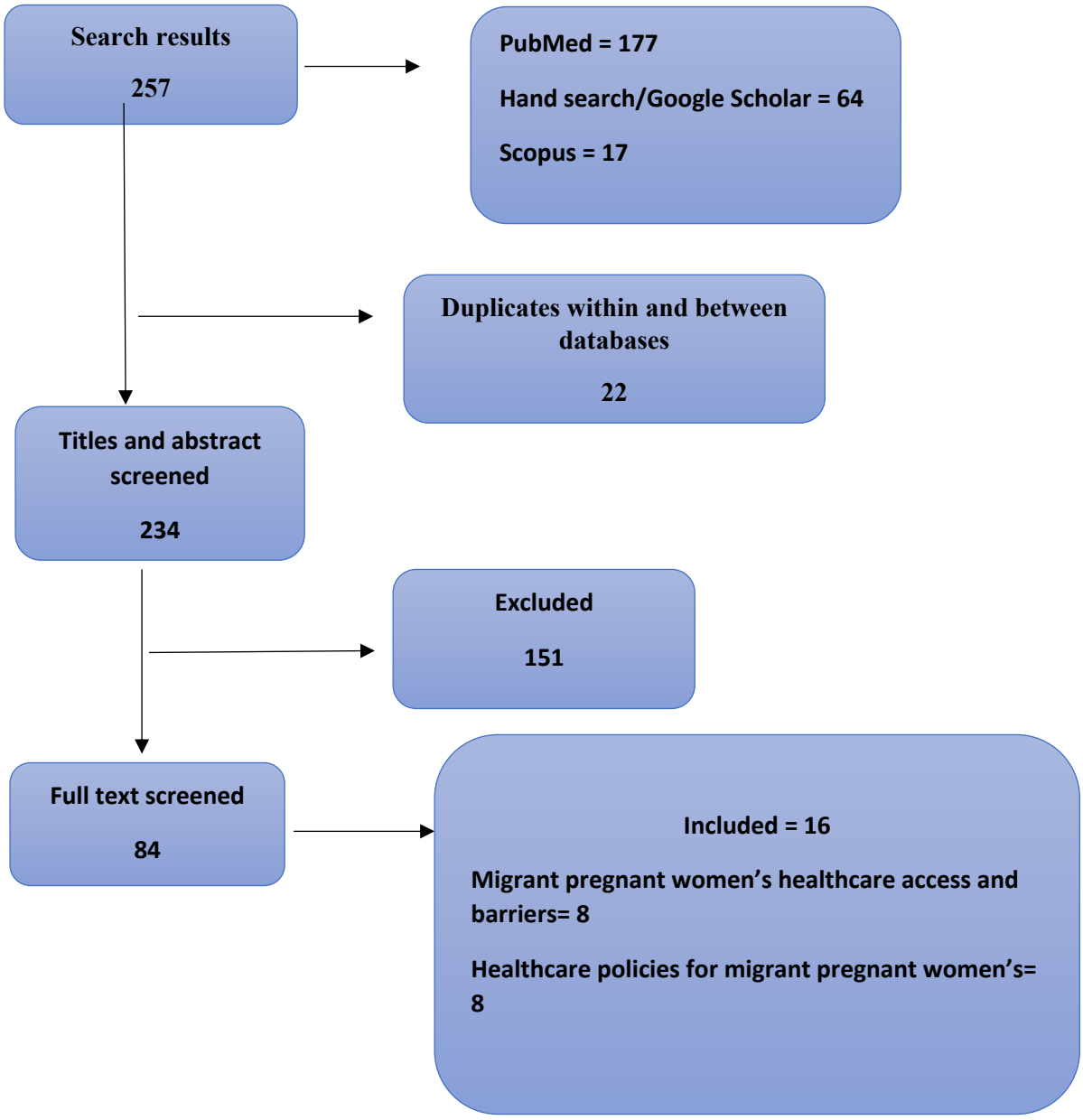

Fig. 1. Flowchart of study selection

Results

This research examined 254 articles and included 16 studies. Some articles were excluded for various reasons such as the article was not in English or the articles did not meet our criteria. Most surveys contain both qualitative and quantitative data. The immigrants in the surveys come from Asia, Africa, Latin America, and Europe.

Overall, researches agree that pregnant immigrant women, especially irregular ones, are more likely to present a higher health risk profile (Almeida et al., 2013; Bray et al., 2010; Dias et al., 2010; Dias et al., 2011; Gagnon et al., 2009; Gagnon & Redden, 2016;

Merry et al., 2011; Merry A. Lisa et al., 2011; Ozel et al., 2018) reduced access to health facilities, poor communication between caregiver and patient are some of the reasons that increase the risk of complications during pregnancy and the risk of maternal and neonatal death. (Gagnon et al., 2009; Gagnon & Redden, 2016) Furthermore, women worldwide can experience abuse, including sexual, verbal, or physical mistreatment, stigma, discrimination, healthcare professionals' failure to provide standard care, ineffective communication, and encountering unsupportive care. Last but not least, refugees, asylum-seeking migrants, women with limited financial resources, and ethnic minorities are more vulnerable to mistreatment. (Vogel JP et al., 2016)

Differences and health risks among refugee women and citizen women

The literature agrees that frequency of diseases in pregnant immigrant women that can affect pregnancy and the postpartum period is higher in relation to the local population. (Almeida et al., 2013; David et al., 2006; Gagnon et al., 2009; Gagnon & Redden, 2016; Schutte et al., 2010; Van Roosmalen et al., 2002) Pregnant immigrant women are twice as likely to have a postpartum maternal death, while the risk of death from hypertensive disorder is four times greater compared to the local population. Interestingly, a percentage of these deaths could have been avoided if immigrant women received the same quality of care as local women. (Almeida et al., 2013; Philibert et al., 2008; Schutte et al., 2010) The risk of preeclampsia is also increased, as well as the appearance of postpartum depression. (Almeida et al., 2013; Alhasanat & Fry-McComish, 2015; Anderson et al., 2017; Collins et al., 2011; De Maio, 2010; Falah-Hassani et al., 2015; Fellmeth et al., 2017; Heslehurst et al., 2018; Stewart et al., 2008; Van Roosmalen et al., 2002) The possibility of premature delivery, low birth weight (Ozel et al., 2018), and perinatal mortality is more frequent in immigrant women in relation to the native population. (Gagnon et al., 2009; Gagnon & Redden, 2016; Heslehurst et al., 2018; Keygnaert et al., 2016) Specifically, the risk of premature birth increases by 47% and 43% probability of low birth weight, while the risk of perinatal mortality reaches 56%. (Bollini et al., 2009) Common factors contributing to these deaths included delayed healthcare, non-acceptance of medical interventions, inadequate monitoring of intrauterine maturity, insufficient medication, misinterpretation of cardiotocography, and interpersonal misunderstandings. (Adetayo Olorunlana, 2019) On the other hand, there have been studies with conflicting data, showing that the results differ according to the country of origin of the immigrants. (Heslehurst et al., 2018; Villalonga-Olives et al., 2017) The fact that women who belonged to high-risk groups, smokers, opioid users, etc., showed a lower risk of premature birth because their participation in prenatal visits was increased is of interest. (Byerley & Haas, 2017)

Healthcare access and barriers

According to the literature, the access to prenatal care is less feasible for immigrant women in relation to the native population and in most cases is characterized as inadequate. (De Maio, 2010; Gagnon et al., 2009; Heslehurst et al., 2018; Higginbottom Gina et al., 2012; Nilaweera et al., 2014; Tobin et al., 2018; Wittkowski et al., 2017) Access to health services and maternal care is a multifactorial procedure, which is compromised or made easier by many factors in different levels. (Keygnaert et al., 2016) Due to the limitations of existing statistical data and audits, it is not possible to determine the exact differences in access to prenatal health services and maternal

mortality and morbidity between migrant women and the host population across Europe. However, there is evidence that MAR women's access to prenatal healthcare services is influenced by financial constraints, administrative problems, coverage issues, lack of information, low levels of health literacy, language barriers, past negative experiences, (Keygnaert et al., 2016) fear of authorities, (Bradby et al., 2015; Iliadi P, 2008; Papadakaki et al., 2021; Phillimore, 2016; Schoevers et al., 2010) cultural differences and incompatibilities, (Almeida et al., 2014; Esscher et al., 2013; Gagnon et al., 2009; Ngo-Metzger et al., 2003; Wolff et al., 2008) and difficulties in integrating into mainstream society, and stress about adapting to host countries. (Khanlou et al., 2017) The above factors, can synergistically impact both migrants' health experiences and their maternal health. (Khanlou et al., 2017)

- In case of language barriers, studies show that interpretation services are used to meet the needs of health care professionals rather than being used routinely, (Bray et al., 2010) and sometimes health service providers have an over-reliance on ad hoc, 'informal' interpretation from family or non-medical personnel, (Lyons et al., 2008) and raising issues about the quality of interpretation, confidentiality, (Lyons et al., 2008) risk of incorrect diagnosis (Villadsen et al., 2016) and as a result, women often stop attending follow-ups, because of poor communication. (Phillimore, 2015)
- MAR women have expressed difficulties with the integration of their cultural beliefs with the recommended healthcare practices during the intrapartum period. (Khanlou et al., 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. (Khanlou et al., 2017) Additionally, religious and cultural notions can admit to not searching for health care or believing that health care is inadmissible and inadequate. (Henry et al., 2019) 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 (Giger et al., 2007) Cultural diversity can be a challenge for midwives, and other healthcare providers who have a duty to act as advocates for refugee women. (Lyberg et al., 2012) Culturally appropriate services may be helpful to motivate women's utilization of maternity care (Jenny Phillimore et al., 2010)
- The necessity of health care is affected by both women's level of health literacy and their premigration experiences, which have an effect on health-seeking. (Henry et al., 2019) Comprehension of needing health care, is essential for healthcare access and pursuit of health care. This has arisen from notions and knowledge about pregnancy, labor, and the postpartum period, which affect women's consequential actions and behaviors. (Henry et al., 2019) Refugees present a higher rate of uneducated women than citizen women. (Ozel et al., 2018) Furthermore, the low level of health literacy and premigration experiences can admit refugee women to stressful conditions. (Henry et al., 2019) In case that the above factors are combined with inadequate information related to the right time for health care looking admitted to belated health care provision and negative health outcomes which compromised the health of refugee women or/and theirs's babies.
- A significant issue for illegal refugees is that health officers are obligated to verify their identity. This means refugees fear apprehension and do not gain

> access to preventive medical services such as vaccinations, prenatal examinations, or general medical check-ups. While hospitals should be perceived as safe places, they often function as immigration-controlled spaces. (Bissonnette, 2022)

In conclusion, a combination of economic, cultural, individual, and social factors is associated with migrants', refugees', and asylum-seekers health, creating barriers and difficulties during the antenatal, intrapartum, and postnatal periods of maternity. These challenges disadvantage pregnant migrant women and compromise their maternal health. (Khanlou et al., 2017) To assure healthcare access, healthcare policies must motivate and embolden patients to be embroiled in the healthcare system. (Levesque et al., 2013)

Healthcare Policies

Maternity care to refugee women operates within the broader context of the refugee crisis and austerity policies primarily affecting Southern Europe. Consequently, austerity policies dominate, resulting in reduced welfare services, increased unemployment, and lower living standards. These factors have led to a strained healthcare system that must adapt to the needs of pregnant migrants while operating with limited resources. (Crotti et al., 2019) As a consequence, improving the living conditions of pregnant migrants is essential for increasing the likelihood of healthy childbirth and newborns. Collaboration between state healthcare systems and NGOs is critical for addressing the unique healthcare needs of this vulnerable population. (Crotti et al., 2019) According to research in Germany, refugee women have the same rights in healthcare access as German citizens during pregnancy, childbirth, and puerperium. Despite the fact that refugee women are entitled to the same maternal care provision as German women, parity in health care doesn’t exist because of lack of interpreters, linguistic barriers and bad communication. (Henry et al., 2019) Furthermore, undocumented migrants typically have only access to emergency services and lack antenatal and postpartum care eligibility. Evidently, the EU must legislate policies to support the well-being of migrants, general healthcare, and maternity care of refugees, as suggested by the WHO (Adetayo Olorunlana, 2019)

Many countries, like the US and Mexico, enact harsh policies towards refugees and migrants. Policies of this nature are considered necessary to control migration and expulsions from host countries, with checkpoints in various locations within towns to be included in these strategies. (Bissonnette, 2022) So, refugees live in fear of deportation, avoiding seeking healthcare due to their illegal status. These barriers are enacted by political leaders and lead to ongoing consequences for reproductive, sexual (RSH), (Okie Susan, 2007) and preventive health because the fear of deportation drive refugee women to avoid vaccinations, prenatal examinations or general medical check-ups. (Bissonnette, 2022) Moreover, healthcare policies intersect with laws for migrants and refugees, implying that the health of undocumented women depends on immigration policies. (Bissonnette, 2022) Therefore, these laws seriously affect undocumented women's health, (Khanlou et al., 2017) and sometimes their health

problems become chronic. (Bissonnette, 2022) Federal migration policies aim to reduce migration flows. (Bissonnette, 2022)

As it is known, more targeted care is vital to be developed for refugee women during the prenatal, intrapartum, and postpartum periods. (Ozel et al., 2018) Consequently, the existence of maternity policies is crucial. However, maternal healthcare policies, which are often standardized and implemented in the same form globally, can negatively impact the quality of migrants' healthcare and lives. Furthermore, policy texts are presented as culturally detached and are expected to be applied by health officers in public or private hospitals, clinics, and health centres worldwide, despite cultural and political variations. (Melberg et al., 2018)

In the UK, the National Health Service (NHS) provides healthcare to citizens and "ordinary residents" for free. However, recent legislation has changed against refugees. Specifically, the 2014 Immigration Act states that family migrants, students, and labor migrants are not considered ordinary residents and, therefore, not eligible for complimentary healthcare. The same policy applies to illegal migrants, undocumented refugees, refused asylum-seekers, or people with expired visas. But the point is that healthcare policies need to adequately consider vulnerable women's needs and status to ensure their health security. (Jayaweera, 2018) The same situation applies in Canada, as refugee applicants have only partial access to health services through the Interim Federal Health Program (IFHP) and undocumented migrants and unsuccessful refugee applicants are not eligible for health insurance. In this context, there are no exceptions for medication coverage or preventive medical examinations for pregnant women, regardless of their migration status. Moreover, while the Canadian government has developed guidelines for refugee healthcare, there is a glaring absence of guidelines for pregnancy. (Khanlou et al., 2017)

A/A	Author, year	Population	Aim	Type of studies	Receiving region	Country of origin	Main findings	Recommendations, Policies and Gaps.
1	A.J. Gagnon et al., (2009)	migrant women (N= 20,152,134 migrant but analysed N= 3,022,178 migrants)	research if migrant women in western industrialised countries have consistently poorer perinatal health outcomes than receiving- country women	23 studies, systematic review of literature	USA UK France Italy Norway Australia Sweden Spain Other Europe/Canada	Asian, North African and sub-Saharan African	• poor communication between caregiver and patient increases the risk of complications • poor communication between caregiver and patient increases risk of maternal and neonatal death • The frequency of diseases in pregnant immigrant women that can affect pregnancy and the postpartum period is higher in relation to the local population • pregnant immigrant women are twice as likely to have a postpartum maternal death in contrast to the local population • the frequency of premature delivery is almost double in contrast with local women • the risk of perinatal mortality is almost double compared to the local women	
2	Paola Bollini et al., (2009)	pregnant native (N=16,690,577) versus pregnant immigrant women in European	to review the association between pregnancy outcomes and integration policies	65 studies, cross sectional	Switzerland & Europe (UK, France, Italy,	not specified	• the frequency of premature delivery is almost double in contrast with local women • almost 43% is the probability of low birth weight in contrast with local women	• Mechanisms by which integration policies can be protective include increasing the participation of immigrant communities in the lives of host societies and reducing the stress and discrimination they may face.

		countries (N= 1,632,401			Netherlands, Belgium, Norway, Spain, Denmark, Austria, Germany)		• the risk of perinatal mortality reaches 56% compared to the local women	• Migrant women clearly need intensive attention to improve the health of their newborns, but serious social change is also needed to integrate and respect immigrant communities into host societies.
3	Malgorzata Miszkurka et al., (2010)	3,834 Canadian-born and 1,495 foreign-born women (immigrants) 25-31 years old	Gauge the high incidence of antenatal depression in Canada's immigrants apropos of duration of stay and their region of origin in comparison with the prevalence in Canadian-born women. Analyze the role of lack of money and social support in depression in immigrant who appertain to above category. Assess the interaction of length of stay and region of origin like deal breaker of prenatal depression.	quantitative research	Canada	Latin America, Caribbean, Maghreb, Sub-Saharan Africa, Middle East, East Asia, Southeast Asia, South Asia, Europe	• The overall prevalence of antenatal depression is 25 +/- 6%, which is in higher ratio above Canadian-born women. • Social support affordability was highly affiliated with depression in pregnant women and specific women from the Caribbean, Maghreb, and Sub- Saharan Africa had twice as much as possible to develop antenatal depression. A result which is arisen after appending women's age over the region of origin. • Women of European or Middle Eastern origin haven't a different possibility to nod antenatal depression from Canadian women. • The interconnection among origin, duration of stay, and depression are clarified from socio-economic factors and social support variates Maghrebian, Sub-Saharan, Caribbean, South Asian, and Middle Eastern women.	

4	Pottie K. et al., (2011)	migrant and refugee women in Canada.	investigates and accrues evidence about care during pregnancy of migrant and refugee women in Canada	systematic review of literature	Canada	not specified	• There is a lack of guidelines for pregnancy care for migrant and refugee women in Canada. • Access to antenatal and postnatal care and services is deficient. • The 60% of migrant pregnant women delay looking for prenatal care.	
5	Almeida et al., (2013)	migrant women during pregnancy or in the year that followed	to review the access, use and quality of healthcare in migrant populations during pregnancy and the postpartum period	30 studies, systematic reviews and/or meta-analysis	mainly in Europe, some in USA, Canada, Australia	Asia, Africa, Europe	• pregnant immigrants present a higher health risk profile • The frequency of diseases in pregnant immigrant women that can affect pregnancy and the postpartum period is higher in relation to the local population • pregnant immigrant women are twice as likely to have a postpartum maternal death in contrast to the local population • the risk of death from hypertensive disorder is four times greater compared to the local population • higher risk of preeclampsia • postpartum depression is more common than in local pregnant women	• If there is a language barrier, a professional interpreter should be arranged. • Special attention should also be paid to the knowledge and perceptions of immigrant populations in order to improve access to health care. • Culturally sensitive strategies are needed to raise awareness of relevant health and social support services in the community. • Policies for public health education may need to target both women and the community to improve health literacy and increase the likelihood of seeking maternal care.
6	Wilson-Mitchell K., Rummens J., (2013)	453 uninsured and provincially insured migrant/refugee women (175	explores how immigrant, refugee and migrant women's insurance status	retrospective cross-sectiona	Canada	African, South Asian, Middl	• Health insurance status is related to the quantity of antenatal care, cause of cesarean section, type of health care provider, duration of mothers' hospital stays, and prevalence of neonatal	

		uninsured and 278 insured)	affects multifarious prenatal outcomes	l study (n=453)		e Eastern, Eastern and Western European, South and Central American, East Asian, American, Canandian	resuscitation. • Uninsured pregnant women (36.3%) looked for midwives' services more than insured (4,0%) • Lack of health insurance isn't correlated with the type or quantity of medical interventions, which are provided. • Neonatal outcomes are positive for both insured and uninsured women. • All insured women received medical services from an obstetrician during pregnancy, while more than half of uninsured women did so. • More than half of uninsured pregnant women received inadequate antenatal care as distinct from 19.6% of insured women. • 6,5% of uninsured women didn't receive antenatal care at all, while all insured women did so.	
7	Keygnaert et al., 2014	Asylum-seeker refugee, and undocumented migrant women in Belgium and the Netherlands. (223 in-depth interviews)	explores how refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands define sexual health, search for sexual health	223 interviews, qualitative and quantitative	Belgium and the Netherlands	Iran, Iraq, Africa, Slovakia, Afghanistan	• MAR women are more likely to suffer from reproductive health problems such as sexual transmitted infections, including HIV, hepatitis B etc.	• They should be enforced to develop sexual health promotion activities that are more desirable in the sense that they reduce the odds of having migration and legal status as a sexual health determinant. • Sexual health promotion activities should be made culturally competent, also taking their sexual health frame of

			information and perceive sexual health determinants.					reference and pathways into account. • Structural organizational and societal factors linked to the asylum reception system that now hamper the building of social networks and their active participation in society should be addressed in order to give refugees, asylum seekers and undocumented migrants the same opportunity as general citizens to be equally in control of their sexual health and sexuality.
8	Anita J. Gagnon et al., (2016)	Migrant women in Organization for Economic Co-operation and Development (OECD) or European Union (EU) 27 countries - excluded refugees who live in camps	• to assess the extent to which current research is able to inform reproductive health care practices for migrant women • to identify topics for which clinicians may choose to advocate for additional research to be performed	228 reports, only quantitative methods	Europe	Not specified	• poor communication between caregiver and patient increases the risk of complications • poor communication between caregiver and patient increases risk of maternal and neonatal death • The frequency of diseases in pregnant immigrant women that can affect pregnancy and the postpartum period is higher in relation to the local population • pregnant immigrant women are twice as likely to have a postpartum maternal death in contrast to the local population • the frequency of premature delivery is almost double in contrast with local women • the risk of perinatal mortality is almost double compared to the local women	

9	Keygnaert et al., (2016)	Female migrants who have access to maternal healthcare services in EU in contrast to host population in WHO European Region.	to assess interventions and policies that work to improve the accessibility and the quality of maternal health care for migrants in the WHO European Region.	systematic academic literature review and critical interpretive synthesis of policy frameworks	Who European Region	Not specified but it makes mention of Syrian refugees, migrants from central Asia Ukraine and the Republic of Moldova.	• Some migrant women have better maternal health because of family networks which are protective to them or informal social support during pregnancy or by healthier habits such as less smoking and drinking alcohol compare with native women. • Increasing time spent in host country in bad living condition has negative effect to maternal health of refugee women. • Migrant women may present poorer pregnancy outcomes, and higher frequency of abortions, caesarean sections, complications during birth, preterm delivery, infant and maternal mortality rates compare to non-migrant women. • sexual violence and exploitation, female genital manipulation, poor living conditions, poverty, the access to only "emergency care", the patchy entitlement to care throughout EU, linguistic barriers, cultural barriers, financial barriers to healthcare access, the inadequate antenatal care, bad experiences of maternal health services, lack of knowledge of migrant rights, failure to recognize and develop initiatives to help to treat or prevent comorbidities by healthcare providers, the absence of continuity of care are some of factors which affects the quality of migrant women's maternal health.	• Creation of well-designed policies covering all aspects of women's sexual and reproductive health by reaching out and educating immigrants, their families and communities. • Provide universal access to maternal care worldwide. • Simplification and standardization of medical administrative procedures to migrant women • Provide interpreters, other supportive services and information regarding the rights of migrant women to health care and a country's administrative procedures for the purpose enable migrant women to effectively navigate health systems. • Governments should develop cultural awareness programs among health workers to reduce discrimination, stereotypes and insensitivity counter to refugee women. • Health policy planning with cross-border information exchange on sustainable strategies to fund health care services for migrant women and their families. • Engage migrant women in health organizations in order to be improve the quality of care. • Staff training on topics such as cross-cultural communication, culturally

								sensitive care, and women's specific health risks in immigration. • Enactment of standardized and evidence-based quality indicators in all maternal health care facilities in order that enable continuous assessment of the quality of care.
10	Khanlou et al., (2017)	group of migrant women, with pregnancy/motherhood status, who were living in Canada (2000-216)	To explore access to health services and the related maternal health outcome.	scoping review	Canada	Philippines, India, Iran, Nigeria, Iraq, Syria, Columbia, Eritrea	• Most of the uninsured asylum-seekers and undocumented refugee women received inadequate antenatal care. • Linguistic barriers and low cultural sensitivity of antenatal care may interfere with existing guidelines. • Cultural factors are considered as a barrier to access to prenatal care both by health care providers and migrant women. • Canadian healthcare system can't often answer to women's cultural expectations and needs and as a result, these women are goaded into looking elsewhere for care. • Migrant women have a higher likelihood to develop prenatal depression than Canadian citizens. • Ascertained risk factors for antenatal depression include lack of social support, crowding, high spousal force, and poverty. • Migrant women rarely admit that had an experience of violence associated with pregnancy. • Risk factors for a violent experience include different cases such as being an asylum-seeker, living without a partner or	• Being elucidated the effects of ethnic and immigrant contributions on maternal health through comparative study designs involving immigrants and nationals with different identities, cultures and lifestyle characteristics. • Being attended to targeted interventions that can provide concrete evidence for scaling up maternal health programs, based on the translation of knowledge on nutrition, procedural and health practices, especially in the antenatal and postnatal period, when migrant women are most at risk. • Refugee mothers should engage in studies prior to actual data collection to inform study design (e.g. through participatory research approaches) or determine post-result relevance to different communities in order to disseminate results and being used in clinical practice to ensure that health care providers and policy makers understand how to personalize services to best meet the needs of migrant pregnant women.

							husband, living in Canada for less than 2 years, and not having a high school education. • Cultural status and socioeconomic factors contribute to the development of postpartum depression. • Factors that constitute barriers for migrant women during their pregnancy and antenatal observation, persist during the postnatal period too.	• Policies need to be developed to reduce the barriers and causes of poor maternal health, such as language needs, health skills and cultural influences. • Should increase opportunities for health care providers to improve cultural communication, especially for the subpopulation of immigrant women and their pregnancy needs related to personal, cultural and family needs. • Policies are needed that aim at a more inclusive model of obstetric care so that obstetric care providers and researchers can consider the multifaceted experiences and challenges of migrating pregnant women and their health implications. • Finally, the lack of current clinical practice guidelines cannot continue. Official providers need to adopt public regulation and establish clinical practice guidelines for the care of pregnant refugee women, similar to those for indigenous peoples.
11	Ozel S. et al., (2018)	76 Syrian refugees and 576 ethnic Turkish women, which was conducted between January 2015 and	analyze and compare obstetric and neonatal outcomes between Syrian refugees and ethnic Turkish women.	Retrospective, observational study (refugee group	Turkey	Syria	• The proportion of adolescents aged 12 to 19 years and pregnancies under the age of 18 was significantly higher among Syrian refugees. • The average pregnancy rate for Syrian refugees was significantly higher than for Turkish women.	

		December 2015 in Ankara, Turkey.		n=576 and control group n=576)			• Hemoglobin and hematocrit stages had been drastically decreased withinside the Syrian refugees than withinside the Turkish citizens. • Refugee group had a higher rate of uneducated women than Turkish women. • Rates of antenatal follow-up, double testing, triple testing, rapid gestational diabetes test, and iron replacement therapy were significantly lower in the refugee group. • Urgent births, the need for oxytocin induction, and meconium-stained amniotic glands were more common in the refugee group. • PPROM, and low birth weight (<2,500 g) were more common in Syrian refugees. • The proportion of newborns whose Apgar score was less than 7 at 1 and 5 minutes was significantly higher in the refugee group.	
12	Nicola Heslehurst et al., (2018)	migrant populations (migrant women, asylum seekers and refugees) including women with asylum seeker and/or refugee status (n= 27) along with	to summarise the perinatal health outcomes and care among women with asylum seeker or refugee status	29 reviews, quantitative & qualitative	Europe, USA, Canada	Middle East, Africa, Latin America	• higher risk of preeclampsia • postpartum depression is more common than in local pregnant women • almost double is the probability of low birth weight in contrast with local women • the risk of perinatal mortality is almost double compared to the local women • access to prenatal care is less feasible for immigrant women in relation to the native population	Current UK and Australian guidelines share the common recommendations. • Health professionals needing to understand the specific needs of these groups of women • A variety of means should be used to support women • There is a need to inform women of antenatal services and how to use them. • Healthcare commissioners should also

		women who had experienced domestic violence, minoority ethnic groups, travelling communities etc.						have a clear understanding of local needs so that appropriate services can be planned. Implementing these recommendations into practice and providing culturally specific training for health professionals have the potential to reduce some of these negative experiences for women and also for health professionals.
13	Jayaweera H. (2018)	asylum seekers, undocumented migrant women or refused asylum seekers, trafficked women, Roma women, EU migrants without health insurance card	examines women accessibility to health care services in England aiming to understand the relationship between migration and women health security.	article	England	not specifi ed	• Healthcare policies in England don't take assailable women's requirements and status into consideration in order that be assured their health security. • there aren't grouped data on the basis of gender vulnerability but policy delegation can cover encroachment on rights in health services. • Providers in voluntary organizations achieve to identify and contend better the health insecurities of frail migrant women albeit the fact that they must counteract barriers like bad interpreting migrants' special needs in health provision and increasing full of hatred policies about migrants' healthcare rights.	For migrant women's human rights, skills and needs to be fully realized in host societies, there is a need to review existing service pathways and interventions and develop new health and social policies that address multiple intersecting concerns.
14	Crotti et al., (2019)	migrant women, health care assistants, nurses, midwives and gynecologists	explores if and how labeling and apprehension of maternity care in refugee and migrant	ethnogra phic case and qualitati	Greece, Spain, Italy	Syria, Afgani stan, Middl e	• Healthcare workers confront challenges attendant with a) migrants' differences from citizens as a result of the bad circumstances during their journey, b) lack of medical files, and c) request for all-	

			women like an emergency in context of alleged crisis creates new conventions of care within healthcare delivery.	ve research		Eastern and African countries	embracing care. • The acceptance of specific circumstances which are presented in the population of migrants and refugees, don't seem to create musing or planning how to adjust medical assistance.	
15	Henry J et al., (2019)	Refugee pregnant women and mothers in Germany (12 Arabic-speaking women from Iraq and Syria and with one Palestinian woman, who had lived in Syria)	Examine how pre-migration experience, beliefs about pregnancy and childbirth, health literacy, and language skills influence health care access, health care experience, and childbirth	qualitative research	Dresden, Germany	Iraq, Syria, Palestine	• Comprehension of needing health care, is essential for healthcare access and pursuit of health care. • Notion and knowledge about the pregnancy period, labor and postpartum period affect the consequential actions and behaviors. • The necessity of health care is affected by both women's level of health literacy and their premigration experiences, which have an effect on health-seeking. • Low levels of health literacy and premigration experiences can admit refugee women to stressful conditions. • Low level of health literacy, premigration experiences, and inadequate information related to the right time for health care looking admitted to belated health care provision and negative health outcomes which compromised the health of refugee women or/and their babies. • Religious and cultural notions can admit to not searching for health care or to	• To ensure access to appropriate medical care, paid interpreters should be used in all health care facilities to facilitate communication between pregnant refugees and their mothers and health care workers. • It is clear that obstetric care should tailored to the specific needs of pregnant refugees and mothers and is critical to ensuring access to appropriate medical care.

							believing that health care is inadmissible and inadequate. • Linguistic barriers and economic self-sufficiency of women affect healthcare use. • Successful interplay between refugee women and healthcare providers affects the quality of healthcare. • Refugee women have the same rights in healthcare access as German citizens during pregnancy, childbirth, and puerperium but in reality, there isn't parity among them as the hands of linguistic barriers and bad communication skills between healthcare providers and refugee women.	
16	Bissonnette A. (2022)	undocummented migrant women in Arisona and Texas.	To analyze the impact on undocumented migrant women's physical health, addressing preventive and emergency care and reproductive and sexual healthcare. To address the impact of that intersection on women's psychological health, assessing how these policies, when	paper	Texas, Arizona	not specified	• The Border is a limitation instead a zone of a golden opportunity, which coupled with policies, develops a multilayered caging situation. • This cage afflicts undocumented women's health, preventive care, reproductive healthcare, and phycological health. • The compound of immigration laws and health care laws afflicts undocumented migrant women in specific ways.	

			combined, worsen the impacts of past traumas and create new ones while restricting access to psychological services					

Discussion

Policies on the provision and funding of health services for refugees can affect access to and quality of care. (Winn et al., 2018) From research and programs that have been implemented in the European Union such as ORAMMA or CARE, we notice that the health protocols not only do not apply absolutely to refugees but also differ from country to country. Some European countries apply more and some fewer health protocols, but none of them apply them faithfully. The large number of immigrants, the entry gates that each country has, the host country, and the health system that applies, the lack of health personnel and interpreters make the implementation of health protocols difficult. (CARE, 2017; Fair et al., 2021) Midwives and other health care professionals should consider that some of these women may experience domestic violence and controlling relationships with family members that are used as mediators for communication. This has been identified as preventing women from getting the care they need and impacting their and the fetus's health. Accordingly, HCPs should not involve relatives or husbands for interpretation because of confidentiality issues that may have a negative impact on the women (Jenny Phillimore et al., 2010). In addition, migrants often live isolated with limited social networks and a lack of support from family. These factors often result in misunderstandings, decreased confidence, and insecurity (Boerleider et al., 2015). To help these women, barriers must be tackled, and this could be achieved by offering social support in order to decrease the feeling of isolation and unhappiness. (McLeish & Redshaw, 2017)

The planning and delivery of health and social care services should be informed by the needs of migrant mothers and local communities, ultimately, leading to greater integration. (Fair et al., 2021) To address social determinants of health and avoid discrimination against immigrant women, it is demanded that people-centered, high-quality, continuum care that includes aspects of care that recognize cultural competence and trauma. (Fair et al., 2020) Culturally appropriate services may be helpful to motivate women's utilization of maternity care (Jenny Phillimore et al., 2010).

Recommendations, Policies, and Gaps.

Health care is a fundamental human right and should be accessible to all, (Keygnaert et al., 2016) so universal access to health care, regardless of legal status, is critical to a health care plan. (HUMA, 2010) It is also very important health systems to recognize the vulnerabilities of specific individuals or groups of individuals as illegal immigrants and asylum-seekers and provide access to adequate health care for them. (HUMA, 2010) Underneath, related recommendations to asylum-seekers' access in health system are cited:

- Existing legislation should not be merely theoretical but should be fully implemented in practice, (HUMA, 2010) especially policies which promote an integrated maternity model of care, benefiting maternity healthcare providers, pregnant migrant women, and their maternal health. (Almeida et al., 2013; Khanlou et al., 2017) It's important to be reviewed existing service pathways and interventions and develop new health and social policies that address multiple intersecting concerns. (Jayaweera, 2018)
- Informing asylum-seeking women about their right to access health care

should be adequate and effective, and they should also be informed about the ways in which they can receive health care. (Almeida et al., 2013; Heslehurst et al., 2018; HUMA, 2010; Keygnaert et al., 2016; Khanlou et al., 2017)

- Providing course materials, tutorials, and educational films about labor, delivery rooms, pain management, the importance of prenatal and postnatal visits, the use of interpreters, and services they can receive from providers and hospitals and implementing a system to remind refugees of prenatal appointments to increase refugee women's doctor visits, (Herrel et al., 2004; Keygnaert et al., 2016) and generally, increase opportunities to improve cultural communication by health providers. (Almeida et al., 2013; Khanlou et al., 2017)
- Health professionals also need to be fully informed and properly trained to be able to meet the needs of refugee women, (HUMA, 2010; Heslehurst et al., 2018) avoiding stereotypes and not only respect but also consider traditional or cultural practices related to the perinatal period (Fair et al., 2020; Henry et al., 2019; Herrel et al., 2004; Keygnaert et al., 2016; Khanlou et al., 2017) and sexual health. (Keygnaert et al., 2014)
- All public health care facilities should have interpreters to enable health care providers to communicate with asylum-seeking women (Almeida et al., 2013; HUMA, 2010; Keygnaert et al., 2016; Khanlou et al., 2017) and develop a friendly and trusting relationship with them. (Fair et al., 2020; Henry et al., 2019)
- Access to examinations and treatments that are not available from public services should be possible. (Almeida et al., 2013; HUMA, 2010)
- Provide universal access to maternal care worldwide. (Keygnaert et al., 2016)
- It is necessary to address he special mental health needs of refugee women, (HUMA, 2010) and also their emotional and economic issues. (Fair et al., 2020) It is required interagency work alongside culturally competent and trauma-based models of obstetric care that incorporate continuity. (Fair et al., 2020)
- It is crucial for refugee women to be allowed to provide feedback about their experiences during labor or treatment, offering information for research and a change for the better. (Herrel et al., 2004) Furthermore, it is useful that migrant women engage in health organizations in order to be improve the quality of their care. (Keygnaert et al., 2016)
- Creation of integration policies which will increase the participation of immigrant communities in the lives of host societies and reducing the stress and discrimination they may face. (Bollini et al., 2009)
- Governments must address the lack of clinical guidelines, (Keygnaert et al., 2016) and healthcare providers should establish official provisions and practice guidelines for migrants' maternal care, (Keygnaert et al., 2016) which should be similar to those for the indigenous population. (Keygnaert et al., 2014; Khanlou et al., 2017)
- Enactment of standardized and evidence-based quality indicators in all maternal health care facilities in order that enable continuous assessment of the quality of care. (Keygnaert et al., 2016)
- Engage in studies that robust evidence on perinatal clinical outcomes for immigrant mothers and investigating the needs of different immigrant populations to facilitate the development of personalized interventions, (Fair et al., 2020) and programs that based on translating knowledge about

procedures, principles of healthy eating, and health practices during antenatal and postpartum periods. (Heslehurst et al., 2018; Khanlou et al., 2017)

In relation to undocumented immigrants' access to health care:

- Access to health care must be accessible to all. (HUMA, 2010)
- Reporting undocumented immigrants by health care providers should be prohibited so that these people are not afraid to seek health care. (HUMA, 2010)
- Pregnant women should have free and full access to health care: perinatal and Childbirth care must be provided unconditionally to all women and babies. (HUMA, 2010)
- Free gynecological examinations should be provided. (HUMA, 2010)

In conclusion, various voluntary organizations made recommendations regarding vulnerable migrant women and refugees and their rights. These recommendations agree with literature in many stances as collecting data by gender on migrants, allocating healthcare services in primary care sensitive to women migrants, providing language support, preventive and mental healthcare, service development for migrant and refugee communities, and suggestions for vulnerable migrant's maternity care and promoting complementary education in detecting and handling gender-based violence incidents and the fact that it is important to avoid interventions on migrant women without their consent. Many of these recommendations still need to be implemented in policy or healthcare services. (Jayaweera, 2018)

By implementing these recommendations, will be ameliorated the way that is addressed the challenges faced by migrant women in accessing maternal healthcare services and their overall maternal health outcomes. (Khanlou et al., 2017) This comprehensive approach can help ensure that these vulnerable populations receive the support they need during their pregnancy and postpartum periods, ultimately contributing to better health outcomes for mothers and infants. (Khanlou et al., 2017)

Limitations

The fact that there is lack of data about undocumented refugee women in contrast to legal refugee women is one of study's limitations. It should also be emphasized that these people, most of the time, under the fear that they may be persecuted and trying to remain invisible make it difficult to contact them, with the result that the samples of the studies are not completely representative. Furthermore, the absence of shared benchmarks regarding migration origin and the lack of consistent data collection on maternal well-being pose challenges when attempting to draw comparisons between nations and migrant subpopulations. Although there is restricted evidence, various suggestions are accessible for enhancing the health of migrant mothers through policies and practices. Several obstacles to obtaining healthcare were frequently emphasized, such as availability of access and knowledge thereof, linguistic difficulties, and differences in cultural communication and expectations. This evidence are steps towards enhancement in both information gathering and medical assistance. To conclude, due to the limitations of existing statistical data and audits, it is not possible

to determine the exact differences in access to prenatal health services and maternal mortality and morbidity between migrant women and the host population across Europe. Last but not least, healthcare policies may be changed and that depends on multiple factors such as: the rate of immigration, the economic situation and the foreign policy of a country.

Conclusions

This systematic review based on systematic reviews, qualitative and quantitative researches with the aim of proving that pregnant refugee women, asylum seekers and irregular women receive less quality or inadequate perinatal care due to the fact that health protocols implementation is not strictly adhered to and of course facing more frequent problems of perinatal health, preterm birth, low birth weight, mental health, both of the offspring and of the mother etc. More research and to a greater extent are required, as well as an understanding of the reasons for these differences. It should also be emphasized that these people, most of the time, under the fear that they may be persecuted and trying to remain invisible make it difficult to contact them, with the result that the samples of the studies are not completely representative. Absolutely related to poverty and the hopeless living conditions, the lack of information about the rights but also the fear of expulsion and the insecurity of what they will find themselves in tomorrow aggravate a particularly difficult situation. Also, pregnant women no matter which category they belong to, immigrants, asylum seekers, irregular immigrants, or the local population are a vulnerable group that needs special treatment, living conditions, and health care so that they and the fetus as a whole are as safe as possible the duration of pregnancy and childbirth. Unfortunately, the aforementioned reasons as well as racism, xenophobia, and the lack of adequate information and health providers make perinatal care for immigrant women unequal in relation to the local population, as well as the dangers to which they are exposed due to this inequality. So, it demonstrably is seemed, health protocols and healthcare policies to be important and should be used without differentiations and inequalities.

Suggestions

It will advisable that more research is required about the obstacles faced by refugee women in accessing health services. Furthermore, each country should establish health policies for the refugee women population by identifying their needs in conjunction with the state's health system and its resources. Finally, it is important to provide feedback on the received health services by refugee women with a view to improving both health services and maternal health outcomes.

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